Public Engagement in Healthcare Policy Formulation:
Contexts, Content & Identity Construction

DISSERTATION

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Abstract

Background: The passage of the federal Patient Protection and Affordability of Care Act (PPACA) has forced a renewed discussion of the appropriate cost, coverage, and organization of health insurance at the state level. In attempting to address the federal requirements public officials must grapple with complex, technical and politically treacherous issues. In order to address these demands, institutions may find that citizen engagement in the decision process is especially useful.

Research Questions: First, what are the various contexts within which citizen participation in policy design might and might not occur? Second, when, how and in what ways do citizens speak about healthcare policy specifically? When citizen input is provided, how do officials interpret input from the various sources available? How does the traditional dominance of expertise in healthcare interact with the demands for consumer control? Finally, how do citizens—especially women—claim legitimacy as stakeholders in health policy discourse? How does this compare to previous generations or other arenas of policy discussion?

Methods: First, this dissertation introduces a typology of contexts for participation. The typology informs theory and practice and is drawn heavily from the literatures of political science and public administration. It is then supported empirically through application to
a sample of case studies already in these literatures. This dissertation then utilizes a case study approach to investigate the application of participatory processes to healthcare. The state of Oregon is seeking to include citizens in the decision-making process as they set about to meet the requirements of the new federal health care laws. Utilizing content analysis of town hall meetings and interviews with decision-makers this research investigates the qualities of citizen participation, including in what ways citizens speak about health care and how officials interpret this input given the highly expertise dominated nature of the discussion.

Implications: The typology of this dissertation provides numerous implications for participation scholars; it suggests directions for future research and indicates new potential for utilizing research that has already been conducted. The Oregon case study of participation similarly suggests new avenues of research. This case was chosen because it is in an area in which the outcomes are typically highly technical and expert driven. Yet, it is also one of many areas in which citizens are demanding more control. This implies a discussion that not only must attend to a complex and technical subject matter but also to the rich, value-laden nature of the decisions to be made. The case study approach makes it possible to identify the mechanisms for navigating these multiple, coinciding conversations and the results thereof. Finally, this research suggests new trends in how women participate in healthcare discourse. The findings suggest that concerns about the representativeness of participants should remain a part of the bureaucratic consciousness.
Caution regarding who participates and how remains necessary in order to avoid the risk of process capture by those who already retain power.
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Fields of Study

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Chapter 1: Introduction

Public Participation in American Politics

Among the five criteria that Dahl uses to define democracy the first is “equal and effective participation” (Dahl, Robert, 1998). Yet, thirty years earlier Dahl had argued that the majority of citizens are “homo civicus” rather than “homo politicus,” (i.e., unwilling or unable to participate in political activity [Dahl, Robert, 1961]). Furthermore, he recognized that the resources necessary for mobilization are unequally distributed in society (Dahl, Robert, 1961). Despite Dahl’s conclusions about the limited amount of participation in 1950’s New Haven, CT, few would argue that the community—or the nation in which it is situated—isn’t a democracy. What then is the meaning of “equal and effective participation”?

This question has been the focus of much criticism of liberal democratic theories of society (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005; Ackerman, Bruce, 1989). A normative theory of liberal democracy that envisions policy and public administration as primarily concerned with making acceptable compromises that secure basic economic freedoms is complicated by the empirical reality of unequal voice and representation in crafting such policy (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Seidenfeld, Mark, 1992). Thus, how bureaucracy has attempted to address the unequal power
dynamics of society is the focus of alternative theories of democracy such as republicanism (Seidenfeld, Mark, 1992; Chan, Hon S. & Rosenbloom, David H., 1994; Rosenbloom, David, 2007) and deliberative democracy (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005; Bohman, James F., 1997; Dryzek, John S., 2001; Fishkin, James & Laslett, Peter, 2008; Lipkin, Robert Justin, 1994; Neblo, Michael, 2005). The answer to the question of what is the functional meaning of “equal and effective participation” has changed drastically over time.

Early Theories of American Public Administration and Democracy

Initially, institutions did not heavily rely upon direct citizen input (Weber, Max, 1946; Seidenfeld, Mark, 1992; Chan, Hon S. & Rosenbloom, David H., 1994; Rosenbloom, David, 2007). The orthodox approach to public responsibility believed that Hamilton’s “due dependence on the people” was achieved through acting upon the expressed will of the legislature (Weber, Max, 1946; Hamilton & Madison, 1788). Similarly, the representatives of the people were considered responsible for ensuring that the administration did not act irresponsibly (Wilson, Woodrow, 1887; Chan, Hon S. & Rosenbloom, David H., 1994; Rosenbloom, David, 2007). This “transmission belt” model of public administration limited the discretion of bureaucrats to the minimum rule making necessary to enact legislative statutes (Reich, Simon, 2000; Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Seidenfeld, Mark, 1992; Seidenfeld, Mark, 1992; Chan, Hon S. & Rosenbloom, David H., 1994; Rosenbloom, David, 2007). “Equal and effective participation” was indirect, through the activity of
elected representatives. It was widely believed that over reliance upon the public will would create massive inefficiencies (Chan, Hon S. & Rosenbloom, David H., 1994; Rosenbloom, David, 2007; Goodnow, Frank, 1900). Furthermore, when the inefficiencies of politics created an inability to act, the credibility of administration would suffer (Goodnow, Frank, 1900; Weber, Max, 1946). It was not until the middle of the nineteenth century that the value of this model of bureaucratic administration began to come into question and was gradually worn away by the increasing size and complexity of administrative responsibility (Seidenfeld, Mark, 1992; Habermas, J. & Rehg, William, 1996).

The Great Depression and resulting social programs of the New Deal created more responsibility and complexity than the orthodox theories could account for (Habermas, J. & Rehg, William, 1996; Seidenfeld, Mark, 1992). The question of accountability and effective participation was then addressed by CJ Friedrich and Edward Mason in 1940 (Friedrich, CJ & Mason, Edward, 1940). Much like Hamilton (Hamilton & Madison, 1788), the authors suggested that motivating administrators to act responsibly relies to a great extent upon securing labor rights for public employees (Friedrich, CJ & Mason, Edward, 1940). However, the role of the public in creating administrative responsiveness suggested by Friedrich and Mason was quite different than previous authors had suggested. In contrast to orthodox theories that relied upon the ability to identify a single public will (Wilson, Woodrow, 1887c; Weber, Max, 1946), Friedrich and Mason argue:
At best, responsibility in a democracy will remain fragmentary because of the indistinct voice of the principal whose agents the officials are supposed to be—the vast heterogeneous masses composing the people. Even the greatest faith in the common man (and I am prepared to carry this very far) cannot any longer justify a simple acceptance of “the will of the people.” (Friedrich, CJ & Mason, Edward, 1940)

Because there is no universal public will, hierarchy alone cannot hold administration accountable (Friedrich, CJ & Mason, Edward, 1940). Therefore, Friedrich and Mason suggested the use of “citizen participation.”

Friedrich and Mason’s conceptualization of citizen participation is limited to referenda and congressional contact via letters. Nonetheless, the idea that direct citizen input is necessary due to the absence of a universal public will sparked the start of both the decentralization and public participation debates.

**Deliberation in Democracy**

In contrast to liberal democratic theories of democracy, republican and deliberative theories recognize that the growing demands for government action require a theory of governance beyond protection of basic limited rights (Habermas, J. & Rehg, William, 1996; Iverson, T & Soskice, D, 2001; Neblo, Michael, 2005; Seidenfeld, Mark, 1992; Ackerman, Bruce, 1989; Vargova, Mariela, 2005; Bohman, James F., 1997; Dryzek, John S., 2001; Fishkin, James & Laslett, Peter, 2008; Lipkin, Robert Justin,
1994). In republican conceptions of governance, legitimacy to act is delegated to representatives based upon the expressed socio-political will of the populace (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Seidenfeld, Mark, 1992). Representatives of the populace are not just the elected officials, but also the communities that arise out of socio-political preferences (Seidenfeld, Mark, 1992). In this manner, republican theories of democracy overcome some of the collective action problems that plague liberal democratic theories (Habermas, J. & Rehg, William, 1996; Ackerman, Bruce, 1989; Seidenfeld, Mark, 1992).

Nonetheless, republican democracy continues to struggle with the unequal power within and between socio-political communities (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005). Deliberative democracy on the other hand, recognizes these inequalities and suggests that they are best remedied through ongoing political discourse (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994; Vargova, Mariela, 2005; Bohman, James F., 1997; Cohen, Joshua, 1989; Dryzek, John S., 2001; Fishkin, James & Laslett, Peter, 2008; Lipkin, Robert Justin, 1994; Neblo, Michael, 2005). While discourse is also subject to power relations, deliberative theorists suggest that attention to procedural justice—the rules that are applied to all people involved in the same manner regardless of their resources and background and which are not themselves subject to deliberation—should mitigate these conflicts (Neblo, Michael, 2005; Lipkin, Robert Justin, 1994; Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005; Ackerman, Bruce, 1989). Additionally, the goal of participation in
deliberation is to arrive at consensus rather than compromise, which makes control of the agenda through power more difficult than in other forms of governance (Ackerman, Bruce, 1989; Vargova, Mariela, 2005; Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Bohman, James F., 1997; Cohen, Joshua, 1989; Dryzek, John S., 2001; Fishkin, James & Laslett, Peter, 2008; Lipkin, Robert Justin, 1994; Neblo, Michael, 2005).

In the majority of these theories, however, because the purpose of citizen participation is to address legitimacy and responsiveness issues, certain types of citizen engagement are considered illegitimate. Participation that is outside the context of regular, institutional forms of policy change is not considered by these scholars as “valid” citizen participation (Allport, Gordon, 1960; Ackerman, Bruce, 1989; Vargova, Mariela, 2005; Seidenfeld, Mark, 1992). As Allport (1960) reported, strikes, boycotts and other forms of disruptive engagement are signs of deficient constructive outlets for engagement. These disruptive acts may result in policy change, but only reactively rather than constructively through ongoing engagement (Allport, Gordon, 1960).

Reconciling Conflicting Demands and Information

Whether it is through disruptive or “valid” participation, however, institutional representatives must constantly navigate how to reconcile traditional information pathways of reliance on expertise with the growing desires for accountability (Behn, Robert, 2001; Simonsen, William & Robbins, Mark D, 2000; Fischer, Frank, 1990; Fuller, Steve, 2008; Morone, JA, 1998). Expertise holds particular power in policy
development and implementation because it provides seemingly clear metrics to which administration can be held accountable (Taylor, Frederick W., 1911; Fischer, Frank, 1990; Behn, Robert, 2001; Reich, Simon, 2000). Accountability in administration has traditionally meant just such procedural accountability (Behn, Robert, 2001). Following the rampant corruption, incompetence and abuse of power brought about by the spoils system in the 19th century, legislators, the public and all those concerned with the future of administration saw it as necessary to ensure that officials had clearly articulated guidelines that could be enforced by those in positions of power both inside and outside the bureaucracy (Finer, Herman, 1941; Wilson, Woodrow, 1887; Taylor, Frederick W., 1911).

In contrast, modern concerns about accountability are less about procedure and more about outcomes and performance (Behn, Robert, 2001; Simonsen, William & Robbins, Mark D, 2000; Fischer, Frank, 1990). As the complexity and scope of situations handled by government has continued to grow, there has been an increasing need for those with experience handling such situations to develop and implement policy (Fischer, Frank, 1990). At the same time, there has been an increasing demand for citizen and stakeholder control of decision-making (Arnstein, SR, 1969; Carrell, Jeptha J., 1969; Morone, JA, 1998; Haider, Donald, 1971; DeSario, Jack & Langton, Stuart, 1987). Such calls for lay-person involvement have been heightened as technology has made information more accessible (Stehr, Nico, 2008; Fuller, Steve, 2008). This increased access to previously exclusive knowledge has led many people to question the authority and credibility of experts (Cohen, Joshua, 1989; Dryzek, John S., 2001; Hunter, Nan D.,
2008; Fischer, Frank, 1993; Turner, Stephen, 2008). However, citizen involvement poses many challenges to administration, not the least of which is who can and should speak on any given topic. Institutions are now attempting to navigate policy formulation in a world in which “expertise” is constantly in question.

*Establishing Legitimacy in Deliberation*

Expertise is, like all categories, socially defined. As such, it is political and subject to debate (Fischer, Frank, 1990; Fischer, Frank, 1993; Deborah, Stone, 2002; Berger, Peter & Luckmann, Thomas, 1966; Dryzek, John S., 2001). Especially as our society has transformed from a primarily “material” one to an “informational” one, expertise has become both more valued and less certain (Fischer, Frank, 1990; Outhwaite, William, 1994). There has been growing recognition that often those people who are “on the ground” or who have “skin in the game” have a better sense of the implications of policy than more traditionally qualified individuals (Fischer, Frank, 1990; Fischer, Frank, 1993; Morone, JA, 1998; Meek, Roy L. & Wade, Larry L., 1976). The role of the expert has shifted from the absolute knower of truth and “mediator” of power to a “facilitator” of dialogue, and there is a growing recognition of a variety of types of expertise that can be drawn upon to construct and implement policy (Fischer, Frank, 1990; Simonsen, William & Robbins, Mark D, 2000; Dzur, Albert, 2008; DeSario, Jack & Langton, Stuart, 1987).

The traditional *bureaucratic expertise* of Weber (1946) is articulated through agency representative and government consultant activity. It is frequently used to heavily
inform budgetary and legal questions. In contrast, *scientific-technical expertise* (Taylor, Frederick W., 1911) may be found both inside and outside the bureaucracy. In either case, however, those with scientific-technical expertise have education and experience that set them apart as professionals in the area of concern. More frequently in modern policy development, however, policymakers are now tapping into the knowledge of those who do not have the formal credentials that distinguish bureaucratic or scientific-technical experts. These citizens or stakeholders may or may not have tangentially related and specific experience that is nonetheless useful to a particular policy discussion. Figure 1 represents this concept.

![Figure 1. Types of Expertise](image)
When and where each type of expertise should be used by bureaucratic decision-makers is still unclear and subject to substantial debate. For instance, Turner (2008) suggests that today the appropriate arena of action for rational bureaucratic or scientific-technical expertise is solely in the realm of regulatory policy. Those policies concerning controversial technology, priority setting, and municipal or public work policy are arenas in which discourse facilitated by expert information is more appropriate (Rosenberg, Shawn W., 2007; Turner, Stephen, 2008; Fox, C & Miller, H, 1995). Similarly, Kweit and Kweit suggest that public opinion is most appropriate when used in determining resource allocation (Kweit, Mary & Kweit, Robert, 1987). However, public opinion on this issue without expert guidance has been shown to be inconsistent and problematic (Davies, Celia, Wetherell, Margaret, & Barnett, Elizabeth, 2006; Simonsen, William & Robbins, Mark D, 2000; Lupton, Carol, Peckham, Stephen, & Taylor, Pat, 1998; New, Bill, 1997; Charles, Cathy & DeMain, Suzanne, 1993). Instead, it is suggested that experts and consumers ought to be involved in a discourse about the dynamics of policy choices (Fischer, Frank, 1993; Simonsen, William & Robbins, Mark D, 2000; Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Fox, C & Miller, H, 1995; Dryzek, John S., 2001; Fishkin, James & Laslett, Peter, 2008).

Discourse, however, is filled with potential paradoxes (Deborah, Stone, 2002). During the process of discussing policy several types of claims can emerge: hermeneutic claims concern questions of interpretation; theoretical-empirical claims concern factual
statements; and practical claims concern normative matters about application (Outhwaite, William, 1994). These claims play out through the evocation of a variety of discursive tools. The number of discursive mechanisms for establishing legitimacy in policy is potentially infinite. However, they can largely be grouped into three categories: goals, problems, and solutions (Deborah, Stone, 2002).

Political and policy goals most often involve attempts to ensure equity, efficiency, security, and/or liberty (Deborah, Stone, 2002). The interpretation of these goals, however, is frequently contested (Deborah, Stone, 2002; Fischer, Frank, 1990) and they are often found to be in conflict with one another (Deborah, Stone, 2002; Behn, Robert, 2001). For instance, equity and efficiency are often conceived of in ways that make them mutually exclusive, and the same is often true of security and liberty. While goals are often conflicting and mutually exclusive, problem definition may utilize a mix of symbols, numbers, causes, interests and decisions (Deborah, Stone, 2002). Discourse around goals and problems is often hermeneutic and empirical-theoretical, concerned with establishing agreed upon interpretations and the veracity of facts (Deborah, Stone, 2002). Solutions discourse adds a layer of complexity by also frequently relying upon practical claims about how to apply the appropriate mix of inducements, rules, facts, rights, and powers (Deborah, Stone, 2002). All of these types of policy discourse involve some hermeneutics as participants work to establish shared understanding of the interpretations of these issues. As Deborah Stone (2002, pg 379) observes, “What communities decide upon when they make policy is meaning, not matter.”
Dangers of Discourse in Policy

A substantial body of work has developed in political science that investigates the prerequisites and characteristics of individual involvement in political participation (Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Eliasoph, Nina, 1998; Dekeyser, Luc, 2001; Larsen, Jorgen Elm, 2005; Berelson, Bernard, Lazarfeld, Paul, & McPhee, William, 1954; Dione, EJ, 1991; Rao, Nirmala, 1998; Neblo, Michael A., Esterling, Kevin M., Kennedy, Ryan P., Lazer, David MJ, & Sokhey, Anand E., 2010; Lijphart, A, 1997; Wang, CC & Burris, M, 1994; Xu, Qingwen, 2007; Hetherington, Marc J, 1996; Meehl, Paul, 1977; Hetherington, Marc J, 1996). This research highlights how demographic variables and societal influences—such as religion or union membership—heavily influence who participates and, thus, can feed biases in policy processes and outcomes. Minorities, individuals with lower education, and those with lower income tend to be less likely to participate in political activity (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960).

Furthermore, they are less likely to feel like their participation is efficacious whether they are actively engaged or not (Meehl, Paul, 1977; Daly, M & Silver, H, 2008; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001).
Such uneven patterns of participation result in much institutional confusion about what the “maximum feasible citizen participation” required by some laws really means (Rubin, Lillian, 1969; United States Congress, 1972). Despite the strong language used in both domestic and international statutes, communities have continued to struggle with how to actually achieve “equal and effective participation” in the face of the growing recognition that the resources required for participation are unevenly distributed (Dahl, Robert, 1961; Mueller, DC & Stratmann, T, 2003; Lijphart, A, 1997). This unequal participation is of particular concern to proponents of citizen participation because it results in a high risk of capture (Lijphart, A, 1997; Mueller, DC & Stratmann, T, 2003).

Citizens of the United States respond fervently to rhetoric about democratic accountability despite relatively low voter turnouts and little actual participation (Mueller, DC & Stratmann, T, 2003; Morone, JA, 1998; Putnam, Robert, 2001; Behn, Robert, 2001). The result of an open democratic system with little actual participation is a high risk of class bias and capture (Mueller, DC & Stratmann, T, 2003; Lijphart, A, 1997a). The purpose of capture is to ensure that policies resulting from the democratic process serve primarily the interests of those in power, usually the socioeconomic elite (Mueller, DC & Stratmann, T, 2003; Lijphart, A, 1997). Participatory structures that do not seek to safeguard minority interests or fully involve some segments of the population will experience class bias resulting from this capture (Morone, JA, 1998; Mueller, DC & Stratmann, T, 2003; Lijphart, A, 1997). The bias resulting from capture can be especially prevalent and damaging in healthcare policy, in which subtle unconscious biases against
the elderly and disabled can become mobilized in unfair ways (DeSario, Jack & Langton, Stuart, 1987).

**Contributing to the Discourse**

This dissertation investigates how discourse plays out in the administrative context. As citizen engagement and deliberative democracy continue to be used to tackle the “wicked problems” of public policy (Fischer, Frank, 1993; Head, BW, 2008), understanding how citizens participate and discuss policy will be ever more important. Thus, this dissertation reviews two very broad research questions: first, how do institutions resolve the tensions inherent in participation; and second, what is the value-added of citizen participation in policy formulation?

*How do institutions resolve the tensions of participation?*

Tensions involved in participation include the balance between citizen and expert input, speed versus thoroughness of process, and access versus representation (Simonsen, William & Robbins, Mark D, 2000; Dryzek, John S., 2001; DeSario, Jack & Langton, Stuart, 1987; Feingold, E, 1977; Kweit, Mary & Kweit, Robert, 1987; Lijphart, A, 1997; Rosenberg, Shawn W., 2007). Expertise may conflict with citizens or may even demonstrate that what citizens express a desire for is also something that they have demonstrated that they don’t actually want (Fischer, Frank, 1990; Simonsen, William & Robbins, Mark D, 2000; Lupton, Carol, Peckham, Stephen, & Taylor, Pat, 1998). Working through the conflicting information may significantly slow decision-making,
which is often not desirable and will also cause public backlash (Tritter, JQ & McCallum, A, 2006; Simonsen, William & Robbins, Mark D, 2000). However, participation processes that are seen as disingenuous or inaccessible by the public create similar backlash (Fischer, Frank, 1990; Behn, Robert, 2001; Morone, JA, 1998). A completely open process though holds the risks of capture and policy slippage (Lijphart, A, 1997; Tritter, JQ & McCallum, A, 2006; Mueller, DC & Stratmann, T, 2003). Given the complex nature of using public participation and the numerous potential forms of engagement, then, there is a need for a conceptual framework to clarify under what conditions which types of participation are likely and stable (Rowe, Gene & Frewer, Lynn J, 2005).

Chapter 2 investigates under what political contexts agencies are likely and able to engage in sustainable participation efforts. In order to do so, this chapter draws heavily from the separate but inter-related literatures of political science and public affairs in order to identify the contributing factors of participation at the individual and institutional levels. The resulting review of the literature constructs a new typology of contexts. This typology furthers our understanding of the environments that foster or hinder meaningful policy discourse. Additionally, it suggests new approaches to future research, such as an emphasis upon contingent effectiveness investigation.
What is the value-added of citizen participation?

As the first question and its related typology suggest, participation patterns are heavily contextually dependent. Therefore, answering this question requires specification of the context and policy area to be examined.

Healthcare is a particularly poignant example of how citizens might engage in policy because it is a traditionally expertise-dominated field. Yet, it is also a field that has profound impacts on many average citizens and it is a topic about which everyone has some knowledge or experience, however limited. Understanding the potential value-added from participation, then, first requires an understanding of how healthcare politics is similar to and distinct from other arenas of policy with regards to expertise and public participation.

Expertise in Healthcare

Prior to World War II much of healthcare was localized and private. States provided regulation of licensure for physicians and the American Medical Association (AMA) Code of Ethics and the American College of Surgeons (ACS) imposed rules regarding fees (Stevens 2006). Care for the poor, elderly, and indigent was left largely to private charitable hospitals sometimes supported by state or local funds (Thompson, Frank J., 1981; Rosenbaum, Sara, Frankford, David M., Moore, Brad, & Borzi, Phyllis, 1999). Healthcare was almost exclusively a matter of personal business carried out between the patient and physician. There was little conflict between professional expertise and citizen opinion as healthcare provision was not a topic for public policy.
However, conflicts about access, quality, and cost of care throughout the twentieth century would see this change dramatically.

In the first decades of the twentieth century, concerns about the certification of physicians prompted the Carnegie Foundation for the Advancement of Teaching to commission research on the status of medical education in the United States (Stevens 2006; Flexner, Abraham, 1910). The newly formed AMA worked closely with the researcher, Abraham Flexner, to rate all existing medical programs (Flexner, Abraham, 1910). As a result of the report’s findings, widespread reform led to the establishment of accreditation processes and highlighted the role of the AMA as a private driver of social policy (Stevens 2006). While not yet involved in national legislation efforts, this activity established the AMA as a legitimate voice in healthcare regulation, which was heeded by state licensure boards throughout the country.

Moreover, the report’s focus on the vast variations in scientific and clinical practice spurred the efforts of medical specialization groups into forming similarly powerful organizations. Prior to the Flexner investigation, a physician could legally establish himself as a specialist in anything from dermatology to surgery with no experience or education to support the claim (Stevens 2006; Ziesler 1901; Reid 1908). Three years after the report, the American College of Surgeons was formed to create the first certification standards for specializations (Stevens 2006). The group was also active in the earliest efforts of hospital standardization and modernization, and would eventually spawn the Joint Commission on Healthcare Organizations to oversee the accreditation of
hospitals (Stevens 2006). By the end of the 1930’s, twelve of today’s twenty-four specialty certification boards had been established (Stevens 2006).

This early activity established a new perception of the medical field in the public eye: they were effective self-regulators and, because of their accreditation and licensing, they were legitimate scientific-technical experts on healthcare policy. As in early public management scholarship, accountability was believed to be best supported by the appropriate application of this expertise. This perception would be crucial in the coming decades as the AMA and other established medical groups would leverage calls for “accountability” to serve their interests (Morone, JA, 1998).

Conflicts with Healthcare Expertise in Policy

During this same period of time, insurance schemes began to develop (Thompson, Frank J., 1981; Morone, JA, 1998). These policies were typically very small, meant as catastrophic coverage of hospital admissions and surgeries, rather than general care (Morone, JA, 1998). In the 1930’s, the ACS used its position of connection to hospitals and hospital quality to support such hospital insurance and the requirements and regulation thereof (Stevens 2006). As insurance expanded and proliferated into a variety of forms, the AMA worked in concert to counter the proposed national requirements and regulation of insurance in the 1940’s (Stevens 2006; Morone, JA, 1998). Following World War II, the support of credible physicians’ groups encouraged legislators at the state and federal levels to provide tax breaks for employers that provided health insurance to their employees (Stevens 2006).
The growing demand for medical care that accompanied the burgeoning middle class’s new employer-based health insurance also generated support for the Hill-Burton Act, passed in 1946 to support medical facility construction (Thompson, Frank J., 1981). The increase in access caused by facility construction and insurance availability, however, also demonstrated that modern healthcare was further from the ideal market than physicians preferred to portray it. Vulnerable segments of the population were left without care, motivating Congress to create Medicaid and Medicare in 1965 (Brown 2006; Thompson, Frank J., 1981). The development of these programs is instructive of how accountability and expertise conflicts shape dialogue about healthcare in the US.

First, it is an important—though often overlooked—fact that, although currently the more contentious of the two programs, Medicaid was relatively little discussed by the Congress that created it (Thompson, Frank J., 1981). Medicare was hotly debated among legislators due to its unique role as the first large scale, federally run national entitlement program, which was an extreme shift in policy (Thompson, Frank J., 1981). In contrast, Medicaid was viewed largely as a way to provide funding support to states for programs that they already ran. The development of the program into the political hot potato that it is today is largely the result of the changing nature of target group construction, special interest group involvement and growing state power (Thompson, Frank 1981; Brown, Lawrence, 2006; Grogan, Colleen, 2006).

The design and implementation of policies of all sorts is a process of coalition definition (Sabatier & Jennings-Smith 1999). Meaning construction is a powerful device in policy. It can allow interested parties to define goals in such a way as to include the
similar goals of otherwise potential adversaries (Sabatier & Weibel 2007; Schneider, A & Ingram, H, 1993). The use of rhetorical devices such as appeals to power, quantification and imagery can make an issue more politically salient and draw the boundaries of issue relevance (Deborah, Stone, 2002). Since passage of Medicaid, the definition of coalition members has been in continuous flux. At times the construction of the target group of Medicaid and similar programs has been harsh, branding beneficiaries as lazy and undeserving (Schneider, A & Ingram, H, 1993; DeSario, Jack & Langton, Stuart, 1987; Soss, Joe, 2002). At other times the targets of the policy have been portrayed in a more sympathetic light, often through a focus on children or an appeal through quantification of the scope of the problem (Behrman, RE & Larson, CS, 1991; Deborah, Stone, 2002; Rosenbaum, Sara, Frankford, David M., Moore, Brad, & Borzi, Phyllis, 1999). Such constant shifts in the rhetoric surrounding Medicaid and its beneficiaries have served to keep the program prominently in view during any discussion of the American health care system.

In addition to generating the occasional attention-grabbing sound bite or catch phrase (such as “Welfare Queen” [Soss 2005]), the rhetorical construction of beneficiaries has served to create an ever widening network of special interest groups that, once included in the program, become entrenched. It has been shown that individuals disproportionately value the potential loss of current utility making them risk averse (Simon 1965; Arrow, Kenneth Joseph, 1963; Rehm, P, 2009; Gold, Marthe R., Siegel, Joanna E., Russell, Louise B., & Weinstein, Milton C., 1996). Once bestowed benefits, groups are unlikely to be willing to accept any decrease in those benefits and
will react fervently to calls to mobilize to protect them (Morone, JA, 1998). Typically, the primary targets of Medicaid policies—the very poor—have little representation in interest group politics, raising the concerns of policy capture, bias, and misrepresentation (Soss, Joe, 2002; Fischer, Frank, 1993; Fischer, Frank, 1990). However, the occasional concern with broad social equity issues has allowed Medicaid beneficiaries to be constructed as also including the near poor, children, the disabled, and, in some instances, the elderly. These groups are more likely to participate through interest group politics (Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). Additionally, the power of the medical professions, hospitals, and their organizations to influence and set policy has frequently been implemented to bring Medicaid issues into the spotlight (Morone, JA, 1998; Stevens 2006).

Medicaid and Medicare creation, revision, and state variations have also functioned to support an ongoing dialogue regarding the appropriate role of the marketplace in healthcare policy. By the 1970’s, the growing medical-industrial complex began to demonstrate quite clearly that the basic market mechanisms that allow for consumer choice and competition were not effective in healthcare (Arrow, Kenneth J., 1963; Starr, Paul, 1982; Tomes 2006).

Growing reliance on technology and pharmaceuticals supported by government funding and oversight via the Federal Drug Administration and the National Institutes of Health have continued to increase the information gap between patient and physician (Brown 2006; Tomes 2006; Arrow, Kenneth J., 1963). Insurance reimbursement structures removed cost from direct consideration by the patient, tended to favor the
physician, and instituted bureaucratic review systems of ostensibly private decisions (Hoffman 2004; Tomes 2006). These changes continued to consolidate the legitimacy to inform healthcare policy in the hands of those with scientific-technical and bureaucratic expertise. The dominance of such expertise minimized the role of citizen and personal experience, despite the extremely personal impacts of healthcare policy. Policy-makers were also increasingly left without adequate understanding of the intricacies of medical science and insurance structures, which meant that, when conflicts arose, they were quite reliant upon the knowledge presented to them by the very groups that they were supposed to be regulating (Morone, JA, 1998).

The 1970’s saw the first concerted effort to push back the influence of the physician groups on policy. In 1974 the Hill-Burton Act began to be phased out. As a result of the growing complaints of consumer advocates, the act, which provided funding for the construction of medical facilities across the country, had come to be seen as wasteful and inefficient (Thompson, Frank J., 1981). Patients began a movement to be treated as informed consumers rather than as the subject of a paternalistic profession (Schwartz, Jerome L. & O'Rourke, Paul F., 1968). Women’s rights groups also pushed back against the heavily male dominated and frequently patronizing physicians’ associations (Baker, Paula, 1984; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Together movements such as these pressed for more accountability in the creation of healthcare policy. Local health governing boards that included consumers were, therefore, attempted as a means of controlling health investment (Thompson, Frank J., 1981) and pushes for evidence-based protocols for
Concerns about Participation in Healthcare

However, these efforts have largely resulted in little actual participation. The power of health governing boards was frequently undercut, resulting in decisions that were largely the result of hospital administration expertise and supported by states that were under broad political pressure (Thompson, Frank J., 1981). The potential offered by the creation of the boards for discourse about the true costs and benefits of hospital construction and investment were meted out in few instances (Thompson, Frank J., 1981; Stevens 2006). And claims of high levels of participation in consumer-based health plans were largely false as well (Schwartz, Jerome L. & O'Rourke, Paul F., 1968). Although membership rates were high and these members had influence on decisions in theory, actual attendance at meetings was low—between 0.5% and 5% (Schwartz, Jerome L. & O'Rourke, Paul F., 1968). Additionally, surveys showed that health professionals still had dominant control of the agenda and ultimate policy decisions (Schwartz, Jerome L. & O'Rourke, Paul F., 1968). Most of the health governing boards created in the 70s have been disbanded and replaced with administrative Certificate of Need reviews. Ohio’s last local health governing board was eliminated in 2010.

This finding reflects the struggle for representation of the citizen experience in a process that is dominated, and sometimes captured, by those with scientific-technical or bureaucratic expertise. The law of small groups (Dryzek, John S., 2001; Schwartz,
Jerome L. & O'Rourke, Paul F., 1968) suggests that participation is only viable in the long-term if membership remains small and administrative duties are restricted. Most attempts to include citizen participation in health policy have been subject to this, demonstrating high initial involvement followed by low sustained levels. This is due, in part, to the fact that large-scale citizen involvement always requires the creation of some mechanism for controlling activity so that it is productive, ultimately consolidating power in the hands of a few, typically highly educated, white, upper class individuals (Schwartz, Jerome L. & O'Rourke, Paul F., 1968).

This disproportionate participation is worrying because it means that those who stand to be most affected by changes in health policy are also those that are least likely to participate in its creation. If the purpose of citizen participation is not only to be more democratic but also to ensure appropriate goal construction for the effectiveness of policy (Behn, Robert, 2001; Kweit, Mary & Kweit, Robert, 1987) then the absence of these disempowered groups has serious implications for the likely effectiveness of the policy developed. Non-participation in health policy development has at times allowed for the mobilization of bias. For instance, the absence of the mentally ill from discussions has often resulted in decisions to decrease services, which in turn has resulted in the decreased effectiveness of policies actually aimed at helping this population (DeSario, Jack & Langton, Stuart, 1987). Non-participation allows for the demonization of groups of beneficiaries (Soss, Joe, 2002) and hampers efforts to provide services in a particular location even if everyone agrees that they are necessary in general—the NIMBY phenomenon (Chaskin, RJ, Brown, P, Venkatesh, S, & Vidal, A, 2001). This policy

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slippage away from initial goals can eventually lead to negative backlash against the policy and the participation (Titter, JQ & McCallum, A, 2006).

In health care policy the necessity of citizen input may be especially important when making decisions about resource allocation. As Doyal argues, there may be substantial disutility experienced by patients, beyond the denial of services, if decisions are made in secrecy (Doyal, Len, 1997). Secrecy in this process can lead to feelings of mistrust and dissatisfaction that can, in fact, compound the harms brought about by the health care decision itself. The use of citizen participation can lend transparency to policy decisions that alleviate these feelings of mistrust and dissatisfaction (Behn, Robert, 2001; Fischer, Frank, 1990; Chaskin, RJ, Brown, P, Venkatesh, S, & Vidal, A, 2001; Doyal, Len, 1997).

Conflicts in Modern Healthcare Policy Deliberation

The decisions made about health policy in the US impact a wide variety of populations. Due to the level of activity in Medicaid and Medicare specifically, health policy disproportionately impacts the poor, disabled, young and old. Unfortunately, these populations are also the least likely to make use of opportunities to participate in the decisions that affect their health care. Not only can this have severe repercussions for the individual as they seek services, but it potentially endangers the legitimacy of the government when policies are rendered ineffective through inappropriate control by citizen majority groups.
The consumer-versus-provider tensions of the 1970’s and the problems that result have continued into the present day (Morone, JA, 1998; Tomes 2006). For example, in 1999, an Institute of Medicine report, *To Err is Human*, uncovered the disturbing prevalence of medical errors (Kohn, Linda T., Corrigan, Janet M., & Donaldson, Molla S., 1999) leading to renewed pressures for regulation of medical practices (Stevens 2006). Although the study was conducted by a professional group, the results have mobilized citizens and further legitimized increased challenges to physician expertise. Patient advocates are working to ensure that consumers have access to needed medication while public health experts attempt to reduce the prevalence of prescription drug abuse. Preventative care has become a national focus, potentially at the expense of stigmatizing those who receive acute care. Today’s policymakers are again trying to construct consumer-oriented insurance plans (Tomes 2006) and the Affordable Care Act seeks to create community based “Accountable Care Organizations.” Additionally, the Patient Centered Outcomes Research Institute (PCORI) was established in 2010 to conduct comparative effectiveness research.

*Value-Added in Healthcare?*

This review of healthcare expertise and participation history suggests some focused research questions and hypotheses about the potential value of engagement in healthcare policy formulation specifically:

1. Given the continued respect for healthcare expertise (Charles, Cathy & DeMain, Suzanne, 1993; Gold, Marthe R., Siegel, Joanna E., Russell, Louise
B., & Weinstein, Milton C., 1996; Rosenbaum, Sara, Frankford, David M., Moore, Brad, & Borzi, Phyllis, 1999; Schwartz, Jerome L. & O'Rourke, Paul F., 1968; Thompson, Frank J., 1981) and the potential conflicts and biases of citizen participation (Borna, S & Sundaram, S, 1999; Rosenbaum, Sara, Frankford, David M., Moore, Brad, & Borzi, Phyllis, 1999; Soss, Joe, 2002; Simonsen, William & Robbins, Mark D, 2000; Nelson, RM & Drought, T, 1992), how does citizen input influence policy outcomes?

a. The literature on participation generally suggests that citizens will speak about those issues with which they have had first-hand experience (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; DeSario, Jack & Langton, Stuart, 1987; Kweit, Mary & Kweit, Robert, 1987; Lijphart, A, 1997; Eliasoph, Nina, 1998).

b. The issues addressed by citizens will be more likely to be about values and goals rather than causes and solutions (DeSario, Jack & Langton, Stuart, 1987; Kweit, Mary & Kweit, Robert, 1987). In contrast, experts (bureaucratic or scientific) will speak more about causes and solutions (Turner, Stephen, 2008; DeSario, Jack & Langton, Stuart, 1987; Kweit, Mary & Kweit, Robert, 1987; Fischer, Frank, 1990).

c. What do policy-makers view as the appropriate role for healthcare experts in policy development? For citizens?

2. Because the motivation for participatory processes is not solely for citizens to influence policy directly but also to ensure a transparent system that informs
citizens (Doyal, Len, 1997; Habermas, J. & Rehg, William, 1996; Ackerman, Bruce, 1989), it is also important to ask how citizens view institutional attempts to engage them in policy formulation.

a. How do institutions communicate opportunity and receptiveness?

b. What do citizens view as the appropriate role for healthcare experts in policy development? For themselves?

c. Do citizens rely on third parties (e.g. advocacy organizations, people they know, etc) to represent their interests in policy deliberation? To receive information about the policy process/outcome?

i. In the public management literature this phenomenon is known as the two-table problem (Cvetkovich, G & Earle, TC, 1994; Margerum, RD, 2008). Does reliance on a third party negatively/positively impact citizen perceptions of the process?

d. How do institutions balance the need to focus on content with the need to attend to the transparency and format of discussion?

i. As Habermas (1991) articulates, the external organization of discourse (the rules, norms, and format regarding dialogue) influences the internal organization (the relevance, sincerity, and understandability of the speech act) (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994). How do institutional actors attend to these two tracks of organization simultaneously? How do
attention to the “two-track problem” benefit or detract from policy formulation?

Approach

Chapter 3 sets out to answer these questions about public participation in healthcare policy formulation by utilizing a case study of Oregon’s recently formed Health Policy Board (OHPB). The board was created in 2009 to implement expansive healthcare reform initiatives, and with the passage of the PPACA in 2010 the OHPB has been responsible for addressing the new federal requirements. Because the OHPB was already underway with much of the work that is required by PPACA by the time it was passed, Oregon is an instructive case for other states moving forward. Their experience with citizen participation in health policy, both past and present, will help inform others about the benefits and potential mechanisms of a successful participatory process.

The case study uses a multi-method approach in an attempt to fully understand the implications of citizen input into the OHPB decision-making process. The board holds monthly public meetings, the majority of which have agendas, minutes, materials and recordings available online. A content analysis of these materials was used to identify common themes of discourse—as categorized by Stone (2002)—from citizens, experts, and board members. Additionally, because some interaction between the public and the policymaker is assumed to occur outside of these documented meetings, interviews were conducted with OHPB board members. Policy output—including OHPB reports, OHA rules and regulations, and Oregon legislation—was then used to identify the specific
policies attributable to citizen input via discourse tracing. Finally, in order to assess questions 2a through 2c a citizen survey was constructed and distributed electronically.

In the process of reviewing these varied materials, however, an additional research question arose related to hypothesis 1a. Literature suggests that citizens will speak about issues with which they have had first-hand experience. This pattern, however, is heavily gendered. Motherhood has frequently been used by women to establish them as a legitimate interest group, and it has been evoked in the name of equity, efficiency, security and liberty. Chapter 4 then examines how policy discourse generally, and healthcare discourse specifically, is influenced by personal appeals to motherhood. A review of recent healthcare debate in Oregon and at the national level reveals that this dominant historical trend is potentially absent from the current healthcare discourse. The implications of its absence recall our concerns regarding political capture. If communities are deciding on meaning when they create policy that is absent an appreciation for motherhood, are mothers now meaningless?
Chapter 2: A Typology of Public Engagement Contexts

Research on public engagement can be found across a multitude of disciplines utilizing various terms including “citizen participation,” “public communication,” “public input,” and “deliberative democracy.” The definition of these terms can be narrowly defined to only key stakeholder consultation or broadly inclusive of “any action [by a member of the public] with policymakers as the intended audience” (Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). The proliferation of terms and frequently conflicting definitions has made research difficult to interpret and caused silos of knowledge within select fields of study.

In 2005, Rowe & Frewer suggested a strategy to mitigate this confusing preponderance of terms. Using an information flow approach, they created a useful typology of the mechanisms of public engagement. This approach focuses upon the intended direction and procedural limitations imposed on communication. Engagement activities in which information flows primarily from the institution to the public is termed “public communication,” while information flow in the opposite direction is considered “public consultation” (Rowe, Gene & Frewer, Lynn J, 2005). Only instances in which information is exchanged in both directions do Rowe & Frewer consider the type of engagement to be “public participation” (Rowe, Gene & Frewer, Lynn J, 2005). These broad categories each have sub-types identified based upon variables such as how
participants are selected/invited to engage and the medium of information exchange (Rowe, Gene & Frewer, Lynn J, 2005).

This typology is an improvement over others because it is multidimensional and non-exclusive (Rowe, Gene & Frewer, Lynn J, 2005). Mechanisms of engagement are potentially infinite, but may be grouped together based upon the typology introduced by Rowe & Frewer. Even currently unknown or untested mechanisms may easily be described with the descriptive categories provided by Rowe & Frewer, allowing for continuity across time and fields. However, they note that this approach to categorizing engagement mechanisms is limited due to the typology’s inability to account for variations in the contexts of engagement. They suggest:

A further step involves understanding and defining, perhaps via a second typology, the different contexts in which engagement takes place. Empirically, once effectiveness is defined and instruments are developed for measuring this, mechanisms of different classes can be compared to the different context classes to establish contingent effectiveness. [emphasis added] (Rowe, Gene & Frewer, Lynn J, 2005)

Certainly, much research has been published that describes the contexts of particular public engagement attempts both successful and not. These accounts, however, are largely descriptive case studies with little direction about how such experiences might be translated to similar areas or replicated under differing circumstances. To be fair this is
largely because the contexts are constructed of innumerable variables, many unknown, and any one of which might have contributed to the particular experience reported. Nonetheless, some headway has been made in determining what makes public engagement more or less likely.

This progress has been concentrated largely in two distinct fields: public administration and traditional political science. However, these fields of study tend to have differing foci. While political science tends to focus largely upon the variables that influence individual participation in public affairs (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Putnam, Robert, 2001; Hetherington, Marc J, 1996; Meehl, Paul, 1977; Lijphart, A, 1997; Rosenberg, Shawn W., 2007; Neblo, Michael A., Esterling, Kevin M., Kennedy, Ryan P., Lazer, David MJ, & Sokhey, Anand E., 2010), public administration scholars focus instead upon the variables that lead legislators or bureaucrats to utilize public engagement (Fischer, Frank, 1990; Arnstein, SR, 1969; Neuse, Steven M., 1980; Borge, LE, Falch, T, & Tovmo, P, 2008; Collins, W. P., 1980; DeSario, Jack & Langton, Stuart, 1987; Kweit, Mary & Kweit, Robert, 1987; Rosener, Judy B., 1982; Merton, Robert, 1957). Each of these literatures has contributed greatly to our understanding of the contexts of engagement; however, neither provides a complete picture. Only by examining the interaction between these two dimensions can a useful typology of engagement contexts help inform future research and its application.
The Individual Dimension—Political Science

The first dimension of variables that contribute to engagement contexts relates to the characteristics of individuals and their desire to engage in public affairs. Working from the assumption that participation of the populace in government affairs is at least minimally desirable scholars have spent a lot of time trying to understand what influences when and how individuals choose to engage in public affairs (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Putnam, Robert, 2001; Hetherington, Marc J, 1996; Meehl, Paul, 1977; Lijphart, A, 1997a; Rosenberg, Shawn W., 2007; Neblo, Michael A., Esterling, Kevin M., Kennedy, Ryan P., Lazer, David MJ, & Sokhey, Anand E., 2010). By almost any measure, engagement in the US is low (Dione, EJ, 1991; Morone, JA, 1998; Putnam, Robert, 2001; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995); however, as many scholars note, the quality of engagement varies between different types of activity (Putnam, Robert, 2001; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995).

A crucial distinction is made between “active” and “passive” engagement in the literature of both political science (Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Eliasoph, Nina, 1998) and public administration (Follet, M, 1926). Passive engagement includes deliberate silence, in which the individual reviews the information,
makes a conclusion on the acceptability of the proposal and then chooses not to voice that opinion (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960). Only a slight improvement is the vote, which makes those silent opinions vocal. This form of engagement is simple “task involvement”. In contrast, “ego involvement” is necessary to achieve true participation and democracy (Follet, M, 1926; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). Ego involvement requires involvement in the formation, modification or implementation of policy. Ideally, this takes the form of council room or town hall type discussion, but may be any action “with policy makers as the intended audience” (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Rowe, Gene & Frewer, Lynn J, 2005).

These distinctions in the literature indicate the varying degrees to which someone can be engaged in public affairs. Since passive engagement is basic task involvement without the desire to engage in modifying policy directly, it is likely that citizens who are “passively engaged” are interested in the policy topic, but not overtly committed to involvement in its formation. In contrast, the idea of ego involvement indicates a desire to actively engage, committing time and resources to the process; thus, it is easily described as individual commitment. Of course interest is a prerequisite to commitment. Therefore, the individual dimension of engagement contexts might best be viewed as a continuum, as depicted in Figure 2.
The variables that influence engagement—either interest in or commitment to—are relatively well identified in the political science literature. Both qualitative and quantitative work has been conducted to disentangle the relationships between a myriad of socioeconomic and personal characteristics (Neblo, Michael A., Esterling, Kevin M., Kennedy, Ryan P., Lazer, David MJ, & Sokhey, Anand E., 2010; Eliasoph, Nina, 1998; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). In so identifying the relevant contributors to individual interest and commitment this research indicates potential ways to encourage (or discourage) individuals to participate. Fostering public forums for conversation, increasing education, and utilizing ethnic, religious, fraternal or sorority institutions to encourage participation are just a few of the potential levers for raising engagement levels in the political science literature (Putnam, Robert, 2001; Graham, Bob & Hand, Chris, 2009; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). All of these solutions, however, suggest that opportunities to engage already exist. The institutional mechanisms or attitudes in place are rarely considered beyond their impact on some fuzzy measure of self-efficacy.
The Institutional Dimension—Public Administration

In contrast, the institutional literature on engagement focuses upon institutional mechanisms and attitudes, often in isolation from considerations of the amount of citizen interest to be tapped (Collins, W. P., 1980; Merton, Robert, 1957; Neuse, Steven M., 1980; Arnstein, SR, 1969; Borge, LE, Falch, T, & Tovmo, P, 2008; Reich, Simon, 2000). In fact, early administrative scholars explicitly isolated the bureaucracy from reliance on the public (Wilson, Woodrow, 1887; Weber, Max, 1946; Rohr, John, 1986; Hamilton & Madison, 1788; Chan, Hon S. & Rosenbloom, David H., 1994; Goodnow, Frank, 1900). It was widely believed that over-reliance upon the public will would create massive inefficiencies and that politics would create an inability to act, damaging the credibility of public administration (Wilson, Woodrow, 1887; Weber, Max, 1946). Instead Hamilton’s “due dependence on the people” was achieved through acting upon the expressed will of the legislature (Hamilton & Madison, 1788; Wilson, Woodrow, 1887; Weber, Max, 1946). Similarly, the representatives of the people were considered responsible for ensuring that the administration did not act irresponsibly. In organizational theory the public was the principal, the administration was the agent and the legislature and scientific management principles were the mechanisms for reconciling principal-agent conflicts (Chan, Hon S. & Rosenbloom, David H., 1994; Eisenhardt, Kathleen, 1989; Wilson, Woodrow, 1887; Goodnow, Frank, 1900; Friedrich, CJ & Mason, Edward, 1940; Weber, Max, 1946).
The Great Depression and resulting social programs of the New Deal created more complexity than these theories could account for. As complexity has increased hierarchy alone has proven unable to hold administration accountable to the public principal (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005; Seidenfeld, Mark, 1992; Friedrich, CJ & Mason, Edward, 1940; Behn, Robert, 2001; Dahl, Robert, 1947). Therefore, the use of public engagement may be needed in order to provide accountability.

How receptive different agencies and bureaucracies have been to this concept, however, is dependent upon a whole range of variables as similarly complex as those that influence individual participation patterns. Somewhat less work has been completed to develop empirical descriptions of organizational patterns of engagement than has been completed of individual patterns of engagement. Nonetheless, in 1980 Neuse completed a survey of a variety of agencies and administrators at multiple levels to describe bureaucratic attitudes toward citizen input. He found that the level of the administrator and the technical nature of the agency were strongly related to lowered receptiveness to citizen input (Neuse, Steven M., 1980). A limited number of other authors have identified additional influences on bureaucratic approaches to citizen engagement, including social construction of the service population (Schneider, A & Ingram, H, 1993) and the presence of organized interest groups (Morone, JA, 1998; Goodnow, Frank, 1900; Rao, Nirmala, 1998).

However, in this literature the operationalization of institutional “receptiveness” to engagement remains inconsistent. In Neuse’s survey, receptiveness was an attitudinal
variable (Neuse, Steven M., 1980). Other authors have constructed “receptiveness” based upon structural variables such as frequency, location, and timing of public meetings (Schneider, A & Ingram, H, 1993). Still others have utilized a combination approach to measure “receptiveness” (Rao, Nirmala, 1998; Merton, Robert, 1957). Clearly, attitudinal measures and structural measures are inter-related: the more attitudinally receptive an agency is to engagement, the more likely they are to hold a greater number of public meetings, and as an agency’s interaction with citizens increases over time it is possible that the agency will become more attitudinally receptive.

Nonetheless, attitudinal and structural variables are distinct variables. Structural measures of receptiveness might best be termed “opportunity” for engagement and attitudinal measures left as “receptiveness.” With these more concise terms in mind, these variables can be arranged on a single continuum much like individual engagement (See Figure 3).

Figure 3. The Institutional Dimension of Public Engagement

Traditional orthodox theories prescribe institutions in which there is little to no opportunity to engage and little to no receptiveness on the part of the bureaucrats. On the other hand it may be possible to find agencies that provide both plenty of opportunity and
receptiveness when engaged with citizens. In between these two extremes there may be
two additional types of agencies: one which is receptive to engagement when received
but that provides little explicit opportunity for citizens to engage, and one which provides
opportunity—likely due to statutory requirements—but that does not actually care to be
involved in such engagement. If we consider both attitude and opportunity to contribute
to institutional engagement levels, then both of these examples would be considered
medium institutional engagement.

Merging Political Science & Public Administration

Combining the individual dimension (Figure 2) of engagement with the
institutional dimension (Figure 3) provides nine distinct contexts (Table 1). Like the
typology introduced by Rowe & Frewer (2005), this typology is not driven by the
mechanisms themselves but by the broader theories that inform the construction of those
mechanisms. Recall that, while the individual dimension of engagement requires interest
as a precursor to commitment, the institutional dimension has no such requirement; an
institution can provide opportunity due to statutory requirement with no receptiveness but
can also be receptive when approached even when failing to provide general opportunity
for participation.

As Tritter and McCallum note, inappropriate reliance on public input can result in
problems such as policy slippage or public backlash (Tritter, JQ & McCallum, A, 2006).
The typology below suggests, the appropriate relationship between institution and public
will support stable interaction over time and prevent such complications. There is room
for the development of specific mechanisms within each of these contexts of participation. Within each of these relational contexts, numerous mechanisms might be utilized and, in fact, the same mechanism might be used in multiple contexts. For instance, Rowe & Frewer’s “Communication type 1” (i.e. traditional publicity) may be found within a context that lends itself to highly controlled, unidirectional, non-face-to-face interactions such as informing or therapy (see Table 1 below). Additionally, there are mechanisms identified in the literature that can impact the contributing variables of institutional or citizen engagement levels, which might alter the relationship context.

Barring such external alterations to the situation, the contexts are named here according to hypotheses about the types of participatory relationships that are likely to remain stable and garner the most benefits.

Table 1. A Proposed Typology of Engagement Contexts

<table>
<thead>
<tr>
<th>Individual Dimension</th>
<th>Low Institutional Engagement (neither opportunity nor receptiveness)</th>
<th>Medium Institutional Engagement (either opportunity or receptiveness)</th>
<th>High Institutional Engagement (both opportunity and receptiveness)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Citizen Engagement (neither interest nor commitment)</td>
<td>Bureaucratic Hierarchy</td>
<td>Informing</td>
<td>Consultation</td>
</tr>
<tr>
<td>High Citizen Interest/ Low Citizen Commitment</td>
<td>Manipulation/Therapy</td>
<td>Tokenism</td>
<td>Placation</td>
</tr>
<tr>
<td>High Citizen Engagement (both interest and commitment)</td>
<td>Disruptive Participation</td>
<td>Initial (or Periodic) Partnership</td>
<td>Sustained Partnership (or Delegated Power)</td>
</tr>
</tbody>
</table>
Low Institutional Engagement Contexts

Bureaucratic hierarchy is what traditional public administration scholars envisioned, with no participation of the average citizen in the decisions of highly technical administration. Accountability in this context is generally thought to be best achieved through technically sound action based on “unbiased” expertise (Weber, Max, 1946; Wilson, Woodrow, 1887; Fischer, Frank, 1990). The traditional conception of bureaucracy, however, is threatened when citizen interest in the topic increases (Behn, Robert, 2001; Morone, JA, 1998; Fischer, Frank, 1990). Citizen attention to administrative choices may call into question the idea of accountability through detached technical processes (Fischer, Frank, 1993; Fischer, Frank, 1990; Habermas, J. & Rehg, William, 1996; Behn, Robert, 2001).

If an organization refuses to provide opportunity to participate and is perceived as being consistently unresponsive to citizen interest one of two outcomes may result, depending upon the level of citizen commitment about the issue. First, a bureaucracy that finds itself in the spotlight of citizen attention but without the pressures of citizen commitment is likely to respond by attempting manipulation or therapy of the opinions held by those outside of the agency. As Arnstein suggests, this type of engagement is “contrived by some to substitute for genuine participation. Their real objective is not to enable people to participate in planning or conducting programs, but to enable powerholders to ‘educate’ or ‘cure’ the participants” (Arnstein, SR, 1969). Second, a bureaucracy with a traditionalist mindset of limited opportunity for, or acceptance of,
participation that runs up against an interested and committed populace is likely to encounter a variety of disruptive participation practices. These disruptions might range from petitions to protests to civil disobedience (Goodnow, Frank, 1900). Obviously, this is an outcome that most agencies would prefer to avoid. Yet, there may be some cases in which disruptive participation is an acceptable cost of implementing necessary but unpopular policies. For instance, the development and implementation of integration policies in the 1960’s encountered much disruptive engagement despite the justness of their creation.

Medium Institutional Engagement Contexts

Sometimes in response to a fear of disruptive participation, sometimes because of statutory requirements, agencies begin offering opportunities for participation without actually desiring the input that they receive from such interaction with the public. In such cases, the participation that occurs may be seen as disingenuous. When citizen interest in and commitment to the issue are low this will typically result in public meetings at which the institution or an expert representative informs people about what is being done. There may be some limited opportunity to comment on these plans, but institutional representatives will rarely be receptive to such comments. When interest is high, however, there is a need for unresponsive institutions to attempt to at least appear invested in the beliefs of the populace. The result is tokenism, wherein specially identified citizens or “stakeholders” are responded to in very public ways—mentioned in press releases, given ineffective advisory roles, or utilized as experts.
Even in cases where institutional representatives are receptive, participation efforts may be reduced to the level of *informing* or *tokenism* if opportunities to engage are limited. An institution that is receptive to what it hears but holds its meetings sporadically, in remote locations, or at times of the day that working people cannot attend may respond to the commentary received from an unrepresentative group, leaving the rest of the public to only be informed rather than engaged. This is not to lay the blame for *informing* or *tokenism* solely at the feet of institutional actors. Low citizen interest or commitment contributes to these forms of engagement. An institution attempting to foster engagement when there is little to no public interest or desire to participate will inevitably end up hearing from only a select group. The result will, therefore, be a de facto *informing* or *tokenism* process that can be difficult for institutions to alter.

If the populace is largely interested and committed to a policy topic and the institution is moderately engaged—providing either opportunity or receptiveness, then the result will be a sort of strained *partnership*. This partnership arrangement will involve mechanisms of Rowe & Frewer’s “public participation” type and power will likely be shared to some extent between institutional and public actors. However, the lack of either meaningful opportunity or institutional receptiveness is likely to reduce public commitment over time, allowing the context to slip into one of the adjacent contexts. If an institution is not as receptive as it could be, or even if it is perceived as such, then the partnership may be broken by moments of *disruptive participation*. Similarly, limited receptiveness or opportunity may simply discourage people from their commitment; thus reducing a promising *partnership* with the public to de facto *tokenism*. Thus, this context
is likely to be only an *initial or periodic partnership*. In some instances, the sporadic nature of this context may be problematic. In others (e.g. where there is concern about future attention shifts or a desire to avoid capture of the process), the periodic nature of engagement may be sufficient to ensure that policies are responsive to the public will without being overly burdened by the costs of a sustained participatory process.

*High Institutional Engagement Contexts*

When institutions are both receptive to input and provide plentiful meaningful opportunities to participate but citizens are largely uninterested they may be forced to turn to *consultation*. In this context, institutional actors do genuinely engage in discourse with those few citizen actors that desire to engage. However, the lack of widespread and sustained interest and commitment make it highly unlikely that institutions will relinquish control of the agenda. While Arnstein and some deliberative democracy scholars find fault with this continued concentration of power (Arnstein, SR, 1969; Fox, C & Miller, H, 1995), the context of limited citizen interest indicates that this may in fact be a rather reasonable solution (Titter, JQ & McCallum, A, 2006). After all, relinquishing agenda-setting and ultimate decision-making control to a predominately absent public is likely to result in capture by groups that would seek to advance their own purposes at the expense of others (DeSario, Jack & Langton, Stuart, 1987; Mueller, DC & Stratmann, T, 2003).

Similarly, what Arnstein sees as a sort of tokenism—*placation*—in the context of high interest but low commitment is a meaningful way for institutions to incorporate citizens through advisory panels, citizen juries and the like without threatening the
sustainability of the resulting policies when few people want to commit substantial time or effort. Placation establishes sustained structures for participation that are meaningful, with some potential for influencing the process or policy outcomes. However, the institution retains agenda and decision-making control to prevent policy slippage during the likely periods of inattention by members of the interested but uncommitted public.

When institutions find themselves with adequate amounts of citizen interest and commitment they are likely to create something more akin to genuine partnerships with citizen groups. These partnerships can take on many forms. They may be formalized into citizen juries or boards with voting power or other authority that is absent in placation use of similar tools. They may be informal connections between the institution and the public, something more like the deliberative ideal with fluid agendas and sustained genuine discourse. In either instance, sustaining this citizen-institution partnership over time can be difficult. It is only when an institution can create a sense of responsiveness and opportunity that high citizen interest and commitment might be supported, resulting in a sustained partnership.

Testing the Typology

To demonstrate the applicability of this typology, it must be determined whether or not the contexts described appear to capture the full range of engagement contexts described in the current literature. Additionally, if the typology is to be of use to practitioners, it must be able to not only describe the experiences of engagement but should be reasonably sufficient at predicting the appropriate context for a given situation.
The ability to predict the context of engagement with information regarding each
dimension is especially critical given that the typology predicts that inappropriate
activity, not suited to the experienced context, can lead to policy complications such as
capture, slippage, and public backlash.

Thus, a snowball sample of case studies on engagement was constructed.
Beginning with Rowe & Frewer’s reference list, eleven articles that described case
studies of engagement activities were identified (Rowe, Gene & Frewer, Lynn J, 2005).
The reference lists of each of these were then reviewed to identify an additional thirteen
articles. At this point, many of the articles began to reference each other and the sampling
was concluded. As displayed in Table 2, the sample size is small but it represents a fairly
diverse cross-section of the arenas of policy in which engagement has been attempted.

Table 2. Sample Case Study Articles by Field

<table>
<thead>
<tr>
<th>Field</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waste Management</td>
<td>1</td>
</tr>
<tr>
<td>Forestry/Land Management</td>
<td>9</td>
</tr>
<tr>
<td>Technology Policy</td>
<td>2</td>
</tr>
<tr>
<td>Health/Human Services</td>
<td>3</td>
</tr>
<tr>
<td>Transportation</td>
<td>2</td>
</tr>
<tr>
<td>Food/Agricultural</td>
<td>1</td>
</tr>
<tr>
<td>Environment/Water/Air Quality</td>
<td>6</td>
</tr>
</tbody>
</table>

The background sections of each of these cases were reviewed. The descriptions
of institutional opportunity and receptiveness and of citizen interest were compared to the
above descriptions of these dimensions (Figures 2 & 3). The background sections of these
articles frequently describe notable citizen interest or activity and institutional
receptiveness or approach preceding the particular case studied. These twenty-four articles describe thirty individual case studies. Of these 30 cases, only 18 (60%) contain information on both the individual and the institutional dimensions. Again, this demonstrates the need for more consistent investigation of both dimensions of engagement contexts. Once the eighteen cases with both dimensions were identified, they were matched to a category within the typology based upon the descriptions of citizen interest and institutional intentions (Table 3).

Table 3. Predicted Stable Contexts of Engagement

<table>
<thead>
<tr>
<th>Individual Dimension</th>
<th>Low Citizen Engagement (neither interest nor commitment)</th>
<th>Medium Institutional Engagement (either opportunity or receptiveness)</th>
<th>High Institutional Engagement (both opportunity and receptiveness)</th>
</tr>
</thead>
</table>

After assigning the predicted category to each case, the section of the article that described the actual mechanisms, experience and results were reviewed to determine if
the prediction was correct. Because the current ability of this typology to match specific mechanisms to specific contexts is limited, Rowe & Frewer’s typology of mechanisms (Rowe, Gene & Frewer, Lynn J, 2005) was used to first determine the flow of information in each case. This step typically narrowed down the context of each case to two or three potential findings. The determination regarding which of these was the most applicable context for the given case was then made based upon descriptions of the amount of power shared between citizen and institutional actors. These power dynamics were compared to the theorized power relationships described above for each of the typology contexts.

Of the eighteen cases reviewed in this manner, fifteen (89%) of the predicted stable categories appear consistent with the case study findings. Of particular interest is how this typology explains instances that are otherwise surprising. For instance, Rosener (1982) investigated a case of a California Coastal Commission where citizen participation was found to be effective at changing policy decisions. She notes that the outcomes of the study “question conventional wisdom that citizen participation in public hearings is ineffective” (Rosener, Judy B., 1982). While conventional wisdom might make the California Coastal Commission case an anomaly, the case study description of a very environmentally aware and committed populace combined with the description of a receptive commission focused on ensuring opportunity to participate suggested that a partnership context would not be surprising. This typology correctly identified that the particular context of this experience would support a stable, sustained partnership while
general theories that are not sensitive to context were unable to provide guidance to the practitioners or researchers in this case.

The three cases that did not conform with the typology’s predicted stable contexts are underlined in Table 3. However, these cases also demonstrate two important contributions of this typology: (1) that mismatches between actual and perceived contexts will result in unstable attempts at engagement; and (2) that the engagement context can be fluid and altered over time.

In the case of Twight & Carroll, the authors describe a highly engaged populace and an institution primarily interested in engagement opportunity but not receptive to input (Twight, BW & Carroll, MS, 1983). This would suggest a periodic or cyclical partnership relationship. The agency either misjudged or did not care to consider the level of citizen interest and instead attempted therapy. This mismatch between perceived and actual contexts is likely what contributed to the conflict and disruptive participation reported by the authors. This case serves as an example for why this type of typology may be needed by practitioners. With attention to both dimensions of the engagement context, institutions or other groups seeking to utilize engagement in public affairs may be less likely to behave in ways that generate unstable relationships with the public.

The mismatch between perception and reality may not be solely the result of institutional problems though. Citizens may have inappropriate perceptions of the process as well. Rosener (1981) examined two cases of participation in water quality management in Florida. In both instances, the institution was highly engaged—both receptive and providing meaningful opportunity. In one instance, the institution utilized a
mechanism of a secondary mediator and in the other they did not. The case report notes that the director later regretted the decision to leave out the mediator (Rosener, Judy B., 1981). Where the mediator was used, the result was an effective, sustained partnership. The absence of the mediator mechanism, though, made a highly engaged public skeptical of the institution’s intentions, resulting in only periodic and ultimately disruptive participation (Rosener, Judy B., 1981). Such an example demonstrates the need for an understanding of both the mechanisms and contexts of engagement. Use of this typology and the classification scheme suggested by Rowe & Frewer (2005) to establish contingent effectiveness may allow future practitioners to ensure that the specific mechanisms chosen will be seen as appropriate by all participants.

In the case of Einsiedel, Jelsoe & Breck (2001), at the time of the consensus conference in Canada that is described there was little interest in the topic of biotechnology regulation and it was handled in a very traditional administrative manner. No governmental agency would even support the conference, which was instead supported by a group of academics and non-profits (Einsiedel, E, Jelsoe, E, & Breck, T, 2001). The expected hierarchical context was correct at the time of the conference; however, as a result of massive media exposure, the contextual category shifted over time. Within a short time, citizens were appointed to a newly created board and the government began utilizing the recommendations from the conference to set a new technology agenda (Einsiedel, E, Jelsoe, E, & Breck, T, 2001). This case demonstrates how contexts can be altered by those participating in order to eventually achieve a different participatory relationship than was originally encountered.
Implications of the Typology

This typology brings together two bodies of literature that investigate the same phenomena and yet investigate separate variables. As Table 4 below shows, the dominant literatures in these fields address the issues raised in this typology differently. Some literatures focus upon the institution and others focus upon the individual. Some, like Arnstein’s ladder of participation (Arnstein, SR, 1969) and Carrell’s planning-programming-budgeting (Carrell, J, 1969), focus upon what the interaction between institution and citizen should look like. Each of these literatures has both normative, theoretical work and empirical research to support their differing foci. The typology introduced in this dissertation, however, allows these silos of intellectual attention to speak more directly to one another.

Additionally, practitioners may use this typology and the table below to identify useful bodies of literature. As mentioned, and demonstrated in testing, the contexts of engagement are not fixed. By determining the current context and the desired context, practitioners can then identify what components (e.g. citizen commitment or institutional opportunity) need to be altered in order to reach the desired context. Table 4 identifies which bodies of literature focus upon which of the component variables of this typology, and could therefore inform efforts aimed at a particular dimension.
Table 4. What Dominate Theories Say About Citizens and Institutions

<table>
<thead>
<tr>
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<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Citizen Interest</td>
<td>not considered</td>
<td>assumed constant/high</td>
<td>result of social determinants</td>
<td>assumed constant/high</td>
<td>assumed constant/high</td>
<td>not constant</td>
</tr>
<tr>
<td>Citizen Commitment</td>
<td>not considered</td>
<td>assumed constant/high</td>
<td>result of social determinants</td>
<td>assumed constant/high</td>
<td>assumed constant/high</td>
<td>not constant</td>
</tr>
<tr>
<td>Citizen Ability</td>
<td>assumed low</td>
<td>assumed high</td>
<td>result of social determinants</td>
<td>assumed moderate</td>
<td>assumed high</td>
<td>not constant</td>
</tr>
<tr>
<td>Institutional Opportunity</td>
<td>limited</td>
<td>necessary</td>
<td>unexplored</td>
<td>should be highly specific and regimented</td>
<td>should be open, numerous and accessible</td>
<td>should be open but institutionalized</td>
</tr>
<tr>
<td>Institutional Responsiveness</td>
<td>limited to responsiveness through voting</td>
<td>necessary</td>
<td>unexplored</td>
<td>should be highly specific and regimented</td>
<td>should be highly citizen driven/controlled</td>
<td>should rely on institutionalized mechanisms</td>
</tr>
<tr>
<td>Interactions b/t Institution &amp; Citizen</td>
<td>limited</td>
<td>two-way, evolving, rhetoric heavy. Undefined what mechanisms are important</td>
<td>implied that institutions can impact individual perceptions of efficacy</td>
<td>limited</td>
<td>institutions should be citizen controlled</td>
<td>are not constant, which creates potential problems for output</td>
</tr>
</tbody>
</table>
Proposed Typology of Contexts is Non-Hierarchical

The names of the typology and hypotheses about contexts are drawn heavily from Arnstein’s “ladder of participation” (Arnstein, SR, 1969). Arnstein’s “ladder” (Figure 4) describes the amount and format of engagement in a clearly hierarchical manner with citizen control of agenda setting and policy decisions as the ultimate goal. Like the typology introduced in this dissertation, Arnstein’s ladder makes distinctions between levels based upon the power dynamics observed at each level (Arnstein, SR, 1969). The eight rungs—manipulation, therapy, informing, consultation, placation, partnership, delegated power, and citizen control—are broadly grouped into three general categories labeled Nonparticipation, Tokenism and Citizen Power. The lower rungs on the ladder—tokenism and nonparticipation—describe types of engagement in which experts and administrators are portrayed as selfishly attempting to retain power for themselves.

Figure 4. Arstein's Ladder of Participation
In practice, however, attempting to move too high on this ladder has at times led to policy slippage, public backlash and inconsistent management, causing some to label the experience “the snakes and ladders” of citizen participation (Titter, JQ & McCallum, A, 2006). Arnstein’s ladder assumes that citizens want control, and that they participate in consistent ways, which will result in the ability of government to rely upon such control. It casts bureaucracy as the enemy of public participation. In some agencies this is true. In many it is not.

By utilizing a multidimensional approach to categorizing the contexts of engagement this typology is unique from previous models, such as Arnstein’s ladder. It departs from a hierarchical concept of participatory methods and does not presuppose the desirability of total citizen control. In fact, it recognizes that in some instances citizen control may be undesirable. In particular, fields in which expertise is highly important to implementation may have justification for being resistant to citizen control. Overreliance on citizen input in such fields can lead to bad policy outcomes, attention slippage and cyclical involvement that can hamper progress (Titter, JQ & McCallum, A, 2006). The reality of citizen engagement demonstrates that, in many cases, problems are not the result of either a completely inaccessible process (as participatory democracy advocates tend to claim) or a completely disengaged public (as institutional officials sometimes complain). Instead, it is how these two dimensions interact over time that generates the observed type of engagement or lack thereof. By recognizing these intersections, the specters of institutional boogeymen and phantom publics must be questioned.
Additionally, whereas Arnstein’s model requires that there be a clearly delineated process for incorporating citizen input into the policy output (Arnstein, SR, 1969), this matrix does not define the outcome of the policy process as one guided only by citizen decisions. Instead, it allows for variation in how institutions incorporate citizen input. This incorporation may occur through the clearly defined mechanisms that Arnstein envisions, but may also occur through a more natural, casual process.

*Proposed Typology Supports Mechanisms to Alter Contexts*

This typology also implies that clearly defined mechanisms may be identified to move between levels of engagement as deemed appropriate and desirable. The political science literature suggests ways to influence citizen interest in politics and mechanisms to mobilize individuals to commit resources. For example, an important contribution from political science is the value of being personally invited to participate (Putnam, Robert, 2001; Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995). An organization looking to move citizen interest into citizen commitment may learn from this that direct invitations can alter the type of engagement experienced. Similarly, the public administration and organizational theory literatures suggest some mechanisms for altering institutional structure or attitudes about public participation (Merton, Robert, 1957; Neuse, Steven M., 1980; Rosener, Judy B., 1982; Schneider, A & Ingram, H, 1993; Fox, C & Miller, H, 1995). Each of these literatures may be drawn upon to change participation patterns; however, by using this typology to first identify the current and desired contexts of
engagement concluding which of the variety of solutions on offer is most appropriate becomes easier and potentially more efficient.

Limitations and Future Directions

First and foremost, while this typology is an improvement upon previous one-dimensional models of citizen engagement it remains limited to two dimensions. Certainly, other variables are likely unaccounted for in this typology. Even so, because other unaccounted for variables are likely to impact the context of engagement through some effect on individual engagement or institutional engagement, this typology presents those researching public engagement with a parsimonious framework that provides clearly testable hypotheses.

A further limitation of this typology, however, is its reliance on hypotheses about the mechanisms most appropriate to a given context. Although the hypotheses seem correct given the limited sample examined within this article, it is quite possible that future research will discover differently. Even conducting a similar literature sample might have produced different results had the snowball been started from a different article. The names provided in this typology should be considered placeholders until future research can confirm their appropriateness or suggest new ones.

It is therefore necessary that this typology be utilized to inform future research. Together with the mechanism typology described by Rowe & Frewer (2005), this typology has the capacity to predict the most appropriate type of mechanism to use in any given context. While Rowe & Frewer’s broad categories of mechanisms were used to
guide the testing conducted in this dissertation, a thorough review of how the sub-
categories and variations therein relate to this typology will better guide future
practitioners about which mechanisms are most appropriate for their situation (e.g.
contingent effectiveness). As the discussion and testing of the typology reveals, similar
mechanisms may be used in multiple contexts. How effective and efficient these
mechanisms are in these differing contexts is unexplored in the current research largely
because of the lack of a conceptual framework like the one described above.
Furthermore, use of this typology will allow future research to better describe how
mechanisms might be modified to fit the context of engagement encountered. For
instance, it may well be that citizen juries are effective and efficient in both placation and
partnership contexts, but that the specific design of the jury must be different in each
context in order to be so.

Such contingent effectiveness will have to be researched in depth in the future. As
is demonstrated in the divergent approaches taken by the different fields of political
science and public administration, current research often fails to appropriately account for
both dimensions of engagement contexts. That 40% of the articles identified in the
snowball sample for this dissertation did not even contain descriptions of both
dimensions demonstrates a shortcoming in our current research methods. By providing a
common language of context experiences this typology has the potential to make current
practice and research more easily generalizable and replicable. As Rowe & Frewer
(2005) note, only through the use of a systematic categorization of contexts and a
typology of mechanisms can we hope to establish contingent effectiveness.
Understanding contingent effectiveness is an imperative if we hope to use research on engagement to meaningfully inform practitioners, and this typology is crucial in shaping that research.

Summary and Conclusions

The suggested typology draws together current thought on the institutional and individual dimensions of engagement. It explicitly focuses upon the relationship between the two, which is an often under-covered component of both political science and public administration research. This explicit focus on the relationship context provides critical insight into how institutions and individuals might improve engagement activities. It calls into question the phantom publics that institutions often blame on failed engagement attempts while also challenging the notion of the institutional boogeyman that public organizers demonize. The suggested typology demonstrates that, instead, both dimensions are important contributors to the participatory relationship that is observed.

Future research guided by this typology will be able to more appropriately inform practitioners. Simply ensuring that more of our future case studies include descriptions of both of the dimensions of the engagement context will allow others to determine if their participatory context is similar enough to make replication plausible. Such generalizations and replications will then be further supported as this typology is combined with mechanism typologies to generate contingent effectiveness research. Even in instances when both dimensions of engagement are difficult to capture, the use of this typology to contextualize the successes and failures of participatory practice will help
guide future application. The case study that follows of Oregon’s participation efforts in health reform demonstrate how isolating an example of one context (partnership) can elucidate the specific mechanisms and discourse that make it stable. Thus, use of this typology may prevent policy slippage and backlash, generating more stable—and thus, hopefully, effective—interactions with the public.
Chapter 3: Public Participation in Healthcare Politics

Historical Healthcare Policy Process in Oregon

Although active use of citizen input in health policy has waned in many places across the country, Oregon has consistently attempted to use a variety of town hall meeting mechanisms to inform state health policy. In the late 1980’s and early 1990’s, Oregon, like many states, faced growing demands on a restricted budget. In an attempt to provide health care coverage for its underprivileged population, Oregon determined that covering fewer services would allow for more individuals to receive care under Medicaid (Bussman, JW, 1993; Department of Human Services & Office of Medical Assistance Programs, 2006; Garland, MJ & Hasnain, R, 1990). The history of Oregon’s construction of a Prioritized Healthcare List (PHL) offers a stark example of the potential conflicts and pitfalls of institutional overreliance on either expert or citizen input.

The Prioritized Healthcare List (PHL) ranked numerous medical condition and treatment pairs. The list was then given to the legislature in order to define a budget. Once the budget was set, a hard line was drawn on the list of services, above which everything would be covered for Medicaid patients and below which nothing would be covered. This model of healthcare coverage was contentious. Many people disagreed

Initial reliance on healthcare and bureaucratic experts resulted in a 1989 list that ranked treatments solely by their cost-effectiveness (Department of Human Services & Office of Medical Assistance Programs, 2006). At the top of this list was treatment for thumb sucking (Oberlander, J, Marmor, T, & Jacobs, L, 2001). Although the treatment was low cost and highly effective, many people agreed that its ranking as a high priority treatment was not appropriate. As a result of the widespread discontent with the first attempt at a PHL, the Health Services Commission (HSC) was charged with overseeing a revised list that took into account societal healthcare priorities (Department of Human Services & Office of Medical Assistance Programs, 2006). Throughout 1990 and 1991, the HSC oversaw approximately one hundred twenty town hall meetings.

Early HSC Meetings

The town hall meeting structure used by HSC involved members of the commission and the Oregon Health Fund travelling to meeting locations around the state. A public announcement was released up to two months before each meeting, though there were some concerns that the announcements were ineffective. The announcements were made primarily via the HSC website requiring that individuals first had to know about the work of the HSC and the potential for meetings (Mehlman, MJ, 1991; Nelson, RM & Drought, T, 1992). Despite this, it is estimated that these early meetings in the PHL process had attendance in the hundreds (Department of Human Services & Office of
The meetings were run in a semi-structured fashion, with presentations from scientific-technical experts about disease-treatment pairings and from bureaucratic experts about cost-effectiveness. To some extent the purpose of these meetings was to inform the population about the value of cost-effectiveness research (Oberlander, J, Marmor, T, & Jacobs, L, 2001; Redden, CJ, 1999). With these presentations in mind, the floor was then opened for public comment. The expert presentations and citizen comment then informed the HSC determinations of potential priority rankings. The list that resulted from HSC deliberations was sent to the state legislature for a strict accept or veto vote, with extremely limited capacity for legislative amendment. The legislature’s main interaction with the PHL was in setting the budget that created the coverage line on the list of priorities. The resulting PHL was somewhat better received but conflicts remained. For instance, the coverage of end of life planning services and the uncovered ranking of some cancer treatments even led several critics to call Oregon’s plan a “right to die” with no “right to live” (Mehlman, MJ, 1991).

Later HSC Activity

Ultimately, the 1991 PHL was also discarded as the federal government denied Oregon’s request for a Medicaid waiver that would allow the use of the list because those who participated in the HSC process were not believed to represent the interests of the Medicaid population well (Oberlander, J, Marmor, T, & Jacobs, L, 2001; Oberlander, J, 2007; Behrman, RE & Larson, CS, 1991; Mehlman, MJ, 1991; Redden, CJ, 1999).
Rather, the HSC process resulted in subtle biases against the disabled and minorities (Redden, CJ, 1999; Garland, MJ & Hasnain, R, 1990). For example, certain mental illness treatments were given very low priority compared to their cost-effectiveness.

In order to counter the federal government’s concern, the HSC was relegated to a primarily advisory capacity for the state’s health and human services agency. In this revised capacity, the lists suggested by the HSC were no longer an absolute that had to be accepted or rejected wholesale. Although the HSC continued to hold public meetings, the number held each year dwindled, as did attendance (Department of Human Services & Office of Medical Assistance Programs, 2006; Oberlander, J, 2007). The federal government’s ruling on the PHL waiver strangled the waning citizen interest in direct participation on the topic (Oberlander, J, 2007). In later years, the commission contracted a survey service to conduct phone surveys that informed revisions of the list without the sustained and direct citizen involvement that the initial town halls had witnessed (Department of Human Services & Office of Medical Assistance Programs, 2006). Thus, the early hopes for a sustained partnership between citizens and the state health bureaucracy shrank to a system of consultation. The HSC remained a department of the Oregon department of health and human services, reviewing and amending the PHL until the creation of the Oregon Health Policy Board and renaming of the health and human services agency into the Oregon Health Authority in 2009.
Contemporary Oregon Healthcare Policy Processes

The passage of state House Bill 2009 established the Oregon Health Policy Board (OHPB), a nine-person board that oversees major Oregon Health Authority rule-making and policy decisions related to the federal health care reform law (Oregon Revised Statutes, 2009; Graves, Bill, 2009). Currently, five of the nine positions are held by individuals with direct professional linkages to the healthcare sector. Of the remaining four positions, one is held by a union representative, one by a local small business owner, one by the chair of the board for an employee benefits firm that does not handle health insurance, and one by the CFO of a major engineering firm located in the state. Jointly the Oregon Health Authority (OHA) and OHPB hold approximately monthly public meetings to discuss issues related to health care reform in the state.

OHPB Town Hall Meetings

Much like the HSC town hall meetings, these meetings are semi-structured. Each meeting begins with a report from the Director of the Oregon Health Authority about the recent activities of the agency. This often prompts questions and discussion from the board members and occasionally will be referenced by citizens who provide comment at the end of the meeting. The majority of the time at most meetings is devoted to presentations from experts on either scientific or bureaucratic matters. The presentations, however, are not a one-way direction of information.

While it has been implied that the HSC meetings and presentations served to manipulate the public by influencing their opinions on cost-effectiveness research, the
OHPB presentations are meant to inform the board members themselves. Frequently, the board members interject questions or sustain conversations that are tangentially related to the original topic. As a number of the board members are not primarily employed in the healthcare arena, these presentations and the discussions that they inspire sustain dialogue rather than instruct observers about the health agencies’ operations. This is clearly observable in how the presentations being made are physically directed to the members of the board, who are typically seated at the front of the room looking out into the audience and at the presenters. Often the presentations are reports from workgroups that the board has created to further investigate a specific topic. The reports from workgroups and from the OHA’s Director of Community Outreach often report what additional conversations with citizens have occurred and the main take-aways from such dialogues.

Statutorily, the last fifteen minutes of each meeting are reserved for public comment that has not been specifically invited by the board. In some cases, no one chooses to make use of this time. In other instances, the public comments extend well beyond the required fifteen minutes. From 2009 through June 2012, six of the thirty-two meetings (18.75%) included no citizen comment, and in eight meetings (25%) comments exceeded twenty minutes. The largest proportion of meetings (44%) had between one and three citizen comments, averaging a total of nine minutes of commentary.

Additionally, the board has at times used alternative structures to insert additional comment periods in the middle of meetings or, in one instance, utilized the “Art of Hosting” techniques that facilitate small group conversations in a focused manner using “powerful questions” (Brown, Juanita, Isaacs, David, Senge, Peter, & Wheatley,
Margaret, 2005; Creative Commons, 2013). All meetings are webcast live, recorded and archived online.

In between the webcast board meetings, the OHPB also assigns a number of tasks to workgroups. Several of the workgroups were established in the OHPB legislation, and thus the specific tasks and reasoning involved in their formation are not entirely observable. However, workgroups have also been formed as a result of discussion at public meetings and new tasks have been delegated to existing workgroups through similar discourse. The workgroups are frequently used by the board as way to request more in-depth information about a topic than would be feasible to investigate during a general town hall meeting. The workgroup topics include workforce development, defining the essential health benefits package, public health benefits purchasing, and clinical guidelines.

The workgroups may call on any resources that they prefer for the purposes of their discussions, but are not entitled to any compensation for their time. The workgroups’ choice of resources is likely linked to their task. Those tasks that are related to highly technical information—such as clinical guidelines—call upon the scientific expertise of healthcare professionals. Other tasks of the workgroup may relate more closely to bureaucratic concerns—e.g. definition of essential health benefits—or to public opinion—e.g. public health benefits. Regardless of the task assigned, however, the workgroups each include at least one non-expert citizen, at least one expert and one board member. They are expected to supplement and support the work of the board and make recommendations regarding their topic area.
The workgroups report, as appropriate, to the OHPB at public meetings. The workgroup meetings are not recorded in an observable fashion beyond the recommendations and reports made to the board. Because the workgroup meetings were not directly observable, the extent of citizen input in their conversations is deduced through review of these public reports.

Significance of the OHPB Study

Oregon’s twenty-four year history of grappling with health policy formulation demonstrates how contexts of participation influence the environment for citizen participation. The 1989 PHL was constructed in a typical expertise-driven manner, in an environment of bureaucratic hierarchy. However, the public backlash to the list generated an intense amount of citizen interest and the creation of the HSC supported the potential for high institutional opportunity and receptiveness. This mix promised a sustained partnership, yet that partnership never fully emerged. The unrepresentative population that participated demonstrated that de facto tokenism had taken root. Citizen commitment was low among key populations, and institutional opportunity may have been a façade. Meetings were generally held at times and locations that were not convenient for most people and the content may have meant as therapy or manipulation.

Notably, the director of OHA, Bruce Goldberg, commented that outreach to targeted populations (i.e., directly asking people to participate) did increase the representativeness of later town hall meetings. Such an experience demonstrates how simple it can sometimes be to shift citizen interest into citizen commitment, but by the
time of these changes in Oregon, the federal government had largely gutted the potential of the process.

Despite the failures of the HSC, citizen interest in healthcare policy has since remained high in Oregon. Governor Kitzhaber is a former emergency room physician and consistently works to make healthcare a state priority. He has created two organizations (The Archimedes Project and wecandobetter.org) aimed at increasing consumer engagement in healthcare dialogue and policy reform (Brunk, Doug, 2008; Belisle, Coleen et al., 2002). The OHPB is constructed of non-expert citizens, bureaucratic experts, and scientific-technical experts. This board, like the HSC, appears to be promising for a sustained partnership in policy formulation. Thus, we must ask why it might be expected to fare any better than its predecessor.

The Oregon Health Policy Board vs. The Health Services Commission

First, whereas the HSC was always a department within the state’s contemporary equivalent of the OHA, the OHPB oversees the OHA. Figure 5 below demonstrates this difference by placing the HSC, in a dotted box, where it was in the organizational structure located in the organizational structure. In contrast to the subordinate role of the HSC, the OHPB answers only to the state legislature and governor.
Figure 5. Organizational Chart of Oregon Health Agencies
Second, the HSC was primarily an advisory committee while the OHPB is directly vested with policy-making authority. Third, the HSC was tasked with one primary and rather concrete duty—the construction of the PHL. While this may have supported the high initial involvement witnessed in the HSC process, citizen interest in policy formulation is known to be fickle (Titter, JQ & McCallum, A., 2006; Dahl, Robert, 1961). The perception that most of the HSC work was completed after the initial years contributed to waning citizen commitment to the process. This is precisely why some scholars have criticized an extensive reliance on citizen participation in healthcare especially (Titter, JQ & McCallum, A., 2006). In contrast, the OHPB was originally tasked with a non-exclusive list of sixteen duties and powers (see Table 5) with varied degrees of specificity and technical complexity.

Table 5. List of OHPB duties

| 1. Establish a Health Insurance Premium Assistance Program |
| 2. Establish health benefits for the public employees |
| 3. Establish and refine statewide health standards for quality performance benchmarks |
| 4. Establish clinical standards and guidelines |
| 5. Approve and monitor community-centered health organizations |
| 6. Establish cost control mechanisms |
| 7. Establish an essential health benefits package |
| 8. Develop and implement new methods of reimbursement to reward efficient and comprehensive care |
| 9. Establish the Oregon Health Insurance Exchange |
| 10. Address issues related to healthcare workforce development |
| 11. Identify evidence-based interventions to promote population health and connect these public health interventions with the health delivery system |
| 12. Investigate and report on the desirability of a health insurance mandate |
| 13. Investigate and report on the feasibility of a state program to subsidize health insurance premiums for moderate income families |
| 14. Investigate and report on the desirability of a payroll tax tied to the provision of health insurance by employers |
| 15. Investigate and report on the desirability and feasibility of a public option for Oregon's Health Insurance Exchange |
| 16. Investigate and report on the development of interoperable electronic health records |
There is a widespread sense that the work of the OHPB will never be completed, and that citizen input will necessary for the foreseeable future. Fourth, the federal government’s decision to deny the state a waiver for its town hall process severely dampened the HSC receptiveness—or at least the perceived receptiveness—to citizen input and thus reduced citizen commitment. Yet, the OHPB’s process was later buoyed by the passage of the ACA, in which much of the activity already underway through the OHPB was now required of all states. Finally, no matter the receptiveness of the HSC, the opportunity to participate was always constrained by the vast size of the state. The enormous number of meetings held from 1990-1991 could not have been maintained over time. Since the time of the HSC, however, technology has altered the options available for participation. The OHPB has made use of social media and internet postings to announce meetings; they have consistently utilized live-streaming web video so that individuals can participate remotely; and they have a variety of ways for citizens, who may or may not have been able to attend the meetings, to contact board members.

The OHPB Challenge

Involving all of this stakeholder input requires that board members interpret information from a variety of sources while simultaneously communicating information to those both inside and outside of the process. The board communicates to those who are at meetings, but also to citizens more generally through press releases, interviews, direct email and phone communication and social media. The OHPB must oversee the ongoing
activities of the OHA and reports its recommendations and decisions directly to the legislature. What the board members, experts, advocates, and citizens choose to say and what they hear from one another is a constantly changing conversation. The nature of these interactions is complex, requiring investigation because these types of interactions are more and more frequently framing today’s difficult decisions, especially those related to “wicked” problems (Head, BW, 2008). Furthermore, the renewed emphasis on community accountability created by the Affordable Care Act requires understanding of how citizens participate.

These characteristics make the Oregon Health Policy Board an ideal choice to investigate as a likely partnership context for healthcare policy. As many previous attempts at partnership have been attempted in health policy and few have been sustainable (Davies et al 2006; New 2007), Oregon’s example could demonstrate how a public participation partnership is made functional and sustainable.

Case Study Foci

In examining this case, previous research and theory guide a focus on points of interest. However, these foci are not so much being tested as used to direct attention to the potential highlights of the case. The hypotheses and research questions discussed here are not looked for or examined in exclusion of other phenomena that present themselves organically. The following section describes in detail the initial foci of this dissertation.
Focus One: Patterns of Discourse

To begin, it is expected that the Oregon partnership is made sustainable through a process that facilitates dialogue between policymakers, experts, and citizens (Fox, C & Miller, H, 1995; Fischer, Frank, 1993; Davies, Celia, Wetherell, Margaret, & Barnett, Elizabeth, 2006; Chaskin, RJ, Brown, P, Venkatesh, S, & Vidal, A, 2001). Therefore, citizens are expected to participate meaningfully in public meetings (focus 1). Their comments and input should receive feedback from board members and may be reflected in resulting reports, rules and legislation (focus 1a). However, this deliberative process is believed to be most beneficial and sustainable when citizens speak primarily on matters of values and goals (focus 1b). In accordance with previous research on citizen participation in healthcare decisions (Kweit, Mary & Kweit, Robert, 1987; DeSario, Jack & Langton, Stuart, 1987; Lupton, Carol, Peckham, Stephen, & Taylor, Pat, 1998) and resource allocation (Simonsen, William & Robbins, Mark D, 2000), it is expected that the most frequent and valued citizen input would occur in discussion about the goals of policy activity. This goal-oriented discussion serves to inform policymakers and bureaucrats about the appropriate foci and measures for identifying problems and implementing solutions (Fischer, Frank, 1990; Kweit, Mary & Kweit, Robert, 1987; Simonsen, William & Robbins, Mark D, 2000). In contrast, it is thought that experts would speak more often about the causes, scope and interests related to the problems that prevent achievement of those goals.
Focus Two: Institutional Opportunity and Receptiveness

As the typology introduced in Chapter Two suggests, another critical component to this partnership is institutional opportunity and receptiveness. Thus, it is expected that this partnership is sustained in part because board members do value the input of non-expert citizens (focus 2). Receptiveness may be demonstrated in a number of ways (Neuse, Steven M., 1980; Rao, Nirmala, 1998; Merton, Robert, 1957). In particular, it is expected that OHPB board members articulate a belief that citizen input is important on many issues (focus 2a). This is especially important in this context as much of the work being conducted by the board is highly technical, making it likely that non-experts would have a low sense of self-efficacy and institutional responsive absent such articulation from the board members. The complexity of the topics combined with a high esteem for healthcare professionals as experts has been found to reduce the receptiveness of bureaucrats and policymakers to citizen input generally (Fischer, Frank, 1990; Neuse, Steven M., 1980). If this case is an example of sustained partnership, institutional actors must make a concerted and consistent effort to combat the perception of this among the citizen population. However, previous research has found that the greater amount of scientific-technical expertise that bureaucrats possess, the more likely they are to articulate that citizen input is not relevant or useful (Neuse, Steven M., 1980). As a result, the support for citizen input is expected to be lower among those board members who have a professional healthcare background (focus 2b).

Receptiveness should also be demonstrated through policy output (Rao, Nirmala, 1998). In the case of the OHPB, board members should be able to identify instances in...
which citizen input significantly shaped their approach to and decisions about policy formulation (focus 2c). Finally, some scholars have included opportunity as a component of institutional receptiveness (Rao, Nirmala, 1998; Merton, Robert, 1957; Schneider, A & Ingram, H, 1993). The OHPB has monthly public meetings and has made an effort to hold these meetings in a number of places around the state in order to provide additional opportunity to participate to rural citizens. Additionally, as previously noted, the OHPB has made use of a variety of technologies in order to expand participation opportunities beyond those who are able to be physically present at meetings. These opportunities contribute to an expectation that institutional engagement is high. However, if meetings occur but discourse within those meetings is restricted then opportunity for participation is actually low. The constraints on citizen communication that are imposed have a significant impact on the value of the communication that results (Outhwaite, William, 1994). Therefore, it is expected that the OHPB is attendant to how the process facilitates discourse (focus 2d). They are expected to adjust the structure of discussion (e.g. extend speaking times, permit extra testimony, alter the meeting format, etc.) to support meaningful citizen discourse.

Focus Three: Citizen Interest, Commitment, and Perception

Yet, the example of Rosener indicates that, regardless of institutional engagement, if citizen perception of institutional engagement is not positive then the process will become unsustainable (Rosener, Judy B., 1981). Oregon citizens, then, are expected to view the OHPB as receptive and transparent (focus 3). Perceptions of self-efficacy to
influence policy are an important aspect of this (Burns, Nancy, Lehman Schlozman, Kay, & Verba, Sidney, 2001; Verba, Sidney, Lehman Schlozman, Kay, & Brady, Henry, 1995; Campbell, Angus, Converse, Philip, Miller, Warren, & Stokes, Donald, 1960; Dione, EJ, 1991; Eliasoph, Nina, 1998; Larsen, Jorgen Elm, 2005; Dekeyser, Luc, 2001). Therefore, citizens are expected to feel that their participation does matter and does impact policy (focus 3a). Additionally, they are likely to feel that their input is just as important to the process as the input of healthcare professionals and bureaucratic experts (focus 3b). A sustainable partnership, however, also ensures that when decisions made by the board are not in line with personal beliefs citizens still view the OHPB as a credible and legitimate actor because the process used to make decisions is seen as fair (focus 3c).

Data & Methods

This dissertation utilizes a multi-method approach. Review of OHPB meeting materials, OHPB output, interviews with OHPB board members, and a citizen survey allow us to thoroughly examine the OHPB process and experience. The multi-method approach ensures that each expectation is thoroughly addressed and examined. Table 6 below demonstrates the coverage of research foci via the multiple methods available.
Table 6. Methods and Foci Map

<table>
<thead>
<tr>
<th>Focus</th>
<th>Meeting Agendas/Minutes</th>
<th>Recording Review/Field Notes</th>
<th>Meeting Transcript</th>
<th>OHPB output</th>
<th>Interviews w/ Board Members</th>
<th>Citizen Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Citizens participate in public meetings</td>
<td></td>
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<td></td>
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<tr>
<td>1a. Citizen input receives feedback from board members, is seen in output</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>1b. Citizen input is primarily about value-laden matters</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>2. Board members are receptive to citizen input</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>2a. Board members say that input is important</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>2b. The greater the expertise of the board member the lower the likely appreciation for citizen input</td>
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<tr>
<td>2c. Receptiveness is demonstrated through policy output</td>
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<tr>
<td>2d. Board members pay attention to how the process influences the participants</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>3. Oregon citizens view the OHPB as receptive and transparent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3a. Citizens feel that their participation does matter</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3b. Citizens feel that their input is just as valued as that of healthcare professionals</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3c. Citizens feel that the process makes decisions legitimate, even if they disagree with the decision</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Meeting Data

In order to identify the patterns of discursive participation related to hypothesis 1, this study utilizes content analysis of selected meeting transcripts (Appendix A). The amount of citizen comment provided varies greatly from meeting to meeting. All of the meetings include a statutorily required minimum fifteen minute public comment period at the end of the board meeting but it is often not utilized by anyone. However, several meetings include extra opportunity for comment in the middle of the meeting and include numerous comments. From 2009 through June 2012, six of the thirty-two meetings (18.75%) included no citizen comment, and in eight meetings (25%) comments exceeded twenty minutes. The largest proportion of meetings (44%) had between one and three citizen comments, averaging a total of nine minutes of commentary during each meeting that received public comments. Additionally, many of the meetings include reports from workgroups and subcommittees that explicitly reference citizen concerns.

Transcription of Selected Meeting Recordings

First, the agenda and minutes from each meeting (Oregon Health Authority, 2013) were reviewed to identify where non-expert public comment occurred. In addition, each recording was listened to in its entirety at least once. This audio review of the meetings allowed for the identification of meetings at which public comment was not specifically noted in the agenda or minutes but where citizen input was a topic of discussion by board members or workgroup reports. Because the 26 meeting recordings between 2009 and December 2011 are not transcribed and resources to complete transcription of all of the
recordings were not available, nine meetings (35%) were chosen for transcription based upon the presence of (1) citizen comment(s), (2) report(s) from workgroups, (3) conversation from board members about citizen or community involvement, and (4) the presence of an amended meeting structure, such as extra public testimony.

The four meetings in which all four of these characteristics were observed were given highest transcription priority, and were all transcribed. The twelve recordings that contained two or three of these criteria were given secondary priority. Within this secondary priority category, a count of each instance of the four criteria listed above was taken. For the purposes of the count, criteria number 3 (conversation from board members about citizen or community involvement) was operationalized as one count for every five minutes, or portion thereof, devoted to discussion of citizen input. The five meetings with the highest total count of the selection criteria were chosen for transcription. Those meetings with none of the four characteristics above were left out of consideration for transcription.

The initial audio review of the recordings, however, ensured that all instances of comment from or about citizens were identified even in meetings that were not ultimately transcribed. Transcription priority was given to those meetings at which numerous comments were made and board member discussions or workgroup reports focused on citizen involvement, but all instances were included in the coding and analysis process. Thus, a single two-minute public comment would not warrant transcription of the entire three hour meeting in which it occurred, but would be noted in research notes and included in the analysis of this dissertation. Transcription was completed by Transcribe
OSU, a university service that employs undergraduates, with funds provided by an Alumni Grant for Graduate Research and Scholarship.

*Interviews with Oregon Health Policy Board*

Interviews with Oregon Health Policy Board members (Appendix B) are used to supplement the meeting transcripts as some citizen-board-expert interaction occurs outside the context of the observable monthly meetings. The interviews also attempted to address those issues related to focus 2 (whether or not board members are receptive to citizen input). The interview questions (also in Appendix B) were developed with the help of members from the dissertation committee and were reviewed by Ohio State’s Institutional Review Board and a staff member of the Oregon Health Authority before administration. The ten questions were written in an open-ended format with a number of sub-questions and prompts to encourage deep description from the respondents. Open-ended questions in a semi-structured interview helped to elicit information about citizen-board interactions and revealed what is most salient to each individual board member (Weiss, CH, 1998).

The interviews were conducted by phone in order to contain costs while still providing a reasonably short time-frame and high expected response rate (Miller, TI, 1996). The interviews lasted in length from ten to forty minutes, with an average length of twenty minutes. Of the nine board members, seven agreed to be interviewed. Due to scheduling conflicts, however, only six (67%) interviews were completed. The professional backgrounds and demographics of the six respondents are not notably
different from those of the three non-respondents. Non-respondents reasons for not participating were related to time constraints rather than to an apparent difference in attitude. The interviews lasted in length from ten to forty minutes, with an average length of twenty minutes. The shortest of these was a result of the respondent’s relative newness to their position on the board, while the longest was with the Chair. The other four respondents spoke for between sixteen and twenty-eight minutes each.

Analysis Method

Meeting and interview transcripts, agendas, minutes, research notes, and board output (reports and recommendations to the legislature and resulting legislation) were imported to NVIVO, a qualitative coding software program. The meeting data and interview responses were separated based upon the OHPB duty addressed (see Table 5 above) so as to identify potential variations in participation patterns across topic and coded using the topics identified by Deborah Stone (2002) as frequent discursive mechanisms: goals, problems, and solutions. Stone’s themes were chosen as the primary coding tool because the three themes map neatly to the dissertation hypotheses. It is hypothesized that citizens can contribute most to “value-laden” and “goal-oriented” discourse (DeSario, Jack & Langton, Stuart, 1987); however, without clear distinctions, almost anything could be categorized as such. Even the most technical and ostensibly objective presentation must first be grounded in goals and values. Stone’s themes provide clarification on where the lines might be drawn.
Coding Themes

Goals discourse is most clearly related to the proposed hypotheses of this research. It most often evokes ideals such as liberty, security, equity and efficiency (Deborah, Stone, 2002). Citizens have been shown to contribute meaningfully to this type of discourse in the past. For instance, when the Head Start program was first evaluated and found to be lacking by experts focused on efficiency (e.g., how well the program raised test scores and academic achievement over time) parents and teachers objected that the true goals of the program were about security and equity (e.g., lower rates of gang activity, access to safe space, and opportunity for underprivileged children) (Fischer, Frank, 1990).

Problem definition is closely related to goal discourse. However, it is often more technical in content. The discussion of problem definition utilizes language related to numbers, symbols, causes, interests and decisions (Deborah, Stone, 2002). Symbol use is the only one among these that is hypothesized to be especially likely in non-expert discourse—even those unfamiliar with budgeting practices, for instance, understand the family budget metaphor when discussing government spending decisions. Stone’s categorization of the other types of problem definition dialogue relies heavily upon an understanding of technical issues and would, therefore, not be expected to appear in the discourse of non-experts. However, with the ease of access to information today, citizens may present this type of discourse (Stehr, Nico, 2008; Fuller, Steve, 2008); in which case it is important to ask how it is received by institutional actors. While citizens may occasionally report general statistics or causal arguments, it is hypothesized that such
discourse will not influence policymakers as much as the same type of discourse from those with scientific-technical expertise (Fuller, Steve, 2008)—healthcare professionals.

Finally, solutions are categorized by Stone (2002) as concerning the appropriate use of rules, facts, inducements, rights and powers. In this case study, these most often are manifest in discussions of what regulations should be made and how they should be enforced. These are topics of a technical nature, which it is hypothesized will be most addressed by those with bureaucratic expertise—economists, administrators, hospital managers, insurance representatives, etc.

Stone, like Habermas, notes that speech acts are rarely cleanly differentiated (Deborah, Stone, 2002; Outhwaite, William, 1994). Instead, any single discussion can include all of these themes. As such, coding was applied liberally, often attributing numerous codes to a single comment or different codes to different sentences/paragraphs within one speech. Eighty-two percent of the material from meetings was coded with two or more themes. Furthermore, while additional themes related to anecdotal stories and gender were not predetermined they emerged during review of the material. These unexpected themes are examined separately in Chapter Four.

In conducting the NVIVO analysis, patterns or themes appearing in one data source were searched for in the other data sources as well. For example, a discussion about citizen involvement in a particular policy aspect during a meeting led to review of legislative output and whether the topic was mentioned during the board member interviews. This triangulation allowed for assessment of whether (a) discussions at board meetings resulted in substantive policy changes, (b) whether board members
spontaneously attributed those changes to citizen involvement or not, and (c) whether board member interview responses were reasonably reliable recollections of actual events.

Citizen Survey

In order to investigate citizen perceptions about the process (focus 3), a citizen survey was constructed (Appendix C). In order to fully understand if the Oregon experience is a sustained partnership context per the typology proposed by this dissertation, the citizen interest and commitment level is important to understand not just in an abstract sense. As the typology testing in Chapter 2 revealed, the perception of the process on each side (institution and citizen) is as important as the reality. Citizen perception of low receptiveness or expertise-dominated process can fundamentally alter the context of engagement whether or not that perception is supported by the content analysis of actual meetings. Thus, the survey was seen as a critical component of assessing both whether the OHPB experience really is partnership and what components of that process are perceived as important for sustained partnership by citizens.

After initial construction, the survey was used to conduct cognitive interviews with a small sample (n=3) of volunteer Oregon citizens. The cognitive interviewing process ensures that the questions are accurately referencing the correct ideas (Schaffer, FC, 1998). During a cognitive interview, the subject is asked to describe what they are thinking about and questioning as they review and answer each of the questions on the survey (Caudle, SL, 1994; Swandt, T, 2007). In this manner, the researcher is able to
assess whether the interpretation of the questions and directions by respondents is consistent with the researcher’s intentions. The results of the cognitive interview process led to the revision of only two actual questions, but substantially altered the instructions given for certain items. With OHA permission, the twenty-one question survey was then distributed via the OHA and OHPB Facebook pages and email listservs. These outlets each reach approximately 1200 members. There is an unknown, but assumed very high, amount of crossover among these lists. The approximate N is estimated to be about 1500 individuals.

This choice of sampling frame may be a concern due to the potential impact of self-selection bias (Miller, TI, 1996); however, while this survey will not be able to assess how the population at large perceives the Oregon participation attempt, it is ideal for the purposes of this research. The questions of most relevance in this research are about the experience of participating. All of the individuals who took part in these forums have previously voiced a minimum level of interest in participating with the Oregon Health Authority. Therefore, this population is ideal for investigating the connection between institution and citizen.

Unfortunately, the survey received only thirteen responses in the five months that it was active despite repeated notifications about the study. I am, thus, unable to conduct any useful analyses or draw any solid conclusions about the citizen perception of the OHPB. The low response rate is thought to largely be a result of the nature of the distribution mechanism employed. While these electronic contact lists constantly display the most recent postings by the OHA, postings by non-agency members are quickly lost
among a host of other posts. This resulted in little visibility for the survey links that were posted. Had OHA been able to post the survey on my behalf, the message would have retained visibility on the site for a number of days. On the other hand, lack of response may indicate some reason for concern. If the citizens on these forums have expressed interest and utilize their membership to passively monitor OHPB activity but are not committed enough to respond to a fifteen minute survey, then the assumption of sustainable partnership may be flawed. Instead, the OHPB process may in fact be an example of *placation*.

Findings

Table 7 below summarizes the occurrences of discussion on each of the board’s duties between December 2009 and June 2012.

Table 7. Discussion by Topic

<table>
<thead>
<tr>
<th>OHPB duty</th>
<th>Dates on Agenda</th>
<th>Citizen Input?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish a Health Insurance Premium Assistance Program</td>
<td>5/2010; 10/2011</td>
<td></td>
</tr>
</tbody>
</table>
(continued on page 88)
<table>
<thead>
<tr>
<th>Task</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate and report on the desirability of a health insurance mandate</td>
<td>Resolved by federal legislation</td>
</tr>
<tr>
<td>Investigate and report on the feasibility of a state program to subsidize health insurance premiums for moderate income families</td>
<td>Resolved by federal legislation</td>
</tr>
<tr>
<td>Investigate and report on the desirability of a payroll tax tied to the provision of health insurance by employers</td>
<td>Resolved by federal legislation</td>
</tr>
</tbody>
</table>
Not every duty of the OHPB has yet been addressed at public board meetings. A few have been resolved through the passage of the Affordable Care Act. Others are likely being discussed by workgroups or subcommittees or delayed until other duties are completed. On several topics there is no public commentary noted, and on many others citizen input is quite limited. While all of the meeting audios were reviewed and a select few chosen for transcription, the highlighted topics are chosen as a focus of the following dissertation discussion because they presented numerous points of analysis, including OHPB output and board member interview responses.

The decision to isolate these topics for specific investigation was made by assessing the presence of numerous comments at the public meetings and correlated commentary in workgroup and board output or member interviews. Thus, the presence of comments in a meeting was not alone enough to instigate focused attention on the topic for the purposes of this research. However, the presence of supporting board output and interview responses was used to determine the relevance of topics on which a limited amount of public comment was observed at meetings. For instance, the number of comments on clinical guidelines observed at public meetings was small, but workgroup reports and interviews with board members provided further data for analysis about how citizens were involved.

As noted in the methods section above, transcripts were not made of every meeting in which commentary occurred, and not every meeting transcribed included only these highlighted topics of discussion. The data on the other twelve topics, however, provided limited insight into the specific foci of this dissertation. Those topics on which
some comment is noted were reviewed and included in the NVIVO review, but without additional data they presented limited information to report. The choice to limit the discussion of results to these topics was therefore made in situ rather than a priori.

Initial Findings & General Patterns

To some extent the general pattern of commentary is consistent with expectations. Those topics with little to no notable citizen input include a number of issues that are highly technical or bureaucratic—electronic health records, evidence-based public health interventions, reimbursement strategies, and cost control mechanisms. Yet, there is also little citizen comment on issues that would appear to lend themselves more readily to deliberation—the desirability of a public option, defining what are “essential” health benefits, defining the health insurance that taxpayers support for public employees, and the creation of premium assistance programs.

This may be due more to the timeframe of this study than to an inherent lack of citizen interest or commitment on these topics. For instance, the essential health benefits definition was primarily the focus of a non-observable workgroup during the study period. It later became a topic of public comment in November 2012 and has been revisited several times since then. Similarly, the absence of sustained and significant public comment on topics such as the desirability of a public option may be a result of external factors related to the OHPB mission. When the ACA passed in November 2010 without a public option component, it is possible that this decision at the federal level severely muted the discussion at the state level. Given that Oregon began considering the
creation of a state run public option before the passage of the ACA this may be only a temporary pattern. The passage of the ACA has signaled to policy-makers and citizens alike what issues must take priority at least for the time being. Strict timelines about the implementation of the Health Insurance Exchange, Accountable Care Organizations and Medicaid expansion plans have likely caused some of the observed anomalies in Oregon participation patterns.

Whether this finding is purely related to timing or not, the pattern is not entirely consistent with expectations about what citizens would comment upon, and it is therefore worth noting. This pattern suggests that the federal government might need to be cautious about the messages that it send to states regarding participation in health policy formulation. While national legislation may buoy citizen engagement in some ways, the imposition of national priorities on state and local affairs may stifle other promising avenues of discourse.

Another surprising finding is that some of those topics on which citizens do provide input appear to contradict expectations. Clinical standards and workforce development are both quite technical matters on which we would expect more expert-driven policy formulation. The value-added of citizen’s to these types of unexpected participation topics may provide especially provoking insight into participation.

To further explore the contributions of citizens to health policy formulation in Oregon, then, this study focuses upon the four topics on which citizen comments were observed and noted in reports, or recalled by board members: Community Care Organizations, Health Insurance Exchange, workforce development, and clinical
guidelines. Each topic is presented using the categories of policy discourse identified as goals, problems, or solutions (Deborah, Stone, 2002). Table 8 below summarizes the patterns uncovered across the topics and themes.

As this table displays, the most frequent and impactful area of input by citizens across topics was in problem definition. On the topics of Community Care Organizations and Health Insurance Exchange development, citizens also contributed directly and meaningfully to solutions discourse. However, on the more technical topics of workforce development and clinical guidelines, citizens often did not have specific solutions to offer. Nonetheless, the contributions that were made by citizens to problem definition often directly impacted the types of solutions that were later developed by experts. The discussion below more deeply investigates these specific patterns.
Table 8. Patterns of Discourse in the Primary Topics of OHPB Participation

<table>
<thead>
<tr>
<th>Goals</th>
<th>Community Care Organizations</th>
<th>Health Insurance Exchange</th>
<th>Workforce Development</th>
<th>Clinical Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed in many meetings,</td>
<td>Not notably discussed</td>
<td>Not notably discussed</td>
<td>Only discussed on rare occasions and always by experts</td>
<td></td>
</tr>
<tr>
<td>but largely by board members &amp; experts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems</td>
<td>Discussed by citizens, board, and experts. Citizens especially focused on discussion of potential interests.</td>
<td>Citizen comments on the causes and decisions that make insurance purchasing difficult.</td>
<td>Citizens often identified alternative interests that should be included in the discussion.</td>
<td>Citizens contributed by questioning the decision metrics under consideration.</td>
</tr>
<tr>
<td>Solutions</td>
<td>Citizens expressed much concern about the balance between rules, inducements, and facts to support system change</td>
<td>Citizens expressed much concern about the rules governing specific aspects of the exchange</td>
<td>Identification of additional interests by citizens led to the development of additional solutions through expanded powers for certain providers.</td>
<td>Citizens suggested only a few specific solutions, but the questioning of decisions and root causes often led to the formation of new solutions.</td>
</tr>
</tbody>
</table>
Community Care Organizations

Community Care Organizations (CCOs) are Oregon’s approach to the requirements for Accountable Care Organizations under the ACA (Berwick, Donald M., 2011; Crosson, Francis J., 2011; Meyer, Harris, 2011; Shortell, Stephen M., Casalino, Lawrence P., & Fisher, Elliott S., 2010). These are envisioned as centers of care that work to ensure that care is coordinated across disciplines. The patient experience is ideally improved through the intimate cooperation that is fostered between all medical professionals that the patient would come into contact with (Berwick, Donald M., 2011; Crosson, Francis J., 2011; Meyer, Harris, 2011; Shortell, Stephen M., Casalino, Lawrence P., & Fisher, Elliott S., 2010). The ACA requirements for Accountable Care Organizations are minimums that are left to the state to expand upon and enforce.

In Oregon, the state is utilizing CCOs as providers for Medicaid recipients. Providers and patients are encouraged to participate in the design of CCO requirements because the CCO approach is believed to provide an alternative way to provide efficient delivery of care without resorting to the bureaucratic mechanisms of rationing, as previously embodied in the HSC and PHL. There is great interest in the organization of these delivery systems because they will ultimately impact citizen’s ability to access care and how that care is delivered once accessed. Patients are also concerned about how information is shared between providers within these systems and what that means for their privacy and security. There are concerns about equity, efficiency and security at play.
CCOs have received media exposure across Oregon, suggesting that they are a topic of interest to the state’s population, and the establishment of these ambitious organizations was the most frequent topic on which citizens gave input at meetings. This combination implies that CCOs are a topic about which citizen engagement is high, per the typology suggested in Chapter 2.

It is also the most frequent topic on which citizen involvement is explicitly mentioned by board members during public meetings, and is the topic of discussion at two meetings in which the structure of discussion was altered to allow for additional public comment. This suggests that board members are attendant to how the process and the structure of meetings impact citizen perceptions of fairness. The board members have consciously made an effort to allow for expanded opportunities for participation and voice a desire to hear and fully understand any citizen input. The institutional opportunity and receptiveness on this topic is also high, suggesting that this topic specifically is a likely context of sustainable partnership.

Discourse about the goals of CCOs revolved largely around concern for equity and efficiency. Because CCOs currently serve only Medicaid and Medicare patients, a major concern is how services are provided in a manner that reduces health disparities and saves the state money. However, these goals were rarely articulated by citizens. Rather, presentations made by experts—both bureaucratic and scientific-technical—tended to reference these goals explicitly while also introducing facts about the problems and potential solutions. Board members also frequently made reference to the goals of
CCOs, sometimes asking pointed questions of presenters about how their information specifically supported the goals of equity or of efficiency.

While expert testimony often presented the board with information about the problems of the healthcare system that offer hurdles to CCOs, they were not alone in doing so. A component of problem definition includes identifying relevant interests to the conversation. While professional healthcare workers spoke on this issue of CCO interests most often, citizens also contributed by suggesting that purchasers and patients who are not currently served by Medicaid should also be considered as these processes are developed. A workgroup report on citizen feedback suggested that structures being created ought to be mindful of broader interests than the limited Medicaid recipients who would be the initial beneficiaries of system reform. One participant commented:

…We’ve had a similar discussion about public purchasers. What we haven’t had a discussion about is the private sector and the largest healthcare purchasers in our state…And what’s the discussion with those folks around changing their way, the way they are thinking about their own insurance models? I think, this is probably, you know, if you combine them all together the second largest purchasers of healthcare in our state. And what’s our plan around moving our vision outside of a Medicaid population, which we all agree doesn’t transform the system? (11/08/11)
This comment sparked a several minute conversation between the board and the workgroup presenter. It was then a theme again in the following two months of board meetings (12/13/11; 1/10/12; 1/24/12) and was ultimately included in a report and recommendations from the OHPB to the legislature.

The comment itself was a hermeneutic discourse about the interpretation of relevant stakeholders, yet it also shaped an ongoing dialogue about the appropriate solution structures. Solutions may utilize a mix of inducements, rules, rights, facts and powers, but the mix of these appeals is likely to be different depending upon the target population and problem definition (Deborah, Stone, 2002; Schneider, A & Ingram, H, 1993). For instance, debate about relevant stakeholders led some citizens to voice concern that “the discussion about the community get[ting] represented doesn’t really matter if the majority is people who have financial risk.”

In discussing potential solutions for CCO construction, a common theme was the appropriate role of rules. In the words of one board member at a meeting, “the difference between recommend and require is an important one.” As a subcategory of Stone’s “solutions” code, rules were a theme that experts (especially bureaucratic experts) were expected to speak most directly about. This expectation was somewhat supported. The balancing act between rules, inducements, the use of facts and the provision of powers was most frequently commented upon by experts and the board members themselves. Committee reports presented at meetings did occasionally cite citizen commentary on proposed rules or regulations, and the occasional public speaker (four speakers in the nine
meetings transcribed) would discuss “governance and accountability” specifically. However, rules and other potential solutions remained a largely expert driven discussion.

Health Insurance Exchange Development

A Health Insurance Exchange is another requirement under the federal Affordable Care Act. Oregon has chosen to construct its own exchange rather than utilize a federally facilitated exchange. This choice requires that Oregon determine the rules and regulations regarding insurance sales in the state, how subsidies and dual-eligible individuals will be handled, what groups are going to be expected to participate in purchasing insurance from the exchange, and how the state will assist individuals and groups in using the exchange. Because this topic has been the focus of widespread national and state media coverage and because citizens and businesses alike are concerned about how the exchange will help them meet the new federal mandates for purchasing insurance, there is notably high interest and commitment on this topic.

The development of a state Health Insurance Exchange (HIE) was the second most frequent topic on which citizen comment occurred. Very early in the process OHPB board members expressed a desire to include citizens in the HIE development process. The outreach and engagement director of OHA was thus charged by the board to conduct a series of meetings around the state in September 2010 to introduce the current HIE proposal and gather citizen feedback. At those September meetings it was estimated that about two-thirds of attendees did not have a health-related background. In the October 2010 monthly meeting of the OHPB, an extensive report of that feedback was presented.
to the board and additional public comments focused on the HIE were made. Again, the board has made a concerted effort to provide ample opportunity for participation and display honest receptiveness to citizen concerns. The high citizen engagement and institutional engagement suggest that this topic is especially supportive of a partnership context.

During OHPB town hall meetings, the goals of the HIE were not clearly articulated using any of Stone’s four goal categories (equity, efficiency, liberty, security). However, the decision to construct a state HIE was made by the legislature. It is quite likely that this study simply failed to capture goal construction on the exchange topic because it occurred during legislative consideration in the year preceding the establishment of the OHPB.

Problem definition and solution identification was, however, observed and both did involve some citizen comment. For example, one citizen testified that although he has an advanced degree in computer science and is extremely web-savvy he had trouble managing to use any sort of rational decision calculus when attempting to purchase an individual health insurance plan online. The feedback report presented to the October 2010 board meeting included citizen suggestions that many of the concerns that citizens had about the HIE were related to rules and inducements.

Citizens were particularly concerned about the rules that would restrict plan offerings in a meaningful way. Specifically, the outreach and engagement coordinator noted:
… that meaningful choices piece didn’t necessarily mean fewer choices. For example in eastern Oregon it was “meaningful choices” meant having more choices than they currently have right now but in other parts of the state it did mean having more limited or streamlined choice. It also meant that it was important that the types of service that were allowed included alternative medicine for example and so a part of having meaningful choice was having inclusive choice as well.

Citizens also wanted to ensure that the rules of the exchange supported the role of insurance brokers to help navigate insurance purchase decisions. Finally, there was a concern expressed repeatedly that the rules provide mechanisms for continued accountability. This citizen concern with HIE accountability, in fact, supported the decision to require a citizen advisory council in the permanent organizational structure of the state HIE. This choice of mechanism by the OHPB definitively displayed a commitment to a sustained partnership with interested citizens. The decision to include citizens in a permanent fashion and vest these citizen advisory councils with serious power—to make decisions about organizational priorities and to challenge the inclusion of insurance providers if those priorities are not met—demonstrates a substantial recognition of the importance of citizens in the creation and administration of HIEs.

Despite a focus on rules, however, citizens were also hopeful about the potential for the exchange to act as an inducement. “There was a strong sense that people wanted an exchange to encourage competition” and innovation.
Workforce Development

Workforce development involves not only education and training of new healthcare professionals but also how to broaden access to care. For instance, one mechanism for broadening the healthcare professional pool under discussion was the prescribing powers of psychologists. It was not a frequent agenda item for the OHPB during the study period, and there was no language from board members during public meetings that suggested that this was a topic on which they felt citizen input would be useful. Thus, this topic was an unexpected finding of meaningful participation. The citizen interest in this topic appears to be reasonable, but commitment is limited. Those who are committed to this issue and speak on it in public meetings are few in number and not demographically representative of the general population. Institutional actors appear receptive to input, but do not go out of their way to create extra opportunities for participation. This topic could prove to be an example of tokenism. Surprisingly, this does not appear to have been the case.

Little to no goal dialogue about workforce development was used in public meetings either, though discussion of efficiency, equity, security and liberty likely occurred in workgroups. Nonetheless, in interviews several board members noted that this was a topic on which citizen contributions fundamentally altered their view of the topic. Again, citizen input most impacted the policy-makers through discussion of alternative interests that should be considered. In contrast, experts tended to focus upon
the underlying causes (e.g., the price of education, reimbursement rates, etc.) of workforce shortages, especially as they relate to Medicaid.

In the case of workforce development, citizens provided testimony about their experience with naturopathic physicians as primary care providers (PCPs). The idea of such physicians as PCPs had not occurred to the board members before these citizens presented it. As a result, the board created an entire new workgroup focused on alternative medicine providers. This newly recognized interest to the workforce discussion then informed potential solutions such as extending the right to treat Medicaid patients and public employees to naturopaths.

Citizens, in large part, did not appear to continue a sustained dialogue with policymakers once their concerns regarding additional interests were satisfactorily met. Yet, the institutional actors did make adjustments to provide new opportunities for participation to both citizens and the newly identified interest groups of concern. A few citizens continue to participate in the newly formed workgroup alongside experts and board members. The willingness of institutional actors to make adjustments to their opportunity structure (a result largely due to their innate receptiveness to input) thus ensured that this topic resulted in placation rather than tokenism. Furthermore, the pattern of responsiveness demonstrated here suggests that, should citizen commitment levels change in the future, the OHPB is willing and able to adjust to the changing context.
Clinical Guidelines

Clinical guidelines were also not a common focus of OHPB monthly meetings. Presentations regarding clinical guidelines tended to be brief and board member discussion was limited. It is the subject of expert testimony in only one of the nine transcribed meetings. Again, citizen interest is moderate, but commitment is limited to an unrepresentative and small number of people. Institutional receptiveness is high and opportunity exists. Though the opportunity at public meetings is limited, the workgroup focused on this topic is open to the public and is noted to have explicitly invited and requested citizen input on a handful of occasions.

The expert testimony addressed clinical guidelines for mental health patients in a holistic manner that made use of all four potential goals (equity, efficiency, security and liberty) as well as problem definitions and solution potentials. However, several citizens also commented on clinical guidelines.

Citizen commentary tended to focus upon general problems in decisions or causes of the health care experience. A citizen at one board meeting that was not transcribed described his mother’s poor treatment experience, suggesting that a number of things had gone wrong with the system as a whole. He may not have been able to pinpoint the exact causes or decisions made that contributed to this poor experience, but his testimony certainly highlighted a number of the potential problems. In their comments, citizens often did not have as clear of an articulation of potential solutions as experts did. Nonetheless, the dialogue that they introduced often shed light on new causes or

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decisions that the board had not previously considered as shaping the problems before them. As one member noted:

…sometimes listening to their experiences and then asking somebody to do some research about what really happened and what caused it. Often when the public comes to us their it’s about an experience that didn’t go very well and finding out what about that experience caused it to go not very well can certainly help us from, to avoid putting into place recommendations or policy that has unintended consequences.

Another board member recalled one instance while visiting a workgroup when a citizen pointed out that the activity measures being considered as a standard for health had been in use since the 1950’s and that one of the measures was the ability to walk:

Well there was a community member there who is an advocate for people with disabilities who pointed out that there are wheelchair athletes who are probably more fit than most people but lack the ability to ambulate. So based upon the guidelines that we were considering they would get points marked off for that and that was something that none of us would of thought of in the room without that person having been there so they contribute.
Appropriate research into and definition of causes and decision metrics have thus helped the board to clarify what types of metrics physicians might be held accountable for in the future.

Again, problem definition is itself critical to defining potential solutions. Still, additional specific solutions were offered to the board by both experts and citizens. One citizen testified about the appropriate clinical use of hemp oil for certain conditions, and another presented concerns about the rules for narcotic painkiller prescriptions for patients with documented chronic pain conditions.

Implications

Drawing on the audio review of meetings, coding of meeting transcripts, interviews with board members and review of OHPB output documents, this dissertation suggests that some of the current assumptions and normative claims about citizen participation may be flawed. Foci 1a and 2 a, b, and d were all supported by this study. Foci 1b and 2c, however, were not. These findings are summarized below in Table 9.
Table 9. Results

<table>
<thead>
<tr>
<th>Focus</th>
<th>Finding</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Citizens participate meaningfully in public meetings</td>
<td></td>
</tr>
<tr>
<td>1a. Citizen input receives feedback from board members</td>
<td>Yes</td>
</tr>
<tr>
<td>1b. Citizen input is primarily about value-laden matters</td>
<td>No</td>
</tr>
<tr>
<td>2. Board members are receptive to citizen input</td>
<td></td>
</tr>
<tr>
<td>2a. Board members say that input is important</td>
<td>Yes</td>
</tr>
<tr>
<td>2b. The greater the expertise of the board member the lower the likely appreciation for citizen input</td>
<td>No</td>
</tr>
<tr>
<td>2c. Receptiveness is demonstrated through policy output</td>
<td>Yes</td>
</tr>
<tr>
<td>2d. Board members pay attention to how the process influences the participants</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Citizens did participate and their comments were often responded to by board members (focus 1a). Furthermore, while specific policy language was often not able to be traced back to citizen input some notable instances suggest that citizen input does shape policy output and was acted upon by board members (foci 1a and 2a). When asked if they felt that public input had impacted the policy outcomes (focus 2a) of the Oregon Health Policy Board all of the board members felt that it definitely had and that it was important to hear from citizens even when their input did not contribute to policy decisions directly (focus 2b). However, the value added by public input was not thought to be about the goals of policy (focus 1b). As one board member noted about experts and lay citizens, “I don’t think their objectives or even in most cases the recommendations for action are widely different.” Rather little of the discussion at meetings was about goals. All of the
goal discussion that did occur was around the meaning and pursuit of equity. Experts, citizens and board members broadly used the same language around the goal of equity as well; they all agreed upon the need for some state-wide standards that still provided flexibility in recognition of the population differences and needs variations from place to place. Counter to the normative assumption of previous scholars that citizens should speak most directly to goal definition, board members felt that the real value of citizen involvement was in sparking discussion of problem definition.

Additionally, previous findings (Neuse, Steven M., 1980) that more technically experienced bureaucrats are less receptive to citizen input (focus 2c) could not be supported by this study. Those board members interviewed who have professional healthcare expertise were, in fact, more appreciative of citizen input than their non-healthcare counterparts on the board. One interview respondent even went so far as to suggest some suspicion of expert testimony because of the potential conflicts of interest involved. In contrast, several board members—both expert and non-expert—noted a sense that citizens were genuine and trustworthy in their intent to participate.

Finally, the board demonstrated attention to the two-tracks (structure and content) of policy discourse, paying heed to how structure influences communication and participation (focus 2d). This study is the first empirical attempt to understand how and why the need to attend to both the content and structure of deliberation impacts participation. Many of the meetings reviewed in this study provided more than the statutorily required minimum for public comment. In several instances, the board allowed public comments well beyond the three minute per comment maximum, and in four of
the nine meetings transcribed an entire extra comment period was inserted into the middle of the agenda. The board was also receptive to the creation of additional workgroups to encourage ongoing discourse about meaningful topics.

When asked about the decision to make these adjustments, one board member noted that extra comment time was added in cases where the topic was complex and it was felt that board members should hear feedback before moving on to other agenda items. This reflects Habermas’s concern that the external organization of discourse might impact the relevance of the information communicated (Outhwaite, William, 1994). In cases where relevance was believed to be potentially negatively affected by having citizen comment several hours after initial discussion, the restructuring of the agenda was felt appropriate. Other board members expressed a sense of responsibility to hear out the people who have spent most of the meeting listening to them.

Limitations

First, due to the failure of the citizen survey this study was ultimately unable to effectively connect to the typology introduced in Chapter Two. This survey would have been able to more directly capture the citizen perceptions of institutional opportunity and receptiveness. As the typology testing in Chapter Two demonstrated, these perceptions can be as important to the observed context as the actual amount of institutional engagement. What third party observers (i.e. researchers) and institutional actors view as mechanisms to support opportunity and receptiveness may not always be the most important mechanisms in the eyes of participants themselves. Thus, the successful
deployment of the survey would have allowed this research to better identify both the context of participation and the mechanisms of importance in this case study.

While the low response to the citizen survey could indicate that Oregon may be an example of placation rather than partnership, the review of OHPB activities and citizen involvement therein suggests otherwise. The OHPB is statutorily required to be composed of a number of people without healthcare expertise. Furthermore, the workgroups each have at least one citizen representative. Beyond these potentially token representatives, the OHPB has made special efforts to have the OHA hold additional public meetings around the state on selected topics and citizens do, in fact, participate in rather impressive numbers. All of this suggests that citizen interest and commitment do run high in general and on some topics especially, though it could not be confirmed with the survey. The discussion of the mechanisms to support participation in this case, however, rest on an informed assumption about the level of citizen engagement rather than empirically confirmed evidence of a partnership context.

The analysis of discourse is also limited. Workgroup meetings and those meetings held by the outreach and engagement coordinator are not recorded or as thoroughly documented as the monthly OHPB meetings. It is quite likely that much of the discussion about goals occurred in these settings and is not captured in this study.

It is also quite likely that the suppressed reference to broad goals observed in this case study is the result of historical discussion that occurred before observation began. As previously noted, Oregon has a long history of at least attempting to maintain citizen involvement in state health policy. The OHPB’s enabling legislation evolved out of a
history of transparency about the goals for Oregon healthcare. There are clear objectives charged to the board in that legislation, which itself was created as a result of years of legislative testimony and a state culture of citizen engagement. This history makes the Oregon experience unique.

Conclusion

While it could be interpreted that Oregon’s unique status means that there is limited information to be generalized about participation in healthcare from this study, it is this history that makes the Oregon example important to understand. With the passage of the ACA, the establishment of PCORI, and a growing interest in healthcare reform among the general populace, citizen engagement in health policy formulation is only likely to increase in the coming years. This case study thus suggests several important contributions to both the theory and practice of citizen participation.

Contributions to Theory

While this case study was unable to definitively connect to the typology introduced in Chapter 2—a limitation which demonstrates why roughly 40% of existing literature fails to capture both dimensions of engagement—the findings still suggest some meaningful contributions to theory.

First, this dissertation empirically challenges the assumptions of some scholars (DeSario, Jack & Langton, Stuart, 1987; Kweit, Mary & Kweit, Robert, 1987; Charles, Cathy & DeMain, Suzanne, 1993; Rosenberg, Shawn W., 2007; Schwartz, Jerome L. &
O'Rourke, Paul F., 1968; Simonsen, William & Robbins, Mark D, 2000) about how citizen input can and should contribute to policy discourse. Citizens provided meaningful input on topics that were not directly related to the definition of policy goals. The normative assumptions that lead to conclusions which limit participation to goal discussion rest upon a belief that citizens do not have the appropriate ability or knowledge to contribute to the more technical matters of problem definition and solution identification. The modern availability of information, however, calls this assumption into question. This phenomenon has also been noted by previous researchers (Roberts, Nancy, 2004; Fischer, Frank, 1993; Fuller, Steve, 2008). The results of this dissertation further suggest that, even when not accessing technical information, citizen insight can often be useful to identify complicating causes and decisions that contribute to problem definition and in suggesting additional interests that ought to be included in the discussion.

Second, the counterintuitive finding that those board members with expertise were more, rather than less, likely to value citizen input challenges traditional theories about the relationship between experts and citizens (Neuse, Steven M., 1980; Merton, Robert, 1957). In fact, in this case, board experts were more skeptical of other experts than non-expert board members. The reason for this result may be related to the process by which people review information to make decisions. The cognitive load of processing the relevant technical information on board members without a related expert background may contribute to a reduced amount of attention (Hillyard, Steven A. & Kutas, Marta, 1983; Wickens, Christopher D., 1991) or appreciation for the information provided by
citizens. Alternatively, attention to self-presentation (Monahan, Jennifer L., 1995) might make non-expert board members more attendant to experts and expert board members more attendant to citizens because each of these groups may be concerned about how they appear to others involved in the process. Non-experts may be concerned that they aren’t viewed as adequately informed and competent while experts may worry that others view them as removed and unapproachable.

Third, the attention that board members paid to the structure of public meetings and the additional opportunities for participation reflects a belief in the contention that the external structure of discourse impacts the internal content (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994). This finding provides empirical support for a largely theoretical claim regarding the mechanisms of necessity for successful discourse. Furthermore, while some deliberative scholars have expressed some concern that if the structure of the process is itself subject to deliberation there may be excessive gridlock as parties focus on altering the process to favor themselves (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994), this dissertation suggests that it is possible to reach a state of true deliberation. This ideal is the goal of scholars such as Habermas, but there has been some question as to whether or not it was a realistic one (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994). Due to concerns about the potential for excessive focus on structure over substance, there is sometimes an institutional desire to adhere rigidly to the rules set up to ensure equality of participants. Oregon, however, has demonstrated that the theoretical goal of attending to
both form and function is, in fact, achievable. Thus, this dissertation moves “constitutional deliberation” ideals (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Outhwaite, William, 1994) beyond normative theory and into empirical reality.

*Contributions to Practice*

While previous scholars have suggested that this engagement is primarily useful in goal setting, this study suggests that there continues to be value in engagement even once goals and objectives are agreed upon. Citizen participation in Oregon health policy has frequently expanded the interpretation of relevant interests. It has raised important and otherwise unexplored questions about causes and decisions. And it has occasionally buoyed board discussion about solutions, the need for rules, inducements, facts and powers.

The Oregon approach to health policy formulation and its success with utilizing citizen input also illustrate that policy formulation is not a linear process of goal, problem and then solution definition. The mechanism of an OHA agency report at the start of each meeting ensures that the board, stakeholders and citizens are all aware of current agency activity. In so doing, discussion and awareness of those activities may support mid-course corrections to policy implementation and inform other ongoing discourse about policies still in formation. The fact that these OHA reports and all presentations to the board are not unidirectional appears to be another key mechanism to fostering sustained participation across a broad spectrum of specific topics. Finally, institutional willingness
to alter the formal structures of participation not only demonstrates to citizens that the board is receptive to input but ensures that the input received is meaningful and timely for decision-making.

Citizens do not participate in the same way as experts, but this was seen as a good thing by all six of the board members interviewed. Citizens did not tend to rely upon traditional symbols or numbers, instead focusing upon the interests that they felt ought to be represented in health policy. Two of the board members noted that when citizens spoke it is not because they “have a dog in the fight but because they have a genuine, [unbiased] concern that they want heard.” To half of the board members who were interviewed, this tended to make citizens distinctly credible, even when their comments conflicted with the testimony of experts or other citizens. The introduction of alternative interpretations of the problem area has been important to the board. Each member could easily provide at least one example in which their thinking about a particular issue was altered by information presented by non-expert citizens. This was especially emphasized by those board members who possess a technical familiarity with health care policy.

This surprising finding suggests that practitioners in other states should make an effort to include a variety of professional backgrounds in decision-making positions. Oregon included experts on the board due to a sense that technical and bureaucratic expertise needed to be represented, but emphasized citizen membership due to a concern that citizen voice would not be well appreciated by experts. Given previous research on expert perceptions of participation, this concern may be warranted—especially in areas that do not possess a similar history as Oregon. However, the findings of this dissertation
suggest that Oregon’s mix of expert and citizen board members is a crucial mechanism for ensuring institutional receptiveness.

Finally, the fact that these dialogues span the duration of the board’s existence and that board members express optimism at their continued inclusion suggests that other states looking to include citizen engagement should seek to establish a process for sustained and ongoing participation. The ability of citizens to meaningfully contribute at each stage of the process suggests that those states who seek to only create a dialogue around goals or primarily early on in policy formulation will be missing out on a vast majority of the knowledge that citizens have to offer in health policy.
Chapter 4: Feminine Discursive Identity in Healthcare Politics

This dissertation uses an extensive multi-method approach to understanding the patterns of discourse and participation that have thus far occurred in Oregon’s Health Policy Board meetings. The patterns identified were not all consistent with previous expectations and some patterns, such as the topics of significant participation, were exposed during the process of reviewing the materials. Similarly, this chapter focuses upon a pattern of discourse that was conspicuous in its absence from Oregon meetings and was not initially a theme that was intentionally coded—personal stories and gender. The unexpected nature of this pattern begs the question of whether the apparent pattern was due to the unique nature of the Oregon case or if it is a generalizable trend. Thus, this chapter introduces an investigation of both Oregon and national level citizen testimony on health care.

Stereotypes about a population and the accepted norms of behavior associated with them are limited world views that can restrict the behavior of the population subjected to them. These stereotypes often find voice during participatory efforts when the process experiences capture. Nonetheless, many populations have also found power in reclaiming and harnessing stereotypes for positive social change (Anten, Tood, 2006;
Edley, Paige P, 2000; Henderson, Anita, 2003). Such is the case with women in American politics. Stereotypes about what “true womanhood” means and norms about the role of mothers in society have at times constrained women, but they have also been crucial mechanisms for empowering women in political discourse (Edley, Paige P, 2000; Baker, Paula, 1984; Capdevila, Rose, 2000; Hayden, Sara, 2003; MacGregor, Sherilyn, 2004; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). While women now participate in politics more often than in the past, how they participate, the type of discourse they adopt and the public identities that they construct may reveal that capture is still occurring in healthcare politics in a rather subtle way.

Motherhood as Entry into Politics

Initially, the American political system was not seen as limiting the ability of women to participate in public affairs. While women could not vote, this was not due primarily to their gender but rather to their status as non-land owners (Baker, Paula, 1984). Additionally, early American life left little distinction between the public and private spheres of activity (Baker, Paula, 1984; Snitow, Ann, 1992). It was not until the 1820’s as the vote was extended to all white men that it became clear that women’s exclusion from politics was intentional and based exclusively upon gender (Baker, Paula, 1984). At the same time, growing divisions between the public and private created new norms of behavior (Baker, Paula, 1984; Snitow, Ann, 1992). Both men and women of the period justified the exclusion of women from politics by appealing to the role of women as mothers and moral caretakers of society (Baker, Paula, 1984; Snitow, Ann, 1992); the
most appropriate contribution that women of the period could make to society was to ensure that the citizens they cared for behaved morally.

Despite their official exclusion from public life, however, women in the nineteenth century increased their sphere of activity to a variety of community organizations. Public activities aimed at supporting the poor, the elderly, or children fell neither entirely within men’s prescribed roles nor within women’s private ones (Baker, Paula, 1984). Thus, women found justification for public, and often very political, activity around these issues. Although not the traditional private sphere of home and family, women utilized the need to provide care and nurturance as legitimate access points to politics and administration (Baker, Paula, 1984; Snitow, Ann, 1992; Prokhovnik, Raia, 1998). Such activity provided ways for women to indirectly and informally influence political activity. Thus, “political domesticity provided the basis for a distinct nineteenth century women’s political culture” (Baker, Paula, 1984).

As federal, state and municipal governments gradually extended their reach into social welfare throughout the nineteenth century, they were increasingly influenced by this culture of political domesticity. The Progressive Era’s efforts to improve hospitals, regulate industry, support public schooling, and enhance various other public services shone a light on women’s involvement in politics (Baker, Paula, 1984; Prokhovnik, Raia, 1998). Women circulated petitions, founded reform-oriented organizations, filled quasi-governmental roles in public service agencies, organized protests and lobbied legislatures (Prokhovnik, Raia, 1998; Snitow, Ann, 1992).
Through these activities, women gained political skills, a consciousness of shared womanhood, and a sense of competence and self-worth (Baker, Paula, 1984; Prokhovnik, Raia, 1998). As a result, suffragists began to claim that the extension of the vote to women was necessary; it was described as a legitimate extension of women’s activity that would benefit society. “True womanhood,” a belief in the moral superiority of women as selfless nurturers, was claimed as a much needed private counterpoint to men’s public tendencies to be selfish and brutish (Baker, Paula, 1984). Such a counterpoint, suffragists claimed, was equally needed in public, electoral politics (Baker, Paula, 1984). Eventually, such arguments won out.

Once women had won the right to fully participate in American politics, it would have been feasible for them to move away from the traditionally feminine areas of policy. Some did so; however, many women throughout the twentieth century continued to mix the domestic with the political. From Prohibition to nuclear arms to the environment, women’s voices claimed a moral high ground and appealed to law makers through stories of motherhood and nurturing (Baker, Paula, 1984; Capdevila, Rose, 2000; Hayden, Sara, 2003; Schepre-Hughes, Nancy, 1996; MacGregor, Sherilyn, 2004; Swerdlow, AG, 1984). In fact, the traditional roles of women in society provided motivation for political activity among even traditionally non-political individuals. Housewives and conservative women across the country decided to “strike for peace” because of their concern for husbands, brothers, and children during the Cold War era (Swerdlow, AG, 1984) and numerous women were spurred into more radical political action by claims such as Betty Friedan’s popular “the personal is political” (Friedan, Betty, 2001; Hanisch, Carol, 1969).
Feminist Critiques of Motherhood in Politics

Despite the motivating force of traditional personal interactions for women in twentieth century politics, feminist scholars and activists also sought to break free from prescriptive gender-based norms of behavior. As such, feminist scholarship has sometimes been critical of the prominence of motherhood in political discourse (MacGregor, Sherilyn, 2004; Prokhovnik, Raia, 1998; Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997). Many people relied on traditional norms to lend legitimacy to female political activism because gender roles idealized women as inherently less self-interested (Baker, Paula, 1984; Swerdlow, AG, 1984; Eliasoph, Nina, 1998); however, reliance on those same norms often cast concern on the credibility of women as informed and logical actors (Prokhovnik, Raia, 1998; Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Discursive appeals to domesticity, it was argued, further entrenched the belief that women were essentially emotional creatures with a limited place in the public sphere (Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010).

While emotion can bring energy to a movement and attract attention, credibility is necessary for meaningful policy change. By reinforcing a belief in the emotional nature of women, feminists were concerned that motherhood discourse would not only lack credibility but cause women to become essentialized. It created a perception of women as “mothers, not persons” (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, &
Wendy, Gunther, 2010). A reinforcement of the motherhood role, therefore, gave women legitimacy to speak on certain issues but forced them to remain invisible in others.

Women have utilized their difference from men as leverage to gain voice in politics and to garner votes for elected office (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). However, once elected, many women have personally encountered the effects of the stereotype of woman as mother. Elected women, like women in many male dominated fields, have faced discrimination based upon their status as mothers, being seen as less dedicated or professional than their male counterparts (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010; Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997). Women in politics have found it more difficult to acquire prominent legislative assignments; they are less likely than equally experienced men to be assigned to high-power committees or to chair committees and subcommittees (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010; Dolan, Julie, Deckman, Mellissa, & Swers, Michele L, 2011). When elected women are assigned to positions, it is frequently to positions on less valued committees and in areas that are considered within a woman’s traditional sphere of responsibility, such as education, child welfare, or poverty (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010).

Feminist critiques of the motherhood discourse, thus, appear to be justified. Utilizing personal stories to motivate political action has been both effective and limiting to women seeking to establish an identity within politics. As a result of the contradictory nature of womanhood in politics, political women have had to prove time and again that
they are fit professionals (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). And due to cultural beliefs about female leadership, media portrayals of women have tended to focus less on substantive issues and more on personal traits (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010), forcing women in political office to work harder to establish themselves as credible figures.

Furthermore, reinforcement of cultural norms in one area of policy bleeds over into others. One cannot justify action based upon the ideal of motherhood in one instance and then denigrate the same appeals to motherhood in another. Reliance on this discourse may empower in certain instances, but ultimately it risks painting women into a corner. “Woman as mother,” “woman as nurturer,” and feminized care dialogues all compel men to act to protect the ability of women to behave according to these roles. This need to protect women as mothers, then, may be extended into other arenas with less benign implications.

Feminine Identity in Healthcare

Healthcare is an arena that has traditionally been considered a women’s issue in politics (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010; Baker, Paula, 1984; Snitow, Ann, 1992). Motherhood featured prominently in early efforts to improve healthcare (Snitow, Ann, 1992; Baker, Paula, 1984). Nineteenth century women petitioned for improved services and licensing requirements due to the detrimental effects of disease on children and the elderly (Baker,
Maternal and neonatal care became a prominent issue at the turn of the century (Baker, Paula, 1984). Motherhood was even used to justify, with little initial political conflict, the creation of Medicaid (Thompson, Frank J., 1981; Arrow, Kenneth J., 1963; Soss, Joe, 2002).

As in other areas of political action, feminist scholars were concerned about this use of motherhood to justify action on healthcare issues (Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997). The potential for appropriation of the motherhood ideal by political actors was believed to be especially high in the healthcare arena (Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997). After all, if woman is primarily a mother and acts primarily to protect children or to care for society, then motherhood and the fertility that support it may be seen as justifiably within the bounds of political regulation. Such a line of reasoning exemplifies the concerns of feminists regarding the intersection of women’s rights and health policy. It was of particular concern to feminist scholars because “women cannot be equal to men so long as they do not have control over the choice of whether and when to have a child” (McGlen, Nancy E., O’connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010).

In fact, ideals about womanhood and motherhood that defined women primarily by their reproductive roles did become a prominent part of the healthcare discourse in the late twentieth century. As birth control became more effective and easily available, the role of woman as mother justified public discussions about ostensibly private matters (McGlen, Nancy E., O’connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Additionally, abortion access, legislation, court cases and eventually *Roe v Wade* forced
into the political consciousness questions about what it means to be a mother (McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010; Jetter, Alexis, Orleck, Annelise, & Taylor, Diana, 1997). These discussions are ongoing in American society, and, as in other areas of politics, women in healthcare have to work harder than their male counterparts to demonstrate that they are professional and credible.

Modern Identity Construction in Healthcare: Methods

In order to investigate the role of motherhood as a political identity in modern healthcare discourse, this dissertation examines testimony given by non-healthcare professionals to political bodies considering healthcare reform efforts from 2007 to 2011. Public testimonies provided to the Oregon Health Policy Board and to the United States House of Representative or the United States Senate were identified for the purposes of this research.

National Level Citizen Participation

At the federal level, all congressional testimony provided to any legislative committee within the given time period and available through the Library of Congress’s HeinOnline database was reviewed for incidence of phrases including “health reform,” “health insurance,” “healthcare,” and “health care.” All testimonies containing these phrases regardless of the demographics of the speaker were included in the sample. This resulted in identification of 49 committee hearings involving 210 instances of testimony.
The sample was then coded by gender (see Table 10 below). Of these 210 testimonies, 71 (33.8%) were provided by women.

Table 10. Federal Testimony on Health Care Reform

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Speakers M W
Totals 210 139 71
This pattern is similar to the underrepresentation of women in national politics that previous scholars have noted (Dolan, Julie, Deckman, Mellissa, & Swers, Michele L, 2011; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010).

Local Level Citizen Participation

Although women tend to participate less at the national level, at the local level women have been known to be more dominant (Dolan, Julie, Deckman, Mellissa, & Swers, Michele L, 2011; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). This local level dominance is not entirely well explained, but it is generally believed to be a result of the personal connection that women are more likely to have to local matters (Dolan, Julie, Deckman, Mellissa, & Swers, Michele L, 2011; McGlen, Nancy E., O'connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). As a result, the testimony provided to a state health policy board would be expected to have more female voices.

Oregon’s Health Policy Board has a comprehensive publicly accessible record of its monthly meetings from January 2010 through the present available online (Oregon Health Authority, 2013). Review of these recordings resulted in identification of 154 public testimonies provided between 2009 and June 2012 (Table 11). Women did participate in these state level discussions more frequently than they did in national testimony. Of the 154 testimonies, 74 (48%) were from women.
Table 11. Oregon Health Policy Board Testimonies

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<tr>
<td>Totals</td>
<td>154</td>
<td>80</td>
<td>74</td>
</tr>
</tbody>
</table>

A comparison between the federal and state level participation patterns is included below in Table 12.
Analysis Methods

Once relevant testimonies at both the federal and state level were identified, they were reviewed for instances in which the witnesses related a personal story. For the purposes of this research, a “personal story” is defined as one in which the speaker relates their own non-professional experience with a topic (Eliasoph, Nina, 1998). The distinction of non-professional stories is important as many of those presenting testimony related a mixture of general statistics about health insurance and their experiences as business owners having to purchase insurance for employees. In such instances, the story is a professional account of how general trends play out on the ground. This type of story is rarely an attempt to generate emotion or lend credibility to the speaker. In contrast, personal, non-professional accounts are explicitly meant to draw upon emotion and sympathy. Personal stories establish the speaker as someone with meaningful first-hand experience of the topic despite an otherwise apparent lack of credentials (Eliasoph, Nina, 1998; Hayden, Sara, 2003). Previous research has demonstrated that even highly informed non-professionals tend to rely upon such personal stories as a means to construct legitimacy when speaking publicly (Eliasoph, Nina, 1998).

Each instance of an “I” statement was flagged for review as a potential personal story. Most of these statements were not stories, personal or otherwise. For instance, a number of them were statements like “I have found that…” or “I interpret this to mean…”. These non-story “I” statements were removed from analysis. Stories were reviewed for context:

- Was the story about professional activity?
• Was the story about someone not directly connected to the speaker?
In such cases, these instances were also removed from further analysis. Personal stories may not always relate to family or motherhood discourse though. Therefore, the instances of personal accounts were then further coded based upon the use of familial stories, motherhood language, and fatherhood language.

Personal stories were reviewed to see if the story was only about the experience of the individual speaking or if the testimony included a story about family of any sort (mother, father, siblings, children, aunts, uncles, cousins, etc.). These stories about family were coded as “familial stories”. It should be noted that familial discourse does not always indicate mother/father discourse; as generational shifts cause elder care to become a growing concern, a number of familial stories relate to the care of elderly or disabled parents rather than of children. Nonetheless, since elder care is a gendered norm not unlike motherhood, such familial stories may be expected to retain a pattern of discussion similar to other discussions about feminized nurturing. Those familial stories that specifically mentioned children, however, were coded based upon the gender of the speaker; if the speaker was female, then a familial story about children was coded as “motherhood language”; if the speaker was male, then familial stories about children were coded as “fatherhood language”. Figure 6 below illustrates these coding choices beginning from when an “I” statement is identified.
Figure 6. Story Coding Decision Tree
Modern Identities in Healthcare: Results

The use of personal stories in federal testimony on health reform was rare. Table 12 below illustrates the pattern at both the state and federal level. Out of the 210 testimonials, only 20 (9.5%) mention a personal, non-professional account of healthcare or health insurance experience. Despite the rarity of personal accounts, women were more likely than men to use a personal story in their testimony; 16.9% of women testified using a personal story compared to only 5.7% of men. This gender difference in communication style is consistent with previous literature summaries on political performance (McGlen, Nancy E., O'Connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Also consistent with previous research, most of the personal stories that were provided related to family (Eliasoph, Nina, 1998; Hayden, Sara, 2003).

Contrary to previous findings, however, women were not more likely than men to use such familial accounts (see Table 12 below). Of all family related stories included in federal testimony, men and women provided an equal share of them. Furthermore, of men who used personal stories, 87.5% related their personal accounts to family; however, of women who used personal stories in testimony, only 58.3% related the stories to family. The other personal stories examined were about the speaker or a non-familial connection. The use of motherhood language was especially muted at the national level. Of those women who related personal stories in federal testimony, only 25% mention motherhood. In sharp contrast, of those men who utilized personal stories, 75% mention fatherhood.

It might be hypothesized from these results that something about the structure of federal testimony or the culture of national politics silences the traditional feminine voice
and discussion of motherhood. Or perhaps the relative lack of numbers of women participating at the national level skews the results. However, these patterns hold true at the state/local level as well. Table 12 below displays the results of both the federal and state testimonial reviews.

Table 12. Personal Story Use in Federal and State Testimony

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th></th>
<th>Federal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
<td>Men</td>
<td>Women</td>
<td>All</td>
</tr>
<tr>
<td>Testimonies (N)</td>
<td>154</td>
<td>80</td>
<td>74</td>
<td>210</td>
</tr>
<tr>
<td>%</td>
<td>51.9</td>
<td>48.2</td>
<td></td>
<td>66.2</td>
</tr>
<tr>
<td>Personal stories (n₁)</td>
<td>16</td>
<td>9</td>
<td>7</td>
<td>20</td>
</tr>
<tr>
<td>% of N</td>
<td>10.4</td>
<td>11.3</td>
<td>9.5</td>
<td>9.5</td>
</tr>
<tr>
<td>Familial stories (n₂)</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>% of N</td>
<td>3.2</td>
<td>2.5</td>
<td>4.5</td>
<td>6.7</td>
</tr>
<tr>
<td>% of n₁</td>
<td>31.3</td>
<td>22.2</td>
<td>42.85</td>
<td>70</td>
</tr>
<tr>
<td>Parental stories (n₃)</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>% of N</td>
<td>0.6</td>
<td>0</td>
<td>1.4</td>
<td>4.3</td>
</tr>
<tr>
<td>% of n₁</td>
<td>6.2</td>
<td>0</td>
<td>14.3</td>
<td>45</td>
</tr>
</tbody>
</table>

Of the 154 testimonies provided to the Oregon Health Policy Board only sixteen (10.4%) related a personal story. Of the 74 women who testified seven (9.5%) used personal stories compared to nine (11.3%) men. Five (31%) personal stories were related to family; women contributed 60% of these stories. Women who chose to use personal stories in their comments also chose to relate those stories to family 43% of the time; men did so in only 22% of cases where personal stories were offered. Only one instance of testimony utilizing a motherhood narrative was recorded in the three years of documented input, and this testimony was provided in writing rather than in person.
At both the national and state level, these results indicate that personal narratives were limited. Furthermore, the use of motherhood discourse was especially muted at both levels, though to a greater extent at the state level than the national. Interestingly, however, fatherhood discourse was noted at a higher than expected rate at the national level. This may indicate that rather than, or perhaps in addition to, the silence of mothers the observed pattern is due to the increased representation of fathers in discourse. Societal norms regarding care giving have shifted slightly over time (Houde, Susan Crocker, 2002; Pleck, Joseph H., 1998; Kaye, Lenard W. & Applegate, Jeffrey S., 1990), making it possible that the displayed rise in fatherhood discourse is reflecting changing societal trends.

**Implications & Limitations**

*Related to Research Design*

This study is limited in scope to healthcare politics. Certainly, there are other policy areas in which motherhood discourse is still prominent, such as in the current gun control debate. Additionally, the state level review of discourse is notably incomplete; a number of more targeted, local discussions took place around the state but are not documented in any reviewable manner. Finally, the design of this study could not identify whether the men and women choosing to present testimony were parents. This limitation, however, does not significantly damage the findings presented here. In a properly constructed process—one not subject to capture—the likelihood of mothers and of fathers...
participating should be roughly equivalent. If the results of this study are due to a paucity of mothers participating, then this demonstrates a reason for concern about how the participation processes at the state and national levels are constructed.

*Related to Comparability*

Furthermore, this dissertation utilized a quantitative review of formal participation. Most existing literature on the topic is qualitative, anecdotal and often focused on the informal participation of women in politics. Nonetheless, the apparent lack of motherhood dialogue in healthcare is especially interesting considering the traditional view of healthcare as a predominately women’s issue (Baker, Paula, 1984; Snitow, Ann, 1992; McGlen, Nancy E., O’connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Because previous qualitative findings are not directly comparable to the quantitative research of this dissertation this may indicate that no serious change in discursive identity construction has occurred. This, however, would also indicate a potential reason for concern.

As no previous work has attempted to quantitatively assess the inclusion of women and mothers into discourse, it is possible that the patriarchal processes of governance have never really changed and are still subject to capture. The discussion of how women have shaped policy through feminist and motherhood identities may be describing how women have influenced policy from outside of the “accepted” process rather than from within it. Such influence is not to be undervalued, but it begs the question of whether the formal deliberative processes utilized by institutions are adequately providing
opportunities to all segments of the population for “equal and effective participation” (Dahl, Robert, 1998).

Related to Causation

It is unclear from this review of public testimony whether or not women are consciously avoiding motherhood discussions and, if so, why. However, it is clear from this review of contemporary healthcare dialogue that, if women were as dominant in health care politics as once qualitatively described, some shift has occurred.

The pattern of engagement identified in this paper runs quite counter to all existing literature on how women perform politically. This may be a result of the differing foci on formal versus informal participation. Yet, this too raises concern that the formal processes used for participation may be exclusionary and potentially subject to gendered capture.

Additionally, the findings of this study suggest that current institutional and/or societal structures may communicate to citizens what types of engagement are and are not valued. Moreover, extensive research has demonstrated that the perception of professionalism is highly gendered (Arkkelin, Daniel & O'Connor Jr, Raymond, 1992; Valian, Virginia, 2004; Warfel, Katherine A., 1984). Women are less likely to be perceived as professional and legitimate regardless of their background and objective presentation styles (Arkkelin, Daniel & O'Connor Jr, Raymond, 1992; Valian, Virginia, 2004; Warfel, Katherine A., 1984).
Future research should build upon this dissertation by investigating why women participate in healthcare politics, how they consciously or subconsciously construct an identity of credibility in the process, and what factors influence this political performance.

Why Women Matter

Despite being unable to identify why motherhood discourse may be silenced in healthcare politics, this study indicates that there may be reason for concern about such a pattern. Although feminist scholars have been consistently critical of reliance on motherhood discourse, motherhood as an identity does exist for many women. A political discourse that does not provide opportunity for the inclusion of such identities thus risks being unresponsive to the real needs of some segments of the population. Democratic scholars note that a process that does not include the voices of all persons is vulnerable to capture by those that are already in power (Lijphart, A, 1997b; Habermas, J. & Rehg, William, 1996; Mueller, DC & Stratmann, T, 2003). Women participating “professionally” and asexually does not prevent capture by those who cannot relate to the demands of motherhood. In fact, this silencing of motherhood may contribute to the ability of those in power—largely older, white men—to retain control over issues that impact others.

It is notable that in the federal hearings included in this study which explicitly involved women’s health issues not a single personal story was related by either men or women. Similarly, in the Oregon experience, the only testimonies provided about
women’s health and reproductive rights were presented clinically and related directly to state budgetary concerns. Removing narrative dialogue of motherhood has not empowered women or questioned cultural norms. It has only silenced a group who stand to be significantly impacted by government action on healthcare.

This silencing and feminine shaming is demonstrated in many recent examples. Women in elected office have found themselves censured for using the word “vagina” when debating women’s healthcare (McGlen, Nancy E., O’connor, Karen, Van Assendelft, Laura, & Wendy, Gunther, 2010). Sandra Fluke, who made every effort to relate stories of women whom she encountered in her professional role as the president of a women’s rights group, was called a slut by national spokesmen. “The personal is political” served to motivate previous generations of women to act politically, but it is increasingly being replaced with a belief that only the professional is political. It should concern our politicians and institutional actors that an important voice is now muted in the national dialogue on healthcare.
Practitioners and previous scholars alike have noted how “messy” public participation processes can be (Davies, Celia, Wetherell, Margaret, & Barnett, Elizabeth, 2006; Morone, JA, 1998; Behn, Robert, 2001; Tritter, JQ & McCallum, A, 2006; Rubin, Lillian, 1969). Nonetheless, discourse is key to effective policy (Habermas, J. & Rehg, William, 1996; Habermas, J. & Rehg, William, 2001; Vargova, Mariela, 2005; Fox, C & Miller, H, 1995; Cohen, Joshua, 1989). Without an agreed sense of the goals and problems there is little hope that solutions will be perceived as meaningful (Outhwaite, William, 1994; Deborah, Stone, 2002; Fox, C & Miller, H, 1995; Fischer, Frank, 1990). Participation remains messy because discourse is a struggle to establish shared interpretations for the purposes of action (Habermas, J. & Rehg, William, 1996; Outhwaite, William, 1994). In that process there is risk that certain populations will not have equal voice (Lijphart, A, 1997; Dahl, Robert, 1961; Dahl, Robert, 1998; Mueller, DC & Stratmann, T, 2003; Morone, JA, 1998). Therefore, institutions must carefully consider how best to engage citizens given the competing calls for accountability through citizen access and accountability through expertise (Simonsen, William & Robbins, Mark D, 2000; Tritter, JQ & McCallum, A, 2006; Morone, JA, 1998; Fischer, Frank, 1990).
Contributions to Theory and Practice

This dissertation has introduced a typology to aid in these considerations generally. By evaluating both the citizen and institutional levels of engagement in the topic, assessing the appropriateness of participation mechanisms will be greatly improved. Furthermore, the typology explains why varied theories of democracy and bureaucracy have all found both normative and empirical support in the modern age. The typology makes no normative claim about the superiority of one context over another in general. Yet, it is clear that which context might be preferred by practitioners is likely to be influenced by their preferred theory of democracy. Traditional liberal theories are most likely to be represented in bureaucratic hierarchy and informing contexts while republican norms are supported in contexts of consultation, tokenism, and placation. The discursive ideals of deliberative democracy theorists remain the rarest and potentially most difficult contexts to sustain (partnership).

However, the typology will support future participation research in establishing contingent effectiveness—in what contexts which mechanisms are most effective. Thus, practitioners will become better able to apply current and future research findings in a way that abandons the current trial and error approach. Furthermore, as Chapter One indicates, the typology will allow practitioners to efficiently identify potential mechanisms in the literature that may alter their engagement contexts. Political science literature has identified demographic variables and civic level actions that influence citizen interest and commitment. Figure 7 below visually displays just a few of the
potential mechanisms that have been identified to influence the citizen dimension of engagement.

Figure 7. Political Science Variables & Connections

Similarly, public administration research (Figure 8) focused upon organizational interaction may provide insight into how to alter institutional receptiveness and opportunity.

Figure 8. Public Administration Variables & Connections
This dissertation then confirms that, given the appropriate context, citizen engagement can meaningfully inform policy even in highly technical fields such as healthcare. Additionally, it challenges the concept that citizen input is most useful in goal definition. While hermeneutic claims are a crucial part of goal establishment, they are also present during problem and solution discourse. These claims about the interpretation of key components are frequently approached by citizens. Thus, when looking to incorporate citizen engagement into the policy process institutions must be mindful that there is likely to be value-added to all of the types of discursive claims, not just to goal definition. While some scholarship has suggested that participation efforts may falter by failing to engage citizens early in the process (Andrews, Christina W. & de Vries, Michiel S., 2007; Borge, LE, Falch, T, & Tovmo, P, 2008; Feingold, E, 1977; Plumlee, JP, Starling, JD, & Kramer, KW, 1985; Tauxe, CS, 1995), this research points out that participation may be equally at risk if mechanisms to engage are not utilized throughout the process as well.

Finally, when considering the types of claims made by citizens involved in healthcare policy, Oregon and recent national experiences suggest that concerns about capture may remain justified. Explicit consideration of the viewpoint of mothers is startlingly absent from modern discourse. Just as a restrictive engagement context in Oregon might have resulted in a failure to consider naturopathic physicians as relevant parties, the de facto environment of motherhood restriction may be resulting in failures to appropriately identify problems and solutions for healthcare.
Whether or not the dialogues in Oregon or at the national level result in improved health outcomes has yet to be seen. Given that Oregon began its discussions long before the ACA became law, it is likely to be many years before other states are in a similar position and any conclusions can reasonably be drawn. This study provides us with reason to be both hopeful and cautious about the future of healthcare discourse. We can be optimistic that other states will make use of the suggested typology to create sustainable dialogues similar to the ones occurring in Oregon. We can be cautiously optimistic that the dialogues will involve citizen voice in a way that causes policymakers to reevaluate their interpretations of causes, interests and decisions. However, we should also be aware of the potential for bias to color the discourse that occurs. Even when the process is generally open and inclusive and no one group has “captured” the process, implicit biases may still silence important segments of society.

Limitations

First, the empirical case study of this dissertation is restricted to healthcare. Healthcare policy is an important field and numbers among the “wicked problems” of American society. It is therefore an important example of the potential of participation. Nonetheless, the findings of this study may not be generalizable or transferable to alternative policy areas.

Second, the case study is limited to Oregon which, as discussed, has a unique history with regards to health policy. Despite this unique context, however, Oregon’s
example serves to inform other states that are now beginning a similar process, spurred on by federal health reform requirements.

A major limitation of this study is the failure of the citizen survey. Without this survey to confirm high citizen engagement and positive perceptions about institutional engagement activity, I cannot be entirely certain that Oregon’s OHPB is, in fact, an example of sustained partnership. This means that the case study is ultimately unable to be certainly connected to the typology in Chapter Two. It might be reasonably assumed from other material in this study that citizen engagement levels are high. Because the survey could not capture citizen perceptions about institutional receptiveness, however, the OHPB should continue being proactive about gathering citizen feedback. In addition to citizen feedback on the HIE, the October 2010 report from the OHA outreach and engagement coordinator mentioned that “the majority of people indicated that we were on the right track” and that the work of the board was appreciated. This type of outreach should be maintained to ensure sustained partnership over time.

Future Directions

As it is the primary weakness of this research, one direction for future research based on this dissertation is to redeploy the citizen survey in a manner that yields more responses. Several alternative deployment approaches have been developed. First, targeting citizen advisory groups directly would likely yield more responses than the general listserv and Facebook approach taken here. Secondly, a paid survey distribution service can be hired to administer the survey. These services have hundreds of thousands
of potential respondents across the country and they can limit distribution only to those who fit a desired profile (e.g., living in Oregon, over 18). Response rates for these paid services tend to be very high as many employ minor compensation in the form of reward points for each survey completed by members. An additional distribution approach that was not obvious at the time of beginning this study is the potential use QRC codes. These codes—which can be read by smartphones and pull up a website directly—could be printed on business cards and then distributed in person at public meetings.

Had the survey received usable results in this study, it is expected that it would have supported the focus on the chosen topics for detailed analysis and the conclusions reached through that analysis. The most frequently noted two topics that the survey’s limited sample had heard about were public meetings related to CCOs and the HIE. Over 50% of respondents had participated in OHPB meetings in some manner, with approximately 47 hours committed per participating person on average. Eighty-five percent of respondents agreed or strongly agreed that participation in health policy formulation is important and 71% felt that experts could not provide information about what is important to people like them. The limited survey results also support the claims of the OHA’s outreach and engagement coordinator that a majority of citizens feel that the board is doing well at listening to citizens (57%).

An additional extension of this dissertation’s research is to conduct a more extensive literature review of participation case studies. This would be similar in format to the approach taken in Chapter Two’s limited literature review and testing, but be much more extensive. A more extensive review of existing literature would ensure that the
results are applicable across the spectrum of participation arenas, allow for the establishment of some conclusions related to contingent effectiveness, and demonstrate that the typology is understandable and interpretable by individuals uninvolved in its initial construction. Additional coders would be employed to construct a measure of inter-rater reliability (Weiss, CH, 1998; Caudle, SL, 1994), and specific mechanisms and outcomes would be coded in addition to participation contexts. This type of study would demonstrate the validity of the introduced typology and go a long way towards establishing contingent effectiveness hypotheses.

Chapter Four also suggests an additional direction for future study. The conclusions of Chapter Four rest upon a number of assumptions (e.g. that previous research on participation suggests that the absence of motherhood discourse found in this dissertation is new), many of which do not have data to support or refute them. Future research ought to be conducted on identity construction in healthcare politics. Interviews with participating citizens should be used to investigate how people, women especially, decide on how to present themselves at public meetings. Are there institutional messages or mechanisms that suggest that particular types of self-presentation are more accepted? The results of the initial research contained in this dissertation suggest as compared to the largely informal participation reviewed by previous scholars strongly suggests that this is likely to be the case. A contemporary review of informal participation discourse should also be conducted to determine if this is the case or if general societal changes are causing these new findings. The surprising presence of fatherhood language at the national level may, in fact, indicate that the findings of this dissertation reflect larger societal
patterns than institutional ones. Therefore, future research should also ask what societal pressures communicate about professional expectations.

Finally, while the health impacts of the OHPB have yet to be fully realized it will be of particular interest to investigate whether or not citizen input actually generates improved health outcomes. There currently exists little systematic review of the impact on health policy that may be directly attributable to citizen input. In many cases where citizens are involved in the formation process, it remains difficult to determine if the resulting policies would have looked any different without citizen involvement. Without such information, there is limited ability to connect citizen participation with resulting health outcomes. This study has allowed the identification of several policy components that are tied directly to citizen participation.

It is my hope to examine if these policies result in changes to health outcomes in Oregon. For instance, Oregon’s state run HIE includes an active and permanent citizen advisory council. Will this result in higher insurance rates in Oregon compared to state run HIEs without such participation? How will Oregon’s access and affordability compare to other HIEs? How does the health status of those covered by policies purchased on Oregon’s HIE compare to those who purchased through an HIE in other states? As another example for potential outcomes research, will Oregon’s decision to include naturopaths as recognized PCPs improve access to primary care? How will health outcomes for those patients utilizing naturopathic physicians compare to those utilizing a traditional provider? If other states have similar policies regarding naturopaths, how do Oregon’s outcomes compare?
Summary

Ultimately, because healthcare is an area where the expertise-accountability conflict is in full force and where there is a high risk of capture or bias, this dissertation establishes a line of inquiry that should shape our understanding of how to balance these concerns and improve healthcare for everyone.

The typology introduced in this dissertation generates new lines of inquiry for all researchers on public participation and will provide much needed guidance to practitioners. Contingent effectiveness cannot be established without the guidance of a typology of contexts. Thus, this contribution cannot be undervalued.

The empirical findings of Oregon’s Health Policy Board case study challenge normative theories about how citizens can and should participate in highly technical policy discussions. The case study also uncovers an interesting conflict between decision-makers with expertise and those experts that participate in the public policy process. The OHPB example finally supports the claim that the external structure of participation influences the internal organization of discourse, and that attention can be paid to structure without sacrificing substance in the process.

Finally, a comparison of the OHPB discourse of women to the national health dialogue suggests that motherhood as an identity may be absent in the debate about healthcare. Therefore, attention to capture in the policy making process should still be a concern; implicit biases may be manifest even as general demographics move toward equal representation.
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Appendix A: Meeting Transcripts
Mr. Chair:
OK, good morning everybody. It's January 10th. We'll call to order the meeting of the Oregon Health Policy Board, and welcome everybody today. For the record, we'll note that all members of the Board are present with the exception of [Nida?]. who will be joining us by telephone. Appreciate everybody being here today. We always seem to start with a very busy agenda, today perhaps even more so than most, so I kind of thought I'd start with just a couple of framing comments to make sure that everybody's got a good feel for how the meeting is going to proceed.

Today, we are going to be reviewing the second draft of the CCO Implementation Proposal. We will be discussing some key elements of how CCO's will be held accountable for the outcomes of what will be expected of them, and we'll talk about a lot of other key elements of the proposal as well. We are going to be reviewing a financial analysis that's going to show that we are on the right track. It has been clear from national research, there are substantial savings to be had from a more coordinated system, and we now have a better sense of how that could play out in Oregon, if we're both thoughtful and vigorous in our approach to implementation. We'll have a presentation about the work being done in the tri-county area to move toward Coordinated Care Organizations. We'll also have a presentation on the workforce that's necessary statewide to fully implement this new model of care so people will have the assistance they need as early as they need it and as often as they need it so that they can stay away from more expensive care whenever it's possible.

Here's where we are today: House Bill 3650 was passed last year by the legislature, and that laid the foundation for Coordinated Care Organizations. New, local health entities that will deliver healthcare and coverage for people eligible for Medicaid and for those who are eligible both for Medicaid and Medicare. The implementation proposal we will be looking at today expands on that foundation. It was requested by the legislature as a part of HB 3650, and we will complete it in time for delivery back to the legislature by February 1. Before we move forward, I want to thank the folks who helped us get here, and the hundreds of others that have made this all possible, the vision of healthcare in Oregon. Many of you in this room and watching online have been working hard to get to this point for years, whether through this Board, or the previous Oregon Health Fund Board or in your local communities, developing and fine-tuning means of coordinated care that have helped become the basis of House Bill 3650. There's been a steady drumbeat forward in Oregon to get us to this point, and the work that's happened over the last year, starting with this board's action plan for health, and moving into HB 3650, is a result of all that work. As a state, I think we're ready for the
next step forward. The plan for Coordinated Care Organizations has been more than a year in the making, and it was vetting through, as I know most of you remember, a 44 person workgroup met in evenings during the month of April; four more months with four more different workgroups this fall where a 133 people dug into the governance, the metrics, the budget, and how to best serve people eligible for both Medicaid and Medicare; community meetings in eight cities around the state, where more than 1,000 people came in person, hundreds more commented online; and finally, the many comments that this Board has received online and otherwise about this proposal. You have all gotten us to the point we're at today, where we have a clear definition of what and how CCO's are, and how they'll work.

I have one point of accountability for health outcomes: one budget that grows at a fixed rate for behavioral, physical and, ultimately, dental care. Qualified CCO's will bring forward new models of care that are patient-centered and team-focused. They will also have flexibility within the budget to deliver the outcomes that are expected of them. Finally, they'll be governed by a partnership that will include partners and providers of care, community members, and the stakeholders in the health system who have the financial responsibility and risk. I sincerely want to thank everybody who has been involved in this process, and I ask you to stay involved. With that, let's get started with our meeting.

Couple of things in terms of overview under Agenda #1. First, I want to point out that Bruce Goldberg, who is usually here in-person, is in Washington D.C. today and is not available to join us. The director's report for January will be presented at the January 24th meeting. Remember that we're having two meetings this month, not just one. We have a consent agenda in Item #1 that includes the minutes and a brief update from [High talk[?]]. Is there any discussion or questions about the items in the consent agenda? Hearing none, is there a motion for approval?

>> Unidentified Speaker:
I make a motion to approve.

>> Mr. Chari:
And a second?

>> Unidentified Speaker:
Second.

>> Mr. Chair:
In favor, aye.

[Muddled ayes, none opposed]

>> Mr. Chair:

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Thank you. The consent agenda is passed. I do want to make one announcement on behalf of the tenants here in the building. I need to start by saying, we get to use this room as a courtesy from OHSU, and Joe we appreciate it very much. It's a great location; it's convenient for all of us. It allows us to handle web streaming, and it works out really well. There are tenants on this floor who are not associated with OHSU or the Health Policy Board, and I think there are times when we let the meeting kind of drift out into the hallway and the common areas, and sometimes the noise and congestion is not conducive to the work that some of them are doing. So, I know that you are going to be riveted here by the action in the room, but if you feel the need to step outside to make a phone call or have a conversation, I'm going to ask that you go down to the lobby or the cafe downstairs or some place like that and now just out in the hallway where the other tenants are impacted. That would be very much appreciated.

I also want to make a comment about public comments. At the end of this meeting, we are scheduled to go until 3 o'clock today with public comments starting at 2:30. I don't know how long this conversation is going to take. We are going to get through it in whatever time it does take, but at the end of the meeting we will certainly reserve time for public comment. There is a sign-up sheet that is out in the hallway right now. At some point it'll transfer in here, but I want to make sure that you know that Tiffany and [Ari?] will be monitoring that sign-up sheet. If you wish to make a comment to the Board at the end of the meeting, we would be more than happy to have you do that. Do please sign up on that sheet, though, before we get there.

With that, let's move to Agenda Item #2. I want to point out that this is a modified agenda. We originally were hoping to have, or expecting to have, a more complete report on the work of the medical liability group. Because of the importance of getting through this document today and making sure that we leave time to do the medical liability stuff really well, and do it right, we have deferred the full report to the January 24 meeting but Janine, I think you're going to come forward and give us a brief update, and we appreciate that. How are you this morning?

>> Janine Smith:
Good morning. Janine Smith, the administrative office, the health policy and research for the health authority, and I know we sent out a bit of reading for you on Friday that was only two-thirds of the activities, but to give you an update on the Medical Liability Project: What you received on Friday, and it's what is posted on the web, is the work of Dr. [Cartchela?] and Dr. [Mellows?] policy analysis that goes step-by-step through the various requests that were as-outlined in Section [16.0.3650(?)]. And then you also received from the Department of Justice two pieces. One was a look at the Oregon statutes and constitutional issues around the same issues. They had intermittent discussions back and forth between the experts and the DoJ, and there was another additional piece reviewing the Stark Laws, which are the federal requirements [regarding?] how folks can interact with each other regarding referrals, etc.
There is a last piece and that is the Defense of Medicine piece. Dr. Wright just wrapped up his survey at the end of December and is scrambling very diligently, but did not have the full, complete report ready today, but we'll be ready by the end of the week and hopefully for sure by Monday. So, we will get that out to you for some reading at a more leisurely pace for the 24th meeting, and they'll all be connecting in at least by phone on the 24th in the morning. We found some available time to reschedule them to that time. They will be presenting, we think, to the legislature next week some preliminary results.

>> Mr. Chair:
Very good. Just for clarification, I'll make sure the Board understands that the recommendations will go to the legislature as the staff's recommendations and based on the work that is being done by the folks Janine described, but we are bringing the work to the Board for, certainly for information, comment to extent that that's appropriate, and that will all occur at the next meeting. Questions or comments? Chuck!

>> Chuck:
Mr. Chair, on the 24th, are we going to talk about Attorney General material as well?

>> [Janine]:
We certainly can.

>> [Chuck]:
The two documents are rather [legal-easy]. So, I think it would help the board to have some sort of Cliff Note version of that, I guess, kind of what's the big picture. I think that would help, and I think that because one is a liability piece, and the other one... [trails off] As you know, I've been concerned about this anti-trust issue for a long time, and I really would like to understand that better. So, if we could do that.

>> [Janine]:
OK. We can make sure we add that in.

>> Mr. Chair:
Very good. Anything else? Janine, thank you very much. We appreciate it. Moving to Agenda Item #3, House Bill 3650; actually, there are two parts to Item 3. First, House Bill 3650 directed OHA to develop and establish criteria and descriptions, education, training requirements that meet CMS requirements, for community health workers, personal health navigators, and peer-wellness specialists. We asked that that work be done through a sub-committee of our Work Force Committee and in partnership with the OHA Office of Equity Inclusion, and [Carol Cheney] will make a presentation on and in addition, the Board asked the Workforce Committee to develop, by the end of the year, description of promising staffing models and workforce rules for Coordinated Care Organizations, person-centered health [homes], similar, integrated, coordinated healthcare delivery organizations. Identification of healthcare workforce compensatees required to implement the promising models and recommended actions necessary to
ensure that the compensees are available within Oregon's healthcare workforce, and Lisa Angus is going to make a presentation on that piece. So, thank you both for being here today, we appreciate it very much, and we will turn to Carol to start.

>> Carol Cheney:
Actually, I think, based on our presentation, we have an exciting slideshow for you, so we are going to go in that order that we put our slides in, so [indiscernible].

>> Mr. Chair:
That works for us.

>> Lisa Angus:
I'm Lisa Angus with the Office for Health Policy and Research, and we are just going to give you a quick overview. The Chair described, we have a [indiscernible] to get back to you on what are the appropriate models for CTO's and patients' in their primary care homes and other sort of integrated care models. This is well within the Workforce Committee's charter. This is just to remind you that our charter is to coordinate efforts in order to recruit and educate healthcare professionals and retain a quality workforce to meet the demand created by expansion, system transformation, and an increasingly diverse population. So to meet this charge, the Committee, which is led by John Moorehead and Anne [Milash[?]], develops recommendations for the Health Policy Board among which are the recommendations we are bringing to you today.

This is just to outline the request, which you've just heard. So, in addressing the Board's request, the Committee took three steps. [We] looked at the existing literature and what national literature says about what kind of workforce models work best in integrated care systems and what the professional competencies are, and then spend quite a bit of time trying to get a sense of what the picture is in Oregon; what differences or additions there might be to what the national literature says based on Oregon's situation, current innovations, and the Committee members themselves, there was a sub-group of the Workforce Committee who took on this task, and they arranged phone interviews with about 30 or 35 experts in Oregon, a few outside Oregon with significant experience in the state, and spent a lot of time talking to people and getting their views, and many thanks to the folks who gave their time for those interviews, some of whom are sitting at the table, and to the committee members who spent a lot of time doing the interviews.

When we had those, we had an independent qualitative analyst just sort of take a look at them, analyze them for themes, to verify the Committee's read, and we combined those together. So, we have sort of a national and an Oregon picture, and the key sort of message or finding out of both of these, the national literature and conversations in Oregon, is that inter-professional, team-based care is sort of the optimal model for working in whether it's CCO's or patient center primary care, any kind of care model like that, which is not necessarily, you know, surprising, that maybe the degree unanimity among the people we talked to was pretty strong in this. So, the consensus from people is
that team-based care enables the sort of processes and outcomes that CCO's or patient center primary care homes are intended to achieve, and there's a quote on this slide. This is sort of a representative quote from one of the folks we talked to.

So if that's the case, then the question becomes, "So what are the competencies required of the workforce to operationalize that model?" In reviewing the national literature and talking to folks in Oregon, there were two sets of competencies that emerged. Some were individual-level, and some were more system or organizational level. So, the individual level's competencies include communication; this is inter-professionally, especially working with [indiscernible] of different preparation than you do, learning how to talk effectively across team members, and then also between teams and people seeking care. So, how to communicate information effectively to patients. Cultural competency: you can think of that not only in the provider-patient relationship, but also the inter-professional cultural competence. Rules and responsibilities for collaborative practice and teamwork that also include things like values and ethics; what do you do with provider-patient confidentiality in a team-based care delivery model? There are leadership and change management, competencies including things like problem solving and conflict resolution, and then a sort of set of, I guess what you could call, [HIT[?]] computer literacy competencies. How to use data effectively to either communicate about the status of patient being cared for by the time or to proactively manage patient care.

That's a whole range of individual level competencies, but at the sort of system or organizational level, particularly with folks we talked to in Oregon, identified some organizational level competencies, flexible reimbursement mechanisms being foremost, and I don't think that's a surprise to anyone here, either, but the comment we got a lot was, "You need to move away from the visit model." It's difficult to provide team-based care if you can only get paid when one particular person on the team sees the person. Another sort of facilitator or, depending on how it works, a detractor from being able to implement this sort of team-based model is workplace culture. So, several of the folks that we talked to who had experience moving toward this sort of model from delivery talked about needing to sort of break down the traditional workplace or medicine hierarchy so that everyone, if you've got a team made up of a team of professionals, that everyone's voice is heard and people can act effectively in the roles they are given. There are some operational infrastructure items that people identified, particularly sort of guidelines and methods for team formation. How do you know what the best combination of professionals is for your team? How do you evaluate people's performance as a team member rather than as an individual clinician? You know, what are the different skill sets that you need as a practitioner, in that sense? So, from that HR, organizational side, and then there was community engagement. A couple of people said strongly when we talked to them that no one sort of team layout, or team organization, fits every situation, and so that there's a necessary part in community engagement to find out what the best team is for your population. So, that's the community engagement sort of competency that folks identified when we were talking to them.
So from those organizational and individual competencies that the Committee asked people, what steps are needed, and we asked the literature. When we looked at the literature, we asked that literature, "What steps are needed to sort of increase those competencies in Oregon's workforce?" And so, the following slides are just a highlight of some of the recommendations for those in three areas: policy, practice, and education, and there is clearly a fair amount of overlap between those three areas but just for ease of presentation, they're broken down that way. The nice thing about this is that we are already underway on several of these. So, well done. Policy recommendations; one of them is to establish or to expand pilot programs to test alternative [payment?] models like, say, a global budget, and those models that facilitate the use of inter-professional teams. Another recommendation was to develop job descriptions for sort of the newer, you know, new is debatable, but the emerging positions like Care Coordinators and Community Health Workers and some of the, sort of, key team members that help the team connect with the community, and that's exactly what Carol's going to talk about next.

Two others that the group identified: one is sort of provide opportunities for multi-pair alignment around reimbursement models so that we get, like, momentum and critical mass behind flexible, outcomes-based reimbursement so people can have the confidence sort of investing in this new workforce configuration, and then also to revise, it's not just sort of the newer, emerging workforce that needs some sense of expectations in job roles. Because everyone will be involved in a team, ideally, then existing expectations for more frequently members of the workforce right now, folks advised us that their job roles and expectations need some revision, too, to account for the nature of team-based care.

People, both the national literature in Oregon, folks that we talked to suggested that, sort of at the individual levels, providers are not routinely acquiring the kind of competencies needed for team-based care as part of their regular education. There's lots of exceptions and new directions in terms of that but on a routine basis not so much, and there's several reasons behind that, but some of the recommendations that the group made for moving education more down this lane, and probably the most important, maybe, is the fourth one down, which says, "Said Expectations for Collaboration between Education and Healthcare Employers." Some sort of ongoing venue or mechanism for collaboration between practice and education so that they're better connected, and they function more interdependently. There are some examples of this right now. There are some conversations among medical assistant education programs and folks who have started to implement a team-based care model or a patient-centered primary care home about changing the curriculum for MA's so that they get the preparation they need to reflect the really expanded rule.

Other recommendations for education are for programs to adopt or endorse, because there are some out there, a set of inter-professional competencies across training programs across disciplines, so that everyone is teaching towards a same set of skills. Because faculty who are full-time teaching may have little experience with emerging models of
care, it's difficult for them, then, to teach to those competencies for students, and then vice-versa. If these models are sort of only beginning to be adopted in various places across the state, it's difficult for students to see those modeled in a clinical setting. So, some complimentary recommendations around providing opportunities for faculty to get experience in new models, and maybe that's through sort of an experience sabbatical or bringing in folks from the field as adjunct faculty to increase learning and then on the flip side, trying to increase opportunities for students to get clinical-level experience working in teams and maybe that means sending them out as, rather than doing a clinical rotation as you yourself, maybe you go with a cohort of folks from your training institution.

In terms of practice, culture change is sort of the strongest one that was identified, and culture change is difficult. When one person we talked to suggested that having students who are coming from training programs with an inter-professional focus, rotate through your facility, could act as sort of a change agent, or at least a highlight of some the culture change, help you move that culture change in your organization. It was suggested to us that identifying people who were doing this well already, and helping other s get off the ground, well, "How do I start building a team? What do I change about my scheduling? Do I have meetings at the beginning of the day, middle of the day, end of the day, so that we can organize our workflow?" So, giving folks who are looking to move to this model some technical assistance.

The other two recommendations are about prioritizing investment in the IT infrastructure that's needed to facilitate communication between members of a team about patient care; or, from one team to another or one clinical care setting to another. Finally, this is more again on the HR sort of organizational side, is to help people revise their hiring and human resources practices to reflect the skill expectations and performance expectations in a team-based care model.

>> Unidentified Speaker:  
When are we taking questions or comments or...?

>> Mr. Chair:  
I think they're welcome.

>> Unidentified Speaker:  
So, I guess just looking at these three sets, I appreciate the breakdown. I think, though, one thing that I see missing from the recommendations is, I'm really concerned about mobility within the team-based setting, because I do think that that's how we're really going to diversify the workforce. Because of, you know, barriers to, you know, getting people of color into, you know, they don't become doctors very often, frankly. Let's call it what it is. Not a lot of them become nurses. They don't use a traditional method to move up in the workforce, so if there's a way... [trails off] And I don't see that as a recommendation about how you can use... [trails off] I'm having a hard time, I'm kind of
sick, but how you can use low-barrier to entry professions to then move people through a career ladder to get them into higher skilled team roles.

>> Lisa Angus:
Well, that's a good point. It's not highlighted in here. I think you'll hear a little bit in the next presentation, but I think one of the things that helps is the making clear the job expectations and roles and so-on, so that there is a clear, if not, at least a path, but a, so that your expectation as, say, an entry-level person in Clinic X isn't hugely different than in Clinic Y, so you can demonstrate, if you want to move, "I have these skills, I did them over here."

>> Unidentified Speaker:
I guess, I'm not necessarily moving within your current scope. I think that that happens all the time, from Clinic X to Y to Z. You see CMA's move from nursing homes to hospitals or back around. What I'm saying is, what I'd like to see is we revising our human services practices to enable, when we talk about recruitment retention and evaluation, I also think that there should be a human services expectation that you offer people and move people through a career ladder so that a low-barrier entry to job. You come in as an MA or a CMA, that there's a career path offered to you that you could end up being a nurse, a doctor. So that's, I believe that's how we're going to diversify the workforce. I mean, we are not going to change criminal justice practices in the country tomorrow. That means, African Americans aren't likely to become doctors, because they have a harder time getting into a college. So, I think how we do that in our current workforce mix is going to be really critical, and I don't see that on here as part of the recommendations.

>> Unidentified Speaker:
That's a good point. I think, not just for community health workers, but for all of the other health career workforce, and it might be one of those developmental metrics for CCO's in terms of having a plan for career development and diversifying of their employees, because then you can actually, if you have some specific indicators, you can actually monitor that.

>> Unidentified Speaker:
Yeah, and I think we're starting to build an infrastructure where we'll be able to find a path of career development with the healthcare workforce place and [seeing number[?]] right where you can see people, even if they may be moving clinics, you can see their career development, which I think is really important to make sure we're getting what we need out of folks. I also just, these recommendations sound great, I'm wondering how we're going to implement them, because I think that the culture change around fostering a collaborative and egalitarian workplace is huge, right? And I just, in my union we see workplaces in a lot of different stages, right? Sort of [Kaiser[?]] being the best model and still having, with the unit-based teams... You disagree?
>> Unidentified Speaker:
I think we're the best. [laughter]

>> Unidentified Speaker:
I disagree. [laughter] We can put together some metrics around that later. Right? But how do you have metrics around that, right? So you can actually implement? And, you know, and I think that it is such a change in the medical model from, "the doctor is the captain of the ship," or whatever you want to call him or her, to "we're going to have an egalitarian workplace." So I guess, to me, I think it would be helpful to see what are the barriers and what's our plan for developing and working with CCOs to address those barriers around best practices, because I think there are best practices out there. Maybe it's Lillian's best practices, maybe it's Kaiser's best practices, maybe it's OHSC's best practices, but how do we get there?

>> Lisa Angus:
Yeah. I think that's one of, I mean, that recommendation in particular is the hardest one to grapple about in terms of implementing, and I just wanted to say that one of the potential next steps this small group of committee members identified was talking to a wider range of folks, maybe who are less involved in policy-level conversations, but who are employers right now on the ground, about among those recommendations, what barriers do they see, which are most feasible, and what are the appropriate venues for starting for starting to implement them? So that's a potential next step that this group of committee members identified that they'd be happy to undertake at your guys' direction, if that would be helpful.

>> Unidentified Speaker:
And I also think, what recommendations can the state provide? Is there a way we can collect a best practices guideline and create sort of, even if it's not one of the CCO [measure mix[?]], but is there a best practices or measurements that get you to overcome some of those barriers that can be provided to clinics? Sort of a menu of options, just like we would on anything else? Just as a next step. Sorry, it's a lot of comments.

>> Lisa Angus:
I think we're switching over to Carol, now, unless anyone has any other...

>> Mr. Chair:
Very good. Thank you.

>> Carol [Tuney[?]]:
Good morning, everyone. Carol Tuney, Equity Manager with the Office of Equity and Inclusion, and I am going to be talking about the work of the Non-traditional Health Worker Sub-Committee. I'll talk a little bit about the name in a second.

>> Mr. Chair:
No. This is, actually, we're getting into the meat of it. [laughter] But wait, there's more! [laughter] So, I just want to point out the legislation that directed our work, which is primarily in Section 11 of the House bill, and you'll see that language written here, but I know you're very, very familiar with it. The Office of Equity and Inclusion was charged with convening and facilitating an ultimately 25 member sub-committee of diverse stakeholders to meet the charge of the section, and we did choose the moniker, "Non-Traditional Health Workers," to include the three types of workers named in the legislation, but I want to point out that the irony of that name was not lost on our committee, given especially the fact that community-based, peer health education and promotion and services have long been a tradition in many countries, cultures, including our own.

So, part of our process, just a quick review of what we did. The process included scanning other state and our own state, other states and national practice among the fields, reviewing existing research and published recommendations from other states, similar workgroups and the recommendations that they developed, and we also conducted a survey of these workers here in Oregon, resulting in responses of 620 non-traditional health workers who sent to us their scope of practice, what they were currently doing, how they were doing it, how often they were doing it, and with whom they were working. With this information, we then developed the [indiscernible] competencies and education and training requirements that you will find, well, you'll learn about, in the remainder of this report.

So to start with the scope of work, we identified and captured, basically, the varying types of work that non-traditional health workers do into four key categories, including outreach and mobilization; so, really making sure that people understand and are aware of health-related information and resources and services, particularly as we move into this new healthcare model and also to connect, make sure that they're connecting with the natural support systems that are already in place. Also, to really encourage and promote the idea of accessing and utilizing healthcare before it becomes an emergency. The second role was to support connections between individuals' families, communities and the healthcare system and other organizations. In other words, taking a holistic approach to an individual, their life, their challenges, and their strengths; their cultural beliefs and practices that actually protect that, in addition to things like linguistic and geographic challenges, barriers and promising practices. So, making sure that what people are bringing along with them when they see a healthcare provider is all taken into consideration, and this individual, this non-traditional health worker, would remind and keep at a heightened level of awareness the idea that it's not just the barriers but the strengths as well that people bring with them.
In terms of case management, care coordination and system navigation, the work would be to collaboratively assess, plan and facilitate individuals receiving fully holistic healthcare. All the options and services that would help them meet and achieve optimal health and assure that across the healthcare team that all of the challenges, barriers and strengths would be recognized and delivered in a culturally appropriate manner, and finally health promotion an coaching would include the process of enabling people to take their own health into their own hands and also to develop ways to understand the way the healthcare system and healthcare provision happens here. So, for example, you know, taking control and doing like, if there's a chronic disease issue, you know, doing the self-management that's required to help better and improve a chronic issue or access, again, the services that they would need to address that.

This slide is unreadable, but you do have this in your packet. [laughter] I just want to point out that this is what it looks like. [laughter] [banter] I just want to make sure people see that this slide is in your packet, and what this slide provides, it essentially illustrates those four roles and then the recommended competencies developed by the sub-committee, and then the attendant training and education that would be required to meet those competencies.

>> Unidentified Speaker:
This is extremely helpful, because I think that, you know, for the industry, and by that I mean the whole spectrum of the industry, you know, this really helps put things in a way that, Felice, you were talking about, you know, "How do organizations write job descriptions and things?" So it's an enormous step forward, you know, for those of us who have been working for thirty years around some of these issues. I think it's really important work, and you guys did a great job.

>> Carol Tuney:
Thank you very much. So, I'm not sure how many people were able to review the table before the meeting, but I think what you'll see, again, is specifically the competencies in training, and one thing I do want to point out is in the training column, you'll see core curricula that we describe for each competency or role and then additional curricula that specific worker types would be required to participate in or receive so that issues specific to their work would be also included and covered. So, just, you'll see that described below or, uh, in the attachment.

>> Unidentified Speaker:
Now, I'm having a problem cross-linking this with the first slides that mention coordinators, navigators, and [indiscernible]. So, I was coming to this table expecting to see three categories. So, help me cross-link between what was at the very start and this.

>> Carol Tuney:
All right, I'll do my best. So, the first challenge was the fact that community health workers, peer wellness specialists, also under the peer specialist title we are actually more
familiar with the peer support model, which is behavioral health model of peer delivered services, and then personal or patient health navigators. The challenge was that, all of these worker types have been actually in existence for a while and have in fact developed many kinds of training models and competencies as well. So, part of our challenge was then to identify what's common across all of these workers and come up with a base curricula, base competencies that would meet the language of the legislation, which would be to come up with something for all of those workers, but then recognize the fact that because of the work that's been done for many, many years by these different groups and because of some of the specificity in the work, that we need to also delineate between the three worker types. So what you'll see is a list of competencies that cross all workers, and there was some significant agreement across all workers about what kinds of competencies they would be able to achieve and meet and then particular to each worker type, well, and again, the training was really the core curricula is related to all of those competencies, and then additional curricula, the additional required curricula, which you will see on the right-hand column of the training is identified by specific worker type.

So for example, under outreach and mobilization, community organizing is a key role for many community health workers across the nation. It's not necessarily a role that is played by, for example, personal health navigators. So, that's why we made the delineation in that section. Is that helpful?

>> Unidentified Speaker:
I think it's helpful, and you know, Jill, I think that's exactly. It's the mobilization piece, which isn't traditionally thought of when you think of healthcare worker extenders, that kind of thing, but I think to get to where we're going, and the upstream public health issues that we've all talked about here, that's a key role that isn't intuitive when you just, you know, are coming from the delivery side. So, I think that's another way that we're trying to expand the horizon of what we can accomplish through the Policy Board and transformation.

>> Carol Tuney:
Thank you. So, if there are no other questions about the table, the competencies, the training, I'll go ahead and...

>> Mr. Chair:
I need to move this along in the next 5 minutes or so.

>> Carol Tuney:
Oh! OK.

>> Mr. Chair:
Thank you.

>> Carol Tuney:
So, um, the sub-committee does recommend a two-part process, and umm...

>> Unidentified Speaker:
I'm sorry, can I just jump in? I'm sorry.

>> Mr. Chair:
Part of the 5 minutes, but yes.

>> Unidentified Speaker:
So under the goals of certification, just as you go back, I don't see the goal up there, the same issue of... [trails off] I see the low barrier to entry, but I don't see the goal of having a career path to move people to different levels. So, I'd like to just make sure that gets added.

>> Carol Tuney:
All right. We can definitely do that, and one challenge for us was just turning this around quickly enough to provide some specifics around competency and training. The career pathway definitely came up in conversation, and we just didn't quite get there in terms of how to really make that very clear, so we're happy to continue to work on that.

So, let's see, where am I? OK. So, one of the things that was very, very important to the committee, and it was also highlighted by the research, was the importance of insuring that certification process would not undermine the integrity and the success of the model of providing community-based, peer-delivered services; however, at the same time, the sub-committee of course did recognize the benefits of certification, including needing to meet standards of knowledge and practice which would, I think, promote the process of developing peer pathways; the ability to request reimbursement through Medicaid, which would also increase the sustainability of the field; and then, increased recognition by other healthcare providers and systems.

In terms of the process or how this would actually ability, the sub-committee recommends that a central body review and approve competency-based training programs rather than certify individuals. Part of the completion of participating in the approved competency-based training programs would be that the individual would receive a certification of completion and that the Oregon Health Authority would require that certification for enrollment as a Medicaid Provider. The minimum hours of training are still under discussion. There was some negotiation about what makes the most sense, and some of it is based on existing practice and availability of training, but also what would the level be to meet the competencies required. Right now, what's under consideration is a minimum of 80 hours, which could include both didactic and on-the-job training; however, there continue to be concerns of this number of hours would limit certain worker types from being able to participate. So, that's still being worked on. Some community health workers have been practicing for many, many years; other workers, as well. So to assure that we're not excluding people who have already been working in the
field, who have lots of experience, the sub-committee recommends that there's an allowance for grandparenting, as we called it, to ensure that non-traditional health workers who are already in the field are able to continue, but the sub-committee also recommended also participating as part of that in some sort of incumbent worker training to make sure that people are up to speed on what's happening now in healthcare. Finally, a recommendation around training was to make sure to limit the cost of training, and you'll see from the results of some of our national survey that other states' fees run anywhere from $0 to approximately $200 to participate in training programs to get certified.

In term of providing oversight for these training bodies, again, the central body would be charged with that. They would review and approve training programs, the methodologies for training and additionally maintain a registry of certification or records that would include things like ethics violations, and part of the work of this body would also to be to bring on some sort of advisory group that would include a sufficient number of practicing non-traditional health workers to assure the integrity of the model, review and renew training programs every 3 years to ensure the quality relevance and compliance, and then also to continue promote the utilization and the role of non-traditional health workers in our new healthcare system. Finally...

>> Mr. Chair:
[indiscernible]

>> Carol Tuney:
I'm almost finished. So finally, the additional recommendations that we considered, that are still under discussion, would be to require the supervision of these workers by license or qualified healthcare professionals, behavioral health professionals, or Master's-level public health workers to provide incentives, and this might get to Ms. Higgins' concerns, to CCOs to develop internal plans for the supervision and ongoing support of non-traditional health workers including developing strategies within that global budget to support both training and retention, and hopefully, as we continue to work, we can identify career ladder pathways. And then, last piece or last recommendation would be to develop strategies for training partners to assess the needs of these workers for continuing education, and how they will continue to stay updated and relevant in the work. OK.
Questions?

>> Mr. Chair:
Very good work. We appreciate it. I know Carlos... [trails off] We have a couple minutes. Carlos, and then to Mike.

>> Carlos:
Thank you. This is very helpful. We have a Bachelor in Health Studies with an area of concentration in community health, and knowing what the competencies and the training is very helpful. This is allows to do, we're always doing curriculum revision, so this is
very helpful. This is a professional. It looks like we are hiring a professional, which means that it does require some level of oversight. I wonder if there is a national accrediting body for community health workers, or if we prefer the organic way of Oregon doing things, you know, as we get ready, but it might be that we just have to look, and there might be a need for a national accreditation for community health workers. I'll list all my questions in one go. Where are we, in the state of Oregon, in terms of supply and demand of community health workers? Do we know that if we implement this next year, we will be able to provide all the community health workers that are needed for a CCO, or not? Where are we in the respect? Because that has an impact on workforce development. And the last comment, which I'm not sure the role of cultural competence in community engagement, and it might be the other way around: How much community engagement will have an impact on cultural competence? And it's an interesting balance about, which one comes first and how these two elements are very linked to community health workers. I'll stop there.

Well, one comment about this career pathway. Maybe not everybody wants to move up and [do those for once[?]], and the key part of this is, if we see this as just an entry-level position, we are going to have a high turnover. I think it's a very noble profession. I think it's very critical. It's a valuable team member, that when people get in to be a community health worker, that they feel, "I can do this for the rest of my life. I have a rewarding career and be happy with what I do." So, the pathway is great, buy I think we should also think about that, this is great. You don't need to be the next [offer[?]].

>> Carol Tuney:
All right. Well, let me go step-by-step through your questions. The first one was about national accreditation, and right now there, for some specific, non-traditional health workers; for example, doulas in House Bill 3311 is something that we have also been sort of conducting a parallel process around through our office does have a national accreditation body; however, for community health workers specifically, there is not one. There have been discussions in terms of peer wellness and developing that kind of national accreditation; however, to my knowledge, that is not happening at this point. In terms of supply and demand, that's a very difficult to answer, and I don't have the answer. I'll be really clear, up-front. I don't have the answer to that. Part of the difficulty is the fact that the utilization of, well, again, because of not all states and not all areas have a role for community health workers or non-traditional healthworkers because at times, if there's funding available, systems will employ these workers, but then when funding disappears, they may end that practice. It's very hard to understand where the need, how much need there is, and also how much demand there is, how much [indiscernible] people would actually be employed. I think what's fairly interesting is that when funding is available, it does seem like this method is adopted at least while it can be, and I think some of the study data that is provided in the report shows the cost-benefit of utilizing these workers. So I think that there is at least, both in terms of community engagement, in terms of outcomes for people who may not readily use the healthcare system, and in
In terms of community engagement, and I'm hoping I'm understand you're question correctly, the relationship between community engagement and culturally specific approaches: I think the more that we can make sure that we're not losing through our process the ability for people to take what are culturally specific practices that are protective factors and things that very clearly are barriers when they're not there. For example, linguistic ability; to speak the language of the person who is being seen. By the cultural competency, when a person walks into a doctor's office and is met with a culturally competent provider, front desk staff, etc., I think... [trails off] And then, having that non-traditional health worker navigate that and help build the relationship, I think, is very, very key to cultural competence and engaging people in the healthcare system sooner rather than later. A recent qualitative analysis of some community stories that the office collected shows a theme of people, particularly from other cultures, not accessing services, healthcare services, at the early point of need but rather later because of cultural competency issues.

>> Mr. Chair:
I...do you have a question?

>> Unidentified Speaker:
I do, and these questions can come back to. We don't have to answer them right now. First, I want to thank you very much. I think this is outstanding work. I think you've really done a great job of kind of capturing the intent, what 3650 had outlined in this. So, I think this is just a great framework for us to build upon. You reference a number of times kind of a central body yet to be determined. You talk about some mechanisms for training, yet to be determined. "When are those to be determined?" I guess is my question, and I think if you could come back, maybe in a couple of weeks, with some recommendations to that, and then also perhaps just some timelines of, "How do we actually begin to link this with our CCO development so we understand the dual track that we'd have to go down and be able to link those two things together?"

>> Unidentified Speaker:
That was my thought exactly. Kind of a next step, sort of. I mean, this is all great information, but I think we want to continue on with this, so we want to get to where we're going. Maybe a [indiscernible].

>> Unidentified Speaker:
Yes. Yes. Yes. I think, you know, I think we talked about revisiting the HR practices, but then when we get to the community health worker, we're using the same supervision practices that we've always used, and so I guess my question is, "Is there a different model of supervision that works better in a team-based setting? And what does that look
like, and is that a possibility for when we're speaking about how community health workers are supervised?"

>> Mr. Chair:
Why don't we use this as the point and say, "Perfect." Thank you. Very good work. We're on the right track. No corrections that I'm hearing from anybody here, but if we can carry on to the next step we'd appreciate that.

>> Carol Tuney:
All right.

>> Mr. Chair:
OK? Thank you both very much. We appreciate it. OK. Agenda Item #4: We have invited testimony today from Dr. George Brown, president of Legacy and representing the Tri-County Medicaid Collaborative. At previous meetings, we've heard about organizing efforts in other parts of the state, and there is some tremendous work going on in the tri-county area, and we're anxious to hear more about it. So, Dr. Brown, welcome. Thank you for joining us today, and we'll let you take it from here.

>> Dr. George Brown:
Thank you Mr. Chair. Good morning and to the Board, thank you for the opportunity. Joining me this morning is Dr. Dave [Levy]? to my right, who's the medical director of Care Oregon and John [Hurston]? who is the project director for the Tri-County Medicaid Collaborative. I passed out the testimony that I'm going to read to you, and I would be happy to, well, we would be happy to entertain questions at the conclusion.

So again, thank you for this opportunity to provide the Oregon Health Policy Board with an update about the Tri-County Medicaid Collaborative. Today, I will be providing you with a brief history of the Collaborative, our vision around how we believe care can be transformed in our community to allow for better health and the challenges that lie ahead, and finally how the Oregon Health Policy Board can assist us in these efforts. In early December, representatives from six organizations, Care Oregon, OHSU, Legacy, Providence, Kaiser, and three counties came together to discuss how best to continue the Medicaid care transformation work that occurred within the Oregon Health Leadership Council over the past six months. The result of that meeting was the formalization and continuation of a community-wide partnership that is truly unique across the nation and presents this community with an opportunity to improve and transform care for an [under-served?] portion of our population. The goal of the Collaborative is to create a new community organization to ensure cost-effective, quality care for those to whom the public shares a responsibility. The organizational and financial structure being established will ensure that both risk and responsibility is born equitably, and that providers are incentivized to produce better care with improved population health and utilization outcomes. The vision of the collaborative is to create an integrated community delivery system that will achieve better community health for the Medicaid and high-risk
uninsured population in the tri-county community, in which all stakeholders invest by committing resources and/or dollars.

The Collaborative has several guiding principles, including the following: a collective, caregiver-lead initiative to include all those who touch patients; optimal system design; maximize resources available for care; accept global financing methodologies; design care for the population that includes a person-centered primary care home model; the integration of physical health, behavioral health, and social services; align and coordinate specialty care with a focus on prevention; a pay-or-play provision to deploy capacity or other resources to meet the need or offset the cost of those who do provide for the need; transitions of care across the continuum, which is plaguing the current system; and, a focus on [an[?] user, consumer-oriented system.

The Tri-County Medicaid Collaborative is led by an executive [steering[?]] committee, which now represents nine major healthcare stakeholders, including Care Oregon, OHSU, Legacy, Providence, Kaiser, Multnomah County, Washington County, Clackamas County, and the federally-qualified healthcare centers. The Collaborative hopes to include additional members, including family care, Portland Adventist, Tuality, and will continue to seek input from other stakeholders in the community. In order to support the work of the executive committee, key workgroups have been established in order to provide insight, guidance, and structure to the Collaborative, including a model of care team, a revenue development and distribution team, a communication team including a larger stakeholder group, and a start-up development team focused on securing a Federal Centers for Medicare and Medicaid Innovation Grant funding for these initiatives. All participating organizations have dedicated significant resources and time to ensure that this effort succeeds.

Let me give you a sense as to the progress that has been made and the level of collaboration that has occurred over the past four weeks. We have an executive [steering[?]] committee and five fully-functioning workgroups meeting at least weekly, all with the common vision and principles guiding their work. In addition, we are in the final stages of [preparing[?]] the above-mentioned CMMI grant mentioned to design specifically to reduce cost for high [indiscernible] Medicaid patients that will serve as the building blocks upon which the metro region's COO can be built, and the few short weeks [indiscernible] [inceptions[?]], the Tri-County Medicaid Collaborative has been able to pull together resources from diverse and historically competitive organizations to build a community-wide effort that is well on its way to submitting a $30 million grant proposal, creating the foundation for transforming care in the metro region.

It is important to remember that this group is only several weeks old, and there are significant challenges ahead: to include a complex and political legislative process; the need to move quickly, yet include numerous stakeholders; touch budget and financing decisions; no roadmap to follow; and many more. In spite of these challenges, doing
nothing is not an option, and this group is committed to transforming the healthcare system in the metro region to better serve our community.

With that in mind, let me turn to the conversation of our vision on how we plan to transform the delivery system. The Tri-County Medicaid Collaborative has brought all components of the healthcare delivery system to the table to design an integrated delivery system for Medicaid and high-risk, uninsured members across the region. These include the major health systems and hospitals, primary care, specialty care, behavioral health, dental health, and health plans. Most of us have been working together for years on multiple projects to improve care for Medicaid and uninsured individuals in our community; however, this is the first time we have all worked together in a coordinated way with one unifying goal, which has been an amazing experience and one that is truly unique and groundbreaking, as well as challenging. As you know, many local primary care organizations have been working for years on transforming their primary care homes. The model of care we envision builds on the primary care home team, adding community outreach workers to go into the community and into the homes of those individuals who appear to be struggling with overwhelming medical, social and personal challenges. It is our belief that these outreach workers will help patients avoid unnecessary emergency department visits and hospitalizations by being a first line of information and coordination for patients as well as a connection with providers.

Simply stated, patients need help navigating the array of complex medical and social services to achieve the best health outcomes. Our plan is to build on the primary care home team by connecting the various entities of healthcare delivery. For example, standardizing the way patients are discharged from hospital. Prior to discharge, we can identify those who really don't have what they need to stay out of hospital and make sure that the hospital team puts in place a post-discharge plan that is coordinated with appropriate non-hospital care entities to avoid unnecessary hospital re-admissions. Part of that plan is to provide the primary care practice and care manager with a discharge summary and a list of critical action items the patient requires to remain at home and a mechanism to follow up on the patient's recovery, compliance with medications, follow-up visits, etc. The idea is to develop a standard transition hand-off not just in one hospital or one clinic, but to develop a standard of coordination and information exchange that all clinics and hospitals can adopt. Our hope is that this standard will ultimately be used for all patients across our community.

In addition to physical health, the Collaborative will also focus on behavioral health, oral health, and social services so that a system is designed and focused on the complete care needs of the individual. We can build a regional collaborative so that these efforts are coordinated to learn the best way to do this new outreach work. Our intent is to identify individuals who need help early and to give them the help they need. The ultimate vision is to increase the quality of healthcare delivered, to improve overall health outcomes, and to reduce the cost of healthcare. The Collaborative participants are committed to
exploring how their collective efforts may evolve to become a coordinated care organization for this region.

Some of the challenges that lie ahead that we think the Oregon Health Policy Board can help us with; given that it will take a few months for the Collaborative to organize and develop, we want to offer four concepts for consideration by the Oregon Health Policy Board. We offer these concepts to help ensure that important options exist for the Collaborative going forward after the legislative session concludes, allowing the Collaborative to develop in the best way to serve the tri-county region. The four concepts we would like to offer for your consideration are in the areas of information sharing, fast-tracking, governance, and finance.

Information sharing: the rules regarding sharing of clinical information for patient care between healthcare providers should not be more restrictive than the federal HIPAA requirements. In order to make the CCO function as designed and truly coordinate and integrate the care for the patients, we need to remove unnecessary barriers for information sharing. The integration of behavioral health, including mental and chemical dependency care, is currently prohibited without special release of information [approvals[?]]. In order to facilitate the sharing of this crucial information across healthcare settings to assist in care integration, we'd like to request a waiver from the federal government to allow this information to be shared more easily when appropriate. The role of public health work in the CCO is crucial in both developing the community needs assessments and ongoing work for health improvement plans. In light of this, we feel that aggregate data sharing should be allowed between the CCO and public health to facilitate that work.

Fast-tracking: as proposed legislation is considered for the 2012 legislative session, the Tri-County Medicaid Collaborative asks that the Oregon Health Policy Board in its recommendations and the legislature in its deliberations consider proposals that support the integrity of the Collaborative's cohesive process. The Collaborative supports legislation that promotes cooperation, flexibility and ingenuity. Specifically, the Collaborative would like to ensure that legislation aimed at fast-tracking CCO determination does not inadvertently create incentives for MCOs participating in the collaborative to pursue CCO determination alone, and that it allows sufficient flexibility for organizations to be [provider-lead[?]] governance. As we work to establish, organize and develop the model of care for the Tri-County Medicaid Collaborative, we will continue to explore the most appropriate governance structure that, in accordance with HB 3650, will allow each Coordinated Care Organization has a governance structure that includes a) majority interests consisting of the persons that share in the financial risk of the organization, b) the major components of the healthcare delivery system, and c) the community at large to ensure that the organization's decision-making is consistent with the values of the members and the community. That's from HB 3650, Section 4, [bullets[?]] 1, [bullets[?]] 0.
In order to ensure that governance options remain available to us as we continue our work after the February legislative session, we would ask that the Oregon Health Policy Board consider our proposal and allow flexibility in the type of governance of a CCO. Specifically, we would ask that a Coordinated Care Organization be allowed to establish itself either as a private, non-profit organization or as a public corporation or through contractual relationships such as a joint venture. In other words, we're very early in the game. We realize the legislative session is upon us, and we would like the flexibility to pursue the best option that suits our mission.

Finance: as established in the guidelines of the Collaborative, maximizing resources available for care is a priority. The Tri-County Medicaid Collaborative urges the Oregon Health Policy Board to strongly recommend to the legislature for its consideration the financing and revenue structures established for CCOs should maximize federal funds that could be available for care for all Oregonians. The proposed $239 million reduction to OHP in the second year of this biennium will result in an additional loss of over $400 million in federal match funding. It cannot be overlooked at the loss of over $600 million to the Medicaid system will have a negative impact now and into the future. This decrease in funding may also trigger a decrease in the baseline for federal match funding in 2014 and beyond when the Affordable Care Act is fully enacted. 36% of Oregon's Medicaid population resides in the tri-county area. In addition, there are thousands more uninsured. The Collaborative stands ready to help pursue all options that will maximize resources available for these Oregonians.

In closing, again, thank you for this opportunity to provide the Oregon Health Policy Board with an overview of the nascent Tri-County Medicaid Collaborative. We appreciate your insights and support as we continue down the transformation path toward better quality of care, improved population health, and reduced cost for our healthcare system. We would be happy to take your questions. This concludes my formal testimony. Thank you.

>> Mr. Chair:
Dr. Brown, thank you very much. I want to start by simply saying congratulations to you and your collaborators on accomplishing so very much in such a short amount of time. Our goal has been to establish a relatively broad set of structure that would bring forth innovative proposals for healthcare in conjunction with a progressive healthcare delivery model, and I think you've done that very well. So, thank you. We appreciate the good work that's been done, the good work that's been done to include so many of the providers and others, including the counties and tri-county area. So, thank you.

>> Dr. George Brown:
Thank you.

>> Mr. Chair:
Let's open it to comments and questions. Dr. Hoffman?
>> Dr. Hoffman:
I might just say that, speaking as an individual and member of the Board, this is very exciting. I think that, you know, as we've gone through our deliberations that I for one was very concerned about the possibility of three or four or five competing metropolitan CCOs, and to see this work being done. [trails off] You know, it's wonderful to realize that maybe we can all get along. [laughter] Because, as you said, the alternative to not getting along is not sustainable. As I read through this, I'm a little confused on where to go from here, also. I think that it's very important, either for your executive committee or a separate ad-hock committee, to start working through how this model might fit into 3650. I mean, we have certain rules that we have to play by, and I don't know that we really, you know, 3650 really anticipated this model. And so to the extent that things need to be changed, I don't know whether that's going to be able to be done [indiscernible] February session. I think there's some things that can be done between the Collaborative and the Health Authority. But all that stuff, you know, I think it's very important for the Collaborative staff to sit down together and start working through all that. I'm sure you're doing that already but you know, I think about the governance requirements in 3650, and a private, non-profit, I start getting kind of confused. So, there's a lot of those sort of issues that can be addressed that I really think, and I'll bet you I think speak for everyone, that's seen y'all get together and bring this forward is really exciting stuff. So, thank you.

>> Mr. Chair:
[Felicia[?]]?

>> Felicia:
I feel like there are two really important things here that I hope that other areas take a look at. The first is the guiding principles that you put together, I think were spot on, and I think if there are other areas where there are competing entities or are people who are thinking about competing entities, I think those are really important to moving forward, so I appreciate that. The other thing I thought was really interesting in the testimony is that you're not just looking at the Medicaid population but the uninsured, realizing that that's a huge issue throughout the state and so, specifically in the metro area, I also think that that's going to be an important future thought for other collaborative efforts. And then, I guess my only question is on the sort of the fast-tracking, and it's not directed at you. I think that's a question for us. I think we've heard two different theories on that here, and so I feel like it would be good for us to have more of an in-depth conversation to figure out what that's going to look like in the future, but I'm exciting about the work. I think it's a good idea, and I think it's very difficult what you guys are doing. I think the recommendations about the transition plan, I heard a lot in my sub-committee on dual-eligibles, so as you dig in deeper in that, I think the long-term care system would be really interested in being engaged around that piece.

>> Dr. George Brown:
If I might offer two comments; first, with respect to fast-tracking, I realize that there's a significant pressure of time to go from zero to functioning organization, so that is a challenge, I think, that when you consider the complexity of what it is we're trying to do, when you consider the disparity and historical competitiveness that the organizations were trying to bring together, it is a force that is really a hammer over our heads of really being able to accomplish this, and the [old saw?] of, you know, if you want it bad, you'll get it bad, and we're trying to avoid that. That's why our plea to the Board is to allow flexibility. For us to work out a lot of issues, some of them are professional issues. We have a lot of historical behaviors that are being carried into the future. We have a lot of stereotypes that really have to be set aside because we're not used to working with one another. This requires time, and I will say that the seminal work that was done over the past six weeks in the Oregon Health Leadership Council really has allowed these organizations to come together with better understanding but still, six months or so is like not going to the moon, it's actually circling Pluto and coming back. So, that's one comment.

The second comment I'd like to offer with respect to the uninsured: We all realize that we have significant shared risk. Some are financial risk, some is care risk, some is both. But this community shares the risk with the uninsured because our traditional methodology of providing care for those who can't pay is cost-shift, and cost-shift to businesses is an impediment to growth in this community. So, it's important that we get our hands around, at least those uninsured who are very high-acuity, and whose care is expensive, so that we can manage that care at least costly and most effective way possible to mitigate, to a great extent, hopefully, the cost-shift. That will allow our community to be more economically and financially vibrant.

>> Mr. Chair:
Makes sense.

>> Unidentified Speaker:
[Mike?], just quickly, just huge kudos, as well. I think, Dr. Brown, you've provided some amazing leadership as well. I think Joe and Lily and all of you guys have just done an outstanding job. I think one of my big takeaways as I've seen this work develop and seeing how it can be kind of translated to other communities, I think you've done a great job of kind of walking the fine line between developing a model of care and governance, and I think this whole CCO conversation in local communities, people have really been challenged of trying to jump to a governance discussion before understanding really what a model of care is looking like. I think Dr. Lab, he's done a fantastic job of really trying to have that highlight. I think you have done that as well, and I think that's a big takeaway for a lot of us, that's it's really got to be kind of in joint conversations. It's tough to jump to a governance without understanding, really, what you're trying to do to transform care. So I think, again, huge kudos to you guys.

>> Dr. George Brown:
Well, I think one of the things that we realize is that not a single entity has the answers for everything, and you know, I will admit that one of the things that traditional physical health knows not very much about, and that's behavioral health. And so, there's a lot to be learned from the counties, who are on the frontlines each and every day. We get sort of a sub-segment of that, but how do we prevent those people from winding up in our in-patient facilities? And typically, we run out of room in our psychiatric units. So, these patients spill over into our medical, surgical units. I will say that, every Friday when we meet, you know, I go into that meeting gritting my teeth, because we have a room full of about 30+ people who are all smart and capable, and my hope is that we can stay focused, and at the end of every Friday, I'm just amazed that we managed to do that. And I think that it's because of their deep and abiding commitment to change of the way we provide care, and we know we can do better. We're just hoping that we are given the opportunity to make good on that promise.

>> Mr. Chair:
Felicia?

>> Felicia:
I think that, you know, one of the things that I actually think that each of the organizations that are in the room share in their own practices is the elimination of healthcare disparities which, you know, I think all of you have done different work on that issue, and I feel like it's so critical for the Medicaid population and the uninsured population when you look at who they are. So, how you work that into your designing care for the population needs as part of your goals, I think it's going to be really critical, especially as you take on the issues of behavioral health and oral health, which have even greater disparities than physical health. And so, figuring that out in the model that you're working towards as a collective actually, also seems like a very exciting moment, so that each of you are on these individual tracks on that issue alone would be great.

>> Mr. Chair:
Any last comments? Dr. Brown, thank you very much. We really appreciate it. We asked you and your partners to come forward with innovation, you've done that in spades. You've asked us for some flexibility. We're going to try to deliver that back to you. Thank you so very much.

>> Dr. George Brown:
Thank you very much Mr. Chair, members of the Board, for this opportunity.

>> Unidentified Speaker:
Mr. Chair? Before our next presentation, if I might, I have this idea that I think is [germane[?]] to the last conversation, to the discussion that we're about to have, and here's the thought, and Joe I'm going to need your help on this. As we transition into this model of [well-managed[?]] care, it occurs to me that we will find that certain services can be provided at high-quality in widely dispersed areas, and that [indiscernible] training
centers might not be the most effective way to do that. And I guess my point is, so, a well-managed organization might find that quality and cost can best be delivered somewhere else. But as we talk about workforce strength, and I guess what I'm saying is I've realized there's a component, this workforce training component, that needs to be considered within that context of cost and quality. If we don't utilize our healthcare training resources, then they're going to dwindle, and we won't have a healthcare workforce.

So, my thought was, you know, as we negotiate with Medicare on this cost, not [indiscernible] savings on this shared savings model. Since so much [graduate?] medical education is Medicare-funded, I think that in our conversations with Medicare, we need to ensure that, as we proceed on with this transformation, that some of those savings need to go back into workforce training, and I guess that's a conversation that we really haven't had. And so as we start talking in this next segment about potential savings, I guess my caveat is, we need to be cognoscente, that we need to make sure that some of the savings go back and, I don't want the use the word subsidize, but go back and help sustain...

>> [Mr. Chair?):
Be reinvested.

>> [Dr. George Brown?):
Right.

>> Mr. Chair:
Joe?

>> Joe:
OK. First of all, thank you for that concern. OK? And if I would parse the question, I think there really, as we move, what I heard you say as we move through transformation, there is some threat to healthcare professional training, and I think there are two potential threats. One is financial, and the other is programmatic. To address the programmatic first: We agree with you, that I don't think you can create one cost structure or one outcomes-based structure that is best for the entire continuum of care. I mean, one of the goals of healthcare reform is to do the right thing at the right time at the right place in the right way, and so we absolutely endorse that. And it maybe that many of the services that conventionally have been provided to this patient population and academic health center should not be provided there; that they are more community-based, and we have a lot of outreach programs, but we will never have the extent. You know, an academic health center will never have the degree of community involvement that a community hospital does. We are not threatened by that per se because if you look at our strategic plan, it's based upon partnership, and it's based upon partnership in every one of our missions, and education should be no exception from that. So over time, what I would see happen is that there would be a continuum of education. We already have a lot of clinical sites, but
that partnership and collaboration that we have with community hospitals over time would be enhanced. I think that that would be the vehicle by which we would address that, and I can talk more but, I mean, just in a nutshell. So that, per se, it requires a change by all parties. It requires a change at the academic health center. It also involves a willingness by the community hospital to begin to enter into that activity.

The second aspect: There is a real financial threat to all education from healthcare reform. We know that clinical margins will be reduced, OK? That overall, from a societal perspective, that's probably a good thing. I mean, [we can?] endorse that. OHSU has endorsed our 8 Principles of Healthcare Reform, fully cognizant of the fact that that's one of the likely outcomes. So if that is, then how do you identify the funding streams that will support education? In the present, they really aren't. There are implicit rather than explicitly, and basically what happens is we take, and this is common across the country, we take the margin from the clinical enterprise and bring that over the [indiscernible] support the public mission. If that's reduced, then I think it is incumbent upon us to find the funding stream that will replace that. And just as a caveat: In the federal, you mentioned GME funding. In the federal budget, GME is in the [gun sights?] for a budget reduction, and there has been some preliminary work done by the, I think it's one of two groups. I think this was done by the University Healthcare Consortium, UHC. It may have been by AAHC. Details, but it shows that with to the degree some of the expected reductions in GME funding could reduce the number of GME slots to the point that there would be an insufficient number of spots for the current number of graduates from osteopathic and allopathic medical schools, not to consider any of the trainees that we're currently accepting from foreign schools.

So, I didn't mean to give you a whole treatise, but that's the... [trails off] We're thinking a lot about the issue that you raised.

>> Unidentified Speaker:
Yeah. I guess my point, and thank you very much for that, I think my point [is?] from a policy standpoint. We need to be cognoscente of that. We can't really talk out of both sides of our mouth. Talk about healthcare workforce development and then not recognize that some of what we're doing, you know, has the potential to really harm workforce education.

>> Mr. Chair:
Carlos?

>> Carlos:
This linkage between healthcare and education has come before, and it goes to medical goes. It also goes to other health professions. I mean, it's very expensive, and then when you have so much money, student loans you have to pay, then you have to have a high salary. Not that it's not deserving, but one way to [attain weight?] is high salaries [indiscernible] why the education is so expensive is to be able to invest so that it is more
affordable for health professions to go to school. But the other linkage is, I think it goes
even back to education, "How do we make sure that we invest in our schools, so they also
provide a healthy environment for the kids, so they're less sick? How do we make sure
that we do have PE in schools? How do we make sure that they eat well?" It's sort of
these connection not just between the healthcare system, but also integrating education as
a whole from pre-k all the way to medical school.

>> Unidentified Speaker:
[Doug is going to[?]] tell us this.

[laughter]

>> Mr. Chair:
Why don't we move forward to Agenda Item #5? Obviously, you know, at the end of the
day, much of this ends up being a discussion about money, and this is the point at which
all of that comes together, so I want to introduce Doug [Ellwell[?]]; Doug, from Health
Management Associates. Thank you for joining us today, we appreciate it very much. We
know you've been asked to do a fair bit of analysis on behalf of OHA and Health Policy
Board with regard to potential outcomes, and we're curious to see where we are. Tina?

>> Tina:
Can I add one thing before Doug starts?

>> Mr. Chair:
Sure.

>> Tina:
That’s just to let everybody know that Doug's work is presented here as part of the
proposal. HMA will be developing a separate report that would become, you know,
probably by next week sometime, we'll have a free-standing report. Right now, it starts
on page 14, or actually 13 in the copy that was made for you today.

>> Mr. Chair:
Very good.

>> Doug Ellwell:
Well, I think just to kind of get started and set the stage, I'm Doug Ellwell. I'm a
Managing Principal with Health Management Associates, which is a consulting firm that
works primarily in the areas of healthcare, primarily with organizations, states,
foundations, hospitals, counties that want to provide care to low-income people and
vulnerable populations. So, this is what we do. We have a little over 100 professionals
stretched out over 12 offices. We have 13 former Medicaid directors from around the
country, as well as a variety of other people. My particular background is in hospitals and
physician networks, but have also done a little bit of work with states. I think, again, what
you've got here is an unprecedented challenge and unprecedented opportunity. You've really basically come forward and said to the healthcare system, "Transform yourself. We're going to take some of the barriers out." We've talked for years, that there's 20-30% waste in the system, but as opposed to imposing the fix on you, we're going to let you work through and come up with the fix yourself." This also allows, I think, for the first time, everyone always talks about having everyone operate at the top of their license. The reality of that discussion has always been, "If you can bill," and so because our system is based on billing, you can't let someone operate at the top of their license if they're not a biller. If they don't have that credential that bills. This, I think, for the first time, will give people the opportunity to say, "Let's bring everyone to the top of their license. Let's take every type of worker and use it because now, collectively, we're receiving this money can find the best way to provide this healthcare. So, it's a tremendously exciting opportunity. I think it's probably the best way to get to a permanent, sustainable system. We've tried everything. You know, the three things that everyone always tries is you lower rates, you lower eligibility, you lower benefits. None of those three work, as we know; you lower rates, costs will go up, people will just do more procedures; you lower eligibility or you lower benefits, quite frankly, you're just creating charity care, and that has to be picked up somewhere.

So, those things have been tried for years. You're one of the few states right now that's come forward and said, "Let's transform the system." We all say it's not sustainable and doesn't work, but we're kind of reluctant to do anything. On the other hand, this is really difficult. So we're going to put some things out there. I don't want to misinform anyone in terms of the difficulty that this is going to present for the healthcare system. You are going to take people, as you heard from Dr. Brown; actually, I'm tremendously encouraged. Dr. Brown basically made my talk much easier. You've heard from Dr. Brown; historically, getting historic competitors to work together is a challenge. I think even more of a challenge is, [in?] mental health and physical health and people who haven't even talked to each other in years and who speak a very different language, but to say these are definitely there. So, the issue is just getting to them.

Where did we start here? Let me make sure that everyone understands. We were not hired to come up to a specific number. In other words, we understand that you've got numbers, and you're doing your thing. We were told, "Take a look at transformation. Tell us what you think is possible," and that's what we've done to the best of our ability is go through and say, "OK, let's look at what they're looking, and let's look at what we think that could amount to." And so, we've also been asked the question a lot already about, "Are these net numbers? Or are these gross numbers, and we have a cost in here that's not there?" We tried very specifically to be conservative in our numbers to pick up, so that these are what we believe are net savings. So, there's a lot of studies out there. They don't necessarily all break out gross and net, but what we basically said: "If our studies, we think the opportunity is 7:9, let's go with 4:7." Let's go to 4:7 for a couple of reasons. One reason being, we think there probably are some costs, and it's going to take a little while to get some of those savings out and two, we also think that trying to figure out the...
additive nature of all the different things, that some of them clearly add to each other, but some of them are going to overlap. And so, we believe we've been conservative in these numbers.

If we start out, and our starting point was to take a look at Milliman. Milliman did a study of what I call your [taina?] population, but better-known as pregnant women and children. So, largest population Medicaid normally covers, and they basically came back and said, "In Oregon, we believe you're somewhere between 118 million and 141 million a year below what a well-managed system would be." And what did they mean by a well-managed system? They basically say, you know, a [indiscernible] moment to find benchmarks of [optimal?] levels. OK, what does that mean? That really means they said, "You know what? A system working well; we think you can get to this number," and they did based on utilizations. They took utilization, and then they took Oregon's cost and applied Oregon's cost to the utilization. It is not the five best things they found anywhere. So, they didn't take the lowest hospitalization, the lowest ER, the lowest doctor's, and just add it together. They basically realize that, and in some cases, if you look at their detailed report, they're saying, "You need to spend more money over here." And what they're saying is, "If you really want to get all these things, you're not spending enough in this area." And so, you're seeing pluses and minuses in that report, and for that reason. So, we do believe [indiscernible] been very good, so what do we do with that? We took at number, and we said, "OK, let's take a look, then, at the other Medicaid populations. Let's take a look at disabled population, the disabled non-duals." In that group we said, "You know what? We're going to go with the," uh, [taina?] population was about at 15%, 12-15% reduction. We looked at the duals, and we said, "You know, this is an age-blank disabled population, but on the one hand these are more expensive patients, so there's sometimes much more opportunity to do things with this group. On the other hand, they also have what are some costs that you aren't going to change." So, someone with hemophilia; the blood clot factor is the blood clot factor. That's the most expensive part of their care, you're not really going to change that very much, so let's not fool ourselves in believing we're suddenly going to reduce that by a significant amount. So we took 11.2% and said, "That's what we think we can get from that population."

We looked at the dual population and, since we were leaving long-term care alone and leaving your waiver stuff alone, we said the dual population opportunity is strictly a Medicare opportunity. And that, we looked at a study and said, "We think that's about 8.5%." Now, that's all on the Medicare side, so that also means you have to work out an agreement with Medicare to be able to get those savings. Then we looked at your expansion group, and we believe that the expansion that's going to happen in 2014, that that group of people is going to look the most like your, I think is the Oregon Standard Plan, and that you're going to have a real [bifurcation?] of some people that are low-cost and some that are fairly high-cost. You're going to find the majority of your chronic disease in this group; that they're not sick enough to be disabled, but they've got a lot of chronic disease that hasn't been managed. We think that there's a lot of opportunity in this group. We put them up with the [taina?] group and said, "We think you can bring that
It's also important to know that where we started was, we said, "We're going to start at 2010. We have complete data for 2010." So, some communities have actually already started the savings process, because there already was a change in how things were done in 2011. We didn't start from 2011; we started from 10. So, they're already below, we think, the benchmark.

So, we looked at that, and we said, "That's our starting point." We also looked at [indiscernible] integration and physical and mental health. Again, very bifurcated here. We believe that, again, that's an area that there's a lot of literature out there. A lot of it would say 20-40% is the potential savings there. We cut that down to 10-20%; part of it related to well-managed, part of it to some of the difficulty getting to it and part of, quite frankly, because at 40% it scared the hell out of us, and we said, "You know, that just doesn't pass the smell test for us." And so, we dropped it to 10-20%. It's still a very big number but again, everything you read, everything you see say it is a big a number, and it is a big opportunity. And it is where there's going to have to be a lot of dialogue and a lot of change in how it's done. [Mental health-preferred drug list[?]], to be honest, again, we were told, "Gosh, that's a political hot-button, should stay away from that one." We said, "You know what? If you're serious, this is an easy starting point. If you're serious, you know, this is, if you're not willing to help this system out by doing this, then how serious are you?" And so, we looked at that and said, this is a place. You know, I do a lot of work in the state of Indiana, and we have Lilly. Even Indiana has said, "We can no longer support Lilly in this way. We're going to have to go to this." And they went to this, because they said, "You know, what we understand, we love Lilly. Lilly gives money to every community foundation in the state of Indiana. There are 92 community foundations. Lilly started every one of them. People don't like to take anything from Lilly. By God, we took something from Lilly this time, because you just have to."

We also looked at coating related audits, and here I want to make sure that I'm really clear. We're not saying, "Do more audits." In fact, we're saying, "Once you turn the money over to the CCOs, don't do any audits. That's, the state's out of that business." But, we work with a lot of companies who routinely go into states and say, "We'll go at risk to recover 2-4% based on coating anomalies." We don't believe these coating anomalies are picked up and well-managed. We believe they still exist. We believe the best organization [that'll cope[?]] with this is, we believe the CCOs. As they change the way payments are made, as they change [indiscernible] this is a cost in the system they can take out. So, I don't want you to think we're suggesting audits. We're just saying, the audit evidence leads us to believe there's 2% there, and it's 2% you can get fairly early on, and it'll track for the whole thing, because once it's out of the system it stays out of the system.

Primary care health homes: You're well on your way in primary care health homes. We believe this is really, as Dr. Brown said, this is bedrock starting place and again, the things we've looked at say 7-9%. You know, I always look at Tina because my favorite study says 40. Tina told me, "No." [laughter] So, you know, but I really liked that study.
So, we really went in and looked at 4-7 because again, we said, "Part of this we're already picking up [with?] well-managed, part of this you guys have started on this process, so 4-7." And then, there's obviously some administrative savings from the MCO reductions.

We used utilization and what your costs were prior, you know, based on where you are today. So, we didn't go past that, and we already talked about the expansion population, saying there's a 12-15% opportunity there. We talked about the others. [Integration of physical and mental?] we said 10-20%. We still believe in that; we got mental health. So these, I think, we've picked up to. Now, in terms of phase-in, that's another thing. How fast can we get there? We believe the savings are there today. Some communities are going to get here faster than others, and part of that is going to be based on the amount of work they've already done. You know, in 2011, in some parts of your state, people did mainly rate reduction type things. It's not transformative, but it got them to where they needed to be. Other parts of your state had actually started doing some transformative things. You obviously have heard that the tri-county area has been at this for six months. Some are going to come in, and its one hospital, one IPA. They have some synergy; others will not have that synergy. So, it's going to proceed at different rates.

We believe, overall, 10-20% was reasonable, and we believe we're pretty confident in 10-20%. Others will say, "Why not a higher number [or faster?]" We believe there's a lot of dialogue that can go on. Others will say, "How do you think we can get anything? Because we're really not even going to come up until June 30th, and we'll be dealing with all these organizational things." We would say, "A lot of your stuff is already in-process." You're in the process, my understanding right now is, trying to [certify?] by 89, you have applications for 89 [health homes?]. So, there's [health home?] things going on; can't get better, yes, but it's going on already. You already have, we know, places where you started the mental health integration, where you've actually started behaviors inside some of your primary care and vice-versa. That's already started, so you have an opportunity to expand that and go faster.

The other thing is and again, being an old hospital executive, you know, the first thing I always go through is denial, and my first thing is, "This really isn't happening. It really isn't happening." And most of the time I've been able to, you know, when I open my eyes, it really didn't happen, and that was great. But I think that this time, it's also going to be how fast you can get past denial and moving into doing this. It's not going to be easy, but the faster you move forward, I think the better-off you are. I think you have people like Dr. Brown. We've got discussions with OHSU. I mean, these are not going to be easy, but these people are ready to take up the challenge. That's a big deal. We hear about things going on in Bend, Oregon, which will fall right in line with what you're talking about. So, that's where you say, "10-20 start, then moving to 40-50, and then getting 100%." The other thing I wanted to say is, you see some big numbers. I want to take just a second and say, "You know, when I break down, and I looked at some things, and I said, 'Well,
what if I looked at [PMPMs[?]]?" And this is a population that the mix of the population is changing over this period of time, so it's a little unfair. It's an amalgam. So, you can't really use it, but what we're truly seeing; in 2010, your per-member per-year was a little over $4,380 for 558,000 people. At the rate you were going, with a population that you'll have, in 2019, you'll have 958,000 people and that [PMPM[?]] would be $6,112. I mean, it's just not going to happen. It's not sustainable. Now, if you look at our low-end savings, that [PMPM[?]] is about $4,559 at the end of 2019. So as you can see, it's pretty flat. There's not much [inflationary[?]] growth there, but that's not, you know, when you think about that there's 20-30% waste in the system, that's not an undoable number to say, "We still have, we're not going down." Now on the high-end, you are going down. It would be just under $3,700 PM per-year, and that's a challenge, but that's probably there. But huge, huge change in the system. Huge change. Everyone operating at the top of their license.

As Dr. Brown, transitions between levels of care they've never seen before, and as OHSU said, maybe certain types of services that have traditionally been performed very well in some settings, they quite frankly are are just high cost. The [indiscernible] built to do other things, and they're too high-cost to do it, but he also talked about other challenges you're going to have is figuring out how you're going to redo transfer medical education, because you're not just going to transform the healthcare system. You're going to transform all the pieces of it and try to keep it all together.

So, it's a challenge, but it's doable. We also believe there are things that we didn't even list that are out there, and the biggest one being connectivity. There are some studies in Oregon that say the return on that is 4:1. We don't know if it's 4:1. We think it's pretty significant; however, if Medicaid does it by itself, you cannot take care of the cost. When you really look at it, unless the whole system is sharing in that cost, Medicaid doing it by itself is a loser. So, we did not include that at all, because we said, "You know, the upfront cost, the cost of doing it on their own." However, we know that through the CMMI grant and through other things, there's money coming into the system to start doing that, and other players will do that. So, we think realistically that's there, and that could come back in. We also believe that, as people like Dr. Brown, as people like Ms. Robertson, as they work on this, they're going to find other opportunities. They're going to look under rocks and find other things that they weren't looking for before this, and we could do this. We also say there's some things that aren't in our report, because they weren't part of what you were looking at. They weren't part of your thing, but we think there are some things to look at in tort reform. We think there's some other things to look at, but it wasn't part of what you're trying to do right now. But there are things that we believe hold back, maybe, getting all the savings that are reasonable to expect.

We projected enrollment out to 2019. You know, 955,000 Oregonians on Medicaid. Scary number, but you know what? We kind of looked at that number, it may come in a little bit lower, but we think that's kind of where it's going. You know, unless there's a real economic change with healthcare reform, we think you're going to be pretty close to 955,000 people. That's a huge number of people.
So, all these other things we've talked about. This, we just broke down, again, some of the populations and where this would fall, and this is a little bit different than your other one. This goes on a year-by-year basis. Inside, wouldn't spend too much time with these, but we just looked again at basically... [inaudible]...

>> Unidentified Speaker:
Is that a subcategory of what you have under the well-managed?

>> Doug Ellwell:
Absolutely. These are subcategories. So really, I would use your report, is better than these, but we just did quickly look at some of these different populations.

>> Unidentified Speaker:
And because, you know, currently, now, I think this is going to change, but currently this is a huge percentage. So, what proportion of the well-managed population do the savings in this [inaudible] group represent? What I'm trying to see, my expectation is that the savings here, because it's a younger, healthier population, may not on average be what it is across the system, and I'm trying to understand that that gives me a conceptual idea of how rapidly this would phase-in, because the savings may be greater in those more like the standard population.

>> Doug Ellwell:
Right, and what we would say is, some of the studies don't yield themselves as easily as Milliman did to [indiscernible], but here's where we would look at this: We would say, your [inaudible] population, the well-managed piece is going to be primarily Milliman. When we look at combining the mental health, physical and mental health, that's going to more effectively hit your ABD populations; age, blind, and disabled. It's going to hit your duals. It's going to hit your Medicare populations, and it's going to hit your expansion population. So more of their savings are going to be driven by that group of patients as opposed to your [inaudible]. You're not going to see as much of that from kids and the other. The PDL: again, you're probably more [talking?] again duals, disabled, that population. So, if I go down, you know, the different pieces we talked about, you know, RAC audits, the audit piece, that's going to be kind of across the board types of stuff.

>> Speaker #5:
On the [inaudible] savings, this also just calculates that, expectation is is that we're going to continue treatment instead of prevention?

>> Doug Ellwell:
This would say, to some extent, yes, but except, I wouldn't say totally. This, again, is a well-managed system. So, built into that you have some prevention, and I would say...

>> Speaker #5:
I'm talking specifically about the pregnancy population of this population, right? Is there investment in prevention? We actually may never see them even enter this population.

>> Doug Ellwell:
Absolutely. You could see lower enrollment. You could see longer time between deliveries. You could see all of that, and I think that would be somewhat outside of well-managed. So in other words, that's why we would say, again, you may say, "Well this piece isn't that or this piece isn't that." There are pieces not in here, because I would argue exactly what you've said, that we can go beyond well-managed. Well-managed is saying, you know, pregnancy rates stay exactly the same way in this population, we do everything the same way, except we manage it very tightly. It's not really saying, we go in and say, "You know what, let's work with people," and there's a lot of really good work that's been done over the last 20 years in that area. It's a Colorado study they did [in Myra, New York(?), and I can't think of the name of it, but very effective, and so I think there are things out there. You know, the same argument can be made. Some of these people, again, if you control some of their issues on mental health, they won't be in the Medicaid population. They'll be in a commercially insured population. So, you may get different results. You maybe drive some of these, but based on what we knew, we said, "Let's make the assumption," you know, and this is always the challenge, "Let's make the assumption that population continues to do what it's been doing, and we manage it better. We transform a system into doing some things better, but not looking at some of the other opportunities, and there certainly are other opportunities, and I think Dr. Brown spoke to that as well.

>> Speaker #14:
So, I just want to make sure, um, tracking right now. So, you've said over and over that what your estimates are, they're conservative, and you know, the conversation that we're having now reminds me that this doesn't include any of the initiatives around model of care. So, that the model of care changes that we're doing, which is focused on keeping people who are at risk from getting sick, and last month we had a long conversation around what kinds of interventions do we need to do around women's health in the state and how we track them. I think if we dial back to that, we see there is a tremendous amount of opportunity to get people out of this, and that's very much in the model of care conversations that we're having.

>> Doug Ellwell:
Right. I would say the answer is probably two-fold. Some of the model of care is in here, but it's what I call the more traditional. So, it's not the intervention that takes someone completely out of the system, but there are some things, there are some prevention things that are in here because they are part of what a well-managed system would do. What you're talking about is an intervention that really, I would say, it may be whether they're done with[indiscernible] or not, I truly do not consider it a health care intervention. That's not in here.
Unidentified Speaker:
It's a public health intervention.

Doug Ellwell:
Absolutely. Absolutely.

Speaker #5:
Which, I also think it goes, though, to the conversation that Dr. Brown had talked about when we're thinking about the uninsured, only thinking about the high-risk uninsured. Typically, people who get pregnant, have an unintended pregnancy, aren't part of the high-risk uninsured. So, how we're working that into the CCL model, I think, is yet to be figured out.

Doug Ellwell:
Although some of those studies, again, I would say, and this is where I looking at these CCOs, because I think the CCOs, if it works as you guys as you guys think it'll work, because it works as we think it'll work, they'll be looking at these things and making those investments, because they'll be managing a population now as opposed to those who come to their shop. They'll manage the population, and at least the studies as I recall them, for the one intervention; quite frankly, they tracked the children, and the children made different decisions as they got older as well, because these interventions also included early work on reading. They were more successful in school. They stayed away from the police department more often and had a more successful... [trails off] So, even in that, which of those would be considered low-risk populations, they do better as well.

Carlos:
Do you mind explaining what connectivity means?

Doug Ellwell:
By connectivity, what I'm talking about is... [trails off] Right now, for instance in the tri-county area: in tri-county area, everyone's on Epic, but the Epic systems don't necessarily talk to each other. So, what you'd really be looking for is the ability for, when you show up in that ER, that guy can pull up a record that says, "Oh, he's got this primary care doctor. He's run these three tests. He's been over to the specialist's office. This is the fourth ER visit this month. I know a lot more about him. He's already had two MRIs; I'm not running another MRI because the results are right there," and so, it's the same side on the other side. The primary care doctor can see, "What are you doing running around to these ERs? Let's see what your [indiscernible]. Let's look at the underlying difference." So, it's basically bringing the system into a more cohesive, so they're sharing their data back and forth, and so we avoid a bunch of tests. And I think it's very, again, it's very effective, but if only a single population bears the cost of bringing it up, it doesn't work, because the cost overwhelms it. But it certainly drives down the cost and improves the
quality, because you're just not doing un-needed tests, and it also starts helping to set the pattern and help people to understand what's going on. So that's really...

>> Carlos:
[Indiscernible] are not...?

>> Doug Ellwell:
They're not in here at all.

>> Carlos:
But they are moving forward with high [indiscernible]?

>> Doug Ellwell:
Yeah. So there's things going on, and I think part of the CMI grant will be some things around connectivity, and I'm sure that you're going after grant here in the tri-county area. I'm sure there are other parts of your state that are going after grants as well. So, we're not trying to say it's not important. We're just saying you can't build it on the backs of Medicaid alone.

>> Mr. Chair:
Any questions or comments?

>> Unidentified Speaker:
This is really good work, and I must say it was a slog to get through some of it. I'm just going to, you know, say that for my own defense here, but... [trails off] So, a lot of people are skeptical of the numbers, Doug. What, you know, we've had the Health Leadership Council. We've been looking at numbers from kind of a lot of different prisms in the last, particularly in the last two months. So, what would you say? I mean, what would you say if we said, "Meh, you know, well, it looks good. You can save 1-2% here, 3-4% here." You know, what would your Reader's Digest story be about, you know, what kind of ground are we standing on here with these numbers?

[SPELL CHECKED TO THIS POINT]

>> Doug Ellwell:
You know, if you'd have shown me these numbers November 15th, I'd have been relatively skeptical, because I hadn't thought about it much, and these are big numbers. But, to be honest with you, I have historically, for many years, being a hospital executive and everything else, 20-30%, and 20-30% without being very innovative. At the end of 9 years, we're talking about 25-39%, very much in the ball park. If we talk about individual things, and we take away the big numbers, and we say, "Let's look at this." Are we saying, "Can we hit well-managed?" Milliman, an actuarial firm, they are a very conservative actuarial firm; they're saying you can get this number with, as I would say, pregnant women and children, which is kind of a population that I was surprised at how
high their number was. So, they're pretty confident in that. When I then go to the other populations, I see no reason why you can't get there. Physical and mental health; that is a huge number. It's always been a huge number. You're very bifurcated here. There's a huge opportunity there. You know, I go down there, I think we're on pretty firm ground. I mean, the question and the challenge always is, how fast can we get there? And some of that is going to be with the want-to, and some of that's going to be with the [indiscernible]. I don't disagree with Dr. Brown. What Dr. Brown says, "Jeez, be careful you don't cut us so far so early that we can't attain this.

On the other hand, again, I'll go back to my experience running a hospital system. You know what? The longer you put it off, the more I smiled and said, "I'll get you distracted before this actually ever happens." And so, you put the platform, you catch the platform on fire, and now you got my attention. I gotta do something. But I'll be honest with you, I spent a career dealing with business coalitions and everything else, and our main goal was to try to talk them into believing that painting fences would actually clean up the neighborhoods and everyone would get healthy from that, and by the time they figured out that that probably didn't make any sense, we were three years into doing something else. And I don't mean that anyone is trying to trick anyone, but it's just, in talking to Joe, these are very big systems with big capital investments and big histories and big investments in what you do and big ego investments, and it is hard to turn these things, and it is hard to say, "My hospital will no longer be the center of the universe"; that the center of the universe is probably going to be a community worker and probably going to be a RN in a doctor's office and probably going to be a primary care doctor. The people who have been at the bottom of the food chain for the last 25 years, probably going to be a mental health worker; probably going to be someone who works hard on getting people who have mental illness housing; something that's not medical at all, but you know what? Housing and employment are the two biggest determinants of what their costs are going to be in the future.

So, do I think we can get to these numbers? Yes. I do, and I wouldn't say it if I didn't believe it. And believe me, we're having a lot of conversations within my firm about these numbers, back and forth, because you go to the end and you look and say, "$4 billion? Oh my god. What were you thinking?" And you say, "Well, what is wrong?" You know? "Do we think we can get 2% out of this?" "Yes." "Do we think this happened?" "Yes." "Well, then, you know what? That's what the number is." And part of this number is, understand, it's stopping the growth. You're growing like this. Part of this isn't even going like this; part of it, on the low savings is saying, let's just level this thing out. We can create some savings, but we're still going to have some cost that's going to go up, but we've got some opportunities here, and we can get this thing cranking down. The other thing I would say is that in 2014, if things happened as planned, other things change for hospitals; huge charity care burden in this state. That charity care burden won't go away, but it will certainly be lessened, and so that frees up funds to do different things and treat different things. So, that creates opportunities as well.
Part 2

Transcribed by Shahmeer A

Starting from 02:00:00

>> NEW SPEAKER: And again, that's not in here, but that is a savings as part of this system. Overall the other things is...that no one wants to talk about is when I was in the hospital business, I never thought I was competing with anybody in my community. I looked at my numbers and said, "You know what? My market share goes up one, down one, up one, down one, up one, down one." If it hit two then somebody got fired. But otherwise, you know...

But generally there was [inaudible]. I was competing against other communities for jobs. Because what I found is, you know what, if we have jobs, then I don't have as much Medicaid. I don't have as much...and we all do well. And you know what, I worked in a system where one of our hospitals got nirvana. They actually got 100% market share. They had 100% market share for the hospital, for the hospice, for the ambulance, for everything. It's because everybody was broke. That was our...that hospital lost more money than any other hospital in our system because nobody had insurance, because every other hospital had given up and they were the only ones left.

So really, and I think someone said this earlier, this is really about Oregon competing for jobs and this is really about controlling this. And quite frankly, you'll have a lot fewer people on Medicaid if your whole system becomes more competitive in terms of healthcare costs and you have more people working. A lot of the people you have on Medicaid don't want to be there. They'd rather be working at a job that can provide benefits.

So I do think...you may get there in a lot of different ways, but I think you can exceed the numbers. I think...I mean we're still talking about pretty significant growth in Medicaid and pretty significant growth in costs overall when we look at the bottom line number. I think you can do better.

>> NEW SPEAKER: To Felicia and then to Carlos.

>> NEW SPEAKER: I think, speaking of the jobs piece, I feel like we have moved to specifically talk about the Medicaid population. I understand why we're doing that around the budget crunch. I do feel like what are the transformation pieces that we're going to put in place that could apply to a commercial population and that businesses and private insurers can see the savings and want the same things that we're looking at. And I think that this work goes a long way in sort of putting the rubber...it meets road.
And so it would be helpful for me, I don't know where we would get this back from, but what are the pieces that we're putting in place for the Medicaid population that just naturally will be applied to the commercial insurance? I understand that with the connectivity, but I'm not so clear on the other pieces. Like a well-managed system, if that applies only to Medicaid.

>> NEW SPEAKER: No, I think well-managed system also applies to other pieces. Also, I would say, again, they all have different impacts. I would say mental health and physical integration, it will have an impact. Not as big as it does with the Medicaid population, but you have a lot of people who have private insurance who are hiding a mental illness because it's not good for their employer to think they're mentally ill. And so they're using a lot of physical health type of stuff.

You've got us...you know, we're trained...and again, it's how much our companies are willing to do. Because we're all trained for convenience too so we're not going necessarily...we all have an ability to have a primary care. That doesn't mean we're not using the urgent cares and the ERs, as opposed to using the primary care doctor. So I think that's there.

Certainly the rock audit issue, the audit coding, getting coding right is there. Building these stronger systems, again, the issue will get...you're also building overall an awareness of kind of what's going on and what's expected and that floats through the whole population. And again, part of what you've talked about before is, you know what, if I have heat in the house, I have decent food to eat and everything else, you know, raises all boats."

>> NEW SPEAKER: Carlos, and then to Mike.

>> NEW SPEAKER: So what's the, in your experience, the per member expenditure in Oregon compares to other states?

>> NEW SPEAKER: The interesting thing about Oregon, again, when we look at that, one, that's a really difficult number to know and let me tell you why. Every state, you look at every study, and every study is a picture in time. So one state that I know of, that state pays out a huge amount of money in UPL, upper payment limit payments. The make those payments sometimes two years after the year closes. So if they take the snapshot right on here, they look like they're the most effective state in the country. Then you make it after they make those payments, they increase their hospital costs by 40%. Suddenly, the don't look quite so effective.

In Oregon the one thing we noted is you are one of the lower states in terms of days per thousand and ER visits per thousand, but your costs aren't necessarily lower than other states. We didn't find you at that...where we would have expected to find you. So you...we think you have some opportunities. We do think...actually, we're encouraged by
the fact that clearly you've been doing innovation here for some time. This is not really all that new to you. The transformation nature, the distance you're going now, the whole transformation, I think is bigger. But you've done some innovative things around the way you've done MCOs compared to other states. You've done some innovative things...so you've historically done some innovation already. So you're not a state that's starting from the bottom of the pack and starting from scratch, where you'd say, you know, "The good news is low hanging fruit. The bad news is we don't have a clue, we've never tried to do any of this stuff." You've got some practice and you've got some good leadership here. But you also have tremendous opportunity.

>> NEW SPEAKER: Mike.

>> NEW SPEAKER: Doug, thank you. I think this is...it's helpful, I mean, to put everything in perspective for us as we've kind of looked at how this would potentially pencil out. The one thing that I've been intrigued about when I've been looking through these numbers: we have everything starting on July of 2012. And the one thing, as you look through all the pieces that you've outlined in terms of well-managed...you know, to me, there's nothing that would prohibit a community from doing stuff now.

>> NEW SPEAKER: Right.

>> NEW SPEAKER: And I think we're trying to establish a structure that would provide some incentives from the CCO side of things. But it doesn't mean that you have to have a CCO and flip a switch before you can actually move in this direction. And I think that's a takeaway for us to say you have communities who could start ahead of this and now you've already outlined all of this work that really, you know, people can start achieving those cost savings immediately.

>> NEW SPEAKER: Yeah, and I don't want to say people are doing nothing. Some people started on this in 2011. Because you already made a change in reimbursement. You didn't demand people change the system, but you lowered reimbursement. People looked at things and started doing some things differently.

And some of the stuff you have in place, it just needs to be magnified in some things. In other words, we found some things that you're doing, but you may be doing on a really small basis that could be magnified as being successful. Again, absolutely. I think you can go farther faster. On the other hand...and that's the push-pull. You absolutely have the opportunity and some communities will take off. But you also have, on the other side, communities that have...I'd go as far as long-standing hatred between pieces of the same system. Not even..."I don't speak the same language, but I hate you. And I wish you would die. And I have no intention of..." They'll get past that, but it probably won't be as fast.
On the other hand, you know, I was once told that working in one community that they needed three more people to die and they could have a good healthcare system. And they knew who the three people were! But I think...so I think you got some of that. But I do think in central Oregon, which was one of the, we looked at the [inaudible] Report, was one of the communities that was lagging, regions that was lagging behind. I think they brought in, as I understand it, new MCOs in that region now. They have a number of initiatives under way. That's a region I think will probably surpass the 10 to 20 in the first year. I think other regions, you know, they've got other things going on. So I think you're right. I think you're going to see some regions are going to exceed this.

>> NEW SPEAKER: So if we summarized, I guess we could say that our assertion that transformation will bend the cost curve significantly has been reaffirmed. I guess the other part is that the fix we're in is largely your fault as a hospital administrator.

>> NEW SPEAKER: You know I would say no, it's your fault for letting me do it. The hospital hired me to work with the rules and you gave me a set of rules and I said, "Hot damn!" And got to work. But no, you're exactly right. It's the system. We set up a system and we reward it in a certain way. And basically...I was in a hospital once. We actually cut our rates by 40%. You know what happened to us? The insurance companies would not cut the discounts. They said, "Nope, got to show a competitive advantage." And our own patients, we had a market share drop, the biggest market share drop we've ever had. And you know when we surveyed the patients, we said, "What's wrong, you've been complaining about healthcare prices for years. We dropped the price, we thought we'd build market share." They said, "Well, for me I want the best healthcare and that obviously costs more." So we had to go...we raised our prices up the next year and brought all the market share back. And we said, "You know this doesn't make any sense. This is not following any type of business thought process we've ever seen before."

And so we kind of built the system. And I don't think you can criticize people for maximizing the system that existed. And so today you're saying, "Change the system." Don't play around with...you know, we're not going to play with rates. We're not going to play with this. Change the system because, otherwise quite frankly, why would I change what I'm doing? You gave me a system, I'm working it. And you know, that's the issue.

And I think other states are still struggling with the idea of well we'll just do this or we'll do that. As long as the system's the same, the system's the same. I'm going to work that system

>> NEW SPEAKER: Doug, thank you. You've set us up perfectly for the rest of the conversation which is we need to make sure we get the rules and the incentives right. Thank you very much. We're really appreciate it.

For those who want to speak at the end of the meeting, remember the sign-up sheet, it's out in the hallway. We appreciate your getting your name on that for us. We're going to
take...we're running a little behind. We're going to take a break. We've got about eight minutes between now and the top of the hour so let's make our eight minute break last no more than about 12 minutes.

[inaudible over each other]

[extended pause in audio]

>> NEW SPEAKER: Okay, everybody, let's come back together, please. Okay. We're going to move forward to agenda item number six. As we all know, an important part of what we're doing is soliciting public comment on the implementation proposal. We have had a lot of said comment and in a lot of different ways. And Tina, I'm going to ask if you will kind of summarize what we have received. Obviously, the board has received a lot of detail about it, but if you can kind of summarize, we would appreciate it.

>> NEW SPEAKER: Yeah, absolutely. I'm happy to. So in your packets is a public comments summary. What we did was we took...there were over...and posted on the web actually. There were over a hundred pages of comments. It was really mostly...we had over 300 individual comments from alternative medicine providers, complementary and alternative medicine providers asking that non-discriminatory language be included in anything that we move forward and be included in this proposal.

I will say that I think that, you know, we are working with that. There is language in the federal ACA that actually talks very specifically to non-discriminatory language. So we have noted that and paid attention to it here. What I've also done, if you look at this document is...not what I've done, what Arry did actually, was to take this and actually put into categories by what the main topics seem to be. And some of these were very lengthy letters with...that covered several areas. So I really do encourage people to go the website, pull down this full report, and take a look at the public comment because there really is a lot of quite thoughtful work there.

What I wanted to do is rather than really talk about these individual categories which you can see here was really to talk a little bit about how I sort of saw this falling into the actual report. And it seemed like there were items that really are items that should be forward to groups that exist or groups that we are creating as a result of this proposal, and I'll talk about that in a minute.

There are items that the board has really dealt with in probably not as specific a way as people would like the board to have dealt with and I'll talk about that. And then there were a lot of language just basically reaffirming things that are already in this proposal. And there were a couple items that we haven't actually talked about too much.

One...so I'll start at the beginning of that. One of the broad buckets is there were several recommendations around metrics, that we should have metrics around specific
populations, around specific areas of health. I am recommending that rather try to hit every single topic and every single area that metrics could address in this actual proposal, that we forward all those public comments to the technical work group that will be created to actually develop the specifications around metrics. I think that that's an appropriate place for it to go and the most useful work can happen there.

There were also quite a few comments about what...to be more specific about what incentive systems. Because we have general language about CCOs proposing incentive systems. There was a request that we be more specific about what those alternative payment methodologies are. Again, I think that's...two things. Number one, I think the board has talked about that and talked about a desire to allow CCOs to come forward with what kinds of alternative payment methodologies they want to apply. I think to the extent that there's work about how those payment methodologies get connected to the metrics and connected to quality, again, is in that technical work group, to do the technical work around that. We can't really address that, the depth of technical requirements in this setting, I don't think.

The other area...there were a lot of recommendations, again, around governance, asking us to be more specific about governance and actually to, in some cases, name names. And I think that the board has already had that discussion and talked about the desire to give CCOs local flexibility. And to meet the requirements of 3650, but to allow them the flexibility to design their governance structure in a way that meets their community need.

A lot of comments about equity. Again, wanting additional language in here, in the proposal around equity and very specific language. Again, I think the discussion we've had at the board has been again around...we've established it as a pillar of what the proposal is. We've talked about that it is at the core of the principles in this proposal. And have basically instructed the CCOs in the proposal have asked that they tell us, based on their community needs assessment, how they're going to address issues of equity and how they're going to move toward eliminating health disparities. So I think that's how, you know, we folded a lot of this in.

In other areas, there was language about, you know, that they wanted language about patient engagement, peer services, use of best practices, choice, promoting prevention. I think that language is really in the proposal now in some very significant ways. So I really took that more as sort of a support for the direction that the board is going in.

I think some areas where we haven't had discussion was, again, it's what Dr. Brown brought up. It's the fast-track notion. There were a few people, a few of the comments were about asking us to have language in the proposal about the fast-track and that it might disadvantage other people and advantage some people. And so there was, I think all the comments were asking that we not fast-track. And then the least cost estimate approach to developing the global budget in that first year, there were some questions about whether that was truly actuarially sound. But I think, given that CMS approved it
and it made it through all of the requirements for actuarial soundness, I think we probably actually did achieve that.

So that's generally, I mean there were absolutely individual comments that don't fit into any of these categories. But I encourage people to take a look at it and if there's anything specifically that you think needs to be brought back on the 24th, just let me know.

NEW SPEAKER: Any questions of Tina or comments or comments about other...any of the comments that we've received? I think your summary was actually very good. Thanks.

NEW SPEAKER: Thanks.

NEW SPEAKER: Thank you. We'll move on. Uh, yes. Please come forward. Moving to item seven on the agenda: I felt like at the last meeting, I spent most of that meeting holding us off from getting into the nitty-gritty of the proposal. And I promised we would get here. And we are here. And so with that, I'm simply going to turn it over to Diana and let you carry us through this.

NEW SPEAKER: Thank you. Diana Bianca with Artemis Consulting. And what we hope to do in the next few hours is exactly what Erik just outlined, is to really walk through the proposal page by page literally. But the way we're going to start: so we have sort of two different pieces of the discussion. The first is we're going to have more in-depth conversation on about five or six topics that are on the agenda. And those are issues we haven't actually looked at the details. All of...everything in the proposal, you all have seen before in some form or another or have heard about in some form or another, whether it be from the action plan or stakeholder input.

I mean, over the last few months...in the last few years, as Erik highlighted in his opening remarks, this has sort of been a steady drumbeat of bringing this stuff forward, talking about it, vetting it, having it go back and then coming back to you. So this first piece is going to be those issues that you haven't spent as much time on. And then we'll be turning to actually literally flipping the pages and making sure that you all are comfortable with everything that's in the proposal. And any changes or comments or questions, we'll be taking those throughout this conversation with the goal of bringing it back to you on the 24th for final approval. So that's really how we want to structure this. And we have some specific pieces that we're going to discuss and then just a general review. Are there any questions about that before we get started?

Okay, so the first piece is alternative dispute resolution and Linda's actually going to walk us through that piece.
NEW SPEAKER: Hi, Linda Grimms, Department of Justice. The dispute resolution process is described in Appendix C of your materials. There's a brief description in the plan itself, but Appendix C has the outline. And it's not very long, but I'm not going to read it to you either. We had a work group of about 11 members from a diverse group of people. And we were facilitated by Mike [inaudible] who is the Department of Justice's dispute resolution coordinator. And we had a couple of in-person meetings and we did some work online. And the document that you see pretty much is the result of seeing this task a fairly focused one. The legislature saying who's necessary to the formation of a CCO and might say that the contract being offered to them is not reasonable. And how will that impose a barrier that could be overcome by dispute resolution process?

It does not require parties to enter into a contract. At the end of the day, that's still a private decision of individuals. This sets in place a process though that has really two components. One is a pre-process. One is, first of all, how do we even know if they're even a necessary...in a necessary relationship. This process doesn't apply to all possible contracts. So we've set up informally that any party can say, "Don't you think we're necessary to this process?" It's mostly likely going to come from a CCO. It might come from the health authority as they're working through the process with CCO applicant. or it might come from a healthcare provider who says, "I think we're pretty important to this process. Why aren't we being offered a contract?"

So you get to that first question and that should go to the health authority for some response. And once that's resolved, it may winnow out quite a few things. It may be like, "Well, we understand you're important, and you guys should continue your conversation, but that doesn't mean you're necessary." This process is focused on the necessary folks that, without this player, you may not be able to achieve certification as a CCO. Nobody really wants that outcome. But healthcare entities themselves have the opportunity to say, "Wait a minute, we need a fair deal." And that's what this process is about.

So our goal is throughout the process that the entities themselves reach their own contract agreements. That this is not an agreement that's driven by the health authority. Yeah?

NEW SPEAKER: Yeah. As I read through this and tried to look at the various scenarios, I understand like if a health system was refusing to join a CCO in a given region and you had to have a CCO there. But in an area where there are potentially multiple CCOs, if a healthcare system has joined with partners to form a CCO and in their efforts has done the things that they think embody the principles and then another CCO comes along and tries to draft them as they might because they need them to be, but the healthcare system doesn't feel that what's being done in that CCO embodies the principles to the degree as where they've made their investment, could they be compelled to play in this other arena?
>> NEW SPEAKER: I don't know and I think that's one of the things that we're taking to the health authority to say, "What do we mean here in terms of necessary in this particular arrangement?" But at most, even finding that there may be some necessary parties here just encourages the parties to have that conversation, get more technical assistance from the health authority.

>> NEW SPEAKER: And I mean, okay. So that's great and that's where it should be, but if that's the case when I read through this I don't feel that we've had a sufficient conversation about that here. The example where somebody is just refusing to play in the CCO is not going to happen if it doesn't and that's the only CCO in the area. That's pretty obvious. I don't think that we have considered the ramifications and implications when you could potentially have competing CCOs and how a given health system, what they could be forced or not forced to do in those various venues. It's just something I think the health authority needs to...and I'm not saying it even has to be in the report. But if the health authority is going to be, in essence, serving this role of an arbitrator I know there's also specific arbitration, but if the first stop's here I think we need some discussion about that.

>> NEW SPEAKER: All right. The second piece is once we figure out that we have the right people at the table, we have a potential CCO and we have a healthcare entity that appears be necessary, again, they should be encouraged to work it out. They may need some technical assistance. They need to at least get together face-to-face, the leadership, and say, "What's holding us up here? Why can't we get to yes?"

If we can't get to yes, if there's a barrier that prevents them from contracting, then one of the parties can invoke the independent arbitrator process that the legislature had in mind. And that's really the focal point of this document which is to say, "Folks should have tried their best. Good faith efforts are warranted. If they can't get their, then what does the arbitration process look like?" That's an interesting question. There are multiple options for doing that. One of the factors we had to consider was timeliness. Some of these can really drag out. But we needed to be able to move forward with the process so, at the end of the day, we know whether someone is being unreasonable or not. And really, that's the only question for the arbitrators: is this unreasonable refusal or not? Because there is a consequence.

So this sets up a process where, after you start, they agree upon an arbitrator who's got to have some basic qualifications. Each side puts their best offer forward or says why they're not willing to contract if that's the scenario. After that, they have 10 additional days to say, "Here's why it's reasonable/unreasonable for us to engage in this particular process."
Now keep in mind that, when they first see those best offers, that may be enough for them to get back to their own table and say, "Oh yeah, we're pretty darn close. Why can't we work this out?" So at any point in the process, the parties can work it out themselves. It doesn't have to reach a conclusion. So we get to the best decision about what's reasonable or unreasonable and then it goes to the arbitrator.

>> NEW SPEAKER: I just have a question about the process. So you don't force people to put their last, best, and final offer across the table before you go into arbitration?

>> NEW SPEAKER: What we indicate is that they should be putting their contract terms out so that there's a reason to have a conversation about why someone's refusing to contract. So before you get into arbitration, we want to have at least that written offer or refusal and a face-to-face meeting with the CFO or CEO, just to say, "What are we talking about? Are we really talking about a significant problem or can we work this out?"

>> NEW SPEAKER: Yeah. To me that's very different than a second face-to-face meeting where each party brings their last, best, or final offer or we're going into arbitration. Does that make sense?

>> NEW SPEAKER: Kind of like a labor contract that goes through...

>> NEW SPEAKER: Yeah, you have to bring...and it makes sense to me. I don't know why...because then it does give you that opportunity then to settle before you head into a process where you bring in an arbitrator who's going to settle for you basically. Right so, those offers may change throughout arbitration, but you should have at least clarity on what's your last and final offer before heading into arbitration. Maybe that will naturally work itself out because people should be reasonable enough to know that.

>> NEW SPEAKER: And this process doesn't foreclose that.

>> NEW SPEAKER: I still...of everything that we reviewed, I have more dyspepsia over this than anything else. Because what are the guidelines for the arbitrator? We're formulating this policy as we go. Then anybody that you bring in is going to have no history in this arena with regard to what is reasonable. Maybe that's a really compelling reason not to go to arbitration, because you don't...

[inaudible over each other]
...by definition, we're going to have an incompetent arbitrator so we better settle this.

[inaudible over each other]

>> NEW SPEAKER: No, it does in here. It says the arbitrator decides in here.

>> NEW SPEAKER: Right. But what I'm saying is both sides agree to the arbitrator..

[inaudible over each other]

>> NEW SPEAKER: Oh, they agree to the person to do the arbitration.

>> NEW SPEAKER: But I do understand what you're saying. There's a potential for gaming the system...

>> NEW SPEAKER: The person you bring in to arbitrate this will have never arbitrated anything similar to this. Not even remotely. They won't have stepped through, you know, the years of development of this. I think it's going to be really difficult to have the context. We have to go there. I just think what I would like to do is have the, at least, have the Oregon Health Authority be able to provide some...there should be a link between the Oregon Health Authority and the arbitrator Because the arbitrator needs to have some type of...what are our bounds of what's reasonable? What do we as an Oregon Health Authority, what are we meaning when we say something is reasonable? I mean, is it financially reasonable, is it the community standard we're developing, is it the community interest? I don't know. Maybe others are...

>> NEW SPEAKER: Joe, I think you're right. I think it is an OHA responsibility. I think they're in the best position to do this. But I think some level of guidance is appropriate so that you know how to proceed with your conversation.

>> NEW SPEAKER: I feel like we have a responsibility if this ever gets to arbitration, the Oregon Health Authority has some responsibility to educate and inform the arbitrator

>> NEW SPEAKER: Some type of training [inaudible]. Like we do with the pilots. They put them in a simulation before they get into a real plane.

[inaudible over each other]
NEW SPEAKER: Some link, I think, so that the arbitrator isn't isolated from the goals and objectives. I guess that's what I want. I want the arbitrator linked to the goals and objectives that we've spent years developing.

NEW SPEAKER: So let's assume that in the US this has never been done. Are there any countries where this is done, where somebody can go for three months sabbatical and see how they're arbitrating, I don't know, some...?

NEW SPEAKER: I mean, hopefully, we won't even have to use...I'm hopeful we won't even have to use the arbitrator So maybe I'm worrying unnecessarily. But you know...

NEW SPEAKER: Might I make a suggestion is that is sounds like what we're talking about are some principles that all arbitrators would ascribe to in doing this kind of arbitration so that OHA could be tasked with, "Okay, here's the background for the arbitrator Here's some background, here are our goals and visions. And here are the standards by which, or the principles, that we would like you to use in this arbitration. Here's what we think is more important." And really, what the arbitrator’s job to do is to balance the interest, but sort of have a main pillar to be guided by. So if you do that...and then you have...you also then have standardization. That all arbitrators have some similar principles that they're being guided by.

NEW SPEAKER: So for the purposes of this proposal, we could just put that language in that, "OHA should develop..."

NEW SPEAKER: Everybody good with that?

[inaudible over each other]

NEW SPEAKER: The beginning points of that are probably in this proposal. Because we say, in the first instance, a arbitrator must be knowledgeable about healthcare, must have been familiar with House Bill 3650, and be prepared to follow the standards in here. So I think we've set the stage for that. Also, we've established...described in general ways the legal standards that an arbitrator has to apply. In one regard, we have one standard that's established by statute. And that is, the legislature said it's not unreasonable for a healthcare provider to refuse to provide services if it's going to be below their costs. So
we know that that standard is there. The second one is we have a healthcare entity may reasonably refuse to contract if the refusal is justified in fact and circumstances, taking into consideration the legislative policies established in House Bill 3650.

So I think we have the beginnings of those things. There was actually a fair amount of discussion in our work group about how detailed do you go in the guidance versus how much do you use a broad standard like this which makes it a a more, "Look at what we're trying to achieve here." Considering that in any given community and the dynamics of an applicant, a healthcare entity, the health authority won't be able to identify all possible circumstances. So at best we'll be able to develop some principles.

>> NEW SPEAKER: No, that's very reassuring to hear what's in here expanded on. It implies that that's very reassuring.

>> NEW SPEAKER: You know, one of the things that I did want to mention before I leave is that we have this set up, the arbitrator does his or her thing, they issue something to the parties, the parties have ten days there, in this process, to take it back to their own businesses and say, "Okay, we now know the answer. Do we still want to enter into a contract anyway?" If they choose to enter into a contract on whatever their terms are, the arbitration decision stays private. If, however, they don't reach agreement in ten days, it goes to the health authority because the health authority by statute has to follow up. So there's another incentive there...you know, once you see what's actually going to come out by the arbitrator, does that affect anybody's decision? It's still a voluntary decision, but it does give the parties another opportunity to take a fresh look. And at any time they can walk away from the process and say, "Let's go get this taken care of. Let's have our contract."

So we will definitely revisit the issue of how some principles could be developed for the arbitrator. Do you have any other questions or comments?

>> NEW SPEAKER: Thank you. Linda, this is helpful. I think the other thing that I wanted to make sure that even we had some discussion from a board...they way 3650 is outlined on this is specific of health entity not potentially unwilling to contract with a CCO. We haven't really had the discussion the other way around. And I just...we've had...I was looking through the public comments and there's, you know, the non-discrimination language there and I wasn't sure if you were referencing this process to go both ways or if it was just for a entity not willing to contract with a CCO. And I guess I'm interested in your thoughts of how does the non-discriminatory language that's in federal law, that's in Medicaid law apply to this? In kind of a [inaudible], so we kind of understand both roles.
NEW SPEAKER: Right. The statue sets up a process for a specific scenario and requires the use of an arbitrator. It's a costly process and it takes a little bit of time. The request that there be some dispute resolution about other kinds of conflicts: I mean that’s reality. There are always going to be conflicts for a variety of reasons for a variety of time periods between contractors and plans of CCOs in existence. There's no reason that other processes can't be made applicable to them. Our sense was that this process, given this particular outcome, if you're found to have unreasonably refused to contract and you're necessary, then you've stalled the system. Arguably, the CCO may be stopped in their tracks for a while.

NEW SPEAKER: We're sorry, your conference is ending now. Please hang up...

NEW SPEAKER: ...and the healthcare entity themselves may face a consequence in terms of their ability to claim reimbursement for Medicaid. Those are pretty serious consequences. So I don't lightly assume that that particular process and consequence applies to all possible disputes between CCOs and healthcare providers. The Medicaid law specifically talks about non-discrimination among providers. The statute itself talks about in subsection eight, "A coordinated care organization may not unreasonably refuse to contract with a licensed healthcare provider." So the law is already in place to set the stage for those conversations. And if they're a complex, there are probably processes that we could develop if requested. So this focuses on the specific mandate from the legislature.

NEW SPEAKER: So just to...so Linda what you just referenced in section eight...

NEW SPEAKER: Eight sub eight. Mhm.

NEW SPEAKER: I mean, you feel like that provides what is necessary in terms of directing kind of CCO and other health entities in terms of how they have to move forward outside of this dispute resolution?

NEW SPEAKER: Right. And Medicaid law, since we're right now talking about Medicaid, also has some parameters around that too.

NEW SPEAKER: Got it. Thanks.
NEW SPEAKER: So if we...and Felicia was talking about this earlier...I think we all believe that this work on the Medicaid side is going to serve as the foundation for expansion to PEB/OEB private insurance. And Lilian and I were just talking. And I think this is what Mike is talking. Let's suppose, in a community, there's two brain surgeons. And one brain surgeon is employed by the hospital and the other one is independent. And I realize this example is physician-centric, [inaudible]...

Let's say the CCO is hospital-based. Okay. The hospital in that community took on the onus of forming the coordinated care organization and they have...they're going to put their brain surgeon on the panel. But they're not going to contract with the independent brain surgeon. And I think what Mike is saying is, or at least what you jogged my thinking about, okay what's the solution for the independent practitioner to go to the CCO and say, "Hey, you can't carve me out."

NEW SPEAKER: And I think there's also not just the brain surgeon. There's a lot of small doctors who are...might be left out.

[inaudible over each other]

NEW SPEAKER: But I think there's lots of providers who would run that risk. Let's say the patient navigators were hired by a hospital and so they were contracting with the hospital patient navigators. And so I think Mike's question, or at least the question I have for Mike's statement is are there current remedies, and I think there are, that that provider then can go through to say, "Hey, you know, that's anti-trust. You can't do that to me and I'm suing you." Am I in the ballpark there? You're giving me that look.

[inaudible over each other]

NEW SPEAKER: I can tell you that my own comfort level is more around Medicaid law because I'm much more familiar with that and I know that there are particular provisions in federal regulations that address those scenarios. I'm less knowledgeable about the private sector and what the insurance industry might have around some of those issues. I know the affordable care act had some provisions specifically. I haven't looked at to see the overlap between our situation and the language in the affordable care act so I can do those things.

But if our topic here is dispute resolution and that's where we really want to get to is saying, "There may be those disputes out there. Do we provide any venue for any kind of...not maybe this process which requires the use of an independent arbitrator Is there another process? If you'd like us to look at that, I think we'd be happy to do that.
NEW SPEAKER: And just to take this example one step further, as Chuck was actually outlining the scenario, what he ultimately said he was concerned about was exactly sort of the corollary to where I thought he was going to go. Where I thought he was going to go was I thought the hospital wasn't going to be able to enjoin the other person because...and they wanted to stay out because they couldn't, especially at peak times and calls and such, couldn't handle the load. So this can go either way. And I mean, this is important public policy. You know, how conscriptive are we going to be in the public interest? For this to succeed, we may need to be, but that is a significant public policy. So I think it's one thing for the legislation and I don't think we have to wrestle this to the ground at this point. But I do think it's something that, we as the Oregon Health Authority, ultimately need to provide some additional guidance about.

NEW SPEAKER: And so, if I can reframe the question in terms of what makes sense to me, it seems to me that we've got the possibility of what happens in this immediate situation with a Medicaid plan and what happens in some other situations. That other situation we can deal with at another time in terms of making sure we're ready today on the Medicaid plan. Let me ask again and make sure we've got the right question: are there dispute resolutions, in Medicaid law or elsewhere, that would deal with these kinds of circumstances for the purposes of these CCOs?

NEW SPEAKER: Not having the regulations directly in front of me, my recollection is that a provider who's going to be denied participation in a Medicaid managed care plan is required to receive a written explanation of that to be able to understand why they're going to be excluded. There are processes that talk about...and sometimes it is appropriate. If you already have an abundance of X type of provider, do you have to pile on and add another who may never get any business from you? No. So there are several factors in Medicaid regulations that say managed care plan can say no under certain circumstances. But I'd be happy to bring those back to you.

So I have two takeaways. One is the process that we're talking about that 3650 has, we're not necessarily on the wrong track but you'd like some additional principles and possibly some guidance around arbitration and what the arbitrator principles would be relying upon. And as to the broader question about these relationships, you'd like a little more information, frankly, about what's out there, what's the current law. Is that correct?

NEW SPEAKER: And I just have just one more thing, which may already be taken care of in the laws that you're going to review here. But we've been talking about this in terms of current Medicaid law with MCOs and people being on the panel or not. We've also been talking about it in terms of payment issues. You know, like you talked about the legislation says if you're not going to pay me what my cost is I can say no and things. But around the CCOs and we put all this effort into making sure that there are metrics
around cost and quality. I want to just ask you: is there some way that we can talk about, you know, not meeting...besides payment, not meeting cost expectations of the CCO. And also quality expectations of who we expect to be providing this care in there. Beyond what Medicaid law says, is there some way we can bring that into the decision making or drive people for better quality and outcomes if they want to participate?

>> NEW SPEAKER: I'll give that some thought and bring back something for you to think about further. And the piece that you'll want to be thinking about is right now the current Medicaid managed care contracts, which is not the universe we're moving into, for the most part says the agreement between the managed care organization and its subcontractor is it's mostly their own business deal. So when you start driving some processes, how do you do that in a way that preserves their contracting independence to develop their business deals with the accountability that the House Bill 3650 is going to be asking the CCOs to be responsible for. So I'll get back to you.

>> NEW SPEAKER: You know, and just on that piece, the bring it back on the 24th, it sounds like it may be that after Linda's review that what you all decide to do is have a sentence in here similar to...something around the patient rights and responsibilities, much of which is governed by existing Medicaid law, that you could have a sentence in the proposal that, if you feel comfortable with that upon hearing what it is, that says the relationships that aren't covered by this ADR piece would be covered by existing Medicaid law. So that could get at some of the concerns that you all have articulated.

>> NEW SPEAKER: That was my piece actually. On that patient rights and responsibilities, if we could just have an outline of those under current Medicaid law as well if we're going to refer back to that.

>> NEW SPEAKER: Because we are going to talk about that. Yep. Thank you, Linda.

Okay, we are now going to move to talking about accountability and we're going to start on looking at page 35. And there's two pieces to accountability. And actually, before we launch into this, one of the things I should have said earlier is obviously you all have read this document. I'm not going to, except in a couple of cases with Tina's help here and there. I'm not going to summarize what's in the document because you all have looked at it. And I expect that you all just as you just demonstrated with the alternative dispute resolution piece, you have some of your questions or comments. So that's really where we want to spend our time. But I will do a little bit of sort of pulling some things out when they feel particularly important to highlight.

On accountability, there's two different pieces to this. One is on the metrics and the second is on remediation. So, you know, how are we going to make sure that...what are
the measures by which we're looking at CCOs. That's the first piece. And Tina's going to
talk a little bit about that. And then what do we do when those measures aren't being met.
What are the remedial steps there? So those are the two pieces of this conversation. So
Tina's going to talk a little bit about the matrix of dimensions. You know, there's a
specific approach that's been outlined here that has to do with core measures and
transformational measures. And some of the minimal performance requirements for those
core measures. Possible performance rewards or quality bonuses for meeting
transformational measures. And then a really important piece on the metrics is the
establishment of a technical advisory group, which will finalize measures.

There are some principles and dimensions outlined that the stakeholder group came up
with that are outlined in this section as well. So with that, I just want to turn it over to
Tina to talk briefly about the metrics of dimensions...matrix.

[inaudible over each other]

>> NEW SPEAKER: So actually, if you look at Appendix G in your...in the folder. It's
actually...the appendices are in a separate part of your packet. It's the very last item in that
bunch. Principles, domains, and example CCO accountability metrics. Again, I think
what's important here and what Felicia had asked actually that we come back with, and I
think Lilian had asked too, was around the domains rather that really focusing on
the...you know, we've reviewed the principles that were developed by the stakeholder
group when they brought their report forward over time during the four different
meetings that they had.

It was really those domains that we'd had public comment about making sure that we
included women's health as a domain here, which again, it's a very simple addition of
women's health as a domain without any additional detail to it. Primarily because, again,
what we want is the technical work group to really work out taking the public comment,
we have some very comments that were submitted to us on what those measures might
be. Again, I think it's for the technical work group to sort it out based on the principles
we've outlined and based on what kinds of outcomes we're trying to attain.

So if you look at that, those domains again...I don't want anybody to think that this is a
final list. That because it's in this report that means that that's all this group will look at. I
think that it's possible that the group will add some domains just that aren't here. They
may actually narrow it too. I don't know. But they definitely will be guided by these
principles.

As far as individual measures, again, the group...I think what we're bound by is that the
group recommended this idea of core measures that you have to meet. You have to meet
some kind of accountability standard. And that then there are measures that are outside
the core. I think it's also really important to note that there's a difference between being
held accountable to a set of measures and reporting on a set of measures for transparency reasons.

So the list here is not, again, meant to be comprehensive at all. The group didn't have the time it would take to do the deep dive and decide what really is core versus what is transformative. They have some ideas. It's in their documents. But this appendix is really just about mainly their principles and the domains. So that's where we are on metrics and that piece of the accountability.

>> NEW SPEAKER: Good.

>> NEW SPEAKER: Tina, can I ask...I'm a little unclear on how the technical advisory group is going to be put together. Is staff going to...I mean, we had a gazillion people on that metrics work group. Are you planning on pulling people off of that or pulling additional people in? How are you going to go about that?

>> NEW SPEAKER: I think that it might be a mixture of the two. I think that, again, I'm really interested in people who understand how you...people who actually do this kind of work and understand what it takes to pull this kind of data together, who are...understand quality measurement. So I would be looking to health plans and health systems for that kind of assistance. And we have some of that on that work group. It's just it's not...

>> NEW SPEAKER: Are you kind of imagining like a group of six or...I mean, not any specific number? I'm just trying to get a feel for...

>> NEW SPEAKER: Like 10, 12. I'm not looking for...but I'm always the person who wants a smaller group.

>> NEW SPEAKER: I think that's what I'm trying to get at. Okay, thanks. I was just wondering how that was going to be run.

>> NEW SPEAKER: You know, and I think we need people who can tie it back to population health too. That we want to make sure that these metrics, you know, not all of them are going to be population health metrics. But there should be a line-of-sight population health metrics.

>> NEW SPEAKER: I think the key for that is going to have it specify, particularly on the core side as well as the developmental side, to have it specified to the extent that the data that is needed can be obtained. But on the other side, one thing we heard time and time and time again was making these metrics a little too onerous and information for information's sake, so to speak. So...
NEW SPEAKER: So I have two pieces on this. I think that when we're thinking about the technical advisory groups for these, I feel like we want a set of core people who have a broad understanding of collection, public health, health equities. And then I think we do want a rotating cast of folks who, for maybe each of the domains, who understand the issue that's related to the domain. Because I think that will help develop sort of the best metrics to be measured.

Then my other piece is I feel like this morning we had a long conversation about workforce and education and how we integrate...I just feel like the metrics are the place where we integrate the larger discussion down to the CCO level. So our workforce and education, do we have a...is that a best practices? Something that we can do as best practices for CCOs or is that maybe a domain? And so I'd like to have some discussion of that in the technical advisory groups. And so I don't want to declare right now, but I feel like...how does that get integrated in.

NEW SPEAKER: Carlos.

NEW SPEAKER: So on the metrics, we were part of the group. And I see the indicators, they're very good. Good health, the metrics, good health indicators, good medical outcomes. This goes back to the issue of the core and governance which is it would be great to have a metric on community engagement, how well the CCOs are engaging the community. And it goes back to governance, but that's a separate comment I have about having the advisory board represented in the governance of the CCO. But in the metrics...and I know we have some developmental, some core, but maybe a core part of the metrics is that the CCOs have to have some level of community engagement and document how they're doing that.

NEW SPEAKER: And you know Carlos, the group, the stakeholder work group, their work you know. I mean, you were at those meetings. They actually tried to grapple with that a little bit. And I think, you know, one of the things that we can add here is I don't want this, anyone to think that this appendix represents all the work that group did because they did a lot that goes beyond this. Or what we could add is an instruction that this technical work group start with those materials. Because they really...community engagement is there.

NEW SPEAKER: Lilian?

NEW SPEAKER: Uh, I would just like to support what Felicia said. And also for us to think about this morning when we heard from Doug that if we're just measuring what we're doing, we won't even think about what it is we could do. And we had...I think the women's health discussion was like just one example where let's have fewer unplanned pregnancies so we'll have fewer people...and so we have to really think about that. And it's really hard when you get people who are...that this is their field. Because they want to go to the thing that they can see and measure it. And so, however we can be creative. But
if we can keep this in our framework that this is a journey, this is not the Ten Commandments...

>> NEW SPEAKER: I just have one more piece on that too. I think one of the key things is actually looking at the main areas that...which is not under the principles that were laid out. But the women's health issue was a key one because if you just look at the main areas on Judy's sort of dashboards about where we're spending money, we should really try to bring those out as part of the metric. I mean, I think cost is one of them. So whoever you need to integrate from the department to address those issues I think is going to be a key person. And I would think of that on the DHS side as well as on the Medicaid side.

>> NEW SPEAKER: Let me see if I can reflect back to you what I just heard. It sounds like most of those...all of those comments were specifically directed to OHA about the technical advisory group in terms of their composition, who's on it, the size, the process by which it's going to happen, building on the work that's already been done. And then also some specific requests that you all made around make sure you're looking at the workforce piece, look at community engagement which would be building on what folks have already looked at, and also thinking about not just looking at what we heard this morning, not just what we're doing, but thinking a little bit beyond that. And being real mindful of the folks who are on the group, both with the core and perhaps with this rotating cast of folks with content expertise.

So that...and I'm going to be clarifying this kind of stuff. So that's not necessarily...those aren't additions to the proposal. Those are specific instructions and requests to OHA about the technical advisory group. Is that correct? And then, what I would also sort of add on there, given the conversation here, it seems to me important to all of you that you hear back from, as you would, this technical advisory group with a specific emphasis on some of those requests you made. Okay. All right.

The next piece around accountability is remediation, sort of what happens when things aren't going well. And there's a piece on page 42 which is specifically on OHA monitoring and oversight. And, you know, the Health Authority is going to be responsible for holding CCOs accountable. And outlined here is a sort of progressive system of accountability. And you can sort of see it starts with technical assistance, because as you all have said numerous times, you want CCOs to be successful because that means Oregonians will be healthier, right? So that's the technical assistance piece is the first really integral component there. And then sort of moving to a corrective action plan, a restricting enrollment, with an ultimate potential penalty of a non-renewal of contracts.

So this is the...these are sort of the accountability system and structures that have been set out here. Mostly, on page 42. And so the question that we have for all of you is are these the right structures and is there anything that, you know, you need to add? Anything that's
unnecessary, anything else on accountability, the remediation piece, that you want to make sure is captured in the proposal?

>> NEW SPEAKER: I have a couple things on that. I know I've been harping and harping and harping on this so I feel like I do have to say that, you know, I just read the tobacco cessation study that came out from public health around MCOs. You know, one of the things that shocked me was so they invited 375 people to enter tobacco cessation programs and only 45 did. And so then what happened, well, the answer was nothing really happened. So I feel like this piece is so critical for this work to actually be successful.

And so one of the things I would add here is a limiting financial discretion. So when we talk about financial penalties, that says to me fines or taking money away. But I feel like, you know, at this point we give people a global budget that says you should spend the money to meet these outcomes. I think if you're not meeting the benchmarks or outcomes, then your financial discretion to meet those outcomes should shrink. So maybe it's here's your global budget, you should meet these outcomes. After you maybe don't meet the outcomes, the next step is here's your global budget and 10% will be spent on this and 15% will be spent on this and 35% will be spent on this and we're going to monitor that. So how do you sort of squeeze the CCOs discretion out until they can meet the outcomes again?

Because I fundamentally do think that that creates culture change. It created a lot of culture change at my own union, frankly, when you sort of limit financial discretion. So I hope that that's a tool that we can add. I also think we had a long conversation about governance as...you know, when we set up governance and how do you use governance as an accountability tool, I think the question still has to remain out there. If we are asking to create culture change, that change has to be lead by the governing body of an organization. If that governing body is resistant to change, then change won't happen. So I feel like it needs to be an accountability tool that the state is able to use. And we should figure out how that can happen. So those are the two tools I'd add.

>> NEW SPEAKER: So let's take those one at a time. So Felicia mentioned this idea of limiting as a, and I assume what you're saying is sort of a potential remedial step here, that somewhere...before financial penalties, you would...OHA would if they could limit the financial discretion of CCOs. So I'd like to hear some other input or feedback about that potential addition.

>> NEW SPEAKER: That's kind of tricky. I mean, I...because...

[inaudible over each other]

>> NEW SPEAKER: Prescriptive. I personally don't have the expertise to say 10% will create the change that we're looking for. It limits their flexibility. But, at the same time,
it's what they will listen to when you start limiting how you spend the money and you're running their business, they want to get out of that situation. And it might work. But it's a hot potato.

>> NEW SPEAKER: Would that be a financial penalty? I guess what I'm saying is that is this a subcategory of financial penalty?

>> NEW SPEAKER: Well the thing about financial...when I think of financial penalties, I definitely think of that as we are going to remove funds, right? Or we're going to fine you or we're going...it could be a subcategory of financial penalties. It could be a reallocation of funding. But I think before we begin taking money out of a CCO, which I think is definitely I feel like kind of the final step before non-contract-renewal. I definitely think that there needs...how do you sort of tighten the financial scrutiny...we are talking about CCOs who aren't meeting standards. That's the key piece to start with it. After several warning, you haven't met your technical assistants, we're tried to help you out, you're still can't get it up and going...

>> NEW SPEAKER: What about the corrective action plan? I mean the corrective action plan could be to say to a CCO, "Look, here's the big problems we see. And here's what we think you need to do, including reallocation of how you're spending your dollars.

>> NEW SPEAKER: ...so when you think through just progressive discipline, frankly, a corrective action plan...so we say, "You're not doing your job well. I'm going to provide you assistance to do your job better." That's the first step, that's technical assistance. "Okay, you're still not doing your job very well. I'm going to check in on you a little more often, continuing to provide technical assistance, so that maybe you can do your job a little bit better." "Okay, you're still not doing your job well. Here's a correction of action plan about exactly what benchmarks you need to meet to do your job well. And that may include financial restructuring...and let's say on that corrective action plan, you take six of the ten things that are offered and then you begin doing your job well. Well that's okay because then apparently the other four things isn't really what you needed, you needed the six. So then you're done and we're back on track.

Now let's say you've taken that corrective action plan and you walk away and say, "That's adorable. Peace out." Then I think the next step is, not only am I going to monitor what you're doing on a day-to-day basis, I'm going to be very specific about what you're allowed to do. I am also going to be really prescriptive about how you're going to spend your financial money to do it. And if that doesn't work, then I'm going to begin taking away money, or costing you money, or taking away patients. And if that doesn't work, then I'm going to have to cancel your contract.

And so hopefully, people don't really actually get to...hopefully the corrective action plan is the last step, right. But I see these things as progressive discipline and you don't just like slam all of them down at once.
>> NEW SPEAKER: But don't you think if the corrective action plan doesn't work, I think you should just cancel the contract.

>> NEW SPEAKER: I wouldn't go any further.

[inaudible over each other]

>> NEW SPEAKER: Once you get to the prescriptive...I mean, if I were a CCO and you were prescriptive, I'd just fold. I think it's just a moot point. It's an intellectual debate. There's so much dissonance at that point that the situation is just completely non-functional. I think we have to cut our losses and think about what else we're going to do to provide services in that area. I just can't imagine that it's going to be successful if we're trying to dictate from some distant point how it's going to work. I think it's a failure at that point.

>> NEW SPEAKER: Erik, did you want to...

>> NEW SPEAKER: I would have said the same thing. To me, I see where Felicia is going. I understand, I think, why. But I think she's actually being more patient than I would be. If somebody is so confident that they can ignore a corrective action plan, you probably don't want them as their CCO.

>> NEW SPEAKER: So what you all are suggesting is potentially taking out that fourth and fifth bullet. Or leaving that in, just in case.

>> NEW SPEAKER: You probably need to leave that in there as an enforcement mechanism to get where you need to go.

>> NEW SPEAKER: Got it. Yes, you would. So if you didn't meet the corrective action plan, this is what happens. Lilian, did you have a comment?

>> NEW SPEAKER: So I'm still...I'm overhearing Chuck's side of the mountains. I mean, I guess that the other thing that is a mitigating factor because one of the problem is we're discussing all of these things in silos. You know, like paragraph by paragraph. I guess if indeed we had a governance structure for the CCO that did include strong representation by the communities that are impacted then you wouldn't get that much dissonance. You're talking like a businessman. Okay, this isn't working. I can't run it the way I want, I'm going to fold and move on.

But if they're really community rooted, I think that they would be bad actors in a CCO. I mean someone who was governing and administering a CCO that way would not meet the spirit of our governance requirements.
>> NEW SPEAKER: I guess my question...I do feel like though, even if you have community board, frankly, I firmly believe that you can get to the point where the whole entire board is like, "I don't care what they..." I mean we see in the union all of the time. I could name states where they're elected local board is for sure on the "I don't care what the international says to me. I'm running my own plan." And so we have a series of penalties to sort of get to that point. And I guess my issue with patients is, I assume you can never walk away fully from a community is my assumption. Because I do think that dissonance will resonate. And so I do feel like how do we add in a governing board piece to that? But that's also why my patience is much greater, I think.

>> NEW SPEAKER: Joe, go ahead.

>> NEW SPEAKER: My patience is still just as short. And the reason, I think, where we will find the people who are the most entrenched are some of the community leaders on these boards. I don't think it's going to be the organization. I think it's going to be...there's going to be as much culture change. People will have certain expectations and they'll have prominent community physicians and they will populate the board and it's just exactly like you described. They will want to preserve the status quo and I think we need the heavy hammer. Because then they will realize that, unfortunately, thing will go into disarray and there will be pain and gnashing of teeth. But that's the threat that will make it work. So we just have an honest disagreement.

>> NEW SPEAKER: I think we all want the hammer. The question is when do you swing it.

>> NEW SPEAKER: I want them to think we're going to swing it.

>> NEW SPEAKER: Go ahead, Mike.

>> NEW SPEAKER: Well, I think there's a difference in what you're saying. I think we all would agree at some point in this process, there is potentially a hammer that comes out if all of these things are met. But what I think Felicia is saying, I'm not sure that I agree with it, is part of that hammer is using governance, having the state come in and reconstitute the governance of a certain CCO. And that's where I feel like, in terms of having a private organization that has articles of incorporation by-laws and all that, I don't feel like the state can do that. It can certainly dissolve...it can not contract with that organization, you can have a new organization come about which then have a new governance model that may meet the needs of that community. But I'm not convinced that the state can actually play that role, if that's what you're referring to.

>> NEW SPEAKER: Wait. Before we get there though...because we're going to have that...I want to have that conversation about the governance, the second issue that you raised. But I want to figure out where we are on this limiting financial discretion piece.
Because there's not consensus. And we want to stay with things until we can figure out where the board is on this proposal. So Carlos do you have a specific comment on the...?

>> NEW SPEAKER: Yeah, it goes back to the patient issues. So maybe we need to have a timeline so we know when things are going to happen. And you have a six month warning and you have one year. And after one year we're taking over finances and two years you're done. I don't what the timeline is, but they might be the hammer is coming and here is the dates where this happening and this the time you need to make the changes. So there is not...

>> NEW SPEAKER: I assume that would be in a corrective action plan. I mean, that's what a corrective action plan would do is outline here are the benchmarks you have to meet an by when. So I think it's there. And I think the piece is there. Do we want another tier in here or no, you go from here to here? Chuck then go to Erik.

>> NEW SPEAKER: So I'm confused. It seems to me that we're all agreeing on the bullets that are there. I mean, are we talking about...

>> NEW SPEAKER: I think the details on financial penalties is...

>> NEW SPEAKER: But isn't that something that's going to come in the specific situation? I mean, you can't be prescriptive at this point about, you know, what day you're going to bring the hammer down or all of that. So I guess Felicia what is it that you would do to these bullets?

>> NEW SPEAKER: There's a couple of things I would do specifically to the bullets. So I actually do think...so there's a timeline for reporting in the previous section. So I would...like Carlos was saying, it's not in here. I just assumed it went with the previous section. But I would tie some of these to the timeline that's in here, right. If so in the first three months you don't meet your measurements or outcomes in your first reporting, then I feel like you have maybe the second reporting to do any corrections that you need. I do feel like it's before a technical assistance comes into play. You can ask for technical assistance at any time, but before the state says, "No, now you actually need technical assistance."

So I would attach a timeline. And then I would get down to some specific...like I think when we talk about financial penalties, I think it's really important to get down to specifics. I do feel like the state has a lot of latitude now about who to contract with and who not to contract with. I have read a public...you know, there's a...I don't know how long we've been talking about tobacco cessation, but probably longer than I've been alive. We get 45 people to attend a tobacco cessation program and what has been the consequences? There hasn't been. And there isn't specific consequences now. The consequence now is we either contract with you or we don't.
So I do feel like we're going to create these organizations that are too big to fail. I think we need to be really specific about the consequences. I think there needs to be a concrete timeline for them. And I think they need to know. Because I think there's a difference between saying, "Well, if we don't do this, there might be financial penalties," and, "Okay, if we don't actually do this, we're about to have all of our funds restricted to specific things." So that's kind of what I'd like to see here because I think that holds people accountable.

>> NEW SPEAKER: So let me take those one a time. So there's an issue around tying this to the timeline around reporting so that the...so the first issue is would you...do you want to say, if we're going to look at three months, six months, whatever the timeline around reporting is. So that's the first specific proposal. What do folks think about that piece? Adding that in here.

>> NEW SPEAKER: I'd really like to agree with you, but I can't. I got to stay at 60,000 feet on this thing. That's just where I'm at.

>> NEW SPEAKER: I'm at the same place. I'm concerned that any level of prescriptivity that we add actually restricts the authority of the director of the OHA and I'd like him to have wide authority to act using good judgment.

>> NEW SPEAKER: At the beginning. At the early stages, it might be that we proceed that way. And I think as we learn more about how things are done, how difficult they are, that we start tightening up the screws.

>> NEW SPEAKER: And I want to stay there because I actually believe that if these organizations are set up right and function right, it will be in their self-interest to do what you want them to do. And it will be in their financial...because they will see the data. And the reason there're only 45 people signing up right now is it's not set so there's enough financial incentive for that. But if these organizations are set up and they're on a global budget, I'm hopeful that the basic structure that we've put into place will provide the incentive. So I don't want to be prescriptive. I'm really an advocate for innovation here.

>> NEW SPEAKER: Lilian, Mike, I'm trying to make sure I hear from everybody on this. So what we're talking about is we want to...and I think this addresses both issues that have been raised. Sort of keep it as it is in terms of, you know, there's steps here. It gives some more discretion in terms of the specific issues with CCOs. But there is sort of progressive steps. Or do we want to be more specific?

>> NEW SPEAKER: I can see the utility of, you know, being more specific. Where I'm sitting right now is I'm harking back to like my foundational principle for the whole document, which was to not be specific and to keep it in principles. And I'm afraid that if, as we go through this, that therefore will lead me down the rabbit hole that I'm going to have to be consistent in abandoning that principle in other areas. Because others of us
may feel different in other areas of this. You know, prescriptiveness, flexibility, kind of...and I'm particularly worried about the consequences when we get to governance. So I'm going to say I can't agree with you.

>> NEW SPEAKER: I would agree. I mean, I think this is consistent, what's currently down there, is consistent with the way the documents been crafted, that it provides this framework for a lot of detail that still needs to get vetted in terms of the global budget, in terms of a lot of those pieces that I think we are going to have OHA work on. So I think I would leave it as is.

>> NEW SPEAKER: So can you live with this?

>> NEW SPEAKER: I would say we are not at...I've heard from everyone here, but I want to be clear that we are not at consensus on this issue. So I think it's fair when we characterize this going forward that we didn't reach consensus, that there were strong feelings that we needed to be more consistent. I'm fine moving forward. I do feel like we are prescriptive in other areas around the accountability piece, around reporting timelines, et cetera. And I feel like when we think about the current system, I feel like there are areas to allow for innovation and creativity that have not yet played out. I feel like on the area of accountability is where we have lacked in the current system, significantly. And so when we think about this going forward, I do this that this is a topic that I don't feel like is done at this level. And so we'll just want to make sure we're continuing it through the rest of our discussions as a board. And beyond us. So...

>> NEW SPEAKER: So given that we don't have full consensus on this, I need to check in with you all about what you want to do about that. Because I think that's important. This is a document that's going to proposal, it's going to the legislature reflective of the recommendations of the Health Policy Board. So if there's not consensus, thoughts about how you'd like to handle that. Or if there's a way to get us closer to it. Go ahead, Joe.

>> NEW SPEAKER: You know, I think that was about the first topic that this board discussed at out very first meeting. We don't have to reach consensus on every item. We can respectfully disagree and I think that's what we have here. That that will not in any way jeopardize because it's...and this may come up the next time I may not agree. But at the end of the day, what we're going to do is submit a work product and we're all going to heartily endorse that work product. It doesn't mean that any of us thinks it's perfect, but that we think it's a very good collective effort.

>> NEW SPEAKER: And I think...I don't feel I'm going to say, "I hate the rest of this." I just want to make sure when it comes to this issue and then we'll move forward on the rest of the document.
>> NEW SPEAKER: Good. And it sounds like, obviously...accountability is very important, right? And so obviously will be something that comes back to the board, you know, on terms of how it's getting implemented as this moves forward.

>> NEW SPEAKER: I'm not even exactly sure who I'm in disagreement with.

>> NEW SPEAKER: And that's the kind of discussion we need to be having as we move through this. Anything else on accountability before...?

>> NEW SPEAKER: I will add one word and that is I believe the director of OHA does have a fair amount of discretion with regard to this. And if he wants to add some pieces, he or she over time, wants to add some pieces in here that are consistent with the discussion we've just had, that's perfectly okay. If it's appropriate to the circumstance.

>> NEW SPEAKER: And I think Carlos's earlier point about let's see how this goes. And I think that's...and you guys are not disappearing. Things will come back to you as issues come up. And you'll deal with them and maybe put different things in place as they evolve. Chuck is trying to disappear. But he's still here.

Okay, I want to move us on to the CCO certification process and this is something, we've talked about it, but you haven't seen it laid out. And so if you take a look at page 15. And it lays out that there's an RFA that will specify criteria, they'll be a submission of applications, there'll be an evaluation in the certification. So just because we haven't...you've talked about it, but you haven't seen it laid out in this way, we wanted you to take a look at it. And my question is, you know, any questions or concerns on this section?

>> NEW SPEAKER: Hang on. I printed this stuff of and the page numbers are different.

>> NEW SPEAKER: So that's because...you know, the old page number I think was 17. And by old I mean the document you got yesterday.

>> NEW SPEAKER: So I need to be looking at this.

>> NEW SPEAKER: The new document. Sorry. Okay, I should have referred you to that. And they're literally just a couple pages off. So the new document, it's page 15, in the one you had previously it's 17. So it's just a couple pages. So I'm working off the newest one.

[inaudible over each other]

...so page 15. Chuck, I want to make sure you have a chance to get there.

>> NEW SPEAKER: He's got it.
Okay. Any questions or comments on this? It's pretty straightforward. Mike?

Yeah, I guess this is more even for Tina. I mean, when we think about process and operations. I mean, we've had this discussion and it's been brought to us on fast-tracking and what the implications are around that. When I read through this, this really is...again, you meet the criteria, you submit your application, we go through the review process. Everybody is kind of on the same playing ground. Is that the thinking of OHA right now?

That's right.

Okay.

I just have one...

That was the feeling coming out of the stakeholder groups. This is really with feedback from the stakeholder group.

I just have one editorial change that I'd...in the third line: "prospective CCOs will be asked...." versus...

Will asked. Yeah. Thanks. Anything else here?

I'm sure a lot of that in here.

Okay. Then we're going to move on to patient's rights, responsibilities, engagement and choice. And in the new document it's pages 19 to 21. And again, you've heard stakeholder feedback on this. There's big chunks of the legislation in here. And then nothing...the little framing in here is, you know, obviously nothing that's in here supplants current statutes in consumer rights, either in Medicaid law or state law around due process, fair hearing, grievances, appeals, all of that...much of that exists in Medicaid and state law. And so we didn't detail...all of that isn't detailed in the proposal because it already exists.

Huge body of work there.

Yeah, huge.

And since there's a mixing of funds, don't we actually have to meet the Medicare guidelines as well. I actually read those a few weeks ago. They're exhaustive. I can't imagine a situation...
NEW SPEAKER: That wouldn't be covered. And so it's all there. But what we really wanted also represented here is the feedback we've gotten from all of you as well as stakeholder groups. So I actually did want to pull out a couple of things in those bullets at the bottom of 20 and moving on to 21. There were just a couple of things that were new, that came directly from the stakeholders.

The first is...and it's not that you all haven't thought about this or talked about it, but we did put it in. The first bullet: "determine the best engagement approaches and barriers by engaging the community and via the community needs assessment," that's been added. And then the last bullet: "meaningfully engage the community advisory council to monitor patient engagement and activation." So that's been added.

NEW SPEAKER: Just on the piece, we're going to get like a...it would be helpful to have a one-pager on the Medicaid and Medicare. I'm thinking of just doing education around this so we can explain those rights to people.

NEW SPEAKER: Yes. So the rights under Medicaid...

NEW SPEAKER: Yeah, I don't think that needs to be added to this document, but it will help us a...

NEW SPEAKER: Okay. So is there anything else on this section on patient's rights, responsibilities?

NEW SPEAKER: This is a minor nit, a wording thing, but in the first bullet it says, "determine the best patient engagement approaches and..."

NEW SPEAKER: And barriers. Not the best barriers.

NEW SPEAKER: We got to figure out the wording there.

[inaudible over each other]

NEW SPEAKER: Okay. The next piece we wanted to talk about was the delivery system piece. Because, again, you haven't seen it in exactly this form and it is on, in the new document, follows immediately after patient's rights piece and it goes from 21 to 24. And you'll see, you know, you saw as you read it. There's really a focus on patient-centered primary care homes. You all had a lot of that discussion around the action plan and much of it was incorporated into 3650 around patient-centered primary care homes. So it's not called out here with all those details. But obviously it is a centerpiece, as is care coordination discussed on page 23 and care integration.
So again, my inquiry to you, any questions, comments? Is this reflective of your thinking as well as affirming the stakeholder input we got? Anything that you want to add or subtract? Joe.

>> NEW SPEAKER: No, sorry.

>> NEW SPEAKER: Okay. Good. All right. Payment methodologies on page 26. And this says, "Payment methodologies that support the Triple Aim." And again, you've had some conversation about this, but not called out specifically in this way. Really comes, this section came from the bill and the stakeholder group on quality and efficiency. And this is, you know, wanting to encourage flexibility and not be too prescriptive, but at the same time, saying, "Look, there's a set of principles here. And there's those bullets on page 26 that we really...CCOs are expected demonstrate how their payment methodologies will promote these principles. And you know, you can just look at those principles.

>> NEW SPEAKER: I have one comment, but it was triggered by something Joe said some time ago and you may be about to go the same place. And that's with regard to evidence-based and emerging evidence-based. Right? To me, it's important that we recognize the ability to continue to innovate.

>> NEW SPEAKER: So how would you want that captured here, Joe?

>> NEW SPEAKER: Well, I don't know. I mean, Wordsmithing on the moment here.

[inaudible over each other]

>> NEW SPEAKER: ...so I would just add it. Because it's specifically germane when we're dealing with non-majority cultures.

>> NEW SPEAKER: It might also be with some experimental procedure that it's working out but, it's in between so it could go...

>> NEW SPEAKER: And just to throw a hypothetical here. Under...the first statement under section 5.1a, "Reimburse providers on the basis of health outcomes and quality, instead of the volume of care." What if they evidence comes back that there is a best marginal value, there might be some slight value, but there's marginal value to something that's currently being done. And the CCO does not think it is in the public interest when there is a limited resource to provide that. But it's technically on a Medicaid or Medicare fee schedule where...and a provider is wanting to do that. Does the CCO have the authority to say, "We don't..." I mean, it's on a Medicare/Medicaid fee schedule, but this is not a good utilization. We can provide far more health in some other way. Does the CCO have the authority under this language to make that decision?
NEW SPEAKER: I don't think so. I mean, my sense is...I mean that's another federal discussion in terms of federal waivers, in terms of the benefit package that we would potentially be modifying.

NEW SPEAKER: So I mean, that's to me one of the transformational aspects that we shouldn't lose sight of. So in our discussion...I know there are other things at stake right now. But in our discussions, I mean, this would be another important step. So in our discussions with Washington, how do we tee that up or put it in the que or set the stage? We may not get there tomorrow, but how do we build toward that?

NEW SPEAKER: Did you mean Washington, D.C.?

NEW SPEAKER: Yeah.

NEW SPEAKER: But Joe, your point really is that every CCO could have the ability to structure their own benefit package?

NEW SPEAKER: I guess if you look at it the conven...yeah.

NEW SPEAKER: Good, Carlos and then Lilian...

NEW SPEAKER: But unless some CCO changes, you know, we are essentially stuck with the benefit package we have today, which I don't think does the best job of utilizing the dollars.

NEW SPEAKER: So let's here from Carlos and then Lilian and then Chuck.

NEW SPEAKER: So I was asking Washington as a state. So then another point then...so does a CCO does X procedures, but doesn't do that many of the other ones. And some hospital in Washington State across the river would do this. And they're doing a lot of them and they're doing it cheaper. Does the CCO can outsource some of those procedures outside...that might not be where you're going after. But the volume of the stuff that they do here. They do a lot of them over there and why don't these procedures...and we'll pay whatever it is. It's much cheaper than me doing one of these once a year.

NEW SPEAKER: Your point is can I get a waiver to not do this...

NEW SPEAKER: Right. Right.

[inaudible over each other]

NEW SPEAKER: Lilian. So I'm think that's a good long-term goal. You know, that we'll send you all to D.C. and you can wrestle with Secretary...
interim, so what I'm also envisioning is, again, that this is an iterative process. And isn't that part of what we want the clinical advisory committees for, the clinical councils? So yes, we not be changing the benefit. But if we have a provider who, as you pointed out, is...maybe they just haven't read the literature or they're too busy to notice that this is a marginal thing. That the clinical advisory committee could provide kind of internal technical assistance.

Because I do feel that part of our evolving experience with this tri-county group is there is much to be learned from each other. And as we create these listening environments which the CCOs can be across provider systems that we've never had before, we can actually achieve those goals without trying to, you know, take down D.C.

>> NEW SPEAKER: I also think if we're going to talk about the sort of benefit packages I do feel like the health fund board had a subcommittee that did a lot of work on that previously for minimum benefit standards. So if we're going to go back around that, I feel like we should bring that back up. And maybe it's not eliminating that Medicare benefit standards, which I don't think they're going to let anybody do. But maybe it is bringing a new proposal forward based on the work that we've done.

>> NEW SPEAKER: So Erik, I think we also need to keep in mind that under the ACA we have to develop an essential benefit package for the state that also has direct impact on Medicaid. It's not just the [inaudible] market that that impacts. So this discussion all has to be part of that discussion as well.

>> NEW SPEAKER: But philosophically, we want to at least, for the purposes of this document, recognize emerging...

[inaudible over each other]

>> NEW SPEAKER: Right. So on that, we're going to add that word in the last bullet to make sure. And also just reflect...I mean, we all know what we do here in Oregon will be...is influenced by the feds. And we also know that we're working with them, CMS, to allow the state to have some flexibility and that this is all part and parcel of that. So anything else on this section? Chuck.

>> NEW SPEAKER: Oh, I haven't even got started. I got a lot of things. This one really gave me a lot of heartburn. And I had that first bullet...well, let me start here. Question: so the parts of this document that quote from 3650, are they going to remain in the document?

>> NEW SPEAKER: Yes.

>> NEW SPEAKER: All right. So realizing, and that's what I assumed, several of these bullets are simply reiterative of the bill. And therefore, in my opinion, don't represent
principles, okay. So I would suggest we strike the bullets that are simply reiterations of what the law says and develop principles. And that would include striking that first bullet. I don't think...I've never been critical of the law, but I think, you know, if I were to be critical of 3650, section 5, was it 5.1a, [inaudible].

What that suggests to me is that the entire payment reform system is going to be based upon pay for performance. And that's not going to be the case. As a matter of fact, that's going to be a very small part and a part that we don't even start with. So there are many other payment methodologies that a CCO is going to use. For example, reimbursing for primary care homes. If you're a primary care medical home, a patient center medical home, then you're going to be receiving reimbursement to do that.

At the end of the day, we're never going to get away from fee for service completely. Even patients in a medical home models include a fee for service component. So I guess that's point number one is new payment methodologies are vastly more complicated than simply pay for performance.

The second thing is, in that first sentence, I would say to encourage, improve quality and efficiency in the delivery of services it will be necessary for CCOs to move from a predominantly fee for service system. And what I would say instead, "to move from a traditionally fee for service payment system." And I think that gets more at the way we've done business before. And we're going to change from that. And so then I would like to see us flesh out some...I would like to see us work on these bullets and strike the ones that are just repetitions. And maybe work on the principles, come back with some principles, and I'm happy to kind of do some thinking about that also.

>> NEW SPEAKER: Okay, so here's a...the first three are repetitive so we know that we can take those out. What I would suggest is can we have a brief discussion about some of those principles right now and then ask staff to Wordsmith that and bring it back on the 24th? Does that sound like a reasonable way to proceed?

>> NEW SPEAKER: Yeah. I also think we had...the health fund board had principles around payment methodologies. So can we dust those off and bring them back out?

>> NEW SPEAKER: All right, so one suggestions is look at the fund board's work on payment methodologies. Let me ask this: anything else that we haven't already discussed that you want to be sure is reflected in these principles? So are there specific...that we want to give to Tina and staff that then they will then play with. So are there somethings here that we haven't discussed that you...other than...we discussed emerging. Other things that need to be pulled out or highlighted? Chuck.

>> NEW SPEAKER: Well, as I was going through this, what struck me as missing in the bullets and I'm not sure I'm confused on this, but there's really no mention...so what's the title up here? Payment methodologies that support the Triple Aim. Yet, that's missing in
the principles. So that's where I first started stumbling and I don't know what to do about that.

>> NEW SPEAKER: Say that again.

>> NEW SPEAKER: So the title of this is "Payment Methodologies that Support the Triple Aim." But as I read through the bullets, I never really saw the right place at the right time.

>> NEW SPEAKER: So the Triple Aim should be incorporated into those principles. The other point you made, Chuck, that I want to make sure we capture is that alternate payment methodologies go beyond pay for performance and we want to be sure that's reflected. And we'll look at the health fund board piece. Are there anything else? Yes, absolutely. We got to get it done.

>> NEW SPEAKER: I was going to let some of this go. And, I mean, I'm willing to, as Chuck said, think about this a little more. In the second to the last bullet, there's a false...it makes it seem too simple. It's, "Prove comprehensive coordination of...or create shared responsibility across provider types and levels of care using such delivery systems as..." Patient-centered primary cares is not a delivery system. It's a model. But a lot of what we talked about in terms of pushing the innovation is really across systems. So if we're going to call something out, we got to find a better way of calling it out.

>> NEW SPEAKER: Agreed.

>> NEW SPEAKER: So what about two bullets? One about the systems piece and one about models of care?

>> NEW SPEAKER: If we can give a specific...I mean, I think those are the kinds of things where it does help to have an example of what we're talking about because people kind of go to their own mental model.

>> NEW SPEAKER: But is a model of care a principle for a payment system? Are we mixing and matching a delivery system with a payment system?

[inaudible over each other]

>> NEW SPEAKER: Really make these principles, right, around payment methodology and make sure we incorporate the health fund board work as well as the Triple Aim. And so we would bring this back. Erik.

>> NEW SPEAKER: Just to plant a seed. I'm not sure where this fits and it's not worth a lot of debate right now but you might think about it as you're trying to figure it out is earlier today, during the financial presentation, we heard about how sometimes money
can be expended that simply reduce the enrollment or do some of those other things. Rather that getting into specifically lead to chronicle illnesses, let's talk about how we really get to the higher level outcomes that we're looking for.

[inaudible over each other]

>> NEW SPEAKER: I think it's important to understand the intent of 3650 and then what we've done. So if you read this, that first line says, "OHA shall encourage CCOs." That's really soft in terms of legislative language. What we've done then is taken this in terms of our report and we say that, "CCOs will be expected to demonstrate." So we've taken it to the next level to say this is how, this is the criteria we're going to use. So the legislature didn't really ask us to take this next step, but we've done that. So we could actually leave it as is if we wanted to. But I think we're saying the criteria we're actually getting to a new level of specificity.

>> NEW SPEAKER: Go ahead, Felicia.

>> NEW SPEAKER: I guess my question is so we have a set of principles and then a set of criteria expectations under here. Because Chuck's saying we're missing the principles, but these things are really...what you're saying is these are more specific criteria?

>> NEW SPEAKER: Well I think what Chuck was saying too is there was an overlap between what was listed here and then what we've...

[inaudible over each other]

>> NEW SPEAKER: And then you're taking the next step of the other criteria expectations?

>> NEW SPEAKER: Yeah, I mean, that's going to be part of that criteria piece...

>> NEW SPEAKER: Okay, so we should come back with thoughts on that as well. Okay. Thanks.

>> NEW SPEAKER: So this section is obviously going to come back to you with some significant revision.

>> NEW SPEAKER: Even that bullet, that fourth bullet, it needs some wordsmithing. I mean, you can be promoting conditions that produce chronic illness. It's some work about making sure [inaudible]....

>> NEW SPEAKER: I also felt like there was some public comments or thoughts on payment methodology from one of the work groups. Maybe it was the Ins and Outs group. So...I can't remember. I felt like the Ins and Outs group came up with some criteria
and principles around payment methodology, as well as the health fund board. So can we bring both of those back together so we can see that in here? Thanks.

>> NEW SPEAKER: And Tina, do you feel like you have a sufficient and direction on this?

>> NEW SPEAKER: Yeah, I'm calling Chuck.

>> NEW SPEAKER: Okay. So we have a number of pieces: look at the fund board work, look at some of the subcommittees in the stakeholder input, and make sure it is...you know, Mike's comment about being clear about that we're actually being more specific than the legislation outlines. But we will come back, come back to you on the 24th with some different language. This will look different. Okay.

Those were...oh, one last issue. Because this...yeah. Duals is on your agenda, but what we're going to do on that, if you go to page 38 of the new document, it talks about share accountability for long-term care. You all heard a presentation on this last month when we came together. And staff is still is still working on this. And what they'd like...what we'd like to do is bring to you on the 24th a strategy framework to clarify the coordination and accountability between CCOs in a long-term care system. So we're going to come back on the 24th. And they are, during this time, working with...

[end of recording]
>> SPEAKER: I'd like to start by simply saying that it's great to be in beautiful Bend. I want to thank Mike Bonetto a member of our board and the Stafford-St. Charles Medical Center here at Bend. And I'm sure many others for making it possible for us to be here today. Mike, do you want to add a thought or two on that?

>> NEW SPEAKER: Thanks, Aaron. I would like to certainly thank my boss, Jim Degal. He couldn't be here today, but he really was very pleased we could make the accommodation. I certainly would like to thank Brad Slate, he's sitting over here. He's been the technical guru to set all of us up today and also Maggie Olsen who's been working with Tina to get all this coordinated. So many thanks to our staff.

>> NEW SPEAKER: Very good. Thank you. It is wonderful to be here. I will note for those in the room and others, we are available to the state of Oregon and others today by way of live web-streaming. So for those of you that are watching this through the web, it's a beautiful day to be in Bend and we're pleased to be here. We have a process by which questions and comments can be retrieved during the course of the meeting. so please feel free to use that process. We'll try to capture those and respond to them during the course of the meeting.

While we're here in Bend, one thing I want to acknowledge is that...is one of the folks here today is Ray Mao. He was a member of the Oregon Health Fund before and predecessor to this group and very much involved in this effort...

>>> Chair: With that I'd like to move to the consent agenda. The consent agenda consists of...actually I guess I should start with roll and that reminds me: we have on phone, I believe, [inaudible] All other members are present here. [inaudible], are you on the phone? Not yet, we hope she'll be joining us. So we'll be watching for her. All others present.

The consent agenda consists of three items today: the minutes of the March 9th meeting we have received and the addition of Dan Clay to our Incentives and Outcomes Committee. And the addition of Paula [inaudible] for Healthcare Workforce Committee. Does anybody wish to remove any items from the consent agenda? May I have a motion to approve the consent agenda? Consent Agenda is passed. Thank You very much. With that I will turn it over to Bruce Goldberg.

>> NEW SPEAKER: I briefly just want...a couple of things. One is I think is everybody knows this past month has been fairly dominated by the federal efforts....and we'll have an opportunity to discuss that a bit more later on in the agenda. My take away from a lot of the discussions around health reform is that it is [inaudible] opportunities from federal...
efforts that I believe we're going to be able to take advantage of to move our work forward and I think that it's going to give us a real opportunity to focus on delivery system change and deviation without cost, quality, and value as well. Some real opportunities for operation [inaudible]...later today.

The other point that...issue that I just want to make everybody aware of is that over the next six weeks both the Department of Human Services and the new Oregon Health Authority are having a series of community budget forums to help the state. I notice about that in my report that each state agency has to put together an agency request budget, which is submitted to the governor late summer/early fall. The governor then puts together a recommended budget and then there's a legislative [inaudible] budget, which is really the budget that the state lives with for the next couple of years. Agency request budgets are [inaudible] in that they are expense-only budgets that...it's not a balanced budget. Agency request budgets don't have a [inaudible] constraint associated with them so it really is simply a compilation of agency requests moving forward.

Over the last several years the Department of Human Services has really put together what we consider to be a weakness budget, which was really trying to look at what common human service needs were across the state and across the spectrum of the program. Which is, you can imagine, that agency request budget ends up being about twice the amount of what was eventually approved. That was, and I think some unique state agency has started to look at what the needs are rather than trying to predict what may or may not be available [inaudible]...trying to stick within some [inaudible].

Fairly successful, we've gone out into communities to get input on the budget. Really our policy forms, per se, but they're opportunities to let folks in communities know what health and human services are being provided, what the budget looks like, get some input from communities around the state as to what some of their priorities are. Likewise, we need to put together...all agencies are being asked to put together what is a 25% reduction [inaudible] for the Department of Administrative Services. That will be later in the summer as well. That's being done, I think, in anticipation of what is likely to be a very difficult budget cut in this situation. Right now, looking at, potentially, a 2-2.5 billion dollar shortfall. A lot of that being driven by loss of a substantial amount of federal stimulus dollars that helped keep the budget together over this [inaudible].

I'll continue to keep the board apprised of...as we put together the budget, we certainly had, you know, some input from some policy [inaudible]. And as we continue to move forward I'll keep the board...

[pause in audio]

...both the budget and the reduction would start to [inaudible]. So let me stop there and see if there's any questions.
NEW SPEAKER: [inaudible]. I wanted to comment, the report sounded very excited about some of these measures. Their enrollment in the kids program is looking strong. The PULSE enrollment, very excited about that...

[pause in audio]

...I had a couple thoughts. One is, you [inaudible] me that we may be, it might be [inaudible] for us to have small one- or two-person committee of the board that's the budget committee to do some review of [inaudible]...review of the budget. Particularly as we get to some of these new federal funds. And we want to put some thought into that so I'm just going to put that as a placeholder for our thinking. It might be a responsible thing to do.

So that's that piece. Um, a couple things on the report. It would be extraordinary...I love this report. I actually think it's a great document for us publically because there's our [inaudible]. If we could add to it, just like we have the workgroup committees. That report was great, by the way, just a nice summary report. But the staff in [inaudible] that we're not updating on [inaudible] to exchanges or the [inaudible] of land, technology. So if we could have some similar structure...

[pause in audio]

...try to understand our 800,000 lives [inaudible]. And so my last question to you, [inaudible], is have we made any [inaudible]?

>> NEW SPEAKER: Well, yes, but not enough. I think that we've now gotten some of them on board. And I think that John Griffin can help some.

>> NEW SPEAKER: [inaudible]. Because I think this is [inaudible over general laughter].

>> NEW SPEAKER: Yeah, to lead that effort. So I think we're beginning that. In turn, what I would say is this: what we've learned over the last three/four months has been a lot of information, little of which is compatible. And so we can present a lot of information about the employees, how that information

[pause in audio]

...the definitions are different. And we have quite a bit of work before us over the next several months getting that into a form that's comparable. And I've...so the work is really just beginning. And I've been reluctant to provide a lot of information that's really difficult to draw comparisons to because it's apples and oranges. And so as we get a little better with that over the next month, we'll have more. But John, and we also have working with us on [inaudible] for a couple months. We have Dr. [inaudible] who was
the chief medical officer for the president for many years. He's recently retired, but he's helping us put that together as well. So I think that'll be next...but you know, my goal is that by the summer we'll have some rudimentary things and then we'll have more of a process later on.

>> NEW SPEAKER: Questions for Bruce?

>> NEW SPEAKER: I simply want to add my news on the report and the contacts with the [inaudible]. And I feel good about that. I want to acknowledge the participation of [inaudible] for making that one possible and then [inaudible]. So we are making progress.

>> NEW SPEAKER: Um, we have a very full and interesting agenda today. A lot, but a lot of good stuff going on. We'll start with a report with regard to [inaudible] health immigration. Bruce, a comment or two about that?

>> NEW SPEAKER: Well, I just wanted to introduce Richard Harris. Richard Harris is the director of our additions and general health agreements [inaudible] for all its programs. Richard has worked many marathons, having led Central City [inaudible] so he has a tremendous amount of experience in how behavioral health and [inaudible] services are [inaudible] that community level. And what we've been really working to do is really begin to focus more on on how we can integrate both behavioral and physical health. It's going to be...as an industry it can help drive value and quality. And will be...I think today's agenda is really structured on beginning to show some of where we are, some problems here out in central Oregon. And hopefully some vision for where we can move some of this, which we'll get to later in the agenda. And so it's great to have Richard.

>> NEW SPEAKER: Well, thank you, Bruce. Good morning. How [inaudible] the board members. This is actually...[largely inaudible]...because it's seems that we have a lot to be thinking about about the state's healthcare systems. [inaudible]...[pause in audio]

...I think the first question is, the question we begin, is that now that most of us who were admitted [inaudible] healthcare servies for some time understand that people don't come to us that just want to talk. They have issues and if we don't address those we end up with having people spend...have more expenses in our folder versus those.

There's no question that the services for people with mental health and healthcare lagging behind is no [inaudible]. The fact that people die a lot earlier with mental health issue problems [inaudible]...and if we don't in some way or another start to address those, they will continue [inaudible]. And that's another reason we need to be addressing this. I think that [inaudible]...Now that seems to be enhanced by the fact that we have federal health reform. It's also [inaudible]...The average person with mental health issues dies somewhere between 20 to 25 years earlier than people who don't have that problem. If
you add in [inaudible]...so it isn't just a matter of preserving somebody's later life. It's a matter of doing early intervention.

So we are serving a population of people that mental health is an affliction. And this is a chart that we've used a lot. We've done [inaudible] studies which would tell you that we have a lot more people with addiction and mental health issues and they're going [inaudible]...folks here in central Oregon about specific studies about how that shows up in our healthcare system. But you can see, in terms of meeting the [inaudible]...

The other characteristic of the system, not unlike the general healthcare system is that we spend a lot of resources on a small number of individuals...

[pause in audio]

...[inaudible]. Which means that we're [inaudible] at the residential facility. [largely inaudible]. The system tends to be complicated in many ways. But in order to...when the Oregon Health Plan was initiated...[inaudible] and you have what's known as the mental health organization and they are managing...

[pause in audio]

...so we then have two different kinds of managed care going on. One from that health services, the other for healthcare outpatient addiction services. So those two systems don't really talk to one another in a business-like way, but they serve the same client.

Then we have our dedicated services, which are those services that are in financial agreements with the [inaudible] candidates which pay for those mental health addiction services which are outside the main sphere. [inaudible]. So [inaudible] contact mechanisms that are through the state and the county, but they [inaudible].

So we went to the legislature and were engaged in conversation with [inaudible] about how we're going to push these things together, how we're going to make sense out of this. [inaudible] the legislature that we needed to do some changes and during the course of that time in the Ways and Means budget committee we made a presentation and worked with that committee around putting together a demonstration project around how you could integrate the services and how you could integrate the management and how you could integrate the finance. On three levels. So we were trying to make sure we had a system that was focused on the way we integrated the task.

So it's really about what the results of that were...

[pause in audio]
...consisting of serving more individuals with a higher quality of care. And so here were some of the very specific goals of the demonstration. So leaving the legislature, we weren't given a pile of money to go off and do this, but we managed to put together some resources that we directed. And Jane Ellen and [inaudible] and our staff has been working with the two projects that are currently going. You'll hear more about those as we go on. So there were really three conceptual frameworks to these. One is the [inaudible]. I'd like to talk about that. That's really [inaudible]...a more collaborative model, which is a model of behavioral health and healthcare services. And integrate a little bit about [inaudible].

So in case you haven't seen [inaudible] yet, [inaudible]. That's for behavioral health and health immigration. And in [inaudible] we aimed to do a way we're going to improve population count. We have groups of people we're underserving now.

And we have to address [inaudible]. And we do have to enhance the patient experience in care because it isn't just going to their hospital or being called in out-patient [inaudible]. The real goal is about being self-sufficient and able to manage their own lives. [inaudible] that require management over a lifelong period. So we're using a recovery model now in mental health and addiction services [inaudible]. Then we also need to move more away from...

[pause in audio]

...and we also to do the same [inaudible]. And we think that that is not just a short-term benefit, but we are actively moving people in recovery and it reduces cost because they don't come back into the system. So, but potentially, the four quadrant model is the thing we're looking at when we're trying to determine what core services people might need, recognizing that we would [inaudible] in the low behavioral health and the low physical health category. But there's not many of us that can show up. Most people that show up in our system are in one of the other quadrants and, of course, the most difficult population are those that coexist [inaudible].

[pause in audio]

...which is doubly important that healthcare system and the addiction to the health system are working together [inaudible].

>> NEW SPEAKER: I understand most of the [inaudible]

>> BOTH: [inaudible back and forth]

>> NEW SPEAKER: Okay, thank you, thank you.

>> NEW SPEAKER: So the four quadrant model really is the one that we're using [inaudible;e]. So we're making sure that we're trying to move people to less acute conditions. That's the primary goal.
So...and there's many ways to do this. And the primary medical homes and the neighbor health homes and these guys do that in many ways [inaudible].

[pause in audio]

...it's somewhat easier to integrate services. It's more difficult to integrate financing because all the financing mechanisms have their own rules and regulations. [inaudible]. They also...there's a big issue about how you integrate the governments of these programs. When we said we wanted to do a demonstration project, we insisted that we have to work in these three areas, that we can't just integrate services without integrating finance mechanisms. That we can't integrate those two things unless you have some level of governance that's integrated that brings those together. Otherwise, they'll all go back to their own separate rooms and start planning [inaudible]. All of them are significant and they actually all have to be addressed in some simultaneous ordinance. We're not going to achieve a level of [inaudible]...the social workers and nurses talk to one another and [inaudible]. And as the demonstration [inaudible] and ordinance have shown, you have to go back to question everything the state does. We have to question what we have in the private sector as well, the local [inaudible] sector. So this is a kind of a requirement that is difficult to do, but fortunately here in central Oregon folks have actually come up with a pretty good idea about how to manage this and you'll hear all about it.

So just a couple of [inaudible] that we're looking for here: the result of this demonstration projects is that, you know, we want to pay attention to this tripling results and here's the way we sort them out.

So the process today...

[pause in audio]

...two voluntary regions here in the three counties here in central Oregon and the three counties in eastern Oregon, [inaudible] and Baker County. How could I forget about Baker County?

[general laughter]

And the one here in central Oregon is over the track and is down by how it's going to go about doing it's business. And I think it's pretty ideal in the sense that it's in all of the counties, the private sector, and the public service entities. And the mental health organizations and the managed care organizations. So it's bringing everybody together to try to work through these issues. And this resulted in the development of the regional health affiliate so you're going to hear more about that.
The current project, this focused on ER diversions and managing people who come into the ER...

[pause in audio]

...the ER is the sort of place where this all shows up. So when we looked at who was in the ER here in central Oregon, as you can see by this flag, we [inaudible]...ave been looking at what brought them to the ER. And you can see kind of the diagnosis where the majority of them are in fact, they're mental and addiction issues and that's what brought them to the ER.

>> NEW SPEAKER: Yes, we have a question.

>> NEW SPEAKER: Can I ask a question about how corrections...can you just talk about how corrections play into it [inaudible]...

>> NEW SPEAKER: Well, I think your question is really aimed at...or really sort of two kinds of mental health systems. There's the public one for mental health and then there's the jail/prison system. In reality this is the sort of...the bulk situation in many communities that people who are involved in criminal justice [inaudible]...In the integration projects, we said that we were going to concentrate on the healthcare side of it. That we weren't going to make an effort at this point to try to integrate the criminal justice side of it.

But it's come up here. Central Oregon is the sort of the secondary, this-is-what-we-have-to-do-next because in that counties and local communities vary cost [inaudible]. The jail system, which is the place where people go, where they end up when they have certain kinds of incidents. They end up there and you hear alcoholism and drug addiction a lot. So it's low-recognized. I don't think [inaudible] chose actively not to try to go to every business. It's going to be a difficult enough task to integrate just the healthcare [inaudible].

>> NEW SPEAKER: And so, even after release, you haven't sort of opened that population...

>> NEW SPEAKER: Well, I think what the [inaudible] communities would tell me is that when people, when they come back to the community, they get engaged in all of these things. And most community justice programs have made efforts to do that. And I'm partnered [inaudible] where, in fact, we operated those programs for years, provided housing and treatment. But it was really wasn't seen an intervention project to also give people healthcare, which is one of the major problems in our system is that people don't come out of the prison and they don't have...they're not members of Oregon Health Lab. So their health service need are not being met. Their health needs are only marginally
being met. So it's a big issue that I think the state and the communities are going to have [inaudible]...

>> NEW SPEAKER: Richard, I find some of this...it may [inaudible]...

[pause in audio]

>> NEW SPEAKER: ...the study that these numbers came from, there were some of the physical healthcare, but they weren't...

[pause in audio]

...it just wasn't contained in the data. But so, I think that what has happened here is that there's an effort to target people at this level because they're consuming wide numers of services and are repeated visitors to the ER. And that is typical of the way that people that aren't being served fully are going to end up in a bad healthcare environment.

[pause in audio]

...similar emergency room diversion project, identifying people who are utilizers has been put in place to start to [inaudible] more integrated mechanisms to ensure people don't go back to the ER repeatedly. So there's a little bit of data coming from that project. It will be more as we get further into it.

And so in the high utilizers in the three counties in northeast Oregon, they collected data a little differently to establish what they needed. Rodney was pretty clear that, in this case, it was just a health plus pain medication that was driving a lot of business into the hospital, with some in-home. Being a person [inaudible] was suspicious that the pain medication...

[pause in audio]

...equally important to the process with integration and that is that we started with a mental health initiative, which is an attempt to get managed care utilization into our residential and institutional care system so that we are managing along the lines of reducing the length of stay. That will help us serve more individuals. Moving people to community based programs where they have access to housing and employment services. And keeping people out of state institution because, at this point right now, we have overcrowded state hospitals, we have overcrowded residential facilities and what we need is people that people that need a hand in the community.

So this is another aspect of integrating mental health services within the mental health department, which also allows us then on a how-they-should basis instead of always [inaudible] residential facilities. That project, as you can see, is going along...
...those two things are [inaudible]. So we're down in the plumbing of the mental health system, trying to connect the pipes together so we get a better flow. [inaudible] overall efforts to do integration on a larger scale in the healthcare system because we won't have any better managed programs within mental health. But just to conclude by saying that I think this is a great time to be working on the initiative to have the opportunity from this. I would like your consideration and dedication to the idea that this is something that ought to be guiding the Oregon Health Authority as we bring these services closer together. And if there are any other questions, I will take them now.

>> NEW SPEAKER: Mr. Harris, thank you very much. We got a little bit of a late start so we're running a little late on our agenda, but we have time for one or two quick questions.

>> NEW SPEAKER: One of the...on the presentation that was given on the webinar talked a lot about early intervention and during...and there's, like, also talk a little bit later in the evening about early intervention or [inaudible]. My question is when you're thinking of one way, and I know you have to [inaudible] acute care health programs and the exchange remember folks and how...I just have a [inaudible] about how that's helping...it doesn't meet the need of early intervention in mental health if you just have an acute care...

[pause in audio]

>> NEW SPEAKER: ...a number of [inaudible] that are now getting off operation for five more years. We're showing that you can divert people out of acute care hospitalization and...

[pause in audio]

...so that the early intervention is preventing more hospitalization. This model, which has been employed in Australia for years now, has a lot of indicators that suggest that early intervention in schizophrenia creates a more healthy person later on. They don't spend as much time in acute or chronic mental health care. Also, their general healthcare is improved so it's the ability to screen and detect the symptoms of early psychosis that aren't that difficult to detect. But it does take care and a little bit of knowledge and this has to be a speciality. It can be...

[pause in audio]

>> NEW SPEAKER: ...and one of the major reasons we are here in Bend today is that the central Oregon community and the region has done some very interesting, is doing
some very interesting things, in terms of regional healthcare. And we're looking forward to hearing a lot more about it. So I'm going to move right along and turn this over to Mike [inaudible] and Bruce Goldberg to get us started.

>> NEW SPEAKER: Let me...as Mike's getting settled, we...I wanted to frame some of the discussion, which is really what we're talking about is...and I gave Richard a [inaudible]...is what's happening here in central Oregon around behavioral health and physical health in agreement is really just the beginning of something that, I think, we see as a larger strategy of regional organizations that have some accountability for the organization and delivery of [inaudible], as well as for the health of their population. Mike, in his spare time, is also as you saw working on our logo for the board...

[general laughter]

...and I think it's a great design. We're in contract negotiations right now. We'll see whether we can [inaudible]. But this is really part of our strategy. And it really...what I want to do is just frame it from a high level and then what we'll get to soon about is what's happening here in Oregon as a start. And what I think Mike wants to take us through at the end is some discussion we've had about what really this all means in terms of new structures, new governance, et cetera.

You know, we have I think, explicity and [inaudible], organizing ourselves around Triple A and we can Wordsmith the words in each of those names, but it really is about enhancing the...

[pause in audio]

...Felicia's comment about department of corrections. We need to look at this about community and not in segmented areas of the healthcare system. So this becomes just sort of an organizational, and really it's more of an operational principle, to organize around. You know, our challenge has been that we have focused much of what we collectively have done on the small piece of medical care systems, when it's many other things that help keep us healthy. And this gets at the issues of social determinance of health that we've spoken about. But it's simply more than just medical care. It's environmental, lifestyle, public health. Sort of the larger issues that really become part of the larger TRIPLE A. You know, we've made our...

[pause in audio]

...the health authority as an organization where there's some accountability and responsibility for health and health services across the state. But this isn't going to be able to simply exist at a state level. It's got to be focused at a local and regional level as well. And, you know, our job as the health authority is to look at the sort of new structures that we can look to put forward in terms of creating some departmental community change
that we're looking for if all of us understand that simply doing more of what we're doing now--putting more resources into the same thing--is just going to get us more of the same outcomes. And we want better outcomes and new ways of doing things.

That will be how we link networks of care across the state, horizontally and vertically. There needs to be clear accountability and joint responsibility [inaudible]. Part of the issue has been there has been no accountability. There's been no accountability at the state level for how we, you know, 850,000 individuals that we're responsible for. But that really filters into all of our communities when the accountabilities are really at a very individual or local level. At a practice level. It's not a community level. It's not coordinated. And we need to be able to create the kind of structures where we can have accountability, both locally and rolled up, and the comprehensive sort of performance measurements and quality outcomes and health outcomes that we collectively want to see happen as a state, at that role up and down throughout our communities.

So, you know, the reason we're out here today is, I think, one to highlight a lot of the great work, but it really is work that's just beginning and it's that [inaudible] of change. And it's something that [inaudible] might sort of talk through, what's going on here. But this is really, I think, about how we can start to build on a foundation and look to create new ways of doing things. So Mike take it away.

>> NEW SPEAKER: Mike, you have three minutes left.

[general laughter]

>> NEW SPEAKER: Well thank you and...

>> NEW SPEAKER: [inaudible over laughter]

>> NEW SPEAKER: Thank you and good morning. It's certainly great to have everybody here. I was telling Chris and Tina, I have some anxiety of everybody coming over here and the expectations are quite high. In fact, we have [inaudible] the model here and it's safe to say we don't have the model. We are working diligently on a number of issues and I think you're going to see some...

[pause in audio]

...I think you know most of us have been working hard for many years on a number of initiatives. We're going to kind of go through those today kind of sequentially. It's been really a, you know, a five, six plus year journey. A lot of collaboration, a lot of hard work, a lot of patience, and certainly a little bit of luck I think put us to where we are today.
Um, if you have your agenda in front of you what I want to do is make sure I walk you through kind of what we're going to be discussing today. Just so we're all on the same page. Bruce went through a little bit about kind of that overview. I'm going to provide just a little bit more context from a health collaborative of really kind of how this works. It initially evolved with this collaborative health called matters [sic]. So [inaudible] is going to be...the director of Health Matters is going to be walking you through the core initiatives that set the foundation for that. And then I'm going to have Dr. Mike [inaudible] present his work in leadership with [inaudible] in central Oregon. That really kind of gets to the crux of what we've been trying to do in creating a more integrated delivery system here in central Oregon. And so I have both the [inaudible], we may be kind of shoving folks around, depending on Dr. [inaudible]'s schedule.

And then, to kind of tank onto Richard's comments, we're going to have Dr. Robin Henderson and Scott Johnson. Robin is the director of [inaudible] health services here at St. Charles and Scott is the director of general health services. And they're going to talk specifically around the acute health integration project they've been working on with the state. And then I think, to wrap it up, I think Tina and I maybe engage you with a little bit more dialogue around how we look at this from a...

...our work in central Oregon. I think this really has been kind of a core foundation of what we've [inaudible]. And I think we really have...TRIPLE A language, for many of us, whether you're from [inaudible towns in Oregon]. This has really been a key foundation for us. So, you know, look at those. Those five elements. Are there more? Absolutely. But those are just the core elements. It's really interesting when you start adding county commissioners and city councilors and school district superintendents start talking up to TRIPLE A. And you think about the power of everybody being aligned around the same vision. They're seeing the policies around the school and the counties and government become [inaudible]. It takes it kind of to the next level away from the board down to actually working to begin with.

So as Bruce said, you know, this has been a key focus on our end as well. That we do see so much...

[pause in audio]

>> NEW SPEAKER: ...just paused and talk about the relatedness of those two slides because so often in organizations like this we become fixated on the ten percent piece of the pie. These two slides are [inaudible]...they come out together. There is sixty percent of that we can categorize in broad socioeconomic educational terms that has a major impact. And that's why your slide [inaudible] is so important. Because it goes beyond the traditional healthcare system and it is enjoying an evolving community. And it's really going to change how [inaudible]...again a great presentation for all of us this evening.
NEW SPEAKER: Well thanks Joe. I think it does kind of get into the discussion at the end for us. You know, if we're in agreement with that that we do have to be thinking you do implement that from below. It's tough to do that from a single perspective and now you really start to allow local communities to be empowered.

This...this graph right here, this has kind of been some of our core work initially. And it really is...you kind of talk about the fragmentation. We're talking about how do we start to build the bridges across health and human services and the medical delivery system. And so what you're going to hear today are really our initial attempts around some of these key programs.

So on that left hand side on health and human services, we've started to outline...

[pause in audio]

...and kind of those four key initiatives that we have going. Many of those key initiatives are now starting to build bridges across and start to connect to the local community. And what we're trying to do on the local community side is get our act together and figure out how do we actually bring hospitals and physicians together to have a more integrated approach based on the TRIPLE A. And that's really what Dr. [inaudible] is going to talk about today.

So I'm going to pause right here and we're going to bring back this presentation at the end to be able [inaudible]. That's really going to be kind of the discussion more for a regional health authority. Let me, uh...

So I'm going to quickly go through this and I know we're getting short on time. But I wanted to set the stage for this whole concept of [inaudible]. Because it really has been part of a cornerstone of what we've been able to do here. And on our end this really started about five years ago, as a group of us who were involved with Volunteers in Medicine, [inaudible] this just nailed a block here. [inaudible] on the right, we saw that it was serving a great need, but it was just barely scratching the surface. And we really thought, "There's much more to this. And how are we going to get multiple stage orders to the table and talk about healthcare reform at the local level?"

So what I found interesting, what I was going around talking to [inaudible] well we kind of have this health collaborative going on in central Oregon. Everybody kind of scratched their heads and said, "What the heck is a health collaborative?" It sounds nice. But I got a lot of strange looks. But when I started trying to ask myself, you know, why the strange looks? When you start to ask yourself what does to collaborate mean, it means, you know, it means to work together, especially in a conjoint effort. Well, it sounds great. But again, when you think about getting multiple stakeholders in the room, competing stakeholders
in an adversarial relationship, people think, "Well, what are you going to do, just kind of sit around and have a good 'Kum-Ba-Yah'? Is that what it's all about?"

And it's not. So that's where I had to kind of think about is "health collaborative" the right word? And there is a second definition to collaborate. And this is probably much more related to our work, what we're trying to do. And it's really going to get everybody together to see how we can take the step forward in a competitive environment. Because if nobody kind of collaborates, everybody's going to fail. And I think that's where we actually start to have a lot of that synergy together.

And so when you look around, you can...

[pause in audio]

...you know, we've had competing entities and folks who have traditionally not gotten along that well, they've really put aside those differences to figure out how can we work together, specifically on these initiatives to figure out how we can move this forward. So I do have to give some kudos where it's [inaudible]...obviously has been certainly my mentor over a lot of this collaborative approach. So I think a lot of this terminology is her. But we've really been able to kind of embed this in the Health Matters culture. We really consider ourselves a neutral convener. So we really are looking at how do you bring people together to do all these things.

And really, kind of first, what we traditionally did was kind of assess and get that baseline data of where we're at. And then figure out what are those things that we need to be able to do.

Um, and I'm going to go through this quickly. This is a slide from Community [inaudible] in Action. There's actually an organization that really links all of these collaboratives around the nation. It's a great group where you really start to share that practice around all these issues. And when you start to boil all of those collaboratives down in terms of what they're doing, you can really kind of link them to eight critical activities. And each one of those activities, what you're trying to do is take a step forward and reorganize the delivery system to get to this future state of healthcare reform. And what you're going to hear from Alicia is really what some of those...what some of our activities are, really all of those, more of those [inaudible].

This is an important one for me because this has been a core piece. And you're going to hear about it from Alicia and even on our "links for health" program. One of the bigger issues you have today, for a state level, is when you are trying to bridge this gap between health and human services and medical delivery, there are a ton of [inaudible].

In this example we've taken of [inaudible] County, Ohio...Dr. [inaudible] kind of pioneers in breaking a lot of these barriers down...but when they were targeting at-risk pregnant
teens, they found that that one individual was being touched by a minimum of 13 different state and federal agencies. At any one time, they had seven different caseworkers. Everybody in [inaudible], nobody talking to each other. Nobody being held accountable to an outcome. Nobody being held accountable to [inaudible]. They thought this was just obviously a travesty. They wanted to turn it upside down. And they did.

And they created something, what they refer to to as a community health hub, that basically allows all of that funding to go into one pod and allow a single community health worker to really help navigate and guide that individual through the system and be rewarded on the outcome. They actually have set up a system where that community is incentivized based on the outcome of the [inaudible]. So you have the whole continuum, from engagement all the way through to the outcome. So they've started to build up different pathways and this has been a core of our work here in building up pathways to help people navigate and get through the system and get involved in the outcome. So it's been, I think, something fundamental for the state to even think about because this really gets to the local charge of how do you start to blend funding, how do you start to pull [inaudible]...

[pause in audio]

...for us, that we emulated for the first few years if we got going on a day there was some outstanding work. Clients have been doing work. Jefferson regional health, Jackson, Josephine, and the NEON, the Northeastern Oregon Network in the northeast and then Project Access now. Everybody's focusing on different elements, everybody's at different levels of readiness. So I think I just want to make sure we're all clear, you know, Health Matters is not the only one in the state. We've got a lot of other activity going on.

Um, and I see, you know, Ray, Eileen, and Chuck, this was a part of certainly the health focus your focus. I think there was an understanding that you really could have some local innovation that could actually help stimulate some healthcare reform. And this is really what we've been trying to incorporate into our work. So any questions before we kind of get in? I just wanted to make sure we kind of set the stage the stage for that.

>> NEW SPEAKER: Mike, I just have a question, and it might be coming up later, but when I look at this it's like blue sky. And Richard really had me grounded in some of the real problems of moving forward. Governance, finances, and services. You know, I mean, [inaudible].

>> NEW SPEAKER: I will say we don't have all of those answers, I think we've just kind of put our foot in the water to try to explore that. But I think there's still a lot more work to be done.

[general pause]
NEW SPEAKER: Thank you for having us here today. We really appreciate the opportunity to share in great work by coming out to central Oregon. So thank you very much. Our vision is to develop and implement an innovative strategy that improves health through the participation of the central Oregon community. And Mike touched on a number of things today that really are becoming actively involved in our community and partners in our community. And that's a very key element to the work that we're trying to do. It's not just a bunch of people trying to make change. It's really the community-at-large coming together. And we have a very diverse forum with multiple stakeholders. But not only at that level...

...of the initiative. So it's very much a community effort. And a community based project. So it's a pretty exciting time. And as you've seen, our board of directors, we have a very diverse group of people that normally don't work together well, they're over raucous laughter. And it's really...you think, "Well, this really wouldn't work well together. They'd come around the table and things get bad." And in a very short time and I joined and we became a horrible. We have accomplished a great amount in this very, very short time. And so it's really kudos to our community and to the board of directors. They really stay in there and push forward and they were not about to stop. They've been like action and they very much let me know that. And my...

...things can happen. And so I'm really very, very proud to be a part of the organization. And just a kind of background: when I came on, there was a big, steep learning curve. I had never heard of a health collaborative myself. And so I pretty much surrounded myself with some mentors, being one and Mike and a group called Communities Joined in Action. There's other health collaboratives across the nation that are really doing great grassroots work. And without some of their inspiration and their best practices, we would.

We've taken a lot of really great, innovative ideas that happened in communities such as ours and really tried to bring those in based on some of the need for...coverage area, the needs assessment back in 2005 and 2006. And from that original needs assessment, they uncovered...just to scratch the surface we have access issues, coverage issues, prevention and wellness. And so those are the first four target areas that the board charged me to go out and really start helping develop key initiatives around those target areas. And so from that, know that it's just to scratch the surface. There's so much more work to be done. But it's definitely something in the right direction, a step forward.

But in Jefferson County alone we're ranked the highest health risk and health for the county health status, we're in the county's list for 2010. And that's, you know, it's
part of our [inaudible] area. So it's a very good focus. We did and Kirk and Jefferson County. Our big focus is on Health Matters.

The first four initiatives that we're targeting in our community, [inaudible] Central Oregon needs for health, and the sharecare [inaudible] status of central Oregon. So they're just four target areas and we'll kind of go over those later. And everything in these target areas ties back into the original needs [inaudible].

[inaudible] is a program with the Population Health Management Initiative that basically is just here to empower the individuals in our community with more information, more knowledge to help them become better in terms of healthcare, to make better healthy lifestyle changes. Um, it gives health coaching, health online tools for our population's to come in together and to learn more about what they can do in their life and also in their healthcare. And also provides health risk assessment tools and opportunities. This benefit is offered...is only offered to our Sharecare members that are coming online shortly. And also to local employers. And it's really [inaudible] a plan, the board has really encouraged the fact as small employers, most of our population here is 94-96% small employers based on, you know, often times now they can't afford some of the tools that they would need in order to help reduce absenteeism, increase [inaudible] and turnover. And so you're looking at ways of collectively bringing everyone together...

[pause in audio]

...more people. And we also have the Living Well Central Oregon program. And this program we...when we came online to use it, the Stanford Model, which is the chronic disease self-management program, was working really, really well here in [inaudible] County. [inaudible] County health services program has been working and working with St. Charles health system, but it was just [inaudible] and it was a program that really needed some additional support, collaboration, and also to take it to the next level, it really is a program that needed to reach...

[pause in audio]

...we put together a regional advisory, kind of [inaudible] that consists of health department directors in Kirk County, people from the hospital in [inaudible] County, some individuals that are...had [inaudible] horses that were interested in being active participants in care for others. And we've been able to work this program tremendously. We secured a grant with the Jackson [inaudible] Foundation in order to support the program, leveraged partnerships with the county. And so the program has grown tremendously. In 2010, we were able to have 17 workshops with over 223 people registered. And this year alone, we've had 7 workshops with 85 people registered. We are targeting [inaudible] and so we have health trainings going around that region and we already have trainings in Health and Health Matters and we have a number of staff that want to do training...
...a really full-fledged regional effort.

The other initiative that we have, which is absolutely...it's a milestone I think here in Oregon. And it's very exciting to see this come alive and for me to be a part of it. It's the community health improvement plan. It is made possible because...

...we really thought that this is a really, really great initiative to bring to the small business employers especially that could not afford the additional health insurance and also do not qualify for OHP and other state-assisted plans. So there's that gap, that lost gap, that they are self-paying, and maybe going bankrupt, and they have health and major...

...luckily we have two of them along with some of your [inaudible]. We've been charged to get bill 862-3 so when that happened, it was a landmark, it was landmark. It was just huge excitement over here on the east side of the mountains. So we knew that we could possibly make this happen. And in a very, very short time. That happened in 2009. We're now in April of 2010 and they're ready to launch our product and at the receipt [inaudible] in January, we'd been able to pull numerous community members together to help build an ethics plan. We have credit exclusions, inclusions, and what it is, what it isn't. Using the administrative role with the state and working very closely with the state, we've been able to really I think, put together a pretty amazing product for our community that's currently underserved and uninsured.

With the Sharecare, [inaudible aside]...with the Sharecare, we'll only focus current issues in [inaudible] County. So it's very targeted just for this community, services will not be provided outside of the community and it is [inaudible] in the community. So it's very much risk-sharing, cost-sharing, and it's all within our community here.

>> NEW SPEAKER: If I could just hit on a few things: there's a lot of documentation we've supplied about Sharecare. Some ethic cues and just our brochure. So there's more information you may want to look through. But again, this is an inclusion method. This goes along with looking at the [inaudible]. And I do want to acknowledge Patrick O'Keefe. I hate to put you on the spot, but Patrick is a Health Matters board member and a local insurance broker, owns Cascade Insurance. He has been absolutely instrumental in launching this product. He has been leading a core group for the last probably four months. So without his leadership, we would not be here today. So I kind of had a chair
up here if Patrick wants to come up. He would serve well with his comments, but I don't want to put you on the spot.

[general laughter]

>> NEW SPEAKER: SO Sharecare is made affordable...it basically offers affordable care. And we...the goal of the program based on best practices around the nation, the seed in Michigan was kind of the start of the whole priceshare concept and how you can really take that group that's really missing in the gap and get him into the system and into the care that they need. But in order to do that, you really need to make them empower this population to be the consumers of healthcare to also support the providers that they're seeking care from, to have a tight front door.

So the goal of the program is when they come on, we immediately get them into a plan where they have care coordination, health education, [inaudible] responsibility. And it's really driven home to empower this population that this is not a freebie. This is something that we all have to do together as a community. If we're not completing this together then we'll fail.

And so it's very much driven with the staff of Health Matters. We're all doing our dual roleplays on how this is going to work because this is all new. And so it's very important, I think, that when we went back to [inaudible] Patrick went with a team with us and we were able to do learning...kind of a learning session with this vegan group that has been around for almost 11 years. And they are very viable and they have a very strong community now that, at first, wasn't as engaged of a community. And if they can do it, we can do it here in central Oregon. And so I know that learning and having the group together is a key thing. Do you have any...?

NEW SPEAKERS: [inaudible over each other].

NEW SPEAKER: I want to kind of concentrate on that for a second. My business is health insurance employment. I've done it for 17 years here in central Oregon. And I can say that this is the population that isn't getting served. They are not on OHP, they are on group health plans, they're not on individual health plans. I was in a meeting once and [inaudible]. This was four years ago. And this population wasn't getting health then either. It is not and will not be available in a group health plan.

Some [inaudible]...and in terms of probably the needs of this population also [inaudible]...either without healthcare or the emergency room, the type of programs that are involved, the things that are associated with Sharecare, I think are huge. Because I think there's probably a population that has the greatest needs for this program also. And I can tell you from group health plans, there's a lot of focus the past couple of years...

[pause in audio]
...best efforts that insurance companies can't do. [inaudible]...

>> NEW SPEAKER: As you see also here that uninsured workers that we're targeting are small businesses with 1-50 employees. So we are kind of with the state mandate accepting sole proprietors. So the goal of it is to be inclusive of that population that normally [inaudible].

And how it works is the employees pay a portion, the employers pay a portion, and [inaudible] pays a portion. So it's definitely a multi-share. It's a community-based product. It will not work without all the parties at the table, playing. So our goal is to encourage the...encourage really the responsibilities. So we have a sustainable program long-term. The premiums that we're starting with: if you have a health improvement plan which is a more in-depth plan, it offers not just the health risk assessment and some of the screening and education up front, but it also requires the members to go to a number of classes in the community during the year, go to some online learning that's uses the Trails to Health program, some online learning modules. If they have some subprime conditions, we'll get them focused on some additional resources in order to help improve their prime conditions and some of their outlying...

[pause in audio]

...standard plan is the plan that is...you still have the [inaudible], you have the helath risk assessment, and you have education, but you don't have some of the other criteria that are required such as the extra online learning and educational classes in the community. So it's definitely...it is an option, but it's a much higher rate if they don't go through the health improvement plan. [inaudible] definitely improve their health.

So the hope being that the healthier community management, all of that, the stakeholders get employers, the hospitals, physicists and patients, and there's definitely increased productivity, increased revenue, and decreased cost and improved health. It is a [inaudible], it's all about working very closely with...contact with the Oregon Health Authority and [inaudible] and we're working on the return on community investment and how we can give really great data to the state and sort of for the state to really look at this as a model long-term. [inaudible] because it is being in the state, and also to make it...kind of show our community what we're able to do here at the grassroots level.

So the eligibility and I won't read through all this now, but I can...you have it at your disposal. And feel free to call us anytime at the office. We would be willing to answer questions as needed. But there are definitely very strict eligibility requirements. And we are very...we have a good structure in place that we're calling [inaudible]. We'll make sure that we adhere to the state guidelines and also that we're not allowing people on the plan that can have conditional insurance or that can afford it, et cetera. It's definitely targeted.
Um, the benefits: if we look at it, it's not an insurance plan but there are standard preventatives and [inaudible] that are very important and very much needed and they're in this plan. And so our goal is to offer benefits to help improve our foundation population without, kind of, over...see the exclusions. There's things that are not included in the plan. You have to be in the tri-county area, you're not going to have to just kind of an area I'm serving that are...that you would normally have an additional plan. And the main thing is the use of the ER for non-emergency services. Our goal is to really educate our population to not go to the ER unless there's an emergency. So that's kind of a key cornerstone to the product.

So do you have any other things to share on Sharecare?

>> NEW SPEAKER: Um, the one thing I want to make sure that we're clear with Sharecare is that it is not the silver bullet. It's a great program; we're very excited about having it. But it is going to cover a portion of that gap that we talked about. There's only so many a resource that we can put out there to cover everybody right now. So I don't everybody watching to say, you know, "MULTISHARE is the way!" It is a way. It is a niche. The one thing that I found very intriguing about this though is that if you read, and I still have more work to do, but if you look at the federal legislation that was just passed, there is something in there that could allow this to become a community option. So I think we're intrigued to see, you know, how can we build Sharecare to be something more than what we currently have in this. So that would give us, you know, some time to kind of, you know, have this evolve. But I think what we have in place is going to be a solid start. But I would love to get the numbers, you know, to cover 40,000 uninsured, something that we could be much more robust.

NEW SPEAKER: Well Mike, what was really interesting too was a meeting I went to on federal reform. This is exactly the population it was talking about in that federal reform as well, the low-income [inaudible].

>> NEW SPEAKER: Right, thanks.

>> NEW SPEAKER: [inaudible]...I don't understand who administers this plan. I mean, who's looking at the medical [inaudible]?

>> NEW SPEAKER: Oh, this is Health Matters.

>> NEW SPEAKER: Health Matters. Which is...?

>> NEW SPEAKER: Health Matters is administering the plan. And we are [inaudible] with the state, the state is very much looking, we have to provide back to the state on a monthly basis. And it's due every quarter, but we would retake it on a monthly basis because we are new. We will have a medicine director on board, we have two nurses on
board, and we also have the [inaudible]. But you would have...in the traditional insurance you have some of the staffing that goes with that. We have those members on board, but we are definitely...

>> NEW SPEAKER: Is it a non-profit?

>> NEW SPEAKER: We are a non-profit.

>> NEW SPEAKER: But it's not a health plan.

>> NEW SPEAKER: But it's not a health plan. It's not a health plan. I'm sorry, I'm missing something.

>> NEW SPEAKER: It's a very good question. I think we were very clear in Senate Bill 862...

[pause in audio]

...so really you're talking about this non-insurance...

>> NEW SPEAKER: But you're paying for medical services?

>> NEW SPEAKER: You're paying for medical services, but they're not through an insurance-type basis...

[pause in audio]

>> NEW SPEAKER: It just seems like an insurance plan to me. [inaudible]...so I can get it.

>> NEW SPEAKER: Well, if you think of traditional insurance, you're thinking of covering against all things. And this is not that. This is really the community coming together to say we have X number of dollars to cover X number of people with this limited infrastructure. And that's what it is. I mean, when you look at those exclusions that's a big list. At the same time, you could do...

[pause in audio]

>> NEW SPEAKER: ...to begin with. And it's just something that, you know, just [inaudible]...is that we end up with an exchange with an...a [inaudible] exchange. This is a type...can you imagine this as a type of, I'm not going to call it an insurance plan, a type of community option that could be offered in an exchange at a regional level.
NEW SPEAKER: It's possible, but again, I think it's important that we understand the limitations...

[pause in audio]

...again, there are the trade-offs of what we're trying to do. So again, it's not typical insurance where you'd actually take it and have it cover anywhere.

NEW SPEAKER: [inaudible], it seems like a club membership.

NEW SPEAKER: It's a different kind.

NEW SPEAKER: So let me see if I understand this. So they employee percent...so you have to be employed. If you're not in the labor workforce...

[pause in audio]

NEW SPEAKERS: [inaudible over each other]

NEW SPEAKER: ...focused on, I mean, how you had community resources to support all this.

NEW SPEAKER: Out of charity care from the hospital and the doctor that are coming together to support this, it can't be understated.

NEW SPEAKER: And actually that was my next question. Because if we have 30% employer, 30% employee, community 40%, and who is...commission, like philanthropy or grants?

NEW SPEAKER: The big thing...when I had my comments, part of our work has been based on a little bit of luck. The luck has been the timing of the Senate bill being passed, the timing has been kind of working with the state to get a [inaudible] grant approved that was targeting our program. So the timing of it just happened to work. So a lot of those community funds right now are going to be based on some support from the state and federal government and in addition with some of our funding that we have.

NEW SPEAKER: And that would be the sustainability part?

NEW SPEAKER: That's right.

NEW SPEAKER: So if you pay less, you get health improvement, but you get more stuff. It's like they said, the online helping assessment and with certain things you pay less and if you don't do that, then you pay more, is that right?
NEW SPEAKER: Just to give you an idea, when [inaudible] started back in 1998, they had their monthly premiums at $44 a month for every member and now they're at $46. So it...talk about truly bending the cost curve. They've done an amazing job of managing the population health and being extremely proactive of who's under that [inaudible].

NEW SPEAKER: Just in terms of the insurance it really is an interesting thing. For starters, it's like, how do you [inaudible]...because there is, you're right, there are similarities. There are people getting care, payment is getting shared, there is, you know...so it does look like insurance. I think--and I'm just saying this as I'm sitting here--if you think of a sphere which is the insurance industry, how typical insurance works, and you carve out a smaller sphere in that sphere, it does some of the same things but it doesn't do everything that the rest of that sphere does. That's what some of these [inaudible] acknowledge because, otherwise, [inaudible mumbling]...This isn't precise. [inaudible] carve out a certain portion of insurance and saying, "Well, this is what it does" and then adding some things to that, but not doing everything insurance typically does...

[pause in audio]

NEW SPEAKER: I just want to see how this all works and how it plays out at the community level. The other piece is, and the coming-together consignment is part of the community funding, is using safety net services. The [inaudible] program safety net services so that's...

NEW SPEAKER: Yeah, I think that's very key and that was touched on was the community resources. It's very, very much important in this in model. So if there's community resources already in play we will direct our population base to the community resources already active in their [inaudible]. So it's very much working with the community that's already in place. And another big point is the Oregon Health Authority really is looking very closely at what we're doing and monitoring...I'm on the, I would say, a couple times to three, four times a week to make sure that everything we do is very much strategic and very much in line with legislation and very much in order of what the senate bill was meant to do and what also the administrative roles are mandating what we do. So I think that for us to say, you know, we are a health improvement plan and we are a health collaborative that is allowed to do this health improvement plan. And they would like something limited, not very much different. And it's a very [inaudible] way of looking at the...helping the population and using community resources and giving the state oversight to make it happen.

NEW SPEAKER: One real quick thing that I think is significant to [inaudible]...one thing I do think though is the population, as they go through [inaudible], if and when they transfer onto some other type of actual health plan because their employer gets a new plan or federal legislation makes access easier than before, they'll be far more educated.
[largely inaudible]...has experience in what we do in the system...knowing what it should look like...

>> NEW SPEAKER: Yes?

>> NEW SPEAKER: So maybe [inaudible] a little longer because as I'm looking at the [inaudible], we're not making that [inaudible] happen, I'm guessing? But I just have a quick question about something. When you [inaudible]...

>> NEW SPEAKER: Honestly, when this built, the community built it. So it was not built by Health Matters staff, it was built by community. So I think, as we go along, we'll look at things and adjust as things are brought to our attention. And definitely tweak things as we go. So it's definitely a newly built plan.

>> NEW SPEAKER: What I would like to do...I'm going to take a break from the Health Matters plan because I have Dr. [inaudible] and I want to kind of get into...I don't want to [inaudible] his time. So we're going to come back, finish up with the Links for Health program, but I want to bring Dr. [inaudible] to talk some more about the [inaudible].

[general pause]

>> NEW SPEAKER: My name is Mike [inaudible]. I'm a neurologist. I've been in private practice in Bend for 23 years and, um...

[pause in audio]

...came to Bend 23 years ago, this medical community was considered a shining example of a rural medical community with very high-caliber healthcare. And, over the years, I believe that the caliber of healthcare is really extremely high, but because of many of the things that have influenced and objected hospitals and physicians in other communities [inaudible] the relationships and the ways of the practice of healthcare delivery have come under significant pressure and basically the atmosphere and chemistry has changed in many, many ways.

So about 18 months ago, a number of physicians, primarily surgical specialists, began visiting with each other, essentially having informal conversations about what was changing and how it [inaudible] with our physician core and in the management of our practices. And so these infrequent, informal discussions began to pick up pace about a year ago. In talking about things such as maybe the surgeons could form surgical IPA, maybe we could form buying groups, maybe we could figure some regulatory structure that we could contract in a more focused way. And so the discussions led us to realize that, as we tried to pull the physician groups together, we really needed to address the fact that, in our community, an element of acrimony, distrust, basically political poison was developing here. And there are many,
many factors in that. And I don't think we're unique. But it got to the point where one large group of physicians had essentially declared war with the hospital. And in between were smaller groups of physicians--onesies, twosies, threesies, foursies that didn't really know where to land. And there was significant fear through this confusion. And tremendous anxiety, as you can imagine.

I won't go into the details of some of the specific things that happened, but basically this group of surgeons became familiar with a concept called physician-hospital alignment. And we began to study this and began to read a bit about the ways that physicians and hospitals around the country were relating to each other in different ways and working with each other in different ways.

Well, several of us in this specialist group, if you will, brought this concept of physician-hospital alignment to the group. And within that small group, that concept of getting together and working with hospital caused a significant fracture. And there were several surgical groups that basically said if you align with the hospitals, whatever that means, we're out. The majority of the group said that we're going to forge ahead with this and figure out a way that we can make this work.

So about a year ago at the hospital strategic retreat, the hospital system had made a very clear-cut decision to form their strategic plans around TRIPLE A. And we were familiar with TRIPLE A and then as we read more about the concept of physician-hospital alignment. And so what we did was we wrote a mission statement and a code of conduct. And the mission statement was based around the TRIPLE A, which I believe everybody here is very familiar with. But it was a new concept for doctor...

[pause in audio]

...and, you know, we're probably co-dependent from the time we grow up and we want to be fixers and take care of people and that's what we do. But for the most part...

[pause in audio]

...physician groups together. And then really realizing that the more we read of why we needed to do something here in terms of pulling the hospital and the physicians together, I think it's, you know, to me it's simple, but you'd believe how many arguments I get into when I say that physicians and hospitals must work together. And that's not the belief of many physicians. And we can get into that a little bit more.

But the assumptions you can see on the screen are many of the assumptions that we made as we sat and began to put together our plan. So we wrote a mission statement and the mission statement was...I've been somebody who always thought that mission statements were pretty stupid, to be honest.
And of all the mission statements that I've ever read, if you took it into the next room and asked somebody to read it and they couldn't tell you what business it was written for or what group it was written for...we tried to write a mission statement that was pretty specific. And so it was this...our group of physicians would work with the St. Charles health system and their partners...

...that we were aligning with the hospital's philosophy. Because there's so much acrimony in the community and we were trying to figure ways to contain that, we put in a code of conduct. And, you know, the original code of conduct, someone said, "Well, let's just [inaudible] the first day you go to first grade." Play nice in the sandbox. And that's essentially what the code of conduct was meant to do. But the idea was that there would be, for the first time in a group, a line. And a line that addresses behavior, because most physician groups never have that line. And so you just get along and pass along and I think many of us in the audience have seen that. So we're very serious about the code of conduct issue.

So having put that together, those of us in the core group then began to go out and talk to physician groups. And it was very interesting as we did so. There were doctors who looked at that and said, "I'm signing." And there were doctors who looked at that who said, "Let me get back to you after I talk to my lawyer..."

...I took this to the St. Charles assistant board of directors. And on July 20 of last year they adopted and embraced this...

...see how it was going to change everything that night. But things that happened almost immediately were the fact that, and it wasn't so much our intention to see this, but it upended the whole medical staff of our medical community. Because there was much contentiousness on the medical staff and the medical staff governed everything through was not working well in the hospital. The medical staff leadership was taking the medical staff...

...Now, we decided that we would not reinvent the wheel. I mean, we knew this was going to be a difficult process because of the political climate and physician's spirit change fundamentally. But we became familiar with different groups around the country
that had successfully addressed physician-hospital alignment. And we also have had the help of John [inaudible] who, as you know, has had much experience with healthcare policy and he's been very, very helpful to us, both in our contacts nationally, but also his perspective and the credibility he brings our community as we discussed this and try to allay the fears of our physicians.

Since we began this...and because we had essentially crossed ourselves that we wouldn't try to reinvent something or make it out of paperware, we'd been travelling around the country to different center to really try to figure pieces of this idea to build a model that would work for our community. And one of the key points that I've had to make multiple times is that physician-hospital alignment does not mean employment. And I can tell you that, as you look at this, there are systems around the country that identify themselves as integrated delivery systems. And their definition of integration is employment, period.

But when you look at the physician-hospital alignment literature, you would never realize that the concept of integration runs a continuum. And as you can see on the slide, that continuum goes from zero integration, which means you never walk in the hospital, to one hundred percent integration where you're employed by the hospital. And in our community, we realize that if...well, I can tell that one of the flashpoints that started so much of the true acrimony in the last year was the fear that the hospital was going to be employing, bringing physicians and employing physicians to communicate with doctors while practicing in the community.

So we tried to make sure that everybody was educated that you could be employed, you could never count, you could be [inaudible] and not come through the door, or somewhere in between. And the model that we set out to build would accommodate those different ways to enter the platform.

Now, since we began that and since we began what turned out to be a roadshow, we have about 470 healthcare providers who have signed the mission statement and the code of conduct. And one of the things that I want to emphasize that we did, it's been difficult, is that we require that individual doctors and providers sign. So a claimant could not sign. An individual doctor had to sign his or her name. And the idea for that took it back to the code of conduct, that if there's an issue, you signed this. You know, live up to your word.

And anyway, we've had significant success in engaging the physicians. We have no delusion that these 470 doctors and providers are true believers. We recognize that this is a time of change and there are several things that have driven [inaudible] so far. One of them was that, as we got to about 300 signees, the hospital system realized that we had close to provider panel for the hospital employee benefit plan. So the hospital made the physician, the PHA member providers, the provider panel for the employee benefit plan. I think most of you have seen gasoline thrown on a fire. Well, that's what happened.
But on the other hand, many, many people who were on the fence decided that they were no longer on the fence. They wanted to be involved. And then other people have kind of continued to come along. The point being, we know that as much as there's a continuum of integration, there's also a continuum of engagement [inaudible]. So our job is to put together a healthcare model here that will allow as many of those people to join the system we put together and be true to their own philosophy and ethics. And that's [inaudible].

I think many of you have probably seen this curve published in a book by Dr. [inaudible]. And if you look, this is a curve for pretty much any endeavor that you would ever look at, whether it be for effort, or any business, or probably even a relationship. But you see the initial curve, and you realize you're going to have growth, you're going to have a plateau, and then unless you pay attention to it, you're going to have a decline.

Well, in [inaudible]'s mind, and we believe this, we have looked at this, we have talked about this, and we have embraced this idea because it helps us explain so much is that you want to start your second curve before you've reached your plateau and begun your decline. It's so much harder to pull any kind of system or movement out of negativity than it is to say, "You know what, we're doing well. But we know we're going to need to change and now's the time to do it." And so we believe that we've embarked on this second curve. And what we're dealing with is this enclosed area here which is really a time of chaos and a time of turmoil and I can guarantee that's exactly what it is.

I have a second job. My second job is pouring oil on the water of every physician misunderstanding going on in this community right now. And it's breakfast meetings and dinner meetings and lunch meetings and weekend meetings. We have our, what we euphamistically call our "breakfast club." The only time we can really catch up to re-hash the week is 6:30 Saturday morning at the pancake house. So that's how we stay in touch of each other.

But we're in the process of going through this time of turmoil and we're comfortable with that. There are a lot of things driving what's going on at the moment. And I would refer many of you to an article in the New York Times on March 26. And it's really a nice little article. But it discusses why doctors are beginning to embrace employment, or closer engagement with health systems. And there's so many pressures out there. Basically, uncertainty about what the future holds for a small private practice. Strength in numbers, if you will, is appealing. The ability to contract within the support of a bigger group. Cost-sharing. Just having people to talk to in the hallway if you will. Maybe even some political strength.

But physicians are moving to this. The second reason for this--and those are the factors that would move some of my generation. The other factors pushing it are new physicians coming out have different attitudes about private practice. And this is not casting dispersions, this is just stating a different philosophy. They don't want to work the long
hours. Wisely, they want to have a family life. They want a shared burden. And within a structured system and maybe a salaried position, they can do that.

When I went to medical school, there were 104 people in my glass. [inaudible] and I were classmates. There were five women in our medical school class. Joe can correct me if I'm wrong on this, but I think we're at 50% of medical students now are female. Where it's a completely different mindset to the practice of medicine and the pressures of the private practice industry.

So anyway, what we're seeing is we're putting together our physician-hospital alignment. And it is simply the step to build the integrated delivery system here. The fascinating and exciting thing in our community has been the, to me, "mind-boggling" is not the right phrase, but close to that, philosophy change from the hospital and the hospital board of directors...

[pause in audio]

...most of the PHA, or most of the physician-hospital alignments, that are successful have significant physician direction involving governance. To the point that some of them have co-executive positions. For instance, you'll have a physician CEO sharing with an executive CEO. Or over the physician platform, a physician medical officer and an executive. Or over other aspects of the position. We're looking at that closely to see if that might be a form that works for us. But we're moving ahead. Our physicians, for the most part, are engaged. They're waiting with bated breath to see what kind of a model that we bring back. And it's not going to be armageddon. And I assured them that it's not. Our intention is to have [inaudible] bringing back harmony, improving communication, and really allowing the physicians to engage their community, to embrace the TRIPLE A.

And it's been very interesting. Almost every contentious discussion I've been in, and almost all of them had to do with misunderstanding or a lack of communication. Every discussion usually comes back to the TRIPLE A. And I've ever done anything like that before, you know. Mine's always been kind of headbutting approach. Now it's a philosophy approach. It's much nicer. And the physicians get it, the hospital gets it. And so I'm excited about what we're going to be able to put on the table for [inaudible].

>> NEW SPEAKER: Very good. Thank you very much. I appreciate it. And I just wanted to say two things and certainly acknowledge Dr. [inaudible]'s work. He has been absolutely instrumental in leading all of this. And what he didn't say is just all of the other workers that we have in place that are kind of working in [inaudible]...such a nice efforts that we have. The health information exchange workers that we have...

[pause in audio]
...talk about this and we kind of talk about those pieces of the pie. You have to have this unified medical community to do what we want to do. And it remains in a type of fragment state. It's great, we can do all the great stuff on the health and human service side, but if I don't have a medical community that truly gets Triple Aim and is willing to link all of these activities, I don't have anything. So I think these two things in common is really instrumental in allowing us to [inaudible].

>> NEW SPEAKER: Yeah. And just a quick comment about that, that [inaudible]

>> NEW SPEAKER: [inaudible]

>> NEW SPEAKER: I'm just going to preface some of their comments and then I'll let them have the floor...

[pause in audio]

...get into more details around what the Links for Health is, but you'll see some elements in this specific project. And we have a number of other halfway that we're building out of this. This is a key one that we've been working on.

>> NEW SPEAKER: Good morning. We appreciate you very much taking the time to come to Bend. My name is Scott Johnson. I'm the director of [inaudible] County health services so we are responsible in the county for behavioral health work and also our physical health, our health department work as well with [inaudible] County. [inaudible], how would you like us to proceed time-wise, knowing [inaudible]?

>> NEW SPEAKER: I don't know what you've got in mind. If we could kind of go through the presentation in the next ten minutes or so it gives us a little room to...

>> NEW SPEAKER: Yeah, we can actually...

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: Now, with me is Dr. Robin Henderson from St. Charles Health Systems. We'll take you through about ten slides pretty quickly. This is typically on the topic of integrating behavioral health services, both mental and [inaudible] services, as well as primary care services in our community.

The first slide I want to work with is the case for action slide. This is a slide that is a bit dated, we've been using it in our community for about five or six months. But it's been our call to action and it's been the slide we've used to really begin getting into alignment and working together much more closely.
You probably are aware people with a serious mental illness on average die 25 years earlier than the general population. That's [inaudible] put, the health disparity there is something that is of great concern to many people. 87% of those lost years are due to medical illnesses. The cause of disparity, there are a number of them. Issues related to medications, tobacco, a little preventative care, poverty, social isolation, and, an area we have responsibility for, the degree to which the health and behavioral health systems are in alignment or in disparity. And that is an area that we're concentrating on.

Also, of particular interest in recognizing that preventative care works and is cost effective. But great concern here in here central Oregon that we prioritize more cost nutriitary care and that would include the degree to which we continue to move forward on the Oregon state hospital system without some corresponding balance in terms of community healthcare systems as well. And so that's less a negative statement about the developments in Salem right now in terms of the new state hospital and more a call to action, that we absolutely must have a community here, that that state hospital masterplan cannot succeed without it.

Um, also federal reform, an important component of Medicaid work and the fact that 65-70% of [inaudible] folks are not currently getting served in an outhome system in central Oregon.

So who's responsibility is this? This is the slide to try to get our local folks thinking about the players that need to come together if we're going to make progress. Of course, the state of Oregon and the health authority. Of course counties, mental health authorities, and public health authorities of regional hospitals. Our fully habitated health plan, et cetera, et cetera. A reference to safety net clinics, VIMs is volunteers in medicine. Our FQHCs, we have two of them. [inaudible] Medical, which has three clinics in three different central Oregon communities, as well as Aligned Community clinic, they're another FQHC.

Go to the next slide. So these is just the graphic if we look who the players are. The left side would be the [inaudible]. We have Best Care Treatment Services that does work, we have the Jefferson Country Lutheran Community Services Northwest does work on behalf of [inaudible]. Your middle column, of course, you've heard of Health Matters. Clear One, ADHA, and the [inaudible] Chemical Dependency Organization are different organizations that have responsibility for part of the OHP work in central Oregon. And then, of course, DHS and now the health authority. On the right side would be our local mommy group, our client groups in the area, of course the hospital system, and there you see some of our key primary care providers.

So where are we going from here? Links for Health health integration project. At first the top of this slide said "Behavioral Health Integration" but it really isn't just that. It is mental health work. It is alcohol and drug work and is primary care work in central Oregon. If you see the timespan, because much like this meeting and everything taking
longer than you might like, you know, in terms of managing an agenda that too is the case with the work that we're doing. And we've really given ourself a five year frame to...

[pause in audio]

...a couple years of cooperation from the new parties. The first point, of course, is that the current system is not sustainable. And I would argue much along the line of Dr. [inaudible]'s comment a minute ago, we're probably on this project also looking at that second curve phenomenon. All is not lost in terms of the quality of work that is currently being done. We have a number of things that we're very proud of here with our current system, [inaudible] do far better than that.

A few of the early concepts in point three. Emergency room diversion would be one, I think Robin will elaborate on that in a moment. Very much an interest in a health home and we're working through that. Triple Aim is not on the list, but we talk about it at every meeting. Behavioral health embedded in primary care settings and integrated. Also, an interest at least in a location, probably in the Bend area to have primary care in a behavioral health setting. And then of course an integrated electronic record.

Point five is really around beginning this lessons of potentially creating a regional health authority and needing to have shared financing decision, mainly the oversight from that. And I might add, I digress from, we actually are having a meeting this afternoon of what we call our transitional board, which is an early conversation much thanks to the support of Dr. Goldberg and others, really try to look at how could we, and even in a governance way, strengthen and basically create some co-dependence in a positive way if you will for the future of the system.

On that slide [inaudible]...I'm not sure if Dr. Henderson is the budget not. You've perhaps probably are familiar with this. This is one of the drivers. We were going to do this work anyhow, but certainly as Senator Bates and Representative [inaudible] and many others took an interest and see some pilots created. We have stepped forward and I believe Richard Harris and I colluded to this this morning: we now are a pilot project under this budget now.

>> NEW SPEAKER: Good morning. What I want to speak with you a little bit about is what we call our primary health immigration project, which is the behavioral health demonstration project in partnership with the department of human services. It was that work that we started...

[pause in audio]

...and then also our [inaudible] to get clinics to really look at kind of conversations we could have about [inaudible]. And we wanted to look at health integration from a standpoint of what would be doable to get us results because when you get results, guess
what. People believe in you and they let you do more and they let you do the harder things.

So we started with a very small number of individuals. We had a theory. The common theory is that if you look at emergency department utilization, many people believe that, "Wow, that's not...

[pause in audio]

...we found out that those sockeyed people average 30.8 visits per year, each of them, individually. And the primary culprit were medicators they used. Primarily Medicaid and Optimium [inaudible]. You see five Medicare there, actually three of those are Medicare/Medicaid, so really it's more like 11 Medicaid. [inaudible]. All of these 15 people have kind of this triad of needs. There weren't really any trauma issues in terms of what you normally see in the emergency room. These were [inaudible] healthcare conditions. And they had [inaudible] et cetera on their primary, tertiary, and secondary diagnoses around pain issues, heart pain, substance use issues, and chronic [inaudible], not in the term of a heart disorder, but more of along the lines of adjustment disorders that stymy a person, anxiety disorders are a little more common types of things that aren't necessarily served by [inaudible].

[inaudible] we went to look at their...what their processes were to help their system. And through our populations came out to find out that, at St. Charles health system, the cost, not the charges but the actual cost after reimbursement care for these 15 people, was a little $150,000. $10,000 per person per year. And that's 15 people.

So we wanted to see what we could do to [inaudible] that. And that meant that we needed to look at...this is just a slide to show you what that actually looks like here. Sorry about that. And it shows you what that cost driver factor is. We wanted to expand that so we...

[pause in audio]

...and we looked at our top 50 visitors found out that, again, the bulk of these folk are on Medicaid. People that are eligible for primary healthcare services. But what we also discovered was we [inaudible]. We saw that same diagnostic infrastructure on a larger basis. Over half of them had pain [inaudible] addiction issues. Three: all 50 of them had at least one of three components. And what we then found when we started to look at are they getting served by county mental health. Guess what. Most of them were not. Most of them were not even [inaudible] county mental health services, but they were coming to the ER for behavioral health issues that they...

[pause in audio]
...$400,000. So we went to the state and said, "This is what we want our integration project to do. This is what we want to look at." And they brought us some components of what they wanted to see from us, we brought them some components of what we wanted to see with them. And that's kind of an idea of what this looks like. But our pilot is due to start somewhere around the first of June. We'll be placing a psychologist at the Mosaic Clinic. And this is where this ties back into the Links for Health program. That psychologist will then be working with our community link specialists. And I know there's a set of slides that we can talk about community link specialists if you look further in your pack and I'll explain that a little bit.

The key to these specialists for this project are primarily peer consumers who will go through the peer-[inaudible] training program in mental health through Cascade Peer and Self Help Center and then they'll recieve additional training from Health Matters in how to become healthcare navigators. And community link specialist is our nomenclature for what is basically a healthcare navigator: somebody who helps you get through the system, walk through the system, get connected to the services you need.

So we get back to our gentleman just [inaudible] ago between the Bend primary hospitals and we say that Joe's got chronic diabetes and he's got some mental issues in there. And he tends to [inaudible]. He's going to be seen by this treatment team through his primary health clinic, which in this would be Mosaic. And they're going to look at what kind of interventions can they do. They'll meet with Joe there at that clinic and find out what are the barriers to him getting services and being able to be served outside of the emergency room. And over time, that healthcare navigator, our community link specialist, will work with them to get him into the appropriate level of care. Because trust me, nobody's enjoying life if they're in the emergency room every week. That's really not the fun place you want to be.

They really start to improve their quality of life and change their overall healthcare picture. By doing that we can leverage these dollars and then rake that out into other programs that we want to go into. Scott mentioned looking at the polls of severe persons with mental illness, the chronically ill in our community. We want to be able to use healthcare navigators, peer specialists, to be able engage both [inaudible] the system in the appropriate fashion so that they're getting care.

So what we found is that the folks in Scott's programs, they're not going to the emergency room for healthcare. They're not going anywhere. And so that's where we see the folks who are [inaudible] conditions, who are dying 25 years earlier. Because they're just not getting services at all.

So those are just some of the things that we're looking at doing. I know we're also using community link specialists right now in our new neonatal intensive care population. We look at [inaudible] babies coming out of the neonatal intensive care unit. And we have nurses from Health Matters who give people a grade, works with the family to determine
what their healthcare needs are, and we hook them up with, again, a specially trained community health specialist who helps them navigate the healthcare system to reduce healthcare issues, but also the social health issues. Because we know that families who are under high stress with a high-risk [inaudible] are at risk for increased child abuse in family stressors. So it really is looking at a global population healthcare issue.

This last slide here that I'll leave you with really just outlines what our structure is for governance right now. Scott refers to the transitional board that will meet this afternoon. That transitional board is made up of three county commissioners, the CEO of the healthcare system, Dr. Goldberg, representative and medical director for Mosaic Medical David Hayes, and a vice president from [inaudible] Health Plans. Those folks right now are making our major decisions about how we're moving forward and are providing that basis for us to discuss what a regional health authority would look like.

They're informed by the stakeholder committee, which is made up of all those different entities, probably 30 different agencies represented in our stakeholder committee right now that have been working together for the last three months. And they're driven, in large part, by the project developer team, which is the small group of people who actually gets stuff done.

>> NEW SPEAKER: Thank you. A question or two?

>> NEW SPEAKER: Do you know what percent of the Medicare/Medicaid patients do not have access to a in-house patient [inaudible]?

>> NEW SPEAKER: I don't know that I could speak to the Medicare/Medicaid, everybody should have access to mental health services. We're going through some expansion right now. In December of '09, we had 14,000 people with Medicaid/OHP issues. In January '10, we had 15,000. So we're just bringing on some additional staff now, but certainly anybody with a medical need for health services should be able to get access to that care.

>> NEW SPEAKER: But at the same time, I think that the partnering problem with [inaudible] is that they don't necessarily meet the level of acute [inaudible]...somebody would like to go to mental health. There's still due to a stigma issue. So somebody may present an REI and say they have depression. They say, "You need to go to county mental health services." They're not going to be able to necessarily access that.

>> NEW SPEAKER: Our two...one last point on this side. Our two best places for real progress which [inaudible] where the FQHC is located and then in the Bend area with the Mosaic clinic on Greenwood and volunteers in medicine. That's where you'll see this out soon.
>> NEW SPEAKER: So I just have a question. On that $150,000 that the state's [inaudible], is that paying for the Link's person? Because if you have Medicaid, you should be able to have some place to send the bill, number one. And number two, if you're going to work with Mosaic, can't they send the bill for the psychiatric services as well as for the [inaudible]?

>> NEW SPEAKER: Those are some of the things that we're working on right now with [inaudible]. Some of the issues around...for instance, with the community link specialists, we have to get the curriculum approved so that we can get [inaudible] prior and that's a process. [inaudible].

In terms of being able to bill, it's not quite...I would love to say that it is that easy. We've had an awful lot of people sit together in a lot of rooms and we're still struggling with how do you figure out what the right prices is, who can bill, can you bill for two services in one day, does it go to the physical side of the health plan or the mental health side of the health plan, where are health behavior codes [inaudible]...? It is an incredibly complex, complicated system that these dollars in large part are going to go [inaudible]. We're bringing on the psychologist whose been a need to this program. Those dollars will go in large part to fund that. We're bringing on a little bit of community link specialists, but also these dollars need to fund the evaluation component so that we can study [inaudible].

>> NEW SPEAKER: Thank you. I think it's really important...

[pause in audio]

...County gets through the Healthy Start program.

>> NEW SPEAKER: Uh, great question. In fact, just this...probably about three weeks from now we're getting together to look through Cocoon, Babies First, Only Starter, and all of the evolution of that that's likely to occur in the next year or two. So we're working on that very closely. It's not all figured out yet, but we're well-attuned to getting that aligned as well as possible.

>> NEW SPEAKER: And part of that [inaudible] clinic goes...

[pause in audio]

...using this as a springboard to start to wrap our arms around that population here.

>> NEW SPEAKER: A last point on this just as we're cleaning up and framing some of the central Oregon projects: the other one that prompts me...that question prompts me to mention is the launch program which we're doing with the state health division. We are the Oregon site for that. It's the same [inaudible] 0-8, early shot for [inaudible]. So that
also is going to tie into that. [inaudible] hospital-based health center, but we're adding additional school-based health centers this year. So it's all part of the systemic work on the children's center.

>> NEW SPEAKER: Last question for this session posted by Eileen [inaudible over laughter].

>> NEW SPEAKER: [inaudible]...for all the work that they've done and for following your progress. I've been [inaudible] in some of these details around these regional health authorities as they emerge and it seems that we should be working fairly closely.[inaudible]. I'm intrigued by the metrics...[inaudible]. And to discover this piece about 30 visits per year [inaudible]...have you guys been working on what the corresponding positive metric would be? There's a metric for our system isn't working. And let's incentivize people to get having surgery to be the positive metric. In this particular scenario, have you [inaudible]...?

>> NEW SPEAKER: We actually had the opportunity to work through just that question in the process of applying for the Beacon grant. And the Beacon grant is one of those [inaudible]. But we used the IHI Triple Aim prototype framework and came out with a series of metrics and I'm happy to share that with you. A series of metrics that look at how this ties, how this particular process ties to improved population healthcare. Some of those include increase enrollment in primary care homes. Some of those include increased utilization of living-well projects and some of the other things that all integrate well together. But it's all they had IHI Triple Aim prototype worksheet that we really look at in terms of doing health screenings in the clinics. They're going out and [inaudible]...we have not been able to put a [inaudible] in every primary care clinic, but you know what? I can put a [inaudible] screening tool in every clinic. I can put medical screening tools in every mental health clinic. We can do those types of integrations that give people the tools to be able to make those connections. And if those folks who have difficulty navigating the system, we provide them the labor methods. So that's all pretty well taken care off.

>> NEW SPEAKER: So I'm intrigued by having a conversation [inaudible]...so thanks for all your good work.

>> NEW SPEAKER: Thanks you very much, I really appreciate it.

>> NEW SPEAKERS: [inaudible over each other]

>> NEW SPEAKER: Thank you for indulging us this morning. I definitely [inadubile]...long time. If you want to take a break or you want to continue with the discussion or you want to hold on to this until later. I know this was a lot of information in a relatively short amount of time. But I think the next question, the next series of
questions really get into all this great work. You know, how do you start to roll into some sort of partnership or relationship with the state or with the health authority?

So what...the slide that you have in front of you right now is I think an interesting framework. one that I came across not too long ago that really kind of looks at today, if moving forward, what a future state could look like. So if you go to that left hand side and understand that, really, our whole model today is based on clinical services that are really in fragmented pockets. Whether it is mental health not connected with physical health or, you know, we venture those scenarios.

Then if you go down that lefthand column and then look at, okay, well what's the alignment payment. Obviously, it's the most part a fee for surgeons and structure. The incentives: conducting procedures, filling beds, you know that's what we're incentivized to do. The metrics is really based on that revenue. And then the governance: for the most part, informal relationships and referalls. What we're trying to figure out right now is how can we actually evo...[pause in audio]

...called something else that can really be in a position to handle global payment. And then be incentivized for the right things, in terms of actually improving population health. Measuring those population and health cost indicators. But then actually the governance structure having immensity that would be [inaudible] were all of those things.

And I think that really is the challenge. I think Bruce and Tina and others have been talking about this for the last several months with us. We have a meeting this afternoon and I think that's really where we're trying to go. I think what this behavioral integration project has allowed us to do is get our foot in the door and just start to have the conversation that, okay, if we're going to go down that road with this project, if we're going to talk about collecting funding, well how could we roll it out to an even bigger...more projects? Or even when we talk about county employees and city employees. You know, school districts. How could we actually start to think about it from that point?

So anyhow, again, I don't have those answers. But I think we're on that road. And I think what Bruce and I talked about is, you know, could we, even from a policy board perspective, talk about what that framework should look like for any region. And what are those criteria that, you know, central Oregon could or should abide by. And then northeast Oregon or south or anywhere. We have to have that same platform.

But I think it's important to talk about, you know, all of this great work of expanding coverage and containing cost. We've been having a lot of conversations with Portland and a lot of conversations with Salem...
>> NEW SPEAKER: So, but I do have a question right now. Because I think that your vision is really broad and it is getting us to understand what are the metrics to [inaudible]. But my question right now is in the framework that your using from Communities Joined in Action, I just have to feel that most of that is still in that ten percent. And that we shouldn't, you know, limit ourselves. And I think you really have a potential here, Mike, with all your collaborators to move beyond that. But we're still pretty much [inaudible] on the ten percent. So I really look forward to...I hope I get asked back, you know, and visit some of the programs and particularly get to know a little more of the operational thing.

>> NEW SPEAKER: Well, I appreciate that. That's a great comment. I think that has been the focus of all of our work for so long, to take that step back to figure out how we're going to do that. I think, you know I've said it many, many times, but I think, you know, IHI and the Triple Aim has helped us go down that road, really broaden that perspective and start talking about those metrics, it gets you outside of that ten percent. And I think that's when you start to bring in those other stakeholders.

>> NEW SPEAKER: I think this starts to frame a lot of what we do moving forward around population health and probability metrics, [largely inaudible].

>> NEW SPEAKER: I think that's exactly right. So as we plan our future agendas, I think what we will do is we will take into account this tremendous amount of good work that you've done and your colleagues that are in central Oregon and turn it into then a discussion of board members who get involved with, get help from staff in terms of figuring of what some of our options are, and in the mean time, [inaudible]. We really appreciate the time and effort that's gone into the presentation. And of course all of the work that it's based on. Mike, thank you very much.

>> NEW SPEAKER: Thank you guys very much.

>> NEW SPEAKER: We'll take a break for no more than ten minutes and come back to our agenda.

[pause in audio]

>> NEW SPEAKER: Okay, welcome back, everybody. Thank you. We talked earlier in the meeting about one of the recent successes being the Pulse project. Another one is some pilots that are in the process of coming together in urgent/primary care. And here to talk about that for ten or fifteen minutes is [inaudible]. Welcome, thank you.

>> NEW SPEAKER: Thank you. [inaudible]...the office of health policy and research. And I wanted to give you a brief overview of where we're trying to proceed with the
patients under primary care home laws. As you may remember, in fact I saw this slide last month, we talked about the completion of the patient center primary care home standards and we talked a bit about why this was a model we really wanted to look at. It's very similar to a lot of the concepts you've been talking about here with the regional health efforts. Enhanced care coordination, but it really targets the Triple Aim in terms of improving population health, helping to reduce unnecessary utilization which leads to reducing cost of system...

[pause in audio]

...so as we talked about last month, we completed the standards which just sets a framework in which payers and others could use to measure and improve the care toward this model. And now there's a sort of...you have a one-pager in your handout, it has a little bit more detail about sort of our next steps.

I'm going to talk first about the first one which is the partnering with the Health Leadership Taskforce on a multipayer pile. This is a...the Health Leadership Taskforce is a collection major payers in the state with health systems and some health provider groups. And they have started down the road of a high-value medical home pilot. It's based off of...

[pause in audio]

...ten percent of the population. Their goals are structured around similarly to the Triple Aim, as are ours. And there's a strong alliance in terms of looking at some of the...

[pause in audio]

...better understand some of the details of that. And there goal was some short-term return on investment in the first one to two years. Their payment is [inaudible], they have to pay their plans...

[pause in audio]

...is focused on some similar aspects of...in terms of Triple Aim and it just outlines some of the areas where they're going to look to see how the models are structured.

The reason they're going down this line is really they looked at the cost of some of these high-care, high-utilizers. So they're really focusing on that top ten percent. They did some analysis. They cost based about $22,000 per person per year. We picked 4,000 enrollees, do the math, you end up with baseline costs of $88 million. The new cost is [inaudible] model, they estimate based on how they're thinking about structuring this. It's about $2 million. So to break even, if they can get at least 2% savings...
...So what [inaudible] want to do as a health authority is try to see how many of our [inaudible] should be included into their model. They're identifying a long list at the moment of potential sites. We're also planning to look to see where their top ten percent are. It's across the state, it's not just Portland. And we're looking to see, since we're self-employed [inaudible]...for the majority of those. [largely inaudible]. They're having the Medicaid agency demap conditional medical systems programs, just looking to see where our top ten percent lie in terms of those first big look at those clinics.

And then over the month, the end of April, the first of May, they're going to narrow it down to 8-10 clinics. [inaudible] and I are on the selection committee to help participate in that. We'll have our data in terms of where our lives are in terms of...[inaudible]. And then we want to participate as a whole payer so [inaudible] employee board has already voted to participate in this. [inaudible] board is considering as well through their major commercial payers. The old Oregon Medical Assistance program is also looking at participating and we are committed to paying through some dollars we have in the Medicaid administrative function and some federal dollars that we have through one of those grants that my office administers to also pay that, an augmented per member per month cost. At least or some portion of it to make sure our lives are part of this.

>> NEW SPEAKER: That's what I was trying to understand that. [largely inaudible].

>> NEW SPEAKER: So the public employees doesn't work as a quality fund, but they're doing it as one of their projects. On the Medicaid...as I said we'll be doing it through some grant dollars that actually the office...[inaudible].

>> NEW SPEAKER: [inaudible]

>> NEW SPEAKER: Right, so the managed care plan. If there's someone here in central Oregon, if one of those clinics gets chosen, then if we have Medicaid lives in that clinic we want to work with the plan, the application to subscribe to, and work to make sure that we're at a player along with the other commercial ones in business.

>> NEW SPEAKER: Also, part of it is initial investment dollars, it's not necessarily...I mean, it all works. It's not just the people that earn a million dollars. [inaudible] would be a loose structure at the clinic level...

[pause in audio]

...and so, that's why they're keeping this list this long. And so it'll get it in there and stay on there.

>> NEW SPEAKER: Are they going to be randomly selected or something?
NEW SPEAKER: They put out an RFP to ask for clinic readiness, to show their signs of readiness. They really, for this first phase, want to do clinics that are already maybe sort of even working toward this. You know, I talked to Melina Bueller, who's had legacy clinics that have been one of the Cure Oregon sites and we also have some money from regents. They think that this is another way to keep furthering the [inaudible] primary care home model broader and further within their community.

So it really augments...it really brings together the uniqueness of this as you've got multiple payers along bonding together to do this collectively rather than one plan trying to do it all by itself. This was a problem we had in [inaudible], we had in our contracts that we wanted to do this, but you know, you only have a few lives here and here and here. So a practice like Dr. Kaufman's might not choose to really change their behavior because there's only one payer, [inaudible]...getting six to eight to ten payers to do...

[pause in audio]

NEW SPEAKER: ...will that be in through [inaudible]...

[pause in audio]

NEW SPEAKER: ...collection data, but not with cost data. And so some of the data about how exactly the data flows will need to be sorted out. Again, this is one to two years so as the all payer database comes up, the cooperation that will help augment, make it smoother for data [inaudible]...and that's what I'm going to be discussing this week with them is that how can we can get a health authority evaluation, sort of our lives inside their larger evaluation so we can really look and see what the impact has been on our lives and the lives of the covered.

NEW SPEAKER: I think it's a good segue into the question I was going to ask about how...I don't see any point in here where the consumer, the patients are actually giving input into how they like their healthcare structured and then how...

[pause in audio]

NEW SPEAKER: ...be a participant. So they will be getting permission to pilot on site.

NEW SPEAKER: And then, I guess, my question is about [inaudible]...the insurance industry and the health systems industry. But there isn't a...there's not a consumer person that we're working with on the development or these kind of projects or...?

NEW SPEAKER: Well, the pilot was already under development before, you know, House Bill 2009 really...sort of a vision and sort of it evolving over time. And so yeah, it has been primarily run through the HLTF networks. I think as the state comes in as a
partner then we bring that sort of viewpoint and thinking of overall...and again, this is just sort of phase one, how phase two [inaudible]. You know, does this get into the full medical home, the patient center home that we all envisioned? Maybe not, but it's a first step for some clinics who maybe haven't had much care coordination on site...

[pause in audio]

>> NEW SPEAKER: ...on the eligibility criteria for clinics, can you say like a minimum number of OHA lives that they would have to have?

>> NEW SPEAKER: I think that there's going to be a look in terms of minimum number of lives overall. But until I see the data of how...I mean, maybe if there's just a handful of OHA lives in any one site, then could we make sure that at least those sites that have the most of them are part of this? And again, we'll go through sort of our next steps. This is just one step down the road of trying to implement this. This is something that was up and starting off that we wanted to make sure we were part of to really get that power of multipayers coming in together. But it's maybe not...you know, could we do additional sites that have a heavier concentration of health [inaudible] lives...?

>> NEW SPEAKER: Sorry, I'm just [inaudible]. I guess I would argue for what I think she was saying, that is that, I agree with what you're saying...

[pause in audio]

...it says the primary goal is to demonstrate short-term return on investment in the first 12-24 months. I'm not sure, and I know what that means, but I'm not sure that someone picking up this document would say that the primary goal is compatible with the Triple Aim. See what I'm saying? So maybe that could be phrased a little different. I understand that this, as you pointed out, will produce returns. We all need that. [inaudible]. But it kind of takes the focus away...

[pause in audio]

>> NEW SPEAKER: ...one is that...first of all, I'm sure the HLCS would be happy to have [inaudible] guessing at what the premise is, but we need to improve patient care and that the health industry is actually the obstacle to this. And they're trying to break through...actually, [inaudible] was a word that was used before. This actual page of this document was actually my [inaudible]...so I'm very impressed to say we're moving...

[pause in audio]

...850,000 individuals. But also trying to get some of these self-insurance programs to participate in this. And I think we have a role as a board to invite participation. [inaudible] that cost to other folks, they really have to think about it. But the way I
[inaudible] this model, it works if there's volume. It has to have volume to work. So I would just like us to consider how we might be a part of broadening that recognition of the project.

NEW SPEAKER: I do believe Bruce sits on HLT task force. I think there is a role where they have connected a lot of the purchasers, realizing that many of them are self-insured and the plans are serving us their target industry. I'll check and see kind of where we are on that. And I would like to do that, but I think we could really use our...

NEW SPEAKER: ...and clinics that are serving, community health clinics, generally qualified med centers, how would we structure them, how we would support the efforts in those areas. And of course, building off of the work already presented by Richard and others in terms of the [inaudible] health clinics. And making sure all of this is integrated and these aren't, like, separate silos of activity, but they're really overlapping.

The other thing to note, and you'll hear more when we get to the federal reform discussion is that there are opportunities to further this in the federal reform bill. It's noted here there's some great federal matching dollars so for every 90 cents from federal dollars, we only put in ten cents. And we can pay for this through a state plan amendment to our Medicaid plan. So there's a lot of opportunities. There's also some demonstration models. There's also interest by Medicare to join the existing multipayer pilots. That really adds some leverage in terms of multipayer. So...

NEW SPEAKER: Two take-aways and one comment. I think the take-aways are consumer involvement and reaching out to the self-insured, which we're in an appropriate position to do. We're using...we're involving a number of our self-insured lives at the state level certainly from fed and working with the administrators to do that. But I think it really pricks to the discussion earlier about governance and how we create a sort of governance structure within the organization and delivery of healthcare that brings in consumers as well as the providers of care. We've operated in a structure where we've got a lot of...

NEW SPEAKER: Very good. Thank you very much. Appreciate it. It's about 20 after 11 and I'd like [inaudible over laughter]. I've heard that there was some activity at the federal level regarding healthcare and we'd like to take the next hour or so to talk about that. The first 20 or 30 minutes, at most, will be basically an update on what has happened and what the federal legislation will mean to us. And then we want to save at least half an hour for discussion among the board members of the implications of what we're about to hear. And then I still want to save about 15 minutes at the end. We have commercial folks I know who I promised floors as well before we adjourn at 12:30. So,
with that, I'm going to turn it over to Amy [inaudible] and Gretchen [inaudible] for an update on the federal healthcare reform.

>> NEW SPEAKER: Good morning. I'm Gretchen [inaudible] from [inaudible] Office of Policy and Research. I'm going to run you through a fairly top-level summary of some of the significant provisions in the federal bill. And Amy's going to walk you through some of the [inaudible] considerations from the federal bill.

So just really getting to the high level to summarize what the federal bill does: there are significant funding opportunities for prevention and population health. More than we could possibly list today. So there's significant opportunities in terms of furthering things, furthering that part of the Triple Aim focus and then your work. There's also, which [inaudible] just mentioned, a number of provisions for delivery system reform, related payment reform, some new funding in terms of Medicare, some reductions, [inaudible] screening service at this point and what that means for the state. And the one thing that the federal bill does do while [inaudible]...fundamentally transform the system in terms of integration of health dot-coms and [inaudible].

It does focus the federal efforts in those areas quite a bit more than it has in the past. In terms of coverage and access, there will be...to those of us who are...kind of self-serve Medicaid, the expansion of a mandatory population for Medicaid to [inaudible] 133% of poverty is a pretty fundamental change to Medicaid on the national level. So that is obviously a big change to highlight. And then for those individuals up to 400% of poverty there are both federally funded tax credits and cost-sharing reductions on sliding scales available through a state home insurance exchange, which obviously aligns with a lot of the work that we have underway at this time. And then there is the individual requirement to purchase insurance and a number of insurance reforms that are being cited at the federal level and not necessarily a state option at this point.

So there's a really high [inaudible]...it doesn't fundamentally change the relationship between public health and healthcare, but a provides a slew of opportunities but, really, it's your job to [inaudible] to states and communities and determine how you can capitalize on those opportunities. The other thing that's worth mentioning since it's been a little bit confusing in the news in terms of the waver authority that's in the federal bill. We've checked every resource, including the bill, that we can come up with and the data is [inaudible]...even though it's been a little bit confusing in terms of when state funds actually kicks in. So that's something, obviously, we'll leave in your track, but we will put all these sources in [inaudible]...that's still a waver to allow states to fundamentally change some of the requirements of the federal bill [inaudible]. So we'll keep you updated on anything...

[pause in audio]
NEW SPEAKER: So those are what we have for other presentations in terms of more detailed slides. And I know we're a little pressed for time so I'm not going to go through each one of the bullets. But...

[pause in audio]

...and there's also going to be a test, or a federal national prevention and health promotion strategy that we'll want to watch closely in terms of what they're working on versus [inaudible].

NEW SPEAKER: And I mean, we see that things are changing. But are there some precipitous dates for all the funding to have a major impact on [inaudible]...that's what I'm trying to get [inaudible]

NEW SPEAKER: In terms of the Medicare payment side, there's the freeze and that sort of reduction from there. I actually don't know the answer in terms of any cliffs or any [largely inaudible]...

NEW SPEAKER: Joe, the one thing I will say is that the biggest cliff to me is the 21% cut that's supposed to take effect now. It hasn't. And I think back to the whole, the cost-of-[inaudible] piece, the $5 billion Medicare cuts is contingent on that 21% cut. And that's it. I don't see that happening.

NEW SPEAKER: I think all of us know the unreality of that [inaudible]. It's sort of hanging out there [inaudible].

NEW SPEAKER: In terms of transforming healthcare delivery, [inaudible]...payment reform options in terms of an enhancement in reversement and planning grants for primary care homework. There is a new CMS innovation center that has developed various payment reform opportunities, with a real focus on community round-up work in that area, which obviously [inaudible]. And this is our two bullets, which is obviously only scraping the surface in terms of Medicare payment issues. And we'll continue to follow...to delve deeper into looking into this statement of [inaudible].

There's also, in terms of community health center funding, there's a significant increase, it would be a doubling of the funding, nationally. And [inaudible] are now waiting for health integration and then a slew of funding grants for workforce issues. Kind of the workforce committee is looking at this and integrating it into their work plan in terms of what opportunities are there.

This slide is just looking at [largely inaudible]. And so I think I can sum up the slide by...

[pause in audio]
...provided to our systems for more research being done in terms of compare
effectiveness [inaudible] what the new institute that we're setting up.

So here I've covered in Access, this slide having some of the early changes that we'll be
seeing in terms of young adults being allowed on parents' health plans until they're 26,
prohibition on things existing conditions for kids and prohibition on assuming coverage
except in cases of fraud, and some prohibition on lifetime benefit caps. So those are all
things that we'll be taking in within 90 days to 6 months of the passing of the bill. They'll
make sure to be things that are decided for us at this point.

Really high-level, this is more of a detailed slide, I don't need to go through it bullet by
bullet, but it is focusing on medicated shift, the expansions for [inaudible] 133%, the
expansion of fostering children up to age 26, and this over here is the schedule of
enhanced federal funding that is provided to be eligible for some of these expansions and
there's some more...[inaudible]. And the one thing just to mention is the last bullet: that
there is a statement of maintenance of effort on current elegibility processes in rules in
order to receive that higher match that obviously the state will be keeping in the event of
[inaudible]...and all of that starts in 2014.

>> NEW SPEAKER: On the...[largely inaudible]

>> NEW SPEAKER: Not sure. That's going to be based on the HHS interpretation of the
bill. There's also another, it's not on the slides, but there is a provision about reductions
being proportional to the size of the state. So in terms of obviously there are states out
there that have much bigger issues with a lot of this than we do since we're normally
considered a low-dish state whenever a federal bill passes. So at this point we don't know
the exact amount of the reduction, walked away for HHS, but ideally we are hit less than
some other states.

So a health insurance exchange. As you know we were required to work on a business
plan for a health insurane exchange for...

[pause in audio]

...there's the requirement that there's both an individual and a small group health
insurance exchange. There is a market outside of the exchange as well, any individual
group market. And there are some...there's definition provided to the benefit [inaudible],
which has a pretty direct effect on the also the work that we're doing on about creating a
central medical [inaudible] exchange. And all of primers around that will have to wait for
HHS to see what kind of box they put around the various tiers of [inaudiable] that are
outlined in the bill.

And then eventually with the tax credit and the cost sharing reductions, those are only
available through coverage for just through the exchange. And in terms of public plan,
there is no federal public plan. There's nothing, as far as we can see in the bill, that precludes the state from continuing its work...

[pause in audio]

...uninsured numbers on the left and right side, in terms of who's visit we chose...the number of uninsured in each of those brackets.

One or two last coverage and access to care slides, but there are a number of...[inaudible] a number of new entities that are created in terms of a high-risk pool. That can be done by [inaudible] directly and then we work and get in contact with HHS if they would be directly implementing the high-risk pool in the federal bill.

In terms of small businesses, there are tax credits for small employers to purchase coverage. And there are systems on employers whose employees access the federal tax credits and cost-share reduction in the exchange. So there is a pay or play mechanism if someone's employees use the tax credits.

>> NEW SPEAKER: Can I just...for the board or any public that may be listening, the tax credits are retroactive to January 1 of this year. It's for any small business that provides a certain level of coverage. And there is a specific percent of the premium. They get a 35% of the cost of the medical coverage back as a tax credit. I think that's a hugely significant opportunity for Oregon's small businesses and this goes up to 50% in 2014 as a tax credit. So it's, I think, important that people be aware of that.

And the other issue that I also wanted to stress is that we...one of the first things out of the chute in terms of national health reform has been setting up temporary [inaudible] schools. And we're currently looking at...we will be implementing the national high-risk pool as well. I think the question for us that we're trying to get clarity from from HHS is what, if any, opportunity we have to build a common high-risk pool based on what is, from our stance, one of the more successful high-risk pools. And so whatever opportunities they have in looking for...we're not sure if that will exist or whether we're really going to have two distinctly separate pools or whether there will be an opportunity to create some greater reform...

[pause in audio]

>> NEW SPEAKER: There's a basic tax penalty starting in 2014. And there are some exemptions in terms of some people not having to pay that tax penalty. One of them is that in terms of...

[pause in audio]
...guarantee issue, renewability, prohibition on lifetime limits, these are all 2014. Except there are some...there are certain annual limits permitted between now and 2014. And it eliminates the waiting period of up to 90 days for coverage, which I believe may or may not actually have a huge impact on [inaudible].

Then in terms of reinsurance pool, there is a reinsurance pool being established for assisting pay the costs of claims for retirees. Close to...over 65% coverage [inaudible] most of the retirees in this. And there's also a transitional reinsurance program for the first two years of 2014 to 2016. [inaudible].

>> NEW SPEAKER: All right. I'm Amy [inaudible], legislative director of the health authority. And I'm going to shift gears a little bit. We have a timeline, I'm not going to go over it in any detail, but I think it lays out some of the big pieces that [inaudible] going to implement it. What's implemented immediately in the next six months of 2010 and then over the next few years. We also have, on the health authority website, a more detailed timeline that we're updating on a regular basis as more information comes out. So I would suggest you check that every now and then. And that will be the most up-to-date place to see when things kick in.

We wanted to shift gears now. Gretchen, I think, gave you a nice, brief overview of what the bill does. And then in this piece of our presentation, we wanted to shift to what are some of the key issues and key questions that passage of this bill now raises for us. One of the things that we now need to make decisions about in terms of how we move forward. There's a couple questions on the next few slides, but they're kind of really centered around timing, the scope of our work, and strategic alignment with our current efforts.

In terms of timing, questions include whether we should go early: should we look at time implements in the key elements of the bills and just exchange earlier than it's currently laid out to be. Should we continue with the activities we have in our plan now, in our work plans, even though we know they'll be altered or maybe even superseded by what happens, you know, as key elements of the bill come into effect over the next few years. And one question that's not on the slide, but I think that should be on the forefront of our minds is what are the impacts of these timing decisions on our funding [inaudible]. What is the impact on our need for state general fund and, you know, does our action either create more opportunities for federal funding or jeopardize federal funding...

[pause in audio]

...you, know, another question, this also raises the funding question. Should we...should we do more and what impact does that have on our funding [inaudible].

These questions really need to be addressed in terms of thinking about how to invest our energy and our resources over the next few years. As Gretchen mentioned, the federal bill
sets the direction and lays out a clear plan for coverage and for financing, to pay for the coverage and some of the elements like that exchange. But there's a lot less detail and a lot less direction on cost and some of the quality issues that we have been focusing on based on the health authority's work.

Now that the bill's passed, our job, a collective task, is to think about how to prioritize given extensive resources and the current political climate. We know that we are continuing to operate in an environment that's scarce and probably diminishing resources at the state level. And our political climate, we need to think about our political capsule moving forward. There may be new opportunities because of momentum around the federal healthcare bill, but I also think we need to think about sort of the flip side of that: the risk that there may be a certain level of fatigue among our elected officials for the healthcare topic. You know, I think there's a very real likelihood that people, legislators, they say we've taken care of this topic. So how do we factor that consideration in our thinking and our...

[pause in audio]

...Other questions that we should focus on are more around our strategic alignment. What do we want to do and how do we want to factor in the federal funding that's available to us. How do we ensure alignment with our current efforts, make sure that what we're working on is what we prioritize as a state, and that we aren't simply chasing dollars that are available to us. Do we want the dollars available to set the tone and direction of our work or do we want to make strategic decisions about what we're doing, where we're going, and then find the opportunity to help us get there.

So there's many, many, many unanswered questions. There's unanswered questions about what the bill does. There's unanswered questions about what the impact on Oregon will be. And I think there's a lot of unanswered questions about what our next step should be. We'll be monitoring very closely as the regulatory process that will start answering some of the questions for us plays out over the next...

[pause in audio]

...groups, task forces, and commissions that were created in the federal bill. Those all need to be populated with people. And we all know that Oregon is the leader in a lot of this work. And so we'll be looking at opportunities to get Oregon representation on as many of these as possible. We've done a lot of groundwork and we should be able to share that and help shape the direction of some of the [inaudible] of the bill that we don't know how they're going to hold out yet.

Um, some staff might be looking into how we might best do that, [inaudible]...probably at our next meeting for how to start thinking strategically about maximizing opportunities for Oregon involvement in some of these [inaudible] panels.
>> NEW SPEAKER: Very good, thank you. Um, obviously there is no way in the world that we are going to answer all these questions today. There's no way we could answer all these questions today. But you have seen the future of our next few agendas. And there are obviously many topics to consider and many questions that do need to be answered.

What I'd like to do now is, in the next, let's do this clock, 22 minutes, I'd like to [inaudible] some general questions and reactions from the board. Kind of about philosophic direction, and what would you like our staff to hear as they think about bringing forward these changes. And then at noon we do have a little [inaudible]...I'm going to ask Tina to enumerate just three or four bits of direction that we probably need to provide to some of our working committees and to the staff as we go forward.

So I think first just questions and reactions. Who'd like to go first? Carlos, you're up.

>> NEW SPEAKER: [largely inaudible]. This question is about the exchange and how and when to start the exchange and the perception that a healthier option might be a money-losing endeavor or a money-neutral and I think the public option we have doesn't delve into it deep enough to know what we're getting into. I think it's a critical [inaudible over others]...how much things do cost. And that's one area that I think we should [inaudible] very carefully.

So we talked about this group of people between 133-400% and how will that will live in the exchange and how do we make sure that the market allows for their balance of [inaudible]?

>> NEW SPEAKER: We'll just go down the table. Ellie, your thoughts.

>> NEW SPEAKER: Okay. Um, I'm extraordinarily excited, to state the obvious, for federal reform. I think we've come a long way in a certain time and it took a lot of people to get there. So [inaudible]...and that we are so aligned with a lot of the premises and the direction behind this federal reform piece, I think it's to our method and to our credit and [inaudible] to implement them. I think there's a fear that I have that a certain number of dollars would come into the state for a variety of these programs and we would lose the...[inaudible] would get lost. It would get put into programs that don't get measured or just be [inaudible]...not necessarily effective or [inaudible]...so I want to be cognizant of that process as funds for those programs are secured.

I'm intrigued by the early methods piece, the timeline I think does drive a lot of this. The early methods pieces would be, potentially, would be essential for building this kind of outreach to get this structure on a Pulse program, on a Health Kids program. Could we then start to get this Young Adult Parent's Plan piece into our communication strategy...

[pause in audio]
...I have a lot to say. I'm excited. I think that we align and I'm very intrigued by the fact that this is very coverage-oriented. This is very coverage-oriented. And that visional pieces to the Triple Aim are some of the pieces that we really need to focus on. The federal reform's got a huge amount of work for us, the coverage and access needs, and up the ante on prevention and upstreaming solutions. And I'm excited that we can now focus on those bigger pieces.

>> NEW SPEAKER: Yeah, I think I share some of this concern about having these...

[pause in audio]

...I just want to make sure that we're comprehensive in our evaluation of what we do for others. That's one thought. And then Amy actually got me thinking when she said what's the...you know what is the [inaudible over others]...leadership's capacity for continued concern about healthcare issues [inaudible]. So I think that it goes back to [inaudible] so they have to understand that...the election's going...no matter what we think of in terms of policy and comprehensive policy development of their political concerns [inaudible]...those are just a couple of my concerns.

>> NEW SPEAKER: As I look at this [inaudible], I'm reminded of an old adage that I can't quite remember so I [inaudible]...but I'm going to try to use it anyway and that is that excellence in implementation accompanied by an adequate strategy will always trump a terrific strategy with only mediocre implementation. And I'm reminded of that because this is about covering the most people in the best possible way. So wherever we have federal mandates, guidelines, et cetera, I think, you know, we should really make an effort not to duplicate or complicate that. If it's a [inaudible]...I think in every possible way we should align ourselves with it. And that's not to say that we're not aspirational about what we've done. But it gives us the opportunity to, I think, more clearly communicate. Because we won't have to communicate from this. So I'd really look at that closely and see where we can align.

Because, we in Oregon, we can [inaudible] do it differently, we can do it better. Because we had that start, I think we're better organized than many states are. So I would really like for us to align and [inaudible]...be a shining example...that then allows us to use our resources, both financial, emotional, and intellectual, to do...there're lots of gamuts in the federal legislation. Among the most obvious is workforce. And I don't mean by that just the number of people we tally in our forces, [inaudible]...it will allow us to put the emphasis on where we [inaudible over others]. So those would be my thoughts.

>> NEW SPEAKER: Thanks, Mr. Chair. I think a couple things. I think I'm agreeing with Gerald actually...[inaudible over laughter]. But I hear what you're calling a [inaudible] up by our principles. That is one of your core [inaudible]. And I think that one of them is that looking at...we don't want to do [inaudible] and we don't want to be in a
situation of...early adopters sometimes [inaudible] the changes. Early adopters [inaudible] the changes. A lot of times they get [inaudible]. I'm very worried about [inaudible] and some of those other things.

And, you know, my personal thing is there are certain stakeholders who are at real risk in the federal health reform. And I think it really showed our maturity [inaudible] of dealing with these issues, as opposed to some other areas of the country simply name those and call [inaudible]. Not that we're necessarily...

[pause in audio]

...I also think that, sort of, the one way to deal with Oregon as a piecemeal, you know, kind of approach to it is to identify it like what it...

[pause in audio]

...is focused basically basically on population health and delivery system right now. Because I think there are differences like 5% and, you know, 8% of [inaudible]...there are areas there that will be identified as normal, but the only way that we'll be able to get to what maybe we want in terms of coverage is if [inaudible] can figure out how are we, not as just as a pilot line, how can we make that sustainable for Oregon. You know, for the whole [inaudible] deal that we're delivering to our community as health...[inaudible].

So I would like us, in our work, to focus on those first two issues because I think those are really our opportunities to get money out of the system, to really not lose part of our community as we go forward. [largely inaudible]...but also at the same time, to understand where we can save that money to do what with our vision coming out of our legislature and with all of our...[inaudible]. You know, how do we make that a reality? Because this is a pay-as-you-go kind of thing. This is the new normal going forward. So we're not going to be able to get grants and foundations to look at this. We're going to have to show that we have a business plan that within these parameters delivers healthcare.

>> NEW SPEAKER: Back to you, Felicia.

>> NEW SPEAKER: I think that I agree. [inaudible]...I think that that only thing I'd like to add is that when we're putting together our best plan is to be agressive about how we're maximizing the federal dollars. Because we are in a position to do that. And I think thinking about how we change the work plans of the committees to integrate some of that work, especially those [inaudible] around workforce is going to be important.

And also the other thing that I'm really excited about is this possibility of collaboration with other states. And how we're reaching out to our partners, both to the north and to the south, who mainly [inaudible]...but they're very similar to us and [inaudible over
laughter]. But to the north, they're very similar to us and we maximize that to hopefully have a workforce plan as well as sort of a population health plan because we do have a huge population in Vancouver that is actually part of our healthcare delivery system.

>> NEW SPEAKER: Thanks. I am [inaudible]...Eileen and Lilian's comments that I see this legislation as doing part of our work that was already outlined in this. And I think it's the coverage. And I think we wouldn't want to replicate that or necessarily need to. But the one thing I see really missing in all of this, we talked about last time, is the cost of the database. And I think if we just let this go for another four years without ever having, you know, putting it back on our front we would reject that [inaudible]. So to really work on population health and delivery system reform where we can spend the time really focusing on that over the next several years I think is going to pay off. And I think, you know, what Joe alluded to earlier, when you look at the federal legislation in terms of the cost of payment mechanism we put in a place was a $500 million cut to Medicare with really no way of understanding how that's going to pay up. They haven't even taken action to get there yet.

So I think that the more, kind of, proactive we can be on that front I think is going to be the...[inaudible].

>> NEW SPEAKER: [inaudible over laughter]. And I don't have a lot more to add other than that [inaudible] state where I am, and that is that I agree with the philosophy that I think has been stated here. That a lot of the work has been done for us and I think the extent that we can align with that work and then go forward from there, we have the greatest opportunity for real impact. I think that real impact comes in the remaining pieces of the Triple Aim in the delivery system and workforce and so on.

I think Chuck made a very good point about trying to do this in a very strategic and comprehensive way and not in a piece meal sort of approach. So I certainly agree with, basically, everything I think I heard here. Bruce, what thoughts do you have?

>> NEW SPEAKER: I wanted to get back to the tremendously helpful and it sounds like there's a growing consensus...you know from a staffing and [inaudible] education perspective I share some of the concerns about needing to be strategic about the implementation [inaudible]. We're approaching this, as we've been talking about this over the last couple of years, really as a very large scale project. And we really need to organize...we need to really understand the depth and breadth of opportunities, what may happen, as well as making some real strategic choices about what to invest time and energy into and perhaps what may be available and what to pass on because it doesn't...you know, a longer term strategic vision. I think every organization in every state had to have set capacity for change and we've got to keep aware of that and I think that's our collective roles. We've already starting putting in place the kind of project management structure that I think will help support the board. And we start to move forward with understanding the opportunities.
And then, I also think we're going to need to, with this, look at, over the next month or two, refocusing some of the committee work now given this. And I think it really speaks to focusing and sharpening some of that work for some real deliverables in the very short-term that will fill in some the gaps and really focus on the health and delivery system cost issues.

>> NEW SPEAKER: Very good, thank you. Tina, we were talking a little bit earlier about kind of some short term things that need to be addressed. Would you like to give us some thoughts about that? [inaudible over laughter].

>> NEW SPEAKER: Yeah, no, it does. I'm just going to ask that, in preparation for the next meeting, what I would ask the staff, the staff committees, and, actually, [inaudible]...that we look at [inaudible] reform and how that changes the work plans. Again, just some guidance to highlight some of those items.

The other thing that has come up is that we're lacking strong health equities language in a lot of our work plans. As long as we have these [inaudible] and we're looking at them in terms of federal reform, I think it would also be a really good idea to work with the office of multicultural health and develop language and [inaudible] the work plans again. And not just the committee work plans, but also the work plans getting done around subject matter by staff. So we would do that between now and the next meeting too.

And then I think, just to let everyone know, that we are tracking this very closely. It is like literally a...

[pause in audio]

...everybody up-to-date on what we're hearing, how it changes our work, it doesn't change our work, and what opportunities there are.

>> NEW SPEAKER: And do you need any formal action from us or just generally [inaudible] that we're all on the right track and does it really feel like that statement of work is on the right track? Very good.

>> NEW SPEAKER: Bruce, I'd like one question. It is really more informational based on...Tina just said, we get info on an almost hourly basis from HHS about, you know, now and today is about medical...you know, timelines about medical operation. Do board members want all of that in sort of real time or would you prefer sort of summaries at times that makes sense?

>> NEW SPEAKERS: [inaudible over each other and laughter]

[pause in audio]
>> NEW SPEAKER: I don't know how it's actually going to play out. Some of them, literally, two days after it was signed we were getting letters from HHS asking us who's your point person and how are you going to address this. So some of it's very fast, some of it won't help for a while [inaudible].

>> NEW SPEAKER: [inaudible]...with all of that information that comes in, turning that into...

[pause in audio]

>> NEW SPEAKERS: The other thing I would add is just that this list of questions that Amy put together, I think you mentioned it. They're very important questions. I don't want to gloss over it. I think we need to look at those questions. And at some work meeting, between meetings we need to decide do those go to the workers, does that come to us? We need some strategy work on this. I think those are the questions at hand and, you know, take them on.

>> NEW SPEAKER: And I agree with that. Carlos, a comment?

>> NEW SPEAKER: [inaudible]...precisely that we have four, five, six work rooms and meetings and they're all worked into...maybe in isolation from each other. And perhaps that might be okay, but the last thing we want is to have one committee saying, "This is what we want to do," and the other one doesn't know that's the opposite. And both are probably reading from the same federal legislation.

This, for me, intercommunication is very important. It's great. I read comments from the other committees. But the chair for all of them should be able to see how...what they're doing [inaudible].

>> NEW SPEAKER: Gretchen, do you want to talk to them about opening a place to deal with that? The staffs of the committees are meeting together. And that...

>> NEW SPEAKER: We're doing a couple things. One is that we are having a regular meeting of the all the committee staffs. That includes those all located within the policy research as well as for the public health.

We're also working on, now that we have a number of committees, working to [inaudible] based on federal reform. But we're working to align work plans and identify the really key interrelation points in making a committee work. So we identified some of those needing a charter, but now we're looking at a timeline in terms of which products are being developed when and where there's some connection points between points. And some education can be done along the way between committees so they're [largely inaudible].
NEW SPEAKER: One example is the population health metrics for the health improvement committee. I mean, we know what population health, we know health and research and that, and I'm sure that commissions are thinking much like that. So...

NEW SPEAKER: The problem is a need for leadership from us to tell them, "Okay, this is what...these are the boundaries."

NEW SPEAKER: Yeah, and I think probably the best way for us to do that is to use the next week or two or three to start to work through these questions, to start to figure out where they track, where they go. Nina, Bruce and I will start that and we'll involve members from the board and hopefully we'll come back at the next meeting with a pretty clear plan.

NEW SPEAKER: All right. Anything else on this topic? Very good, thank you very much. We have time on our agenda for another comment and for a few questions that I believe have been coming in. And [inaudible]...I have only one person who has, Dr. [inaudible]? Am I pronouncing that correctly?

NEW SPEAKER: Yes, you are.

NEW SPEAKER: Wonderful, thank you. Good afternoon. How are you today?

NEW SPEAKER: Very good. And welcome to [inaudible]...central Oregon.

NEW SPEAKER: It's great to be here.

NEW SPEAKER: First I'd like to thank you for allowing us to meet today. I've had occasion to work for the last two years with Dr. [inaudible] and Dr. Smith. And in the past month I've been working more closely with Dr. Smith and Jeremy. I appreciate that opportunity.

And I believe that the policy board of, ultimately, the Oregon Health Authority will be both in charge of application of the priority list and in developing [inaudible] insurance plans to be offered to state and county employees as well as teachers. Furthermore, down the line the insurance exchange will use such plans as models for the rest of the commercial insurance plans. I would like to state on behalf on the medical community that physicians are trained with the Hippocratic oath of "Do no harm" and with the dictum "Patients come first."

We all recognize the needs of [inaudible] and the needs of the socially responsible healthcare system with the needs of a quality, cost-effective healthcare for our patients. Over the next few years, as this agency is instructed with this sacred task, it is my hope to openly seek testimony from patients and from physicians that you will re-examine the
priorities risk and the methodology used to make such [inaudible] determinations. In particular, I would draw your attention to the issue of what are acceptable types of cost-effective studies. Clinical physicians have their interpretations...

[pause in audio]

...that this confusion lies. An expert has noted that it makes sense to first identify the effective approaches and then make them more...make them cost-effective.

In going forward, most institutional review boards, in framing perspective studies, would consider it unethical to withhold what is considered standard treatment from one group of patients in order to see if they incur greater downstream costs to the healthcare system. Now it is possible for the Oregon Health Commission by itself, or with the aid of OHSU, to look retrospectively at the overall costs associated with withholding coverage of standard care. Similarly, it would be important to compare overall costs to remove presently...

[pause in audio]

...to complicate this process is that the Oregon Health Commission would use diagnostic lines only once every two years, which really doesn't allow for dynamic back-and-forth discussions. And that the priority line is also based on how much money is entered in and spent in the system. I would ask you parenthetically how does the policy board or the health authority plan...

[pause in audio]

...closely monitor the progress and alert and their patients as to their concerns. I look forward to any questions you may have.

>> NEW SPEAKER: Very good, thank you...

[pause in audio]

>> NEW SPEAKER: ...and in that capacity we testified two years ago to the Oregon Health Commission with over 400 pages of both summaries and articles on cost-effective studies. And that's kind of why we're frustrated at this whole distinction about cost-comparative and cost-effective studies. And I will just share with you that the allergy community feels that everything you've heard here today...the dedication to preventative medicine is what we're all about.

I am the son of a plumber and Dr. [inaudible], a very prominent [inaudible], used to compare the work that we do is when some people walk by a room and there's water coming through the door, and you have people that go in and they mop the floor. And
you have people that go in and fight it, unclog the sink. And then you've got people that take a look at the faucet and try to actually fix the leaky faucet. And that's what our team is all about: preventative care. We do a good job of keeping patients out of the hospital. In fact, this fine institution that you're sitting in I actually was demoted from active to courtesy privileges because, in 16 years, I've only had two hospitalizations. I think that's [inaudible]. And I would ask you to recognize that what allergists have to offer is to keep people out of the hospital, keep them out of the ERs, and that...I find that there's proper post-specialities that feel the same way, that one should look at severity of conditions or clusters of conditions in helping to determine what the most cost-effective of treating these complex patients.

>> NEW SPEAKER: Thank you. Chris?

>> NEW SPEAKER: Thanks, David. You know what, I wanted to make clear to the board is we've been working with Dr. [inaudible] around...he's referring to the health services commision and the prioritization of services for the Oregon Health Fund. And one point that I'd just like to make is that the board hasn't made any commitments or plans to expand that to anything larger [inaudible over other voices]...

>> NEW SPEAKER: Thank you. Jeremy, do we have some other questions or comments.

>> NEW SPEAKER: We do.

>> NEW SPEAKER: All right. The floor is yours.

>> NEW SPEAKER: We actually have a number of emails today so I'll just start at the top and address the [inaudible]. The first question, actually I have a few questions around the public option, what federal reform...what the impact of federal reform would be on our public option. So the question is about what obstacles do we face now in terms of...when are we going to discuss those and are we also going to discuss the possiblity of [inaudible]...non-profit?

>> NEW SPEAKER: I'll take the first shot and Bruce please...I saw a little bit of information earlier today about the fact that, so far, we don't think there's anything in the legislation that prevents public options. But I think it's very much up to this board to determine how we best proceed with regard to that specific topic. That probably comes up in the agenda in the next two or three weeks, I would think. Bruce?

>> NEW SPEAKER: Statutorily, we continue to have a charge to develop a plan...put a plan before the legislature for a public option. So in a lot of ways we continue to move forward on it.
NEW SPEAKERS: Thank you. And then with regard to the ban on [inaudible]...or at least on lifetime limits, what recommendations does the board have or what are the board's thoughts on how we're going to enforce those?

NEW SPEAKER: I think that's going to be [inaudible]. The enforcement of, you know, all the new insurance regulations is really going to be a job of the insurance commissioner and the department of consumers. And the health authority was created, and I think this is an important piece of background and history for everyone...one of the issues that was considered was whether or not to put some of the insurance oversight and regulation within the health authority or to keep it outside. I think there's pros and cons and there was a lot of debate. With that said, regulation and enforcement of insurance law lies with the insurance division. There's going to be some resources that come to states for some enhanced infrastructure, as well as some greater transparancy that's going to be required of insurance companies to do that. So I think that's all going to [inaudible] nationally enforced by the powers that come to be.

NEW SPEAKER: I think one more thing I would add to that is that within our mandate there are a couple of areas where we are directing work with the department of consumer business affairs. And we probably should include in our requested staff that the federal bill has granted or changed any of that work [inaudible]...

NEW SPEAKER: Thank you. The next question is, actually it's a couple of questions concerning the high-risk pool. Do we know yet what the federal high-risk pool will have out-of-pocket expense sharing or is that a question...[inaudible]?

NEW SPEAKER: We have no info on what is going to be the requirements of the federal high-risk pool.

NEW SPEAKER: Thank you. And then the follow-up to that: what community engagement does the board see when we get to the point of knowing what decisions can be made about [inaudible]...what I would add to that is I guess we first need to figure out what decisions the state has the ability to make.

NEW SPEAKER: I think that's exactly right. And I think the next step there is that we are very transparent in our work as a board. Also very transparent about the work our committees are doing and ensuring people have access to those committees as well as [inaudible]...

NEW SPEAKER: The next question: assuming that adding additional population to Medicaid [inaudible] some cost in savings system. How can we go about capturing those cost savings and returning them to [inaudible]...?

NEW SPEAKER: I'm not sure if you're asking these questions to help you with your communications...
NEW SPEAKER: Oh, let me clarify. These questions [inaudible over laughter].

NEW SPEAKER: People are emailing in questions and we're answering them!

NEW SPEAKER: Thank you for speaking up to all the people who aren't in the room.

NEW SPEAKER: It's a new format. We're learning.

NEW SPEAKERS: [inaudible over each other]

NEW SPEAKER: I think that's been the age-old dilemma, not just in healthcare but in any organizational change. How do you...when to find efficiencies, how do you take some of the dollars out and redirect them. And there's no doubt, and I think it's a great question for the board and for our [inaudible]...I think it's some of the things that Health Matters has been grappling with is they put together the three-shares. There's a significant amount of resource that is going into covering the uninsured. And I think that's what the question is really geared at. And the certainly we're going to have a large number of people who will gain coverage. And there's a bunch of resources that are going to provide some level of care. And it's how do we capture that and repurpose that within the system I think is going to be a really important question. Not sure anybody can...

NEW SPEAKER: So, and I don't know where the question is coming from, but do [inaudible] supposed to go back to the general populace as a recycled [inaudible] that DHS could use them to outmatch another federal program...[inaudible]

NEW SPEAKER: Let me actually clarify because I think there's two bits of [inaudible]. One would be the non-general fund money, whatever money is going to provide care now. The other is, I guess, the question can also be interpreted is there some, you know, general fund money that the state will see. And if you look at the sort of ten year continuum of health reform, there are some places where health reform does free up some general fund money. Actually, in the early years, there's some opportunity. For example, when [inaudible] reimbursement, [inaudible] matched on the federal government increases 23%. There'll be some general fund dollars freed up. I think what the question for the legislature and for this board will be kind of continue to capture some of that and where that goes.

As you get toward the outyears of health reform, the balance starts to tip a little bit and there's, you know, a small cost [inaudible] for the additional coverage. Over a ten year period, our sense is it's fairly ready and neutral that the state will get additional...

[pause in audio]
...including the variety of population-based improvement opportunities. And the general fund expenditure could sort of leverage that. As best we can tell is somewhere plus or minus $50 million. So it's about as cost-neutral as we can get [inaudible]. I don't know if that totally answered your question, Carlos. I guess it's something we'll all have to pay attention to. And a great question.

>> NEW SPEAKER: I have one more question. How do we assure that, as we more forward, the Oregon isn't penalized for the work that we've done to cover kids and adults that are 100% versus some of the states that haven't contributed additional state funds?

>> NEW SPEAKER: We've been working 24/7 over the last year with our congressional government to be certain that that doesn't happen. And we think, right now, that we're not going to be penalized for that. But we also believe that we shouldn't just trust, we need to verify. And that as the rules get written, we're going to be certainly working with our congressional delegations to be certain that rules don't get written in a way that would potentially disadvantage us. But we've been working really hard and I think it's been a credit to the way the language of the bill, the health reform bill is such that we won't get penalized. And there was very technical issues around waiting lists for OHB [inaudible] and a variety of things. And it won't be an answer...[inaudible]...but we're going to continue and I think we need to be vigilant about that.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: Thank you very much.

>> NEW SPEAKER: I'm sorry, I just have a comment about sort how we capture the dollars. I think it's important that we make possibly the focus of all of the subcommittees that are reducing cost is how to actually [inaudible] those dollars for consumers. If we're just driving down costs, but not seeing any return on that people are going to get very angry.

>> NEW SPEAKER: [inaudible]. Appreciate it. Is there any other business to come before the board today? [inaudible]. Mike, once again, thank you and your colleagues...

[end of recording]
MALE SPEAKER 1: ...the data itself, and that contains the minutes of two previous meetings, the August 10 meeting and the September 14 meeting. Also included is a table of contents, essentially, for a comprehensive plan. The comprehensive plan is a work in progress. In a sense it will become a sum of the recommendations that we deal with over a period of meetings here as all of our various activities come together, but I want to draw that to you.

We will be talking in detail about the comprehensive plan at our November 9 meeting, so we're not going to get into that in great detail today. Let's see, is there anything else in that...Oh, we also have a matrix of agendas for the rest of the year, showing our meetings through December and note that we've added a second meeting in November: we're going to meet November 9 and November 16.

So with all of that, are there any comments, corrections, or additions to the minutes or any other comments about the consent agenda? Hearing none, we'll deem the consent agenda to be approved and move on. Thank you.

Number two is the director's report, and [Dr. Burton], I'll turn it over to you.

DR. BURTON: A couple of corrections to the written report: the date was not August 10th, it was October 12th, and that first bullet under the equity review from the healthcare workforce committee is incorrect, it should be under the health insurance exchange.

Having said that, what I just wanted to do was update the board about a couple of things, one of which I know there's been a lot of discussion about and we can have some opportunity to discuss, which is some of the federal changes that happened over the last few weeks around [kids? KITS? 1:52] coverage. Hold on that for a second and we can spend a little time with that. What I wanted to do was just update the board on some of the budget issues that have transpired since we met in August. Since we met in August, there was an additional State Revenue Forecast, which has the state an additional $377 million short on revenue from the projections on the rest of the biennium.

That was really on top of a June revenue forecast which had the state down $577 million, which was 9% less than what would be needed for the next 12 months. Then there was this additional $377 million which is is really an additional about 8% of what is needed for the rest of the biennium.

So two very substantive issues. I think the most concerning thing about the August revenue forecast was not just what it did for this biennium but it also rolls out into some predicted decreases in revenue out into the next biennium. The basic underlying issue from the state economist is that what had been expected to be a slow, shallow recovery in
the economy and in the job market is now shallower and pushed out a little slower. So it clearly rolls up to another 500 to 600 million dollar loss in revenue for the next biennium.

How the state has responded to that has been in a couple of different ways. In August the governor asked all state agencies to put forth an additional 8% in reductions. We had taken a 9% reduction across the board in all of our programs in the Spring and had been implementing large reductions both administratively as well as in a number of programs and services. We were asked to take another 8% in reductions; fortunately on the Health and Human Services side there was an extension of the federal Medicaid-match enhancements, which brought in about another 123 million dollars of federal money.

That in essence offset the reductions on the Health and Human Services side. So on the programmatic side, we haven't had to take any additional reductions at this point, but we were asked by the legislature to reduce our administrative expenditures by another 10.8 million dollars, which is another 6% decrease in our administrative budget on top of a 9% that we took back in June. So we've been implementing that, it's meant a variety of layoffs of managerial staff as well as a continued freeze on hiring; we have a lot of turnover in a number of positions and there is sufficient enough turnover that by not filling those positions, we don't have to move to layoffs to reduce our administrative expense but there is such a degree of turnover that as people leave positions, we simply just don't fill them.

The consequences clearly of such are some of the workload issues across the agency, whether that is in Eligibility, Child Welfare, contracting, etc. We're continuing to work to manage that and continue to provide as much service as we can with the limited administrative dollars. Just as a reminder, when they look at the total DHS or Oregon Health Authority DHS budget until July 1, 85% of the dollars are spent on what we call programmatic expenses in the community. 85% of the money goes to foster parents, hospitals, doctors, nursing homes, etc. There's only about 15% of the budget that is spent on state employees, state government infrastructure. Half of that is direct-service, in terms of state hospital, direct child welfare workers.

So the ability to continue to ratchet down that small piece of the budget has become increasingly challenge. I think over the last couple of months have been a pretty unprecedented time for the agency as we've really been dealing with a number of things, any one of which would be a massive undertaking. We've been transitioning to the two agencies, splitting the single DHS into the two agencies where that work is actually going quite well. I'm on track, on time, very confident in our ability to make that transition in a way that will be smooth. We've been dealing with this series of quarterly revenue forecasts and budget reductions which mean both a series of exercises that are coming up with what those budget reductions are, presenting them to the legislature and then implementing them.
And then certainly a lot of work on both sides preparing budgets for the next year, dealing with federal reform as health reform as well as the work of this board and state reform. It's just been an unprecedented time in terms of continued transitions, the uncertainty, and the diminished resources. At the same time I think it has shown a resiliency certainly on the agency side to continue to move forward in each of these areas, given the resource climate.

So that brings me to the federal reform piece. Let me just stop there and see if there are any questions...

>>CHUCK: Is there a contingency plan on the programmatic side...I assume you have a game plan for if and when service reductions are in place?

>>[DR. BURTON]: Yes, but. One of the issues that begins to happen certainly in our world as we get to the last six months of the budget...and I think what you're referring to, Chuck, is "What happens if we have a December Revenue Forecast which continues to be as dismal as the others and then there's another Revenue Forecast in March." We're beginning to develop those plans. What's really difficult is that as you get out into the last six months of the budget, it is really hard to very quickly operationalize a lot of programmatic changes, primarily due to a lot of federal issues, contractual issues, notification issues, etc.

So even if on January 1 we need to make some programmatic reductions, often to provide the kinds of notifications to clients and changes in contracts and other types of things, it can take 2-3 months. So it makes it very very difficult to implement those sorts of changes in that kind of compressed timeframe. Where we've begun to engage in some discussions with the legislative fiscal folks, the budget management folks and our folks about what and how we can do those things, it's very difficult.

I think the issue is we've got to stop budgeting...we've got to start looking at this and that sets up a lot of our discussions over the rest of the day: this isn't a six month problem. We're really looking at a 2-4 year issue. When we make decisions around our budgets and look at things, we've got to really look at the horizon and how what we do over the next several months really takes us through the next several years.

The problem with state budgeting as we continue to kind of reset every two years and it's as if we start at zero. We're clearly looking at a multi-year horizon of decreased revenue, so what we do over the next six months has to be as much about the next four years as it is about the next six months.

>>[CHUCK?] : I think many of us believe that cuts made now actually end up costing four years from now. So you have to figure that part out also. A programmatic cut now could end up having profound impacts down the road in terms of...
>>[DR. BURTON]: Correct, that's exactly the issue, so...

>>[CHUCK]: Good luck. And keep us posted.

[Laughter]

>>[DR. BURTON]: We will. It's an extremely challenging time for everybody, and I think it's going to require a new way for all of us to think about this and certainly I think the fiscal imperatives are pretty dramatic, particularly when we look at the health programs and the fact that we certainly can't continue to sustain 10 and 12 percent increases in healthcare costs when state revenue is growing by 2 and 3 percent. That becomes unsustainable; that has got to drive our work as a board in what we do. It has to be not what do we do over the next six months but what do we do for the next decade. This state spends about 18% of its budget on healthcare costs, and so you can't have that big of a piece of the budget growing at a rate [that's out of synch with what the state ledgers are...]

Very sobering. So: federal reforms. On September 23 was the six month anniversary of the passage of the Federal Health Reform Act and there were four reforms that came online. They were, number 1, guarantee issue for kids. That's the one I really want to talk about because it interfaces with the healthy kids plan. Number two was that healthcare plans have to cover preventative...new plans covering preventative care without copays and being exempt from deductibles. No more lifetime limits on healthcare coverage, and there was a change to the decision rules so that to remove from coverage they have to show fraud, etc.

The biggest piece for us and certainly a lot of news in the newspaper and we've all been having a number of conversations about it has been the issue of guarantee issue for kids, and what that's done to the kids' health insurance market, how that interacts with our healthy kids plan, and what we can and can't do to help stabilize the kids' marketplace.

A lot of things have happened over the last couple of weeks as we've thought more about this, worked with carriers, etc. What's happened is that some carriers have decided to no longer issue new policies for kids. A number of carriers have, in this state, continued to do that; when a couple leave, it creates an environment in the marketplace where those that are staying are concerned about their ability to spread the risk. That's the environment we're working in.

What we've tried to do is a couple of things: we know that in the Healthy Kids Plan, there is guaranteed issue and has been guaranteed issue for the last eight months, and certainly in kids between 200 and 300% poverty. So that's been guaranteed issue, that's been...we've been looking at subsidized, looking to continue to enroll kids. Right now we've got about 2300-2400 kids in that part of the market. The issue is for families above 300%, what these changes are going to mean.
We've done a couple things: we have an open enrollment period for the over-300%. We've been working with the Healthy Kids carriers and those carriers that are staying in the childrens market to synch the open enrollment of the Healthy Kids plan with the open enrollment that's going to happen in children's market in general. The way the children's market is going to work is there's going to be two open enrollment periods in a year; those rules were put forth by Theresa Miller in the insurance division, so they'll be guarantee issue but it'll only be during two open enrollment periods for kids.

We've had a lot of discussion about should we offset the healthy kids enrollment with the enrollment with the general commercial market, and since some of the...the issue has been to try and work together with the entire carrier market that's providing kids coverage, to be certain that we don't inadvertently spread more risk to a small subset of the carriers. For example, of all the carriers that are continuing to issue individual policies for kids, some are also Healthy Kids contractors. Not all of them are in the Healthy Kids piece, so the whole notion was we don't want to adversely affect those carriers that are both in the general commercial market for kids as well as in the Healthy Kids market. So we've been working to try and equilibrate that risk.

We've also had a lot of discussion and I think I indicated to board members a week or two ago in a note I sent out that we were looking at what we could do to change the Healthy Kids benefit over 300%. We thought that making that...we had some discussion about making that a more competitive product; it's a comprehensive benefit, very expensive...could help out in this, so maybe we should very quickly move to making that a much more competitive benefit. Although sitting down with carriers, there was some concern that doing that would actually have the same effect about the offset enrollment periods, in that that might adversely affect those carriers that are both the general market as well as in the Healthy Kids'. So we're continuing to discuss that and sort of backed away from that in terms of moving on that very quickly as we try and really look at what we can and can't do to keep us a stable market.

The last piece that we've been working on- and it's been a great effort between carriers, insurance division and us in the high-risk pool is we've been looking at the high-risk pool and how that interacts with all this. At the [Omit] board meeting they just voted to make the high risk pool available to kids who don't have access to any coverage during the closed periods. That's the good news. The difficulty with that is that it's going to take a statutory change and it can't happen until probably February. The reason being is that the way the statute is set up for the high-risk pool now is it is set up so that you can only get in for one of two reasons: you have to be underwritten out of the market- by definition that can't happen- or you have to have one of a list of about 40 or 50 conditions that you can get into the high risk pool. Kids that have those conditions can now still get into the high-risk pool; the issue is that other kids that don't have those conditions and are being underwritten. So we're looking at the [Omit] board approve moving forward with a statutory change to fix that hopefully early in the session so that can be taken care of.
>>EILEEN: Do we have any early reports from carriers or our own experience of whether there has been a rush to the individual children's market, a demand for it? Any sense, do we have any sense of whether we have kids rushing in and then getting denied coverage or whether...

>>[DR. BURTON]: No, we...

>>EILEEN: You haven't heard rumors about...

>>[DR. BURTON]: One way or another, it has been all of about two weeks.

>>CARLOS: So not to name names, but how many Healthy Kids-only policy health insurance providers do we have and which are the health insurers who chose for whatever reason to not insure [indistinct; mumbling].

>>[DR. BURTON]: You know what, probably the best thing for me to do, Carlos, is to let us put together a list. There are 2-3 carriers that I know off the top of my head that I know have decided not to, although there are a lot of what we call "non-domestic carriers," a lot of the national carriers have decided not to. A bunch of them have been issuing very small numbers of individual policies here in Oregon. There are a couple of our domestics that have chosen not to and a number that are continuing to. I think the best thing for me to do is rather than be accused of either indiscriminately promoting or dissing one group or another, I think probably the best thing is we'll put together a list and get that out. Actually we can probably put that out to board members and get it on the website. Probably the best way to do that.

>>CARLOS: Basically I was trying to find out if there were two or three and the market is composed of 5 or 6- that's half. If we have 10, 20, I don't know what the denominator is. How much stability or how imbalanced might it be if it is approved, if it's a big issue or not.

>>[DR. BURTON]: And that's what we've been trying to put together and Theresa Miller has been working on exactly that: how many carriers are in the market, how many policies have each of them issued...because it's not so much a question of number of carriers. If there's 100 carriers but only 5 are issuing 95% policies, that's the issue. We're putting together that information.

>>MIKE: How does the high risk pool program affect children? I understand what you're saying about Oregon's rules, but is there an opportunity on the federal program that can enter that program?

>>[DR. BURTON]: Yes, so kids can...the [Omit] board recommended another change which synchs the state high risk pool with the federal pool, which is this. The state high
risk pool, you can get in if you have one of these conditions but sadly your coverage for those preexisting conditions took six months to kick in. And so although you get on the plan, the coverage other than pharmaceutical coverage, but some of the other coverages, there was a six month waiting period. What the board just did was recommend that they cover kids during those first six months, which synchs it with the federal pool. So we're looking at what we can do in that regard.

>>FEMALE SPEAKER 1: I'm very excited that we're being proactive about this; I think we have to look at it as part of the whole package of providing quality care. I would love to be able to see some sort of data, even if it is informal, from carriers and our experiences as to how much of an issue this is, what the scale is of this problem.

>>[DR. BURTON]: I think that's been the learning from all of this, it's been many-fold. One has been this way forward with all of our reforms, to understand the consequences and unintended consequences of a variety of issues and what you can and can't do to mitigate that. A lot of that takes some thought. We've also learned that we need some additional data/information. My first question the day this happened was exactly like Carlos' question: "How many plans does each carrier have?" And what we've learned is that getting that information has been a little more difficult than any of us anticipated. We'll get that over the next week.

>>MIKE: The other interesting thing I've been following, getting to Eileen's point, when you look at your Healthy Kids, some of the numbers down here...one concern that I have is when I keep looking at these Healthy Kids Connect enrollments, 2300...I was trying to keep in mind in terms of how that compares to the projected in terms of total, because Connect...I think that gets to Eileen's point of has there been this mad rush and from a carrier perspective you are looking at if these are just the sickest coming in. I don't know that yet, but we were anticipating a higher enrollment in Healthy Kids Connect.

>>[DR. BURTON]: Yeah, I think that's been perplexing to us for a number of reasons. We've had guarantee issue...when you consider median income in this state as being close to 300% of poverty we've had the availability of guarantee issue for kids with a very good benefit and a very good subsidy available for the last year, and we've been doing our best with outreach and enrollment issues and have gotten the word out and have application assisters out there, a whole host of ways to bring these kids in. We had anticipated about 10,000 kids and we've got about 2300. Certainly we've learned about some of the administrative issues around enrollment and we've worked to simplify that but it's not all of it. What we know from other states is that getting this segment into the market has been [beeping overtone]...I think there's some real lessons there as we move forward.

>>MIKE: There's two other points that I think...one is the affordability. That product hasn't been terribly affordable, and you can actually make the opposite argument that Eileen is suggesting with guarantee issue: if you have a product that isn't terribly
affordable, you can wait until you need the insurance. I think that's what is driving the concern of some of these larger insurers and I get that. I think there's an opportunity for us to work with them and try to mitigate those concerns.

>>[DR. BURTON]: The 200-300% market has been pretty affordable...

>>MALE SPEAKER 2: I'm talking about the 300%

>>[DR. BURTON]: Yeah, no, absolutely.

>>FEMALE SPEAKER 1: I think that Mike is right, though, that in between 200 and 300% poverty, the rates I actually read as fairly affordable, talking about between 22 and 30-something dollars if you have one child a month, if you're in the 44-66,000 annual [income] range. I wonder if it's a marketing issue or what we can learn or do we know that really kids only get coverage when their parents get coverage, is that basically...

>>FEMALE SPEAKER 2: I think that's part of it. The Healthy Kids Program has run a lot of focus groups around this issue to try and find out what the problems are and a lot of it is around the application and then there's been a lot of work done to simplify. A lot of these are families that don't touch the human services system at all and so they're not really comfortable in that environment and we need to work on that. A lot of activities are starting up as a result of those focus groups. But yeah, it's a new group for us and I think the parent piece is critical and there's a lot of evidence that shows that if the parents aren't covered the kids don't come in as readily.

>>[DR. BURTON]: We've been circling around this issue at each meeting and I know we've got really full agendas coming up but I think it might be a really good idea - and we'll see if we can't sort of squeeze out the time - is maybe to have a half hour with maybe some of the people that have been involved on the community side, on the agency side, on the insurer side, really talk about some of the issues.

>>FEMALE SPEAKER 2: Could be work sessions.

>>[DR. BURTON]: Right. Just something that could be a good discussion, I think there's a lot to learn from it.

>>MALE SPEAKER 3: Has Theresa picked up the...she was going to get three additional staffers with that grant; has she been able to get those people on board to help collect some of this data?

>>[DR. BURTON]: So that's the news from Lake Woebegone.

>>MALE SPEAKER 3: Well said.
MALE SPEAKER 1: Any last questions for [Bruce]? 

FEMALE SPEAKER 2: Do we have time for one more on the director's report or should I save it? I meant to ask about the workforce committee, it'd met since this report was published and I was wondering if they got into that issue of what is the ultimate goal or envisioning what does the workforce of the future look like so we can then back into the strategy. 

FEMALE SPEAKER 3: No, I don't know if they did or not - I wonder if there's a staff member here that can...[come up and answer that quickly] 

MALE SPEAKER 4: Yes, they did. 

[laughter] 

MALE SPEAKER 4: We can talk about it offline, too, but.. 

FEMALE SPEAKER 2: Getting our arms around the bigger picture and... 

MALE SPEAKER 4: Yup. 

FEMALE SPEAKER 2: OK. 

[DR. BURTON]: The bit of feedback I've gotten from that group is they felt a little hard-pressed with our coming forth and suddenly telling them to envision a bit of what they thought was a broader scope and are starting to address that. 

MALE SPEAKER 5: I have spoken to a couple members and they're considering that project-creep, that the orientation had been a bit more concrete than that and that there wasn't any philosophical objection to this, just not the way they were oriented. 

[DR. BURTON]: Along those lines, two issues about the committees and committee reports I just wanted to [audio cuts out] while we're here. One is that it occurred to me that getting 12-15 pages of committee minutes in one fell swoop is mind-numbing and that it is probably going to be better to send out committee reports within a couple of days of the committee meetings and stagger them out rather than sending them out in one fell swoop, unless you want to continue to get them in one fell swoop. 

MALE SPEAKER 3: Trickle-down. 

[DR. BURTON]: We'll trickle it down. Seems to be a bit easier for me; by the last one I get a little...it gets tough. I think the other issue is that just to clarify with all the board members. We've been trying to work with the committees and I've had meetings in between board meetings, with Eric and Lillian- chair and co-chair and myself and we've
been trying to help move the work of the committee to really synch with the board. In doing that I've drafted some methodological instructions to the committees to try and clarify things because it's always really important to clarify what expectations are...in doing that, I've often indicated that this is...that if the request of the board...and I realize that in doing that it hasn't been...every board member has signed up for that, that it's been board leadership and just trying to correct that as we move forward.

>>[MIKE]: I do think that the result of that effort has been a lot of good focus in the committees and they are getting to the issues that we need to hear about.

>>MALE SPEAKER 1: Move to agenda item number 3. Jeremy, do you want to come forward? Most of you all know and we certainly know that there have been considerable efforts in the last month, month and a half to reach out to the public for input and Jeremy, do you want to tell us what's been going on and what sort of results you've received?

>>JEREMY: [Audio cuts in and out- volume drops intermittently] Absolutely. Is this working? Thank you, Jeremy [?] Oregon Health Authority. Just wanted to follow up a little bit with two big pieces, community meetings we've had in the last month and the public input we've had. We took September off to gather public input primarily around the insurance exchange and we gathered input in really four areas through written e-mails, which people have always e-mailed comments in but we specifically solicited that. We held six community public meetings and then we had an input tool up and then I would also note that a lot of staff have been out working [audio cuts out]. Really in the last two months were two big areas: one was to get initial feedback on the general direction of the board, even though a lot of the committees haven't come back yet, sort of where we think we're going with the comprehensive plan as well as the insurance exchange. Next [slide] please.

So this is just a picture of our communities. Next please. So we had six meetings: Baker City, [Bend], Corvallis, Florence, Portland, and Medford. They were held from the 1st through the 16th of September, were facilitated by [Oregon Consensus of Oregon State University] in conjunction with local dispute resolution centers, so they were neutrally facilitated. We did a lot of outreach both in-house and through media and social media. We had a number of radio interviews and good stories around the state to publicize it and we also wanted to know we had a lot of outreach done by our community partners, stakeholders, advocates...there were canvasing efforts, e-mailing, phone banking efforts. So a lot of effort in the community to get people out to these as well. We had about 850 people attend between the six meetings; Portland was the largest with 300 but several of the others had more than 100 people. The average satisfaction- we asked people to leave feedback- was almost 4 out of 5, so people were very satisfied with the meetings themselves. We had a really active participation and a diverse group of folks that showed up. We gained input through both written and oral comments. Next slide please.
Just to quickly touch on sort of who showed up to these meetings, about a third of people who showed up collectively, through the 850 people and this is just a kind of rough guess based off of people showing hands when we asked questions- but about a third were employed in small business, a third worked in healthcare and 15% in insurance, and about a third reported they obtained their insurance through work. We asked people how satisfied they were with their current insurance and about half said they were satisfied, about a third "unsatisfied" and about the last 20% or so were neutral.

A couple of the reasons for why they mentioned that they were satisfied was the cost and range of services that were offered and we also had a number of...we had a lot of Medicare beneficiaries show up and that was pretty widespread that people reported being happy with their Medicare coverage. Couple of the reasons they were unsatisfied, obviously an increase in premiums and costs was number 1 but also diminishing coverage and limited choices in plans and services offered. The way these were set up was we gave them a little bit of an overview with the Health Authority, we gave an overview of the direction the board is headed generally, really around the triple aim and some of the work the committees are working on and then we went into the insurance exchange.

So I'll summarize some of the themes first on the insurance exchange and then we'll go into the general direction of the board. The insurance exchange was difficult to explain and we mastered it toward the end but the question we really presented to people was the issue of trying to balance simplicity and choice within the exchange and does the exchange mirror the open market where we set some standards and allow everyone in or are we going to control it a bit more. And then we asked for some more general feedback from other areas on the exchange, other qualities that were important.

>>JEREMY: Generally I think the majority of people across the state wanted the exchange to be somehow more streamlined or more limited but having meaningful choices, and that having meaningful choices piece didn't necessarily mean fewer choices. For example in eastern Oregon it was "meaningful choices" meant having more choices than they currently have right now but in other parts of the state it did mean having more limited or more streamlined choice. It also meant that it was important that the types of services that were offered including alternative medicine for example...and so part of having meaningful choice meant having inclusive choices as well.

We asked people if they wanted standards in the exchange than what the federal requirements are going to be and the general consensus, the general feeling was that they did, they did want Oregon to take a more active role than what the federal government is going to require and have the exchange actually drive innovation. At the same time there was concern whether that would mean additional levels of bureaucracy and there was a strong sense that people wanted an exchange to encourage competition.
One of the themes that was consistent was assisting customers and having strong consumer assistance: people mentioned that it was important that there was transparency in the exchange, that they be able to compare not only price but other meaningful indicators and even things like medical loss ratios, so they can make decisions on what the quality of the plans is. They mentioned in-person assistance as well as the phone or website and recommendations that insurance agents be involved or that they have some link to get to an insurance agent.

One of the concerns was providing comprehensive care within the exchange and making sure that the benefits included dental, oral, and mental/behavioral help. There was strong support at at least three of the forums for a publicly loaned health benefit plan to be offered within the exchange and at at least one of the forums there was a strong turnout for a veer away from an exchange and looking at a single pair system.

Probably the biggest concern that we heard was how the exchange was going to control costs. That came up a lot and people seemed to understand the concept of the exchange but would be more favorable of seeing how we could use it as a vehicle to control costs.

When you get outside the Portland area there was a concern about continued accountability within the exchange and having the exchange be accountable to other areas and other regions throughout the state. I think one good takeaway for the board was that there was a lot of appreciation for the tough choices the board has. There were a lot of people at the meetings that said they don't envy you for the choices you have to make over the next couple of months but they did generally support having a citizen board making these decisions and just asked that you make the decisions as best you can for Oregon.

Then we switched to some general input on the direction of the board. We had outlined some general areas of where the board was headed and the examples such as looking at electronic medical records, looking at patients under primary care homes, administrative simplification and asked people if we were on the right track...and overall people felt that we did. The majority of people indicated that we were on the right track for where we were headed for reform in Oregon.

There were very few strong concerns about where we were headed and the people who had any concerns, a lot of them just raised issues that we are actually working on but didn't have time to go through in detail- for instance I don't think we had medical liability on our list and so people would mention that. In terms of the themes that came out around general direction of the board, preventative care, wellness, and incentivizing healthy behaviors were very popular across the board, at every meeting both on the website and at the community meetings; people were really concerned about preventative care and understand/grasp that.
There was a lot of support for focusing on primary care and putting patients back at the center and putting patients in primary care homes, feeling like that was a good direction. And then, again, providing comprehensive care and making sure that we include oral, dental, vision, behavioral health.

We asked for folks to give some advice to the board on what they would like the board to keep in mind as you move forward and make decisions. The number one, not-so-surprising concern was making sure to keep costs in mind, that the focus really needs to be on how we can contain costs and also expand coverage at the same time and make sure that we are expanding coverage to pick up the uninsured in Oregon. Again, concern about layers of bureaucracy, to keep that in mind as well as a lot of voiced concerns about profit nature of healthcare, at least a perceived profit nature. There was a mention a few times of making sure that we don't focus too much on insurance reform when we look at healthcare reform generally, and I think part of that was we were also out and presenting insurance questions to the public so it did seem like we were focusing on insurance.

Again, to work comprehensively on reform, medical liability, access, and choice of providers, eliminating duplicate procedures on paperwork and utilizing alternative medicine providers and care, [these all] came up as some things where people would like us to focus on that they didn't see. Looking at needs across the state and making sure that we're addressing needs regionally, in rural and frontier areas as well.

So that was the community meetings and then we also had a public input website up that we developed and this was sort of our first rollout of the website; we were intending to use it for other areas down the road and we had- you can move to the next slide, sorry- we had about 1500 people who were able to use this website. We were able to track IP's to see if they were unique, so this was the unique IP's, I think we had 1900 or 2000 hits total. We asked six questions, again on the direction of the board...there were vision statements around, the triple aim, and some examples under each one of the work the committees are doing.

Then we asked five questions on the insurance exchange, three of them were where they were just given a choice and two of them were more open-ended. People weren't required to go through and answer every single one, they could kind of breeze the sight and answer which questions they wanted to. The questions that got the most answers got 604 responses, and I'll just note that the purpose of the website was really to supplement the community meetings and provide another level of input but by no means is it a scientific measure or scientific survey.

We had 71 cities in Oregon hit the website and this is just a map of that. Obviously nobody looked at it with their iPhone so there's no accounting for that, or driving across the coast range, but otherwise we got some statewide hits.
On three of the questions on the exchange, the first question was similar to what we asked at the community meetings, about balancing choice and simplicity. Again, setting up around the number of health plans that are offered and whether people want the exchange to be wide open or whether they want it to be more limited or streamlined in choices. We had over 400 responses to that question and 46% of people wanted some limited choice, 20% wanted it wide open, and the last...over a third weren't sure or wanted something in between.

We asked users what they wanted the role of the exchange to be, whether they wanted it to be very active or if they wanted it to carry out federal law and set the minimums. About 400 people responded, 69% wanted the exchange to take an active role and really drive innovation, 18% wanted it to just enforce the federal guidelines and about 13% were unsure.

We asked whether people wanted the exchange to be the sole marketplace for the individual and small group markets or whether we should maintain an outside market. About 400 people responded, just under 50%, 49% wanted to maintain the outside market as well as have the exchange. 35% said exchange-only, 16% were unsure.

We asked an open-ended question, asked people to write down some notes of the community meetings and then we also asked the question online of what qualities would contribute to people's satisfaction in the exchange. Actually the input was pretty similar in both so I just put it in one spot here. Number 1 thing easily was ease in enrollment and having a one stop shop for where people could enroll. Even if you had numerous programs or numerous different steps for enrollment, having just one portal, one place where they can enroll was important. Excellent customer service and being able to get a hold of somebody and feel like you're being listening to or are important. Easy to compare plans and again transparency was very important.

On the website the transparency thing was really around copayments and what people were actually picking between the plans in terms of price and out of pocket cost. It was important for people to understand which provider network they were choosing between and have some information about that, that they have the ability to use an insurance agent if they have questions...and then there was a lot- both at the community meetings and on the website, a lot of people indicated that they wanted the exchange to...it was important for them to know that the exchange was both independent, it was governed by a board that was independent of the insurance industry and that they felt that the exchange was negotiating or advocating on their behalf.

Next, please. So that was the exchange, but [here are] some general themes on where the board was going. We had six questions- and I won't go through each of the questions- but out of those six questions there were a few themes that came out. Probably the very top one was that at the public meetings there was a lot of turnout publicly-owned health benefit plan as well as single-pair. On the website it was probably half and half of people
who said that and people who said to keep the government out. Just to mention that difference between the two.

There was a lot of focus on prevention, people really grabbed prevention, wellness, incentivizing healthy behaviors, was very popular on the website. General support for evidence-based care was popular with the caveat that we make sure we have some flexibility in there for there is and isn't evidence as well as situations where best evidence may not be the best situation for a patience. Again ensuring transparency and actually it came out on the website that people wanted transparency both in insurance as well as in the delivery systems, again so they could make an educated or informed decision between health plans. We asked folks how if we could capture costs how they'd like those reflected and there was a lot of interesting ideas out there but the top idea by far or the top feedback by far was reduced costs: lowered premiums, lowered out-of-pocket costs, not a surprise there.

Finally, local collaboration and innovation was very popular on the website and a lot of people actually indicated that they felt like that was the area where we have the best ability to make reform was to try out pilots locally and then be able to spread those around the state.

>>JEREMY: This next is for the public more than the board: we did post an updated schedule last week for public input on areas outside of the exchange and the publicly owned benefit plan and comprehensive plan. I know there are a lot of stakeholders who are waiting for committee reports to come back...so we did post a schedule of when people can start writing input and when they can expect committee reports back. So for those listening, feel free to check out our website and look at that. I guess I made up some time so I can take some questions.

>>MALE SPEAKER 1: First off I want to thank you for a lot of good work, a lot of good effort and acknowledge some of the board members; almost everybody was able to make at least one of the public meetings, many of you more than one and that was really helpful, I really appreciated that and the staff did a great job of organizing these and...questions for Jeremy or thoughts that this brings up? Dr. Robinson.

>>DR. ROBINSON: [audio cuts in and out] Just a couple of thoughts. First of all I'd just like to add to what you said in complimenting the staff and everyone that participated. I think it is very effective in gathering a lot of information and summarizing it. I did very much try to review the information as it came in to have the opportunity...and I was struck by a few things. One, there was a reasonable degree of consensus and I think you've stated it very well about what people wanted. There seemed to be what I was hoping for, quite honestly, because as a board member I was very much hoping for a mandate that I would take away, that by listening intently I would have an opinion as to what the citizens of Oregon really wanted when it came to their health plan choices. That to me was clearly lacking, that there was not a mandate about the specifics. That was
probably the number one thought that I took away because absent that mandate it places a much greater burden on us...we are going to have to develop plans that are simple and that we can easily communicate, because there is not a common expectation out there so there has to be a clear and compelling reason for what we do.

The other thought that I had - and this was not mentioned in the summary here- was that in listening to the comments, Medicare seems to be a relatively safe haven. So where parallels can be drawn to that I think that as I listened to people talk about their insurance, most of the Medicare beneficiaries were actually fairly well satisfied. I think that was another general thought that I was struck with as I listened. Just my two cents.

>>MALE SPEAKER 1: Good comments. Carlos?

>>CARLOS: I was very impressed with the [orientation] and also the participants. I sensed that there was probably a self-selection bias by the people who came. They were very interested or they had some vested interest in how this works out and they were to voice their opinion. But having said that, I think there was a consistent message to make: prevention works. And again, I don't know if this was healthy people who liked prevention, but I think that was a relatively common denominator in reviewing the comments in the presentation that I went to. That was, for me, actually gratifying.

>>MALE SPEAKER 1: [Garbled]

>>[ Poss. DR. BURTON]: I just wanted to recognize Jeremy, who did...[talked over] everyone, thank Jeremy [drowned out]...really the person that's been helping to organize this and just did a great job and I think every comment was that this was a beginning, not an end, in that as we move forward how we continue to engage people around the state is going to be really important, and how we do that- whether it's through continued community meetings, through a variety of electronic media that we've been trying to solicit a whole lot of input from that we're...I just view this as a start, not a finish and Jeremy has been doing a great job, and any suggestions that anyone has- board members, general public that's listening, etc...one of the things I continue to hear is people just wanting to continue to have information and an impact, and the more that we can continue to be transparent and have all meetings and information and questions available in a variety of formats is just going to enhance our success. So thanks, Jeremy.

>>JEREMY: Thank you.

>>MALE SPEAKER: Let me echo that just very quickly. The information we're receiving is more than helpful; it is absolutely vital that as we do make some of these difficult decisions we do have time on our agenda...it seems like we have a packed agenda every month and that's true today, too: we have time today twice for comment, once in the early afternoon for comment with regard to the public health plan and then at the end of the meeting we'll take comments on any other topic and if there are those in

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the room here today that would like to speak this afternoon, please sign up with [garbled], raise your hand over here. Make sure we get you on the list so we don't miss anybody later. And if we just run out of time, please continue to use the website and any of the other tools because we do [audio garbled, 1:02:13].

>>MALE SPEAKER 1: Let's move to item 4, Dr. Smith. We've had requests for a comparison of the evaluation between a couple of different benefit packages and I think we have some information coming today.

>>DR. JEAN SMITH: Hello, I'm Jean Smith, the administrator for the Office of Health Policy and I have my own favorite actuaries [drowned out by background noise, moving papers]...James Mathison, who has actually worked doing modeling with us off and on and six years ago to help design Healthy Kids, so it's quite a success story.

>>FEMALE SPEAKER 1: You've got an actuary outside the back room. This is what one actually looks like, huh?

>>DR. JEAN SMITH: This is what one looks like.

[laughter, microphone tones out]

>>MALE SPEAKER 1: Not only that but I would like to point out that we've been working with James for a long time and he's been a great asset and because this is a...not-video, I just wanted to dispel the myth for anyone listening that actuaries are dull and drab- James has a fantastic tie on.

[All laugh, overlapping speech]

>>MALE SPEAKER: Special guy.

>>JAMES MATHISON: If you look closely you'll see it's Full Sail Brewery.

>>FEMALE SPEAKER: Conveniently located...

>>MALE SPEAKER: Numbers guy has to have some sort of recreation.

[mic tones out]

>>DR. JEAN SMITH: So we will get going, we're going to give you a short update on where we are in pricing and looking at the essential benefit package. Just to remind you, Dr. Lisa Dodson and I were here a couple months ago to give you an overview of the kind of work that Health Fund Board has started and that we continue to work on around a central benefits package that had some components to it. One was in value-based services where there were twenty services and a great deal of evidence that you should
not put up any barriers to obtaining that care, and then some tiered co-insurance based on where the evidence fell with the underlying methodology being based on the prioritized list of health services. Then that was coupled with an evidence-based drug [formulary].

This next was just to refresh your memory about the tiers, ideally where there was highly effective care were up at the lower cost shares in Tier 1, next level of cost-share was with still very effective care and the next...Tier 3, you're starting to get to effective care but perhaps not as life-threatening of illnesses and then Tier 4 is where the highest level of cost share was, and more preference-sensitive conditions you hear the terminology for...and then the Medicaid, these are often the places where we don't provide any coverage. But in this case it would just be that you have a higher level of cost-sharing, for those items.

And then you asked us to compare to the Health Leadership Council's design and so this just kind of tears them up. The Health Leadership Council's design has Tier 1, where there are no barriers to care; we called ours the "value-based services." The next level of cost sharing was Tier 2- in the essential benefits package it was Tier 1, 2, and 3- and then when you get to the highest cost-sharing or not covered, the Health Leadership Council call theirs Tier 3 and then what's in Tier 4 would be equivalent. Just to re-ground you before we go into the numbers.

[Male speaker, inaudible]

>>KEN: ...can you hear me? So I want to go through these slides and I'll go through some of them pretty quickly, some of them I'll take a little more time on and if you want me to slow down or speed up, just make a little noise.

To do this work is actually pretty new. It's been done once before but only on some Medicaid data, did that a couple years ago. So this was an assignment where the wishful thinker said "Hey, let's just use that old model and put some commercial data through it and everything will be fine." And roughly speaking we did pretty well. It did kinda work, but there is a little risk that I sometimes refresh myself about that sometimes old models don't exactly fit into new worlds. But this slide, I wanted to say we used it and did apply it successfully to commercial [ODF? 1:06:51], we used all the ODF data. I'd like to give a little hand to the [OHA/DHS] actuarial services folks, who did the heavy data lifting. When this project came my way I was pretty worried about [inaudible 1:07:06], and then there are some expensive options for partnership consult and contractors, but the OHA folks did an amazing job and I think nicely and coincidentally they were working on a very similar part of the work for their ongoing Medicaid...so they were fresh and successful. We started...

>>MALE SPEAKER: Ken, can I just stop you for a second? You may answer this later but when you're talking about all this I'm a little confused with how this differed from the
Health Leadership Council's process of doing their actuarial analysis, and why we didn't necessarily model it on what they?

>>KEN: I am not totally familiar with what they did, for actuarial...

>>MALE SPEAKER: I'm not either, but obviously they must've done some work to get to some actuarial analysis on what they put together and was that in the context of how this work was done?

>>DR. JEAN SMITH: We did have some conversations with the ODF actuaries but what we did is we took the model that we had developed back in the Health [Fund] Board days and applied the commercial data to it and then adjusted the benefit structure to fit the various...like the [HLTF] version and then this version. We had some guesstimates based on what they'd given [OEBB] of what some savings would be so we had the ballpark, but for actually how they drove that we haven't had a chance to sit down and have detailed discussions with them.

[Mic tones out]

>>DR. JEAN SMITH:...their comments on this work before we can include our processes.

>>KEN: OK, the next slide is just some basic...I'm trying to express this in 2010 dollars, the costs that you see here would be per adult person. For this work, putting the value-based essential benefits into the four tiers is really straightforward, but [with] both from the value-based essential benefits and the other plan design there is a fair amount of what I last called "bailing twine" and actuarial "magic," in terms of how some of the estimates for value-based services, the stuff that is not immediately computer-allocated to line items...so that's a little qualifier. Again, I've had great help; I'm happy to be [Janeane's]favorite actuary or one of them and I'm having to work with these guys because the work with the [OHPR] staff is quite collaborative and I think it's a good way for us to get a job done. We're going to look at ODS Plan 7, that's our baseline for 2009, and then we've tried to model what Plan 7 would look like in 2010 with the approved benefit changes that we have made, the Health Leadership Council and then of course the value-based essential benefits.

Before we get into it I wanted to do just one deeper dive on the next slide and talk about value-based services. Actuaries like data, and actuaries chomp it up and punch it out and come up with things that sometimes we assume that what happened before is going to happen in the future. Some of these value-based services are more of a health researcher exercise and I've worked with the OHPR folks to do some of that and so this is one that we go pretty deep on. I'd like to say we dove in deep on all twenty, but...
So asthma as a value-based service is just about a break even in total. We find-- and some of these are assumptions-- but we think we might see 30-35% more people having the right medication in their medicine cabinet when they need it and that costs more. Even when we switch to the right drugs.

But then the offsetting of emergency room use and the offsetting of hospitalizations in our first flush, first try, value-based service called asthma makes it about a break even.

>>FEMALE SPEAKER: Can I...just a couple quick questions- that break-even, compared to the baseline plan? Essentially the same as the baseline plan or is it compared to the...

>>KEN: Compared to not doing it. So we're going to change the rules and say free drugs for asthma.

>>[DR. JEAN SMITH]: Compared the current, [OEBB] utilization pattern...

>>FEMALE SPEAKER: OK. And then secondly, is this an annual look? It doesn't say...so if you take care of asthma this year then it might look different five years out. You just took an annual look, correct?

>>KEN: Right, and both parties...Later on I'll have a five year look that needs to be worked on.

>>CARLOS: I haven't seen the rest of the data, especially for Asthma, there may be age groups, differences I think in the younger age and the older age, it gets complicated...

>>KEN: Yeah, and toward the end of this presentation I will say to you all that if you think this has merit, tell us to go back and work harder on these 20 value-based services. The work we've done, the research literature we've reviewed makes us feel like we can improve years of life, quality years of life, health, and not spend as much as you might think. But these value-based services...Asthma is one that looks to be about a break even, there are some that are going to be a cost and some that have a small savings. The bigger savings comes down the list when we stop paying for things that aren't working. Next slide, please.

I wanted to further stay on asthma because of the modeling we're doing. The overall costs went down 29 cents per member per month for adults. But because we built in some incentives to get asthma compliance rates and drugs ramped up, the cost of the plan goes up $1.11. The member saves about $1.40 or $14 if you're one of the members with asthma. So in this case, just to make sure that everybody sees it clearly, the effect of this value-based service is offset by other Tier 4 cost sharing but it is break even in total and a slight positive on the plan constant. Let's go to the next slide.
These are just more...I'm full of qualifiers. These are just more actuarial qualifiers. This is somewhat of a groundbreaking analysis. We don't have perfect information so we're having to do some estimates of copays into coinsurance. I've already said that OHPR parks some of these estimates on the...especially on the value-based services. And this is talking about measuring drug costs; we do not have vision or dental costs for what you're about to see.

So here is a boring chart. Oh no, I'm sorry.

[Laughter]

>>KEN: Have you guys seen these slides? Do you want me to go through every bullet?

>>FEMALE SPEAKER: [under her breath] No, not really.

>>KEN: [OEHB] Plan 7 is a $500 deductible, $2500 plan. It's a relatively standard plan, has 20% coinsurance...preventative services don't apply toward the cost-sharing. There's somewhat unusual $1000 out of pocket on drugs but nothing crazy. The drug benefit is $5 for generic, 25% preferred and 50% for non-preferred. And in 2011 they added a few value-based features. So there's an additional cost tier, $500 copays for certain procedures like one I had a year ago, shoulder arthroscopy. I think that's because a lot of times shoulder arthroscopy could instead be handled by physical therapy...my physical therapist said "No way, get it cut!" [Asks a question aside, inaudible 1:15:32]? OK. $100 copay for...

>>MALE SPEAKER: Going to have to arrest you now.

[Laughter]

>>KEN:...for sleep studies, MRI diagnostics...some of the OM plans put in an incentive tier, the Plan 7 that we used as a baseline did not do that. However, the drugs have a preferred value-based tier. So it is 4 and 8 instead of a flat 5 for the first tier.

The next plan we used is the Health Leadership [Comp? 1:16:06], and it didn't say what cost sharing should be, as I understand it. So we're trying to make it about like the [OEHB] Plan 7 by putting in these special features from the Health Leadership [inaudible] council, and then the value-based Plan 7 is a $500 deductible, 25[%]...we kept this $1000 out-of-pocket. You probably remember the value-based tier, that the preferred stuff includes two visits and it includes all the value-based services. The tiered co-insurance, we have four tiers in this benefits package that Janeane went through. We used 10%, 20%, 30%, and 50% co-insurance. And then there's a concept of a tiered diagnostic co-insurance-- this is one of the areas we had to kind of throw a dart a little bit but future versions we might be able to better isolate those. For now it's kind of lumped in with an...
average. Again, there's the drug plan where the value...free drugs, $5, 25% and 50%. Now can we go to the boring stuff?

We struggled a little bit-- and I'm trying to think what exactly the message is or should be and I guess I will say that part of the assignment was to do everything with about the same cost-sharing. So everything costs about the same amount on the righthand side of this graph. Doing this work and through the back-and-forth, what I came to be positively impressed by is that the value-based plan gives you the most refinements, the best/most opportunities to mitigate benefit budget problems, incent the good stuff and dis-incent the bad stuff. So you can see there's the lowest bar. We could make that bar lower, we could increase some of those co-insurances on the stuff that is less effective. We could put a little co-insurance on the really good stuff. There are different experts that think that a little bit of cost-sharing makes people appreciate it and do it more and free is not better than small.

You should be happy I'm not showing you the spreadsheets behind all this...

>>MALE SPEAKER: We are.

>>KEN: But roughly speaking, I think that these patches all cost about the same. The Plan 7 is a little less because there's a little more stick and not much carrot. The Health Leadership has some carrots on the value-based side and some sticks on the preference-sensitive. Value-based has the biggest spectrum, from the many value-based services and the [full fourth tier of less effective healthcare].

>>FEMALE SPEAKER: [Inaudible]

>>KEN: That one is about 3.5-4 or 5% savings on the value-based. Here's that chart pushing out five years. We did this because people love charts pushing out to five years but the message I have is that this is probably about how things would track, but in terms of bending the trend curve we don't know yet. It would take a lot of work to see which of these plans or how much the value-based concept can flatten it. There are a lot of components of medical trend and a lot of what we're doing feels, to this actuary, like a one-time correction, at which point we start mashing up the medical trend curve again. But I'm not sure enough about that that I can say it's for sure. I think there are components of the medical trend that are increasing [improper] utilization and easy utilization of things that aren't working. So this is a chart that says we tried and there's a lot more work to do.

[Inaudible]...chart is "Let's Review." All these plan designs are doing great things to encourage the best trend and discourage the ineffective. We kind of wanted our early work on the value-based services to look more cheery, but every life year you add to your population of healthy people, they're there, they're alive, and they've got healthcare costs. So I think generally we need to remember that carrots are more expensive than sticks. If
we make drugs free, we just gave away a carrot. If we add a $500 co-pay on shoulder arthroscopy, we have a nice little stick. The sticks always works. If people still get the shoulder arthroscopy they pay $500, and if they choose to go get physical therapy we win even more. Originally I guess I was hoping that we'd see everything "Save, save, save." But now I guess it feels more right to me that the redistribution of priorities is that we will save some money on things that don't work and put it into things that are the best for the population. In that context, in the work we just did, the value-based package has the largest spread between the best and the rest. We had more stuff on the top, we had more stuff on the bottom, and we can private cost-sharing for the bottom and make the top a high priority.

"Going Forward" is the last slide I've got. If this is attractive...depending on how it rolls out, but I think, in general, that more work on those value-based services would make sense. That is speculative, research-y work. I think additional modeling...had we just started with a new model instead of using the old one we might've been able to do some interesting things and maybe there's a way for us to do some tighter modeling of just that OEBB data set. And then of course to work with the stakeholders. So I think that's my update. It is not [trails off, inaudible].

>>DR. JEAN SMITH: And then just to add: we're also in the midst of focus groups, we're just finishing those up this month. So we don't have a detailed analysis for you yet but those will be available when you come back in November. We're doing them across the state as well as online. There are 15 in-person focus groups, trying to pick different groups: providers, consumers, people having to administer the plan and if there seems to be, overall, some general interest in the general approach...devil in the details comes up when you're talking about how to administer it but hopefully we can get you some detailed ideas on what some of the challenges are with that here in the next couple of weeks.

>>DR. BURTON: Very good. Let's just take a couple of minutes for questions and reactions. Eileen?

>>EILEEN: Before we get into a lot of detail about the tiers and some other questions...but I want to step back and use your asthma example. It seems to me that this is very important work but we're still working on just one corner of the Triple Aim Triangle. To understand our goal around the Triple Aim also includes the population base, such that we may be saving those dollars but we're not factoring in the areas of missed work, productivity, loss to employers, quality of life...and I think that as we make decisions going forward, I just wanted to remind us that we're working on the whole triangle. It's important that we do the right thing in that corner but there are some decision implications where like in the different between $1 and $1.10 but we're really driving where we want to go for healthy Oregonians with the $1.10 as opposed to the $1.
KEN: Right, and I meant to include comments about that, because a big hole is that we have not measured increased productivity, and every day that that parent gets to go to work when they're not at home with their asthmatic kid or when they're not in the hospital...

EILEEN: And I understand that it is practically impossible through all these spreadsheets, but that is part of our decision making. I just wanted to thank you because this is...it's in English, for me that's a really good thing, and it makes the choices clearer.

DR. BURTON: Lisa?

LISA: I just have a...[microphone tones out]...I don't know what Eileen did...

[Laughter]

LISA: I just have a comment about the concept of carrots/sticks, because I do feel like we do have to go down this path with both of these items but what I found was a lot of sticks for the consumers, so where are the sticks for the providers? Because I think that in that moment of decision making, I think that it is hard for consumers to make those decisions. And just for myself, even if I were to decide...I've had broken ribs and it's awful, worst experience ever, so the first time is $300, you go to the emergency room and they give you the $10 ace bandage. Then the second time you break out the $10 ace bandage [yourself] because you know they're not going to do anything. But I think that in that moment when you can't breathe, I want you to do something. So I feel like there is that question about patients not being able to make decisions in that moment.

FEMALE SPEAKER: And I guess I would add as one that you're going to have a little discussion in a few minutes about incentives and outcomes and how do you tie that to payment structures. Also this design has something similar to what they do in Medicaid with one or two visits just to get the diagnosis, which is in the essence of the tiering...but if you have a strong relationship with your medical home then ideally you would get that advice in a timely manner to help you ferret through what you should or shouldn't do and perhaps not go to the emergency room and come on in to the clinic and have somebody help you.

DR. BURTON: [Garbled]?

FEMALE SPEAKER: Mike's had his hand up.

DR. BURTON: Oh, I'm sorry. We'll just start here and go around. Everyone'll have a chance to...otherwise I'll lose track.

FEMALE SPEAKER: Sorry, Mike.
>>MIKE: That's alright.

>>NEW FEMALE SPEAKER: First of all, thank you. I know that I'm one of the people that asked for this and I very much appreciate it, I appreciate the process. I think this is the kind of data we need to look at to see if we're being effective. To [Lilian's] point, this reminds me of the work that's being done on managing businesses to triple the bottom line. It needs to have the quality piece built in. But just looking at it for what it is. I'm intrigued that our value-based benefit nips away at the edges. I think that we should ask the Health Leadership Task Force to comment on this work so that we can look at it as we look at what types of benefits we might want to offer in the exchange, etc. I know they have a plan that is basically going in to place, that they're...some plans are offering it. Obviously the takeaway here is that this doesn't deal with the cost-[benefit], the cost-[?] 1:27:53. I appreciate the bigger message as well, that we need to change the game here somehow. Although if you do take 5% of [PEB] and OEBB [suspend], which is around $2.5 billion, you're looking at $125 million reduction in cost. If you add [OMIF] in, it's another [stumbles over the number-- likely .541 billion, 1:28:14] dollars, so you're almost getting up to about $150 million dollars saved just by tweaking 5% off your benefit. It gives us a huge impact for a single or a couple years. Thank you, and I do think we should continue this work and talk about how to do that.

>>DR. BURTON: [Jeff], and thoughts?

>>JEFF: A couple points. Who is responsible for the [? carrots and sticks names 1:28:38]? Was that your phraseology?

>>KEN: Yes, I'm afraid so.

>>JEFF: No, I wanted to compliment you on that, because to me that's really the takeaway from this. I would look at that-- and I agree with it completely, in light of Lilian's comments-- and that is that carrots cost more than sticks initially but there are opportunities for savings down the road, so if we can maintain a healthier population then there are the additional savings down the road. So I echo what Lillian was saying, that in the next version of this I'd like to see some attempt-- and I realize this would be difficult--but some attempt to try to quantify those down-the-road savings.

For me, I've been a fan of the value-based package primarily because-- I guess this is the physician in me-- it allows an almost microsurgical ability to tweak the costs, so that as we're talking about controlling costs this really gives us the ability to have very focused cost control issues. You have many dials that you can turn and you can do it from a policy perspective. So I really think we're on the right track. The question I have is: what is it that you all need from us today? What is our action that we need to take on this today, direction that we need to be given. Continue on merrily or...? What's the deal?
DR. BURTON: I believe what we want to do is simply get reactions to this. If there's something about which we still have unanswered questions or if we see value in additional work, then this would be the time to highlight and then have the staff develop how that would play out.

MALE SPEAKER: I think the initial reason for doing this is that we had a discussion about this as a means to get at our Triple Aim. I think part of this was "OK, great idea, but doesn't start to pencil out..." I think one of my takeaways today is that there is no one answer to any of this, but that this looks promising in terms of an ability to do a variety of the things that we've talked about, and that an initial analysis is difficult as it was to predict behavior and new ways of doing this that no one's ever really looked at, that there's some real opportunities here, something that we probably need to continue to pursue. That was the whole reason to try and get a quick sense of "does this pencil out." Thanks a lot

DR. BURTON: [Mia]?

MIA: I need to say ditto to everybody, going back to it. I'm a big fan of spreadsheets; however, I think that the amount of data you are using is so limited that if you think it is a break-even right now, we really need a lot more data. Probably will start seeing a little more where we'd be seeing cost-savings over years. Or even between different things: asthma might break even but maybe diabetic care is not, because that's very expensive. I'm a big fan of this. I see huge costs-savings on preventative care. Stopping people from going in to see the doctor every time they have the sniffles. God knows I have an employee that does that.

[Chuckling]

[MIA]: Don't laugh!

MALE SPEAKER: No, means we just have to arrest you.

[MIA]: No, no...This needs to continue on. We can't have a really good idea on what we're doing unless we have some really great background. This is a great start; however, one year plus a couple months' data in a purely statistical standpoint really doesn't tell us a whole lot. I think there's something out there that's just going to blow your mind. But I think you've done a really great job. I've been absolutely fascinated by this since August, when Eileen accused me of drinking the Cool-Aid. I think this is great, this is the best piece of the entire board.

KEN: I will say that there is one new tool or product out there that was just released last Thursday for a special government free/charitable look. It's a very expensive 17-year developed called the Archimedes Model that tries to do a more clinical version of looking
up to 9 or 30 years into the future. We've got a quick demo of it and it is stupefying but very exciting.

>>DR. BURTON: [Lillian], anything further? Mike, finally got to you.

>>MIKE: Couple comments. One, I think this is a great start and I'm in full support but [Tia], could you just go to slide 5? Just wanted to make a couple of comments there. I do think it is paralleling what Eileen had talked about in making sure that we're clear on this bridging the gap between the Health Leadership Council and what this is doing. We've got to bring this up together. I was part of that task force for the Leadership Council and there was some great people in there working on this and I think one of the key messages they were hearing from the employer groups was to keep it simple, and I think that is a difficult thing when we start to make this even more complex. I understand the level of specificity but I think from the consumer perspective it makes it really difficult. I think that when they were doing this-- I believe-- it was costing at about a 5% savings at the time, as how they were penciling it out. I think you had a number of plans and I don't know how many are here today but launched obviously in 2010, who I understand...Today, the takeup rate is very, very low.

I think there's a big question that needs to be answered around that in terms of the trade-offs: is the marketplace really willing to accept what those trade-offs look like right now? I'm not sure. So when I look at this, I look at cost-savings I think that the potential is there, but how do we actually get the market to move there in our favor? I'm not quite sure yet.

>>MALE SPEAKER: We're continuing with some focus groups with consumers and others and I'll be back to talk about that to try to get a different...those were the two issues we discussed: does this pencil out, and B) if you build it, will they come? How do we begin to understand how to translate something in a simple meaningful way?

>>DR. BURTON: Carlos?

>>CARLOS: Just a brief...I noticed [unintelligible 1:35:36]. Reminds me of my days at the National Center for Health Statistics: when you have a lot of raw data you can get very creative, so you have the option to run different models and take into account different assumptions, for example: asthma as related to obesity, asthma as related to tobacco smoke and if those questions are taken into account, to estimate variability and confidence intervals in the predicted outcomes, then it makes it...you can provide "It's 3.5 more or less that this will happen, this is where the curve will go in terms of savings." And I'm not sure that the data you have might have that.

>>KEN: I think no.

>>CARLOS: You have to use, perhaps, population...
KEN: So our asthma analysis— which was really largely done by some good researchers here at OHPR— involved some literature searching, some piecing together of data sets that are national, plus some that are OEBB, plus some state-wide. It's finding a way to do an analysis vs. a good data-based model. This new tool I mentioned has got some pretty strong...it's a simulation-based, very beautifully done mathematical tool but it doesn't do asthma with some good layers of overlap. That's not so much a data-based as a simulated population but it is really well constructed.

DR. BURTON: Joe?

JOE: I just have a really simple question and it's based upon trying to get a better understanding, some familiarity with the value-based plan, and it pertains to the out-of-pocket expense. Once you hit that $2500 out-of-pocket expense, then are you fully covered in every tier? So once you add your arthroscopy, your acne or whatever, for the remainder of the year your incentive is to use every service? So once you've had a major procedure there is no...the system is no longer value-based?

KEN: And if that's right— and that might be an interesting suggestion for refining the value-based package, taking that into consideration.

DR. BURTON: Be interesting to see if medical utilization goes up in December.

MULTIPLE SPEAKERS: I think it does.

DR. BURTON: Lillian?

LILLIAN: I think at the beginning you said that if this is useful, let us know if we should move ahead? Yes, that wasn't ever a question. So I would like you to move ahead and try to see some other areas notwithstanding all of the problems. It seems to me that cardiac and diabetes is the...that's the big ticket item for money in the system at every stage, whether it is outpatient/inpatient or surgeries and prevention. I would like you to pick one of these big-ticket items that lots and lots are going to have problems with these and run this kind of analysis.

DR. BURTON: Thank you. And then to conclude it, I'm just going to make a quick statement and if anybody disagrees, let me know. What I've heard here is generally a good reaction, helpful information. I think what our goal is to be able to, as time goes by, be able to be more and more confident that as we tell this story we have good facts to back it up. And to the extent that you can, continue to work that's going to help us with that, OR if it turns out to be the case— I don't think it will be— that it doesn't work, we need to know that, too. But the fact is that to the extent that your additional work can help us go forward with confidence, organize continuing efforts. Make sense? OK, let's take a break.
>>FEMALE SPEAKER: I think we can safely say it wasn't boring.

>>DR. BURTON: I wanted to say that more than anyone at this table and maybe in this room, I've had the opportunity to listen to a lot of actuaries and this is one of the best experiences.

[Laughter and applause].

>>DR. BURTON: It is 16 minutes after 10:00; let's be back here at about 20 to 11:00.

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>>DR. BURTON: Twenty minutes til 11:00, as we said, and we'll come back into session and I want to start with just a couple introductory comments. One of the most challenging things we did early in our lives was create a charter for what has come to be known as the Ins-and-Outs or Incentives and Outcomes Committee, which in fact has two parts. Very important work that bears on just about everything we are trying to do and today we have the opportunity to hear the results of your good work and we're looking forward to that. So, Denise, I'll introduce you and let you take it from here. Denise [Hanzel?].

>>DENISE H.: [Inaudible, too far from mic]...I'm Denise [Hanzel] and this is John [Wooster], we're your co-chairs for the Ins-and-Outs Committee and [speaks too far from mic] to Dr. [Bart McMullen], who is the chair of the Payment Reform Committee and to his left is Dr. Glenn Rodriguez, who is the chair of the Quality and Efficiency Committee. So we're here today to present the recommendations...there are also several committee members who participated in the work. We've been working for four months and they've done a yeoman's job, so we would just like to recognize them so if they could wave or stand up and be recognized.

[Applause]

>>DENISE H.: I'd also like to thank the staff that helped us. I think we're the only group that had four staff members assisting us; I think they called us the "high maintenance group." So Lynn-Marie, Lisa, Gretchen, Nicole, and Janeane-- get by with Janeane, she's the ringleader so we just wanted to recognize them. We really couldn't've accomplished this in the timeline without their assistance. And Eileen and Mike, thank you for participating in our sessions as well, we found that very helpful.

So today how we're going to structure this is I'm going to go through the recommendations at a very high level but as you can imagine we have some pretty strong opinions from this group of folks and so everyone will chime in and add their commentary to provide the most information to you. We know that you've received the
report already, so you have a lot of the details and so we're going to keep this at a high level, but we are here to answer any questions that you might have.

The first page of the overhead talks about the charter, the charter that you gave us which is to make recommendations about state-wide healthcare quality and standards, adopt principles for payment and recommend to the board some payment methodologies that would provide incentives for cost-effective care, patient-centered care and reduced variations in cost and quality of care. Most of this work was done by the two subcommittees and there's a significant amount of work that was done, and Bart and Glenn deserve a lot of kudos for leading their groups through that process, because I think we have some real specifics that will help us as we advance forward in this work.

Three weeks ago we met to integrate this work and we've just started that work and so we're interested in getting your feedback on are we headed in the right direction and how can we bring this together to advance us. I think there's a real recollection and understanding among all the committee members that time is of the essence: we need to get healthcare costs down and we need to advance this work as quickly as we can.

The next slide goes over the guiding principles for provider payment. This was the first step that we took in the Payment Reform Committee. Equity to provide incentives to support evidence-based care but not advantage or disadvantage on factors other than medical care need. Accountability. Incentives for providers to achieve the Triple Aim. Getting people healthy and access to reliable and affordable care. Transformation: encourage innovation across all payers-- some critical elements there-- and also across the continuum of care. Cost containment to control the rate of growth and healthcare: reward efficiency and encourage health. Then simplicity, to standardize to reduce administrative expense, and clarity to reduce the potential for fraud and abuse. And then transparency, and here we've both wanted transparency for cost and quality for treatment options but also wanted to make sure that the consumers know the incentives that are created by different payment reforms, we thought that was important. Bart, do you have anything you would like to add to this page?

>>BART: Just that it's one page with just a few words but we spent a lot of time on this. Sometimes it seemed like an agonizing amount of time but we felt that the principles had to be clearly articulated and understood for the rest of the work.

>>DENISE: Thank you. The Quality and Efficiency Committee, again I really give a lot of accolades to Glen for the work he did here, because there was a lot of work here. And what they looked at was a host of metrics that were well established and then also that were aspirational, of where we wanted to go. They looked at all this, looking both at measurement priorities and potential indicators for payment reform, while looking at the feasibility of alignment with local and national efforts that provide a burden vs. the benefit of measurement-- really an important feature. And making sure we had a mix of
types of quality measures that they were recommending, and they've really done excellent work.

Then the priorities and indicators they also identified within and across the settings of care and identified some really key areas in patient- and family-centeredness, quality, effectiveness, and safety, and cost-efficiency. Glenn, did you want to...

>>GLENN: Just wanted to emphasize the tension we felt between setting long-term aspirational goals to measure true transformation in the system and then short-term, practical things. And we really ended up working on the short-term or immediate priorities, areas we thought could be used for additional measurement and to drive change quickly. That other work is important, we don't want to let go of it but we focus short term really on those things that could be linked...could be done now to support payment reform.

>>DENISE: On the committee front, just for the payment reform, the next slide was as Bart mentioned developing the guiding principles that we reviewed. And I think there was a real recognition within the group that we needed to move away from fee-for-service but we also recognized that we weren't going to get there overnight. So we needed to develop some demonstration projects and methods to get there.

The group actually broke down into three groups, looking at primary care, special-needs care and hospital care, all understanding that we needed to pay attention to the care across all three of those continuums and beyond, and came up with three really broad areas for recommendations about simplifying payment by standardization of the payment methods. We found that this was a foundational piece, implementing payment methods that coordinate care across sites, increase patient involvement, achieve efficiency and quality, and making sure that we have a feedback loop and an evaluation loop.

So as I mentioned before, the committee met three weeks ago to review the work. We really didn't have time to go into the detail of each of the groups, which was unfortunate, but we were able to pull the groups together and we came up with six recommendations that we were bringing to you for our feedback. You won't see things in this packet that we weren't able to get agreement on. For example, we had a lot of discussion about paying physicians and hospitals or not paying physicians and hospitals for hospital-acquired infections and conditions. There was a lot of debate about that because then it's "are you going to take cost out of the system because of that or is that really just a cost shift." So we couldn't get agreement on that given the timeframe but we think that as we get your direction and focus on the areas where we can bring the two subcommittees together that we can get to more detail and come up with more specific plans for the group.

The six areas that we'll go into more detail with is again, standardizing payment methods to align more with Medicair, not payment rate, transform primary care delivery, focus
measurement and payment efforts on those areas that have the potential for greatest impact. Encourage the delivery system to be more patient- and family-centered, understanding that the role of the patient in a family is critical if we're going to achieve success. Initiate the use of new payment incentives and methodologies and our recommendation for you is to set a global healthcare spending target.

So this is really a summary of the recommendations and I'll go through them in detail. Any questions yet, or...

>>DR. BURTON: Questions?

>>MALE SPEAKER: [very quiet, microphone issues]...preamble, I don't know whether you have this, there's a [? clear statement that people leave] that [we have to get out of the [inaudible] service environment. Failure to do so will not allow us to make the [profits/projects] that we need to make and the recommendations are really centered around that.

>>DENISE: So the first recommendation and the way that the staff has formatted these is that we articulated the objective, the recommendation we're making, we have specific implementation steps to accomplish that, and then the outcomes that we're trying to achieve. The first one is to standardize payment methods-- not rates-- to align with Medicare. This is focused on the DRG urban hospitals, ambulatory care, surgery centers, and professional services. We felt...there was a lot of debate on whether Medicare should be the guideline and maybe not, it's not perhaps where we're going to but it was consistent and already out there and that we should align with Medicare. We think that this recommendation is the foundation if we're going to do any type of measurement or evaluation, get to payment standards, that this is the foundational element.

The next step would be to convene a group to standardize, to look at those Medicare standards and then standardize them. There was discussion and a recognition that in order to get to this level of standardization, we probably need legislation in 2011. There was a concern about not being too specific in that legislation, [to an extent]that would link us or prevent us from doing any innovative things, but to get as focused on that Medicare. There was also some discussion that there were some elements in Medicare that we may not want. So we feel like we need to get experts together to do that work for the standardization. Then in 2012, our recommendation was to standardize those, probably in October for hospitals so when Medicare changes that we would align that with the standardization.

The second recommendation-- and this was another foundational element, we think that these are two recommendations that need to be incorporated-- is to move forward decisively and quickly to transform the primary care delivery system. The steps here would be to adopt the patient-centered primary care home standards and the group proposed aligning payment for tiers and that this would allow investment in primary care
infrastructure and also the care coordination. We also talked about the pairs that they could pay at the different levels based on what we could accomplish based on what they were trying to achieve. Also to develop sponsored development and evaluation of infrastructure for implementing models as a basis for payment to make sure that we're measuring and evaluating this and to support the payment methodology. And then to look at restructuring primary care payment for the Oregon Health Authority.

[Janeane] and Glenn, if you guys want to add more here, any thoughts?

>>GLENN: Well, yeah, a couple things that I'd like to emphasize. I really think that this is a foundational element. I believe that the work of the standards and measures of patient-centered primary care home work group, the legislature that you all chartered is really excellent work. We had Barbara [Starfield], the primary care researcher from Johns Hopkins out last Spring and her comment was that this work is the best document she'd seen to describe what she thought were the critical elements in primary care transformation, which I thought was quite a compliment.

When I talk to practitioners, their biggest fear about this movement is that it would be somehow bureaucratic and create lots of new layers of regulation. I would really like to push us to build off of these standards and to create our own accreditation system. I think we can do that effectively and cost-effectively. The example I would pull out is the Oregon Medical Association in the 1990's in collaboration with all the big insurers developed a system that is called the OMA ambulatory reference certification program that created one set of standards for certifying office-based medical records so all insurers weren't separately going into offices and they led that with a very lean staff and they ended up having a program that would make site visits to every physician office on a two year cycle. I think it was very efficient and the kind of lean, focused certification program we can create here locally in the state that would really align us, move us forward, wouldn't be as comprehensive and expensive as current systems like [NCQA? 1:54:01] but I think would build off these standards and move us forward.

>>JANEANE: And I would just add that we're just wrapping up an updated version of the primary care home standards. We have providers that care for children, those with special needs, your family physicians and pediatricians just to make sure we've got the right language in there, since it was a little more focused on adults the first time around. So I think we're going to come out with that in another few weeks so that'll be available to you. I think having gone and looked at a lot of different models, this is very big across the country. Most pilots have been very stuck on the NCQA and the essence of this is that it is really paying for the outcomes and not necessarily paying for how you get there. So it allows creativity in Dr. [Hoffman's] office versus Dr. Rodriguez's office, how to get there, really trying to incentivize the outcome. This is the first time that we really had how those payments could really be tiered to that, to those standards.
DENISE: Good, thank you. Please interrupt me if you have any questions, Eric had said you needed to pick up some time. So recommendation 3 is really a recommendation that the payers, the purchasers, providers, and patients come together and focus measurement and payment efforts that are going to give us the greatest opportunity to reduce cost and eliminate defects. I think in your packets you have some materials that paint...the quality and efficiency group identified. There's also the areas that the payment reform group identified and what we would like to do is to work with staff with where is the greatest opportunity and where could we get focused. We really believe we need to get focused on the critical few in order to start making changes quickly. So that's the recommendation of the group. Then to develop specific payment approaches for the selected conditions and process issues. We think that there is great opportunity here; we just need more work, to do this work collectively.

The fourth recommendation, both groups recognized the need for patients and families to be more engaged in the healthcare team, but I think the quality group really did a lot of work in this area, thanks to Mary [Mannetti] for leading this effort. So the quality committee actually came up with six ways that physicians and facilities can be more engaged, including things like self-care, getting more patient input on processes and surveys and such. So the recommendation, the implementation is really to build patient and family engagement in the design of the new systems. They are in the primary care standards already, so that exists there. We also talk about pulling those into the other paper performance and bundled payments that we discussed. And then develop a measure of patient experience and engagement. I think there's a lot of measurement going on in patient satisfaction but it is done by each health client and it is not done at the medical group level and I think there is opportunity for us to come up with a common way to measure this that would be more effective and efficient and not just focus on satisfaction per se but the actual patient experience and the engagement in the care. We talked about if you're trying to make a change, are you...the change you're trying to measure, you need to measure the patient engagement in that.

We also thought that the Health Authority could offer learning networks for technical assistance to help patients and families, involving them with the medical groups.

MALE SPEAKER: Denise, if I could just add, I think that this-- among the quality and efficiency group, the sub-team working on this did some of the most creative work and really dove deep into this. They really believe we need to move beyond just surveys of patient experience to really look at...like Dr. [Judy Hibbard], and University of Oregon's framework around measuring patient activation, which is a feeling empowerment and ability to advocate for your own health and work effectively in the system and also share decision making tools focused especially on the high cost, discretionary areas, patient-sensitive, value-sensitive areas. Those shared decision making tools have real potential.

This group also had real active engagement from mental health and chemical dependency providers. Again, this is one aspect of the integration of those and physical health is
really important. But this team really did some creative work and as I listen to various other groups speak about it, they always go ["Oh, yeah, they're going to get an apple pie at patient/family-centeredness."] There is real substantive stuff here and we need to move this agenda quickly. It also speaks to the public's accountability to contribute to this effort and make sure that their values and choices are respected and that they understand some of the difficult choices. So this is really important.

>>GLENN: It's not just about patient-centeredness. The engagement piece, and engagement on a long-term basis is not at the side, engagement around a single clinical, emotional, or psychological issue, this engagement over a long period of time really makes sense.

>>DENISE: Great, thank you. The fifth recommendation-- again, both groups recognize that to make this effective we really needed to develop effective redesign across the continuum of care. The recommendation is to use new payment incentives and methodologies including pay-for-performance, episode, bundled services, gain-sharing schemes and the like to look at ways to put in new payment approaches that can create the proper incentives across the continuum of care. The group felt that these should not increase total payments but that the savings that were incurred by providing better care and coordination would offset the additional costs for some of the upfront investments.

There was a lot of discussion on pay-for-performance and bundled services, a lot of work out there on the evaluation and proof of effectiveness being mixed, and so what the group recommended is that we should focus on the critical few and start demonstrating some of these different payment approaches.

>>FEMALE SPEAKER: Critical few what?

>>DENISE: Critical few areas, high...

>>FEMALE SPEAKER:...of conditions.

>>DENISE H.: Yup. And that if we could get focused on the critical few and then do some creative innovation around the payment approach that this would be the best focus. We had a lot of discussions, on pay-for-performance, for example. Medicare has some pay-for-performance and some of the group just felt like we should adopt those medicare ones across the board. Others felt that we needed to agree on the measurement for pay-for-performance but that the application or deployment of those would be at the discretion of whatever we were trying to accomplish. So we did reach agreement on that, did reach agreement that we needed to have standardized measures but not how they would be implemented, so we still have some work there. [Inaudible], do you have anything...?
>>[GLENN]: Just that at no other part of our lives do we tolerate the kind of fragmentation in terms of professional performance, outcomes, and costs that we do in healthcare. We simply wouldn't tolerate it. So we've got to find a way to deal with that that exists today and move it to another arena, another era. Payment reform is part of it but not the whole.

>>DENISE H.: The next recommendation was that we really felt it was important to test the value of service agreements, as a lot of these demonstration projects have the goal to establish service agreements between primary care and specialists within hospitalists and primary care and we think those are really good models but we need to test them. We had a lot of discussion about should we pay specialists for providing these services-- we didn't reach agreement on that-- but we need to be able to test these models to see what is going to be the most effective way to increase the effectiveness of the parties working together and making sure the right care is delivered at the right place at the right time. And we need to learn from it, so we need to get moving and see if these are requirements.

We also think that the patient engagement strategies, the shared decision making that Glenn talked about would be good ways, of how can we build this into some of these payment reform processes and test their effectiveness. So that was our thinking there. And then to make sure we're giving feedback to physicians and information on provider performance and then again set priorities and measures across the OHA programs. With all these programs we all felt very strongly that we needed a strong evaluation component to measure the effectiveness to see...personally sometimes I think we start a lot of stuff in healthcare and we just don't continue it because we don't know if it is effective or not. We probably have a lot going that's not effective but it is both difficult to end it but we really don't know. The group really felt that we needed to get some demonstrations in place to evaluate and then build on those that are successful.

The other piece that was really important for which we had feedback from the public was that we really need to set up these programs where the clinicians and the payers see opportunity for innovation and gain-sharing and opportunity. These programs...people have to take risks. We think we need to have some enthusiasm and some excitement to make sure that these demonstrations are going to be successful. If we don't have the leadership by the culture of the medical groups and excitement, we're not going to get there. So we need that. Anyone want to add...?

>>MALE SPEAKER: Just to underscore: we need the energy and enthusiasm of physicians in the hospitals and other providers. We really need that, there's a tremendous amount of creativity there and we need to harness that energy and not step on it.

>>DENISE H.: The sixth recommendation is that we all recognize that we need to stop consuming an ever-greater share of public and private resources on healthcare. So we attempted to come up with a target and with Mike's advisement, we punted that to you. But we do recommend that we need to adopt a global healthcare spending target and act
aggressively to keep spending within that target. The group suggested the CPI or some similar measure. Bart, would you like to add anything?

>>BART: While the committee did not agree, I think CPI should be the target. I think the longer we wait, the longer we fuss around, the more vague it is, the harder it'll be to get to a meaningful solution. And maybe that's not achievable. If we don't achieve that, you know what happens in education and other parts of our economy-- federal dollars have got to go somewhere. So I believe it should be CPI and [inaudible].

>>MALE SPEAKER: What's the argument against it?

>>JOHN: Actually I think the committee agreed that we need to have a number. There was some discussion over whether it should be CPI or should it be GDP but that there needed to be a number I think we were in agreement. From a business perspective and my perspective as I directed benefits and compensation programs for a steelmaker, we have plants both in the U.S. and in Canada and in the U.S. we're spending about $10,000 per employee per year for health insurance. $10,000. The average wage of those employees is about $40-45,000. So $10,000 on top of what we're already paying these people. Now when I go to Canada and I ask our own employees up there: "how's your healthcare?" they say "OK. Why do you ask?" So the perspective from a Canadian perspective is that things are going fine, and if you look at what the U.S. is spending-- I know I'm preaching to the choir so bear with me, but we're spending almost 17% of GDP on healthcare, 2.5 billion dollars, and Canada spends about half of that with generally better outcomes. I'm not advocating single payer, the Canadian system has its warts. One of the people who just started working for me, needed a hip replacement and she's been on the waiting list for 12 months but her time will come up and when she walks out of the hospital, she won't have a bill.

Now, she'll have been paying through her taxes but again, thinking of what Bart just mentioned about education, we're talking about an opportunity cost here. If we spend 17% of GDP on healthcare, what's missing? And as I was telling the group last week when we were meeting, that the superintendent of the school district where I lived just announced that they're going to cut another 9 days from the school year, just don't have the money for it. And this is death by a thousand cuts. So the overall recommendation of the committee was that we've got to be bold here. Got to set a number. We're not talking about reducing costs, we're just talking about bending the trend and setting the budget. Eileen and I can certainly talk about the importance of setting a budget and living within a budget but that's what you do when you have a business. I think we're united that we need to have a number, but may differ with what the number should be but we definitely need to have that number.

>>DENISE H.: Thank you, John. The other recommendation is that we've got to develop improved measures to measure the effectiveness of the deliver system. That was a global concern of the group was do we have the measurement system in place to measure this?
And just in some other work yesterday on the all-payer, all-claims database, do we have the claim system that would support some of these new payment approaches? I'm wondering, if we're looking at where we want to go ahead, and are we building our data systems to be building to that desired state of payment approach. So this is a thing that we need to work on. We can't just assume that they're there, that we have the measurement capabilities in order to measure these things. Nor do we have the infrastructure to pay differently with our existing systems. And then our third recommendation here was to develop benchmarks for the cost of delivering high quality care and use them in payment.

So those were the six high-level recommendations. The next slide gives you an illustration of where we think our work is headed, pending input from you all, is that this is where we start bringing the work of the two committees together. It's just an illustration. For example, both groups recognized that we wanted to decrease readmissions. Well, some of the measurement tactics could be requiring the reporting of the three CMS condition-specific readmissions or a standard overall readmission rate. The payment methodologies you could consider discontinued payment for hospitals and physicians for those readmissions or maybe you can set a target and pay for performance of achieving those targets or benchmarks. And then another one that we talked about in the payment reform group was episode-based payments that cover up to 90 days. I think they're doing some work where they're paying for acute hospitalization but making sure that the bundled payment goes for a 90-day period, so they're making sure that that readmission doesn't occur. We think there's opportunity to blend these two together and that's what we see as our future work.

The next couple of slides-- and again, I think several people want to comment on these-- the full committee had just started to look at these, but we recognize that we need to move away from fee-for-service. We're not suggesting that this is the total percent of payment. We're just saying that this may be the approach to get to some other payment approach process in the future. Looks like we'll probably be doing fee-for-service for some time but also base payment, bundled payment, pay-for-performance, some shared savings. We haven't talked about dates or how we would get there but this is what we're thinking.

So you can see that there is an increase on primary care. When you get to 2019, it's not clear how we would pay for a global budget, per se. One of the issues that I keep thinking about is that these are the ways payers will pay the medical groups and hospitals but how will the compensation to the providers coincide with this or not? So right now a lot of folks are paid on a productivity basis and there's a lot of value in that and there are also some [problems with that]. While we may pay differently to a medical group, how they compensate those folks within their...either supported or not, help with this process.

The hospital care payment, again the recognition that the hospital costs will go down because we're providing better coordination and care and incentives to reduce readmissions and avoid unnecessary [E.D.'s]. For specialty care, better care coordination,
the use of evidence-based care guidelines and patient decision support. We need to have much more discussion on it but this was a model that we're working on.

>>MALE SPEAKER: Could you be a little more explicit by what you mean by "shared savings" in this bar graph?

>>DENISE H.: I think, for example, through the Leadership Council we're rolling out this high value patient-centered model and the model space where we're putting the [TMPM? 2:12:49], standard fee per service, and then if there is a savings, looking at the total cost of the intervention population with a tightly controlled match group that there are any savings there, then that would be shared 50/50 between the payer and the clinician or the clinician group.

>>MALE SPEAKER: What I'm really trying to understand here is the basis by which the bar gets so much smaller in 2019.

>>DENISE H.: That's what we haven't talked about. We haven't had any discussion about...

>>MALE SPEAKER: Because if you just looked at it, where did this, quote "shared savings" come out? So that's what I was trying to...

>>DENISE H.: We haven't talked about what the proportion is. We need to get some programs operational first and see. Shared savings may even be a larger portion...

>>NEW MALE SPEAKER: I think at the end of the day, shared savings goes away. Once you reach a state of efficiency, then you're looking to somehow fund...it's a transition strategy.

>>[Previous] MALE SPEAKER: That's what I was trying to understand. Thank you.

>>DENISE H.: I think we just showed this at the last meeting three weeks ago so there's a whole lot of discussion still to come, and a recognition that once you do this, then where do you go? That's why we haven't put anything into that box. The last area is just a perspective, looking at payment reform and understanding that there are a whole lot of other things that are going to have to drive the improvement in healthcare. But if you look at what we've got today-- the fragmented, high-cost system-- under these models of payment reform people will get less money and so if we're successful, they'll get better quality care, better coordination of care but at a lower cost. At the same time we're going to be expanding coverage so that expansion will help offset that loss in income. I think what's really important about this is that these institutions to this percentage of revenue and income and so we need to make this change and be adapting to this new environment as we move to the coverage expansion in 2014. So we need to have people that are willing to take the risk, participate in these demonstrations, learn, and then how do they
adapt to this lower revenue stream on a fee-for-service basis but potentially more on this other avenue.

So we think that the payment reform, if we can get the demonstrations going now that this will help in the adaptation of the delivery systems so we can take on this additional enrollment when it comes. Bart, John, Glenn?

>>GLENN: Yeah, I just wanted to comment-- maybe in the minority opinion here-- I really feel strongly that payment reform and coverage expansion are not in and of themselves the only domains that we have to drive change. You also have to have structural system change and you have to measure meaningful things and feed it back to clinicians. I think one of the problems that people don't understand is that clinicians often don't get meaningful feedback about the quality and outcomes of their work. And in a number of clinical groups and specialty sites I think they're doing really good work to put in those fundamental clinical measurement systems and I believe this is a level of measurement that cannot be achieved with claims data; you have got to get down and get the clinical data, figure out ways to do that.

So that's groups like the American College of Surgeons who developed a program they called [? 2:16:38] that really measures clinical outcomes and feedbacks and we have a handful of Oregon area hospitals participating in this that have shown real results with that program. Likewise the American Nursing Association and the Nursing Magnet program has an effort around nurse-sensitive conditions, preventing skin injuries and falls, where they've shown real substantive changes by using measurement and feeding back to clinicians and changing practice patterns. There are other groups: American College of Cardiology, the Neonatal Society, etc., a variety of groups that really are developing important clinical measurements systems that need to drive...so that box in the middle, "high quality appropriate care" has got to have clinical feedback loops that we can really prioritize. I think there's opportunity to partner with those groups to really accelerate adoption of those systems and direct change.

>>MALE SPEAKER: However-- another comment-- coverage expansion at left and at so-called commercial right is your provider. The trouble with payment reform, it'll break the system, in the absence of system transformation. So we have to use these pressures to find a way to transform how care is delivered, the structure and the process. It won't work. Expanding coverage will just break the system as it currently exists.

>>FEMALE SPEAKER: I would just like to reiterate what Glenn said about the measurement and the evaluations. Clinicians do want this information and we're trying to look at claims data right now and it's not very effective but it is the best that we have and I would agree that the clinical data...but it's sometimes the best we have at the given time, so I think that in all the payment reform approaches we need to provide that measurement and evaluation back to the clinician so there's data to show how they're performing.
DENISE H.: So the next slide is work that Janeane and her staff have done about recommending a timeline. Again, we haven't talked about this at the full committee, so I'm going to turn this over to Janeane to talk about the implementation.

JANEANE: This is the really messy slide but if you go onto the next slide then I won't belabor them because in many ways Denise has touched on them but we just tried to attach some time to the actual implementation step so that for recommendation 1, to standardize these methods so that everyone is using the same methodology and realizing that Medicare is usually for older folks, so what do we need to do for younger folks...So there was discussion that probably for the DRG payment synergy, that that wouldn't take a whole lot of time but there would probably need to be quite a bit of discussions of how to do it for professional services and the [RDRBS] system to make sure that everyone was on the same page and come to consensus. Then having the strong stick of the legislative measure was felt very strongly would have to happen to be a really effective implementation and then laid out how we would go forward, timing, evaluate, and then continue to make further recommendations depending on how it is going.

Recommendation 2, the primary care delivery system-- that one we really have the standards already done, have a proposed payment structure. We need to figure out how we would collectively assess and evaluate who is doing it and then make sure that the systems can pay appropriately and how are we going to spread it across the OHA population but at least we have that as a potential large number, 8000 folks coming through. Again, in 2011 and in 2013 to continue to evaluate these with a strong emphasis on learning collaboratively, meaning sharing best practices on how to do that. I just spent a whole day with the North Carolina folks who have been doing pretty amazing things in North Carolina, with provider portals that feedback information, their drug adherence that they have pharmacists helping them with, it's a very elaborate but very useful system that docs up in the Appalachian Mountains are using and synergizing even across small practices, collectively. So I think there are ways that you can approach this even outside of the larger systems.

Next slide is recommendation 3. In order to get this going we do need to do some technical detail work about exactly where is the most bang for your buck in terms of the focused areas. The quality group spent a lot of time thinking about it and then that payment group as well, so how can we make sure there's some synergy. For instance, there's efforts by the HLC to focus on lower back pain, Quality Corporation wants to focus in on low back pain, so how can we synergize these efforts so it works across a practice where they're going to see patients and have different payers. And then how do you incorporate that into contract language and then as Denise pointed out, how do you make sure that rolls on out to the providers?

The patient and family engagement recommendation. Again, need further background work but then how do you extend a learning network to help providers do this better and how do you collaborate getting the information on patient satisfaction surveys? You don't
want 27 versions of them coming from 27 different practices, you want to think about how you can do this synergistically to get the information and also get the information out to the teams inside the clinics. So again, laid out a timeline for these and how to maybe use web tools for that.

Recommendation 5, we need to see where the bang for the buck and could we outline 5-10 bundles of care that we would like to try to implement, partner with existing efforts to try to do that and then how could you roll it out. Then this is a timeline, throwing it up against the calendar of how you might try to approach this and again, evaluating and feeding back in a rapid process improvement approach.

Then recommendation 6, we were debating between GDP vs. CPI. We had Dr. John [McConnell] in the room who said there isn't an Oregon GDP and it's basically the same as the CPI. So we need good heads like him to help us with developing some good efficiency measures and then how can you then use those and evaluate those and set what that target is for the global cap. But again, these were just our efforts to try to put it on a timeline, knowing that...of course, we also have that side job of writing your blueprint reports so we knew you needed something to work from. That's just a first stab.

>>DENISE H.: So I think that summarizes our report. I think the sentiment of the group is that we feel that we feel the urgency from a physician recruitment standpoint, from the impact on consumers, the impact on businesses that this group really wants...that we need to do something quickly. Again, if we could continue to work on those focus areas and get some demonstrations going, we think that will be a really good step to get those moving by working collaboratively with others. Glenn, Bart, John? Other comments?

So now we'd love to get your feedback: are we in the right direction or...

>>DR. BURTON: Very good, very strong report, thank you very much. Questions and reactions? Eileen? Oh, or...

>>MALE SPEAKERS: No, we can take regular turns.

>>SECOND MALE SPEAKER: Go around the table again.

>>DR. BURTON: Nono, Carlos go ahead.

>>CARLOS: So I appreciate this, a lot of work here. I'm not a physician or play one on TV but there are a couple of things that...I think the graph where you have the charts, that's theoretical I would say and then on one of the axes we're talking money and that in 2019 there is a delta and there are three charts. I would call it primary care payment- that would be that big difference between current and 2019 and that would be "Delta 1," and then on the next slide would be "Delta 2," and then on the third one, "Delta 3." So are these numbers hypothetically the same? Is Delta 1 equal to Delta 2 equal to Delta 3 or is
Delta 1 just...So I think you probably don't have the statistics but this is critical because we are-- don't know if this is the proper wording-- stealing from one to give to another specialty, then we're probably not that thrilled about that. The hospital insurers are probably like "Yeah!" So I think there is...you're throwing it to us but then we have to deal with...

>>DENISE H.: Right. Again, we haven't looked at those Deltas. I think the sentiment is that the total cost, the total payment should remain the same or go up with CPI but we haven't done any analysis to say what the Deltas are. And with primary care you're investing in those infrastructure and outcomes so that'll require investment and that should offset [with the specialists]...provide more effective care, getting to the specialist and into the hospital. But this is a lot of work that we need to do. So it's very theoretical, Carlos.

>>CARLOS: And there's the element of healthcare workforce which you mentioned at the end and I'm not sure if the turnover of healthcare professionals of older, more expensive, professionals retiring younger, hopefully less expensive and less student loans coming in would offset some of the costs of the healthcare workforce.

>>DENISE H.: Potentially. [Too faint]...we did talk about the workforce.

>>MALE SPEAKER: I do think the workforce issue is a significant one but in the long run we will not-- in my opinion-- be able to train enough healthcare workers to meet the capacity as long as people are deployed doing the work that they do today. So we need to find a way to educate more people but unless we find a way to fundamentally restructure how the workforce does its work, including physicians, we cannot solve our capacity issues.

>>MALE SPEAKER 2: I would just like to underscore that; I couldn't agree more.

>>DENISE H.: One of the things we're talking about, this model we're deploying with the Leadership Council, is we've hired RN's, with the medical groups. We're contracted with 14 medical groups and we have RN's going back into the primary care setting to provide that support to the patients and clinicians. I know Glenn has strong feelings about it, RN is really a critical one. We just started the training program for 21 out of 23 yesterday and they were all pretty excited about being able to do this type of care delivery again.

>>MALE SPEAKER: If I could just make a couple points: these are totally theoretical, made up charts. But they're a starting point for a debate and a discussion. But they also give you the implication that we spend equally in these three areas, and that is totally not true. Right now in primary care in a commercial premium-- people, correct me on these numbers-- top of my head, it's less than a dollar a day. About $25 a month in a commercial premium that goes to the whole bucket of primary care. Specialist care is
three or four times that and hospital care is four or five times that. So the starting height of these bars are very different, to begin with.

It ties very directly-- I believe, my other hat is as a family physician in the Academy of Family Physicians-- and what I can say for those of us on the frontlines of primary care, we believe that we have to work differently. So we own this, we need to practice and work differently for ourselves as well, to make these sustainable, viable practices. What kills primary care is if you did a log of my day, my clinical day, it is probably only 30 or 40% of my time that I get paid for. I'm saying my clinical day metaphorically in aggregate of everything, of calls and coordination and everything you do. And that fundamental is broken and we need multi-disciplinary teams based in a primary setting that really can deploy across all the coordination issues. So these are very theoretical, they raise the right issues but we haven't done the subsequent work of really coordinating them.

>>SPEAKER 1: Gene, you had a thought?

>>GENE: I guess my first is a huge kudos. I think knowing where you started and that first meeting and trying to get your arms around all this and then where you landed I think this is pretty phenomenal. I think that for this group it is very important as you look through these recommendations I think, Jean, that this graph that you put together is actually very helpful. I found myself weaving in and out of private and public sector and trying to get my arms around what should we be thinking about from a board...what should those next steps in the implementation be. So this is helpful but I would also encourage us to think about focusing a little bit more. So when we talk about OHA, whatever falls under the OHA, what does that actually mean and how can we move on that sooner rather than later. The biggest piece in all of this, the recommendations 1-5 I think are outstanding. Number six is the big one and I don't think we should kid ourselves, when you start talking about a global budget, the implications of what that actually means and that actually sets everything up for that transformational change. So that is not a small one to look at.

So my other comment would be that when I look at that graph that you have on recommendation six we have "set costs and payment levels by 2015" or out beyond that. I would argue that we don't necessarily have that time. I would think that we should be thinking about bumping that sooner rather than later. I think we can have that conversation with others but I think that as we do it today, it's whether you want to do it explicitly or implicitly and how do we actually go about it.

>>SPEAKER 1: Good point. Lillian?

>>LILLIAN: So I have a question for you. Are you saying that
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>> JIM H.: My comments today are in support of public corporation. I think that I could recommend the State Accident Insurance Fund as a model not precisely that model but a model for a public insurance corporation that has long-standing experience so that you don't need to reinvent the wheel. It is well respected; it is loved by small businesses and you need small business buy in, I believe, for a program like this to work. The cost savings--for anybody that's been in business very long the cost savings in health care that have been generated by health care. Other expenses saved are legendary and the model allows for a mix of public insurance, private insurance like Liberty and self-insured which seems to be a goal. So, that's my perspective that I'd like to offer. Thank you very much.

>> DR. BURTON: And thank you. We appreciate it. Ms. Baxter I saw your hand as well. How are you today?

>> MS. BAXTER: Good. I don't have any prepared remarks, but I actually have a question. So, I know that the Archimedes Movement provided some written testimony at your August meeting about the publicly owned plan and I guess that one of the things that I would encourage when you're considering this and it goes to Dr. Crespo's question is that the federal legislation does have a section about coops and I just think that as we're doing a business plan how much detail one needs to have in order to have that business plan done. I would really like to encourage that you ask Bill Kramer to look at that coop language and to see where there may be some opportunities for us to shape a publicly owned plan that might meet the criteria of the coops, because there is money for the states in startup costs around the coops. So, I just wanted to ask that that get put in to the mix as you're considering the publicly owned plan.

>> DR. BURTON: Very good; thank you very much and that's a good segue to ask Mr. Kramer to come back up and for us to move into our discussion. Thanks to everybody who offered comments. We do appreciate it and we've received as well a number of written comments, letters and postings on the website and so on and those do get our attention. So, thank you very much. I think the question before us is where are we in regards to the presentation that was made. Any further questions that have come to mind. Nita? Do you want to begin?

>> NITA: Based on your presentation the startup costs and the research required would be anywhere from $20 to $40 million dollars initially and you also stated that there is no funding in the federal government or the state of Oregon right now. Now, where would those funds come from considering that we had to cut 20% percent out of our budget already. I just don't see how we can afford a public option when we don't have any funding for it. I mean we want to the exchange and we want to insure all the state of Oregon, but adding in this without having anything behind it I don't know if we can afford it for the state of Oregon.
MR. KRAMER: It does appear that at least initially the most obvious option would be an appropriation from the state for the startup costs and the setup of the reserves. I should say though that it would be understood that this would have to be paid back over time. That doesn't solve the problem, because appropriation would have to happen immediately, but at least it would be—the expectation would be paid back over time. There may be some other creative financing options I haven't had a chance to explore other ones yet. You're right though if it isn't appropriation that's a significant option I think given the current economic environment.

NEW SPEAKER: When you say financed over time that that mean like a revenue bond or is that of an appropriation or a G-Bond; because that's a very different situation politically.

MR. KRAMER: That's one of the options we need to explore.

DR. BURTON: And the comments we heard about coops and other sources as well I think would be worthy of some explanation.

MR. KRAMER: Yes, I will explore both the safe option or the safe model and the coops as a potential model with potential source of federal funds for startup.

DR. BURTON: Other thoughts? Go ahead.

LILLIAN: I just have a question on some of the assumptions bill. In the chart review assessment of the model on page 21 under medical clause if we did a piggy back PEB as opposed to a piggy back OHP for instance why is there a discrepancy in the medical clause that you were also saying that we'd have a lot more people in potentially? Don't numbers matter?

MR. KRAMER: Well, I think the difference reflect a different group of providers that we would have. In PEB it is the self-provided plan, it is managed by Providence Health Plans. Providence really established those contracts with the providers and I think there is some opportunity for savings there particularly if they can push forward with some innovative payment mechanisms. But I think the basic rate in terms of discounts while they may be able to get some discounts because of volume I'm not anticipating that to be large. I could be wrong, but I'm assuming it is at least compared to the OHP piggy back with narrow provider network that there would be a greater likely hood that they could get below market or below private commercial rates through the providers in the MCOs.

LILLIAN: So, you're assuming that the payment rate would be current Medicaid?

MR. KRAMER: Actually I think it would probably between current Medicaid and current outreach rates. So, I think that could be a significant discount over commercial
rates for the market. This is the kind of thing though where I think the--I'm not locking to my--that's my thinking but if input from you and others think that maybe I've goosed it too high or too low I will--goosed is the wrong word. That's not a technical term. If your input is that you think I may have under estimated or overestimated something I will go back and take an extra look at that.

>> NEW SPEAKER: Bill I think you did a great job. I think the last time you came and we asked for more detail when we came back I'm still struggling a bit and I guess the best way I would articulate it is I feel like you did what you were supposed in terms of coming with these plans but I also feel like I'm being stuffed into these decision points that based on the status quo; that these trade ons in terms of provider networks and I feel like it is the same old game that we've always played and I'm not getting any additional value out of that. The discussion that we had with the ins and the outs committee, I feel, is trying to set that pathway in terms of how we're trying to restructure that. So, I understand that we're obligated in our house bill 2009 to lay out this frame work and I guess my initial thinking is that I would probably recommend that it be linked to PEB based on the structure that we're trying to do right now with the payment reform and everything else. Everything else I struggle with actually penciling it out and actually getting the value out of that.

>> NEW SPEAKER: Before you spoke I had a question for Bill and that is, do you feel that there are any advantages--I understand the advantages of a link plan compared to some standalone plan. I'm not too sure if you feel there are advantages of a standalone plan, the broad network compared to the others. I guess what I'm saying, Bill, is I think what I'm hearing below the surface are advantages for linking and we can talk about linking to Organ Health Planner or PEB, I'm confused about that but am I correct in interpreting your material that linkage in terms of startup costs and etc., etc. in your mind is a preferable route?

>> BILL KRAMER: I've tried to avoid pressing a preference.

>> NEW SPEAKER: Yes, I know. I won't allow you to do that. I'm holding you to a higher standard than the CEO, you see.

>> BILL KRAMER: Just to try to preface this, I think it depends--when you say what's preferable it depends on what we want to accomplish. I'll tell you in conversations with advocates many of them have felt very strongly, do we need a standalone plan with a broad provider network.

>> NEW SPEAKER: That's what I'm hearing also.

>> BILL KRAMER: And for them that's the idea they have in mind; that I think has had the greatest impact in the short run and long run. My analysis indicates that while that would get a large enrollment medical costs probably would be only slightly lower at best
than the private insurer. Administrative costs would only be slightly less and a reserve requirements would be similar to private plans. So, when you're going to compare it to other plans, say a piggy back with PEB, you may be able to get lower medical costs. You probably would have lower startup costs and administrative costs because of use of the PEB infrastructure and you could still get fairly a large number of enrollees. So, those are probably the two most comparable plans, the A-1 and B-1 both of which are a broad provider network.

>> NEW SPEAKER: Thank you, I appreciate that input without trying to pigeon-hole.

>> CHUCK: Now, turning to Mike. Mike can you help me understand the linkage to PEB preferable to the Oregon Health Plan?

>> MIKE: You know, Chuck, I don't know if I can articulate it well. I think right now as the payment stands I think we would be hard pressed to put more people into OHP and have the capacity too. Now, with payment reform and a different way of doing this I'm intrigued. I think the one conversation that we probably didn't get at that we didn't get at with the ins and outs is that we had a lot of decisions about costs and buying services but we didn't necessarily talk about paying for help. I think this is where this conversation gets into--we're kind of in this traditional health care model of kind of antiquated. So, if you move to a new model where you have the state in position to try to delivery reform if it is through OHP or or PEB I'm there, but as longs as you have capacity and you have that structure in place.

>> NEW SPEAKER: I'm there also; it just seems that maybe the opportunity to implement that innovation might be greater if the Oregon Health Plan level it rather than at the pebble level. Now, the pebble are outstanding.

>> MIKE: Right and I guess there are just some things I don't understand in terms of the medicade rules in terms of what you can have it tied to. It seems to me it would just be easier just to have--

>> NEW SPEAKER: Again with the possible exception of the rules from the other goals that we've set it seems to me that the link would be stronger with the Oregon Health Plan and again that's with saying triple A is always first and foremost. When I look at this and I look at the public option I think about affordability, access, a demonstration project and in this environment keeping the initial costs low. So, when I think about those four factors the fit to me seems to be better with OHP. I think the upfront possibly will be less. I think what we've heard from the ins and outs committee is going to fund its way to OHP sooner that it would to PEB. So, I think if access is what we're looking to demonstrate we can do that and I think there's looking at this as a very basic option because we want to make sure that there's something out there for everyone. I mean we're really not trying to corner the market with this we're trying to insure access and demonstrate that it can be
done. So, that's for those reasons it would seem to me that it might be a better match with OHP.

>> NEW SPEAKER: I here you; I guess my counter to that would be I believe that if we do this right there should be no difference between PEB and OHP, truly. I mean if we're--

>> NEW SPEAKER: Or the exchange.

[indistinct]

>> NEW SPEAKER: The difference is mostly the payment to providers in terms of how some of the costs benefits in terms of OHP and that might limit the number of providers and you have the age of enrollment. Are people willing to put money on the table to buy into Medicaid? If you don't reach the 40,000 people who are willing to pay for it then you have a problem. So, OHP would probably have to increase and be more competitive and I know we had a brief discussion about whether this change is going to stimulate competition. There are different opinions, but without a viable public option or a competitive public option they actually aren't going to do much in terms of cost. We're having a public option; now you are competitive with patient quality and patient care that people will like to then compete with the market itself. My question would be whether it would because a political environment doesn't allow for a $20/$30 million investment upfront on the way it is whether it be a piggy bank startup, but it would be moving towards a standalone. So, it would be this is how we'd start the public option and this is the path to become a standalone at some point. Is this something that can be considered?

>> NEW SPEAKER: I know that we have hybrids; I'll look at that to see whether it might be possible. So, I'm starting up with the infrastructure and subsequently spinning off as a standalone plan. I could--depending on what direction you'd like to go I'm sure we can look at it.

>> NEW SPEAKER: A couple things, I am disappointed in this. No reflection on Bill's work which I actually think on that level is really accurate and right on point and summing up the situation pretty well. None of these really I think achieve the revolutionary idea of change in the system and you're not going to disagree or agree because that's not your role. So, I'm looking forward to our conversation about the exchange and what we might be able to do. What is the bigger idea here; because even if we saved a 5% on the head piece that's really just kicking the can further along down the street? We really haven't dealt with care and how care is delivered. So, that's my takeaway. A couple directions: I don't know this Christina Dock, but I'm curious about what the testimony was about. Could you take a look at those numbers as long as it involves the coop?

>> NEW SPEAKER: Yes.
>> NEW SPEAKER: That would be great. In terms of which direction to recommend maybe we could hold that thought until the end of our meeting. Does that make sense or does that--

>> NEW SPEAKER: We were thinking about that and then I can't; the next discussion is so important. One thought that I had--first of all do you have thought or comments?

>> NEW SPEAKER: No.

>> NEW SPEAKER: And Anita anything more? One option that I'm concerned with is it seems to me that I think we all share the idea that there's nothing here that's really banging us on that head that we just got to go down this direction and yet I don't know that any of us want to get up on it either. So, my suggestion is that we ask staff to work with Bill and me and maybe pursue both of the hybrid opportunities as we're trying to figure out which is going to have the greatest potential impact for us? My own stance is I don't know where the startup costs are going to come from and the reality is I don't know where the reserves are going to come from which maybe directs me in the OHP direction. On the other hand I think that there's a lot more that I don't know and I do understand and I'm wondering if--is that enough direction for you and does the board agree that this is a reasonable direction?

>> NEW SPEAKER: I'd take a decision, any decision.

[laughter]

>> NEW SPEAKER: Just a point of clarification on this clause. We bring something to the legislature and the legislature assigns a number to it and then the legislature will decide whether or not to move forward or not. We're not deciding whether to move forward or not right?

>> NEW SPEAKER: Correct. Well actually it is a--I think that what we're locking ourselves into today more or less is just moving forward with pricing out some of the hybrid options. I think we're responsible for giving that business plan to the legislature. I don't think that that locks us in in any way to a decision or a recommendation that that is exactly the direction we want to recommend. I think that we're learning in all of this that it is a lot of very complicated decision making. It takes a lot of thought and what we're doing today is really recommending to Bill what price and pursue and it may be that we submit that to the legislature and some period of time down the road we may say, "Well, you know what we've given this some more thought and maybe we need to get some more analysis on something else." We need to move forward and to finish our responsibility and I think that's really all we're locking ourselves into. This isn't decision making about a recommendation.
NEW SPEAKER: I would add one piece that kind of relates to what Chuck was saying and what Bill's implied. I'm not sure A-1 is worth spending much time. I don't see a benefit on that and if you were going to go focus on--I can't narrow it down on A-1, B-1 and B-2; but I can say A-1 seems like I wouldn't spend as much effort on it.

NEW SPEAKER: Well, how realistic is it for you to go in-depth on 3 options? And on top of that investigate a coop and on top of that investigate this other piece of legislation that's going to be produced and researched by Dr. Dot. I understand that, but I think we--

NEW SPEAKER: Within 30 days

NEW SPEAKER: Yeah, within 30 days. I think that--

NEW SPEAKER: We just talked about 2 and suddenly you expanded it to 3.

NEW SPEAKER: Ilene did.

NEW SPEAKER: Within 30 days.

NEW SPEAKER: I'm trying to get down to one.

NEW SPEAKER: If the coop is there then I think B-1 is back on the table. I mean if there are funds from the federal legislature to start these things then we can't just scratch it off right away. The other part of it is, for me, it is just that the philosophical premise was that we will have an opportunity to control the growth of expenditure; that we would know what was inside. Right now we just depend on what somebody is telling us. We don't know exactly if that's the case. I mean if Kaiser can do it at 5% and then that's a target. So, then my thinking it that we can probably start looking and we have it under control and we know exactly will this do or not.

NEW SPEAKER: I just have one point of clarification which may be somewhere in there in the background materials and I missed it, but when we look at the concept of the OHP and you're comparing it to MCOs I just want to make sure they put these carve-outs for mental health and dental that for whatever analysis we do for the public plan rolls in all those carve-outs. Including administrative, because I know they're different of course.

NEW SPEAKER: I don't think when we talk about tacking on the Oregon Health Plan or PEB that we're talking about identical benefit packages; so, that's not my impression. My impression is there's administrative opportunities.

NEW SPEAKER: Right and I just want to make sure that it's apples to apples.
NEW SPEAKER: Let me try again to summarize and see if we can get to some place that's manageable.

NEW SPEAKER: It's over there.

[laughter]

NEW SPEAKER: Well, I'm going to go to the same place. We need to check and see if coops for some other mechanism can create some opportunity for startup costs. If they can I think the staff need to come up with what's possible and we'll be talking. If there is no such source of funds and realistically we're not going to get an appropriation from the legislature, but I think that you need to work with staff to figure out which of the B selections make the most sense in terms of delivery and pursue that and bring it back to us. If we need to then expand it later we can do that. That at least gets it down to a manageable assignment. Is that fair?

NEW SPEAKER: Once again we're allowing--we're sending the decision making to the staff.

[laughter]

NEW SPEAKER: We're good at that.

NEW SPEAKER: We'll take it on.

NEW SPEAKER: Okay, great. Thank you very much; we appreciate it. We'll take about a 10 minute break and be back here at 10 minutes until.

NEW SPEAKER: Okay. Okay, everybody. It has been a long day, but thank you very much for hanging in with us. We will begin the final leg of the journey. So, back into session we're now on item 8 of the agenda. Before we begin we have one more period at the end of this meeting with public comment. If there's anybody in this room who hasn't signed up and would like to be able to say something. This would be a great time to find Katy with the sign up sheet and will manage accordingly so thank you very much. The next section of the day is really intended to be an open period for general discussion. As we were planning the agenda for today we've been working for some time to try to get to some key decisions particularly about the exchange. As we've moved in that direction, as we've learned more about exchanges and how they work and what they might do I think some of us actually came to the conclusion that there might be value to accomplish by pausing a little bit for some additional conversation. I want to take us back to our February meeting where we first talked about the exchange and we said, "What is it we really want this exchange to accomplish?" I think we came up with about 4 or 5 key goals, if you will. One of which was to simplify access regulation and plan rules; one was to increase access to coverage and care; one was to change the way services were
provided and one was to contain costs. I think probably those all still hold up pretty well as we have gone through an educational process and learned more about what we need to accomplish. Certainly our charge from OHP in 2009 was to think about and come up with a good implementable idea for an exchange. Federal reform kind of changed that and defined to some degree what an exchange is and told us by what date we will have one. Before we take the next steps and say, "So, this is what we will have" I think maybe it makes sense to back up a little bit and say, "Are we still on track in terms of what we want to accomplish with the exchange and are we thinking big enough about how to use this tool?" What I don't want to do is get so far down the road with the design of a tool that we lose opportunities to make the really big impacts that we've talked about at subsequent meetings. The most important one being how do you improve quality and improve access and reduce costs by using all of the tools that are available to us. So, that's kind of the framework that I want to set for this conversation and Bruce I think you've got some comments as well.

>> BRUCE: Now, I want to piggy back on a couple of things that we've talked about this morning and throughout the day. The first thing I think is the sense of urgency; that we have a sense of urgency to accomplish all these things that--and probably the biggest issue and the biggest sense of urgency I think for all of us and certainly where I sit is the finite resource climate that we're all living in and I think it's how we got into this which is that we continued to live by what's been called medical trend. Over the last 20 years--I was thinking about that this morning when I saw the lines that James and Janine put together on the value based benefit and we saw those three lines. We saw the Health Leadership council; we saw the ODS line and we say the value benefit line. You know the one line we did see was the resource line and it would have been really interesting if the resource line actually followed that same trajectory. We could all probably sit back and do as Anita indicated--it is a nice day--and take the rest of the day off. Unfortunately I don't think that the funding line, whether that be state's income, whether that be businesses income, whether that be personal income is following that kind of growth line it is much, much flatter. People can't afford healthcare, businesses can't afford healthcare, the state can't afford health care. We've talked about this endlessly, but there's now I think a renewed urgency as the two rocks are getting closer together and we need some bold ideas and we need some bold ideas and that's the other theme I heard about. We've been thinking a lot about this; this sort of fiscal reality and then the other reality is the scatter gram reality or the fact that we are not only at this fiscal imperative but that we have a healthcare system that delivers a buck shot outcomes. We need to both deal with the issues of living within a reasonable budget and actually being able to do that should hopefully provide the incentive for innovation. We've been trying to innovate for 20 or 30 years now in health care and you've got a lot of innovations. We've got wonderful innovations that improve our help and fortunately they seem to widen the gap between the haves and the have-nots rather than narrow them. So, we've really got to look at innovation that's going to help us live within the fiscal reality. I think the reality of that is we've got to work within and we've got to sort of change how we're thinking about this. So, we've been talking a lot about the tools we have and today we've talked about a lot of
the tools. One of the tools is going to be an exchange, one of the tools is going to be a benefit package, one of the tools is going to be payment and payment reform and quality, one of the tools is going to be what we do around population health and I think one of the issues are how we sort of start to put all those tools together into a package. We've often been using the analogy of these are all tools we're going to need and it seemed to us that one of the issues we've been dealing with is as we've started to look at some of the exchange recommendations that perhaps we were using one of those tools the exchange perhaps a bit prematurely, that we maybe need to sit back a second and be certain about the strategies by which we wanted to use that tool. We know we've got a tool, we know we need to use it but before we go out there and take that saw and that piece of wood let's make certain it is the right piece of wood, let's make certain it fits in our overall strategy of the house we want to build. So, we put together and you have before you some recommendations that really began and I think to begin the discussion today was to really think about some of the strategies that we need to use. Eric just went through the goals and I think those are great goals and I watched everybody kind of nod as we went through them, but we're going to need more than goals; we're going to need some strategies and we started to look at some strategies I want to put on the table for discussion and then open it up. You know, one, and first and foremost is the one I indicated before which is maintaining costs within a sustainable fixed rate of growth that we can no longer live by 10% medical trend that's unsustainable and as we move forward with any of our tools they have to work to create that sustainability and live within that fixed rate of growth. We've also been looking at how healthcare is delivered and our whole issue as we started out--you know, one of the strategies of the board has been we're going to change the way healthcare is delivered not simply change the way healthcare is paid for. This isn't about insurance reform; it is about delivery reform. I think one of--we've said that, but I don't think we've gone the next step and started to think about that as a strategy, because when we think about that healthcare is delivered regionally. You can look at a map of Oregon and you can--we can all put our hands on the 6 or 7 regional delivery systems that exist around hospital referral networks and there's been a lot of work done around this. We think that another strategy has to be around how we regionalize and rationalize our resources and how we regionalize our accountability. It is going to be very difficult to sit in Portland and ask someone in Bend to be accountable. It is going to be just as hard for someone to sit in Bend and ask for Portland and be accountable. That regional healthcare, if it is going to be delivered regionally we've got to have some local accountability. I think the four strategies had been one of alignment and coordination and I think that really is sort of part and parcel of the simplicity. We've created a really complex system. We've created a million different ways of delivering care, a million different ways of paying for care that we need to align and coordinate the purchasing power around the four strategies which is standardizing some of this. How we can we use these tools to be certain that we start to bring benefits, quality measures, contracting, all of the things within healthcare that are scattered all over the place in towards some reasonable standardization? I mean this is really about creating reasonable, simple standards in a market place that we can all get our healthcare through and that this is what any rational business does is standardized towards a product that you can deliver.
reliably that's quality and that gets people value. If we, I think, can think about and start to enact all of these strategies as we start to look at our tools, one of them being an exchange how can we use the exchange as a tool to achieve some of these or how do we use these strategies to help design and think about the exchange. As a result, you've all gotten some of the recommendations and we'll get to a couple of the details in a bit, but the first is really we feel an urgency to start to think about a bold idea and I think that these four strategies are in many ways that bold idea. There may be bolder out there an if there are let's talk about that, but this is what we want to put on the table for some discussion and see if there is some alignment, some thought, some input, some change sending us back to the drafting table etc. Let me leave it there for a moment.

>> NEW SPEAKER: Very good. Like he said, Bruce has put in front of us the result of some good thinking that's occurred among the staff and in conversations with some of us at various times and is consistent with what I think most of us has said along the way and that is we want this work that we're doing to have some significant impact. We want to make a difference. We don't want to come to meetings for point of coming to meetings and this is a proposal for a set of strategies that could have that impact. I'm curious to have reactions I'd like for this to be more of an informal conversation than something more formal. We'll get to something more formal with regard to the exchange under item number 9, but I'm curious to have your thoughts and reactions.

>> NEW SPEAKER: I'll jump in. I think first this is I found this to be a thoughtful piece in terms of staff; I think truly capturing a lot of our thoughts with the last several months. I think there're many things that resonate. I guess I first would want to take a step back and not necessarily have this conversation so focused on exchange, because I'd like to see bigger pieces tied together and I'll come back to that in a second. Bruce, one thing I don't think we've done a great job even for the boarder even for others is to frame this sense of urgency and I think we talk about it a lot, but I don't think I even understand or grasp the significance. When we talk about the shortness in the upcoming session of $3 billion and you've mentioned earlier today, you were talking 18% of the state budget you multiply that out and we're talking some significant dollars, $5/$600 million. When you talk about it in the short term I guess the concern that I have is that when you talk about those tools that you've listed off and I think you've been very diligent in kind of adhering to House Bill 2009 and having going through the task list of what our deliverables are there's a feeling I have like we're on the Titanic and here we are putting a recommendation for admin simplification or for the exchange or anything that's not really going to get us some significant reform. So, I kind of feel like this is the time if we could all acknowledge that we have some serious lifting to do. In the legislature I have someone who is going to look at this policy and say, "What do you have?" If our recommendations are these small twigs, we have to do the structural reform and our value added has been minimal at best. So, I think we have this opportunity to say we know what is upcoming and what to be proactive and we would actually want to say this is what we have. So, I was actually looking--you kind of jotted down your tool list, but I opened up Jeremy's presentation. I don't know for those of you who had it. The last page of Jeremy's On the
Next Steps for Public Input he outlined kind of those key things in terms of needing the public input, but it kind of outlined where our steps were and in terms of comprehensive plan, health improvement plan, HIT, incentives and outcome all of our pieces--and again there's times where I think we've been a little piece meal in going about this and I think having this conversation about the exchange we can think about it in terms of bringing this together. So, I take that and link it and start to think about it in terms of these four strategies and I think we have something for the first time to really start to put some meat on the bones. So, when you start to think about it in terms of what was just presented to us on the incentives and the outcomes and we start to think about that in terms of connecting that to the value based benefit design, you think about that in connecting that to the exchange. You think about that connecting to a regional type of structure and you think about that in terms of potentially this, what you talked about, alignment coordination consolidation in what we have in terms of how the lives covered I think you've got momentum and I think you possibly have something that you could start to drive reform. Otherwise I feel like we're starting to tinker around this thing we haven't made any substantial changes.

>> NEW SPEAKER: You know, Mike, I--let me just say I totally agree and I appreciate that this isn't totally about the exchange, because let me make it more urgent. We're not going to have an exchange up and running July 1. That's not going to happen. We're talking about governments and how to set something up a couple years down the road, but I can tell you we're going to need to deal with some of the budgetary issues July 1. There's going to be a new budget and so this has to be how we start to set out, how we change for the next two years and then on out to the next several and I do believe that's the urgency and opportunity, because unless we--I get asked two questions everyday about the next biennium budget. One I don't like to answer, because it is unsatisfactory to me and the other I'm not sure I have the right answer yet; and the two questions are what are you going to cut and I don't like that, because we can put out the list of reductions and that's not going to get us anywhere. The question I'm having a greater difficulty with and I think that's the question we're going to start answering today is, "How do you take the 75 or 80% that's left and what do you do with it that's meaningful?" I think this starts to frame exactly that and move it forward.

>> NEW SPEAKER: Any comments? Ilene.

>> ILENE: I'm going to pick up on a couple of things. One is I like the idea of stepping back and taking a pause here. I think we all know that even though the gentleman in the audience at the break from Miami that you guys are way ahead of the curve here and this is some pretty ground breaking stuff. I think this ground has got to be--we've got to be able to look at a big, bold solution and I think a lot of the components of the solution have been presented to us over the last really couple of years and more apparently in the past 6 months to a year. We need a system of care delivery system particularly primary care, chronic care, disease measuring system that is local and integrated. We need an integrated delivery system. The way this system is currently setup it does not encourage
or incentivize or give permission to our great caregivers to set themselves up that way. So, I want to pick up on one of your four items. You guys did put out four potential strategies or one of them has to do with coordination consolidation. To me I think we've talked before about creating a vehicle whether it is an exchange or a super-exchange and having that be a smart purchaser. I think what we haven't gotten clear and I've only recently gotten clear of it in talking to a variety of people, some of the board members and others, is that we really want to consolidate our purchasing power not first to change the cost equation, first to change the delivery system. We want to be able to consolidate purchasing power, to change the delivery system, which we believe ultimately will result in probably the only reasonable hypothesis on how we can change the cost equation. So, I am a proponent of a large vehicle that can allow not only our 800 lives in this state, the public displays, the teachers, the Medicaid population, but also municipalities private companies etc. to participate. On the principle of consolidation and purchasing I just want to flesh it out a little bit.

>> NEW SPEAKER: Yeah, Ilene, I was just add on to that--when you talk about the cost equation, I would add on to that the value equation. I think what we're trying to get at is that quality and cost piece. I think as I look through those four pieces that first one I'm kind of looking at it through the triple pan lens so that's the first one I'm look at we would be looking at on the cost piece still. The last one in terms of quality measure really would be kind of around population health and quality measures. I think that's where whether it is the policy board or the insurance exchange board who would really have that scope to say the key for what we're looking at and kind of state metrics.

>> NEW SPEAKER: Carlos.

>> CARLOS: I get creative, when you start talking about tools and I've heard a lot of different options here with if we have the exchange which actually could be a setting where you could implement all these tools. The public option, health improvement strategies, the liability malpractice which we haven't heard from, the incentives and outcomes and the assertion of benefits and the assertion of methods in signification, payment reform, how to absorb or retrain our healthcare workforce, being able to have the same access of quality healthcare to all our union. It costs money to distance when 30 to 40% of your employees get substandard quality care just because they speak funny or look different. Yet you pay the entire premium. So, how do we bring those equitations in a saving format having access to the old claims data where we can then start giving feedback as fast as possible to providers to figure what's working and what isn't working and we have a lot of tools here and the exchange is just one of here. As I step back and I look at the exchange it is a nice place to put all these things in place and see how when all the players have the information and these tools, what happens to costs?

>> NEW SPEAKER: Joe
>> JOE: Well, I don't speak anymore to the aspirational goals that have been outlined. I'll direct my comments more towards incrementation practicalities and that is it is great if quote, we're ahead, but we aren't going to be able to obtain the fundamental reform unless it is pushed by the consumer as well and I'm not--we can be as aspirational and talk about this as much but if people don't sign up or don't embrace it and I guess that's what I'm also worrying about especially to get back to the lack of the mandate that we heard. In this document we have both the board of the public cooperation and then we have the consumer advocacy group and we haven't spent very much time talking about that consumer advocacy group and I think it could be a critical element in driving, for a lack of a better term, the marking of what we're doing because we need to get the word out and if it is perceived that this is what the mass majority of the population wants it is going to be much more successful. So, I don't know how that board is going to fit and I think as I thought more about this having the consumer advocacy group and the governing board provides a very nice balance for this organization because somebody that's unpopular but might have the exact technical expertise can be placed on the governing board but yet we can still also have the populous leader placed on the consumer advisory board. So, as this is working out I think it could be a very nice balance, but we haven't talked very much about that consumer advocacy board so I don't know how that's going to be selected or at some point I would like to give us some consideration to that as well.

>> NEW SPEAKER: Mr. Chair.

>> NEW SPEAKER: Speaking specifically to that I'd like to suggest the possibility of regional consumer advocacy course. I mean I think that might be one way to help us get to this regionalization.

>> NEW SPEAKER: Lisa, thoughts?

>> LISA: I don't have any right now.

>> NEW SPEAKER: Alright, Anita?

>> ANITA: Not right now.

>> NEW SPEAKER: Okay, Lillian? Okay, I'm not hearing anybody saying this isn't a direction we want to pursue. Is that a fair conclusion? Okay.

>> NEW SPEAKER: I'm not saying this isn't a direction I want to pursue. On the four larger implementations I think that's the direction agreed upon I'm excited about pursuing that direction. I think as we talk about the implantation I think that I've raised concerns with folks about a public corporation and I just want to make that public that I'm concerned about that. I believe that the structure of the board is really critical in that accountability and so I'm not exactly sure whether I would want to separate a consumer
board from a governing board because that level of separation makes me nervous and then to test point about having a regional consumer board I actually think it is good to have regional input based on that regional accountability, but I think the farther and farther away you separate a consumer board from the governing structure of an exchange the more tenuous that the operation of that exchange can be.

>> NEW SPEAKER: I agree. Let me suggest in our next agenda item we actually have opportunity for discussion of these specific exchange mechanism and governance structure and so on. So, let's keep those thoughts in mind and make sure that we have a kind of conceptual direction agreed upon and then we'll get to that to those questions. Is that okay?

>> NEW SPEAKER: Yes, so then my other comment is in order to meet the goals of the exchange standardization of benefits, quality measures, contracting and other relevant areas I think another relevant area is payment. So, I just want to make sure that we're including that specifically because I do think it is one of the key elements under the relevant areas.

>> NEW SPEAKER: Where are they talking--

>> NEW SPEAKER: She's on the fourth bullet under one.

>> NEW SPEAKER: Oh okay. Can I ask a question?

>> NEW SPEAKER: Sure.

>> NEW SPEAKER: In bullet number one maintaining costs within essence paying the fixed rate of growth. Does that relate to the ins and outs committee reports and thoughts on selecting CPIs of potential concepts or working within their recommendation over 6 budget if that all kind of wraps up inside that bullet?

>> NEW SPEAKER: Yes, and I think that both as a short term and a long term that as we look to the next two years there's going to be a fixed sustainable level to grow and that it is not going to be what we choose it is going to be what we have. I think our ability that start to live within that and move out into the next several years is going to mean that we're going to have to just very dramatically change the way we think, because if we think that what we're going to do is still maintain medical CPI and live within something lower than that, that only means all we're going to do is cut some sort of a benefit as opposed to thinking about how we change the way care is delivered. So, I think what we choose is going to be chosen for us for the next two years as a state we want it at least and beyond that yes we're going to have to choose what that is but I think understanding and using this as something we operate within that isn't well we're just going to operate with what we have now but when it goes up we'll push up--the balloon is not going to be
sustainable. So, we've got to pick out a sustainable greater growth but maybe that comes a little later.

>> NEW SPEAKER: Lillian.

>> LILLIAN: So, just a couple observations. One is as I read the four strategies one thing that stuck out and I did question it was In the third one align coordination and consolidation and patient purchasing power in the state and I ask is that going to state. Did you mean for the state or in the state? And the conversation that we had--I mean I think that it is important to for me to call it, because that's part of the big idea. So, I really support that direction and I think that--so, that tells me that we're serious about thinking of the exchange. Really not a lot of what we talked about this morning and with Bill's presentation with kind of in the details of really insuring. How do we insure what specific things we're buying, how we're buying them and I think that this gets us to the exchange isn't about delivery reform, not insurance reform. What we're looking at is a purchasing strategy not as a regulatory strategy. So, that's what I'm getting from this. When we get to talking about who's going to actually look at the details that's the second conversation, but I think I would like to hear--I mean that's what I'm hearing and agreeing about and I guess in that what I want to make sure doesn't get lost in the details, the delivery reform and just a purchasing strategy and it is about purchasing in the state not just for state.

>> NEW SPEAKER: I'd actually like to expand on that a little bit. I agree with everything you said and it seems to me if we're going to use a purchasing strategy as opposed to a regulatory strategy we're going to have the maximum possible impact if we can maximize the number of lives affected. So, what that says to me is that we want to make sure we put in place in an exchange as an example the kinds of tools and recommendations that we've been hearing about in the last few meetings. We also want to do the same--in some cases we have the direct ability to act; in some cases our ability to act is indirect and in some cases we really have no authority at all but what the heck. It seems to me that if we want to really maximize the impact then we need to think about not just the exchange but what we can do in terms of bringing as many of these reforms as we can to the OHP lives, the PEB lives, the OHA lives. Then I go another step; it seems to me that many, many people who run businesses and provide medical care for their employees, medical coverage for their employees don't necessarily want to be in that business at least in that business in the way they're in today. If we can manage a system that is also attractive to that group we'd bring in more lives and we'd have greater impact and yes the impact has to be applied at a reasonable level. We're not going to do a one time, one way with the state, but it seems to me that at some point we can get to a critical mass where we can truly impact the way that care is delivered and thus get to the cost issue. So, that's kind of what's on my mind and I guess first is that consistent with what you're thinking?

>> NEW SPEAKER: Absolutely.
>> NEW SPEAKER: Alright.

>> NEW SPEAKER: I want to add on again a few comments. I guess Rowland's point--I agree with you but I also think the focus initially is in the state or for state purchasing. I mean I think you have to be able to get your arms around that and demonstrate their values before you can actually bring the business community in. I mean I think that's an essential step that I don't want to lose sight of. I think if we can do this with OHA lives and we can do well then I would say the private market would have some decision points if they don't like it. You made a point that I want to make sure that I'm clear on. You wanted to add on to that last bullet in terms of standardization I think of payment. Is that what it was?

>> NEW SPEAKER: I just want to make sure that we're calling out some key standards and pin points. So, then I said payment methodology is another piece that I want to--

>> NEW SPEAKER: And I know that was kind of the ins and outs I'm sure was asked and I want to make sure I'm leaving room for variation innovation as long as if you have set your global budget and if you have set your tripling metrics how people pay themselves I don't care. If we're achieving the best health outcomes and if we're within our budget I think we've done a great job. I think you've actually would now incentivize regions to do things differently and I think that's what we have to want to see.

>> NEW SPEAKER: Other thoughts or comments?

>> NEW SPEAKER: Can I build on the conversation that you and Mike are having about maximum purchasing power? It seems to me that we might, and Mike as much as I absolutely agree with you I'm also coming from--I'm involved in the business community and the business community is an interesting opportunity that might want to participate, right? I think we may end up seeing at a region to region level a different--like we might see maximum participation or average about 50 to 70% participation in any given region and not in another region to start with and we may end up with a regional pilot just by nature of participation which could be very interesting.

>> NEW SPEAKER: Yeah, just like on that local delivery system.

>> NEW SPEAKER: Yeah, but I think that some of these areas if you just look at the scatter gram on just our 800,000 lives we're not going to have maximum impact in that particular region to allow for the integration of the system. So, I don't--please don't say sequence. Well, let's look at it more carefully first.

>> NEW SPEAKER: Chuck?

>> CHUCK: No, I have one other bullet that I'd like to have us consider for and I'm not sure where we are at the end of the discussion but are we there? This is my thought. Our
discussion about innovation and implementing delivery system reform and payment reform within the exchange I'm very excited about that and I'm glad we're doing that but I also think there's some core responsibilities of the exchange that I don't want to get lost in the process of all the innovation. We're going to bring on a lot of people into the health insurance realm who have never had health insurance before and who are not well schooled in the ability to purchase health insurance. At the same time a lot of those people are going to be eligible for the tax credits related to their income. So, my point in this is I think there might be value in adding another bullet that core responsibility of the exchange is to keep the enrollment process as consumer friendly as possible and to administer the tax credits as best as it can be. So, that's--and I realize that's kind of more of the popaca role of an exchange and we've been focusing out talk mainly on the innovation thing but again I kind of look at that as a coo responsibility and I think that that's not mentioned as a primary strategy that it might get lost down the road. That was my thought.

>> NEW SPEAKER: Thank you. Bruce, why don't you summarize what you've heard and what the implications are and then take us further into the exchange conversation. Does that make sense?

>> BRUCE: Yeah, I mean I'm going to see if I can do that, because I like--Bart said this morning he had the 5 or 6 principle private set goals and he said there were like 10 words on the page but they spent a hell of a long time on getting to those 10 words. We've got maybe 20 and we didn't spend nearly that much time and we're--but want to start to have this conversation and I think that's what that did and I think a lot of it based on it--these strategies really what I heard and let me see if I've got this right is that we just laid out four now with an amendment of being certain that all of this is being kept simple; that these aren't goals of the--these aren't strategies just simply to meet the goals of the exchange, these are strategies we've got to adopt right now. As we develop the exchange which is going to happen out 2 or 3 year from now, these are some of the strategies that are certainly going to guide that work but they're also going to have to guide some work over the next 6 to 8 months to get us to the point that what we do over the next couple years in the state to me what is going to be some of the fiscal imperatives around certainly what we're going to be dealing with as an Oregon Health Authority which will be its own entity July 1 that we will need to look at these and keep these in mind as strategies that there was I think some general agreement about them. We can do some wordsmithing that there was some agreement with these as directions. I think some of the next steps which we'll get to later are going to be how we start to operationalize some of these both for and exchange but in the short term to begin to setup for the exchange. Is that a fair summary?

>> NEW SPEAKER: Yeah, and I'm looking at if we're going to get into this section but as I'm looking at the next step you kind of what to be clear with of us that we're basically taking all of this that we just talked about and trying to roll this up into one legislative concept.

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>> NEW SPEAKER: Correct.

>> NEW SPEAKER: That we need to see in the next 4 or 6 weeks.

[laughter]

>> NEW SPEAKER: That, basically, I think is what this means.

>> NEW SPEAKER: It wouldn't be as affective if we keep peacemealing and doing something here and something small there and allowing other groups that are affected through this month or whatever it is repelling not seeing the big picture.

>> NEW SPEAKER: Loving all the details, but this is the--what you sort of what to see is that this reflected in that.

>> NEW SPEAKER: Just want to make sure I'm following the conversation here with what you just said, Mike, that is a substantial change in the way the legislature has deal with health issues. So, I just want to make sure we're all--

>> NEW SPEAKER: I want to say more about that.

>> NEW SPEAKER: Well, I'm on the fringes of this say with, you know, the policy option packages and every. Now what you're saying is just line item by line item, a little bit here, a little bit there; it reminds me of the reverse of what you just said, Bruce, like ants that take a little bit at a time. We're trying to change that dynamic completely.

>> NEW SPEAKER: Absolutely. How do we help to shape the system that we can live with in the future?

>> NEW SPEAKER: If there are no objections. Roots, you are authorized to go forward and start to put some meat in the details or on the bones for other conversation. Makes sense?

>> NEW SPEAKER: Makes sense.

>> NEW SPEAKER: Let's get into the item number 9 on the exchange.

>> NEW SPEAKER: So, this sort of--

>> NEW SPEAKER: I'm sorry. Can I just ask a question between?

>> NEW SPEAKER: Yes, no going back now.
NEW SPEAKER: I want to make sure I didn't get confused, but before we get into the details I would just like to say that these strategies as I relay them to our the goals that they work, but as I listened to the reports this morning and as I read through the detail that was sent to us beforehand--really these strategies work for much more that the exchange. So, I just want to get that on record first of all. I think we need to think about using these as whatever we're doing whether payment reform, medical liability are they achieving these things? Do they further these points for just get in the way or don't have anything to do with them. If they don't anything to do with them I think we don't have time to pay attention to them. So I just want to lay that out.

NEW SPEAKER: It wouldn't be a bad thing to have in the front of next month's board packet, these things on page one.

NEW SPEAKER: I really see this moment as ending contest here. I think you've been doing a lot of listening and that is kind of the beginning of this board really owning its own identity here and its and that's important and exciting because you can spend years never getting that.

NEW SPEAKER: Well, and we use the terms delivery system reform and payment reform. The way I look at it and I think I'm agreeing with you, Lillian, that these are strategies to get us to those places whether within an exchange, outside an exchange. So, you know it is gratifying to see three years of work put down into four bullets. If we can use this as a litmus test for everything we do it.

NEW SPEAKER: Okay, the board has a position.

NEW SPEAKER: So, number 9 was not the ninth strategy.

[indistinct]

NEW SPEAKER: Sorry about that.

NEW SPEAKER: That's a big surprise.

[laughter]

NEW SPEAKER: That is agenda number 9 which really is--you know we took a step back in thinking about direction strategies and we've also taken a bit of a step back around the exchange in terms of understanding that a lot of the decision points that Barney and Nora had been bring to us over the last bunch of months are all going to be very, very important decisions as we move forward on exchange. It is about sequencing timing and that we don't, A, need to make many of those decisions right now. Many of those decisions will need to made but, A, they don't need to be made right now and B, some of them are likely going to need, actually, further analysis and consideration and
work when we look at what some of the consequences whether intended and unintended of them are going to be. So, what we've tried to do is look at the couple three things that we think we need to move forward to start to plan for in exchange that we need to nail down now and understanding that we many of the next levels of decisions will continue to get made by this board later on and if and when there is a governing operational board of exchange that there will be at some point decisions perhaps made elsewhere but that all the decisions don't need to be made today. What we need to make are a couple. It is really establishing the structure and governance of the exchange. The other issue is going to be the enabling legislation to allow the exchange to have the kinds of power and authority as indicated federal law and that if we can really look at that we can then start to consider some of the other things as we move forward hence what had been 9 or 10 or 11 different decision points really now are several and the first this probably gets back at Lisa's comment earlier which was the public corporation and maybe we should take each of them one-by-one.

>> NEW SPEAKER: Indeed. Nina.

>> NINA: I'm just going to jump in. I was on the exchange subcommittee. I'm a big fan of safe and so after much discussion decided the safe model was really great. It has the ability to use the resources of the government, but also be private enough so we wouldn't really have government receivers so much in this operation. So, I was surprised to read about having two boards, because I'm a firm believer of the more people you have trying to cook you're burn it down. So, having two boards I think is really unruly. Then it should be 9 to 11 members nominated by the governor and then it has recommendations on majority of the members speaking should be employed in health, small business, large business. I think those need to be named in statue; not that I'm really into conspiracies--okay I am, but you could loaded board unless it is named in statue you could loaded board with all of the insurance executives or you could load the board with all doctors. I think it should be name in statue; one doctor, one nurse, one small business, one insurance and that way you always have a good mix of different opinion just to make everybody equal.

>> NEW SPEAKER: And I feel strongly in the opposite, very strongly. I think you're much more likely to have a loaded board when you put it in statue and you can't--you need to be able to balance the board and you need to be able to very quick ordered bring expertise to the board and when you nominate the board in statute and I've seen this in boards that I've been on time and time again we setup voting blocks. Every member of this board should only have one constituency and that should be every member of the state or board of health and wellbeing. They should not represent any specific group and I think that's actually--I usually agree with you that I don't like two boards, but I think it is a consumer advocacy board that will be the watch dog to make sure that the governor and the legislature put the right people on the board and we end up with a board without constituent groups. My two cents.
NEW SPEAKER: Any thoughts? Lisa I know you have many.

LISA: I guess I sort of think that when you create a board that's making governing decisions and then you create a board that should be overseeing those governing decisions to me it comes down to a question of power. So, who is going to have the majority of the say in the decision making process in that scenario and I see that it is the board that's making the governing decisions. So, then it makes me nervous to have--so, what's the watch dog's account--right? A good watchdog has a bit; so, what's the bite when the board becomes accountable?

NEW SPEAKER: Can I interject? To clarify some of the two boards I think the idea was to have a governing board, a governing operational board which is primarily consumer focused, because the membership of that board would only a small minority can talk about what a small minority is. We tried to keep that there would be a small minority that were a part of the healthcare industry or finance industry; that people needed to purchased health insurance. They needed to be a healthcare club member too and part of the exchange--the consumer advisory board and I think would be better framed as a consumer to put into statute a consumer advisory group not a board power, but it is actually a consumer advisory committee to insure that isn't going to go away. There was a strong consumer advisory focus as well. Now, whether consumer--but it is that consumers of the exchange. So, it would be certain that you actually--and this is not general healthcare consumers, but it is saying that we're going to setup this exchange. There's going to be a governing body; the governing body will be primarily not industry people, it will have consumers on it but then there will be a group of people who have purchased health insurance though the exchange to be certain that they advise that board that's user/member advisory group and not a board. I think that two boards--and I don't to think the intent of this was to have two boards and we apologize for the two boards. I hope now that makes a little more sense and I don't know if that changes any of your thoughts about kind of the conflicts between the two.

NEW SPEAKER: When I was suggesting regionalization I wasn't trying to disperse that advisory input. What I was suggesting was as we look at the different opportunities and innovation in regions advice from one region might not pertain, especially Germaine, to another region. So, I think that there really is some value in regionalizing that advisory input.

NEW SPEAKER: Lillian.

LILLIAN: I'm actually worried about the accountability than the advice. I think that our culture we're going to get wherever we are we're going to get lots of advice.

[laughter]

LILLIAN: So, my journey on this board has proven me true.
>> NEW SPEAKER: It has only just begun.

[laughter]

>> LILLIAN: But I had that conflict too. I guess I ended up first for effort and I noticed it and I said well I'll keep it. But I do want to make sure that the governing board will actually have to have people that belong in the exchange; they get their insurance there. So, there has to be that factor. I do think we all need advice. I'm a firm believer in environmental health advisories and this advisory and that advisory committee, but I think that's a dive. I'm wondering now who's everybody accountable to? Maybe that's your who can bite and I want to explore that a little bit because I just think that with the best intentions people get fatigue; innovation fatigue, change fatigue or we think at the end of the day we might think we've solved the problems for healthcare reform and we'll go home and we won't want to talk about this again. So, somehow we need to institutionalize the accountability structure so that it is like a kid's game of capture the flag. You can switch teams, but I'm afraid that there can be some switching of teams here and someone will capture the flag that will have the same language and how do we make sure we get back to the intent of let's just say our four thing-a-ma-jiggies here. And just a governing board doesn't do that by itself. There's always danger of you haven't gotten to who's is going to point them but things are going to change. I understand what you're saying, but this is too big of a deal, to big of a change and it impacts too many people's real lives that we can't think about how can we make sure 10 years down that we are at the intent. The intent is fresh and if the intent isn't there's a mechanism for making sure that the intent is made whole in the operations.

>> NEW SPEAKER: The staff are a benevolent dictator.

[laughter]

>> NEW SPEAKER: Did you volunteer?

>> NEW SPEAKER: That comes up every single day.

[laughter]

>> NEW SPEAKER: Can I ask a question? So, how do the bullet points that we outlined here--do they meet your needs here or are they too general? I mean a small minority should be gainfully employed in healthcare delivery, a specified number must be consumers within the exchange of exchange products. We're not naming every single seat, but you're sort of making sure that there's general representation on the board.

>> NEW SPEAKER: Yes, but once they look at a final who does the public corporation answer to? Who does the sum of the parts answer to?
NEW SPEAKER: Are they appointed by the governor? Are they?

NEW SPEAKER: Right.

NEW SPEAKER: That might be--

NEW SPEAKER: I have a couple of questions I'd like to ask you.

NEW SPEAKER: Right, but it seems to me at the end of the day, I mean I don't mean to—I totally appreciate your concern I agree with it. But I can think of a structure that has a failsafe mechanism to avoid some sort of difficulty. So, I've come back to the strength and clarity of the mission as really the check point. Clearly it seems to me the accountability is to the public. We have a due process, by the governor's office, by which we make public decisions but it has to be consistent with the mission we have set forth. I think the addition of somebody from this board as something the addition of the head the health authority and the consumers group and the services section had something. Staggered terms would be another way to build something. At the end of the day I don't know how it could be failsafe.

NEW SPEAKER: It is an interesting point though on one we haven't considered before. I don't remember the details of the staff sheets that is was created for but I don't remember reading any impeachment proceeding for--

[laughter]

NEW SPEAKER: We can build those in.

[laughter]

NEW SPEAKER: Actually, if you want the staff to come on board we service the pleasure of the governor.

NEW SPEAKER: Yeah, but is each year, I mean is it continuous? For instance, at the OHU board there are no impeachment proceedings. You initially serve but then there is—so, what is the method for our review to determine if some here are fortunate to have the full four year term? So, what is the method of what is—and I think this is what you're getting to. What is the method of performance evaluation? Evaluation in which we insure the board member is still involved three years into this to the same degree that they were in the first year. Is that--

NEW SPEAKER: We may become irrelevant; I mean I don't know. I don't know what the end product is for every fall. If we become irrelevant now are we sure that this public corporation is able to—as you sent me in an email—maintain its connection to its
mission but safe. I just think it is something that people assume it is going to, but I just don't think it will work all the time.

>> NEW SPEAKER: With any corporation you have the CEO, the President, the CFO and the basic governing body of the organization. They have to keep a handle on the board or perhaps the people in it and a lot of them. With any type of public or private corporation there's no guarantees it's going to run right. You see companies come and go based on this management of the executive teams and executive teams have been replaced and brought companies back. So, it is just there's no guarantees in this.

>> NEW SPEAKER: I would add to that a couple things. One is I don't hear any objection to the public corporation which I think is the more significant conversation right now.

>> NEW SPEAKER: Just going to check that out. Before we get into medical we've gone way into membership can we go back to this, sum it up and--

>> NEW SPEAKER: Can I just finish? I just want to say that I actually think that this is an interesting vehicle. I too am--anybody who lived through the early 90s on workers comp has a certain respect for state and the work that accomplished it and there are some other examples. I liked the idea. I think it is worth pursuing; I wanted to open it up to check that out.

>> NEW SPEAKER: And can everybody either support or live with the idea of a public corporation?

>> NEW SPEAKER: I'm unclear at this moment.

>> NEW SPEAKER: Everybody else is a yes. Okay, thank you.

>> NEW SPEAKER: Can I also just add that there certainly a certain number of conflict of interest standards that can be added to any board. So, in talking about the composition and the last pieces, either this board should consider being the launch board for that operation or this board should have some input as to who's on that board, because I think that there's going to be a very tenuous launch period her where we want to make sure we've got vision that matches. I don't know exactly how to accomplish that. I just wanted to point that out.

>> NEW SPEAKER: Ilene, I agree with you as well. Given the conversation we had just prior to this, this board's got a pretty clear vision, I think, as for as far it wants to go and how it is going to incorporate some pretty keen strategies at least for a period of time and this board probably is the launch board but at some point it becomes an implementation and operational board that we need it--I think the key point that we need to think about is when the strategy should occur in mind and make sure that we have a conceptual
direction agreed upon and then get to those questions. So, I've got three issues that need to probably be fleshed out at some point as a legislative concept comes forward; one--we'll get to the term measure, but what I heard before was for a lack of a better term was the impeachment issue, the term issue and there is the timing and transition and the kind of handoff and when and how that occurs and I think that's something I've been trying to think about and quite frankly is going to need some further thought over the next bit. Let's leave it at that point and then give it discussion.

>> NEW SPEAKER: I would just like to know if Lisa has not said one way or another and that we should somehow make room for this in the process and that we're not going to walk away with a 100% decision and come back and revisit it if she's been really busy; just get the wisdom of her.

>> NEW SPEAKER: I feel like I should explain why I'm kind of tense. I think I'm not saying no, I don't want a public corporation. What I'm saying is I'm unsure at this moment, because I think there's a lot of questions about the failsafe and that for accountability and I have seen public corporations and the state come to the legislature and lobby in direct conflict with the governor's agenda or other state agenda. I believe it is about Oregon. So, I think that for me is the question how do we create those mechanisms in place so that doesn't happen? So, if that is not having a public corporation or is that having a different structure for the board or--before I move forward with a yes with the public corporation I want to make sure those other pieces are in place.

>> NEW SPEAKER: Now, Lisa, do you have some suggestions on the safeguards that you'd like to have?

>> NEW SPEAKER: I'm thinking of other people here, but I just think the make-up of the board is one of the places where I think safeguard needs to happen. I think the question of accountability, for example, I've long term credit union; so, we vote on people who are on our credit union. If they steal money we boot them off, right. So, for shareholders the things are the same, right? That's the point of shareholders in corporation. So, the idea that the members of the exchange would be shareholders in this public corporation; so, how could in that play out is one question for me. I guess for William's impeachment question, but I think that's another piece of it. [indistinct chatter] Then I also believe that the accountability structure of how state is accountable to the governor or how OHU is accountable to the governor or how--I feel like maybe I'm not understanding how that is actually structured in statute and I've only seen how it's laid out in the legislature. So, maybe there should be some clarification with me on that.

>> NEW SPEAKER: I think it is a side conversation that could be worked on. If it's not a public corporation, then what are the options here? They could be governmental, state agency or private nonprofit, private for profit.

>> [laughter]
NEW SPEAKER: We'll work on that.

NEW SPEAKER: I'm just trying to find an impeachable offense.

[laughter]

NEW SPEAKER: Moving on. Thank you very much. I need a gavel. First what more do we need here?

NEW SPEAKER: Well, I'm assuming just going through the governance, members nominated by the governor, confirmed by the senate. We talked about a small minority to be gainfully employed in healthcare through finance.

NEW SPEAKER: Obviously small has to be defined.

NEW SPEAKER: It will be defined as we move forward to—right under suggested legislative concept I think the idea today was to just agree on the small minority. Number of board members, again, needing to be specified to represent those who purchase through the exchange. So, actually there'll be one, two, three, four people who actually purchase through the exchange and the other one was including those other individuals.

NEW SPEAKER: Joe.

JOE: So, not all the members will be an exchange purchaser, just some?

NEW SPEAKER: Correct.

JOE: I would think the majority—-I mean these are the consumers themselves and they should be, I don't know; it could work, but the majority should be people that are in the exchange.

NEW SPEAKER: I don't want to limit expertise, but at the same time you want to have a balance of owners of the exchange. So, I don't know where that falls, but I think that would be really good.

NEW SPEAKER: I think that's why we try to have the member group actually connified certainly having a number of people purchasing the exchange on the board but not—-try to maintain some of that flexibility to get some of that financial actuarial expertise on board. It is balancing a lot of different perspectives and it is pretty complicated stuff certainly getting started.

NEW SPEAKER: It's just that the very practical means—-I think it is very likely that we're going to have to have a legislature that is going to meet every year and if any of this
begins to get out of balance--I mean all of this is by statute so it can be changed at any point.

>> NEW SPEAKER: In the legislature there's trust that they would--

>> NEW SPEAKER: As a practical reality with regard to the board realizing what the authority is. There could be a rather immediate, in the relative time term, change.

>> NEW SPEAKER: Could you--in the charter or the bylaws could it be put in that the board could remove the director for certain offenses? I mean you could do that right?

>> NEW SPEAKER: Yeah. The board can hire a director?

>> NEW SPEAKER: Yeah, I'm sorry I shouldn't have said director; I meant member.

>> NEW SPEAKER: Oh okay.

>> NEW SPEAKER: I think that if we're starting, I mean, we're trying to put together an abrupt, constant. We'll keep coming back, but we just need to know that we're on the right tract; the last is in the authorities and the authorities looking at this pretty boiler plate from the federal health reform and these would be the authorities that at any board is going to need to implement what would be a federal health insurance exchange to be able to administer the tax credits, etc. So, not a lot of wiggle room here.

>> NEW SPEAKER: If you look at the last pages that were in the packet that outlined staff included, it outlined what would be minimally required in let's say a concept to meet several guidelines and then anything of course that we specify we would want we would add on top of this. Those were just some examples that were taken from that federal example; just in the form of federal.

>> NEW SPEAKER: Kermit.

>> NEW SPEAKER: We're saying what do you need?

>> NEW SPEAKER: Maybe I'm getting tired, but the authorizing the enabling legislature--I think it need to be broader than the federal reform. We need to--

>> NEW SPEAKER: These are minimums.

>> NEW SPEAKER: These are minimums, but these minimums are things--minimums we have to meet to meet the federal guidelines. You can go broader.

>> NEW SPEAKER: Are we brainstorming that now or you're just stating these are the minimums?
NEW SPEAKER: I'm just stating.

NEW SPEAKER: We'll be back to more specifics in May. My thought would be, let's be sure we were using safe issue which is a broad list of authorities that have worked in the past.

NEW SPEAKER: I think we've got what we need. We will be back in spring?

NEW SPEAKER: Okay, very good.

NEW SPEAKER: I think this has been excellent. We're making progress. Very good.

NEW SPEAKER: Final comments on this topic before we move on? Okay the last item on the agenda, well it is the next to last, is item number 10, general public testimony. Edie, do you have a list of folks who would like to speak to us? I have one name and that is Laura ETHERTON. Are there others in the room who would like to speak to us? I see one, two, three, four over here. Okay, we've got Laura and then we'll go through these four, again, two minutes at a time please. Is Laura is still here? There she is, yes. Hi there.

LAURA ETHERTON: Hi there.

NEW SPEAKER: How are you?

LAURA ETHERTON: I'm good.

NEW SPEAKER: Welcome, and thanks for your patience.

LAURA ETHERTON: My pleasure. I think everybody here, but my name is Laura Etherson and I'm a healthcare advocate with OSPIRG, Oregon State Public Insurance Research Group for a nonprofit, nonpartisan, consumer advocacy organization and I just want to say a couple of comments and reflect a couple of things, thoughts that occurred to me through the conversations today. The first is that I wanted to thank you for your really thoughtful consideration of how to structure exchange and integrate it in with the rest of the transformative delivery system changes that you're contemplating. I liked Carlos's description of this a sort of the tool of all tools, it is a tool belt, it is a--the analogies could go on and on, but this really can be an interesting place to bring together a lot of the interesting thinking about value based benefits aside and other pieces. As folks know, at OSPIRG we had concern about the draft recommendations that were brought to you at the last board meeting and I think it has been really refreshing to see that that really was a draft. It was a starting place and that of course now that you've added your thinking to this that it is going in a direction that I think consumers and small businesses can begin to get really excited about. The emphasis on cost is what pretty much everybody whether
they are deep in the weeds on health policy or are just struggling to make ends meet right now are thinking about. We're all getting our renewals right now and a lot of folks are looking at continued increases in the cost of health insurance. Consumers are looking with emphasis in out of pocket costs and everything is of course is driven with ongoing increased costs of the underlying costs of care. So, it is really great to see the focus on the how can we use the exchange as a tool to actually address costs. As we heard from Massachusetts, they haven't had tremendous success in that area but I think as folks here have discussed that's not that surprising they didn't actually design the exchange to contain costs. So, it is no surprise they didn't get that result; but because you're looking at this in a much more integrated way with delivery reform, Ilene mentioned using the purchasing power in terms of the exchange to achieve delivery reform, to achieve cost containment that is a much different approach. A couple of just specific things that I'd love to mention that occurred to me during your conversation, one was that it may make sense to actually make that point that Lillian made around the purchasing strategy. One of the--to call that out among the strategies, but I think it is really clear when you look at the four strategies that Bruce presented that's a key one, but just I think that's the key one that will be important for the continuity that the idea here is to use purchasing power to leverage that to drive delivery reform and make that crystal clear. The secondary piece is on accountability and the governance structure. I think consumers and businesses that are a part of OSPRIG and that brought public interest that really--and that if everyone here would agree with it that matters a lot to get right. This is a time in our country where people are getting clobbered by costs, but public trust is not at its high point and for very, very clear accountability structures to be there coupled with very robust parenting measure is incredibly important. One suggestion in that, well a couple of suggestions. One is to look--Ilene you mentioned conflict of interest protections. In California's exchange law that Governor Schwarzenegger just signed about 10 days ago that legislature does include some conflict of interest gross protection in the legislation. Their legislation is very small. It is focused mainly on enabling work, but it does have some sort of key pillars and key important provisions and conflict of interest piece is one of the elements there so that might be useful to look at. The other thing that has come up in a number of instances would be your comments. Given that this is using the purchaser strategy how it is different from other boards and the idea that is this in some ways like a credit union? Should maybe it is the membership themselves that elect from their own ranks a set of people to be on the board; maybe that's the whole board, maybe that's the--I don't know if we have an opinion on that but that's an interesting analogy and interesting dynamic there. The final piece that I wanted to offer our help with anything that we can do to be helpful. I know that a lot of our members are excited about this and a lot of our member have still just barely heard of an exchange. I think we all know that we're all getting creamed on costs and we'd like to get some better quality and see some really good accountability in this system. I think those things can really resonate with the public. So, good luck.

>> NEW SPEAKER: Thank you very much.
>> NEW SPEAKER: Mr. Chair this reminded me of the prop that I meant to bring up earlier and that is could we have staff look into the governance of the connecter and that's just to make sure that we have an appeal for what's on there?

>> DR. BURTON: Sure.

>> NEW SPEAKER: Thanks for reminding me.

>> DR. BURTON: There are one or two others that I think we should look into as well. Very good. Laura thank you. Okay, very good thank you. Start the next.

>> NEW SPEAKER: Thank you for allowing me to double mike. There are two points on the sheet up there that deserve emphasis. One is, I believe Mr. Hoffen brought up lots of new people will be in this exchange who are relatively unsophisticated about healthcare. I have had 13 years of higher education most of it in healthcare and I'm completely lummox by my policy. I live in fear that a family member is going to come down with something that this small print doesn't cover. The board should insure that no matter who buys what kind of policy on the health insurance exchange that they're not going to buy inadequate policy without realizing it. The second point: can you be attractive to business? One of the great contributions that's safe to businesses is that it combines high risk businesses with low risk businesses if you choose creates two great things. Everybody gets coverage and average cost goes down. If you have a risk pool that includes small businesses, you achieve the same great things but the first thing you do is you have small business men like Mr. Housier who testified who want to provide healthcare insurance for his employees now has a way to do it without having to assume the administrative headache and responsibilities. Most importantly you then dilute out the sick and the old who are very expensive to insure with this huge pool of young, healthy employed people. You expand the coverage to more people. You provide financial stability and most importantly you reduce the overall per capita costs. So, protect the naive consumer like me from unscrupulous insurance on the exchange and two make the coverage from the very beginning attractive to as many people in Oregon and businesses as possible to make this whole program as viable a possible. Thank you.


>> BAKER: We're both here to speak on a topic that is well known to many of you which is we testified in this group again about a topic that is therapy coverage. We're here again because our group firmly believes that you're missing an opportunity to use health care coverage to prevent problems before they emerge and you're overlooking what actually is able to do with preventive treatment and especially what the adherence is able to do and we feel that you're overly biased towards treating problems that exist and trying to solve those under biased towards letting people like us try to prevent problems like this in the future. Now, we have presented more data today that supported in therapy is showing that it is a consensus treatment are our national guidelines. We're here again to
make comments about this to make comments directly about the proposal and I'll make a few more comments about our general attitude.

>> NEW SPEAKER: In sitting here for just and hour an a half hour before, it almost feels like our testimony is out of context for the subject that being--and I apologize for that. In general I think ours especially represents a quality of life rarely a length of life disease and I think the board is going to meet to take into direct thought about how are you going to deal with these diseases which are not fatal, but consume very high dollars? Asthma is the highest, most common chronic disease in America and it occupies one of the biggest costs. I take care of seven patients with hereditary Angieodema and get an injection costing $4,000 every three days; that's upward of $80,000 a year just to take for these 7 patients. I think our specialty in general deals with these little boutique situations. We've submitted the data of just showing in Florida patients treated by immunial therapy versus those not treated with immunal therapy and the whole overall cost of their care was simply less. This was a study done using actual data from the Medicare population or Medicaid population. It has come to my attention that this is the most difficult group to treat allergy disease. The more well informed and the more affluent population, I think, does much better with allergy care and when statistics show that the Medicaid population can get buy cheaper with this form of therapy I think this is very strong evidence. I think I'd--not to get into details that you all would be here beyond 4:30 this afternoon I'm not going to go into that and I think I would more rather here if you have any questions about that. I'm concerned that I'm dealing a little bit with the paranoia of our group fearing that we're going to be left out in the cold and I think there's part of that behind the emphasis of trying to fight for a little piece of our income, but I guess I would like to hear more if you--how are specialties such as ours and such as medical ophthalmology, medical, you know there's all these little boutique areas that are going to be dealt with. It is very apparent to me that the generalists do not deal with these problems.

>> NEW SPEAKER:  Let me just jump in and say that there's nothing to lead me to believe that this group opposed to any particular physician or practitioner. So, I'm not sure where you got that. We didn't--we shouldn't have that conversation now. This group is specifically very focused on preventative care. It has been at the top of our list. I would say there's going to be a time where this might be a really appropriate conversation, but I wouldn't start something you don't need to start yet. That's my advice.

>> NEW SPEAKER:  Let me just provide maybe a little context which is, I think, and correct me if I'm wrong that there has been some concern for allergists about--I think not about this group and the decisions made here, but about some of the decisions with the health services committee commission and the health services commission has been determining the ranking and efficacy of services covered in the Oregon Health Plan. I think that there has been some ongoing consideration of a number of services such as immunial therapy and the evidence basis around that. There's been some really good discussions from both the members of the commissions and the physicians on the commission and the allergy community and there's been some difference of opinion
about where and who things should be ranked and I think that's the context for the remarks today and I think that the concerns by some of the allergist in the state to be certain that this remains on the radar screen and that as we continue to move forward with value and evidence based care that we work together and I think Ilene said with well when there's no predisposition to do anything at this point and as you can see by the levels of discussion--

>> DR. BURTON: It is going to be a while. We hope we get down to where there's some oxygen.

>> NEW SPEAKER: That's why I thought it was so out of context, because you're dealing with global issues and we're dealing with minutia and it seems early in the process.

>> NEW SPEAKER: I would add on that one I'm acquaintances with Dr. Putin in Bend so I certainly have heard this many times, but I don't know if you heard the conversation today about the value based benefit design. I think that really kind of gets to the heart of this and I know there has been some issues just with the Health Service Commission has prioritized just on the OHP above or below the line. I think, and Bruce correct me if I'm wrong, when you look at the value base I look at that as a different setup and I look at peers. So, I really don't think of anybody being in or our; there's a different base of value based on the research. I see that as ongoing and we still have more work to do on that.

>> NEW SPEAKER: We certainly feel that it is on its way up, but there has been a difference of a opinion about what are the pyramid pieces of evidence about how valuable you are and in whose eyes that judgment will be made and whether there is and what there could be as accurate scientific evidence can look at value. Considering where American healthcare has been and what it has been doing. So, there is not going to be evidence based medicine with every decision you all are making. We understand that, but on the other hand we also live and breathe this all of the time. We and have our national committees and their guidelines believe that they understand what this is taking for. So, the debate is we are trying to inform you about what we think is correct and trying to see for us what you think is correct and this debate is going on and on and on. We are here again to say where we think something valuable is and you have to show us where and when we're supposed to do that, but we want to make sure that we all don't get characterized as well they can't prove it to us so it can't be valuable.

>> NEW SPEAKER: I think that's a perfectly fair request and we appreciate your being here today and believe me you are on the radar screen. So, thank you and we appreciate it. Is there any other business to come before the Oregon Healthcare Policy board today? Hearing that, we are adjourned and I'll thank you very much. It has been a long day, but a very much productive one I believe.
NEW SPEAKER: Well, good morning, everybody. Let's call to order the November meeting of the Oregon Health Policy board. We have a couple of members who are caught in traffic and still on their way. But will be along shortly. I'm expecting Felicia and [inaudible] as well. So thanks to the rest of you for being here as always. And we'll begin.

A couple of things. First up is the consent agenda, which includes the minutes of the October meeting. Those have been distributed prior to this meeting. And in addition, there is a report on the non-traditional healthcare workers committee, an update on that group. Hello, Chuck. Welcome. We're just beginning. And so, I guess first, I would like to entertain a motion to approve the consent agenda, including the minutes.

NEW SPEAKER: So moved.

NEW SPEAKER: And a second?

NEW SPEAKER: Second.

NEW SPEAKER: Moved and seconded. Those in favor, aye.

NEW SPEAKERS: Aye.

NEW SPEAKER: And opposed? It passes, thank you very much. I have really only a couple of things to announce as a part of this. One is the December meeting may end up conflicting in part with another opportunity that we may have to talk about some of the work that's underway with an important segment of the community on December...what is it, December 13th. And so, if you can maintain a little flexibility on your calendars, we may end up starting a little later in the afternoon than originally scheduled, which may mean we'd have to go an hour or two later. It wouldn't be much of a change, but there might be a little bit of a change in order to make that work. So heads up there.
And the other thing is that today's agenda is a little bit different in that we...because the agenda is so full we are not going to have the monthly update from PEB and the Oregon Health Plan. But they will be back on the agenda next month. So that's underway. We're going to go quickly to Bruce for a director's report and then we'll proceed through the agenda.

>> NEW SPEAKER: And I will be quick as well. You've gotten some of the stats about Healthy Kids in writing, et cetera. I just wanted to touch on a couple of things very briefly because we're really going to spend the meeting today on what our work has been, which has been moving forward the business plan and all of that.

But in terms of that, three quick things. One is that we are working with some consultants, as well as CMS, to look at how we can perhaps get some federal investment in some of this system change. And I think that it's showing some promise in being able to do that. Nothing is certain at this point. But I think what this would do, and we're putting a lot of effort into this, is be able to help us, I think, meet what are some real aggressive timelines. And be able to be certain that as we have CCOs get started in July, that they could get some of, I think, the financial support to move forward pretty rapidly and not...I think all of us know that to be able to sort of get those sort of savings from system change isn't going to happen on July 1. It's certainly going to happen. It's got to happen sooner rather than later. But it's going to take some months to start to get the changes that are going to reap both the improvements in care and quality as well as the savings.

And so what our hope is is that with some federal investment, which in the long run is in the federal government's best interest because as we can become more efficient and effective given that they're actually a majority partner, paying, you know, 60+% of our Medicaid expenditures, it's in their interest as well to have us be successful in creating this kind of system change. So very promising. More to follow as that happens, but I just wanted to keep everybody in the loop on that.
Likewise, as we look at this sort of system transformation externally and...in terms of the delivery system, we're also, as an agency, looking internally at how it is we need to reorganize in how we do our work. And so we're working with a group who some people around the table may know, Mass Ingenuity, that are helping us really talk about how to reorganize and move forward on that front. Looking at some beginning thoughts from them, some plans on January 1. And I'll keep everyone in the loop and send some information via email.

And then the last piece that I just wanted to mention as kind of a foreshadowing of work to come for us is the pieces about medical liability. We're working on the business plan today, but we also have a charge to put forward some recommendations about medical liability policy reform. And what we're done is...this is obviously a very complex area. We've engaged some nationally recognized consultants on two fronts. One is Dr. Michelle Mellow, who many of you may know, and someone else from the Harvard School of Public Health who are going to put together some policy studies and some recommendations for us based on national work for us to consider.

And the second piece is to...we're going to...we've got Bill Wright from the Providence Center for Outcomes Research as well as Kate Baker, who's an economist from Harvard, who are going to be looking at doing some studies within some statewide data over the next couple of months about defensive medicine and overutilization, looking at how we might be able to start to quantify some of that. The caveats are very complex issues, very compressed timeline. We'll start to get some information out to everybody. But that's going to start to happen...they're just starting their work. It's going to be November, December, and start to get some stuff to us in January. But real promising and I think we can get some good work from that. So that's my report.

>> NEW SPEAKER: Very good. Any questions for Bruce? Okay, super. Thank you very much. We will move on to item number three. And Tina, I think we're...what, we've completed our third month of work group efforts and looking forward to an update.
NEW SPEAKER: That's right.

NEW SPEAKER: So this month...we usually spend, for the last couple months since these external stakeholder groups have started, we spend a pretty significant amount of time here going through the feedback that we get out of those groups. I'm going to spend less time today than I usually would, primarily because the next section of the agenda is where we're going to do a really deep dive on some of the questions that have emerged and some of the discussions that have emerged out of the stakeholder group. So that's the part of the...the next item is where we'll really spend some time.

So let me start with...and I do apologize. There were some typos in your printed copy. We got it, hopefully, corrected on this version, the screened version. So the first area that we have some pretty significant feedback on is in the area of governance. It was one of the questions that was addressed in the CCO criteria group. This slide just go through what the guidance is in 3650, that the governance structure has to have a majority interest of persons that share in financial risk, that it has to represent the major components of the healthcare delivery system, and it has to represent the community at large. So the key points that the stakeholder group identified that they wanted to come forward to the board is, again, they thought the governance structure should, and community engagement, should reflect the needs of that local community as the result of a community needs assessment. And it should reflect...it should always keep the Triple Aim in mind.

They felt that there needed to be clarification, a lot of discussion about what does it mean that persons that share in financial risk of the organization. There was discussion about, at the individual level, you share risk in a pretty significant way. It might not be the same as the financial risk that an insurance company might have. But they did think that needed to be clarified. They also thought that the board should consider a requirement that a member of the community advisory council, which is a requirement in 3650, that every CCO has a community advisory council, that you might consider a requirement that the chair or a member
of that council sit on the governance board of the CCO.

Again, you know, there was a feeling that there should be transparency and accountability. In the board's consideration of any recommendations that come from the community advisory council, there is a lot of discussion and a lot of fear, I think, that that organization...that that group would make recommendations that could fall on deaf ears and no action be taken. So the transparency piece was really, really important to the groups as they talked about this. And then, again, everyone wanted to make sure that the issues of mental health and addictions were represented on either the governing board or the community advisory council.

So just stop me if you have any questions because I'm just going to rush through so that we get to the next agenda item.

>> NEW SPEAKER: I do have a question, sorry.

>> NEW SPEAKER: Yeah, it's okay.

>> NEW SPEAKER: I have a question about...if there was discussion on the governance topic about providers or local governments. I know the discussion around counties was a huge one, around services that they provide. So...

>> NEW SPEAKER: Mhm. And that actually came up in this concept of persons that share financial risk that, you know, what does that mean? Can it be a county, can it be providers in the local...because everyone...there's different levels of risk and that's why they...I mean, they really sort of punted it back to the board saying that they thought that should be a consideration. But yeah.

>> NEW SPEAKER: Tina, can I ask a follow-up question? What's the intent...all this language aside. The persons that share in the financial risk of the organization. The idea is that...

>> NEW SPEAKER: If you're at financial risk, that you should be in the governance structure. The legislation actually says the majority need to represent people who
have financial risk. Again though, you know, the question was what does that mean. Is it just purely financial risk from an investment point of view or is it bringing dollars to the table? Is it the kind of risk that a provider carries, which is performance risk more than...

>> NEW SPEAKER: Or the employers who are paying for the insurance.

>> NEW SPEAKER: So it has to do with the organizations providing care, what financial risk they have?

>> NEW SPEAKER: Mhm.

>> NEW SPEAKER: Okay.

>> NEW SPEAKER: Okay? Financial solvency: again, the 3650 calls for OHA to develop a proposal for financial reporting requirements. And based on the presentation that was made to this group, the question was asked, "Which were the most important factors that they thought the state should consider in evaluating the financial status?" The other item that's in 3650 is that we should...it's actually language that the groups wanted more clarification on. It's language about not requiring them to report to more than one agency. So the discussion was that perhaps the Department of Consumer and Business Services, where the insurance division resides, is the best place for this financial reporting to happen. That they have...they have a breadth of knowledge with the commercial market and evaluating the financial solvency and financial status of commercial health plans so that might be the appropriate place for that reporting to happen.

So then, the question was asked, "Is that going to be a requirement that would be even across all CCOs? Could one CCO do their financial reporting to OHA and another one do their financial reporting to DCBS?" And that just a question that was brought up.

They thought that the evaluations should really include an analysis...should explicitly include an analysis of reinsurance, risk reserves, risk sharing, providers enrollment levels, with a real focus on how effective
looking at reinsurance and risk reserves can be in doing a financial analysis.

They also thought that there are going to be a lot of areas in the state where you have small organizations, a local community coming together, and they might not be able to afford full risk right out of the gate. And that there should be sort of a ramp up of some kind to allow them to build toward an organization that can absorb full risk and thought that that should be part of the thinking that goes into the criteria for CCOs.

>> NEW SPEAKER: Tina, can I stop you?

>> NEW SPEAKER: Mhm. Yeah.

>> NEW SPEAKER: Can you go back to slides?

>> NEW SPEAKER: Two slides. That?

>> NEW SPEAKER: CHCS presentation, can you refresh my memory?

>> NEW SPEAKER: It was the Center for Healthcare Strategies. They presented on the different kinds of risk arrangements that organizations can have. And the presented the idea that, you know, you can have a...

>> NEW SPEAKER: Okay, so this is at the CCO meeting.

>> NEW SPEAKER: It was at the CCO meeting. I'm sorry. It wasn't here.

>> NEW SPEAKER: Okay. Yeah. I didn't remember that. But then I don't remember a lot of things.

>> NEW SPEAKER: So I guess it's a good thing it didn't happen here.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: No, this happened at these meetings. Um, public comments. We did not get very many public comments. But there was, on solvency, they wanted to make sure that
we bring real entities to the table when we're having these discussions so that those sort of unique...that issue of needing time to ramp up, for instance, is on the table. Again, an expression that the community should be represented. And a couple of expressions from people who, I think, are probably a little more cynical about this and thought that it doesn't really...the discussion about community gets represented doesn't really matter if the majority is people who have financial risk.

>> NEW SPEAKER: That is cynical.

[inaudible over each other]

>> NEW SPEAKER: So the global budget, was there any more questions on that? The global budget methodology group, the question that they were asked was what are the key risk adjustment considerations for CCOs...

>> NEW SPEAKER: Tina, I'm so sorry. Can I just one question? And just, I'm sorry. I may not be caught up-to-date on all this. For the financial solvency, was the issue addressed...so if the indicates that the CCO is not financially solvent two years down the lines, who is then liable for that? Is that part of this discussion of...

>> NEW SPEAKER: It wasn't explicitly part of this discussion, no.

>> NEW SPEAKER: Okay. So what happens when and if that happens? Who gathers around to try and resolve and maintain continuation of care? That...

>> NEW SPEAKER: Would be us. I mean, I think the issue is to try and, first off, assure that...prevent that from happening so that there is the needed kind of financial reserves to assure that that's not going to happen. Whether that be through reinsurance, whether that be through reserves. And we're looking at a variety of ways to do that. In the end, if people do become insolvent, I think the issue is a how can you intervene before there is catastrophic failure? And maybe that would be the responsibility of the agency of us to intervene at a time that was appropriate to minimize the kind of losses, which
would really be losses to the provider community. It would be care that's been delivered, but not paid for.

>> NEW SPEAKER: So it seems to me...I don't know where in this this fits, but if we had some sort of intervention strategy that's up front and explicit. Having been through situations where it's not explicit, you can miss the opportunity and it can be a lot more difficult to make the transitions. I just suggest at some point, I don't know if it's in this criteria or if it's written in the contracts, that we have some sort of process for reporting and escalation and intervention.

>> NEW SPEAKER: I think another part of that strategy would be...my suspicion is that...you know, we can build safeguards so that catastrophic loss doesn't occur. But I don't think it's unlikely that certain entities that form CCOs, after a period of a year or two or three, will say, "You know what? Although we're not suffering catastrophic loss, we're no longer in this game." And so I think part of the strategy ought to be, okay, upon withdrawal of organizations, what's the strategy to put things back together.

>> NEW SPEAKER: I think part of this...and I'm sure we'll be developing some straw plans around this issue. But I think part of it too is to make sure, and part of this discussion, is to make sure that we have timely and accurate data so we get early readings on those kinds of issues so we can intervene early. And I think that's...

>> NEW SPEAKER: Permission to intervene. So I love the data piece. But let's get the permission to intervene piece early piece of it.

>> NEW SPEAKER: Um, okay, so the next question was what are the key risk adjustment considerations for CCOs. And again, they...you know, risk adjustment is needed and it's important and everyone acknowledged that. Don't ask me what the CDPS system is. I don't know.

[inaudible over each other]

>> NEW SPEAKER: Chronic disease something system.
>> NEW SPEAKER: So there's some sort of a system out there that could be used as...

[inaudible over each other]

>> NEW SPEAKER: We've been using it for ten years.

>> NEW SPEAKER: How's it work? It must work great since I've never heard of it.

>> NEW SPEAKER: It's a system designed for risk adjusting Medicaid. It's the most prevalent system used to adjust Medicaid plans in the nation. I think it's used by 10, 15 states. We've been using it for 10, 15 years now. Obviously, anybody that gets a low risk score thinks it's a bad system. And everyone that has a high risk score thinks it's working very well. Having said that, I think that we've got...the wisdom of the group was we've got something that's generally been tried and true and has been working. Why would you want to change that?

>> NEW SPEAKER: Can we...maybe, at some point, email us what some of the criteria for this. I'd be interested in looking at some of the criteria.

>> NEW SPEAKER: Sure. Okay. There was a feeling that we could include some additional data into the risk adjustment mechanisms, such as pharmacy data which makes it...the consultants have told us...said at this meeting that that adds a richness to the risk adjustment that isn't currently there. There's also a strong feeling that any current risk adjustment mechanism doesn't take into account sort of the socioeconomic factors such as poverty, race, ethnicity, education. And there's a really strong feeling in this group that somehow we should start to address that issue through either stratification or or risk adjustment mechanisms. So we need to pay attention to that.

Need to avoid penalizing positive outcomes or really trying to avoid encouraging, unintentionally, any gaming of the system.

>> NEW SPEAKER: Can I just...I just have a question about
risk adjusting based on race, ethnicity, and primary language and how that works in a positive way and not a negative way. I just feel like I've heard that before, you know, redlining and other...so maybe you can explain to me how that doesn't end up with people of color having...

>> NEW SPEAKER: Those who have more diabetes and stroke...

>> NEW SPEAKER: I think Carlos has brought that up before too.

>> NEW SPEAKER: Yeah, not being risked out of systems.

>> NEW SPEAKER: You'd adjust it the other way.

[inaudible over each other]

>> NEW SPEAKER: Okay. I just want to make sure we're really clear about that and that isn't a way to adjust your risk by excluding those people from your plan.

>> NEW SPEAKER: The less risk you have, the lower the payment is. So there isn't an incentive to shed risk based on any kind of sociodemographic or illness factor.

>> NEW SPEAKER: Perfect. Yeah, I just want to be...we should be absolutely clear about that when we're talking about adjusting risk based on socioeconomic factors. The language is really critical for me there.

>> NEW SPEAKER: I also want to say no one, as far as I know, does this. I mean, you can stratify by those factors. But risk adjusting, no one's cracked that code yet. So we're not there.

>> NEW SPEAKER: Since we're talking about risk adjustment I'll take just a moment here to...humor me while I express my frustration about our vernacular. This is a very important discussion. But I think it demonstrates why "global budget" is a misnomer. If you truly have a global budget, you don't have to risk adjust. I mean, and that's why the size of these organizations is important. And I mean, it is really...it is semantics. But I think it's important to remember that this is a term we're using. But
if it were truly a global budget, it would be all-in in a manner that wouldn't require this.

>> NEW SPEAKER: Wouldn't...I mean, Joe, just for my clarification: I guess when I think of the global budget, I think of it from the context, the macro from the state perspective. And is that...

>> NEW SPEAKER: I understand that. But if you were sufficiently...I'm espousing an ideal system that will never be achieved.

>> NEW SPEAKER: Don't give up, Joe.

[inaudible over each other]

>> NEW SPEAKER: Yeah, if all risk were in one pool you would have a global budget and we wouldn't be engaged in this discussion. Yeah.

>> NEW SPEAKER: Maybe you could back up and we could talk about what...why we're doing risk adjustment, just at kind of a macro level, Tina, for the CCOs.

>> NEW SPEAKER: Well for...if a CCO has...a CCO is likely to carry different levels of risk. I mean, they'll have...a particular CCO, because it's in an urban area, might have, you know...people with severe disabilities tend to live in urban areas because that's where the services are. So you could have...that CCO in an urban area might have a sicker population and more...you need to bring more resources to bear on that sicker population. So that's why you would risk adjust, to reflect the fact that their population might be...

>> NEW SPEAKER: Well, if we look at it from the state perspective...this is hopefully not humoring me too much, but are we risk adjusting between Portland and Bend or are we risk adjusting within, let's say, the Portland Metropolitan area? I mean, are we saying three's multiple CCOs there so we're going to risk or is the risk adjustment really a statewide exercise between regional diversity? Or don't we know yet?
NEW SPEAKER: Well, I don't know that we know for the CCO delivery system, but I think we do both right now. I mean, that's...that we regionally...geographically adjust and adjust within region.

NEW SPEAKER: And the intention is to carry that system...a similar system?

NEW SPEAKER: It's the Chronic Disease and Disability Payment System.

NEW SPEAKER: Oh, is that what it is?

NEW SPEAKER: Thanks, Rick.

NEW SPEAKER: Let the record show that that took him 15 minutes.

[inaudible over each other]

NEW SPEAKER: Tina, why don't we proceed?

NEW SPEAKER: We'll go to the next question. So one of the questions that was asked at the global budget methodology group is how you might tie quality incentives into the global budget framework. And again, the key point that they wanted to share with the board is that they did believe that quality incentives should be part in rewarding good performance and protecting against loss of assets. They thought that we should center on health outcomes. Again, the same idea of gradually...of introducing this in staging. That they thought that timing and staging was going to be important because these are new organizations. We're not going to know in many cases what the baseline is and we need to be able to build toward performance goals.

They thought that we should...everything should be built with an eye to building that larger picture, accomplishing population health goals and building from that and not just focusing on individual health goals. Um, focusing on children. They...again, since children are the future health of the nation, that may be where we focus our efforts is on children's health.
Then they thought, you know, the relationship that we're talking about here is the relationship between the state and CCOs. But that the relationship...the provider quality relationship is really between the CCO and their provider network and not between the state and their providers. And then there was a suggestion that we might be able to use non-financial incentives such as sort of less burdensome reporting requirements overall for a CCO that has a history of good quality and performance.

So the outcomes, quality and efficiency work group, this...again, I think what I would say about this group, sharing it, is, again, they prefer...there's a strong feeling outcomes measures whenever possible. They've agreed that there should be three general buckets of measures: there should be a core set, then there should be a menu set that the CCO can choose from for themselves that reflect their particular population and what's going on in their particular population. And then there should be the set of developmental measures that really are the transformational things that we're not very good at measuring and we want people to experiment with. You know, we're not very good at how we really look at whether you're truly integrating services or not because it's new and people across the country are struggling with it. So we do want there to be some developmental work going on. We didn't want to be stuck purely with this, you know, don't try anything new ad don't reinvent things.

I think the big point of confusion in this group or point of clarity that we're trying to get to in this group is the levels of accountability. So far, what we've done, is just talk about...again, there's these buckets of metrics and there's this increasing feeling, I think, that, you know, the way we've looked at it it could all be occurring at the provider level. You know, so we have put together a document that we'll bring forward to this group next week that really outlines where we think the levels of accountability are. There's accountability at the provider level, but this is really about accountability at the CCO level and that's really where we're focusing our efforts. And then there's accountability at the OHA levels so hopefully we'll get better clarification at this next meeting.
So again, there's this real struggle with how we balance this interest in outcomes and transformational measures with the acknowledgment that not everybody...to truly get to the transformational stuff, you need HIE, you need health information exchange, and you need HIT systems. And not everybody is there. So again, there's this ramp-up period to get to that. There's this desire to align with other reporting systems who don't include a lot of transformational work in them. And there's an interest in being clear about the standard of care that a CCO should provide. And again, what's that baseline?

I think, too...I'll have to...Carlos shared a slide with me. I'm going to have to wait until I get out of this though, I think, to share that. Around the...as one of the board representatives on the quality group. I think...I will say we had a call with CMS about the work that this group is doing this week. And they are actually really, really excited about the work that's being done, especially around the transformational pieces of this. That they're struggling very much the same way internally and we're really very interested in that and how we're looking at those issues.

So let me...well, I don't want to...I'll come back to your slide, Carlos. If I escape from this I'm escaped forever. So the Medicare and Medicaid integration group, what they...again, they were asked the question, "So what would effective coordination look like?" And...so they really emphasized it would be patient centered and it'd be culturally appropriate. That it would include non-traditional healthcare workers. That we would provide adequate workforce development and training and a livable wage. That we would have individualized care plans when it was appropriate for people who need the individualized care plans. And that there'd be IT systems that would help with communication and sharing of information. Especially with these high-risk populations, the very vulnerable populations that case managers and all the different providers involved on the team really need to be able to share information in a timely way.

Anticipated challenges: how do we adapt these models for
rural areas? The rural piece of this important in every piece that we look at. How we make it work in rural areas. We need to align with patient centered primary care home models so that we avoid duplication. A lot of the work that was done on the primary care home model is really about addressing these vulnerable populations. And then reimbursement models really need to support care coordination and encourage care coordination.

Again, they had a task of looking at quality incentives and I wouldn't...there's...I won't go over this. There's very much the same issues that the other groups talked about when they talked about quality measures and incentives. And public comment: again, the main public comment, I think, was really around the idea of asking the patient what works for them. Allowing the patient to look to their family members to help with care coordination isn't a bad thing. It doesn’t all happen in the doctor's office. And they wanted...there was an expression of that.

So I will see if I can find Carlos's slide. And then...here it is.

>> NEW SPEAKER: So actually, this...what I found in some of the meetings is that there seems to be a disconnect between the role of prevention and community engagement. And I think it's hard and I had very interesting conversations with some of the community members. And I think it's true. The way they're defining prevention is not going to be that much cost-effective. It's still a one-on-one approach and basically makes more paperwork, more involvement, and maybe the outcomes is not going to be that much visible right away. And to think outside of the usual way of doing prevention, at a community level, it's more complicated and it's...I think they're frustrated because they know they don't have control over the schools, over the police, over the housing. And those are very important parts, especially when you're thinking about mental health and recovery, et cetera.

And we should think about how to engage those other sectors to have a [inaudible]...

>> NEW SPEAKER: Skin in the game.
>> NEW SPEAKER: Skin in the game. Because there's no incentives or rewards for anybody. So to the extent that they can visualize that it's...the way I see this going, it's still expensive. It's how many people are we going to screen for cholesterol versus what percent of the entire community have had their cholesterol checked, whether they're members or not. What percent of the people who rent low-income homes have houses that are livable?

So that probably is no efficacy stuff, efficacy in terms of how they're going to do it. But it is...I think it's critical that we get all of these other components that are more cost-effective, that are population based. And I think there might be some frustration that this is the government job. That's public health, people, that's not what we do. But if those people are not in the governance, they will never be able to get their input and follow them.

>> NEW SPEAKER: Can I comment on that? Sorry, Chuck.

>> NEW SPEAKER: Mr. Chair...

>> NEW SPEAKER: I think this is an extraordinary observation. I also think this is...at some level, it's beyond community engagement. Carlos, this is really about moving from the old system to the new system and it's a mental model that we all want to adopt. And I'd like to figure out how do we...it'd be interesting to know how to measure this. I actually think if we can...if what's on the right side ends up being the focus for the entire system, whether you're at a CCO level or OHA level or a provider level, that would be an indicator of success. So that's just a thought for you to think about how do we get at this. This is...that is transformation right there.

>> NEW SPEAKER: Let me just add my two cents. I totally agree. And I think, as we've been thinking about this though, part of that is sort of evolutionary in terms of how do you start with this organization, a CCO which we're starting around not the whole population, but around Medicaid. But I think the vision is if we can be successful and as you bring in more members of the community into this, it does then move you toward a greater community
approach. And I think from the start one of the issues that we're going to have to deal with is how do we involve the public health and population based sort of sector in CCOs from the start to be able to get at that approach. Because I think Carlos is exactly right. That's where the...eventually, that's where the true savings come from is from the population based approaches, not from that individual piece.

>> NEW SPEAKER: Can I ask a question about this? I do think that this has been sort of...it's a good one slide about where our vision is going and the discussion we've had about Medicaid. We've had a similar discussion about public purchasers. What we haven't had a discussion about is the private sector and the largest healthcare purchasers in our state. And I know that there's been a discussion with the Health Leadership Task Force, which is mainly made up of hospitals and insurance industries, which are the largest employers in our state.

So how is this discussion moving to the population that they already insure as the largest employers in our state? And then the other question is what about the next largest businesses on that list? And what's the discussion with those folks around changing their way they are thinking about their own insurance models. I think, this is probably, you know...if you combine them all together the second largest purchasers of healthcare in our state. And what's our plan around moving our vision outside of a Medicaid population that we all agree doesn't transform a system?

>> NEW SPEAKER: I'll jump in. Felicia, I think it's a fair question. I think we've been talking about this a lot. I think the one thing that we've been falling back on is that we've got to demonstrate value. This is a vision and I think the business community is aligned with the vision, but at the same time, we've got to demonstrate that this works. And I think, then, if they see better value in it, I think they have every reason to participate.

>> NEW SPEAKER: Can I push back on you just a touch on that? So I do think that we have to demonstrate value. But I think the vast majority of the business community can
admit today that the system they have doesn't work. And they have a much more innovative culture, I think, than the public sector sometimes does. So are there those businesses that we haven't reached out to that would be willing to go...I think we haven't even reached out with our vision to them is my nervousness. So are there some that are willing to say, "All right, you know what, we'll go down the path with Medicaid. We're going to try it out. We're going to go down the path." And the largest providers who are doing this transformation are also the largest employers. Have any of them committed to say, "We'll pick our own population of healthcare workers that we employ and we'll go down the same path with Medicaid."

[inaudible over each other]

>> NEW SPEAKER: I haven't heard that yet. I think there's too much uncertainty still about what is the path. What I would say is according to this...if I look at this slide, I think the entities that you mentioned are actually far ahead of anybody else. I mean, if you look at the wellness programs that are being introduced in...what you do in your wellness program is going to affect, beginning next year, how much your insurance costs at OHSU. You're going to have a menu of what you can do to personally reduce your healthcare costs.

So, from this perspective, I think the entities you mentioned are a head of us. From saying their wagon is hitched to something that's still unknown, I haven't heard that.

>> NEW SPEAKER: I can give you just a little bit. I think the business community through the Healthcare Leadership Task Force and the Oregon Business Council's Healthcare Roundtable is actually quite well-informed about the activities that we're pursuing and that others are pursuing. I think that they are very interested in seeing how this goes forward. And a few of their members have begun to adopt some of the kinds of things that we're talking about now. I think those that are not involved in the healthcare industry are not feeling that they have the influence to change the delivery system. They're hoping, with our purchasing power, we can begin to change the
delivery system. And if we can show that we're making progress and having a positive effect, I believe they're going to want to join this effort.

Some have begun to take some steps. Some are changing the way that they're doing pricing and participation in healthcare programs. But they're looking for ways that they can be part of the collective impact. What I mentioned earlier, that we may have to watch the timing on our December meeting, that's so we can make a presentation at the Oregon Business Plan summit, which I think, has probably as great a platform as any to pursue our objectives. So there may be more going on than has been publicized so far.

>> NEW SPEAKER: I also think it would just be good to get their investment and their feedback early as opposed to not being invested later. And I really am talking about, excluding the healthcare industry which the Healthcare Leadership Task Force is mainly the healthcare industry with a couple of exceptions. Right? So private sector businesses in the state who are large purchasers, of [inaudible] who are large purchasers. I just...this is my little web camera plea to help us really transform...if we're going to transform the system, it would be good to get that feedback and that input now.

>> NEW SPEAKER: Yeah. My greatest concern is not about the employers that are healthcare related or the largest employers. My greatest concern is about the second tier that is not the largest and is not those that are 50 or eventually...or a hundred or less. We have a big job to sell this to them. My biggest concern is that those will choose not to play, I think, and just choose to pay the penalty. I think there is a very, very significant risk of that. That's my greatest concern in what I've heard.

>> NEW SPEAKER: Well, the vast majority of them will because those employers aren't providing healthcare now.

>> NEW SPEAKER: And those are the ones that will benefit from an infrastructure that is going to work for everybody. It's the way it is. They're seeing it as, you know, "I pay for this and I get that." Whereas, if there's a collective
work to improve everybody, then they might benefit from that.

The comment I was going to make was the one way for us it's to make sure that either one, I don't know how many, but people that are outside this health medical model, but the transportation [inaudible], that those folks are involved in the governance of CCOs. And I think that's when you're actually going to get not just input, it's going to have voice and some vote that will go both ways.

>> NEW SPEAKER: That's a great segue to the next section.

>> NEW SPEAKER: Right. Are we ready to move ahead?

>> NEW SPEAKER: Yeah.

>> NEW SPEAKER: Okay. Um, we are about almost a half-hour behind on our agenda so we're going to need to continue to move along. But Diana, if you want to come forward, we'd appreciate it.

The next...we've actually kind of gotten into a few of these topics a little bit already so I think this has been a productive use of time. But essentially, what we want to do now is, with Diana's help and leadership here, begin to address some of these questions where the staff is actually looking for input from the board. So Diana, I turn it over to you.

>> NEW SPEAKER: Thank you, Erik. So just to do a time check, when do you want to finished with this piece?

>> NEW SPEAKER: Can we maybe be ready for a break at 10:45?

>> NEW SPEAKER: Sure. I think that'll work. Good morning, everybody. You all, as Erik has said, already started touching on a number of the questions that we wanted to discuss with you this morning. And, you know, Tina outlined a lot of what the work groups have been talking about and you've been hearing that. And increasingly, we need to get to some of the details and some of the sort of areas of struggle and tension. And so what we want to do with you in the next hour and fifteen minutes or so is to pose several
questions around a number of different issues. And we'll be talking about...we have some questions under governance, around health equity. We'll be talking a bit about some issues that have come up in global budget work. And then we'll spend a short period of time talking about some issues that you're going to be delving more deeply into in December. And that will be around long-term care as well as system transition. So we're going to reserve a little bit, maybe 15 minutes, at the end of this conversation.

And we're going to start with governance. And here's where we're at. As we thought about these questions for all of you today, there's sort of two big areas that these questions fall into. One is around the level of specificity. How specific, how prescriptive should we be around CCOs. And there has been a, and I would say a healthy tension, throughout this process around prescription and maybe a baseline. And a healthy tension with ensuring local innovation and flexibility. And knowing that communities across Oregon are different from one another. So how do you balance that, where is the line that you...how do you do that?

So the one set of questions that we're going to talk about really is around specificity, how detailed to get. And then the second, there's some other questions here, really looking to all of you for some direction in terms of fleshing out the business plan. Where do you want us to focus attention? So those are sort of the two big areas that we're going to delve into. Any questions about that before we leap into governance?

On the governance piece, if you'll look at this first question, it is exactly on this level of specificity. And it's...you know, there is a statutory requirement, as you know, that there is representation of the community at large. And, you know, the work groups there, there has been some discussion that it should be required that there be consumer representation. And what, you know...on the level of specificity and we'll...all three of these questions that we're going to be considering are about sort of how prescriptive. And it could be that, you know, you want...on the one end of the scale you say, "You're all going to have ten seats and this is what they're going to look like.
You're going to have a consumer representative, you're going to have a provider representative." You know, knowing that there's also the statutory requirement of a majority having the financial risk, and that's a whole nother piece as to the interpretation of that as you all started to explore.

So you're going to have on the one hand a very prescriptive model and then on the far end of the other spectrum, a model that said, "You know, tell us who is going to be on your governing board and how it will meet your transformational goals." And we want to explore with you in this conversation is where are we in that. So this first question is around should there be a specific requirement that is more specific than what already exists in the legislation. And connected to that is the second question around the community advisory committee chair. So I'd like to just open this up for discussion in terms of thinking about consumer representation, in terms of thinking about the CAC chair, what are your thoughts about this piece in terms of requiring consumer representation or not?

>> NEW SPEAKER: Could I just ask a question on the definition of what consumer representation means. You know, I'm a little confused by that. Does that mean, you know... for example, county government provides mental health services. Does that make a consumer representative or a provider? I'm a little vague on the definition of consumer representation.

>> NEW SPEAKER: Go ahead, Lilian.

>> NEW SPEAKER: Well, from my experience with other federal programs, a consumer is... like if I was on your board, I would have to be someone who came to you and got my services from. I would have to be someone who is actually getting... an individual who is consuming what you're selling. And in this case, it's healthcare. So if I was going to be a consumer representative on a CCO board, you'd have to be responsible for my health and well-being.

>> NEW SPEAKER: And I get that. I guess my concern is that, often times, physical health consumers will have a different set of issues than mental health consumers versus
people who have housing issues. So I understand that part. But, you know, I guess if the...the more broad the definition, it seems to me the less valuable that person might be to the board. The more specific perhaps the more valuable. Then you star, you know, then you start saying, "Look, you need a mental health, you need a county government, you need a consumer." So pretty soon...

>> NEW SPEAKER: This gets to the tension that Diana just outlined, I think.

>> NEW SPEAKER: Right. Felicia and [inaudible].

>> NEW SPEAKER: I just was wondering if we could just back up and talk about what our goal is for these boards. So there's the statutory intention. But maybe we could just talk about what's our goal for the board. What does that look...what do we think that looks like? And then I think that will help us sort of say do we want to be more prescriptive or do we want to be less prescriptive, what does consumer mean. If we talk about what's our vision for the role of this board.

>> NEW SPEAKER: Let's come back to that. [inaudible].

>> NEW SPEAKER: Well, my personal opinion is, from being on past boards, I would actually like to have membership called out, specifically. Not saying that intentionally it would be overrun if you just give a generalization with certain people. Because there's a lot of people that volunteer a lot and you just go to them over and over again. But I think, in order to ensure that there is a wide range of interest, I think we need to specify exactly what the board makeup needs to be. I really...you know, I don't want to say bad things. But I don't want to give latitude to somebody just to fill the board with whoever.

>> NEW SPEAKER: Chuck.

>> NEW SPEAKER: One of the problems with that, [inaudible], is that these entities are going to vary from one to another. Some might be hospital-based, some might be physician-based, some might be community-based. And so, you know...I understand what you're saying about, you know,
slots, but I think there's risk in being too prescriptive about the non-financially at-risk members...

>> NEW SPEAKER: Maybe not specify out 100% of the board, but say at least half needs to be one consumer, one mental health...I mean, really call it out so that they know that there is...at least half the board is a good mix from that area.

>> NEW SPEAKER: I'll go back to Felicia's comment and talk a little bit about what the goal is here. And it seems to me that what we want to accomplish is the creation of some long-term, successful, sustainable organizations that are successful in improving...in meeting the Triple Aim and improving health and wellness and controlling costs and so on.

I think that I am not so interested in who's on the board and so on. If there were one right answer and if we knew what it was, I could see being pretty prescriptive and we could have one statewide plan and go forth. I don't think there is one right answer. I think there are 36 counties and a lot of other different elements to be taken into account. And even if there were one right answer I'm pretty sure I don't even know what it is. And so I'm a lot more interested in saying to the potential CCOs, "Tell me how the consumer interest is going to be well-represented in your balance of governance." And then make sure that they follow up on that.

>> NEW SPEAKER: I wanted to come back to Felicia's comment as well because the group I worked with at the CCO subcommittee had a very strong feeling about the vision of what the board should be and what the board should do. And their take on it was the CCO should be able to articulate how this board would lead to helping them achieve their transformational goals. So they felt you shouldn't have...you know, you shouldn't prescribe the representation because that might not assist them in meeting their transformation goals. So that was their...you know, it sort of piggybacks on what Erik's saying, that the vision would be, "Tell us how this board will help you achieve what you've told us you're going to achieve." Joe.
>> NEW SPEAKER: Yes. And I would just like to reiterate what Erik said. I probably won't say it as well, but to me, the goal of the board is to deliver the greatest possible health with the resources available to the population that's covered. And I think the means of doing that is going to be different in different communities and I am much more concerned about the regulatory burden we could place on them. I think we will have...I think it will actually be a good result when various CCOs are successful to varying degrees. That's like having multiple beta sites. And I think we will learn a lot. And I think, as we allow these boards to be structured differently, maybe someday, we might then come up with what the right composition would be. But I, for one, would be at a loss for how to achieve that going in.

>> NEW SPEAKER: Go ahead Felicia, then Carlos, then Mike.

>> NEW SPEAKER: So I have a question, then. You know, I think we all agree on what the sort of mission for CCO is and that these boards should be invested in transformation. So then is the prescription that, the licensing I guess, that the state agency can say no to your board if they believe you have not put forward a transformative board?

>> NEW SPEAKER: Yeah.

>> NEW SPEAKER: If I might follow up on that, I have exactly the same question as Joe. When that proposal comes forward to whoever it comes forward to and there is an answer to how does your board design meet the triple aim and you read that proposal and you go, "BS. That ain't gonna cut the mustard." Then what happens? See what I'm saying. I don't understand the process.

>> NEW SPEAKER: Carlos.

>> NEW SPEAKER: Taken care of.

>> NEW SPEAKER: Okay. Mike.

>> NEW SPEAKER: Yeah, I guess when we talk about what we want to see in the board, I want to see a board, much like Erik was saying, that can be held accountable to overseeing
those outcomes. And I think our challenge, and we've talked about it before, is coming out of the gate saying, you know, if we want to see better value I'm very interested in how that group is going to manage the global budget and manage to achieve those outcomes. If, at the end of the day, they have these world-class outcomes, I mean, we have to ask ourselves do we really care what that board composition looks like.

The challenge for us though is, coming out of the gate, we don't have those outcomes in place. So what's the benchmark, what's the criteria we're trying to get at? And I think that's the struggle that we're grappling with.

>> NEW SPEAKER: Exactly.

>> NEW SPEAKER: So people complain who's going to answer, who's going to arbitrate, you know, some community says, "They never ask us. They never come here. Who do we go and complain?"

>> NEW SPEAKER: ...went to the same people. Right, [inaudible] issue. They went to the same people who look like us, who talk like us, who act like us, and who've been on our board for 20 years. And so we thought those people would make a transformative board. Who gets to say no?

>> NEW SPEAKER: I think that's a question we need to explore. Because I saw when...Felicia, when you suggested what if we could say, "We're going to say 'no' if this is not a transformational board or it does not achieve transformation." I'd like to hear people's thoughts on that because I saw lots of nodding heads about that might address a number of the concerns and issues around the table. Eileen, do you...?

>> NEW SPEAKER: I have often thought that there's another way of selecting board members in general. And that more by their prior success or commitment to certain pledges or their open-mindedness or their...that they're not too risk-averse, that they're innovators. That they're more the character of the board. And I don't know, I think that's just opening a whole can of worms. But that's what's going through my head is we want transformation. So you need the
right characteristics of individuals on that board. Not only do they fit in these slots, but their mental models have got to be open-minded because they're embarking on something we've never done before. So...

>> NEW SPEAKER: You could do Meyers-Briggs on them.

>> NEW SPEAKER: So if...to go back to this issue, if you said and you put it in the business plan that the Oregon Health Authority, making up this language, reserves the right to go back to a CCO and say we don't think this board either is transformational or will be able to meet the goals for these specific reasons, you don't have this group or you don't have sufficient consumer representation or it appears that you've just taken your old board and turned...flipped it and turned it into your new board or whatever it is. So is that a model and if that's a model, if that's something that you'd like to say, what tools then would you give the health authority to make those determinations? Or what guidance? Or would all the guidance be they have to meet all the CCO criteria? This is one piece of it and so...

>> NEW SPEAKER: Do CCOs have to be accredited? Is there some federal language that CCOs have to...

[inaudible over each other]

>> NEW SPEAKER: We have to accredit...

>> NEW SPEAKER: So would there be need to be some more guidance then? Tell us if the board is transformational?

>> NEW SPEAKER: Yeah, it's a fair question. Because otherwise, we could somehow be setting ourselves up for OHA's kind of going down the definition of "porn." Right? I mean, you know when you see it. But how are we going...

[inaudible over each other]

>> NEW SPEAKER: What your analogy? Everybody in the audience knew what I was talking about.

>> NEW SPEAKER: Let me try this one out. It's sort of like
Moneyball. No, my analogy is a sports team which...on paper you have a baseball team that looks like it's got the nine greatest players in the league. And then it doesn't win the World Series.

>> NEW SPEAKER: Right. Spoken like a true Yankees fan.

>> NEW SPEAKER: No, it's true. But that's exactly it. In the end, how do you know? I guess my issue is how do you know what that is based on the characteristics of people? I don't know, I think it's maybe more what Mike was alluding to earlier, which is it about the people you choose or is it about the outcomes that the organization gets? I think that's the tension here. And how are you guaranteed that if you get six of this, six of that, six of the others, six of that, that they're going to do any better than random selection?

>> NEW SPEAKER: So I have Chuck, Felicia, then Eileen.

>> NEW SPEAKER: I just, and this is a little off topic, but I guess the point I want to make is that, in these proposals, there are going to be many, many other components beyond the governance of the board that the health authority is going to have to review and make a decision on. So while you're trying to define...it's not just board governance that you're going to be looking at. You're going to be looking at metrics and all sorts of stuff. And I'm not really sure we've figured out, I mean, you know, is that administration's job? Is that staff's job to evaluate that? Is that the policy board...is that a subcommittee? You know, some sort of structure needs to be set up for that review.

>> NEW SPEAKER: Felicia and then Eileen.

>> NEW SPEAKER: So I'm going to make a concrete suggestion.

>> NEW SPEAKER: No analogies?

>> NEW SPEAKER: No analogies. I'm going to decide not to bring up porn at the board meeting, right.

>> NEW SPEAKER: Now, that was your webcam moment.
NEW SPEAKER: Ooh, higher ground.

NEW SPEAKER: Um, my concrete suggestion is that we let the CCOs determine their boards. We give them a mission to follow in determining their board selection as opposed to specific criteria. We let the Oregon Health Authority determine if that board meets transformation or not. If the CCOs board becomes unsuccessful then the Oregon Health Authority or the governor, whoever, which is basically the Oregon Health Authority, will have the ability to remove that board and put in place a board that they deem as more successful, that's approved by the Senate. So just like any other statewide board, that's my suggestion.

NEW SPEAKER: Eileen, and then let's hear some other reactions as well.

NEW SPEAKER: I would just build on that. I think one of the core competencies that OHA has, which is an interesting core competency, is the ability to create a list of potential people to join task forces and work...and committees. And that it is, I think...and one of the things that's sometimes hard to do in community is to broaden your pool. And one of the things that OHA could do is to provide additional suggestions, actually do some of the work, the heavy lifting, of looking for potential board members and submit them to CCOs for consideration.

NEW SPEAKER: Go ahead.

NEW SPEAKER: So Felicia, as an...if I'm thinking about this just as an administrator, I'm with you. You know, I mean, it's a good logic model, it has an end time, it has a fallback option, and it has a failsafe, like if it doesn't work. I think the other variables that we have to worry about is trust and credibility. And I think that that, in it's purest form, that suggestion appeals to me as an administrator. Like this is like the straight line to get to what we need and all of our principles about having communities determine this, you know, having...did they win the World Series, being able to look at that with not just the metrics that we're using for the CCO, but the hard,
concrete morbidity/mortality status of a community. We have all that, you know, that we can apply as well.

But what my challenge is, you know, the variables that have to do with trust and credibility. So I think, you know, if you have any ideas of how that can be incorporated into, you know, this kind of real balance of community control with the principles that we're trying to achieve.

>> NEW SPEAKER: I just...sorry.

>> NEW SPEAKER: Do you want...Felicia, respond and then Erik.

>> NEW SPEAKER: I would hope that...that's what I see the failsafe being, the governor...the failsafe is elected by the people. So sometimes, it's a roll of the dice, Lilian. We all know. 51% sometimes. But that failsafe is a pretty unarguable sort of, right...that's the person who represents the state as a whole.

>> NEW SPEAKER: Can I just interject on the end piece there? I'm not so sure, quite frankly, that we have the authority to change the board of a private organization. I don't think we, the governor, the Senate, or anybody has that. I think what we do have the ability to do in a contract is to not renew a contract if an organization is not meeting the goals and deliverable. But I don't think we can change a board.

>> NEW SPEAKER: I guess I'm confused. Can I ask a question then? How can we prescribe a board to a private entity, but not remove a board of a private entity? That doesn't make any logical sense to me. Well and...statute typically doesn't, but that...

>> NEW SPEAKER: So let's...I want to...let's hear from Erik, Carlos, [inaudible], and then I'm going to try something because we have a number of other areas we want to discuss.

>> NEW SPEAKER: I'll be short because Bruce got to part of what I wanted to talk about anyway. I think I should go where Felicia started out going. I think the first 60% or
so I was with you all the way. I think the idea of replacing the board and putting the new one in is a pretty heavy hammer. I think we need to recognize, going in, that we are taking some risks in this thing. Some of them are going to play out very well. Some of them, not so much. And when they play out not so much, I think the community that you talked about, Lilian, needs the opportunity to go back, have a second shot, maybe even a third shot, at getting it right. At the end of the day, it's up to the health authority to decide whether to renew the contract with the CCO or to go out for bids with somebody else who might form another one that's more successful if the first one isn't. So that would be my approach.

>> NEW SPEAKER: Go ahead, Carlos.

>> NEW SPEAKER: So I follow Felicia until the successful, which is we need the variables to define success. Maybe the health of the people is great, but they're broke and they spend more money than they have. I mean, you can have a great team and you can't pay them. So that's another component. So there's a lot of variables that have to be taken into account. We might not have the expertise; we're doing this for the first time. So who knows what are we going to take into account. We might, I think, need a, I hate more bureaucracy, but we might need a third party that has nothing to do with the governor or whoever gets elected to accredit this. And then in order for you to have to a contract with whoever, you have to be accredited by this group and they define those variables and what is and what's not a good CCO. Uh, that's it.

>> NEW SPEAKER: Okay. [inaudible].

>> NEW SPEAKER: Um, I'm with Felicia. My only concern is we're going to prescribe a board prior to the contract. So we're going to give our rubber stamp saying, "Okay, we think this is going to go well." The only authority we have over them if the board is not performing is not renewing a contract. Historically, in my 20 years of being on boards, it's been very, very hard to pull a contract. And you keep giving chances over and over and over again with a non-performing contract because you have reassurances. My only concern is, if that's our only authority, I think that we
need to act quickly to deal with non-performances rather than a decade of renewing with promises. That's my only concern with that.

>> NEW SPEAKER: Let me make a comment on that and then I want to wrap this up because I think you all have...I think you've come to a place that we can try and then come back to you with some language and see how it feels. I think the other piece here that exists is that, if in fact a CCO wasn't performing, there would obviously be technical assistance. And the technical assistance piece could be around the board. And...because there could be a variety of factors that were significantly influencing the failure to meet some of the expected outcome.

So one piece could be, and it's sort of in the middle between replacing the board and doing nothing about the board, but providing some intensive technical assistance that...the expertise exists in the health authority to say, "Here's what we think is wrong and here are some thoughts about how you need to change this." Because you have to make some assumption that the CCO wants to be successful. Right, and if they want...

>> NEW SPEAKER: I'm a huge fan of progressive discipline.

>> NEW SPEAKER: Right, so and maybe we come back to you on this piece. I mean, what I've heard you all say is let's start with...and this also goes to the CCO, the matrix, what are the initial baseline expectations. And then down the line, what are those transformational competencies. You have a board that helps you do that.

And there are some unknowns. But what I think you all have come to is let's set something up where we say, you know, here's what the statute says about your board. And here's...we want your board to achieve the vision that you've set out for yourself as a CCO. If you're not achieving those goals, we're going to look at whether your board is a factor in that and what has to change about your board in order for you to continue contracting with the state. So it's something like that. And so if we come back to you with language, does that sound amenable to folks? I know it was a long sentence.
NEW SPEAKER: And Tina wrote down every word.

NEW SPEAKER: I know. All right. So let's...are people okay with moving on to equity? Similar set of issues in that, you know, folks in the work group felt very clear that every CCO had to design and implement a community health disparities assessment. And so the questions here are around how specific should the criteria be around this assessment and the CCOs approach for reducing disparities. And related to that, the second question and we'll come to this separately, but are there some pieces of disparities that we want to focus on as we review the approach in effectiveness?

And again, the scale...the range of this could be the state provides a template for this is what your assessment, these are the questions. Here's the template for the assessment that you're going to do. And here are some required approaches. Or you could say suggested approaches. And then on the other end it's tell us how you're going to do your assessment and reduce your disparities. And each of them could look vastly different from the other. And the question for you all, again, is how specific should the CCO criteria be around the assessment and around a CCO's strategic approach.

NEW SPEAKER: Well, I understand that the CCOs may differ with populations depending on where they are. However, I'm a big fan of baseline so that we get some statistics across the state with the understanding that there may be some uniqueness depending on where they are. But I would like to have a baseline to start.

NEW SPEAKER: Mhm. Mike?

NEW SPEAKER: I guess the way I've been looking at this and the language during these conversations, for me, has focused more on a health needs assessment. And a portion of that is focused on disparities. At least, in my mind, I've been thinking a portion of that is part of disparities. So I think, you know, there's a lot of work being done with health departments, with hospitals around what...how you set up a community or regional needs assessment and then a
portion of that being focused on the disparities side.

>> NEW SPEAKER: Chuck.

>> NEW SPEAKER: Is there a role for the Office of Multicultural Health Services to play in developing some of these baseline criteria? It seems to me there would be. So maybe we can utilize them to help us get to where we want to be on these baseline disparity issues within the health needs assessment.

>> NEW SPEAKER: Yep. No, I think that would be great. I mean, I think there's a lot of best practice out there already, specifically on the hospital side. I mean, these are tax exempt organizations that are required by law that they have to do this. So I think any CCO is going to have to partner with their kind of local hospital, hospital systems to do this. But I think having a factor with the disparity piece with multicultural health makes a lot of sense.

>> NEW SPEAKER: Go ahead, Joe, and then Felicia.

>> NEW SPEAKER: Yes, just...basically, I would like to lobby for as much standardization of this as possible. Quite different than the composition of the board because the more...it's like using the same electronic health record, we have to get our hands around the data and look at this from a statewide perspective.

>> NEW SPEAKER: I just had a question. I feel like we're moving away from...with the discussion of a whole community needs assessment, which I think is important and we should standardize, I feel like we're moving away from this specific conversation with the issue of health disparities. And granted, hospitals have done a better job of sort of figuring out how they're going to do community needs assessments. But people of color, people who are low income die much younger than the majority population. That hasn't been addressed across the board. So I think a standardization, I think that [inaudible] suggested, to create the baseline for people of color, low income folks, geographic disparities so we have a clear starting point. Then maybe we have best practices that have been
implemented that are suggestion points. And then we allow for innovation and integration of other concepts.

And I think that CCOs...this is an area where I think community input on how to address disparities is a really critical part of CCOs plans and criteria. And I also think this is another place where there...that workforce is going to be a huge...should be a huge part of the conversation about how to address health equities. So if there's a way that we can be prescriptive about the general overall areas, the baseline tool, and then we allow for innovation to come up to address those issues, I think that seems agreeable to me. But I don't...I understand the health needs assessment and getting a baseline on everything else. I don't want to move away from this issue to talk about that right now.

>> NEW SPEAKER: And I'm in totally agreement, Felicia. And I think if you look at some of the best practices that are being laid out on the community benefit side, there's something called advancing the state-of-the-art of community benefit, the five factors. And number one is disproportionate unmet need. And I think that's just right in line with the disparities piece. So I think you've got a lot of folks that are really in alignment with that and it's something for us to maybe take into account on the standardization of the needs assessment.

>> NEW SPEAKER: Carlos.

>> NEW SPEAKER: So, uh, following the standardization and baseline and consistent with the federal initiative, we should aim to eliminate health disparities. I mean, the reduction of health disparities, it just...it provides leeway for say, "Oh, I'll reduce ten percent. Oh, I need thirty, I need forty." I think it's elimination of health disparities. And then we...this risk adjustment may be moot point. We may not have to talk about risk adjusting because we'll all be in the same boat.

I have a question about this CCO and community health. So a community might have just one CCO or would there be multiple CCOs for a community? It's like cable, you know. You might be stuck with one cable, that's what you got.
Where if you have multiple CCOs competing, and some might do a better job than others, so at that...and maybe we don't have the answer to that. But that's important. And maybe some communities might not be able to have more than one CCO.

>> NEW SPEAKER: It's likely to be all of the above. None, one, and perhaps several. So I think that's what we have to prepare for.

>> NEW SPEAKER: So here's what I think. I want to see...I want to check if folks are in this space in terms of how you'd like to proceed on this. First of all, that while this may be...the elimination of health disparities could be part of a community health assessment, it needs to be pulled out specifically. And we've heard that in all of our conversations in the work groups. And that there is a desire for standardization on some of these pieces. Both in terms of what you have to assess, baseline, some baseline expectations there. As well as, I think I heard you say, Felicia, and I want to check this with other folks, some of the components that might have to be addressed as part of your strategic approach, such as workforce. So it wouldn't just be tell us how you're going to eliminate disparities, but tell us how you're going to eliminate disparities using a workforce approach, for example. So that there might be specific approaches that you have to call out. Is that right?

>> NEW SPEAKER: Yeah, that's what I heard.

>> NEW SPEAKER: Okay, good.

>> NEW SPEAKER: Yeah, because we hadn't really, in the discussion, addressed the second point under health equity. And I think that we have to get back to that. Because I think, you know, there are certain proven things that matter more, you know, in achieving equity. And I think, to me, it's equity. It's not eliminating disparities, Carlos. I mean, it's just a semantic thing.

But achieving equity may require more investment in certain sectors. I think one of the challenges, and there's no answer here but I want to put it somewhere, I think, which
gets to the quality outcomes committee and also the [inaudible] discussion that we had last month. If we don't have the data collected on income and things like that, we can't answer these questions. So that's got to be an interface that is present in the document.

>> NEW SPEAKER: I want to tee off of Lilian's point about this second question. Are there other particular aspects on disparities or equity that you want the health authority to focus on? Other particular pieces?

>> NEW SPEAKER: I would like to ask the metrics group about what are the other components? I feel pretty strongly about workforce, I feel pretty strongly about data. But I don't know...there are probably other components where you have to specifically address equity.

>> NEW SPEAKER: And that certainly is a place where we could go to the Office of Multicultural Health too and to say what would you want covered, both in the investment and this strategic approach? Does that sound like a good way to move forward?

>> NEW SPEAKER: I think so.

>> NEW SPEAKER: Okay, good. Okay, we're going to move to a piece on global budget. And this is...the two previous areas that we've been talking about really...I mean, it's similar in that it's looking at how specific should we be. But the question here, and I'll walk through a little bit of the slide, but the question that we want to come to is what principles and priorities should govern what Medicaid programs and funding will be included in the global budget.

And if you look in terms of...this is some of the feedback from the work group that you want to consider all of these pieces as you look at a global...you know, why you'd have a global budget and what you would hope for that budget would achieve. And there's, you know, pieces here about you're hoping for greater care coordination, you want to not lose...maintain those non-Medicaid funding streams and leverage. And also know that CCOs, as we've been talking about today already, will have different capacities and relationships to enable them to provide services.
What we've heard from the work group is, you know, CCOs should be as inclusive as possible. The funding in this actually goes parallel to our governance discussion. It should further...you know, whatever...you include funding if it furthers the goal of health transformation rather than just including it because you think it should be included. But really what difference would it make.

Bring in programs that have larger utilization and budgets. You might have to face, I mean again this is the timing piece, it's not all going to happen on day one. And then think about the tradeoff between CCO flexibility and consistency and that because that could have implications for clients as well as the administrative burden.

So this is some of the background on this question and it's not...it's not an easy question to say tell us what should be in and what should be out necessarily. But rather, we thought it was a better approach to sort of step back and say what principles and priorities should govern this decision about what would be in the global budget and what wouldn't be. So I just want to throw that out to folks to say what would you want the health authority and CCOs to be considering as, you know, we have this global budget discussion.

>> NEW SPEAKER: Seems to me that the easy place to start is to say we want to include those budgets which further the purpose of transformation consistent with the Triple Aim. So that's the easy part that probably everybody will agree with. The question then becomes so which pieces are those? And they may vary some from community to community. I guess what I'd kind of like to see is maybe a range of, I don't want experimental approaches, but if there were different approaches in different communities, I think we could...I think it would be an educational opportunity for us to see how those play out. It also recognizes the fact that transformation may occur at different paces in different places.

>> NEW SPEAKER: Eileen and then Chuck and then Lilian. Do you have a clarification?
>> NEW SPEAKER: It's just a question and maybe that helped me clarify it. But we have a really basic question. Isn't all the Medicaid dollars in the global budget? Or there's some...are we talking about which dollars to go to which CCO or are we talking about which Medicaid program funds actually are part of the CCO program. I need some help.

>> NEW SPEAKER: The latter.

>> NEW SPEAKER: Okay.

>> NEW SPEAKER: Not all Medicaid dollars go through the CCO. Some Medicaid dollars go straight through the county delivery system. There's a variety of ways that care is delivered with Medicaid dollars. So not all of them would go.

>> NEW SPEAKER: Okay, so is there way that we have a one minute overview on what dollars might not go...what our funding streams might be outside of this global budget.

[inaudible over each other]

>> NEW SPEAKER: We have a complete list. It's a pretty comprehensive list. There's something like 65 different funding streams that...I mean, targeted case management is one of them that doesn't necessarily go into the current MCO budget; it goes out through counties, out through organizations.

>> NEW SPEAKER: I'm sorry, what's the percentage of dollars that do not currently go through MCOs right now?

>> NEW SPEAKER: I think the highest percent is in the budget, the sort of direct medical care is the highest percentage and that is in. But there's significant...I mean, non-medical transportation is not in the current budget and is an item that you could consider for inclusion. And that's a fairly significant amount of money. Off the top of my head, what else...

>> NEW SPEAKER: My general comment is I think I'm back to is this really a global budget and should we be including more services than less? If we really want to have a global
budget, shouldn't we have a global...

>> NEW SPEAKER: Get as global as we can.

>> NEW SPEAKER: Get as global as we can. Get as many dollars in the pie as possible. And maybe Lilian could comment on that.

>> NEW SPEAKER: Well, you know, back to...we could go on one end of the spectrum and we could go on the other end of the spectrum. I mean, one principle that comes to mind are things that if we want to be transformative to our community outcomes, shouldn't anything that really impacts communities in a preventative way be included.

>> NEW SPEAKER: So housing, are you going to include all the housing dollars in the state in the global budget?

>> NEW SPEAKER: Yeah, so...

>> NEW SPEAKER: ...and now it's the CCO's responsibility to provide housing for mentally ill patients.

>> NEW SPEAKER: Would I want to do that if I was a hospital? Um, I'm not sure. So I think that...

>> NEW SPEAKER: Yeah, would a housing guy be willing to share his budget if it's not in governance with...so that's the other part. There might be funds that, because we haven't allowed these people to have a say, they might not be willing to share.

>> NEW SPEAKER: So I know Chuck has a comment and then Erik and Bruce.

>> NEW SPEAKER: This is incredibly, incredibly complex. As you know from email, you know, this is one of the things that's keeping me up at night. So as I've been thinking about this, I wonder if there's a way to categorize services based on the Medicaid population. As I've pointed out, we've talked about that 30% that consumes the 70% and the 70% that consumes the 30%. I think it's pretty clear, at least as I've thought about it, that acute care services are easy to put into a global budget. But these long-term
care, housing, transportation, all that stuff gets very murky. And what's frustrating me is that's the big bulk of the services. So we do cut out the housing costs, the custodial costs, out of that 70%. I don't know, but it seems to me that there's maybe a foundation to start on this versus the acute care versus the long-term care services. I don't know about that. As I've thought about this more and more this whole Medicaid categorical lumping of groups of populations that have entirely different needs is...it's just insanity. So that's just my struggle.

>> NEW SPEAKER: Great. Erik and Bruce. Bruce.

>> NEW SPEAKER: I just want to point out, I think initially we're talking about Medicaid funding and not, I think, getting beyond that. And then I think the issue is, within that Medicaid funding, which particular pieces are the place to start? I think, in the end, everybody's been looking at this as the appropriate thing is how do you get to the point where we have a global integrated...it's not just a global budget, it's an integrated system where there's accountability for all of the...a single point for accountability for health and the resources in one place. I think the question is how you sort of get from where we are today with the multiple different funding streams and plot out a course to get there.

>> NEW SPEAKER: So can I throw out a principle on the table?

>> NEW SPEAKER: Yeah.

>> NEW SPEAKER: That we...one principle would be that we would not jeopardize any ability to leverage public dollars by the way we distributed the dollars. Or...

>> NEW SPEAKER: And it seems to me, I guess this may just be a question for Bruce, but it seems to me that, maybe again at the principle level, what we might indicate is that if the goal over time is to get to the most consolidated...most reasonably consolidated global budget possible, that simply as the applications are being reviewed, that priority be given to those that do a better job of building more of the budget in in a more reasonable
way, recognizing that we're expecting progress over time. I'm not sure that we can be a lot more specific than that. Does that make sense?

>> NEW SPEAKER: What do folks think about that approach?

>> NEW SPEAKER: I think those are a couple of reasonable principles.

>> NEW SPEAKER: I do too.

>> NEW SPEAKER: And not to lose Bruce's point about, you know, tracking the dollar with the care that promotes care coordination.

>> NEW SPEAKER: I feel like there has to be...I also think that tracking is one thing. I think this is the big accountability piece. And so there needs to be some sort of principle around accountability and transparency with your funds. Not just tracking where they go, but sort of the what happens if.

>> NEW SPEAKER: It's the same piece as the governance in a way. What happens if you...

>> NEW SPEAKER: ...present a global budget and then you buy pop cans, I don't know. Right? But what happens if you present a global budget and suddenly the CEO of the CCO makes 78% of the global budget. So are...you're refusing care. What you're doing is trying to drive down your costs by refusing care.

>> NEW SPEAKER: ...transformation, that would be reduction from current levels.

>> NEW SPEAKER: Go ahead, Lilian.

>> NEW SPEAKER: No, it's...

>> NEW SPEAKER: Mike.

>> NEW SPEAKER: Felicia, my only pushback is I think that becomes a much bigger factor when you have an entity that's not meeting those outcomes. I mean, if you have an entity
that's meeting, you know, it's off the charts on all those outcomes how they spend that money, are we...

>> NEW SPEAKER: No, I disagree. I actually...I disagree. Especially when we're talking about the Medicaid population here because that is tax dollars.

>> NEW SPEAKER: But again, the value is the outcomes of what we're getting and I think that's where it's going to be critical in understanding what are the metrics that we're going to hold a CCO accountable to they should take into account all of those concerns that you're bringing up. That's my point.

>> NEW SPEAKER: Yes. Okay. I see what you're saying. So...

>> NEW SPEAKER: The focus on the outcome measures.

>> NEW SPEAKER: The focus on the outcome measures.

>> NEW SPEAKER: I think that that's the principles is it's got to be focused on the outcome measures. It also has to be fair and equitable.

>> NEW SPEAKER: We have a list here, and I know Tina's been capturing these, but some of the sort of general themes are accountability and transparency, focus on outcome measures, fair and equitable, don't jeopardize leveraging federal dollars, give preference or, you know, extra points, whatever you want to call them, to those community or CCOs that are able to really demonstrate that they're moving as...towards a global budget that really makes sense in terms of leveraging as many dollars as possible, to be as close to a global budget as you could get in a way that, again, leads you to the right outcomes. And that goes all the way back to Erik first sort of criteria around, you know, furthering the goals of transformation and the Triple Aim.

>> NEW SPEAKER: You know, it might help...I think we may be getting...have a little bit askew of I think what the question is. Because I think part of this is, for us, there are how many funding streams, Tina?
>> NEW SPEAKER: 60+

>> NEW SPEAKER: 60+. And we're going...we're going to have to determine what goes into that budget. And of those 60 streams there's probably 70 or 80 entities that don't want that way it's happening now to change. And, I mean, this is about transformational change and what we have is a list of folks who want to see actually things stay exactly as they are.

We're not getting, let me put it differently, we're not getting a lot of feedback saying, "Oh, take our stream and put it in the global budget." I don't...actually, I don't think we've gotten one. I'll be very frank. So the issue is going to be what of those streams to put in there. And I think what might help, I don't mean to prolong the conversation, is we'll probably resend out that list so people can get a sense of what that is. Because I think some of it is...I mean, my personal opinion is I don't know how you get to the kind of transformational, single point of accountability which when we started with those four boxes on the side, one of them was a single point of accountability. Until there is that, I think the question is how we get from here to there.

>> NEW SPEAKER: So is it, I mean, kind of the chicken and the egg. I mean, to me, the first thing is if we're going to be clear on the outcomes first then we can have that discussion of what funding streams need to be in there to help achieve those outcomes.

>> NEW SPEAKER: The other thing: I think that we can't...it's interesting what Erik was implying. It's kind of an interesting...I don't know if you meant this or not. But that, in fact, that in a CCO application that the CCOs could say, "I'd like to have these funding streams and I've gone and talked to the stakeholders associated with these funding streams and I've got buy-in from them because I think it's going to work." And that potentially becomes a transformational conversation. And it puts the onus on the stakeholders to have those conversations. It's just a thought.

>> NEW SPEAKER: Felicia and Chuck. And then I want a follow
up question to that.

>> NEW SPEAKER: I just...this has nothing to do with the question up there, but I do want to have a conversation here which is not on the list of questions that we've asked about this concept of accountability. Because I think it keeps coming up, I think all of us have different visions about what accountability means, what does that progressive discipline look like, who's accountable for what and when they're accountable. So I think as we get the last round of feedback from the work groups, I'd like to have questions related to that so we can have a discussion.

>> NEW SPEAKER: Maybe...sorry. Just along those lines, we can have a discussion on...just so we're clear on the accountability that exists today. To match it up in terms of what do we have today and then what would we want to see.

>> NEW SPEAKER: So getting back to the 65 different funding streams, I suggest that maybe a starting place would be to look at which of those services render acute care services. And I didn't get any feedback on that at all, which makes me suspect that that's not a good idea, but I don't understand why it's not a good idea. So is there value in looking at those services...it seems to me that's low-hanging fruit. So, um, maybe there's some value in doing it that way.

>> NEW SPEAKER: Yeah, I actually think that's actually an easier way to go. I mean, dollars that support care coordination is, I think, a good place to go too. But again, all of these, as Bruce said...

[inaudible over each other]

>> NEW SPEAKER: And part of what you all are trying to seek here is consistency to some extent, right. That the way things are in and out isn't, well, that's too hard a fight or whatever it is. But that there's some consistency around if something's out, why is out. If something's in, why is it in. Erik and Lilian.

>> NEW SPEAKER: Let me give one more look at, then,
principles and priorities that you might want to consider. And I'm sure I'm leaving some out. But it seems like, again, stuff that's pretty easy and obvious. You start with the big dollars, you start with the dollars that have the greatest potential to impact health outcomes and quality of health outcomes. And you look for the dollars that have the greatest potential to deter the transformation we're trying to accomplish. And if you can get those three sets of funding streams, you've probably got the base.

>> NEW SPEAKER: I think that's what I was trying to say.

>> NEW SPEAKER: Lilian. That's a friendly amendment for you, Chuck. What I'm worried about is, and I think your suggestion controlled for it, is not to set up a system where it's easy to, you know, have under-the-table or behind-the-curtain disincentives for getting to the health status outcomes that we want. And if we just look at the acute care stuff, you know, that's a set-up for cost-shifting. And if we're not looking at it broadly, we're not going to notice it. Because I understand where the money is. The money is on the acute care side. But at the same time, we're not going to get to our ultimate goal.

So I...I don't know. I really think the three principles that you outlined have to be where we draw the money down and put it in the pot and say, What's this a go for?"

>> NEW SPEAKER: Are there opportunities that we are missing like outside of Medicare dollars...

>> NEW SPEAKER: Medicaid.

>> NEW SPEAKER: Medicaid. If we're dealing with children, are we at the school, does the school have anything that overlaps so we're not...

>> NEW SPEAKER: If you're think they're flushed with cash...if you think healthcare is in trouble...

>> NEW SPEAKER: You have two broke people together then they come together and say...

[inaudible over each other]
NEW SPEAKER: It's the same thing with other systems who might be in a similar situation where they're equally broke. But your ten cents will help them and they will help you. So...and I'm not sure if they're at the table or if there's a way to get them involved.

NEW SPEAKER: I wonder if that goes to Eileen's earlier point about, if in fact a community came with a proposal around a CCO that had some really innovative funding streams folded into it, wouldn’t that be, you know, wouldn't you get some real attention for that?

NEW SPEAKER: Well, beyond that, strategic partners who may not be funding that exchanges, but it creates a resilient community, that creates a healthier community.

NEW SPEAKER: How do we push CCOs to think that way? Because we could think about this way. They're going to go back and do what they always do. You know, deal with the same group of people, trying to solve with the same amount of money, knowing that they're going to be accountable for this.

[inaudible over each other]

NEW SPEAKER: I actually think giving people the permission to think...I think there's a lot of groups and organizations out there that are looking for the permission to do that. I think right now where things are at is we have a system that really doesn't say come to us with your ideas. It says here's the Medicaid dollars, et cetera. So I think that by doing that, you'll get in some communities some really interesting partnerships. We're certainly seeing that around the state right now as there's discussions happening in communities with organizations that, for the first time, are realizing that they have some real strategic alignment. And the sort of light's going on. And so I think that there's going to be a lot by just providing the space to say, "Come to use with your ideas. We'll help you make them happen."

NEW SPEAKER: I think we have some next steps on this one in terms of what we'd bring back to you. This list of
principles, and I think leading with Erik's piece around, you know, where the big dollars with the greatest potential, where the dollars that would deter transformation. We'll put that in better language, but we have...I mean I captured a lot. And I know Tina did in terms of coming back to you with some of those principles. You also will...it sounds like you'll see that list of 65 funding streams. And it may be to think about, if you all want or need, should there be some preliminary based on global budget discussions as well as this conversation about what feels like it really easily fits. You know, given the principles that you outlined, what easily should be in there? What are the questionable ones? And you could even do an experiment to see how well your principles worked against some of those harder ones.

And then I think there was a follow-up piece here that a number of you discussed around really giving direction and permission to CCOs and communities to push. Not only in terms of coming up with some creative funding streams in their communities, but also continue to push on the strategic partnership piece that may or may not come with resources. So all of that will be sort of folded into what comes back to you. Okay?

>> NEW SPEAKER: I'd also like to have the accountability conversation.

>> NEW SPEAKER: Yes, yes, absolutely. Thank you. All right. Okay. The last piece of business that we wanted to have during this discussion was to plant some seeds for December. And there are two, at least two, things that staff wants to discuss with you in December. One is around the shared accountability for outcomes between CCOs and long-term care. And looking at this list, sort of what...and we're going to talk about this in a sec. Sort of what you want to be highlighted and where you'd like to delve in December. And then the next thing we want to talk about for a few minutes is the system transition piece. And we have some...we want to talk to you a little bit about getting some feedback on how to most effectively encourage CCO development.

>> NEW SPEAKER: I have a question. Isn't process...I'm
going to go back to our discussion about the business plan> At some point we're going to talk about the financial realities as it relates to business plan. Is that for December or is that...at what point do we actually look at the business plan? We say, "There's this much money, there's going to be this many CCOs and here's how it's going to be spent. Or here's how it could be or the straw person."

>> NEW SPEAKER: Yeah, in December you'll see a more...a business plan with more meat on the bones in terms of those specific financials. So...

>> NEW SPEAKER: Okay. So if you look at...we wanted to just get some...and we have just a few minutes to do this. Get some things on the table about what structures you would expect or like to see in place that would hold CCOs and the long-term care system jointly accountable for these outcomes around coordination, avoiding and reducing cost shifts, maintaining quality and providing seamless care for beneficiaries in long-term care settings. And so the question is really from you what are some of the pieces you want this staff to be thinking about around these structures? How would we insure coordination and maintaining quality as these two systems interact?

>> NEW SPEAKER: So I've been on the dual-eligible committee and I feel like we are having this conversation about long-term care, but I do think the accountability piece. So I would like to hear from the staff what's currently happening in the long-term care system around accountability. Maybe we could review the dual eligibility pieces on coordination, which I think Tina did today which were really helpful.

So are you asking us to respond to what the dual eligible committee already talked about or are you asking us to retalk about what the...

>> NEW SPEAKER: No, to help staff think about what issues you'd like to go deeper on in December, in terms of some of these specific structure pieces. And you just said accountability. I'd like to hear more about accountability that exists in the long-term care system. So it could...
NEW SPEAKER: Well, across the board actually. Not just...

NEW SPEAKER: Right, no, you want the accountability, the whole piece.

NEW SPEAKER: The whole shebang. In December, I'd like to talk about that for an extensive period of time.

NEW SPEAKER: And just to piggyback on that, we're nearing the end of this discussion and one concept that I've been waiting for that I haven't heard mentioned yet is evidence-based medicine or quality adjusted life years. And we've done nothing in this discussion so far, and maybe that's for the December discussion, to ensure that the resources will be utilized in the manner that will allow the delivery of the most health and the most care.

And unless we do that...I mean, it's not enough to just determine whether or not people have had their hemoglobin A1C checked. We need to go beyond that. And there isn't going to be a prescription. This is something new. There's...so we really need to encourage these organizations to use their resources in an evidence based manner.

NEW SPEAKER: So Tina, was that...is that something that you all were going to bring back in December or should we just add that as a new...

NEW SPEAKER: No, I think we need to add it.

NEW SPEAKER: So can I just...you know, Joe, let me just push back on you a little bit. It just gets back to our conversations we had around equity and disparities. I think, with evidence based, we have to also call for emerging best practices because for a lot of the disadvantaged populations, they haven't been included in evidence. But there are a lot of really, you know, pretty mature emerging practices have been peer-reviewed.

NEW SPEAKER: Absolutely. Totally agree. And, in fact, that is the Achilles Heel of evidence based medicine is
that there just isn't enough of it. But we have to use it wherever possible. Then couple that with emerging best practices, totally agree.

>> NEW SPEAKER: Because that's where I get the innovation.

>> NEW SPEAKER: Eileen.

>> NEW SPEAKER: I'm not sure exactly what this question is getting to, but it remind me of the conversation we just had about strategic partners. And that, in fact, the CCOs...I see the CCOs as having a strategic partnership with the long-term care system. And that we would expect, as we would expect with other strategic partners, that there's an outcomes based approach. That there's a coordination team that shows how you're going to maximize that partnership. I'm not sure exactly where you're going, but that's....

>> NEW SPEAKER: No, I think that's...you're answering the question that we've posed in terms of what does this issue surface for all of you in terms of what you'd like to explore further in December. Mike.

>> NEW SPEAKER: I guess, when I look at that slide, I say yes. Right? All of it.

>> NEW SPEAKER: The question is around structures. And I'm not...are there some in your specific...that you have that you're thinking of?

>> NEW SPEAKER: Well, you can have...you know, there can be contractual relationships, share savings arrangements with long-term care and CCOs to get to the same outcome. It's just, you know, so far the conversation has been, "Well, we want to see everybody coordinate. You know, but really we need to be talking about what kind of structures we put in place to make sure that coordination happens. So it is looking at...I mean, the staff will bring forward some ideas too that have emerged, not only from the stakeholder group, but from national conversations and...for the board to take a look at.

But I just wanted to put a little more meat on the bones
than just, you know...yeah, we want to see these nice things happen. We want to actually talk about what kinds of structures might exist to really push us in that direction.

>> NEW SPEAKER: Go ahead, Felicia.

>> NEW SPEAKER: So I think, then, the similar principles that we've applied to every other category should apply to this category, right? People who can do this well...maybe that's the CCOs role. Maybe if you're on the southern coast where you have a large aging population, maybe you're the CCO who integrates with long-term care the best and the brightest and does that incredibly well, right.

>> NEW SPEAKER: I guess the other question I have: what are the contracts that exist today in terms of long-term care and can can you have similar contracts that you have with CCOs on the accountability side? Whatever metrics that we're looking at, can we have similar metrics from long-term care?

>> NEW SPEAKER: I mean, what I'm getting from this is that I agree with Felicia. I think the general principles probably are going to apply. I think we need some education as to exactly what options we have to talk about here.

>> NEW SPEAKER: And then we're going to move on just with the comment that Felicia's piece on accountability...I mean, this conversation, I think, in December will fold really well into that piece. Because this is about accountability. It's on piece of accountability.

I want to move us on just to this last piece around system transition. And this is, as all of this is, complicated. And we wanted to just get some ideas. And this is going to be a longer, broader conversation about your thoughts in terms of transition. And the specific question we've posed is what mechanism will be most effective in encouraging CCO development. I mean, these are just some of the scenarios we could see across the state. And in thinking about how do you really encourage CCO development in any of these scenarios is what we just wanted to talk very briefly with you about because we're going to...there's going to be more conversation about this in December. Just like to hear some
thoughts on this from all of you.

>> NEW SPEAKER: Can we have a full-day meeting in December?

>> NEW SPEAKER: It sounds like you might need one.

>> NEW SPEAKER: So if you were to rank this, all the mutually exclusive scenarios, if you were to rank them in terms of, you know, problems areas and less problematic, where should we start looking at?

>> NEW SPEAKER: I think it's worst first.

>> NEW SPEAKER: Number one: no MCO, no CCO, no Medicare advantage, no nothing.

>> NEW SPEAKER: I think the most problematic is going to be an area with an MCO, but nobody works to create a CCO because they think that's how they can maintain the status quo.

[inaudible over each other]

>> NEW SPEAKER: I think the question I think has to do, and I wanted some clarity, on just the mechanisms. What do we mean by mechanisms? I guess, to me, I mean, what sticks and carrots are I guess what you're looking at. And I think we're looking at, potentially, even what incentives, even on the quality reimbursements or whatever that, you know, you want to become a CCO because you know there could be some additional dollars down the road.

>> NEW SPEAKER: That's what I was going to say that from my perspective what I was really looking...those were really just meant as examples of some of the issues that we're going to need to deal with. And I'm most interested in what kinds of incentives do people think we could put in place that really encourage CCO development in an area.

>> NEW SPEAKER: So it's...yeah, there's incentives of more dollars and less expenditure. And that's the economy of scale would be that you joined a CCO so you'll spend less money in certain areas or you'll get more help, rather than money coming in.
NEW SPEAKER: Other thoughts on incentives?

NEW SPEAKER: Well, I think the obvious is financial and we'd have to look at what the opportunities are. I do think there's a real opportunity emerging about creating a learning organization. And if we miss the opportunity, we may miss...this is something that's going to be transitioned over time. And I think one of the incentives is you get to be part of this learning organization. And we want your wisdom at the table and there's going to be a lot of opportunities for your organization and individuals to grow and we're going to look at best practices across the board. And it's an opportunity, because of this learning community, we expect that you're going to see better outcomes because there's a shared set of practices. So...

NEW SPEAKER: You know, can I just add to that? You know, I hadn't thought of this, but this is another way of looking at workforce and workforce development.

NEW SPEAKER: That's where I was going with it.

NEW SPEAKER: And one of the successes over the last ten, fifteen years has been community health centers who transition to academic community health centers in terms of retention, innovation, adoption of new best practices. You know, because it really energizes the workforce to be engaged and to go for it So I think that this should not be...this is not kind of out there. I mean, it could be something that could really motivate a community to want to participate.

NEW SPEAKER: At the risk of going backwards, which is what I don't want to do, I think there is still a wide range of understanding in the world about the difference between an MCO and a CCO. And I can see a benefit of next month's discussion being an opportunity to really have everybody in the room walk away with a clear understanding of the difference and what we're trying to accomplish. If that we're a part of what we set up, I think it would be good.

NEW SPEAKER: Any other thoughts? And again, you're going
to be talking about this in more detail. But about this system transition piece and the...what kind of incentives or how you...the question is how do you encourage CCO development in communities throughout Oregon. That's the question.

>> NEW SPEAKER: I would just add that I would love to hear from the MCOs. I think we should talk to them. And that may be part of the public conversation. Same with long-term care. I think we should talk to them about, "Hey, what works, what doesn't work, how can we move this thing forward?"

>> NEW SPEAKER: Okay, so we have a number of follow-up pieces here on all of these discussions. And you'll be continuing to have the conversation in December and moving forward. Thanks.

>> NEW SPEAKER: Very good. Diana, thank you very much. And you finished a couple of minutes early. We appreciate that. I want to let everybody know that at the end of this meeting there will be an opportunity for public comment. I have already a long list of people who are signing up. I encourage other to do the same. We have a sign-up sheet over here. One of the things that will mean is I'll have to be a little more strident than usual about managing time. But we will get it done and everybody that wants to comment will have the opportunity to do so. Let's take a break and be back, in the interest of time, let's reconvene at ten minutes til. So let's go.

[extended pause in audio]

>> NEW SPEAKER: Everybody have a seat, please. Okay. We're ready to begin. Can everybody please take a seat? Okay. The next section of the agenda, item five, is three groups of invited testimony. As I mentioned before the break, our time is really tight and so I'm going to manage this a little more prescriptively than I would like to, but we're going to get everybody's opinion on the table, on the record here before our time ends.

Our first group is a panel representing hospitals and medical provider community and I'm please to invite Greg
[inaudible], George Brown, and Dennis [inaudible]. We have Greg from Providence, George from Legacy, and Dennis [inaudible] from [inaudible]. So gentlemen, thank you very much for joining us. What I'd like you to do is each take a few minutes and provide some comments and then we'll have some questions. We have three groups within a 45 minute period so what I'm going to do is ask each of our invitees to make a few comments. We can ask some questions of the entire group when they're done and I'll kind of manage the time as we go through. Is that okay? Greg, you're on.

>> NEW SPEAKER: Okay.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: First, thank you very much. We haven't rehearsed this so you might hear some duplication. I'll stick mostly to the Portland area, where we've been giving a lot of attention. George chairs our Oregon Health Leadership Council which has brought together the combination of health plans, hospitals, MCOs. And just to give you some perspective from the Providence perspective...and I chair what we call the Big Idea Group which is, for lack of a better term a big idea in terms of how we change the healthcare in the community.

We also serve as an MCO. So we have some of those experiences. With Joe and Lilian here, I can tell you how the experience feels is we're moving really from building cars to being accountable for transportation. And merging organizations of very different histories and experiences at the same time with hundreds of millions of dollars less to work with. And do this in six months. And so this is the challenge that we face. Just the change management and the sheer complexity of how we bring these organizations together and really ask thousands of providers to change their roles, change the way they are paid, change what they are rewarded for, and then also have the infrastructure in place so that we really can provide the kind of care and expectations that our citizens both want and deserve.

So where we are right now, you know, how do you, first...what is it that we're trying to accomplish. And that's the sausage-making that we're into right now. And
then how do you start simpler and develop a transition plan over time. I think everyone will tell you to get this done in six months is impossible. However, we can get started.

So we need transition time. There's also this idea of capitalization for restructuring. None of the organizations come to this with development capital. And this costs, just the studies are literally hundreds of thousands of dollars to say, "How would this work?" And there will be millions of dollars that are necessary in terms of infrastructure costs to put together data systems, to put together information systems, what we call attribution models as to where we can assign members to medical groups or to patients and follow them to see how the expenditures are used. The contracting, many of you spoke to earlier about...with different care providers. That infrastructure costs dollars.

And then there is the risk capital for the global budget. And the risk capital, when you're talking about just the Portland area of up to 300,000 people, can be huge. It can be hundreds of millions of dollars. So trying to figure out how you plan and then provide for the risk capital on insurance losses, if in fact you are taking these global budget responsibilities.

So I will end there. I think the one thing that we find interesting talking with our physicians right now...and I'll use two examples, breast cancer and prostate cancer. And this is not on the prevention side. And Joe has spoken to this. Many times, evidence base is historical. But when you are the patient, and our surgeons will tell us this, that as much as 30% of the referrals to them may not be necessary. But when it is you, when it is your spouse, when it is your child, to be told that that referral is not necessary and this test isn't necessary and you have a 5% chance of not having anything wrong, or the other way around of only a 5% chance of anything being wrong, you want to be quite certain that you're not in that 5%.

And this is some of the things that we're struggling with in terms of the changed management, working with our colleagues, is assuring that as we move to this new model
we have the kinds of checks and balances in place that we
first do no harm. I'll stop there.

>> NEW SPEAKER: Thank you. George. How are you?

>> NEW SPEAKER: Well. Good morning and thank you for the
opportunity. I'll try not to be redundant, but there are
several points that I do feel...that are important to make.
Legacy really provides the bulk of care for the Medicaid
population and uncompensated care. About 35% of the
Medicaid population receives their care at Legacy Health.

I, too, think that transformation is the right thing to do.
The timeline is very, very optimistic and I would say it's
near impossible. I'm also very concerned about the need for
investment capital because we do have to restructure. I
think our current infrastructure is disease-management
based, not wellness based. And it requires a much different
approach. Last night, while I was doing my mandatory watch
of "Dancing with the Stars," I did have the latest copy of
the New England Journal. So when "Dancing with the Stars"
was over, I turned myself to academic pursuits. And there
was an article there that caused me some concern and I
brought some copies for the committee. And it's the results
of the Medicare Health Support Disease Management pilot
program. About 240,000 patients were enrolled in this pilot
to have a commercial database and commercial disease
management programs, nurse-based call centers, to see if
they could receive reductions in utilization.

And the conclusion is in this large study commercial
disease management programs, using nurse-based call centers,
achieved only modest improvements in the quality of care
measures with no demonstrable reduction in the
utilization of acute care or the cost of care. And this
pilot cost over $400 million. So I think we have some good
ideas, but to say that we know exactly what it is we need
to do I think would really be a stretch.

I also want to say that many of us are struggling with the
economic impact of the Medicaid cuts. The short-term looks
like in the tens of millions, but in the next year, the
bi-ennium, we're trying to understand what that $239
million impact is going to mean to us. And we think it's
going to mean somewhere between $30 and $50 million alone at Legacy. So how do you prepare for that in terms of restructuring to make sure the organization continue to be viable?

I would also call the board's attention to some of the data that's available from the Oregon Health Program. As that program wound down, the uncompensated care in the state ramped up. So there definitely is, to use a tired phrase, there's a hydraulic there. And, of course, Medicaid cuts are one thing. But the totally uninsured coming through the doors is something that we do need to get our hands around since we'll be responsible, ultimately, for both. And so it's one thing to know how much reduction in the Medicaid budget. But we have no way of knowing how many will come through our doors who have no coverage whatsoever.

I would also say that there was an editorial in the same issue of the New England Journal talking about deficit reduction and keeping America's promise to the underserved that if the committee of 12 failed to come up with a proposal that we can act on, they'll be some pretty drastic cuts in defense and I'm sure with healthcare. And the safety net programs as we're familiar with now will not be there. And that's going to have a calamitous effect, I think, on our society. So I think Oregon is just sort of a small microcosm of that.

So I'm very encouraged by, I think, the cooperation you see in the Portland community. organizations such as Legacy and Providence that are used to being competitive are trying to find a way to be cooperative to care for this population. But, in the allotted time, I think it is not going to be doable, even though I think we're making great efforts and it's wonderful to link up with the county agencies, the not-for-profits who are there all caring for the underserved. And trying to make sure that we can provide care for that group so that we lessen the cost shift to business so that we have a good business climate in this state. But I'm very concerned about the trajectory that we're on. But I do applaud the efforts that the governor is making in moving us towards a move towards healthcare transformation.
NEW SPEAKER: Thank you. Dennis.

NEW SPEAKER: Well, thank you. And I'm Dennis [inaudible]. I'm President at Good Shepherd Healthcare System and that's in Hermeston, OR.

NEW SPEAKER: Hmm, I apologize.

NEW SPEAKER: That's okay. And I also have had the pleasure of being the Oregon Association of Hospitals small and rural committee chair for probably the past five years. And I'm here to reflect on some of the comments that is in our group as they look to health reform. By the way, I came in a little early and watched the dynamics of this group. And this is extraordinarily good discussion and we should have just had it many, many years ago is probably the best perspective I can provide on that.

However, the...I wanted to convey that, from a small and rural hospital perspective, we have some concerns. But we don't want to be perceived as dragging anchor because we too recognize that transformation needs to happen. We need to do something different that we're doing. It's just that we're a little bit sometimes not quite sure how to get from point A to point B. And when the federal government came out with their patient protection and affordable care act, there were some reasons as to how ACOs would roll out into rural areas.

Now even the American Hospital Association conveyed to us there was really very little discussion, very little thought given to how this would transition to rural areas. They were picking a low-hanging fruit in the urban areas. And that's not...that is understandable, of course.

At that time, we looked at, well, we need to have some sort of an opportunity for doing some testing, some modeling. So we formed in Oregon, we formed the rural health initiative, rural health reform initiative, so that we could begin looking at that. We have various small and rural organizations in our state that are testing various models that may work better in rural areas than others. But at least having some idea of what we're doing there. The Medicare center for innovation, somebody may help me a
little with that, but there was a center for innovation with some funds. Some of our organizations were beginning to the process of applying for funds.

Then we come along to Oregon with the, the sort of rush to CCOs. And I don't want to sound too negative on that. But the timetable is a little bit alarming because I'm not sure how the juxtaposition of us experimenting with federal funds, opportunities for looking at different models is going to work with the timetables of CCOs in Oregon. We kind of hope that maybe some of those would be similarly modeled so that if those are...would be that effective. So we do have some concerns there.

Rural hospitals now, most of us are on a cost-based reimbursement. And I realize that's become sort of a...almost like an evil phrase to talk about it. And yet, it has probably been the most stable and provided the best, most reliable funding source of anything we've done here to fore. Now we comprise about...32 hospitals are on cost-based reimbursement and comprise a little bit less, I believe, than 4% of the entire Medicaid budget. And yet, that's always up for challenge. It's always up for review. And certainly within the concept of CCOs, once again, it has the target on its back.

I think one of the things I'd like to convey is that we do need some time, I think, to make sure that the models that we roll out in rural areas really work. Managed care did not work well. And for those of us that have been there for a few years, we remember the eighties and it was a time of significant concern for us. And so we want to make sure that, what we do, we recognize we have to play a part. We know that there a lot of dollars probably to be gained in additional coordination and some of the things that we're talking about. But the concept that's already been discussed about rural areas being in a position to bear significant risk is going to have to be worked on very carefully. And the concept of trading excess capacity for discounted services, fee-for-service, that's not existent. We're almost, to a community, we're underprovided and we do not have the adequate numbers of staff to take on much more additional volume than what a lot of us are already faced with as it is.
So some of the old managed care concepts, which we do hear kind of threading through to the CCO environment, do not appear to...they may not work like it's envisioned. We want to be part of the solution, but we feel that the timetable is a little bit challenging.

>> NEW SPEAKER: Thank you very much. And I think we feel challenged by that timetable as well. So I want to make sure you have all heard that from us. We do very much acknowledge and appreciate all of the good work that all of you are doing in trying to think through the various alternatives ahead of us and to try to help us to meet these very difficult timetables and so thank you very much. We have time for just a couple of questions. Mike.

>> NEW SPEAKER: Just one, I guess for all of you, if you have time. I guess from the urban perspective and the rural, as you know what we're embarking on over the next two to six months, what recommendations do you have for this board as we proceed in our work?

>> NEW SPEAKER: One thing is, and this came up in the governor's task force as well, some flexibility and tolerance for expectations around governance, around some of the performance reporting. This just takes some time. And then also, and Bruce and I have talked just briefly about this, again this transition period where there is some either, I'll call it either stoploss or some kind of risk tolerance bands that we might be able to enter into so that we...one of the other experiences from the nineties is we had a lot of bankrupt too-small IPAs and managed care organizations. They just took on risk that they didn't have the capital to protect themselves from the ups and downs. So it's those sort of things. How do we get this done over several years?

>> NEW SPEAKER: You know, I would add to that that we will need clarification of some of the legal structures that exist with any trust that prevent us from cooperating in meaningful ways. And so, in spite of our best efforts and intentions, if we're prohibited from cooperating then we can't achieve our goals. The other thing I would ask, and I know this seems to be an issue that's been solved, but the
adjustment in the cap ratio for the MCOs is a movement of monies into MCOs and away from providers. And I would ask that we look carefully at their loss ratios and at their reserves because if there are substantial reserves and they are growing beyond what the experience is then that is, to use one of the phrases that the governor uses, that's indeed trapped equity that can't be redeployed to solve this problem.

The last thing I would ask is a clarification of, at least for us, of where we're going to go with this pilot. Is this this the uninsured in Medicaid or is there an intent to migrate this program to state beneficiaries as well because that will certainly put a different level of effort on it.

>> NEW SPEAKER: Indeed. Dennis.

>> NEW SPEAKER: And I would just kind of reinforce Greg's comment. It's tough in rural areas because it's small volumes and small numbers to take on large amounts of risk. Now small amounts of risk, I think we're open to evaluate that. But your ship can get sunk pretty easily with some large, catastrophic issues. The other thing I'd just like to bring up is right now a lot of the rural hospitals, their margins are thin. I think a third are underwater, a third are right at, maybe a third doing a little bit. But, for the most part, they're thin. I would just be cautious about pulling that cost-based reimbursement, which does work for Oregon's smallest hospitals, until we're sure we have a workable model that we can replace it with.

>> NEW SPEAKER: We have time for one more and I'm going to assign it to Felicia.

>> NEW SPEAKER: So my question, actually, I want to go back to what you said about where are we going this and does this include state beneficiaries as well. Because, you know, I know that both Providence and Legacy operate commercial plans. You're both...all three of you are the largest employers in your area and I asked the board this. So where are you going with those commercial plans, with your own workforce, and what have you done so far that can be applied to how we're moving forward in transformation?
NEW SPEAKER: Well, just by way of clarification, Legacy does not have a plan, does not have a commercial plan.

NEW SPEAKER: I'm sorry, you're self-insured.

NEW SPEAKER: We are self-insured, but perhaps we should consider a commercial plan. So we are self-insured and that currently is about $93 million a year. We have instituted some significant changes in the way we administer that plan and some of the plans benefits and I think it's a move in the direction of healthcare transformation. And our employees have readily accepted, for the most part, those changes. So we're very, very optimistic about moving that plan forward.

NEW SPEAKER: It is a great question and Providence has done many of the same things that George speaks to with our own employees. And we do have commercial plans, we have Medicare plans. I think the thing we have learned is the populations and their needs are very different. And sometimes we...it's not something we talk too openly about when we're developing policy. But we really do. There's a value to segmenting populations and designing products that really serve that population.

For example, Medicaid members will use the emergency department three times more than commercial. And so how do we work, for example, with the county, how do we work with other providers to design products that are really targeted for that population. And so, to me...and this is...we've had these conversations. If this is primarily designed to serve that population then the governance structure, the systems and structures that we develop should be really targeted toward that population. They will get better care. It will be less expensive. And sometimes out philosophy of a kind of one-care model for everyone is not to, how should I say it, to the beneficiaries benefit. So what we try to do, Felicia, is really target and develop products that suit the population that we're serving.

NEW SPEAKER: So you don't think state workers then should move into this in the future?

NEW SPEAKER: I wouldn't go...I would say that if...this
obviously comes up as a...could it be a public option? Yes. But I think, going from a consumers' point-of-view, there will be many kind of attributes of this model that won't be of interest to a commercial population. It's, you know, it's why some people take the bus and why some people buy cars. And I think that's what we have to keep remembering is, in healthcare, we are doing more and this project specifically is designed around a very different, or I should say a very unique, set of needs versus maybe a commercial population. Intel is very different than, you know, the population that Lilian serves. And we have to remember that.

>> NEW SPEAKER: Dennis, a thought on that.

>> NEW SPEAKER: Well one thought, I guess, on that. Oh, by the way, I'm not sure exactly how your question was directed but one of the last things we would probably consider doing would be dropping out and then just paying the penalty. That won't happen.

But one of the thoughts that I had to your comment was the fact as to the role that the emergency room is playing. And in rural communities, when you're significantly...you know, you do not have the professionals, you're underdoctored, the emergency room becomes...that is really your safety net in the community. And our volume, I mean, our ER percentage in terms of what we offer as primary care versus true emergency is upwards of 75, 80% now. So we have become...just decided that that is the primary care, you know, clinic in the community and our beginning to gear that way.

But the problem is is that these other programs, if they get moved in or these other plans, if the process begins to compensate for those individuals, to reimburse for those individuals significantly less what happens in the provider community is, a lot of times, their practices become restricted, those people. That immediately impacts the size of our primary care emergency clinic.

>> NEW SPEAKER: George, one last comment.

>> NEW SPEAKER: I would say that...in fact, I would
paraphrase the great American philosopher Donald Rumsfeld. It's the unknown unknowns that we really have to be concerned about. So I think that we need to proceed with deliberate and careful movement towards solving a problem for a specific population. I do think that Greg's idea of we can't create an equal program for everybody is the right way to go.

The other thing I would say is an opportunity for us is community mental health and behavioral health. I think that that's an area that all of the resources could rally around and provide significant improvement in the level of care and also significant efficiency of care if we can come together and cooperate in that area.

>> NEW SPEAKER: I would just...if I could just put a bug in your ear because I'm all about that this meeting. On the health leadership task force which both of you...all three of you chair different pieces of the work in that community, I would like to hear about what are the solutions you do have for the commercial side and the private sector that could mirror what we're doing on the Medicaid side to reduce costs. I know you've come forward with a lot of different initiatives. It would be good to go down a more comprehensive improvement of health and a community-centered medical environment for the whole population.

>> NEW SPEAKER: Can I give one example?

>> NEW SPEAKER: One example and then we will figure out how to...

[inaudible over each other]

>> NEW SPEAKER: The medical home is an example. We have many clinics within Providence and now Lilian and their clinics are in our network. But if we focus those clinics for the geographies and the neighborhoods where many of our Medicaid members might be, they really specialize, so to speak, in the kinds of services that that population needs.

Now we have the medical in-home model across the organization, but depending on the population that it's
serving, the mix of services in that medical home is going to be very different. Does that help?

>> NEW SPEAKER: Yeah, I think it...I totally get the concept. I think it will be...it's going to be exciting to see a fuller plan when you are finished with your work.

>> NEW SPEAKER: And we'll ask our staff to follow-up and figure out a way to get some of that information because I also know that you're doing some great work. Gentlemen, thank you very much. We really appreciate it. We take this as a dose of reality. We know we all need that and we appreciate your good work.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: I will admit that I am failing miserably at managing time. We have two more doses of reality ahead of us which will be helpful as well. I'm going to ask Dr. Rachel [inaudible], did I get that right, I hope, John Morehead and Susan King to come forward.

>> NEW SPEAKER: I'm Dr. Elizabeth [inaudible] and I was part of this panel...

>> NEW SPEAKER: We have one more panel in just a moment. And you're on it. Thank you very much. Thank you. No problem, we'll be right with you. I'm going to try harder to manage time this time and so I'm going to ask if we can keep the remarks to two minutes. We'll try to keep our piece to two minutes and see if we can get this done. Thank you all for joining us today. We appreciate it very much.

>> NEW SPEAKER: Linda is always saying we come after the hospitals and we get less time.

[inaudible over each other]

>> NEW SPEAKER: Thank you for the opportunity to be here. I'm John Morehead. I'm an emergency physician from Portland. I'm past-president of the OMA and here representing the OMA. I'm here to give you some thoughts about what physicians are feeling at the current time. I think you're well aware of some of them. We clearly
recognize that we're trying to deliver care and coordinated care in a broken system and we very much look forward to moving ahead to a different system.

I think physicians, frankly, are feeling totally overwhelmed. I think they're feeling very frustrated. And I think they feel the stress of decreasing reimbursement and increased administrative and regulatory burden that they're asked to comply with. Physicians, I would say, are cautiously optimistic that there's an opportunity to improve care by better coordination, what you've been talking about this morning. Clearly integrating physical, dental, mental, and behavioral health is an important step to significantly improving the health of Oregonians. And we appreciate that provider and patient choice are incorporated into the bill. These are important principles.

However there are a couple of issues that are unresolved in the transformation bill. At the end of the day, physicians and other providers are responsible for providing quality care to the CCO patients. And I think physicians feel if they're not equal partners in the governance structure, we're worried that patient interest will not be adequately represented. We really feel it's important that interim proposals define the governance structure of CCOs and make sure that we don't create power divisions at a time when we believe stakeholders need every assurance that the transformed system will be fair for everyone. The process for creating CCOs must be deliberate, must provide continued legislative oversight and must be based on a transparent payment model.

We're very keenly interested in the development of quality measures that will be adopted and how those measures are tied to provider reimbursement. While we believe medicine needs to move in this direction, the current measures are imperfect and they aren't always good indicators of improved health. This will be a challenging process and, if not set up correctly, patients will stand to lose.

We like that the CCO model encourages patients to be active partners in the delivery of their care. However, patient responsibility is such an important part of the CCO model that we would like to see patient incentives to prioritize
healthy lifestyles and emphasize personal responsibility.

Additionally, we're concerned that the CCO model shifts more liability to individual providers and feel it important that liability reforms are adopted. We're encouraged that the bill requires the Oregon Health Authority to bring back proposals to address this issue in February. But we most incorporate these improvements in the final CCO package.

As chair of your workforce committee, I also have to relate that physicians are concerned that the healthcare workforce will be insufficient to meet the increased clinical needs for health services. While we're trying to ramp up our educational programs and are faced everyday with our students who have a literally overwhelming amount of debt as they finish their clinical training. We see evidence from Massachusetts in their recent study as they've incorporated a new healthcare system with universal coverage that in fact there's been no increase in the number of physicians there and there have been no increase in the number of nurses. But there were an 18% increase in the number of administrators.

We're concerned that the elements within the delivery...there are still elements within this delivery system that have more of a competitive nature and we believe that with greater collaboration among systems between physicians and other providers, physicians and hospitals within systems, we believe there are administrative savings which could support additional clinical services.

Finally, physicians are concerned that, as you've mentioned many times this morning, that the savings predicted in the bill are optimistic. One of our concerns is that if the savings aren't realized, additional cuts will be required and this will impact Oregonians access to care. Physicians should not bear a disproportionate share of the cost of expanding health coverage. Administrative efficiency seems like an appropriate source of additional direct funding for clinical services. Thank you.

>> NEW SPEAKER: Thank you very much.
NEW SPEAKER: Good morning, members of the board. I'm Susan King. I'm the executive director of the Oregon Nurses Association here speaking on behalf of my association. In addition, I practice in emergency nursing. I actually worked a short shift before coming right over here. So some of the comments from rural hospitals about the emergency department becoming the quasi-primary care clinic are certainly well known to me. And they don't occur only in the rural areas. I would say all but one of the patients I saw in my short shift this morning really could have been dealt with outside of a hospital emergency department.

So just as Dr. Morehead said, I think nurses have clearly seen for years the faults with our current system and we've all discussed that issue at length over the last few years. I'd just like to offer a few comments about the process that we're involved in at this point.

First of all, we are very pleased to be a part of the transformation committees. Even though the night before each meeting, it does make me wonder where a good novel, a light reading novel might be in my future. That would be nice. In terms of where we're going with this, I do feel that the process that we're in is a bit overwhelming and that the timeframe is probably unrealistic or if not impossible as a previous speaker has identified.

I serve on the metrics committee which is attempting to decide how we will measure the CCOs performance on cost and quality and patient experience. At the same time that the CCO committee is deciding, I think, what a CCO is going to be. And I feel a little bit like we have the process backwards. Likewise, and I think I expressed this to Dr. Hoffman at our last meeting, I remain confused around the issues of how we will determine what the performance of the CCO is and therefore how much of the cost it should have in its coffers versus what the performance at the provider level or at the clinic level should be. And I think many of my committee members are struggling with that confusion as well. Maybe you're not confused anymore, but I still am.

[inaudible over each other]
So I think that is one strong recommendation that I would make is that we have an opportunity to come back and look at the metrics of the CCO after we see what the CCOs are really going to be. It's a difficult process.

We do believe and have participated in the development of the patient-centered primary care home standards and we believe that is a model that is going to work and it's going to be successful both on quality and cost in the future. But it is not going to produce savings in the immediate future. We also believe that those primary care homes have to be made up of the community that they serve and that, for that reason, they will be effective in delivering the kind of care and preventing unnecessary use of ERs for example.

One other observation, and maybe it's just that I'm not that knowledgeable about the CCOs and where they committee is going. But it isn't clear to us at this point whether groups of patients, if you will, or consumers, if you will, will be limited to one CCO or whether they'll have the choice to move freely between provider groups that might be associated with more than one CCO. And this relates, obviously, to the measurement of the outcomes of CCOs. If people move freely as they do in the healthcare system now, how will we hold either a practice or a CCO accountable for the outcomes of their care? We're not clear about that and perhaps it's just that I'm missing a piece of information.

We have had a lot of discussion in our committee about dealing with the social determinance of health, about which I think we're all pretty well-informed. We believe that those are important considerations. But we are concerned about taking too big a bite out of the apple at this point. Trying to hold the accountable for factors which it might be able to maybe influence in the long term, but not able to control in the short term.

A strong recommendation from our perspective is that we should focus on efforts through the primary care home on care coordination, particularly with individuals who might have chronic illnesses or complex healthcare needs. We do believe that's a model for the future, even though some of the national studies aren't delivering the exact outcomes
we want yet. We do believe that the coordination of care between multiple providers and across systems of care is going to be critical. Obviously, in my practice in the emergency department, those with mental illness rise to the top in terms of the need to have available services, but services that are coordinated.

I am going to skip comments on the workforce because I'm trying to adhere to your timeframe. But the one final comment I would like to make is while we're all designing the system that we want to see in the future, I do hope that the Health Policy Board will consider that we need to continue to fix, albeit with shrinking budgets which may be an impossibility, we need to fix the problem in our current delivery system, which we're going to be living with for quite some time. And obviously, one of our biggest concerns is payment reform for services in primary care, for example, and mental health care, ensuring that we are realistically incenting providers to provide the most cost-effective care that they can. So we all know that we want a system of the future, but we also know that we need to attend the policies for the current system and make sure that it works for the population that will be using it as long as they will. Thank you.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: Thanks for having me here. I'm Rachel [inaudible]. I'm the medical director at Central City Concern. And I'm speaking to you today from a multitude of perspectives. One is as the medical director of a very integrated delivery system such as Central City Concern. Also as the director of our community health center there as well as as a board member of the Oregon Primary Care association, which is our state association of community health centers surveying about 300,000 vulnerable patients across Oregon.

And many of these folks are people who, as you referenced, whose social determinance of health really limit the choices that they're able to make. And I know that we're familiar with this ground, but just to enumerate them again, that there's chronic medical illness as well as mental illness, alcohol and substance abuse, homelessness,
rural isolation. And then one which we pay particular attention to at Central City Concern which is just individual social isolation and lack of supportive peer relationships.

And also speaking to you today as someone who's been fortunate to be a member of one of the CCO work groups. I'm on the Medicare/Medicaid work group. So a couple of, I'll condense this a bit, but a couple of key concerns, I guess, or thoughts about the process and where this CCO may land. I know we've talked a lot today already about CCO design and governance process. And I believe that it's community driven solutions are where the action is here. And the extension to which the design and governance, excuse me, is by traditional healthcare entities concerns me to the extent as to which they're regarded as payers and not as collaborative community health development organizations.

And I think under the latter...in the latter framework, we can really transform the system and under the former, not as much. So I would propose a process of true, to borrow a phrase from [inaudible] Oregon, of true cocreation and true codesign. We've been particularly successful at this at Central City in building a pretty expansive care model because 50% of our employees are in recovery themselves, 25% of them are former recipients of our care. And this goes from the doctors and the directors to the frontline workers. And they...these individuals not only have a lot of skin in the game, but also are really our best tests in terms of how to deliver care to individuals who are homeless, who are in addiction, who are coming in to early recovery. And, in fact, some of our most effective programs were designed by and now are run by these individuals.

So to this end, I would propose that as we design a governance structure for CCOs that it be made up...the majority be made up of community stakeholders in addition to payers. And I would actually, speaking as a physician, I would actually put doctors at the bottom of that list. I've been fortunate to work in an organization where the real action is around these supportive relationships among peers, between alcohol and drug counselors, supportive housing case managers. Medical care actually plays a relatively small slice in that continuum of care.
The second point that I wanted to make is around recognition of the social determinance of health and how those may affect quality measures. I think we need to really dig in and understand how complex it is to treat a sizable number of our Medicaid recipients.

So I'll give you, hopefully, a quick salutary example which is a patient from our 12th Ave. recovery center at Central City Concern, which is a specialty mental health center for people who are dually diagnosed addictions, severe mental illness, as well as often homeless. And this is a patient who's schizophrenic, has asthma, sort of lived at his mother's house but was essentially on the streets. And his...he wouldn't take his anti-psychotics, he didn't take his asthma medications. His delusions would become very anxious to him, it would trigger an asthma attack and he'd end up in the emergency department for a nebulizer treatment.

So in the course of a year, he had 40 ED visits and three hospitalizations. And so a community health team came together, composed of a nurse, a case manager, an outreach worker, visited him regularly, got him to take his asthma medications and his anti-psychotics and then three times a week he would come to our primary care clinic, which is embedded in the mental health center so it's more accessible to him, for nebulizer treatments. And he hasn't been in the emergency department since.

So I think the two points here...there are a couple. One is we use these typical measures in healthcare, you know, compliance with inhaled corticosteroids would be one for asthma patients. So you can see for someone like me maybe taking that corticosteroid is a relatively...I can deliver on that measure relatively easily. For this fellow, what's required there is much more expansive and that we, as we look at these measures, need to think about how we are...the time that is allowed as well as what resources are necessary in certain individuals to be able to deliver the very, frankly, biomedical measures that we've chosen.

And lastly, the last point I'll make, is about the role of supportive housing. And this fellow happened to live with
his mom and ultimately engaged with her, but there are many individuals like him who are homeless. So think about trying to do that type of intervention with somebody who is on the streets. It's impossible. And as this came up in our work groups, I was surprised to hear that...or maybe I shouldn't have been surprised, but there is still very traditional thinking around...we have this budget crisis. We can't afford to pay people's rent. And of course we can't afford to pay everybody's rent. But in someone like this, where supportive housing is such an instrumental part of reducing that emergency department utilization, the investment is pretty clear. That he needed...in order to be able to deliver this intervention, he needed to be in some stable housing. So those were my two thoughts. Thanks for the opportunity.

>> NEW SPEAKER: Very good. Thank you very much. And because of the clock, I'm afraid that we're not going to be able to do questions, but if people have questions we will make sure we get them to you and have an opportunity to get a response. Thank you very much. And our last panel for invited testimony is Elizabeth [inaudible] and Art Towers.

>> NEW SPEAKER: Can I just that say that if you've not had the opportunity to go visit Central City Concern, it's an extraordinary, extraordinary example of an integrative care facility.

>> NEW SPEAKER: It certainly is. It certainly is. Hello and welcome. Thank you for joining us today.

>> NEW SPEAKER: Thank you so much.

>> NEW SPEAKER: Art, you want to start?

>> NEW SPEAKER: Sure. My name's Arthur Towers. I'm the political director for service employees here in locale 503. Thank you very much for the opportunity to testify today. We remain very committed to enthusiastically advocate for the healthcare transformation. We feel good about the progress that's being made. The timeline is the timeline and we're trying to be solution-oriented around meeting that timeline that's got to be met for budgetary reasons, among others.
We believe that the CCO model could produce a quality product that PEB can elect to purchase. We think that it's...while Mr. [inaudible] comments were on target about the needs of the populations being different, nonetheless we're intrigued by the idea of finding a low-cost, high quality alternative to the care that we have now.

What I wanted to focus on today was the potential that the CCOs present in terms of building on the social model of care that's found in the long-term care system. As the previous presenter talked about, the idea of the social determinance, the idea of the action not being with the doctors but instead being with the community, I think, is a powerful idea.

It feels to use that we face three pretty huge challenges before. One is a shortage of trained workforce to deliver this community based care. Also, the lack of a culture of coordinated care and we're really disturbed by that. At the Medford community hearing the OHA held, the best presenter that they could...the presenter that came forward described the sort of work that's done in the Central City Concern community health and mental healthcare as services provided by "mommies." And he didn't mean that in a good way.

And so changing the culture to value the community based care, I think, is really, really crucial and one of our biggest hurdles. And the third challenge I think is the...again, meeting the timelines to quickly transform the system to save the money that we need to save. I think that, to a certain degree, all three of those challenges can be met by the heavy reliance on the Oregon Homecare Commission. That's a body that understands consumer choice which is directly linked, in our experience, to cultural competency. That when the consumer has the opportunity to choose the care provider, especially the care provider coming into their home, that the opportunity for there to be cultural competent care provided rises dramatically.

I know that in our union hall we have a monthly meeting of Russian-speaking homecare providers that, you know, 100, 150 folks month after month come to visit, come to meet. And that's the sort of thing that we can do, the Homecare
Commission can promote. Also I think that it promotes care in rural communities as well in meeting the special needs of a rural community. In a county like Douglas County, there's more than 500 homecare workers currently employed. I believe that the homecare commission's programs for training and instruction for both providers and consumers is a model that can be built on for the community healthcare workforce that's going to be needed.

Already, nearly 30,000 folks have been trained by the homecare commission That's the sort of thing that we need to build on and expand upon if we're going to meet the workforce needs for the community based care here in the very short term.

The third thing that I would mention is that the Homecare Commission also provides the opportunity for administrative efficiency. If we're going to be providing community-based care for 630,000 people on the health plan fast, where are you going to find those workers? I mean, it's just a math problem to start with. And the Homecare Commission is in touch with 13,000 providers. They have a registry and referral system where people can find care providers to do this sort of work. And building on that system rather than asking every CCO in the state to recreate the wheel on this front would be a ridiculous waste of resources.

And in the interest of time, I think I'll just add one more point. And that is that the missing piece that hasn't been discussed, the conversation has been very, very good I think, but one piece that hasn't been discussed is the idea of a care provider's advocate for the client, for the consumer. I think that that's another really important piece on which to measure CCO performance. Is there the opportunity for care providers to advocate for the consumer because I think that's going to be one measurement that'll be critical to both good health outcomes and also consume satisfaction. Thank you.

>> NEW SPEAKER: Very good. Thank you. And before I move to you, I just want to say that we're getting close to noon. I know that a couple of our folks here have prior commitments and so if you have to excuse yourself we certainly understand, but we'll continue on through the
rest of the agenda. So Elizabeth, thank you for joining us today.

>> NEW SPEAKER: Thank you. I'm Elizabeth Steiner. I'm a family physician. I'm President of the Oregon Academy of Family Physicians this year. Can you all hear me? No, we'll try again. I'm still Elizabeth Steiner and I'm still President of the Oregon Academy of Family Physicians for another six months.

So we appreciate the opportunity to come talk with you about the role of primary care in really changing the way we deliver healthcare in Oregon and promoting the health of all Oregonians. And that's what we really want to focus on. I think we're all really tired of hearing the term "Triple Aim" but we believe in it. We believe that this transformation has the opportunity to improve outcomes, increase patient satisfaction, which we think is very important as well, and reduce costs. And to do that, we have to make sure that we have a robust primary care base.

The overwhelming evidence, both internationally and in the United States, shows that when there is a robust primary care base we do achieve that Triple Aim. There are lots of examples of that. I would have to disagree with some of our colleagues who spoke earlier. I do not think that patient-centered primary care homes are just for Medicaid patients. In fact, I think...I could not have been happier, frankly, to hear my colleague here say that PEB is interested in exploring this opportunity. We believe that engaging PEB and OEB in this early on will dramatically increase the likelihood of success and extending it as rapidly as possible to commercially insured patients is the only way that we'll be successful in this in the long-term. The idea that I, as a commercially insured patient, don't deserve the same kinds of services that patients on Medicaid have doesn't strike me as sensible. Just because somebody happens to have a job that they receive commercial insurance doesn't mean that they have the level of health literacy that they need to access the system in a way that's going to ensure good outcomes for this. We all need this and we hope that, ultimately, in the not-too-distant future, everyone in Oregon will have a place to call home when it comes to their primary care.
We believe that the rules that have been posted, the checklist if you will based on the work of the task force earlier on the patient centered primary care home, are great. We're strongly supportive of the way that these were put forward and we think they're excellent benchmarks and we hope that, ultimately, pay-for-healthcare-provision will be based on those benchmarks.

Ultimately what we have to be thinking about is paying for the right care at the right time and place by the right providers. And I think the example given by my colleague from Central City Concern is a great example of that. That patient was getting his care in the emergency department in the hospital by emergency physicians and in-patient nurses and hospitalists. Great providers, all. But really, what he needed was community health nurses going to his home to work with him there. And that was the right care at the right time in the right place by the right person. And we have to be thinking very carefully about all of those things.

So and...we have examples. I suspect many of you are familiar with the community care model in North Carolina, with what Care Oregon has done with primary care renewal, with what southern Alaska has done. All of those are great models of the kinds of coordinated, integrated care models that we think the CCO has the potential to become.

We understand that it won't be appropriate or useful to prescribe exactly how CCOs allocate their money. We do believe very strongly, however, that a requirement that they commit a substantial portion, by which we mean on the level of about 15% at least so they're resources toward primary care has a much higher likelihood of improving the ultimate success, increasing the likelihood of success of CCOs. A great example of this is the Rhode Island model where their insurance commission decided that they were going to require all insurers to commit 15% of their resources to primary care. And I sent Justin an article from Health Affairs that he's going to be distributing, if he hasn't already, to all of you describing that model and its success in lowering healthcare costs in Rhode Island and improving outcomes simultaneously.
So we hope that one of the things that comes about as the rules are promulgated for the CCOs is a prescription that one of the few things that has to be done is a strong investment in primary care so that all of our patients have access to the kinds of care that allow them to not show up in the emergency department to see Susan there. But show up in my office where we can give them care in an environment they're familiar with and coordinate their care better. So thank you very much for inviting us to come and talk with you.

>> NEW SPEAKER: And thank to both of you. We appreciate your thoughts very much. And to all of our invited guests. Thank you. We really do appreciate it. Thanks.

For those who are following the agenda, we are moving to item six of nine and we're going to talk for just a couple of minutes about a legislative concept that's ahead of us. Going to keep it pretty short, but we need to kind of know what we have to deliver next. So Linda, how were you today?

>> NEW SPEAKER: I'm fine. My name is Linda Grooms. I'm legal counsel for the Health Authority and for this board. And what we have to report today is hopefully short and sweet. The basic concept that I think we'd like to propose to the legislature is a simple measure that says that the work that's been done is approved and that the Health Authority and the board are authorized to proceed to implement. I think that can be short, pretty sweet. Doesn't require a lot of complex legal language.

The other thing that I think you heard earlier today that may want to also be included: we've talked about around financial solvency. There's some questions, some decisions, that are going to have to be made around the relationship between the Department of Business and Consumer Services and the Health Authority. How to streamline those processes.

Assuming that those proposals go forward, it's likely that we'll want to just make sure that information sharing between OHA and DCBS can proceed without interruption, while protecting the information in a way that it need to
be protected. So that would be another piece that we probably want to be suggesting. So those are kind of the really small, targeted concepts that we're thinking about right now.

>> NEW SPEAKER: Makes sense to me. Questions? Chuck?

>> NEW SPEAKER: Linda, you know, some of our previous testimony revolved around possible anti-trust impediments to some of the care coordination. Are you going to be looking at that also and, you know, I think we heard a request to look at that and I'm confused about that also. So I wonder if we ought to be looking and making sure that some of the recommendations we end up making don't conflict with federal...and I don't know if there is state anti-trust. There is certainly federally anti-trust.

>> NEW SPEAKER: There are federal and state anti-trust laws. And what we see in our existing statute and then in House Bill 3650 are recognitions that, when providers get together that normally compete, that starts raising anti-trust concerns. So it's the case that anti-trust laws, especially on the federal level, have some absolute can't-go-there. You can't do price fixing and you can't engage in non-competitive behaviors. But, on the other hand, anti-trust law favors clinical integration models and financial risk sharing. So there's a lot about what Oregon's doing that is consistent with the objectives of the federal laws that basically find that kind of thing to promote competition.

So what we actually have in current state law is a recognition, even from the earlier stages of the Oregon Health Plan, that providers need to be able to get together to enter into collaborative relationships in order to create the delivery system. And House Bill 3650 adds to that by really explicitly talking about the role of state supervision and making the Oregon Health Authority an active participant in those discussions because there's an aspect of anti-trust law called state action immunity that can provide some protection. So again, there are some absolute no-nos that state law, the legislature can't change. Those are federal requirements. But by taking the action that is in House Bill 3650, the ability to have
those conversations is certainly available under state law.

>> NEW SPEAKER: I just want to make sure that we have an action item around this because we've now been dealing with it now for almost four years. And it continues to be a potential obstacle for our healthcare leadership people to talk. So we either need some kind of ruling, some written statement so that there's more obvious permission based on existing statute. Or we need to move forward and be more aggressive about making sure.

So my challenge, I think, to the board is to say we need to ask for some sort of assurance, either...and maybe it's based on existing or future statutes. Because we can't proceed any further. We're at a point where these guys are struggling with that issue.

>> NEW SPEAKER: Is there anybody on the board who has some issue with what Eileen just said? I think we're looking for as much comfort as assurance as we can provide to these people who are thinking really very creatively about how they can push these things forward.

>> NEW SPEAKER: So we need...just to clarify, we need a document and a document that can be a public document. Because just in the last month, I've been in two conversations where I said, "I'd really like to talk to him about it, but I can't because we're from competing..."

>> NEW SPEAKER: We just put something together on data sharing and I think we could put something...

>> NEW SPEAKER: My suggestion would be to actually ask that last panel to actually provide an example of what they'd like to do and talk about. And then have some sort of statement based on that. So that we can...we want to be able to open that up.

>> NEW SPEAKER: Can you initiate a process that can pull this together? Great, thank you. Anything else that we should be thinking about?

>> NEW SPEAKER: No.
>> NEW SPEAKER: Okay. Linda, thank you very much. We appreciate it.

>> NEW SPEAKER: Um, Jeremy. Community meetings and a little bit of feedback.

>> NEW SPEAKER: Thank you. Jeremy [inaudible] with Oregon Health Authority. I know...I think it was a typo. I had 20 minutes, but I think I only need two. So...

[inaudible over each other]

...I won't even use my PowerPoint. It's in there and you have a handout and just for the...so you know, there's also going to be a report coming out. We had the final copy last night. I don't think it's been emailed around yet, but it'll be posted online and you'll get it as well. It's a 33-page report that actually summarizes each of the meetings, what we heard as well as kind of an executive summary of all of them.

Um, we had eight community meetings. About 1,300, 1,400 people participated between about a thousand at the community meetings and about two or three hundred in an online survey. And we kind of split the meeting up so there was a number of questions that small groups had some time to discuss. There was a presentation by Mike and John and Bruce. And then we actually spent a lot of the time in the meetings doing question and answer and hearing other comments as well. So, you know, actually listening to the invited testimony today, a lot of what was addressed during the invited testimony today mirrors the themes that we heard and so I don't want to just go back through all of those again.

But just some of the key elements that we heard...I mean, I guess first, my first impression really was that there seemed to be kind of the right questions at the right time. People were really excited to be talking about this kind of stuff. We had a hard time keeping people from not just immediately diving into the small group conversations and it seemed like it was really the topic at the right time. We heard about ensuring that the...the view of the whole person is really seen by the CCOs, that we have

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comprehensive care for people, they're at the center. We heard from a lot of alternative providers, from homecare workers and ensuring the providers are at an equal footing. But most importantly that patients are at the center of that care.

We heard about the importance of OHA having a collaborative relationship with the CCOs, that there is really important that there be flexibility in the communities to come up with a community solution that is going to meet the needs of the community. The communities obviously know the needs of their area the best. But they also know what they've tried in the past, what hasn't worked, what is working. And they also have...there's also things that the state could help with, but in a collaborative way. For instance, I think data, I think, is one of those pieces where there's some data locally that people have on what's happening in their community, there's some stuff that is happening that the state has. And then just ensuring that we have a collaborative relationship where we can share that and ensure that the CCOs can be successful is important.

The two kind of key ingredients that we heard above all really were preserving enough flexibility, that there needs to be enough direction so the communities understand what a CCO is and what is expected of them and understand what the metrics are and how they're going to be used. But also ensuring there's enough flexibility to come up with a solution.

And also we heard about what could...some items, or things that we could be doing right now as a state, at the state level, to remove some of the barriers that are currently preventing people from working more innovatively, locally, just different bureaucratic barriers for reporting, for example. And just ensuring and I know we've already started work on what some of those things are that we could do as a state to help promote this work.

So I'm just going to kind of leave it right there, I think, in the interest of time. Like I said, we've got a large report that's going to be going out. I also just wanted to highlight that, while we had eight community meetings, we've also been meeting with folks and doing outreach.
around the state, not just in these eight community meetings. I know Betty Johnson is here, is going to be talking about some of the community meetings that she's having as well. So...

>> NEW SPEAKER: Jeremy, thank you very much. We appreciate it. We appreciate the feedback. Thank you. And so we are going to go to item eight, public testimony. And Betty I'll have you come up first. Basically, we've got about 12 or 14 names here and we're going to get kicked out of this room in about 24 or 28 minutes. So what I'm going to do...pardon me?

>> NEW SPEAKER: Mike...

>> NEW SPEAKER: Yeah, sure. And what I'm going to do is ask everybody to keep their comments to a couple of minutes. If I wave the watch, that means we're getting really close and I need to have you wrap it up. So Betty, thank you for joining us.

>> NEW SPEAKER: Yes, and I'm Betty Johnson. I'm with...I'm on the board for Healthcare for All Oregon and I'm a member of PNHP and currently serving on one of the work groups buried in concerns with the criteria for certifying CCOs. So this discussion this morning was really, really good. I really appreciated it. And I was only wishing that some of the people from our CCO, representatives, our stakeholders were here to hear that. If you taped it, I would like to have a copy of it and I'll share it locally.

I just wanted to tell you a little bit about our efforts in the three county area--[inaudible], [inaudible] and Lincoln Counties. And Dr. Mike Huntington is here with me because we're partners in everything we do and he has a lot to add to this. And we'll try to make it really short.

I wanted to start off by quoting one comment from one of the members who participated in one of the public meetings that we had. The person said, "People in my community must be informed and active in the formation of the CCO, thereby ensuring that the community CCO will have a healthy start." I thought that was right on.
So we had a...I think one of the distinctive things we did in our area: in each of the counties, we had a planning committee that was comprised of local residents and key stakeholders. And so they planned the meeting. And we did use the same format that was available in the other eight meetings that OHA sponsored throughout the state. But it was really a wonderful example of the kind of collaboration that one would hope would happen in the process of developing the CCOs. We've had a lot of really good communication and collaboration.

We had enormous outreach in the community meeting in [inaudible] county. I would say that it was in the many, many years that I've been involved there since 1991, I don't think we've ever had the outreach and the broad scope and the diverse populations communicated with that we had in this particular event. So I know we don't have time to go into the compilation of the report, which has been given to you and I guess is being sent electronically also.

But I just wanted you to know that we felt it was worth the tremendous amount of time and effort that went into it by the level of engagement, and Mike was there and could tell more about his experience with it also. But we were very enthused about the level of engagement, the depth of their interest, and we asked people to sign the attendance record and indicate whether or not they wanted to be kept informed and 70% of the nearly 200 people who attended the meeting in [inaudible] county did indicate that they wanted to be kept informed. So we're having a debriefing meeting this coming week and we want to try to figure out some way we can follow through with these same people to keep them informed and keep them part of the process. And one of the things that we hope to do is encourage the applicant for the CCO in our three county area to hold a public hearing on the proposal before OHA decides whether or not to certify that group. Mike wanted to had we had one last night in Albany so...

>> NEW SPEAKER: Last night we had 75 people in Albany who expressed the same concerns that Betty just mentioned in the Corvallis meeting. One concern from an independent practitioner, a family practice doctor, was how will independent practitioners be included.
Um, and cautions that I bring from the national PNHP meeting last weekend: risk adjustment measures have not worked well in pilot projects. It's kind of like grade migration in schools. Providers and consultants will grade their patients as high-risk as they can. Another one that brought concern was pay-for-profit projects seemed not to show benefit in the UK or here. Maybe temporary improvement in the measured criteria, but deterioration of outcomes in the non-rewarded criteria.

And one comment from a ENT doctor who said, "If CCOs, ACOs, HMOs are going to save us so much money, why hasn't [inaudible] swallowed up the market? It's not-for-profit, has a 95% medical benefit ratio. Well, I'll tell you why. None of this decreases healthcare inflation. It doesn't put brakes on the high cost of new and old expensive technologies and drugs. We must have a system of evidence based and guidelines that has teeth.'

I think I read in [inaudible] that even saying "quality adjusted life years" is forbidden. I may be wrong. But we have to have teeth that ensures we use good quality guidelines. I'm thinking of how we use the new information about PSA, for example. Will CCOs be readily adjusting to new guidelines like this? Thank you.

>> NEW SPEAKER: Thank you very much. Appreciate it. Next up, Mike [inaudible].

>> NEW SPEAKER: Call up three or four.

>> NEW SPEAKER: Yeah, might as well. I'm having trouble reading the next one. Is it Keisha?

>> NEW SPEAKER: Yes.

>> NEW SPEAKER: Okay, why don't you come up too? And then Ann [inaudible] behind.

>> NEW SPEAKER: Good morning, or good afternoon. I'm Mike [inaudible]. I'm a member of the consumer advisory panel of [inaudible]. I have attended, with pleasure, Betty's meetings in Albany and Corvallis and I'm looking forward to
tomorrow night's in Newport. In Corvallis, I sat at a table of what I would describe as middle class activist. In Albany, I sat at what I would describe as a table of present and retired county commissioners and other elected officials, many friends. And one of the things which was true in both meetings is the subject of this one-pager, which I'm not going to read to you. You can read it and see.

I believe that this is a way for the board and the staff to consider a framework, an administrative framework, which can encompass both the global budget and non-global budget portions of a CCO, whatever CCO it is, wherever it is in the state. I think it's simpler to think of it this way than to think of the 65 programs or whatever. These are broad categories. I think that, to work with the public and the legislature, we need to think this way as often as we can. Thank you.

>> NEW SPEAKER: Thank you very much. Keisha?

>> NEW SPEAKER: Yes. My name is Keisha Reardon. I'm a registered nurse and the administrator at Northwest Ambulatory Surgery Center. I'm also the President of the Oregon Ambulatory Surgery Center and thank you for allowing me to testify today.

Alaska is supportive of healthcare transformation. Last week, our leaders met with Senator [inaudible] who is a champion for surgery centers and our role in the national ACO model. And we also believe that we have a role in the state's CCO model. As small business, we have already figured out how to provide the Triple Aim. The great quality care, great outcomes, at affordable prices. We currently save the Medicare system two...a little over $2 billion every single year. And they said if even half of the remaining outpatient surgeries for Medicare patients came to surgery centers, we'd double that to $4 billion.

We currently are paid 56% of what hospital outpatient departments are paid for the exact same procedures, same high quality care. So we have already figured out how to provide this great care at affordable costs. We're also very focus on quality of care. Patient satisfaction rates
are very high for us. We have very low infection rates and we have very low complication rates. And part of that is because we believe in that model: right patient, right procedure, right location. And keeping healthy patients in places that are relatively infection-free is something that makes a lot of sense.

We are currently developing a national quality reporting system through CMS and that will begin next year. And many surgery centers currently are releasing data to a national databank and to the patient safety commission.

Our concern lies in that, because we are small businesses and we're a small portion of the healthcare, that we could be left out of the Oregon CCO model. And so what we're asking of the board is that you would ensure our place in the CCOs. We would actually like a list of non-excluded providers in the legislation to ensure that everyone who wants to be a part of this is allowed to.

Once again, we thank you for this. We feel like we're...have already shown that we can be successful in this model. And we ask that we're given that opportunity. Thank you.

>> NEW SPEAKER: Thank you very much. Anne?

>> NEW SPEAKER: Thank you. Good afternoon and thank you for allowing me to testify today. My name is Anne [inaudible] and I'm here with Oregon Foundation for Reproductive Health. Nearly every woman needs contraception or preconception care at some point in her lifetime. Yet there's no recognition of these preventative reproductive health services and primary care as a standard. We want to secure preventative reproductive health as a core component of primary care by ensuring that, as an accepted standard, a covered benefit, and a required outcome measure for all CCOs and plans offered in the health insurance exchanges and healthcare reform.

We urge the CCO work groups and OHPB members to consider the long-term health needs of women living in Oregon. We need access to these preventative reproductive health services. The average US woman desires two children but is
fertile for about 35 years. That means half of our population will spend 30 years of their lives trying to prevent unintended pregnancies. Prevention of unintended pregnancies in Oregon is one of the most cost-effective initiatives in primary care. In 2008, 49% of all Oregon births were from unintended pregnancies and almost 48% of those deliveries were to women on the Oregon Health Plan and/or Medicaid.

Unintended pregnancies are a major cause of women falling into poverty. And also derails their life plans, including career choices and educational opportunities. While unintended pregnancies occur in all groups of women, as a health disparity issue, that disproportionately affects low-income women and African-American women. Taking both the economic and social impact of unintended pregnancies in Oregon into consideration, we urge that the final CCO proposed to CMS explicitly list preventative reproductive healthcare as covered benefits in these metrics that are tracked by the CCOs. And thank you for your time and consideration.

>> NEW SPEAKER: Thank you very much. Thanks to all of you. We appreciate it. Uh, next up John Mullon and Stephanie, is it [inaudible]? Did I get that right?

>> NEW SPEAKER: Uh, she has left.

>> NEW SPEAKER: Go ahead.

>> NEW SPEAKER: Okay.

>> NEW SPEAKER: Welcome.

>> NEW SPEAKER: Thank you, Mr. Chair, members of the board. For the record, John Mullon with the Oregon Law Center. I'll be very brief today and appreciate this opportunity. As I've said on a number of occasions, we're very supportive of the goals of 3650. And I want to point out a few things that cause us some concern and suggestion of some solutions to meet those concerns.

So, first of all, we're very, very supportive of the whole person-centered approach. And the things that we think
about and that pop up in our network are things that relate to consumer protection issues. Um, health equity, which we're very supportive of the goals of health equity and yet, these are some of the issues that pop up in local communities where there are language barriers, there are mental health issues, and providers say they can't handle a particular person. That's really not going to fly in the face of what we're...where we're moving to as far as providing a person-centered approach.

The clear roles that are needed on protection of information, we have particular concerns and we talked about this in testimony on 3650 itself about those who have suffered domestic violence and sexual assault. And this may be something that can be done through rulemaking with the authority, but we wanted to point this out. There also need to be model practices in place about notice, grievance procedures and hearing rights that really pertain up and down the system. So this is...there are standards that exist now, but the world is changing in the way the delivery of services will happen.

And then there needs to be, from our view, the strengthening of [inaudible] functions that already exist in the Oregon Health Authority and we'd love to see these [inaudible] functions also happen in the CCOs as well. I've attached to the report an example of something that involves issues that will need to continue to be considered. And it's not my expectation that the board deals with the issue of medical debt. But it simply points out that there are a variety of things that have to change, not only at the CCO and the community level, but also about how the Oregon Health Authority is going to do its business, the responsibilities that it has.

Bruce mentioned at the beginning of the meeting that OHA is engaged in looking at ways in which it needs to reorganize. We think that that makes lots of sense. We have continued to talk about the need for an ongoing stakeholder group that looks at issues that pertain, in the Oregon Health Authority, to Department of Human Services if we're to have a successful way in which we reach that person-centered approach here in Oregon. Thank you.
NEW SPEAKER: Very good. John, thank you so much. Appreciate it. Next two up are Kevin Wilson and Laura [inaudible].

NEW SPEAKER: Kevin?

NEW SPEAKER: Hi.

NEW SPEAKER: How are you today?

NEW SPEAKER: Good. How about you?

NEW SPEAKER: Good, thanks.

NEW SPEAKER: Uh, I'm Kevin Wilson. I'm a naturopathic physician. I've been in practice for 29 years in Hillsboro, OR. And I'm here with Laura [inaudible], representing the Oregon Association of Naturopathic Physicians.

The good news is we're here. We represent this paradigm shift that is the whole person-centered practice. We're also involved in [inaudible] city concerns and other community services like Outside In. We have evidence in front of you, when you have time to look at our PowerPoint, that proves our efficacy and cost effectiveness. We can reduce, when our services are included, we can reduce ER visits, hospital visits, prescription medication uses, the utilization of specialists, and improve overall sense of well-being.

I echo the concerns of the hospital administrator about MCOs and the surgery centers that if we have the same players deciding who's participating, then we're going to have the same outcome and we will not have the transformation that we need.

So what I'm asking of the Health Fund Policy board is to include us specifically in any draft legislation because, if we're not included, we will be excluded. And the track record of exclusion by MCOs and everything is gross and consistent and we can prove that to you. So I'm hoping that this is an opportunity to improve the healthcare of Oregonians by fully embracing us and not letting us be discriminated against still. Thank you.
NEW SPEAKER: Thank you.

NEW SPEAKER: I'm Laura [inaudible], I'm the executive director of the Oregon Association of Naturopathic Physicians. I am consistently in awe at the task that you all have. You've heard at every meeting, every public meeting held around the state, that the public was demanding inclusion of naturopathic medicine as part of their primary care benefits. And I'll echo the concern of Dr. Wilson that what we're hearing back is CCOs will be given the flexibility to determine what fits the need of their community and don't worry, the law requires them to be held accountable.

And I want to share with you some of the common insurance barriers that we have today. And insurance barriers are frankly the number one barrier for patient access to naturopathic care, which focuses on prevention. Some insurers tell patients that they can see a naturopathic doctor, but they won't cover prescriptions written by a naturopathic doctor. So in order to get that prescription filled that patient then has to go to another doctor, adding cost to that system, duplicating the visit, delaying care, and impeding quality of care. Other insurance companies tell naturopathic doctors that they can't perform physicals or gyn exams or administer vaccinations, which all fall into the category of prevention. Why? I don't know.

MCOs, in particular, Dr. Goldberg, at one of the public meetings, you had mentioned that there's a non-discrimination clause already in statute about naturopathic doctors. That's true. Patients who have the open card for the Oregon Health Plan can see a naturopathic doctor as a primary care physician. However, that non-discrimination breaks down when the contract when the MCO...we don't know why, but it does. Almost categorically, MCOs refuse to credential naturopathic doctors.

One MCO told me that their leadership is philosophically opposed to naturopathic medicine, so they will never credential naturopathic doctors unless there's a mandated change. Another MCO told me just yesterday, in fact, that
they are a physician-owned healthcare system, only credential M.D.'s and D.O.'s and their ancillary providers--meaning nurse practitioners and PAs. And when I asked them how they would respond to the fact that consumers and OHP patients already do see naturopathic doctors for their primary care and that consumer demand is increasing and they'll be held accountable for that in the CCO model, he responded, I quote, "The fact that consumers demand that they be allowed to see NDs is not sufficient to indicate that NDs should be on the panel."

This falls into the category that, Felicia, I know you have mentioned and brought up many, many times, today especially, that...the accountability piece and the response to consumer demand is going to be really critical. So what we're asking specifically is that your baseline needs to be a prescription that CCOs must call into service all available providers who are licensed to provide the very services that are needed. Your leadership in doing this is imperative. That, while the state works on finding new healthcare providers, creating new healthcare categories, incentivizing and training them better, that you first prioritize fully utilizing the trained licensed and already available pool of primary care practitioners that are here, waiting and asking to be used by the system. So I will wrap up my comments on that note.

>> NEW SPEAKER: Very good. Thanks to both of you. Appreciate it. Next up, Jennifer Havens and Steve [inaudible]. I get that right? Good afternoon. Welcome.

>> NEW SPEAKER: Good afternoon, members of the board and thank you for hearing us today. My name is Jennifer Havens and I represent homecare workers in Oregon, specifically homecare workers that deal with people and seniors with disabilities, one of our most medically fragile populations in Oregon.

I have come today because I want to make you aware that homecare workers began negotiations for their contracts eight months ago. Despite months of negotiations, the state's current proposal on healthcare would mean that half of homecare workers currently receiving healthcare benefits would lose them. Currently, healthcare workers need to work
80 hours a month in order to qualify for our benefits. Under the state's proposal, that would change the eligibility requirement to 130 hours a month and require $70 pay-in. This would mean that 3000 state-funded care providers will be eliminated from insurance under this new contract.

Homecare workers are a low-income workforce as it is. Approximately 1/3 of our homecare workers receive SNAP benefits as well as other assistance from the state and federal government. Eliminating thousands of homecare workers from health insurance could lead to cost stress on healthcare systems such as the overuse of the emergency rooms and more expensive treatment for the lack of preventive care which, as of today's board meeting, you guys are seeking to prevent.

The state has not considered the cost-shift to public assistance that will result from their contract proposals. 3000 more people will likely become eligible for the Oregon Health Plan and thousands more could be forced on to food stamps because of the burden of the pay-in. I urge the board to consider these points and please stress them to the governor, of retaining a qualified pool of homecare workers for our most needy people here in Oregon. Thank you.

>> NEW SPEAKER: Thank you. Steve.

>> NEW SPEAKER: My name is Steve [inaudible] and I've been providing in-home care services through the [inaudible] for about 12 years now. And homecare workers have fought to bring quality services at a consumer employers...homecare workers were making less than minimum wage and we had no paid trainings or any healthcare.

Over the past decade we've improved health benefits for homecare workers. We've stabilized the workforce that experienced an over 200% turnover in 1999. As homecare workers stay on the job because they receive health benefits, they are much more likely to receive training and may be able to provide the quality care that we all seek for our most vulnerable citizens and people with disabilities.
We're now at $10.20 an hour with access to good training, we have access to healthcare. And homecare workers, among many of Oregon's most vulnerable citizens to remain in their homes with independence, dignity, and choice.

A takeaway of healthcare would directly impact the quality of care to seniors and people with disabilities that they receive. And I want to ask for the board's support in this matter. And also ask that you share this with the governor. Thank you.

>> NEW SPEAKER: Thank you both. We appreciate you coming today. And the last name on my list is Bill Walker.

>> NEW SPEAKER: Walter.

>> NEW SPEAKER: Walter, indeed it is. Thank you. Good afternoon.

>> NEW SPEAKER: Good afternoon. Thank you for hearing my comments. I'm Bill Walter, I'm an naturopathic physician in Eugene, OR. I'm going to keep my comments brief because Laura and Kevin already touched on most of the major points. I'm here to ask for support of the board in ensuring access, not just to naturopathic physicians, but to all licensed healthcare providers. As it stands right now in Eugene, I am the only credentialed naturopathic director by the MCO, but that credentialing was conditional based on my employment by the federally qualified health center down there. That doesn't actually allow me in the building. I provide services on the street to homeless people. I do wound care. And every night, I was out there last night, I turn away people who say, "I want to see you in private practice."

The other naturopathic doctors that are in practice in Eugene, in these more rural communities also want to see these patients have a...excuse me I'm a little bit nervous today. We're here. We're in the state. Please make sure that we are part of the system. We want to be part of the system. And for those that are concerned about what these alternative providers might get up to, if we are in the system we will have better dialogue with the conventional
providers. Thank you.

>> NEW SPEAKER: Thank you very much. We appreciate it. That's the last name on my list. Is there anybody else that was expecting to comment? Okay, very good.

[inaudible over each other]

...we have two minutes to consider any other business that may come before the...Dr. Hoffman, please. Go for it, Chuck.

>> NEW SPEAKER: Okay, so what I'd like to know...I get that, you know, we've really focused our attention on the CCO development aspect of things. I understand why that's important. But I think there's some other policy stuff that maybe would be appropriate to address. And you know, I sent you all an email last week about whether or not there was a role for this body to play in making some recommendations to health insurance exchange board. And the specific issue that I brought up, of course, was whether Medicaid patients would be allowed to...not to purchase, but to obtain their insurance through the exchange.

I don't know that we have health policy board policy on that. If we do, then that's fine and [inaudible], I'd like to know what it is. If we don't then I guess I'd like to ask the board, you know, some of these other policy sort of issues deserve some time during some of our meetings. I really...I personally think this is incredibly important, this particular issue. But, you know, there may be others. So I just kind of put it out there to see if it's something that we want to talk about or just let the exchange board have their way with it.

>> NEW SPEAKER: No, I think you make a really good point and I suspect that we probably should talk about it. Bruce or Tina, do you want to comment to today or do we want to just get that on the agenda for the next meeting?

>> NEW SPEAKER: Let's just put it on the agenda for the next meeting. I think you raised two important issues. One was about [inaudible] and I think we're looking at how to address that. And then the other is, I think as you
mentioned, whether or not Medicaid patients would be actual...eligible for something on the exchange. I think that's a more complicated question that also involved federal law and worthy of a great discussion and so let's have that, I think, with some preparation probably would be better.
>>SPEAKER 1: Good afternoon everybody. Good afternoon and thanks for everybody joining us this afternoon. Those of you that are regular attenders know that each month we pack just a little bit more into the agenda and still try to get done on time. This month is no exception. We've got a jam-packed agenda and among other things we have a pretty hard stop time at 6 o'clock because of the facility. I think we're going to start with a quick word from Tina about how we exit at the end and then I'm going to get back to some introductory comments.

>>TINA: So the lobby shuts down in this building at 6 o'clock, so you can get down to the lobby but you can't get out. So...

>>SPEAKER 1: So you can help us finish on time.

>>TINA: So this is what we have to do: these are the south elevators, you actually do have to take these elevators down to the lobby, then you have to get into the north elevators and take it to the garage and then exit through the garage. I just wanted you to know that because if you go down to the lobby and try to get out, you won't be able to, unless we get firefighters involved. So that's what we have to do at 6 o'clock.

>>SPEAKER 1: Ok, very good. I wanted to start by acknowledging a couple of guests that are here with us today that are actually going to be on the agenda just a little bit later: we have Senator Bates and Representative Freeman, thank you very much for joining us today. Usually when we're with you guys we're on the other side of the table and so we appreciate you coming and sharing some thoughts with us a little later in the agenda. Thanks very much for doing that. Carlos will not be here today but everyone else is present. We have a couple that will have to leave a little bit early so we'll try to keep things moving along. We have several items on the consent agenda, including the minutes of the previous meeting. We have a report on alternative dispute resolution. That material was provided in a written report and we'll have additional details about that in the January 10 meeting. We also have some stakeholder workgroup summaries that were provided to us and Tina will be touching on them just a little bit later in the agenda.

So basically the way the meeting is going to work is up until about 3:10 PM or so-- that's agenda number 8 where we're essentially in the process of getting updates. For the remainder of the meeting we're hoping to have a substantive discussion about the draft of the implementation plan that is just now coming together and we're looking forward to getting into that. We also have-- normally we meet monthly, but in January we'll have two meetings, with the next being on the 10th. Most of that agenda will be devoted (after a period of public comment) to substantive conversation about that plan specifically, so making sure we can get through each section in detail and solicit input from all of the board members, as well as the general public.

I want to make one more announcement and that is simply to recognize that this is Eileen Brady's last meeting. She has been a faithful servant and advocate for healthcare and
healthcare transformation going back certainly to the Health Fund Board, as one of the original members of this board, probably previously to that, and she's been a tremendous advocate for access, for outcomes, for kids, for all of the things that we all really care about and I simply want to say thank you Eileen for your great service and it's been a pleasure working with you.

>>EILEEN: Thank you. It's been a great honor to be part of the process, and I can't believe my term has come to an end. Is this why I get to sit next to you at this meeting?

[Laughter]

>>SPEAKER 1: And why I'm wearing a suit. I don't always wear a suit and a tie.

>>EILEEN: I got moved up to the big table? Thank you.

[More laughter]

>>SPEAKER 1: Absolutely. Dr. Hoffman's term is also ending officially at the end of this year but he's already been mayor of his hometown so he agreed to give us a couple of additional months. He'll be with us through February, and we appreciate your service and we'll talk more about that in a couple of months. So alright.

With regard to the consent agenda, any comments, questions, any items to be removed? Motion for approval?

>>EILEEN: I'll make the motion to approve.

>>NEW SPEAKER: Seconded.

>>SPEAKER 1: Motion seconded. Those in favor, aye.

[Multiple "Aye's"]

>>SPEAKER 1: Opposed? So the consent agenda is approved. Thank you very much. Item number 2: Pam Curtis is with us today. Pam, do you want to come forward? We think that there may be a great opportunity to intersect the work of the early learning council and the work that the Health Policy Board is doing and we're anxious to hear a little more about what you're doing and thank you for joining us today.

>>PAM: Thank you for having me, I really appreciate it. So I brought handouts-- not nearly enough, I apologize-- for everybody who is here. My name is Pam Curtis, I am the...have the honor of chairing the Governor's Early Learning Council, which is part of the big 0-20 education investment board, and during my day job I work for Dr. Robertson at OHSU, I'm the deputy director of the Center for Evidence-based Policy. So what I've
given you are excerpts of an 80 page report that was required by Senate Bill 909 in the last legislative session and delivered by the Early Learning Council to the Education Investment Board, accepted as part of their larger report that is going forward. I want to call your attention first to page 9 and the graphs on page 9 for our target populations and I want to spend just a moment with you on that and then I want to get to your point, Mr. Chair, about great opportunities for collaboration and coordination.

So if you'll look at the graphics that are on this page what they try to do is illustrate a bit about what we think are the target populations for our work. So just by way of context, every year in Oregon about 45,000 children are born, so if you're like me and you like babies, that's a really good thing. The bad news is that about 40% of those kids are born with risk factors or into families that have risk factors that place them at great disadvantage to fully participating in kindergarten and school when they enter. Many of those risk factors cross your jurisdictions with health, but we also know that most of the health-related risks are really borne out of the community, social, and family risks as well. So there is quite a bit of crossover in the target population.

That sort of puts us in with a cohort of about 108,000 kids between the ages of 0-5 that we really ought to be zeroing in on with those risk factors, preparing them as they move through their young childhood and into school, which brings me to these graphics. Of those 108,000 kids, the Early Learning Council believes that our best investment is by prioritizing three overlapping populations of kids: those kids who are significantly economically disadvantaged or live in families in poverty, those kids who are children of color or belong to families of color and by that we really mean all ethnic and racial minorities, not just African American for example, and then kids whose families are already receiving some sort of state supported help. So families whose kids are in Medicaid or whose families are on Medicaid. Those are overlapping categories and those are the highest populations for this Early Learning Council.

Now If I could redirect your attention to pages 4 and 5, this is really the bulk of an executive summary that outlines the recommendations of the Early Learning Council and now the Oregon Education Investment Board to the legislature, per Senate Bill 909. So there's a lot of detail that goes behind these recommendations. It's put together in this 80 page report, with attachments. But those that are highlighted here are those that I think represent particular opportunities for coordination as you look at your implementation plans going forward.

So let me just highlight them as they are highlighted here and then see what kinds of questions you have and what kinds of opportunities we might be able to gin up for a bit of coordination across them. They're not going to be unfamiliar to you. So for example, starting at the bottom of page 4, we are-- through Service Redesign for Early Learning and Early Childhood programs-- wanting to use a hub concept. We're calling them "accountability hubs," and in your world they're called community care coordination organizations or coordinated care organizations. So we have the same sort of concept that
care is organized and delivered through these hubs using what we call family resources managers, which you call care navigators.

So they're very similar concepts, grew up independently but again they're very similar in terms of how we might even implement them. So you'll see that the second bullet from the bottom that's highlighted on page 4 even talks about forming these hubs through the issuance of an RFP, which I know there's been some conversation with this board as well.

As an early learning council, we also will be responsible for organizing and aligning services and setting outcomes standards and policies across all the early learning programs. You're in somewhat of a similar position, and because we believe that one of the sets of outcomes we ought to pay attention to is health, we think we have a lot in common with you. We'd like to forward for your consideration the notion that we are able to place orders with each other, that child health outcomes ought to be a responsibility for the early learning world and we believe early learning ought to be an outcome that is important to you as well. We don't believe that we can separate them and so as we're working to set outcomes we would like to work in concert with you as we do so.

You will see then that in the process of-- if you look at all of the recommendations-- that in the process of doing all of that coordination and alignment, we're not recommending a new agency or budgetary control but we are recommending that policy direction for a set of programs be governed by the Early Learning Council. Two of those that may be quite of interest to you are on the top of page 4, home visiting programs and some health and nutrition-related programs.

Moving now to page 5, we've talked about coordinated care organizations but embedded in these recommendations is a recommendation that we identify those 40% of children as early as possible in their life. We would like to identify them prenatally if at all possible at birth, if not possible then as soon as possible thereafter. So we think that that is a pivotal place for connection with you and the work that you are doing. We know that in Oregon before kids enter school they really consistently-- besides with their families-- show up in two places: they show up in the healthcare system somewhere and they show up in childcare. So many of these recommendations have to do with alignment with childcare and developing a childcare workforce that is able to do that. We'd like to have connection with you through that screening and the early identification processes that already happen in healthcare settings so that there are referrals and connection for those social supports and social indicators of health that really are the jurisdiction of the Early Learning Council.

So with that I'll stop, I've said quite enough, and see what questions you have and what ideas you have for how we might be able to make better connections as we both move forward with implementation.
>>SPEAKER 1: Thanks, Pam. Questions?

>>NEW SPEAKER: I just have one: do we know how many kids we're talking about right now?

>>PAM: We have an estimate of how many kids we're talking about right now. As a cohort between the ages of zero and five, we're talking about somewhere in the neighborhood of 108,000 children.

>>SPEAKER 1: Yes, Eileen?

>>EILEEN: I haven't read this completely, but data collection? Is there a way or have you looked at any particular metrics that we could literally share and collect together, jointly, and then manage our outcomes based on?

>>PAM: Yes, thank you for the question. We actually have a couple of ideas about that. In terms of the metrics question and then the data question, I'll take them separately. So on the metrics side of things we've organized our thinking into five developmental domains around Early Learning. One of them is health-- I won't be able to tick them all off-- it's health, literacy & language development, it's parenting & family support, etc. Certainly we would like to measure outcomes and hold the entire system accountable for achieving those outcomes, from the Early Learning Council through the delivery of services. So we would absolutely love to have the conversation with you about how we measure the same...how we think about child health in the same way and how we measure that in the same way. On the data side, embedded in this is a series of recommendations related to an interoperable data system. We have 16 different data systems in our Early Childhood programs in the state right now. We'd like to make those a connected, interoperable system and we'd like to connect it to the K12 system on the one end and then we'd love to make a connection to the work you're doing on the other.

>>NEW SPEAKER: I think that would really be a way to combine efforts.

>>SPEAKER 1: Absolutely. Common data, clearly we have common concerns and common opportunities.

>>EILEEN: It might interesting to go so far as to say that having children ready to learn--Ready to Read, isn't that one of the metrics you guys are focused on?

>>PAM: Yes, so we have "Ready to Learn" when they enter kindergarten, Ready to Read in first grade, and...

>>EILEEN: Be interesting if the healthcare side of this actually took on some joint responsibility for those particular targets.
PAM: Would love that.

SPEAKER 1: Other comments or questions? Lillian?

LILLIAN: Thanks, Eileen. That's the question that's buzzing about, as you know, questions around that. We have a presentation later from Carol Robertson and I just want to know if you all have interfaced with Carol's group, the Oregon Health Information...

PAM: No, we have not.

LILLIAN: I think that it is important to have somebody reading what they're doing because we can want to do these things but we might be able to identify places to start. Number two, the other question that is definitely on the minds in the community the dollar amount and the service delivery. People are concerned that there may be double dipping in the counting of savings between the work that we are doing and the work that is projected. So can you address that? Has that been looked at and isolated? I know it says you don't want budget authority but people are adding things up and coming up with a number at the bottom.

PAM: Yeah. Actually, Lillian, thanks for the question. There are a series of recommendations that you'll find in here; I did not speak to them all. To just pull out one example is a suggestion that we spend the next six months accounting for line item by line item for those programs, and differentiating those that seem to be best to be delivered via this hub system mechanism vs. those that may stay or better be served at the state level. Then how do we make the connections so the families get what they need rather than having to go through multiple channels to get their needs met.

SPEAKER 1: Tina?

TINA: I just wanted to offer that our CIO, Cameron Lawson, has been talking to the Department of Education to think about how we have interruptible data, there are some Federal laws that interfere with our ability to do it immediately but they are doing some creative thinking and I think it will be a real opportunity for us.

PAM: Great, thank you.

SPEAKER 1: Palma, thank you for the great work that you're doing and for joining us today. Obviously we need to maintain connections at the board level but also at the staff level, so we will talk about how to go forward. Thank you so much. In my introductory comments I should have mentioned that Bruce is with us, he is in that little silver box at the end of the table next to Tina and he is up for item number three, which is the CCO implementation program proposal. Bruce?

BRUCE: [Garbled]...I'm in an Airport in Washington, DC, on my way back, so...
SPEAKER 1: At least you are going in the right direction.

BRUCE: Right, heading in the right direction, but I can only be on for just a little bit more. But what I wanted to do was frame up just a little bit of work that we're going to be doing today, and to introduce Doug from Health Management Associates. The bulk of the work today, and the bulk of the work for the next two months is going to be really making our way through and continuing to revise the draft proposal. The board members received the draft proposal last week, and I cannot stress enough that these are initial recommendations, that there's going to be opportunities to continue to refine what really is this initial draft. I think that everybody knows there's an opportunity for public comment, now through January 3 we're going to be presenting this to a joint legislative subcommittee on December 20. Following that, we will revise this draft once again, and then we have a meeting on January 10 and then following that meeting there will be an opportunity for one more week for feedback from the 11th through the 18th and that will culminate in the last week of January of the board finalizing what will be recommendations that will go to the legislature. So I just wanted to be certain that we had a clear sense of the timeline, for both the board members and the public.

At the last board meeting there was a robust discussion about governance, community needs assessment, [? equity 19:13] and global budget and the results of those discussions as well as feedback from more groups within the general public is what is incorporated into the initial recommendations the board has brought for them today, and that there will be more discussion about other pieces today.

The last thing that I want to touch on is something that is not in the initial draft that you have before you but that is on the way, and that is an important piece of the proposal, the estimates of the value we can achieve with the kinds of delivery systems change that we are undertaking. We have got a placeholder estimate, which is $239,000,000, which I just want to reiterate is the State portion. There is an accompanying Federal portion fund portion which brings the total up to about $600,000,000. Each board member in your packet has a copy of an executive summary with some work done by [garbled]. This was done for the statewide Health Leadership Council and really was thinking on Medicaid data, it took all of our state's Medicaid claims data including fee for service and managed care and benchmarked it against some benchmarks that [Hillman? 20:49] has for high performing Medicaid systems.

They were only able to do that benchmark for about half of the OHP population, primarily kids and [garbled] adults. So it is about half of the expenditures and it is the population that probably has the least amount of chronic illness as opposed to adults with mental health issues which were not included in the estimate. What you'll see from that estimate is that looking at in essence half of the OHP population, it was their conclusion that we had a moderate performing Medicaid system and that moving to what they considered to be a high performing Medicaid system, with national benchmarks that
already have been achieved would say that for the part of the population about $140,000,000...again, didn't include the duals and likewise didn't include some of the more transformative issues that we're thinking about taking on in the Coordinated Care Organizations.

The work that is being done by Health Management Associates, this is a national expert firm that does a lot of for states, has done a lot of work here in Oregon for the Health Leadership Council, for several professional associations. And Health Management Associates is working to provide an estimate the kind of value that can be created by the changes that are being proposed in House Bill 3650. We'll have those numbers at the January 10 meeting. I want to be publicly clear about something that we had talked to the HMA and the team about, which is that we're not asking them to back into any number. We're not asking them to back into 239, we're not asking them to back into 600, we're asking them to really use their expertise, use their experience, use their judgment and look at all the information that they have-- nationally, the Oregon claims data, all the information that they have-- and give us a sense of what we might be able to achieve in efficiencies and savings but also over what kind of a time frame we will be able to do that.

So with that it is a privilege to introduce Doug [garbled 23:47, Allwell?], who is one of the principles in Health Management Associates who we have been working closely with, and a can describe the approach HMA is taking to develop those savings.

>>DOUG: Thank you, Bruce. This is Doug [?], calling from the beautiful state of Indiana today. As Bruce said, we are starting with no preconceived notion of where we have to end up. We are basically using the [Milliman] data as a starting point and we're looking at various evidence based programs that we are aware of for potential to apply in Oregon that could yield savings, as well as just based on our experience. We have a lot of physicians, and as Bruce said, a lot of experience working in a number of different places and we're going to take that evidence as well as expanding the environmental scan that we have already completed in the Portland area, but expanded for the entire state so we can have a good feel for Oregon's situation is and a good feel for what some of these evidence based medicine changes could have on Oregon, and what that savings number could be in and then work to determine over what length of time. Obviously some things are harder to do than others and will take a little bit longer than others, but we don't start with any numbers we're basically going to come up and say based on working on this, this, this, and this, this is what we think you can achieve over this period of time.

>>SPEAKER 1: Doug, that sounds just right. I appreciate your good work and look forward to seeing some more in January. Are there one are two questions for either Bruce or Doug? Joe.
>>JOE: Well I don't know who the question is for, but I presume this is the time...because I think this topic and the next tend to run together but if we are discussing this document at this time then I have two questions.

>>SPEAKER 1: We're going to spend a good share of the second half of the meeting in this document but if there's something specific to the HMA work, and this would be the perfect time.

>>JOE: No, I will say...It just matched with the title on here.

>>SPEAKER 1: OK, got it. We will be back.

>>JOE: OK.

>>SPEAKER 1: Other questions?

>>NEW SPEAKER: He is a lot smarter than I am-- he only has two questions on that document.

[Laughter]

>>SPEAKER 1: We have the rest of this meeting, of the next meeting, and the one after that to figure the document out, so here we go. OK. Thank you very much, Bruce, for joining us and as I said to everybody we will be back into this document shortly, and Doug, we'll look forward to hearing from you or seeing you in January.

>>DOUG: Thank you very much.

>>SPEAKER 1: So we will move to item number four and first, Linda, do you want to come up and tell us a little bit about the legislative concept and then we're going to have some comments from Senator Bates and Representative Friedman. How are you today?

>>LINDA: I'm good. So in your package you should have a two page document, the governor's legislative concept request, and it pretty much summarizes what I reported to you as our goal last meeting. The actual statutory changes we're proposing are on the second page. One is basically to get an official legislative approval that says we're good to go, and the second is related to assuring that there is adequate information sharing between DCBS and the Health Authority, particularly around financial solvency and those issues that are still frankly to be determined, but to make sure that we have the legislative approval to do that. We worked within an existing DCBS statute, and just at the the end of that statute adds specific reference that and allows the information sharing the DCBS and the Oregon Health Authority. So that is really all that I have to report; it has been submitted to the legislative counsel's office and we are waiting to see what they say about it.
>>SPEAKER 1: Very good. Questions of Linda? It is a relatively simple concept, we just need to make sure that we have an implementation proposal that works.

>>LILLIAN: Can I...?

>>SPEAKER 1: Yes, Lilian.

>>LILLIAN: Hello, Linda. I have gotten a couple of your emails and I just wanted to ask a question for clarity to make sure that I'm on the same page. My understanding is that our legislative concept as we have it written here is really rather simple because what we're trying to do is implement what the legislative gave us in House Bill 3650. So really that is our legislature that we're trying to move forward, and we're not rewriting things here. Because I feel there was some confusion and questions in the community about "well, this is awfully brief..." for healthcare transformation and when I got the packet, I was thinking that it goes back to the years' worth of work with the legislature last year and that is still our guiding North Star, implementing that. So I just wanted to bring that up.

>>LINDA: Yes, that is correct. The legislature, House Bill 3650 in and of itself is pretty complete. It is setup in statutory form and it is basically good to go but the legislature put a stop in there and and said "Bring us back the plan, we want to make sure." This is really saying that assuming they have completed their review, but they agree, then it really is time to go. Until that approval is received there are any number of pieces of 3650 that are on hold, including seeking Federal approval. So does really just up the belief that the bill was basically complete; they just wanted to see more details. As has the get the green light, it is good to go, and that is our perspective.

>>SPEAKER 1: OK. That is a perfect segue into our next conversation, and that is that this all goes forward if in fact the legislature approves our implementation plan. And so Senator Bates, and Representative Friedman if you would like to come forward, obviously we have got a significant input opportunity in front of us during the coming month: another meeting, another public input opportunity. But we wanna make sure that we are on a track that is not terribly dissimilar from what the legislature is expecting, and so thank you for making time to join us today and we're looking forward to hearing your comments.

>>SENATOR BATES: Thank you and thank you for having this year, appreciate the time you're taking to listen to us, and what we would like to do was make a few comments and then take questions. I think I'm going to lead off...

>>REPRESENTATIVE FRIEDMAN: Briefly let me also thank you for having us here and let you know that Senator Bates and I have traveled the state and done this dog and
pony show together and today he is the pony and I am the dog, so with that you can get started.

>>SPEAKER 1: And one more interruption, I want to apologize for Representative Friedman-- we met earlier today and he had one request and that was that the room temperature be somewhere around 62 to 65 and in this small room with this many people I do apologize, it is just not going to happen.

>>SENATOR BATES: Thank you. I'm going to try to lead this off and then the good representative will come in behind me and correct my ears and make sense out of the whole thing. We're going to try to do a couple things today. We're gonna give you some idea of what the legislative intent was with 3650--sometimes what is between the lines is more important than what is in the lines and so we wanna go through a couple things are. I just wanted to say that I'm always a little fearful when I'm asked to give legislative intent. There are 90 of us up there and on any given topic there are 180 opinions because we are all schizophrenic and so I'll do my best to show you what I think the legislative intent was and surely what mine was, as we've had discussions with other legislators as we were leaving session and around the state. I think it is much clearer in some of our minds what some of us meant and what we were trying to do with it. I'll do the best I can to.

First, I would like to talk to you about the requirements for a CCO and how you could reach what those requirements are. I really believe, and I believe most people believe, that there should be two tracks getting their. The first rock would be a fast track for the present MCO's, if they've had a five year or longer experience and the reason we're thinking this way is that we have a very short timeline to form CCO's, and they're going to look different in each community across the state. We've already known that from going around the state and I'm sure that Tim will comment on that also, but if we don't have an ability to move some of these forward quickly we're going to have some serious problems just from a timeline of what we have to save in the budget and moving us forward with waivers and other issues involved, as you are aware of.

And there are reasons to have a fast track for an MCO. In our state, I don't know of any organizations that first off have the experience of handling risk on a regular basis for the Medicaid population. They have done that for 10 years and they have done that quite successfully. They've already worked with other partners, hospitals, managed care organizations that take care of mental health and drug and alcohol and dental care, they have had a lot of integration there and it varies from place to place sometimes. Some are very broad in what they do, and some of them are smaller, but they have done a lot of things that we need done for a CCO and for the most part I believe they're going to lead the pack on this and are the ones we're going to have to rely upon to get this done quickly. So I'm hoping that we will be looking at something as we go forward with the Oregon Health Authority with deciding how requirements are laid out and how someone
qualifies as a CCO, with one track that is a fast track for existing agencies or the organizations that have the ability to do so.

The second track would be as you would expect the kind of things that you have to go through to prove that you can handle the risk, handle the reserves, and that you can actually get this job done, have enough experience somewhere with integration that you can do these things. I think that that is the key thing, those two tracks, and that one should be considered very clearly before going forward farther than that.

The other thing is the actual integration of care, and I'm assuming by this point that you have had enough discussion to have some concept in your mind of what that really means, that to really bring integration in across a broad group of people is not a simple thing to do. I often talk about the 80/20 split, that 20% of the population spends 80% of the money and that those people need integration and need support, they need help. I firmly believe that-- in my other job as a primary care physician and Chuck and others here may agree or disagree with me-- most of my patients don't need a lot of management, don't need a lot of guidance, they can take care of it, but a significant population really does. Getting them into the right care can be a real battle. Making sure they take the right medications, getting them to quit smoking, do the things they need to do to get the system really working for them, lining them up with mental health and other issues is really something difficult to do and this was where a CCO really shines in can really do a better job on the triple-aim. Other than that I think people can actually be pretty much left alone.

Want to give you an example of that, too-- and again, the physicians here may disagree-- but I think you have all probably gone through this experience...As I traveled around the state, I always thought of my own practice to make something real to people who are not practitioners, who are not actually in the system or working down in the trenches like I still do, and unfortunately it is still pretty easy to pick one out without much trouble. About six weeks ago I got a call from a local hospital, and I'm going to tell you from the beginning of the story that there are no bad characters in here. Bad system, no bad characters. I got a call from the hospital about a patient that I had never seen before, never heard of before and they're calling me because the patient was on his fourth or fifth hospitalization last year, and the person calling me was a hospital physician who said "there's really no reason why this person should ever have been admitted to the hospital at all and this is his fourth or fifth admission and if we don't do something different this time we're going to see him back here again in a few weeks.

We found out later the reason that they had called me was that the system had made a mistake and said I was his primary care physician, so that's just another issue to deal with. They told me the situation: a 55 year old white male with an IQ of about 45, he has chronic schizophrenia, is barely verbal, has been living for 18 years in an assisted living facility and actually doing pretty well until the last year, when he'd gotten an infection and had some problems. He had been admitted four or five times to the hospital for
constipation. Each one of those hospitalizations at about $10,000 a day is probably $100,000. So we have blown $400,000 or $500,000 on this patient before I ever saw him and he kept getting sent back to his assisted living facility and they couldn't deal with him anymore and they didn't want to deal with him anymore but they did not know how to get him somewhere else.

So being the eternal optimist I thought "Well, this is going to be very easy to fix. I'll make a couple of phone calls, we will find a nice nursing home for him to be in, probably one with an Alzheimer's wing where he can get proper care and won't to go back into a hospital. Well I'm also naive sometimes, especially for being around this long, so we started calling around and my staff chewed up about 20 hours of staff time and actually found two or three places that would take him because he's Medicaid, and then we started trying to place him. What we found when we tried to place him was that he was in the system as a mental health patient any could not be transferred to a nursing home, he had to be transferred to either a state hospital or back where he was. Well, state hospital is about $280,000 a year and that is money that is not matched by the Federal government and it would be a terrible place for this guy. Terrible place for him. So we had to go to the DHS and find out how we could transfer him from a mental health hold for his schizophrenia and get him put into the physical health side so that we could get him into a nursing home.

By the time that we had all that done--which was a real process to do--he had been put back in his foster home and been put back into the hospital for another 10 day stay. We finally got him placed maybe six weeks later, more like eight weeks later, into a nursing home where he is being properly taken care of, is not going to be readmitted to the hospital for those kinds of issues, and is actually going to be a safe, good place for him. The total cost for this man has got to have been close to half a million dollars of lost money for a patient that was mishandled for the system and everyone who was trying to work with him-- the doctors, the nurses, the social workers-- were stymied by a system that doesn't talk to itself and can't integrate. So I don't want to take up a lot of your time telling a story but it illustrates what we have to do to change and just how difficult that difficult that change is probably going to be. Even in a simple case like that, where it is straightforward and obvious what needs to happen. The savings in the system I do not think the can actually be calculated by the actuaries because they have never had an opportunity to see this kind of system actually work. So whatever numbers you might be getting, I am not sure they are correct. I have had some actuaries tell me that we are in a new area here when you guys start talking about a CCO, a true integration of care, and an incredible savings that could potentially come from this and the improvement in patient care. So I'm going to stop there and let Tim pick it up but I wanted to share that story with you in case you had any doubts that we're going in the right direction, that I can settle with you and give you case after case after case and Dr. Hoffman and others here may be able to do the same thing. We want to stop that kind of practice and want this to work. We want to be efficient and we want what is best for our patients.
>>REPRESENTATIVE FRIEDMAN: Thank you, Dr. Bates. For the record, I am not that patient. Just to keep it straight.

>>SENATOR BATES: Except for the schizophrenia.

>>REPRESENTATIVE FRIEDMAN: So as we started this process and I've gotten to know is it's as quite a few of you and sat through many meetings together, it dawned on me very early on that words matter. One of the first things we did was get off of the word "Accountable Care Organization" and talked about "Coordinated Care Organization," really to better describe what we're trying to do here. If I had to do that again I would talk about one more "C" and talk about "Community Care Organizations." Now you all have continued to talk about the need for community buy-in and ownership, and we're going to continue to talk about that and I believe that will be the success of whatever we do. The other word I wish we would have caught and could be more descriptive of what we're doing, and can be a little bit misleading on what we are currently using is the word "transformation." We should have called the "evolution." We should really have talked about all the great systems we have in place now here in Oregon and how we're going to evolve those to make them work together in a better way. We should talk about what we're going to evolve as best practices around the state into some sort of shared mechanism so that we can learn from what others are already doing in innovation is that we are already seeing around our state.

Dr. Bates talked a little bit about the traveling we have done around the state and some of the we have talked to. Each of the groups could give an example like the one Dr. Bates gave on the problem, and they could also give an example of what their organization is doing that is innovative and what they would love be able to do if not for the government being in the way. So really the challenge as we move forward is to allow enough flexibility for our communities and our community organizations to be innovative, but as a legislature having enough accountability to the taxpayer to make sure that what we're getting done makes sense. So you have to have the flexibility, but you have to feel that for the billions of dollars we are spending we have some measure of what we're getting. That is really the broad challenge of what we are doing.

Quite honestly, as a legislator and recognizing that the legislature oftentimes has trouble handing off staff for allowing other people to in charge of it...I see that being a very tough spots to get to, the perfect spot, and we may not get there in February but we can get close and allow some work to get done and come back in 2013 and 2014 and further adjust and this evolution of healthcare delivery systems may take some time. If there is any silver lining in this budget crisis and with the number of people who say they can do it better, I feel like we're going to move forward. It may take a little bit more time than between now and February but I'm convinced that we will move forward. I'm very blessed that my community-- and I represent part of Douglas County, Josephine, and Jackson and I actually live in Douglas County-- and we are really fortunate there that when we talk about integrated care if it is going to be much easier than in some other
parts of the state. We have one hospital, we have one managed care organization, and we have one county that does mental health, we have one drugs and addiction provider, we have one federally qualified Health Care center and we have one dental program. So you don't have the competitiveness that other parts of the state are going to have.

That being said, they are all competing for the dollars that we allocate, so there has been some trust that has been developed over time and I'm feeling very confident that there will be areas of state that will be ready to use what Dr. Bates described as the "fast track," and I think we would be wise to figure out a way to let that occur.

I wanted to talk a little bit about my vision of what a governance model, recognizing there may be many different governance models but I think it is important, that we are at that point in time where we have to start talking about examples of what are going to be coming up so we can get the legislation broad enough to allow for its these things. So as I describe this please don't take it as the only way to do it, but it is deftly one way we can do it in the community and I would also is say that this is a way my community would like to do it. So a governance model could include each Coordinated Care Organization has a structure that includes the majority of interests consisting of persons that share the direct financial risks. So the people on the board have to share the financial risk of the decisions that they make. The majority, not all of them, but the majority and of course it would be subject to state and Federal laws. I know Dr. [Goldridge] back in Washington today is continuing to work on that.

I think it is important on the community aspect for the community to have board members, large members. So at least two of the members, I believe, should be community members so that you have that community buy-in and that ownership that will be required to make this work. I think it is vitally important that we have at least one member that is on the full board that is part of the community advisory council, which I will talk about a little bit next.

As we look at fast tracking, we have to realize that we're going to have some organizations that already have a board structure in place and I'm ok with that moving forward as long as they add those community people and those advocate/patient type people. I think it is important that we don't get extremely proscriptive on what type and who should be on these boards. It really has to be developed from the community.

I wanted to spend a little time on the actual advisory committee, the makeup and the role I see them playing in this, because I really think this is key to making the successful is to make sure that those people that are receiving care have a voice in how that care is going to be delivered. So I think all CCO's should have a community advisory committee. Again, and this could be different in different parts of the state but I think each organization should have a community advisory committee that includes representations of the community and the county governments is but it also has to have consumers making up a majority of the membership. I just want to spend a moment on the word
"consumer." Some of you have heard me say this; I want you all to hear me say this. We have to define what that word means. You all, when you say consumer, mean the patient receiving the care or the person receiving the care, I know using the patient is not the right word sometimes. Some of us when we hear the word consumer we think of the person paying for the care. So we need to define that in a way that is mutually understood by whoever is going to be doing this. I'm not suggesting that we don't want all the board members to be those receiving the care but I think there might be a role for a person on the board that maybe isn't receiving the care but as a taxpayer and to be part of that as a sounding board back and forth on the type of care that is delivered. I just think that is something, an important word that we will have to define clearly.

And they have to meet regularly. This idea of setting something up and having it not function often occurs in government structure and I don't want that to be the case here. I want there to be regular meetings and I want it to be focused on the health care needs of those people receiving the care and the community needs are being addressed. So there might be community needs that are outside of health care but impact health care and those should be discussed also within this group. At least one of these representatives needs to be from the county, and there could be will more than one from the county on the board, but it is imperative that our counties are involved, that our local governments that are key partners in our healthcare are on the board and that one of the consumer members or one of the patients need to be on the CCO full governance model that I talked about. I think that is a really important function to have somebody at the table that is getting the care and we have all heard examples or can give examples of why that is so important; I won't get into that now.

But really their role is to advocate for preventative practices, the CCO's, and to develop a wellness program for the community. That is really where I see the role for these Coordinated Care Organizations, or rather these community advisory committees, to really focus and hone in on. I think they'll be the best at telling the coordinated care organizations how wellness programs will work, what the community's needs are and how they will address that. I think it is pretty important that the meetings are public and open and very transparent, and that they take place on a regular basis. We can choose monthly, every three months, or whatever but set a defined time and allow that process to work. And then I think this community advisory committee at least once a year should develop a health of the Coordinated Care Organization report, which would review the work of the Community Advisory Committee and to make recommendations to the governance board on what to do and what to do better. I think there has to be a huge role for those people in the community that do receive this care to be a part of the decision making on how we move forward. Again, community buy-in, community ownership, is the only way I see us doing any kind of cost curve bending and taking and building upon the great things we're already doing here in Oregon and the investments on managed care and all the other delivery systems have made, we need to take advantage of that investment moving forward. So I'll turn it back over to Dr. Bates.
SENATOR BATES: Thanks. Three other topics to cover quickly and then we'll take
questions. Hope we're not burning through all of our time so we can take more questions.
One issue is the global budgeting. This is going to be a really big part of this and in some
ways perhaps the most important part. Right now we have [silied] budgets up and my
example gives you the difficulty with that and as we go around the state and talk to
people about this I often find that afterwards, after the meeting is already over somebody
will come up to me and say "Well, I understand you're talking about a global budget but I
don't really want my budget cut and I'm not sure that's going to work." That's the kind of
issues you've got to get past. The global budget has to be set in a way that's reasonable
and the CCO really has to have an ability to move that money around as they see the
greatest need and the greatest integration. That's a tough one but it can be done and must
be done. The MCL's have done that so far pretty routinely and pretty well but they're
doing-- for the most part, not all of them-- family care, a couple of them being big
exceptions. They basically said we can manage physical health as complex as it is and
we've been successful in doing that, now they've got to step up and do something much
broader and actually with more meaning, and so it's going to be interesting to see it
happen but the goal budget is important and we want to make sure it is set in a reasonable
fashion and then followed.

The other issue is the arbitration of issues. This is going to be tough. There are two levels
of arbitration I think of: one is inside a CCO. What if inside a CCO a hospital or managed
care plan that takes care of mental health or dental plan can't come to an agreement with
the CCO about moving those funds around. How do you deal with that? I really think you
have to set an arbitration system outside that they can all go to if they need to and solve
it. There is another level of that also and one we've dealt with before and not very
successfully, where we have managed care organizations who feel that they don't have
the right rate setting for themselves, the right global budget for themselves and then there
is a battle between them and the administrative part of the state government. The
arbitration for that ends up being the state legislature and I will tell you that we are not
good at that. We don't want to be doing that, but right now we don't have a good way of
doing it and it becomes a political fight every time it comes up. It's a fist fight on the
floor and it is ugly and it doesn't necessarily get the right people the right rewards. So we
also have to think about an arbitration system in that arena, that both sides agree to. The
last piece, or maybe the next-to-last piece, really, that Dr. Goldberg spoke to is how you
go about doing your metrics and assessments of the CCO's. This has to be done carefully,
also. There clearly should be-- I believe-- a committee of experts set up to sit down and
decide what those metrics are. They should be broad enough that they cover the CCO's
and what they're trying to do and they should be narrow enough that they're meaningful
and they should not be bureaucratic.

I'm going to give you an example of what my concerns about that are: right now, our
managed care organizations, our mental health organizations, I should say, are working
very hard to get rid of an incredible amount of bureaucracy they have to go through to get
their job done. Some of these organizations for reporting-- again, metrics-- are spending
40-50% of their time reporting to the state and not in taking care of patients. We're working very hard with the agency and with the plans to try cut that back down to what it should be. As an example, I spend 10 or 15% of my time with patients as far as reporting paperwork. I claim to my wife that it is 90%, and she says "I've measured, it's 15%. So that's the truth, but the real truth for mental health is somewhere around the 40% mark, maybe more in some areas. That makes them ineffective. They do the best they can with very difficult patients but when we are requiring them to report that much, then it's really hurting them. We don't want to end up doing that with CCO's, so let's learn from that and not get into that area.

And the last thing I'll say is what I think a may happen in February is we can make 36-50 alive and active just by pulling one section out, section 13 out and saying go do good things, we trust you all, my children. I don't think that is going to happen. This is the way I have envisioned this and that is probably a bad way to speak to it, but I'm going to speak to the way I think of it. This CCO's are going to be like race cars in NASCAR; we're going to drop a green flag out there for some of them along the line and they're going to take off, at least I hope they are. I don't want any winners or losers and I don't want any crashes, I want everyone to cross the finish line at roughly the same time, but some will be ahead and some will be behind and some will be in the middle of the pack. I don't feel that the legislature's going to be completely comfortable with completely turning that race loose. Somewhere along the line we're going to just want to drop a yellow flag, and slow things down, and make sure things are OK. That may mean coming back in reporting to the emergency board or there may be some other way of dealing with it, but just dropping the flag and saying I will see you in 2013 is something that most legislatures are not going to feel comfortable with. There's too much money involved, there too many chances for fiery crashes and I don't want that to happen. We want this to be a successful race for all, with some leading the pack and some following but everybody gets the checkered flag of the variant. That may not be a very good parallel but since I've watched quite a few NASCAR races is...but I don't want that to happen. We will be giving you broad authority to move forward-- I shouldn't say you but rather the administration-- but there will be some caveats before everyone feels comfortable. Tim, you may want comment on that more.

>>REPRESENTATIVE FRIEDMAN: Part of that balance to be met between the legislature comfortable enough with what we're doing to allow it to go forward as in yet also allowing enough flexibility in the community to make it work. One of those things about handing it all off to the agency to move forward, that level of freedom with the agency to work will be beneficial to the process but it could also alienate a certain group of legislators and cause problems in the future. So as we move forward I think it is important to stay connected so that this evolution can move forward in a way that everybody is on board with. Earlier today in a meeting we talked about how there was broad bipartisan support is of 36-50. It is easy to talk about the bipartisan no votes; there were two and one on the no-votes, so it was a huge show of support in the House, I'm not sure about the Senate...
SENIOR BATES: I think we had two no's. About the same.

REPRESENTATIVE FRIEDMAN: So the fact is that in the current concept, the current form, you do have a tremendous amount of support around the state. Moving forward I just think we need to be careful to keep the legislature engaged so we don't come back in 2013 and have some big blowup in the meantime with one community and all of a sudden the whole thing goes into the tubes. So we'll figure out that balance out, I'm confident we'll find a way to work through that.

SPEAKER 1: Thank you very much. Obviously very important and very helpful thoughts and advice and something that we need to make sure we're taking care of. We have just a few minutes, have a phone call that is timed at a certain...at 10 after, but we have a few minutes for questions. Chuck, first, and then Felicia.

CHUCK: Well, thank you Mr. Chair, and thank you, gentlemen. I was a little apprehensive when I saw you on the agenda for fear that you were going to come in and blow us all up but I'll be honest with ya, as a member of the board I think what you're talking about is exactly what we've been talking about. I haven't heard anything that is contradictory to the direction we've been going. So I think you're going to be very happy with our business plan. I'm a little confused, Senator Bates, on the fast and the slow track. Are you anticipating two application processes, where you expect that the fast track would be one process and the developmental organization would be different...I'm a little confused how we would recommend the fast track process actually working.

SENIOR BATES: The fast track was left to have criteria in it, but to qualify for it they'd at least have to have a five year experience of handling risk in these populations and be ready to step in and show that they have expertise to do it. It wouldn't be automatically if you have five years' experience, but that experience is key, it is unusual to have in most states. We have it in this state and we need to take advantage of that. I'm afraid that if you're trying to build 10 or 15 of these, whatever the number ends up being across the state, up from scratch then I don't see how we get there in July, I just don't see it happening. It's too complex, so allowing for a fast track for those organizations already in place with criteria for them and a little different criteria for the slower track organizations, those starting from scratch, I think is a reasonable way to move forward. You don't exclude people but you do give the advantage to those people who have done this before. If you ask me to go build a new car for you tomorrow and I've never done one before, it would take me a while-- or actually, it wouldn't get done, but that's a different story. When you take a manufacturer and you want them to change their line, that's different.

CHUCK: I guess that one of the criteria that I would suggest is that the degree of integration experience of that organization is important, too, because if I want to build a car and I have a company that only makes tires, I don't know what I'm going to get out of
it. So I think that would need to be a criteria. And Representative Friedman, as I've thought about this, because county government has such a huge stake in mental health care and community activity, I've wondered if there ought to be a designated slot on the actual governance board for County representatives-- whether it is the County Chair or whatever-- rather than just on the community advisory committee. Do you have any...I know you mentioned it on the...

>>REPRESENTATIVE FRIEDMAN: Thank you for that question, because the county issues is one that we've been an inordinate amount of time on in developing the bill and trying to figure out where that works. And really what you end up with is if you say that every CCO is going to have a County person on it, then you're doing one-size-fits-all for the state. You've got some counties that put zero dollars that they put into Mental Health, and you've got some counties that want to give away their Mental Health Authority altogether, so the idea of leaving the flexibility...in some areas where the counties are very involved in delivering mental health and other services, they're likely to be on the CCO board, that would make perfect sense. So trying to be proscriptive and say "OK, every CCO is going to have a County person on it" doesn't work, but then trying to say "OK, well we don't want any county people involved" doesn't work either. So what I suggested...and I'll tell you the interesting thing in my county is that the organization that'll be formed will have a county person if not a county commissioner, the county health director will be on the CCO. But maybe down in [Curry] County or over on the coast or in eastern Oregon, maybe the counties won't want to be...they may not want to be on the board. I agree that the counties have a role to play, it is just hard to figure out a one-size-fits-all for the state.

>>CHUCK: Fair enough.

>>REPRESENTATIVE FRIEDMAN: I don't know the solution. I know up north here it is pretty important for the counties to be involved.

>>SPEAKER 1: [Felicia?]

>>FELICIA: I have a question about...I feel like I have spent so many nights with the two of you...

[Laughter, "Whoah, whoah"]

>>FELICIA: At meetings. With your families. Shock. You and Mike, every meeting.

>>MALE SPEAKER: Late night meetings.

>>SECOND MALE SPEAKER: Too much information.
>>FELICIA: I have a question about accountability. I feel like we're headed down a path...we have talked about the amount of dollars, the amount of trust that we are placing in these organizations, and what I have really struggled with is that if you have an expectation of cultural change-- which is really what we're asking folks to do, creating cultural change-- there are incentives and then there has to be a path where people will, if they are not meeting the outcomes, if they are not being financially responsible that they are held accountable for the promises that they've made. I think the incentive piece is clear there, the accountability piece I continue to struggle with, about what that looks like. So I'm interested in hearing your thoughts about what that would look like.

>>SENATOR BATES: I'll start and then you can finish...?

>>REPRESENTATIVE FRIEDMAN: Please.

>>SENATOR BATES: Accountability to a certain degree is assumed, you know what it does to people. So some of us assume because we have had experience with these companies in the past, with some notable exceptions-- and I won't go into those. So you have to have financial accountability for sure, and that will be one of the easiest ones to achieve in some ways: you have a global budget, did you meet that budget? The more difficult accountability areas will be your physical health outcomes, your mental health outcomes, and making sure that populations of minorities are treated equally and fairly in these organizations. I think when you set these metrics up, that has to be part of your metrics and that is where I go with that primarily. Those metrics have to be developed not only by the CCO itself but it probably has to pass muster with the state as well. Knowing that the different parts of the state are incredibly different...I spent the last four years traveling the state with my off time and was amazed. I went and saw Dr. Hoffman up in Baker and I am glad that we drink the same beer up there that we do here, appreciated that, but there are other things that were quite different. What is happening in [Loma? 1:04:01] County, what's happening at the coast, what happens down in my area, what happens in Burns, what happens out in Paisley are all quite different and there are some inequities that need to be dealt with and this is one way of doing that.

>>REPRESENTATIVE FRIEDMAN: And then real briefly-- I know you are running right up onto the time for your phone call-- but the current system of accountability leaves quite a bit to be desired. The contractual relationship the Oregon Health authority has with organizations for physical health, mental health, all of it is really outside of accountability as far as the legislature. We have a little bit of oversight when it comes to budget process, but very little. I have to believe that a community based organization, with community board members, is going to be more accountable and responsible to their community than our current structure. I have that faith in people, and recognize-- I serve in a community cancer board and many of you serve on other boards-- that as a locally controlled and operated organization, that I have to believe that you will have more accountability and more transparency than in the current system and that being said we will have to put mechanisms into place to make sure that we're getting what we're asking
for. But also recognizing that not every decision that a CCO makes is going to be a home run, that there are going to be some mistakes made with innovation and we're going to have to allow for that and find that spot where we can be tolerant of people being innovative to get to those perfect solutions. So there is a balance to be met there.

>>FELICIA: I think that if we could spend some time on what you think those mechanisms are, I would like to hear about that. Because I definitely think that a lot people are struggling with that question: what are those mechanisms?

>>SENATOR BATES: I believe that will come out in the discussion of the metrics. The metrics have to speak directly to those issues but still give leeway—as Representative Friedman had said—to local authority. I do not believe you'll get to those communities in need and get to the needs of the community at a statewide level. Frankly, we have tried that. It didn't work very well. We have had black holes that we dropped money into and we cannot find out what is really happening out there. That is in all areas: physical health, mental health, drug and alcohol. We just didn't get the information back that you really needed to find out which programs were really successful and which ones aren't. CCO's are designed to give us that information.

>>SPEAKER 1: Joe? One last question.

>>JOE: I applaud the emphasis of the community solution to a community problem that concerns community health. I think that as Chuck said we are in alignment. I have one question about governance and one about the timetable. My question about governance: I would hope that the enabling legislation is broad enough that it would allow new types of structures to be formed, especially a health authority or a public corporation...I think there are some real opportunities to grab additional IGT dollars, GME funding. I think we really need to look at that because I think there is an opportunity not just organize that actually garner some additional funding. We have some people looking into those possibilities and we would love to talk to you about them. The second is that I'm confident about the ability for the CCO's, once the green flag has dropped, to meet the 2013 deadline. But there is another deadline and the immediate crisis is that I am concerned that they can fulfill all of the worthy criteria that we're putting on them by July of 2012 when there has to be a major reorganization to fulfill the needs of the population that needs to be served by that time. I understand the evolution of leading to a CCO ideal; I'm concerned what is going to happen July 1.

>>REPRESENTATIVE FRIEDMAN: So up just real quick, in Douglas County they up have already come together and send their bylaws to attornies to come together and agree on what is going to be their proposal for a CCO. So there are people that are way ahead of the curve and they're kind of waiting to see what we come up with to make sure that what they're doing...that's why they've shared some of that with me, that it is broad enough to allow that to happen. I guess what I would say is that not everybody is going to be ready but that those that are, we should take advantage of.
>>JOE: Yeah, we're saying the same thing. Hallelujah for those that are; we're going to have to spend some concern on those that aren't.

>>SENATOR BATES: I would go back to what you talked about earlier, too. There are communities that are stepping up faster than others, and Eugene, the area around Albany and Corvalis is. Ours is a little lagging. Others are a little faster, moving forward faster. Probably the flag has already been dropped to a certain degree. But there's going to be changed, and they're going to learn from each other and they're going to accelerate this process for each other. I think we're going to get their partially in July, not completely, but we're going to push hard. If you don't push we will never get there. If we just keep talking it will be five years from now and us saying "Well, that was a great idea." We need to keep pushing hard and make this thing happen. Do you want to tell people what IGT's are and "Graduate Medical Education" is...

>>JOE: Intergovernmental transfers and [GMT] is graduate medical education. Thank you.

>>SPEAKER 1: I think I'm reading Tina as saying we have a couple more...

>>TINA: I have one question, one comment if I could...

>>SPEAKER 1: One for you and then one for Eileen and then we'll let you go.

>>TINA: I think it goes to Felicia's comment, that there's another partner here that we haven't talked about at all and that's the federal government. I know we're looking to ask for flexibility from them but they have their own accountabilities in place and they're a majority stakeholder in this whole thing. I know we've tried as a group to think of CMS as a partner in all of this as we move forward, so I just wanted to put that on the table, too, that that's another partner that we need to be thinking about.

>>NEW MALE SPEAKER: Giving a comment back to that: in 1989 and through the 90's, our federal partners were very difficult to work with. I was only a Health Service commissioner at the time, moving the line, that kind of stuff. You would commonly run into a brick wall. Things have changed at the Federal level. They've gotten a little financial problem, as you may have noticed, and the doors are opening to have logical, reasonable discussions. Dr. Goldberg is leading those discussions and I think we're going to have a real breakthrough here. It should take us two to three years to get a waiver. The first waiver ever granted for Medicaid was here in the state, it took seven years and two presidents. That is not the way they're operating any more. I think we'll get what we need from them because they're looking to states like us to have a breakthrough in both Medicaid and Medicare, to balance this budget out and find a better way of handling the population, getting to the Triple Aim.
>>SPEAKER 1: One last one, finally, and then we'll let you go.

>>FEMALE SPEAKER: One of the more impactful conversations we had was with the workgroups, the In's and Out's workgroup we'd had, the Incentives and Outcomes Committee. They came to us with a very bold proposal about global budgets and a shared savings program which essentially is the incentives program and they were in a transition from a fee for service program to a global budget program but the way that works is with the shared savings program. I urge you guys to go back and look at that particular report, even the one page Powerpoint slide that I can still see in my head. Because if we don't implement this with some kind of shared savings program, here's my fear: somebody is going to do a great job, and they're going to bring their costs down and then we're going to punish them the second year by lowering their budget and we will have lost the war, because we want to incentivize the groups that are actually doing the good work.

>>SENIATOR BATES: I understand. That is foremost in our minds. I'll give you a quick example: in Jackson County our local people put together an integrated system for taking care of foster kids. We dropped our foster care rolls from an average of 440 a month to 240 a month. As a result, our budget was cut.


>>SENIATOR BATES: And so people learn pretty quickly not to be successful, maintain your budget at the highest possible level you can, budget that way and go forward. We don't want to go that way again.

>>SPEAKER 1: And as we talk about risk assessment and about how we currently do things, I think that initially there's going to have to be some sort of baseline risk assessment for the people that we're taking care of, but over time we're going to have to rely less and less on that and more and more on what CCO's do. If not, if you continue to reallocate on risk assessments every year, you're going to punish those that are doing well and reward those that are doing poorly.

>>FEMALE SPEAKER: Write it into the bill.

>>SENIATOR BATES: We'll nail it for ya.

>>SPEAKER 1: Gentlemen, thank you once again. I really appreciate your time and your sharing of your thoughts. I'm optimistic that we are on very similar paths, and we will stay connected. You are welcome to stay; I understand that you have busy schedules, but if you are inclined, please do plan to stay. Thank you.

We're going to move to agenda item number five. Janeane, how are you today?
JANEANE SMITH: Good. Janeane Smith, the office of Health Policy and Research. I believe we have a couple of on the phone who I will...we only have a limited window of time, I believe one of them is going to come off at 2:30, but I'm here to talk about the section in 36-50, the medical liability/cost containment section, and the work that the authority has initiated there. You will have a one page summary that is in your booklet that summarizes that, and on the phone today we have Dr. Michelle [Meadow], from Harvard School of Public Health. Michelle, are you there?

MICHELLE: Yes, I am. I must say, I'm having a little bit of trouble hearing you but I think I can follow along.

JANEANE SMITH: I also have a Dr. Kate Baker from Harvard University School of Public Health.

KATE BAKER: Yes, I am here and I am doing my best to hear.

JANEANE SMITH: In the audience, who doesn't want to come up to the table and join me yet, is Dr. Bill Wright from the Center for Outcomes Research at Providence, and the three of them are contacted consultants on this project and doing various pieces of it and they are here to answer any questions. As you can see we've outlined on the paper, we have divvied up the work because it was a large body of work. Dr. Mellow and her partner in this, Dr. Allen [? 1:15:08] are looking at some of the policy...outlining up the benefits and potential opportunities and several areas of policy related to medical liability. The medical panels, the joints and liability options to consider-- especially in this new world of Coordinated Care Organizations IP-- caps on damages, and the potential possibilities of extending the Oregon Tort Claims Act to those who are participating in Coordinated Care Organizations, and then the administrative compensation systems.

Dr. Wright and Dr. Baker are doing the analytics related to the defensive medicine calculations. Dr. Wright has a survey in the field right now, asking providers...trying to assess their behavior changes related to the concerns about defensive medicine in a couple of different ways, to ask that question. Dr. Baker is then going to use that information to look at what potential cost containment approaches we could use based on that fear of defensive medicine, of the costs related to defensive medicine. In addition, Linda [Grimms] and her team at the Department Of Justice are looking at the legal aspects related to all of these areas in terms of what our statutes say, knowing that our experts are out of state and in alignment with them and also around the Stark laws and some of the other "asks" that were in there. We have gone around the state and talk to a large group of stakeholders in the course of talking about some of our results on "Safe Harbor," which was one of the "asks" of what we had done the work on on the task force. At some point when you have spare time we can certainly go through that, but in the course of that we have talked to the Trial Lawyer Association, the Oregon Medical Association, the Patient Safety Commission, the Health Services Commission, a small
number of consumer advocates, about information that we should pass on to our consultants. So they're busy working away and we're hoping to bring you back more details about their findings by January and also to the legislature as well. So with that I will leave it to questions, and certainly tap into the folks on the phone for specific questions.

>>SPEAKER 1: I will remind everybody that this is part of the deliverable back to the legislature when they come into session, and so this is good work underway and the results are to come. Questions and thoughts? Lisa?

>>LISA: So I'm looking at this list of things that we are studying and I don't see insurance reforms. We're not studying insurance rate review for medical malpractice insurance. Is that not on the list, or?

>>JANEANE SMITH: Well, the "asks" on the list were what were directed to us by the legislation.

>>LISA: By the legislation. And we cannot go beyond that?

>>JANEANE SMITH: We have a very short window on turnaround to achieve this, so I think we could certainly open up some discussions about whether that does or does not lead to some additional work, but based on our funding that we were given and the time span we're given...

>>LISA: I guess we're going to go forward with this, and I feel like I have expressed my frustration with this topic where we continually study it never reach conclusions and we spent a lot of money doing that. I feel like as a board, the next time this topic comes before us, which I'm sure it will before the next...

>>SPEAKER 1: January 10.

>>LISA: Decade of our lives, if we could have insurance reforms included in a discussion about this because I feel like that should be politically viable, at the legislature. I feel like the medical liability task force came up with some ideas; I think we should keep moving four on some of those things to actually get something accomplished. I know that is not a question to the folks who are here working on this, so...

>>SPEAKER 1: Joe, do you have a question? Other questions or comments? OK. Made it easy for you. We'll look forward to the results in January.

>>JANEANE SMITH: Thank you very much to those on the phone.
>>SPEAKER 1: OK, we are actually ahead schedule. Agenda item number six is invited testimony. The [Schultz? 1:19:53] count commissioner, Tammy [Bainey]. Is Tammy on the phone, do we know?

[Inaudible response]

>>SPEAKER 1: I wonder if we should take a break now, maybe 10 minutes, and then resume with item number six. Be back in 10 minutes.

[Break in audio 1:20:08-1:34:40, background conversation with live mic until 1:35:35]

>>SPEAKER 1: OK. If we could have everybody sit down. [Aside:] There you go, a wine glass works too, you know...

[Side conversation continues up]

>>SPEAKER 1: OK. Item number six of our agenda. As we all know, one of the key aspects of House Bill 35-60 is the recognition of the great work that the counties are doing with regard to healthcare, public health, and so on, and so we have been looking for some input from a county perspective, so Tammy Bainey is here from [Schultz] County today. Tammy Bainey, thank you so much for joining us today, we appreciate it.

>>TAMMY: Absolutely.

>>SPEAKER 1: Looking forward to some comments and perhaps some questions.

>>TAMMY: Absolutely, and I will be brief with my introduction with what we've been working on, because I want to be available for your questions as well. I wanted to start off first of all by just saying thank you for the work you're doing, because it matters a great deal. And also starting off with saying, why would one drive six hours for 20 minutes? And I would do that because it is important and if we're going to shift what we are doing in a more sustainable healthy way, we have to have all hands on deck. So my hands are here to let you know that it matters that much. And I also started out going to Salem, so I'm happy that I made it to Portland. I'm directionally challenged, so thank you for the coffee.

First and foremost, I wear a few hats. I'm the county commissioner, but I'm also the chair of our Central Oregon Health Council. That is essentially our drive toward looking at population health in our community. The members of that board, for those of you that are not aware, are Jim [Diegel], who is the CEO of our hospital system in St. Charles. We also have Dr. Steven [Mann], who is part of our independent provider network, he's the chair of that work. We also have a consumer advocate, Linda McCoy. We have three county commissioners, one from each of the counties, because we are a regional approach. And then we also have Dan Stevens, who is the designee for [Ken Proventure].
I share that in that we have determined that whether or not the state or the federal
government takes a look at doing something around healthcare reform, in our region it is
important enough for us that we are out on that path and we are going to do it regardless.
So we appreciate the partnership, the dedication, and the drive that you have given.

One of the other hats that I wear is as president of the Association Of Oregon Counties,
and so I understand that the word "flexibility" is one that you have heard already today,
and I'm going to underscore that, star it, because counties are different. And Ben Boswell,
county commissioner from [?] 1:38:50] would tell you if you've seen one Oregon County
you have seen one Oregon County. If you have seen one region, you have seen just one
region. Our region is going to be different than other regions. We need to not, as counties,
as looking at our counties as being divided by boundaries that more by access to service
for those that we're serving. We essentially serve the same people: we are talking about
Oregonians. So for us in the [?] :55] county area, it's not us or just [Crook] and
[Jefferson]; we also have a section in Klamath county that is very close to us. Should they
have to go to the Klamath County clinics, driving maybe 100 miles, or should they be
able to just cross that border-- which nobody really knows when it happens-- we don't
have a welcome sign, "welcome to Las Vegas." It is about making sure that our
community members are healthy, and that they have their needs met. So I just wanted to
be here to say that we like what is in 36-50, we like the flexibility, not all counties are
going to want to be at the table, but they need to be able to have that initial conversation
about what it would look like. Because if we're only going to the Medicaid/Medicare
populations, then that is one thing, and maybe there isn't a role for counties to just be at
the table for that. But if we are truly looking at bending that cost curve, truly looking at
shifting population health, then we need to be talking about tobacco prevention, we need
to be talking about HIV prevention, we need those public health components. We needed
be making sure that we're looking at our land use and that we're looking at entire
population health and how we get there together. It is not just that we're coming to the
public without a dish, either: we also have the opportunity to prepare grants and write
grants. We have the opportunity to bring general fund dollars, flexible dollars,
unrestricted funds. I'm here to let you know that we are ready and that there are a lot of
unanswered questions. I hear from my colleagues around the state, "well what about this?
Or what about that?" Well I don't know. But I do know that if we do not have sent our
county boundaries and our hats that we wear, per se, when we have the conversations--
whether you are a provider, a county hospital, whatever it might be-- we have to think
about things differently in order to get where we are trying to go. So with that I will open
it up questions and I intend to be pretty unfiltered so you can ask me anything.

>>LILLIAN: Thank you so much for coming. And I have a couple spare bedrooms...

>>TAMMY: You know, I was in Portland yesterday and I drove all the way home
because I have a beautiful daughter, she is 11. So getting home and driving her to school
and being there is...thank you, though.
>>LILLIAN: Well, next time you can bring her too. And we follow up a little bit on some of the things of the representative and the senator were saying about accountability, and the issues that you brought up around what I call the "denominator," the population's health to nominate are, and how you get that information into the metrics. Not just if I'm in there are you taking good care of me, are my tests OK, are you taking care of me, but that does what happens to me look like the denominator of the county as a whole. And I don't have the answer for this, but we have been struggling among our own conversations with where does that fit. So if it is not part of the governance structure, then what makes the CCO have to listen to it? The morbidity, the mortality, you might be doing very good, but you're not moving the needle. You've brought up your accountable, regardless, and even if there are places where some of the counties-- Representative Friedman talked about some of the counties-- don't have money and for certain services but there is an opportunity cost because they have the responsibility. If nothing does happen, they wind up picking up the tab. So they might not have dollars on the table but when it comes time and the tables fall apart, they're paying all the bills.

>>TAMMY: Absolutely.

>>LILLIAN: So can you talk a little bit as head of an association about what you are hearing that people need from that accountability?

>>TAMMY: Well, the unintended consequences are huge. If we don't care for the people that we're serving that they will drop into our public safety system, they will drop out of our school system...so the social determinants are huge and we start looking at the difference between the medical care-- which a lot of the CCO work right now is structured around that--and healthcare, which is much different because that is the health of the people vs. just the care for the condition. As we look at the accountable peace, we are accountable because we are elected. We have our day in court every four years. We will hear about the lack of services at the supermarket, at picking up our child...it is that close to us, in that if someone has not had services met, we hear about it that quickly. In areas like [Monteloma], it probably is not the same, but we only have a handful of really large counties. So the piece about accountability is huge: we need to be able to have a say in what we're trying to achieve and we need to have our communities come together and determine how are we going to solve that: is it going to be through some of the nonprofit work that is happening in the community, or is that also threw some of the work that the providers are doing as well? Because we don't just want to address what is right in front of us: we want to address what is coming up behind and stop that from happening. So all of that together gets to what are you asking us to achieve, and it is up to the community in their unique fabric of how they are set up to tell you how you are going to accomplish that.

So there won't be...I can't tell you that accountability is going to look like the governance structure of the chair of the county commission and the CEO of the hospital system...it may not look that way in every county. But if it works best for the county to have that,
and they're going to be most accountable in that way, then I think that is great. If it is better in more of an administrative council position, they find that they can achieve that they are, then I think that makes more sense. But again, I cannot say what that is going to look like for them because they need to have a conversation in their own community because I'm not sure of how each one is made up. I know it is not a direct, because we have 36 unique areas, and they will have to shore that up. I know [Gobi] is working with 17 counties, but I would say here's what we want you to do; how are you going to achieve that? And hold them accountable to what they say, because I wouldn't want counties...I think the worst thing that happens in legislatures is that you give someone an outcome and you have 36 different ways that they are trying to achieve it and nine of those are not achieving the numbers that are necessary, and it goes away because then it becomes those nine being the story vs. the overall.

>>SPEAKER 1: Other questions? Comments? Nina?

>>NINA: I just had a comment: I actually am from Washington County, one of the larger counties. I envision that the east-side counties, the smaller counties are going to be the race cars here, because I hate to say it but they are smaller communities, they're more cohesive and like you said you get stopped everywhere you go because people know you. I envision that the tri county area is going to be the laggard, just because of the size of the counties. I would say that I hope with the CCO we're just trying to get a barebones flexibility, because again I don't think every county is going to fit the same standard. However, accountability wise there's going to be a minimum that people are going to have to meet, because the one frustration that I have is that when nine or five CCO's do not meet it, what do we do to them? Historically the state of Oregon is not good at yanking funding. I think it would go a long way to make sure people do tow a line. But I do not want them to have an absolute matrix. Does that make sense? Flexibility is number one because like I said, your county is entirely different than Washington County, made up of different residents, made up of very small numbers, and you can get stuff done quickly. So I was actually hoping that you would be done by now and we could just follow you for example.

>>TAMMY: Well we are-- and thank you for that-- we are waiting, and do have criteria to look at and I would say that we are ready. We are in the pre-nup stage of the marriage, and making sure that everything is good and that we have an exit strategy because again this is new. At the end of the day, I want counties involved where they feel it is best to get to the piece where we're not just looking at the medical care, where we're getting to the health and we're looking at juvenile diabetes, we're looking at asthma, obesity, ways that we can stop just focusing on Medical Care.

>>FEMALE SPEAKER: My concern-- going back to the interventions-- is with the way the budgets in the state of Oregon, is that until we can get the school system under a solid funding stream, wellness is never going to be within our school system. When I have discussions about "McTeacher Nights" and everybody needs to go to Chuck E Cheese for
funding and everybody needs to go and buy a Big Mac for funding...until we get those two on the same playing field, I think the CCO's are going to have an uphill battle dealing with children in schools.

>>TAMMY: Thank you.

>>SPEAKER 1: We'll have allies.

>>TAMMY: Yes, you will. Mr. Chairman, I would just add that that opens the door for discussion about the early learning work and that we are also looking at that in our peripheral vision. We're not sure where that is going to go but we are ready to be partners in that as well.

>>SPEAKER 1: Wonderful. Felicia?

>>FELICIA: I wanted to ask a question about how are the counties getting feedback now. I'm hearing you on the fact that each county is different. I think we've heard from two different counties now, but I'm wondering what is the process where they feel like they are being heard? I know that oftentimes that the counties are going to have to pay when the table breaks, that is the reality just like William said. And if they're not being heard in the process now, what I'm fearful of is that they sort of walk away and say this wasn't my problem. So how are they getting that input and feedback into the process now?

>>TAMMY: Well there have been a lot of unanswered questions. I can say that we were at the table for the 36-50 conversation and that that was wonderful. We have worked closely with Mike Bennetta, worked closely with Dr. Goldberg, worked closely with Richard Harris, with Jane Ellen. We have worked very closely with the Oregon Health Authority in general. Right now it is essentially a holding pattern while we're waiting until we have the materials so now I think we can answer a lot of those unanswered questions. Dr. Goldberg in the Oregon Health Authority has offered us to put together a small group to talk about the information that came out, and so we can disseminate some of the questions that counties might have for the association back in a small group format, and we realize the turnaround on that is quick. We are essentially doing that, and we also had our summer conference where we brought in Representatives [Kotek] and Thompson and we were talking about questions you can ask in your community to set the table for CCO work. What questions should you be asking? Who are those natural partners and who are those...so we have tried to guide but not dictate and leave open...I would say that we have been at the table and been able to offer the conversation some comments and such and I will now meet with the Oregon Health Authority and give comments. So essentially it is smaller format and then trying to disseminate that out. But again a lot of angst about unanswered questions and this really will help.
>>SPEAKER 1: Tammy, thank you so very much. We appreciate your input and your comments and your willingness to come this far for such a short time but we do appreciate it.

>>TAMMY: Absolutely, thanks.

>>FEMALE SPEAKER: I just wanted to say that this is still a draft, but I think there's still some anxiety hanging overhead, and that there's still plenty of time for public comment to come before us again for discussion. So I just wanted to make sure that that gets out there.

>>TAMMY: Great, and we're going to disseminate our comments into one and then meet with the Oregon Health Authority.

>>SPEAKER 1: Thanks so much. Before we go to agenda item number seven, I just wanted to point out that at the end of the meeting we will have an opportunity for public comment. I think most of you here are not first timers but if you do have input for us, feel free to plan on doing that. We have a signup sheet which is over at this table now. So take a minute, and make sure that your name is on there and we will plan the time so that we can get everybody's input heard.

>>FEMALE SPEAKER: [faint] When the county submits their comments, can we get a copy of those?

>>TAMMY: Sure.

>>SPEAKER 1: Item number seven is November stakeholder group feedback and we're going to ask Tina to summarize a little bit, as promised earlier.

>>TINA: I'm only going to spend a few minutes on this, primarily because a lot of this stakeholder feedback has been woven into the proposal and so the conversation at the end of this meeting, and in fact the whole second half of this meeting about this proposal really gets into a lot of this feedback. So what I'm going to do is just highlight a few things and then ask if you have any questions. It is actually in your packet, it is three pages front and back in your packet. There was also a little bit of public comment on the web, not much but some, and the comments on there really tried to emphasize the need to really tried to include R.N.'s when we're looking at workforce issues, the need to focus more on women's health issues with metrics, which is also a comment that Lillian had sent as well, in reaction to the metrics section. Overall-- and I would say that you would see this in all of the stakeholder feedback--there was an emphasis on the need to focus on prevention and primary care. So the CCO criteria workgroup meeting, and again you can ask questions at the end here but I will just zip through this. They focused on patient engagement and rights and responsibilities and the delivery system, which are both items that we will have a more focused discussion on in our next meeting. They talked about
the need to work for the CCO's, to have criteria that they work with their community advisory council, that they actually have a range of strategies to engage the patients to adjust the particular barriers for diverse populations. They also thought there was an appropriate role for OHA to be a clearinghouse for best practices and emerging best practices.

On the provider networks, again, there was a real emphasis on the ability of the CCO to be able to describe how they're going to maintain access standards and how they're going to maintain access to primary care and specialty care, and to ensure that the network is really broad and diverse and represents the needs of the community. A lot of emphasis on the need for access to primary care. On the global budget methodology workgroup, I would say that the main thing there-- and you'll see this in the main proposal-- is that the strategy with the global budget should be an all in strategy, that as many programs and as many dollars and as much Medicaid population as you can have there, you should put there. And that is absolutely the discussion that happened here last month. There was real concern expressed about the fact that long-term care and mental health drugs are carved out of the global budget and so there was a discussion about how are we going to ensure that there is shared accountability between those two systems and coordination between those two systems, and emphasizing just how important metrics are to measuring that. They also talked about the savings opportunities in all of this have really emphasized the patient primary care home as probably one of the primary avenues to savings and if we focus on social determinants of health, we will probably actualize more savings.

On the metrics workgroup there was an interesting...the metrics workgroup had settled on the idea of having a core set of measures and then moving up to more traditional measures. At the last meeting there was really a lot of discussion about moving some of this transformation measures into the core set, to ask people to be more transformative from the very beginning of their establishment of the CCO. They also talked about the need to phase in the accountability structures, that you might perhaps start with just getting people to report and then actually develop your benchmarks from the baseline data and move forward from that.

Talked about the importance of risk adjustment-- did you have a question?

>>FEMALE SPEAKER: I did. Back on slide 11, that last bullet. Can you talk a little more about members advocating-- I did not see this in the notes, so I did not understand what it means. "In general, members for more choice among developmental or transformation measures..." But who has got the choice, does the CCO decide?

>>TINA: The feeling of the group was that the core set should be pretty much described and that everybody reports on the core set, but then there is something like a menu of transformational measures that the local CCO could choose from, because they have different populations and different things that they're trying to achieve in their local
communities, so they should not be required to have to report same measures when it comes to those innovations that they're trying to adopt.

>>FEMALE SPEAKER: OK, and this might be for the discussion later, but something that I feel must go hand in hand with that is that it still has to somehow still be tied to the epidemiology of that community and the community health assessment. It is not just us sitting around the table saying "This is what I'm saying."

>>TINA: So it needs to be tied to to the community needs assessment.

>>FEMALE SPEAKER: It has to be structurally what the CCO can achieve-- back to fast- and slow-tracks we were talking about-- but it has to be rooted somehow in the reality of that community, the reality of the medical care system that is setting this up.

>>NEW FEMALE SPEAKER: Are we asking questions, are we making comments now or?

>>SPEAKER 1: Comments about the public feedback, yes, questions about the plan, in 30 minutes.

>>NEW FEMALE SPEAKER: Thanks.

>>SPEAKER 1: We'll get there, I promise.

>>TINA: For the metrics group, they asked that we started with incentives and have penalties later as people gain more experience, and a strong feeling that metrics alone were not going to drive innovation, that it will take more than that. And then there was a feeling that metrics should be evaluated continually, because as the needs of the population change we need to have a mechanism. As we know or that as anybody who has had to have reporting systems would knows that sometimes they get put in place and they stay that way for years and years, long after the real need is gone or that the need has changed. Then there was a request that we always evaluate the value of data collection: is the information that you are getting out of it actually informing the move forward? Or "is the juice worth the squeeze?"

Then for the Medicaid and Medicare integration of services, again the discussion was around how they will share financial accountability and what some of those elements might be. Susan is going to be presenting right after me, so she will be talking a lot about these so I will not go into them much at all. It was the same language that we have heard a lot today, the need to balance flexibility with accountability and to allow people to find that space, that we really need to look at tying our financial incentives to metrics and that that is one approach to this shared accountability. So that was really the two key things that were coming out of that group, and the need for care coordination and better patient engagement, obviously. So I'm sorry, I wanted to go through this very very fast again
because the meat of the rest of this meeting is really getting into these issues but I wanted to get you a summary.

>>FEMALE SPEAKER: A comment on the Medicaid integration: I was the board liaison for that committee and I have to say that when the questions were asked at that meeting, I think there was some confusion about how folks were supposed to respond to the questions. I think there was actually a lot of confusion about how the breakout groups were supposed to respond to that question. I personally was completely confused, I did not engage appropriately, frankly, to get the outcomes that I think the stuff were looking for or for the comments that the staff for looking for. So part of what you'll be hearing from Susan today, if folks were part of that group then maybe you'll be hearing something different today that part of that is because we didn't actually answer questions that that staff was asking. So just to clarify that. And also why the feedback from that group was incredibly light.

>>TINA: I think that is part of what Susan will be trying to be doing, is to clarify some of that.

>>SPEAKER 1: Questions about some of the input? OK. Tina, thank you very much. A couple more input items and then we will get to the discussion of the proposed plan. Next up is Susan, as promised. Please come forward. How are you today? And we all know that the legislation does carve out a couple of things, including long-term care, and yet we know that great opportunity exists for coordination. So looking forward to thoughts about how that might be accomplished. Thank you for joining us today.

>>SUSAN: Thank you. Though. First I should say that unfortunately I was not able to attend the final meeting of the workgroup. The project that we're on, the Federal funding that we have, they had a national conference on that same day. So I'm relying a little bit on staff and Felicia and Tina to reflect that. So I am Susan [Alder], I am the project director for the CMS design contract project, to integrate care for individuals who are dually eligible for Medicare and Medicaid. The interesting thing I think about this project is that integrating care for the duals overlays all the other pieces of healthcare transformation, really looking at a slice of the population that has pretty severe needs. So today I would like to bring you up to speed on the work that we have done and we will be coming back in January with some of the more we find strategies that we'll be looking at to put into our proposal to CMS.

So in terms of the individuals who are dually eligible in Oregon, there are 59,000 individuals who are eligible for both Medicare and Medicaid and about 27,000 of those are eligible for the aid to the blind and the disabled and about 32,000 are eligible under old age assistance for their eligibility criteria for Medicaid. Many of the duals are eligible for managed care plans for Medicare or Medicaid, 39% are not in any managed care at all so 39% are in fee for service on both sides....or, sorry, 61% are in fee for service for
Medicare, Medicaid, or both, and 31% are in both fee for service. It is 39% that are in managed care for both Medicaid and Medicare. So there is the flip of the 61%.

>>FEMALE SPEAKER: Did you get that, Jeff?

>>SUSAN: Did you want me to say that again?

>>MALE SPEAKER: Got it all written down a piece of paper.

[Multiple speakers overlapping]

>>SPEAKER 1: We've got opportunity here.

>>SUSAN: That's the message here, yeah. 31% of individuals who are dually eligible in Oregon are in special needs Medicare advantage plans and those are plans that are serving dually eligibles and coordinating their Medicare and Medicaid. But the folks that are not in special needs plans are not in plans that are coordinating the Medicare and Medicaid sites, so there is an opportunity there. About 41% of the dually eligible beneficiaries receive long-term care services, Medicare funded long-term services. In Oregon, we're very efficient with our long-term care in terms of moving folks into the community. We have talked about that, that 80% of folks in Medicaid funded long-term care are served in home and community based settings, so about 20% are in nursing facilities.

In terms of spending, Medicare is the primary payer for individuals who are dually eligible. So Medicaid comes behind and pays co-pays and cost sharing and picks up pieces that Medicare does not cover like long-term care services. So we have at the national level roughly 80% of spending on individuals who are dually eligible is Medicare, about 20% is Medicaid, and then when you add in the long term care costs, that flips to about 45% is Medicaid and 55% is Medicare. For Oregon, we spent $275,000,000 in 2010, not including our long-term care budget, and then we spent about $1.7 billion was spent in 2009 in Medicare. So those aren't the same years but if the 2009 spending stayed flat for Medicare, it would roughly be 85 or 87% of the total spending as Medicare, not including long-term care.

Dual-eligibles are nationally 15% of the Medicaid population and 39% of the costs for Medicaid, and then 21% of the Medicare population and 36% of the costs. Those figures are in the narrative handout.

>>MALE SPEAKER: I'm sorry, I'm trying to keep up but I'm in the slow group today. Going back to slide 2-- I have not gotten my head around three or four yet-- but going back to number two, 24,000 who receive long-term care services, he said that 80% were community based and that 20% were in long-term care facilities.
SUSAN: I'm sorry. So when we talk about long-term care, we talk about a spectrum of facilities and services. So 20% are in nursing facilities.

MALE SPEAKER: Not assisted? I guess my question is are assisted living facilities counted in that 20%?

SUSAN: They are not.

MALE SPEAKER: So they're considered community based?

SUSAN: They are.

MALE SPEAKER: OK. Now I'm good.

SUSAN: So Oregon has the opportunity to include Medicare funding into our Coordinated Care Organizations for individuals who are dually eligible. The importance of including Medicare funding is, one, the scale. As I mentioned it is a lot of dollars for dually eligibles in Oregon, and that provides the Coordinated Care Organizations with a lot of money to work with, more flexibility ease with using the funding streams more flexibly. The way this is laid out, which I will talk about a minute, is in blending the Medicare and Medicaid funding so that you do not have a payment for a Medicare-covered service separate from a payment for a Medicaid-covered service when you are reimbursing care. It is also an opportunity to integrate care more effectively for these beneficiaries that are high needs.

There are significant opportunities for potential savings from working with this population and integrating care. One is in reducing hospitalizations and emergency room utilization and other acute care, and reducing other unnecessary duplicative services utilization, and there are also administrative efficiencies. CMS is also willing to work with demonstration states to align Medicare and Medicaid administrative and regulatory requirements so that plans that have a Medicare and Medicaid line right now have to juggle between those two different processes. I can tell you a lot more about that, but they're helping us to align those different processes and anticipating that plans will see significant savings that way as well.

So we are one of fifteen states that has received what is called a design contract. We received $1 million from CMS for a 12 month planning process to develop a proposal to CMS to integrate care for individuals who are dually eligible. When CMS is talking about integrating care, they are looking at integrating physical care as well as mental and behavioral, as well as long term care. In addition to the 15 design contract states-- I'm going to try not to confuse anybody here-- CMS has offered all states the opportunity to enter into three-way contracts to integrate care. So if you think about this as CMS having two strategies for the same thing, one was earlier, the design contracts, and then a little later they thought "ok, well we can do this for all states. So they've aligned those and for
the design contracts states we will be going in line with that three-way design contract offer with CMS.

>>FEMALE SPEAKER: And the three-way design contract would be between the state, CMS, and the CCO in this case?

>>SUSAN: That is correct. The three-way contracts are to bring in Medicare funding for the individuals who are dually eligible. We've submitted a letter of intent that we'll be interested in participating in that under a [capitated?, 2:13:11] and we're working with CMS around that and defining the timeline that we need to work with CMS and what their involvement will look like. CMS does need to approve our efforts at a number of points. Once we get our design proposal in to CMS, then we'll work with CMS if they want to continue working with us, which we believe they will, to develop a memorandum of understanding, and that will form the basis of our agreement going forward. At that point then we will work with CMS around a joint contracting process and negotiating with them around the rates that the Medicare dollars will be coming into Oregon and sort of the Medicare participation. We've already been working with CMS around that and we're getting the information as it comes from them.

In addition to integrating care through the CCO's, our design contract proposal is also an opportunity to explore other promising models and we've talked about CMS about our interest in looking at flexibilities for PAICE, the Program for All-Inclusive Care for the Elderly, as well as potentially exploring a demonstration around Housing With Services and some of those different models.

>>FEMALE SPEAKER: Susan, can you just explain to me what the difference between Housing With Services and PAICE is?

>>SUSAN: Sure. So PAICE is a specific federal program that allows a higher level of federal reimbursement for integrating care, coordinated care, medical and long-term care and social services. It's being used in Oregon for a fragile population. Housing With Services is a general idea of an assisted living facility or a section 8 housing where you would bring in services to that facility to care for folks who were dually eligible and coordinate their care and services. So it would be a lower level of care.

>>FEMALE SPEAKER: Can I just ask a followup question about that? So CMS has been more open around the flexibility of the requirements for those types of services than they have been with the PAICE model?

>>SUSAN: Yeah. So CMS-- and we're just starting that conversation with CMS, actually. We have a couple of communities that are interested in pursuing some specific models and we're starting to talk to CMS about what that might look like in our proposal. So we have talked with Vermont, who has a similar model and they had some particular flexibilities with their Housing With Services model that we're interested in exploring.
FEMALE SPEAKER: And can I ask just one more, sorry. One more question on the Housing With Services: there's flexibility in Vermont, Vermont is such a small place so we're asking for CMS to be flexible with us for the given areas of the CCO, for example one housing services in the metro area may look one way and one housing services in the bend area will look another and one housing services in Lake County will look entirely different given the spread of the population and so we're asking for that, we don't have that yet?

SUSAN: That's correct. So what we're talking with CMS about is exploring being able to do demonstrations basically that would fit our broad set of criteria, that they would be the housing services ideal or model and that we would be coming back to CMS with different ideas about what proposals would come to us and what we're looking at. Again, we're at the very initial stages of talking about that with CMS.

FEMALE SPEAKER: Thanks.

SPEAKER 1: Question from Eileen?

EILEEN: Susan, is there actually a risk with this design contract that we might actually get less dollars for Medicare? It hadn't actually occurred to me until you said that we're negotiating rates. Is it possible that we might end up with less dollars than we currently have in the system vs. the same amount we can work with and blend with the Medicaid dollars?

SUSAN: Well, that's an interesting question. So the way that CMS is setting up the demonstrations is that they need to see shared savings that they achieve before the end of the three-year demonstration. So they'll be keeping some of the savings when they look at what they've historically spent and looking at the savings that we achieve and they'll need to see that they can keep some of that savings by the end.

FEMALE SPEAKER: Doesn't sound like such a great deal to me. Sounds like a risk, to me, in terms of what our current reimbursement rates are in Oregon.

SUSAN: If you assume that those current reimbursement rates are going to stay in place at that level. So I think part of what we're also trying to talk to CMS about is to more heavily invest in us at the front end because we think we can achieve some significant savings for them and again because we are a state that has lower Medicaid reimbursement than other states on the fee-for-service side, that we want a different kind of formula.

FEMALE SPEAKER: I would just suggest to the board that as this information comes in, before we sign the contract that we take a close look at whether we may end up with less resources than we want to end up working with.
>>SPEAKER 1: Great point.

>>SUSAN: The other side of that is that the savings we expect to achieve are...

>>FEMALE SPEAKER: I understand. At the net.

>>MALE SPEAKER: Hopefully the net will be more, with the transformation and evolution or whatever we're calling it today. But yeah, by bringing those Medicare dollars onto the Medicaid side and integrating the care and potential savings that you have mentioned, I think it should be huge.

[New female speaker, inaudible]

>>SUSAN: I didn't hear you, I'm sorry.

>>NEW FEMALE SPEAKER: We have more Medicaid patients in managed care than Medicare patients and if you blend the dual-eligibles into the population and so the population are already paying the high rates because they're in fee-for-service instead of managed care.

>>SPEAKER 1: I need to point out that our time is a little over half gone for this topic, so.

>>SUSAN: So I'll just show you where we've mapped out where folks who are eligible for both Medicare and Medicaid live in Oregon, by county. We have [Monteloma] County has the highest number at 14,400, Lane County has about 6,300, Washington County about 5,500, Marion County about 5,100 and [Clackmouth? 2:20:19] about 4,500. We've broken it down by zipcode as well, which I won't go into.

So one thing I would like to talk about the challenge we have in Oregon around coordinating around long-term care services with the CCO's. As I mentioned, CMS is expecting to see states that have integrated care including long term care, to participate in the demonstration project and to participate the Medicare dollars in and being able to blend those into our three-way contracts. And so we've worked with CMS around what our shared accountability might look like and how we can meet their needs without integrating long-term care because Medicaid long-term care is carved out by House Bill 36-50, as you all know. So the Medicaid-funded long-term care will continue to be funded through the Department of Human Services budget and the medical care and the mental/behavioral health will be covered through the CCO's. This creates a challenge for coordinating between the two systems. There are potentials for cost shifting and these are cost shifts that we are seeing currently as well. These are inappropriate care planning leading to unnecessary ER visits and hospitalizations. I know Senator Bates talked about an example that may have been related to inappropriate placements or a setting that
wasn't meeting a person's needs leading to higher costs as well. Premature entry into long-term care after deteriorating due to poorly managed behavioral health or lack of access to durable medical equipment, overuse of mental health drugs, the lack of capacity to address behavioral health needs in long-term care settings and failures of long-term care placements due to poor hospital discharge planning, folks getting out of the hospital too quickly without a good transition and then ending up back in the hospital.

>>MALE SPEAKER: How is that a "cost shift," though? In terms of the way we usually discussed cost shifts. I understand cost shift in the sense of the emergency room visit that's uncompensated and then the costs of that being shifted onto privately insured. But I don't understand how in terms of cost shift...who are we shifting costs from, from where to where? Who is being gouged here? I'm a little confused by the use of the term "cost shift" to describe this kind of activity. I understand that there needs to be coordination of care and I understand that there needs to be partnership between long term care facilities and assisted living facilities and coordinated care organizations but I start getting a little confused with this cost shift and shared accountability. I understand custodial costs are carved out, the acute care costs...

>>SUSAN: Sure. So I have a couple-- just to be very explicit-- take the durable medical equipment. So if the CCO or MCO looks at a request to approve a particular piece of equipment and according to their assessment it's not a good return on investment and so the person doesn't get that, what thing will help them live more independently. That can shift so that the long-term care system has to pick up a higher level of personal and staff to serve that person. So we've seen examples of a $10,000 piece of equipment, a bed or that sort of thing that results in four times as much in home care workers. So the long term care system is picking up the costs.

>>MALE SPEAKER: So that's a sort of shift from the acute side into the long-term care side.

>>SUSAN: That's right.

>>FEMALE SPEAKER: I asked the same question and it's between agencies.

>>NEW FEMALE SPEAKER: However, if the care was coordinated and you had the shared accountability in place, maybe the overall costs would be less, is really the issue. The cost shift is causing the overall cost to go up, even though it is just between agencies.

>>FEMALE SPEAKER: This is why I had a problem with the term "cost sharing," too, when you discussed it at the meeting, is because a cost shift is actually just between agents. But it leads to poor outcomes. The example that was given in the meeting I was at was a wheelchair, so Medicare says it's a medical cost, we don't want to pay $10,000 for a wheelchair but we'll keep you in your home and then you get to live in a nursing home.
MALE SPEAKER: Right, and I guess it can go the other way, where if I want motorized wheelchair in my home it costs $10,000 and I can get by with a lightweight pushchair and then I guess you could shift it the other way. Because then the acute care side would be picking up the extra $9,000 and there would not be a benefit. What there has to be is this leap of faith and maybe what you're calling the shared accountability is what I'm calling this leap of faith and partnership between the agencies, that everyone will do their best to do what's right for the patient at the right time and in the right place.

FEMALE SPEAKER: Unless we put structural things in place that provide incentives for that to happen.

MALE SPEAKER: Right, or disincentives for it not to happen.

SUSAN: That's tee's me up for my next slide, actually. So thinking of structural accountability mechanisms, we did a survey of the mechanisms currently in place to hold the long term care system accountable and to hold the medical system accountable. These are some examples. We have long term licensing and certification of long-term care facilities, monitoring and reviews, on both sides we have appeals, complaints, we have adult protective services on the long-term care side and then on the medical side we have similar mechanisms, performance reporting, contract monitoring, etc. There are no system-wide structures for sharing accountability between those two systems. There are limited cases where nursing facilities are responsible for some pieces of medical care like medication administration and nursing services, but other than that, the two systems operate very independently.

There are some promising models going on in the state, and these are really-- since there are no system-wide accountability structures, that doesn't mean that enterprising folks aren't doing things. We've found that there are promising models around co-location and team approaches, so that would be having a social worker, a long-term care case manager in a hospital or primary care setting or team approaches like participation in multidisciplinary care teams, services in congregate settings. We talked about Housing With Services and the PAICE model where those medical and social services are coordinated. We have physician-extender or home-based programs, so we might have nurse practitioners or other folks who are out there in the home or community care based setting, there actually in the assisted living facilities where they go out and check on folks for their medical needs as well and try to keep them out of emergency room settings. And then we have other ad hoc care coordination that is going on. We heard about one community that gets together with their fire department and police department and they talk about the folks that show up on all sides: they see them at the hospital, the fire department, and with the police. So we do have some promising approaches that are going on. Folks are forging some of those relationships, but there aren't system-wide structures in place to encourage accountability state-wide.
We've discussed some proposed accountability structures. We have four pieces that we would like to talk to you about or highlight for you and then come back in January with more specifics. One is around...these are the accountability structures that we've also talked to our external workgroup about. One is around metrics and performance measures to monitor how things are working and look at outcomes. Two is around incentives and penalties based on performance and those metrics. Three is requiring contracts and memorandums of understanding between the healthcare side, the CCO's, and the long-term care side. And four is around specific requirements that would be made on both sides that we could make through our CCO contracts and our contracts with long term care providers, for example. Requirements that both sides would participate in a multi-disciplinary team, that they communicate, what that communication might look like and that they share a service plan, that there's a joint service plan that covers both the long-term care service plan needs as well as the medical service needs.

I was going to move on to stakeholder feedback, are there any questions on those so far?

>>FEMALE SPEAKER: I have a quick question: on the slide, it says "medical system." Is that really the CCO's or really the whole medical system? The focus here is between CCO's and long term medical care, is that correct?

>>SUSAN: That's right, and so that really is the CCO's.

>>FEMALE SPEAKER: OK. And is there really any reason we can't just put something into the CCO criteria...it feels like there's too much potential structure we would need to put in place there. I'm looking for a simpler solution. Is there a way to put something that is more outcomes-based into the criteria for the CCO's that just says they need to have these types of outcomes with the long-term care and that that's part of the deal when they sign up to be a CCO?

>>SUSAN: We can...

>>FEMALE SPEAKER: I may be asking something too simplistic but it just feels too cumbersome to me.

>>MALE SPEAKER: But it's really challenged by the fact that it's separate. You can't make somebody accountable for something that you don't have control over.

>>FEMALE SPEAKER: But if it's given that it is separate, then isn't there some sort of contracting or just simple understanding with the CCO's, the state is going to set up the CCO and say "here's how we want you to interact with long-term care or what the outcomes-based approach should be.

>>MALE SPEAKER: I think-- and Susan, correct me if I'm wrong-- but that's what she's trying to outline, just from both sides, so that you have this dual process on the CCO side
and on the long-term care side so that there's accountability, not necessarily just on the CCO side.

>>NEW MALE SPEAKER: Each to their own agency.

>>MALE SPEAKER: Right.

>>[SPEAKER 1]: And it seems to be that in the RFP, instead of saying "You shall" in the RFP, you could have a section that says "Explain how your coordinated care organization will work the long-term care organizations in your community to ensure that there's cost-effective care and how the savings hopefully that will result will be shared among both sides.

>>FEMALE SPEAKER: And how the communication will happen from the caretakers and...

>>MALE SPEAKER: And report back to us as to how that works.

>>NEW FEMALE SPEAKER: If you look at the report they sent out, the Medicare, Medicaid Integration of Care Services Workgroup Summary of Input, on page 8 there's the domains that people actually suggested we measure and go over, which was at our...I forget what meeting this was at but it was one of the discussion topics we had around those incomes. It's sort of buried in this.

>>SUSAN: And so part of our work has been to feed into the metrics workgroup's work in terms of there are metrics that we are holding CCO's accountable to that would be relevant for this population but I think what we're talking about here is just that middle box of holding folks accountable to outcomes or performance metrics through their contracts, our contracts with them, and I think that the second piece is around shared accountability, so to what extent do you have financial skin in the game about whether or not you're meeting those performance metrics, for example. So if there is cost-shifting and if we're looking at reducing cost-shifting and improving integration of care, then to what extent can we do that through financial accountability, which is what CMS has talked about needing to see, to pull in the Medicare dollars.

>>FEMALE SPEAKER: I'll wait until the end of the presentation. There's just got to be a simpler way to do this and it has something to do with the leap of faith and setting outcomes. I just don't want to set up too much bureaucracy for...I'm just giving you the gut feeling, I know you have done all this work and you're in the weeds with it and I'm not, so...

>>SUSAN: OK.

>>FEMALE SPEAKER: I'll hold my next thought.
SUSAN: OK. So we did get feedback from our stakeholders on shared accountability. We have talked obviously with the larger workgroup that Felicia was talking about as well as a subgroup of that group. So that subgroup is made up of about nine members to respond to a budget note request of the legislature for the department of human services. And that subgroup has continued to meet and we've used that group as a deeper dive on these pieces. And that's been very helpful for us. That group will have their final meeting on December 19 and we were able to dive deeper with them around this coordination of shared accountability topics. So from both of those groups we have support for shared accountability measures or strategies, including the performance metrics, using a contractor MOU, requiring that between the two sides and then putting in specific requirements that folks coordinate, communicate, that the CCO's on the long-term care side participate in coordination and communication. We did get folks that are open to financial accountability mechanisms but we had- I have a little bit more to talk about with that. There is a desire for local flexibility, which we've heard before as well.

I'm going to skip ahead a bit. We gave folks in the November meeting, as Tina was talking about, three options around shared accountability: one is incentive payments or penalties based on performance metrics, two was shared costs or savings based on benchmarks related to spending or utilization, and then three was changing how we allocate costs between the long-term care system and the CCO to better align where we're really talking about a medical based long-term care that would be the responsibility of the CCO as opposed to the long-term care side. In general, folks were not interested in the third option. It was seen as very specific and there were elements of that that folks liked but in general we got support for financial incentives based on performance metrics or some considerations around shared costs or savings.

This is in your packets: this is the pro's and con's we shared with folks at that meeting and then in the deeper dive, the budget note subgroup we tried to talk more about what we would see as incentives and penalties. There was a lot of concern about placing any risks or penalties on small long-term care providers like in-home care providers or small adult foster home providers. There was some talk about being open to penalties by not paying for duplicative services. So for example, if there was an integrated care plan that called for a particular test and a later provider didn't refer to that care plan that that second test wouldn't be paid for. So there was some discussion about trying a penalty approach related to that.

We are working on taking the feedback that we have gotten and fleshing out our model, our draft model, that we would like to put in the duals proposal after getting input. We're hoping to work with our external stakeholders to help us flesh that out and react to that model and then come back to you in January to get your input on that.

SPEAKER 1: Chuck?
>>CHUCK: Going back to the three-day state- do you anticipate asking for some sort of relief from the three-day state to be part of that...that's really huge, the best example that I can give you of where that is insane is a stable pelvic fracture, where someone comes in, they've broken their pelvis in a fall, they need care but they don't need acute care and we have to admit them for three days at a cost of a gazillion dollars and then in three days, poof, they can automatically go to sub-acute care when in fact in all honesty their health might be enhanced by not being in an acute bed but rather going directly to a [scaled] bed. So I think there's a lot of savings that could be realized there as well. And I think there's a very small number to start with of events that should be waived so that there's not abuse of the system. Myocardial infarctions don't get moved into sub-acute care on an admit, but I think there's some opportunity there.

>>SUSAN: Absolutely, that's one area that CMS has been very receptive about providing flexibilities.

>>SPEAKER 1: Any more comments or questions?

>>FEMALE SPEAKER: We're going to be discussing this at the January meeting?

>>SPEAKER 1: January meeting, that's correct. More input to come. OK? Thank you very much, appreciate it. OK, we are almost to the discussion of the plan. We have one more agenda item between us and that, you've all been very patient. Carol, welcome back.

>>CAROL: Thank you. I'd like introduce Tom [Wonderlick], one our lead policy analysts at the Office of Health [IT], who has contributed a great deal to this work and so may add to the discussion as well. HITOC, the Health Information Technology Oversight Council, which the Office for Health IT provides the staff for, was asked to provide advice and input. We took those words very seriously. Those were the exact words in the minutes from this group's meeting and so that's what we're bringing back to you. I just wanted to direct you to a couple of pages in your packet. On page 18 of the proposal are the HITOC recommendations for HIT and HIE within the CCO criteria. We also included a discussion summary from the two meetings where HITOC met to discuss this and they did validate all of the ways we captured that discussion in their December meeting.

We included a memo from the Office of Health IT just outlining some of the statuatory and technological barriers to health information sharing and we also included a one page overview on what the direct project really will mean and I'll go through that. First I wanted to point to the analogy that the image that we used here on this slide represents. We call it the ripple effect because we really believe that HR adoption and the introduction of electronic health information exchange will create that ripple effect across all kinds of systems. You brought up the great example earlier today in the Early Learning Council, that we look a the department of corrections and our county systems.
We look internally at all the state systems, the public health registries and all of that work and external to the healthcare stakeholders that will need to adopt this.

>>MALE SPEAKER: I interpret that as simply being a drop in the bucket.

[Laughter]

>>CAROL: I have additional slides of the drop in the bucket. So in House Bill 35-60, we actually used several sections of the bill as guidance in developing the recommendations to the Health Policy board for HIT and HIE, but the principles that we set forward were really to meet providers where they are and then expect and require improvement over time. That's the way we've tried to develop with that principle in mind. We also really wanted to align the requirements with the federal incentives that are in place right now for electronic health record systems and so on Medicare and Medicaid there's incentive payments to some types of providers, not all, for adopting and meaningfully using electronic record systems. And then over time we would like to see the criteria expand and develop more robustly in terms of meaningful use of electronic medical record systems.

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We expect that the Health Policy Board and the legislature would want to allow for regional variance in HIT maturity. But the approach that we suggest that be taken leverages the maximum advantages for all providers by, again, meeting providers with a low-cost entry-level technology and building out over time.

And I guess the fourth is really about how to move forward in other kinds of reimbursement models for using other kinds of technology to help coordinate care. So the use of telehealth and mobile devices on your smartphone, in-home medical devices that can be linked to a coordination of care unit within a CCO or within a health plan or within the Medicaid structure for the state. There's a lot of ways we can go about using technology differently. And so that's...those were our principles.

To give you just a little bit of background about where we are right now: based on 2009 survey of ambulatory care providers on electronic health record systems we found that 32% of those clinicians who works in organizations and 9% in private practices have what we would deem fully functional EHR systems. So that was 2009. We know we're coming along. There is great news on the Medicaid incentive payment program here in Oregon. We'll be issuing additional checks and I think we've paid out well over $6 million or $7 million dollars as of this week. And it could be substantially more than that in incentive payments here in Oregon since we launched that program on September 26.

So we know this is moving forward and this is kind of an old number. But it does give you a little bit of a pause that we have a long way to go before all providers and all providers types within CCOs will have the kind of technology and know how to use that
appropriately. Um, 15 out of the 36 counties don't really have any organized HIE services. HIE is health information exchange. Remember, between the labs, the hospitals, and providers.

And when we talk about that, we're not just talking about Epic to Epic kinds of functionality. Because we know that in...not only in the Portland region, but across the state, lots of the large health systems are moving to one particular vendor, that being Epic. There are limitations to the exchange within that system. I will say that it's an excellent EHR system, first of all. It's very highly functional and providers that use it love it. But the providers that don't use it can't communicate with those Epic providers. And that we see as a piece of our white space, what we describe as the white space of the state that doesn't have functionality. And so we called that as part of the environmental scan.

Now this page 18 in your proposal lays out foundational components that [inaudible] would like to recommend. And transformational considerations as well. In the foundational components, for EHR adoption rates there was a lot of discussion around, you know, the variability within provider types and also within regions. And so the recommendation was that CCOs would need to initially do that environmental scan and identify the adoption rates of the certified and non-certified EHR systems that are in use within their provider network. And then submit a plan for improving that rate of adoption, expecting that in year two or beyond that there would be minimum requirements for EHR adoptions.

So that's kind of an easy step. You know, that gives you that...meet providers where they are and don't create so many barriers that we heard the good elected officials talk about earlier today.

>> NEW SPEAKER: Mr. Chair?

>> NEW SPEAKER: Yes.

>> NEW SPEAKER: Carol, on page 18, the paragraph under "Electronic Health Records Systems," I think I heard you just speak to that where you said that you would recommend that CCOs develop a plan. When I read this and I saw, "[inaudible] recommends that CCOs facilitate providers adoption of meaningful use of EHRs," and then I looked at those three bullets, I didn't see a lot of facilitation there. And I actually wrote down maybe a better word would be "encourage" with those bullets. And so then I looked at the second bullet and I thought if it said identify and implement strategies, that gets us a little closer to a plan. But I wonder if you shouldn't be explicit and add a fourth bullet that you recommend that the CCO be required to adopt and implement a plan to facilitate EHRs within their organization. I thought that this was just a little EHR-light.

>> NEW SPEAKER: A little weak. I can understand that. And I think that's great feedback. I think that's one of the questions that we would have for the Health Policy
Board's consideration in this discussion is who does evaluate those plans? How are the plans for improvement approved? And then how are they held accountable, who do they report to? And [inaudible] is interested in what their role could or might be in doing that. So I think that's great feedback.

On health information...

>> NEW SPEAKER: Can I just add...oh, I'm sorry. We can't discuss it here, but I would like not just the financing. You know, because we've talked a lot here about incentives for financing and [inaudible]. But the other thing that is white space, as you say, is who's going to pay if I'm in one system, does the CCO is that in their global budget? Because I have to pay to get into your electronic health record in some of these systems. So there's a transaction cost there. Who pays the transaction cost? And is that part of the global budget, is that something outside of it? I don't have an answer, but I think it's going to be a huge barrier unless somebody sits down at the table and comes up with one.

>> NEW SPEAKER: I agree with you. And so, as you look at the Oregon strategic plan for health information exchange which we're now in the process of bringing into implementation, we have considerations within that plan of a financing strategy state-wide for the assistants of the infrastructural technology that's so important to transformation. But, you know, I think there's a lot of open questions around payment and around what should be provided at the community level versus at the statewide level and the economies of scale that can be addressed within that. And we'll talk a little bit more about that.

On HIE, the recommendation that we have, on page 18, for health information exchange: we're becoming a little bit more specific in that we...that [inaudible] recommends that there be a requirement for all providers to be registered with direct secure messaging. And that's not our brand name yet, but we'll be developing a brand over the next several weeks and we're signing a contract with a vendor in the next couple of weeks as well, so that's in final negotiations for this direct secure messaging service.

Unless...so this would accommodate some measure of electronic exchange. It's not the be-all-and-end-all, but it's a start. And it's meets providers where they are with or without an electronic health record system. So...or, and you'll see an "or" in this page 18, that says that if the CCO can show that all their members...or all their providers are members of an existing health information organization with the ability for providers on any EHR systems to be able to share electronic information with any other provider within the CCO network, that would qualify and they might be excused from having direct. Now, they may not choose to be excused from having a direct address for all their providers. And I will say that while the Douglas County Roseberg area is the best example of ubiquitous EHR adoption with one system in their community, even there, the Indian Health Services and the VA can't communicate with that system. So there is no "or"
community in the state currently. That doesn't mean there won't be. And that communities aren't moving there and we've been doing some research on that.

>> NEW SPEAKER: But direct would allow some information exchange, correct? Even though those entities can't communicate under the current situation, there would be at least some communication that could occur under the direct system.

>> NEW SPEAKER: Exactly. And so the next slide, and the next two slides, kind of show how that works. Direct project, it was a national initiative that was sponsored by the Office of National Coordinator for Health Information Technology and brought together large vendors. States, including Oregon, participated in the planning for this and stakeholders across the country to develop a secure standards based approach to push health information technology.

So this is...the security is really based on a provider directory and registering within that. So not anybody can have a direct address. You have to go through a registration process and a validation process. It's standards based so that means that it looks very much like using a Gmail account, essentially. And it's really simple. That said, right now...the next slide really shows that the first step for utilizing direct will really be, in most areas, through an email client or a web portal. And so our vendor will set up a web portal here in Oregon at the statewide level. There'll be others--they're called health information service providers--. And we're not dictating, within this recommendation, that a CCO would have to choose the state health information service provider in our direct address. But we will be setting up standards so that those address and those provider directories will be able to easily link to each other.

Eventually, over time as the standards and the certification requirements at the federal level come out in next phases for electronic health record systems, we fully expect that direct will be a module within those. And that creates a much better work flow for those providers that have electronic health record systems in place. But initially, remember we're meeting providers where they are. And so that's kind of the first step.

>> NEW SPEAKER: And by having the direct system as a starting point, then those who adopt EHRs are going to have some degree of familiarity with the EHR when they come to it because direct will be part of their EHR. Is that fair to say, they're going to have some familiarity because a module within their EHR is something they're going to used to using?

>> NEW SPEAKER: Well, I think that's very true. And I think that there are email systems that...you know, lots of large hospitals set up secure email systems for providers to communicate with the hospital already. And this isn't a lot different from that except that it's available to everyone.
NEW SPEAKER: Right. So I can't...I don't have an OHSU email address. So they can communicate, but when I refer a patient to OHSU, I can't send a secure email to whoever I'm sending them to, you know, saying...basically, I use snail mail. I write a letter and it goes and it gets there. So maybe all the records don't get there, are faxed or something like that, but it sure would be tremendous to be able, as a starting point, to be able to communicate with referral physicians and referral hospitals in a secure way.

NEW SPEAKER: Exactly. And we know that most health information exchanges is really in a push environment. It's a care summary that's a part of a referral to another provider. It could be a push of a lab order to a lab and a push back of those results. It could be a push into the immunization registry and a push back, essentially. So it does reduce the cost of the expensive interfaces. And that we see as a high value. But I will say it isn't what providers will need when they think about what Susan's comment was. If you're thinking about penalties for duplication services, you need to know what services have been provided and where. And for that reason, we've always referred to this as...this is phase one of health information exchange here in Oregon. And it's been our strategy, or [inaudible]'s strategy, to over time and with the support of those stakeholders that would then need to contribute financially, in one way or another, to build those services that they then see. So those conversations about that financing is really at the heart of the next phase of those services.

Um, number three on page 19 I will say also I think important consideration for health information exchange and that's about the idea that there could be a consideration of minimum required rates of e-prescribing and electronic lab orders. Those are some of the metrics that we have to report from Oregon back to the Office of National Coordinator for our grant. And so that could be a consideration that could also be put into the requirements for CCOs.

I think the other...the next slide really talks about those transformational HIT components for proposed CCOs. And we don't want to leave this out because these are really the pieces that can weave together, you know, the whole basket of support, of that foundational support that IT can bring. The analytic, the capability to assess the provider performance within the CCOs, use data to provide better care, certainly the quality reporting, being able to not only report to Oregon Health Authority, but be able to facilitate quality improvement within the CCO and use that to compare providers against each other.

We think the patient engagement tools are essential to help patients understand their healthcare better, including the use of direct into a patient health portal, Microsoft has one set up, the other companies and organizations are doing so as well. And we think that there is a tremendous potential within telehealth, mobile health devices, in-home care devices that could help coordinate the care and be really managed by care coordinators for improvement of the system.
But there are a lot of challenges. And what...I underlined one being that interconnectivity does not mean interoperability and I think what we're trying to do with this plan right now is really underscore the interconnectivity piece of this. Interoperability is something that is a long-term goal. Clearly, it's, you know, the idea that when all EHRs will be able to be part of one...of a health information exchange and have ubiquitous, seamless exchange, uploading and downloading information into those systems, that's the end goal. But we know we have to move incrementally towards that.

The functionality for case management in existing EHRs is very, very limited at this point and time. Care coordination involves, of course, the different care settings and different provider types that may not have those incentives in place. And of course that's something that every state is wrestling with and dealing with. And, you know, as a state with very lofty goals for improving the health, the health systems, and lowering costs, I would say that looking at that as a state policy would be part of the underpinnings, potentially. And then I think the other piece of this is really the idea that provider level versus organizational level tools, that it goes to that economy of scale conversation.

So the state is putting some technology in place and has the capability to increase that. The idea that investments will need to be made by every coordinated care organization to buy record locator services and set up the kinds of technology, to me and I believe to [inaudible], really seems like a waste of precious funds. And so the idea of where we can find that economy of scale and how we can set forward enough coordination between the right technologies at the local level and the right coordination of technologies at the statewide level is really the mark that we're trying to hit. And, of course, you know that in House Bill 3650 that it states that we should explore options in assisting providers in funding their use of HIT. So I imagine that's...

>> NEW SPEAKER: Send me a check.

>> NEW SPEAKER: ...part of the discussion. So we'd be glad to answer questions. I think that...it was really interesting to me that driving between meetings today I heard Dr. [inaudible] on NPR and talking about the accountable care organizations and kind of comparing that to managed care of the past. And what he said was that patients should have choice of their providers, but their care needs to be coordinated and so what we feel like with our recommendations is that we've got the right pathway allowing that flexibility for coordinated care organizations without being too prescriptive. And that's really what [inaudible]'s goal was.

>> NEW SPEAKER: Very good. Thank you. Lilian, a couple...we're overtime, but a couple of quick questions. Lilian.

>> NEW SPEAKER: Quick question for another time. The concern I have is your second bullet on the last slide. There is no good case management software here and everybody is managing their patient. And everything that we've been listening to all day and last
year, you know, the real transformative ability to move care upstream, to do the kinds of things that really address the social determinance of health, if we're going to integrate mental health, public health, we can't do it with the systems that we have. So I'm wondering, who's in charge of figuring that out or finding some case management interoperability?

>> NEW SPEAKER: Absolutely. And I think that that falls to the Office of Health It and the state and the state CIO Caroline Lawson as well to really investigate and put this forward as options. We have talked to case management software developers. In fact, last week we met with one particular one. The idea that there are solutions, none of them are fully formed or developed or perfect as you know, but I think that there very could likely be at the statewide HIE level a case management tool put into place and offered as a solution. So I think these are some of the considerations that really need to occur and quickly. So in the next several months and we're having conversations with, of course, our PEB plans and other plans around this as well. It's not just specific to coordinated care organizations. It's really about coordination of care whether you're covered by a commercial plan or by the Oregon Health Plan, it's necessary. So...

>> NEW SPEAKER: [inaudible]?

>> NEW SPEAKER: I think I need more coffee because I'm getting really cranky.

>> NEW SPEAKER: Uh oh.

>> NEW SPEAKER: No good can come from that.

>> NEW SPEAKER: Coffee, quick!

>> NEW SPEAKER: I have a little left, but it's decaf.

>> NEW SPEAKER: Yeah, that's not going to help.

>> NEW SPEAKER: I have concerns that, you know, with this whole CCO, with the flexibility, they want people to have the warm fuzzy, happy feeling. I think that this software should be the bones of the system and we need to take a stronger standpoint on, "Yes, you must use it." And granted, I understand that it's a financial consideration, especially for the smaller areas and give them timeframes.

I am concerned, if we don't actually name some goals, name the software, give timelines, we're going to create a Franken-system where it'll never be integrated. I have huge concerns over it. Good example, at least years ago, Fred Meyer pharmacies were standalones. You went to one, your records never followed you. You create new ones at every Fred Meyer. I switched to Walgreen's because it's nationwide and they know who I am and forward it. I have huge concerns that we are not taking this IT seriously as
something that should be way above everything else because this is the bones of the house. Seriously.

>> NEW SPEAKER: Joe.

>> NEW SPEAKER: I would echo that, but I do think that there is an important practicality to remember. And that is, for instance, in the tri-county area 50% approximately, I don't have the exact number, of the physicians that care for the patient population that we're charged to care for are not employed physicians or part of a large system. And if we impose this standard upon them, the one that we very much would like to have, I am very concerned they won't play.

>> NEW SPEAKER: I would think...I would not want to do it everyone, right now, tomorrow. But CCOs, good starting point. Get the bones of the house going and then start drawing people in. I wouldn't make it a statewide standard, but for CCOs, something that's our purview that we want to work well, they need to coordinate. The coordination needs to be software. Software needs to be able to talk to each other. We need to start somewhere. And we can't let people make their...I hate to say it, can't let people make their own choices on the timeline or the software because it's not going to work. High-tech industry, you get your MRP for inventory, everybody can choose one. There's thousands of them. You talk to a customer, your MRP won't talk to theirs. It's horrifying. I'm just saying we need to really, really make some strong decisions on this.

>> NEW SPEAKER: So let me talk about where we're going next and that is we're about to move into a discussion of the plan. It has a number of topics that are going to be addressed. This is one of them. I'm not sure that we're going to get to it today. But between today and the next meeting or two, we're going to talk about a whole bunch of the sections of this plan. This'll be an opportunity for each of us to come back to it.

>> NEW SPEAKER: Mr. Chair, if I can drive off the cliff real quick, I don't know how long you guys are going to stay around. But I just have one question on...or not...one comment, not a question on 19 where you refer to direct. When I read this not knowing, you know, having down the packet several pages, I couldn't understand why direct was capitalized or what direct...you know, and I understand that between now and the 10th you'll probably brand this thing. But you might put a sentence in there explaining because when people pick this up and read that, I think they're going to be as confused as I was.

>> NEW SPEAKER: Sure. Right. I think that's a great point. I think they...and to the point of the small providers, I just would remind the board that there are types of providers that can receive incentive payments based on their Medicaid or Medicare patient mix and that will substantially move the dial on adoption of electronic health record systems. There are substantial number of providers that will be very, very important to the success of a CCO that will not be eligible for those incentive payments.
And that to which it will be cost-prohibitive and work flow prohibitive for some period of years. And so, you know, having a plan that is developed over time to increase those goals I think is really important. Setting measures and then having that reportability to those. We would welcome the chance to participate in that.

>> NEW SPEAKER: One more from Eileen.

>> NEW SPEAKER: I first have to say hopefully my colleague Dr. Hoffman can agree with me that has Carol not progressed into being a complete wonk since we've known her? She's really...

>> NEW SPEAKER: I'm not going to...

>> NEW SPEAKER: I'm extraordinarily impressed. Just a comment, I think. I'm remembering back to, and I'm going to forget the name of this gentleman's last name, Jacob who does the eco-system, the healthcare eco-system work that says, you know, generally there are a couple of hospitals of primary and a secondary that surround a care area and beyond Medicaid. And a set of doctors that work with those hospitals.

I'm just wondering, from an implementation standpoint, I have the same kind of urge. Like, this is great, how do we implement it faster. Is it possible to actually start at a hospital level and somehow the hospitals are going to pick up some of the responsibility for early adopters, getting some of these adopters on board? I don't know how the costs fall out, but it seems to me that it might be better if it was led by an existing set of providers versus the state. And if you could simply infuse the system and, you know, as OHSU communicated with Dr. Hoffman, they would bring Dr. Hoffman up to the 21st century.

>> NEW SPEAKER: Joe could write me a check.

>> NEW SPEAKER: And so I think that's been a very large part of [inaudible] process and consideration in developing a plan that has federated aspects of it. But CMS has really given us some clear directives and financial incentives to centralizing the approach to a greater degree. So I think states...we're looking at other states and how they're developing somewhat of a hybrid, you know, federated in some areas and centralized in some services approach.

The complication of this, and in many, many areas the hospitals are...under [inaudible] regulations, they can give a significant percentage of the cost to providers to adopt EHR systems. That said, not every provider is going to be interested in becoming affiliated with in that way. Not every provider is going to be comfortable, you know, with a state HIE necessarily either. So he bridge that, the key is that as you're looking at these technology investments as a state, I think that really trying to bring people to the table and saying, "There is CMS money available to help pay for the infrastructure of this. Not
just the electronic systems, but the HIE components themselves." And within that, you can get a lot more if you're not building it redundantly. So how do we come together and manage this and do it in a way that makes people feel comfortable? That's a big challenge.

>> NEW SPEAKER: Carol, thank you very much. We appreciate your help and your recommendations. Thank you.

>> NEW SPEAKER: Thank a lot.

>> NEW SPEAKER: Diana, you want to come forward?

[inaudible over each other]

>> NEW SPEAKER: A couple...three comments if we may. We have between now and about 5:30 to cover as much as we can of items 10, 11, and 12. And I know that there are two or three of us that have to leave when that time comes. We've extended the time for this meeting. So when that time comes, feel free to go ahead and take off. But what we want to do is begin the discussion of working through this and I will simply turn it over to you, Diana.

>> NEW SPEAKER: Thanks. Diana Bianca with Artemis Consulting. And in fact, we have a couple more things to discuss than what's listed here on the agenda. So let me just make a couple of preliminary remarks. Bruce talked a little bit about what the next few meetings look like and I just want to do sort of a quick reminder to sort of see how we're going to get from here to January 24th.

So the first thing we're going to do today is actually do a temperature check on a number of the items, the items you discussed last month. And I'm just going to briefly go over those to see if we captured, accurately captured, what all of you wanted included in the plan. So we're going to do that. And then we're actually going to talk about the items on the agenda, those three items that are listed out there. Next month on the 10th when we come back together, we're going to be marching through this proposal section by section. You will all have read it and digested it. But we're really going to be doing a very close check, especially on those issues that we haven't yet touched on to make sure that this is the proposal that you all are comfortable with, taking additions, deletions, comments and to make sure we're ready for sort of the final clean-up and approval on January 24th.

Now in the proposal, you'll see that it says in a number of places "the health policy board recommends." I mean, those are things, obviously, that you all have vetted or will vet. So all of those issues, we'll be covering. And...

>> NEW SPEAKER: I just said, "have recommended or will recommend."
NEW SPEAKER: Exactly. And the...but all of this, but I think the important part here is none of this comes out of left-field. I mean, all of this builds on discussions you all have been having, builds on what the work groups have said, what the fund board did. So this has been an iterative process. None of it is...my guess is that very little of it would be brand new to any of you. So that's a really important piece.

Now the other important piece here is even as you...as we go through today and the 10th and we get additions, deletions, comments, head nods, those are your preliminary recommendations, right. And they're still going to be preliminary because we still have public comment coming in. So all of this, I want to be really clear about that, we're looking for where you all have consensus and agreement and where we need to make changes. But we also recognize there's going to be more feedback coming in. So that's why the 24th is really the date that we're all working towards together.

So with that said, as I said the first item we want to do is sort of a quick check-in on last month's topics. And so before we actually get to the piece on the agenda about systems transition, financial solvency and accountability, I want to do a check-in on the four issues we discussed last month.

NEW SPEAKER: Is there a hand-out that you have for this?

NEW SPEAKER: No, I'm going to be referring to pages though, Eileen. So what we're going to be looking at, it's not...I don't have anything here that's different. It's going to be...we're going to be looking on the proposal. We're going to be referring you, starting right now, to specific pages. So does everybody feel clear and comfortable with where we're going? Yeah?

So one of the things that we discussed last month was community needs assessment and that is on page 11 so take a look there. And what you'll see...what we heard from you all and others that we integrated into this is that CCOs should work with community public health and hospital systems to develop a shared assessment. And we're looking at some administrative streamlining from a number of duplicate processes already that...to try to build a shared community strategic vision within available resources. And so that's what we heard from you all, that's what we heard from all of you. And I wanted sort of just to check that that's where we are, folks okay with that, any questions or comments. Lilian, go ahead.

NEW SPEAKER: I have just a couple...further up under governing board, the last bullet. Okay, so as I was reading, you know, the draft, when I got to community needs assessment, it felt that what was missing under the last bullet under governing board, "how the board make-up reflects the community needs, imports the goals of the healthcare transformation," I would like to put in there, "and identify issues in the local community needs assessment." Because I think these are not standalone processes. We're creating a whole cloth. And I think that's a missed opportunity if we don't call it out.
And then under...then back in that paragraph, community needs assessment, "recommends that the CCO partner with a local public health," blah blah blah. Somehow, I don't if the bottom after areas can be meaningfully compared, recognized. Given our conversation we just had earlier and it struck me, I'd like to somehow put in parentheses or something. Say like, "See [inaudible] or health information exchange recommendations," so that, again, it's very clear that we're recommending that people go back to the date. Bottom of page 11, that sentence continues, Chuck...

But like somehow reference them to that because we're talking about hard data, we're not just...

>> NEW SPEAKER: Okay, so going on to page 12.

>> NEW SPEAKER: Yeah, yeah. So those are kind of my initial things. When it says "publicly funded providers for payment for certain point-of-contact services," I didn't know, was that a way of not saying public health? And, you know, if it was meant to be public health, can't we say public health? I mean, I don't know...

[inaudible over each other]

>> NEW SPEAKER: We're on page 11. I'm sorry. [inaudible]...Okay, so under page 11, under the partnership paragraph, it's the end of the third...the third line to the bottom.

>> NEW SPEAKER: Other publicly supported programs...

>> NEW SPEAKER: Let's be...let's...what are they? And we heard earlier from the representative and the senator that in some places really there's no money for services in there. But there is this activity across the state. So...

>> NEW SPEAKER: Are there, you know, let's think. Is there an unintended consequence there? Is there other publicly supported programs that if you eliminate the catch-all and replace it with public health, that we've eliminated?

>> NEW SPEAKER: I'm not saying...I mean, I'm sure somebody's got a program somewhere that they want represented under publicly funded. But I'm just saying that the public health, it is concept...

[inaudible over each other]

...it's kind of a governmental contract with communities. It's not a program.

>> NEW SPEAKER: Got it.
>> NEW SPEAKER: Other comments on the community needs assessment piece? Specifically on that piece.

>> NEW SPEAKER: How about any comments on that piece?

[inaudible over each other]

>> NEW SPEAKER: We're looking at community health needs assessment right now. And then we're going to look at health equity. Then we're going to talk about global budget. Then governance. Okay, these are the things we discussed last month. Then we're going to talk about systems transitions, financial solvency and accountability.

>> NEW SPEAKER: And today, we're going to talk about equity...

>> NEW SPEAKER: Yes, I did say equity. So I'm going to really try to have us be disciplined because there's so much to talk about and we'll get there.

[inaudible over each other]

>> NEW SPEAKER: The next piece is equity on page 17. And now what you talked about last time we came together was...

>> NEW SPEAKER: I'm sorry. Can we go back on the community needs assessment? The thing that I thought was missing was the idea that that's transparent and public so people can actually see it?

>> NEW SPEAKER: And we did talk about that.

>> NEW SPEAKER: I mean, that's exactly...what did we miss or what has occurred to you since? So that's great. And so if we go look at equity, and that's page 17, what we all talked about was the importance of CCOs identifying health disparities, baseline data, as part of the community needs assessment. And you all were pretty explicit about CCOs working with the Office of Equity and Inclusion to identify which components should be included in the assessment. So you said, "Let's pull on that existing expertise and have CCOs use some of that."

>> NEW SPEAKER: I remember that.

>> NEW SPEAKER: Good.

>> NEW SPEAKER: I'm concerned about this piece. And I have a couple concerns. One, I feel like it's this broad wonderful statement of nice things, but it doesn't say in here somewhere...it doesn't say that part of the goal of the CCO should be eliminating health disparities. Where is that? I feel like we've had that discussion, I feel like maybe we
haven't. I'd like to put it on the table. The goal of the CCO should be to eliminate healthcare disparities.

>> NEW SPEAKER: I guess one of my questions would be, and I don't know the answer to this, is that somewhere in the metrics or is that somewhere in what would be measured? And I don't know the answer to that.

I guess I don't understand the difference between talking about it in this paragraph and putting it in the metrics. I think it should be...

>> NEW SPEAKER: No, I'm just saying is it somewhere that we should...in addition to here?

>> NEW SPEAKER: I think it should...I have a lot of comments on the metrics section. But I think it should be part of the metrics as well and identifying and reducing the disparities that are outlined in the metrics. But I also think if we're going to have this piece of the conversation we should be explicit about what we're talking about there.

>> NEW SPEAKER: So Felicia, a statement that CCOs should be working toward eliminating health disparities?

>> NEW SPEAKER: I just want to say that I have that on my list. I don't know, on this thing. Appendix A.

[inaudible over each other]

>> NEW SPEAKER: Page eight of ten. "Ensuring health equity including interpretation and cultural competence and elimination of avoidable gaps in health quality and outcomes as measured by gender, race, ethnicity, language, disability, sexual orientation, age, et cetera." That that becomes...

>> NEW SPEAKER: Yeah, I get that it's in the appendix...

>> NEW SPEAKER: It says improving health equity and reducing health disparities. So...

>> NEW SPEAKER: So I think what you're saying is let's put it into the document.

>> NEW SPEAKER: Felicia...

>> NEW SPEAKER: There's two words. It's we recommend and we encourage. But we don't make them. Is that the problem?
NEW SPEAKER: Yeah, we're not recommending that you eliminate health disparities. We're telling you you should eliminate health disparities. We're not encouraging people not to be, you know, a little bit racist. We're saying don't be.

NEW SPEAKER: So the language that is in some of the other paragraphs that might work here is, "be required to demonstrate."

NEW SPEAKER: Yes.

NEW SPEAKER: So CCOs should be required to demonstrate.

NEW SPEAKER: To demonstrate elimination of health disparities.

NEW SPEAKER: Thank you.

NEW SPEAKER: Should be required to elimination of health disparities.

NEW SPEAKER: [inaudible]

NEW SPEAKER: You can't shout out, Caroline.

NEW SPEAKER: Okay. Anything else on health equity? All right. Global budget, page 20. We had a big discussion about this last month. And you all said it's an all-in strategy, unless it can be shown that the services are delivered more efficiently with better outcomes if dollars are left outside the global budget. So you said we're starting with the presumption that it's all in. Yeah?

NEW SPEAKER: Everybody remembers that and still agrees?

NEW SPEAKER: And Diana, the language around that, is the second bullet? Is that where it says, "clearly define Medicaid services and programs not currently included?" I want to make sure we're clear on that. I'm on page 21.

NEW SPEAKER: It's also on page 20. The third paragraph: "in considering which Medicaid funding stream should be included..."

NEW SPEAKER: Yeah, the budget should start with the presumption that all Medicaid dollars are in the global budget.

NEW SPEAKER: With the exception of those that are carved out by the legislation.

NEW SPEAKER: Joe?
NEW SPEAKER: And it has the statement after that about the...about what that includes. So...

NEW SPEAKER: Yeah, I like it being all-inclusive, but I'm...I'm very concerned about the manner in which it was determined. I mean, for instance, right there on page 21, it says, "under this approach, potential CCOs would submit a completed base cost template using internal cost data that is representative as of January 1, 2012." That seems to be locking this in the past. And it doesn't seem to me to be open to system redesign. I mean, that was very concerning to me because I don't think we want to base what we're doing on the past. I think we want to encourage new ways of doing it. So I would not want...I mean, I'm not saying I know at this point how to do it, but I don't think it should be based upon something that we've done. And I think that by definition our saying wasn't successful.

NEW SPEAKER: So we should be looking at a different way to state that that doesn't set it on that date?

NEW SPEAKER: Exactly.

NEW SPEAKER: Funding streams all in, but...

NEW SPEAKER: Okay, so global budget, we're okay on that one?

NEW SPEAKER: Yep.

NEW SPEAKER: I just want to reiterate...in the global budget section is also, on page 23, is the quality incentives payment piece. And I know that wasn't what we talked about last time. But again, I just wanted to...I don't know if you captured that from the earlier conversation about having shared savings or not dropping payments for the succeeding years if we see success in initial years. So some early framework for this incentive program.

NEW SPEAKER: And I'll just say on a piece like that the comments, you know, the discussion that you all had earlier, those things, if they had direct relevance to the proposal, hopefully will be folded in and we're going to be talking about that explicitly in the next month. But I appreciate you pointing that.

NEW SPEAKER: Diana, quickly getting back to that second bullet, I just wanted to make sure that that second bullet is paralleling the language on page 20. I just...

NEW SPEAKER: The second bullet under global budget [inaudible] development, Mike?
>> NEW SPEAKER: Right. So basically we're just...on page 20 we're saying all-in. I just want to make sure that's echoed in that second bullet there.

>> NEW SPEAKER: Got it. Good. Yeah, that should be consistent language. All right. Now the next...?

>> NEW SPEAKER: Can I ask...so Mike this is really just a...that bullet is really about part of this will be in capitation. It's all in the global budget, but part of it's in the capitation and part of it's outside the capitation. See what I'm saying? It's not all...it won't all be in the capitation.

>> NEW SPEAKER: That's fine. But maybe there's a third bullet that...the initial piece is CCO's initial global budgets will include. And I think the point is that all Medicaid...

>> NEW SPEAKER: Okay, so just need to make that clear. So maybe that's the first bullet. Okay.

>> NEW SPEAKER: But I understand the capitation piece.

>> NEW SPEAKER: Okay. So we're all set on global budget. The next piece that we wanted to talk about, and this actually...there's two different pieces to this conversation, is on governance. So I'd like you to take a look at page 10. And there's two different pieces of discussion here. The one is to just check in about the conversation you all had last month. And where you ended up was we don't want to be...we want to have some baseline, but we don't want to be too prescriptive because we really want to make sure, you all said, we really want to make sure we go within the statutory definition. But we understand and we heard a lot about this today, that there are different needs in different localities. And so you all said let's have some important pieces here but let's also make sure we're not too prescriptive. So that's the check-in on last time. Is everybody there? Because then there’s piece that we haven't yet discussed that I want to move to.

>> NEW SPEAKER: Can I just ask Felicia: have you looked at page ten?

>> NEW SPEAKER: I'm on page ten.

>> NEW SPEAKER: Yeah. Since you've been following this really closely, did this end up about where you were hoping?

>> NEW SPEAKER: I...I think I'm missing. I have some notes here, but I don't know. And I don't think we're going to get to know, frankly. I feel like we're at a place where, I think, we've heard from the legislators, their concept that the bill says 51%. I think it's that other 49% to be determined by local communities. And I think it really comes down to holding these boards accountable. And I feel like, you know, I have a lot of tension around this issue because I get really nervous that when we have the discussion about
governance and choosing people to lead these organizations, it really is going to be about who are the pickers are. And so if you're the entity that is the risk and you're the 51%, most likely you are going to choose people who are like you. That's just the way things are, right? I don't want to...it's how people operate.

And so if you choose a board that's like you and you have a firm belief in moving that board forward and meeting these metrics and really having accountability and all of those things, that's fantastic. If you choose a board who's like, but then they don't hold you accountable to anything and you don't meet the metrics and you really are shifting in inappropriate ways, et cetera, then I feel like there has to be a point of stepping in.

>> NEW SPEAKER: So that's with the accountability conversation. Got it. Okay.

>> NEW SPEAKER: The two things that I...

>> NEW SPEAKER: But I do have a comment on this piece, which I think ties back to another piece. I feel like I did hear a lot of discussion about basically settling disputes, right. I think that we've agreed that there's a dispute resolution for the CCOs. And the patients. There's a dispute resolution against major providers. Right, so if a CCO gets in a fight with a hospital then there's a dispute resolution for that.

I didn't hear about...so there's a clinical advisory council, and I'd like to charge them for developing a resolution process for individual providers. So not big systems, right, but if you have a primary care physician who's feeling like the CCO is prohibiting or limiting their ability to meet their outcomes with their patients, who's the arbitrator on that?

>> NEW SPEAKER: And you've actually taken me exactly where we wanted to go, which was, specifically, to the discussion about the clinical advisory council as well as the community advisory council. So let's start with the clinical...

>> NEW SPEAKER: I just have one thing. Just one thing I didn't see, just making sure we have a link on the document, maybe on page ten somewhere, to appendix A. Because I think that's what we're trying to show so that we have people being able to get into the detail there.

>> NEW SPEAKER: Good. Great. So I think before we move to the clinical advisory panel and the community advisory council, anything else on that governance piece that we talked about last month? Is everybody...did we capture what you all discussed last month? Okay.

So before now we move into...we're very close to moving into system transitions, financial insolvency and accountability, but there is two pieces that we just wanted to double check because they're, like everything in here, important.
Under the community advisory council, the health policy board recommends that at least one member, either the co-chair or the chair, also serve on the board, the governing board of the CCO. And we wanted to make sure that that reflected where you guys are.

[inaudible over each other]

...And then the second piece was on this clinical advisory council that the policy board would encourage, although not require CCOs to establish a clinical advisory panel. And it sounds like Felicia, you would like to see and I'd be interested to hear from other folks that...would you want that reflected in here, your statement about...if there is a cap that they set up some resolution process for individual provider arbitration. That's what you were saying, yeah?

>> NEW SPEAKER: Yeah. I feel like there are several ways, I feel like, that issues have to be resolved in the CCO before being taken to the next level, right? One if with large providers, one is with individual providers, one is with patients. And then the other is maybe there's a community...community based issues, right? If you're in charge of public health, folks in the community who may not be participating in your CCO should be able raise issues about your community behavior.

And so how do those...I don't know if that's in this section under governance or if it's under accountability and I know there's this dispute resolution section. So I don't know where that is.

>> NEW SPEAKER: So it's those different levels of settling disputes. And I guess that was my question. Is it the ADR...in the alternative dispute resolution piece? Okay, so we will figure that out.

>> NEW SPEAKER: Should we be going this far down the chain? Because I know we need to have dispute resolution with the CCOs. But now you're almost getting down to the employee-employer handbook thing. Should we be trying to go that far and telling the CCOs how to manage their own employees and supplier base? I don't know if we're overreaching ourselves.

>> NEW SPEAKER: I don't think we should be telling them...I think they should establish a process for it. That's what we should tell them to do. And it could be...maybe it's a crappy process some place and a great process other places. But they should have some sort of way that's a transparent way for people to raise and resolve issues.

>> NEW SPEAKER: So easiest thing I can think of would be give us a copy of your supplier contract and it'll be a one page contract saying that we agree to arbitration. Or something like that just saying that they do have a system. We don't want to reach far down and start slapping them around...
>> NEW SPEAKER: It sounds like you're saying you should have a process. And all of you know that there are some federal requirements already around Medicaid and dispute resolution. So it may be that what we need...I think you all are agreeing.

>> NEW SPEAKER: I guess I have a question whether that process should be in the cap. I wonder if that's the right place for it. I have two questions. Number one, should that be spelled out as a cap activity? Because it seems to me there's a lot of other cap activities that are necessary and why in the world we would encourage but not require a cap is beyond me. I don't know where that came from. Well you got to have one, don't you? It seems to me you got to have some sort of clinical...I mean what sort of CCO wouldn't do that, I guess?

>> NEW SPEAKER: So let's just start there, Chuck. So do you guys...

>> NEW SPEAKER: So we're on page 11. It says clinical advisory council. So let's take this one piece at a time. So what Chuck is saying, it says encourages but would not require. And I think Chuck, you're saying we should require.

...so that's the first piece. Go ahead.

>> NEW SPEAKER: The one thing I think that I see over and over again in this whole thing is encourage and recommend. We don't tell. And I think that we are getting a little bit to wishy-washy on things and we need to start telling and requiring. And sometimes recommend. But really, I can look through this and go, "Hey, you just recommended it. I don't have to do that. Are you kidding me? You just recommended it."

>> NEW SPEAKER: Yeah, and I guess my question would be, if we're going to require things...we're used to calling these medical advisory committees. But now with the integration of all the other care, I think clinical advisory panel is a good name. But it seems to me you have to have one of those. I don't know that dispute resolution is a best use of that. Maybe it is. But I know there's a lot of clinical stuff that's going to have to be dealt with.

>> NEW SPEAKER: So let's take the dispute resolution piece in a minute. But is there specific comments on requiring this versus encouraging this?

>> NEW SPEAKER: Yeah, just a general comment and I think we have to be very careful. In my mind, there are really two classes or groups of CCOs. And I think when we
eventually get the exchange in a commercial market, there will be plenty of CCOs. On July 1, 2012, I'm very concerned that there are not. And I think what we're doing here today suits the exchange and the commercial market very well. But I really am beginning to fear the barriers that we're putting up to the organizations that might form to serve the most needy among us. Because the people that are going to participate in that are only going to participate out of a community spirit and a sense of community obligation. So it is in that group that I get worried as we become more and more prescriptive and the time period becomes shorter and shorter.

I couldn't be more endorsing that we require a clinical advisory council. It's just as I've listened to the discussion there is a certain sense of urgency of finding...putting some organization together, especially in the tri-county area, that's going to meet this patient population's needs. And I am as...probably more worried that we will not be able to get that done in a satisfactory manner in the time period that remains than I am...I'm confident that we will evolve over time. I am not as confident that we will meet the crisis before us.

>> NEW SPEAKER: Got it. Go ahead, Mike.

>> NEW SPEAKER: I mean, I think I would just echo part of what Joe was saying. I mean, I agree with Chuck that I think it's going to be a necessary component, but I think that's for every CCO to make that determination.

>> NEW SPEAKER: Go ahead, [inaudible].

>> NEW SPEAKER: I kind of agree with my co-person over here. However, you know, I just think there needs to be a happy medium. Because we recommend and encourage throughout this entire document. We do have to require some things so that we have a good...this is my thing for today. We got to have a good bones of this. And encouraging and recommending throughout an entire document doesn't lay a good foundation. We have to require something.

>> NEW SPEAKER: Can I just comment? And I think, again, people can tell me if they don't agree with this, I do think that the board's position...the board's place here is that we're making a set of recommendations to the legislature. The legislature is the body that can require. I don't know that we can require anything.

>> NEW SPEAKER: ...we're recommending that the legislature adopt?

>> NEW SPEAKER: But we're recommending the legislature...so wait just a second. So we're recommending that the legislature encourage CCOs to do...?

>> NEW SPEAKER: No, no, no, no, no. I actually would agree about the encourage language. But I do think, you know, you make a recommendation to the legislature.
NEW SPEAKER: But those are two different...there's a set of recommendations and you would recommend that CCOs be required to do X, Y, and Z. I mean, you can make a recommendation...but the Health Policy Board would be saying, "We think you should require X, Y, and Z."

NEW SPEAKER: I guess I want to go back to what we're sending to the legislature. Because what we're sending to the legislature, which they will have an up or down vote on, is a piece of legislation...

NEW SPEAKERS: No.

NEW SPEAKER: We are. We're sending a piece of legislation that is outlined in this packet. Let me just finish what I'm saying and then it will make complete sense, hopefully. So we're sending a piece of legislation that the legislature will have an up or down vote on. And then we are sending a plan for the legislature that is an agency plan of implementation that the legislature will say, "This looks like a good plan. I would add or change this in the plan." But they are not going to have an up or down vote on the plan. Right, is that my understanding? And so what we're trying to come before them with is that plan. This is that plan.

NEW SPEAKER: The way I've been viewing it, their vote on the legislation is their vote on the plan. So if they give an up or down vote on the legislation, they're basically approving the plan. That's the way I've been viewing that.

NEW SPEAKER: Yes.

NEW SPEAKER: So they go hand in hand?

NEW SPEAKER: So this is the plan we're sending them, right? Okay, thanks.

NEW SPEAKER: So on this requires versus encourages, on this, on this specific clinical advisory...

NEW SPEAKER: Requires.

NEW SPEAKER: Requires.

NEW SPEAKER: The way I look at it is basically we are requiring two board subcommittees if you will. You know, instead of a nominating committee and a by-laws community, we're recommending a community...we're recomm, see now you got me doing it. There must be community advisory committee spelled out here and there must be a clinical advisory panel.
>> NEW SPEAKER: So the question I have: is there anybody who has concerns, who does not want to require clinical advisory panel?

>> NEW SPEAKER: You know, if there's a majority I'll go along with it, but I still feel like, I mean, that's for every CCO to make that determination. At the end of the day, we want to see that they're meeting the outcomes within the budget. How they get there, again, they may have some separate group that does that. I don't know, I think...

>> NEW SPEAKER: Well, I get that, Mike. A rose by any other name, I guess, smells as sweet. But, you know, from a clinical standpoint, I guess and that's where I'm coming from. And I guess I'm coming from it because I'm a clinician. There are clinical issues that will come before the CCOs that need to be dealt with by some sort of mechanism. And I guess you can call it whatever you want, but I think we should require that there be that process. So I don't really care what the name is. But does that make sense? And I think we're saying the same thing. It's just that, you know, this is a name and what you're talking about is a process so there needs to be a process to deal with those clinical issues. There has to be. And they're going to be more complicated, in my opinion, because of the integration of many different services, not just acute medical services.

>> NEW SPEAKER: So I don't know, Mike, if you have a direct response, but I have Eileen and Lilian too.

>> NEW SPEAKER: I guess my response is, you know, every plan today has those. Are they required? No. But they have them. That's my point, that part of the process is it's in their best interest to do that.

>> NEW SPEAKER: And I'm good with that. But then why do we even have that encourages, but would not require. I mean, you know, why even have that?

[inaudible over each other]

>> NEW SPEAKER: Let's hear from Eileen and Lilian and then let's see if we can figure out where we're in agreement...

>> NEW SPEAKER: It's beginning to sound like we're into a four-hour meeting here. Yeah. This just gives me an opportunity to say what I had thought about this document. That what seems like it may be missing in general, and I don't want to add too much flower language to this. But there's some value statement pieces, almost like why we're doing some of these things. So, for instance, on the clinical advisory panel, to me this is where we jumpstart the learning organization. This has to be a learning organization with innovation where clinicians are learning from each other, where lessons can be shared. Or we want a community needs assessment because we're trying to improve the health.
So I'm fine with requiring the clinical advisory panel. But I wouldn't mind having a little bit more purpose statements written into this so that we get the transformational impact that we're looking for.

>> NEW SPEAKER: Lilian.

>> NEW SPEAKER: Just quickly, Joe, I think what you said, i think, resonates particularly today after yesterday. But I think another way of looking at it, it's giving...these are complicated...we're going to be asking providers to perform in ways they haven't before. And play with different tools in the sandbox and different kids in the sandbox. And, you know, it might actually be something that they...it would help them take the risk to stay in with this complexity of outcomes that they're responding...they can't control just their discipline anymore.

And so, I think it might actually work in the other way that they feel they have some place where they can air what's not working that isn't the bureaucracy of the funding mechanism of the CCO. So...

>> NEW SPEAKER: So we're going to change the language to say "requires." Any other comments on that and then I'm going to make a...so everybody's okay with that? And here's what I'll say. I mean, we're looking at the pieces of it. And what I'm really going to urge you all for January 10th is to really take a holistic view of the document. Because there's going to be things in here that you say, "We absolutely have to require that." And then there's going to be things...to find that balance between prescription and flexibility that then you'll say, "You know what, that's where we're going to have a softer touch on that one." We're going to march through it on the 10th, but I really want us to be looking at it as a whole document.

And it may be, Eileen, to your point about what's the purpose. That may be somewhere in the beginning to sort of let's set the stage. Why are we doing this? What's the underlying purpose here for all of these pieces that are being put into place? So maybe we could capture it that way.

Okay, so now we're going to move on to what's actually on the agenda, which is...and this is...and again, these are things that have come out of...these don't come out of just nowhere. We're going to start with page 32. These are things that came from you all, from work groups and from work coming before. But if you go to page 32, we're going to be talking about system transitions. And what's key here is that there are a number of incentives. And this goes exactly to what we were just talking about which is how do we...what incentives do we put in place for folks to form CCOs as early as possible.

And so listed out here are some financial incentives, enrollment incentives, and flexibility incentives. And then if you look under that next piece, transitional provisions in 3650, also walks through, you know...if it's not a CCO, you still have to do these things because
they're in the legislation and the legislation is going to require you to still do that. The question that, you know, we wanted to check in with you all on these incentives, are these the right ones? Are we missing anything significant on some of the incentives? Because this is really critical. Any concerns about what's here?

>> NEW SPEAKER: Now which page are you on?

>> NEW SPEAKER: I'm on 32, it says "Transition Strategy." There's three bullets. It says under nine, implementation plan, transition strategy, and then there's three bullets right there. They're limited to, they should include but are not limited to the following options.

>> NEW SPEAKER: I don't know whether this is...if a threat is the corollary to an incentive...

[inaudible over each other]

...we're trying to have the incentive, but I mean, I remain very concerned that certain organizations won't play and there's, especially with the population that I just alluded to, there's been a lot of discussion over the last six to twelve months about play or pay. But I don't see any reference to that.

>> NEW SPEAKER: I think that's in accountability.

>> NEW SPEAKER: Well, I didn't find it under accountability. So to me, it has to be in either incentive or accountability. I don't know which...I actually don't know which category it's in. But I couldn't find any reference to that here. You know, what is, if we're talking about community solutions and you're an organization that exists for the community benefit, what incentive is there for you to participate if the financial incentives of not participating are greater than those of participating? And I can't find that in here.

>> NEW SPEAKER: Do other folks have comments? Or how...I mean, if you all say we want that reflected in here, we'll find a place for it. So I guess what I want to check in with you about, is that something that you want included? And if so, give the spirit of what you would want included there.

>> NEW SPEAKER: Joe, can you give us...if we don't have that, what's the scenario, what happens, what's the risk? So we can understand it better. I'm not asking...I think I agree with you.

>> NEW SPEAKER: If you don't have it, I mean, there is a lot of incentive just to stay out of the way. I mean, it's going to be a long time before the CCOs dominate the commercial market. It will eventually happen, but...and I think it probably isn't going to
happen now at the rate that we were anticipating when we first convened. And we thought that that was going to be enough of a carrot to draw everyone in. But I think the carrot will still be there. But it's going to be much further down down the line. And I think that you could easily make the assessment that it would be in your financial best interest to stay on the sidelines for a while.

>> NEW SPEAKER: And who would this pay or play apply to?

>> NEW SPEAKER: I think that's what we...it has to...I don't see how we...you have to apply it to those entities that at least purport to have a public purpose.

>> NEW SPEAKER: So there are lots of non-profit entities in our state that are committed to the community good. They get benefits because of their commitment to the community good. So what you're suggesting is this pay or play is a testament to your commitment to the community good. If your mission has you committed to the community good, then you clearly will want to play because that's the mission of your organization. If you choose not to work within that mission and not play, then what are the consequences for that? And maybe that's paying because we've given you community benefits because of your mission is for the community good.

>> NEW SPEAKER: But it gets even more muddy because, you know...muddier. So I've decided to pay, okay. I've decided I'm not going to play, I'm going to pay because I feel a 17% over a year or two until this works out is more advantageous to my organization. So I'm paying.

But what that does...you know, we were talking earlier about cost shift. This is the part of cost shift I do understand is okay. Someone is going to have to pick up that slack now. They're going to suffer tremendously because of adverse election, if you will. So...

>> NEW SPEAKER: Well, then the question is, how do we incentivize you to play? So if it's a 17% cut, right. You don't...you've decided I'm going to pay 17%. What if I said then I'm not going to play. I just think it's unfair. I'm just not going to do it. So what if I said, "Okay, you don't have to play. Then we're going to charge you 32% actually. So you have to pay 32% or you could take the 17%. It's your choice."

>> NEW SPEAKER: Then I'm going to send my lobbyist down to...

[inaudible over each other]

>> NEW SPEAKER: So I want to see where folks are on this. I mean, I hear a number of folks saying, "Yeah, we should...there should be some piece here." It sounds like there'd be a number of details because I still want to know where folks are on this piece and how it might be reflected.
>> NEW SPEAKER: On the pay or play specifically?

>> NEW SPEAKER: Yeah.

>> NEW SPEAKER: I guess I was viewing it more like Chuck was saying. I mean, the pay side I have been viewing it as the cut. So that you can play or not. And if you choose not to then you're going to be taking that 17% cut and it's your choice. That's the pay side. I guess I'm being looking at that.

>> NEW SPEAKER: Yeah, I don't look at that 17% cut as the pay side because I think that can be avoided if you just don't treat the patient population. So you don't have to take cut. And I think the thing, as I've thought about this it could actually be very interesting and I'm way, way out beyond where I know anything, okay. Very transparent.

But since we are now have Medicare money mixed into this, I think it's worth a very close look at the federal regulations. Because there may even be a requirement that you play. Because if you don't then you may not be able to have access to any federal program. That would include Medicare. Now, I am so far out over my skis, but it did make me think that once you include the dual eligibles in this, it changes the nature of...this is no longer just about the regulations or no longer just about Medicaid and the uninsured. There's a whole new set of regulations that come into play.

>> NEW SPEAKER: So I think that's sort of a request of can we look into whether there is a lever there? And what do other folks...other comments about that because we could ask the OHA staff to look into is there a lever there?

>> NEW SPEAKER: And it might be a question for CMS too.

>> NEW SPEAKER: Yeah, CMS. What I want to know: do you all want to further explore that how would we...what lever would we use on that pay or play piece? Do folks have concerns about that further investigation? I mean, we're just talking about further investigation. Erik.

[inaudible over each other]

>> NEW SPEAKER: ...a specific part of that exploration could be to talk to CMS and say does Medicare participation, does your agreement to participate in Medicare, require playing? Because you're right. I hadn't thought about that. But, I mean, there are Medicare rules that are not...that don't apply to Medicaid, but if you roll them all together, now who are you playing with, Medicaid or Medicare?

>> NEW SPEAKER: So we have a lever there. We'll ask staff to go back and...

>> NEW SPEAKER: ...quickly, as effectively as we can. We need some options.
NEW SPEAKER: Yeah. Yep. Any other levers?

NEW SPEAKER: Not on...I just had on the transition piece, on the incentives. And Tina, we've talked about this, but we have financial enrollment and flexibility. I'm just wondering if there's an opportunity to put down technical assistance as an opportunity to...

NEW SPEAKER: Yeah, it's a nice...it's elsewhere, but it is also a benefit. Sure. Right. Good.

Okay, so, anything else on the play or pay piece that staff...you want staff to come back with?

NEW SPEAKER: Can we, on the technical assistant, also training assistants, because I think if you have some workforce issues, it would actually be incredibly helpful for the state to pick up some of the training assistance.

NEW SPEAKER: Okay. Anything else on incentives then? So folks good with this section, with the additions we've just discussed and the additional exploration of the pay or play piece?

NEW SPEAKER: Yeah.

NEW SPEAKER: All right. We're going to look at financial solvency. We're going to look at a pretty discreet piece of it because 3650...and let me tell you the pages. it's 27, 28, 29, 30. So 27 through 30 is a different way to say that. And now, 3650 is pretty prescriptive on the financial solvency piece. And one of the things we wanted to check in with you about is one of the things it says is that, in section 13D of 3650 directs the health authority to develop a process that allows a CCO to file financial reports with only one regulatory agency, okay. And that's a key piece and doesn't require a CCO to report information to both the health authority and DCBS. So there's this direction the legislation that it has to go to one agency.

So that's the one piece...there's one question we'd like to discuss which is does the board have some direction about which single agency CCO should report to. So that's the first piece. The second piece is, if you look at 27 through 30, there's sort of some, some structure that we've laid out, you know. If you look at, like, the first paragraph after the legislation. The Health Policy Board recommends that OHA collaborate with DCBS. You know, that paragraph right there. The second question I have for you is what's outlined there and moving forward, does that make sense in terms of the reporting structure, knowing that much of it is already prescribed by the bill, okay?
So the first question is on the single agency piece. And we were looking for some input from you all about, you know, do you direction about which single agency CCOs should report to on the financial solvency piece.

>> NEW SPEAKER: I guess my question is it's still transparent so OHA can get it from DCBS, DCBS can get it from OHA. So I guess to me it doesn't matter.

>> NEW SPEAKER: It doesn't matter. And that's what we're looking for. Do folks have thoughts about that? It's transparent. It will be collaboration. It will be a partnership, obviously.

>> NEW SPEAKER: It can only be one?

>> NEW SPEAKER: It can only be one.

>> NEW SPEAKER: I would say DCBS.

[inaudible over each other]

>> NEW SPEAKER: Where do MCOs report to now?

>> NEW SPEAKER: OHA.

>> NEW SPEAKER: But even to Joe's point, when you talk about the Medicare side and you think about what happens today with Medicare advantage or with [inaudible]... 

>> NEW SPEAKER: So do folks agree that it should be DCBS in close collaboration with the health authority?

>> NEW SPEAKER: Yep.

>> NEW SPEAKER: Okay. Then the second question is just...oh please.

>> NEW SPEAKER: On the financial solvency piece, I don't feel like there's anything about...I know there's transparency in the legislation on the financial solvency. I guess not. I think there's transparency somewhere in the legislation, but there's no...I feel like the organization financial of CCOs should be transparent somewhere...

>> NEW SPEAKER: So look, I don't know if this is what you're talking about Felicia, but if you look on page 28, the paragraph that starts with "the board recommends," the last sentence there, and it may not be sufficient to what you're addressing, "made publicly available as required by statute." And I don't know if that's it or you want more than that.

>> NEW SPEAKER: Yeah, except it wasn't in the...
>> NEW SPEAKER: In the section up here?

>> NEW SPEAKER: It's not in the section of the statute, so is that insurance statute? Where is that statute?

>> NEW SPEAKER: No, it's in 3650. It's just not in this section.

>> NEW SPEAKER: That's what I thought. Okay.

[inaudible over each other]

>> NEW SPEAKER: This may be a nit and I'd be...on the top of page 27 and I think this is actually coming out of 3650, we talked about the filing of quarterly and annual audited statements. I'm not aware of organizations that look for quarterly audits. And if that is unintended, it could be a huge expense. And it may actually be in the...

>> NEW SPEAKER: So Tina it's at the top of 27. It's actually from 3650. It's 8A and it says, "the filing of quarterly and annual audited statements."

>> NEW SPEAKER: The filing of quarterly statements makes sense. The filing of audited quarterly does not.

>> NEW SPEAKER: So is that a fix?

>> NEW SPEAKER: We need to figure out what we can do.

>> NEW SPEAKER: So we have to figure out if that's a fix.

>> NEW SPEAKER: Whether this is a typo or we need to fix this.

>> NEW SPEAKER: Yes, because folks are saying that quarterly audited statement doesn't...

[inaudible over each other]

>> NEW SPEAKER: So does that have to go in the legislative concept?

>> NEW SPEAKER: Yeah. I mean, any kind of fix...

[inaudible over each other]
NEW SPEAKER: Okay. Anything else on the financial solvency piece, that paragraph at the bottom of 27, just the way it's set up, again, very prescribed by the legislation. Anything else? Folks okay with the way this reads?

NEW SPEAKER: Yeah.

NEW SPEAKER: Last thing, and we're going to have to figure out our time because it's 20 after 5.

NEW SPEAKER: Actually, I have a request. I have an unusually lengthy list of people who'd like to make comments. I know that accountability is a really important issue. I also know it's going to take some time to sort it out. So I'm wondering if we can put that off.

NEW SPEAKER: Yeah. I don't think...I would really not want to rush through this piece because I think it's really important. And I think it also could benefit from...on the 10th...and we got to talk about how many hours we have on the 10th. You guys up for a full day retreat? Because there's a lot. And I will say about the accountability piece is that is...really this holistic view of this whole proposal. And finding the balance between the prescription and the flexibility, finding the balance on the...and that accountability goes directly to that piece. So Erik, I think that's right on. I think to take it on at this point when you have such a long list is not the way to go.

But we'll figure out, for the 10th, we'll figure out sort of the order and if we're going to march through it. And here's what I actually know. There will be some pieces that we're going to want to lift up in that discussion on the tenth. And, you know, you'll be hearing from us about...really to take a close look because we're going...and getting feedback in advance.

NEW SPEAKER: Information to Tina.

NEW SPEAKER: Yeah, if as you read this and you're thinking, "Oh wow, we missed this, this, and this." To the extent that we have that in advance, we can work on that and then come to you with a more...further down the road. Go ahead, Chuck.

NEW SPEAKER: I guess I wonder if we could go a step further than that and still be within our open meeting laws. I wonder if there could be some facilitated discussion electronically on some of these issues, rather than just comments out of the blue. Could we do something? And realize, we're not going to be making any decisions. Those will come back, those discussions, I don't know.

NEW SPEAKER: Tina's saying I don't think so.

[inaudible over each other]
>> NEW SPEAKER: So I think the appeal for the meeting on the 10th is to have spent some time with the document, to get, if there are big issues, to get them to Tina in advance...

>> NEW SPEAKER: Can I ask a clarifying question? So are we still using recommend as long as it's not recommend to encourage?

>> NEW SPEAKER: Tina, I think we need to think about this. I was listening to that conversation as well. When this gets to the legislature, they're going to vote yes or no and it will be the plan. And I doubt they're going to vote yes to a lot of recommendations that have yet to be determined...I mean, I think we need to make some decisions about what is required and what is not. So maybe that's an offline conversation that we can have.

>> NEW SPEAKER: You know, and it may be that we can go through the document and sort of sort out where are we requiring...where we said require and where we said recommend. And sort of show that to you all and you can say, "These feel like the right place to recommend."

>> NEW SPEAKER: I think there are some places where recommend is the right thing to do. But we need to be clear.

[inaudible over each other]

>> NEW SPEAKER: I just want to say thank you. Good job. I mean, when I saw what we had to do today, I thought, "Well, good luck."

[inaudible over each other]

...you set up a process that allowed us to not get bogged down, but to get our thoughts on the table. So really thank you.

>> NEW SPEAKER: Well and that...and I appreciate that comment too Lilian because as we move forward, we're going to have continue striking that balance of you all have to vet this whole thing. And we have to figure out where the most important pieces are that you all want to spent the time on discussing. So that's going to be really key.

>> NEW SPEAKER: Thank you very much. So lucky agenda item 13 is basically a quick review of the timeline. Actually, Bruce went through it during the initial piece. I just want to make sure everybody understands we've got a public comment period, we've got a meeting on January 10, we've got another public comment period, we've got another meeting after that. During those two meetings we'll have opportunities for considerable discussion. But a lot of focus on the agenda. The agenda on the 10th will have nearly this many items. There may be some input, it's mostly for this group to discuss, reach
consensus, and move forward. And then we'll be ready to recommend to the legislature. Okay?

With that, we shall go to public testimony. And I thank you all for staying with us, thank you all for staying with us. I have, as I said, a pretty lengthy list. There are about 17 names on this list and we have to leave here at 6 o'clock so I'm going to ask everybody to be really crisp and I will promise that, in return, we will listen really carefully. And I also am going to ask in advance for some forgiveness. Some of these names I can read really well and a few of them I cannot so please help me get them right. First up is Deborah [inaudible].

>> NEW SPEAKER: You can call three people up at a time...[inaudible].

>> NEW SPEAKER: You know, that has been confusing in the past. It has. I think we can move it through this way. Good evening. How are you?

>> NEW SPEAKER: Great, thanks.

>> NEW SPEAKER: So I'm going to kind of watch the clock and after about a minute and a half, I'm going to start waving the watch just so everybody knows that we have to stay on.

>> NEW SPEAKER: Actually, I'm going to...I'm Deborah [inaudible] from Capital Dental Care and we're the largest dental organization in the Oregon Health Plan. We have about 33% of the covered lives in the program. I'm not going to try to cover everything that I had intended to cover today. I know I've spoke to individuals like Dr. Hoffman and I've spoke to Mike and perhaps at another time we can bring some dental people back. Because I don't really see where I'm seeing very much discussion or input from the oral health community in some of your conversations.

I've looked through a lot of the work groups. Many of us...a few of us were on those work groups. And we really struggled to try to get our voices heard. Because in all of this that's taking place, oral health is like a tiny little voice trying to make a big noise in a loud commotion going on. So hopefully again, I'll have an opportunity to come back and maybe share more detail. I do want to say that oral health has a distinct opportunity in disease management and reducing costs to address some of these better health outcomes, lower costs, those kinds of things. I have a whole bunch of ideas that relate to that.

The metrics that I see that have come out of...and I actually was on the metrics group. But again, I am a little tiny voice trying to be heard...don't really speak to oral health. They speak to county widgets or doing things. And that's not really what I think we're trying to do here. I think we're trying to...it's not whether somebody has a visit. Maybe I do things that doesn't even equate to a visit. Meaning I've been engaged, our plan, in a lot of primary care prevention where we're getting out in front of the disease. So you may never
get a visit. But then, I'm doing the right thing for the right reasons. And I think that's kind of what we're trying to get to here.

The dental plans are open to being early engagers. But you need to help us. We have no [inaudible] or a champion. We have nobody looking out for us. We're a very fee for service oriented system. That's how dentists work. We're not going to change them into global budgeters overnight. We need help getting to that place. But that doesn't mean that we can't be on the inside or trying to work towards these same health outcomes. But you have to help us. We have to have the leadership at this end.

It's also very difficult to get dentists to stay engaged when we are constantly fighting for the Save Adult Dental. I don't know how you have...you know, ten years of surgeon generals have indicated that you can't have health without oral health. Yet, in the 10.5% OHA new budget cut list, eliminating adult dental is in the top 3.5% cuts. So those are the first places you go. I don't understand how that's going to save you costs, get you health if you're...again, it puts tremendous challenges on those of us in the dental delivery system to keep dentists and dental health professionals engaged when they constantly think they're going to have a pink slip. Why are they going to give you chair time or give you investments of infrastructure if they don't know whether they have parity or not?

I would like to indicate just two examples where you could go. With disease management, two large, large insurance companies that have both dental and medical underneath them. ETNA itself in 2007 came up with a disease management program where they're actually using technology to look for those with chronic disease who have not had a recent dental visit and/or pregnant women. Case managers then proactively outreach. Then they followed those people as far as the medical costs and what they found in the study that they did, which actually covered more than one million of their members over the time that they've been doing it, they were able to save 9% in diabetic costs on the medical side, not on the dental side. 16% in coronary artery disease costs, 11% in cerebral vascular disease, and I probably mispronounced that.

SIGNA is also another dental, medical insurance carrier with a large amount of members. They, in diabetics alone, were able to save $2500 per patient that was actively engaged in oral health while they were being also monitored for their diabetes. So there's tremendous opportunity and these is just two examples of what we could get to if we work collaboratively towards integration of oral health into this transformation.

>> NEW SPEAKER: Thank you very much. And I think that we need to make sure that we reach out and make sure that the dental voice is clearly heard. Thank you. Appreciate it.

>> NEW SPEAKER: I should probably...
NEW SPEAKER: I think we're good. Thank you very much. Michael [inaudible]? Next up will be John [inaudible]. Good evening.

NEW SPEAKER: I'm Mike [inaudible]. I'm a member of the consumer advisory panel of [inaudible]. And you have my one-pager. My written testimony. I'll be brief, draw your attention to the last paragraph. You will have to require [inaudible] words, and I encouraged her to look at this as she left. I think you need to require this. It does not cost a person with a computer and an Internet connection a penny to connect to [inaudible] direct process. Point one.

Point two, and the second thing I have to say, secure e-mail by direct, after conferring with Caroline Lawson who is the health information officer for both OHA and DHS, you don't have to have just a blank screen like you have in regular email. You can have templates or attachments. It would be very easy, and I've proposed this to Susan, that cook up a very simple continuity of care form with the key activities of daily living and instrumental activities of daily living and risk factors on it. So regardless of whether somebody has an EHR, regardless of what kind of assessment they do, there is a lingua franca. There's a common language that can be used. This is not something which has to take a long time. It doesn't mean going to outside vendors. I've offered to do this work myself, as a matter of fact, because I have a lot of pride in what we've done in the state. And I think we can get this done well within the time limit so that every CCO that has opened on July 1 can, in fact, be using direct in this fashion.

NEW SPEAKER: Very good. Thank you very much.

NEW SPEAKER: Mike, can you write an app for that?

NEW SPEAKER: I will.

NEW SPEAKER: Is Mr. [inaudible] here? Next up is Paula Hester. Good evening. How are you tonight?

NEW SPEAKER: Good evening. I'm good thanks. You guys have a done a remarkable job today just sitting in these chairs. I'm Paula Hester with the Oregon school-based healthcare network. Obviously, for those who aren't familiar with SBHCs, this is our job is to be that voice for them. And I'm here tonight to really gain you all as champions for school-based health centers. I'm here to gain champions from around this room in that work. So thank you for taking time to listen to what we have to say.

We would like to encourage the board to include school-based health centers as providers and regional CCOs. They're talked about, it's not a requirement, it's suggested language. It's also suggested that they be paid for such series. Hmm, good idea. So in addition, we would request that SBHCs receive fair compensation to implement the requirements for coordination and outcome measurements. And especially as the clientele for the school-
based health centers are overwhelmingly low-income children and represent ethnic and racial minorities.

Everybody know what a school-based health center is? Okay. Like the doctor's office right in the school. And as our early founder in the sixties said, "Let's put health right where kids can trip over it." So they do that in high school, I hear. So they provide comprehensive medical services, mental health services, age-appropriate risk assessments, and as well as patient care and particular prevention messaging. We currently have 63 centers open in the state. I will point to the fact that in the top 3.5% cut that has been recommended is also $1.2 million of cuts to the SBHCs, which we just expanded from...in the last four years we're expanded from 42 to 63. So clearly communities talk about the needs that are there. And many of you live and work in communities where that will have an impact and it will keep those that are currently ready to be certified in the next year from being funded as well.

So those are some important things. 43% of SBHC patients are on OHP and all SBHCs help their uninsured patients, 42%, apply for Healthy Kids. So that gives you a total of, what, 85% who might qualify for OHP...OHSU, why am I saying that. I don't know. And this year, 81% of students that used the SBHC said they were unlikely to receive care outside of the school-based health center. So there are a lot of reasons, including those that are academic. Graduation rates go up in every state where SBHCs that exist and I think that's a formidable piece of data. I have testimony here I'll share with you.

And then I just want to share a quick story because I thought A, I want to ditto everything that was earlier by Pam Curtis around early childhood intervention. Let's ditto that to K12. The kids health connection services in Jackson County said in early November the SBHC nurse practitioner began seeing a 5-year-old girl who had asthma. She came to the SBHC with a cough, her lungs sounded loud, and her color was off. The NP gave her a nebulizer treatment and followed up in two subsequent weeks with three more treatments for the persistent systems. Although the family had a primary care provider, the father's reported that it was challenging for him to take time off of work and additionally they were uninsured. Based on this treatment and ease of access, the father decided that SBHC nurse practitioner was better situated to be his daughter's primary care provider. In turn, the provider has prescribed a daily medication for asthma that she was able to cover with some specialized funding she had, seen the girl everyday to get baseline function of her lungs and introduced the father to an eligibility specialist to apply for Healthy Kids. She's also scheduled the child and her two sisters for Well Child check ups.

I think that we know what it costs for a child to go to the emergency room, particularly when asthma is the number one issue for a child walking through the door and the costs that are soaring around that. And whether it's covered by the Oregon Health Plan or Healthy Kids or not, it still will be less expensive treatment if it's dealt with on a regular basis.
I think you all know that SBHCs are probably particularly the most specialized providers of adolescent care and I think it's really important that when we're talking about a group of people that are the least likely to walk through a physician's door, this is a great partnership. It's well within the communities of CCOs in that they are constantly utilizing all the services within the community to help ensure the overall security. And the other thing I think is really truly great is that the SBHCs typically have advisory councils. Many of them have youth advisory councils. I think [inaudible] County's youth committee is a very shining example of that, as well as others. And these kids are able to even bring back to their health boards recommendations on what can be done there to best serve them.

I think all the SBHCs are in a good position to meet the tier one criteria for a primary care home. And we just ask for your support and your influence on help changing that budget cut. Okay? Thanks you so much.

>> NEW SPEAKER: Very good. Thank you so much. We appreciate it. Next up is Arthur Towers and following would be Anne [inaudible]. Good evening, sir.

>> NEW SPEAKER: Hello.

>> NEW SPEAKER: How are you doing?

>> NEW SPEAKER: Very well. Thank you very much for the opportunity to visit today. I will be cognizant of your 90 second request. My name is Arthur Towers, I'm political director for service employees, local 503. And I wanted to visit with you about metrics, particularly for workforce. Today, we are 200 days away from the implementation of CCOs. We talked quite a bit about the bones of the system. But I also think we want to talk about the flesh of the system too. That is the workers who are going to be out doing the work. And I'd like the health policy board to consider the idea of metrics around workforce issues. We feel that there is a direct line between training of frontline workers, retention of frontline workers, directly to quality of care.

We believe that, especially with the advent of non-traditional healthcare workers in a variety of different roles, that there should be measurements that CCOs are held accountable for for training these workers, retaining them, giving them the chance to advocate for their consumers. And also making sure that consumers have the opportunity to choose their care providers, especially those that come into their home. We believe that consumer choice is the best way we have to ensure cultural competency of care providers. So I'll leave it right there. Hand around some potential workforce metrics for you to consider. And be in future contact over the course of the next six weeks.

>> NEW SPEAKER: We look forward to it. Thank you very much. [inaudible]?

>> NEW SPEAKER: Good evening.
NEW SPEAKER: Hi, how are you?

NEW SPEAKER: I'm very well thank you. My name is Anne [inaudible] and I'm here with the Oregon Foundation for Reproductive Health. We would like to recognize and applaud all the work that the CCO work groups and the Oregon Health Policy board have done to improve the affordability, quality and efficiency of healthcare as well as getting Oregonians the health services they need.

We did notice, however, there are no proposed core measures that directly affect women's preventative reproductive health and this needs to be remedied. Most American women are fertile for about 35 years and desire, on average, two children. That means women spend 30 years of their lives trying to avoid an unintended pregnancy and the remainder of those years trying to optimize the health of a pregnancy. The pervasiveness and duration of this need make a compelling case for routine screening for pregnancy intention in primary care. Knowing whether or not a woman desires to be pregnancy allows primary care providers to proactively provide contraception services and preconception care. Half of all pregnancies in Oregon are unintended and almost 48% of all deliveries are paid for by the Oregon Health Plan.

Family planning services have a 4:1 return on investment by the most conservative estimates. Contraception and preconception care are the most important preventive services that we can offer women. And they're not, to date, represented in the plan. We believe that the core measures of CCOs should include measures of unintended pregnancy, contraception services, and preconception care. And since unintended pregnancy, access to contraception, and poor pregnancy outcomes are all health disparity issues, that they should be included in the community health assessments that will be conducted by the CCOs once established.

We have submitted written testimony that provides both the rationale and the additional data for your reference. And please contact our organization as we would like to act as a resource for you. Thank you very much for your time this evening.

NEW SPEAKER: Thank you. We appreciate it very much. Next, I have five names that were all written by the same person. And I'm wondering if you want to come up at the same time. And I'll not get them all right. Tracy [inaudible], Mariam [inaudible], Laura Winters, Susan [inaudible], and Paula [inaudible]. Are you together?

NEW SPEAKER: We are kind of together.

NEW SPEAKER: Very good.

NEW SPEAKER: Yes, we're in the same group here. So my name is Tracy [inaudible] and I am the president for the Oregon Foundation for Reproductive Health.
And it's a non-profit organization dedicated to improving access to comprehensive reproductive healthcare. And I'm here because I, and the organization I represent, share a deep commitment to evidence-based medicine, as you all do. As Anne mentioned, the core metrics are fantastic, but there's an extraordinary omission that we need to recognize and remedy around this.

Family planning affects every single Oregonian. Certainly, most directly, child-bearing aged women. And according to the census estimates, there are over 750,000 Oregonian women of child-bearing age, between age 15 and 44. That's a lot of women. So that's over 750,000 women who are trying for 30 years of their lives to not get pregnant. And we really need to do a better job of helping them do that and helping them facilitate healthy pregnancies when they do want to become pregnant.

We really truly do know surprisingly little about women's pregnancy intentions and whether or not they have access to contraception and whether they are happy with it, whether it works for their life and whether or not they're taking folic acid. Those are very important indicators not only for health, but how our providers are giving health and recognizing those preventive opportunities where they come up. And so this board has a tremendous opportunity to impact how we assess and improve public health across the state and I very much hope that you will take care to remedy this in the revision.

>> NEW SPEAKER: Yes, we have a question.

>> NEW SPEAKER: So I think I've talked to a lot of people on the board about this being a missing area in the metrics and outcomes section. And I think one of the things I'm taking away from this testimony is is I actually think it just needs to be a domain and there need to be different metrics. So if you look at your metrics sheets, there are the metrics underneath it and then there are domains like behavioral health. I feel like there are a lot of different component to this, reproductive health, so I feel like it needs to be its own separate domain with a lot of different metrics that fall under...maybe not a lot. But a handful of really core, key metrics that fall underneath that domain. Especially given the percentage of Medicaid that's actually spent on pregnancy. So...

>> NEW SPEAKER: So Tina, I assume you can kind of address that for us and see what you can bring back. Lilian, do you have...

>> NEW SPEAKER: No, I'm saying bye to Joe.

>> NEW SPEAKER: Let's move through quickly. I think we're getting the core message, but if there are things that we haven't yet heard we'd like to hear more. Otherwise, we need to move along because we're about to get kicked out.

>> NEW SPEAKER: Right. I'm Dr. Susan [inaudible], same organization and thank you for allowing me to give testimony. As a clinical practitioner and HMO in Portland, I've
done a lot of wellness and prevention counseling with patients. Since the time with patients is limited, I've consulted the research literature for evidence-based results for the core medical problems that have the highest statistical evidence affecting the age and the gender of the patient that I'm counseling.

Your CCO metric from the Outcomes, Quality, and Efficiency metrics work groups addresses issues like diabetes care, tobacco use, blood pressure, core measures which have a prevalence rates from 5.4 to 25.8 in Oregon. However, a core measure missing from this and a core measure which we'd like to include is contraception and preconception care for women, mostly who struggle with issues such as birth control from the ages...for 35 or so years of fertility. This is extremely important. Women of reproductive age should be asked, "Do you want to become pregnant in the next year?"

And depending on the answer, should be offered appropriate counseling supporting contraception or pregnancy and folic acid use.

So why is this so important? In Oregon, 49%, or almost half of all pregnancies, are unintended. The Institute of Medicine states that there is a strong supporting evidence for counseling women during wellness visits on contraceptive use and counseling and preconception counseling. This evidence is backed by Healthy People 2010, the American Medical Association, the American Academy of Family Practitioners, and private health plans such as [inaudible].

One key issue that should be included is contraception and preconception counseling. And that is missing from your core values. I strongly encourage you to include this due to the phenomenal impact it will have on the health and welfare of the women and the families in Oregon. Thank you very much.

>> NEW SPEAKER: Thank you. And I'll say to the others if you have a similar message, I think we've got it. And this would be a time to quit while you're ahead. If there's something more to add, we'd like to hear it.

>> NEW SPEAKER: And submit.

>> NEW SPEAKER: And certainly submit anything you wish.

>> NEW SPEAKER: Okay. Um, I would just want to add...my name is Paula Abrams, I'm vice president of [inaudible] Choice and I'm a constitutional law professor at Lewis and Clark College also. I would just like to add a little bit of data in terms of financial costs in relation to reproductive health issues and particularly unintended pregnancies. Data that's fairly new, based on Oregon 2006 data, but a study that just came out in the last couple months indicating that, as you know, based on 2006 data that 35,000 unintended pregnancies occurred in Oregon in 2006 alone. And of the births resulting from those unintended pregnancies, 61% of those births were publicly funded. The 61%
translates in Oregon to 11,300 births from unintended pregnancies that were publicly funded.

The cost in Oregon, just in terms of Oregon state public money in that year alone, was $28 million of the health consequences of unintended pregnancy. So and you know, obviously I can emphasize the social justice issues and the importance of governing reproductive issues are considerable also. So...

>> NEW SPEAKER: We knew there were. Thank you for very much.

>> NEW SPEAKER: I'm Mary Rosenthal, vice chair with the Oregon Foundation for Reproductive Health. My message was much the same as my colleagues that very much, extremely important that preventative measures be included for women in the core measures. Okay.

>> NEW SPEAKER: Very good. And thank you all very much for bringing your opinions forward. We do appreciate it. I don't think we disagree.

>> NEW SPEAKER: So we had you at hello.

[inaudible over each other]

>> NEW SPEAKER: I've still got six more names and ten minutes. And now I'm getting to the ones that are harder to read. Caroline [inaudible]?

>> NEW SPEAKER: Thank you. Very close. [inaudible]. I'm honored to be here. I was given the...do I need a...

>> NEW SPEAKER: We're being webcast so this way everybody can here it.

>> NEW SPEAKER: I didn't know that. I'm Caroline [inaudible]. I'm honored to be here and Felicia [inaudible] has directed me to Tina [inaudible] who has been able to answer my question. My purpose to be here is to locate the curriculum committee. I am a home care worker. I have...I know how to dress. So I disguise my job clothing well. So I am honored to be here and I will make attempts to get covered so that I can be here as I am here today in the next two meetings.

I'm not going to name names and give credentials and stuff like that because that's not the purpose of my being here. But I initially say thank you to the gentleman in the corner who has directed me to be here to start with. Thank you.

>> NEW SPEAKER: Very good. Thank you very much. Thanks for being here.

>> NEW SPEAKER: I emailed that information to you.

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NEW SPEAKER: Thank you.

NEW SPEAKER: And I'm very sorry that the next one I know I can't pronounce but it starts with a "y" and he's from OHSU, he or she.

NEW SPEAKER: I think he left.

NEW SPEAKER: Very good. Jennifer [inaudible]?

NEW SPEAKER: She left too.

NEW SPEAKER: Betty Johnson.

NEW SPEAKER: Betty left.

NEW SPEAKER: Okay, we're moving through this. B.J. [inaudible]?

NEW SPEAKER: Gone.

NEW SPEAKER: Gone. Jim Carlson, I know you're here.

NEW SPEAKER: I choose to defer, Erik. I think a wise man right now would choose to defer.

NEW SPEAKER: I appreciate that, but you're the last name on the list and if you'd like to take a minute or two, we're here.

NEW SPEAKER: Just very briefly...

NEW SPEAKER: Jim, you can't help yourself, can't you?

[inaudible over each other]

NEW SPEAKER: I think Susan did an excellent job of laying out a lot of the information around the Medicaid/Medicare integration. I would just have three brief comments.

Number one is there are a number of excellent models out there that have been developed in the Medicare marketplace, in mature Medicare plans like Providences and [inaudible] and Pace models, special needs plan, institutional special needs plans, have really shown you how to coordinate care in this population successfully and to drive costs down. Because that has not been a part of the Medicaid program, there's not as much knowledge
about that within the Medicaid agency and folks who work there. But great deal of success.

There's a report out today from AARP's research institute that actually shows dual eligible beneficiaries actually have very high satisfaction rates with special needs plans, pace plans, institutional special needs plans. Higher satisfaction than in fee for service...

>>SPEAKER: I'd like to start by simply saying that it's great to be in beautiful Bend. I want to thank Mike Bonetto a member of our board and the Stafford-St. Charles Medical Center here at Bend. And I'm sure many others for making it possible for us to be here today. Mike, do you want to add a thought or two on that?

>> NEW SPEAKER: Thanks, Aaron. I would like to certainly thank my boss, Jim Degal. He couldn't be here today, but he really was very pleased we could make the accomodation. I certainly would like to thank Brad Slate, he's sitting over here. He's been the technical guru to set all of us up today and also Maggie Olsen who's been working with Tina to get all this coordinated. So many thanks to our staff.

>> NEW SPEAKER: Very good. Thank you. It is wonderful to be here. I will note for those in the room and others, we are available to the state of Oregon and others today by way of live web-streaming. So for those of you that are watching this through the web, it's a beautiful day to be in Bend and we're pleased to be here. We have a process by which questions and comments can be retrieved during the course of the meeting. so please feel free to use that process. We'll try to capture those and respond to them during the course of the meeting.

While we're here in Bend, one thing I want to acknowledge is that...is one of the folks here today is Ray Mao. He was a member of the Oregon Health Fund before and predecessor to this group and very much involved in this effort...

>>New Speaker: With that I'd like to move to the consent agenda. The consent agenda consists of...actually I guess I should start with roll and that reminds me: we have on phone, I believe, Nita Werner. All other members are present here. Nita, are you on the phone? Not yet, we hope she'll be joining us. So we'll be watching for her. All others present. The consent agenda consists of three items today: the minutes of the March 9th meeting we have recieved and the addition of Dan Clay to our Incentives and Outcomes Committee. And the addition of Paula [inaudible] for Healthcare Workforce Committee. Does anybody wish to remove any items from the consent agenda? May I have a motion to approve the consent agenda?

>>New Speaker: I motion.

>> New Speaker: Seconds?

>> Multiple Speakers: Second.

>>New Speaker: All those in favor?

>>Multiple Voices: Aye.
New Speaker: Opposed? [pause] Consent Agenda is passed. Thank you very much. With that I will turn it over to Bruce Goldberg.

NEW SPEAKER: I briefly just want to mention a couple of things. One is I think is everybody knows this past month has been fairly dominated by federal health reform and we'll have an opportunity to discuss that a bit more later on in the agenda. My take away from a lot of the discussions around health reform is that there is going to be a lot of opportunities from federal efforts that I believe we're going to be able to take advantage of to move our work forward and I think that it's going to give us a real opportunity to focus on delivery system change and the issue about without cost, quality, and value as well. As well as some real opportunities for population based health. We’ll get into that later today.

The other point that...issue that I just want to make everybody aware of is that over the next six weeks both the Department of Human Services and the new Oregon Health Authority are having a series of community budget forums to help the state. I notice about that in my report that each state agency has to put together an agency request budget, which is submitted to the governor late summer/early fall. The governor then puts together a recommended budget and then there's a legislatively approved budget, which is really the budget that the state lives with for the next couple of years. Agency request budgets are rather unique in that they are expense-only budgets that...it's not a balanced budget. Agency request budgets don't have a revenue stream associated with them so it really is simply a compilation of agency requests moving forward.

Over the last several years the Department of Human Services has really put together what we consider to be a needs-based budget, which was really trying to look at what common health and human service needs were across the state and across the spectrum of the program. Which is, you can imagine, that agency request budget ends up being about twice the amount of what was eventually approved. That was, and I think somewhat unique state agency has started to look at what the needs are rather than trying to predict what may or may not be available revenue wise and trying to stick within some what was to me an unknown budget

That’s been fairly successful, we've gone out into communities to get input on the budget. Really our policy forms, per se, but they're opportunities to let folks in communities know what health and human services are being provided, what the budget looks like, get some input from communities around the state as to what some of their priorities are.

Likewise, we need to put together...all agencies are being asked to put together what is a 25% reduction list for the Department of Administrative Services. That will be due later in the summer as well. That's being done, I think, in anticipation of what is likely to be a very difficult budget climate for this state which is Right now, looking at, potentially, a 2-2.5 billion dollar shortfall. A lot of that being driven by loss of a substantial amount of federal stimulus dollars that helped keep the budget together over this biennium.
I'll continue to keep the board apprised of...as we put together the budget, we certainly had, you know, some input from some policy option packages. And as we continue to move forward I'll keep the board apprised and in the loop to the extent that I think the board members as group or individually want to be involved but I think of course that both the budget and the reduction would be available to the board to review and comment on. So let me stop there and see if there's any questions.

>> NEW SPEAKER: Are you taking questions about the whole director’s report or just what you were just speaking on?

>>Bruce: Open for everything

>>Speaker: I wanted to comment, on the report itself. I was very excited about some of these measures. Our enrollment in the healthy kids program is looking strong. The PULSE enrollment is, I’m very excited about that. And the usage data related to the PULSE it’s fascinating so it’s being used and obviously we need to get more people involved that I’m impressed with the tracking system as well so kudos to the staff. I had a couple thoughts. One is, it occurred to me that we may be in might be useful for us to have maybe a small one- or two-person committee of the board that’s the budget committee to do some review not a detailed review but at least a 65,000 foot level review of the budget. Particularly as it begins to interact with these new federal funds. And we want to put some thought into that so I'm just going to put that as a placeholder for our thinking. It might be a responsible thing to do.

So that's that piece. Um, a couple other things on the report. It would be extraordinary...I love this report. I actually think it's a great document for us publically to be transparent about some of these things that are being done. If we could add to it, just like we have the workgroup committees. That report was great, by the way, just a nice summary report. But the staff in inside OHA is working on some projects that we're not updating on; so for instance the exchanges were the comprehensive plan or the technology. So if we could have some similar structure piece in that report on those items that would help to answer some questions for some of us last I am always on this issue of trying to understand our 800,000 lives, and who are these people and what are the medical status within that group. And so my last question to you is have we made any have we made any progress on that?

>> NEW SPEAKER: well yes but not enough I think that we have now got someone on board that I think you’ve met John Griffin who can help

>> NEW SPEAKER: who I cornered at breakfast actually. I was like I think this is the guy.
NEW SPEAKER: Yeah, to lead that effort. So I think we're beginning that in earnest. what I would say is this: what we've learned over the last three/four months has been a lot of information, little of which is compatible. And so we can present a lot of information about the public employees, how that information is gathered is very different from how it is in the Oregon health plan population the denominators are different the time periods are different the definitions are different. And we have quite a bit of work before us over the next several months getting that into a form that's comparable. And I've...so the work is really just beginning. And I've been reluctant to provide a lot of information that's really difficult to draw comparisons to because it's apples and oranges. And so as we get a little better with that over the next few months, we'll have more. But John, and we also have working with us on contract for a couple months. We have Dr. [inaudible] who was the chief medical officer for Kaiser for many years. He's recently retired, but he's helping us put that together as well. So I think that's going to be next...but you know, my goal is that by the summer we'll have some rudimentary things and that it'll only get more robust later on.

NEW SPEAKER: Questions for Bruce?

NEW SPEAKER: I simply want to add my kudos on the report and the contents of it. The PULSE is an early win and we should feel good about that. I want to acknowledge the participation of OH SU for making that one possible and then you in your associates for all that you did. So we are making progress.

Um, we have a very full and interesting agenda today. A lot, but a lot of good stuff going on. We'll start with a report with regard to behavioral health integration. Bruce, a comment or two about that?

NEW SPEAKER: Well, I just wanted to introduce Richard Harris. If board members and the public don't know Richard Harris is the director of our addictions and mental health division responsible for all its programs. Richard has a known to many here long history having led Central City concerns. He has a tremendous amount of experience in how behavioral health and addiction services are delivered really at that community level. And what we've been really working to do is really begin to focus more on how we can integrate both behavioral and physical health. It's going to be I think an issue that's going to help drive value and quality. And indeed I think today's agenda is really structured on beginning to show some of where we are, some problems here out in central Oregon. And hopefully some vision for where we can move some of this, which we'll get to later in the agenda. And so it's great to have Richard here.

NEW SPEAKER: [inaudible]...JOB [inaudible] and be followed by the presentation [inaudible]

...I think the first question is, the question we begin, is why should we be dealing with this issue now? I think that now that most of us who were have been in the field of
addiction and mental healthcare services for some time understand that people don't come to us that with just the one problem they come with a multitude of issues and if we don't address those we end up with having people spend...have more expenses in our whole healthcare system. So, there's no question that the services for people with mental health and healthcare lagging behind and is illustrated in the fact that people die a lot earlier who have mental health and addiction problems. There are huge health disparities and if we don't in some way or another start to address those, they will continue to drive costs but moreover people don't get the care they need. In the state right now need outstrips the ability to provide services. And that's another reason we need to be addressing this. I think that the system for delivery of mental health addiction and healthcare offers many silos and they and of being a very complicated system in fact it’s difficult to calm the system. More like a bunch of parts that sometimes relate to one another and other times don’t. The great opportunity here of course is that the formation of the Oregon health authority puts us in a place where we now have an opportunity to do this. Now that seems to be enhanced by the fact that we have federal health reform. It's also going to move us in the right direction. So little bit about health disparities, it’s quite clear that people in Oregon are having more serious health problems when they also have mental health or addiction problems. The average person with mental health issues dies somewhere between 20 to 25 years earlier than people who don't have that problem. If you add in addictions which has been even higher premature death rate here you come up with about 25 years less life that if you look down at some of the particular conditions you see that they’re mostly treatable and in some cases preventable. So it isn't just a matter of preserving somebody's later life. It's a matter of doing early intervention which would have large payout.

So we are under serving a population of people that mental health and addiction. And this is a chart that we've used a lot. We've done prevalence studies which would tell you that we have a lot more people with addiction and mental health issues and they're going largely unaddressed and you’ll hear from the folks here in central Oregon about specific studies about how that shows up in our healthcare system in multiple ways. But you can see, in terms of meeting the needs of the public this is not the total need of the public services is that were way way underserved.

The other characteristic of the system, not unlike the general healthcare system is that we spend a lot of resources on a small number of individuals. So if you look at the bulk of our spending in institutional care both in the state hospitals and residential programs were spending 60% of our funding though the slide says 50% it’s really 60% on about 14% of the population, which means that we're heavily loaded at the residential and institutional facility end. That keeps us from spending money earlier on out in the community to prevent institutionalization. So again this is really another illustration about not managing the whole system but managing the parts as they come along. The system tends to be complicated in many ways. But in Oregon when the Oregon Health Plan was initiated we carved mental health services out of that plan and there administered separately so then you get the 13 fully capitated plans
and you have what's known as the mental health organization and they are managed care entities that are mostly entities of counties and groups to manage the mental health benefits that come to the counties and so we then have two different kinds of managed care going on. One from that health services, the other for healthcare and outpatient addiction services. So those two systems don't really talk to one another in a business-like way, but they serve the same client.

Then we have our non-Medicaid services, which are those services that are in financial agreements with the 33 counties entities which pay for those mental health addiction services which are outside of managed care. So those are all contained within the contact mechanisms that are through the state and the county, but they [inaudible].

So we went to the legislature and were engaged in conversation this last term about well how do you how are we going to push these things together, how we're going to make sense out of this. There was some feeling in the legislature that we needed to do some changes and during the course of that time in the Ways and Means budget committee we made a presentation and worked with that committee around putting together a demonstration project around how you could integrate the services and how you could integrate the management and how you could integrate the finance. On three levels what we were trying to make sure we had a system that was focused on delivering integrated care. So this slide is really about what the goals of that were and it was clear that we needed to in many ways boil this down to meaning the goals for the triple aim consisting of serving more individuals with a higher quality of care. And so here were some of the very specific goals of the demonstration. So leaving the legislature, we weren't given a pile of money to go off and do this, but we managed to put together some resources that we directed. And Jane Ellen and [inaudible] and our staff has been working with the two projects that are currently going. You'll hear more about those as we go on.

So there were really three conceptual frameworks to these. One is the triple aim. I'm not going to talk a lot about that. I mean you guys are really familiar with that. The four quadrant model which is a model of behavioral health and healthcare services. And then a little bit about the three domains of governance finance and services.

So in case you haven't seen the triple aim yet, here it is I don't think we need to dwell on that. But for behavioral health and health integration in the triple aim we think the way that were going to improve population health is that we serve more of the people that we’re under serving now. We have to address disparities. And we have to serve more effectively those people who are symptomatic with mental illness or substance abuse disorders. And we do have to enhance the patient experience in care because it isn't just going to an acute care hospital or being involved in an out-patient drug treatment program, the real aim here is about being self-sufficient and able to manage their own lives with these what we call long-term illnesses that require management over a lifelong period. So we're using a recovery model now in mental health and addiction services in that what we need to do is make sure that people have full benefits of things like
employment and housing that go along with and help people deal with their issues over the rest of their lives and we also need to make sure to move away from presidential as the only response and that needs shortening up links of stay and moving people to housing and successful employment and we also at the same time need to reduce costs and we think that that is not just a short-term benefit, but if we are actively moving people in recovery and it reduces cost because they don't come back into the system. So, conceptually, the four quadrant model is the thing we're looking at when we're trying to determine what sort of services people might need, recognizing that we would love to have all of our clients in the low behavioral health and the low physical health category. But there's not many of those people that show up in the system. Most people that show up in our system are in one of the other quadrants and, of course, the most difficult population are those with coexisting health conditions and coexisting mental health conditions and addictions all simultaneous and when you look at the numbers from the central organ project will discover that most people are in this upper right-hand quadrant, which is doubly important that healthcare system and the addiction to the health system are working together on the projects otherwise they're going to miss a lot.

>> NEW SPEAKER: I understand most of the [inaudible]…can stand for many things. So, in this instance what does IP stand for in the analysis quadrant?

>>Speaker: Which quadrant?

>>The bottom to the right, medical-surgical IP.

>> You know you’ve got me on that. [pause] In Patient?

>> NEW SPEAKER: Okay, thank you, thank you.

>> NEW SPEAKER: So the four quadrant model really is the one that we're conceptually using one were trying to design things going forward with the various aspects of integration. So we're making sure that we're trying to move people to less acute conditions. That's the primary goal.

So...and there's many ways to do this. primary medical homes and the neighbor health homes and you guys do that in many ways in discussion and it isn’t very different here except that the medical home needs to include a component that’s actively working on behavioral health. My own belief is that it's somewhat easier to integrate services. It's more difficult to integrate financing because all the financing mechanisms have their own rules and regulations. And they’re not really designed to interact with the funding sources. They also...there's a big issue about how you integrate the governance of these programs. When we said we wanted to do a demonstration project, we insisted that we have to work in these three areas, that we can't just integrate services without integrating finance mechanisms. That we can't integrate those two things unless you have some level of governance that's integrated that brings those together. Otherwise, will all go back to
their own separate rooms and start playing by our own separate rules again. So the slide is really designed to point out that there are separate challenges to each of these. All of them are significant and they actually all have to be addressed in some simultaneous order. We’re not going to achieve a level of cost savings if all we’ve done is got the social workers and nurses talk to one another in the ER room more than that does require that we pay attention to financing. And as the demonstration and experience here in central Oregon have shown, you have to go back to question everything the state does. We have to question what we have in the private sector as well as the local public sector. So this is a kind of a requirement that is difficult to do, but fortunately here in central Oregon folks have actually come up with a pretty good idea about how to manage this and you'll hear all about it.

So just a couple of outcomes that we're looking for here: the result of this demonstration projects is that, you know, we want to pay attention to this triple aim results and here's the way we sort them out.

So the process to date: we got directions from Ways and Means we’ve created a demonstration management system at addictions and mental health and were working with (32:21) two voluntary regions with the three counties here in central Oregon and the three counties in eastern Oregon, [inaudible] and Baker County. How could I forget about Baker County?

[general laughter]

And the one here in central Oregon is over the track and is down by how it's going to go about doing it's business. And I think it's pretty ideal in the sense that it's in all of the counties, the private sector, and the public service entities. And the mental health organizations and the managed care organizations. So it's bringing everybody together to try to work through these issues. And this resulted in the development of the regional health affiliate so you're going to hear more about that.

The current project, this focused on ER diversions and managing people who come into the ER...

[pause in audio]

...the ER is the sort of place where this all shows up. So when we looked at who was in the ER here in central Oregon, as you can see by this flag, we [inaudible]...ave been looking at what brought them to the ER. And you can see kind of the diagnosis where the majority of them are in fact, they're mental and addiction issues and that's what brought them to the ER.

>> NEW SPEAKER: Yes, we have a question.
>> NEW SPEAKER: Can I ask a question about how corrections...can you just talk about how corrections play into it [inaudible]...

>> NEW SPEAKER: Well, I think your question is really aimed at...or really sort of two kinds of mental health systems. There's the public one for mental health and then there's the jail/prison system. In reality this is the sort of...the bulk situation in many communities that people who are involved in criminal justice [inaudible]...In the integration projects, we said that we were going to concentrate on the healthcare side of it. That we weren't going to make an effort at this point to try to integrate the criminal justice side of it.

But it's come up here. Central Oregon is the sort of the secondary, this-is-what-we-have-to-do-next because in that counties and local communities vary cost [inaudible]. The jail system, which is the place where people go, where they end up when they have certain kinds of incidents. They end up there and you hear alcoholism and drug addiction a lot. So it's low-recognized. I don't think [inaudible] chose actively not to try to go to every business. It's going to be a difficult enough task to integrate just the healthcare [inaudible].

>> NEW SPEAKER: And so, even after release, you haven't sort of opened that population...

>> NEW SPEAKER: Well, I think what the [inaudible] communities would tell me is that when people, when they come back to the community, they get engaged in all of these things. And most community justice programs have made efforts to do that. And I'm partnered [inaudible] where, in fact, we operated those programs for years, provided housing and treatment. But it was really wasn't seen an intervention project to also give people healthcare, which is one of the major problems in our system is that people don't come out of the prison and they don't have...they're not members of Oregon Health Lab. So their health service need are not being met. Their health needs are only marginally being met. So it's a big issue that I think the state and the communities are going to have [inaudible]...

>> NEW SPEAKER: Richard, I find some of this...it may [inaudible]...

[pause in audio]

>> NEW SPEAKER: ...the study that these numbers came from, there were some of the physical healthcare, but they weren't...

[pause in audio]
...it just wasn't contained in the data. But so, I think that what has happened here is that there's an effort to target people at this level because they're consuming wide numbers of services and are repeated visitors to the ER. And that is typical of the way that people that aren't being served fully are going to end up in a bad healthcare environment.

[pause in audio]

...similar emergency room diversion project, identifying people who are utilizers has been put in place to start to [inaudible] more integrated mechanisms to ensure people don't go back to the ER repeatedly. So there's a little bit of data coming from that project. It will be more as we get further into it.

And so in the high utilizers in the three counties in northeast Oregon, they collected data a little differently to establish what they needed. Rodney was pretty clear that, in this case, it was just a health plus pain medication that was driving a lot of business into the hospital, with some in-home. Being a person [inaudible] was suspicious that the pain medication...

[pause in audio]

...equally important to the process with integration and that is that we started with a mental health initiative, which is an attempt to get managed care utilization into our residential and institutional care system so that we are managing along the lines of reducing the length of stay. That will help us serve more individuals. Moving people to community based programs where they have access to housing and employment services. And keeping people out of state institution because, at this point right now, we have overcrowded state hospitals, we have overcrowded residential facilities and what we need is people that people that need a hand in the community.

So this is another aspect of integrating mental health services within the mental health department, which also allows us then on a how-they-should basis instead of always [inaudible] residential facilities. That project, as you can see, is going along...

[pause in audio]

...those two things are [inaudible]. So we're down in the plumbing of the mental health system, tring to connect the pipes together so we get a better flow. [inaudible] overall efforts to do integration on a larger scale in the healthcare system because we won't have any better managed programs within mental health. But just to conclude by saying that I think this is a great time to be working on the initiative to have the opportunity from this. I would like your consideration and dedication to the idea that this is something that ought to be guiding the Oregon Health Authority as we bring these services closer together. And if there are any other questions, I will take them now.
Mr. Harris, thank you very much. We got a little bit of a late start so we're running a little late on our agenda, but we have time for one or two quick questions.

One of the...on the presentation that was given on the webinar talked a lot about early intervention and during...and there's, like, also talk a little bit later in the evening about early intervention or [inaudible]. My question is when you're thinking of one way, and I know you have to [inaudible] acute care health programs and the exchange remember folks and how...I just have a [inaudible] about how that's helping...it doesn't meet the need of early intervention in mental health if you just have an acute care...

[pause in audio]

...a number of [inaudible] that are now getting off operation for five more years. We're showing that you can divert people out of acute care hospitalization and...

[pause in audio]

...so that the early intervention is preventing more hospitalization. This model, which has been employed in Australia for years now, has a lot of indicators that suggest that early intervention in schizophrenia creates a more healthy person later on. They don't spend as much time in acute or chronic mental health care. Also, their general healthcare is improved so it's the ability to screen and detect the symptoms of early psychosis that aren't that difficult to detect. But it does take care and a little bit of knowledge and this has to be a speciality. It can be...

[pause in audio]

...and one of the major reasons we are here in Bend today is that the central Oregon community and the region has done some very interesting, is doing some very interesting things, in terms of regional healthcare. And we're looking forward to hearing a lot more about it. So I'm going to move right along and turn this over to Mike [inaudible] and Bruce Goldberg to get us started.

Let me...as Mike's getting settled, we...I wanted to frame some of the discussion, which is really what we're talking about is...and I gave Richard a [inaudible]...is what's happening here in central Oregon around behavioral health and physical health in agreement is really just the beginning of something that, I think, we see as a larger strategy of regional organizations that have some accountability for the organization and delivery of [inaudible], as well as for the health of their population. Mike, in his spare time, is also as you saw working on our logo for the board...
...and I think it's a great design. We're in contract negotiations right now. We'll see whether we can [inaudible]. But this is really part of our strategy. And it really...what I want to do is just frame it from a high level and then what we'll get to soon about is what's happening here in Oregon as a start. And what I think Mike wants to take us through at the end is some discussion we've had about what really this all means in terms of new structures, new governance, et cetera.

You know, we have I think, explicity and [inaudible], organizing ourselves around Triple A and we can Wordsmith the words in each of those names, but it really is about enhancing the...

...Felicia's comment about department of corrections. We need to look at this about community and not in segmented areas of the healthcare system. So this becomes just sort of an organizational, and really it's more of an operational principle, to organize around. You know, our challenge has been that we have focused much of what we collectively have done on the small piece of medical care systems, when it's many other things that help keep us healthy. And this gets at the issues of social determinance of health that we've spoken about. But it's simply more than just medical care. It's environmental, lifestyle, public health. Sort of the larger issues that really become part of the larger TRIPLE A. You know, we've made our...

...the health authority as an organization where there's some accountability and responsibility for health and health services across the state. But this isn't going to be able to simply exist at a state level. It's got to be focused at a local and regional level as well. And, you know, our job as the health authority is to look at the sort of new structures that we can look to put forward in terms of creating some departmental community change that we're looking for if all of us understand that simply doing more of what we're doing now--putting more resources into the same thing--is just going to get us more of the same outcomes. And we want better outcomes and new ways of doing things.

That will be how we link networks of care across the state, horizontally and vertically. There needs to be clear accountability and joint responsibility [inaudible]. Part of the issue has been there has been no accountability. There's been no accountability at the state level for how we, you know, 850,000 individuals that we're responsible for. But that really filters into all of our communities when the accountabilities are really at a very individual or local level. At a practice level. It's not a community level. It's not coordinated. And we need to be able to create the kind of structures where we can have accountability, both locally and rolled up, and the comprehensive sort of performance...
measurements and quality outcomes and health outcomes that we collectively want to see happen as a state, at that role up and down throughout our communities.

So, you know, the reason we're out here today is, I think, one to highlight a lot of the great work, but it really is work that's just beginning and it's that [inaudible] of change. And it's something that [inaudible] might sort of talk through, what's going on here. But this is really, I think, about how we can start to build on a foundation and look to create new ways of doing things. So Mike take it away.

>> NEW SPEAKER: Mike, you have three minutes left.

[general laughter]

>> NEW SPEAKER: Well thank you and...

>> NEW SPEAKER: [inaudible over laughter]

>> NEW SPEAKER: Thank you and good morning. It's certainly great to have everybody here. I was telling Chris and Tina, I have some anxiety of everybody coming over here and the expectations are quite high. In fact, we have [inaudible] the model here and it's safe to say we don't have the model. We are working diligently on a number of issues and I think you're going to see some...

[pause in audio]

...I think you know most of us have been working hard for many years on a number of initiatives. We're going to kind of go through those today kind of sequentially. It's been really a, you know, a five, six plus year journey. A lot of collaboration, a lot of hard work, a lot of patience, and certainly a little bit of luck I think put us to where we are today.

Um, if you have your agenda in front of you what I want to do is make sure I walk you through kind of what we're going to be discussing today. Just so we're all on the same page. Bruce went through a little bit about kind of that overview. I'm going to provide just a little bit more context from a health collaborative of really kind of how this works. It initially evolved with this collaborative health called matters [sic]. So [inaudible] is going to be...the director of Health Matters is going to be walking you through the core initiatives that set the foundation for that. And then I'm going to have Dr. Mike [inaudible] present his work in leadership with [inaudible] in central Oregon. That really kind of gets to the crux of what we've been trying to do in creating a more integrated delivery system here in central Oregon. And so I have both the [inaudible], we may be kind of shoving folks around, depending on Dr. [inaudible]'s schedule.
And then, to kind of tank onto Richard's comments, we're going to have Dr. Robin Henderson and Scott Johnson. Robin is the director of [inaudible] health services here at St. Charles and Scott is the director of general health services. And they're going to talk specifically around the acute health integration project they've been working on with the state. And then I think, to wrap it up, I think Tina and I maybe engage you with a little bit more dialogue around how we look at this from a...

[Pause in audio]

...our work in central Oregon. I think this really has been kind of a core foundation of what we've [inaudible]. And I think we really have...TRIPLE A language, for many of us, whether you're from [inaudible towns in Oregon]. This has really been a key foundation for us. So, you know, look at those. Those five elements. Are there more? Absolutely. But those are just the core elements. It's really interesting when you start adding county commissioners and city councilors and school district superintendents start talking up to TRIPLE A. And you think about the power of everybody being aligned around the same vision. They're seeing the policies around the school and the counties and government become [inaudible]. It takes it kind of to the next level away from the board down to actually working to begin with.

So as Bruce said, you know, this has been a key focus on our end as well. That we do see so much...

[Pause in audio]

>> NEW SPEAKER: ...just paused and talk about the relatedness of those two slides because so often in organizations like this we become fixated on the ten percent piece of the pie. These two slides are [inaudible]...they come out together. There is sixty percent of that we can categorize in broad socioeconomic educational terms that has a major impact. And that's why your slide [inaudible] is so important. Because it goes beyond the traditional healthcare system and it is enjoying an evolving community. And it's really going to change how [inaudible]...again a great presentation for all of us this evening.

>> NEW SPEAKER: Well thanks Joe. I think it does kind of get into the discussion at the end for us. You know, if we're in agreement with that that we do have to be thinking you do implement that from below. It's tough to do that from a single perspective and now you really start to allow local communities to be empowered.

This...this graph right here, this has kind of been some of our core work initially. And it really is...you kind of talk about the fragmentation. We're talking about how do we start to build the bridges across health and human services and the medical delivery system. And so what you're going to hear today are really our initial attempts around some of these key programs.
So on that left hand side on health and human services, we've started to outline...

[pause in audio]

...and kind of those four key initiatives that we have going. Many of those key initiatives are now starting to build bridges across and start to connect to the local community. And what we're trying to do on the local community side is get our act together and figure out how do we actually bring hospitals and physicians together to have a more integrated approach based on the TRIPLE A. And that's really what Dr. [inaudible] is going to talk about today.

So I'm going to pause right here and we're going to bring back this presentation at the end to be able [inaudible]. That's really going to be kind of the discussion more for a regional health authority. Let me, uh...

So I'm going to quickly go through this and I know we're getting short on time. But I wanted to set the stage for this whole concept of [inaudible]. Because it really has been part of a cornerstone of what we've been able to do here. And on our end this really started about five years ago, as a group of us who were involved with Volunteers in Medicine, [inaudible] this just nailed a block here. [inaudible] on the right, we saw that it was serving a great need, but it was just barely scratching the surface. And we really thought, "There's much more to this. And how are we going to get multiple stage orders to the table and talk about healthcare reform at the local level?"

So what I found interesting, what I was going around talking to [inaudible] well we kind of have this health collaborative going on in central Oregon. Everybody kind of scratched their heads and said, "What the heck is a health collaborative?" It sounds nice. But I got a lot of strange looks. But when I started trying to ask myself, you know, why the strange looks? When you start to ask yourself what does to collaborate mean, it means, you know, it means to work together, especially in a conjoint effort. Well, it sounds great. But again, when you think about getting multiple stakeholders in the room, competing stakeholders in an adversarial relationship, people think, "Well, what are you going to do, just kind of sit around and have a good 'Kum-Ba-Yah'? Is that what it's all about?"

And it's not. So that's where I had to kind of think about is "health collaborative" the right word? And there is a second definition to collaborate. And this is probably much more related to our work, what we're trying to do. And it's really going to get everybody together to see how we can take the step forward in a competitive environment. Because if nobody kind of collaborates, everybody's going to fail. And I think that's where we actually start to have a lot of that synergy together.

And so when you look around, you can...

[pause in audio]
...you know, we've had competing entities and folks who have traditionally not gotten along that well, they've really put aside those differences to figure out how can we work together, specifically on these initiatives to figure out how we can move this forward. So I do have to give some kudos where it's [inaudible]...obviously has been certainly my mentor over a lot of this collaborative approach. So I think a lot of this terminology is her. But we've really been able to kind of embed this in the Health Matters culture. We really consider ourselves a neutral convener. So we really are looking at how do you bring people together to do all these things.

And really, kind of first, what we traditionally did was kind of assess and get that baseline data of where we're at. And then figure out what are those things that we need to be able to do.

Um, and I'm going to go through this quickly. This is a slide from Community [inaudible] in Action. There's actually an organization that really links all of these collaboratives around the nation. It's a great group where you really start to share that practice around all these issues. And when you start to boil all of those collaboratives down in terms of what they're doing, you can really kind of link them to eight critical activities. And each one of those activities, what you're trying to do is take a step forward and reorganize the delivery system to get to this future state of healthcare reform. And what you're going to hear from Alicia is really what some of those...what some of our activities are, really all of those, more of those [inaudible].

This is an important one for me because this has been a core piece. And you're going to hear about it from Alicia and even on our "links for health" program. One of the bigger issues you have today, for a state level, is when you are trying to bridge this gap between health and human services and medical delivery, there are a ton of [inaudible].

In this example we've taken of [inaudible] County, Ohio...Dr. [inaudible] kind of pioneers in breaking a lot of these barriers down...but when they were targeting at-risk pregnant teens, they found that that one individual was being touched by a minimum of 13 different state and federal agencies. At any one time, they had seven different caseworkers. Everybody in [inaudible], nobody talking to each other. Nobody being held accountable to an outcome. Nobody being held accountable to [inaudible]. They thought this was just obviously a travesty. They wanted to turn it upside down. And they did.

And they created something, what they refer to to as a community health hub, that basically allows all of that funding to go into one pod and allow a single community health worker to really help navigate and guide that individual through the system and be rewarded on the outcome. They actually have set up a system where that community is incentivized based on the outcome of the [inaudible]. So you have the whole continuum, from engagement all the way through to the outcome. So they've started to build up different pathways and this has been a core of our work here in building up pathways to
help people navigate and get through the system and get involved in the outcome. So it's been, I think, something fundamental for the state to even think about because this really gets to the local charge of how do you start to blend funding, how do you start to pull [inaudible]...

[pause in audio]

...for us, that we emulated for the first few years if we got going on a day there was some outstanding work. Clients have been doing work. Jefferson regional health, Jackson, Josephine, and the NEON, the Northeastern Oregon Network in the northeast and then Project Access now. Everybody's focusing on different elements, everybody's at different levels of readiness. So I think I just want to make sure we're all clear, you know, Health Matters is not the only one in the state. We've got a lot of other activity going on.

Um, and I see, you know, Ray, Eileen, and Chuck, this was a part of certainly the health focus your focus. I think there was an understanding that you really could have some local innovation that could actually help stimulate some healthcare reform. And this is really what we've been trying to incorporate into our work. So any questions before we kind of get in? I just wanted to make sure we kind of set the stage the stage for that.

>> NEW SPEAKER: Mike, I just have a question, and it might be coming up later, but when I look at this it's like blue sky. And Richard really had me grounded in some of the real problems of moving forward. Governance, finances, and services. You know, I mean, [inaudible].

>> NEW SPEAKER: I will say we don't have all of those answers, I think we've just kind of put our foot in the water to try to explore that. But I think there's still a lot more work to be done.

[general pause]

>> NEW SPEAKER: Thank you for having us here today. We really appreciate the opportunity to share in great work by coming out to central Oregon. So thank you very much. [inaudible] to central Oregon. Our vision is to develop and implement an innovative strategy that improves health through the [inaudible] participation of the central Oregon community. And Mike touched on a number of things today that really are becoming actively involved in our community and partners in our community. And that's a very key element to the work that we're trying to do. It's not just a bunch of people trying to make change. It's really the community-at-large coming together. And we have a very diverse forum with multiple stakeholders. But not only at that level...

[pause in audio]
...of the initiative. So it's very much a community effort. And a community based project. So it's a pretty exciting time. And as you've seen, our board of directors, we have a very diverse group of people that normally don't work together well, they're [inaudible over raucous laughter]. And it's really...you think, "Well, this really wouldn't work well together. They'd come around the table and things get bad." And in a very short time [inaudible] and I joined and we became a horrible [inaudible]. We have accomplished a great amount in this very, very short time. And so it's really kudos to our community and to the board of directors. They really stay in there and push forward and they were not about to stop. They've been like action and they very much let me know that. And my...

[pause in audio]

...things can happen. And so I'm really very, very proud to be a part of the organization. And just a kind of background: when I came on, there was a big, steep learning curve. I had never heard of a health collaborative myself. And so I pretty much surrounded myself with some mentors, [inaudible] being one and Mike [inaudible] and a group called Communities Joined in Action. There's other health collaboratives across the nation that are really doing great grassroots work. And without some of their inspiration and their best practices, we would [inaudible].

We've taken a lot of really great, innovative ideas that happened in communities such as ours and really tried to bring those in based on some of the need for...coverage area, the needs assessment back in 2005 and 2006. And from that original needs assessment, they uncovered...just to scratch the surface we have access issues, coverage issues, prevention and wellness. And so those are the first four target areas that the board charged me to go out and really start helping develop key initiatives around those target areas. And so from that, know that it's just to scratch the surface. There's so much more work to be done. But it's definitely something in the right direction, a step forward.

[inaudible], but in Jefferson County alone we're ranked the highest health risk and health for the county health status, we're in the county's list for 2010. And that's, you know, it's part of our [inaudible] area. So it's a very good focus. We did and Kirk and Jefferson County. Our big focus is on Health Matters.

The first four initiatives that we're targeting in our community, [inaudible] Central Oregon needs for health, and the sharecare [inaudible] status of central Oregon. So they're just four target areas and we'll kind of go over those later. And everything in these target areas ties back into the original needs [inaudible].

[inaudible] is a program with the Population Health Management Initiative that basically is just here to empower the individuals in our community with more information, more knowledge to help them become better in terms of healthcare, to make better healthy lifestyle changes. Um, it gives health coaching, health online tools for our population's to come in together and to learn more about what they can do in their life and also in their
healthcare. And also provides health risk assessment tools and opportunities. This benefit is offered...is only offered to our Sharecare members that are coming online shortly. And also to local employers. And it's really [inaudible] a plan, the board has really encouraged the fact as small employers, most of our population here is 94-96% small employers based on, you know, often times now they can't afford some of the tools that they would need in order to help reduce absenteeism, increase [inaudible] and turnover. And so you're looking at ways of collectively bringing everyone together...

[pause in audio]

...more people. And we also have the Living Well Central Oregon program. And this program we...when we came online to use it, the Stanford Model, which is the chronic disease self-management program, was working really, really well here in [inaudible] County. [inaudible] County health services program has been working and working with St. Charles health system, but it was just [inaudible] and it was a program that really needed some additional support, collaboration, and also to take it to the next level, it really is a program that needed to reach...

[pause in audio]

...we put together a regional advisory, kind of [inaudible] that consists of health department directors in Kirk County, people from the hospital in [inaudible] County, some individuals that are...had [inaudible] horses that were interested in being active participants in care for others. And we've been able to work this program tremendously. We secured a grant with the Jackson [inaudible] Foundation in order to support the program, leveraged partnerships with the county. And so the program has grown tremendously. In 2010, we were able to have 17 workshops with over 223 people registered. And this year alone, we've had 7 workshops with 85 people registered. We are targeting [inaudible] and so we have health trainings going around that region and we already have trainings in Health and Health Matters and we have a number of staff that want to do training...

[pause in audio]

...a really full-fledged regional effort.

The other initiative that we have, which is absolutely...it's a milestone I think here in Oregon. And it's very exciting to see this come alive and for me to be a part of it. It's the community health improvement plan. It is made possible because...

[pause in audio]

...we really thought that this is a really, really great initiative to bring to the small business employers especially that could not afford the additional health insurance and
also do not qualify for OHP and other state-assisted plans. So there's that gap, that lost
gap, that they are self-paying, and maybe going bankrupt, and they have health and
major...

[pause in audio]

...luckily we have two of them along with some of your [inaudible]. We've been charged
to get bill 862-3 so when that happened, it was a landmark, it was landmark. It was just
huge excitement over here on the east side of the mountains. So we knew that we could
possibly make this happen. And in a very, very short time. That happened in 2009. We're
now in April of 2010 and they're ready to launch our product and at the receipt
[inaudible] in Janury, we'd been able to pull numerous community members together to
help build an ethics plan. We have credit exclusions, inclusions, and what it is, what it
isn't. Using the administrative role with the state and working very closely with the state,
we've been able to really I think, put together a pretty amazing product for our
community that's currently underserved and uninsured.

With the Sharecare, [inaudible aside]...with the Sharecare, we'll only focus current issues
in [inaudible] County. So it's very targeted just for this community, services will not be
provided outside of the community and it is [inaudible] in the community. So it's very
much risk-sharing, cost-sharing, and it's all within our community here.

>> NEW SPEAKER: If I could just hit on a few things: there's a lot of documentation
we've supplied about Sharecare. Some ethic cues and just our brochure. So there's more
information you may want to look through. But again, this is an inclusion method. This
goes along with looking at the [inaudible]. And I do want to acknowledge Patrick
O'Keefe. I hate to put you on the spot, but Patrick is a Health Matters board member and
a local insurance broker, owns Cascade Insurance. He has been absolutely instrumental in
launching this product. He has been leading a core group for the last probably four
months. So without his leadership, we would not be here today. So I kind of had a chair
up here if Patrick wants to come up. He would serve well with his comments, but I don't
want to put you on the spot.

[general laughter]

>> NEW SPEAKER: SO Sharecare is made affordable...it basically offers affordable
care. And we...the goal of the program based on best practices around the nation, the seed
in Michigan was kind of the start of the whole priceshare concept and how you can really
take that group that's really missing in the gap and get him into the system and into the
care that they need. But in order to do that, you really need to make them empower this
population to be the consumers of healthcare to also support the providers that they're
seeking care from, to have a tight front door.
So the goal of the program is when they come on, we immediately get them into a plan where they have care coordination, health education, [inaudible] responsibility. And it's really driven home to empower this population that this is not a freebie. This is something that we all have to do together as a community. If we're not completing this together then we'll fail.

And so it's very much driven with the staff of Health Matters. We're all doing our dual roleplays on how this is going to work because this is all new. And so it's very important, I think, that when we went back to [inaudible] Patrick went with a team with us and we were able to do learning...kind of a learning session with this vegan group that has been around for almost 11 years. And they are very viable and they have a very strong community now that, at first, wasn't as engaged of a community. And if they can do it, we can do it here in central Oregon. And so I know that learning and having the group together is a key thing. Do you have any...?

NEW SPEAKERS: [inaudible over each other].

NEW SPEAKER: I want to kind of concentrate on that for a second. My business is health insurance employment. I've done it for 17 years here in central Oregon. And I can say that this is the population that isn't getting served. They are not on OHP, they are on group health plans, they're not on individual health plans. I was in a meeting once and [inaudible]. This was four years ago. And this population wasn't getting health then either. It is not and will not be available in a group health plan.

Some [inaudible]...and in terms of probably the needs of this population also [inaudible]...either without healthcare or the emergency room, the type of programs that are involved, the things that are associated with Sharecare, I think are huge. Because I think there's probably a population that has the greatest needs for this program also. And I can tell you from group health plans, there's a lot of focus the past couple of years...

[pause in audio]

...best efforts that insurance companies can't do. [inaudible]...

>> NEW SPEAKER: As you see also here that uninsured workers that we're targeting are small businesses with 1-50 employees. So we are kind of with the state mandate accepting sole proprietors. So the goal of it is to be inclusive of that population that normally [inaudible].

And how it works is the employees pay a portion, the employers pay a portion, and [inaudible] pays a portion. So it's definitely a multi-share. It's a community-based product. It will not work without all the parties at the table, playing. So our goal is to encourage the...encourage really the responsibilities. So we have a sustainable program long-term. The premiums that we're starting with: if you have a health improvement plan
which is a more in-depth plan, it offers not just the health risk assessment and some of the screening and education up front, but it also requires the members to go to a number of classes in the community during the year, go to some online learning that's uses the Trails to Health program, some online learning modules. If they have some subprime conditions, we'll get them focused on some additional resources in order to help improve their prime conditions and some of their outlying...

[.pause in audio]

...standard plan is the plan that is...you still have the [inaudible], you have the health risk assessment, and you have education, but you don't have some of the other criteria that are required such as the extra online learning and educational classes in the community. So it's definitely...it is an option, but it's a much higher rate if they don't go through the health improvement plan. [inaudible] definitely improve their health.

So the hope being that the healthier community management, all of that, the stakeholders get employers, the hospitals, physicians and patients, and there's definitely increased productivity, increased revenue, and decreased cost and improved health. It is a [inaudible], it's all about working very closely with...contact with the Oregon Health Authority and [inaudible] and we're working on the return on community investment and how we can give really great data to the state and sort of for the state to really look at this as a model long-term. [inaudible] because it is being in the state, and also to make it...kind of show our community what we're able to do here at the grassroots level.

So the eligibility and I won't read through all this now, but I can...you have it at your disposal. And feel free to call us anytime at the office. We would be willing to answer questions as needed. But there are definitely very strict eligibility requirements. And we are very...we have a good structure in place that we're calling [inaudible]. We'll make sure that we adhere to the state guidelines and also that we're not allowing people on the plan that can have conditional insurance or that can afford it, et cetera. It's definitely targeted.

Um, the benefits: if we look at it, it's not an insurance plan but there are standard preventatives and [inaudible] that are very important and very much needed and they're in this plan. And so our goal is to offer benefits to help improve our foundation population without, kind of, over...see the exclusions. There's things that are not included in the plan. You have to be in the tri-county area, you're not going to have to just kind of an area I'm serving that are...that you would normally have an additional plan. And the main thing is the use of the ER for non-emergency services. Our goal is to really educate our population to not go to the ER unless there's an emergency. So that's kind of a key cornerstone to the product.

So do you have any other things to share on Sharecare?
NEW SPEAKER: Um, the one thing I want to make sure that we're clear with Sharecare is that it is not the silver bullet. It's a great program; we're very excited about having it. But it is going to cover a portion of that gap that we talked about. There's only so many a resource that we can put out there to cover everybody right now. So I don't everybody watching to say, you know, "MUltishare is the way!" It is a way. It is a niche. The one thing that I found very intriguing about this though is that if you read, and I still have more work to do, but if you look at the federal legislation that was just passed, there is something in there that could allow this to become a community option. So I think we're intrigued to see, you know, how can we build Sharecare to be something more than what we currently have in this. So that would give us, you know, some time to kind of, you know, have this evolve. But I think what we have in place is going to be a solid start. But I would love to get the numbers, you know, to cover 40,000 uninsured, something that we could be much more robust.

NEW SPEAKER: Well Mike, what was really interesting too was a meeting I went to on federal reform. This is exactly the population it was talking about in that federal reform as well, the low-income [inaudible].

>> NEW SPEAKER: Right, thanks.

>> NEW SPEAKER: [inaudible]...I don't understand who administers this plan. I mean, who's looking at the medical [inaudible]?

>> NEW SPEAKER: Oh, this is Health Matters.

>> NEW SPEAKER: Health Matters. Which is...?

>> NEW SPEAKER: Health Matters is administering the plan. And we are [inaudible] with the state, the state is very much looking, we have to provide back to the state on a monthly basis. And it's due every quarter, but we would retake it on a monthly basis because we are new. We will have a medicine director on board, we have two nurses on board, and we also have the [inaudible]. But you would have...in the traditional insurance you have some of the staffing that goes with that. We have those members on board, but we are definitely...

>> NEW SPEAKER: Is it a non-profit?

>> NEW SPEAKER: We are a non-profit.

>> NEW SPEAKER: But it's not a health plan.

>> NEW SPEAKER: But it's not a health plan. It's not a health plan. I'm sorry, I'm missing something.
>> NEW SPEAKER: It's a very good question. I think we were very clear in Senate Bill 862...

[pause in audio]

...so really you're talking about this non-insurance...

>> NEW SPEAKER: But you're paying for medical services?

>> NEW SPEAKER: You're paying for medical services, but they're not through an insurance-type basis...

[pause in audio]

>> NEW SPEAKER: It just seems like an insurance plan to me. [inaudible]...so I can get it.

>> NEW SPEAKER: Well, if you think of traditional insurance, you're thinking of covering against all things. And this is not that. This is really the community coming together to say we have X number of dollars to cover X number of people with this limited infrastructure. And that's what it is. I mean, when you look at those exclusions that's a big list. At the same time, you could do...

[pause in audio]

>> NEW SPEAKER: ...to begin with. And it's just something that, you know, just [inaudible]...is that we end up with an exchange with an...a [inaudible] exhange. This is a type...can you imagine this as a type of, I'm not going to call it an insurance plan, a type of community option that could be offered in an exchange at a regional level.

>> NEW SPEAKER: It's possible, but again, I think it's important that we understand the limitations...

[pause in audio]

...again, there are the trade-offs of what we're trying to do. So again, it's not typical insurance where you'd actually take it and have it cover anywhere.

>> NEW SPEAKER: [inaudible], it seems like a club membership.

>> NEW SPEAKER: It's a different kind.

>> NEW SPEAKER: So let me see if I understand this. So they employee percent...so you have to be employed. If you're not in the labor workforce...
[pause in audio]

>> NEW SPEAKERS: [inaudible over each other]

>> NEW SPEAKER: ...focused on, I mean, how you had community resources to support all this.

>> NEW SPEAKER: Out of charity care from the hospital and the doctor that are coming together to support this, it can't be understated.

>> NEW SPEAKER: And actually that was my next question. Because if we have 30% employer, 30% employee, community 40%, and who is...commission, like philanthropy or grants?

>> NEW SPEAKER: The big thing...when I had my comments, part of our work has been based on a little bit of luck. The luck has been the timing of the Senate bill being passed, the timing has been kind of working with the state to get a [inaudible] grant approved that was targeting our program. So the timing of it just happened to work. So a lot of those community funds right now are going to be based on some support from the state and federal government and in addition with some of our funding that we have.

>> NEW SPEAKER: And that would be the sustainability part?

>> NEW SPEAKER: That's right.

>> NEW SPEAKER: So if you pay less, you get health improvement, but you get more stuff. It's like they said, the online helping assessment and with certain things you pay less and if you don't do that, then you pay more, is that right?

>> NEW SPEAKER: Just to give you an idea, when [inaudible] started back in 1998, they had their monthly premiums at $44 a month for every member and now they're at $46. So it...talk about truly bending the cost curve. They've done an amazing job of managing the population health and being extremely proactive of who's under that [inaudible].

>> NEW SPEAKER: Just in terms of the insurance it really is an interesting thing. For starters, it's like, how do you [inaudible]...because there is, you're right, there are similarities. There are people getting care, payment is getting shared, there is, you know...so it does look like insurance. I think--and I'm just saying this as I'm sitting here--if you think of a sphere which is the insurance industry, how typical insurance works, and you carve out a smaller sphere in that sphere, it does some of the same things but it doesn't do everything that the rest of that sphere does. That's what some of these [inaudible] acknowledge because, otherwise, [inaudible mumbling]...This isn't precise.
[inaudible] carve out a certain portion of insurance and saying, "Well, this is what it does" and then adding some things to that, but not doing everything insurance typically does...

[pause in audio]

>> NEW SPEAKER: I just want to see how this all works and how it plays out at the community level. The other piece is, and the coming-together consignment is part of the community funding, is using safety net services. The [inaudible] program safety net services so that's...

>> NEW SPEAKER: Yeah, I think that's very key and that was touched on was the community resources. It's very, very much important in this in model. So if there's community resources already in play we will direct our population base to the community resources already active in their [inaudible]. So it's very much working with the community that's already in place. And another big point is the Oregon Health Authority really is looking very closely at what we're doing and monitoring...I'm on the, I would say, a couple times to three, four times a week to make sure that everything we do is very much strategic and very much in line with legislation and very much in order of what the senate bill was meant to do and what also the administrative roles are mandating what we do. So I think that for us to say, you know, we are a health improvement plan and we are a health collaborative that is allowed to do this health improvement plan. And they would like something limited, not very much different. And it's a very [inaudible] way of looking at the...helping the population and using community resources and giving the state oversight to make it happen.

>> NEW SPEAKER: One real quick thing that I think is significant to [inaudible]...one thing I do think though is the population, as they go through [inaudible], if and when they transfer onto some other type of actual health plan because their employer gets a new plan or federal legislation makes access easier than before, they'll be far more educated. [largely inaudible]...has experience in what we do in the system...knowing what it should look like...

>> NEW SPEAKER: Yes?

>> NEW SPEAKER: So maybe [inaudible] a little longer because as I'm looking at the [inaudible], we're not making that [inaudible] happen, I'm guessing? But I just have a quick question about something. When you [inaudible]...

>> NEW SPEAKER: Honestly, when this built, the community built it. So it was not built by Health Matters staff, it was built by community. So I think, as we go along, we'll look at things and adjust as things are brought to our attention. And definitely tweak things as we go. So it's definitely a newly built plan.
NEW SPEAKER: What I would like to do...I'm going to take a break from the Health Matters plan because I have Dr. [inaudible] and I want to kind of get into...I don't want to [inaudible] his time. So we're going to come back, finish up with the Links for Health program, but I want to bring Dr. [inaudible] to talk some more about the [inaudible].

[general pause]

NEW SPEAKER: My name is Mike [inaudible]. I'm a neurologist. I've been in private practice in Bend for 23 years and, um...

[pause in audio]

...came to Bend 23 years ago, this medical community was considered a shining example of a rural medical community with very high-caliber healthcare. And, over the years, I believe that the caliber of healthcare is really extremely high, but because of many of the things that have influenced and objected hospitals and physicians in other communities [inaudible] the realtionships and the ways of the practice of healthcare delivery have come under significant pressure and basically the atmosphere and chemistry has changed in many, many ways.

So about 18 months ago, a number of physicians, primarily surgical specialists, began visiting with each other, essentially having informal conversations about what was changing and how it [inaudible] with our physician core and in the mangement of our practices. And so these infrequent, informal discussions began to pick up pace about a year ago. In talking about things such as maybe the surgeons could form surgical IPA, maybe we could form buying groups, maybe we could figure some regulatory structure that we could contract in a more focused way. And so the discussions led us to realize that, as we tried to pull the physician groups together, we really needed to address the fact that, in our community, an element of acrimony, distrust, basically political poison was developing here. And there are many, many factors in that. And I don't think we're unique. But it got to the point where one large group of physicians had essentially declared war with the hospital. And in between were smaller groups of physicians--onesies, twosies, threesies, foursies that didn't really know where to land. And there was significant fear through this confusion. And tremendous anxiety, as you can imagine.

I won't go into the details of some of the specific things that happened, but basically this group of surgeons became familiar with a concept called physician-hospital alignment. And we began to study this and began to read a bit about the ways that physicians and hospitals around the country were relating to each other in different ways and working with each other in different ways.

Well, several of us in this specialist group, if you will, brought this concept of physician-hospital alignment to the group. And within that small group, that concept of getting
together and working with hospital caused a significant fracture. And there were several surgical groups that basically said if you align with the hospitals, whatever that means, we're out. The majority of the group said that we're going to forge ahead with this and figure out a way that we can make this work.

So about a year ago at the hospital strategic retreat, the hospital system had made a very clear-cut decision to form their strategic plans around TRIPLE A. And we were familiar with TRIPLE A and then as we read more about the concept of physician-hospital alignment. And so what we did was we wrote a mission statement and a code of conduct. And the mission statement was based around the TRIPLE A, which I believe everybody here is very familiar with. But it was a new concept for doctor...

[pause in audio]

...and, you know, we're probably co-dependent from the time we grow up and we want to be fixers and take care of people and that's what we do. But for the most part...

[pause in audio]

...physician groups together. And then really realizing that the more we read of why we needed to do something here in terms of pulling the hospital and the physicians together, I think it's, you know, to me it's simple, but you'd believe how many arguments I get into when I say that physicians and hospitals must work together. And that's not the belief of many physicians. And we can get into that a little bit more.

But the assumptions you can see on the screen are many of the assumptions that we made as we sat and began to put together our plan. So we wrote a mission statement and the mission statement was...I've been somebody who always thought that mission statements were pretty stupid, to be honest.

[general laughter]

And of all the mission statements that I've ever read, if you took it into the next room and asked somebody to read it and they couldn't tell you what business it was written for or what group it was written for...we tried to write a mission statement that was pretty specific. And so it was this...our group of physicians would work with the St. Charles health system and their partners...

[pause in audio]

...that we were aligning with the hospital's philosophy. Because there's so much acrimony in the community and we were trying to figure ways to contain that, we put in a code of conduct. And, you know, the original code of conduct, someone said, "Well, let's just [inaudible] the first day you go to first grade." Play nice in the sandbox. And that's
essentially what the code of conduct was meant to do. But the idea was that there would be, for the first time in a group, a line. And a line that addresses behavior, because most physician groups never have that line. And so you just get along and pass along and I think many of us in the audience have seen that. So we're very serious about the code of conduct issue.

So having put that together, those of us in the core group then began to go out and talk to physician groups. And it was very interesting as we did so. There were doctors who looked at that and said, "I'm signing." And there were doctors who looked at that who said, "Let me get back to you after I talk to my lawyer..."

[pause in audio]

...I took this to the St. Charles assistant board of directors. And on July 20 of last year they adopted and embraced this...

[pause in audio]

...see how it was going to change everything that night. But things that happened almost immediately were the fact that, and it wasn't so much our intention to see this, but it upended the whole medical staff of our medical community. Because there was much contentiousness on the medical staff and the medical staff governed everything through was not working well in the hospital. The medical staff leadership was taking the medical staff...

[pause in audio]

...Now, we decided that we would not reinvent the wheel. I mean, we knew this was going to be a difficult process because of the political climate and physician's spirit change fundamentally. But we became familiar with different groups around the country that had successfully addressed physician-hospital alignment. And we also have had the help of John [inaudible] who, as you know, has had much experience with healthcare policy and he's been very, very helpful to us, both in our contacts nationally, but also his perspective and the credibility he brings our community as we discussed this and try to allay the fears of our physicians.

Since we began this...and because we had essentially crossed ourselves that we wouldn't try to reinvent something or make it out of paperware, we'd been travelling around the country to different center to really try to figure pieces of this idea to build a model that would work for our community. And one of the key points that I've had to make multiple times is that physician-hospital alignment does not mean employment. And I can tell you that, as you look at this, there are systems around the country that identify themselves as integrated delivery systems. And their definition of integration is employment, period.
But when you look at the physician-hospital alignment literature, you would never realize that the concept of integration runs a continuum. And as you can see on the slide, that continuum goes from zero integration, which means you never walk in the hospital, to one hundred percent integration where you're employed by the hospital. And in our community, we realize that if...well, I can tell that one of the flashpoints that started so much of the true acrimony in the last year was the fear that the hospital was going to be employing, bringing physicians and employing physicians to communicate with doctors while practicing in the community.

So we tried to make sure that everybody was educated that you could be employed, you could never count, you could be [inaudible] and not come through the door, or somewhere in between. And the model that we set out to build would accommodate those different ways to enter the platform.

Now, since we began that and since we began what turned out to be a roadshow, we have about 470 healthcare providers who have signed the mission statement and the code of conduct. And one of the things that I want to emphasize that we did, it's been difficult, is that we require that individual doctors and providers sign. So a claimant could not sign. An individual doctor had to sign his or her name. And the idea for that took it back to the code of conduct, that if there's an issue, you signed this. You know, live up to your word.

And anyway, we've had significant success in engaging the physicians. We have no delusion that these 470 doctors and providers are true believers. We recognize that this is a time of change and there are several things that have driven [inaudible] so far. One of them was that, as we got to about 300 signees, the hospital system realized that we had close to provider panel for the hospital employee benefit plan. So the hospital made the physician, the PHA member providers, the provider panel for the employee benefit plan. I think most of you have seen gasoline thrown on a fire. Well, that's what happened.

But on the other hand, many, many people who were on the fence decided that they were no longer on the fence. They wanted to be involved. And then other people have kind of continued to come along. The point being, we know that as much as there's a continuum of integration, there's also a continuum of engagement [inaudible]. So our job is to put together a healthcare model here that will allow as many of those people to join the system we put together and be true to their own philosophy and ethics. And that's [inaudible].

I think many of you have probably seen this curve published in a book by Dr. [inaudible]. And if you look, this is a curve for pretty much any endeavor that you would ever look at, whether it be for effort, or any business, or probably even a relationship. But you see the initial curve, and you realize you're going to have growth, you're going to have a plateau, and then unless you pay attention to it, you're going to have a decline.
Well, in [inaudible]'s mind, and we believe this, we have looked at this, we have talked about this, and we have embraced this idea because it helps us explain so much is that you want to start your second curve before you've reached your plateau and begun your decline. It's so much harder to pull any kind of system or movement out of negativity than it is to say, "You know what, we're doing well. But we know we're going to need to change and now's the time to do it." And so we believe that we've embarked on this second curve. And what we're dealing with is this enclosed area here which is really a time of chaos and a time of turmoil and I can guarantee that's exactly what it is.

I have a second job. My second job is pouring oil on the water of every physician misunderstanding going on in this community right now. And it's breakfast meetings and dinner meetings and lunch meetings and weekend meetings. We have our, what we euphemistically call our "breakfast club." The only time we can really catch up to re-hash the week is 6:30 Saturday morning at the pancake house. So that's how we stay in touch of each other.

But we're in the process of going through this time of turmoil and we're comfortable with that. There are a lot of things driving what's going on at the moment. And I would refer many of you to an article in the New York Times on March 26. And it's really a nice little article. But it discusses why doctors are beginning to embrace employment, or closer engagement with health systems. And there's so many pressures out there. Basically, uncertainty about what the future holds for a small private practice. Strength in numbers, if you will, is appealing. The ability to contract within the support of a bigger group. Cost-sharing. Just having people to talk to in the hallway if you will. Maybe even some political strength.

But physicians are moving to this. The second reason for this--and those are the factors that would move some of my generation. The other factors pushing it are new physicians coming out have different attitudes about private practice. And this is not casting dispersions, this is just stating a different philosophy. They don't want to work the long hours. Wisely, they want to have a family life. They want a shared burden. And within a structured system and maybe a salaried position, they can do that.

When I went to medical school, there were 104 people in my class. [inaudible] and I were classmates. There were five women in our medical school class. Joe can correct me if I'm wrong on this, but I think we're at 50% of medical students now are female. Where it's a completely different mindset to the practice of medicine and the pressures of the private practice industry.

So anyway, what we're seeing is we're putting together our physician-hospital alignment. And it is simply the step to build the integrated delivery system here. The fascinating and exciting thing in our community has been the, to me, "mind-boggling" is not the right phrase, but close to that, philospohy change from the hospital and the hospital board of directors...
...most of the PHA, or most of the physican-hospital alignments, that are successful have significant physician direction involving governance. To the point that some of them have co-executive positions. For instance, you'll have a physician CEO sharing with an executive CEO. Or over the physician platform, a physician medical officer and an executive. Or over other aspects of the position. We're looking at that closely to see if that might be a form that works for us. But we're moving ahead. Our physicians, for the most part, are engaged. They're waiting with bated breath to see what kind of a model that we bring back. And it's not going to be armageddon. And I assured them that it's not. Our intention is to have bringing back harmony, improving communication, and really allowing the physicians to engage their community, to embrace the TRIPLE A.

And it's been very interesting. Almost every contentious discussion I've been in, and almost all of them had to do with misunderstanding or a lack of communication. Every discussion usually comes back to the TRIPLE A. And I've ever done anything like that before, you know. Mine's always been kind of headbutting approach. Now it's a philosophy approach. It's much nicer. And the physicians get it, the hospital gets it. And so I'm excited about what we're going to be able to put on the table for bringing back harmony, improving communication, and really allowing the physicians to engage their community, to embrace the TRIPLE A.

>> NEW SPEAKER: Very good. Thank you very much. I appreciate it. And I just wanted to say two things and certainly acknowledge Dr. [inaudible]'s work. He has been absolutely instrumental in leading all of this. And what he didn't say is just all of the other workers that we have in place that are kind of working in...such a nice efforts that we have. The health information exchange workers that we have...

[talk about this and we kind of talk about those pieces of the pie. You have to have this unified medical community to do what we want to do. And it remains in a type of fragment state. It's great, we can do all the great stuff on the health and human service side, but if I don't have a medical community that truly gets Triple Aim and is willing to link all of these activities, I don't have anything. So I think these two things in common is really instrumental in allowing us to...]

>> NEW SPEAKER: Yeah. And just a quick comment about that, that [inaudible]

>> NEW SPEAKER: [inaudible]

>> NEW SPEAKER: I'm just going to preface some of their comments and then I'll let them have the floor...

[talk about this and we kind of talk about those pieces of the pie. You have to have this unified medical community to do what we want to do. And it remains in a type of fragment state. It's great, we can do all the great stuff on the health and human service side, but if I don't have a medical community that truly gets Triple Aim and is willing to link all of these activities, I don't have anything. So I think these two things in common is really instrumental in allowing us to...]

>> NEW SPEAKER: Yeah. And just a quick comment about that, that [inaudible]
...get into more details around what the Links for Health is, but you'll see some elements in this specific project. And we have a number of other halfway that we're building out of this. This is a key one that we've been working on.

>> NEW SPEAKER: Good morning. We appreciate you very much taking the time to come to Bend. My name is Scott Johnson. I'm the director of [inaudible] County health services so we are responsible in the county for behavioral health work and also our physical health, our health department work as well with [inaudible] County. [inaudible], how would you like us to proceed time-wise, knowing [inaudible]?

>> NEW SPEAKER: I don't know what you've got in mind. If we could kind of go through the presentation in the next ten minutes or so it gives us a little room to...

>> NEW SPEAKER: Yeah, we can actually...

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: Now, with me is Dr. Robin Henderson from St. Charles Health Systems. We'll take you through about ten slides pretty quickly. This is typically on the topic of integrating behavioral health services, both mental and [inaudible] services, as well as primary care services in our community.

The first slide I want to work with is the case for action slide. This is a slide that is a bit dated, we've been using it in our community for about five or six months. But it's been our call to action and it's been the slide we've used to really begin getting into alignment and working together much more closely.

You probably are aware people with a serious mental illness on average die 25 years earlier than the general population. That's [inaudible] put, the health disparity there is something that is of great concern to many people. 87% of those lost years are due to medical illnesses. The cause of disparity, there are a number of them. Issues related to medications, tobacco, a little preventative care, poverty, social isolation, and, an area we have responsibility for, the degree to which the health and behavioral health systems are in alignment or in disparity. And that is an area that we're concentrating on.

Also, of particular interest in recognizing that preventative care works and is cost effective. But great concern here in here central Oregon that we prioritize more cost nutritiary care and that would include the degree to which we continue to move forward on the Oregon state hospital system without some corresponding balance in terms of community healthcare systems as well. And so that's less a negative statement about the developments in Salem right now in terms of the new state hospital and more a call to action, that we absolutely must have a community here, that that state hospital masterplan cannot succeed without it.
Um, also federal reform, an important component of Medicaid work and the fact that 65-70% of [inaudible] folks are not currently getting served in an outhome system in central Oregon.

So who's responsibility is this? This is the slide to try to get our local folks thinking about the players that need to come together if we're going to make progress. Of course, the state of Oregon and the health authority. Of course counties, mental health authorities, and public health authorities of regional hospitals. Our fully habitated health plan, et cetera, et cetera. A reference to safety net clinics, VIMs is volunteers in medicine. Our FQHCs, we have two of them. [inaudible] Medical, which has three clinics in three different central Oregon communities, as well as Aligned Community clinic, they're another FQHC.

Go to the next slide. So these is just the graphic if we look who the players are. The left side would be the [inaudible]. We have Best Care Treatment Services that does work, we have the Jefferson Country Lutheran Community Services Northwest does work on behalf of [inaudible]. Your middle column, of course, you've heard of Health Matters. Clear One, ADHA, and the [inaudible] Chemical Dependency Organization are different organizations that have responsibility for part of the OHP work in central Oregon. And then, of course, DHS and now the health authority. On the right side would be our local mommy group, our client groups in the area, of course the hospital system, and there you see some of our key primary care providers.

So where are we going from here? Links for Health health integration project. At first the top of this slide said "Behavioral Health Integration" but it really isn't just that. It is mental health work. It is alcohol and drug work and is primary care work in central Oregon. If you see the timespan, because much like this meeting and everything taking longer than you might like, you know, in terms of managing an agenda that too is the case with the work that we're doing. And we've really given ourself a five year frame to...

[pause in audio]

...a couple years of cooperation from the new parties. The first point, of course, is that the current system is not sustainable. And I would argue much along the line of Dr. [inaudible]'s comment a minute ago, we're probably on this project also looking at that second curve phenomenon. All is not lost in terms of the quality of work that is currently being done. We have a number of things that we're very proud of here with our current system, [inaudible] do far better than that.

A few of the early concepts in point three. Emergency room diversion would be one, I think Robin will elaborate on that in a moment. Very much an interest in a health home and we're working through that. Triple Aim is not on the list, but we talk about it at every meeting. Behavioral health embedded in primary care settings and integrated. Also, an
interest at least in a location, probably in the Bend area to have primary care in a behavioral health setting. And then of course an integrated electronic record.

Point five is really around beginning this lessons of potentially creating a regional health authority and needing to have shared financing decision, mainly the oversight from that. And I might add, I digress from, we actually are having a meeting this afternoon of what we call our transitional board, which is an early conversation much thanks to the support of Dr. Goldberg and others, really try to look at how could we, and even in a governance way, strengthen and basically create some co-dependence in a positive way if you will for the future of the system.

On that slide [inaudible]...I'm not sure if Dr. Henderson is the budget not. You've perhaps probably are familiar with this. This is one of the drivers. We were going to do this work anyhow, but certainly as Senator Bates and Representative [inaudible] and many others took an interest and see some pilots created. We have stepped forward and I believe Richard Harris and I colluded to this this morning: we now are a pilot project under this budget now.

>> NEW SPEAKER: Good morning. What I want to speak with you a little bit about is what we call our primary health immigration project, which is the behavioral health demonstration project in partnership with the department of human services. It was that work that we started...

[pause in audio]

...and then also our [inaudible] to get clinics to really look at kind of conversations we could have about [inaudible]. And we wanted to look at health integration from a standpoint of what would be doable to get us results because when you get results, guess what. People believe in you and they let you do more and they let you do the harder things.

So we started with a very small number of individuals. We had a theory. The common theory is that if you look at emergency department utilization, many people believe that, "Wow, that's not..."

[pause in audio]

...we found out that those sockeyed people average 30.8 visits per year, each of them, individually. And the primary culprit were medicators they used. Primarily Medicaid and Optimium [inaudible]. You see five Medicare there, actually three of those are Medicare/Medicaid, so really it's more like 11 Medicaid. [inaudible]. All of these 15 people have kind of this triad of needs. There weren't really any trauma issues in terms of what you normally see in the emergency room. These were [inaudible] healthcare conditions. And they had [inaudible] et cetera on their primary, tertiary, and secondary
diagnoses around pain issues, heart pain, substance use issues, and chronic [inaudible], not in the term of a heart disorder, but more of along the lines of adjustment disorders that stymy a person, anxiety disorders are a little more common types of things that aren't necessarily served by [inaudible].

[inaudible] we went to look at their...what their processes were to help their system. And through our populations came out to find out that, at St. Charles health system, the cost, not the charges but the actual cost after reimbursement care for these 15 people, was a little $150,000. $10,000 per person per year. And that's 15 people.

So we wanted to see what we could do to [inaudible] that. And that meant that we needed to look at...this is just a slide to show you what that actually looks like here. Sorry about that. And it shows you what that cost driver factor is. We wanted to expand that so we...

[pause in audio]

...and we looked at our top 50 visitors found out that, again, the bulk of these folk are on Medicaid. People that are eligible for primary healthcare services. But what we also discovered was we [inaudible]. We saw that same diagnostic infrastructure on a larger basis. Over half of them had pain [inaudible] addiction issues. Three: all 50 of them had at least one of three components. And what we then found when we started to look at are they getting served by county mental health. Guess what. Most of them were not. Most of them were not even [inaudible] county mental health services, but they were coming to the ER for behavioral health issues that they...

[pause in audio]

...$400,000. So we went to the state and said, "This is what we want our integration project to do. This is what we want to look at." And they brought us some components of what they wanted to see from us, we brought them some components of what we wanted to see with them. And that's kind of an idea of what this looks like. But our pilot is due to start somewhere around the first of June. We'll be placing a psychologist at the Mosaic Clinic. And this is where this ties back into the Links for Health program. That psychologist will then be working with our community link specialists. And I know there's a set of slides that we can talk about community link specialists if you look further in your pack and I'll explain that a little bit.

The key to these specialists for this project are primarily peer consumers who will go through the peer-[inaudible] training program in mental health through Cascade Peer and Self Help Center and then they'll receive additional training from Health Matters in how to become healthcare navigators. And community link specialist is our nomenclature for what is basically a healthcare navigator: somebody who helps you get through the system, walk through the system, get connected to the services you need.
So we get back to our gentleman just [inaudible] ago between the Bend primary hospitals and we say that Joe's got chronic diabetes and he's got some mental issues in there. And he tends to [inaudible]. He's going to be seen by this treatment team through his primary health clinic, which in this would be Mosaic. And they're going to look at what kind of interventions can they do. They'll meet with Joe there at that clinic and find out what are the barriers to him getting services and being able to be served outside of the emergency room. And over time, that healthcare navigator, our community link specialist, will work with them to get him into the appropriate level of care. Because trust me, nobody's enjoying life if they're in the emergency room every week. That's really not the fun place you want to be.

They really start to improve their quality of life and change their overall healthcare picture. By doing that we can leverage these dollars and then rake that out into other programs that we want to go into. Scott mentioned looking at the polls of severe persons with mental illness, the chronically ill in our community. We want to be able to use healthcare navigators, peer specialists, to be able engage both [inaudible] the system in the appropriate fashion so that they're getting care.

So what we found is that the folks in Scott's programs, they're not going to the emergency room for healthcare. They're not going anywhere. And so that's where we see the folks who are [inaudible] conditions, who are dying 25 years earlier. Because they're just not getting services at all.

So those are just some of the things that we're looking at doing. I know we're also using community link specialists right now in our new neonatal intensive care population. We look at [inaudible] babies coming out of the neonatal intensive care unit. And we have nurses from Health Matters who give people a grade, works with the family to determine what their healthcare needs are, and we hook them up with, again, a specially trained community health specialist who helps them navigate the healthcare system to reduce healthcare issues, but also the social health issues. Because we know that families who are under high stress with a high-risk [inaudible] are at risk for increased child abuse in family stressors. So it really is looking at a global population healthcare issue.

This last slide here that I'll leave you with really just outlines what our structure is for governance right now. Scott refers to the transitional board that will meet this afternoon. That transitional board is made up of three county commissioners, the CEO of the healthcare system, Dr. Goldberg, representative and medical director for Mosaic Medical David Hayes, and a vice president from [inaudible] Health Plans. Those folks right now are making our major decisions about how we're moving forward and are providing that basis for us to discuss what a regional health authority would look like.

They're informed by the stakeholder committee, which is made up of all those different entities, probably 30 different agencies represented in our stakeholder committee right now that have been working together for the last three months. And they're driven, in
large part, by the project developer team, which is the small group of people who actually gets stuff done.

>> NEW SPEAKER: Thank you. A question or two?

>> NEW SPEAKER: Do you know what percent of the Medicare/Medicaid patients do not have access to a in-house patient [inaudible]?

>> NEW SPEAKER: I don't know that I could speak to the Medicare/Medicaid, everybody should have access to mental health services. We're going through some expansion right now. In December of '09, we had 14,000 people with Medicaid/OHP issues. In January '10, we had 15,000. So we're just bringing on some additional staff now, but certainly anybody with a medical need for health services should be able to get access to that care.

>> NEW SPEAKER: But at the same time, I think that the partnering problem with [inaudible] is that they don't necessarily meet the level of acute [inaudible]...somebody would like to go to mental health. There's still due to a stigma issue. So somebody may present an REI and say they have depression. They say, "You need to go to county mental health services." They're not going to be able to necessarily access that.

>> NEW SPEAKER: Our two...one last point on this side. Our two best places for real progress which [inaudible] where the FQHC is located and then in the Bend area with the Mosaic clinic on Greenwood and volunteers in medicine. That's where you'll see this out soon.

>> NEW SPEAKER: So I just have a question. On that $150,000 that the state's [inaudible], is that paying for the Link's person? Because if you have Medicaid, you should be able to have some place to send the bill, number one. And number two, if you're going to work with Mosaic, can't they send the bill for the psychiatric services as well as for the [inaudible]?

>> NEW SPEAKER: Those are some of the things that we're working on right now with [inaudible]. Some of the issues around...for instance, with the community link specialists, we have to get the curriculum approved so that we can get [inaudible] prior and that's a process. [inaudible].

In terms of being able to bill, it's not quite...I would love to say that it is that easy. We've had an awful lot of people sit together in a lot of rooms and we're still struggling with how do you figure out what the right prices is, who can bill, can you bill for two services in one day, does it go to the physical side of the health plan or the mental health side of the health plan, where are health behavior codes [inaudible]? It is an incredibly complex, complicated system that these dollars in large part are going to go [inaudible]. We're bringing on the psychologist whose been a need to this program. Those dollars will
go in large part to fund that. We're bringing on a little bit of community link specialists, but also these dollars need to fund the evaluation component so that we can study [inaudible].

>> NEW SPEAKER: Thank you. I think it's really important...

[pause in audio]

...County gets through the Healthy Start program.

>> NEW SPEAKER: Uh, great question. In fact, just this...probably about three weeks from now we're getting together to look through Cocoon, Babies First, Only Starter, and all of the evolution of that that's likely to occur in the next year or two. So we're working on that very closely. It's not all figured out yet, but we're well-attuned to getting that aligned as well as possible.

>> NEW SPEAKER: And part of that [inaudible] clinic goes...

[pause in audio]

...using this as a springboard to start to wrap our arms around that population here.

>> NEW SPEAKER: A last point on this just as we're cleaning up and framing some of the central Oregon projects: the other one that prompts me...that question prompts me to mention is the launch program which we're doing with the state health division. We are the Oregon site for that. It's the same [inaudible] 0-8, early shot for [inaudible]. So that also is going to tie into that. [inaudible] hospital-based health center, but we're adding additional school-based health centers this year. So it's all part of the systemic work on the children's center.

>> NEW SPEAKER: Last question for this session posted by Eileen [inaudible over laughter].

>> NEW SPEAKER: [inaudible]...for all the work that they've done and for following your progress. I've been [inaudible] in some of these details around these regional health authorities as they emerge and it seems that we should be working fairly closely.[inaudible]. I'm intrigued by the metrics...[inaudible]. And to discover this piece about 30 visits per year [inaudible]...have you guys been working on what the corresponding positive metric would be? There's a metric for our system isn't working. And let's incentivize people to get having surgery to be the positive metric. In this particular scenario, have you [inaudible]...?

>> NEW SPEAKER: We actually had the opportunity to work through just that question in the process of applying for the Beacon grant. And the Beacon grant is one of those
But we used the IHI Triple Aim prototype framework and came out with a series of metrics and I'm happy to share that with you. A series of metrics that look at how this ties, how this particular process ties to improved population healthcare. Some of those include increased enrollment in primary care homes. Some of those include increased utilization of living-well projects and some of the other things that all integrate well together. But it's all they had IHI Triple Aim prototype worksheet that we really look at in terms of doing health screenings in the clinics. They're going out and...we have not been able to put a [inaudible] in every primary care clinic, but you know what? I can put a [inaudible] screening tool in every clinic. I can put medical screening tools in every mental health clinic. We can do those types of integrations that give people the tools to be able to make those connections. And if those folks who have difficulty navigating the system, we provide them the labor methods. So that's all pretty well taken care off.

>> NEW SPEAKER: So I'm intrigued by having a conversation [inaudible]...so thanks for all your good work.

>> NEW SPEAKER: Thanks you very much, I really appreciate it.

>> NEW SPEAKERS: [inaudible over each other]

>> NEW SPEAKER: Thank you for indulging us this morning. I definitely [inaudible]...long time. If you want to take a break or you want to continue with the discussion or you want to hold on to this until later. I know this was a lot of information in a relatively short amount of time. But I think the next question, the next series of questions really get into all this great work. You know, how do you start to roll into some sort of partnership or relationship with the state or with the health authority?

So what...the slide that you have in front of you right now is I think an interesting framework. one that I came across not too long ago that really kind of looks at today, if moving forward, what a future state could look like. So if you go to that left hand side and understand that, really, our whole model today is based on clinical services that are really in fragmented pockets. Whether it is mental health not connected with physical health or, you know, we venture those scenarios.

Then if you go down that lefthand column and then look at, okay, well what's the alignment payment. Obviously, it's the most part a fee for surgeons and structure. The incentives: conducting procedures, filling beds, you know that's what we're incentivized to do. The metrics is really based on that revenue. And then the governance: for the most part, informal relationships and referalls. What we're trying to figure out right now is how can we actually evole...

[pause in audio]
...called something else that can really be in a position to handle global payment. And then be incentivized for the right things, in terms of actually improving population health. Measuring those population and health cost indicators. But then actually the governance structure having immensity that would be [inaudible] were all of those things.

And I think that really is the challenge. I think Bruce and Tina and others have been talking about this for the last several months with us. We have a meeting this afternoon and I think that's really where we're trying to go. I think what this behavioral integration project has allowed us to do is get our foot in the door and just start to have the conversation that, okay, if we're going to go down that road with this project, if we're going to talk about collecting funding, well how could we roll it out to an even bigger...more projects? Or even when we talk about county employees and city employees. You know, school districts. How could we actually start to think about it from that point?

So anyhow, again, I don't have those answers. But I think we're on that road. And I think what Bruce and I talked about is, you know, could we, even from a policy board perspective, talk about what that framework should look like for any region. And what are those criteria that, you know, central Oregon could or should abide by. And then northeast Oregon or south or anywhere. We have to have that same platform.

But I think it's important to talk about, you know, all of this great work of expanding coverage and containing cost. We've been having a lot of conversations with Portland and a lot of conversations with Salem...

[pause in audio]

>> NEW SPEAKER: So, but I do have a question right now. Because I think that your vision is really broad and it is getting us to understand what are the metrics to [inaudible]. But my question right now is in the framework that your using from Communities Joined in Action, I just have to feel that most of that is still in that ten percent. And that we shouldn't, you know, limit ourselves. And I think you really have a potential here, Mike, with all your collaborators to move beyond that. But we're still pretty much [inaudible] on the ten percent. So I really look forward to...I hope I get asked back, you know, and visit some of the programs and particularly get to know a little more of the operational thing.

>> NEW SPEAKER: Well, I appreciate that. That's a great comment. I think that has been the focus of all of our work for so long, to take that step back to figure out how we're going to do that. I think, you know I've said it many, many times, but I think, you know, IHI and the Triple Aim has helped us go down that road, really broaden that perspective and start talking about those metrics, it gets you outside of that ten percent. And I think that's when you start to bring in those other stakeholders.
NEW SPEAKER: I think this starts to frame a lot of what we do moving forward around population health and probability metrics, [largely inaudible].

NEW SPEAKER: I think that's exactly right. So as we plan our future agendas, I think what we will do is we will take into account this tremendous amount of good work that you've done and your colleagues that are in central Oregon and turn it into then a discussion of board members who get involved with, get help from staff in terms of figuring of what some of our options are, and in the mean time, [inaudible]. We really appreciate the time and effort that's gone into the presentation. And of course all of the work that it's based on. Mike, thank you very much.

NEW SPEAKER: Thank you guys very much.

NEW SPEAKER: We'll take a break for no more than ten minutes and come back to our agenda.

[pause in audio]

NEW SPEAKER: Okay, welcome back, everybody. Thank you. We talked earlier in the meeting about one of the recent successes being the Pulse project. Another one is some pilots that are in the process of coming together in urgent/primary care. And here to talk about that for ten or fifteen minutes is [inaudible]. Welcome, thank you.

NEW SPEAKER: Thank you. [inaudible]...the office of health policy and research. And I wanted to give you a brief overview of where we're trying to proceed with the patients under primary care home laws. As you may remember, in fact I saw this slide last month, we talked about the completion of the patient center primary care home standards and we talked a bit about why this was a model we really wanted to look at. It's very similar to a lot of the concepts you've been talking about here with the regional health efforts. Enhanced care coordination, but it really targets the Triple Aim in terms of improving population health, helping to reduce unnecessary utilization which leads to reducing cost of system...

[pause in audio]

...so as we talked about last month, we completed the standards which just sets a framework in which payers and others could use to measure and improve the care toward this model. And now there's a sort of...you have a one-pager in your handout, it has a little bit more detail about sort of our next steps.

I'm going to talk first about the first one which is the partnering with the Health Leadership Taskforce on a multipayer pile. This is a...the Health Leadership Taskforce is a collection major payers in the state with health systems and some health provider
groups. And they have started down the road of a high-value medical home pilot. It's based off of...

[pause in audio]

ten percent of the population. Their goals are structured around similarly to the Triple Aim, as are ours. And there's a strong alliance in terms of looking at some of the...

[pause in audio]

...better understand some of the details of that. And there goal was some short-term return on investment in the first one to two years. Their payment is [inaudible], they have to pay their plans...

[pause in audio]

...is focused on some similar aspects of...in terms of Triple Aim and it just outlines some of the areas where they're going to look to see how the models are structured.

The reason they're going down this line is really they looked at the cost of some of these high-care, high-utilizers. So they're really focusing on that top ten percent. They did some analysis. They cost based about $22,000 per person per year. We picked 4,000 enrollees, do the math, you end up with baseline costs of $88 million. The new cost is [inaudible] model, they estimate based on how they're thinking about structuring this. It's about $2 million. So to break even, if they can get at least 2% savings...

[pause in audio]

...So what [inaudible] want to do as a health authority is try to see how many of our [inaudible] should be included into their model. They're identifying a long list at the moment of potential sites. We're also planning to look to see where their top ten percent are. It's across the state, it's not just Portland. And we're looking to see, since we're self-employed [inaudible]...for the majority of those. [largely inaudible]. They're having the Medicaid agency demap conditional medical systems programs, just looking to see where our top ten percent lie in terms of those first big look at those clinics.

And then over the month, the end of April, the first of May, they're going to narrow it down to 8-10 clinics. [inaudible] and I are on the selection committee to help participate in that. We'll have our data in terms of where our lives are in terms of...[inaudible]. And then we want to participate as a whole payer so [inaudible] employee board has already voted to participate in this. [inaudible] board is considering as well through their major commercial payers. The old Oregon Medical Assistance program is also looking at participating and we are committed to paying through some dollars we have in the Medicaid administrative function and some federal dollars that we have through one of
those grants that my office administers to also pay that, an augmented per member per month cost. At least or some portion of it to make sure our lives are part of this.

>> NEW SPEAKER: That's what I was trying to understand that. [largely inaudible].

>> NEW SPEAKER: So the public employees doesn't work as a quality fund, but they're doing it as one of their projects. On the Medicaid...as I said we'll be doing it through some grant dollars that actually the office...[inaudible].

>> NEW SPEAKER: [inaudible]

>> NEW SPEAKER: Right, so the managed care plan. If there's someone here in central Oregon, if one of those clinics gets chosen, then if we have Medicaid lives in that clinic we want to work with the plan, the application to subscribe to, and work to make sure that we're at a player along with the other commercial ones in business.

>> NEW SPEAKER: Also, part of it is initial investment dollars, it's not necessarily...I mean, it all works. It's not just the people that earn a million dollars. [inaudible] would be a loose structure at the clinic level...

[pause in audio]

...and so, that's why they're keeping this list this long. And so it'll get it in there and stay on there.

>> NEW SPEAKER: Are they going to be randomly selected or something?

>> NEW SPEAKER: They put out an RFP to ask for clinic readiness, to show their signs of readiness. They really, for this first phase, want to do clinics that are already maybe sort of even working toward this. You know, I talked to Melina Bueller, who's had legacy clinics that have been one of the Cure Oregon sites and we also have some money from regents. They think that this is another way to keep furthering the [inaudible] primary care home model broader and further within their community.

So it really augments...it really brings together the uniqueness of this as you've got multiple payers along bonding together to do this collectively rather than one plan trying to do it all by itself. This was a problem we had in [inaudible], we had in our contracts that we wanted to do this, but you know, you only have a few lives here and here and here. So a practice like Dr. Kaufman's might not choose to really change their behavior because there's only one payer, [inaudible]...getting six to eight to ten payers to do...

[pause in audio]

>> NEW SPEAKER: ...will that be in through [inaudile]...
NEW SPEAKER: ...collection data, but not with cost data. And so some of the data about how exactly the data flows will need to be sorted out. Again, this is one to two years so as the all payer database comes up, the cooperation that will help augment, make it smoother for data ...and that's what I'm going to be discussing this week with them is that how can we can get a health authority evaluation, sort of our lives inside their larger evaluation so we can really look and see what the impact has been on our lives and the lives of the covered.

NEW SPEAKER: I think it's a good segue into the question I was going to ask about how...I don't see any point in here where the consumer, the patients are actually giving input into how they like their healthcare structured and then how...

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NEW SPEAKER: And then, I guess, my question is about...the insurance industry and the health systems industry. But there isn't a...there's not a consumer person that we're working with on the development or these kind of projects or...

NEW SPEAKER: Well, the pilot was already under development before, you know, House Bill 2009 really...sort of a vision and sort of it evolving over time. And so yeah, it has been primarily run through the HLTF networks. I think as the state comes in as a partner then we bring that sort of viewpoint and thinking of overall...and again, this is just sort of phase one, how phase two... You know, does this get into the full medical home, the patient center home that we all envisioned? Maybe not, but it's a first step for some clinics who maybe haven't had much care coordination on site...

NEW SPEAKER: And then, I guess, my question is about...the insurance industry and the health systems industry. But there isn't a...there's not a consumer person that we're working with on the development or these kind of projects or...

NEW SPEAKER: I think that there's going to be a look in terms of minimum number of lives overall. But until I see the data of how...I mean, maybe if there's just a handful of OHA lives in any one site, then could we make sure that at least those sites that have the most of them are part of this? And again, we'll go through sort of our next steps. This is just one step down the road of trying to implement this. This is something that was up and starting off that we wanted to make sure we were part of to really get that power of multipayers coming in together. But it's maybe not...you know, could we do additional sites that have a heavier concentration of health...?
>> NEW SPEAKER: Sorry, I'm just [inaudible]. I guess I would argue for what I think
she was saying, that is that, I agree with what you're saying...

[pause in audio]

...it says the primary goal is to demonstrate short-term return on investment in the first
12-24 months. I'm not sure, and I know what that means, but I'm not sure that someone
picking up this document would say that the primary goal is compatible with the Triple
Aim. See what I'm saying? So maybe that could be phrased a little different. I understand
that this, as you pointed out, will produce returns. We all need that. [inaudible]. But it
kind of takes the focus away...

[pause in audio]

>> NEW SPEAKER: ...one is that...first of all, I'm sure the HLCS would be happy to
have [inaudible] guessing at what the premise is, but we need to improve patient care and
that the health industry is actually the obstacle to this. And they're trying to break
through...actually, [inaudible] was a word that was used before. This actual page of this
document was actually my [inaudible]...so I'm very impressed to say we're moving...

[pause in audio]

...850,000 individuals. But also trying to get some of these self-insurance programs to
participate in this. And I think we have a role as a board to invite participation.
[inaudible] that cost to other folks, they really have to think about it. But the way I
[inaudible] this model, it works if there's volume. It has to have volume to work. So I
would just like us to consider how we might be a part of broadening that recognition of
the project.

>> NEW SPEAKER: I do believe Bruce sits on HLTF task force. I think there is a role
where they have connected a lot of the purchasers, realizing that many of them are self-
insured and the plans are serving us their target industry. I'll check and see kind of where
we are on that. And I would like to do that, but I think we could really use our...

[pause in audio]

NEW SPEAKER: ...and clinics that are serving, community health clinics, generally
qualified med centers, how would we structure them, how we would support the efforts in
those areas. And of course, building off of the work already presented by Richard and
others in terms of the [inaudible] health clinics. And making sure all of this is integrated
and these aren't, like, separate silos of activity, but they're really overlapping.
The other thing to note, and you'll hear more when we get to the federal reform discussion is that there are opportunities to further this in the federal reform bill. It's noted here there's some great federal matching dollars so for every 90 cents from federal dollars, we only put in ten cents. And we can pay for this through a state plan amendment to our Medicaid plan. So there's a lot of opportunities. There's also some demonstration models. There's also interest by Medicare to join the existing multipayer pilots. That really adds some leverage in terms of multipayer. So...

>> NEW SPEAKER: Two take-aways and one comment. I think the take-aways are consumer involvement and reaching out to the self-insured, which we're in an appropriate position to do. We're using...we're involving a number of our self-insured lives at the state level certainly from fed and working with the administrators to do that. But I think it really prays to the discussion earlier about governance and how we create a sort of governance structure within the organization and delivery of healthcare that brings in consumers as well as the providers of care. We've operated in a structure where we've got a lot of...

[pause in audio]

>> NEW SPEAKER: Very good. Thank you very much. Appreciate it. It's about 20 after 11 and I'd like [inaudible over laughter]. I've heard that there was some activity at the federal level regarding healthcare and we'd like to take the next hour or so to talk about that. The first 20 or 30 minutes, at most, will be basically an update on what has happened and what the federal legislation will mean to us. And then we want to save at least half an hour for discussion among the board members of the implications of what we're about to hear. And then I still want to save about 15 minutes at the end. We have commercial folks I know who I promised floors as well before we adjourn at 12:30. So, with that, I'm going to turn it over to Amy [inaudible] and Gretchen [inaudible] for an update on the federal healthcare reform.

>> NEW SPEAKER: Good morning. I'm Gretchen [inaudible] from [inaudible] Office of Policy and Research. I'm going to run you through a fairly top-level summary of some of the significant provisions in the federal bill. And Amy's going to walk you through some of the [inaudible] considerations from the federal bill.

So just really getting to the high level to summarize what the federal bill does: there are significant funding opportunities for prevention and population health. More than we could possibly list today. So there's significant opportunities in terms of furthering things, furthering that part of the Triple Aim focus and then your work. There's also, which [inaudible] just mentioned, a number of provisions for delivery system reform, related payment reform, some new funding in terms of Medicare, some reductions, [inaudible] screening service at this point and what that means for the state. And the one thing that the federal bill does do while [inaudible]...fundamentally transform the system in terms of integration of health dot-coms and [inaudible].
It does focus the federal efforts in those areas quite a bit more than it has in the past. In terms of coverage and access, there will be...to those of us who are...kind of self-serve Medicaid, the expansion of a mandatory population for Medicaid to [inaudible] 133% of poverty is a pretty fundamental change to Medicaid on the national level. So that is obviously a big change to highlight. And then for those individuals up to 400% of poverty there are both federally funded tax credits and cost-sharing reductions on sliding scales available through a state home insurance exchange, which obviously aligns with a lot of the work that we have underway at this time. And then there is the individual requirement to purchase insurance and a number of insurance reforms that are being cited at the federal level and not necessarily a state option at this point.

So there's a really high [inaudible]...it doesn't fundamentally change the relationship between public health and healthcare, but it provides a slew of opportunities but, really, it's your job to [inaudible] to states and communities and determine how you can capitalize on those opportunities. The other thing that's worth mentioning since it's been a little bit confusing in the news in terms of the waver authority that's in the federal bill. We've checked every resource, including the bill, that we can come up with and the data is [inaudible]...even though it's been a little bit confusing in terms of when state funds actually kicks in. So that's something, obviously, we'll leave in your track, but we will put all these sources in [inaudible]...that's still a waver to allow states to fundamentally change some of the requirements of the federal bill [inaudible]. So we'll keep you updated on anything...

[pause in audio]

>> NEW SPEAKER: So those are what we have for other presentations in terms of more detailed slides. And I know we're a little pressed for time so I'm not going to go through each one of the bullets. But...

[pause in audio]

...and there's also going to be [inaudible] test, or a federal national prevention and health promotion strategy that we'll want to watch closely in terms of what they're working on versus [inaudible].

>> NEW SPEAKER: [largely inaudible]...and I mean, we see that things are changing. But are there some precipitous dates for all the funding to have a major impact on [inaudible]...that's what I'm trying to get [inaudible]

>> NEW SPEAKER: In terms of the Medicare payment side, there's the freeze and that sort of reduction from there. I actually don't know the answer in terms of any cliffs or any [largely inaudible]...
NEW SPEAKER: Joe, the one thing I will say is that the biggest cliff to me is the 21% cut that's supposed to take effect now. It hasn't. And I think back to the whole, the cost-of-[inaudible] piece, the $5 billion Medicare cuts is contingent on that 21% cut. And that's it. I don't see that happening.

NEW SPEAKER: I think all of us know the unreality of that [inaudible]. It's sort of hanging out there [inaudible].

NEW SPEAKER: In terms of transforming healthcare delivery, [inaudible]...payment reform options in terms of an enhancement in reversion and planning grants for primary care homework. There is a new CMS innovation center that has developed various payment reform opportunities, with a real focus on community round-up work in that area, which obviously [inaudible]. And this is our two bullets, which is obviously only scraping the surface in terms of Medicare payment issues. And we'll continue to follow...to delve deeper into looking into this statement of [inaudible].

There's also, in terms of community health center funding, there's a significant increase, it would be a doubling of the funding, nationally. And [inaudible] are now waiting for health integration and then a slew of funding grants for workforce issues. Kind of the workforce committee is looking at this and integrating it into their work plan in terms of what opportunities are there.

This slide is just looking at [largely inaudible]. And so I think I can sum up the slide by...

[pause in audio]

...provided to our systems for more research being done in terms of compare effectiveness [inaudible] what the new institute that we're setting up.

So here I've covered in Access, this slide having some of the early changes that we'll be seeing in terms of young adults being allowed on parents' health plans until they're 26, prohibition on things existing conditions for kids and prohibition on assuming coverage except in cases of fraud, and some prohibition on lifetime benefit caps. So those are all things that we'll be taking in within 90 days to 6 months of the passing of the bill. They'll make sure to be things that are decided for us at this point.

Really high-level, this is more of a detailed slide, I don't need to go through it bullet by bullet, but it is focusing on medicated shift, the expansions for [inaudible] 133%, the expansion of fostering children up to age 26, and this over here is the schedule of enhanced federal funding that is provided to be eligible for some of these expansions and there's some more...[inaudible]. And the one thing just to mention is the last bullet: that there is a statement of maintenance of effort on current elegibility processes in rules in order to receive that higher match that obviously the state will be keeping in the event of [inaudible]...and all of that starts in 2014.
NEW SPEAKER: Not sure. That's going to be based on the HHS interpretation of the bill. There's also another, it's not on the slides, but there is a provision about reductions being proportional to the size of the state. So in terms of obviously there are states out there that have much bigger issues with a lot of this than we do since we're normally considered a low-dish state whenever a federal bill passes. So at this point we don't know the exact amount of the reduction, walked away for HHS, but ideally we are hit less than some other states.

So a health insurance exchange. As you know we were required to work on a business plan for a health insurance exchange for...

[pause in audio]

...there's the requirement that there's both an individual and a small group health insurance exchange. There is a market outside of the exchange as well, any individual group market. And there are some...there's definition provided to the benefit [inaudible], which has a pretty direct effect on the also the work that we're doing on about creating a central medical [inaudible] exchange. And all of primers around that will have to wait for HHS to see what kind of box they put around the various tiers of [inaudible] that are outlined in the bill.

And then eventually with the tax credit and the cost sharing reductions, those are only available through coverage for just through the exchange. And in terms of public plan, there is no federal public plan. There's nothing, as far as we can see in the bill, that precludes the state from continuing its work...

[pause in audio]

...uninsured numbers on the left and right side, in terms of who's visit we chose...the number of uninsured in each of those brackets.

One or two last coverage and access to care slides, but there are a number of...[inaudible] a number of new entities that are created in terms of a high-risk pool. That can be done by [inaudible] directly and then we work and get in contact with HHS if they would be directly implementing the high-risk pool in the federal bill.

In terms of small businesses, there are tax credits for small employers to purchase coverage. And there are systems on employers whose employees access the federal tax credits and cost-share reduction in the exchange. So there is a pay or play mechanism if someone's employees use the tax credits.
NEW SPEAKER: Can I just...for the board or any public that may be listening, the tax credits are retroactive to January 1 of this year. It's for any small business that provides a certain level of coverage. And there is a specific percent of the premium. They get a 35% of the cost of the medical coverage back as a tax credit. I think that's a hugely significant opportunity for Oregon's small businesses and this goes up to 50% in 2014 as a tax credit. So it's, I think, important that people be aware of that.

And the other issue that I also wanted to stress is that we...one of the first things out of the chute in terms of national health reform has been setting up temporary schools. And we're currently looking at...we will be implementing the national high-risk pool as well. I think the question for us that we're trying to get clarity from from HHS is what, if any, opportunity we have to build a common high-risk pool based on what is, from our stance, one of the more successful high-risk pools. And so whatever opportunities they have in looking for...we're not sure if that will exist or whether we're really going to have two distinctly separate pools or whether there will be an opportunity to create some greater reform...

[pause in audio]

NEW SPEAKER: There's a basic tax penalty starting in 2014. And there are some exemptions in terms of some people not having to pay that tax penalty. One of them is that in terms of...

[pause in audio]

...guarantee issue, renewability, prohibition on lifetime limits, these are all 2014. Except there are some...there are certain annual limits permitted between now and 2014. And it eliminates the waiting period of up to 90 days for coverage, which I believe may or may not actually have a huge impact on [inaudible].

Then in terms of reinsurance pool, there is a reinsurance pool being established for assisting pay the costs of claims for retirees. Close to...over 65% coverage [inaudible] most of the retirees in this. And there's also a transitional reinsurance program for the first two years of 2014 to 2016. [inaudible].

NEW SPEAKER: All right. I'm Amy [inaudible], legislative director of the health authority. And I'm going to shift gears a little bit. We have a timeline, I'm not going to go over it in any detail, but I think it lays out some of the big pieces that [inaudible] going to implement it. What's implemented immediately in the next six months of 2010 and then over the next few years. We also have, on the health authority website, a more detailed timeline that we're updating on a regular basis as more information comes out. So I would suggest you check that every now and then. And that will be the most up-to-date place to see when things kick in.
We wanted to shift gears now. Gretchen, I think, gave you a nice, brief overview of what the bill does. And then in this piece of our presentation, we wanted to shift to what are some of the key issues and key questions that passage of this bill now raises for us. One of the things that we now need to make decisions about in terms of how we move forward. There's a couple questions on the next few slides, but they're kind of really centered around timing, the scope of our work, and strategic alignment with our current efforts.

In terms of timing, questions include whether we should go early: should we look at time implements in the key elements of the bills and just exchange earlier than it's currently laid out to be. Should we continue with the activities we have in our plan now, in our work plans, even though we know they'll be altered or maybe even superseded by what happens, you know, as key elements of the bill come into effect over the next few years. And one question that's not on the slide, but I think that should be on the forefront of our minds is what are the impacts of these timing decisions on our funding [inaudible]. What is the impact on our need for state general fund and, you know, does our action either create more opportunities for federal funding or jeopardize federal funding...

[pause in audio]

...you, know, another question, this also raises the funding question. Should we...should we do more and what impact does that have on our funding [inaudible].

These questions really need to be addressed in terms of thinking about how to invest our energy and our resources over the next few years. As Gretchen mentioned, the federal bill sets the direction and lays out a clear plan for coverage and for financing, to pay for the coverage and some of the elements like that exchange. But there's a lot less detail and a lot less direction on cost and some of the quality issues that we have been focusing on based on the health authority's work.

Now that the bill's passed, our job, a collective task, is to think about how to prioritize given extensive resources and the current political climate. We know that we are continuing to operate in an environment that's scarce and probably diminishing resources at the state level. And our political climate, we need to think about our political capsule moving forward. There may be new opportunities because of momentum around the federal healthcare bill, but I also think we need to think about sort of the flip side of that: the risk that there may be a certain level of fatigue among our elected officials for the healthcare topic. You know, I think there's a very real likelihood that people, legislators, they say we've taken care of this topic. So how do we factor that consideration in our thinking and our...

[pause in audio]
...Other questions that we should focus on are more around our strategic alignment. What do we want to do and how do we want to factor in the federal funding that's available to us. How do we ensure alignment with our current efforts, make sure that what we're working on is what we prioritize as a state, and that we aren't simply chasing dollars that are available to us. Do we want the dollars available to set the tone and direction of our work or do we want to make strategic decisions about what we're doing, where we're going, and then find the opportunity to help us get there.

So there's many, many, many unanswered questions. There's unanswered questions about what the bill does. There's unanswered questions about what the impact on Oregon will be. And I think there's a lot of unanswered questions about what our next step should be. We'll be monitoring very closely as the regulatory process that will start answering some of the questions for us plays out over the next...

[pause in audio]

...groups, task forces, and commissions that were created in the federal bill. Those all need to be populated with people. And we all know that Oregon is the leader in a lot of this work. And so we'll be looking at opportunities to get Oregon representation on as many of these as possible. We've done a lot of groundwork and we should be able to share that and help shape the direction of some of the [inaudible] of the bill that we don't know how they're going to hold out yet.

Um, some staff might be looking into how we might best do that, [inaudible]...probably at our next meeting for how to start thinking strategically about maximizing opportunities for Oregon involvement in some of these [inaudible] panels.

>> NEW SPEAKER: Very good, thank you. Um, obviously there is no way in the world that we are going to answer all these questions today. There's no way we could answer all these questions today. But you have seen the future of our next few agendas. And there are obviously many topics to consider and many questions that do need to be answered.

What I'd like to do now is, in the next, let's do this clock, 22 minutes, I'd like to [inaudible] some general questions and reactions from the board. Kind of about philosophic direction, and what would you like our staff to hear as they think about bringing forward these changes. And then at noon we do have a little [inaudible]...I'm going to ask Tina to enumerate just three or four bits of direction that we probably need to provide to some of our working committees and to the staff as we go forward.

So I think first just questions and reactions. Who'd like to go first? Carlos, you're up.

>> NEW SPEAKER: [largely inaudible]. This question is about the exchange and how and when to start the exchange and the perception that a healthier option might be a money-losing endeavor or a money-neutral and I think the public option we have doesn't
delve into it deep enough to know what we're getting into. I think it's a critical [inaudible over others]...how much things do cost. And that's one area that I think we should [inaudible] very carefully.

So we talked about this group of people between 133-400% and how will that will live in the exchange and how do we make sure that the market allows for their balance of [inaudible]?

>> NEW SPEAKER: We'll just go down the table. Ellie, your thoughts.

>> NEW SPEAKER: Okay. Um, I'm extraordinarily excited, to state the obvious, for federal reform. I think we've come a long way in a certain time and it took a lot of people to get there. So [inaudible]...and that we are so aligned with a lot of the premises and the direction behind this federal reform piece, I think it's to our method and to our credit and [inaudible] to implement them. I think there's a fear that I have that a certain number of dollars would come into the state for a variety of these programs and we would lose the...[inaudible] would get lost. It would get put into programs that don't get measured or just be [inaudible]...not necessarily effective or [inaudible]...so I want to be cognizant of that process as funds for those programs are secured.

I'm intrigued by the early methods piece, the timeline I think does drive a lot of this. The early methods pieces would be, potentially, would be essential for building this kind of outreach to get this structure on a Pulse program, on a Health Kids program. Could we then start to get this Young Adult Parent's Plan piece into our communication strategy...

[pause in audio]

...I have a lot to say. I'm excited. I think that we align and I'm very intrigued by the fact that this is very coverage-oriented. This is very coverage-oriented. And that visional pieces to the Triple Aim are some of the pieces that we really need to focus on. The federal reform's got a huge amount of work for us, the coverage and access needs, and up the ante on prevention and upstreaming solutions. And I'm excited that we can now focus on those bigger pieces.

>> NEW SPEAKER: Yeah, I think I share some of this concern about having these...

[pause in audio]

...I just want to make sure that we're comprehensive in our evaluation of what we do for others. That's one thought. And then Amy actually got me thinking when she said what's the...you know what is the [inaudible over others]...leadership's capacity for continued concern about healthcare issues [inaudible]. So I think that it goes back to [inaudible] so they have to understand that...the election's going...no matter what we think of in terms of
policy and comprehensive policy development of their political concerns [inaudible]...those are just a couple of my concerns.

>> NEW SPEAKER: As I look at this [inaudible], I'm reminded of an old adage that I can't quite remember so I [inaudible]...but I'm going to try to use it anyway and that is that excellence in implementation accompanied by an adequate strategy will always trump a terrific strategy with only mediocre implementation. And I'm reminded of that because this is about covering the most people in the best possible way. So whereever we have federal mandates, guidelines, et cetera, I think, you know, we should really make an effort not to duplicate or complicate that. If it's a [inaudible]...I think in every possible way we should align ourselves with it. And that's not to say that we're not aspirational about what we've done. But it gives us the opportunity to, I think, more clearly communicate. Because we won't have to communicate from this. So I'd really look at that closely and see where we can align.

Because, we in Oregon, we can [inaudible] do it differently, we can do it better. Because we had that start, I think we're better organized than many states are. So I would really like for us to align and [inaudible]...be a shining example...that then allows us to use our resources, both financial, emotional, and intellectual, to do...there're lots of gamuts in the federal legislation. Among the most obvious is workforce. And I don't mean by that just the number of people we tally in our forces, [inaudible]...it will allow us to put the emphasis on where we [inaudible over others]. So those would be my thoughts.

>> NEW SPEAKER: Thanks, Mr. Chair. I think a couple things. I think I'm agreeing with Gerald actually...[inaudible over laughter]. But I hear what you're calling a [inaudible] up by our principles. That is one of your core [inaudible]. And I think that one of them is that looking at...we don't want to do [inaudible] and we don't want to be in a situation of...early adopters sometimes [inaudible] the changes. Early adopters [inaudible] the changes. A lot of times they get [inaudible]. I'm very worried about [inaudible] and some of those other things.

And, you know, my personal thing is there are certain stakeholders who are at real risk in the federal health reform. And I think it really showed our maturity [inaudible] of dealing with these issues, as opposed to some other areas of the country simply name those and call [inaudible]. Not that we're necessarily...

[pause in audio]

...I also think that, sort of, the one way to deal with Oregon as a piecemeal, you know, kind of approach to it is to identify it like what it...

[pause in audio]
...is focused basically on population health and delivery system right now. Because I think there are differences like 5% and, you know, 8% of [inaudible]...there are areas there that will be identified as normal, but the only way that we'll be able to get to what maybe we want in terms of coverage is if [inaudible] can figure out how are we, not as just as a pilot line, how can we make that sustainable for Oregon. You know, for the whole [inaudible] deal that we're delivering to our community as health...[inaudible].

So I would like us, in our work, to focus on those first two issues because I think those are really our opportunities to get money out of the system, to really not lose part of our community as we go forward. [largely inaudible]...but also at the same time, to understand where we can save that money to do what with our vision coming out of our legislature and with all of our...[inaudible]. You know, how do we make that a reality? Because this is a pay-as-you-go kind of thing. This is the new normal going forward. So we're not going to be able to get grants and foundations to look at this. We're going to have to show that we have a business plan that within these parameters delivers healthcare.

>> NEW SPEAKER: Back to you, Felicia.

>> NEW SPEAKER: I think that I agree. [inaudible]...I think that that only thing I'd like to add is that when we're putting together our best plan is to be aggressive about how we're maximizing the federal dollars. Because we are in a position to do that. And I think thinking about how we change the work plans of the committees to integrate some of that work, especially those [inaudible] around workforce is going to be important.

And also the other thing that I'm really excited about is this possibility of collaboration with other states. And how we're reaching out to our partners, both to the north and to the south, who mainly [inaudible]...but they're very similar to us and [inaudible over laughter]. But to the north, they're very similar to us and we maximize that to hopefully have a workforce plan as well as sort of a population health plan because we do have a huge population in Vancouver that is actually part of our healthcare delivery system.

>> NEW SPEAKER: Thanks. I am [inaudible]...Eileen and Lilian's comments that I see this legislation as doing part of our work that was already outlined in this. And I think it's the coverage. And I think we wouldn't want to replicate that or necessarily need to. But the one thing I see really missing in all of this, we talked about last time, is the cost of the database. And I think if we just let this go for another four years without ever having, you know, putting it back on our front we would reject that [inaudible]. So to really work on population health and delivery system reform where we can spend the time really focusing on that over the next several years I think is going to pay off. And I think, you know, what Joe alluded to earlier, when you look at the federal legislation in terms of the cost of payment mechanism we put in a place was a $500 million cut to Medicare with really no way of understanding how that's going to pay up. They haven't even taken action to get there yet.
So I think that the more, kind of, proactive we can be on that front I think is going to be the...[inaudible].

>> NEW SPEAKER: [inaudible over laughter]. And I don't have a lot more to add other than that [inaudible] state where I am, and that is that I agree with the philosophy that I think has been stated here. That a lot of the work has been done for us and I think the extent that we can align with that work and then go forward from there, we have the greatest opportunity for real impact. I think that real impact comes in the remaining pieces of the Triple Aim in the delivery system and workforce and so on.

I think Chuck made a very good point about trying to do this in a very strategic and comprehensive way and not in a piece meal sort of approach. So I certainly agree with, basically, everything I think I heard here. Bruce, what thoughts do you have?

>> NEW SPEAKER: I wanted to get back to the tremendously helpful and it sounds like there's a growing consensus...you know from a staffing and [inaudible] education perspective I share some of the concerns about needing to be strategic about the implementation [inaudible]. We're approaching this, as we've been talking about this over the last couple of years, really as a very large scale project. And we really need to organize...we need to really understand the depth and breadth of opportunities, what may happen, as well as making some real strategic choices about what to invest time and energy into and perhaps what may be available and what to pass on because it doesn't...you know, a longer term strategic vision. I think every organization in every state had to have set capacity for change and we've got to keep aware of that and I think that's our collective roles. We've already starting putting in place the kind of project management structure that I think will help support the board. And we start to move forward with understanding the opportunities.

And then, I also think we're going to need to, with this, look at, over the next month or two, refocusing some of the committee work now given this. And I think it really speaks to focusing and sharpening some of that work for some real deliverables in the very short-term that will fill in some the gaps and really focus on the health and delivery system cost issues.

>> NEW SPEAKER: Very good, thank you. Tina, we were talking a little bit earlier about kind of some short term things that need to be addressed. Would you like to give us some thoughts about that? [inaudible over laughter].

>> NEW SPEAKER: Yeah, no, it does. I'm just going to ask that, in preparation for the next meeting, what I would ask the staff, the staff committees, and, actually, [inaudible]...that we look at [inaudible] reform and how that changes the work plans. Again, just some guidance to highlight some of those items.
The other thing that has come up is that we're lacking strong health equities language in a lot of our work plans. As long as we have these [inaudible] and we're looking at them in terms of federal reform, I think it would also be a really good idea to work with the office of multicultural health and develop language and [inaudible] the work plans again. And not just the committee work plans, but also the work plans getting done around subject matter by staff. So we would do that between now and the next meeting too.

And then I think, just to let everyone know, that we are tracking this very closely. It is like literally a... [pause in audio]

...everybody up-to-date on what we're hearing, how it changes our work, it doesn't change our work, and what opportunities there are.

>> NEW SPEAKER: And do you need any formal action from us or just generally [inaudible] that we're all on the right track and does it really feel like that statement of work is on the right track? Very good.

>> NEW SPEAKER: Bruce, I'd like one question. It is really more informational based on...Tina just said, we get info on an almost hourly basis from HHS about, you know, now and today is about medical...you know, timelines about medical operation. Do board members want all of that in sort of real time or would you prefer sort of summaries at times that makes sense?

>> NEW SPEAKERS: [inaudible over each other and laughter]

[pause in audio]

>> NEW SPEAKER: I don't know how it's actually going to play out. Some of them, literally, two days after it was signed we were getting letters from HHS asking us who's your point person and how are you going to address this. So some of it's very fast, some of it won't help for a while [inaudible].

>> NEW SPEAKER: [inaudible]...with all of that information that comes in, turning that into...

[pause in audio]

>> NEW SPEAKERS: The other thing I would add is just that this list of questions that Amy put together, I think you mentioned it. They're very important questions. I don't want to gloss over it. I think we need to look at those questions. And at some work meeting, between meetings we need to decide do those go to the workers, does that come...
to us? We need some strategy work on this. I think those are the questions at hand and, you know, take them on.

>> NEW SPEAKER: And I agree with that. Carlos, a comment?

>> NEW SPEAKER: [inaudible]...precisely that we have four, five, six work rooms and meetings and they're all worked into...maybe in isolation from each other. And perhaps that might be okay, but the last thing we want is to have one committee saying, "This is what we want to do," and the other one doesn't know that's the opposite. And both are probably reading from the same federal legislation.

This, for me, intercommunication is very important. It's great. I read comments from the other committees. But the chair for all of them should be able to see how...what they're doing [inaudible].

>> NEW SPEAKER: Gretchen, do you want to talk to them about opening a place to deal with that? The staffs of the committees are meeting together. And that...

>> NEW SPEAKER: We're doing a couple things. One is that we are having a regular meeting of the all the committee staffs. That includes those all located within the policy research as well as for the public health.

We're also working on, now that we have a number of committees, working to [inaudible] based on federal reform. But we're working to align work plans and identify the really key interrelation points in making a committee work. So we identified some of those needing a charter, but now we're looking at a timeline in terms of which products are being developed when and where there's some connection points between points. And some education can be done along the way between committees so they're [largely inaudible].

>> NEW SPEAKER: One example is the population health metrics for the health improvement committee. I mean, we know what population health, we know health and research and that, and I'm sure that commissions are thinking much like that. So...

>> NEW SPEAKER: The problem is a need for leadership from us to tell them, "Okay, this is what...these are the boundaries."

>> NEW SPEAKER: Yeah, and I think probably the best way for us to do that is to use the next week or two or three to start to work through these questions, to start to figure out where they track, where they go. Nina, Bruce and I will start that and we'll involve members from the board and hopefully we'll come back at the next meeting with a pretty clear plan.
>> NEW SPEAKER: All right. Anything else on this topic? Very good, thank you very much. We have time on our agenda for another comment and for a few questions that I believe have been coming in. And [inaudible]...I have only one person who has, Dr. [inaudible]? Am I pronouncing that correctly?

>> NEW SPEAKER: Yes, you are.

>> NEW SPEAKER: Wonderful, thank you. Good afternoon. How are you today?

>> NEW SPEAKER: Very good. And welcome to [inaudible]...central Oregon.

>> NEW SPEAKER: It's great to be here.

>> NEW SPEAKER: First I'd like to thank you for allowing us to meet today. I've had occasion to work for the last two years with Dr. [inaudible] and Dr. Smith. And in the past month I've been working more closely with Dr. Smith and Jeremy. I appreciate that opportunity.

And I believe that the policy board of, ultimately, the Oregon Health Authority will be both in charge of application of the priority list and in developing [inaudible] insurance plans to be offered to state and county employees as well as teachers. Furthermore, down the line the insurance exchange will use such plans as models for the rest of the commercial insurance plans. I would like to state on behalf on the medical community that physicians are trained with the Hippocratic oath of "Do no harm" and with the dictum "Patients come first."

We all recognize the needs of [inaudible] and the needs of the socially responsible healthcare system with the needs of a quality, cost-effective healthcare for our patients. Over the next few years, as this agency is instructed with this sacred task, it is my hope to openly seek testimony from patients and from physicians that you will re-examine the priorities risk and the methodology used to make such [inaudible] determinations. In particular, I would draw your attention to the issue of what are acceptable types of cost-effective studies. Clinical physicians have their interpretations...

[pause in audio]

...that this confusion lies. An expert has noted that it makes sense to first identify the effective approaches and then make them more...make them cost-effective.

In going forward, most institutional review boards, in framing perspective studies, would consider it unethical to withhold what is considered standard treatment from one group of patients in order to see if they incur greater downstream costs to the healthcare system. Now it is possible for the Oregon Health Commission by itself, or with the aid of OHSU, to look retrospectively at the overall costs associated with withholding coverage of
standard care. Similarly, it would be important to compare overall costs to remove presently...

[pause in audio]

...to complicate this process is that the Oregon Health Commission would use diagnostic lines only once every two years, which really doesn't allow for dynamic back-and-forth discussions. And that the priority line is also based on how much money is entered in and spent in the system. I would ask you paranthetically how does the policy board or the health authority plan...

[pause in audio]

...closely monitor the progress and alert and their patients as to their concerns. I look forward to any questions you may have.

>> NEW SPEAKER: Very good, thank you...

[pause in audio]

>> NEW SPEAKER: ...and in that capacity we testified two years ago to the Oregon Health Commission with over 400 pages of both summaries and articles on cost-effective studies. And that's kind of why we're frustrated at this whole distinction about cost-comparitive and cost-effective studies. And I will just share with you that the allergy community feels that everything you’ve heard here today...the dedication to preventative medicine is what we're all about.

I am the son of a plumber and Dr. [inaudible], a very prominent [inaudible], used to compare the work that we do is when some people walk by a room and there's water coming through the door, and you have people that go in and they mop the floor. And you have pepole that go in and fight it, unclog the sink. And then you've got people that take a look at the faucet and try to actually fix the leaky faucet. And that's what our team is all about: preventative care. We do a good job of keeping patients out of the hospital. In fact, this fine institution that you're sitting in I actually was demoted from active to courtesy privelges because, in 16 years, I've only had two hospitalizations. I think that's [inaudible]. And I would ask you to recognize that what allergists have to offer is to keep people out of the hospital, keep them out of the ERs, and that...I find that there's proper post-specialities that feel the same way, that one should look at severity of conditions or clusters of conditions in helping to determine what the most cost-effective of treating these complex patients.

>> NEW SPEAKER: Thank you. Chris?
NEW SPEAKER: Thanks, David. You know what, I wanted to make clear to the board is we've been working with Dr. [inaudible] around...he's referring to the health services commission and the prioritization of services for the Oregon Health Fund. And one point that I'd just like to make is that the board hasn't made any commitments or plans to expand that to anything larger [inaudible over other voices]...

NEW SPEAKER: Thank you. Jeremy, do we have some other questions or comments.

NEW SPEAKER: We do.

NEW SPEAKER: All right. The floor is yours.

NEW SPEAKER: We actually have a number of emails today so I'll just start at the top and address the [inaudible]. The first question, actually I have a few questions around the public option, what federal reform...what the impact of federal reform would be on our public option. So the question is about what obstacles do we face now in terms of...when are we going to discuss those and are we also going to discuss the possibility of [inaudible]...non-profit?

NEW SPEAKER: I'll take the first shot and Bruce please...I saw a little bit of information earlier today about the fact that, so far, we don't think there's anything in the legislation that prevents public options. But I think it's very much up to this board to determine how we best proceed with regard to that specific topic. That probably comes up in the agenda in the next two or three weeks, I would think. Bruce?

NEW SPEAKER: Statutorily, we continue to have a charge to develop a plan...put a plan before the legislature for a public option. So in a lot of ways we continue to move forward on it.

NEW SPEAKERS: Thank you. And then with regard to the ban on [inaudible]...or at least on lifetime limits, what recommendations does the board have or what are the board's thoughts on how we're going to enforce those?

NEW SPEAKER: I think that's going to be [inaudible]. The enforcement of, you know, all the new insurance regulations is really going to be a job of the insurance commissioner and the department of consumers. And the health authority was created, and I think this is an important piece of background and history for everyone...one of the issues that was considered was whether or not to put some of the insurance oversight and regulation within the health authority or to keep it outside. I think there's pros and cons and there was a lot of debate. With that said, regulation and enforcement of insurance law lies with the insurance division. There's going to be some resources that come to states for some enhanced infrastructure, as well as some greater transparency that's going to be
required of insurance companies to do that. So I think that's all going to [inaudible] nationally enforced by the powers that come to be.

>> NEW SPEAKER: I think one more thing I would add to that is that within our mandate there are a couple of areas where we are directing work with the department of consumer business affairs. And we probably should include in our requested staff that the federal bill has granted or changed any of that work [inaudible]...

>> NEW SPEAKER: Thank you. The next question is, actually it's a couple of questions concerning the high-risk pool. Do we know yet what the federal high-risk pool will have out-of-pocket expense sharing or is that a question...[inaudible]?

>> NEW SPEAKER: We have no info on what is going to be the requirements of the federal high-risk pool.

>> NEW SPEAKER: Thank you. And then the follow-up to that: what community engagement does the board see when we get to the point of knowing what decisions can be made about [inaudible]...what I would add to that is I guess we first need to figure out what decisions the state has the ability to make.

>> NEW SPEAKER: I think that's exactly right. And I think the next step there is that we are very transparent in our work as a board. Also very transparent about the work our committees are doing and ensuring people have access to those committees as well as [inaudible]...

>> NEW SPEAKER: The next question: assuming that adding additional population to Medicaid [inaudible] some cost in savings system. How can we go about capturing those cost savings and returning them to [inaudible]...?

>> NEW SPEAKER: I'm not sure if you're asking these questions to help you with your communications...

>> NEW SPEAKER: Oh, let me clarify. These questions [inaudible over laughter].

>> NEW SPEAKER: People are emailing in questions and we're answering them!

>> NEW SPEAKER: Thank you for speaking up to all the people who aren't in the room.

>> NEW SPEAKER: It's a new format. We're learning.

>> NEW SPEAKERS: [inaudible over each other]

>> NEW SPEAKER: I think that's been the age-old dilemma, not just in healthcare but in any organizational change. How do you...when to find efficiencies, how do you take
some of the dollars out and redirect them. And there's no doubt, and I think it's a great question for the board and for our [inaudible]...I think it's some of the things that Health Matters has been grappling with is they put together the three-shareds. There's a significant amount of resource that is going into covering the uninsured. And I think that's what the question is really geared at. And the certainly we're going to have a large number of people who will gain coverage. And there's a bunch of resources that are going to provide some level of care. And it's how do we capture that and repurpose that within the system I think is going to be a really important question. Not sure anybody can...

>> NEW SPEAKER: So, and I don't know where the question is coming from, but do [inaudible] supposed to go back to the general populace as a recycled [inaudible] that DHS could use them to outmatch another federal program...[inaudible]

>> NEW SPEAKER: Let me actually clarify because I think there's two bits of [inaudible]. One would be the non-general fund money, whatever money is going to provide care now. The other is, I guess, the question can also be interpreted is there some, you know, general fund money that the state will see. And if you look at the sort of ten year continuum of health reform, there are some places where health reform does free up some general fund money. Actually, in the early years, there's some opportunity. For example, when [inaudible] reimbursement, [inaudible] matched on the federal government increases 23%. There'll be some general fund dollars freed up. I think what the question for the legislature and for this board will be kind of continue to capture some of that and where that goes.

As you get toward the outyears of health reform, the balance starts to tip a little bit and there's, you know, a small cost [inaudible] for the additional coverage. Over a ten year period, our sense is it's fairly ready and neutral that the state will get additional...

[pause in audio]

...including the variety of population-based improvement opportunities. And the general fund expenditure could sort of leverage that. As best we can tell is somewhere plus or minus $50 million. So it's about as cost-neutral as we can get [inaudible]. I don't know if that totally answered your question, Carlos. I guess it's something we'll all have to pay attention to. And a great question.

>> NEW SPEAKER: I have one more question. How do we assure that, as we more forward, the Oregon isn't penalized for the work that we've done to cover kids and adults that are 100% versus some of the states that haven't contributed additional state funds?

>> NEW SPEAKER: We've been working 24/7 over the last year with our congressional government to be certain that that doesn't happen. And we think, right now, that we're not going to be penalized for that. But we also believe that we shouldn't just trust, we need to verify. And that as the rules get written, we're going to be certainly working with our
congressional delegations to be certain that rules don't get written in a way that would potentially disadvantage us. But we've been working really hard and I think it's been a credit to the way the language of the bill, the health reform bill is such that we won't get penalized. And there was very technical issues around waiting lists for OHB [inaudible] and a variety of things. And it won't be an answer...[inaudible]...but we're going to continue and I think we need to be vigilant about that.

>> NEW SPEAKER: Thank you.

>> NEW SPEAKER: Thank you very much.

>> NEW SPEAKER: I'm sorry, I just have a comment about sort how we capture the dollars. I think it's important that we make possibly the focus of all of the subcommittees that are reducing cost is how to actually [inaudible] those dollars for consumers. If we're just driving down costs, but not seeing any return on that people are going to get very angry.

>> NEW SPEAKER: [inaudible]. Appreciate it. Is there any other business to come before the board today? [inaudible]. Mike, once again, thank you and your colleagues...
Lillian Shirley: Good afternoon. I’m going to call to order the Oregon health policy board’s March meeting is now in session. I just want to recognize that Eileen Bright-Brady who is one of the members is on the telephone. I don’t know Eileen can you hear us.

Eileen: yes I can hear you

Lillian: Okay great. Thanks and as I mentioned earlier the chair Eric Parsons will not be able to join us today. Thank you all for coming. We have a really full agenda and we have a really exciting status update on the work of the board. Now I would like to turn the agenda over to Bruce Goldberg for a sad moment of recognition.

Bruce Goldberg: Thanks, Lillian. I just wanted to take a moment to have all of us recognize and remember Ben Westland. Whom I think many people around the table know and for those who don’t know it’s important to recognize the much of the work were doing here today and much of the work reasons were here today is a result of the work and vision of Ben Westland. He really helped move through the state the work of the health fund Board and as a result of that work we’re all here today doing what we’re doing. Ben was a champion of assuring that everybody in the state was able to get the healthcare that they need. He certainly worked tirelessly to do that. I think that we can do two things. One we can honor him today by remembering that. And I think two, we can honor and remember him by working to see that vision to fruition and really devoting all of ourselves and our work to meeting that vision and reminding ourselves every day that we are here to make sure this is a healthier state and that everyone in this state is healthier and can get the health care that they need. Let us just take a moment and remember our colleague and friend Ben Westland and think about how we can honor him with the work going on in the future.

Lillian: Thank you Bruce very well put. Any other comments or any or anyone else want to say anything else at this time? Moving on to the agenda the first item of business is the meetings from our February 9 meeting and I’d liked call for an approval of those minutes

Felicia: seconded

Many voices: approved

Lillian: okay the second item on the agenda is our legislative concepts which are available in your packet and are available online. And I just wanted to remind people that this is very informal informational documents. It’s early in the process most of them are just placeholders. That will be that will be fleshed out over the next several weeks. As we see what is the progress that the board makes and that the input that we get from the community and how things are moving ahead at the state and also what is happening at the federal level. Suggest as you read that and go over them just keep an open mind. It’s definitely not set in stone. So the next item of our business is our next meeting, the board
is required to hold a meeting and every congressional district over the biennium. And this was in our enabling legislation. And the timing is very good for us to have a meeting in Bend in April. And part of that reason is the agenda on your work plans that you saw here at the Oregon health policy board is the were trying to dovetail the work that comes to the board with activities that are actually kind of happening in the state and also relevant to the decisions have to be made. So the timing is good because partly Bend is engaged in some very exciting and significant innovative pilots and experiments in the delivery system. They are engaged in, well, they’ve just received a lot of funding for your health resources and service administration grant to begin a multi-share project and that definitely goes back to what we were talking about a couple of months ago, around payment reform and experiments like that. And a multi-share program is where I believe an employer and employee in the community will be sharing the cost of coverage. So this will be an interesting opportunity for us to see how this is working in a community and also for those who are online and listening run the state can have a first-hand kind of visit virtually with us to Bend. The other thing is that they have a behavioral health integration project and as we know that’s definitely been a great recommendation that we’ve received not only across the board from best practices but also where hearing that this is what our state wants us to look at and are predecessors the Oregon health fund Board recommends strongly. So this is a great opportunity to see how that’s working. And last but not least they’ve just established a transitional board for a regional health authority. And there’s been a lot of starts and stops and different conversations around the state as well as nationally about what that would look like to bring accountability for the health of the community to a broad range of providers public health not-for-profits and policymakers. So that’s very exciting as well. So Mike you’ll be a host do you want to say a few words?

Mike: no thanks we look forward to hosting everybody. I think it’s a great opportunity to have some discussion about what those things can look like. And we can hopefully certainly over time learn from other communities.

Lillian: and others of us that cannot make it will try to have the technology so that we can certainly be involved.

new speaker: I just want to encourage everyone to talk with Tina Marie about your travel arrangements soon as possible. If you need to go over early or spend the night she can handle all that for you.

Lillian: so thank you Mike for offering all of that opportunity to all of us. Now the next is Bruce and the directors report and were experimenting with a template for the directors report this month so for those of you in the audience and listening hopefully you’ll be able to follow the issues as they build and see how the interface between health authority and health policy board this is an experiment that is being fleshed out as we go along.
Bruce: thanks Lillian. I think everyone got the report. Let me just cover a couple of the highlights and then I think open it up for questions. What’s written there is pretty self-explanatory. This was certainly a busy month. Being occupied with the legislative session. One of the next items is the legislative report what happened during the legislative session certainly contained activity on the national health reform front we continue to exceed the enrollment targets around healthy kids are beginning to add additional individuals onto the Oregon health plan standard program what I really want to go take a look at the moment to highlight what I took some time this month to give board members a sense of what were beginning to look at with the 750,000 800,000 individuals were now responsible for purchasing the healthcare making sure that we do the best possible job to get the best value has the best outcomes and value we’ve begun to sort of look at how to do that. One I wanted to call your attention to the chart that’s in there the last couple of pages that Barney Spitzer is so aptly put together which really look at the coverage of the health authority regionally. I think that’s important because I think we know healthcare is delivered really regionally and so looking at how that breaks out across the state starts to give us some sense of where we have the most opportunity to engage local communities and how we can begin to look at better ways to deliver care look at some of the ways we can hope to transform the delivery system. And I started to outline some of the ways that we’d begun to approach some of this. How we can identify a better control high cost high variation services. We’re looking at developing an initial list of how we can begin to pay for care differently and get the outcomes that we want. Certainly some of the work around patient centered primary care homes and looking at dovetailing with the work of the health leadership task force. And reducing pharmaceutical costs for the state and for some of our partners like a OHSU and beginning to engage local health systems in some of this work. So really what I was trying to do this month was give board members of sense of some of the directions that we are beginning to move in as the work of some of the committees starts to come on board particularly though workaround incentives and outcomes it will dovetail with the work that were doing on a day-to-day basis to begin to get better value for the states purchasing and use that as an opportunity to begin to hopefully catalyze some of the changes in the delivery of care statewide. So let me stop there and take any questions.

Carlos: that’s great news. Enrollment is exceeding expectations I take it and any my question is about do we have enough providers now that we have increased demand.

Bruce: I think that Nate statewide as well as nationally will continue to have this discussion as well as a previous board member meeting certainly primary care capacity is going to be stretched and I think that one of the issues that were going to have to grapple with as a state is how we can make some of the investments in that. I think in the short run we are not seeing access problems. That’s not to say that that situation may not change. I think that one of the problems around that is that when it comes to some of the care for kids the community of providers whether that be pediatricians family docs Safety net clinics etc. have been providing a lot of this care without some of the reimbursement ability to get some of the secondary and tertiary care so our sense is that right now
because of that right now were not seeing some of that acute problems with access but we have got to begin to address that.

Chuck: do you have a feel for how many if any individuals with incomes over 300% with kids have signed up for kids connect?

Bruce: yeah I don’t think any yet. And kids connect let me back up kids connect just started. You’ve got the premium chart in here. We’ve got close to 200 enrolled in the first month. I think and we’ve had these discussions internally over 300% we need to rethink. And the reason is the cut is that in putting the program together we created a comprehensive benefit for kids and that was one of the policy objectives and the governor and the legislature was pretty certain that we had a more comprehensive product and provided dental care mental health care and a complete package of what kids need the flipside is in buying that without any subsidy is extremely expensive. And quite frankly what we are aware of is that without any subsidy of her income families above 300% can go out and buy health insurance product for their kids at less of a cost. Of course it’s less of a benefit as well. So one of the issues that we have to look at and begin to consider is whether or not that benefit is and whether or not we want to consider changing that package of services. There is a number of strategies that we can probably come back in and couple of months and talk about

Chuck: I’d be interested in that because in looking at your report it is a very dramatic change from 299% to about 300 and there are just a lot of children who can’t afford to ensure their children and if they can find an affordable policy with less benefits they would. I mean they might feel terrible about it but they would and I don’t really feel like were filling that niche.

Bruce: I couldn’t agree more. And I think, one, the largest number of kids are in the 200 to 300% range so I think we pegged that well and I think for that group we not only get not only a large subsidy but it helps with the affordability and value proposition for the state to offer that benefit. But above 300%... we...Now that we’ve got everything up and going we need to sit down with the carriers and rethink.

Mike: Bruce and Barney, certainly complements on the chart. This is the first time I’ve seen the numbers laid out like this. I guess one thing I’m just sort of interested in is just the thinking around the strategy behind this it’s great to have the data but now that I’m looking at some of these, the counties in the breakdown that penetration and all that are you guys thinking anything when you look at this about where you would go from this or is this just sort of a preliminary look at this?

Bruce: yes to both. I think what it does is well it does a couple of things one is it has given us a sense of not just state that local government and we’ve been we’ve got our public purchasers committee up and going we’ve been having a variety of discussions with other local government partners so it helps I think illustrate to them as well some of
what we can achieve together and I think it provides us with a sense of where we might be able to have more success but I think success isn’t just about market share it’s also about the willingness of the community so I would say it really wind it provides us some information that helps us move forward and I’m not so certain it provides us with an exact roadmap of where to go but it helps define and quantify where we are around the state.

Lillian: Bruce that’s all there is?

Bruce: okay Yep.

Lillian: great thanks for the formatting. And thanks for the comprehensiveness of data and everything.

Bruce: and we’re still struggling I think with we all are as just a tremendous amount happens on an operational basis on when and where to keep the board of form is I think continues to be an iterative process so continue to give me feedback if you’re not getting the information will keep working on it.

Lillian: if there’s no further questions for Bruce or the items contained in his report we’re going to move on to the next item on the policy board’s agenda which is back to the committees were still working on the committees. Last month as we said we didn’t feel that we had the right correct breath of stakeholder involvement and expertise on the medical liability task force and that was corrected this month and I’d actually like to ask Chuck if you could put the additional name in nomination for the committee.

Chuck: sure thanks, Mdm. Chair. so you have the revised list with the additional name on the list now is Mark Stevenson of capital Pacific Bank so these are the proposed names of the task force I think it has a very good breadth of representation from attorneys, both trial and defense, public members as well as providers. I guess in the spirit of the cooperative effort of this group that were hoping to see I would like to suggest that we appoint co-chairs of this committee as opposed to a chair and vice chair and if that’s agreeable with the board I’d like to suggest

Lillian: can I just first ask how does everyone feel about that because that’s a slight departure? Is everyone okay with that?

Chuck: is a slight departure. (Nodding and murmurs of agreement)

Lillian: okay we’ll go with cochairs

Chuck: that’s wise.

Lillian: Chuck says that’s wise and we’re not going to contradict him (laughing)
Chuck: I knew you would all see the wisdom of the idea. So in anticipation of your acceptance of that idea I did talk to Mick Alexander, who’s a trial attorney, and to Joe Symenzec, who’s the chief medical examiner of Providence Medical North, and they’ve agreed to serve in the role of cochairs if the board so desires. If that’s acceptable to the board then I would move that we appoint the members and we appoint those two as cochairs.

Lillian: And just for clarification, the cochairs with them both represent both sides of the issue one from the medical side one from the attorney side?

Chuck: exactly. The idea is that this is a cooperative effort and we won’t get pinned down into picking sides.

Lillian: (laughing) but structure helps. So any other comments on the medical liability task force membership and structure if not I’m going to call for a vote.

Other speaker: Solomon-esque (laughing)

Lillian: how do you vote? (Numerous Ayes) I heard Eileen down there. Let the record show Eileen’s voting. So the next committee that we have some cleanup business on because we didn’t quite finish it off. We have one error, just procedure error, that was on the published list that came out of the health incentives and outcomes committee the name of Bill Merry who represents docs which is a Oregon coast southern coast Medicaid managed care organization was on the list to be presented and it was just a clerical error that he had been dropped from the list and we wanted to just correct that. The second issue is we were charged at the last months meeting to expand somewhat the scope of who was sitting on that committee and there was some recommendations that we wanted a purchaser and wanted to expand the provider community for that committee. So that being said I’m going to recommend that for purchasers we appoint Jim Russell, who represents a firm called vigilant which advises purchasers about benefits and he would then sit on the health incentives and outcomes committee. And then in addition to that David Shelactus, who represents a new provider kind of niche and Oregon which is the ambulatory surgery system which is a growing part of our delivery system and since this committee will be impacting on how to incentivize and work with different types of purchasers it was really thought that that would be an important oversight that we want to correct. So if there is agreement on that I would like to it recommend that we move ahead on those three additions to this committee, which were calling our ins and outs committee, incentives and outcomes. Any comments from my fellow board members on that?

Felicia: I think we’re still looking for a attached Taft-Hartley trust (indecipherable end of sentence)
Lillian: right you are going to get us one

Felicia: I think there are three people and they’re discussing amongst themselves.

Lillian: right. So it’s my understanding that we’re going to continue with the work of the committee and they will be welcome to join it. So I just want make sure they were clear to go ahead. Right? Thanks. I just wanted to make that clear to everybody. Okay. Because we’re on the ground running here. So now I think we’re up to Amy on the agenda. Amy’s going to address the legislative session and president Obama’s legislative proposal which is changing on the ground as we speak here.

Amy: it is.

Lillian: Bruce’s report included a lot of data about the February session but we really are looking forward to clarification.

Amy: great well I’ll give a little bit of an overview of the session and then highlight a couple of bills that are on that summary chart that is included in his report. So the session lasted 25 days. It convened on February 1 and ended on February 25. As a lot of you probably know the executive branch and the governor’s office is not allowed to introduce legislation in the special sessions. As expected there was no large-scale health reform activity but that doesn’t mean there weren’t a lot of bills about healthcare. Just to give you a sense. it was a very popular topic. 215 bills were introduced this legislative session and health authority was tracking over hundred of them that impacted our work in some way. Of the hundred bills the past one quarter of them dealt directly with healthcare issues. Not all of them directly affected programs within the health authority but they were all health related bills. So for a short, special session we had a lot going on in the capital this month. In your packet is a list of the key bills that I put together for Bruce and as I said I’ll go over a few of these that affect the healthcare world in Oregon. House Bill 3664 expands Oregon health plan coverage to kids aging out of the foster care system. I walked in during the Bruce’s discussion so I’m not sure if he covered this already.

Lillian: he said you would handle all of that

Amy: okay great. Right now when kids are in foster care when they turn 18 they’re on their own and they’re on their own for health insurance as well unless they income qualify in some other way or can get in through a waitlist. So this bill expanded coverage and made them presumptively eligible until they reach age 21. This was a bill that had been active in the 09 legislative session and didn’t pass so it was a pretty big feat to get it passed in this short session. Senate Bill 1025 was a bill that our public-health division helped work on a little bit. It requires radon resistant construction standards for residential and commercial buildings. Radon I was surprised to learn is the second leading cause of lung cancer nationwide. Reading the testimony for this bill made me think that I need to go get a radar detector for my basement. I still haven’t done it but
going to. The public-health division’s radon coordinator will provide technical assistance to the building codes division and there will be a nice partnership there. There were two bills I wanted to highlight for you that affect the healthcare workforce. One was Senate Bill 1046. It gives limited prescribing rights prescription rights to psychologists who currently have no rights to prescribe drugs. It’s housed the board of prescribing psychologists within the Oregon medical board. So there’s physician oversight of it. This was a very controversial bill. I think this was the third or fourth session that they came back with it. And this time they were able to get through the system. House Bill 3642 addresses physicians assistants and how their supervised by doctors. It changes the rules so that a group of doctors could oversee a physician assistant versus a physician to physician assistant relationship. Proponents of the bill said it would allow them more flexibility and staff in their clinics. House Bill 3631 prohibits insurers from treating injury sustained during sexual violence as a pre-existing condition. And then the final one that I’ll highlight for you which is not on your list is Senate joint resolution 41, which impacts my world a lot because that’s the annual sessions bill. That bill passed in the last minutes of session and will be referred to the voters so you’ll all have a chance to vote on this in November. And it will specify a maximum length of 160 days per session during odd-numbered years and 35 days during even numbered years and just for context the last legislative session, the 09 session, was about 180 days. And then we obviously just had a 25 day legislative session. It’s a constitutional amendment has to go for a vote of the people. So we’ll know in the fall if that’s going to be a reality. Before I move on to a quick federal update I wanted to see if any of you had any questions about the bills that are on the list of legislation or the February session in general.

Dr.Hoffman: Amy if I could just ask a question about the psychologist prescribing, you mentioned that there’s physician oversight but it’s my understanding that Oregon will become the third state that allows this and the physician oversight in the other two states and I can’t remember what they are is dramatically different than the proposed OMB oversight. Am I right about that?

Amy: you know Dr. Hoffman I’m not entirely sure about that. I wasn’t involved in the negotiations of this bill so I don’t know how the other states are structured.

Dr. Hoffman: I think it’s a dramatic difference. Thanks

Joe: just one question with the extension of the ability to remain coverage for those that have been in foster care what was the rationale between picking DH 21 because that is still such a deviation from the standard in the commercial world. I mean it’s laudable that we’ve made progress but I was wondering about the justification of that.

Bruce: we were able to do this under CHIP and CHIP-RA which made it affordable and doable.

Joe: that’s a logical answer.
Lillian: I just have one question that the follow-up to Chuck’s. My understanding is too that it’s not just physician supervision of psychologists but also that there is criteria for practicing psychologists before they can apply.

Chuck: I think it’s actually the OMB that is going to be providing the oversight that it’s not just going to be. I guess my point is it’s not just a physician to physician relationship is not good to be anything like that.

Amy: Correct

Lillian: good clarification. Are we going to evaluate the impact on access to read some of these issues?

Amy: I don’t believe there is an evaluation component of the bill though I’m certain that the legislature and health committees will be asking for updates and may ask for that information down the road but it wasn’t actually written into the bill.

Bruce: when the governor signs the bill the actual prescribing doesn’t start for two years. So it’s going to be quite a while before we actually have the opportunity to do any sort of evaluation.

Lillian: the reason I ask this is from my colleagues here as we look at better workforce issues here in the state and as we look at the scope of practice I think it’s really going to be important for us to look at any of these changes over time because nothing’s ever you know the one right way. So I think we should think about this going forward, too.

Chuck: this is a dramatic variation from previous standards and I think my feeling is that it’s very important for us to track those changes. This is since we formed this is probably the primary delivery policy change that’s come about since we’ve existed. So it’s really important to watch its development.

Amy: I think I just want to add one more thing. Think it will be really interesting to see just how many psychologists go through the education programs that are required to go through the same to be able to prescribe I think it’ll be a really limited number. Time will tell how many take advantage of the opportunity.

Lillian: any further discussion before we move on to the feds?

Amy: great. Well as you’ve said vice chair Shirley, things are changing as we speak so who knows what happened as I was having lunch so feel free to tell me if I’m not totally up-to-date. As you all read the Obama plan, compromise plan placed on February 22 and his office has recently announced that they’ll be moving forward with the strategy of using the reconciliation process. So the goal as laid out was to have the house pass the
Senate version of the bill and then to have the compromise provisions that they can get agreement on go through the reconciliation process starting in the Senate and then ending up in the house and that of course that is to avoid filibuster. You only need to have a majority of votes to pass the reconciliation bill in the Senate. The limitations of the reconciliation process is that any element of that bill must have a budget impact or has to be germane to the budget. Yesterday the White House announced that they would like to have the bills on the floor within 10 days so March 18. They have their next recess starting on March 27. So I think the thinking was if you work back in the time it takes from when this bill is scheduled on the floor to when it can be potentially passed their building in time for all the steps. I think the reality is that the reconciliation time process could take a very long time. There’s a lot of procedural motions in place there’s a lot of opportunity for procedural motions that could delay the bill for quite a long time for the minute process and the challenges to Jermaine this of any piece of the bill. But you know the White House has set a goal and we’ll see if it’s scheduled for a vote. The Senate Bill has not been scheduled yet. As of this morning neither Harry Reid nor Speaker Pelosi had submitted bill language for the reconciliation bill to the Congressional Budget Office for scoring because that hasn’t happened yet none of the details of that bill are public. We probably wouldn’t see that until they come back from the CBO and are released much like earlier versions of this bill. So in that chart that you have in the packet there is an updated side-by-side comparison that shows the elements of house Bill 2009 that you’ve been seeing into every one of these next to that is the Senate bill that was passed in December that hasn’t changed from the last one and then the office of health policy research put together components of the Obama plan and I’ll say with the big caveat that this is based on information that we have available. So that is the public document that you have in that packet and a few press releases. We have no legislative language. So there’s a lot of questions that arise when reading this that we just can’t answer yet. But from what we know I’d like to highlight just a few of the key changes from the Senate bill that are listed in there. The first has to do with market reforms. The Obama plan adds more protections in for the grandfathered plans so most of us who have insurance plans our plans will be grandfathered in. In the Obama plan adds most of the protections of guaranteed issue and a couple of the other things that are listed there. One of the biggest changes though is around the federal funding available for the plan. The Obama plan adds an additional year of full federal funding so one hundred percent match rate. The Senate bill was for two years 2014 and 2015 this adds a third year to 2017. And then ratchets down to the over the next two years to 95% before going down to 90% match rate in 2020. Just for comparison the Senate bill had the two years and then went down to the 90% reimbursement rate in 2017. So this would be, this Obama plan would be, if enacted into law, would mean more money coming into the state as a match rate for Medicaid than the Senate bill. In terms of premium assistance and credits the Obama plan increases the tax credits and lowers the premiums charged to most families. And it closes it does a better job of closing the doughnut hole under Medicare. It provides a $250 rebate once the person reaches that hole that gap in their coverage for 2010 and then over the next 10 years phases down the hole by lowering the amount of coinsurance that a person has to pay until the hole is eliminated in the 25% coinsurance rate is across no
matter how much they spent on prescriptions during that time. In terms of population health it increases by $1 billion funding for community health centers and FQHC’s. And it is slightly I would say easier on employers on the employer responsibility piece when we talk about financing than the Senate bill had been. It decreases the assessment on employers who offer insurance to their employees but whose employees are receiving subsidy through the exchange because maybe they can’t afford the plan offered to them. It decreases that assessment from $3000 a person to $2000 a person. It also exempts the first 30 employees. So there’s a discount if you will for those employers who offer insurance but have to offer insurance was not quite as portable to some of their employees. The Obama plan also offers $40 billion and tax credits for small employers that was not included in the other versions of the bill. In terms of individual responsibility the Obama plan lowers the flat dollar assessment it’s ratcheted up over time that will eventually landed $695 per person and raises the percentage of income to 2.5%. so person would pay the higher of either $695 or 2.5% of their income. The flat assessment of the 695 is lower than the Senate bill but the 2.5% of income is a little bit higher than the Senate version. This proposal also lowers the excise tax on high-cost plans and delays their implementation, delays the implementation of the tax until 2018. It was set to go into effect in 2013. Just a few other things I’ll mention. The Obama plan has a 2.9% tax on unearned income on individuals who earn over $200,000 a year and for joint income earners who earn over $250,000 year. It increases fees on brand-name drugs by $10 billion over 10 years. And finally assessment on insurers that was in the Senate bill under the Obama plan is to lead it’s not implemented until 2014. Originally it was intended to go into effect in 2010. So that’s just a brief summary of some of the key things in the chart that’s their front of you but I’ll be happy to answer any questions that you all have.
Appendix B: Board Member Interviews
Interview Questions

Verbal Informed Consent Script:

I am Samantha Howe from The Ohio State University. I am researching the town hall process utilized by Oregon in implementing the federal health reform mandates. I have asked you to participate in this research because of your position with the Oregon Health Policy Board. This interview will take approximately forty-five minutes of your time today.

There is a risk of breach of confidentiality, as you are one of a small group of public figures participating in this study. However, all efforts will be made to ensure that everything discussed in this interview is kept confidential. I will not link your name to anything you say, either in the transcript of this interview or any other publications. Participation is voluntary. If you decide not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled. You can decline to answer any question, as well as decide to stop participating at any time, without any penalty or loss of benefits to which you are otherwise entitled. Do you have any questions? Do you wish to participate?

I would like to record this conversation so that I may accurately represent what you tell me today. After our discussion I will transcribe the recording and remove your name and other identifying information from the transcript. After transcription the recording will be destroyed. Is this all right with you?

1. To begin, could you please confirm for me your position with the OHPB.

2. What about this position appeals to you? Why did you choose to take on this role?

3. What sort of information is most valuable to you in this role?

4. How much would you say that you rely upon the input of experts in the field to receive that information?
   a. When is expert input most helpful?
   b. How is it best communicated to you?
   c. Do you seek out or draw upon information not presented to the board? (Do you do your own additional research into the issues being discussed? Do you draw upon personal experience/knowledge?)

5. How often do you seek input from other board members?
   a. On what issues are your fellow board members most helpful?

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b. How does the information received from other board members compare to that received by experts? To that received from citizens?

c. How does this sort of information help to shape your thinking about Oregon health reform?

6. Do you seek input from non-experts? Why/why not?

   a. For what situations/issues do you seek (or would you seek) non-expert input? (For what issues does non-expert input seem most useful?)

   b. From whom specifically do you seek input (group representatives, friends, colleagues, etc)?

   c. How do you go about soliciting this input?

   d. How do you find it best communicated to you? (Are public comments at meetings useful? Do you prefer letters/phone calls/in-person discussions?)

   e. How does the input you receive from lay citizens compare to that received by experts?

   f. Can you provide me with any examples of a time when the information that you received from a non-expert helped to shape your thinking about a particular issue faced by the board?

7. What do you think about the input received from the OCAC/the various working groups?

   a. How does this input compare to that received by non-committee citizens? (Is it consistent? Are there particular interests that appear to be more heavily represented on the committee?)

   b. How do you incorporate the committee recommendations into your decisions or thinking process?

8. I know that there are statutory requirements for public comment time. In looking over the minutes from your meetings, however, there have been a few instances in which the board decided to go beyond those requirements and allow extra commentary time in the middle of meetings during which you were discussing particular topics/reports from the your working groups. How was it decided that those were needed?
a. There were some other instances where that time wasn’t used so much for public comments as it was to answer questions previously posed to the board by citizens. What process or thinking goes into deciding how to structure the public comment time at any given meeting?

9. Do you think that citizen participation has contributed to the policy outcomes? Is it useful even if it has not lead to direct changes in policy? How could it be made more useful?
I know that you mentioned that you just recently started with the health policy board. Could you tell me a little bit about what about the position appeals to you why you decided to take on the role?

Uhhh, I was asked to join. It’s not like I sought it out. I had followed the work of the board and was actually on a different board for the state of Oregon and a couple of other state boards but there’s a concert not a concern and attempt or desire to make sure that public policy has business input. And we’re one of the largest employers in Oregon. The of about 45,000 coverage lives here and about 15-16,000 employees. So we want to make sure that whatever they build or whatever they put in the policy in the state has our input. So that’s kind of why I’m interested in providing that perspective. So it isn’t just the public entities building just for the public you know ultimately so that any care model that they would roll out if it’s successful to be ultimately successful would include the commercial market.

So what type of information do you find most useful in that role? What types of presentations to the board do you find valuable?

Anything that’s more innovative is more interesting to me. You know push the envelope a little bit. All the premise behind healthcare in the US that sort of thing anything that pushes the envelope a little bit is more entertaining and interesting. Rehashing old policies connecting all dots it up and try before or a failed attempt to keep all the stakeholder secure those are lot of less interest to make. I tend to bring more of an edgy and provocative train of thought just so that we can be intellectually honest with ourselves and not just lines that were done 50 years ago and call them now. When presentations come before us in the committee I’m not trying to be belligerent but if it’s rehashed to let folks know that it’s rehashed I’ve seen it before you know a lot of the stuff that we see if the board is a report out from the work groups and that’s everything. Those are helpful to see what they had to say. You know the more proactive stuff it’s interesting to me.

So how much would you say you rely upon the input of other experts in the field when you’re seeking out information?

How much do I rely? I balance it against what I know. I don’t let the board which you know goes a little bit back to what the differences between a layperson who doesn’t track this on a day-to-day basis so somebody who’s on the board who spends most of their time running their business because their small business or you know if there in the hospital managing the hospital is a different perspective. I can track this stuff on a day-to-day basis so you know when expert or policy expert or delivery expert or an insurance expert comes in I tend balance that against what I know and I’ll often go and validate it or status check it or fact check it against other folks I’ve considered their opinions worthwhile. I mean, it’s helpful but you always get a remember who the messenger is. If it’s coming from an outside opinion the expert of the hospital CEO I have to remember who’s
speaking. If the patient that’s obviously I have a higher regard for that than you someone who’s not getting the care.
Okay well that’s great.

Does that make sense?

Yeah. So do you ever seek out information from other board members? I know that you’ve talked about how you are sort of distinguished from a number of them who have other responsibilities so how do you interact?

With this board so far no. I mean I haven’t had the chance to sort of do that and just kind of getting you know I know a couple of them but some of them I don’t really know. So I haven’t really had the chance to have any of those off-line conversations. Other than you know organizers state who put the board together you know I had some clarification questions but at this point kind of drinking through a fire hose to try to understand how the last few years works and how I can help to move this thing forward.

You mentioned that when patients come and talk to the board you kind of evaluate that differently. So how do you think about input from those nonexpert people?

If it’s again someone receiving care who has a vested interest, has no ax to grind, no subtext there I think it’s highly regarded in my opinion. Those are the folks who are either at risk from a pretty bad system or a questionable system or folks who are who don’t have a dog in the fight there’s no money at stake they’re not trying to make a buck they’re not getting consulting fees are not trying to steer business towards themselves and by positioning what they present in a certain fashion. That’s to me more interesting rate they speak through heart and it’s not nothing is no airs are put on and there’s no misaligned incent- er misaligned goals.

Okay. Are there any particular situations or issues that you can think of that would be particularly useful to have layperson input on?

I think it’s important to get layperson perspective on everything. Because you know even in the technology side we get so wrapped around the axle that we can’t see the forest for the trees and it’s the same thing for physicians and caregivers we get so wrapped around policy that we can see the reality we talked amongst ourselves so often that we forget the real facts so I think it’s refreshing to have a new set of eyes on the problem and just kind of caught some of the obvious things that we didn’t see or ducked around because were so afraid of offending other people in the room or calling out the Elephant in the room but if you have people who don’t know any better will step up and say it looks to me like you haven’t addressed “X” and that’s always nice when it happens.

So how do you think about going about soliciting that input, getting people to actually contact you or other board members or come to these meetings?
You know I don’t. I haven’t ever thought that we were charged with that. It tends to be
directed by the state. That the folks who run the board. I’ve never like been asked to you
know flip through my Rolodex and bring interesting people in.

So you do rely solely on people coming to those meanings or do you also have contacts
with people by letters or in person discussions and that sort of thing that help inform you?

There’s a variety of public comments there’s public input in public comments. Public
input and would distinguish you know go back to that whole no ax to grind and no and
blanking on the word I’m looking for there’s no… intent to get some point across in some
veiled way. So public input is coming more the layperson perspective on how to solve the
problem. You know those meetings are well attended but most of the people in the room I
would say are the public perspective and I could be clearly wrong but my take on this is
that they are there for reactive purposes which means they’re there to listen to see if
anything bad happens to their association or organization and if they think so then they’ll
step up in the public comment and talk about why that adversely impacts their group or
their association kind of their want. You don’t see a lot of paying attention just out of
interest there some, some patients will show up you know people who’ve had a bad
experience with the health system will show up to give their input. But again I’ve only
been to two of these specific meetings and that’s kind of how I see it playing out with any
of these boards. In a the first meeting is oh is like a packed room, standing room only the
next meetings a little less people after the ground rules been put in place and the scope of
what this group are to cover and if folks don’t believe that their [inaudible] they’ll listen
to the recordings they’ll read the transcripts to see if anything bad happens but they’re
acting as step up in the meantime. I don’t see a ton of just people there who are just
interested in this for the sake of butter public health other than those who are like public
health officers.

They mentioned reports out from the committees. What you think of the reports that are
received from the citizen advisory committee and groups like that?

So the work groups vary in my opinion. Some workgroups the input is really valid
because you can’t get the best and brightest working on a problem and it’s nice to see the
consensus opinion on the next steps layperson input is best if it’s constructive in
somewhat of an orderly fashion next seen some reports out that are missing an element of
logic. So you can tell when it’s kind of just folks that are venting and the report out is
kind of shotgun approach. And those are tough because you’re not really sure what
problem they want you to go solve it’s just like their mad at the system in a variety of
ways whether the access or cost or insurance options and they’ve got a get a little bit
more focused. So again some of the workgroups that are focused around access and
specific things that they think need to be addressed those are helpful. It kind of depends
on who’s running the group most of the times pretty good sometimes I do know what I’m
supposed to do with you know take it as input and move on.
Okay. So with that input whatever the quality may be do you think that it has actually contributed to policy outcomes?

Oh yeah. Absolutely. Now with this board I assume so but I’m speaking from my past experience on others.

Okay. So how do they could be made more useful?

It being public input?

Yes sorry public input.

How could public input be more useful? Good question. Let me think about that. The challenges are whether it’s federal advisory or state advisory there’s certain public meeting requirements that they have to adhere to. So some of the structure is a, makes layperson or public comment or public input at a disadvantage because if left at the end. Hmm. Good question. Could you repeat it again?

Sure. How could public input be made more useful for contributing to policy outcomes?

Maybe earlier on in the process. May be again as citizen advisory earlier on whether the workgroup board something talking about the expected output and again I don’t know whether the health policy board did that or didn’t do that.

Great. So I have I do have some questions for some of your other colleagues on the board about some of those structural requirements because there are some meetings in the cart archives that I’ve reviewed where special time was made for public comments earlier on in the meetings which was unusual to me so I wanted to find out more about that but I know that you don’t have that experience and background.

Yeah. So maybe it was probably around the specific area where they wanted to stop for a second and open the floor up to see if anybody had any guidance or a thoughts or anything to say around a specific issue. I’ve not seen well typically public meeting leave the public comments to the end of the meeting. Which is again why I say public comments are different than public input with the input been more constructive targeted and comments being sort of that vetting where they have something to say because they’re not really happy or they believe the board you know has made a major policy decision or flaw there hasn’t to get something into consideration.

Great. Well, this is been quite helpful. Thank you for your time.
Can you confirm for me your position with the health policy board and how long you’ve been there?

Sure I’ve been on the health policy board for four years.

And what about this position that appealed to you?

I’d been working with a group of advocates and the legislature on healthcare reform and health care reform implementation and a lot more actually on reform when I first started because the national ACA had not been passed yet. And so during the legislature the health policy board was created and I had applied to be on it and and I feel that it had been a natural fit for the work that I had been doing.

Great. So what information do you find most valuable to you in your role on the board?

That’s a really good question. What type of information?

Yeah. Who do you turn to most often when you have questions about something? what types of presentations to find really useful or interesting?

I see. Well I think there are a lot of information that comes from the board and the presentations that I find most valuable really clearly articulate the problem and then outline some potential solutions and then after that I do find that the community input on those solutions and how they actually impact the on the ground work I think those are probably the most valuable.

So how much would you say you rely upon the input of people that are considered experts in the field?

I think we’re like pretty heavily upon experts but I think that I do feel like that I feel like that’s loosely defined I think that who is an expert depends upon the perspective. I think that if you’re may be the CEO of the health plans that doesn’t actually make you an expert on how the on the ground health plan gets implemented.

Great. so do you ever seek out information that isn’t necessarily presented to the board?

Yes all the time actually.

so where do you go to seek that out? What sort of background you rely upon to draw on that information?

If you like there’s a multitude of areas. People have issue expertise in a particular issue than him a call. Advocates. People who are health plan participants. You know County health folks may have something. There is a bunch of different places.
So what situations or types of issues to seek out non-expert input?

When you save non-expert opinion you mean non…?

It means someone who’s profession where experience is in in healthcare related field but whose opinion you want and would value.

I think I seek out non-expert opinion almost on every issue because I do feel like it’s really critical to have people who are actually participants of the plan weighing in on what that looks like because I think the thing about the health plan is the way that low income people experience their lives is very different from the way that I might experience my life or other people on board might experience their life and so it’s really important to hear that before making changes. And I also think there are lots of advocates who may not have expert background you know they may not work in healthcare but they have a lot of they’ve been longtime advocates on an issue and I think it’s important here with a headset

So how do you go about soliciting that type of input?

Oh I call people or send them an email

And are the sort of direct interactions of phone calls the best way that you find communicate or are the comments in public meetings and such more or less useful?

I think it varies widely. I think sometimes the public comments are really useful when they’re thoughtfully done and they help shape some of the thinking that goes into the lake the next steps and then I think sometimes there not relevant to the conversation but may shape the future decision so I think it’s yeah a mixed bag.

So how would you say the input you receive from nonexperts compares to the input you receive from the experts or providers where the sort of health professionals?

I think both are invaluable so I think the information received from nonexperts is just as important as the information from experts.

Great. So can you maybe provide me an example of when you think that the information you received from nonexperts really helped to shape your thinking about a particular issue?

So I think one of the areas that I think is when advocates and a Medicaid recipient invited me to the Medicaid advisory group in Multnomah county that she sits on. And that group is composed of a mix of experts in nonexperts, family members and advocates and it’s for mental health and drug and alcohol addiction and that experience really helped shape my
opinion about the community advisory councils for the CCO and how critical they were and how critical they were and how successful the actually could be. So that’s one example of there’s probably 1000 more.

So it seems like you have really gone out of your way to engage citizen groups and citizen representatives. Do you believe that citizen participation has directly contributed to the policy outcomes of the board?

Yes! Absolutely. I actually believe that without that participation all the work that we’ve done that we’ve done to this point, we would not be as far along as we are without that participation.
Could you just go over really quickly with me how long you been on the policy board and what your position there has been?

Sure the policy board was created with legislation out of 2009 and I think my appointment started soon after that I do know I think I was confirmed in September 2009 and I’ve been on the board since it I just got reappointed for an additional three years last month.

So what about this position appealed to you?

I think just having to be part of the process of developing a long-term plan for healthcare reform at the state level is very appealing. You know I think knowing that you provide some input and insight from various backgrounds that not everybody in the legislature has so I think that though is helpful to kind of have a forum where that discussion and debate and dialogue can take place.

So in your role with the policy board what sort of information do you find most valuable to your thought processes?

Well I think for me most of all obviously most of the discussion is focused on just the policy around Medicaid public employees in a Fed but you know really trying to grapple with the cost quality access issues within the Medicaid program and I have had the opportunity to be to work in healthcare system and settings health insurance settings but also on the policy side so it helpful for me to be able look at this from multiple angles to see how we can assist develop solutions.

How much would you say they rely upon the input of experts to receive the information that you need?

A very much you know I think that’s part of the process that we really use with the board I think the board is trying to state a fairly high level from a policy perspective but we do need to understand some of the details and for those areas we really relied upon some committee work where we brought in outside folks who really have the expertise whether it’s on new payment models or delivery models where we can really get some experts working together on that so we’ve got how many committees we had some great expertise and then they can serve develop their own recommendations next be right board for that can be further dialogue. We did that not just that long ago for the essential health benefits for the affordable care act. We really had a team of great folks who really didn’t details on that number out back the recommendations to the board.

Yeah. I was at the December meeting and saw that process sort of going on. And how you provided them with some more questions and send them back to talk some more. It seems like a good process.
Exactly.

So do you find that that sort of subcommittee process is the most useful way to that you find for communicating with experts?

I do. I think one way that I found it to be maybe more helpful is when you have the committee or subcommittee work can be more beneficial at times when you have a board member said on that committee and they can generally provide some insight or overview of the board’s thinking and then when that discussion comes back to the board then you have a board member at the table who is sort of been part of those MIDI discussions and that can very much be to the benefit of the board.

Great. Is there any information or people that you go to in particular to get information that isn’t presented directly to the board?

Fair question. I can’t off the top my head. It’s just definitely depends on the issue. If there are delivery system questions unlike medical homes I certainly could reach out to some folks who I know who are really in the process of building up out those medical homes and clinics for insurance issues I would probably lean on others. Have I in specific situations? Maybe a few times but generally not too much I generally rely more on staff work in the committee work to give us that overview.

So you mentioned having the board members on the committees sort of helps with that process. Do you sometimes seek to get input from other board members on certain issues?

Yeah I think that’s really part of the healthy dialogue that we can have these board meetings you know we’ve got such diversity on the board I think that really it helps all of us some people come from the stronger public health background some people come from health systems background Nina comes from a small business background I think we’ve all learned from each other so when somebody speaks up and they have concern is probably perspective that we haven’t thought about and we haven’t really discussed so there have been some times when I’ve certainly reached out to the board members to kind of get their thoughts on things based on their own insight and perspective.

And do you seek out input from non-experts like citizens and consumers of the Medicaid program that sort of thing?

Yeah I think we can always do a better job of that. We certainly always have time you saw if you’ve been at the meetings some open agenda items for public testimony and even if we have a certain issue that we’re grappling with we always try to have some public testimony around that I would always like to see more because I think that really is helpful and many times unfortunately that public testimony may not surface during some of the board discussions but many times it could surface during the legislative hearing
and I think what we’re trying to do is make sure that we understand all of those stakeholder issues had of time as error putting those policies together in trying to limit any thing from blowing up during the legislative process.

So can you think of any examples from when information was provided from non-experts that is helped to shape your thinking about an issue?

Yeah I think the development of the coordinated care organizations is a great example. We’ve spent a lot of time kind of putting some structure together really in terms of how do we best court may care and break down all these barriers which was fantastic we got the super response but what we were lacking I think was the community needs and how does the community really have input over this process so part of that feedback that we got from pet public testimony and additional workgroups was the development of what we call a community advisory Council and I was included in the bill and is now in legislation now was really based on input from advocates of community members that were saying hey look we really just don’t want this to be driven by traditional health systems and insurers and that’s everything we want a bigger stake and I think the people it really resonated with the board and it certainly resonated with the legislature and now we’ve got 15 community advisory councils who are really providing input to their CCO boards and really being held accountable to working towards a community health needs assessment and then also putting together health improvement plan for their local communities which I think is fantastic.

So in general how do you feel that the input they receive from lay persons compares to that of experts?

It really just depends on the issue. You know sometimes there may be something more technical that were dealing with that may require more expertise from technical experts but I think for the most part we do really rely on input from from the lay public in a think that if you go back and listen to the essential health benefits piece that was you know that was an interesting piece because here we had the experts sitting around table saying here’s what’s in traditional packages today and here’s what it could look like in our statewide essential health benefit and then you have people coming in and saying we think it needs to be expanded or should include XY and Z for these reasons and then we were able to have those discussions which I think was great and I think for that specific issue is really trying to weigh the pros and cons of the additional benefits versus the additional cost versus you know how does that play out to the plot to the public over time it’s essential that we have those over time again when you get into the legislative session it’s very easy for many of those decisions to be made in somewhat of a vacuum more behind closed doors so what were trying to do especially with the health policy board is to be as transparent as possible and allow for that public form to occur.

So one thing that I’ve noticed in reviewing the videos is that statutorily the requirements about when the public has to be allowed to testify a comment but it seems that rather
frequently the board decides to make extra time for public comment or insert time in the middle of a meeting. And I was wondering what the processes for making the decision of when to make those extra allocations and why that’s important?

Well I think it’s important all the board members because we don’t want to get too far down the road on any issue without getting some public feedback and if there’s some things that we’ve missed or some oversight you’ve got a here that up front. So I certainly deferred at Eric Parsons you know the chair of the board he’s really responsible for setting the agenda and I think he’s very committed I think it’s worked well with how he’s done it for getting that feedback earlier or continuously during the meeting so we can hear from folks.

My final question is just how do you think the citizen participation has contributed to policy outcomes overall? is it useful?

Yeah I think it’s extremely useful. And I think one of the best examples that I can think of has been this whole process of the coordinated care organizations and when there was a discussion early on probably back in 2010 around healthcare reform there was a lot of work on integration and coordination and payment reform so we have specific workgroups within the policy board that were focusing on those areas and then as we were entering into 2011 which was the legislative session a lot of that work done kind of came to the front and was kind of a foundation for that legislation that really was the formation of the CCO is that the 2011 legislation was really just like the very beginning they were kind of like yeah we really like this idea but there’s a lot of work that has to be done so you guys go fleshed out and bring us back more robust proposal and implementation plan so throughout 2011 the policy board oversaw 45 worker groups massive workgroups of 3040 people from around the state getting into the delivery reform and payment reform in all of these great things so there was constant updates the board about how things were going and board members were on these workgroups and then all of that kind of aggregated into an implementation plan and the actual implementation ledges legislation in 2012 so that balance between the public process and then linking it to the legislative process I think was really outstanding much of that was successful because of the way the Oregon health authority has structured itself so it’s kind of this lean machine in terms of how it can carry out organizing these big workgroups and having transparency on the web and information accessible so people feel like they’re very engaged we’ve been fortunate so in many states that I’ve been consulting with some of these decisions are made at the 11th hour by the legislature without people really knowing what’s going on so here it from the very beginning people have known about about it so if they had issues with that they were going to make statements about it early on and we had time to potentially acknowledge it and potentially make changes and I think that was just extremely extremely helpful.

Great. Well, that’s all the questions that I have for you. Thank you again for your time.
To begin with can you just confirm with me you’ve been on the board first four years basically since the beginning, right?

Yeah.

And what about the position appealed to you?

It’s somewhat related to my job as director of the school community health. I think it also allows me to represent a perspective from the community of color and these two things allow me to motivate me to be on the board

And what sort of information do you find most valuable to you know on the board?

One there’s a lot of hands in the cookie jar. We have made a simple issue extremely, complicated. It shouldn’t be that complicated if you get sick you go to the doctor if you need to go the hospital you go to the hospital and we ask people for money and that is probably the employers or the state and we pay the people that provide the service. It seems relatively simple but we have too many entities coordinating that.

So how much would you say the you rely upon the input of experts in the field?

To create the policies? Or to propose policies?

Yeah. Yeah in working on the health policy board how much does expert testimony inform your thought processes?

So I think you have two things going on which is the board which is made of what “citizens and then the staff the Oregon health authority so if you’re asking me about the board it’s one question the other one how much is the Oregon health authority rely on experts or consultants it’s a different question and then if the board from my perspective I would say the staff the health authority employees I consider them experts and there are also private entities that are experts. So considering staff as experts almost I’d say 80% if you take the staff out of the picture and I’d say may be our reliance on experts as maybe 20 to 30%. So yeah did I just make a simple question more difficult?

It’s good though. it adds some depth. Do you seek information or drop on information that you know about from your role as a director of the healthcare school do you seek or draw upon information does not necessarily presented to the board to inform your decisions?

Yeah.

What sort of additional research have you done or brought up were introduced to other board members? Can you think of maybe an example?
Well you know since I work in public health I look at the role of health promotion and disease intervention in improving the health of the population and draw on the triple aim’s so mostly of peer review articles some books from the Institute of medicine and some international comparisons.

Okay. Great.

Actually the times this week the magazine time has very good article.

So do you seek out input from nonexperts like lay citizens?

Yeah.

What do you feel the role of that sort of input is for you?

So I talked to members of the community and they talk to me also and they’re not experts they feel the pain of the expert’s opinion and how they’re implemented.

So what sort of issues D particularly find that sort of nonexpert opinion very useful?

They some of its unbiased. And it’s it’s real life outcomes for decisions that we make.

How do you find that sort of information as communicated to you? The public comments at meetings or personal contacts or emails? What resonates with you the best?

Well i.e. hear from them by a me having meetings that I have to have as part of my job as the director of the school community health I hear from the students in the classroom I hear from I am a member of the Board of Directors of several community-based organizations and these things also come up in those meetings and by attending the town hall meetings.

Can you provide me an example of when input they receive from nonexperts really helped to shape your thought processes about a particular issue?

Um. Yeah.

Okay. Can you describe it to me?

There are invisible people in this process. There are for example people who are not documented in the US and we don’t seek their input there’s nothing in our federal level reform to provide care for them and yet they are an integral part of our economy the do provide services if they are being paid however their paid there are monies that are being taken away from their paychecks to cover Social Security and that sort of stuff and yet we
have no we don’t take them into account in any of our decisions. It’s a risk or liability I would say because you can’t totally ignore the segment we don’t know what percent is that but if somebody gets sick they end up in the emergency room. And that is the most expensive way to provide care so we have to start thinking more broadly.

Do you feel that citizen participation has contributed to the policy outcomes from the health policy board?

You want to ask the question again so that I didn’t say anything that is…

Do you feel that the citizen or lay input they were talking about that has informed your thought processes has actually affected the policies that get passed through recommendations the get made to the legislature?

Somewhat yeah. Not a total yes but it’s not a know I think there are from my perspective as a board member it does. I think for an entire board for the most part it does.

How might it be made more useful?

It’s a very political process and you have to be aware of the different forces in place and we are board we’re an advisory board we are not elected officials for not Senators or state legislators who by law spend the money they create the budget and they say who’s going to pay for what so at the end of the day we have to be really it doesn’t matter what we think are proposed it’s the legislature the takes their comments and say that’s a good idea that you guys know what you’re doing let’s do that so you have to be very sensitive to make sure that these people who ultimately the Gov. and the legislature are aware of what we want without alienating them or without breaking down any potential compromise that could happen in the budgetary process.

So talking about long what supposed to be required in everything I know the in the town hall requirements there’s statutory requirements about when public comment is posted current how long testimony is supposed to last that sort of thing but I’ve noticed in reviewing the videos that in a number of meetings extra time has been allotted or there have been extra opportunities to comment. I was wondering how you go about deciding when that is necessary or how to provide that extra comment period.

It’s a time that’s people are mostly the people are going to be directly impacted by that so there is a vested interest in the people who show up and sometimes they have very opposing views so you have to be aware I don’t think you’re going to see the average Joe who just decided to come there’s a self-selection bias in this places where you collect input which is okay which basically tells you where the two extremes what the range is, those who wanted dad those who want it to move forward those who want to compromise are there but they all have something to say see you have to have some time to try to digest where people are coming from and I think that’s one of the valuable things that
you get in these town halls. It has to be done in the respective coordinated way and I think the states have done a good job of hiring professionals like the Oregon consensus development which is part of our university they that’s their job they go all around the state and build consensus on specific issues so these people have been instrumental in organizing these town halls.

Thank you so much for your time. That’s all the questions that I have.
First of all how long have you been with the policy board? Pretty much from the start right?

So I was with the policy board when it was first created so that must’ve been this is 2013 so just about three years ago maybe October of 2009

And what about the position appeal to you what made you decide to take on that role?

Well it seemed like some good... well first of all I worked for years for a company that provided employee benefits not including medical insurance so I’m is generally aware of the impact of employee benefits and critically healthcare costs so on the overall economy and was somewhat concerned about that and I was aware that the state was in, particularly the leadership of Gov. Kitzhaber in his first two terms and that he was likely to run again and was likely to be a position to do something fairly innovative and maybe leading edge and I was offered an opportunity to be part of the health policy board really I think because they were looking for somebody who is familiar with insurance familiar with benefits and did not have a particular conflict of interest with regard to health insurance so there aren’t that many people in Oregon who have that set of qualifications and I was recruited.

So what sort of information have you found most valuable to you in this role?

Well first of all I’ve learned just a heck of a lot about the causes of our healthcare situation I mean when you really start to break down I had no reason to in the world to do a serious review of literature or attempt to understand the causes that would provide healthcare costs to be so unreasonable in the US until this appointment came along and so in the interest of getting up to speed quickly I did a lot of research and dean’s just a whole lot of basic information about what causes healthcare to be so expensive what causes results to be so disappointed because of access to be so difficult and so on and so I’d have to tell you that that basic learning was terribly valuable. Since then understanding the impact of various government programs the opportunities associated with those programs the costs associated with those programs this all come in the much clearer focus as a result of gosh just scads of work in testimony that is come to the board.

And how much would you say that you rely upon the input of experts in the field to receive the sort of information that you need?

I would say that I don’t know if you’re going to ask questions about other sources as well but I would say experts provide a very serious amount of the information that we have. And obviously not all experts agree so we get conflict reports but that’s fine too because that gives us the ability to sort and make judgments but I would say well over half of the useful information that we receive comes from experts.

And when you find it most helpful order on what topics they find it really useful?

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Well what’s really useful to us is really I guess two things: number one understanding programs and facts about programs governmental health programs and programs the impact health are very complex so understanding what the how the programs operate and what the impacts are whether their intended or unintended is a huge part of it; I’d say the other thing is simply understanding basic facts and statistics so that we can separate fact from fiction there is a lot of assumptions that is made about healthcare some of its accurate some of it’s not. there’s a lot of anecdotal information available some of its accurate some of it’s not. So quality research that helps us understand what’s factual is high on my list of valued items.

You mentioned that before work really got underway with the board you did some background research on your own. Where do you tend to draw upon information that is in necessarily presented directly to the board?

I had a lot of sources certainly a received a lot of good leads from health authority staff. I would say that’s the other really significant source of good information our staff is excellent and they do a good job of delivering what we ask for. And I ask for a lot in the beginning and they were able to get me to some good materials some good reading and some good work from Robert Wood Johnson and other foundations and so so forth. I would say other places that I gleaned good information were from members of the previous board that had existed the Oregon health fund board there were a couple of members that they knew including the former chair he was able to give me some good information in terms of where to go for reading and so on a couple of previous members of that board who became members of the health policy board specifically Eileen Brady was a good source of information in terms of getting up to speed. Generally where they led me was to material from Robert Wood Johnson material from CMS and a lot of other sources as well.

See you mentioned that Eileen Brady and other members of the policy board help you find information. What sort of issues did you find it helpful to go to other board members on? With a primarily the beginning basic information?

Very very basic beginning information like an understanding of the triple aim what its basis was in very fact and research how one could be optimistic and see future for healthcare that made some sense all really started with an understanding of triple aim thinking.

Comparing the sort of information they receive from other board members was there has there been a difference between that’s of approach and he approached you get from say experts that come to testify to the board?

The answer is yes to some and no to others. Certainly some of the experts that we’ve asked to testify were well steeped in that sort of logic and information and were able to
help clarify and deepen our understanding. There were some experts who came with very
different points of view we heard from actuaries who in some cases they looked at it from
a different point of view. We heard from folks in the Oregon insurance division who had
a very different view we heard from insurers and healthcare providers who in some cases
agreed in some cases disagreed in some cases agreed in part so I’d say that in the early
days there was a lot of mixing matching and sorting out.

So how about input from non-experts, the lay citizens? How do you seek that out?

Well one of the things that I think the health policy board has done and I want to give a
lot of credit staff here for making sure that this happens is that we tried to be very open
about our meetings in our deliberations the public as I was been invited to all of our
meetings we have made time for the public to testify at each of those meetings and almost
always we do have members of the public offering their opinions in addition on certain
topics we have invited people to come and express opinions sometimes when we knew
that they would be in agreement and supportive of what was being proposed to
sometimes when we knew that they would likely be opposed to what was being proposed
the range of public input has been all over the board from people who are interested from
a philosophical point of view and want to help us get to good Ray answers whatever they
may be the people who have very parochial point of view and want to make sure that
their economic interests are enhanced or at least not compared and pretty much
everything in between.

What sort of issues defined that that type of input is especially useful?

It is been especially useful to us in understanding impacts on the healthcare workforce
it’s been particularly helpful to us to understand how theory actually ends up playing out
in practice I mean sometimes something that seems like a really good idea and that
having implications that are foreseen in the theory and so therefore hearing from the
doctors and nurses are the hospital administrators or the other care providers sometimes
it’s the the providers of in-home healthcare or institutionalized healthcare all of those
folks see rules regulations and proposed rules and regulations through different lenses
and we can’t almost always almost never can we satisfy everybody almost always we can
get to a better overall conclusion if we understand what the impacts are on the whole
range of healthcare providers.

See you would consider practitioners and healthcare workers to be nonexperts?

Well it depends on the circumstance. Certainly there are instances when they come in as
experts and there are times when they come in with a, and as I say with a very parochial
point of view I guess you look to either in those cases.

How about consumers? What sort of experience have you had on the board with
consumer input?
We have been I would say that the consumers have been included I need to back up and make a point that I should’ve made earlier and that is that a lot of the work the board has actually been done by subcommittees or committees appointed by the board who will bring as recommendations and for consideration usually option or sometimes modification and adoption something like that virtually all of those committees have consumers on them on purpose so we get a fair bit of input that way consumers are welcome and are frequent contributors to public comment periods and we received a lot of information that way it’s kind of interesting I would say I want to be careful how I say this because I don’t want to malign anybody and at the same time I will make sure that point is somehow made the vast majority of consumers don’t know that we exist and if they did not that we existed probably wouldn’t go to a lot of effort to share with us their opinions. A small number of consumers are very well organized are very much aware of our existence and have made a fair amount of effort to influence the opinions. And I appreciate that it’s been helpful we know more than we would if they were not active that they don’t always represent a majority point of view and we have to keep that in mind.

So comparing those lay citizens and consumers to the experts’ opinion that you receive do you find that they are different in content and scope or focus?

I would say this is a right generalization because certainly we get a much wider range of opinions and topics from consumers and often very much steeped in their own personal experience some of which are very good and some of which are not all good I would say that the consumers and experts probably have very much the same and send mind good quality healthcare at a fair price with access broadly available that message comes through often the way it sounds as you listen to specific members of the communities but before the board can sound quite different experts will come back broad research and well thought out well documented points and opinions and recommendations the public is the general consumer public is more interested more likely to make their points based on anecdotes and personal experiences which may or may not have broad applications at the end of the day I don’t think there objectives or even in most cases the recommendations for action are widely different. Does that make sense?

Yes. So do you find that that extra layer input that is personal stories is useful whether or not the conflict with the experts?

It’s absolutely useful and sometimes it’s useful and a range of ways I mean certainly knowing what the public and even the organized public if they represent a minority knowing what the thinking and where they’re coming from is helpful no way what experiences they have had is helpful sometimes listening to their experiences and then asking somebody to do some research about what really happened and what cards. Often when the public comes to us their it’s about an experience that didn’t go very well and finding out what about that experience cost it’s not very well can certainly help us from to avoid putting into place recommendations or policy that has unintended consequences.
Can you maybe provide me with an example in which the input that you received from the lay public to shape your thinking about a particular issue?

Yeah. An example this is kind of a mixed example naturopathic physicians as a professional organization are feeling somewhat left out of the system they appeared as individuals their association appeared in a points feel some of the lightest a number of their patients to appear and I would say that the combination of the two communication from the professionals and from their patients probably caused us to have a better appreciation of where naturopathic and other alternative physicians fit into this family practice healthcare provider assist him and made sure that we didn’t accidentally or on purpose omit them from the family practice universe when we were trying to consider how much workforce was really available to deliver primary care. Does that make sense?

Yeah. You mentioned the various working groups that you have. How does the input that you receive from them help to shape your thinking about things? How do you incorporate that into the process?

Usually the groups are subsets of the healthcare professional together with consumer and other members of the public who have some greater knowledge of some piece of the healthcare system than most of us members have as individuals so for example we have a workforce subcommittee have a quality and metrics subcommittee we have there’s another one the kids minded just jumped out of my head all the public-health professionals the public health subcommittee. So for example on the public health committee we would have practitioners and members of the community on the workforce committee we would have members of the workforce we would have people who educate the workforce and members of the general public so basically they’re able to in addition to understanding the size and makeup of the healthcare workforce today they can also tell us who’s being educated how many are being educated what those people who are getting an education are likely to do you there likely to practice are we going to get the healthcare professionals we need in the world areas as well as the urban areas that could be done to increase if that were necessary the number of people who are being trained to be medical technicians or nurses practitioners or whatever the current case maybe so these people have greater specific knowledge in an area the metrics subcommittee we have in addition to healthcare providers and healthcare hospital administrators who certainly have their own certain sets of metrics we would bring in economists and metrics specialists who could get for instance the Quality Corporation, which specializes in healthcare metrics, to make sure that were looking at it all in a very professional way. Does that make sense?

You mentioned that their citizens on these various working groups and committees. Do you see any sort of difference in who participates in the committees versus who just comes to meetings to give public comment for instance?
Oh interesting. Interesting. Certainly the members of the committees are often present at our meetings especially if recommendation from their workgroup is being considered. Is there a difference actually I think there are probably more likely than members of the general public to be present.

So another question and that you already sort of addressed and that some of the other board members thought I should most appropriately address to you, is there a statutory requirements public comment time.

Right.

Play in reviewing the minutes and washing listening to the recordings there are many times you actually Extra times sometimes in the middle of the meetings instead of the end and allow people to talk for longer on occasion things like that that go beyond the statutory requirements. So I was wondering what sort of thinking goes into when it might be necessary to allow that sort of extra commentary?

Good question. You know as the chair you have a fair amount of discretion in managing the agenda. One of the things that is try to do is make sure you are using our time in a productive way and not using time in a way that is unproductive because all the members of the board are busy folks with other things to do so what I try to do is trying to measure two things one is well three things one is the knowledge of the board members as best I can figure it out and I do know is know for sure with regard to the topic being discussed if it seems like something we been over many times before in the board generally has a pretty good understanding of the issues I’m probably a little less likely to put extra time before into something that is less familiar more likely to provide extra time I try to judge number to the interest of the board members themselves if they’re asking a lot of questions if they seem to be good and well reasoned questions and if it seems that were gaining knowledge that has not previously been available to us or particularly bears on the decision that I know we need to make that would be reason to add a little extra time to the agenda if it seems again like the board members themselves are feeling pretty well satisfied that they understand what’s going on then maybe not so much the third and I tried to measure as best I can is the importance of the issue to those who come to testify it seems to me if people have taken time to come especially from out of town which is quite often the case when you’re in a state as big as ours to sit through a three-hour meeting for the end they can have a few minutes conversation about something important to them I certainly like it’s incumbent upon us to hear them out and if even if they don’t make the important point in the first minute or minute and a half seems like their building to something that is worthy of consideration or even if it’s in their minds is worthy of our consideration I try to find time so that they can get to it.

Semi final sort of big picture question here is do you feel that citizen input and participation has contributed policy outcomes?
I think the answer is no question that has. The I’m trying to think how I can emphasize that in a way that makes sense. I think that it probably has here’s what I’m trying to get at Oregon has sort of a we laugh at ourselves as we are so consensus oriented and so conflict of us so we only have inconsistent point of view presented to us it is not uncommon to take way too long to make a decision in the hopes of finding a decision that will satisfy most if not all the parties involved that leads us to some lengthier conversations leads us to taking them to come consideration a lot of points of view and make sure that if the public does show up and want to say something what they have to say and less is something that is just absolutely off-the-wall which happens very rarely will be taken into consideration and will one way or another impact the outcome.

Any last thoughts about maybe how it might be made more useful?

You know a lot of work has gone into figuring out with the public processes and it seems to work I think there are times when we could probably get the same answer on more direct path but we might lose some people feeling uninvolved who want to be involved so therefore I wouldn’t try to make it more efficient if you is there a way to somehow get more input more useful and more useful and productive input we can know is due a better job of publicizing them were having a conversation and going to make a decision but if somebody really has an interest in knowing about what were up to not hard to find. So I think we’ve got a pretty good system in place. Sorry to babble.

No. It’s been very useful. Thank you again for your time!

What about the OHPB role appeals to you? How did you first get involved?

The Oregon health policy board first formed Iowa is involved in the commission called health services commission and health services commission was the group that oversaw the Oregon health plans prioritize list of services and it felt to me that that was the next step as part of my involvement with the Oregon health plan and healthcare in the state. So I actually applied for the position and did not receive it at that time. The physician who got it is the president of Oregon health sciences University so I didn’t feel too bad about it. Then last year was one of the physicians who was on the board who is a rural physician out of Baker city asked if I would be willing to be nominated again. And I said yes. So originally I was interested in it because it seemed like a natural progression in my a involvement with health policy and in my work with the Oregon health plan. And I was lucky enough to be your free nominated last year and you pointed this time.

So being on the health services commission you have a lot of previous experience with these town hall style meetings?

When I was on the health services commission the list was already in place so they did not use a town fall for a lot of the time I was on the health services commission. They did that a lot when they were first put into the list together which was many many years ago.
So since you’ve been on the health policy board what type of information do you find to be most useful to you?

I want two things. I want the background behind why were doing the things that were doing that’s because of legislation whether it’s because of particular studies that have been done I like to know what the thinking is behind it. So for example were currently working on creating something called the transformation center and I want to know where that came from why are we doing this specifically in this way. The second thing I like to know how it’s going to impact people I like the practical aspects of the things. So it’s always good to have good policy but good policy isn’t always practical so in order for it to truly be good policy and needs to be practical.

[Break in the audio. Dropped call]

Actually flows pretty well into my next question which is how much would you say that you rely upon input of experts?

We actually rely upon the input of experts quite a lot. So we have various people who come and speak to the board about particular topics and sometimes experts sometimes advocates sometimes there people who work for the Oregon health authority who are doing the very very specific work that needs to be done.

Great and you find that expert input is most useful on particular topics? On one or the other or both of those types of information you mentioned before?

I think they’re more useful in background depending on the person sometimes their useful from a practical standpoint but sometimes their policy people and they don’t have the on the ground experience that can tell them whether this is practical or not

So how often would you say that you seek out or draw upon information isn’t necessarily presented directly to the board? So for instance your own background information or contacting people that you perhaps know that sort of thing.

Well for me I’d say quite a bit but I’m sort of in a unique position because I’m working on my Masters of Public Health right now so I’m focusing on health management and policy so as a result because of my classes I read a lot of stuff that is not presented to the board.

Do you ever seek out input from non-experts or lay citizens?

We have a public comment period. So will hear from public the public during those times which are often laypeople. There’s also of place on the website where people can post comments and they print does offer as they read through those.
Are there particular situations or issues they find that type of input to be especially useful?

Well I think that sometimes is where you get more of the practical comments so for example one of the issues that we’ve come up several times is about the role of naturopaths within the court Medicare organizations and we’ve heard from the professional organization but we’ve also heard from patients who have naturopaths as their primary care providers and how these changes in legislation have impacted them so those are very practical comments about how policy and the rules have impacted not only their practice but also their patients.

Great. So how would you say that the input they receive from lay citizens compares to that you receive from experts?

Well I think if it’s definitely a different level so the experts tend to be the 2000 foot level where is laypeople tend to be personal it’s one to one.

Excellent so I know they citizens often serve on the committees and workgroups. How does the input that you receive from those citizens or the committee workgroups influence your thinking or compare to that information that you receive from experts?

While most of the citizens that serve on committees tend to be advocates so I’ve worked on commissions where I think there’s been an advocate for like the developmentally delayed or advocates for mental health and so these folks are citizens but they also tend to be people who are passionate about a particular area so I think once again the input they really make us think about things differently there was one meeting that I was at with the health services commission that was about critical guidelines for determining a person’s ability I guess is the best way to put it well these guidelines were created back in the 1950s when they were a standard of care and one of the measures was the ability to ambulate. Well there was an advocate there who is an advocate for people with disabilities who pointed out that there are wheelchair athletes who are probably more fit than most people but lack the ability to ambulate. So based upon the guidelines that we were considering they would get points marked off for that and that was something that none of us would of thought of in the room without that person having been there so they contribute but very rarely is a everyday Joe who doesn’t have a particular passion serve on these commissions.

Okay. So my last question you have sort of already answered already do you think they citizen participation has contributed policy outcomes?

Yes for sure. I mean that was one of those things that particular case with the wheelchair thing it was all of us in the room were kind of like wow it was really great that that person was there because we never would’ve thought about that.
I do have one other question that has developed out of talking to your fellow board members. So I know that you are statutorily required to have public comments time in their rules about the structure and duration of that. However in many of the meetings the board puts in extra times or people have been allowed to speak longer than is statutorily provided. What is the thinking that goes into deciding when to allow this extra commentary?

Well the public comments are usually at the end of the meeting and that means they people have often been sitting there for three hours listening to us so I think it’s just respectful to listen to them once in a while you’ll have someone who’s just really going off track and many of these people are very nervous when they come and speak to us and they have written comments that they’ve prepared ahead of time and once in a while you’ll have somebody who just goes off with his comments and found that the kind of lost their and those folks will need to be redirected but in general it’s very clear that people know what they’re going to say in the have it all written down and that they have very specific issues and concerns that they want heard and I think it’s just respectful to listen to them.

Well thank you again for your time and I apologize again about the drop call in the middle.
Appendix C: Citizen Survey
Survey Questions

Informed Consent (first page of survey): This survey is being conducted by researchers at The Ohio State University to determine your level of involvement in and satisfaction with Oregon Health Authority (OHA) and Health Policy Board (OHPB) activities. This survey will take approximately twenty minutes of your time. Of particular interest are your perceptions of Oregon’s progress toward establishing a Health Insurance Exchange and meeting the requirements of the federal health reform laws. The results of this survey may help to inform future activities. Your participation in this survey is completely voluntary and anonymous. No information that you provide will be connected to you personally in writing or discussion. You may choose not to answer any question and choose to stop participating at any time. If you have questions or concerns about this survey please feel free to contact the survey administrator, Samantha Howe, at howe.148@osu.edu. For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251. Thank you for your time.

1. Are you aware of opportunities to participate (e.g. attend in person, watch online, provide public comment at, or present material during) in Oregon Health Authority/Oregon Health Policy Board meetings? __Yes (skip to question 3) __No

2. (If no on 1) What do feel would be the best way for the Oregon Health Authority to communicate opportunities to participate to people like you? (open response)

3. Have you heard about any of the following public meeting topics? Check all that apply.
   ___Health Insurance Exchange creation ___Community/Accountable Care Organizations
   ___Prioritized Healthcare List/Oregon Health Plan ___ Other. Please indicate:
   ___None of the above

4. Have you ever participated in an Oregon Health Authority/Oregon Health Policy Board meeting?
   ___Yes ___No

5. Have you participated in any of the following public meeting topics? Check all that apply.
   ___Health Insurance Exchange creation ___Community/Accountable Care Organizations
   ___Prioritized Healthcare List/Oregon Health Plan ___ Other. Please indicate:
   ___None of the above

679
6. In what way(s) have you participated? Check all that apply. (create table that references #5)

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<th>Community Care Organizations</th>
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<td>Commented on or shared a social media post</td>
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<td>Spoken with a policymaker (legislator, board member, etc.)</td>
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<td>Served on a committee or board</td>
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7. (If yes on 5 or a check on any of 6) How often have you participated in meetings? ____ meetings, roughly _____ hours

8. What are the main reasons that may have prevented you from participating in a meeting? Check all that apply.
   ___ Time    ___ Location    ___ Didn’t feel informed enough
   ___ Didn’t think my opinion mattered    ___ Don’t care/Not Interested
   ___ Felt that others would adequately represent my opinions    ___ Other: specify

9. Are there others that participate who you feel hold the same values/opinions as yourself? (y/n)

10. Do you know of a person/people who is/are specifically identified as representing your group or your interests in public meetings? (y/n) (If no on 9 & 10 then skip to 12)

11. Do you sometimes feel that the participation of others is enough to ensure that your opinions are heard by the board? (y/n) [add why/why not question(s)]
12. Please mark your agreement with the following statements. [include knowledge questions]

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<th>Statement</th>
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<th>Disagree</th>
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<td>Experts cannot always give the right advice about what is important to people like me.</td>
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<td>I learn from my participation in health policy meetings.</td>
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<td>Policymakers need to hear about what people value in healthcare, not just what things cost.</td>
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<td>Public meetings help inform me about the trade-offs involved in health policy choices.</td>
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<td>Decision-makers are genuinely interested in the experiences and opinions of citizens.</td>
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<td>Citizen input is valued by policymakers.</td>
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<td>Discussion about the policy process occurs frequently at public meetings.</td>
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<td>Discussion about the policy process makes decisions transparent.</td>
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<td>Even when I don’t agree with the outcome, the process used to make decisions appears legitimate.</td>
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<td>Experts are good at talking about facts, but not about values.</td>
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<td>Health policy experts (doctors, nurse, insurance providers, etc) are best suited to inform policy decisions.</td>
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13. How might the OHA/OHPB public meeting process be improved? (open response)

14. What has been your most valuable experience with the OHA/OHPB? (open response)

15. What is your age?

16. What is your race/ethnicity? Check all that apply.
   __ Hispanic
   __ African American
   __ Native American
   __ Caucasian
   __ Other

17. What is your gender? (m/f)

18. What is your highest level of education?
   __ Less than high school
   __ High school
   __ Some college
   __ Associates degree
   __ Bachelors degree
   __ Some graduate education
   __ Masters or other professional degree
   __ PhD, MD, JD, or other terminal degree

19. How many people (including yourself) live in your household?

20. What is your approximate annual income?
   __ 0 to 10000
   __ 10001 to 25000
   __ 25001 to 50000
   __ 50001 to 100000
   __ 100000 to 200000
   __ more than 200000

21. Do you work in a health-related profession? (y/n)
Appendix D: Testimony Tracking
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