

State of Oregon
Public Employees Benefit Board

Implementation of Vision 2007

Report on Communications and Technical Implementation Strategies

Part I: Overview and Technical Recommendations

Foundation for Accountability
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Table of Contents

Part I: Overview and Technical Recommendations

Overview.....	2
Recommended vendor rating approach.....	5
Medical home.....	7
Evidence-based care.....	9
Member self-management.....	12
Service integration.....	14
Infrastructure.....	16
Transparency.....	18
Managing for quality.....	20

Part II: Specific technical criteria by care setting

- Primary care
- Specialty and hospital care
- Prescription drugs
- Behavioral health
- Wellness and screening
- Chronic care
- Information services

- Technical Advisory Committee membership

Part III: Communications Plan

- Background
- Purpose
- Resources
- Member communications
- State government and labor leadership communications
- Health system leader communications
- Purchasing and policy partner communications

- Communications Exhibits

Part IV: Background summaries of models referenced

Part I: Overview and Technical Recommendations

Overview

In May 2004, the Oregon Public Employees' Benefit Board contracted with FACCT – The Foundation for Accountability to provide consulting assistance to the implementation of its *Vision 2007*. The Vision was based on extensive consultations with PEBB Board members and community and health system leaders from throughout Oregon.

PEBB'S PROBLEM STATEMENT

Approved December 17, 2002

The Public Employees' Benefit Board believes the current healthcare system is in crisis. From the member to the provider to the insurer, the system is broken. At this time PEBB is not confident that the current marketplace can offer a tangible, statewide solution for the short or long term. The depth, breadth and complexity of this problem require long-term solutions. PEBB has developed the following vision statement to articulate its desired future. This vision statement says what the long-term solutions might look like. During the next five or more years, it will serve as a guide for the Board's strategic planning, its decision-making and its commitment of resources towards achieving that future.

PEBB VISION FOR 2007

PEBB envisions a new state of health for its members statewide.

Key components of the PEBB program will include:

- An innovative delivery system in communities statewide that provides evidence-based medicine to maximize members' health and utilize dollars wisely;
- A focus on improving quality and outcomes not just providing healthcare;
- The promotion of consumer education and informed choices;
- Appropriate market and consumer incentives that encourage the right care at the right time;
- System-wide transparency through explicit, available and understandable reports about costs, outcomes and other useful data; and
- Benefits that are affordable to the state and employees.

Several methods for achieving the vision were described in the *Strategic Plan 2003*, developed by Aon Consulting and the OHSU Center for Evidence-based Policy (published January 15, 2004). The Strategic Plan recommended an ambitious, multi-layered process for bringing the vision to fruition for the 2005 benefit year. Ultimately, PEBB felt that more time would be needed to define specific purchasing criteria and work with Oregon's health care community to develop a successful approach. FACCT's role has been to "translate" the elements of the Vision and Strategic Plan into a set of specific contracting criteria

that appear to be within the capabilities of Oregon's provider and insurance community.

From May to November 2004, FACCT convened two processes. First, we addressed PEBB's need for specific **technical quality criteria** that could be used in a health benefits RFP process. We conducted this work through several steps:

- Developed a framework of nine service categories that characterize PEBB's contracting scope, including primary care, hospital care, prescription drugs, behavioral health and others
- Established a Technical Advisory Committee (TAC) comprised of ten experts from across Oregon
- Worked with the PEBB Board to identify its concerns and quality objectives in each of the nine service categories
- Developed background briefing papers for each of the nine areas
- Reviewed each background paper with the TAC and made appropriate revisions
- Reviewed each revised paper with the PEBB Board at a public meeting
- Presented each revised paper to a public Stakeholder Forum, typically attended by about 30 Oregon health care providers, vendors and carriers
- Presented final revised papers to a second meeting of the PEBB Board for discussion and approval.

Secondly, FACCT supported the development of a set of **communications materials** to help PEBB explain its Vision and the emerging program changes to important constituencies throughout the state. FACCT convened a Communications Advisory Committee (CAC) made up of nine communications professionals, some from within state government and some representing providers, unions, and independent public relations practice. FACCT developed a series of materials that were reviewed and revised during monthly meetings of the CAC. In addition, FACCT convened a Member Advisory Committee (MAC), comprised of 10 PEBB members drawn from across the state. The MAC also reviewed draft materials and provided broad guidance on the perspectives and messages that made sense to members.

This report includes both final recommendations and some of the background material used in developing those recommendations. Part I contains recommended criteria for use in the 2006 Request for Proposals. Part II includes the background material developed by FACCT and the TAC during our examination of each of the nine service categories. Much of this work has been brought forward into the Part I recommended criteria, though organized in a different format. Part III contains the 2005 Communications Plan. Part IV

includes background information on some of the important national models that we have referenced throughout these documents.

Recommended Vendor Rating Approach

Overview

PEBB wishes to provide its members with comprehensive, coordinated, and well-integrated health care services. It seeks service providers who are committed to and capable of offering the full array of services and able to demonstrate continuous improvement towards the Vision 2007 objectives, including:

- Evidence based medicine
- Improving quality and outcomes
- Consumer education and informed choices
- Incentives for the right care at the right time
- Transparency

FACCT and the Technical Advisory Committee have reviewed specific performance criteria in each of nine areas spread along the continuum of care. This report presents these criteria in two ways. First, we identify essential domains that present themselves in most – if not all – care situations and settings and recommend an approach to the relative weighting and evaluation of these cross-cutting domains. Second, we present detailed evaluation criteria for each of the care settings.

Each vendor proposal, regardless of its focus on a particular care setting, can be evaluated using the simple thematic rating scheme presented here.

For each domain, this section provides the following information:

- An explanation of the domain
- Guidance on how to evaluate an offeror's proposed approach to the domain
- Guidance on how to assess the credibility of each proposal, i.e., the likelihood that the offeror can actually implement the proposed system improvements
- Guidance on realistic and acceptable approaches to phasing the implementation over time: a sequence of activities and commitments which are likely to achieve PEBB's objectives over a three-year period.

Each proposal will be rated on seven domains, listed below. For each domain, the rater will assign a score. The total quality score will reflect a weighted composite of the seven domain scores.

Constructing the Proposal *Quality Score*
Domains of Delivery System Quality

Domain	Relative Weight
Medical home	25%
Evidence-based care	20
Member self-management	15
Service integration	10
Infrastructure	10
Transparency	10
Managing for quality	10

Medical home

FACCT and the TAC believe that PEBB's vision can only be achieved if a health professional has primary responsibility for coordinating the care provided to each member. The concept of a "medical home" emerged from the challenges of coordinating care for children with chronic illness and other special health care needs, but has now been generalized to address the needs of adults as well as children. Some members may not wish to develop a close association of this kind with an individual provider, so it is important to know that the offeror has the capability to provide this level of support, but not that such support is necessarily in place for every member. PEBB may wish, over time, to have data indicating that every member has been offered the opportunity to identify a primary provider and a medical home, though some may decline.

Building blocks of the medical home

- Care is accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally competent.
- Parents, other caretakers and the community are partners in identifying the patient's medical needs.
- Unbiased information about specialty and community health care services is shared.
- Ambulatory and inpatient care for acute illnesses is provided 24 hours a day, seven days a week.
- Transition to other physicians or medical homes, when necessary, is planned.
- Primary care and specialty care physicians collaborate with families and other caretakers to develop shared management plans.
- Medical personnel interact with schools and community organizations to ensure patients' special needs are met.
- A central, accessible medical record is maintained.

Source: Policy statement on the medical home, American Academy of Pediatrics, July 2002

Weighting system

Minimum requirements/benchmarks

- Willing to implement standardized patient survey (ACES-SF or ambulatory CAHPS) for each PEBB primary care provider (across all patients, not just PEBB members) in 2006.
- Willing to report how many PEBB members have medical home, based on claims or survey results.
- Willing to report how many PCPs in network have EMR.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder can document (offer of) medical home for each member; provides reports and can hold each provider accountable (and has incentives) for screening, preventive services, chronic care and coordination services; able to measure outcomes for patients with target conditions (i.e., asthma, diabetes); can produce patient satisfaction scores for each PCP; > 60% of PCPs have EMR and permit patients to access own EMR.
- **Moderate rating:** Bidder can document which members have source of routine care; produces provider-level reports of utilization/HEDIS-type wellness services, including immunizations, screenings, smoking cessation; has system to encourage members to select PCP.
- **Low rating:** Bidder can document which members have source of routine care; produces population-level utilization/HEDIS reports; can document population-level delivery of chronic and wellness services.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for medical home:

- Bidder can provide patient satisfaction survey results that show high proportion of patients reporting a current, positive relationship with PCP
- Bidder can provide sample reports of individual provider quality profiles (not just utilization)
- Bidder has a system in place for tracking patient assignment to PCP
- Bidder has provider contracts in place reflecting PCP obligation to coordinate all care.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Produce provider-level reports; implement system for PCP assignment
- 2007: Demonstrate that each patient has had opportunity to select "medical home" provider
- 2008: Fulfill all of the high-rating criteria.

Evidence-based care

PEBB expects that an increasing proportion of the care provided to its members should be consistent with scientific evidence and that documentation will exist to show that the care provided is evidence-based. In some cases, there are structural tools available to facilitate the use of evidence-based practices. The proposed evidence-based formulary, for example, can lead to more common use of appropriate medications. PEBB expects that an increasing proportion of behavioral health services will be based on appropriately applying the six recommended SAMHSA practices. In many other areas of medical practice, there is no codified and easily accessed standard for evidence-based care. Instead, bidders should be able to describe how they support increased use of evidence-based practices, including:

- Identification of preferred evidence-based practice guidelines
- Promotion and support for use of those guidelines (e.g., detailing, profiling, feedback)
- Measurement of conformity to guidelines (e.g., selected HEDIS measures)
- Incentives to encourage use of evidence-based practice (e.g., Bridges to Excellence model).

For 2006, PEBB will look for programs that can demonstrate adoption of evidence-based practices across all care settings and populations. It will also give particular attention to evidence-based practice in four areas:

- Asthma care
- Diabetes care
- Behavioral health care
- Medication management.

Evidence-Based Medicine: What it is and what it isn't. [David L Sackett, William MC Rosenberg, JA Muir Gray, R Brian Haynes, W Scott Richardson](#)

This article is based on an editorial from the British Medical Journal on 13th January 1996 (BMJ 1996; 312: 71-2)

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgement that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and compassionate use of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.

Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough. Without clinical expertise, practice risks becoming tyrannized by evidence, for even excellent external evidence may be inapplicable to or inappropriate for an individual patient. Without current best evidence, practice risks becoming rapidly out of date, to the detriment of patients.

This description of what evidence-based medicine is helps clarify what evidence-based medicine is not. **Evidence-based medicine is neither old-hat nor impossible to practice.** The argument that *everyone already is doing it* falls before evidence of striking variations in both the integration of patient values into our clinical behavior and in the rates with which clinicians provide interventions to their patients. The difficulties that clinicians face in keeping abreast of all the medical advances reported in primary journals are obvious from a comparison of the time required for reading (for general medicine, enough to examine 19 articles per day, 365 days per year) with the time available (well under an hour per week by British medical consultants, even on self-reports).

Evidence-based medicine is not "cook-book" medicine. Because it requires a bottom-up approach that integrates the best external evidence with individual clinical expertise and patient-choice, it cannot result in slavish, cook-book approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient's clinical state, predicament, and preferences, and thus whether it should be applied. Clinicians who fear top-down cook-books will find the advocates of evidence-based medicine joining them at the barricades.

Evidence-based medicine is not cost-cutting medicine. Some fear that evidence-based medicine will be hijacked by purchasers and managers to cut the costs of health care. This would not only be a misuse of evidence-based medicine but suggests a fundamental misunderstanding of its financial consequences. Doctors practicing evidence-based medicine will identify and apply the most efficacious interventions to maximize the quality and quantity of life for individual patients; this may raise rather than lower the cost of their care.

Evidence-based medicine is not restricted to randomized trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions. To find out about the accuracy of a diagnostic test, we need to find proper cross-sectional studies of patients clinically suspected of harboring the relevant disorder, not a randomized trial. For a question about prognosis, we need proper follow-up studies of patients assembled at a uniform, early point in the clinical course of their disease. And sometimes the evidence we need will come from the basic sciences such as genetics or immunology. It is when asking questions about therapy that we should try to avoid the non-experimental approaches, since these routinely lead to false-positive conclusions about efficacy. Because the randomized trial, and especially the systematic review of several randomized trials, is so much more likely to inform us and so much less likely to mislead us, it has become the "gold standard" for judging whether a treatment does more good than harm. However, some questions about therapy do not require randomized trials (successful interventions for otherwise fatal conditions) or cannot wait for the trials to be conducted. And if no randomized trial has been carried out for our patient's predicament, we follow the trail to the next best external evidence and work from there.

Weighting system

<p>Minimum requirements/benchmarks</p> <ul style="list-style-type: none"> • Able to conduct retrospective data analysis to identify potentially inappropriate test and procedure use • Able to identify members with asthma or diabetes and create patient registry. • Willing to report population-level HEDIS measures for asthma and diabetes. • Able to implement evidence-based drug formulary or willing to work with selected prescription drug plan to implement evidence-based formulary. • Able to document appropriate provider use of SAMSHA evidence-based practices.
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Guidance for evaluating proposals:

- **High rating:** Bidder supports implementation of evidence-based formulary through education, e-prescribing, pricing and incentives, feedback systems. Uses retrospective data analysis to profile high-variation procedures. Network providers have EMR and/or registries that allow protocols to be implemented and supported, with feedback to providers. For diabetes and heart disease, network has established guidelines, can report HEDIS and Bridges to Excellence measures for population and by provider; for asthma, reports HEDIS measures for population and by provider. Network documents adherence to SAMHSA evidence-based practices. Network hospitals adopt Leapfrog practices for Computer Physician Order Entry, evidence-based referrals, and intensivists. Network has training system and information infrastructure in place to support evidence-based practice.
- **Moderate rating:** Bidder supports evidence-based formulary, develops asthma and diabetes registries and reports HEDIS measures. Bidder identifies and supports practice guidelines for asthma, diabetes, heart disease. Network generates management and provider feedback reports on high-variation procedures, such as back surgery, hysterectomy, c-section.
- **Low rating:** Bidder only meets minimum criteria above.

<p>Assessing the credibility of the proposed approach:</p> <p>Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for evidence-based care:</p> <ul style="list-style-type: none"> • Bidder can identify recommended practice guidelines and has systems for training, measurement, and feedback. • Bidder can provide data showing performance against guideline indicators for selected conditions, tests, procedures (e.g., imaging, back care, asthma, diabetes, heart disease). • Network providers have EMR with decision-support programs enabled.
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<p>If contract is awarded initially, acceptable phase-in schedule for contract renewal:</p> <ul style="list-style-type: none"> • 2006: Implement evidence-based formulary support; generate HEDIS measures for population. • 2007: HEDIS measures at provider level. Guidelines training in place for provider network. Baseline measures collected • 2008: Fulfill <u>all</u> of the high rating criteria.

Member self-management

PEBB believes that improved health and a more efficient health care system depend upon members' ability to identify their own health risks and take actions to manage their own health to the degree possible. Key elements of this model include:

- Health risk assessment and a plan for lifestyle change
- Guidance and tools for selecting providers
- Guidance and tools for participating in treatment decisions
- Assistance with medication adherence
- Accessible and coordinated support for lifestyle change and chronic care programs.

PEBB expects providers and provider organizations to implement systems that support members – wherever they may be on the spectrum of health status and needed care – to understand what they can do to manage and improve their own health.

The Chronic Care Model

Empower and prepare patients to manage their health and health care

- Emphasize the patient's central role in managing their health
- Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

All patients with chronic illness make decisions and engage in behaviors that affect their health (self-management). Disease control and outcomes depend to a significant degree on the effectiveness of self-management.

But effective self-management support means more than telling patients what to do. It means acknowledging the patients' central role in their care, one that fosters a sense of responsibility for their own health. It includes the use of proven programs that provide basic information, emotional support, and strategies for living with chronic illness. But self-management support can't begin and end with a class. Using a collaborative approach, providers and patients work together to define problems, set priorities, establish goals, create treatment plans and solve problems along the way.

From <http://www.improvingchroniccare.org/resources/index.html>

Weighting system

Minimum requirements/benchmarks

- Able to acquire and distribute health risk assessment and health screening information to providers
- Provides members with access to shared decision-making tools
- Offers chronic care management, disease management, and/or medication adherence programs in support of primary care role
- Willing to coordinate health education and outreach programs with PEBB-sponsored (e.g., worksite) programs

Guidance for evaluating proposals:

- **High rating:** Bidder offers patients access to electronic medical record (personal health record) including email contact with providers, automated reminders, alerts, remote monitoring links (e.g., blood glucose monitors). Providers receive health risk assessment and screening data, develop personal health maintenance plan with patients, generate annual data on health risk reduction per provider. Patients with chronic illness have personal care plan, telephone support, routine measurement of relevant outcomes. Medication adherence program in place. Providers actively refer to and work with shared decision-making tools.
- **Moderate rating:** Bidder has ability to share health risk assessment data with providers and evaluate behavior changes. Telephone support and related educational tools are in place for chronic care management and medication adherence.
- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for member self-management support care:

- Bidder has strong disease management program in place with high participation levels and well-defined outcomes data.
- Bidder has significant HRA data collection and system for sharing with providers.
- Bidder has strong wellness programming, including smoking cessation, cardiac risk reduction, nutrition and exercise.

IF contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Implement HRA data collection and distribution, chronic care education and outreach systems. Shared decision-making tools available.
- 2007: Medication adherence program in place; 20% or more of patients have personal health record. Physicians refer to shared decision-making tools.
- 2008: Fulfill all of the high rating criteria.

Service Integration

PEBB recognizes that contemporary health care is most effective when it addresses not only the patient's "medical" presentation – typically met with medications and procedures – but when it also integrates patient self-management, lifestyle change, mental health, and social circumstances. Because many medical practitioners are not experienced or comfortable dealing with these non-medical domains, a fragmented array of ancillary services have arisen: disease and case managers, adherence programs, wellness classes and services, behavioral health carve-outs, and information and decision-support suppliers. PEBB expects successful vendors to either offer these services within their own portfolios or describe mechanisms that ensure the integration of independent suppliers with their own medical care networks. These

solutions could range from co-location of specialized providers (e.g., mental health, chronic care management) with the primary care practice, to use of 24/7 "curbside consultation" services or consolidated on-line data systems. PEBB's goal is that the critical information and array of services for each patient is consolidated and coordinated through the primary care or medical home entity, so that care is effective, patient-centered, and accountable.

Organization of Health Care/Leadership

- Make sure senior leaders and staff visibly support and promote the effort to improve chronic care
- Make improving chronic care a part of the organization's vision, mission, goals, performance improvement, and business plan
- Make sure senior leaders actively support the improvement effort by removing barriers and providing necessary resources
- Assign day-to-day leadership for continued clinical improvement
- Integrate collaborative models into the quality improvement program

Decision Support

- Embed evidence-based guidelines in the care delivery system
- Establish linkages with key specialists to assure that primary care providers have access to expert support
- Provide skill-oriented interactive training programs for all staff in support of chronic illness improvement
- Educate patients about guidelines

Delivery System Design

- Identify depressed patients during visits for other purposes
- Use the registry to proactively review care and plan visits
- Assign roles, duties and tasks for planned visits to a multidisciplinary care team. Use cross training to expand staff capability
- Use planned visits in individual and group settings
- Make designated staff responsible for follow -up by various methods, including outreach workers, telephone calls and home visits

Clinical Information System

- Establish a registry (Note: while this concept is in broad use in CHCs and many primary care networks, it is not well known or understood by BH providers)
- Develop processes for use of the registry, including designating personnel to enter data, assure data integrity, and maintain the registry
- Use the registry to generate reminders and care planning tools for individual patients
- Use the registry to provide feedback to care team and leaders

Self-Management

- Use depression self management tools that are based on evidence of effectiveness
- Set and document self management goals collaboratively with patients
- Train providers and other key staff on how to help patients with self management goals
- Follow up and monitor self management goals
- Use group visits to support self management

Community

- Establish linkages with organizations to develop support programs and policies
- Link to community resources for defrayed medication costs, education and materials
- Encourage participation in community education classes and support groups
- Raise community awareness through networking, outreach and education
- Provide a list of community resources to patients, families and staff

From "Integrating Behavioral Health and Primary Care Services: Opportunities and Challenges for State Mental Health Authorities"

Weighting system

<p>Minimum requirements/benchmarks</p> <ul style="list-style-type: none"> • Has arrangement with behavioral health specialty network that includes 24/7 support to primary care • Has capacity to share health risk assessment data with primary care providers • Has capacity to share formulary information with prescribers in real time • Willing to require primary care providers to complete ACIC or similar chronic care assessment tool • Has internal capability or willing to collaborate with third-party predictive modeling and case management systems • Requires new IT acquisitions to conform to Federal Consolidated Health Informatics (CHI) data standards (http://www.whitehouse.gov/omb/egov/gtob/health_informatics.htm) <p>Otherwise: non-responsive.</p>
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Guidance for evaluating proposals:

- **High rating:** Bidder has close relationship with behavioral health network, including co-located behavioral health specialists in major primary care clinics, 24/7 telephone consultation, and tight data feedback systems; uses PHQ -9 or similar depression screening tool. Has implemented e-prescribing including real-time formulary information to prescriber. Most PCPs have standards-compliant EMR, can acquire lab and pharmacy data electronically, permit multiple providers and patients to access EMR as appropriate. Primary care providers have completed ACIC and are taking steps to implement chronic care model. Bidder has system in place to identify and intervene with high-risk patients, including multiple chronic disease, polypharmacy, underserved.
- **Moderate rating:** Bidder has established relationship with behavioral health network, including 24/7 telephone consultation and data feedback to providers. New IT acquisitions are standards-compliant. E-prescribing systems being deployed. Bidder has established program for identifying and intervening with high-risk patients.
- **Low rating:** Bidder only meets minimum criteria above.

<p>Assessing the credibility of the proposed approach:</p> <p>Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for service integration:</p> <ul style="list-style-type: none"> • Bidder has established behavioral health network relationship. • Has implemented standards-compliant, interoperable EMR and e-prescribing. • Has implemented predictive modeling and case management services.
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<p>IF contract is awarded initially, acceptable phase-in schedule for contract renewal:</p> <ul style="list-style-type: none"> • 2006: Implement behavioral health consultation, referral, and feedback system; implement predictive modeling and case management; administer ACIC. • 2007: E-prescribing, behavioral health measurement system, data on case management, chronic care outcomes. • 2008: Fulfill <u>all</u> of the high rating criteria.
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Infrastructure

Oregonians can now benefit from decades of scientific and technological progress in health care. Enormous reservoirs of insight into illness and its treatment and the maintenance of health are available to help PEBB members live healthier and longer lives. But this knowledge is not always brought into practice, clinicians are not always informed of each other's activities, patients and families rarely get quick and accurate access to their own data, and new technologies are not always used appropriately or to best effect. Contemporary health care knowledge and technology can not be successfully used unless it is supported by a comprehensive, interoperable information platform. PEBB expects

providers to make aggressive efforts to acquire appropriate information technology, to choose tools that interoperate with those of other providers and information suppliers, and to integrate all of that information in the service of excellent care.

Readiness for Change

There is a great need for information tools to be used in the delivery of health care. Preventable medical errors and treatment variations have recently gained attention. Clinicians may not know the latest treatment options, and practices vary across clinicians and regions. Consumers want to ensure that they have choices in treatment, and when they do, they want to have the information they need to make decisions about their care. Concerns about the privacy and security of personal medical information remain high. Public health monitoring, bioterror surveillance, research, and quality monitoring require data that depends on the widespread adoption of HIT.

Vision for Consumer-centric and Information-rich Care

Many envision a health care industry that is consumer centric and information-rich, in which medical information follows the consumer, and information tools guide medical decisions. Clinicians have appropriate access to a patient's complete treatment history, including medical records, medication history, laboratory results, and radiographs, among other information. Clinicians order medications with computerized systems that eliminate handwriting errors and automatically check for doses that are too high or too low, for harmful interactions with other drugs, and for allergies. Prescriptions are also checked against the health plan's formulary, and the out-of-pocket costs of the prescribed drug can be compared with alternative treatments. Clinicians receive electronic reminders in the form of alerts about treatment procedures and medical guidelines. This is a different way of delivering health care than that which currently exists, but one that many have envisioned. This new way will result in fewer medical errors, fewer unnecessary treatments or wasteful care, and fewer variations in care, and will ultimately improve care for all Americans. Care will be centered around the consumer and will be delivered electronically as well as in person. Clinicians can spend more time on patient care, and employers will gain productivity and competitive benefits from health care spending.

From The Decade of Health Information Technology: Delivering Consumer-centric and Information-Rich Health Care, from DHHS, Office of the National Coordinator for Health Information Technology (July 2004)

Weighting system

Minimum requirements/benchmarks

- Information technology plan addresses primary care EMR, adoption of CHI data standards, common patient identification approach, patient e-mail, clinical registries, CPOE, e-prescribing, predictive modeling.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- High rating:** Bidder has high proportion (>60%) of primary care providers with EMR; all hospitals (>150 bed) with CPOE. Patient-provider email in place. Network policies address use of CHI data standards. Master patient index or equivalent patient identification algorithm in place. E-prescribing, including formulary and pricing access, in place. Capability to import HRA, screening, pharmacy, lab data to EMR and share with providers. Patient ability to access medical record and input personal health information (PHR).
- Moderate rating:** Bidder has high proportion (>60%) of primary care providers with EMR; most hospitals with CPOE; significant percentage of PCPs using patient-provider email; network policies address use of CHI data standards.
- Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for infrastructure development:

- Network has high standards-compliant EMR use in place.
- Network has master patient index.
- Network has clinical registries (e.g., diabetes, coronary, stroke, asthma).
- Network provides patients with on-line access to lab results, medication lists, clinical e-mail, EMR.
- Network has significant capital allocated to further IT development and a clear IT plan.

IF contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: High primary care EMR penetration; standards defined, registries for diabetes, asthma, risk assessments.
- 2007: E-prescribing, patient clinical email, and patient portal or PHR implemented.
- 2008: >60% of PCPs using EMR and e-prescribing.

Transparency

PEBB puts a high value on transparency: ensuring that members have all the information they need to make good decisions about their own care, their providers, and their benefit choices. PEBB expects that each provider type and care setting will make a commitment to collect and disclose information that will help members make better decisions and, in the aggregate, help PEBB develop the most effective health care program. PEBB expects that contracted providers will, at a minimum, participate in all industry standard reporting initiatives, such as Leapfrog, the Oregon Patient Safety Commission, the CMS hospital measures, CAHPS, and HEDIS. In addition, PEBB expects providers to be responsive to requests for information that will help members make good decisions, such as procedure volumes and chronic disease outcomes.

The blind players — purchasers, plans, patients, even some providers — are starting to call for the same thing: universal transparency, that is, standardized performance metrics and outcomes reports that are easily accessible to absolutely everyone. Hospital and surgical mortality and morbidity rates, physician compliance with chronic disease management, charges and reimbursements — everyone knowing everything at the click of a mouse, and we know how elephants feel about mice.

Transparency is seen as the beginning of an awakening. It has the ability to create a paradigm shift, to move us from a model of acute care that primarily rewards episodic intervention to a model of chronic care management that rewards — and here's a shocking thought — keeping people healthy.

The theory is that data exposure will lead to patient empowerment, which will result in an increase in the demand for evidence-based medicine, because it demonstrates effectiveness, which will improve the quality of care. And better care means lower overall costs.

From "Can Transparency Save Health Care?" *Managed Care*. March 2004.

Weighting system

Minimum requirements/benchmarks

- Bidder requires participating hospitals to report data to the Oregon Public Safety Commission, Leapfrog criteria, procedure volumes, and participate in the HCAHPS survey in 2005.
- Bidder requires participating primary care providers to report HEDIS-like measures and cooperate with patient satisfaction survey program.

Otherwise: non-responsive.

Guidance for evaluating proposals:

- **High rating:** Bidder reports chronic disease outcomes (particularly asthma, depression and diabetes) for the population as a whole and by provider or clinic. Bidder develops and shares provider report cards, for hospitals, medical groups, and individual providers. Participating hospitals report Leapfrog, Oregon Patient Safety Commission, and CMS data, as well as procedure volumes. Network conducts and publishes annual primary care patient satisfaction survey, with scores for each primary care physician. Network has on-line capability to share formulary, pricing, and performance data with patients.
- **Moderate rating:** Bidder requires hospital participation in Leapfrog, Oregon Patient Safety and CMS. Can report chronic disease outcomes for overall population.
- **Low rating:** Bidder only meets minimum criteria above.

Assessing the credibility of the proposed approach:

Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for transparency:

- Hospital and medical group performance reports.
- Patient satisfaction surveys with public results of physician and hospital performance.
- On-line provider selection tools.
- Chronic disease outcomes measurement and reporting.
- Adverse event reporting, to JCAHO and to Oregon Patient Safety Commission.

If contract is awarded initially, acceptable phase-in schedule for contract renewal:

- 2006: Hospital report card and on-line tools for members.
- 2007: Physician ratings available. Chronic disease outcomes reported.
- 2008: Fulfill all of the high rating criteria.

Managing for Quality

PEBB expects its contractors to have systems in place that encourage providers and other suppliers to address the elements of PEBB's 2007 Vision. Certainly one of the principal mechanisms to signal and reward preferred behaviors is the payment system. PEBB recognizes that the economic incentives for both providers and patients can shape behavior, and will look to provider organizations to demonstrate their ability to implement reward systems and other management tools that produce higher quality care.

Benefit Design Incentives for System-wide Improvement

The time has come to reform the way in which these incentives are used. The Task Force agrees that demand side approaches will play a critical role in the creation of a health system that is both affordable and efficient, but the true utility of demand side tools will be found in their ability to provide economic incentives for consumers to make informed health care decisions based on the principles underlying the strategies outlined in this report. Examples of such an approach might include lowering or waiving the co-payment requirements for all chronic care management visits, charging a high co-insurance fee for emergency room usage, but waiving such a fee if the consumer is actually admitted to the hospital for treatment, or charging no consumer fee at all for interactions with medical professionals via email.

The Use of Supply Side (Provider) Tools

In addition to the consumer related strategies discussed above, the Task Force recommends that the provider community have access to a series of performance-based payment initiatives to support those types of care that have proven to provide positive health outcomes efficiently and effectively. Unlike the system now in place which essentially rewards higher utilization, the Task Force recommends that plan designers create a system of payments that are structured to reward providers for doing such things as ordering appropriate screenings for high risk conditions, having in place a registry of information to better track patient compliance with treatment protocols and achieving high levels of customer satisfaction on standard customer survey tools.

It is critical to note that all of the provider based financial rewards should be directly linked with those financial incentives put in place to provide incentives for consumer behavior. For example, if benefits design programs are to waive insurance deductibles for patients that make all of their scheduled appointments for the maintenance of a given chronic condition, those doctors that are responsible for scheduling and tending to those appointments should be given a similar bonus should the patient adhere to the schedule. Such a program of incentives could be made available to insurers as well. As noted by a leading health economist "[i]nsurers that had more patients who got recommended screening, better risk factor control, and good surgical outcomes would earn bonuses over those that did not."

From King County Health Advisory Task Force Report, June 2004, Appendix 1.

Weighting system

<p>Minimum requirements/benchmarks</p> <ul style="list-style-type: none"> • Bidder has a provider payment system in place that rewards high performance on quality, outcomes, or clinical systems (could include chronic disease process measures, health outcomes, patient satisfaction, and/or adoption of EMR and related technology). • Bidder has management information system that permits periodic assessment of provider performance and qualification for incentive payment. • Bidder has plan with specific implementation schedule for providing patient economic incentives for risk assessment and reduction, chronic disease outcomes, and/or medication adherence.
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Guidance for evaluating proposals:

- **High rating:** Bidder has shared incentive system in place tied to clinical outcomes, similar to Bridges to Excellence or Integrated Healthcare Association (Calif.) pay for performance systems. Both managers and clinicians receive reporting and compensation tied to performance. Parallel system is available to reward members' achievement of health goals. Bidder has management information system such as predictive modeling that permits rapid identification of high-risk patients, and case management system to support those patients. Information system can track utilization and outcomes. System has capital and implementation plans to support quality improvement and incentive systems.
- **Moderate rating:** Bidder has pay for performance system for providers based on HEDIS and other process measures. Bidder has predictive modeling or equivalent systems and case management capability.
- **Low rating:** Bidder only meets minimum criteria above.

<p>Assessing the credibility of the proposed approach:</p> <p>Bidders that have already implemented the following programs can be judged more likely to fulfill PEBB's vision for managing for quality:</p> <ul style="list-style-type: none"> • Pay for performance already in place. • Some member/patient incentives already in place. • Chronic care outcomes already measured and available via registries. • Clinical performance (not utilization) feedback reports are routinely provided to clinicians with medical director follow-up.

<p>If contract is awarded initially, acceptable phase-in schedule for contract renewal:</p> <ul style="list-style-type: none"> • 2006: Provider pay-for-performance tied to outcomes, satisfaction, process indicators. • 2007: Member and patient incentives implemented. • 2008: Fulfill <u>all</u> of the high rating criteria.
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