INTRODUCTION AND OVERVIEW

On behalf of Zoom+, which operates the ZoomCare complete healthcare delivery system and ZOOM+Super clinic in Oregon, I am pleased to submit this written testimony as part of the record for the rulemaking proceeding for proposed amendments to Oregon Administrative Rules Chapter 333, Divisions 500 and 501, "Hospitals, Generally" and "Hospital Monitoring, Surveys, Investigations, Discipline, And Civil Penalties." We appreciated the opportunity to participate in the rulemaking advisory panel. This written testimony expands on the comments made at the advisory panel meetings and supplements the oral testimony we presented at the public hearing conducted on September 16, 2016.

We share the Oregon Health Authority's public policy interests in providing reliable access to high-quality care. And throughout this rulemaking process we have taken this subject very seriously and asked for evidence that the proposed rules represented a smart approach to achieving those important public policy goals. Few healthcare topics have received so much national policy attention and research as the excess utilization of overpriced Emergency Room (ER) services. And the national consensus is clear: excess utilization of costly ER services is a significant, root cause of healthcare dysfunction and merits government leadership to provide public policy support to advance alternative solutions.

The OHA and proponents of the proposed rules have failed to provide evidence that would support the need for the proposed rules. Indeed, decades of evidence-based research support the effort to build a frontline care funnel whereby consumers are encouraged to engage the healthcare system at the most accessible, least intensive, lowest risk, lowest cost access points and then progress down the funnel, making visits to the ER only when such services are truly needed. In stark contrast, the apparent policy behind the proposed rules seems to encourage consumers to enter the health system, via the ER, at the highest risk, highest cost, least accessible access point for fear that the consumer might not receive an intensive service level. That the state would pursue such an approach ahead of careful research, evaluation, and demonstration is reckless and idiosyncratic public policy.

Our state government's leading public health institution should not rush into promulgating rules without meeting its burden of thoroughly reviewing the evidence -- or lack thereof -- in support of the rule, and evaluating the implications of the rule on the access to high quality, affordable care.

This submittal is organized into several parts: first, we provide a summary and some excerpts of the vast public health research and literature regarding ER overutilization and the negative community outcomes of such overuse; second, we provide some orientation to how the Zoom+Super model responds to and ameliorates these negative outcomes; and finally, we offer a simple drafting solution to correct the most needless and onerous of the Rules' restrictions.

Oregon's Rising Healthcare Costs Hurt Oregonians, Businesses and State Government

In 2016, the Oregon Insurance Commissioner Laura Cali approved insurance premium increases for individual Oregonians of over 20% for the third year in a row.[1] Oregon's rapidly rising health insurance premiums hurt individual Oregonians, businesses, the state of Oregon and its taxpayers.[2]

Oregon Insurance Commissioner Laura Cali explained that the underlying cause of the rising cost of health insurance is the rising utilization and cost of healthcare.[3]

Healthcare cost inflation will continue to consume public and private resources at an accelerating rate. Ultimately, painful choices will need to be made. Two articles in Health Affairs reiterate that the U.S. is channeling an increasing percent of its GDP to healthcare without commensurate return in the form of measurable health or productivity improvement.[4]

ER Excess Utilization and Excess Cost is a Root Cause of Unaffordable Healthcare

On September 9, 2009, President Obama went before Congress in a televised speech to press for the need to overhaul health care in the United States. In this extensive presentation, he cited Emergency Room excess utilization and excess expense as a fundamental problem. In multiple speeches, Obama suggested that excess emergency room visits added almost $1,000 a year to the average family's medical insurance costs.[5]

The President was confident in citing emergency room excess utilization and expense because *emergency room overuse and expense is one of most extensively researched topics in the U.S. public health literature over the past twenty-five years* -- the literature includes many hundreds of peer reviewed research articles examining emergency room waste.

In 2007, the New England Healthcare Institute (NEHI) published the seminal report, Waste and Inefficiency in the Health Care System – Clinical Care: A Comprehensive Analysis in Support of System-wide Improvements. The research found that 30 percent, or nearly $700 billion, of all health care spending is wasteful, meaning it could be eliminated without reducing the quality of patient care. NEHI's research also identified the six major sources of this waste: unexplained

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[1] Oregon health insurers want to hike rates to hike rates again -- by a lot. Elizabeth Hayes, Portland Business Journal, May 3, 2016.

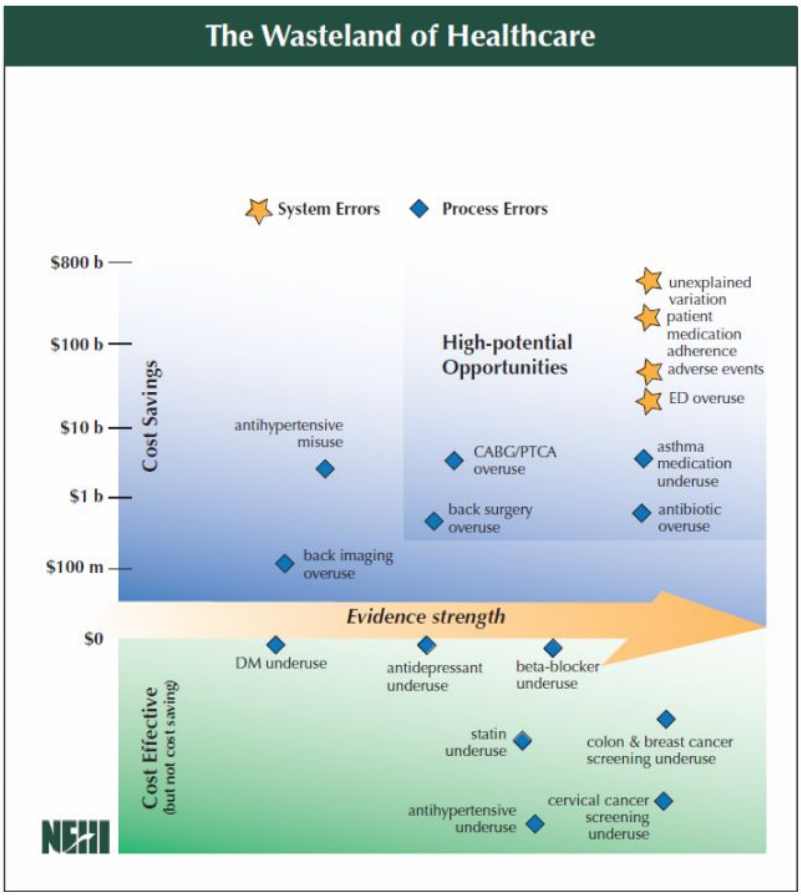
[2] As health insurance costs rise, workers in Oregon and U.S. spend more on premiums and deductibles. George Rede, The Oregonian, January 08, 2015.

[3] Oregon insurance regulators agree rates need to rise next year. Elizabeth Hayes, Portland Business Journal, June 16, 2016.

[4] "Health Spending Growth: Still Facing A Triangle Of Painful Choices. Charles Roehrig, Health Affairs, June 23, 2016 "Health Costs, But Not Obamacare, Dominate The Future Of Federal Spending. Eugene Steuerle, Health Affairs, June 27, 2016.

[5] "Emergency Room Usage is Way Up in Medicaid Expansion States. Peter Suderman, Reason, September 9, 2014.

variation in clinical care, patient medication adherence, misuse of drugs and treatments, ER overuse, underuse of appropriate medications, and overuse of antibiotics. A visual representation of the findings appears in the "Wasteland of Health Care'' graphic, below.
Figure 1



As shown, ER overuse represents the fourth largest category of waste and is responsible for up to $38 billion in wasteful spending in the U.S. every year. Given the tremendous opportunity to lower health care costs by addressing this problem, NEHI launched an initiative to examine ER overuse in detail. Through this initiative, NEHI has identified the key factors driving this costly ER overuse, including who overuses the ER, what causes ER overuse and what can be done to reduce it.

NEHI calculated the $38 billion in ER waste as follows:

Average Cost of ED Visit in 2007 [15]	$767
Average Cost of Office-Based Visit in 2007 [16]	$187

Cost Difference in 2007= **$580**

Total # of ER Visits in 2007 X Percentage of Avoidable ER Visits) = National ER Overuse Costs
$580 X (116.8 million visits X 56% avoidable ER Visits) = $38 billion

In fact, the Massachusetts Department of Health Care Finance and Policy found that the annual cost of ER overuse in 2005 was approximately $1 billion in Massachusetts alone, and that was ten years ago.

The research demonstrated that the drivers of ER overuse include:

- lack of access to timely primary care services
- referral to the ER by primary care physicians themselves
- the hospital business model and the role of the ER in driving its financial results

With regard to hospital financial incentives, the article elaborated:

"The emergency department is a major source of revenue for hospitals. A study examining the impact of ER admissions on hospital revenue found that 34 percent of total hospital gross revenue for inpatient services came from patients admitted through the Emergency Department. The ER also generates revenue for the hospital through ancillary testing. In 2006, imaging was ordered at 44.2 percent of ER visits and blood tests were ordered at 38.8 percent of ER visits. Thus, redirecting emergency department visits to other sources of care, regardless of the severity of the visit, does not align with a hospital's financial incentives."

This assessment was corroborated in a study published in Health Affairs by Michael Wilson and David Cutter, "Emergency Department Profits Are Likely To Continue As The Affordable Care Act Expands Coverage."

"We estimated that hospital revenue from ED care exceeded costs for that care by $6.1 billion in 2009, representing a profit margin of 7.8 percent (net revenue expressed as a percentage of total revenue). However, this is primarily because hospitals make enough profit on the privately insured ($17 billion) to cover underpayment from all other payer groups, such as Medicare, Medicaid, and unreimbursed care. Assuming current payer reimbursement rates, ACA reforms could result in an additional 4.4-percentage point increase in profit margins for hospital-based EDs compared to what could be the case without the reforms."

In summary, one man's misery is another man's fortune. ER overutilization and overpricing has been well documented for decades and is well understood to be a key waste stream in American healthcare, yet it continues because it is a profitable and vital element of the U.S. hospital business model.

Solutions to ER Overuse: Enter ZOOM+Super

We founded ZOOM+ over ten years ago to invent a new future for American healthcare. ZOOM+ offered a refreshing vision of the future: Twice Half Ten (twice the health, half the cost, ten times the delight). And we went beyond mere words to build out a first of its kind on-demand complete health system. Over the past decade ZOOM+ has deployed over twenty neighborhood locations in the greater Portland area, providing on-demand access for a wide range of illnesses and injuries seven days a week. In doing so, it has successfully diverted hundreds of thousands of Oregonians from wasteful ER visits to far safer, less time-consuming, and more affordable visits.

Most public health papers on solutions to ER overuse and excess cost address:

- Redesigning primary care to improve access and scheduling
- Providing alternative healthcare locations and services
- Improving the case management of chronic disease patients
- Financial incentives and disincentives for visits to the ER

The ZOOM+ health system addresses all of the above elements, including the development of alternative healthcare centers and services. The Zoom+ health system design reflects state of the art thinking from over one hundred articles from the public health literature, including analysis and proposed solutions to ER overutilization.

ZOOM+'s experience in its neighborhood clinics is consistent with the published research which suggests that a majority of ER visits can and should be treated outside the ER (Figure 2).[6] Over the past decade, people have consistently self-selected or self-triaged use of ZOOM+ with a high level of efficacy. Approximately 98.5% of customers who self-selected ZOOM+ were successfully treated at ZOOM+ and only 1.5% were referred to the ER. And of those 1.5%, there are no cases where patients suffered a negative clinic result due to beginning their care journey with ZOOM+. ZOOM+ identified that nearly the entire 1.5% of customers referred to an ER did not need an ER and that in fact, receiving care in an ER would decrease patient safety and would drive up wasteful expenses.

[6] "Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics.Robin M. Weinick , Rachel M. Burns, and Ateev Mehrotra, Health Affairs, September 2016.

Figure 2

Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics

Minimize

Exhibit 2

Diagnoses Treated At Retail Clinics, Urgent Care Centers, And Emergency Departments, And Percentage Not Requiring Emergency Care

Condition	Percent of retail clinic visits	Percent of urgent care center visits	Percent of emergency department visits	Percent of emergency department visits not requiring emergency department care[a]	
				Any time of day	When alternative site is typically open[b]
N	1.1 million	1,235	31,197	–	–
Upper respiratory infections	60.6%	33.3%	9.8%	–	–
Rhinosinusitis, laryngitis	26.1[c]	18.7[c]	5.0	81.1%	48.4%
Pharyngitis	22.2[c]	8.1[c]	2.3	93.9	56.7
Ear infections	12.3[c]	6.5[c]	2.5	95.7	53.0
Musculoskeletal conditions	0.1	21.5	19.4	–	–
Strain and fractures	0.0	14.5[c]	8.9	50.0[d]	34.0
Back pain	0.0	0.5	2.8	–	–
Joint and muscle problems[e]	0.0	3.0[c]	2.7	87.5	58.3
Contusions	0.0	3.6[c]	5.0	50.0[d]	33.4
Dermatological conditions	0.7	9.7	7.8	–	–
Cellulitis or abscess	0.6	5.1[c]	2.5	66.7	45.7
Burns	0.1	0.6	0.4	–	–
Lacerations	0.0	4.0[c]	4.8	50.0[d]	31.8
Symptoms without specific diagnoses	0.1	6.7	11.7	–	–
Abdominal pain	0.0	1.4	4.3	–	–
Headache	0.0	1.5	2.9	–	–
Unclassifiable symptoms	0.0	3.8	4.6	–	–
Urinary tract infections	3.7[c]	3.1[c]	2.4	75.6	43.7
Chronic illnesses and psychiatric conditions[f]	0.0	2.5	1.5	–	–
Lower respiratory conditions[g]	0.4	2.0	3.8	–	–
Other minor conditions	9.5	11.7	4.7	–	–
Allergies	2.3[c]	1.5[c]	0.4	91.5	43.0
Insect bites, rashes, contact dermatitis	2.1[c]	5.7[c]	2.4	74.8	47.6
Conjunctivitis	5.1[c]	2.3[c]	0.9	83.3	55.9
Constipation	0.0	0.5	0.5	–	–
Eye injuries	0.0	1.8	0.6	–	–
Preventive care	21.6	0.0	3.8	–	–
Other conditions	3.5	8.9	34.9	–	–

ZOOM+Super is the latest evolution of the ZOOM+ response to Oregon's healthcare crisis. ZOOM+Super features on-demand ER physicians with nearly all the tools of an ER, at one-tenth the price of a hospital-based ER. Innovative features of the ZOOM+Super clinic include:

- Open 20 hours per day
- Staffed by board certified emergency physicians, as well specially trained nurse practitioners and physician assistants and imaging technicians
- Onsite CT, x-ray, ultrasound
- On-demand online and app based scheduling
- 5,000 square feet with ample parking
- Easy to locate on transit hub in inner East Side of Portland

ZOOM+Super lowers of the cost structure for frontline care by 20%, generating system savings and making it more affordable than an ER visit because:

1. ZOOM+Super does not charge facility fees
2. ZOOM+Super offers a bundled low self-pay rate of $299 per visit

Decades of public policy research support the Zoom+Super design, in contrast to the unstudied assumptions behind the dhm perception survey on the issue of "consumer confusion." The survey was poorly constructed in four ways:

1. The survey did not correlate customer decisions with clinical outcomes. For example, the survey did not reflect that in the experience of ZOOM+ and in multiple published studies, consumers effectively select the right level of care. The assumption or the assertion that consumers cannot safety differentiate and self-triage is contrary to the available research.

2. The survey included Oregonians from across the state, even though the services and companies featured are based primarily in the Portland metropolitan area, so the respondents have little familiarity with these services and companies.

3. The survey did not recognize that ZOOM+ is a health system comprised of multiple lines of care similar to a Legacy Health or a Providence. For example, Providence and Legacy advertise cancer services. Consumers do not expect cancer services at their urgent care centers. ZOOM+ offers specialist services by board-certified specialists. Consumers do not expect board-certified specialists at all its locations. ZOOM+ offers pediatric services by board-certified pediatricians. Consumers do not expect pediatricians at all locations. ZOOM+ offers board certified emergency physicians who provide emergency services. Consumers do not expect emergency physicians at all locations.

4. The survey did not take into consideration that its entire premise is contrary to the decades of public health research. The best public health system architecture is not for consumers to start with the emergency room or to go prematurely to the emergency room. In fact, nearly all research and system architecture science points to the need for the consumer to enter the health system at the most accessible lowest cost point in the health system. The premise of the dhm survey is that consumers should be able to pinpoint navigate where to enter the health system, and that it is best to enter at the highest cost access point.

In sharp distinction to this politically-motivated poll, the peer reviewed research repeatedly and definitively has pointed in the opposite direction. For example, a recent study specifically addressed the issues posed by OHA, but uses research rather than conjecture. The paper "Many Emergency Department Visits Could Be Managed At Urgent Care Centers And Retail Clinics," by Robin M. Weinick et al, raises important questions about patient ability to self-direct and self-triage that need additional study before a rule is promulgated that channels and traps patients in the highest cost centers of the delivery system (i.e. hospital ER).

While this study (and the many others like it) are asking these hard questions, their overall strategic position is geared to supporting public policy that creates a funnel frontline care model that progresses consumers from low risk, low intensity offerings to the high risk, high cost ER -- rather than perpetuate the current and failed ER-first model.

This Weinick study concludes as follows:

"If 13.7–27.1 percent of all emergency department visits could take place at retail clinics or urgent care centers, why do patients go instead to emergency departments? The answer may be because of difficulty obtaining accessible, affordable, convenient care for these conditions elsewhere. Diverting these patients to alternative care sites could decrease the time spent waiting to be seen by a clinician, since many patients spend extended periods in emergency department waiting rooms. Diversion also could generate potential savings. Prior studies have estimated that costs of care at retail clinics and urgent care centers are $279–$460 and $228–$414 less than emergency department costs, respectively, for similar cases. Assuming the smallest of each of these savings and assuming that 16.8 percent—our midpoint estimate—of the 104 million emergency department visits that did not result in a hospital admission in 2006 could take place in one of these alternative settings, the potential savings to the health care system would be approximately $4.4 billion annually, or 0.2 percent of national health care spending."

So while the OHA proposed rules come from a "concern" about undertriage, we could not find any research that supports this thesis.

A carefully structured OHA policy analysis and rulemaking could lead to important leadership in developing an innovative frontline care delivery system that could improve consumer access and drive down costs for Oregonians. Sound frontline care public policy would be structured as a funnel whereby consumers began with the most accessible, lowest cost entry points and then progressed to more advanced, to higher risk and more expensive service.

Oregon policy and OHA rules should feature emergency medical services as a critical component of a modern Frontline Care Funnel. At a time when state leaders across the country supported by decades of evidence-based research are aiming to build a frontline care funnel whereby consumers are encouraged to engage the healthcare system at the most accessible, least intensive, lowest risk, lowest cost access points and then progress down the frontline care funnel, making visits only to the ER when such services are truly needed, the state of Oregon under the guidance of OHA seems to either have no strategy at all or is promoting a pyramid strategy that encourages consumers to enter the health system at the highest risk, highest cost, least accessible access point for fear that the consumer might not receive an intensive service level. That the state would pursue such an approach reinforces the dysfunctional status quo and undermines the efforts for innovation and healthcare transformation that would benefit Oregon consumers.

KEY OBSERVATIONS ABOUT THE PROPOSED RULES, AND SOME LANGUAGE TO FIX THE FLAWS

We believe the Rules as proposed are a solution in search of a problem.

The Statement of Need published for this Rulemaking asserts that there is a "patient safety and public health issue [that] may result in patients being turned away due to inability to pay, delays in needed care for life threatening medical conditions, poor health outcomes, and increased costs to patients, their families, and to the health care system."

But it has been Zoom+'s experience, in ten years of delivering care at more than twenty locations all over the region, that patients are in fact very good at picking the right facility to receive care.

Our records show that less than one percent of the hundreds of thousands of patients that we have served have required transfer from our neighborhood ZoomCare clinics.

And in the year since opening our Super+ location in Northeast Portland, of the 8,000 Portlanders that we have served, only 0.13% have required transfer to a hospital ER – the other 99.87% were able to receive the hands-on care, imaging, and lab tests that they needed, in most cases with no wait, and in every case in less than the average time they would have spent waiting in a hospital-based ER.

And as for those 10 (yes, 10 out of 8,000) patients who required transfer to an ER, how lucky they were to have landed at Super+ first, where they received immediate stabilization, and doctor-coordinated transfer to the front of the line at the appropriate next facility.

As to the concern of delivering increased costs to patients and the health care system, we note that each Super+ patient encounter costs an average of $299, as compared with the average cost of a hospital ER visit at $2,168. So for each month in which we provide Super+ care to 1,000 Portlanders, we actually deliver $1,869,000 of savings to the system – an annualized savings of $22,428,000. And unlike the traditional ER, Super+ provides clear transparent pricing, and does not impose facility fees or other special fees and high-cost supplies and services often associated with ER visits.

The Rules as proposed are vague, offer little guidance on compliance, and will be difficult to implement and enforce fairly.

The Classification Rule as proposed states that "No person shall hold itself out…in a posted name or advertising that would give the impression that emergency medical services…is provided." Were the Rule to be implemented, we might expect lengthy

administrative discourse on what "posted" means, what an "impression" is, upon whom might this "impression" be made, and how would we know that such an impression had formed?

And the Investigation Rule as proposed states that "In determining whether a violation has occurred…the Division will consider the facility name, advertising used and related content." In addition to being a purely subjective determination, susceptible to individual interpretation, this Rule's reliance on "related content" is so broad as to render the investigation process completely whimsical and unpredictable, creating an undue burden on any agency or facility that finds itself subject to such scrutiny.

Finally, and most important, the Rules as proposed impermissibly limit providers' use of the word "emergency" to describe their own qualifications.

There is no public policy research or specific evidence of concerns that a board-certified emergency physician who describes the services he or she provides may result in delays in needed care for life threatening medical conditions, poor health outcomes and increased costs to patients, their families and to the health care system. Placing this unqualified restriction on medical providers' ability to describe their qualifications pointlessly limits the ability of highly trained professionals to practice their craft, and might in fact have the outcome of creating more confusion among patients, who would like to know in advance that qualified staff will be available at the facility that they select.

To avoid this unintended outcome, we propose that the following curative language be added to the end of the rule at 333-500-0032(6) ("Classification"):
"*No person shall be denied the ability to use the words "certified in emergency medicine" in describing their own qualifications or the qualifications of providers at a particular facility."*

And we further propose that the following curative language be added to the end of the rule at 333-501-0020(8) ("Violations"):
"No person shall be in violation of this section for using the words "certified in emergency medicine" in describing their own qualifications or the qualifications of providers at a particular facility."

Thank you for your consideration.

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