Quality & Health Outcomes Committee

Monday, November 13, 2017

Please do not put your phone on hold – it is better if you drop off the call and rejoin if needed.
Welcome and Introductions
HSD Update
HERC Update
BREAK
PDMP and Medicaid Claims Analysis for Opioid Prescriptions
Payer Policies to Reduce Prescription Opioid-related Harms

Dan Hartung, PharmD, MPH
Associate Professor
OSU/OHSU College of Pharmacy
Disclosures

US Centers for Disease Control and Prevention
• U01 CE00278 (Prescription opioid performance improvement metrics and heroin abuse)
• U011CE00250 (Opioid analgesic policies and prescription drug abuse in state Medicaid programs)

Agency For Healthcare Research and Quality
• R18 HS024227 (Pharmacy Prescription Drug Monitoring Program Toolkit to Improve Opioid Safety)

Consulting
• MedSavvy Inc. scientific advisory board
Outline

• Summarize payer strategies to reduce opioid-related harms
• Highlight key findings from work using Oregon PDMP data for Medicaid policy analysis
  • Epidemiology of OOP cash payment
  • OOP payment to circumvent opioid-related policies
Policy efforts aimed at reducing prescribing risks

✓ Guidelines
  • CDC Guidelines for Prescribing Opioids for Chronic Pain (2016)

✓ State prescription drug monitoring programs (PDMPs): operational in 49 states

✓ State policies that limit day supply/quantities
  • Ohio, Pennsylvania, New York, Maine, Connecticut

✓ Payer policies: utilization management mechanisms
CVS tightens restrictions on opioid prescriptions in bid to stanch epidemic

By Andrew Joseph (@ajosephstat) / September 21, 2017

The health insurer Cigna on Wednesday announced it will no longer cover OxyContin prescriptions for customers on its employer-based health plans, the second major announcement in two weeks from an industry group billed as an effort to slow the opioid epidemic.
Current State Medicaid Efforts
(KFF Survey)

✓ Adoption of CDC guidelines
  • 9 states “have adopted”
  • 23 states “plan to adopt”
✓ Most states (FFS) have adopted specific benefit strategies aimed at opioid harm reduction
  • Preferred drug lists (formularies)
  • Quantity limits: 46
  • Prior authorizations: 45
  • Step therapy: 32
  • Lock in programs: 46
✓ Reducing barriers to naloxone availability
✓ Few studies of payer mechanism to reduce risks associated with Rx opioid use

## Payer Policies

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>Evidence</th>
<th>Utilization</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| **PAs High Dose**    | 2 studies  
Garcia MM (Mass Medicaid)  
Hartung DM (OR FFS Medicaid) | -20% in MME dose  
-53% in high dose use                  | NR  
No change          |
| **PAs LAO**          | 3 studies  
Morden NE (21 state Medicaid)  
Garcia MC (MA BCBS)  
Keast/Hartung (OK Medicaid) | -34% Oxycontin  
-8% members with LA/ER opioid  
-53% in use of LA/ER opioids  | NR  
NR  
No change          |
| **Quantity Limits**  | 2 studies  
Garcia MC (MA BCBS) – 30 DS  
Riggs CS (CO Medicaid) – 120 tabs in 30 days | -12.9% members with SA opioid  
-24% in MME per day  | NR  
NR          |
| **Misc.**            | 2 studies  
Faul M (SC, NC, FL Medicaid)  
Cochran G (PA Medicaid) | NR  | ~50% fewer methadone OD |
|                      | -# opioid PAs                   | NR                                          | ~12%-25% fewer ED/hospitalizations |
In Sum.....

• PA driven policies consistently affect opioid utilization across studies

• Effect on opioid-related harms is mixed and uncertain

• Study quality generally poor
  • Single group pre-post studies
  • Cross-sectional

• Many unresolved questions about unintended consequences
Measuring Policy Effectiveness

Written

High-risk Rx
Appropriate Rx

Pharmacy Benefit Policy

Filled

High-risk Rx
Appropriate Rx

Misuse

Opioid-related overdose and poisoning

Administrative Claims Data

Comprehensive Fill Data

Out of pocket cash Or other 3rd Party Transaction

High-risk Rx
Appropriate Rx
Opioid and benzodiazepine prescription fills per person per month for the study cohort of enrollees in the North Carolina Medicaid lock-in program, October 2009–September 2012.

Andrew W. Roberts et al. Health Aff 2016;35:1884-1892
Using Prescription Drug Monitoring Data to Characterize Out-of-Pocket (OOP) Payments

Objectives

1) Describe epidemiology of OOP opioid use in Oregon Medicaid population

2) Assess the effect of OOP on Oregon high dosage opioid PA (April – June 2012)

Linking Oregon PDMP to Medicaid data enables assessment of normally unobserved utilization

Oregon Prescription Drug Monitoring Program (PDMP)

- Web-based database containing information on controlled substances II-IV
  - Operational 2011
  - Housed in Public Health Division
- Nearly all eligible pharmacies reporting by 2012
  - Waiver for institutional pharmacies (inpatient, LTC, community-based facilities etc)
- Probabilistic Match to Medicaid (the Link King)
  - Name
  - DOB
  - Gender
  - Zip
Study Sample Inclusion/Exclusion

• Inclusion
  • Continuous non-interrupted Medicaid enrollment from 2012-2013
  • One opioid fill matching a pharmacy claim in both years

• Exclusion
  • Dual Medicare enrollment
  • Residence in long-term or community based (group home) care facility
  • Evidence of third party liability on file with Medicaid
Matching PDMP to Medicaid Data

![Diagram showing the process of matching PDMP to Medicaid data]

**Table 1**
Demographic and diagnostic summary of study cohort; N = 33,592

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Count (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>23,275 (69.3)</td>
</tr>
<tr>
<td>White</td>
<td>27,585 (82.1)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>&lt;20</td>
<td>2216 (6.6)</td>
</tr>
<tr>
<td>20-29</td>
<td>6379 (19.0)</td>
</tr>
<tr>
<td>30-49</td>
<td>14,739 (43.9)</td>
</tr>
<tr>
<td>50-64</td>
<td>10,117 (30.1)</td>
</tr>
<tr>
<td>&gt;64</td>
<td>141 (0.4)</td>
</tr>
<tr>
<td>Opioid fills per patient (mean, sd) during study period</td>
<td>16.9 (17.0)</td>
</tr>
<tr>
<td>Disability</td>
<td>10,052 (29.9)</td>
</tr>
<tr>
<td>Diagnoses</td>
<td></td>
</tr>
<tr>
<td>Spinal disorders</td>
<td>22,193 (66.1)</td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td>25,091 (74.7)</td>
</tr>
<tr>
<td>Headache</td>
<td>12,326 (36.7)</td>
</tr>
<tr>
<td>Cancer</td>
<td>1857 (5.5)</td>
</tr>
<tr>
<td>Substance use disorder</td>
<td>9983 (29.7)</td>
</tr>
<tr>
<td>Alcohol use disorder</td>
<td>4106 (12.2)</td>
</tr>
<tr>
<td>Opioid use disorder</td>
<td>3487 (10.4)</td>
</tr>
<tr>
<td>Other drug use disorder</td>
<td>6449 (19.2)</td>
</tr>
</tbody>
</table>
Prescription Matching Process*

1. Patient, NDC, Quantity, Date
2. For those remaining unmatched after step 1,
   - Patient, NDC, Quantity, Date (+/- 7 days)
3. For those remaining unmatched after step 2
   - If 2 unmatched fills occurred within 3 days for same patient, NDC, we collapsed (summed quantity) and matched
4. For those remaining unmatched after step 3
   - Patient, NDC, +/- 7 days, regardless of quantity

<table>
<thead>
<tr>
<th>N=555,103</th>
<th>Addl Matches</th>
<th>Claims Matched</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>474,603</td>
<td>474,603</td>
<td>85.5%</td>
</tr>
<tr>
<td>Step 2</td>
<td>4317</td>
<td>478,920</td>
<td>86.3%</td>
</tr>
<tr>
<td>Step 3</td>
<td>366</td>
<td>479,286</td>
<td>86.3%</td>
</tr>
<tr>
<td>Step 4</td>
<td>864</td>
<td>480,150</td>
<td>86.5%</td>
</tr>
</tbody>
</table>

13.5% of OPR fills could not be matched to pharmacy claim

*Exclude buprenorphine fills
### Table 2: Fills without corresponding Medicaid pharmacy claims by drug name

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Fills Without Medicaid Claim</th>
<th>Total Fills</th>
<th>Percent of Fills Without Medicaid Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydrocodone/acetaminophen</td>
<td>33,400</td>
<td>261,465</td>
<td>12.8%</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>13,974</td>
<td>112,794</td>
<td>12.4%</td>
</tr>
<tr>
<td>Oxycodone/acetaminophen</td>
<td>9,936</td>
<td>82,572</td>
<td>12.0%</td>
</tr>
<tr>
<td>Methadone</td>
<td>5,879</td>
<td>34,013</td>
<td>17.3%</td>
</tr>
<tr>
<td>Morphine sulfate</td>
<td>4,700</td>
<td>32,345</td>
<td>14.5%</td>
</tr>
<tr>
<td>Codeine/acetaminophen</td>
<td>1,110</td>
<td>10,018</td>
<td>11.1%</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>2,579</td>
<td>8,558</td>
<td>30.1%</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>957</td>
<td>5,207</td>
<td>18.4%</td>
</tr>
<tr>
<td>Other</td>
<td>2,418</td>
<td>8,131</td>
<td>29.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>74,953</strong></td>
<td><strong>555,103</strong></td>
<td><strong>13.5%</strong></td>
</tr>
</tbody>
</table>
Prescription-level Factors Associated with OPP

**Table 4** Proportion of fills without corresponding claims by fill and patient characteristics. Odds ratios are adjusted for clustering by individual, age, race, and number of fills.

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Fills Without a Medicaid Claim 74,953 (A)</th>
<th>Total Fills 555,103 (B)</th>
<th>Percent of Fills Without Medicaid Claim (A/B)</th>
<th>Adjusted Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fill Characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Opioid-opioid overlap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32,043</td>
<td>204,507</td>
<td>15.7%</td>
<td>1.37</td>
</tr>
<tr>
<td>No</td>
<td>42,910</td>
<td>350,596</td>
<td>12.2%</td>
<td>(1.34-1.4)</td>
</tr>
<tr>
<td>Opioid-benzodiazepine overlap</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>11,634</td>
<td>74,478</td>
<td>15.6%</td>
<td>1.05</td>
</tr>
<tr>
<td>No</td>
<td>63,319</td>
<td>480,625</td>
<td>13.2%</td>
<td>(1.02-1.09)</td>
</tr>
<tr>
<td>Multiple pharmacies*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7,627</td>
<td>38,864</td>
<td>19.6%</td>
<td>1.45</td>
</tr>
<tr>
<td>No</td>
<td>67,326</td>
<td>516,239</td>
<td>13.0%</td>
<td>(1.39-1.52)</td>
</tr>
<tr>
<td>Multiple prescribers*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>15,329</td>
<td>97,699</td>
<td>15.7%</td>
<td>1.20</td>
</tr>
<tr>
<td>No</td>
<td>59,624</td>
<td>457,404</td>
<td>13.0%</td>
<td>(1.2-1.37)</td>
</tr>
<tr>
<td>Day of week</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saturday or Sunday</td>
<td>7,623</td>
<td>51,768</td>
<td>14.7%</td>
<td>1.18</td>
</tr>
<tr>
<td>Monday to Friday</td>
<td>67,330</td>
<td>503,335</td>
<td>13.4%</td>
<td>(1.14-1.22)</td>
</tr>
<tr>
<td>Opioid type</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-acting opioid</td>
<td>11,846</td>
<td>72,934</td>
<td>16.2%</td>
<td>1.52</td>
</tr>
<tr>
<td>Short-acting opioid</td>
<td>63,107</td>
<td>482,169</td>
<td>13.1%</td>
<td>(1.47-1.57)</td>
</tr>
</tbody>
</table>
Patient-level Factors Associated with OPP

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Fills Without a Medicaid Claim 74,953 (A)</th>
<th>Total Fills 555,103 (B)</th>
<th>Percent of Fills Without Medicaid Claim (A/B)</th>
<th>Adjusted Odds Ratio (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Characteristics</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>60,851</td>
<td>434,236</td>
<td>14.0%</td>
<td>1.31 (1.24-1.39)</td>
</tr>
<tr>
<td>No</td>
<td>14,102</td>
<td>120,867</td>
<td>11.7%</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>62,969</td>
<td>462,886</td>
<td>13.6%</td>
<td>1.11 (1.04-1.18)</td>
</tr>
<tr>
<td>No</td>
<td>11,984</td>
<td>92,217</td>
<td>13.0%</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>32,000</td>
<td>226,307</td>
<td>14.1%</td>
<td>1.12 (1.06-1.18)</td>
</tr>
<tr>
<td>No</td>
<td>42,953</td>
<td>328,796</td>
<td>13.1%</td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5,705</td>
<td>41,327</td>
<td>23.8%</td>
<td>0.99 (0.9-1.1)</td>
</tr>
<tr>
<td>No</td>
<td>69,248</td>
<td>513,776</td>
<td>13.5%</td>
<td></td>
</tr>
<tr>
<td>Alcohol use disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9,548</td>
<td>66,791</td>
<td>14.3%</td>
<td>1.15 (1.06-1.23)</td>
</tr>
<tr>
<td>No</td>
<td>65,405</td>
<td>488,312</td>
<td>13.4%</td>
<td></td>
</tr>
<tr>
<td>Opioid use disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>13,137</td>
<td>84,866</td>
<td>15.5%</td>
<td>1.15 (1.06-1.24)</td>
</tr>
<tr>
<td>No</td>
<td>61,816</td>
<td>470,237</td>
<td>13.1%</td>
<td></td>
</tr>
<tr>
<td>Other drug use disorder</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>16,977</td>
<td>120,810</td>
<td>14.1%</td>
<td>1.07 (1.01-1.14)</td>
</tr>
<tr>
<td>No</td>
<td>57,976</td>
<td>434,293</td>
<td>13.3%</td>
<td></td>
</tr>
</tbody>
</table>
Oregon Medicaid High-dose Opioid Policy: Key Study Findings

53% relative reduction in high-dose opioid prescriptions (>120 MED)

Change in % of high dose fills paid OOP

- Long-acting
- Short-acting
Effect of Data Source on Policy Effect

- Claims: 16 MED -29%
- PDMP Fills: 9 MED -16%
Summary

✓ Small growing literature suggests pharmacy payer policies are effective at reducing intended utilization targets
  • High-dose prescriptions
  • Formulation specific use

✓ Comprehensive PDMP data can complement administrative claims data
  • Utilization surveillance
  • Policy evaluation

✓ HOWEVER!......Effects on intended (overdose/poisonings) OR unintended outcomes (under managed pain, heroin use, suicide) is unclear
“Back on Track” Study of OHP Back Pain Changes
Back on Track

A Naturalistic Experiment Evaluating the Impact of Medicaid Treatment Reimbursement Changes on Opioid Prescribing and Patient Outcomes Among Patients with Back Pain

Oregon Health Authority
Quality and Health Outcomes Committee Meeting
November 13, 2017

Lynn DeBar, PhD, MPH, Meghan Mayhew, MPH, and Perry Foley, MPH, MSW
Grappling as a nation with how to reduce opioid prescribing

Oregon’s effort is unique: offers evidence-based alternatives
Back on Track

- Evaluate impact of OHA’s new back pain treatment and opioid prescribing guidelines (Guideline Note 56 and 60) on...
  - Opioid prescribing
  - Utilization of pain-related health care services
  - Patients’ pain, functioning, satisfaction with services, treatment-related adverse events, illicit/recreational substance use

- Understand facilitators and barriers in adopting guidelines
Back on Track Study Team

Study Advisory Committee (SAC)
Patients with back pain, caregivers of people with back pain, primary care clinicians in Oregon and other states who primarily serve Medicaid patients, our research team, and state-level health care decision makers from Oregon and other states

Research Team
- OCHIN
- KPWHRI
- KP CHR
- Harvard

Clinician Advisory Panel
State and National Policy Panel

Established Panels and Workgroups
- OCHIN Patient Engagement Panel
- OCHIN Practice-Based Research Network
- Medicaid Evidence-based Decisions Project
OCHIN: Focusing on Innovation and Transformation

**The OCHIN Mission:** OCHIN is a nonprofit health care innovation center designed to provide knowledge solutions that promote quality, affordable health care to all.

- **Technology**
  - Best-of-breed technologies targeted to the needs of the safety net and health care transformation
  - Data Analytics
  - Electronic Health Records
  - Networking & Broadband
  - Telehealth

- **Research**
  - Research focused on improving the health of underserved populations, enhancing quality of care and informing health policy
  - Chronic Pain & Opioids
  - Diseases Affecting the Safety Net
  - Health Equity & Health Policy
  - Social Determinants of Health

- **Services**
  - Professional services that range from clinic operational support to strategic planning
  - Billing
  - Compliance & Security
  - Consulting
  - Staff Augmentation
Where Are OCHIN Members?

OCHIN serves over 20 million patients with over 10,000 clinicians

OCHIN Products & Services

- **OCHIN Acuere** (126 Organizations)
- **OCHIN Billing** (22 Organizations)
- **OCHIN Broadband** (78 Organizations)
- **OCHIN Epic** (106 Organizations)
- **OCHIN NextGen** (36 Organizations)
- **OCHIN Research** (22 Active Partnerships)
- **OMMUTAP**
  - Oregon Medicaid Meaningful Use Technical Assistance Program (141 Clinics, 1,360 Providers)
- **California Telehealth Network** (80 Organizations)

This map is a representation of the overall products and services provided to OCHIN members and their clinics. This information indicates the states in which member organizations are based, though they may also operate in additional states.

Kaiser Permanente Washington Health Research Institute
Where is OCHIN in Oregon?

- OCHIN Member/Partner Headquarters (188)
- OCHIN Member/Partner Sites (>700)

*Many members/partners operate in multiple locations and in multiple states*
Goal: Evaluate impact of Oregon Medicaid reimbursement guidelines for back pain

Substudy A: Compare opioid prescribing and use of other pain-related health services (Electronic Health Record)

Substudy B: Compare patient-centered outcomes (Patient Surveys; n=2,500)

Substudy C: Understand contextual factors underlying successes and challenges (Qualitative Data Collection)
Key Role of CCOs

- Help study team understand how your CCO has responded to and adopted guidelines
  - Web-based survey in follow-up to this meeting

- Contribute knowledge to substudy C
  - Interviews

- Help spread the word
  - Study has contact at all health system levels
Feedback Requested

- What other information do you want to know about the study?

- How can we keep you informed about the study?

- Are there other questions that the study should try to address?
Thank you!
LUNCH
Welcome/Announcements
TQS Update
Purpose of the Transformation and Quality Strategy

To support safe and high-quality care for all CCO members by ensuring the quality and transformation plan adequately covers federal requirements, pushes health transformation forward, and continues the path toward the triple aim (better care, better health, lower cost).
Deliverables schedule

CCO contract language:

• Due March 16, 2018
  – Transformation and Quality Strategy (TQS)
    • TQS effective January 2018

• Ongoing
  – TQS due annually on March 16 (effective January–December)
  – TQS progress report due on September 30 (progress for January–June)
Webinar series – registration information

OHA Transformation Center Technical Assistance for CCQs
Transformation and Quality Strategy

Coordinated care organization (CCO) staff are invited to participate in technical assistance for developing the Transformation and Quality Strategy (TQS). This series is hosted by the OHA Transformation Center.

- **Background:** The TQS will replace the CCO Transformation Plan and Quality Assessment and Performance Improvement Plan. This streamlined approach aims to reduce duplication, align CCO priorities, and enhance innovation supported by targeted activities. CCQs will submit an annual TQS using a shared template (beginning March 26, 2018) and a tri-monthly progress report.
- **Audience:** CCO transformation staff, quality staff and subject area leads depending on webinar topic.
- **Contact:** If you have questions, please contact Anna Gold (Anna.Gold@oha.state.or.us or 971-675-3832).

### Webinars

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Title</th>
<th>Register at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2</td>
<td>11 a.m.-12:30 p.m.</td>
<td>Introduction to the CCO Transformation and Quality Strategy</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
</tr>
</tbody>
</table>

Office hours will be open times; not recorded. No need to pre-register. Participants can just call into the conference line.


- Webinars will be recorded for shared use and reference later.

- Conference line for all: (866) 399-1010. Participant code: 69398232

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Title</th>
<th>Register at:</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 8</td>
<td>10:30 a.m.</td>
<td>Transformation and Quality Strategy: Template Walk-through</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<th>Date</th>
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<tr>
<td>November 15</td>
<td>10:30 a.m.</td>
<td>Transformation and Quality Strategy: Access</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>November 20</td>
<td>1:30 p.m.</td>
<td>Transformation and Quality Strategy: Health Equity</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>December 5</td>
<td>12:30 p.m.</td>
<td>Transformation and Quality Strategy: Health Information Technology</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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Office Hours:

CCQ staff are invited to join by webinar or conference line to ask questions about developing and submitting their CCO’s Transformation Plan and Quality Strategy. CCO staff may join the office hours at any point during the scheduled time. The office hours will not be recorded, but an FAQ document will be updated after each call.

- Conference line for all: (866) 399-1010. Participant code: 69398232

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<th>Date</th>
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<tr>
<td>November 28</td>
<td>10 a.m.</td>
<td>Conference Line for all: (866) 399-1010</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>December 19</td>
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<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>January 23</td>
<td>10:30 a.m.</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>February 27</td>
<td>10:30 a.m.</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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<td>March 15</td>
<td>10:30 a.m.</td>
<td><a href="https://attendee.gotowebinar.com/register/7652953453064634365">Attendee response</a></td>
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Next steps

- CCOs will continue/adapt previous health transformation and quality work or take on new work at the direction of their board/CAC/community.
- CCOs will report the “plan” for their 2018 work in the TQS.
- OHA will update CCOs on social determinants of health component inclusion as soon as it’s confirmed with CMS.
- OHA will review submitted TQS documents to provide technical assistance.
- OHA will engage with CCO staff (each CCO, please send designee name(s) to Anona Gund, Anona.E.Gund@dhsoha.state.or.us) for developing the feedback tool that will be used in March 2019.
  - Tentative work group time commitment:
    - Hour-long monthly meetings April 2018 – August 2018
Statewide PIP: Opioid
TOPIC Generation for 2018 QPI Sessions
Items from the Floor