

Quality and Health Outcomes Committee

October 10, 2016

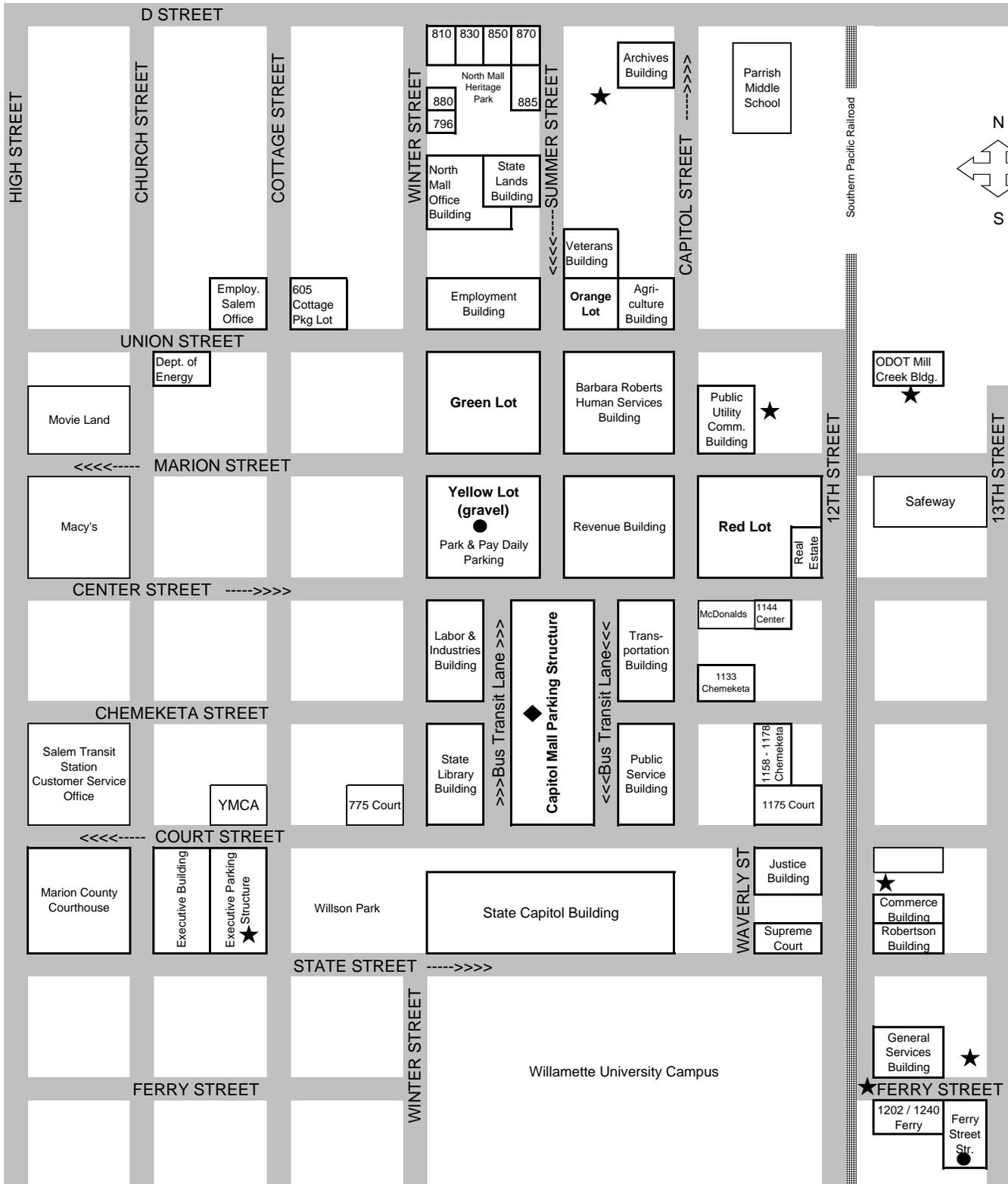
HSB Building Room 137A-D, Salem, OR

Toll free dial-in: **888-278-0296** Participant Code: **310477**

Parking: [Map](#) ° Phone: 503-378-5090 x0

Clinical Director Workgroup			
Time	Topic	Owner	Related Documents (page#)
9:00 – 9:10	Welcome, Introductions, Updates	Mark Bradshaw	-Speaker Contact Sheet (2 – 3) -September Meeting Notes (4 – 9) -Metrics Update (10 – 11) -Public Health Update (12)
9:10 – 9:20	Pharmacy & Therapeutics Update	Roger Citron	P&T Agenda and Materials
9:20 – 9:40	Behavioral Health Integration Resource Library	Natalya Seibel Summer Boslaugh	-Presentation Slides (13 – 20)
9:40 – 10:00	Patient Support Tools	Center for Evidence-based Policy	-Presentation Slides (21 – 27)
10:00 – 10:20	2017 Patient Centered Primary Care Home Standards	Chris Carrera	-Presentation Slides (28 – 35) -Model and Standards Revisions Overview (36 – 37)
10:20 – 10:40	Health Evidence Review Commission	Cat Livingston	-Meeting Minutes (38 – 48) -Coverage Guidance (CG): Tobacco Cessation During Pregnancy (49) -Prioritized List: Tobacco Cessation During Pregnancy (50 – 52) -Guideline Note 60: Opioids for Back and Spine Conditions (53 – 54) -CG: Metabolic and Bariatric Surgery (55) -CG: Noninvasive Testing for Liver Fibrosis in Patients with Chronic Hepatitis C (56 – 57)
10:40 – 10:45	QHOC Charter	Lisa Bui Mark Bradshaw	-QHOC Charter (58 – 59)
10:45 – 10:50	Items from the floor	All	
10:50 – 11:00	BREAK		
Learning Collaborative Session			
11:00 – 12:30	OHA Opioid Initiatives		-Agenda (60) -Presentation Slides (61 – 74) -House Bill 4124 Fact Sheet (75 – 76) -Statewide PIP on Opioid Safety (77)
12:30 – 1:00	LUNCH		
Quality and Performance Improvement Workgroup			
1:00 – 1:15	QPI Update – Introductions	Jennifer Johnstun Lisa Bui	
1:15 – 2:00	Complaints and Grievances <ul style="list-style-type: none"> • Trends reporting • Q&A 	OHA	-Presentation Slides (78 – 81)
2:00 – 2:30	Statewide PIP Intervention Follow-up Discussion	All	
2:30 – 2:45	2017 QPI Session Planning	All	
2:45 – 3:00	Items from the floor	All	
3:00	Adjourn		

SALEM CAPITOL MALL AREA



- ★ State of Oregon Meters - OK to use Agency issued one-day permit
- ◆ Capitol Mall Structure Meters - OK to use Agency Issued one-day permit
- Yellow Lot & Ferry Structure Rooftop Visitor Spaces - OK to use Agency issued one-day permit

Speaker Contact Sheet QHOC – October 2016

Agenda Item	Contact Information
Pharmacy & Therapeutics Update	<p>Roger Citron, RPh OSU-College of Pharmacy Drug Use Research & Management OHA Division of Medical Assistance Programs Roger.a.citron@state.or.us 503-947-5220</p>
Behavioral Health Integration Resource Library	<p>Natalya Seibel, MPH Program Coordinator, Oregon Health Care Quality Corporation natalya.seibel@q-corp.org</p> <p>Summer Boslaugh Transformation Analyst/Transformation Center Summer.h.boslaugh@state.or.us</p>
Patient Support Tools	<p>Moira Ray, MD, MPH Clinical Epidemiologist, Center for Evidence-based Policy raymo@ohsu.edu</p> <p>Valerie King, MD, MPH Director of Research, Center for Evidence-based Policy kingv@ohsu.edu</p>
2017 Patient Centered Primary Care Home Standards	<p>Chris Carrera Improvement & Implementation Manager/Transformation Center Christopher.c.carrera@state.or.us</p>
Health Evidence Review Commission Update	<p>Cat Livingston, MD, MPH Medical Director Health Evidence Review Commission Catherine.livingston@state.or.us</p>
Learning Collaboratives Session: OHA Opioid Initiatives	<p>Jim Rickards, MD, MBA Chief Medical Officer James.s.rickards@state.or.us</p> <p>Katrina Hedberg, MD, MPH State Epidemiologist and State Health Officer Public Health Division Katrina.hedberg@state.or.us</p> <p>John McIlveen, PhD, LMHC State Opioid Treatment Authority John.w.mcilveen@state.or.us</p>

Speaker Contact Sheet
QHOC – October 2016

	<p>Ariel Smits, MD, MPH Associate Medical Director Ariel.smits@state.or.us</p>
QHOC Chairs	<p>Mark Bradshaw, MD Mark.bradshaw@allcarehealth.com</p> <p>Jennifer Johnstun, RN QHOC Chair jen@ohms1.com</p> <p>Lisa Bui Lisa.t.bui@state.or.us 971-673-3397</p> <p>Kim Wentz, MD, MPH Kim.r.wentz@state.or.us</p>

Chair- Mark Bradshaw (All Care)

Co-Chairs- Jennifer Johnstun (Primary Health)

Attendees: (*in person*) Cynthia Ackerman (AllCare); Susan Arbor (OHA/HSD); Joell Archibald (OHA); Chris Barber; Amanda Blodgett (CHA); Mark Bradshaw (All Care); Lisa Bui (OHA); Jim Calvert (CHA); Emileigh Canales (FamilyCare); Barbara Carey (Health Share); Jody Carson (HealthInsight); Christine Castle (CareOregon); Roger Citron (OHA/OSU); Cheryl Cohen (Health Share); Laurence Colman (GOBHI); Bruce Croffy (UHA); Kevin Ewanchyna (IHN/CCO); Mike Franz (PacificSource); Bennett Garner (FamilyCare); Jim Gaudino (OHSU/Gaudino Consult.); Rebecca Geist (WCHHS); Estela Gomez (OHA); Walter Hardin (Tuality); Rosanne Harksen (OHA/HSD); Jenna Harms (Yamhill CCO); Theresa Heidt (Yamhill CCO); Hank Hickman (OHA/HSD); Holly Jo Hodges (WVP/WVCH); Bethany Hollister (CareOregon); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Charmaine Kinney (Mult. Co./Health Share); Donna Larkins (OHA); Alison Little (PacificSource); Andrew Luther (OHMS); Laura Matola (AllCare); Ruth McBride (Primary Health); Nicole Merithew (CareOregon); Tracy Muday (WOAH); Lisa O'Dell (OHA); Ellen Pinney (OHA); Bhavesh Rajani (Yamhill CCO); Nancy Siegel (HealthInsight); Ariel Smits (OHA/HERC); Dayna Steringer (DK Strategies); Anna Stern (WVCH); Melanie Tong (Washington Co.); Kim Wentz (OHA/HSD); and Mark Whitaker (Providence)

By phone: Ellen Altman (IHN/CCO); Graham Bouldin (Health Share); Kristie DePreist (UHA); Lyle Jackson (AllCare); Anna Jiminez (FamilyCare); Safina Koreishi (Columbia Pacific); Rose Rice (UHA); Bells Shepherd (OHA);Debbie Standridge (UHA); Anna Warner (WOAH); Amarissa Wooden (WOAH/NBMC); Cheryl Yook (Trillium)

CLINICAL DIRECTORS SESSION	
Introductions/ Announcements	<p>Announcements:</p> <ul style="list-style-type: none"> ▪ July meeting notes are in the packet; ▪ The QHOC Charter is also included in the packet. A review of the charter will be at the October QHOC meeting; ▪ It is time to consider selection of a new Chairperson for the QHOC meeting for 2017. Also, a representative of behavioral health and a representative of oral health are both needed in the QHOC leadership planning group.
General Updates	<p>HSD Update:</p> <ul style="list-style-type: none"> ▪ Meeting coordination follow up: (Chris Norman) <ul style="list-style-type: none"> ○ A follow-up of last month’s meeting- Chris identified two codes with ABA- 0360T & 0361T are being researched for implementation in the Fall ▪ Discussion on Advanced Directives: (Rhonda Busek) <ul style="list-style-type: none"> ○ more specific to dental; ○ PAAHP doesn’t apply. May if you are PHIP; ○ Open to any providers and how CCO wants to implement ▪ Advanced Benefit Planning: (Rhonda Busek) <ul style="list-style-type: none"> ○ Do CCO’s have step therapies in contraception? CCO Medical directors responded no. ▪ Out of Hospital Birth Workgroup (Kim Wentz) <ul style="list-style-type: none"> ○ Reminder that the Out-of-Hospital Births workgroup meeting is convening September 14, 2016. <p>Metrics Update: (Sarah Bartlemann)</p>

	<ul style="list-style-type: none"> ▪ Metrics update: Metrics & Scoring Committee have considered a health equity measure. There is a current proposal and feedback is invited from the CCO's. Feedback is for information only and is not binding. To be considered – which measures and which population. Further information will be sent this week with an allowance of 6 weeks to respond. Work will begin and implementation will not be until 2018.
<p>Pharmacy & Therapeutics (P&T) Update- Roger Citron</p>	<ul style="list-style-type: none"> ▪ The September meeting addressed PTL needs; ▪ Hepatitis- proposed criteria is posted on the website; ▪ Stage 2 Fibrosis- opening up to these patients. Stages 3 and 4 still need to be seen by specialists; ▪ Went over recommendations and service criteria.
<p>Comprehensive Primary Care Plus (CPC+)- Jim Rickards</p>	<ul style="list-style-type: none"> ▪ Trying to get providers participating. Encouraging all to apply; ▪ All of Oregon will be participating; ▪ CPC+ will qualify as an alternate payment; ▪ Three CCO's are not participating. ▪ Information on the website. CMS has a resource sheet.
<p>Health Evidence Review Commission (HERC) Update- Ariel Smits w/ Cat Livingston</p>	<ul style="list-style-type: none"> ▪ HERC met in August. Minutes will be posted soon; ▪ Uncomplicated nasal fractures-uncovered; ▪ Tinitis- uncovered line; ▪ Discussed ICD-10; ▪ Acupuncture guideline; ▪ Tobacco use; ▪ Opioids- clarification on tapering; ▪ Back surgery guideline discussed; ▪ Added coverage on implantable cardiac loop recorders;

	<ul style="list-style-type: none"> ▪ ETTF moved- did not get to any biennial review; ▪ There will be future discussions on inguinal hernias; ▪ October agenda will include CDT Codes discussion; ▪ 2017 CPT codes to come out this month; ▪ Wigs; ▪ Habilitative services; ▪ Podiatry- flat foot non-coverage; ▪ Music therapy; ▪ High frequency chest wall oscillation- mixed evidence; ▪ Dr. Cat Livingston discussed bariatric surgery; ▪ Tobacco and elective surgery- want this applied to all elective surgeries; ▪ Genetic testing- delayed until November.
<p>Statewide Opioid Prescribing Task Force- Anna Stern & Kevin Ewanchyna</p>	<ul style="list-style-type: none"> ▪ Accepted and endorsement CDC for guidelines.. Needed to amend to fit Oregon specifically; ▪ Four sub-committees- 1) Opioids & Marijuana, 2) Communications, 3) Implementation, 4) Substantive issues other than Marijuana; ▪ There is also an oral health sub-group with Dr. Gary Allen participating.
<p>Back Guideline Check-in</p>	<ul style="list-style-type: none"> ▪ CCO's shared experiences and concerns; ▪ Code placement; ▪ Intent; ▪ Funding lines; ▪ Some clarification or a re-look needed; ▪ Change the guidelines or the codes;

	<ul style="list-style-type: none"> ▪ Co-morbid conditions- Will they now be covered for back pain; ▪ Legal ramifications discussed.
Items from the floor	<ol style="list-style-type: none"> 1. Kevin Ewanchyna discussed ovarian cancer prevention and alternatives to tubal ligation. 2. Behavioral health- who gets to be billed. Mixed information. Chris Norman to follow up with OHA staff.
JOINT LEARNING COLLABORATIVE SESSION	
	Childhood Immunizations
QUALITY AND PERFORMANCE IMPROVEMENT SESSION	
QPI Update and Introductions-	<ul style="list-style-type: none"> ▪ October meeting will review complaints and grievances; ▪ Review of QI protocol (HealthInsight). Who is the best from the CCO's to attend the review? This will occur sometime in October; ▪ Discussed the 2017 Quality Waiver. <ul style="list-style-type: none"> ○ QAPI and Transformation plan combination: Lisa is preparing with cross agency representation for framework of new plan; ○ New plan contingent upon CMS approval of waiver; ○ 2017 CCO contract language has been updated with extension of current 2015-2017 Transformation Plans goes until December 31, 2017.
CCO Performance Improvement Project (PIP) Topics - Lisa Bui	<ul style="list-style-type: none"> ▪ CCO Performance Improvement Projects (PIP's); ▪ PIPs quarterly summary document shared. Representative of PIP reports submitted to OHA by July 31, 2016.

<p>PIP Reporting Template</p>	<ul style="list-style-type: none"> ▪ Pluses/minuses discussion on new form; ▪ Problem/Aim statement- where do they go? ▪ Recommendations on measurement plans (add a column); ▪ Barriers (pg. 3) Does this need clarification? ▪ Add root cause after problem statement
<p>Statewide PIP Performance Discussion- HealthInsight</p>	<p>There was a group discussion with focus on interventions for the statewide PIP.</p>
<p>NEXT MEETING: October10,2016</p>	<p><i>Salem - HSB Conference Room 137 A-D</i> Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: Map Office: 503-378-5090 x0</p>

Metric Updates for QHOC

October 2016

Metrics & Scoring Committee

The Committee met September 16th and finalized selection of the 2017 challenge pool measures:

- Effective Contraceptive Use (replaces Diabetes: HbA1c)
- Developmental Screening
- Depression Screening
- SBIRT

The Committee also heard presentations on the intent and context for the Effective Contraceptive Use measure, and introductions to Kindergarten Readiness and Medication Therapy Management measures.

The Committee will next meet October 21 and continue these discussions, and hear about potential obesity measures. <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>

2017 Documentation

Documents including the list of 2017 measures, benchmarks, and challenge pool measures have been posted online: <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>

OHA plans to post *draft* 2017 specifications for the incentive measures in mid-October and give CCOs a small review period to incorporate any feedback or needed edits before posting finalized 2017 specifications. OHA hopes this process will reduce the need for multiple corrections to the specifications once posted. The review and any potential changes or concerns will be discussed at the October 27th Technical Advisory Workgroup meeting.

Guidance Document Updates

OHA is currently reviewing and updating the measure specific guidance documents to incorporate any new policies or best practices, and to reflect updated specifications. OHA is interested in highlighting any CCO case studies in these updated documents – if interested in sharing or highlighting any of your CCO's work on an incentive measure, please contact metrics.questions@state.or.us by October 14th.

Equity Measure Template

REMINDER: OHA is asking CCOs to complete the equity measure template that was distributed in September and return it to metrics.questions@state.or.us by November 4th.

PCPCH Reporting

REMINDER: Q3 2016 PCPCH enrollment data is due Tuesday, November 1st. PCPCH enrollment data should be submitted online here: <https://www.surveymonkey.com/r/PCPCHReport/>

Health Plan Quality Metrics Committee – Open for Application

Applications for the new Health Plan Quality Metrics Committee, which will convene in early 2017 and is charged with identifying an aligned menu of measures for CCOs, PEBB, OEBC, and health plans sold on the insurance exchange, are **due 8:00 am Wednesday, October 19th**.

<http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx>

Hospital Performance Metrics Advisory Committee

The Hospital Performance Metrics Advisory Committee met September 21st to continue their discussion on a safe opioid prescribing in the emergency department measure, as well as benchmark selection for the Hospital Transformation Performance Program (HTPP) Year 4.

The Committee will continue their Year 4 benchmark discussion in October, as well as Year 4 challenge pool selection. <http://www.oregon.gov/oha/analytics/Pages/Hospital-Performance-Metrics.aspx>

Hospital Metrics Change – Impact on Primary Care Providers

There has been a change to one of the hospital incentive metrics that may impact the notifications primary care providers in your networks may be receiving from hospitals when high utilizers are seen in the emergency department (ED). As part of the Hospital Transformation Performance Program (HTPP), hospitals received incentive payments for notifying primary care providers (PCPs) when high utilizers are seen in the ED.

However, beginning October 1, 2016, the metric changed, and hospitals will no longer receive incentive payments for pushing these notifications to PCPs, or for creating care plans in the Emergency Department Information Exchange (EDIE) platform. PCPs with PreManage subscriptions will continue to be able to pull notifications for their panels – but the ‘push’ from hospitals may end.

Some hospitals may continue to push notifications to PCPs, but this will likely vary across the state. If your clinics do not have access to PreManage and would like to continue receiving these notifications, please work with your local hospital.

The new incentive measure for hospitals will focus reducing the number of high utilizers revisiting EDs (specifically, reducing the number of patients readmitted to the ED within 30 days of their fifth visit in 12 months). This new measure will allow hospitals more flexibility in how they address high utilizers, and focuses on patients individual EDs see with some consistency.

For more information about HTPP and hospital measures:

<http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>

For more information: metrics.questions@state.or.us

**Quality and Health Outcomes Committee
Public Health Division updates – October 2016**

State and county immunization rates for two year olds and adolescents: The Oregon Health Authority, Public Health Division has released its annual state and county immunization rates for two year olds and adolescents.

- The 2015 population-based rates for two year olds show the percent of two year olds who receive recommended vaccines by two years of age. These rates are available at: <https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/researchchild.aspx>.
- The 2016 adolescent rates show the percent of 13-17 year olds who received recommended vaccines by May 1, 2016. These rates are available at: <https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/researchteen.aspx>

For more information, contact Rex Larsen at rex.a.larsen@state.or.us or (971) 673-0298.

Immunization Excellence Club: The Oregon Health Authority, Public Health Division publishes a quarterly list of Vaccines for Children clinics that meet or exceed program requirements for vaccine inventory accountability. These requirements help to ensure patient immunization records are complete in ALERT IIS and federally purchased vaccine is being administered correctly to eligible patients. Clinics that meet or exceed vaccine accountability requirements contribute to achieving high immunization rates for their patient population. The list of clinics that achieved VFC Excellence in Q2 2016 is available at: <https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/VFC100Club.aspx>. For more information, contact Rex Larsen at rex.a.larsen@state.or.us or (971) 673-0298.

Task Force on School Nursing: The Task Force on School Nursing recently published its recommendations on how to: 1. sustainably support school nursing; 2. develop standards of school nursing practice; and 3. collaborate with multiple sectors to provide coordinated health services in the school setting. The report and supporting information is available at: <http://healthoregon.org/schoolnursing>. For more information, contact Jamie Smith at jamie.leon.smith@state.or.us or (971) 673-0724.

Behavioral Health Integration Resource Library

October 10, 2016

OHA Transformation Center

[BHI Resource Library](#)

About the Institute



Managed by

OREGON HEALTH CARE
QUALITY
CORPORATION

In Partnership with



Support PCPCH adoption & primary care redesign

Multi-stakeholder partnership to leverage existing resources

Connect practices and other stakeholders to resources and TA

Foster information sharing, peer learning, promising practices

Build capacity for ongoing transformation

Institute Activities

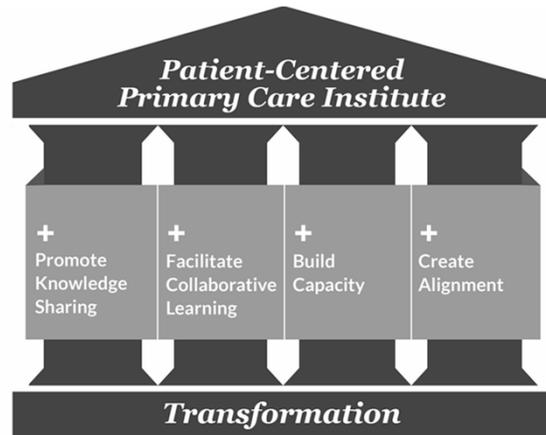
Web-based resources

In-person learning events

Convening peer groups in person and online

Tracking organizational activity

Connecting local & national efforts



Institute by the Numbers

Webinars

60+ webinars, viewed more than 8,000 times

Resources

460+ links, documents, videos

Online Learning Modules

1,000+ users

Technical Assistance Network

190 members

Community-driven blog

90+ posts

Project Scope

- ✓ Create and distribute “virtual clinic visit” and “expert interview” videos
- ✓ Build a Behavioral Health Resource Library on Institute website; create sub-categories to make it easier to search/locate resources on specific BH topics
- ✓ Conduct outreach and marketing

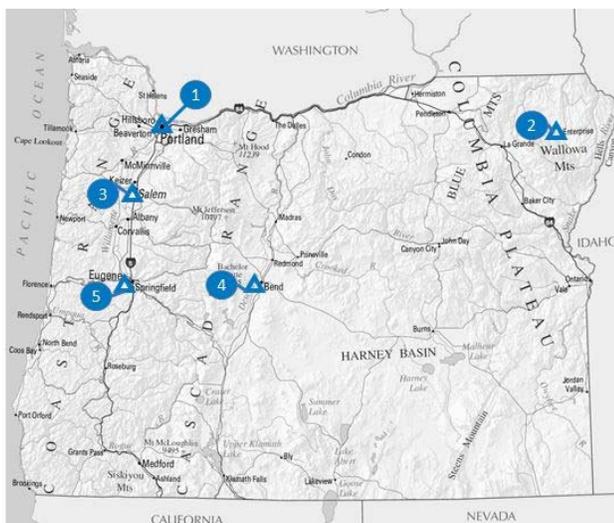
Resources – 150+

- **Behavioral Health Homes**, including standards and best practices for integrating primary care in community mental health settings
- **Clinical Practice**, including screening, assessment & treatment and specific topics like substance use, suicide prevention and trauma-informed care
- **Integration/Implementation**, including Coordinated Care Organization Transformation Plans, integrated models, telehealth

Resources – 150+

- **Policy & Regulation**, including certification & standards; financing & sustainability; information sharing and legislation
- Care for specific **Populations**, including children & adolescents, cultural competence, women's health and older adults
- Integrated care **Roles**, such as Behavioral Health Consultants, BH in Primary Care, Psychiatry, Team Development and Traditional Health Workers

Virtual Clinic Visits



Other virtual clinic visits in this series are:

1.  Yakima Valley Farm Workers Clinic
2.  Winding Waters
A Non-Profit Community Health Center
3.  Childhood Health
Associates of Salem
4.  Mosaic Medical
Quality Care For All
5.  PEARL STREET HEALTH HOME

Expert Interviews

Video	Featuring – Name (s) & Organization
Student Practicums	Staff & students - Childhood Health Associates of Salem
BH in Women's Care Settings	Kimberly Swanson, PhD - St. Charles Family Care
Psychiatric Consultation in Primary Care	Jim Phelps, MD - Samaritan Mental Health
BH for Older Adults	Nirmala Dhar, LCSW - Oregon Health Authority
Traditional Health Workers	Renee Boak, MPH, CADC I - Cascadia Behavioral Healthcare & Elva Lopez - Mosaic Medical
SBIRT Alcohol & Drug Use Screening	Michael Oyster, LPC, CADC III - Oregon Health Authority
Telehealth Services	Robert Brasted, MD, Janet Perez, LCSW - PeaceHealth Medical Group & Michael Franz, MD - PacificSource
Addiction Treatment in Primary Care	Brad Anderson, MD - Kaiser Permanente Northwest
BH & Primary Care - A Health System Perspective	Robin Henderson, PsyD - Providence Medical Group
BH & Primary Care - Part One	Lance McQuillan, MD - The Corvallis Clinic & Mark Helm, MD & Ken Carlson, MD - CHAOS
BH & Primary Care - Part Two	Julie Oyemaja, PsyD – Multnomah County, Christine Pierson, MD - Mosaic Medical & Kimberly Swanson, PhD - St. Charles Family Care
Trillium Integration Incubator Project	Lynnea Lindsey-Pengelly, PhD, MSCP - Trillium Behavioral Health

Demo Site

- [Family-Centered Health for Children and Adolescents: Childhood Health Associates of Salem's Integrated Care](#)
- [Behavioral Health Expert Interviews: Psychiatric Consultation in Primary Care](#)

Next Steps - Outreach

Clinics and
Experts

Institute
Communications
Channels

Technical
Assistance
Organizations

Associations

Educational
Institutions

Oregon Health
Authority/CCOs



Behavioral
Health
Integration
Resource
Library

We welcome your feedback!

* 1. How valuable are the resources available in the [Behavioral Health Resource Library](#) to your organization or practice.

0 - Not Valuable 3 - Moderately Valuable 5 - Extremely Valuable



2. What would you suggest to improve the resource library?

3. Which of the BH library resources have been most useful?

4. Can you suggest any resources that might be good additions to the library?

Done

Support Outreach

- Think of 3 – 5 places you can share an announcement about the BH Resource Library

- Professional Networks
- Projects/Initiatives
- OHA Colleagues
- CCOs

We will provide email language in the next few weeks!



Resource Suggestions? Feedback?
Want to learn more about Institute Resources?

Email us anytime at info@pcpci.org

Questions?



Bonus Features

- [Effective Collaboration: Winding Waters' Integrated Care](#)

DECISION SUPPORT FOR PATIENTS

Updates: New Tool Available

September 27, 2016

Center for Evidence-based Policy



Project Overview, Purpose, and Methods

- OHA's Transformation Center & the Center for Evidence-based Policy
- Investigated patient decision support tools to determine needs & feasibility at the point of care
 - Conducted key informant interviews
 - Reviewed evidence review & gray literature
 - Developed toolkit for providers



Patient Decision Support Tools

- Variety of tools for patients, caregivers, and clinicians to navigate decision-making in health care
 - Decision aids
 - Shared decision-making tools
 - Novel approaches to care
- Particularly helpful for preference-sensitive conditions
 - Multiple legitimate treatment options
 - Patient preferences & values, along with clinician expertise
 - Significant tradeoffs



“A collaborative process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient’s values and preferences.”

– *Informed Medical Decisions Foundation*



High-Quality Decision Tools



- Provide evidence-based information about:
 - Screening, diagnosis, & treatment options
 - Benefits & harms
 - What is known & what is uncertain
 - Role of patient preference
 - Relative risks of various outcomes
 - Text based, audio-visual, web-based



Decision Aid for Type 2 Diabetes Medication

Blood Sugar	Daily Routine	Daily Sugar Testing	Low Blood Sugar	Weight Change	Side Effects	Costs
<p>Blood Sugar</p> <p>Metformin 1 - 2%</p> <p>Insulin Unreversed %</p> <p>Pioglitazone 1%</p> <p>Liraglutide/Exenatide 0.5% - 1%</p> <p>Sulfonylureas 1 - 2%</p> <p>Gliptins 0.5 - 1%</p>	<p>Daily Routine</p> <p>Metformin 1 - 2%</p> <p>Insulin Unreversed %</p> <p>Pioglitazone 1%</p> <p>Liraglutide/Exenatide 0.5% - 1%</p> <p>Sulfonylureas 1 - 2%</p> <p>Gliptins 0.5 - 1%</p>	<p>Daily Sugar Testing</p> <p>Metformin S M T W T F S Monitor 2-5 times weekly, less often once stable.</p> <p>Insulin S M T W T F S Monitor once or twice daily, less often once stable.</p> <p>Pioglitazone S M T W T F S Monitor 2-3 times weekly, less often once stable.</p> <p>Liraglutide/Exenatide S M T W T F S Monitor twice daily after meals when used with Sulfonylureas, as needed when used with Metformin.</p> <p>Sulfonylureas S M T W T F S Monitor 2-5 times weekly, less often once stable.</p> <p>Gliptins S M T W T F S Monitor 2-5 times weekly, less often once stable.</p>	<p>Low Blood Sugar</p>	<p>Weight Change</p>	<p>Side Effects</p>	<p>Costs</p> <p>Metformin (Generic available) \$0.50 per day \$10 / 3 months</p> <p>Insulin (No generic available - price varies by dose) Lantus: Vial, per 100 units: \$10 Pen, per 100 units: \$43 NPH: Vial, per 100 units: \$6 Pen, per 100 units: \$20 Short acting analog insulin: Vial, per 100 units: \$10 Pen, per 100 units: \$43</p> <p>Pioglitazone (No generic available) \$10.00 per day \$900 / 3 months</p> <p>Liraglutide/Exenatide (No generic available) \$11.00 per day \$1000 / 3 months</p> <p>Sulfonylureas (Generic available) \$0.50 per day \$10 / 3 months</p> <p>Gliptins (No generic available) \$1.00 per day \$630 / 3 months</p>

Why Promote Decision Support?

- Exposure to a decision support tool:
 - Improves knowledge & risk perception
 - Increases patient-controlled decision-making
 - Decreases decisional conflict for patients



Website



A Toolkit for Patients, Providers, & Policymakers



This toolkit is designed to be used by anyone who wants to promote the use of patient decision support tools. Some of the tools are focused on the medical directors of Oregon's Coordinated Care Organizations (CCOs), while others are more likely to be useful at the individual practice level. For example, CCO medical directors may be particularly interested in the information on existing decision support tools that correspond to Health Evidence Review Commission coverage guidances and CCO incentive metrics, while practices may be more interested in tools for implementation and measuring the effects of decision support tools.

[Introduction](#) →



Case Studies



Group Health's Orthopedic Division's Implementation Findings

In 2009 Group Health leadership implemented video and written decision aids across multiple specialty clinics as part of a regional demonstration project in Washington State, distributing over 12,000 aids over two years. The decision support tools were provided free of cost from the Informed Medical Decisions Foundation and Health Dialog for the first two years. Twelve tools were implemented in total; example topics included knee and hip osteoarthritis, benign prostatic hyperplasia, and early-stage breast cancer. A patient satisfaction survey



Evidence Review



- Based on moderate to high quality evidence, exposure to a decision aid for a treatment or screening decision is consistently associated with improved knowledge, risk perception, and reduced decisional conflict for participants.
- The use of decision support tools is also associated more patient-controlled and less provider-controlled decision making.



Also Included in the Toolkit

- Best practice checklists
 - Distinct for health plans & clinics
- Implementation best practices
- Resources to
 - Identify
 - Ensure quality
 - Measure effects
 - View sample tools



Next Steps

- The toolkit is available now
 - www.decisionsupporttoolkit.com
 - Will be updated regularly
 - Share with OHLC
 - The Patient-Centered Primary Care Institute will help promote



References

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Transformation Center



Core Attributes of a Primary Care Home

Oregon's PCPCH model is defined by six Core Attributes,
each with specific Standards and Measures



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Changes for 2017 Standards

- 12 standards will be revised.
- One formerly optional measure will become must-pass, totaling 11 must-pass measures overall.
- A new tier structure: From 3 tiers to 5 tiers.
- New technical specifications are now available for review.
- Online application system that includes the revisions will be available January 2017.

Access

- 1.C.0 and 1.C.1 combine to become a single must-pass: Continuous access to clinical advice by phone and documented pertinent encounters (become 1.C.0).
- 1.E.3 Meaningful Use measure pertaining to provision of copy to patients of their health information: reduced in point value from 15 points to 5 points (becomes 1.E.1).
- 1.F.1 Tracking time to completion for prescription refills: increases from 5 points in value to 10 points (becomes 1.F.2).

Accountability

Only one change!

- 2.A.2 changed from requiring only the reporting of core & menu set measures to requiring demonstrated improvement

Comprehensive Whole-Person Care

- 3.A.1 PCPCH routinely offers or coordinates appropriate preventive services based on best available evidence: now includes a requirement for identifying areas for improvement.
- Standard 3.C – “stackable measures”
 - Revised 3.C.0 (Must Pass): change to “and” instead of “or”; add “...local referral resources and processes”
 - Revised 3.C.2: Emphasizes robust cooperative referral and co-management and/or co-location.
 - Revised 3.C.3: formerly emphasized co-location of specialty mental health, substance abuse, or developmental providers. Revised to place greater emphasis on, and specifications for: functional integration, population-based care, and same-day consultation.

Comprehensive Whole-Person Care

- Standard 3.E: Preventive service reminders.
 - Old 3.E.3 (Meaningful Use measure) reduced in point value from 15 points to 5 points (becomes 3.E.1)
 - Revised 3.E.2 emphasizes thoughtful, data-driven generation of lists that are then used for proactive outreach to patients missing evidence-based recommended preventive services.
 - Revised 3.E.3 – like 3.E.2, but with tracking to monitor completion of recommended preventive services.

Continuity

- 4.G.3 Medication reconciliation: changes from a Meaningful Use measure to requiring a more comprehensive, robust medication management strategy. Meaningful Use process is incorporated into 4.G.1 (5 point measure)

Coordination & Integration

- 5.A.1a and 5.A.1b Pertaining to population data management: combine into one measure to become 5.A.1.
- 5.A.2 New measure: requires PCPCH to demonstrate ability to risk-stratify patient population according to health risks based on health needs or behavior.
- 5.C.1 Changes from assigning individual responsibility for care coordination to: more broadly requiring that PCPCH have defined roles among the care team members for care coordination overall.

Person- and Family-Centered

- 6.C.1 Patient survey which was formerly optional becomes 6.C.0, must-pass.
- 6.C.2 Now requires a patient survey every two years instead of annually, and utilization of the survey data within the practice.
- 6.C.3 Also changes patient survey frequency from annually to every two years, and utilization of the survey data within the practice.

Tier Revisions

- To encourage continued primary care practice improvement and address the feedback from stakeholders, the revised PCPCH model has been expanded from 3 tiers to 5 tiers.
- The additional tiers segment the current Tier 3 PCPCHs to better distinguish clinic capability without causing any PCPCH to “drop a tier.”
- The highest tier in the revised model – 5 STAR - aligns with the current 3 STAR designation that was introduced in February 2015 to recognize clinics on the forefront of transformation.



Tier Revisions

Tier	Thresholds	Additional Requirements
Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65-125 points	+ All must-pass standards
Tier 3	130 – 250 points	+ All must-pass standards
Tier 4	255 -380 points	+ All must-pass standards
5 STAR	255 – 380 points	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit



Application Timelines

- Clinics that were recognized in 2014 and due to re-apply for recognition in 2016 were granted an extension of their recognition until January 1, 2017. This applies to over 400 clinics (out of 600). The PCPCH program recently granted a 90-day grace period to these clinics so all must re-apply by March 30, 2017.
- Clinics that were recognized in 2015 are due to re-apply 2 years from their recognition date. For example, if a clinic was recognized on April 6, 2015 they are due to re-apply on April 6, 2017. This applies to about 150 clinics. There is a 30 day grace period for these clinics.
- Clinic that were recognized in 2016 are due to re-apply on January 1, 2017. This applies to about 75 clinics. The PCPCH program recently granted a 90-day grace period to these clinics so all must re-apply by March 30, 2017.

What Can You Do To Prepare?

- Read the [PCPCH 2017 Recognition Criteria Technical Specifications and Reporting Guide](#) (TA Guide) which details the revisions to the standards and the requirements for each measure.
- [Webinar on November 17, 7:30AM - 8:30AM - Q&A with PCPCH Program Staff](#). PCPCH program staff will answer your specific questions about PCPCH program changes and how the revised standards impact your clinic. Registration will be available soon through the Patient-Centered Primary Care Institute (PCPCI).
- [Complete the Online Learning Modules](#). Online learning modules for the PCPCH 2017 recognition standards will be available through the PCPCI in November.
- [Complete the PCPCH 2017 Recognition Standards Self-assessment Tool](#) which can help you determine which standards your clinic meets and help you estimate your clinic's tier level before filling out the application. This tool is not required, but many find it useful.

Questions?

PCPCH@state.or.us
503-373-7768

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PCPCH Model and Standards Revisions Overview

This document provides an overview of the revisions to the PCPCH model of primary care delivery that will be implemented in January 2017. Please read the [PCPCH 2017 Recognition Criteria Technical Specifications and Reporting Guide](#) (TA Guide) for more information.

PCPCH Model Revisions

- 12 Standards were revised
- One additional “must pass” measure (6.C.0 – Patient & Family Surveys)
- Expanded tier structure from 3 tiers to 5 tiers
- 5 STAR aligns with current 3 STAR criteria that was implemented in 2015 to recognize practices on the forefront of transformation

Tier 1	30 - 60 points	+ All must-pass standards
Tier 2	65-125 points	+ All must-pass standards
Tier 3	130 – 250 points	+ All must-pass standards
Tier 4	255 -380 points	+ All must-pass standards
Tier 5 (5 STAR)	255 – 380 points	+ All must-pass standards + Meet 11 out of 13 specified measures + All measures are verified with site visit

PCPCH Standards Revisions

Core Attribute 1: Access To Care – “Health care team, be there when we need you.”

- 1.C.0 and 1.C.1 combine to become a single Must-Pass: Continuous access to clinical advice by phone and documented pertinent encounters (become 1.C.0).
- 1.E.3 Meaningful Use measure pertaining to provision of copy to patients of their health information: reduced in point value from 15 points to 5 points (becomes 1.E.1).
- 1.F.1 Tracking time to completion for prescription refills: increases from 5 points in value to 10 points (becomes 1.F.2).

Core Attribute 2: Accountability - “Take responsibility for making sure we receive the best possible health care.”

- 2.A.2: changed from requiring only the reporting of core and menu set measures to requiring demonstrated improvement.

Core Attribute 3: Comprehensive Whole Person Care - “Provide or help us get the health care, information, and services we need.”

- 3.A.1 PCPCH routinely offers or coordinates appropriate preventive services based on best available evidence: now includes a requirement for identifying areas for improvement.
- 3.C.0 (Must Pass): change to “and” instead of “or”; add “...local referral resources and processes”
- 3.C.2 Emphasizes robust cooperative referral and co-management and/or co-location.
- 3.C.3 Formerly emphasized co-location of specialty mental health, substance abuse, or developmental providers. Revised to place greater emphasis on, and specifications for: functional integration, population-based care, and same-day consultation.
- 3.E.3 Preventive Service Reminders - changes from a Meaningful Use measure to requiring a data based strategy to manage preventative service reminders. Meaningful Use process is incorporated into 3.E.1 (5 point measure).

Core Attribute 4: Continuity - “Be our partner over time in caring for us.”

- 4.G.3 Medication reconciliation: changes from a Meaningful Use measure to requiring a more comprehensive, robust medication management strategy. Meaningful Use process is incorporated into 4.G.1 (5 point measure)

Core Attribute 5: Coordination and Integration - “Help us navigate the health care system to get the care we need in a safe and timely way.”

- 5.A.1a and 5.A.1b Pertaining to population data management: combine into one measure to become 5.A.1.
- 5.A.2 New measure requires PCPCH to demonstrate ability to risk-stratify patient population according to health risks based on health needs or behavior.
- 5.C.1 Changes from assigning individual responsibility for care coordination to: more broadly requiring that PCPCH have defined roles among the care team members for care coordination overall.

Core Attribute 6: Person and Family Centered Care - “Recognize that we are the most important part of the care team.”

- 6.C.1 Patient survey is a new Must-Pass measure (6.C.0)
- 6.C.2 Now requires a patient survey every two years instead of annually, and utilization of the survey data within the practice.
- 6.C.3 Also changes patient survey frequency from annually to every two years, and utilization of the survey data within the practice to meet specific benchmarks.

Questions? Email PCPCH@state.or.us or visit www.primarycarehome.oregon.gov

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
August 11, 2016

Members Present: Som Saha, MD, MPH, Chair; Beth Westbrook, PsyD; Wiley Chan, MD; Mark Gibson; Leda Garside, RN, MBA (arrived at 1:45 pm); Susan Williams, MD; Kim Tippens, ND, MPH; Kevin Olson, MD; Derrick Sorweide, DO; Chris Labhart; Holly Jo Hodges, MD; Gary Allen, DMD.

Members Absent: Irene Crosswell, RPh

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Denise Taray, RN; Jason Gingerich.

Also Attending: Jesse Little (Oregon Health Authority); Valerie King, MD, MPH, Adam Obley, MD, MPH, Craig Mosbaek (OHSU Center for Evidence Based Policy); Amara McCarthy; Amanda Kerbe; Duncan Neilson (Legacy Health).

Call to Order

Som Saha, Chair of the Health Evidence Review Commission (HERC), called the meeting to order. Role was called.

Minutes Approval

[Meeting materials](#), pages 4-11

MOTION: To approve the minutes of the May 19, 2016 meeting as presented. CARRIES 11-0. (Absent: Garside)

Director's Report

Membership Update

Darren Coffman said Dr. Jim MacKay, vice-chair of the Health Technology Assessment Subcommittee (HTAS) recently retired. Also, in HTAS news, to fill the role of retired oncologist Gerald Ahmann, staff recruited and vetted a physician willing to serve on that subcommittee. Dr. Vinay Prasad is an oncologist and hematologist at OHSU specializing in lymphoma. He is nationally known for his research that seeks to improve the medical decisions doctors make, and improve the quality of evidence that doctors use to treat patients. Dr. Prasad is the author of "Ending Medical Reversal: Improving Outcomes, Saving Lives." Olson, also an oncologist, added his support for Dr. Prasad's appointment. Prasad regularly publishes papers about topics this body debates and is a perfect fit for this work.

Darren said there a dentist is interested in serving on the Oral Health Advisory Panel (OHAP). Dr. Len Barrozini, who is the Multnomah County dental director and would bring a nice perspective to the already-seated group.

MOTION: To approve the appointments of Drs. Prasad and Barrozini to HTAS and OHAP, respectively. Carries 11-0. (Absent: Garside)

Other Business

Dr. Livingston explained, as background, there is a statewide opioid taskforce, comprised of a diverse group of members (including medical, pharmacy and nursing boards, associations, clinics, and Federally Qualified Health Centers). Their guidelines are expected by the end of this year.

This year, guideline note 60 was approved, which allowed for an array of treatments for back pain (acupuncture, chiropractic, yoga) not previously covered. The guideline also limited use of surgical interventions and eliminated opioid use for chronic back pain.

It appears the Commission may need to revisit the guideline to see how it applies to other types of chronic pain. Staff considered forming a workgroup to look at the opioid guidelines but decided to wait for the taskforce's recommendations and until a sufficient time has elapsed (6-12 months) for stakeholders to gain experience with the new guideline so that the appropriate issues can be discussed.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes

[Meeting materials](#), pages 58-567

Ariel Smits reported the VbBS met earlier in the day, 8/11/2016. She summarized the subcommittee's recommendations.

RECOMMENDED CODE MOVEMENT (effective 10/1/16):

- Make various straightforward coding changes.
- Place the 2017 ICD-10-CM codes on various lines on the Prioritized List or in alternate implementation files.
- Add treatment codes and a new guideline to the covered laryngeal stenosis line to allow treatment of vocal cord dysfunction in children with dysphonia or dysphagia.
- Add placement code for implantable cardiac loop recorders to the diagnostic list with a new diagnostic guideline note.
- Add treatment codes for electronic tumor treatment fields to a covered cancer line with a new guideline limiting use to initial treatment of glioblastoma that meets certain criteria.
 - Commissioners concluded that it was discriminatory to disabled persons to include performance measure requirements such as the KPS or ECOG score over a certain level. There was concern that this provision might be in conflict with the ADA. Commissioners struck that portion of the proposed guideline (represented as red strike through wording):

GUIDELINE NOTE 155 ELECTRIC TUMOR TREATMENT FIELDS FOR GLIOBLASTOMA

Line 299

Electric tumor treatment fields (codes HCPCS A4555 and E0766) are included on this line only when:

- 1) Used for the initial treatment of supratentorial glioblastoma
- 2) Used in combination with temozolomide
- ~~3) The patient has Karnofsky Performance Status score of 70 or higher or Eastern Cooperative Oncology Group (ECOG) performance status 0-1~~

Electric tumor treatment fields are not included on this line for recurrent glioblastoma or any other indication.

RECOMMENDED GUIDELINE CHANGES (effective 10/1/16):

- Edit the preventive services guideline to remove dates for documents and add in links to the underlying government documents.
- Edit the hyperbaric oxygen guideline to correct two ICD-10-CM codes.
 - After a brief discussion about the coverage of hyperbaric oxygen therapy for radiation cystitis and radiation proctitis the Commissioners added codes for radiation cystitis (ICD-10-CM N30.4) and radiation proctitis (ICD-10-CM K62.7) on line 337 CONDITIONS REQUIRING HYPERBARIC OXYGEN THERAPY
- Delete the diagnostic guideline regarding TB testing.
- Add a new guideline specifying coverage of acute mediastinitis, but not chronic mediastinitis.
- Add a new guideline requiring that the underlying diagnosis be covered to allow for an encounter for desensitization for allergens.
- Edit the acupuncture guideline to clarify that the number of visits covered are per year or per pregnancy.
- Edit the back conditions medical guideline and opioid guideline to clarify the intent of coverage.

MOTION: To accept the VbBS recommendations on *Prioritized List changes* not related to coverage guidances, as amended. See the [VbBS minutes of 8/11/2016](#) for a full description. Carries: 12-0.

Coverage Guidance Evidence Submission Policy Clarification

[Meeting materials](#), pages 569-570

Coffman began by recalling the discussion started at the [May 19, 2016 meeting \(pages 5-6\)](#). Recently, after a coverage guidance was created and vetted through the established policies and was being presented at a meeting, new evidence was submitted. The decision was to stop discussion until it was determined if the new evidence would change the recommendation. In this case, it turned out that one of the documents didn't meet inclusion criteria and the other had been reviewed and did not meet inclusion criteria. This step significantly delayed the approval process. Staff have proposed a few changes to the previously reviewed language that would allow staff to determine if the evidence is a "game-changer" and allow staff to restrict consideration evidence submitted outside of 30-day public comment period.

Dr. Perez, a guest, testified that he was a previous late-submitter and explained there is some confusion about what was meant by "reviewed." He felt his submitted evidence, though late, would be added to the evidence directly addressed in the coverage guidance public comment disposition. Coffman clarified staff followed the policy for comments received outside the official public comment period. Though they were not included in the coverage guidance public comment disposition because they were late, they were sent to Commissioners to be reviewed seven days prior to the meeting as specified in HERC's

policy. If the proposed policy language is accepted, staff would have discretion to decide if the submitted evidence meets the threshold to stop the current process.

Gingerich and Livingston added that staff have implemented a new communications system to inform stakeholders about topics of interest.

There was some discussion centered on agreement and minor text editing of the policy document; please see Appendix A for the final language.

MOTION: To approve the Evidence Submission Policy as amended. Carries 12-0.

Coverage Guidance Topic: Tobacco Cessation In Pregnancy

[Meeting materials](#), pages 571-651

Dr. Obley began the presentation. The rate of smoking at any time during pregnancy is 8.4%; in Oregon, the rate is 10.3%, slightly higher than the national average. Of women who smoke in the first or second trimester, only 1 in 5 will successfully quit smoking by the third trimester. Smoking in pregnancy increases risk of miscarriage, stillbirth, preterm birth, growth restriction, placental abnormalities and abruption, and premature rupture of membranes. Exposure to secondhand smoke can also impact low birth weight and can increase the risk of sudden infant death syndrome.

The scope of this coverage guidance looked at:

- Population: Women during pregnancy and the postpartum period
- Intervention: Screening for tobacco use, pharmacotherapy, behavioral interventions (telephonic, in person, individual, group), Internet based interventions, and multisector interventions such as policy, systems, and environmental change
- Comparator: No care, usual care, other studied interventions
- Outcomes: pregnancy complications (critical), low birth weight (critical), infant death (critical), abstinence from tobacco during pregnancy (important), long-term abstinence from tobacco (important)

Evidence sources included Cochrane and AHRQ systematic reviews.

Dr. Charles Bentz, a Professor at the Pacific University College of Health Professions and a private practice physician at Fanno Creek Clinic in Portland and **Dr. Duncan Neilson**, Clinical Vice President, Legacy Health System of Portland, served as experts for the subcommittee's review of this topic. Dr. Neilson attended the meeting to address questions and provide additional assistance, if required.

Livingstone read through the GRADE-Informed Framework ([page 574](#)):

- Coverage question: Should pharmacotherapy or electronic nicotine delivery systems be recommended for coverage for tobacco cessation in pregnancy?
- Coverage question: Should behavioral interventions be recommended for coverage for tobacco cessation in pregnancy?
- Coverage question: Should ultrasound with high feedback be recommended for coverage for tobacco cessation in pregnancy?
- Coverage question: Should financial incentives be recommended for coverage for tobacco cessation in pregnancy?

- Coverage question: Should partner support be recommended for coverage for tobacco cessation in pregnancy?
- Coverage question: Should clinical interventions to reduce secondhand smoke exposure be recommended for coverage for tobacco cessation in pregnancy?

Saha commented on the wording of some of the questions such as *partner support* and *high feedback*. He said we seemed to be using terms from studies and he would rather see more common and understandable terms used. Further, he took issue with the statement about FDA-approved pharmacotherapy for smoking cessation (blue box, last paragraph). The way it reads, the language appears to imply that pregnant women would be treated differently due to their condition and he suggested that their coverage be the same as for others in terms of pharmacotherapy for tobacco cessation .

Neilson said that nicotine replacement is routinely uses for pregnant patients. He also said that studies with pregnant women are flawed and difficult to conduct, making study results difficult to interpret.

After some discussion, Commissioners edited the contested paragraph in the draft proposal as follows:

Federal law requires coverage of tobacco cessation services, including FDA-approved pharmacotherapy, for pregnant women. There is insufficient evidence of effectiveness of pharmacotherapy on critical pregnancy-related outcomes. ~~Therefore, there is no coverage recommendation on pharmacotherapy for smoking cessation in pregnant women~~ Coverage should be based on evidence for the use of pharmacological smoking cessation therapies in adults and adolescents with attention to their safety profiles in pregnant women.

Further discussion led to deleting all instances of “partner support.”

Staff were advised to not make assumptions about a pregnant person’s gender. Staff will make the language consistent throughout the coverage document, using “during pregnancy” where appropriate. Direct quotes from literature will be kept intact.

MOTION: To approve the proposed coverage guidance for Tobacco Cessation In Pregnancy as amended. Carries 12-0.

MOTION: To approve the proposed coding changes edits and edits to Guideline Note 4 TOBACCO DEPENDENCE, INCLUDING PREGNANT WOMEN and Guideline Note 99 ROUTINE PRENATAL ULTRASOUND for the Prioritized List as amended. Carries 12-0.

Approved Coverage Guidance

HERC Coverage Guidance

For women who use tobacco during pregnancy, the following interventions to aid in tobacco cessation are recommended for coverage:

- Behavioral interventions (*strong recommendation*)
- Financial incentives (incentives contingent upon laboratory tests confirming tobacco abstinence are the most effective) (*weak recommendation*)
- Prenatal ultrasound with feedback around smoking impacts on the fetus (*weak recommendation*)

The following interventions are not recommended for coverage:

- Electronic nicotine delivery systems (*strong recommendation*)
- Counseling-based interventions to reduce secondhand smoke exposure (*weak recommendation*)

Federal law requires coverage of tobacco cessation services, including FDA-approved pharmacotherapy, for pregnant women. There is insufficient evidence of effectiveness of pharmacotherapy on critical pregnancy-related outcomes. Coverage should be based on evidence for the use of pharmacological smoking cessation therapies in adults and adolescents with attention to their safety profiles in pregnant women.

Multisector Interventions

To reduce the use of tobacco during pregnancy and improve associated outcomes, the evidence supports the following interventions:

- Financial incentives (incentives contingent upon laboratory tests confirming tobacco abstinence are the most effective) (*weak recommendation*)
- Smoke-free legislation
- Tobacco excise taxes

No or insufficient evidence is available for the following:

- Internet or text messaging based interventions
- Mass media campaigns specific to pregnant women

Changes to the Prioritized List of Health Services

Modify Guideline Note 4 as follows:

GUIDELINE NOTE 4, TOBACCO DEPENDENCE, INCLUDING PREGNANT WOMEN

Lines 1, 5

Pharmacotherapy and behavioral counseling are included on ~~this~~ line 5, alone or in combination, for at least 2 quit attempts per year. A minimum of four counseling sessions of at least 10 minutes each (group or individual, telephonic or in person) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions. [For pregnant women, additional intensive behavioral counseling is strongly encouraged and not subject to limits.](#)

Inclusion on this line follows the minimum standard criteria as defined in the Oregon Public Health Division “Standard Tobacco Cessation Coverage” (based on the Patient Protection and Affordable Care Act), available here:

<https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx>. The USPSTF has also made “A” recommendations for screening, counseling, and treatment of pregnant and nonpregnant adults, included in Guideline Note 106.

[The development of the pregnancy-related portions of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-reduce-tobacco-use-pregnancy.aspx>](#)

Modify Guideline Note 99 as follows:

GUIDELINE NOTE 99, ROUTINE PRENATAL ULTRASOUND

Lines 1,39,41,67

Routine ultrasound for the average risk pregnant woman is included on these lines for:

- A) One ultrasound in the first trimester for the purpose of identifying fetal aneuploidy or anomaly (between 11 and 13 weeks of gestation) and /or dating confirmation. In some instances, if a patient’s LMP is truly unknown, a dating ultrasound may be indicated prior to an aneuploidy screen
- B) One ultrasound for the purpose of anatomy screening after 18 weeks gestation. [For women using tobacco during pregnancy, additional counseling around smoking impacts on the fetus is included during this ultrasound.](#)

Only one type of routine prenatal ultrasound should be covered in a single day (i.e., transvaginal or abdominal).

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-routine-ultrasound-pregnancy.aspx>

Changes to multisector interventions

MULTISECTOR INTERVENTIONS: TOBACCO PREVENTION AND CESSATION, INCLUDING PREGNANT WOMEN

Benefit coverage for smoking cessation on Line 5 and in Guideline Note 4 TOBACCO DEPENDENCE is intended to be offered with minimal barriers, in order to encourage utilization. To further prevent tobacco use and help people quit, additional evidence-based policy and programmatic interventions from a population perspective are available here:

- Oregon Public Health Division’s Health Promotion and Chronic Disease Prevention Section: Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/evidence-based_strategies_reduce_tob_use_guide_cco.pdf
- Community Preventive Services Task Force (supported by the CDC) - What Works: Tobacco Use <http://www.thecommunityguide.org/about/What-Works-Tobacco-factsheet-and-insert.pdf>

The Community Preventive Services Task Force identified the following evidence-based strategies:

TASK FORCE FINDINGS ON TOBACCO USE

The Community Preventive Services Task Force (Task Force) has released the following findings on what works in public health to prevent tobacco use. These findings are compiled in The Guide to Community Preventive Services (The Community Guide) and listed in the table below. Use the findings to identify strategies and interventions you could use for your community.

Legend for Task Force Findings: ● Recommended ◆ Insufficient Evidence ▲ Recommended Against (See reverse for detailed descriptions.)

Intervention	Task Force Finding
Reducing Tobacco Use Initiation	
Increasing the unit price of tobacco products	●
Mass media campaigns when combined with other interventions	●
Smoke-free policies	●
Increasing Tobacco Use Cessation	
Increasing the unit price of tobacco products	●
Mass media campaigns when combined with other interventions	●
Mass-reach health communication interventions	●
Mobile phone-based interventions	●
Multicomponent interventions that include client telephone support	●
Smoke-free policies	●
Provider reminders when used alone	●
Provider reminders with provider education	●
Reducing client out-of-pocket costs for cessation therapies	●
Internet-based interventions	◆
Mass media – cessation contests	◆
Mass media – cessation series	◆
Provider assessment and feedback	◆
Provider education when used alone	◆
Reducing Exposure to Environmental Tobacco Smoke	
Smoke-free policies	●
Community education to reduce exposure in the home	◆
Restricting Minors’ Access to Tobacco Products	
Community mobilization with additional interventions	●
Sales laws directed at retailers when used alone	◆
Active enforcement of sales laws directed at retailers when used alone	◆
Community education about youth’s access to tobacco products when used alone	◆
Retailer education with reinforcement and information on health consequences when used alone	◆
Retailer education without reinforcement when used alone	◆
Laws directed at minors’ purchase, possession, or use of tobacco products when used alone	◆
Decreasing Tobacco Use Among Workers	
Smoke-free policies	●
Incentives and competitions to increase smoking cessation combined with additional interventions	●
Incentives and competitions to increase smoking cessation when used alone	◆

Visit the “Tobacco Use” page of The Community Guide website at www.thecommunityguide.org/tobacco to find summaries of Task Force findings and recommendations on tobacco use. Click on each topic area to find results from the systematic reviews, included studies, evidence gaps, and journal publications.

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.

To reduce the use of tobacco during pregnancy and improve associated outcomes, the evidence supports the following interventions:

- Financial incentives (contingent upon laboratory tests confirming tobacco abstinence are the most effective)
- Smoke-free legislation
- Tobacco excise taxes

Coverage Guidance Topic: Skin Substitutes for Chronic Skin Ulcers

[Meeting materials](#), pages 652-760

Saha said VbBS did not complete their discussion on this topic so it is tabled.

Public Comment

Amanda Kerbe, a former fire fighter, with no conflicts of interest offered testimony about Guideline Note 60. She said she suffers from stage 4 complex regional pain syndrome and has tried alternant therapies such as acupuncture, massage, and yoga. The only thing that helps her function and thrive are opioids, which are prescribed by her medical team. She founded “Patients Not Addicts”, which advocates for chronic pain patient’s right to opioids. She stated, “Pain is hard, but even harder having doctors look at us as addicts.” She said doctors should fight for those who are unable to fight for themselves, including patients who, for medical reasons, need opioids to function. Amanda shared about the stigma she experiences in her daily life, including doctors and professionals in positions of power. In a recent custody battle, the state appointed custody evaluator said that chronic pain is just an excuse for an addict to get drugs. Amanda said in the absence of correctly prescribed medications, people who live in persistent pain have three options: alcohol, street drugs, and suicide

She urged the commission to find a way to restrict inappropriate use without restricting appropriate use.

Amanda shared her frustration that it is difficult for citizens to find out about meetings where topics like this are discussed. Smits and Williams said that HERC’s policy is one part of the discussion; there is a multi-disciplinary taskforce who are deciding on statewide policies. They urged her to connect with that group and offered a link to the website.

Similarly, Amara McCarthy shared her struggle with chronic pain, which stemmed from a motor vehicle accident in 2001. Among other things, she stated that an addict takes drugs to *run* from life; a persistent pain sufferer takes medication to *engage* in life

Saha clarified that Guideline Note 60 OPIOIDS FOR CONDITIONS OF THE BACK AND SPINE applies to spine pain treatment so her pain condition, as well as may others such as sickle cell anemia, are unaffected. He thanked the public commenters and ended by saying the he knows the commission is avoiding collateral damage with its actions.

Items for Next Meeting

Staff will modify wording in the Tobacco Cessation in Pregnancy coverage guidance so that no assumptions are made about a pregnant person's gender.

Adjournment

Meeting adjourned at 4:30 pm. Next meeting will be from 1:30-4:30 pm on Thursday, October 6, 2016 at Clackamas Community

DRAFT

Appendix A

Coverage Guidance Policy on Consideration of Evidence Discovered After Formal Public Comment Period

For coverage guidances, the Health Evidence Review Commission (HERC) generally only includes studies during its initial Coverage Guidance development (before the relevant subcommittee reviews the first draft) or when these studies are submitted during the formal written comment period. These studies are reviewed based on how well they address the pre-specified scope of the Coverage Guidance and their methodological quality.

In exceptional circumstances, however, the HERC recognizes the need to review studies submitted by stakeholders or discovered by staff outside the formal comment process. To minimize biases which may be introduced by consideration of evidence at other times in the process, HERC has approved this policy, outlining the circumstances which may justify consideration of new evidence when it is discovered outside the formal routine guidance process and public comment period.

Decisions about whether to delay the process for a new study will be made by staff, based on where a coverage guidance is in the development process and the importance of the evidence in question.

The new study or studies need to be likely to alter a recommendation in a way that would significantly impact health outcomes or cost for the population in question. Such studies are also typically:

- Randomized controlled trials or systematic reviews of randomized trials demonstrating comparative effectiveness or harm, or large registry or population-based studies demonstrating harm, AND are of
- Moderate or high quality according to HERC criteria

If staff learns of a study after the formal comment period ends, staff will make a determination of the importance of the study in question based on the criteria above. Staff would delay the process as needed in order to incorporate the study and update the existing literature search to assure that there are not any additional studies which may be appropriate to include. For studies that do not meet these criteria, they could be resubmitted at the next scheduled two-year topic rescan. New coverage guidance topics can also be nominated for consideration annually.

In the case of new evidence (that meets the criteria above) being identified after a Coverage Guidance has already been approved by the originating subcommittee, it would be referred back to that subcommittee before coming to HERC and VbBS. Less significant changes may be incorporated by the Commission during the final approval process.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE AND MULTISECTOR INTERVENTION REPORT: TOBACCO CESSATION DURING PREGNANCY

Approved 8/11/2016

HERC Coverage Guidance

For women who use tobacco during pregnancy, the following interventions to aid in tobacco cessation are recommended for coverage:

- Behavioral interventions (*strong recommendation*)
- Financial incentives (incentives contingent upon laboratory tests confirming tobacco abstinence are the most effective) (*weak recommendation*)
- Prenatal ultrasound with feedback around smoking impacts on the fetus (*weak recommendation*)

The following interventions are not recommended for coverage:

- Electronic nicotine delivery systems (*strong recommendation*)
- Counseling-based interventions to reduce secondhand smoke exposure (*weak recommendation*)

Federal law requires coverage of tobacco cessation services, including FDA-approved pharmacotherapy, for pregnant women. There is insufficient evidence of effectiveness of pharmacotherapy on critical pregnancy-related outcomes. Coverage should be based on evidence for the use of pharmacological smoking cessation therapies in adults and adolescents with attention to their safety profiles in pregnant women.

Note: Definitions for strength of recommendation are provided in Appendix A *GRADE Informed Framework Element Description*.

Multisector Interventions

To reduce the use of tobacco during pregnancy and improve associated outcomes, the evidence supports the following interventions:

- Financial incentives (incentives contingent upon laboratory tests confirming tobacco abstinence are the most effective) (*weak recommendation*)
- Smoke-free legislation
- Tobacco excise taxes

No or insufficient evidence is available for the following:

- Internet or text messaging based interventions
- Mass media campaigns specific to pregnant women

Oregon Health Plan Prioritized List changes Tobacco Cessation During Pregnancy

The Health Evidence Review Commission approved the following changes to the Prioritized List of Health Services on August 11, 2016, based on the approved coverage guidance, “Tobacco Cessation During Pregnancy.” The changes will take effect on the Prioritized list of Health Services for the Oregon Health Plan on October 1, 2015.

- 1) Modify Guideline Note 4 as follows

GUIDELINE NOTE 4, TOBACCO DEPENDENCE, INCLUDING PREGNANT WOMEN

Lines 1, 5

Pharmacotherapy and behavioral counseling are included on ~~this~~ line 5, alone or in combination, for at least 2 quit attempts per year. A minimum of four counseling sessions of at least 10 minutes each (group or individual, telephonic or in person) are included for each quit attempt. More intensive interventions and group therapy are likely to be the most effective behavioral interventions. For pregnant women, additional intensive behavioral counseling is strongly encouraged and not subject to limits.

Inclusion on this line follows the minimum standard criteria as defined in the Oregon Public Health Division “Standard Tobacco Cessation Coverage” (based on the Patient Protection and Affordable Care Act), available here: <https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/pubs.aspx>. The USPSTF has also made “A” recommendations for screening, counseling, and treatment of pregnant and nonpregnant adults, included in [Guideline Note 106](#).

The development of the pregnancy-related portions of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-reduce-tobacco-use-pregnancy.aspx>

- 2) **Modify Guideline Note 99 as follows:**

GUIDELINE NOTE 99, ROUTINE PRENATAL ULTRASOUND

Lines 1,39,41,67

Routine ultrasound for the average risk pregnant woman is included on these lines for:

- A) One ultrasound in the first trimester for the purpose of identifying fetal aneuploidy or anomaly (between 11 and 13 weeks of gestation) and /or dating confirmation. In some instances, if a patient’s LMP is truly unknown, a dating ultrasound may be indicated prior to an aneuploidy screen

Oregon Health Plan Prioritized List changes

Tobacco Cessation During Pregnancy

- B) One ultrasound for the purpose of anatomy screening after 18 weeks gestation. [For women using tobacco during pregnancy, additional counseling around smoking impacts on the fetus is included during this ultrasound.](#)

Only one type of routine prenatal ultrasound should be covered in a single day (i.e., transvaginal or abdominal).

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/Pages/blog-routine-ultrasound-pregnancy.aspx>

3) Modify the MULTISECTOR INTERVENTIONS: TOBACCO PREVENTION AND CESSATION to include interventions for pregnancy:

MULTISECTOR INTERVENTIONS: TOBACCO PREVENTION AND CESSATION, INCLUDING PREGNANT WOMEN

Benefit coverage for smoking cessation on Line 5 and in Guideline Note 4 TOBACCO DEPENDENCE is intended to be offered with minimal barriers, in order to encourage utilization. To further prevent tobacco use and help people quit, additional evidence-based policy and programmatic interventions from a population perspective are available here:

- Oregon Public Health Division's Health Promotion and Chronic Disease Prevention Section: Evidence-Based Strategies for Reducing Tobacco Use A Guide for CCOs
https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/evidence-based_strategies_reduce_tob_use_guide_cco.pdf
- Community Preventive Services Task Force (supported by the CDC) - What Works: Tobacco Use
<http://www.thecommunityguide.org/about/What-Works-Tobacco-factsheet-and-insert.pdf>

The Community Preventive Services Task Force identified the following evidence-based strategies:

Oregon Health Plan Prioritized List changes

Tobacco Cessation During Pregnancy

TASK FORCE FINDINGS ON TOBACCO USE

The Community Preventive Services Task Force (Task Force) has released the following findings on what works in public health to prevent tobacco use. These findings are compiled in The Guide to Community Preventive Services (The Community Guide) and listed in the table below. Use the findings to identify strategies and interventions you could use for your community.

Legend for Task Force Findings:  Recommended  Insufficient Evidence  Recommended Against (See reverse for detailed descriptions.)

Intervention	Task Force Finding
Reducing Tobacco Use Initiation	
Increasing the unit price of tobacco products	
Mass media campaigns when combined with other interventions	
Smoke-free policies	
Increasing Tobacco Use Cessation	
Increasing the unit price of tobacco products	
Mass media campaigns when combined with other interventions	
Mass-reach health communication interventions	
Mobile phone-based interventions	
Multicomponent interventions that include client telephone support	
Smoke-free policies	
Provider reminders when used alone	
Provider reminders with provider education	
Reducing client out-of-pocket costs for cessation therapies	
Internet-based interventions	
Mass media – cessation contests	
Mass media – cessation series	
Provider assessment and feedback	
Provider education when used alone	

Intervention	Task Force Finding
Reducing Exposure to Environmental Tobacco Smoke	
Smoke-free policies	
Community education to reduce exposure in the home	
Restricting Minors' Access to Tobacco Products	
Community mobilization with additional interventions	
Sales laws directed at retailers when used alone	
Active enforcement of sales laws directed at retailers when used alone	
Community education about youth's access to tobacco products when used alone	
Retailer education with reinforcement and information on health consequences when used alone	
Retailer education without reinforcement when used alone	
Laws directed at minors' purchase, possession, or use of tobacco products when used alone	
Decreasing Tobacco Use Among Workers	
Smoke-free policies	
Incentives and competitions to increase smoking cessation combined with additional interventions	
Incentives and competitions to increase smoking cessation when used alone	

Visit the "Tobacco Use" page of The Community Guide website at www.thecommunityguide.org/tobacco to find summaries of Task Force findings and recommendations on tobacco use. Click on each topic area to find results from the systematic reviews, included studies, evidence gaps, and journal publications.

The Centers for Disease Control and Prevention provides administrative, research, and technical support for the Community Preventive Services Task Force.

To reduce the use of tobacco during pregnancy and improve associated outcomes, the evidence supports the following interventions:

- [Financial incentives \(contingent upon laboratory tests confirming tobacco abstinence\) are the most effective](#)
- [Smoke-free legislation](#)
- [Tobacco excise taxes](#)

GUIDELINE NOTE 60, OPIOIDS PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE

Lines 351,366,407,532

Opioid medications are only included on these lines under the following criteria:

~~The following restrictions on opioid treatment apply to all diagnoses included on these lines.~~

For acute injury, acute flare of chronic pain, or after surgery:

- 1) During the first 6 weeks ~~after the acute injury, flare or surgery~~, opioid treatment is included on these lines ONLY:
 - a) When each prescription is limited to 7 days of treatment, AND
 - b) For short acting opioids only, AND
 - c) When one or more alternative first line pharmacologic therapies such as NSAIDs, acetaminophen, and muscle relaxers have been tried and found not effective or are contraindicated, AND
 - d) When prescribed with a plan to keep active (home or prescribed exercise regime) and with consideration of additional therapies such as spinal manipulation, physical therapy, yoga, or acupuncture, AND
 - e) There is documented ~~lack of current or prior~~ verification that the patient is not high risk for opioid misuse or abuse.
- 2) Treatment with opioids after 6 weeks, up to 90 days after the initial injury/flare/surgery, ~~requires the following~~ is included on these lines ONLY:
 - a) With D documented evidence of improvement of function of at least thirty percent as compared to baseline based on a validated tools.
 - b) ~~Must be~~ When prescribed in conjunction with therapies such as spinal manipulation, physical therapy, yoga, or acupuncture.
 - c) With V verification that the patient is not high risk for opioid misuse or abuse. Such verification may involve:
 - i) Documented verification from the state's prescription monitoring program database that the controlled substance history is consistent with the prescribing record
 - ii) Use of a validated screening instrument to verify the absence of a current substance use disorder (excluding nicotine) or a history of prior opioid misuse or abuse
 - iii) Administration of a baseline urine drug test to verify the absence of illicit drugs and non-prescribed opioids.
 - d) Each prescription must be limited to 7 days of treatment and for short acting opioids only
- 3) Chronic opioid treatment (>90 days) after the initial injury/flare/surgery is not included on these lines except for the taper process described below. ~~Further opioid treatment after 90 days may be considered is included on these lines ONLY when there is a significant change in status, such as a clinically significant verifiable new injury or surgery. In such cases, use of opioids is limited to a maximum of an additional 7 days. In exceptional cases, use up to 28 days may be included on these lines, subject to the criteria in #2 above.~~

Transitional coverage for patients on long-term opioid therapy as of July 1, 2016

~~For patients with chronic pain from diagnoses on these lines currently treated with long term opioid therapy, opioids must be tapered off using~~ For patients on covered chronic opioid therapy as of July 1, 2016, opioid medication is included on these lines only from July 1, 2016 to December 31, 2016. During the period from January 1, 2017 to December 31, 2017, continued coverage of opioid medications requires an individual treatment plan developed by January 1, 2017 which includes a taper with a quit date an end to opioid therapy no later than January 1, 2018. Taper plans must include nonpharmacological treatment strategies for managing the patient's pain based on Guideline Note 56 NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE. If a patient has developed dependence and/or addiction related to their opioids, treatment is available on Line 4 SUBSTANCE USE DISORDER.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: METABOLIC AND BARIATRIC SURGERY

DRAFT for 10/6/2016 VbBS/HERC meeting materials

HERC Coverage Guidance

Coverage of metabolic and bariatric surgery (including Roux-en-Y gastric bypass, gastric banding, and sleeve gastrectomy) is recommended for:

- Adult obese patients (BMI \geq 35) with
 - Type 2 diabetes (*strong recommendation*) OR
 - at least two of the following other serious obesity-related comorbidities: hypertension, coronary heart disease, mechanical arthropathy in major weight bearing joint, sleep apnea (*weak recommendation*)
- Adult obese patients (BMI \geq 40) (*strong recommendation*)

Metabolic and bariatric surgery is recommended for coverage in these populations only when provided in a facility accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (*weak recommendation*).

Metabolic and bariatric surgery is not recommended for coverage in:

- Patients with BMI $<$ 35, or 35-40 without the defined comorbid conditions above (*weak recommendation*)
- Children and adolescents (*weak recommendation*)

Note: Definitions for strength of recommendation are provided in Appendix B: GRADE Informed Framework – Element Descriptions.

RATIONALE FOR GUIDANCE DEVELOPMENT

The HERC selects topics for guideline development or technology assessment based on the following principles:

- Represents a significant burden of disease
- Represents important uncertainty with regard to efficacy or harms
- Represents important variation or controversy in clinical care
- Represents high costs, significant economic impact
- Topic is of high public interest

Coverage guidance development follows to translate the evidence review to a policy decision. Coverage guidance may be based on an evidence-based guideline developed by the Evidence-based Guideline Subcommittee or a health technology assessment developed by the Health Technology Assessment Subcommittee. In addition, coverage guidance may utilize an existing evidence report produced by one of HERC's trusted sources, generally within the last three years.

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: NONINVASIVE TESTING FOR LIVER FIBROSIS IN PATIENTS WITH CHRONIC HEPATITIS C

DRAFT for VbBS/HERC meeting materials 10/6/2016

HERC Coverage Guidance

If a fibrosis score of $\geq F2$ is the threshold for antiviral treatment of Hepatitis C, the following are recommended for coverage (*weak recommendation*):

Imaging tests:

- Transient elastography (FibroScan®)
- Acoustic radiation force impulse imaging (ARFI) (Virtual Touch™ tissue quantification, ElastPQ)
- Shear wave elastography (SWE) (Aixplorer®)

Blood tests (only if imaging tests are unavailable):

- Enhanced Liver Fibrosis (ELF™)
- Fibrometer™
- FIBROSpect® II

If a fibrosis score of $\geq F3$ is the threshold for antiviral treatment of Hepatitis C, one or more of the following are recommended for coverage (*strong recommendation*):

Imaging tests:

- Transient elastography (FibroScan®)
- Acoustic radiation force impulse imaging (ARFI)
- Shear wave elastography (SWE)

Magnetic resonance elastography is recommended for coverage for $\geq F2$ or $\geq F3$ only when at least one imaging test (FibroScan, ARFI, and SWE) has resulted in indeterminate results, a second one is similarly indeterminate, contraindicated or unavailable, and MRE is readily available (*weak recommendation*).

Noninvasive tests should be performed no more often than once per year (*weak recommendation*).

The following tests are not recommended for coverage for the detection of liver fibrosis to guide treatment decisions with antivirals in chronic hepatitis C (*strong recommendation*):

Imaging tests

- Real time tissue elastography

Blood tests (proprietary):

- Hepascore® (FibroScore®)
- FibroSure® (FibroTest®)

Blood tests (non-proprietary):

- Age-platelet index
- AST-platelet ratio index (APRI)
- AST-ALT ratio
- Cirrhosis discriminant score (Bonacini index)
- FIB-4
- Fibro- α score
- FibroIndex
- Fibronectin discriminant score
- FibroQ
- Fibrosis–cirrhosis index
- Fibrosis index
- Fibrosis probability index (Sud index)
- Fibrosis–protein index
- Fibrosis Routine Test
- Forns index
- Globulin–albumin ratio
- Göteborg University Cirrhosis Index (GUCI)
- HALT-C model (Hepatitis C Antiviral Long-Term Treatment Against Cirrhosis)
- King’s score
- Lok index
- MP3 score
- Pohl index
- Sabadell NIHCED index (Non-Invasive Hepatitis-C–Related Cirrhosis Early Detection)
- Significant fibrosis index
- Zeng index

Note: Definitions for strength of recommendation are provided in Appendix A *GRADE Informed Framework Element Description*.

RATIONALE FOR DEVELOPMENT OF COVERAGE GUIDANCES AND MULTISECTOR INTERVENTION REPORTS

Coverage guidances are developed to inform coverage recommendations for public and private health plans in Oregon as they seek to improve patient experience of care, population health and the cost-effectiveness of health care. In the era of the Affordable Care Act and health system transformation, reaching these goals may require a focus on population-based health interventions from a variety of sectors as well as individually-focused clinical care. Multisector intervention reports will be developed to address these population-based health interventions or other types of interventions that happen outside of the typical clinical setting.

HERC selects topics for its reports to guide public and private payers based on the following principles:

CHARTER (Updated 07/13/2015, Approved 8/10/2015)
Oregon Health Authority | Quality and Health Outcomes Committee

Background	
<p>Since 1993, the Quality Health Outcomes Committee (QHOC), formerly known as the Medicaid Medical Directors meeting and the Quality and Performance Improvement Workgroups, served as the forum for communication of the clinical and quality aspects of implementation of the Oregon Health Plan (OHP) with statewide health systems serving the Medicaid population. In 2013, in compliance with the 1115 Waiver, QHOC added learning collaboratives to share best practice implementation of the quality incentive measures and overall health transformation.</p>	
Purpose	
<ul style="list-style-type: none"> • Provide a forum for community leadership in physical, behavioral, oral, and population health for the Oregon Health Plan population • Develop community improvement strategies from identified trends in quality and compliance • Serves a liaison and consultation role to the OHA for clinical and quality aspects of implementation of the Oregon Health Plan, including a focus on clinical guidance, benefits implementation, and quality assurance policies. • Identify integrated approaches and strategies to improve health outcomes • Provide a mechanism for community programs to reach Coordinated Care Organization (CCO) clinical leadership for policy and implementation issues that support the quality delivery of health care across the spectrum of care. • Share best practice to community partners for issues and concerns regarding quality initiatives 	
Principles	
<ul style="list-style-type: none"> • QHOC promotes integration, efficient working relationships, data driven decision making • Maximizes the in-person learning experience while also recognizing the commitment of time and resources • Coordinating clinical community efforts towards achieving the Triple Aim (Better health, better care, and lower cost) is the primary goal 	
Scope	
<p>QHOC brings together clinical leadership from CCOs and their community partners across the state to coordinate and lead quality improvement efforts and support the implementation of innovative health care practices throughout the state.</p>	
Membership, Roles & Responsibilities	
Project Sponsor(s)	Oregon Health Authority
Leadership:	Tracy Muday, MD, QHOC Medical Director Chair
	Barbara Carey, QHOC Quality Program Chair
Members:	<ul style="list-style-type: none"> • Medical directors and quality managers from each CCO • Dental health and behavioral health directors of the CCOs
OHA Staff:	OHA representatives from Medicaid Assistance Program, Transformation Center staff and the Office of the Chief Medical Officer

Key OHA Staff Resources:	<ul style="list-style-type: none"> • Medicaid Director • Quality Improvement Director • Quality Assurance Manager • Meeting Support Staff
Leadership Responsibilities	<ul style="list-style-type: none"> • Facilitate meeting • Collaborative agenda development with key OHA staff • Field QHOC member questions and concerns
Leadership Term	QHOC chairs are nominated and voted by the full membership with terms lasting one year with the option of a second year.
Key Responsibilities	
Key Responsibilities: <ul style="list-style-type: none"> • Review, discuss, provide input on changes, and advice regarding clinical policy implementation for HERC, Pharmacy and Therapeutics Committee, MAP and other relevant OHA programs. • Support community clinical and population health initiatives and standards • Sharing best practices and approaches amongst CCOs and with OHA • Evaluate waiver-required External Quality Review Organization (EQRO) findings and Statewide performance improvement projects status and implementation review • Quality metrics monitoring and performance improvement plans • Advise and provide consultation to OHA Quality Strategy development, implementation and review • Collaboratively develop and improve best practices for contractual quality expectations reporting between CCOs and OHA; following the Center for Medicare and Medicaid Services' regulations 	
Key Stakeholders	
<ul style="list-style-type: none"> • Health System Members • Coordinated Care Organizations • Community Partners • Oregon Health Authority • Center for Medicare & Medicaid Services 	
Meeting Format	
Frequency:	Meetings occur monthly in Salem, Oregon (telecom also available)
Format:	Integrated morning session for clinical leadership with a joint learning collaborative mid-morning with both clinical and quality leaders. Breakout afternoon session for role specific workgroups (behavioral health directors, quality managers)
Materials:	QHOC briefing book is distributed monthly with agenda posted to OHA QHOC website no later than 2 weeks prior to meeting
Charter Review & Modification	
Annual Review (at a minimum), beginning July 2015	

Statewide CCO Learning Collaborative: 17 CCO Incentive Measures

Quality and Health Outcomes Committee Meeting
Human Services Building, 500 Summer St NE, Salem, OR, Rm 137A-D
October 10, 2016
11:00 a.m. – 12:30 p.m.

Toll-free conference line: 888-278-0296
Participant code: 310477

Opiods

Session Objectives

Participants will:

- Understand OHA initiatives to addressing opiod use.
- Understand clinical guideline recommendations.
- Identify and share emerging best practices in Oregon to treat chronic pain and address opiate misuse.
- Discuss the role of CCOs in supporting strategies to address chronic pain and opiate misuse at the provider level.

1. **Introductions and reflection** (Jim Rickards) (5 minutes)
2. **OHA general overview of initiatives** (Lisa Bui) (10 minutes)
 - Naloxone update, Hospital ED opiod metric update, Statewide PIP
3. **Panel: Promising practices to improve childhood immunization status** (Lisa Bui) (40 minutes)
 - CDC/State Opioid Guidelines (Katrina Hedberg)
 - HERC Back Pain Opioid Plan (Ariel Smits)
 - PA Opioid Criteria (Roger Citron)
 - Medication Assisted Treatment (Jon McIlveen)
 - Panel Q & A
4. **Small group discussion and report out – at your table** (Facilitators: Lisa Bui, Cat Livingston, Summer Boslaugh, Jim Rickards, Katrina Hedberg, Ariel Smits, Lisa Shields) (25 minutes)
 - Share one unique strategy that you are using in your community to address opiod misuse
 - Share one thing you learned today that you will take back to your community to explore or share
5. **Next steps** (Jim Rickards/Lisa Bui) (10 minutes)
 - Closing
 - November 14, 2016 QHOC meeting: HealthInsight – Opioid Research Discussion
 - Evaluation

Opioid Learning Collaborative

QHOC Meeting
October 10, 2016

OHA Clinical Panel

- **Introductions and reflection:** Jim Rickards, MD, MBA, Chief Medical Officer
- **OHA general overview of initiatives:** Lisa Bui, Quality Improvement Director
- **CDC/Statewide Prescribing Guidelines:** Katrina Hedberg, MD, MPH, State Epidemiologist and State Health Officer, Public Health Division
- **Medication Assisted Treatment:** John McIlveen, Ph.D., LMHC, State Opioid Treatment Authority
- **HERC Guideline Note 60 – Opioid Plan:** Ariel Smits, MD, MPH, Associate Medical Director
- **PA Opioid Criteria:** Roger Citron, RPh, OSU-College of Pharmacy, Drug Use Research & Management



Opioid Learning Collaborative Agenda & Objectives

- **LC Session Objectives**
 - Understand OHA initiatives to addressing opioid use.
 - Understand clinical guideline recommendations.
 - Identify and share emerging best practices in Oregon to treat chronic pain and address opiate misuse.
 - Discuss the role of CCOs in supporting strategies to address chronic pain and opiate misuse at the provider level.
- **Agenda**
 - OHA General Opioid Initiatives Panel Presentations
 - Panel Q&A
 - Small Group discussions:
 - Share one unique strategy that you are using in your community to address opioid misuse
 - Share one thing you learned today that you will take back to your community to explore or share



Oregon's Opioid Initiative: Goals

Improve Population Health

- Decrease drug overdose deaths
- Decrease drug overdose hospitalizations / ED visits
- Decrease opioid misuse

Improve Care

- Improve pain management practice
 - Alternative therapies
- Increase medication assisted treatment for opioid use disorder



Oregon's Opioid Initiative: Strategies

Limit Rx Opioids

- Decrease the amount of opioids prescribed

Promote Access

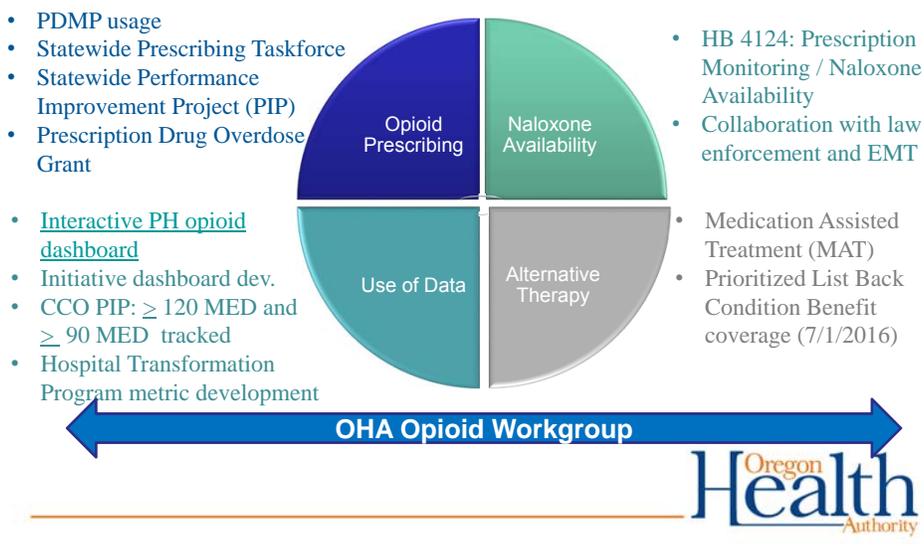
- Increase availability of naloxone rescue
- Ensure availability of treatment of opioid misuse disorder

Data Analytics

- Use data to target and evaluate interventions



Oregon Opioid Initiatives



HB 4124: Integration of PDMP and Health IT Systems

WHAT: Integration of PDMP with health IT systems means prescribers, pharmacists and delegates can query PDMP within their workflow.

- PMP Gateway is an interface that will securely integrate OR PDMP data into existing infrastructure of health IT systems like HIEs, EDIE, and health systems.
- HB 4124 requires anyone planning to use the PMP Gateway to have active, valid MP user accounts with OHA.

WHY: Integration saves time and helps health care professionals have accurate, relevant, timely PDMP data at the point of care.

WHEN: PDPMP Gateway implementation goal: **First Quarter of 2017.**

A HB 4124 Fact Sheet is posted on orpdmp.com.
Stay tuned for updates.



Offering Naloxone to high-risk patients

- Consider offering naloxone to patients with
 - ✓ History of overdose
 - ✓ History of substance use disorder
 - ✓ Higher opioid dosages (≥50 MME/day)
 - ✓ Concurrent benzodiazepine usage
- Oregon pharmacists can prescribe and dispense naloxone (“behind the counter”):
<https://www.oregon.gov/pharmacy/Imports/Rules/September16/TemporaryCertandStmntofJustificationNaloxone.pdf>
- New OHA naloxone training protocol on [EMS/Trauma Systems site](#)
- OHA naloxone work group meets quarterly (email lisa.m.shields@state.or.us to join)
- More information on naloxone co-prescribing: <http://prescribetoprevent.org>



Hospital Transformation Performance Program (HTPP)

- Incentive measure program for DRG hospitals in Oregon
- Hospitals must achieve benchmarks or improvement targets to qualify for incentive payments on 11 measures
- 28 participating hospitals
- Subject to CMS approval through OHA’s 1115 Medicaid waiver



Proposed ED Opioid Metric

- An alternate metric based on work from Washington state was proposed and agreed upon by the Committee.
- The proposed metric is developmental, and embraces the spirit of the CDC¹ and OCEP² guidelines.
- Hospitals would begin reporting in HTPP Year 4 (2017)
- If approved by CMS, would be pay-for-reporting in Year 4 (as developmental measure), moving to pay-for-performance in Year 5 (2018)

¹<http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>

²<http://www.oregon.gov/oha/analytics/HospitalMetricsDocs/ORACEP%20Opioid%20Prescribing%20Guidelines.pdf>

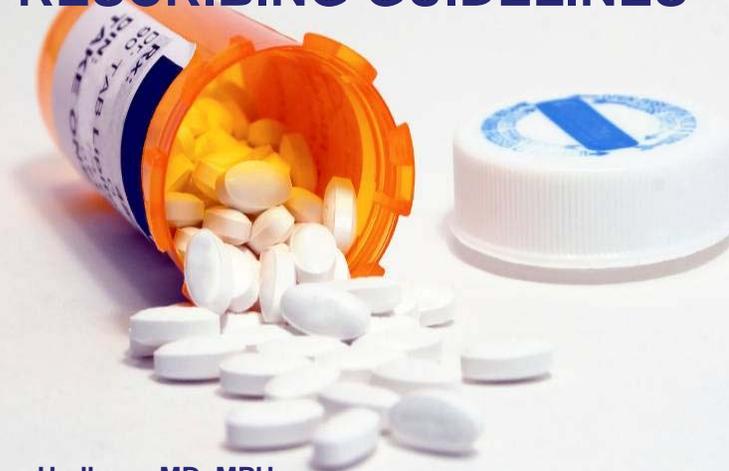


Proposed ED Opioid Metric

- To remain comparable to WA and address some of concerns from ED physicians, the current proposal is in three parts:
 - 1) Average number of pills per opioid Rx in the ED
 - 2) Total average morphine equivalent dose strength per prescription written in the ED***
 - 3) Percent of ED visits that result in an opioid Rx
- *Contingency for Year 4 (if pay-for-performance required):*
 - *To qualify for payment, hospitals would have to report on all three parts of the measure, but reduce the total average morphine equivalent strength by 1% from the baseline*



OREGON OPIOID PRESCRIBING GUIDELINES



Katrina Hedberg, MD, MPH
Health Officer & State Epidemiologist
Oregon Public Health Division



Prescription Opioids in Oregon: Scope of the Problem



Non-Medical Use of Prescription Opioids

- Tied for 2nd in the nation in 2012-2013; 1st in 2010-2011.¹
- 212,000 Oregonians (5% of population) self-reported non-medical use of prescription pain relievers



Hospitalizations

- \$9.1 million in hospitalization charges in 2013,
- \$8 million in 2014



Death Rate

- 4.3 pharmaceutical opioid overdose deaths per 100,000 residents in 2014 (unintentional and undetermined intent)

Source: National Survey on Drug Use Health (NSDUH)¹



CDC prescribing guidelines

Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 65
March 15, 2016

CDC Guideline for Prescribing Opioids for
Chronic Pain — United States, 2016



- When to initiate or continue opioid for chronic pain
- Opioid selection, dosage, duration, follow up, discontinuation
- Risk Assessment and addressing harms

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Opioid Prescribing Recommendations

- **When to Initiate / Continue opioid for chronic pain**
 - Alternative pain treatment options preferred
 - Treatment goals for pain and function
 - Discuss risks and benefits of opioid treatment
- **Opioid selection, dosage, duration, follow up, discontinuation**
 - Immediate release opioids rather than extended release
 - low initial dose; max 90 mg daily morphine equivalent dose (MED); <3 days if possible
 - methods for discontinuing opioids (e.g., taper, referrals to substance use Rx)

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Opioid Prescribing Recommendations

- **Risk Assessment and addressing harms**
 - physical exam, patient history: pain, medical, family/social
 - PDMP to monitor prescribing; and dispensing
 - pain treatment agreements; documenting progress
 - limit co-prescribing opioids, benzodiazepines, and sedatives
 - access to medication assisted therapy



Oregon Opioid Prescribing Guidelines Task Force

- Endorse CDC guideline as the foundation for opioid prescribing in OR
- Oregon-specific addenda: marijuana use; chronic patients (consultation/ documentation); MAT; naloxone
- Implementation/ communication strategies and plans



John W. McIlveen, Ph.D., LMHC, State Opioid Treatment Authority,
Oregon Health Authority, Health Systems Division

MEDICATION ASSISTED TREATMENT UPDATE: OREGON



Oregon TCE MAT Grant: Areas of Focus/Opioid Deaths and Hospitalizations



Oregon TCE MAT Grant: Summary of Project

- **Increasing MAT Capacity Statewide**
- Expanding MAT services through rural health centers in the North Coast Region
- Three new OTP's in SW Oregon
- Outreach services to connect rural primary care practices in Central and Eastern Oregon with an OTP (hub and spoke)
- Increase the number of buprenorphine-waivered physicians in Oregon who are actively prescribing buprenorphine
- **Education and Outreach**
- Provide expert, inter-professional consultation (including psychiatry, infectious disease, and addictions medicine) via Project ECHO
- Improve treatment retention and health outcomes for enrollees
- Implement the Motivational Stepped Care Model within 3 OTP's



Ariel Smits, MD, MPH
Associate Medical Director
Health Evidence Review Commission

BACK CONDITION - GUIDELINE NOTE 60



Guideline Note 60: Opioid Medications (Coverage Criteria)

During the first 6 weeks after injury, flare, surgery:

- Prescription limited to 7 days, and
- Short acting opioids only, and
- First line pharmacologic therapies are tried and ineffective, and
- Treatment plan includes exercise, and
- Opioid risk assessment

Opioid use after 6 weeks, up to 90 days:

- Functional assessment – 30% improvement
- With spinal manipulation, physical therapy, yoga, or acupuncture
- Opioid risk mitigation:
 - PDMP
 - Screen for opioid use disorder
 - Urine drug test
- Prescriptions limited to 7 days and short acting only

Opioids after 90 days:

- Not Covered without new injury, flare, surgery

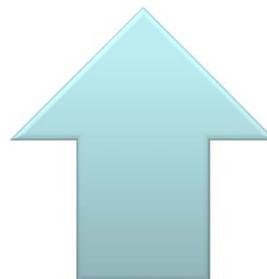
Transitional coverage for those on long-term opioid therapy through 1/2018:

- Taper plan
 - In place by January 2017
 - Include nonpharmacologic treatment strategies

Increased Coverage:

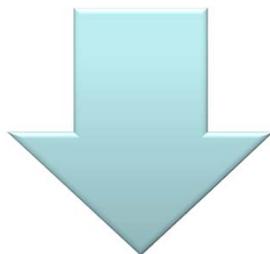
- Cognitive Behavior Therapy
- Spinal Manipulation
- Acupuncture
- PT/OT
- Non-opioid medications
- Yoga *
- Interdisciplinary Rehab *
- Supervised exercise *
- Massage Therapy *

* If available



Decreased Coverage:

- Surgeries
- Opioids
- Epidural Steroid Injections



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Anticipated Outcomes

- Reduced opioid use for back conditions
 - Improved public health: fewer ER visits, overdoses, deaths
- Improved outcomes for patients
 - Reduced pain and better function
 - Access to evidence-based effective care
 - Reduced harms from opioids and ineffective surgery
- Better educated medical workforce
 - Evidence based assessments and tools
 - Improved knowledge of best practices
- Ultimately, reduced costs through paying only for effective care



Implementation Challenges

- Workforce for alternative therapies
- Payment challenges for some therapies
- Integration of behavioral health services
- Education of providers, patients, public
- Dissemination of evidence based tools
- Controls on narcotic prescriptions
 - Prior authorizations
 - FFS vs CCOs
- Ability to taper patients on chronic opioid therapy
- Availability of services for patients with opioid use disorder
- Possible issues with cost of care for alternative therapies



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OHA-College of Pharmacy
Drug Use Research & Management

PROPOSED PRIOR AUTHORIZATION CRITERIA FOR OPIOIDS



Opioid Prior authorization Criteria for Guideline Note 60

- FFS population
- Draft PA criteria available on P&T website
 - http://www.orpdl.org/durm/meetings/meetingdocs/2016_11_17/drafts/OpioidsClassUpdateDRAFT.pdf



Resources

- OHA Opioids Website: <http://healthoregon.org/opioids>
 - Interactive Data Dashboard
 - Community Information
 - Guidelines
- Oregon Prescription Drug Monitoring Program Website: <http://www.orpdmp.com/>
- OHA Hospital Transformation Performance Program (HTPP) <http://www.oregon.gov/oha/analytics/Pages/Hospital-Baseline-Data.aspx>
- Statewide PIP website: coming soon
- Article: [Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates](#)
 - Author: Deborah Dowell



Integration of Prescription Drug Monitoring Program (PDMP) and health information technology (IT) systems

The Bill

- House Bill 4124 (HB 4124) passed in the 2016 legislative session thanks to the efforts of many stakeholders and partners who supported the bill.
- HB 4124 allows integration of the PDMP with health IT systems so prescribers, pharmacists and their delegates who are PDMP authorized users, will be able to query the Oregon PDMP within their workflow.
- Utilizing existing health IT systems and clinician workflow will save time and help healthcare professionals have accurate, relevant and timely PDMP information at the point of care to make better informed clinical decisions.

What you need to know

- The Oregon Health Authority (OHA) and the PDMP Advisory Commission identified an ad hoc group of stakeholders representative of the Emergency Department Information Exchange (EDIE) partners and vendor, regional health information exchanges (HIEs), and health system partners who have been evaluating solutions for the integration technology.
- The stakeholder group evaluated technical, contracting, and timing factors of available options and recommended the Appriss PMP Gateway to OHA and the PDMP Advisory Commission. Stakeholders determined the Appriss solution would have the shortest implementation timeline due to prior integrations with health IT systems and the PDMP vendor.
- The PMP Gateway is an interface that will securely integrate Oregon's PDMP data into the existing infrastructure of health IT systems. The Gateway model will enable multiple health IT systems to integrate without requiring separate connections for each system.
- HB 4124 requires individual prescribers, pharmacists and delegates to have active, valid PDMP user accounts in order to receive data back from the PDMP through the PMP Gateway query. This means unregistered prescribers, pharmacists and delegates who plan to use the integrated technology need to register as an account holder with OHA.

Work in progress & Next Steps

- The goal for implementation of the PMP Gateway technology is the Q1 of 2017.
- Oregon Administrative Rule 333-023 for PDMP is being amended to comply with HB 4124. A Rules Advisory Committee has been formed and is meeting to adopt new language to support HB 4124 requirements. The amended rule is expected to be in place by January 2017.
- PDMP business operations that will facilitate integration are being finalized. This includes an organization application process to ensure compliance with security and privacy requirements necessary for connection and an access agreement for information exchange required by OHA.
- The state is funding the connection between Oregon's PDMP vendor (Health Information Designs) and the Appriss PMP Gateway. PMP Gateway connections to health IT systems will be paid for by

health IT system (e.g. HIEs, facilities or health systems) via an annual fee to Appriss. The EDIE utility intends to support the costs for EDIE to connect to the PMP Gateway and provide PDMP information through EDIE alerts to Oregon's emergency department (ED) providers. EDs will need to ensure their providers are enrolled and have active PDMP accounts. Jefferson Health Information Exchange (JHIE) will connect to the PMP Gateway using funding from a federal grant from the Office of the Nation Coordinator for Health IT. Longer term, a utility model for funding gateway services is being explored for future implementation.

- OHA is working with Appriss to ensure that the gateway interface will meet the data security, encryption, auditing and reporting requirements of the PDMP program.

**Statewide PIP on Opioid Safety
Intervention Highlights**

Interventions that span the CCOs include formulary and guideline changes, alternative treatment options, provider and community education, tapering plans, pain classes, removal of prior authorizations and institution of quantity limits, high-user lists to providers, and the exploration of MAT network development.

CPCCO	Collaboration to evaluate pain clinics CPCCO continues to conduct the pain clinics including North Coast Pain Clinic, Revitalize Wellness Center, and Ivy Avenue. CPCCO is working with OSU to develop a comprehensive evaluation of the pain clinics, as well as the implementation of the larger CCO opioid strategy.
	Partnership to expand MAT in primary care Partnering with OHSU to expand medication-assisted treatment within primary care. A CPCCO ambulatory care pharmacist has been hired who will develop a naloxone program
HealthShare	Expanding access to MAT in primary care and specialty addictions settings. Development of a hub and spoke collaboration between Central City Concern and CODA, to be rolled out in the coming year. CODA is hiring a project manager for this. It will include agencies that provide MAT initiation, stabilization, and maintenance in various combinations.
Health Share: Tuality	Analyzing members on opioids according to demographics Tuality created a dashboard that includes race, ethnicity, and language and provider information.
IHN	Telephone needs assessment of community knowledge 295 telephone surveys were conducted with residents of Linn, Benton and Lincoln counties on their awareness and perceptions of opioid misuse issues. Results were that while the majority of respondents recognized the existence of opioid abuse, most underestimated the severity of the problem. Survey respondents indicated that public service announcements would be an effective way to communicate about opioid use to the community.
JCC	Transitioning chronic pain management to primary care JCC is aligning intervention efforts with their philosophy that treatment for chronic pain should be the responsibility of primary care. Outreach efforts are focusing on PCPs and providers who are requesting assistance. In this quarter, behavioral health and pharmacy staff mentored a PCP in an independent practice on how to deal with difficult patients.
S. Oregon Region (All Care, JCC, PHJ, WOA)	Regional opioid collaborative group—Opioid Summit Southern Oregon CCOs have joined efforts; AllCare, Primary Health of Josephine County, Jackson Care Connect and Western Oregon Advanced Health. Current activity is working with the Oregon Pain Guidance group to develop region-wide educational materials, guidelines and prescribing practices. Summit in North Bend to be held 10/27/16 to develop SW Oregon action plan.
WOAH	Dental activities WOAH's DCO, Advantage Dental, has been raising awareness among dental providers: Included information about opioids in newsletters; invited a speaker on alternative pain management and a PDMP representative to the summer meeting to assist dentists with enrollment in the PDMP; also promoted use of the OPG dental guidelines.
YCC	Telephone survey of clinician knowledge and awareness—increases PDMP registration YCCO conducted a brief telephone survey and clinic discussions about practice knowledge about the PDMP, registration, work flow, etc. As a result, 74% (14/19) of providers are registered users, have a registered delegate and use the PDMP of a regular basis when prescribing opioids.
	Alternative Payment Methodology In January 2016, YCCO implemented the Alternative Payment Model (APM), where add-on payments of \$1 per member per month were given to practices that did not have any members on greater than 120 mg MED for non-cancer pain management.

CCO Member Complaints and Grievances

2nd Quarter 2016 Review
CCO Complaints Reporting Process Discussion



Complaints and Grievances Trends Analysis

Background

- Updated complaint submission template utilized as early as October 2015; as a result of a year long workgroup.
- Quarterly summary report is generated from individual submissions from each CCO.
- Quarterly summary report is submitted to CMS.

Updated C&G Reports Comprised of:

- Quarterly C&G Summary Report
- New: Trending graphs
 - Total Complaints received from CCOs from 1Q2016 and 2Q2016.



Quarterly C&G Summary

- Report available on the OHA website
 - OHA OHP Data and Reports: <https://www.oregon.gov/oha/healthplan/Pages/reports.aspx>

Report Type	Report Date	Category	Name
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- Select "Quarterly Report"
- Click on "Complaints and Grievances Summary"

- Example of report



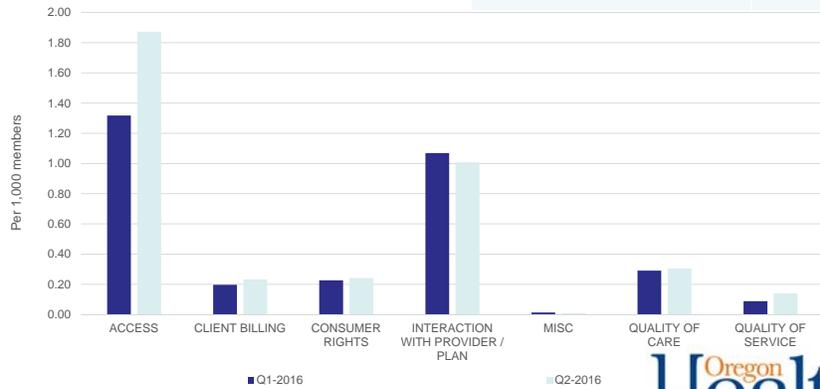
CCO Complaints and Grievances Summary, April-June 2016

	AICare	Cascade Health Columbia Pacific	Eastern Oregon	Family Care	Health Share	IHN	Jackson Care	PSCS CO	PSCS CG	Primary Health	Tillamook	Umpqua Western Oregon	Willamette Valley	Yamhill County	Total		
ACCESS - "A"																	
TOTAL:	14	9	25	4	158	694	7	67	29	0	32	88	13	232	479	21	1872
PENDING:	0	0	0	1	0	4	0	1	0	0	2	0	0	0	0	0	8
RESOLVED:	14	9	25	3	158	690	7	66	29	0	32	88	13	232	479	21	1864
RANGE:	0-7	0-7	0-11	0-2	0-138	0-580	0-2	0-53	0-11	0-0	0-28	0-46	0-4	0-81	0-338	0-9	
INTERACTION WITH PROVIDER OR PLAN - "IP"																	
TOTAL:	27	5	22	13	45	282	15	38	51	3	4	193	22	95	111	25	951
PENDING:	0	0	0	0	5	21	0	1	0	0	0	2	0	0	0	0	29
RESOLVED:	27	5	22	13	40	261	15	37	51	3	4	191	22	95	111	25	922
RANGE:	0-12	0-1	0-9	0-4	0-18	0-118	0-5	0-11	0-14	0-1	0-1	0-43	0-11	0-50	0-26	0-11	
CONSUMER RIGHTS - "CR"																	
TOTAL:	7	2	4	4	8	64	4	8	13	2	1	40	4	17	18	16	212
PENDING:	0	0	0	0	0	5	0	0	0	0	0	0	0	0	0	0	5
RESOLVED:	7	2	4	4	8	59	4	8	13	2	1	40	4	17	18	16	207
RANGE:	0-4	0-2	0-2	0-4	0-5	0-37	0-4	0-3	0-4	0-1	0-1	0-11	0-2	0-14	0-9	0-10	
QUALITY OF CARE - "QC"																	
TOTAL:	8	1	8	8	23	202	5	13	37	0	4	60	4	7	20	6	406
PENDING:	0	0	1	0	1	21	0	0	0	0	2	0	0	0	0	0	25
RESOLVED:	8	1	7	8	22	181	5	13	37	0	4	58	4	7	20	6	381
RANGE:	0-3	0-1	0-5	0-3	0-11	5-79	0-4	0-7	0-23	0-0	0-2	0-24	0-2	0-3	0-12	0-4	
QUALITY OF SERVICE - "QS"																	
TOTAL:	2	1	5	0	1	52	16	12	17	0	0	37	2	1	18	1	165
PENDING:	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	2
RESOLVED:	2	1	5	0	1	51	16	12	17	0	0	36	2	1	18	1	163
RANGE:	0-2	0-1	0-5	0-0	0-1	2-26	0-13	1-6	0-17	0-0	0-0	4-28	0-1	0-1	1-12	0-1	
CLIENT BILLING ISSUES - "CB"																	
TOTAL:	0	0	14	2	1	91	1	17	0	0	0	8	0	1	114	23	272
PENDING:	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	1	3
RESOLVED:	0	0	14	2	1	89	1	17	0	0	0	8	0	1	114	22	269
RANGE:	0-0	0-0	0-13	0-2	0-1	0-85	0-1	0-17	0-0	0-0	0-0	2-3	0-0	0-1	0-113	0-22	
OTHER	0	0	0	0	0	0	0	0	1	0	0	8	0	0	6	0	15
GRAND TOTAL	58	18	78	31	236	1385	48	155	148	5	41	434	45	353	766	92	3893
Enrollment Numbers: as of 6/2016	50,234	17,906	26,447	47,627	127,535	230,158	57,117	30,998	61,328	12,638	11,462	95,632	26,338	20,639	100,573	25,054	931,586
Per 1000 members:	1.15	1.01	2.95	0.65	1.85	6.02	0.84	5.00	2.88	0.40	3.58	4.54	1.71	17.10	7.62	3.67	3.91



C&G by Category average per 1,000 members

Complaints average per 1,000 members	Q1-2016	Q2-2016
ACCESS	1.32	1.87
CLIENT BILLING	0.20	0.23
CONSUMER RIGHTS	0.23	0.24
INTERACTION WITH PROVIDER / PLAN	1.07	1.01
MISC	0.01	0.01
QUALITY OF CARE	0.29	0.30
QUALITY OF SERVICE	0.09	0.14



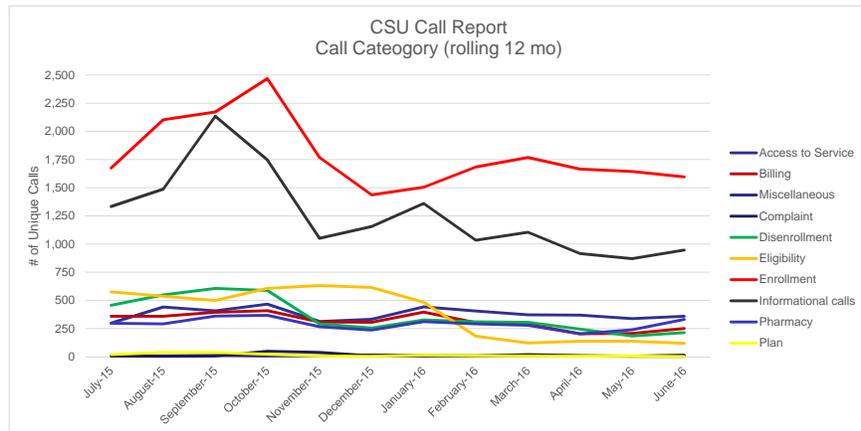
Provider Interaction and Access Complaints by CCO

INTERACTION	Average Per 1000 members	Total Complaints	ACCESS COMPLAINTS	Average per 1000 members	Total Complaints
AllCare	0.39	40	AllCare	0.23	24
Cascade Health	0.51	19	Cascade Health	0.62	23
Columbia Pacific	1.06	58	Columbia Pacific	0.81	44
Eastern Oregon	0.38	37	Eastern Oregon	0.20	20
Family Care	0.63	166	Family Care	1.22	317
Health Share	1.56	745	Health Share	2.85	1350
IHN	0.26	30	IHN	0.13	15
Jackson Care	1.11	70	Jackson Care	2.15	136
Primary Health	0.67	16	Primary Health	2.30	54
PSCS CG	0.27	7	PSCS CG	0.22	6
PSCS CO	0.89	94	PSCS CO	0.57	60
Trillium	1.75	341	Trillium	0.86	168
Umpqua	0.62	33	Umpqua	0.48	26
Western Oregon	4.75	201	Western Oregon	8.14	341
Willamette Valley	0.81	165	Willamette Valley	3.95	812
Yamhill County	0.96	49	Yamhill County	0.79	40

Data from CCO submitted C&G reports 1Q2016 & 2Q2016



Client Services Unit Report Example



What's Next: Complaints and Grievances Review

