

## Quality and Health Outcomes Committee Agenda

**November 9, 2015**

DHS 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	<b>Welcome / Introductions</b>	Tracy Muday, Chair	-October QHOC minutes (1 – 4) -PH Update (5 – 7)
9:10 – 9:20	<b>Public Health: Syphilis Screening</b>	Katrina Hedberg	-Presentation Slides (8 – 14)
9:20 – 9:35	<b>Health Systems Update</b>	Chris Norman Rhonda Busek	
9:35 – 9:45	<b>Back Guideline Discussion</b>		
9:45 – 10:15	<b>HERC Update</b>		-HERC & VbBS Agenda (15 – 17) -GAP Highlights (18 – 22) -HERC Minutes (23 – 31)
10:15 – 10:35	<b>Technical Assistance Projects</b>	Acumentra OHIT ORPRN	-Acumentra Flyer (32 – 33) - OHIT Presentation (34 – 37) -ORPN Flyer (38)
10:35 – 10:50	<b>Clinical Directors Items from the Floor</b>	All	
10:50 – 11:00	<b>Break</b>	All	
Learning Collaborative Session			
11:00 – 12:30	<b>Childhood Immunizations</b>	Panel	-Agenda (39) -Presentation slides (40 – 51) -Resources (52 – 64)
12:30 – 1:00	<b>LUNCH</b>		
Quality and Performance Improvement Session (2 hrs)			
1:00 – 1:10	<b>QPI Update - Introductions</b>	Barbara	
1:10 – 1:25	<b>2016 Schedule of Activities</b>	Acumentra	-Proposed EQRO Schedule (65) -External Quality Review Activities (66)
1:25 – 1:40	<b>Deliverables: Schedule &amp; Activities</b>	Lisa/Justin	
1:40 – 2:00	<b>Standard 8 Reporting Template</b>	Acumentra	-PIP Standard 8 tools (67 – 76)
2:00 – 2:30	<b>Statewide PIP: Metric Specifications &amp; Data Review</b>	Jon Collins Sara H.	-120 MED Specifications (77)
2:30 – 2:45	<b>Statewide PIP: Next Steps</b>	Acumentra	
2:45 – 3:00	<b>Items from the Floor</b>	All	

## MEETING NOTES

# Quality & Health Outcomes Committee (QHOC)

October 12, 2015

Website: <http://www.oregon.gov/oha/healthplan/Pages/CCO-Quality-and-Health-Outcomes-Committee.aspx>

Chair- Tracy Muday (WOAH)

Co-Chair- Barbara Carey (Health Share)

### **Attendees:** *(in person or by phone)*

Cynthia Ackerman (AllCare); Anne Alftine (JCC); Gary Allen (Advantage Dental); Susan Arbor (MAP); Joell Archibald (OHA); Bruce Austin (OHA); Joseph Badolato (FamilyCare); Summer Boslaugh (OHA); Graham Bouldin (Health Share); Bill Bouska (OHA); Stuart Bradley (WVCH); Mark Bradshaw (AllCare); Lisa Bui (OHA); Jim Calvert (Cascade Health Alliance); Barbara Carey (Health Share); Jody Carson (Acumentra); Tom Cogswell (OHA); Laurence Colman (GOBHI); Colleen Connolly (Trillium); Bruce Croffy (FamilyCare); Kevin Ewanchyna (IHN/CCO); Rosa Frank (OHA); Mike Franz (PacificSource); Ruth Galster (UHA); Sara Hallvick (Acumentra); Walter Hardin (Tuality); Rosanne Harksen (OHA); Jenna Harms (Yamhill CCO); Maria Hatcliffe (PacificSource); Hank Hickman (OHA); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Charmaine Kinney (Mult. Co./Health Share); Deborah Larkins (DHS); Lynnea Lindsey-Pengelly (Trillium); Alison Little (PacificSource); Cat Livingston (HERC); Andrew Luther (OHMS); Laura Matola (AllCare); John McIlveen (OHA); Kevin McLean (FamilyCare); Ben Messner (WOAH); Caryn Mickelson (WOAH); Jetta Moriniti (Providence); Tracy Muday (WOAH); Chris Norman (MAP); Laureen Oskochil (Acumentra); Dana Peterson (OHA); Ellen Pinney (OHA); Jordan Raweins (Moda/EOCCO); Rose Rice (UHA); Christine Seals (UHA); Ellen Singer (Kaiser); Amit Shah (CareOregon); Jim Shames (Jackson Co.); Nancy Siegel (Acumentra); Debbie Standridge (UHA); Dayna Steringer (WOAH/Advantage Dental); Anna Stern (WVCH); Ron Stock (OHA); Steve Stolzoff (GOBHI); Trish Styer (VCC); Priscilla Swanson (Acumentra); Denise Taray (OHA); Jed Taucher (AllCare); Melanie Tong (Washington Co.); and Jennifer Valentine (OHA);

### **By phone:**

Ellen Altman, Christine Castle, Lyle Jackson, Mark Whitaker, Tiffany Dorsey, And Melinda West

## CLINICAL DIRECTORS SESSION

### 1. Introductions & Announcements

Introductions/  
Announcements

- Introductions were made in the room, and with those on the phone.
- Ron Stock spoke briefly about the Diabetes presentation.
- PH Update included in packet

Review of September Notes

Notes from the September QHOC meeting were reviewed and approved.

### 2. Program Reports (Reports are given by the staff representatives of each program)

Pharmacy & Therapeutics  
Update: (Roger Citron)

- PT&T- last meeting held September 24, 2015
- Reviewing for recommended changes in January;
- Utilization of drugs- ¼ are for unfunded conditions;
- PAs are recommended for new starts;
- Next meeting will be November 19th. A final agenda will be ready in 1 week;
- There is a P&T Committee vacancy. Interested parties are encouraged to submit their name.

Metrics Update: (Sarah  
Bartelmann)

- 2016 measures/metrics selected;
- Save the date November 19, 2015 Webinar with Dr. David Labby;
- October 30, 2015- Joint meeting between Hospital Transformation and the Metrics Committee

HERC: (Cat Livingston)

- Discussed some issues with ICD-10;
  - Discussion on flat feet and bunions;
- Behavioral Health Advisory Panel (BHAP):**
- Child abuse and neglect codes;
  - “children under 5” in many guidelines- this terminology has been eradicated;
  - Discussed substance abuse and intoxication;
  - Integrated care- updated;
  - BHAP is an ongoing work group;
  - Referred to Appendix A. Methods.

	<p><b>Evidence –based Guidelines Subcommittee:</b></p> <ul style="list-style-type: none"> <li>▪ Dr. Alison Little (PacificSource) serves on this subcommittee;</li> <li>▪ Coverage guidance on Nitrous Oxide use for labor pain management;</li> <li>▪ Discussed cervical cancer screening.</li> </ul> <p><b>Health Technology Assessment Subcommittee (HTAS):</b></p> <ul style="list-style-type: none"> <li>▪ Proton Beam Therapy;</li> <li>▪ Bariatric surgery;</li> <li>▪ Continuous Glucose Monitoring (CGM) - Scope documents.</li> </ul> <p><b>Oral Health Advisory Panel (OHAP):</b></p> <ul style="list-style-type: none"> <li>▪ Partial dentures;</li> <li>▪ Silver diamine fluoride applications.</li> </ul>
<p>Health Systems Update (Rhonda Busek &amp; Chris Norman)</p>	<p>Rhonda Busek:</p> <ul style="list-style-type: none"> <li>▪ Out-of-hospital births – when member goes to FFS, how does the CCO know? Working on a process to alert the CCO;</li> <li>▪ Discussed the OHA/HSD organizational chart; a department wide format is being developed with a division format coming after. Upon completed format an organizational chart will be distributed at QHOC</li> <li>▪ HSD new Chief Health Officer will begin November 2nd.</li> </ul> <p>Chris Norman:</p> <ul style="list-style-type: none"> <li>▪ CCO related workgroups- some have changed from monthly meetings to quarterly, and one has been eliminated;</li> <li>▪ ICD-10- Went live October 1st;</li> <li>▪ MEOC- The Metropolitan Group has looked at our communications and there have been some findings;</li> <li>▪ Member Handbook- minor revisions will be made;</li> <li>▪ CMS State Alignment- has not met in some time;</li> <li>▪ Contracts and Compliance- Contracts are with CMS now.</li> </ul>

TOPIC	DISCUSSION	ACTION ITEM(S)
Back Pain Condition Guideline Changes- All	Back pain guideline changes- A roundtable was conducted where attendees were asked to share concerns and give input. Questions asked were about implementation, and frequency: <ul style="list-style-type: none"> <li>▪ How will this be implemented?</li> <li>▪ What is the frequency?</li> </ul> A study may be shared in the future.	<b><u>Action Item:</u></b>
From the Floor	Behavioral Health Directors meeting- meeting separately now. Will it be incorporated into this meeting? Need to elect a behavioral health director to be on the planning committee. Dr. Lynnea Lindsey-Pengelly was nominated. After a vote that was in favor, she accepted;	<b><u>Action Item (Lisa):</u></b> -Invite Dr. Lindsey-Pengelly to agenda setting meetings.
<b>JOINT LEARNING SESSION</b>		
Opioid Management	Learning forum agenda: <ul style="list-style-type: none"> <li>▪ “How to Get Started” panel discussion</li> <li>▪ Applying Lessons Learned</li> <li>▪ “Implementing Improvement Strategies” panel discussion</li> <li>▪ Reducing Opioid Overdose, Misuse and Dependency: A Guide for CCOs and Health Systems</li> <li>▪ Topic Table break out session</li> </ul>	
<b>Next Meeting</b>		
Monday, November 9, 2015 9:00 am - 3:00 pm <i>HSB Conference Room 137 A-D</i> Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: <a href="#">Map</a> Office: 503-378-5090 x0		



800 NE Oregon St., Ste. 930  
Portland, OR 97232-2195  
Voice: 971-673-1222  
FAX: 971-673-1299

## Quality and Health Outcomes Committee Public Health Division updates – November 2015

### Data and Reports

**Strategies to Support Tobacco Cessation and Tobacco-Free Environments in Mental Health and Substance Abuse Facilities:** In a recent report, The Centers for Disease Control and Prevention (CDC) highlighted Oregon and Utah’s work to promote smoking cessation and smoke-free environments in treatment facilities for mental illness and substance abuse. This work occurred during a 2-year American Recovery and Reinvestment Act (ARRA) funding period.

Both Utah’s Recovery Plus and Oregon’s Tobacco Freedom used 3 key strategies: being ready for opportunity, having a sound infrastructure, and having a branded initiative. A high level of engagement was achieved by identifying champions; sharing client success stories; and ensuring involvement of stakeholders, including community members, clients, and others. Partners participated in developing a realistic and feasible plan for applying the evidence base for tobacco cessation and treatment to a population that has a disproportionate share of smoking-related illness and death. This article is available at:

[http://www.cdc.gov/pcd/issues/2015/14\\_0585.htm](http://www.cdc.gov/pcd/issues/2015/14_0585.htm)

### Resources and Updates

**Indoor Clean Air Act Expansion:** In 2015, the Oregon legislature expanded the Indoor Clean Air Act to include the use of all types of inhalants (nicotine, marijuana or any other substance delivered into a person’s respiratory system) and “inhalant delivery systems.” Inhalant delivery systems are devices that can be used to deliver nicotine, cannabinoids and other substances, in the form of a vapor or aerosol. These include e-cigarettes, vape pens, e-hookah and other devices.

Beginning January 1, 2016 people may not smoke, aerosolize or vaporize any inhalant in workplaces, restaurants, bars and other indoor public places in Oregon. Additional details are available at: <http://www.healthoregon.org/morefreshair>. Or contact Kim La Croix at 971-673-0984 or [kimberly.w.lacroix@state.or.us](mailto:kimberly.w.lacroix@state.or.us).

**USPSTF recommendations for type 2 diabetes screening and intensive behavioral counseling interventions:** The U.S. Preventive Services Task Force (USPSTF) has issued a new

recommendation for screening for abnormal blood glucose as part of cardiovascular risk assessments in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

Last year, the USPSTF issued a recommendation for diet and physical activity counseling for adults at high risk for cardiovascular disease. Payers may comply with these USPSTF recommendations by offering or referring patients to CDC-recognized lifestyle interventions operating under the National Diabetes Prevention Program (DPP). For more information about the DPP, or guidance on starting a program or developing referral protocols, visit [www.healthoregon.org/takecontrol](http://www.healthoregon.org/takecontrol). Or contact Andrew Epstein, Diabetes Program Coordinator, at [andrew.d.epstein@state.or.us](mailto:andrew.d.epstein@state.or.us).

USPSTF recommendations are available at:

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes-Updates>

<http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/healthy-diet-and-physical-activity-counseling-adults-with-high-risk-of-cvd>

**Public Health Modernization:** The Oregon Health Authority Public Health Division will hold two public meetings to seek input on the draft Public Health Policy Manual. The manual defines the "foundational capabilities and programs" for state and local health departments across Oregon. These standards were adopted by House Bill 3100, which was signed into law in July 2015.

Members of the public can attend one of the following meetings in person or via webinar to provide comment on the draft manual:

**Wednesday, November 18, 3-4 p.m.**

Portland State Office Building, Room 1E

800 NE Oregon St., Portland

Conference call: 1-877-402-9753; access code 1439464

Webinar registration: <https://attendee.gotowebinar.com/register/6597944247819002625>

**Friday, November 20, 11 a.m.-noon**

Portland State Office Building, Room 1A

800 NE Oregon St., Portland

Conference call: 1-877-402-9753; access code 1439464

Webinar registration: <https://attendee.gotowebinar.com/register/5550612143362462977>

**HIV Testing in the Oral Health Care Setting:** The AIDS Education and Training Center (AETC) has updated their website to include recommendations and resources for implementing an HIV testing program in the oral health care setting. In 2013, 61.7% of adults 18 to 64 years of age visited a dentist, highlighting the dental setting as a key opportunity for routine HIV testing. Recommendations and resources are available at:  
<http://www.aidsetc.org/resource/hiv-testing-oral-health-care-setting>.

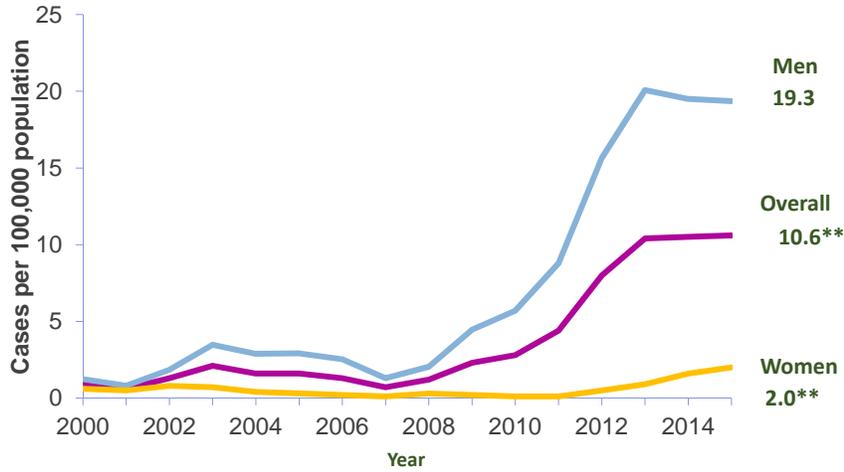
## Quality and Health Outcomes Committee November 9, 2015

- Katrina Hedberg, MD, MPH
- Oregon Health Authority
- Public Health Division
- [katrina.hedberg@state.or.us](mailto:katrina.hedberg@state.or.us)
- Sean Schafer, MD, MPH
- Oregon Health Authority
- HIV/STD/TB Program
- [sean.schafer@state.or.us](mailto:sean.schafer@state.or.us)

## Purpose of Presentation

- Advise CCO Medical Directors of Impending Oregon Health Authority Recommendation for Prenatal Syphilis Screening in Oregon
- Answer related questions
- Listen to any related discussion about impact, effectiveness, cost, billing
- Heads up about public awareness campaign

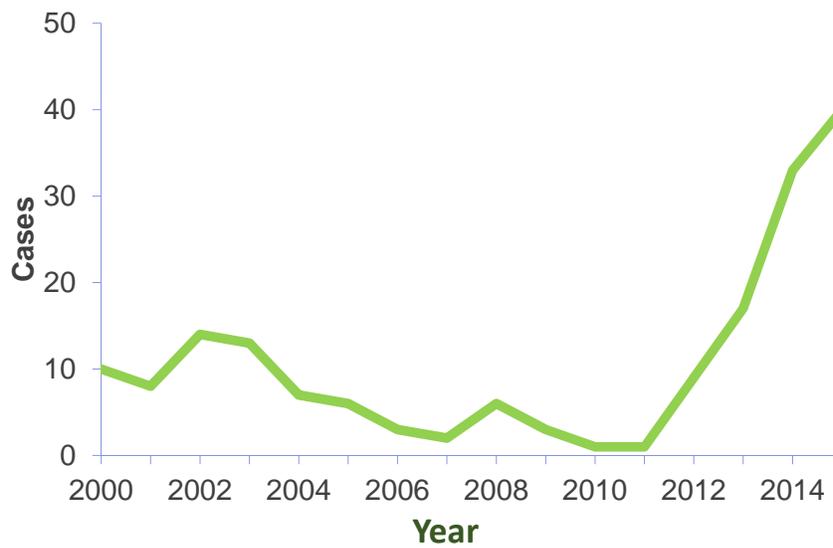
### Rates of early\* syphilis by sex and year— Oregon, 2000–2015



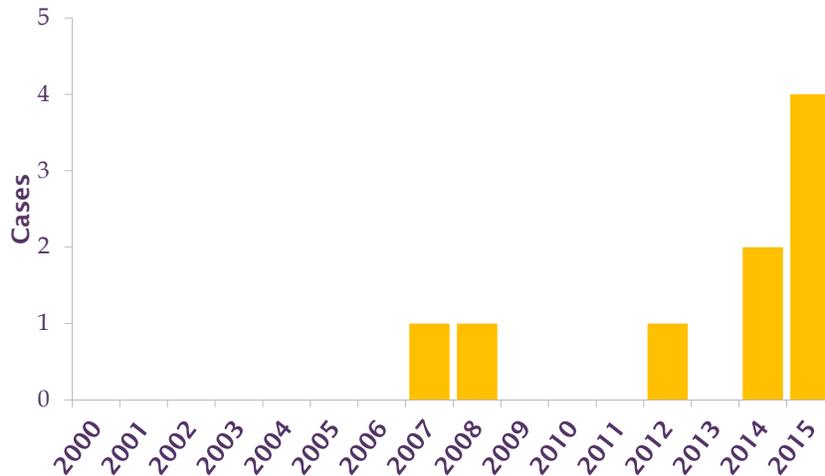
\*includes primary, secondary and early latent within 12 months of exposure

\*\*for 10 months....will be higher by 25–30%

### Syphilis in women, Oregon, 2000 – 2015



## Congenital Syphilis, Oregon, 2000–2015



## Congenital Syphilis, Case Histories

- 20 y/o, RPR negative in first trimester, presented in third trimester with anomolous ultrasound, syphilis serology positive, live birth with bone stigmata of congenital syphilis. No drug use, past h/o chlamydia
- 21 y/o, RPR negative at first prenatal visit ~9 weeks, named as sex partner to case @ ~17 weeks and treated, stillbirth at 21 weeks (hydrops)
- 33 y/o, had negative RPR at ~12 weeks. Live infant at term had rash, diagnosed with congenital syphilis. Mother tested again...positive. Both treated. Drug history not recorded.

Self reported risk factors among female early syphilis cases (80), Oregon, 2013 – 2015 (October)

- Drug use 20 (17 meth)
- Exchange sex for money/drugs 2
- Past reported chlamydia or gonorrhea or HIV (28)
- None of above (40)

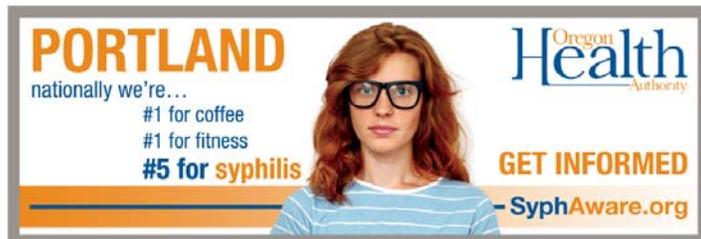
### **CDC, ACOG Prenatal Syphilis Screening Recommendations**

- **Low risk women, low community prevalence of syphilis**
  - screen once at first prenatal visit
- **“In communities and populations in which the risk for congenital syphilis is high**
  - screen again at 28 weeks’ gestation and at delivery

## OHA Recommendation

- Until further notice
  - Screen all pregnant women for syphilis at first prenatal visit, at beginning of third trimester (28 weeks) and again at delivery
  - Use traditional screening algorithm if possible (RPR, followed by treponeme-specific test such as FTA for confirmation if positive)
  - Be aware that some laboratories automatically conduct “reverse algorithm” screening that involves doing a treponeme specific test first, can be confusing

If you have time to share...

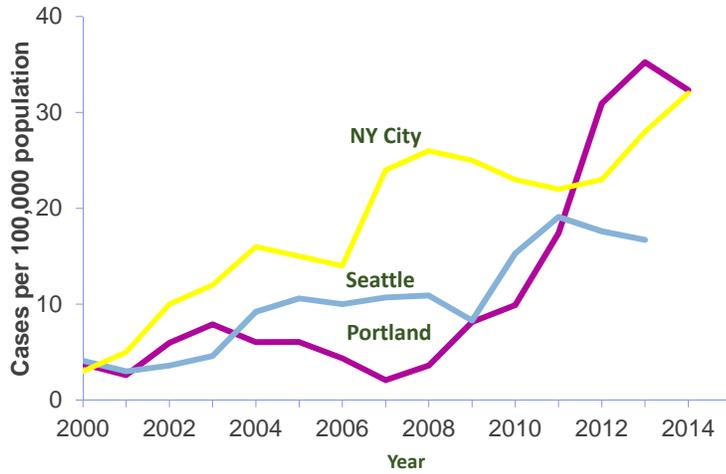


<https://public.health.oregon.gov/DiseasesConditions/HIVSTDViralHepatitis/Pages/index.aspx>

Most effective step to reduce syphilis transmission

- Recommend that sexually active men who have sex with men get a serologic test for syphilis every 3 months
- Consider adding routine syphilis serology to regular CD4 and viral loads in men who have sex with men who have HIV

### Rates of early\* syphilis by year— NY City, Seattle, Portland, 2000–2015



\*includes primary, secondary and early latent within 12 months of exposure

\*\*for 10 months....will be higher by 25–30%

## AGENDA

### HEALTH EVIDENCE REVIEW COMMISSION

Wilsonville Training Center, Rooms 111-112

November 12, 2015

1:30-4:30 pm

*(All agenda items are subject to change and times listed are approximate)*

#	Time	Item	Presenter	Action Item
1	1:30 PM	Call to Order	Som Saha	
2	1:35 PM	Approval of Minutes (10-1-2015)	Som Saha	X
3	1:40 PM	Director's Report	Darren Coffman	
4	1:45 PM	Planned Out-of-hospital Birth <ul style="list-style-type: none"><li>• EbGS Recommended Coverage Guidance</li><li>• VbBS Recommended Prioritized List Changes</li></ul>	Cat Livingston	X
5	2:45 PM	Value-based Benefits Subcommittee Report	Ariel Smits Cat Livingston	X
6	3:30 PM	Indications for Proton Beam Therapy <ul style="list-style-type: none"><li>• HTAS Recommended Coverage Guidance</li><li>• VbBS Recommended Prioritized List Changes</li></ul>	Cat Livingston	X
7	4:20 PM	Next Steps <ul style="list-style-type: none"><li>• Schedule next meeting – 1/14/16 Wilsonville Training Center, Rooms 111-112</li></ul>	Som Saha	
8	4:30 PM	Adjournment	Som Saha	

Note: Public comment will be taken on each topic per HERC policy at the time at which that topic is discussed.

**AGENDA**  
**VALUE-BASED BENEFITS SUBCOMMITTEE**

**November 12, 2015**

**8:00am - 1:00pm**

Clackamas Community College

Wilsonville Training Center, Rooms 111-112

Wilsonville, Oregon

*A working lunch will be served at approximately 12:00 PM*

*All times are approximate*

- |             |                                                                      |                |
|-------------|----------------------------------------------------------------------|----------------|
| <b>I.</b>   | <b>Call to Order, Roll Call, Approval of Minutes – Kevin Olson</b>   | <b>8:00 AM</b> |
| <b>II.</b>  | <b>Staff report – Ariel Smits, Cat Livingston, Darren Coffman</b>    | <b>8:05 AM</b> |
|             | <b>A.</b> Errata                                                     |                |
|             | <b>B.</b> Back line change delay                                     |                |
| <b>III.</b> | <b>Straightforward/Consent agenda – Ariel Smits</b>                  | <b>8:10 AM</b> |
|             | <b>A.</b> Straightforward table                                      |                |
|             | <b>B.</b> Straightforward back lines corrections                     |                |
|             | <b>C.</b> Peripheral vascular disease line revisions                 |                |
| <b>IV.</b>  | <b>2016 CPT code review – Ariel Smits</b>                            | <b>8:15 AM</b> |
|             | <b>A.</b> Consent agenda                                             |                |
|             | <b>A.</b> Straightforward/consent 2016 CPT code spreadsheet          |                |
|             | <b>B.</b> Ureteral embolization or occlusion                         |                |
|             | <b>C.</b> Paravertebral nerve blocks                                 |                |
|             | <b>B.</b> Codes requiring discussion                                 |                |
|             | <b>A.</b> Endobronchial ultrasound (EBUS)                            |                |
|             | <b>B.</b> Sclerotherapy for cysts/seromas                            |                |
|             | <b>C.</b> Intra-arterial interventions for acute stroke              |                |
|             | <b>D.</b> Intracranial intravascular infusion other than thrombotics |                |
|             | <b>E.</b> Fetal MRI follow up                                        |                |
|             | <b>F.</b> Gastric emptying with small bowel/colon transit            |                |
|             | <b>G.</b> Genetic testing codes                                      |                |
|             | 1. Non-prenatal genetic testing guideline                            |                |
|             | 2. Prenatal genetic testing guideline                                |                |
|             | <b>H.</b> Tumor marker codes                                         |                |
|             | <b>I.</b> Genetic tests for disease management                       |                |
|             | <b>J.</b> Vestibular tests                                           |                |
|             | <b>K.</b> Arterial pressure waveform analysis                        |                |
|             | <b>L.</b> Photoscreening                                             |                |

- |              |                                                       |                 |
|--------------|-------------------------------------------------------|-----------------|
| <b>V.</b>    | <b>New discussion items – Ariel Smits</b>             | <b>10:30 AM</b> |
|              | A. Adjustment disorder coding specification           |                 |
|              | B. Thromboangiitis obliterans                         |                 |
| <b>VI.</b>   | <b>Guidelines – Ariel Smits, Cat Livingston</b>       | <b>10:50 AM</b> |
|              | A. Acupuncture                                        |                 |
|              | B. Tobacco cessation coverage and prevention          |                 |
|              | C. Tobacco use and elective surgery                   |                 |
| <b>VII.</b>  | <b>Coverage Guidances for review – Cat Livingston</b> | <b>11:30 PM</b> |
|              | A. Planned out-of-hospital births                     |                 |
|              | B. Indications for proton beam therapy                |                 |
| <b>VIII.</b> | <b>Public comment</b>                                 | <b>12:55 PM</b> |
| <b>IX.</b>   | <b>Adjournment – Kevin Olson</b>                      | <b>1:00 PM</b>  |

## Highlights

Genetic Advisory Panel  
Conference Call hosted at:  
Barbara Roberts Human Services Building  
500 Summer Street NE, Room 559, Salem, Oregon  
10/13/2015  
9:00-11:00 am

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**Members Present:** Karen Kovak; Kathryn Murray; Sue Richards, PhD

**Staff Present:** Ariel Smits, MD, MPH; Jason Gingerich

**Also Attending:** Devki Saraiya and Karen Heller, Myriad Genetics

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### Review of New Genetics CPT Codes for 2015

The following recommendations were suggested for staff to present to the Value-based Benefits Subcommittee at their November 12, 2015 meeting:

1) Breast cancer syndrome genetic testing:

a. Specific tests

- i. 81162 BRCA1, BRCA2 (breast cancer 1 and 2) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis
- ii. 81432: Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 14 genes, including ATM, BRCA1, BRCA2, BRIP1, CDH1, MLH1, MSH2, MSH6, NBN, PALB2, PTEN, RAD51C, STK11 AND TP53

- iii. 81433: Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer) duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, AND STK1
  - b. Discussion: NCCN guideline contains a table of recommended genetic tests--some of the tests included in the panels above are listed as evidence based, others do not have evidence support. However, the NCCN table has the caveat that even those tests without evidence to support their use might be useful in specific clinical situations. There was discussion about using panel testing versus using customized testing for certain genes. The advisory panel felt that panels are useful in some situations, and the more specific testing might be all that is indicated in other situations. However, the panel tests are frequently the same price as more specific tests. GAP felt that the panel tests above may be more cost effective than singling out the specific tests called out by NCCN as evidence based. Myriad representatives testified that 81432 and 81433 are not priced by Medicare and therefore will likely not be billable for 2016. A miscellaneous genetic testing CPT code is likely to be used instead.
  - c. Suggested staff recommendation to VbBS: Add all to the Diagnostic Procedures File and add to the Non-Prenatal Genetic Testing Guideline D1
- 2) Ashkenazi Jewish panel testing
- a. 81412: Ashkenazi Jewish associated disorders ( eg, Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Fanconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1 and SMPD1
  - b. GAP discussion: The group discussed “pan-ethnic” testing, which is becoming increasingly common. These tests are large panels which include genetic defects seen in different genetic groups. The issues with this type of testing are difficulty in determining a patient’s ethnic background, as well as the fact that “pan-ethnic” testing is frequently less expensive than more targeted testing. However, these types of large panel tests have the possibility of finding mutations of questionable significance, or may provide information that the patient/family does not desire to know. There was a question about whether specific Ashkenazi Jewish testing panels will continue to be used, or whether pan-ethnic panels will become the standard.

The specific use of this test for prenatal testing was discussed in the context of the Prenatal Testing Guideline. This guideline specifically prohibits the use of panels that include tests not specifically approved in the guideline. Based on this wording, GAP felt that the Ashkenazi Jewish panel could not be added to the Prenatal Genetic Testing Guideline.

They recommended that this guideline be brought back through the Coverage Guidance process, with specific attention paid to whether larger panel testing should be allowed for all types of prenatal testing as well as specifically for Ashkenazi Jewish patient screening. The Prenatal Genetic Testing Guideline review should also include a discussion about whether pre-conception testing should fall under this guideline or under the non-prenatal genetic testing guideline.

GAP members pointed HERC staff to the American College of Medical Genetics guideline on preconception counseling for information on the probability of each of these types of test being positive.

- c. Suggested staff recommendations to VbBS:
  - i. Add 81412 to the Diagnostic Procedures File
  - ii. Amend the Non-Prenatal Genetic Testing Guideline to allow testing for pre-conception counseling only when the panel test is used in place of individual tests and is of similar or lower cost than the individual tests.

### 3) Hereditary retinal disorders

- a. 81434: Hereditary retinal disorders (eg, retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
- b. GAP discussion: This appears to be a minimal list of genes to include in a panel; most panels have far more genes. This type of testing influences management significantly
- c. Suggested staff recommendation to VbBS: Add 81434 to the Diagnostic Procedures File

### 4) Hereditary neuroendocrine tumor disorders

- a. 81437: Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX, SDHB, SDHC, SDHD, TMEM127, and VHL
- b. 81438: Hereditary neuroendocrine tumor disorders (eg, medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paraganglioma); duplication/deletion analysis panel, must include analyses for SDHB, SDHC, SDHD, and VHL
- c. Gap discussion: testing is appropriate, will change management or screening
- d. Suggested staff recommendation to VbBS: Add 81437-81438 to the Diagnostic Procedures File

## 5) Noonan spectrum disorder testing

- a. 81442: Noonan spectrum disorders (eg, Noonan Syndrome, cardio-facio-cutaneous syndrome, Costello syndrome, LEOPARD Syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF, CBL, HRAS, KRAS, MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2, and SOS1
- b. GAP discussion: This is an important test to cover. The test will affect management, as some genes affect cancer risk and patients will need surveillance for these cancers if positive. The gene list in this panel is reasonable. The single genetic defect PTPN11 is positive in 50% of kids, but cost difference between this test and whole panel is only about \$100. Requiring testing for PTPN11 first, and then the panel if negative, will delay testing and treatment.
- c. Suggested staff recommendation to VbBS: Add 81442 to the Diagnostic Procedures File

The non-prenatal genetic testing guideline was reviewed. HERC staff proposed integrating the genetic testing algorithm into this guideline. The OHP medical directors and plans have expressed confusion about the algorithm and it currently is physically separated on the Prioritized List from the guideline note. The GAP members agreed with this change, as well as a change to move a clause which requires the least expensive set of tests that can be expected to come up with a diagnosis to the beginning of the guideline. The other changes consisted of updating the NCCN guideline references and adding clauses for the newly adopted CPT codes above. GAP members requested the addition of a clause in the genetic counseling for cancer section specifying that cancer survivors should have genetic counseling. GAP members are seeing many cancer survivors who were never offered appropriate genetic tests which would affect their treatment and screening options. For example, breast cancer survivors who qualified for BRCA testing but had not received it; such testing could influence decisions for oophorectomy or for frequency and/or modality of breast cancer screening. There was a request to specify the training requirements for clinicians who order genetic tests by the OHP medical directors; however, GAP members did not feel that this was appropriate as there is a workforce shortage of genetic counselors and other clinician training requirements are not easily specified. The GAP group discussed the requirement in the non-prenatal genetic testing guideline that a patient have a >10% chance of having a genetic disorder for coverage of testing. In many cases in pediatric conditions, the disorders are very rare and even a very syndromic child with a very abnormal physical exam has a very low chance of having a specific genetic disorder. The group suggested that “reasonable suspicion” be substituted instead, but noted that this change was likely too vague. The group was concerned about what evidence was required to meet this 10% threshold, particularly for very rare, poorly studied conditions.

The GAP group lastly discussed having some of of panel of experts pulled together to review requests for OHP genetic testing. There is a possible pilot group for this type of review being done in the state of Washington. The GAP group felt that the criteria for deciding coverage for genetic tests varied too widely between CCOs, and was not decided on a timely basis in some cases. HERC staff suggested that this idea be brought to the QHOC group at OHA for further discussion.

DRAFT

## MINUTES

Health Evidence Review Commission  
Clackamas Community College  
Wilsonville Training Center, Rooms 111-112  
Wilsonville, Oregon  
October 1, 2015

**Members Present:** Som Saha, MD, MPH, Chair; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC; Irene Crowell, RPh; Mark Gibson; Leda Garside, RN, MBA (arrived at 1:45 pm); Susan Williams, MD; Chris Labhart; Derrick Sorweide, DO; Holly Jo Hodges, MD.

**Members Absent:** Gerald Ahmann, MD, PhD.

**Staff Present:** Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Denise Taray, RN; Jason Gingerich; Daphne Peck (by phone).

**Also Attending:** Kim Wentz, MD (by phone), Jessie Little (Oregon Health Authority); Carl Stevens (Care Oregon); Neola Young & Emily McLain (Basic Rights Oregon); Amy Perkins and Erica Pettigrew (OHSU).

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### Call to Order

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

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### Minutes Approval

**MOTION: To approve the minutes of the 8/13/2015 meeting as presented. CARRIES 10-0. (Absent: Garside)**

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### Director's Report

Darren Coffman said Gary Allen, DMD, has been confirmed by the Oregon senate as the dental representative to this Commission. Dr. Allen is the clinical director for Advantage Dental that serves a broad spectrum of the state. Dr. Allen has been involved in dental policy since the 1990s, in various advisory panels and subcommittees. Coffman asked that Allen serve on the Value-based Benefits Subcommittee (VbBS) as did the previous dental representative.

**Motion: To appoint Dr. Gary Allen as a member of VbBS. CARRIES: 11-0.**

Coffman stated the Evidence-based Guidelines Subcommittee (EbGS) lost a CCO representative when Dr. Lueken left the state. He offered Alison Little, MD, MPH as a candidate. Dr. Little worked with HERC and its predecessor, the Health Services Commission, as a commissioner, staff and contractor over the past 20+ years. Recently, she work with the Center for Evidence-based Policy on HERC's coverage guidances but left in December to take a position as medical director for PacificSource in Bend.

Saha commented that Little is second only to Coffman in knowledge about the Commission and its progenitor.

**Motion: To appoint Dr. Alison Little as a member of EbGS. CARRIES: 11-0.**

Dr. Ariel Smits announced ICD-10-CM went into effect today. Any references to ICD-9-CM in the meeting materials are purely informational at this point. She mentioned we expect there to be some errors in the Prioritized List of Health Services, as the conversion to ICD-10-CM was a major undertaking. Errors should be reported to us at [HERC.Info@state.or.us](mailto:HERC.Info@state.or.us) as soon as they are discovered.

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

[Meeting materials](#) pages 69-234

Ariel Smits reported the VbBS met earlier in the day, 10/1/2015. She summarized the subcommittee's recommendations.

**RECOMMENDED CODE MOVEMENT (effective 1/1/16)**

- Remove the procedure codes for temporary prostatic stents from 2 covered lines and place on the Services Recommended for Non-Coverage Table as investigational
- Add the 2016 CDT codes to various dental lines as recommended by the Oral Health Advisory Panel
- Add the procedure code for silver diamine fluoride application to the covered dental caries line
  - There was a brief conversation by the Commission to discuss how the medicament is applied and some high-level details of the FDA approval
- Delete the procedure code for vertebral fracture assessment using DXA from the Diagnostic File and add to the Services Recommended for Non-Coverage Table as investigational
- Add several ophthalmology visit and evaluation codes to the Diagnostic File to allow for the evaluation of urgent eye conditions
- Add procedure codes to a covered line to allow trochanteric bursitis to be treated with steroid injections
- Clarify placement of various procedures and diagnoses relating to nose deformities. The repair of the tip of the nose not involved with cleft palate was moved to the Services Recommended for Non-Coverage Table.
- Add procedure codes for stem cell transplant to the covered line containing neuroblastoma with a new guideline limiting use to high-risk neuroblastoma
- Move all child abuse and neglect diagnosis codes to a single covered line, which had all mental health service procedure codes also added to it
- Add diagnosis and procedure codes for repair of ear drum perforations to the two covered hearing loss lines with a guideline
- Add and delete codes related to various straightforward changes
- Remove procedure codes for penile implants from this line

**RECOMMENDED GUIDELINE CHANGES (effective 1/1/16)**

- Add a new guideline governing the use of silver diamine fluoride for use only with dental caries up to twice a year
- Delete the existing guideline indicating lack of coverage for silver compounds for dental caries

- Add a new guideline outlining when ophthalmology codes are considered diagnostic
- Add a new guideline to clarify when trochanteric bursitis is included on a covered line (for steroid injections and physical therapy) and when it is included on a non-covered line (for surgical procedures)
- Modify the guideline for nose tip repair in cleft palate to clarify when this procedure is covered
- Delete the guideline regarding reconstruction of the nose
- Add new guidelines limiting the use of botulinum toxin injections for the treatment of migraines and bladder conditions
- Modify the time period allowed for repair of peripheral nerve injuries from 8 weeks to 6 months in the nerve injury guideline
- Delete the statement of intent about behavioral and physical health integration

**MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances, as stated. See the VbBS minutes of 10/1/2015 for a full description. Carries: 11-0.**

#### **Gender dysphoria discussion: Breast augmentation**

Smits said VbBS recommended the addition of breast augmentation as a treatment for gender dysphoria in a split vote, 4 to 3, and encouraged the Commission's discussion. Currently female-to-male chest surgery is a funded condition. Breast augmentation is covered for breast cancer survivors as well as the surgery on the contralateral breast for symmetry.

The proposal is to allow augmentation in individuals who, after a year on hormones, are unable to reach Tanner Stage 5 (breast development stage measuring the structural shape and contour of breast – not size). Individuals who are unable to take hormones would also be candidates.

Saha asked to hear the basis of the minority opinion. Smits explained some VbBS minority voices felt the procedure to be strictly cosmetic, citing that many cisgender women feel their chest size or shape is inadequate for social functioning or have perhaps even mental health symptoms from their chest size. Breast augmentation for those issues is not covered. The proponents felt gender dysphoria is now covered because of the reduction in hospitalizations, anxiety, depression, and suicide. The evidence upon which HERC based their decision included a whole menu of treatment options, including breast augmentation. Williams also mentioned there are other viable, nonsurgical alternatives available. Saha said the procedure/treatment is *sex reassignment*. He opined if we offer gender dysphoria treatment then we should not fall short of one of the major manifestations of sex reassignment. Further, he asked for anyone to present evidence, including studies, showing that woman with small breasts, who are biologically women, have high rates of suicide and depression to the same degree as someone who has gender dysphoria. It is fundamentally different than a small breasted woman with stress. The compelling difference is between "having breasts" and "having the breasts you want."

Gibson remarked on the matter being "a tough call" but added he was not persuaded by the argument.

**MOTION: To approve the VbBS recommendations on coverage of breast augmentation as stated on page 150 of the meeting materials with the paragraph on mammoplasty coverage appended to the existing guideline as shown below . CARRIES: 8-3. Opposed Gibson, Hodges, Williams.**

Approved guideline:

**GUIDELINE NOTE 127, GENDER DYSPHORIA**

*Line 413*

Hormone treatment with GnRH analogues for delaying the onset of puberty and/or continued pubertal development is included on this line for gender questioning children and adolescents. This therapy should be initiated at the first physical changes of puberty, confirmed by pubertal levels of estradiol or testosterone, but no earlier than Tanner stages 2-3. Prior to initiation of puberty suppression therapy, adolescents must fulfill eligibility and readiness criteria and must have a comprehensive mental health evaluation. Ongoing psychological care is strongly encouraged for continued puberty suppression therapy.

Cross-sex hormone therapy is included on this line for treatment of adolescents and adults with gender dysphoria who meet appropriate eligibility and readiness criteria. To qualify for cross-sex hormone therapy, the patient must:

1. have persistent, well-documented gender dysphoria
2. have the capacity to make a fully informed decision and to give consent for treatment
3. have any significant medical or mental health concerns reasonably well controlled
4. have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care ([www.wpath.org](http://www.wpath.org)).

Sex reassignment surgery is included for patients who are sufficiently physically fit and meet eligibility criteria. To qualify for surgery, the patient must:

1. have persistent, well documented gender dysphoria
2. have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual
3. have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4. have the capacity to make a fully informed decision and to give consent for treatment
5. have any significant medical or mental health concerns reasonably well controlled
6. for breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.
7. for genital surgeries, have two referrals from mental health professionals provided in accordance with the version 7 WPATH Standards of Care.

Electrolysis (CPT 17380) is only included on this line for surgical site electrolysis as part of pre-surgical preparation for chest or genital surgical procedures also included on this line. It is not included on this line for facial or other cosmetic procedures or as pre-surgical preparation for a procedure not included on this line.

Mammoplasty (CPT 19316, 19324-19325, 19340, 19342, 19350, 19357-19380) is only included on this line when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale OR there is a medical contraindication to hormonal therapy.

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**Coverage Guidance Topic: Planned Out-of-hospital Birth**

[Meeting materials](#), pages 236-406

Livingston presented the proposed coverage guidance from EbGS. VbBS was unable to complete its review during the morning's meeting, therefore this presentation was informational.

Livingston explained that planned OOH births (OOHB) include birthing at home and in a birthing center. The evidence, which has a potential for indirectness from various factors such as systems of care, licensure and regulatory requirements, came from predominately observational studies from other countries (Australia, Canada, Netherlands, UK). The studies were population-based and focused on perinatal mortality, neonatal mortality, cesarean rate and postpartum hemorrhage.

Saha said this is an issue where there were strong opinions on both side, an uncommon situation. In opposition, hospitals and OB/GYNs and citizens all advocated against it because of the higher infant mortality rate. As great as the out-of-hospital birth movement sounds, there have been many problems. In support, largely the midwifery community, contended they can provide the care and restrictions should be loosened so they can be paid for their services. He said this topic is the most contentious issue the Commission has faced: If families decided to go against the set guidelines and restrictions, should the health plan be responsible for the health related consequences that can arise?

Livingston said the OHA, who have been involved with this topic, has the Licensed Direct Entry Midwifery Workgroup addressing multiple issues related to out of hospital birth. Currently, births outside a hospital setting are being paid for under “fee-for-service” rather than through the Coordinated Care Organizations (CCOs). Livingston went on to say that the Health Systems Division (formerly DMAP) and CCO medical directors have asked HERC to be extremely explicit with coverage criteria.

There was some discussion around “informed consent;” it may be the mother’s right to give birth outside a hospital. Others countered the health system should pay for only the safest and most effective care. Others in the healthcare field shared that many times they have seen informed consent forms signed *after* procedures.

Saha explained one issue that makes this contentious is there was evidence presented that OOHB was just as safe as hospital birth. There was come contrary evidence as well. Patient selection becomes an issue in these studies. In-hospital births will always be stacked with the higher complexity births that you would expect to have worse outcomes because the complexity causes someone who might have otherwise had an OOHB to have an in-hospital birth; accounting for risk-adjustment is often imperfect. The second issue is the best studies came out of Europe (the Netherlands), where the networking system between OOHB delivery providers and in-hospital delivery providers is very strong. If something goes wrong, the woman can briskly be transported to the hospital; the communication between the midwife in the home and the OB/GYN in the hospital is very strong. That is not necessarily the case in the United States. We cannot expect the same level of safety.

Livingston reviewed the GRADE-Informed Framework ([page 272](#)). There was no discussion. She then began to review the Box language components, which are four pages long.

**High risk criteria examples in the proposal VbBS is reviewing (no out-of-hospital coverage):**

- Cesarean section or other hysterotomy (vaginal birth after Cesarean (VBAC))
- Unexplained stillbirth/neonatal death or previous death related to intrapartum difficulty
- Baby with neonatal encephalopathy
- Gestational age - preterm or postdates (defined as gestational age < 37 weeks + 0 days or > 41 weeks + 6 days)
- Pre-existing chronic hypertension

- Pregnancy-induced hypertension with diastolic blood pressure greater than or equal to 90 mmHg or systolic blood pressure greater than or equal to 140 mmHg on two consecutive readings taken at least 30 minutes apart
- Multiple gestations

Livingston clarified the risk of vaginal birth after Cesarean (VBAC) is death since uterine rupture occurs suddenly, not allowing time for transfer to a hospital. Hodges said some rural hospitals in Oregon stopped allowing that even in a hospital setting because they were unable to get adequate malpractice insurance. Agreeing it can be dangerous, Livingston added that when it occurs it will be catastrophic for the mother, the baby or both, and there is no way to accurately predict which birth is likely to be the one.

#### **Transfer criteria examples being reviewed**

- Uterine rupture, inversion or prolapse
- Hemorrhage (hypovolemia, shock, need for transfusion)
- Retained placenta > 60 minutes
- Non-cephalic fetal presentation
- Eclampsia or pre-eclampsia
- Placental abruption/abnormal bleeding
- Certain serious infections

#### **Consultation criteria examples being reviewed:**

- More than three first trimester spontaneous abortions, or more than one second trimester spontaneous abortion
- Blood group incompatibility, and/or Rh sensitization
- Pre-eclampsia, not requiring preterm birth
- More than one preterm birth, or preterm birth less than 34 weeks 0 days in most recent pregnancy
- Cervical insufficiency/prior cerclage

#### *Life threatening fatal anomalies*

Livingston said some feedback given involved the situation where a baby is not expected to survive due to a pre-birth diagnosis of a fatal anomaly. Families sometime choose to give birth in the home, to allow for bonding time before the infant passes away. In those cases the families opt for non-resuscitation. She reports concerns from others that sometimes the pre-diagnosis is wrong and sometime the parents change their minds and want resuscitation, which may not be possible in a home setting. VbBS discussed changing births of this type to fall under the proposed consultation criteria instead of a high risk coverage exclusion criteria, because in some cases it is clear that nonviability will occur and nonresuscitation may be fully appropriate

Livingston gave a summary of VbBS member's struggles with implementation. EbGS did not delve into implementation details. However, explicit requests from those who would implement these recommendations necessitated VbBS members needing to identify which conditions must explicitly be known and which tests must absolutely be required for coverage. Chan added this is the most granular coverage guidance we have written to date; he feels perhaps it borders on a clinical guideline. The core of the guidance is to ensure the risks are low enough so there is no unnecessary risks to the child and no extra costs to the health system. Saha agreed and went on to say when there is a condition is a common

as pregnancy there is likely going to be long extensive list of permissible and not permissible circumstances. Some community objections center around the “consultation criteria” because in some areas it is hard to get consultations and there are some places where a midwife cannot order an ultrasound because the radiology group is unwilling to take on the risk. Saha added someone who wants to have OOHB is unlikely to want to have many tests and that is fine; the health system just will not pay for the delivery if is unable to confirm that the pregnancy is low-risk.

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**Coverage Guidance Topic: Indications for Proton Beam Therapy**

[Meeting materials](#), pages 407-504

Livingston presented the proposed coverage guidance from HTAS. VbBS was unable to complete its review therefore this presentation is informational. No vote is required.

Protons are positively charged subatomic particles; proton beam therapy (PBT) deposits radiation energy at or around a target at the end of the beam range, with little spread to surrounding tissue and organs, and no exit dose radiation. There are two main types of proton beam treatment: primary, with a curative intent, and salvage treatment, for recurrent disease. It is twice as expensive as traditional radiation. Use in non-sensitive areas probably is not warranted. Saha added this technology is becoming an industry, with more clinics opening around the country.

Conditions considered for coverage included:

- |                                                       |                                                                              |
|-------------------------------------------------------|------------------------------------------------------------------------------|
| ✓ Bone tumors                                         | ✓ Pediatric cancers (e.g., medulloblastoma, retinoblastoma, Ewing’s sarcoma) |
| ✓ Brain, spinal, and paraspinal tumors                | ✓ Prostate cancer                                                            |
| ✓ Breast cancer                                       | ✓ Soft tissue sarcoma                                                        |
| ✓ Esophageal cancer                                   | ✓ Seminoma                                                                   |
| ✓ Gastrointestinal cancers                            | ✓ Thymoma                                                                    |
| ✓ Gynecologic cancers                                 | ✓ Arteriovenous malformations                                                |
| ✓ Head and neck cancers (including skull base tumors) | ✓ Hemangiomas                                                                |
| ✓ Liver cancer                                        | ✓ Other benign tumors (e.g., acoustic neuromas, pituitary adenomas)          |
| ✓ Lung cancer                                         |                                                                              |
| ✓ Lymphomas                                           |                                                                              |
| ✓ Ocular tumors                                       |                                                                              |

**Evidence Summary**

- Bone cancer: Low quality evidence of effectiveness, unknown risk, higher cost
- Brain, spinal, and paraspinal tumors: Very low quality evidence of incremental benefit and higher costs
- Esophageal cancer: No evidence on effectiveness, unknown risk, higher cost
- Head and neck cancers: Very low quality evidence of comparable benefits, fewer harms, higher costs, but patient preference
- Liver cancer: Low quality evidence of comparable benefits and harms, higher costs
- Lung cancer: Low quality evidence of comparable benefits, similar risk, higher cost
- Malignant ocular tumors: Moderate quality evidence of greater benefits with fewer harms
- Pediatric cancers: Very low quality evidence of comparable benefits, fewer harms, potential health impact over decades
- Prostate cancer: Low quality evidence of similar benefits, similar risk, higher cost

- Ocular hemangiomas: Very low quality evidence of comparable benefits and harms
- Other benign tumors: No evidence on effectiveness, unknown risk compared to alternative, higher cost

Feedback during the written public comment period was made about the following topics, which the experts in attendance at the HTAS meetings also shared:

- Recurrent cancers
- Definition of pediatric
- Longevity of benefit (children, lymphomas)
- Coverage with evidence development
- Noncomparative studies
- Dosimetric modeling
- Relative costs

### *Pediatric Cancers*

Comparative studies are lacking, most likely due to a lack of clinical equipoise. Other than one study of secondary malignancy, there were no comparative studies of the harms of PBT in patients with pediatric cancers. PBT's theoretical potential to lower radiation-induced toxicity in children serves as the comparative evidence base.

Saha added this treatment is frequently used with children because people who receive radiation therapy as a child have a big chance to have recurrent cancer present by 40 years of age. PBT is thought to reduce the risk of future cancer. The subcommittee's discussion was driven largely by values considerations. Saha relayed the subcommittee's deliberation about the definition of "pediatric" saying there is no good clinical way to decide on an age cut-off, so they used an administrative rationale.

Livingston read through the GRADE-Informed Framework ([page 425](#)). She said PBT appears to be equally effective in most things and is more expensive.

Chan objected to the use of the word "sufficient" in the GRADE-Informed Framework. The group discussed the meaning of *no evidence*, *low quality evidence* and *very low quality evidence*. Chan suggested using the phrase "*no evidence met our inclusion criteria about benefits vs. harm.*" Saha advocated for using the term *very low* until the Grade Work Group defines another term to use. Livingston will remove the term "sufficient" for the next meeting.

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## **Multi-sector Interventions**

Livingston said at the meeting on August 13, 2016, this group, in concept, agreed there is a need for a way for HERC to make statements on effectiveness and appropriateness of services that do not fit within the current constructs of the Prioritized List. These would be strategies for population health management on topics such as obesity, chronic pain, and tobacco use for services not traditionally billed as medical services.

She said the CCOs are accountable for metrics of improved health that are not necessarily improved by more procedures or codes but would improve in concert with other interventions. One example is to employ community health workers to do hotspotting, a practice of engaging with patients who are high utilizers. Then, identify potential interventions that might improve the patient's ability to access needed care and services outside the hospital or emergency room.

Livingston proposed a new part of the Prioritized List of Health Services called *Multi-sector Interventions*. This section would include strategies that may be outside the traditional doctor/patient relationship. If approved, staff will bring a tobacco related policy/interventions. Future topics may include obesity, opiate use and management of non-cancer pain without opiates.

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**Audience Participation by Phone**

Saha said that over the years members of the public have expressed interest in participating in our process remotely. There is a renewed interest from the CCO members and other stakeholders. He suggested now is a good time to open our meetings remotely but would like to limit acceptance of testimony to written statements (already accepted) and by those who arrive in person. There was general agreement with this proposal. Staff will handle the logistics.

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**Public Comment**

There was no public comment at this time.

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**Adjournment**

Meeting adjourned at 4:20 pm. Next meeting will be from 1:30-4:30 pm on Thursday, November 12, 2015 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.



# Healthy People, Healthy Communities Providing Better Care at Lower Cost

## Improving Behavioral Health for Older Adults

### *Promoting Primary Care Screening and Referral and Post-Hospital Care Coordination*

Depression and alcohol misuse are common in the Medicare population, impacting the well-being of millions of older adults. Both put individuals at greater risk for hospitalization and complicate the treatment of other chronic conditions. Yet behavioral health problems are often under-identified in primary care, where most treatment for depression begins for this age group.

As a result, roughly two-thirds of older people with a behavioral health disorder do not receive treatment. Untreated depression has a significant effect on adherence to treatment and on health outcomes—for example, patients with depression may be less likely to fill their medications as recommended.

For people who have been hospitalized for behavioral health conditions, effective treatment depends on coordinating care after discharge for successful transition into the community. Poor mental health transitions contribute to high rates of inpatient readmission—major depression currently has a higher readmission rate than any other condition except heart failure.

Our aim: help communities build the connections to close gaps in care for this vulnerable population.

### A Community-Based Approach

HealthInsight, the regional Medicare Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Oregon, Nevada, New Mexico and Utah, and its Oregon affiliate Acumentra Health are addressing older adult behavioral health through a four-year initiative funded by the Centers for Medicare & Medicaid Services (CMS).

Our community-based initiative engages primary care practitioners (PCPs), mental health practitioners, and inpatient psychiatric facilities (IPFs) in community-focused approaches to

- increase primary care screening and referral for depression and alcohol use disorder
- reduce 30-day readmission rates following discharge from an IPF, and
- increase outpatient follow-up and care coordination post-discharge to reduce readmission rates.

### Our Goals

HealthInsight joins five other QIN-QIOs across the country that are leading similar initiatives in their regions. Nationally, CMS expects that by 2019, this work will result in 10,000 primary care practices screening a majority of their Medicare patients for depression and alcohol use disorder, using a simple, validated screening instrument.

In Oregon, the initiative could affect more than 141,000 Medicare beneficiaries. **We welcome your participation.**

**As many as 10 percent of older adults have clinically significant depression**



Only **half** are recognized, and **1 in 5** receive treatment in primary care.



**4 out of 5 cases** of seniors who seek substance abuse treatment **are for alcohol-related conditions.**

75+: Age of adults with **highest male suicide rate.**



**1 in 9:** Medicare beneficiaries who **consume 30+ alcoholic drinks per month** and **4+ drinks per occasion.**



# Healthy People, Healthy Communities Providing Better Care at Lower Cost

## Key Strategies and Interventions

### Benefits to All Participants

- Participation opportunities in Learning and Action Network activities organized by HealthInsight QIN-QIO
- Educational materials for patients, families, and providers
- Sharing of best practices with peers

### Benefits to Primary Care Practitioners

- Support to help behavioral health screening happen reliably: Technical assistance in adopting simple, validated screening tools and folding them into the visit work flow; staff training in engaging patients and families about sensitive issues; technical support for electronic health record documentation and reporting
- Resources for patient referral for behavioral health follow-up

### Benefits to Inpatient Psychiatric Facilities

- Support for key Medicare quality measures on avoiding readmissions
- Community-based work to build connections and communication pathways with behavioral health and providers and the patient's primary care provider.
- Technical assistance in building reliable processes to ensure post-discharge follow-up in the community
- Resources for patient education and engagement during hospitalization and at discharge

### Benefits to Behavioral Health Providers

- Community-based work to build connections and communication pathways for
  - referral after PCP depression and alcohol misuse screening
  - care coordination after hospitalization (smoother transitions to community and fewer emergencies)

## Join Us!

Please contact us for more information or to participate:

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This material was prepared by HealthInsight, the Medicare Quality Innovation Network-Quality Improvement Organization for Nevada, New Mexico, Oregon and Utah, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-G1-15-07-OR 9/22/15



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## Oregon Medicaid Meaningful Use Technical Assistance Program

**Susan Otter**

Director and State Coordinator for  
Health Information Technology



1

## Oregon Medicaid Meaningful Use Technical Assistance Program

**Purpose:** To support Oregon Medicaid providers/clinics to “meaningfully use” their Electronic Health Records (EHRs)

- Enable providers to use their EHRs to:
  - Maximize the value of their investments in EHRs, including bolstering their use of local and statewide HIE and use of clinical quality metrics to improve delivery of care
  - Incorporate information shared via local HIE or statewide Direct secure messaging more efficiently into their delivery of care
  - Meet federal Meaningful Use requirements and apply for Medicaid or Medicare EHR incentive payments that can support clinic investments in EHRs
- OHA is in contract negotiations with OCHIN for delivery of TA services



2

## Provider Eligibility

- Medicaid Eligible Professional Type – enrolled Medicaid provider who is a
  - physician,
  - dentist,
  - nurse practitioner, or
  - physician assistant in certain circumstances
- Provider restrictions:
  - Inclusive of any area of medicine, specialists, primary care
  - Does not restrict practice setting
  - No Medicaid patient volume requirements

## Flow of Activities

1. Regional Work Plan: OHA, OCHIN, and CCO(s)
  - Discuss goals for region
  - Identify key practices and TA needs in the region
  - Coordinate communication and outreach to key practices
2. Clinic/provider agree to participate;
  - outline of TA activities and timeline
3. Periodic updates to discuss progress and priorities
4. Program available: January 2016-June 2018

## Next Steps/Request for CCOs

OHA will send a formal call to CCOs to participate in the TA Program. Execution of the OCHIN contract is anticipated by the end of 2015. In the meantime, CCOs can:

- Internally discuss interest in participation
- Revisit TA Needs Assessment from 2014 and consider priorities for TA and key practices
- Identify Point of Contact and staff to collaborate with OCHIN on engagement and outreach



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## Menu of Services Technical Assistance for Providers/Clinics

Service Categories	Activities
1) Outreach to key practices about TA Services	<ul style="list-style-type: none"> <li>• Provider/Clinic assessment of needs and agreement to TA services</li> </ul>
2) Medicaid and Medicare EHR Incentive Program Support	<ul style="list-style-type: none"> <li>• On-going training and support around the Incentive Program, including attestation</li> <li>• Workflow analysis around Meaningful Use measures</li> <li>• Assist with attestation for EHR Incentive Program</li> </ul>
3) Certified EHR Technology Implementation Support	<ul style="list-style-type: none"> <li>• Certified EHR Technology assessment, analysis, and recommendations</li> <li>• Decision point on Certified EHR Technology</li> <li>• Project planning consult for implementation/upgrade of Certified EHR Technology</li> </ul>
4) Certified EHR Technology Interoperability <ul style="list-style-type: none"> <li>• Transition of Care</li> <li>• Lab Exchange</li> <li>• Patient and Family Engagement</li> <li>• View/Download/Transmit (VDT)</li> <li>• Public Health</li> <li>• Electronic reporting of Clinical Quality Metrics</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment and improvement plan for provider to meet interoperability, focus on measures</li> <li>• Workflow analysis and support</li> <li>• Project plan framework development</li> </ul>
5) Privacy and Security	<ul style="list-style-type: none"> <li>• Risk Assessment</li> <li>• Recommendations on privacy and security</li> </ul>



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**For more information on Oregon's HIT/HIE developments,  
please visit us at <http://healthit.oregon.gov>**

**Susan Otter, Director of Health Information Technology  
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## WHAT?

**Healthy Hearts Northwest (H2N)** is part of [EvidenceNOW](#), the AHRQ grant initiative to transform health care delivery. With partners Qualis Health, and the MacColl Center for Health Care Innovation, ORPRN will select 130 small- and medium-sized primary care practices throughout Oregon to participate in H2N.

For over a decade, [ORPRN](#) has provided at-the-elbow support for practices to implement the chronic care model to improve diabetes care, develop a care coordination structure, establish patient and family advisory councils, and meet medical home targets. A key ingredient to these changes has been the presence of a practice facilitator or coach. At ORPRN, we call these highly skilled individuals **Practice Enhancement Research Coordinators (PERCs)**. Practices are always asking: “When am I going to get my PERC?” [H2N](#) provides that opportunity.

*H2N PERCs will help primary care clinics:*

- #1 Be able to use EHRs to generate data reports**
- #2 Look at the data and identify care gaps**
- #3 Develop processes for improving care and outcomes**
- #4 Report data on a regular basis**
- #5 Understand what is coming down the pike, and the need to change in order to survive**

## WHO IS NEEDED?

- Small to medium-sized primary care practices throughout Oregon
- Practices with 10 FTE providers or fewer

## WHEN?

Study begins November 2015; practices can enroll through February 2015

## HOW TO GET INVOLVED!

- Contact the ORPRN H2N Manager: Caitlin Dickinson, [summerca@ohsu.edu](mailto:summerca@ohsu.edu)
- Visit: <http://healthyheartsnw.org>

“The goal of the EvidenceNOW initiative is to give primary care practices the support they need to help patients live healthier and longer. By targeting smaller practices, we have a unique opportunity to reduce cardiovascular risk factors for hundreds of thousands of patients, and learn what kind of support results in better patient outcomes.”

– HHS Secretary, Sylvia Mathews Burwell

EvidenceNOW  
Advancing Heart Health in Primary Care



## Statewide CCO Learning Collaborative: 17 CCO Incentive Measures

Quality and Health Outcomes Committee Meeting  
500 Summer Street NE, Salem, OR 97301, Room 137 A-D  
November 9, 2015, 11:00 a.m. – 12:30 p.m.

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

### Childhood Immunization Status

#### *Session Objectives*

Participants will:

- 1) Understand factors that lead to low immunization rates for two year olds.
  - 2) Describe evidence-based strategies for improving two year old immunization rates.
  - 3) Identify opportunities to incorporate evidence-based strategies at the CCO, and among local health care providers and the community.
1. **Introductions and reflection** (Summer Boslaugh, MBA/MHA, Holly Jo Hodges, MD) (5 minutes)
  2. **Pair share** – turn to the person sitting to your right, introduce yourself and briefly discuss the following questions (5 minutes)
    - What are the challenges around immunization in your community?
  3. **Presentation: Oregon Immunization Program Resource Guide** (Sara Beaudrault, MPH) (15 minutes)
  4. **Panel: Promising practices to improve childhood immunization status** (Sara Beaudrault) (30 minutes)
    - **Cascade Health Alliance** (James Calvert, MD)
    - **Sanford Children’s Clinic in Klamath Falls** (Tracy Graham, MD)
    - **PacificSource Community Solutions CCO Columbia Gorge** (Kristin Dillon, MD)
  5. **Small group discussion** – four groups (OHA staff and presenters lead each session) (20 minutes)  
Each CCO shares with the group the answers to the following questions:
    - What is your CCO currently doing to enhance childhood immunization status?
    - What could your CCO do to improve childhood immunization rates in your community?
  6. **Group debrief** (Facilitator: Summer Boslaugh) (10 minutes)
    - Presenters share general comments on target interventions and CCO support
    - Group to share any other comments, thoughts, barriers
  7. **Next steps** (Summer Boslaugh) (5 minutes)
    - January 11, 2016 meeting: Behavioral Health Integration
    - Evaluation

## Strategies to Improve Childhood Immunization Rates



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### Objectives

- Review measure specifications for 2016 CCO incentive measure
- Share information about childhood immunization rates in Oregon
- Discuss strategies included in the immunization resource guide for CCOs



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## 2016 measure specifications

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## 2016 Childhood Immunization Status Measure Specifications

- No change from the established statewide performance measure
- NQF 0038, combo 2
- The percentage of children 2 years of age who had 4 DTaP, 3 IPV, 1 MMR, 3 Hib, 3 Hep B, and 1 varicella by their second birthday (4:3:1:3:3:1 series)
- Data source: MMIS/DSSURS and ALERT IIS

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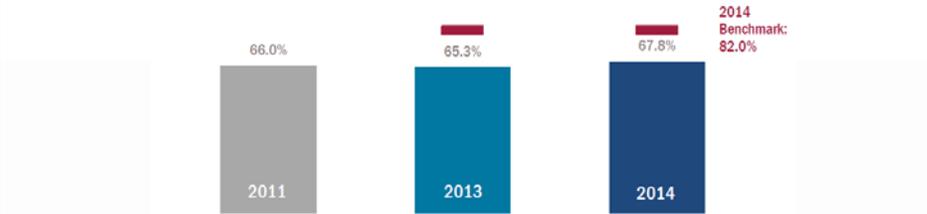


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## CHILDHOOD IMMUNIZATION STATUS

Statewide, childhood immunizations improved.

Data source: Administrative (billing) claims and ALERT Immunization Information System  
 2014 benchmark source: 2013 National Medicaid 75th percentile



Oregon's Health System Transformation: 2014 Final Report



Hispanic/Latino and Asian American children received immunizations more frequently than other members in 2013 and 2014.

Gray dots represent 2011. Data missing for 8.9% of respondents. Each race category excludes Hispanic/Latino.



Oregon's Health System Transformation: 2014 Final Report



Fourteen of 16 CCOs improved childhood immunizations between 2013 and 2014.

Gray dots represent 2013 baselines, which are per-CCO and based on data from the predecessor care organization. Baseline data for PacificSource Central and Gorge are combined.



Oregon's Health System Transformation: 2014 Final Report

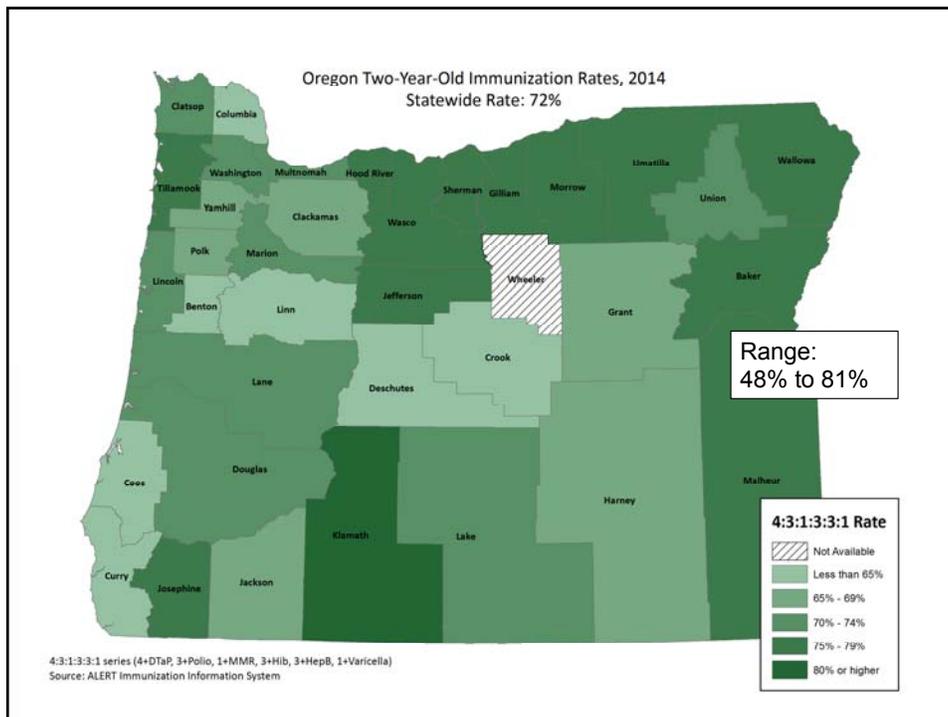


## Childhood immunization rates in Oregon

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## Rates for individual antigens

	2013	2014
4 DTaP	77%	81%
3 IPV	89%	92%
1 MMR	89%	92%
3 Hib	91%	92%
3 Hep B	85%	88%
1 Varicella	87%	90%

Source: Alert Immunization Information System

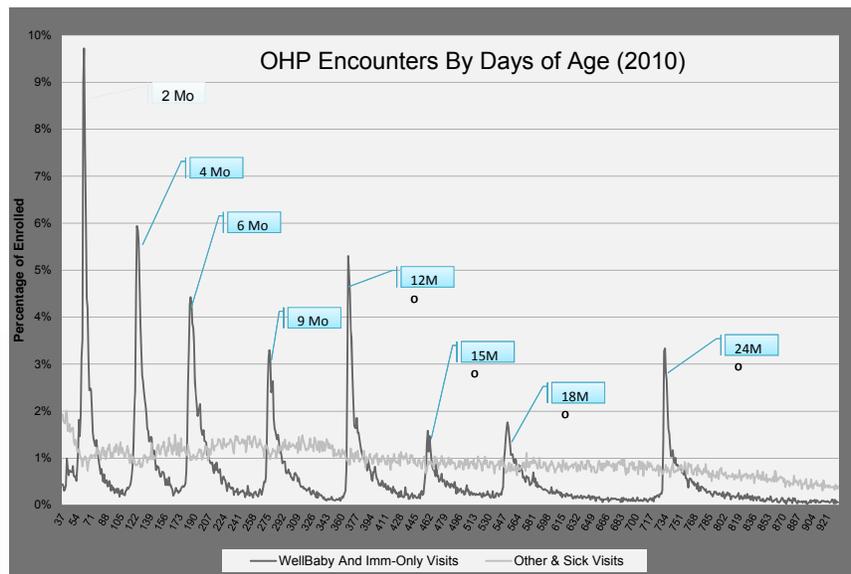
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## Factors that affect childhood immunization rates: falling behind schedule

Missed opportunities are tied to ~65% of under-vaccination by age two.

In most cases, providers can catch patients up on well-baby/immunization visits before the second birthday.



## Factors that affect childhood immunization rates: missed 15-18 month visit

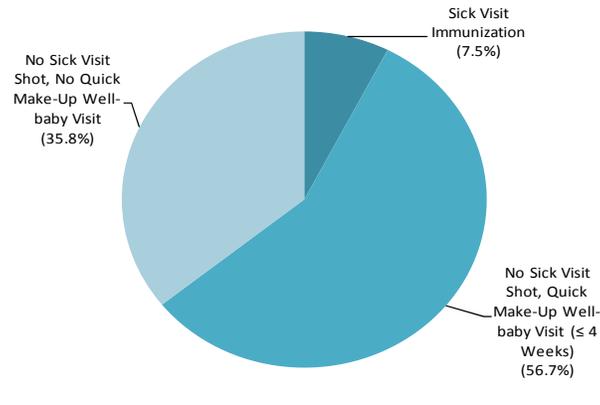
Most common missed shot in the 4:3:1:3:3:1 series is the 4<sup>th</sup> DTaP, due at 15-18 months.

Among those missing a 4<sup>th</sup> DTaP at 24 month, almost half did not have a 15-18 month well-baby visit.



## Factors that affect childhood immunization rates: sick visits

Figure 1: Acute Otitis Media Visits and Outcomes (N=1060)



Source: Sick-Visit Immunizations and Delayed Well-Baby Visits. SG Robison: *Pediatrics*, 2013



## Factors that affect childhood immunization rates: vaccine hesitancy

Why are parents hesitant?

- low disease rates → increased focus on vaccine risks
- Low tolerance for vaccine risks
- Complicated immunization schedule

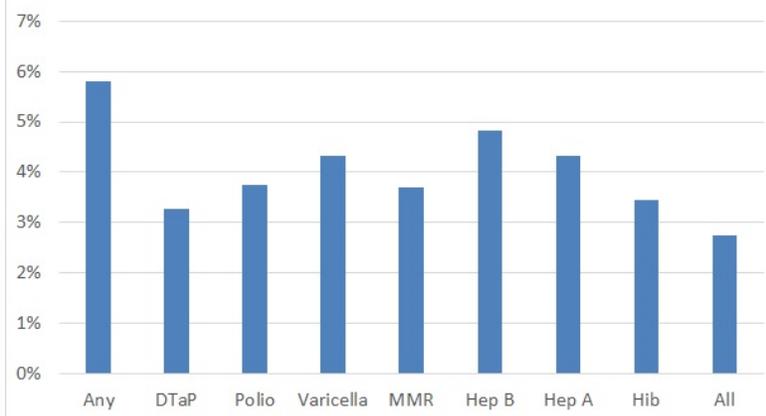
Source: American Academy of Pediatrics

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Nonmedical Exemptions, Oregon Children's Facilities, 2015



Source: Oregon School Law data

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## Factors that affect childhood immunization rates: vaccine hesitancy

Some truths about vaccine hesitancy

- Having questions and concerns is normal. It does not mean they will delay or refuse vaccines.
- Less than 1% of children are completely unvaccinated.
- Nearly all parents list their health care provider as a trusted source of information.
- AAP and CDC produce trainings and materials for health care providers and clinic staff for working with parents who have questions or concerns.

Source: American Academy of Pediatrics

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## Strategies to improve immunization rates

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## Strategy 1: Use data to identify reasons for low immunization rates

CCOs and health care providers can:

- Routinely assess rates
- Share information on rates
- Identify root causes
- Participate in AFIX

## Strategy 2: Identify and eliminate barriers to access

CCOs can:

- Identify which providers are not enrolled in VFC
- Identify areas with little/no access
- Reimburse out-of-area health care providers
- Ensure culturally appropriate immunization services

Health care providers can:

- Use standing orders
- Offer nurse-only appointments
- Offer expanded clinic hours and walk-in appointments

### Strategy 3: Reduce missed opportunities and recall patients who are behind on vaccines

#### CCOs can

- Encourage providers to follow the AAP schedule for well-child visits
- Focus on 15 and 18 month visit
- Recall members

#### Healthcare providers can

- Check immunization record at every encounter
- Immunize at sick visits, or schedule a follow up appointment
- Recall patients
- Contact patients who miss appointments
- Track delayed schedules

### Strategy 4: Increase knowledge and awareness about immunizations

#### CCOs can:

- Make training opportunities available
- Provide routine updates
- Use parent reminders
- Share success stories

#### Health care providers can:

- Identify an immunization champion
- Build a culture of immunization
- Make resources readily available

## Strategy 5: Increase demand for immunizations

CCOs can:

- Convene and engage local partners
- Support strategies to reduce nonmedical exemptions
- Provide incentives to parents and families
- Provide incentives to health care providers

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**Health**  
Authority



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## Childhood Immunization Status (Combo 2)

### Measure Basic Information

**Name and date of specifications used:** HEDIS® 2016 Technical Specifications for Health Plans (Volume 2)

**URL of Specifications:**

n/a

**Measure Type:**

HEDIS  PQI  Survey  Other  Specify:

**Measure Utility:**

CCO Incentive  Core Performance  CMS Adult Set  CHIPRA Set  State Performance   
Other  Specify:

**Data Source:**

MMIS/DSSURS and Public Health Division Immunization Program Registry (ALERT)

**Measurement Period:** January 1 – December 31, 2016

**2013 Benchmark:** 82%, 2012 National Medicaid 75<sup>th</sup> percentile (Combo 2)

**2014 Benchmark:** 82% 2013 National Medicaid 75<sup>th</sup> percentile (Combo 2)

**2015 Benchmark:** 82% 2014 National Medicaid 75<sup>th</sup> percentile (Combo 2)

**2016 Benchmark:** 82% 2015 national Medicaid 75<sup>th</sup> percentile (Combo 2)

**Incentive Measure changes in specifications from 2015 to 2016:**

OHA is using HEDIS 2016 specifications for all 2016 measurement. Changes from HEDIS 2015 to 2016 include:

- Added a note to MMR clarifying that the “14-day rule” does not apply to this vaccine.
- Added a new value set to the administrative method to identify Hepatitis B vaccines administered at birth. This change does not affect OHA’s measure specifications as data from the ALERT Immunization Registry are used to identify numerator compliance rather than claims. Value set information is provided below for information only.

*HEDIS specifications are written for multiple lines of business and include a broad set of codes that could be used for measurement. Codes OHA is not using include, but are not limited to, LOINC, CPT, and HCPCS codes that are not open to Medicaid in Oregon. A general rule of thumb is that only CPT/HCPCS codes associated with the prioritized list will be used to calculate the measures; however as some measure specifications include denied claims, a claim that was denied because it included codes not on the prioritized list might still be counted toward the measure.*

OHA is following HEDIS guidelines for Effectiveness of Care, Access/Availability of Care, Experience of Care, and Utilization measures to determine which services count for measures.

Denied claims: Included  Not included  Not applicable

Member type: CCO A  CCO B  CCO G

## Measure Details

### Data elements required denominator:

Children who turn 2 years of age during the measurement year. See HEDIS® 2015 Technical Specification for Health Plans (Volume 2) for details.

### Required exclusions for denominator:

See continuous enrollment criteria.

**Deviations from cited specifications for denominator:** None.

### Data elements required numerator:

OHA is using HEDIS® 2015 Combination 2 for the state performance measure: The number of children who turned 2 years of age in the measurement year and had all of the following specified vaccinations.

NOTE OHA relies on the Public Health Division Immunization Program Registry (ALERT) data, instead of calculating from the claim/encounter data. HEDIS Value Set names and codes are listed below only as a reference.

- DTaP – at least four DTaP vaccinations (DTaP Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. Do not count a vaccination administered prior to 42 days after birth.
- IPV – at least three IPV vaccinations (Inactivated Polio Vaccine (IPV) Administered Value Set), with different dates of service on or before the child’s second birthday. IPV administered prior to 42 days after birth cannot be counted.
- MMR – Any of the following on or before the child’s 2<sup>nd</sup> birthday:
  - At least one MMR vaccination (Measles, Mumps and Rubella (MMR) Vaccine Administered Value Set).
  - At least one measles and rubella vaccination (Measles/Rubella Vaccine Administered Value Set) and at least one mumps vaccination (Mumps Vaccine Administered Value Set) on the same date of service or on different dates of service.
  - At least one measles vaccination (Measles Vaccine Administered Value Set) and at least one mumps vaccination (Mumps Vaccine Administered Value Set) and at least one rubella vaccination (Rubella Vaccine Administered Value Set) on the same date of service or on different dates of service.
  - History of measles (Measles Value Set), mumps (Mumps Value Set), or rubella (Rubella Value Set) illness.

Note: General Guideline 39 (i.e., the 14-day rule) does not apply to MMR.

- **HiB** – At least three HiB vaccinations (Haemophilus Influenzae Type B (HiB) Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday. HiB administered prior to 42 days after birth cannot be counted.
- **Hepatitis B** – At least three hepatitis B vaccinations (Hepatitis B Vaccine Administered Value Set), with different dates of service on or before the child’s second birthday; or history of hepatitis illness (Hepatitis B Value Set).
- **VZV** – At least on VZV vaccination (Varicella Zoster (VZV) Vaccine Administered Value Set), with a date of service falling on or before the child’s second birthday; or history of varicella zoster (e.g., chicken pox) illness (Varicella Zoster Value Set).

Value Set Name	CPT/HCPCS	ICD9CM-Diagnosis	ICD10 CM Diagnosis
DTaP Vaccine Administered	90698, 90700, 90721, 90723		
Inactivated Polio Vaccine (IPV) Administered	90698, 90713, 90723		
Measles, Mumps and Rubella (MMR) Vaccine Administered	90707, 90710		
Measles/Rubella Vaccine Administered	90708		
Measles Vaccine Administered	90705		
Mumps Vaccine Administered	90704		
Rubella Vaccine Administered	90706		
Measles		055.0, 055.1, 055.2, 055.71, 055.79, 055.8, 055.9	B05.0, B05.1, B05.2, B05.3, B05.4, B05.81, B05.89, B05.9
Mumps		072.0-072.3, 072.71, 072.72, 072.79, 072.8, 072.9	B26.0, B26.1, B26.2, B26.3, B26.81, B26.82, B26.83, B26.84, B26.85, B26.89, B26.9
Rubella		056.00, 056.01, 056.09, 056.71, 056.79, 056.8, 056.9	B06.00, B06.01, B06.02, B06.09, B06.81, B06.82, B06.89, B06.9
Haemophilus Influenzae Type B (HiB) Vaccine Administered	90645-90648, 90698, 90721, 90748		
Hepatitis B Vaccine Administered	90723, 90740, 90744, 90747, 90748, G0010		
Hepatitis B		070.20-070.23, 070.30-070.33, V02.61	B16.0, B16.1, B16.2, B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, Z22.51
Varicella Zoster (VZV) Vaccine Administered	90710, 90716		

Value Set Name	CPT/HCPCS	ICD9CM-Diagnosis	ICD10 CM Diagnosis
Varicella Zoster		052.x, 053.0, 053.1, 053.20-053.22, 053.29, 053.71, 053.79, 053.8, 053.9	B01.1, B01.11, B01.12, B01.2, B01.81, B01.89, B01.9, B02.0, B02.1, B02.21, B02.22, B02.23, B02.24, B02.29, B02.30, B02.31, B02.22, B02.33, B02.34, B02.49, B02.7, B02.8, B02.9

See HEDIS® 2016 Technical Specifications for Health Plans (Volume 2) for additional details.

**Required exclusions for numerator:** None.

**Deviations from cited specifications for numerator:** None.

**What are the continuous enrollment criteria:** 12 months prior to the child’s 2<sup>nd</sup> birthday.

**What are allowable gaps in enrollment:** No more than one gap in enrollment of up to 45 days during the 12 months prior to the child’s 2<sup>nd</sup> birthday.

**Define Anchor Date (if applicable):** Enrolled on the child’s 2<sup>nd</sup> birthday.



## Enrollment Delay for Vaccines for Children Clinics

Vaccines for Children (VFC) is a federal entitlement program that provides vaccines at no cost to clinics that serve Medicaid-enrolled, uninsured, underinsured, or American Indian/Alaskan Native children from 0 through 18 years of age. Oregon's VFC program is implemented by the Oregon Health Authority/Public Health Division/Immunization Program (Immunization Program). Oregon rule requires clinics that vaccinate Medicaid-enrolled children and adolescents to be enrolled in VFC in order to access federally purchased vaccine through the program. Non-VFC enrolled providers who choose to vaccinate eligible children and adolescents will not be paid for privately purchased vaccine, nor for the administration of such vaccine. ([OAR 410-130-0255](#))

Currently more than 600 clinics in Oregon are enrolled in VFC. In 2014, approximately half (52%) of children and adolescents in Oregon were eligible to receive vaccine through VFC.

The Immunization Program is currently restructuring its VFC program so that it can meet its federal requirements for oversight of VFC-enrolled clinics, including compliance site visits at least every two years. The number of VFC clinics has increased since health system transformation efforts began in 2012, and federal oversight requirements have also increased; however, no additional resources have been made available to meet this increased demand.

Here's what the Immunization Program is doing to ensure that it can meet federal requirements for oversight in 2016:

- Delaying enrollment for most clinics that apply to become a VFC provider. The Immunization Program is continuing to enroll clinics in areas of need. And VFC program staff are working with clinics that want to enroll now to make sure the clinic is ready to meet all program requirements upon enrollment (i.e. training, proper vaccine storage equipment). This enrollment delay is temporary;
- Working with Oregon Health Authority/Health Analytics to look at areas where access to vaccine through VFC is low (i.e. areas with no or few VFC-enrolled clinics);
- Considering an enrollment-prioritization model so that clinics in areas without adequate numbers of VFC clinics will be enrolled first; and

- Restructuring its staffing model in order to meet federal deferral VFC requirements for site visits in 2016.

Here's what CCOs can do:

- Identify clinics that serve children or adolescents but are not enrolled in VFC, either because of this enrollment delay or because they choose not to participate. Work with these clinics to ensure that patients have access to immunizations at another location and that referrals are made;
- If you believe a clinic needs to be enrolled before 2016 in order to resolve an access issue, contact Mimi Luther, VFC Program Manager, at [lydia.m.luther@state.or.us](mailto:lydia.m.luther@state.or.us) or (971) 673-0296.

Here's what clinics can do:

- Clinics that wish to enroll in VFC should contact Jennifer Steinbock at (971) 673-0309 or [jennifer.steinbock@state.or.us](mailto:jennifer.steinbock@state.or.us) to be added to a waitlist;
- Clinics can prepare for enrollment by downloading materials at: <https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/vfc/Pages/enroll.aspx>.

For additional information, please contact: Mimi Luther at [lydia.m.luther@state.or.us](mailto:lydia.m.luther@state.or.us) or (971) 673-0296.



## Evidence-based Strategies for Improving Childhood Immunization Rates: A Guide for CCOs

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Immunizations are among the greatest public health achievements of the 20th century. A recent economic analysis estimated that vaccinating the 2009 U.S. birth cohort with the recommended childhood immunization schedule prevented approximately 42,000 deaths and 20 million cases of disease, and resulted in a net savings of \$14 billion in direct costs and \$69 billion in total societal costs.<sup>1</sup> Despite the effectiveness of vaccines to prevent disease and death, and unnecessary costs to the health care system, immunization rates for children in Oregon remain flat and well below national Healthy People 2020 goals.

Much attention is given to families and communities that choose not to vaccinate their children. However, these families and communities represent the minority in Oregon. Most parents do intend to vaccinate their children according to the American Academy of Pediatrics schedule and as recommended by their health care provider. This resource guide focuses on evidence-based strategies that CCOs and health care providers can implement to improve childhood immunization rates.

Prior to the availability of measles vaccine in the United States, as many as 3-4 million cases and 500 deaths occurred each year. In 2014, just five cases were reported in Oregon. The same dramatic reduction in death and disease is seen for almost every disease for which there is now a vaccine. Achieving and maintaining high immunization rates is essential to assure community immunity, keep vulnerable people protected, and stop transmission when cases appear.

### State Contact:

Rex Larsen  
Provider Services Team Coordinator  
Oregon Public Health Division, Immunization Program  
(971) 673-0298  
[rex.a.larsen@state.or.us](mailto:rex.a.larsen@state.or.us)

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<sup>1</sup> Zhou, F, Shefer, A, Wenger, J et al. Economic evaluation of the routine childhood immunization program in the United States, 2009. *Pediatrics* 2014;133:577-85.



## Strategy 1: Use Data to Identify Reasons for Low Immunization Rates

*Overview: Improving childhood immunization rates begins with assessing rates and sharing information about rates with health care providers. Routine assessment of immunization rates can be used to monitor trends and to identify root causes for why children are not fully vaccinated with recommended vaccines by two years of age. The Community Preventive Services Task Force recommends [assessment and feedback](#) based on strong evidence of effectiveness in improving vaccination rates.*

### What CCOs can do

- ✓ **Routinely monitor immunization rates for two year olds.** CCOs can monitor rates using data available on the CCO dashboard. Or CCOs can work with contracted clinics to run their clinic rates in ALERT Immunization Information System (ALERT IIS).<sup>1</sup>
- ✓ **Share information about the CCO's rates** with health care providers and clinic staff. If possible, parse the CCO rate and make rates available at the clinic level. Providers often overestimate the percent of children in their practice who are up-to-date with recommended vaccines. Increasing awareness of coverage rates is an important first step to improve rates.
- ✓ **Assess root causes for low immunization rates.** Work with providers to review records of children who were not up-to-date by two years of age. Identify the root causes for why babies and young children fell behind. Common causes include:
  - Children are not coming in for routine well-baby visits;
  - Children are receiving some, but not all, vaccines that are due at a given visit. The clinic has no process to track these children or provide vaccines at encounters outside of well-child visits.

Once root causes are known, CCOs and healthcare providers can implement strategies to correct the issue.

### What Healthcare providers can do

- ✓ **Routinely assess rates** through the EHR or ALERT IIS. Assess rates at 24 months and at earlier points in time. Use data to identify appropriate improvement strategies and track progress toward goals. Consider assessing rates and tracking progress toward goals every 1, 3 or 6 months.
- ✓ **Share information about the clinic's rates with clinic staff.** Involve staff in identifying and implementing appropriate interventions to improve rates.
- ✓ **Participate in the Oregon Immunization Program's AFIX Program.**<sup>2</sup> AFIX (Assessment, Feedback, Incentive, eXchange) is a federal quality improvement program designed to improve immunization rates and services through assessing rates, sharing information and working with clinics to develop and implement action plans for improving rates.



## Strategy 2: Identify and Eliminate Barriers to Access

*Overview: Insurance status is typically not a factor in whether a family has access to immunizations for their children. The Affordable Care Act requires that vaccines are provided at no cost to families as routine preventive care.*

*The federal Vaccines for Children (VFC) program provides vaccines at no cost for children enrolled in Medicaid, or who are uninsured, underinsured, or American Indian/Alaskan Native. Oregon Administrative Rule prohibits providers who vaccinate Medicaid-enrolled children but are not enrolled in VFC from seeking reimbursement for the cost of vaccine or for administration fees (OAR 410-130-0255). Providers who choose not to enroll in VFC may refer families elsewhere for vaccines, which can lead to inconvenience and increased out of pocket costs for families.*

*Reducing out of pocket costs where they exist is an effective strategy to improve childhood immunization rates. CCOs and health care providers should also identify and address other barriers to access.*

### What CCOs can do

- ✓ **Identify which providers are not enrolled in VFC.** Encourage all providers who serve children and adolescents between 0 through 18 years to be enrolled.<sup>3</sup> For those that choose not to, work with these providers to ensure patients have access to immunizations at other locations. Monitor rates for these clinics closely to ensure that patients referred elsewhere for immunizations are receiving recommended vaccines.
- ✓ **Identify areas of the CCO region where there are few or no VFC providers.** Work with partners and the community to develop solutions to ensure access.
- ✓ **Reimburse out-of-area health care providers** and local health departments that administer vaccines to members.
- ✓ **Ensure access to culturally appropriate immunization services.** Many parents have questions about vaccines. Work with clinics to make sure they provide Vaccine Information Statements (VIS) and other materials in languages other than English, and that translation services are available.

### What Healthcare providers can do

- ✓ **Use standing orders** so that registered nurses, physician assistants and medical assistants can assess immunization status and give vaccines according to protocol, without the need for examination or direct orders from a physician. The Oregon Immunization Program publishes model standing orders for providers in Oregon.<sup>4</sup>
- ✓ **Offer immunization-only appointments** with a nurse or medical assistant when immunizations are due, but a well-baby visit is not. Immunization-only appointments are generally quicker than a complete well-child visit, and, for patients with commercial insurance, may reduce out of pocket costs associated with office visit fees or other fees.
- ✓ **Offer expanded clinic hours and walk-in appointments for immunizations.** Walk-in or immunization-only appointments make immunizations convenient for families and eliminate long waits for an opening. Expanding hours to include evening and weekend options help working parents.

**Note:** Clinics that wish to enroll in VFC may experience an enrollment delay. This delay is expected to be in place until early in 2016. These clinics should contact Jennifer Steinbock at (971) 673-0309 or [jennifer.steinbock@state.or.us](mailto:jennifer.steinbock@state.or.us) to be added to a wait list.



## Strategy 3: Reduce Missed Opportunities and Recall Patients who are Behind on Vaccines

*Overview: Missed opportunities occur when a patient is seen at a health care provider's office, but they don't receive any vaccines, or they receive some but not all vaccines that are due. Patients with missed opportunities often fall behind schedule. Employing strategies to reduce missed opportunities and recall patients who are behind will result in improved rates by two years of age.*

### What CCOs can do

- ✓ Encourage providers to **offer all well-child visits** according to the American Academy of Pediatrics schedule. Place emphasis on the 15- and 18-month well child visits. Work with clinics to identify and remove barriers to providing all well child visits.
- ✓ **Recall members** on behalf of the provider's office who are past due for well-baby visits or immunizations before two years of age. Recalls are commonly done at 13, 16 and/or 20 months.

### What Healthcare providers can do

- ✓ **Check immunization records** at every encounter. If no immunizations are due, provide an update on what immunizations will be given at upcoming visits. ALERT IIS and many EHRs forecast which vaccines are due or past due.
- ✓ **Immunize at sick visits** if no contraindications or precautions exist.
- ✓ **Immunize children who present for well-child care with mild symptoms of illness.**
- ✓ **Provide all vaccines for which a patient is eligible on the day of the well- or sick-child visit.**
- ✓ **Schedule a follow up visit** before the patient leaves the office. For most clinics, this is easier than trying to identify patients who are due for immunizations when no appointment has been scheduled.
- ✓ **Recall patients** who are behind on immunizations. Effective recall systems are narrow in focus, conducted routinely, and follow a consistent process. Clinic staff can run recall lists in ALERT IIS and in many EHRs.
- ✓ **Contact patients who miss appointments** within 3 to 5 days to reschedule. This reiterates the importance of well child visits and immunizations to families.
- ✓ **Track patients who follow an alternative schedule.** Alternative schedules typically require more visits to be up-to-date by two years of age. Ask families to document their intended schedule, make the planned schedule visible to clinic staff providing care and implement a system to ensure that families adhere to their schedule.



## Strategy 4: Increase Knowledge and Awareness About Immunizations in Clinics and for Families

*Overview: Most parents intend to fully vaccinate their children, and health care providers and clinic staff want to vaccinate patients according to the AAP/ACIP recommended schedule. Increasing knowledge and awareness of the routinely recommended immunization schedule, and providing resources to answer questions are effective strategies to improve immunization rates.*

### What CCOs can do

- ✓ **Identify training needs and make training opportunities available** to providers and clinic staff. Clinics may have different training needs, from the basics of why we immunize to how to communicate effectively with parents who have concerns about vaccines. CDC and AAP have a range of materials available for health care providers and clinic staff.<sup>5</sup>
- ✓ Use a systematic approach to **provide routine immunization updates and resources** to health care providers.
- ✓ **Provide routine reminders to parents** about the recommended vaccination schedule for 0-24 months. Couple reminders with messages conveying the importance of vaccination.

### What Healthcare providers can do

- ✓ **Identify an immunization champion** to regularly bring resources and information to coworkers, track and report on progress toward goals and offer coaching to coworkers.
- ✓ **Use a systematic approach to build a culture of immunization in the clinic.** Clinic staff and families at clinics with a strong culture of immunization understand that immunization is the expectation. Methods to employ may include making sure each employee understands how their role supports immunizations, and promoting vaccination of employees.
- ✓ **Make resources readily available** to parents and clinic staff. The CDC and AAP publish resources for effective communication about vaccines with parents, understanding vaccine safety, and about specific vaccines and diseases. Make sure clinic staff know how to access resources.



## Strategy 5: Increase Demand for Immunizations

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*Overview: CCOs can employ numerous strategies to increase demand for immunizations. The Community Preventive Services Task Force recommends implementing a combination of [community-based interventions](#) to increase immunization rates. Providing incentives is another proven strategy to improve immunization rates.*

### What CCOs can do

- ✓ **Convene and engage local public health agencies, health care providers, representatives from health systems, schools and children’s facilities and community organizations to:**
  - Share data on immunization rates;
  - Identify and understand pockets of low immunization rates;
  - Develop and advance a common set of priorities and strategies.
- ✓ **Support strategies to reduce nonmedical exemptions.**<sup>6</sup> Strategies may include working with local public health agencies, schools, children’s facilities and parent groups to understand and address prevalent concerns in the community, or supporting legislation to tighten existing school and children’s facility requirements.
- ✓ **Provide incentives to parents and families.** The Community Preventive Services Task Force [recommends parent incentives](#) based on evidence of effectiveness in increasing immunization rates. Incentives may be given for keeping an appointment, completing a vaccine series or for other pro-vaccine behaviors. Consider providing toys or other baby items in addition to or in place of monetary incentives.
- ✓ **Provide incentives to health care providers.**



## Resources and Additional Information:

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- <sup>1</sup> **ALERT Immunization Information System (ALERT IIS)** – Clinic staff have access to a number of reports in ALERT IIS that can help clinics to improve immunization rates. The benchmark report allows users to assess coverage rates for selected age groups or vaccines. The reminder/recall report allows users to generate lists of patients who are due or past due to receive specified vaccines. ALERT IIS reports training is available at: <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/alert/Pages/Reports-Training.aspx>.
- <sup>2</sup> **Oregon Immunization Program AFIX page** – under development
- <sup>3</sup> **Vaccines for Children enrollment page** – Clinics can begin the VFC enrollment process by completing the checklist available at: <http://bit.ly/OregonVFCenrollment>
- <sup>4</sup> **Oregon Immunization Program Model Standing Orders** – The Oregon Immunization Program publishes model standing orders that can be signed by a licensed independent provider to allow nurses and medical assistants to administer vaccines without a provider order. These model standing orders are available at: <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/stdgordr.aspx>.
- <sup>5</sup> **Resources for health care providers and families** – CDC and AAP make available a range of materials for health care providers, clinic staff and families. Resources are available at: <http://www.cdc.gov/vaccines/hcp.htm> and <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/immunization/Pages/default.aspx>.
- <sup>6</sup> **Oregon Immunization Program immunization requirements for school and child care** – Immunizations are required for children who attend public and private schools, preschools, child care facilities and Head Start programs in Oregon. Information about Oregon’s immunization school law, including information about nonmedical exemptions, is available at: <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/GettingImmunized/Pages/school.aspx>.

### General Resources

**Centers for Disease Control and Prevention (CDC)** - <http://www.cdc.gov/vaccines>

**Oregon Immunization Program** - <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/Pages/index.aspx>

**Guide to Community Preventive Services** - <http://www.thecommunityguide.org/vaccines/index.html>

**Immunization Action Coalition, Suggestions to Improve your Immunization Services** - <http://www.immunize.org/catg.d/p2045.pdf>



## Proposed 2016 EQRO Schedule

MCO/MHO/CCO	Pre-site Visit Call – Est.	Site Visit Scheduled Week of:
PH Tech	12/14/15	01/25/16
Greater Oregon Behavioral Health, Inc.	12/28/15	02/08/16
Jackson Care Connect	01/11/16	02/22/16
Columbia Pacific CCO	01/25/16	03/07/16
PacificSource Community Solutions - Columbia Gorge	02/08/16	03/21/16
PacificSource Community Solutions - Central Oregon	02/22/16	04/04/16
Willamette Valley Community Health	03/07/16	04/18/16
Eastern Oregon CCO	03/21/16	05/02/16
Intercommunity Health Network	04/04/16	05/16/16
FamilyCare	04/25/16	06/06/16
Umpqua Health Alliance	05/09/16	06/20/16
Yamhill Community Care	05/30/16	07/11/16
Primary Health of Josephine	06/13/16	07/25/16
AllCare Health Plan	07/04/16	08/15/16
Western Oregon Advanced Health	07/18/16	08/29/16
Trillium Community Health Plan	08/01/16	09/12/16
HealthShare of Oregon	08/15/16	09/26/16
Cascade Health Alliance	08/29/16	10/10/16
OHA ISCA	09/12/16	10/24/16

## 2016 External Quality Review Activities

- **Full Information Systems Capability Assessment (ISCA):**
  - Full day interview on-site at CCO
    - Will need assigned experts to speak on the following subjects:
      - Information systems (data flow)
      - Claims and encounter, authorization
      - Hardware systems
      - Security
      - Administrative data
      - Enrollment systems
      - Vendor data integrity and ancillary systems
      - Integration, report production, and control of data for performance measure reporting
      - Provider data (compensation and profiles)
      - Meaningful use of electronic health records
      - Delegation oversight including all risk-accepting entities (RAEs)
    - Data Center walk-through (on-site)
  - RAE\*/Provider Interviews
    - ❖ 4 interviews negotiated with OHA based on CCO structure
    - \*Does not include interviews with dental RAEs (dental RAEs will have a full ISCA in 2017)*
- **Compliance**
  - Follow-up and updates on all findings and recommendations from 2014–2015 report; 2–3 hour teleconference call or on-site as negotiated
    - Enrollee rights
    - Grievance system
    - Quality assessment/performance improvement
    - Program integrity
- **Performance Improvement Project (PIP)**
  - Quarterly technical assistance consults will occur throughout the year
  - Quarterly reports of progress on Statewide PIP on Standard 8 requirements
  - Learning sessions at QHOC as negotiated with OHA
  - No site visit activities
- **Trainings**
  - Training as negotiated on issues identified in 2015 (1-2 trainings)

### Review Process

- Pre-site teleconference six weeks prior to scheduled review
- Document submission two weeks prior to scheduled review
- Review
- Document resubmission two weeks after review

## PIP Review Tool Statewide PIP

**Date:** [Click here to enter text.](#)

**CCO name:** [Click here to enter text.](#)

**Primary contact for this quarter:** [Click here to enter text.](#)

**E-mail:** [Click here to enter text.](#)

**Study question:**

### Standard 8: Improvement Strategies

Using the text boxes, please provide an overview of the interventions in chronological order and address all criteria for each intervention.

**Part 1: To be completed prior to intervention implementation**

- a. Describe the root cause analysis or quality improvement process used to select the intervention. Please include information on:
- Local data that you analyzed to determine root cause(s)  
[Click here to enter text.](#)
  - Root causes or contributing factors to the problem/gap  
[Click here to enter text.](#)
  - Stakeholders involved in the decision-making process  
[Click here to enter text.](#)
- b. Describe each initial intervention strategy and include the following information for each of the interventions: start dates, staff roles and qualifications, tools or instruments used. (*Modifications made to the intervention over time can be discussed under 8g: Next Steps.*)

[Click here to enter text.](#)

## PIP Review Tool

### Statewide PIP

- c. Describe how each intervention addresses causes/barriers identified in the root cause analysis and is a system intervention:

[Click here to enter text.](#)

- Are the interventions expected to improve the study indicator because they also
  - are supported by research literature?  Yes  No
  - have a history of success?  Yes  No
  - are based on clinical knowledge?  Yes  No
  - use a methodology that promotes rapid evaluation and modification?  
 Yes  No
  - Other?  Yes  No

Please explain: [Click here to enter text.](#)

- d. Cultural and linguistic appropriateness of each intervention:

- Describe how the intervention addresses racial, ethnic, and/or linguistic differences in the study population.

[Click here to enter text.](#)

- Describe how each intervention addresses other cultural considerations such as socioeconomic status, geographic location (urban vs. rural living), literacy status, serious and persistent mental illness, etc.

[Click here to enter text.](#)

- e. Tracking and monitoring plan - Initial  
(Results from tracking and monitoring should be documented below in Part 2 for each quarter):

- Study indicator:

- How often do you plan to collect data to track your progress?

[Click here to enter text.](#)

- Intervention implementation:

- If applicable, what qualitative data will you collect (e.g. interviews, focus groups, minutes, etc.) to demonstrate that the intervention(s) will be implemented as planned?

[Click here to enter text.](#)

- If applicable, what quantitative data (e.g., attendance records, surveys, etc.) will you collect to demonstrate that the intervention(s) will be implemented as planned?

[Click here to enter text.](#)

- How often do you plan to collect data related to intervention implementation? [Click here to enter text.](#)

## PIP Review Tool Statewide PIP

**Part 2: To be reviewed and updated as appropriate each quarter**

**CCO Name:** [Click here to enter text.](#)

**Date:** [Click here to enter text.](#)

**Measurement Period:** Choose an item.

**Contact Name:** [Click here to enter text.](#)

e. Tracking and monitoring plan (continued)

Results:

- Study indicator:

- Have you made any changes to the frequency of data collection?

Quarter 1:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 2:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 3:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 4:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

- What are the results for current reporting periods?

(If available please attach run/control charts or other data collection tools.)

Quarter 1:

[Click here to enter text.](#)

Quarter 2:

[Click here to enter text.](#)

Quarter 3:

[Click here to enter text.](#)

Quarter 4:

[Click here to enter text.](#)

## PIP Review Tool Statewide PIP

- Intervention implementation:
  - If applicable, have you made any changes in the qualitative data you are collecting (e.g. interviews, focus groups, minutes, etc.) to demonstrate that the intervention(s) has been implemented as planned?

Quarter 1:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 2:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 3:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 4:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

- If applicable, have you made any changes to the quantitative data (e.g., attendance records, surveys, etc.) you are collecting to demonstrate that the intervention(s) has been implemented as planned?

Quarter 1:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 2:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 3:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 4:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

- Have you made any changes to the frequency of data collection related to implementation of the intervention?

Quarter 1:  Yes  No

## PIP Review Tool Statewide PIP

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 2:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 3:  Yes  No

If yes, please describe changes:

[Click here to enter text.](#)

Quarter 4:  Yes  No

- What are the results of data analysis related to intervention implementation for each of the reporting periods?

Quarter 1:

[Click here to enter text.](#)

Quarter 2:

[Click here to enter text.](#)

Quarter 3:

[Click here to enter text.](#)

Quarter 4:

[Click here to enter text.](#)

- What is the number or percentage of the study eligible enrollees reached by each intervention?

Quarter 1:

[Click here to enter text.](#)

Quarter 2:

[Click here to enter text.](#)

Quarter 3:

[Click here to enter text.](#)

Quarter 4:

[Click here to enter text.](#)

- f. What are the barriers you encountered during intervention implementation, and how will they be addressed or have they been addressed?

## PIP Review Tool Statewide PIP

- Please note if barriers prevented any of the interventions from being implemented as planned:

Quarter 1:

[Click here to enter text.](#)

Quarter 2:

[Click here to enter text.](#)

Quarter 3:

[Click here to enter text.](#)

Quarter 4:

[Click here to enter text.](#)

### g. Next steps

- At the end of each reporting period, please describe how interventions will be either:
  - Adapted (continue implementation, but with changes)
  - Adopted (implement on a larger scale or plan for sustainability)
  - Abandoned (discontinue in favor of other interventions)

Quarter 1:

[Click here to enter text.](#)

Quarter 2:

[Click here to enter text.](#)

Quarter 3:

[Click here to enter text.](#)

Quarter 4:

[Click here to enter text.](#)

***\*Please note: if you determine that you need to implement a new intervention strategy, you should complete Part 1 and Part 2 for the next quarterly submission.***

## PIP Review Tool Statewide PIP

**Date:** [Click here to enter text.](#)

**CCO name:** [Click here to enter text.](#)

**Primary contact for this quarter:** [Click here to enter text.](#)

**E-mail:** [Click here to enter text.](#)

**Study question:** [Click here to enter text.](#)

### Standard 8: Improvement Strategies

Using the text boxes, please provide an overview of the interventions in chronological order and address all criteria for each intervention.

**Part 1: To be completed prior to intervention implementation**

- a. Describe the root cause analysis or quality improvement process used to select the interventions. Please include information on:
- Local data that you analyzed to determine root cause(s)  
[Click here to enter text.](#)
  - Root causes or contributing factors to the problem/gap  
[Click here to enter text.](#)
  - Stakeholders involved in the decision-making process  
[Click here to enter text.](#)
- b. Describe each initial intervention strategy and include the following information for each of the interventions: start dates, staff roles and qualifications, tools or instruments used. (*Modifications made to the intervention over time can be discussed under 8g: Next Steps.*)

[Click here to enter text.](#)

## PIP Review Tool

### Statewide PIP

- c. Describe how each intervention addresses causes/barriers identified in the root cause analysis and is a system intervention:

[Click here to enter text.](#)

- Are the interventions expected to improve the study indicator because they also:
    - are supported by research literature?  Yes  No
    - have a history of success?  Yes  No
    - are based on clinical knowledge?  Yes  No
    - use a methodology that promotes rapid evaluation and modification?  
 Yes  No
    - Other?  Yes  No
- Please explain: [Click here to enter text.](#)

- d. Cultural and linguistic appropriateness of each intervention:

- Describe how the intervention addresses racial, ethnic, and/or linguistic differences in the study population.

[Click here to enter text.](#)

- Describe how each intervention addresses other cultural considerations such as socioeconomic status, geographic location (urban vs. rural living), literacy status, serious and persistent mental illness, etc.

[Click here to enter text.](#)

- e. Tracking and monitoring plan – Initial

(Results from tracking and monitoring should be documented below in Part 2 for each quarter):

- Study indicator:
  - How often do you plan to collect data to track your progress?  
[Click here to enter text.](#)
- Intervention implementation:
  - If applicable, what qualitative data will you collect (e.g. interviews, focus groups, minutes, etc.) to demonstrate that the intervention(s) will be implemented as planned?  
[Click here to enter text.](#)
  - If applicable, what quantitative data (e.g., attendance records, surveys, etc.) will you collect to demonstrate that the intervention(s) will be implemented as planned?  
[Click here to enter text.](#)
  - How often do you plan to collect data related to intervention implementation?  
[Click here to enter text.](#)

## PIP Review Tool Statewide PIP

**Part 2: To be reviewed and updated as appropriate for each quarter  
(please copy template for each quarterly report)**

**CCO Name:** [Click here to enter text.](#)

**Date:** [Click here to enter text.](#)

**Contact Name:** [Click here to enter text.](#)

**Measurement Period:** Choose an item.

**Quarter:** Choose an item.

### e. Tracking and monitoring plan (continued)

#### Results:

- Study indicator:
  - Have you made any changes to the frequency of data collection?  
 Yes    No  
If yes, please describe changes:  
[Click here to enter text.](#)
  - What are the results for the current reporting period?  
(If available please attach run/control charts or other data collection tools.)  
[Click here to enter text.](#)
- Intervention implementation:
  - If applicable, have you made any changes in the qualitative data you are collecting (e.g. interviews, focus groups, minutes, etc.) to demonstrate that the intervention(s) has been implemented as planned?  
 Yes    No  
If yes, please describe changes:  
[Click here to enter text.](#)
  - If applicable, have you made any changes to the quantitative data (e.g., attendance records, surveys, etc.) you are collecting to demonstrate that the intervention(s) has been implemented as planned?  
 Yes    No  
If yes, please describe changes:  
[Click here to enter text.](#)
  - Have you made any changes to the frequency of data collection related to implementation of the intervention?  
 Yes    No  
If yes, please describe changes:  
[Click here to enter text.](#)

## PIP Review Tool Statewide PIP

- What are the results of data analysis related to intervention implementation for the reporting period?  
[Click here to enter text.](#)

- What is the number or percentage of the study eligible enrollees reached by each intervention?  
[Click here to enter text.](#)

- f. What are the barriers you encountered during intervention implementation, and how will they be addressed or have been addressed?
- Please note if barriers prevented any of the interventions from being implemented as planned:

[Click here to enter text.](#)

g. Next steps

- At the end of each reporting period, please describe how interventions will be either:
  - Adapted (continue implementation, but with changes)
  - Adopted (implement on a larger scale or plan for sustainability)
  - Abandoned (discontinue in favor of other interventions)

[Click here to enter text.](#)

***\*Please note: if you determine that you need to implement a new intervention strategy, you should complete Part 1 and Part 2 for the next quarterly submission.***

## #1: Percentage of patients on opioid doses $\geq 120$ mg Morphine Equivalent Dosage (MED) per day

Specifications	
Measurement year	January 1, 2014 – December 31, 2014 (baseline) July 1, 2015 – June 30, 2016 (PIP year 1)
Ages	12 years and older as of the last day of the measurement year. Report two age stratifications and a total rate: <ul style="list-style-type: none"> <li>• 12-17</li> <li>• 18+</li> <li>• Total</li> </ul>
Continuous enrollment	The measurement year.
Allowable gap	No more than one gap in enrollment of up to 45 days during the year of continuous enrollment.
Anchor date	The last day of the measurement year.
Drugs of interest	Include all drugs in the “narcotic analgesics” therapeutic class (standard code 40) –
Event	Capture all opioids filled during the measurement year. There is no test for negative medication history. Daily MED is calculated as: $MED = \text{drug strength} * (\text{quantity} / \text{days supply}) * \text{conversion factor}$  MED should first be calculated per prescription, then summed to reach patient total. Any patient with one or more days with an MED $\geq 120$ will be counted in the numerator.
Exclusion Criteria	Diagnosis of any neoplasm-related pain (ICD9 338.3) or end-of-life care, palliative care, or hospice care in the measurement year or the year prior to the measurement year.
Denominator	Any member age 12+ as of the last day of the measurement year that meets continuous enrollment criteria, with at least one opioid filled in the measurement year. Inclusive of dual eligible population.
Numerator	Population with one or more days with an MED $\geq 120$
Reporting frequency	Calculated monthly, looking at a rolling 12 month period