

Quality and Health Outcomes Committee

May 9, 2016

HSB Building Room 137A-D, Salem, OR

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

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

Clinical Director Workgroup			
Time	Topic	Owner	Related Documents (page#)
9:00 – 9:10	Welcome/Introductions -Consent Agenda	Mark Bradshaw	-April 2016 Meeting Minutes (1 – 8) -Public Health Update (9) -PCPCT Flyer (10)
9:10 – 9:15	Metrics Update	Sarah Bartelmann	-Update (11)
9:15 – 9:30	Doula Program	Debra Caitlin	-Presentation (12 – 27) -Doula Service Flow Chart (28) -Reimbursement for Doula Care (29 – 33) -Supportive Actions and Benefits (34 – 37)
9:30 – 9:45	WIC -Provider toolkit	Cheryl Alto Jolene McGee	-Presentation (38 – 42) -Annual Report (43 – 46) -Healthcare Provider Brochure (47 – 48) -Letter of Support (49)
9:45 – 10:15	HERC	Cat Livingston	-Back Conditions Technical Changes (handout) -VbBS Agenda (50 – 51) -EBGS Minutes (52 – 57) -HERC Agenda (58) -Obesity Task Force Minutes (59 – 63)
10:15 – 10:25	Primary Care Spending Report	Jim Rickards	- Primary Care Spending Report (handout) -Presentation (64 – 71)
10:25 – 10:40	Waiver	Lori Coyner	- Waiver Site
10:40 – 10:50	Clinical Directors Items from the Floor	All	
10:50 – 11:00	BREAK		
Learning Collaborative Session			
11:00 – 12:30	Back Conditions Benefit (72 – 76)		
12:30 – 1:00	LUNCH		
Quality and Performance Improvement Workgroup			
1:00 – 1:10	QPI Update – Introductions	Jennifer/Lisa	
1:10 – 1:30	Statewide PIP	All	
1:30 – 1:45	PIP -Reporting format -Start/stop process	All	-PIP Report Template (77 – 78) -Model for Improvement (79 – 85)
1:45 – 2:45	Peer Learning	All	
2:45 – 3:00	Items from the floor	All	
3:00	Adjourn		

MEETING NOTES

Quality & Health Outcomes Committee (QHOC)

April 21, 2016

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

Chair- Mark Bradshaw (All Care)

Co-Chair- Jennifer Johnstun (Primary Health)

Attendees: *(in person)*

Cynthia Ackerman (AllCare); Anne Alftine (JCC); Gary Allen (Advantage Dental); Susan Arbor (MAP); Joell Archibald (OHA); Joseph Badolato (FamilyCare); Maggie Bennington-Davis (Health Share); Tara Bergeron (Tuality); Graham Bouldin (Health Share); Bill Bouska (OHA); Mark Bradshaw (All Care); Stacy Brubaker (JCC); Lisa Bui (OHA); Jim Calvert (Cascade Health Alliance); Barbara Carey (Health Share); Jody Carson (Acumentra); Christine Castle (CareOregon); Darren Coffman (OHA/HERC); Bruce Croffy (FamilyCare); Eric Davis (JD Health); Donna Erbs (Acumentra); Neidra Evans (Acumentra); David Fischer (OHA); Ann Ford (Options); Mike Franz (PacificSource); Bennett Garner (FamilyCare); Jim Gaudino (OHSU); David Geels (WOAH); Stan Gilbert (CHA); Jason Gingerich (HERC); Estela Gomez (OHA); Walter Hardin (Tuality); Jenna Harms (Yamhill CCO); Maria Hatcliffe (PacificSource); Theresa Heidt (YCCO); Hank Hickman (OHA); Michael Hlebechuk (OHA); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Bridget Kiene (American Cancer Society); Charmaine Kinney (Mult. Co./Health Share); Kerry Kostmun-Bonilla (Astra Zeneca); Lynnea Lindsey-Pengelly (Trillium); Ellen Pinney (OHA); Alison Little (PacificSource); Cat Livingston (HERC); Andrew Luther (OHMS); Laura Matola (AllCare); Laura McKeane (AllCare); Kevin McLean (FamilyCare); Nicole Merithew (CareOregon); Tracy Muday (WOAH); Brian Niebuurt (OHA); Chris Norman (MAP); Nicole Okane (Acumentra) Dana Peterson (OHA/HSD); Stefan Shearer (YCCO); ; Nancy Siegel (Acumentra); Anastasia Sofranac (OHA/OEI); Janna Starr (OHA/HSD); Anna Stern (WVCH); Jed Taucher (AllCare);

Jaclyn Testani (CPCCO); Melanie Tong (Wash. Co.); Anna Warner (WOAH); Kim Wentz (OHA/HSD); and Ted Williams (OHA/HSD)

By phone:

Ellen Altman, Stuart Bradley, Kristi DePreist, Kevin Ewanchynna, Ruth Galster, Rosanne Harksen, Matthew Hough, Wendy Houstel, Lyle Jackson, Cyndi Kallstrom, Safina Koreishi, Cynthia Lacro, Colleen O'Hare, Dan Reece, Rose Rice, Rebecca Ross, Melinda West, and Melissa Wooden

CLINICAL DIRECTORS SESSION

1. Introductions & Announcements

Introductions/ Announcements	Introductions were made around the room and from the phone.
Review of March Notes	
Psychotropic Meds Prescribing for Children- Dr. Kim Wentz	<ul style="list-style-type: none"> ▪ GAO Report 2009; ▪ DHS and CCO list of assurances; ▪ GAO letter to state Medicaid Directors; ▪ Common themes; ▪ Oregon goals; ▪ Strategy; ▪ Information – DHS staff; ▪ Information – providers; ▪ Strategy: Consent; ▪ Strategy: Clinical practice red flags dashboards to providers and CCOs;

	<ul style="list-style-type: none"> ▪ Clinical practice oversight.
<p>P & T (Pharmacy & Therapeutics) Meeting- Ted Williams</p>	<ul style="list-style-type: none"> ▪ Ted shared a webinar on accessing the Pharmacy Dashboard. The webinar was a virtual tour of the sight with tips for successful navigation. This is not an open access site and providers/CCOs need to provide certain information for access.
<p>HERC Update- Cat Livingston</p>	<p>Prior to Dr. Livingston’s updates, Daphne Peck and Jason Gingerich presented on the newly created searchable prioritized list. They did some sample searches and explained how this product works.</p> <p>HERC updates:</p> <ul style="list-style-type: none"> ▪ VbBS Minutes- began 2018 biennial review; ▪ Diaphragmatic hernia; ▪ Intracranial stenting and angioplasty for atherosclerosis; ▪ Gender dysphoria- laser hair removal; ▪ Pectus excavatum/pectus caravatum; ▪ Autism/dementia; ▪ Skin substitutes for skin ulcers; ▪ Metabolic and bariatric surgery; ▪ Creating language for adding/deleting to the prioritized list; ▪ Topic scoring has been changed for Coverage Guidances; ▪ Bariatric surgery- look at option 1 & 2 (pg. 51 in packet); ▪ Behavioral interventions; ▪ Technical summary.

**BH Crisis
Presentation – Mike
Morris**

- Objectives;
- Mental health crisis pyramid;
- Community services;
- Early intervention/pre-crisis;
- Crisis first access;
- Community crisis placements;
- Emergency department;
- Peer services;
- Marion county;
- The living room model;
- The Alameda model;
- Unity Center for Behavioral Health

**EPSDT/Mental Health
Parity- Dr. Kim Wentz**

Dr. Wentz shared her concerns on mental health parity and rehabilitative therapies. A letter from the DOJ on this matter was included in the packet. Background information provided:

- I. Mental health parity and Medicaid plans
 - A. Federal mental health parity laws
 - B. Quantitative limits under mental health parity
 - C. Mental health benefits

JOINT LEARNING SESSION (1.5 hrs.)**Medication Assisted Treatment (MAT)-
John McIlveen**

Learning session objectives were reviewed. Panelists were Melissa Weimer, Rachel Solotaroff, Jennifer Davis, and John McIlveen.

Medication Assisted Treatment for Opioid Use Disorder: Specialty Addiction Lens-

- Objectives;
- Medication efficacy for opioid use disorder;
- Methadone vs. buprenorphine;
- Treatment retention; buprenorphine detox vs. maintenance;
- Best practices;
- Innovative programs;
- Building capacity for MAT in primary care;

Provided were a CME flyer on the 5th annual pain management event, and a flyer from Acumentra announcing a pain medication study.

Quality and Performance Improvement Session (2.5 hrs.)**Introductions****QPI Update and
Introductions-
Jennifer Johnstun
and Lisa Bui**

- PDSA Template will be discussed at 2:00;
- Back benefits were approved and will be implemented July 1, 2016;
- May Learning Collaborative will be covering back conditions;

	<ul style="list-style-type: none"> ▪ QAPI's have been received. Working with OHA. Feedback welcome; ▪ PIP quarterly reports due end of April. Acumentra will begin to review quarterly reports and submit summary report to OHA for technical assistance deployment and compliance follow up. ▪ CCO 2017 contract language updated to include PIP quarterly reporting.
<p>OEI Equity and Inclusion Coaches- Anastasia Sofranac</p>	<p>The process for OEI technical assistance was explained and detailed on the last page of the QHOC meeting packet. A small group exercise was held. Topic: What is the one issue question that your organization could use technical assistance on? After the exercise, discussion was shared on the findings.</p>
<p>Quarterly Complaints Report- Ann Brown</p>	<p>Ann shared background on this topic and explained that a webinar, with a focus on technical assistance, was held in January 2016. She took meeting attendees on a tour of the reports website. Discussed and shown were quarterly and annual reports. Ann was asked to send instructions on how to access this site.</p> <p>There is a workgroup looking at complaints and grievances. More volunteers are welcome as they find solutions for accurate/uniform reporting of complaints and grievances. Dr. Tracy Muday suggested that a perfect solution for accurate/uniform reporting is to have training or a webinar.</p>
<p>PIP Notification</p>	<ul style="list-style-type: none"> ▪ Do we need to clarify the AIM statement?

	<ul style="list-style-type: none"> ▪ Discussed forms- PDSA worksheet, Model for Improvement, and the OIP worksheet; ▪ Discussed recording cycles; ▪ What should be on the report? - background information, summary, interventions, focus of quarter?
Next Meeting	
<p>Monday, May 9, 2016 9:00 am - 3:30 pm <i>HSB Conference Room 137 A-D</i> Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: Map Office: 503-378-5090 x0</p>	



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Quality and Health Outcomes Committee Public Health Division updates – May 2016

Resources and Updates

Enhance Your State’s Tobacco Cessation Efforts among the Behavioral Health Population: A Behavioral Health Resource. People with mental or substance use disorders are more likely to smoke and get sick or die of tobacco-related causes. This document, recently released by SAMHSA, is a resource for state substance abuse and mental health agencies for integrating tobacco use prevention and cessation in behavioral health services. This resource is available at:

http://www.bhthechange.org/wp-content/uploads/2016/04/State-TA-Tobacco_Cessation_Resource.pdf. Additional information about tobacco prevention in Oregon is available on the Public Health Division’s website at:
<https://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Pages/index.aspx>.

Resources for Violence Prevention: CDC’s National Center for Injury Prevention & Control recently released two technical packages for violence prevention. Both tools are designed to help states and communities take advantage of the best available evidence to prevent violence.

- **Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities.** <http://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf>
- **StopSV: A Technical Package for Preventing Sexual Violence.** <http://www.cdc.gov/violenceprevention/pdf/sv-prevention-technical-package.pdf>

Additional information about violence prevention in Oregon is available on the Public Health Division’s website at:
<https://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/reports.aspx>.

Practice Coaching for Primary Care Transformation

June 28 – July 1, 2016

Portland, OR

Practice Coaching for Primary Care Transformation (PCPCT) is a multi-faceted training program designed for leaders at all levels who have a formal or informal coaching role in primary care transformation efforts. The course is an orientation to, and comprehensive review of, the science of change in primary care practice that equips participants with practical tools and coaching skills necessary to engage and support teams as they evolve into high-performing Patient-Centered Medical Homes.

Focused on the 10 Building Blocks of High Performing Primary Care (Bodenheimer & Ghorob 2013), the course is created by UCSF Center for Excellence in Primary Care and the Patient & Population Centered Primary Care program (PC3) of CareOregon. It draws on the combined expertise of these partners by exploring national and local best practices implemented in high-performing clinics in areas such as team-based care, prompt access to care and population-based care.

This course includes four full days of classroom training, a pre-training assessment, curriculum materials, a site visit to a high-performing primary care practice and optional post-training mentoring support. This robust training approach educates participants on the fundamental content of practice coaching while also providing them with the resources needed to empower clinic teams in utilizing quality improvement methods for sustainable change.



Fees

- Individual Registration: \$4,500
- Group rates are available, please email info@pcpci.org for more information.

To ensure a comprehensive learning experience, the number of participants per training is limited and available on a first-come, first-served basis.

Learn more & register: <http://bit.ly/PCPCTtraining>



This training program is hosted by the Patient-Centered Primary Care Institute in partnership with CareOregon. The Institute is a multi-stakeholder partnership managed by the Oregon Health Care Quality Corporation (Q Corp), a nonprofit organization dedicated to improving the quality and affordability of health care in Oregon. Content experts from CareOregon serve as faculty for this training program.

www.pcpci.org

Metrics Update for QHOC

May 9, 2016

Final CY 2015 Metrics

On April 29th, OHA released full year 2015 incentive measure results to the CCOs. This report reflects what OHA believes is the final CY 2015 performance for the claims-based measures and kicks off the validation process before the distribution of the 2015 quality pool. Remaining measures will be released for CCO review in May.

OHA is aware that some diagnosis codes on claims adjusted after their original submission may not be reflected accurately in the April 29th data. We are actively working to resolve the issue and plan to release a refreshed dashboard in mid-May with all correct diagnosis codes included. CCOs may wish to wait on validating the Effective Contraceptive Use measure until the refreshed dashboard is available.

➤ 2015 Quality Pool Amounts

The final 2015 quality pool amounts were also released on April 29th and can be found online at: <http://www.oregon.gov/oha/analytics/CCOData/Final%202015%20Quality%20Pool%20Amounts%20by%20CCO.pdf>

➤ Validation

CCOs can submit questions or potential corrections to the CY 2015 data until May 31, 2016 by emailing metrics.questions@state.or.us.

➤ Office Hours

OHA has scheduled “office hours” on Thursday, May 12th from 10:00 – 11:00 AM with staff on hand to answer questions about the April 29th data, measure validation, etc. To join, please use conference line 1.888.398.2342 and code 5731389# to participate.

➤ Reporting

OHA will be publishing the next Health Systems Transformation Report reflecting CY 2015 performance and quality pool distribution in late June. CCOs will receive notification of their final results and quality pool payments the day prior to publication.

CCO Metrics & Scoring Committee

The Metrics & Scoring Committee will next meet on May 20th from 9 am – noon. Agenda items include:

- Continued discussion on measuring health disparities
- Reviewing results of the stakeholder survey.

The agenda and materials will be available online at:

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

➤ 2016 Stakeholder Survey

The stakeholder survey is open through Friday, May 13th

<https://www.surveymonkey.com/r/2016MetricSurvey>

Integrating Doulas in Maternity Care A Health Care Transformation Measure



A joint presentation of:

Oregon Doula Association: Courtney Everson, MA, PhD, Birth Doula,
Jesse Remer, BDT/PDT(DONA), LCCE ,Debra Catlin, BDT(DONA)



Office of
Equity & Inclusion

Introduction

Goal:

Collaboratively envision the role of doulas as integral members of the maternity care team and in health care transformation.

➤ Key objectives:

- Review Oregon's plan for THW doula care integration;
- Summarize the research on the benefits of doula care;
- Describe the role of the birth doula;
- Name the first step to implement doula services for your clients.

What is a Birth Doula?

- “BIRTH DOULA means a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience”

(OAR 410-180-0305)

- “A COMMUNITY-BASED DOULA is a woman of and from the same community who provides emotional and physical support to a woman during pregnancy, birth and the first months of parenting.”

(HealthConnect One, 2014)



HB 3311 (2011)

Requires Oregon Health Authority to explore ways **to use doulas** to improve birth outcomes for women who face disproportionately greater risk of poor birth outcomes and to report to legislative committees in February 2012.

Declares emergency, effective on passage.

Committee formed to establish scope of practice, descriptions, and education/training requirements.

Final report released Feb 22, 2012

Doula Care and the Triple Aim

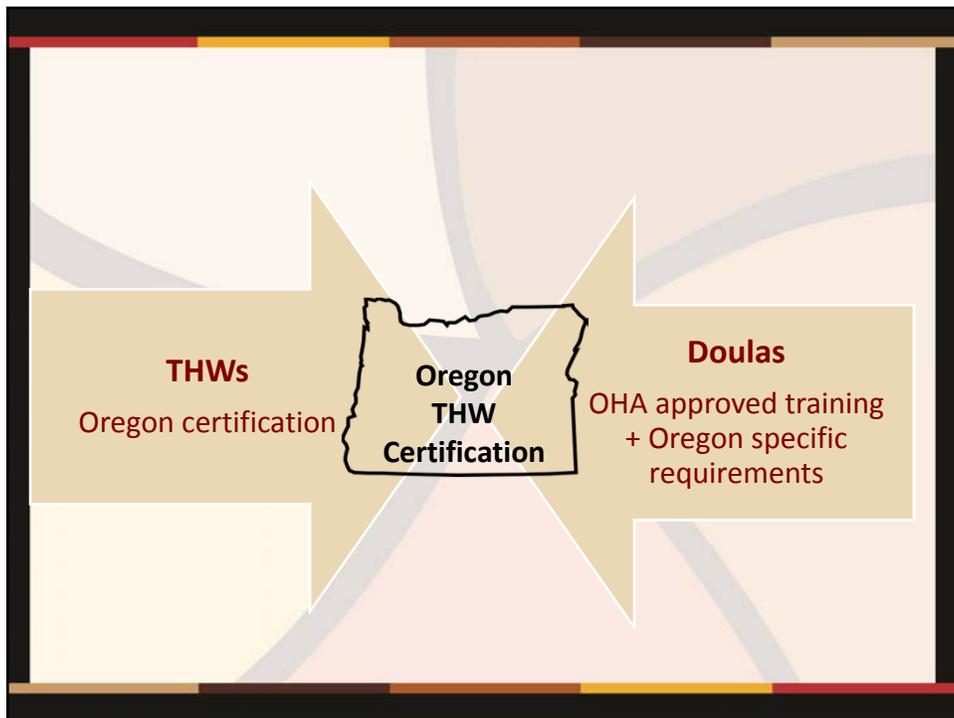
- Improving the experience of care
- Improving the health of populations
- Reducing per capita costs of health care

Improving Health Equity

- Expand use of a birth doula workforce consisting of individuals:
 - From the community served
 - Who have a high level of familiarity with population served
- Cultural competency training for doulas
- Outreach to populations prioritized by OAR rule 410-130-0015

➤ **Priorities include:**

- A woman with a racially or ethnically diverse background including, Black/African American, Asian, Pacific Islander, Native American, Latino, or multi-racial;
- A homeless woman;
- A woman who speaks limited to no English;
- A woman who has limited to no family support;
- A woman who is under the age of 21;
- Medically high risk clients



Oregon's Traditional Health Care Workers



Doula Care is now a covered service for all OHP clients



Perinatal Health Outcomes and Childbearing Experiences Associated with Doula Care

Positive Outcomes

Community-based doula programs improve birth outcomes, infant health, strengthen families, and establish supports to ensure ongoing family success, including:

- Improved prenatal care
- Reduction in preterm birth
- Improved resource usage
- Decrease interventions/Cesareans
- Increased breastfeeding success
- Improved mother-child interaction



HealthConnect One
Engage. Train. Change.

Quantitative Research Reviewed

Hodnett et al. (2013) – *Cochrane Review: Continuous Support for Women during Childbirth*

- Decreased use of epidural and other analgesia
- Decreased average labor length
- Decreased assisted vaginal delivery (forceps, vacuum) rates
- Decreased cesarean section rates
- Decreased rates of low 5 min Apgar scores
- Improved patient satisfaction with labor and delivery experience

2013 Cochrane Review

Author's Conclusion:

“Continuous support during labor has clinically meaningful benefits for women and infants and no known harm. All women should have support throughout labor and birth.”

(Abstract, pg 1)

“Continuous support from a person who is present solely to provide support, is not a member of the woman's social network, is experienced in providing labor support, and has at least a modest amount of training, appears to be most beneficial.”

(Abstract, pg 2)

Kozhimannil et al. (2016) – *Modeling the Cost Effectiveness of Doula Care Associated with Reductions in Preterm Birth and Cesarean Delivery (in Medicaid Populations)*

Preterm Birth 4.7 vs 6.3 (22% reduction)

Cesarean Birth 20.4 vs 34.2 (40% reduction)

Doula care supports near-universal breastfeeding initiation among diverse, low-income women

- 97.9% breastfeeding Kozhimannil et al. (2013)
– initiation rate (compared with 80.8% of the general Medicaid population)
- 92.7% BF initiation rate among African American women (compared with 70.3% of the general Medicaid population)

Qualitative Research Reviewed

Themes include:

- Increased knowledge about childbearing
- Enhancement of self-care
- Early attachment to the baby
- Improvements in their supportive networks
- Tailored approaches, individualized and culturally-matched care
- Reassurance and encouragement (in birth, in life)



Breedlove, 2005; Campero, 1998;
Koumouitzes-Douvia, and Carr, 2006
Everson 2015

Oregon's Community Based Birth Doula Care Model

- At least 4 prenatal home visits
- Attendance at the birth beginning at client's request through the immediate postpartum period
- At least 2 postpartum home visits
- Phone contact and referrals as needed
- Back-up doula for continuity of care



Just what does a birth doula do?



Creates a Therapeutic Relationship

Extends welcome, acceptance, kindness, compassion, and positive regard.

Uses communication skills and emotional support techniques with all interactions.

Creates safety, trust, and an unconditionally supportive dynamic

Before the Birth

The doula meets with the mother and her support team to:

- Address healthy lifestyles, discomforts, mental health, and warning signs during pregnancy
- Explore worries/fears about the upcoming birth
- Identify labor support needs and birth desires
- Provide evidence based information about childbearing options
- Develop coping strategies, communication tools, and a birth care plan
- Plan for family's needs after the birth

During Labor and Birth

- Physical Support
 - Hydration, position changes, relaxation, comfort measures, pain relief, rest, privacy



- Emotional Support
 - Confidence building, reassurance, focus, encouragement, validation, nurturing touch, and a caring, safe, and trustful presence



➤ Informational Support

- Evidence-informed education, support and suggestions for partner, anticipatory guidance, feedback, explanation



➤ Advocacy

- Encouraging questions, speaking up about concerns, shared decision making, and suggesting options to consider



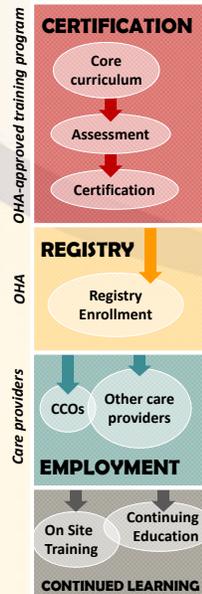
After the Birth

- Immediate postpartum support and initiation of breastfeeding as needed
- Home visits to:
 - Assess maternal and infant well-being
 - Give referrals for concerns
 - Troubleshoot breastfeeding and milk intake
 - Offer guidance on infant care and behavior
 - Debrief the birth experience
 - Screen for Postpartum Mood Disorders

Limits to Practice

- Doulas do not speak instead of the client or make decisions for the client.
- Doulas do not perform clinical or medical tasks such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, postpartum clinical care, or delivering babies.
- Doulas do not “prescribe” treatment. Any suggestions or information provided within the role of the doula must be done with proviso that the doula advise her client to check with her primary care provider before using any application.

How can CCOs and Providers find and utilize state certified Doulas?



Schedule an in-depth presentation
with key decision makers!

Contact Debra Catlin

debcatlin@aol.com

541-393-6380

“Never doubt that a small group of thoughtful, committed citizens can change the world; indeed, it’s the only thing that ever has.”

~Margaret Mead

Acknowledgements

Oregon Doula Association



ORCHWA

Office of Equity and Inclusion



Oregon State University

MAP

International Center for Traditional Childbearing

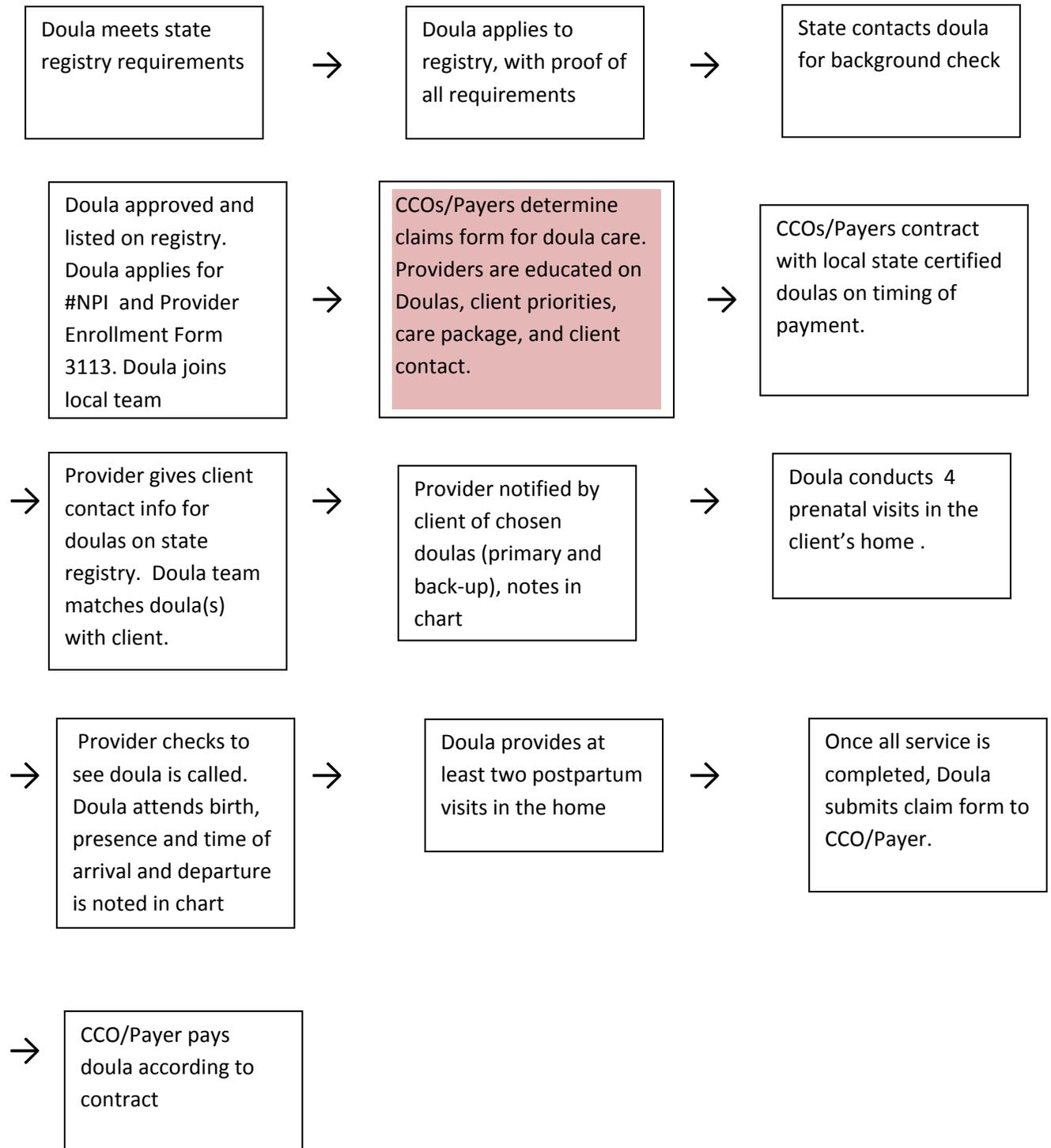


Providence Medical Center



THANK YOU!

Doula Service Flow Chart for CCO OHP Clients



REIMBURSEMENT FOR DOULA CARE: AN OVERVIEW PROCESSES & POTENTIALS FOR OREGON STATE



Correspondence should be directed to:

Jesse Remer, LCCE, CD/PCD(DONA), BDT(DONA)

Founder, Mother Tree Birth Service; Staff Doula/Community Outreach Providence Maternal Care Clinic
Policy & Advocacy Chair for the ODA

jesse@mothertreebirth.com or 503-407-4732

& Courtney Everson, MA, PhDc

Medical Anthropologist, Birth Doula, Oregon State University

Vice President for the ODA

CEverson@gmail.com or 360-490-0220

Supporting Authorship by members of the Oregon Doula Association (ODA)

Overview

As of January 1, 2014, Oregon Medicaid will give eligible mothers access to doula care in the intrapartum (labor and delivery) period.¹ Qualified, certified doulas will be able to seek reimbursement through state-outlined pathways, as specified in OARs 410-130-0015¹ and OARs 410-180-0300 through 410-180-0380.² This document serves to provide background information to make reimbursement decisions with the goal of consistency across health plans. These OARs resulted from the 2011 legislative passage of HB3650, which “mandates that members enrolled in Medicaid have access to Traditional Health Workers (TWHs) [including doulas] to facilitate culturally and linguistically appropriate care.”¹

Definition

Definition of a birth doula from OAR 410-180-0305(3)²: “Birth Doula” means a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and postpartum experience.

Certification & Continuing Education

A qualifying doula is certified and registered with the Oregon Health Authority (OHA), as specified in OAR 410-180-0315 and OAR 410-180-0375:

To be certified in Oregon as a birth doula, an individual must:

(1) Successfully complete an approved birth doula training program

(<http://www.oregon.gov/oha/oei/Pages/approved-thw-training.aspx>); or

(2) Have successfully completed all birth doula training requirements as described in OAR 410-180-0375 through one or a combination of non-approved birth doula training programs and meet the cultural competency course requirements through an approved training program for doulas. Completion of training currently includes:

- 16 contact hours in labor training
- 4 contact hours in breastfeeding training
- 12 contact hours in childbirth education training
- 6 hours in cultural competency training
- Read 5 books from an authority approved reading list
- Write an essay on the value of labor support
- Create a resources list
- Attend at least three births and three home visits
- Submit evaluations from work with three families
- Be CPR-certified
- Have a valid food handler's permit.

Doulas will engage in continuing education and recertification pursuant to their professional associations and OAR 410-180-0320, which states:

- (1) To maintain certification status, all THWs must complete at least 20 hours of continuing education during every three year renewal period.
- (2) Continuing education hours taken in excess of the total number required may not be carried over to the next renewal period.
- (3) The Authority shall award continuing education hours for:
 - (a) Additional THW training offered by a training program; and
 - (b) Any other Authority approved training or event.
- (4) Requests for approval of continuing education may come from the hosting organization or from a certified THW attending the training or event.

Scope of Work

Defined Support Period: 2 prenatal visits; continuous support during the intrapartum period, including the onset of labor (as defined by the mother) to a minimum of 2 hours after delivery; 2 postpartum visits

Average length of work: 24 hours per birth for the intrapartum period; this number is highly variable because each mother and course of labor unfolds differently. 24 hours is an average that accounts for standard deviation on both sides.³ Average prenatal and postpartum visits will last for one to two hours.

Type of work: On-Call. The doula goes on-call for a mother at 37 weeks (term, or earlier if indication arises) through the time of delivery (40 – 42 weeks, on average). Prenatal and postpartum visits are scheduled with the mother on a timeline conducive to her needs. Doulas are required to secure back-up to insure coverage of client in case of emergency or unforeseen illness/circumstance. Partial fees are shared with back-up.

Doula has accountability to the provider to uphold her professional scope of practice in accordance with her professional associations, and to uphold standards of professional conduct as outlined in OAR 410-180-0340:

- (a) Acquire, maintain and improve professional knowledge and competence using scientific, clinical, technical, psychosocial, governmental, cultural and community-based sources of information;
- (b) Represent all aspects of professional capabilities and services honestly and accurately;
- (c) Ensure that all actions with community members are based on understanding and implementing the core values of caring, respect, compassion, appropriate boundaries, and appropriate use of personal power;
- (d) Develop positive collaborative partnerships with community members, colleagues, other health care providers, and the community to provide care, services, and supports that are safe, effective, and appropriate to a community member's needs;
- (e) Regardless of clinical diagnosis, develop and incorporate respect for diverse community member backgrounds including lifestyle, sexual orientation, race, gender, ethnicity, religion, age, marital status, political beliefs, socioeconomic status or any other preference or personal characteristic, condition or state when planning and providing services;
- (f) Act as an advocate for community members and their needs;
- (g) Support self-determination and advocate for the needs of community members in a culturally competent, trauma informed manner

(h) Base decisions and actions in support of empowerment and respect for community member's culture and self-defined health care goals using sound ethical reasoning and current principles of practice;

(i) Maintain individual confidentiality; and

(j) Recognize and protect an individual's rights. Individuals being served have the right to:

- Be treated with dignity and respect;
- Be free from theft, damage, or misuse of personal property;
- Be free from neglect of care, verbal, mental, emotional, physical, and sexual abuse;
- Be free from financial exploitation;
- Be free from physical restraints;
- Voice grievances or complaints regarding services or any other issue without discrimination or reprisal for exercising their rights;
- Be free from discrimination in regard to race, color, national origin, gender, sexual orientation, or religion; and
- Have their information and records confidentially maintained.

Duties: Birth doula services include the following activities that support physiologic birth practices and informed choice during childbearing:

- Initiates relationship with client to establish birth preferences and support desires;
- Joins the woman upon arrival at the birth facility, at her request for continuous support, and stays through labor, delivery and through the immediate postpartum period;
- Provides emotional, physical and non-pharmacological pain management and comfort measures, including, but not limited to: breathing techniques, use of focal points (visualization), positioning, comfort massage, counter pressure, hot and cold therapy, hydrotherapy, and verbal reassurance;
- Offers informational support and education to the woman and her support team in accordance with the provision of evidence-based, informed choice during childbirth and personal empowerment;
- Helps to communicate the clinical care team's instructions and recommendations to the mother, as well as the mother's birthing desires to the clinical care team;
- Aids and encourages the mother and her support team to communicate with the clinical care team about any questions or concerns they may have;
- Assists with building positive and thorough communication between the patient and care team;
- Assists in initiating and sustaining breastfeeding postpartum;
- Screens clients for perinatal mood disorders and provides appropriate referrals; and
- Supports the client in navigating community resources and social services, as needed

Anticipated Outcomes: improved health, decreased interventions, and associated cost-savings.⁴

In 2013, Hodnett and colleagues published an updated Cochrane Review on the effects of continuous intrapartum support compared with standard care. The review included all randomized controlled trials that compared support during labor with standard care from the Cochrane Pregnancy & Childbirth Group's Trials Register. In total, twenty-two trials accounting for 15,288 women were included in the review. Significant main findings are as follows:

- Increased likelihood of spontaneous vaginal birth
- Decreased likelihood of epidural and other analgesia intrapartum

- Shorter average labor length
- Decreased likelihood of cesarean birth or instrumental vaginal delivery (forceps, vacuum)
- Decreased likelihood of low 5 min Apgar scores
- Decreased likelihood of dissatisfaction with labor and delivery experience

Multiple other studies have demonstrated the efficacy of doula care, including improved maternal confidence, increased breastfeeding rates, and improved mother-infant bonding. References available upon request.

Compensation

Currently in Oregon, there are a number of organizations providing doula care, particularly in the Tri-County area where the examples below come from. There is a range of payments from no payment (pro bono) to \$1400+. Women contact doulas through various resources such as doula agencies, online referrals, or provider recommendations, and then hire them as private contractors or via community-based agencies.

Market pricing for doula care varies widely based on several factors, including the setting in which the doula is working, the demographic of the women she serves, the experience of the doula, the add-on services she provides before and beyond intrapartum care, and the market demand and availability for doula care.

- Community-based Doulas: (free or average of \$200/birth via grant funding). These are doulas working in a non-profit or volunteer programs, and providing pregnancy, birth and postpartum support or just intrapartum support. Examples include: [International Center for Traditional Childbearing](#) (ICTC), [PDX Doulas](#), [Gateway Doula Project](#).
- Private Doulas: Hired by the mother and/or expectant family (\$300 - \$1400) with a range of experience from 3 (standard certification minimum) to 1000 births. Examples: [Mother Tree International](#), [Doula Love](#), [Renaissance Doulas](#), [Portland Doula Association](#)
- Hospital-based Doulas: hired by the hospital to provide intrapartum care. Average hourly cost is \$30.55, including FTE benefits, with ten 24-hour shifts a month and an average of one birth per shift. Example: [Providence MCC Staff Doulas](#)
- Medicaid of Oregon currently reimburses \$75 for intrapartum services only, pursuant to OAR 410-130-0015, and this rate only applies to fee-for-service (“open card”) clients. This rate was established as a starting point after examining projected cost-savings associated with intrapartum doula services in terms of two outcomes (cesarean section, epidural use) and associated Medicaid fee structure and claims history. Reimbursement rates for clients covered by the Oregon Health Plan and whose care is managed by Coordinated Care Organizations (CCOs) are under negotiation. The recommendation below is for Medicaid clients whose care is administered via CCOs. Additionally, we recommend additional investigation of the \$75.00 rate for fee-for-service clients with possibility for increase.

Compensation Recommendation: \$600 one-time fee per client, to include: 2 prenatal visits, continuous support at the labor/birth, and 2 postpartum visits.

Based on community standards for the doula profession in Oregon and the importance of professional sustainability, we recommend that CCOs administering Oregon Medicaid health plans reimburse doulas a fee of \$600/client. Rationale: The doula profession follows an on-call structure and aims to support normal physiologic birth and a woman’s personal autonomy, in conjunction with the recommendations of her clinical care team and evidence-based practices. As a traditional health worker (THW), the provision of doula care to all women is an essential ingredient for achieving reductions in documented health disparities and improving maternal-child health outcomes for all families. Further, the reimbursement rate for doula services must be a sustainable living wage commensurate with the private professional realm of doula care and associated THW fields. The recommended fee of \$600/client will help to insure long-term sustainability and viability of a professional workforce of doulas that are reimbursed through Medicaid health plans, in commitment to health equity for all and concurrent cost-savings in maternity care systems.

Compensation Structure

Provider Payment for Oregon Medicaid fee-for-service clients: Clinical provider will recommend a doula, or the mother will hire a doula from the certified registered doulas list maintained by the OHA. The provider will bill on behalf of the doula via a U-9 modifier, as specified in OAR 410-130-0015 and summarized below:

- The licensed obstetrical practitioner may be eligible for an additional payment, as remuneration for the attending doula providing the doula services;
- Doulas shall not receive direct payment from the Division;
- To be considered for the additional payment, the professional claim for the delivery services must include the unique Medicaid modifier –U9 appended to the appropriate obstetrical code billed at the time of delivery;
- This modifier may only be billed once per pregnancy. Multiples (i.e. twins, triplets) are not eligible for additional payment for the doula’s services;
- Only one additional payment shall be made for the doula services regardless of the number of doulas providing the services;
- Only providers with a provider type designation of 34 or 42 may bill the U9 modifier.
- Doula services at the time of delivery are the only services eligible for payment under this rule.

Payment structures for Oregon Medicaid clients managed by CCOs should be established ASAP.

The Provider has accountability to pay the doula in a timely manner.

Disputes will follow an established Grievance Process, as specified in OAR 410-180-0380, summarized below:

- Any individual may make a complaint verbally or in writing to the Authority regarding an allegation as to the care or services provided by a certified or provisionally certified THW pursuant to OAR 410-180-0305 or that an approved training program has violated THW statutes or these rules.
- The identity of an individual making a complaint shall be kept confidential to the extent permitted by law but may be disclosed as necessary to conduct the investigation and may include but is not limited to disclosing the complainant’s identity to the THW’s employer.
- If a complaint involves an allegation of criminal conduct or that is within the jurisdiction of another local, state, or federal agency, the Authority shall refer the matter to the appropriate agency.
- The Authority shall investigate complaints and take any actions that are necessary for resolution.

Recommendations & Summary

We concur with Hodnett and colleagues (2013)⁴ who conclude their Cochrane Review of continuous labor support with this recommendation: “Continuous support during labour should be the norm, rather than the exception. Hospitals should permit and encourage women to have a companion of their choice during labour and birth, and hospitals should implement programs to offer continuous support during labour...Given the clear benefits and absence of adverse effects of continuous labour support, policy makers should consider including it as a covered service for all women.” Therefore, given the documented benefits and associated cost-savings of doula care and continuous doula support, we recommend that doulas who meet established state requirements be eligible for a per client reimbursement payment of \$600 by all Oregon Medicaid health plans.

References Cited

(1) Doula Services: OAR 410-130-0015. Retrieved from: <http://www.oregon.gov/oha/healthplan/Policies/130-0015-010114.pdf>

(2) Traditional Health Workers, Division 80: OARs 410-180-0300 through 410-180-0380. Retrieved from: http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_180.html

(3) Laughon, S.K., Branch, D.W., Beaver, J., & Zhang, J. (2012). Changes in labor patterns over 50 years. *Am J Obstet Gynecol*, 206:419.e1 - 419.e9.

(4) Hodnett, E.D., Gates, S., Hofmeyr, G.J., and Sakala, C. (2013). Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews*, Issue 7: Art. No.: CD003766. DOI: 10.1002/14651858.CD003766.pub5

Supportive Actions and Benefits of Doula Care

Debra Catlin, Oregon Doula Association

Prenatal Visit Supportive Actions	Benefits
Home visits in which the doula establishes a therapeutic relationship with client by extending welcome, acceptance, kindness, compassion, and positive regard. Uses communication skills and emotional support techniques with all interactions.	Creates a therapeutic relationship with client that carries into the labor and birth and postpartum periods; Increases sense of self-worthiness; Instills confidence; Promotes trust; Client more likely to ask for and utilize help; Improves maternal mental health and may avoid birth trauma
Coordinates with service providers, health plans and community resources involved in client care	Enhanced continuity of care, Effective utilization of services based on client/family need
Elicits client birth priorities and preferences and fosters ways to manifest them	Helps client to articulate priorities and take more responsibility for their birth
Reviews past pregnancy and birth experiences, identifies helpful aspects, areas for improvement, and previous difficulties/trauma	Care is tailored to individual needs-increased patient satisfaction; Improved maternal mental health
Explains Doula's role and scope of practice; Doula does not project own values or goals upon client	Creates boundaries by clarifying doula's role, responsibilities, limits to practice, and differences among care team members; Clients feels support is unconditional
Assesses labor and birth support needs in regards to safety, trust, respect, communication, encouragement, autonomy, and nurturing	Care is tailored to individual needs; Decreases stress and anxiety; Mother feels more secure and in control; Increased patient satisfaction; Improved maternal health
Provides a counter-narrative of labor and birth as compared to negative images and stories clients often hear. Creates a coping mindset about labor pain, and relates factors that facilitate a positive birth experience.	Reduces maternal stress and fear; Instills confidence in ability to birth; Decreases need for pain medication and interventions; Shortens labor; Reduces complications and re-hospitalization of mother and newborn
Explains birth process in relation to physiology, hormonal orchestration, sensations, and emotions.	Normalizes birth process; Facilitates client's knowledge of factors that enhance or inhibit physiological birth; Improves birth outcomes
Addresses any client disclosed special needs including history of abuse, trauma, or previous difficult birth	Identifies needs for professional help; Care is tailored to special needs-increased patient satisfaction; Mother feels more secure and in control; Improved maternal mental health
Educates client on ways to enhance physiologic birth such as calming techniques, mental focusing, mobility, hydrotherapy, massage, etc.	Optimizes hormonal output for mother and baby resulting in shorter labors, less intervention use, breastfeeding success, enhanced bonding, and improved maternal mental health.
Reviews warning signs and preterm labor signs, refers as needed; Offers pregnancy comfort measures	Timely referrals for early intervention in potential complications: Improves birth outcomes; Reduces hospital admissions
Identifies any challenges to healthy lifestyle practices; offers supportive measures, resources; Offers referrals; Screens for antepartum mood disorders	Better compliance with healthy behaviors; Reduces health complications; Early identification of mental health issues
Assesses and personalizes labor coping strategies	Facilitates better coping with labor; less or later pain medication use; Fewer interventions

Supportive Actions and Benefits of Doula Care

Debra Catlin, Oregon Doula Association

Teaches pre-labor positioning to encourage optimal fetal positioning	May facilitate anterior fetal positions, shortening labor and reducing mal-presentations
Discusses pain management options and their effects; Supports client's choice	Informed decision making; Maximizes benefits of pain medication use while reducing side effects
Works out role with partner/helpers so as to maximize their participation at their comfort level	Supports partner/helpers role; Enhances father/partner's birth experience
Explores parent's pregnancy experience, including readiness for parenthood and relationships with family	Fosters more positive relationships with the family's support system; Identifies needs for professional help
Identifies cultural practices/language considerations in regards to childbearing	Culturally appropriate care and communication; Identifies need for interpreter services
Assists client to create strategies to address fears and concerns about birth, especially when they feel frightened, ashamed, and overwhelmed	Reduces stress and anxiety; Mother feels more secure and in control; Enhances physiologic birth; improved birth outcomes; Increased patient satisfaction; Improved maternal health
Empowerment support- Teaches communication strategies and tools for shared decision making with care team; Educates in general about benefits/risks of common interventions and Cesarean birth;	Informed decision making, reduces non-medical use of interventions; Active participation improves client satisfaction; Reduces complications and hospitalization of mothers/newborn; Decreases possibility of obstetrical violence and birth trauma; Improves maternal mental health
Develops a birth care plan for several contingencies, includes a newborn care plan	Enhances communication with care team; Facilitates patient-centered care; Improves patient satisfaction
Offers local resources for education on birth, breastfeeding, infant care, early parenting Fills in any gaps in education	Education is proven strategy for enhancing birth and infant outcomes
Provides parents with a postpartum care plan and information on maternal mental health	Facilitates family adjustment; Early identification and treatment of postpartum mood disorders
Arranges a back-up doula in the event of illness, emergency, or primary doula's unavailability	Facilitates continuity of care; Promotes security and trust with client

Labor and Birth Supportive Actions	Benefits
Client contacts doula at beginning of labor, reminds clients of reasons to contact caregiver	Review signs of true labor and active labor; Client contacts provider and goes to hospital as directed, reducing hospital triage use
Doula with client during established early labor Keeps calm, reminds to rest, hydrate, nourish Recommends coping strategies for early labor Make sure family is ready to transport	Client in good physical and emotional state with entry into active labor; Fewer complications of long labors; Reduces possibility of unattended birth
Review signs of active labor with client	Client contacts provider and goes to hospital or birth center as directed
Provides continuous companionship with high quality emotional care	Reduces maternal stress; Less disruption in hormonal output, Increases spontaneous vaginal birth; Improves

Supportive Actions and Benefits of Doula Care

Debra Catlin, Oregon Doula Association

	birth outcomes and maternal mental health
Encourages mobility and pelvic opening positions throughout labor	Improves labor progress and reduces mal-presentations; Less intervention use; ; Reduces complications
Uses comfort measures, massage, pressure, hydrotherapy and other pain relief techniques	Reduces pain-less need for pain medication or delayed use
Supports client and partner in using relaxation, breathing, focusing and rhythmic guidance techniques to cope with labor	Improved coping; Less need for pain medication or delayed use; Positive perception of self and partner; Enhances bonding
Knows, supports, and facilitates client's preference on use of pain medication	Improved communication with staff, better patient satisfaction
Reassures, validates, gives feedback, keeps up confidence, encourages, checks in	Emotional support helps mother to cope, reduces stress and anxiety, reduces pain, shortens labor
Roadmaps the birth process, explains to mother and helpers as needed	Reduces stress and anxiety
Encourages upright pushing positions and guides effective pushing techniques	Increased progress in second stage; Reduced instrumental delivery; No or less tearing of perineum; decreased Cesarean birth
Supports information gathering and shared decision making if needed	Informed decision making; Reduces non-medical use of interventions; Enhances communication with care team; Active participation improves client satisfaction; Mother feels more secure and in control; Reduces possibility of obstetrical violence and birth trauma; Improved maternal mental health
Helps parents cope with changes in plans	Reduces stress; Improves patient satisfaction
Helps with coping techniques for uncomfortable or painful procedures or dealing with unpleasant side effects	Reduces stress and anxiety; Greater comfort; Improves patient satisfaction
Cesarean birth support	Reduces stress and anxiety; Improves patient satisfaction; Improves maternal mental health

Immediate Postpartum Supportive Actions	Benefits
Supports delayed cord cutting and immediate skin-to-skin contact with mother	Promotes successful breastfeeding; Improved newborn transitioning; Promotes seeding of infant's microbiome; Improves parent-infant attachment- mother has higher regard for newborn, increased sensitivity and responsiveness toward newborn
Support provided with any post birth problems or complications, or NICU admission	Reduces stress and anxiety; Improves patient satisfaction; Improves maternal mental health
Early Breastfeeding support measures	Facilitates good positioning and latch, early and frequent feeding; Promotes adequate infant weight gain
Helps parents get to know their newborn-appearances and behavior	Parents understand infant's cues; appropriate and immediate responses; facilitates parent-infant attachment

Supportive Actions and Benefits of Doula Care

Debra Catlin, Oregon Doula Association

Postpartum Visits Supportive Actions	Benefits
Assesses physical recovery of mother; Offers comfort measures; Reviews warning signs and refers to provider as needed;	Timely referrals for early identification and treatment of complications; Reduces hospital readmissions
Reviews warning signs for infant, refers to provider as needed	Timely referrals for early identification and treatment of complications; Reduces hospital readmissions
Assess and troubleshoots breastfeeding; Refers to professional help for problems beyond the scope of the doula	Breastfeeding problems are addressed immediately; Milk supply and infant weight gain problems are reduced; Improves breastfeeding success and duration; Improved infant health
Address any infant care and behavior questions, and teaches infant soothing techniques	Parents more responsive to their infant's cues; increases parent's confidence in the role; Reduces parent's stress and improves their mental health; Reduces chance of shaken baby syndrome
Assesses parent-infant attachment dynamics	Identifies need for professional help; Reduces incidence of child abuse
Assesses emotional status and adjustment of parents; Offers tips for self-care	Differentiates between normal transitions of early parenthood and mental health concerns; Improves parental adaptation and self-care, thus reducing stress and improving mental health; Timely referrals for professional help
Uses screening tool to identify signs of Postpartum Mood Disorders	Timely referrals for early evaluation and treatment; Improved maternal mental health; Reduces incidence of child abuse
Debriefs and processes the birth experience with the parents	Facilitates mother's and partner's integration of the birth experience; Identifies any negative repercussions or possible birth trauma; refers for early evaluation and treatment; Improved maternal mental health
Elicits feedback on the doula's role and service	Continuous improvement of doula care

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Oregon Doula Association

www.oregondoulas.org



Partnering with WIC & the Healthcare Provider Toolkit

Oregon
Health
Authority

POLICY AND ANALYTICS
Transformation Center

WIC – Public Health Nutrition Program

- Serves over 155,000 Oregon women, infants and children every year
- Provides essential nutrients during critical times of growth and development to support lifelong health
- OHP patients that are pregnant/nursing, infants or children up to age 5, may qualify for WIC

 2015 Annual Report



POLICY AND ANALYTICS
Transformation Center

Oregon
Health
Authority

WIC Benefits

- Participant-centered nutrition education
- Nutrient-dense foods
- Breastfeeding support
- Access to registered dietitian nutritionists and lactation specialists
- Gateway to social services and preventive healthcare



POLICY AND ANALYTICS
Transformation Center



3

WIC-Clinical Services Meet Public Health

- WIC can help with certain performance metrics
- Supports coordinated care around early prenatal nutrition, breastfeeding services, an infant's healthy growth, immunization referral and obesity prevention
- Saves money--for every dollar spent on a pregnant women in WIC, up to \$4.21 is saved in Medicaid
- Fiscally impacts your community – 62 million to Oregon in food dollars last year



POLICY AND ANALYTICS
Transformation Center



4

WIC & Healthcare Provider Toolkit

WIC Improves Health Outcomes for Oregon Families

- A child can have up to 21 WIC contacts
- A woman can have up to 8 WIC contacts



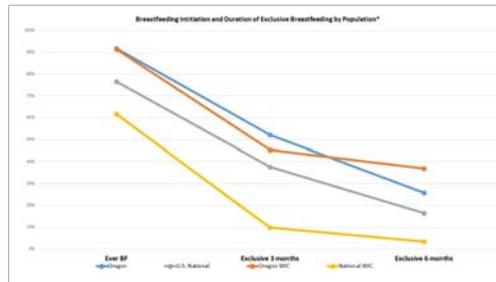
POLICY AND ANALYTICS
Transformation Center



WIC & Healthcare Provider Toolkit

Oregon WIC Breastfeeding Support and Education

- Oregon's breastfeeding rates are the highest in the nation
- WIC offers professional lactation support, prenatal breastfeeding education, peer support and an enhanced food package



POLICY AND ANALYTICS
Transformation Center



WIC & Healthcare Provider Toolkit

WIC and CCOs are teaming up to:

- Offer dental health services
- Support pregnant women
- Provide lactation services

WIC & CCO Partnership =
Prevention = Savings!



POLICY AND ANALYTICS
Transformation Center



9

WIC & Healthcare Provider Toolkit

www.healthoregon.org/wic

Click on the For Medical Providers tab on the left sidebar

CCOs:

- Share WIC resources with your network of pediatricians & OB/GYNs
- Encourage county partnerships and referrals to WIC



POLICY AND ANALYTICS
Transformation Center

WIC Nutrition Services

NAME _____ DATE _____

Your doctor suggests that you consider visiting WIC for these services to help your family be healthy.

<input type="checkbox"/>	Prenatal nutrition
<input type="checkbox"/>	Breastfeeding support
<input type="checkbox"/>	Infant and child feeding
<input type="checkbox"/>	Child's healthy growth
<input type="checkbox"/>	Assistance with family meals
<input type="checkbox"/>	Nutritious foods
<input type="checkbox"/>	Other: _____

TO-DO
Call WIC

LEARN MORE at www.healthoregon.org/wic
DIAL 211 to find a WIC clinic near you

USDA is an equal opportunity provider and employer.
WIC Administration is provided by Northwest State of Oregon Health Department under a license from Oregon Health Services and has been in partnership with your provider.

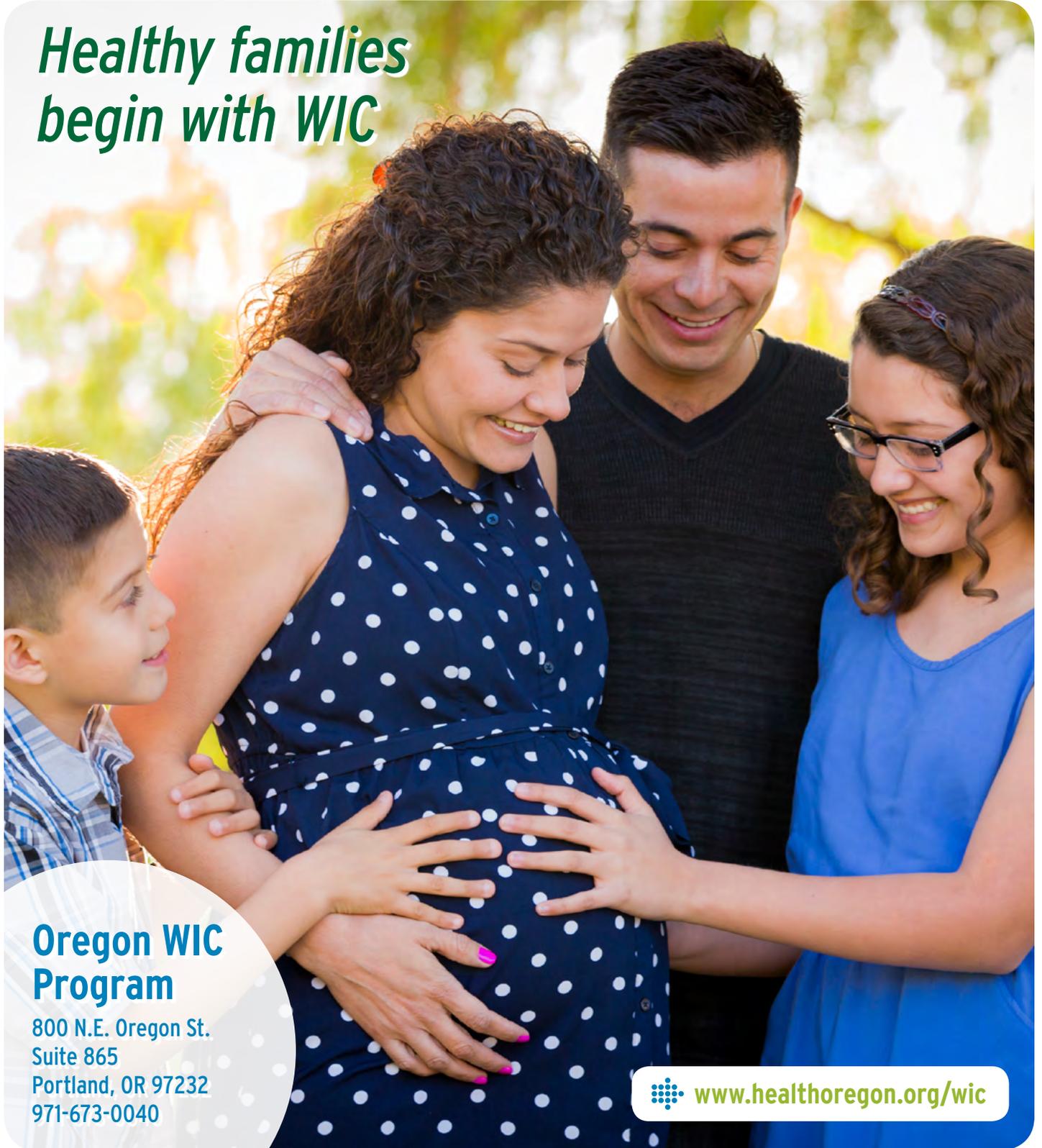


10



2015 Annual Report

*Healthy families
begin with WIC*



**Oregon WIC
Program**

800 N.E. Oregon St.
Suite 865
Portland, OR 97232
971-673-0040

 www.healthoregon.org/wic

2015 – banner year

The Supplemental Nutrition Program for Women, Infants and Children – commonly known as WIC or the Women, Infants and Children Program – continues to serve Oregon families' nutritional needs during early childhood.

2015 was a year of exciting changes and new opportunities for Oregon WIC. The highlights include:

-  Implementing the eWIC project and other major technology improvements to better serve families;
-  Strengthening our work in the area of nutrition education; and
-  Practicing continuous quality improvement throughout Oregon WIC programs.

Focusing on these areas helped us improve the delivery and effectiveness of WIC services across the state.

eWIC Improving the WIC shopping experience

WIC began a new era by offering families a safe, simple and convenient way to shop for WIC foods using an electronic benefit transaction card instead of the traditional paper voucher. This new way of shopping is called "eWIC."

With the new system, WIC families are now able to:

- Use their eWIC card to buy healthy WIC foods as they need them;
- Easily track their monthly food balance;
- Use our new WICShopper smart phone app to look up their food balance and scan product barcodes to check if a food is WIC-eligible.

All Oregon WIC participants will shop with eWIC cards by June 2016.

Other WIC technologies that improve services to families:

- Breastfeeding peer support via text messaging
- Online nutrition education classes
- Appointment reminders by phone, text and email



Tishalee Chavez of Medford has helped both her sons get a healthy start in life by using WIC nutrition benefits in their early childhood. Tisha is a big fan of eWIC because she no longer has to present individual vouchers for her WIC food at the grocery check stand.

It's nice that we don't hold up the line and we can get through much faster. It sometimes took me a half-hour to get through the line with the vouchers.

-Tishalee Chavez

Helping Oregon families improve their nutrition

Almost half of all pregnant women in Oregon use WIC.

The program also serves women after birth and their children until age 5. WIC services help Oregon families achieve better lifelong health.



WIC nutrition education

helps families reach their health goals. WIC nutrition education sessions are designed to help families with an array of health topics including breastfeeding, infant feeding, picky eaters and many others.

(Photos: Breastfeeding peer support classes in Linn County)

WIC counts

In 2015

155,055 Oregon women, infants and children were served by WIC.

- 110,353 Infants and children
- 44,702 women

57% of women living outside of metro/urban areas used WIC during their pregnancy.

- In rural counties, 54% of pregnant women used WIC during pregnancy.
- In metropolitan counties, 38% of women used WIC during pregnancy.



\$62.13 million in WIC benefits were spent at authorized grocery stores, pharmacies, farm stands and farmers' markets.

\$344,342 in WIC Farm Direct Nutrition Program (FDNP) benefits were spent at authorized farm stands and farmers' markets.

- The FDNP program provides fresh, locally grown fruits and vegetables and education on selecting and preparing fresh produce while supporting local farmers markets and farmers.
- FDNP includes 665 authorized farmers.



Continuous quality improvement promotes stronger emphasis on customer service

According to the National Learning Consortium, continuous quality improvement (CQI) is a quality management process that encourages all health care team members to continuously ask the questions, "How are we doing?" and "Can we do it better?"

Oregon WIC local agencies focused on these questions throughout the year.



The Crook County WIC team

used continuous quality improvement to improve the WIC clinic experience. Participants can select one or two topics from the "topic wall" before a nutrition appointment. By choosing what to discuss with their counselors, parents feel more a part of the process.

All Crook County WIC staff members have been on WIC at some point, says WIC Coordinator Emma Reynolds. "So we really understand what will help participants."

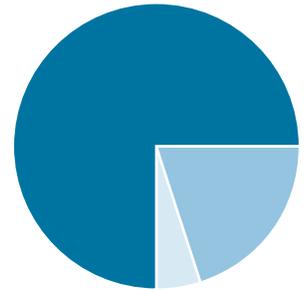
2015 WIC funding

WIC funding sources:

- U.S. Department of Agriculture
- State and federal funds for the Farm Direct Nutrition Program
- Local government funds
- Provider agency and community contributions
- Infant formula rebates

Where the funding goes:

- **75%** Healthy food
- **20%** Participant, nutrition and breastfeeding services
- **5%** Administration



VISION: Oregon families have the resources and knowledge to achieve optimal nutrition and lifelong health.

MISSION: Assure the provision of premier public health nutrition services by providing leadership, guidance and resources to local WIC programs, vendors and partners.

Oregon Health Authority

PUBLIC HEALTH DIVISION
Nutrition & Health Screening
Program for Women, Infants & Children

This institution is an equal opportunity provider. This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this publication in another format or language, contact Oregon WIC at 971-673-0040 or 711 for TTY.

INCLUDE WIC IN YOUR TREATMENT PLAN

The American Academy of Pediatrics recommends that physicians refer eligible patients to WIC. Oregon WIC serves 44% of infants born. However, there are still thousands of pregnant women and babies, and even more children ages 2-5, who are eligible but not participating. People on Oregon Health Plan are automatically eligible for WIC*.

*Families are eligible for WIC if they have income up to 185% of the federal poverty level or are enrolled in other programs such as OHP or SNAP.



CONNECT PATIENTS with WIC

For more information, download our **Healthcare Provider Toolkit**

Visit our website and click on "For Medical Providers"

www.healthoregon.org/wic



WIC Rx Forms

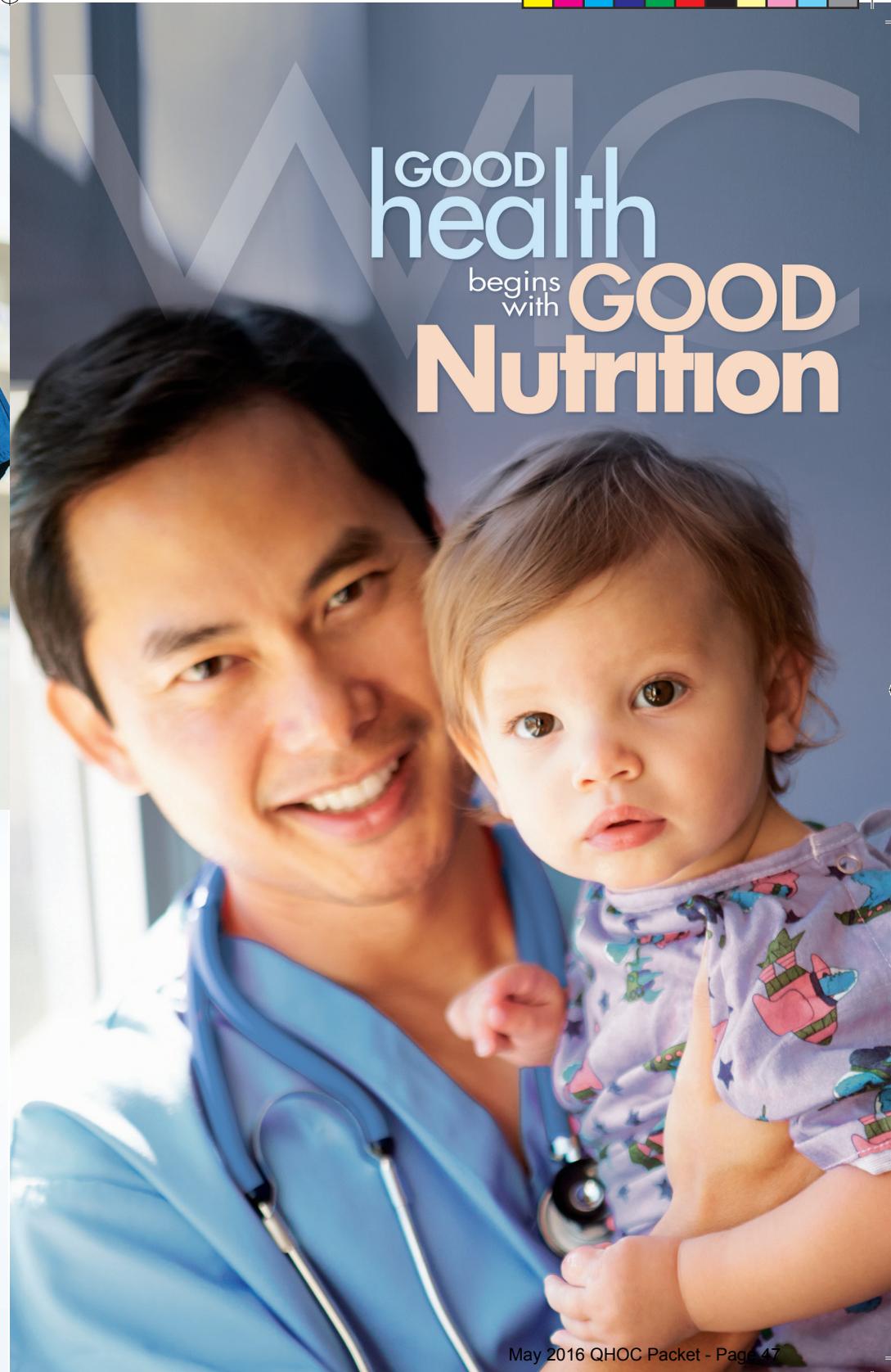
For families that need extra nutritional help



Oregon WIC Program
800 NE Oregon St #865
Portland, OR 97232
www.healthoregon.org/wic
971-673-0040

WIC Rx materials were developed by Minnesota Dept. of Health WIC Program with funding from Hunger-Free Minnesota and have been adapted with their permission. USDA is an equal opportunity provider and employer.

GOOD health
begins with **GOOD Nutrition**



WHEN YOUR **goals** for a patient include

- breastfeeding support
- a child's healthy growth
- a healthy diet
- successful feeding
- sufficient iron in the diet
- prenatal nutrition
- a healthy pregnancy



Get RESULTS with WIC

Increase key nutrients in the diet

Increase breastfeeding rates and success

Improve healthy growth and development

Better birth outcomes, with fewer preterm and low birth-weight babies

For every \$1.00 spent on WIC during pregnancy, up to \$4.21 is saved in medical costs!

WIC Services

The WIC team includes nutrition professionals (RDNs), nurses (RNs & PHNs), certified lactation consultants and trained breastfeeding peer counselors. Together WIC can offer your patients follow-up care in four key areas:

Breastfeeding	Resources	Nutrition	Food Choices
<ul style="list-style-type: none"> • Assistance & tips • Peer support 	<ul style="list-style-type: none"> • Consultations • Referrals 	<ul style="list-style-type: none"> • Assessment • Education 	<ul style="list-style-type: none"> • Food packages • Shopping guidance
			
<p>One-on-one breastfeeding support and encouragement.</p>	<p>Connecting families to health and community services, resources and programs unique to each participant.</p>	<p>Personalized nutrition consultation with routine follow-ups, working with families to address dietary needs, meal planning and feeding concerns.</p>	<p>Nutritious food packages include fruits & vegetables, whole grains, low-fat dairy and iron-rich foods tailored to the specific needs of moms, infants and children to age 5.</p>

You promote healthy eating
WIC can help!

April 11th, 2016

Greetings,

Enclosed is information about WIC, Oregon's premier public health nutrition program. WIC, or the Special Supplemental Nutrition Program for Women, Infants and Children, offers participant-centered nutrition education, breastfeeding support, nutrient-dense foods, and is a gateway to social services and preventative healthcare.

WIC is where clinical services and public health meet. Specifically, WIC:

- saves money—for every dollar spent on a pregnant woman in WIC, up to \$4.21 is saved in Medicaid.
- supports coordinated care around early prenatal nutrition, breastfeeding services, an infant's healthy growth, immunization referral, obesity prevention and more.
- serves over 161,00 Oregon women, infants and children up to age 5, statewide.
- helps families get the essential nutrients needed during critical times of growth and development.
- fiscally impacts your community in a positive way; last year, WIC brought in \$64 million in food expenditures to Oregon's economy.

The enclosed WIC & Healthcare Provider Toolkit includes examples of collaboration between WIC and CCOs, a WIC Rx pad for referring patients, WIC data specific to your area, and more. The toolkit can also be accessed online at www.healthoregon/wic; choose *For Medical Providers* on the left sidebar. You can print and share these resources with your network of healthcare providers.

Please encourage local WIC and healthcare provider partnerships and patient referrals to WIC. The earlier families get into WIC, the greater the impact on lifelong health and the health of the community. Thank you, for your continued support of this vital public health nutrition program.

Sincerely,



Lillian Shirley, BSN, MPH, MPA
Public Health Division Director
Oregon Health Authority

AGENDA
VALUE-BASED BENEFITS SUBCOMMITTEE

May 19, 2016

8:30am - 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

- | | | |
|-------------|---|----------------|
| I. | Call to Order, Roll Call, Approval of Minutes – Kevin Olson | 8:30 AM |
| II. | Staff report – Ariel Smits, Cat Livingston, Darren Coffman | 8:35 AM |
| | A. Errata | |
| | B. Back line implementation | |
| | C. Searchable List demo | |
| | D. HSD “other” lists searchability—Nathan Roberts | |
| III. | Straightforward/Consent agenda – Ariel Smits | 8:50 AM |
| | A. Straightforward table | |
| | B. Straightforward guideline changes | |
| | C. M99 series code placement | |
| | D. Back lines straightforward changes | |
| | E. Ureteral procedures | |
| | F. Remote imaging for screening and management of retinopathy of prematurity | |
| | G. Fitting for spectacles and contact lenses | |
| IV. | 2018 Biennial Review – Ariel Smits | 8:55 AM |
| | A. Tension and migraine headaches | |
| V. | Guidelines – Ariel Smits, Cat Livingston | 9:15 AM |
| | A. Tobacco cessation and elective surgery | |
| | B. Acupuncture for tobacco cessation | |
| | C. Hyperbaric oxygen | |
| | D. Opioids for back conditions | |
| VI. | New discussion topics – staff | 9:45 AM |
| | A. Pediatric Urology | |
| | A. Hypospadias | |
| | B. Retractable testicles | |
| | C. Congenital urologic conditions | |
| | B. Physical therapy modalities | |
| | A. Physical therapy modality review overview | |

- B. Physical therapy modalities with little utilization and little or no evidence of effectiveness
 - C. Paraffin wax therapy
 - D. Vasopneumatic devices
 - E. Mechanical traction and TENS for back and neck conditions
 - F. Whirlpool therapy
 - C. Incontinentia pigmenti
 - D. Implantable cardiac loop recorders
 - E. Electric tumor treatment fields for initial treatment of glioblastoma
 - F. Sacroiliac joint fusion
 - G. Severe insomnia in young children
 - H. Low frequency ultrasound for wound healing
 - I. Posterior tibialis tendinopathy/flatfoot
- VII. Previous discussion topics – Ariel Smits 12:15 PM**
- A. Disorders of bilirubin metabolism
 - B. Pectus excavatum and pectus carnitatum
 - C. Habilitative and rehabilitative services for mental health conditions
- VIII. Public comment 12:55 PM**
- IX. Adjournment – Kevin Olson 1:00 PM**

MINUTES

Evidence-based Guidelines Subcommittee

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
April 7, 2016
2:00-5:00pm

Members Present: Wiley Chan, MD, Chair; Eric Stecker, MD, MPH, Vice-Chair (by phone); Beth Westbrook, PsyD; George Waldmann, MD (by phone); Alison Little, MD, MPH; Kim Tippens, ND, MPH.

Members Absent: None

Staff Present: Darren Coffman; Catherine Livingston, MD, MPH; Jason Gingerich.

Also Attending: Adam Obley, MD, Moira Ray, MD, MPH and Craig Mosbaek (OHSU Center for Evidence-based Policy); Erica Pettigrew, MD (OHSU); Charles Bentz, MD and Duncan Neilson, MD (Legacy Health); Kim Wentz, MD (by phone) and Jessie Little (OHA); Joanne Rogovoy (March of Dimes), Maria Rodriguez (OHSU), Emily Elman (OHA Public Health).

1. CALL TO ORDER

Wiley Chan called the meeting of the Evidence-based Guidelines Subcommittee (EbGS) to order at 2:00 pm.

2. MINUTES REVIEW

No changes were made to the February 4, 2016 minutes.

Minutes approved 6-0.

3. STAFF REPORT

Coffman welcomed Tippens to the subcommittee. She introduced herself as a naturopath and acupuncturist. She is an assistant professor at the National College of Natural Medicine. She will be serving on HERC as well.

Coffman reported that the HERC has referred the draft coverage guidance on Skin Substitutes for Chronic Skin Ulcers back to EbGS and requested that it be put out for an additional public comment period. This coverage guidance will come back to the subcommittee at its June meeting.

4. DRAFT COVERAGE GUIDANCE: Timing of Long-Acting Reversible Contraceptive (LARC) Placement

Ray reviewed the draft coverage guidance and evidence as presented in the meeting materials. Coffman introduced Maria Rodriguez as appointed expert on the topic. She is an assistant professor at OHSU in the Obstetrics & Gynecology/Generalist Division. Her research has focused on the evaluation and monitoring of family planning programs, including reproductive health outcomes and disparities among the Medicaid Population. She has received research funding from the National Institutes of Health as a Women's Reproductive Health Research Fellow. She has consulted for the World Health Organization. She has been trained as a trainer for Nexplanon insertions.

Livingston also invited Dr. Duncan Neilson to participate as he is familiar with the topic and was already present in preparation for the upcoming discussion of Tobacco Cessation During Pregnancy. Dr. Duncan Neilson is Clinical Vice President, Legacy Health System, Portland. His responsibilities include program development in Women's Services, Quality and Patient Safety measurement and program implementation. He has served in the past as clinical vice president of Legacy's Women's Services and Surgical Services. He has served the commission as an expert on previous obstetric-related topics, including Out-of-Hospital Birth and Elective Induction of Labor.

Chan asked what the comparison was for the observational study which reported higher perforation among women who had delayed insertion and who were breastfeeding. Ray said that the study followed women over time and collected baseline data as well as information about expulsion events, perforation events and other adverse events, then looked retrospectively to find risk factors for the adverse events. Breastfeeding was found to be an independent risk factor for perforation over other factors like nulliparity and recent pregnancy. Chan said that breastfeeding is clearly correlated with time after delivery, but Ray said she believes the association was stronger than one would expect even given that fact.

Waldmann asked why breastfeeding would be associated with a higher risk than immediate postpartum status. Ray explained that it is believed to be related to hormonal changes affecting the uterus after delivery, and that six weeks postpartum is a vulnerable time; Neilson and Rodriguez confirmed this understanding. Rodriguez said it could also be that the placement was guided by ultrasound in the postpartum setting but not in the outpatient setting at 6 weeks. Chan said it may just be time after delivery rather than breastfeeding that is the major risk factor.

Livingston reviewed the resource allocation, values and preferences and other factors influencing the recommendation in the GRADE table. She also explained that despite lack of evidence specific to the timing question, there is CDC guidance saying that it is appropriate to place an implant postpartum or post abortion.

Little asked about the administrative issues surrounding reimbursement for these services. Staff recognized that with this intervention, ensuring appropriate reimbursement is key as the devices are expensive and providers can't be expected to stock them and pay for them if not reimbursed. Neilson shared of his experience at Legacy where they started offering LARC immediately postpartum, but were asked by administrators to stop because it was cost-prohibitive. This is because the global rate for delivery paid to a hospital isn't adjusted as a matter of course if a LARC is placed. He said that there are two separate issues—device manufacturers charging providers hundreds of dollars for a simple device

costing under two dollars to the manufacturer, and insurance companies failing to reimburse providers for their acquisition costs for the devices. Ray said that some states use outpatient billing to pay, while others do a periodic query of their claims data and make an extra payment to reimburse for LARC. Waldmann asked about using a modifier on professional claims. Others stated that there are ways of getting reimbursement for professional services; the issue is paying for the device itself.

Kim Wentz spoke about research she and Oregon Health Plan staff have been doing on reimbursement for LARC devices in the inpatient setting. There are three methods used by 18 states. She believes there are ways for the Oregon Health Plan to pay for these devices, along with their insertion, in all settings, but they need to be implemented. Rodriguez said OHSU has been providing postpartum LARC to uninsured women because of a charitable gift, but that they haven't been available for insured women because of the reimbursement issues. They have not had success getting reimbursement for these devices after discussions with state officials and legislators. The hospital has been donating the physician services, which are fairly minimal in the postpartum setting.

Livingston said that this coverage guidance will advance efforts to get health plans to pay for these devices in all setting. Waldmann said this shouldn't be difficult and that he doesn't understand why we can't solve this problem. Westbrook and Little also expressed support for the coverage guidance. Little requested a separate document to address implementation issues and motivate policymakers to find a solution. Livingston said that Wentz is already beginning some of these discussions now, even though the coverage guidance wouldn't be officially implemented until January for the Oregon Health Plan. The hope is that by January there will be a clear plan.

The subcommittee discussed various options for emphasizing that both the device and insertion should be reimbursed appropriately and bureaucratic barriers addressed. They considered adding language to the recommendation box but decided that this policy aspect should be kept separate from the evidence-based report. Several members and attendees expressed frustration that this issue has not been solved in Oregon despite a lack of philosophical opposition. Livingston directed the subcommittee's attention to sections of the coverage guidances which do address payment and administrative issues.

After discussion the subcommittee requested that staff draft a cover letter to accompany the report, addressing implementation issues and barriers to reimbursement, and describing the administrative issues in the coverage guidance more thoroughly. Waldmann specifically requested that the cover letter address the hospital's discontinuation of postpartum LARC placement as described by Neilson.

Because of an issue with posting sources, the subcommittee deferred voting on the draft coverage guidance until its June meeting.

5. DRAFT COVERAGE GUIDANCE: Tobacco Cessation During Pregnancy

Livingston introduced the report, reminding the subcommittee that this is the first evidence-based report to include multisector interventions (which may occur outside of the clinical setting, and not require any coverage changes from health plans, but nonetheless be effective ways of achieving health outcomes). Staff ran into challenges with the subcommittee's request to separate the document into two separate reports, and so has kept the report together as shown in the meeting materials.

Coffman introduced Dr. Charles Bentz who is the appointed expert on this topic. He is a Medical Director and Professor at the Pacific University College of Health Professions and is in private practice at Fanno Creek Clinic in Portland. In addition to his clinical and academic work, he has published several articles on tobacco-related topics. He has also worked on tobacco-related quality measurement, smoking cessation programs and reimbursement strategies. He has received funding from the National Institutes of Health, the Robert Wood Johnson Foundation, state health organizations, as well as manufacturers of all tobacco cessation products (including nicotine patches, lozenges, gums and sprays as well as bupropion and varenicline).

Coffman also re-introduced Neilson, who has been appointed as an expert for this topic. Neilson declared no conflicts of interest with respect to this topic.

Bentz said other interventions have been studied, such as provider and health system incentives. He asked why they were not included in the review. Bentz said beyond simply covering services, promoting them in the provider community and providing incentives to providers can be important. Obley said that evidence was not found in the evidence review. Bentz also asked about carbon monoxide as feedback. This was not included in the Cochrane review. Livingston asked whether these would have been included in scope. Obley said they may have been grouped under behavioral interventions. This grouping includes everything from the “Five A’s” program advocated by the Centers for Disease Control to more intensive interventions. Bentz said that his practice uses carbon monoxide as feedback and that it is actually helpful. Livingston noted that these interventions could be submitted as public comment. Bentz said some of the studies he is referring to were not conducted in pregnant women, and this may explain why they weren’t included. Livingston said we would need evidence in the pregnant population.

Chan asked whether there is any reason to think that most interventions effective in other populations would have differential effectiveness in pregnant women? Obley said that the Patnode review does divide pregnant women from the general adult population. He assumes this is because pregnant women may have been excluded from general population studies. Bentz said that pregnant women can be particularly motivated to quit. Sometimes they spontaneously quit or suspend smoking during the pregnancy. He agreed that the behavioral interventions would work in pregnant women. But in designing interventions for pregnant women you need to think about special issues including relapse after the birth. Bentz said all behavioral interventions are tailored by type of tobacco use and cultural factors and pregnancy is another similar factor.

Coffman noted that the Commission has already approved a statement on multisector interventions for tobacco. He suggested that when implemented on the prioritized list, a special statement about pregnant women could be added to that section.

Westbrook asked about levels of addiction. Neilson said that interventions would need to be tailored to women based on the number of years they smoked and how much they smoked. For instance, behavioral interventions would more likely be effective in a casual smoker. Both clinicians and researchers are reluctant to do drug research on pregnant patients. Thus the drugs are generally reserved for the most nicotine dependent patients, resulting in a biased population for any research that would be done (that is, the study population would include the most difficult-to-treat patients). However, he also said that more dependent patients generally show a better response to nicotine replacement therapy (NRT), because they have more nicotine receptors. He said that there is a strong dose response for behavioral interventions (more intensive counseling is more effective) and that at any intensity of counseling, NRT doubles the quit rate.

Livingston turned the group's attention to the GRADE table for NRT. Most outcomes showed equivalence, though it showed effectiveness for tobacco abstinence during pregnancy. Ordinarily the staff recommendation might be to recommend noncoverage based on this evidence profile. Federal law, however, requires coverage of medication therapy for tobacco cessation for pregnant women in Medicaid, and the prohibition on prior authorization of tobacco cessation aids in the Affordable Care Act would make it difficult for most commercial insurers to restrict coverage. Based on this, the staff recommendation is for the subcommittee to state that it makes no recommendation for this population.

Bentz said that study designs for tobacco cessation during pregnancy are fatally flawed because of high relapse rates among postpartum women. Most studies weren't designed to include postpartum support. He advocated for coverage because there is no harm and because getting people to quit is the most important thing. Because of the ethical issues around conducting trials in this population, it is unlikely that evidence is likely to change. Neilson agreed.

Chan noted that there is no good evidence that NRT has harms. Obley confirmed this, noting that the studies included the pregnancy outcomes for the purpose of showing that NRT is no more harmful than continued smoking based on these outcomes, not to show a benefit of NRT for these outcomes. Chan asked if a recommendation could be made based on the broader evidence base for NRT in nonpregnant populations. Livingston noted that for the nonpregnant population, the outcomes of interest would be chronic obstructive pulmonary disease, asthma and lung cancer, which is different than the outcomes of interest in the pregnant population. Bentz and Neilson agreed that the population is distinct.

After discussion the subcommittee accepted the lack of recommendation for pharmacologic therapy and changed the recommendation for noncoverage for electronic nicotine delivery devices in pregnant women to a strong recommendation.

The subcommittee affirmed the recommendation for coverage for behavioral interventions with little discussion.

For high feedback ultrasound, the subcommittee discussed the large effect size, balanced by the fact that it is based on a single RCT from 1982 with 129 participants. The subcommittee also discussed that in another context, high feedback ultrasound can be considered coercive, as it is used by abortion opponents to influence women's reproductive choices. Westbrook stated that sometimes this is termed "obstetric violence." Bentz noted that even with carbon monoxide feedback, clinicians need to be careful, or patients can become anxious and not return for care. Livingston noted that concerns about psychological distress appear in the values and preferences column.

After discussion, the subcommittee decided that the context of tobacco smoking is sufficiently different than in the case of counseling about abortion and that in this context, smoking cessation can only improve outcomes for the mother and baby. Obley noted that the GRADE assessment from the Cochrane review was low. Livingston noted that with skin substitutes, low quality evidence was considered sufficient. Bentz noted that the cost would be relatively small cost on top of the existing cost of the ultrasound. After discussion the subcommittee decided to make a weak recommendation for coverage, while noting the age of the study.

The subcommittee accepted staff recommendations for financial incentives, partner support, interventions to reduce secondhand smoke exposure, smoke-free legislation and tobacco excise taxes.

There was discussion about how social supports including partner support are supported by evidence in the general population, but the evidence may not exist in pregnancy. Livingston noted that behavioral interventions are covered in general, it would just be an intervention targeted solely at partner support that would not be recommended.

Bentz suggested adding system-level interventions such as provider and plan incentives, though they are difficult to implement. He said systems interventions may be the most important thing that can be done to increase tobacco cessation. Livingston said we didn't find evidence about these interventions, so evidence that these interventions affect pregnancy-related outcomes would need to be submitted during public comment in order to add statements about them in this document.

The subcommittee discussed options for distinguishing between coverage recommendations and statements on multisector evidence. After discussion the subcommittee agreed to use the current format with different colors to highlight the distinctions between the coverage recommendations and evidence statements on multisector interventions as well as the distinctions between the GRADE tables and evidence tables. Chan requested that staff include an explanation of what a multisector intervention is along with the evidence statement. Staff will also make heading changes to clearly delineate which sections relate to multisector interventions.

After brief additional discussion, the subcommittee decided to remove the description of the effects of the multisector interventions to be consistent with the coverage guidance recommendations.

The subcommittee voted to put the draft coverage guidance (as amended) out for a 30-day public comment period by a vote of 5-0 (Stecker absent).

6. ADJOURNMENT

The meeting was adjourned at 5:00 pm. The next meeting is scheduled for June 2, 2016 from 2:00-5:00 pm at Clackamas Community College, Wilsonville Training Center, Rooms 111-112, 29353 SW Town Center Loop E, Wilsonville, Oregon 97070.

AGENDA

HEALTH EVIDENCE REVIEW COMMISSION

Wilsonville Training Center, Rooms 111-112

May 19, 2016

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 (3/10/2016)	Som Saha	X
3	1:40 PM	Director's Report	Darren Coffman	
4	2:00 PM	Value-based Benefits Subcommittee Report	Ariel Smits Cat Livingston	X
5	2:45 PM	Discussion of Multisector Intervention Evidence Review Work	Cat Livingston	
6	3:30 PM	Clarification of Coverage Guidance Evidence Submission Policy	Cat Livingston	
7	3:45 PM	Discuss Presentation of Evidence in GRADE-informed Framework in Coverage Guidances	Cat Livingston	
8	4:20 PM	Next Steps <ul style="list-style-type: none">Schedule next meeting – August 11, 2016 Wilsonville Training Center, Rooms 111-112	Som Saha	
9	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.

MINUTES
HEALTH EVIDENCE REVIEW COMMISSION'S
Obesity Task Force-Phase 2
Clackamas Community College
Wilsonville Training Center, Rooms 111
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
April 15, 2016
1:30-4:30pm

Members Present: Molly Haynes, MPH, RD; Luci Longoria, MPH; Pat Luedtke, MD, MPH (via phone); Miriam D. McDonell, MD; Sandy Miller, MS, RD (via phone); Jimmy Unger, MD; Helen Bellanca, MD, MPH; Lynn Knox; Tracy Muday, MD (via phone); Kim Wentz, MD.

Members Absent: Nkenge Harmon Johnson

Staff Present: Cat Livingston, MD, MPH; Jason Gingerich; Denise Taray, RN

Also Attending: Craig Mosbaek (OHSU Center for Evidence-based Policy); Adam Obley, MD (OHSU Center for Evidence-based Policy); Anna Jimenez (Family Care); Elizabeth Barth (Multnomah County); Dave Edwards via phone, (One Community Health, Columbia Gorge); McKenzie Peterson, via phone (Family Care), unknown participant from Trillium in Eugene.

1. CALL TO ORDER

Livingston called the meeting to order. Members and attendees present in person, and on the phone, introduced themselves.

2. MINUTES REVIEW

Minutes from the Obesity Task Force Phase 1 meetings were briefly presented.

3. REVIEW OF OBESITY TASK FORCE CHARGE, EXISTING HERC MULTISECTOR INTERVENTIONS

Livingston reviewed the charge to the Obesity Task Force, and the scope of Phase 1 and Phase 2. . This phase of the Obesity Task Force will be multisector interventions, including paraclinical interventions such as EHR reminders, financial incentives, community interventions and regional policy interventions. For CCOs the most effective way to achieve a health outcome may not always be a clinical intervention. Livingston also presented previously approved multisector interventions on tobacco prevention and cessation interventions for comparison. The subcommittee also reviewed the Oregon Public Health Division's [CCO guide](#) for reducing tobacco use. There was minimal discussion.

4. MULTISECTOR INTERVENTIONS FOR OBESITY - EVIDENCE REVIEW

Obley spoke about some of the characteristics and limitations of the evidence. Most evidence involved narrative reviews rather than meta-analyses due to the heterogeneity of the interventions studied. The Center found well over three dozen systematic reviews and narrowed the results by focusing on those that reported weight outcomes or adiposity. Many studies were excluded, as they reported on other outcomes such as physical activity and nutrition but not weight outcomes. Follow up in many of these studies was limited, and blinding was challenging. Obley discussed that while effect sizes of many of these interventions are small, even a small change at the population level can have a large impact on health care. For instance, even a 0.5% reduction in obesity can be important.

Obley reviewed the systematic reviews as presented in the meeting materials.

A member asked about the difference between a societal and community intervention. Obley stated that the definition varied somewhat by study. A study by Hillier-Brown makes the case that community interventions can be targeted at neighborhoods or cities while society interventions are broader policy changes such as food policy.

Wentz discussed return on investment for pediatric interventions. For instance, when you reduce screen time it reduces health disparities, reaping multiple benefits. There would be similar benefits from physical education in school. Obley added that a review not included reported that adding recess at school also improved physical activity, though weight-related outcomes were not reported. Unger discussed that ultimately what we are looking for is not lower BMI, but health outcomes. Obley said that distal health outcomes are not yet reported in the literature for these interventions. Bellanca said that it is established that increases in physical activity and nutrition result in improved health outcomes even in the absence of weight-related outcomes. Prevention of weight gain is also an important outcome. Knox suggested that goals should not be weight reduction but improvement in nutrition and physical activity. Others suggested that reduction in consumption of sugary beverages was an important outcome.

Jimenez asked about the study on mass transit, which appeared to show the largest effect. Obley noted that there were methodological issues with the study, including self-reported outcomes.

Livingston presented a draft multisector interventions statement. McDonnell discussed concerns about "limited evidence" by putting it into a blanket statement, that this could discourage use of interventions because of insufficient study, or that specific effective interventions within the broad categories reported in this review might be masked by the category as a whole. Obley said that insufficient evidence does not mean that these are ineffective. Haynes suggested that the task force should be promoting policies that increase physical activity, reducing sugary beverage consumption and improve nutrition rather than focus strictly on weight outcomes. Others agreed that including studies that report on these outcomes might result in the inclusion of additional studies showing stronger effect. Filtering the results to focus on certain settings such as early childhood or studies that reported on reducing inequities might help refocus the evidence search, as the volume of studies would otherwise be large.

Livingston noted that the document has twelve strategies that the evidence supports or have limited support, and asked Haynes about these. Haynes agreed that there were good options, and said that while she would prefer to focus on the outcomes of physical activity and good health habits, it would be important from a Medicaid perspective to have interventions targeted

at obesity specifically. She would support another document focused on physical activity and nutrition interventions.

Gingerich asked members from the CCOs for feedback on whether these high-level recommendations are actionable for CCOs. Some members suggested that recommending more specific programs would be helpful but also said that each locale may need different programs, so it might have unintended consequences to include specific programs and not others. Livingston said that often with HERC recommendations, HERC leaves it to Medical Directors and plans to implement the recommendations appropriately in each community. Obley added that the strength of evidence for each particular program is often extremely low, just a program evaluation.

Muday noted that the Prioritized List looks at things through the lens of prevention and treatment of disease. Increasing physical activity isn't the same as preventing or treating the disease state of obesity, though that doesn't mean it isn't good for health. It may even be more important for health outcomes than treating obesity. That said, she said that it is valuable to call out which interventions have evidence of effectiveness. It may be worth adding studies that showed evidence of physical activity (not obesity outcomes). What she wants to know for her CCO is, given limited funds, where to spend those funds to get the best outcomes for her community.

Several members highlighted the importance of including the evidence that education alone is ineffective, as this is sometimes counter-intuitive for decision makers who may be hopeful that public health issues can be addressed by education.

5. MULTISECTOR INTERVENTIONS FOR OBESITY - POLICY REVIEW

Livingston asked Longoria to review the Public Health Division's recommendations. Longoria is a Health Promotion Manager in the Health Promotion and Chronic Disease Prevention section and team lead for tobacco prevention, obesity prevention and cancer control. She reviewed the handout posted separately from the remaining meeting materials.

McDonnell asked about engaging schools. Longoria said that Oregon hadn't invested in obesity prevention in schools, but that the Public Health Division has ongoing partnerships with schools and the Oregon Department of Education. Despite lack of funding, they are looking at low-cost ways of structuring school to promote physical activity, including providing safe routes to school.

Leutdke discussed implementing Good Behavior Game in his CCO with first grade school teachers. He said that obesity hasn't been measured as an endpoint, there are surrogates with data about improving alcohol, tobacco use and truancy. Whole project cost \$17,000 of CCO money – it is very low cost with potential high return on investment. Longoria said they are watching to see the results in Lane County around obesity. She believes the jury is out about applying that intervention at a population-based level and appreciates that they have an evaluation plan.

Witbeck asked about availability of sweetened beverages in schools. Discussion centered around whether the statewide ban is being consistently implemented (at school events and fundraisers) and on concerns that diet soda and sports drinks are allowed; sports drinks have less sugar but more sodium and are allowed under the ban.

Mosbaek reviewed an obesity cost-effectiveness analysis by Gortmaker (included in meeting materials) and then briefly summarized the recommendations of several organizations including the Institute of Medicine, Centers for Disease Control and Prevention, the Association of State and Territorial Health Officials, and the World Health Organization.

Livingston asked the group about how best to present this information in a form that would be relevant and useful for HERC as well as CCOs. She clarified that these recommendations could be associated with the obesity line on the Prioritized List or appear with the Multisector Interventions section of the list. As the list is structured it would be difficult to mandate that CCOs provide many of the interventions and difficult for them to implement some of the policies listed.

Muday provided an example of how such a statement might be useful. Her CCO has a committee on healthy eating and active living. She stated that she would use these listed evidence-based interventions as a basis for this group. Rather than having them come up with ideas that are untested, she can provide them with interventions that have evidence of effectiveness. She also said that there can be counterintuitive results with these programs. The state is thinking that if you shift spending to prevention and not having disease it will save money, but as costs decline, premiums decline and it becomes difficult to maintain the programs. Therefore the state is looking at ways to include community-based interventions as a part of the rates, so that sustainable funding for effective community programs remains available even if overall health costs decrease. Having a HERC statement about these types of interventions may help these discussions advance.

In that light, Livingston questioned whether removing the list of interventions with insufficient evidence might be appropriate, as this may harm initiatives in some communities. After discussion the group decided to modify this language to say that these interventions were considered but there was insufficient evidence to conclude they impact obesity outcomes, though they may be effective. Plans implementing these programs should consider including strong program evaluation components. Livingston will work on language along these lines.

Several members supported sharing these recommendations with hospitals as they may have resources for some interventions as a part of their community benefit obligations. Livingston said this document would be available to other groups including hospitals and non-Medicaid health plans. There was broad support for distributing this report broadly to groups who may have resources to implement them, beyond CCOs. Longoria said having a HERC document would augment the Public Health Division's efforts. She requested that diabetes prevention programs and programs like Weight Watchers are established community programs and should be included, even though they are also included as clinical interventions in Phase I.

Livingston invited public comment. Elizabeth Barth from Multnomah County Health Department testified. She expressed concern that the obesity framework can be stigmatizing, whereas promoting physical activity and nutrition can have benefits other than reducing obesity. She said that racial and ethnic disparities as well as racism can be a factor in poor outcomes including obesity. She suggested that any new evidence include the impact of these issues as well as poverty and trauma. She spoke of community-based interventions such as Community-Supported Agriculture boxes. Haynes said that Kaiser has chosen. for many of these reasons. to focus on programs that have multiple benefits, as the factors referenced by Barth underly many poor health outcomes.

Gingerich said that HERC typically ties interventions to specific disease conditions. There is no line on the Prioritized List for physical activity. There are lines for obesity and cancer conditions which often result from inactivity. Is there a condition that HERC could consider adding that would more accurately reflect the goals of these interventions? Livingston suggested they could be included on line 3, preventive services with evidence of effectiveness. Obley noted that the evidence from the interventions discussed here will not rise to the level of the evidence for the services which appear on line 3. Some members suggested that exercise literature has strong evidence, but Livingston pointed out that the literature is about what happens when people exercise, not interventions that cause people to exercise. Gym memberships don't cause people to exercise, for example.

Livingston proposed that staff develop a standalone document that is formatted for use by a variety of audiences. It would include statements about the evidence for various interventions as well as narrative about the evidence as shown in the document presented today. It could also include recommendations from other groups as presented today. Others suggested including recommendations of the American Academy of Pediatrics and other primary care specialty societies, the 2010 federal government recommendations on childhood obesity and the Surgeon General's recommendations on breastfeeding. Others suggested highlighting interventions shown to reduce inequity. Staff will consider various options for presenting and categorizing the interventions..

Luedke requested that staff consider highlighting the public health perspective that policies have a higher impact than programs, though communities are often more interested in programs. Livingston suggested addressing these with a background discussion about how to change population health, rather than focus on interventions on individuals. The interventions will be separated into programs and policies to highlight the different potential impact. Jimenez suggested organizing it around setting as well, such as schools versus the broader community. Livingston suggested stratifying by effect size. Obley said this could lead to misleading conclusions, because studies with weaker evidence often show a larger effect.

The group also decided not to expand the outcomes to include physical activity and nutrition. This would likely increase the scale of the document without necessarily leading to different evidence statements. Much of this evidence would be included through recommendations from others.

Staff will prepare a new draft document along the lines discussed today and bring it to the next meeting.

6. ADJOURNMENT

The meeting was adjourned at 4:30 pm. The next meeting is scheduled for June 3, 2016 from 1:30-3:30 pm in Room 111 of the Wilsonville Training Center of Clackamas Community College.

Primary Care Spending in Oregon: SB 231

Jim Rickards, MD, MBA



POLICY AND ANALYTICS
Transformation Center

Primary Care Spending in Oregon

A report to the Oregon State Legislature.



March 2016



POLICY AND ANALYTICS
Transformation Center



Purpose

- Snapshot % Spending on Primary Care in 2014
- Help Policymakers & Public Assess Resource Allocation
- Inform Primary Care Payment Reform Collaborative

Data Source

- Claims-based Payments (APAC)
- Non-claims-based Payments Specialized Reporting
 - Incentivize Efficient Health Care Delivery
 - Reward Quality & Cost-Savings Goals
 - Build Health Care Infrastructure & Capacity

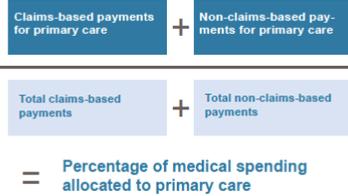
Spending Included

Primary Care Spending: What's Included?

Consistent with the definition of primary care in SB 231, this report includes the following types of primary care spending:

- 1. Claims-Based Payments:** Payments to primary care providers or provider organizations for primary care services rendered to health plan members. These payments are based on paid medical claims reported by health care payers. They exclude prescription drug payments.
- 2. Non-Claims-Based Payments:** Payments to primary care providers or provider organizations that are intended to incentivize efficient care delivery, reward achievement of quality or cost-savings goals, and build primary care infrastructure and capacity.

To calculate percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims based payments to all providers (illustrated at right).



Carriers

- **Prominent Carriers** – Premium Income > \$200 million
- **(PEBB) and Oregon Educators Benefit Board (OEBB)**
- **Medicaid coordinated care organizations (CCOs)**

Prominent Carriers

- Health Net Health Plan of Oregon, Inc.
- Kaiser Foundation Plan of the Northwest
- Moda Health Plan, Inc.
- PacificSource Health Plan
- Providence Health Plan
- Regence BlueCross BlueShield of Oregon
- UnitedHealthcare Insurance Company
- UnitedHealthcare of Oregon, Inc.

Commercial plan spending by one carrier and Medicare Advantage plan spending by two carriers were excluded due to issues with claims-based data. See Methodology for additional information about data collection and analysis.

CCOs

- AllCare Health Plan
- Cascade Health Alliance
- Columbia Pacific CCO
- Eastern Oregon CCO
- FamilyCare
- HealthShare
- Intercommunity Health Network
- Jackson Care Connect
- Pacific Source Community Solutions
- PrimaryHealth of Josephine County
- Trillium Community Health Plan
- Umpqua Health Alliance
- Western Oregon Advanced Health
- Willamette Valley Community Health
- Yamhill Community Care Organization

Non-Claims Payments

- Capitation Payments & Provider Salaries
- Risk-Based Payments
- Patient-Centered Primary Care Home or PCPCH
- Quality or Cost-Savings Goals
- Developing Capacity
- Adopt Health Information Technology
- Supplemental Staff, ie practice coaches, behaviorists

Excluded Payers

- Non-prominent Commercial Carriers
- Medicaid FFS
- Medicare FFS
- Self Insured Employers

Caveats

- Psychiatrists & Ob/Gyn Included
- Excluded Payers
- Carrier Names Not Linked with Data

Blinded Carrier Data

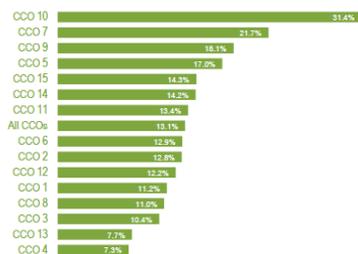
Coordinated Care Organizations: Primary Care Spending

The graphs on this page show two measures of medical spending allocated to primary care across CCOs in calendar year 2014:

- **Percentage of total medical spending allocated to primary care.** This measure allows for comparison of spending allocated to primary care as a share of total medical spending, regardless of total dollars spent.
- **Per-member, per-month (PMPM) primary care spending and non-primary care spending.** This measure represents the average amount paid to health care providers in a month for each member with coverage. It allows for comparison of dollars per person spent on primary care and other types of care. On the graph, the dark part of each bar shows primary care spending PMPM and the light part of each bar shows non-primary-care spending PMPM.

PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, share of spending allocated to primary care ranged from 7% to 31% among CCOs.

The share of medical spending allocated to primary care by CCO 10 was almost 10 percentage points higher than that of the next highest CCO.



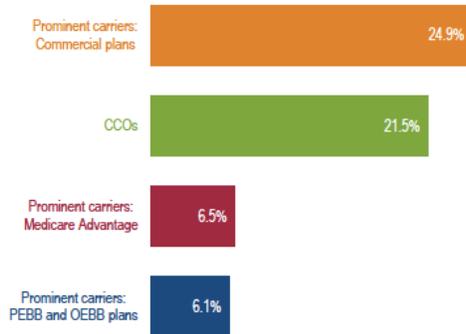
PER-MEMBER, PER-MONTH (PMPM) PRIMARY CARE SPENDING: In 2014, primary care spending ranged from \$23 PMPM to \$112 PMPM among CCOs.

PMPM primary care spending by CCO 10 was twice that of the next highest CCO.



Percentage Population Covered

PERCENTAGE OF OREGON'S POPULATION COVERED BY HEALTH CARE PAYERS IN THIS REPORT: In 2014, prominent carriers and CCOs provided coverage for 2.3 million Oregonians, 59% of Oregon's population.²



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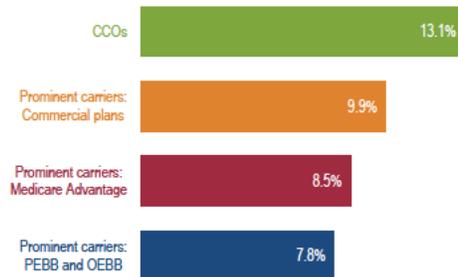


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Percentage of Total Medical Spending

PERCENTAGE OF TOTAL MEDICAL SPENDING ALLOCATED TO PRIMARY CARE: In 2014, CCOs allocated 13% of total medical spending to primary care on average.

Commercial, Medicare Advantage, and PEBB and OEGB plans allocated 10% or less of total medical spending to primary care on average.



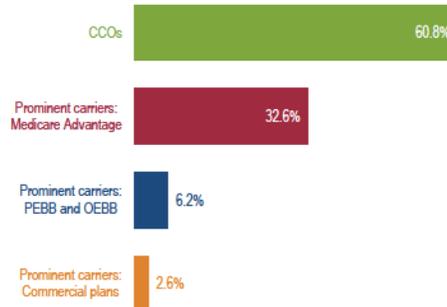
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Non-Claims Based Spending

NON-CLAIMS-BASED SPENDING AS A PERCENTAGE OF TOTAL PRIMARY CARE SPENDING: In 2014, 61% of primary care spending by CCOs was non-claims-based. One-third of spending by Medicare Advantage plans was non-claims-based.



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Observations

- Extreme Variability of Spending
 - Commercial Carriers Range **3.1 - 15.6%**
 - CCOs Range **7.3 - 31.4%**
- CCO's Largest Total **13%**
- Low Commercial Non-Claims Spending **2.6%**
- High CCO Non-Claims Spending **60%**
- Low Percentage PEBB/OEGB Total Spending
 - **< 6% for 86%** of Population

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Well that was interesting - now what ?

- Additional Reports
- SB231 Primary Care Payment Initiative
- CPC+ ?

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
May 9, 2016
11:00 a.m. – 12:30 p.m.

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

Low Back Pain Management

Session Objectives

Participants will:

- 1) Identify and share emerging best practices in Oregon to treat low back pain.
- 2) Discuss the role of CCOs in supporting strategies to address low back pain.
- 3) Identify tools to share or develop for use across CCOs.

1. Introductions and reflection (Mark Bradshaw) (5 minutes)

2. Setting the stage (Cat Livingston) (10 minutes)

3. Group discussion (facilitators: Mark Bradshaw, Carl Stevens, Tracy Muday, Cat Livingston) (60 minutes, 10 minutes per topic)

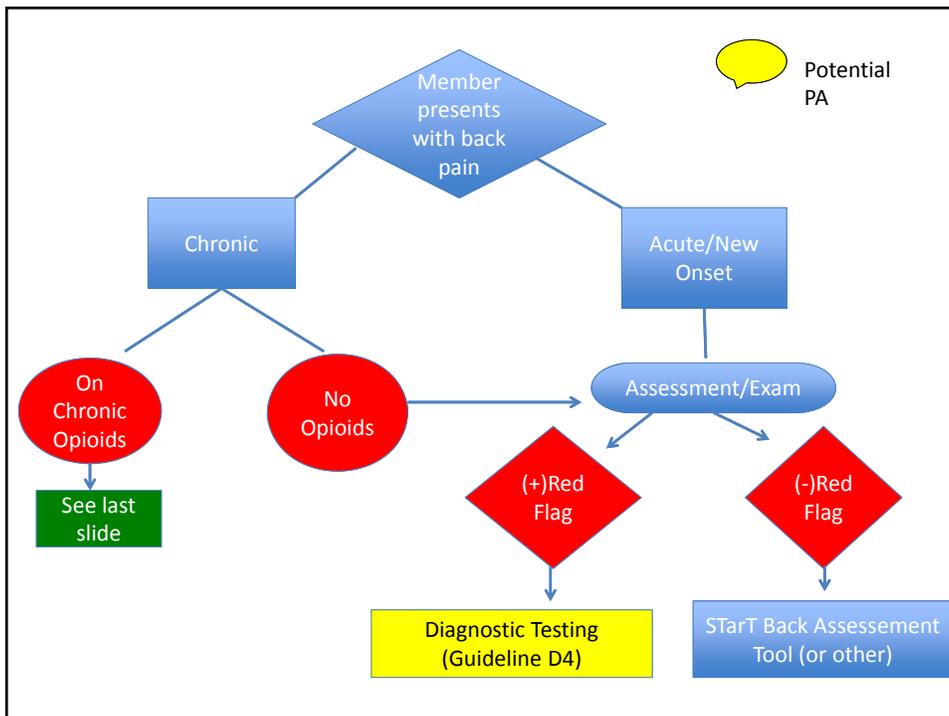
- a. Initial Risk Assessment
- b. Opioid
- c. Integration
- d. ESI - spine injections
- e. Encounterable and Non-Encounterable services
- f. Outcome tracking

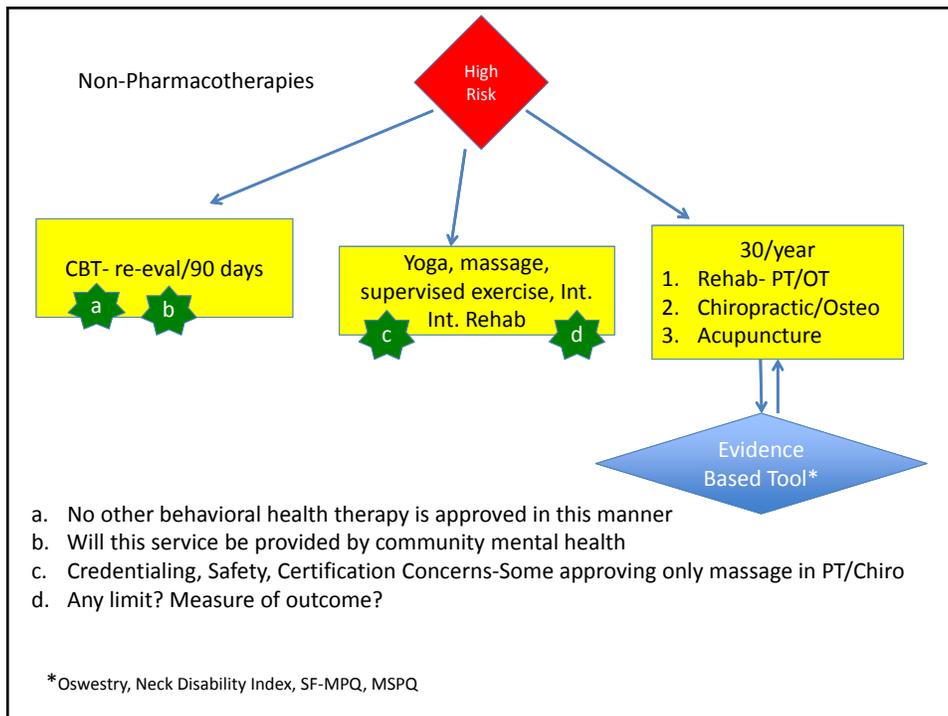
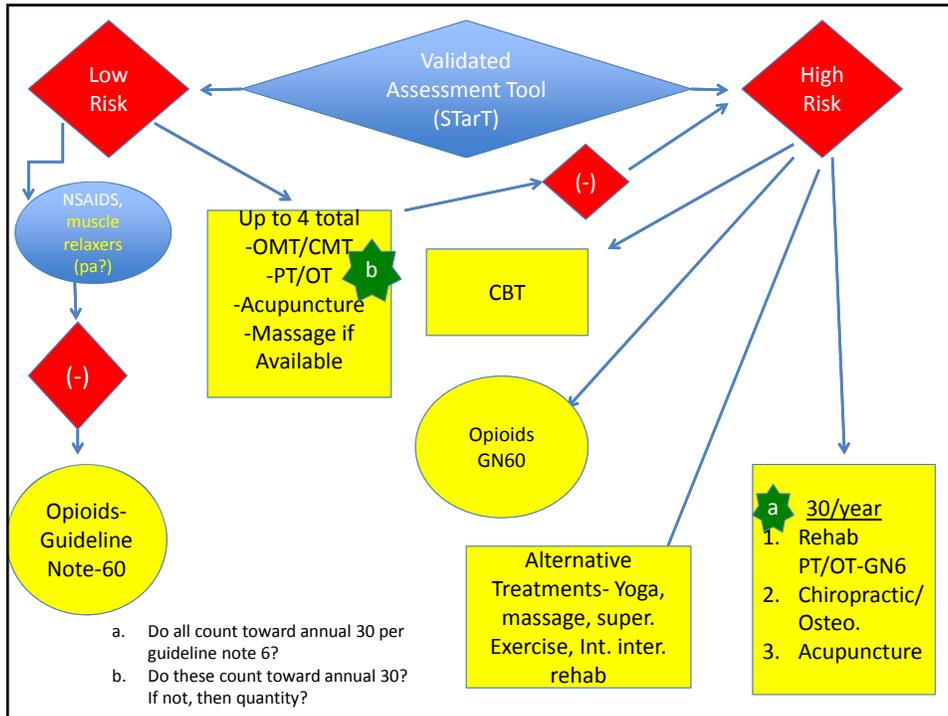
4. Next steps (Mark Bradshaw, Carl Stevens, Tracy Muday, Cat Livingston) (10 minutes)

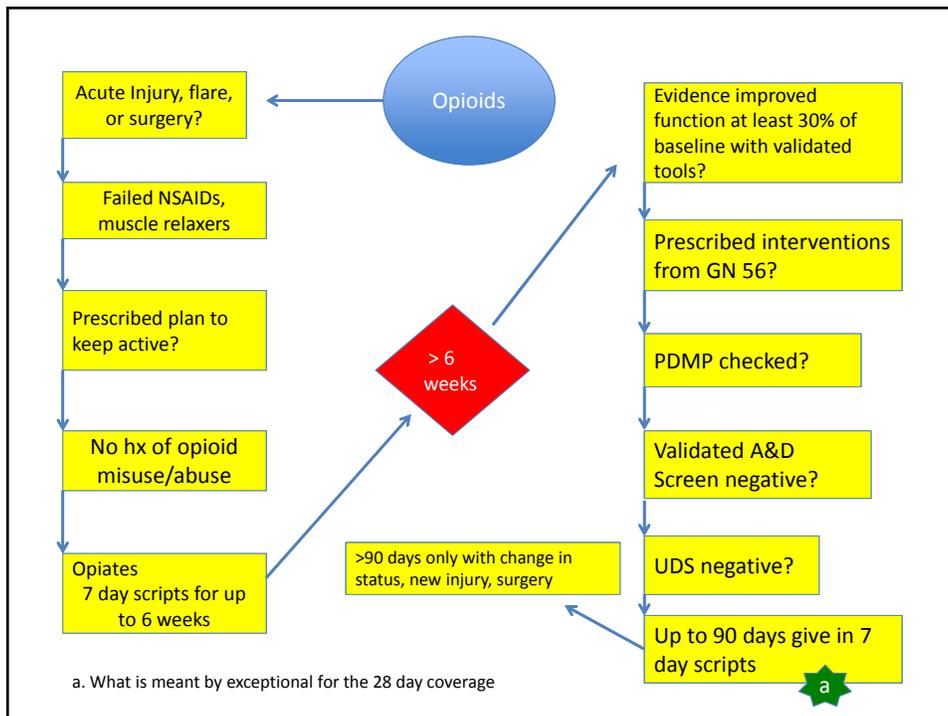
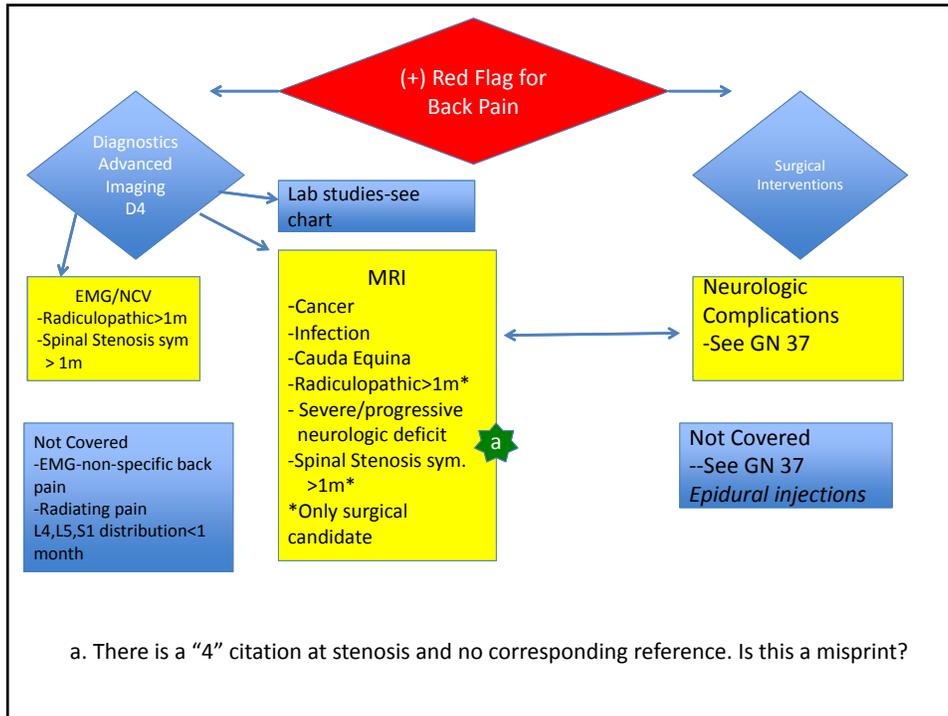
5. Wrap up (Summer Boslaugh) (5 minutes)

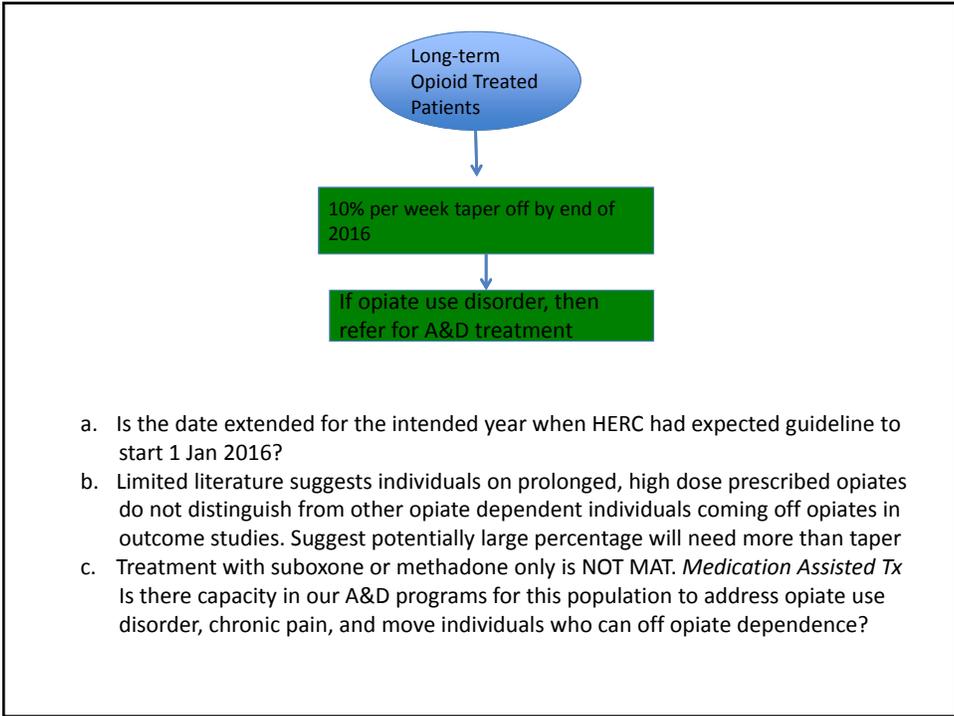
- a. **June 13, 2016**
- b. **Evaluation**

New Back Pain Coverage Workflows









Process Improvement Project (PIP) Report

Report Date:

Primary Contact:

Email:

Project Open Date:

Project Close Date:

PIP Focus Area:

Background:

Project Team:

Team Leader:

Team Members:

Measurement plan: *(objective indicators, what data is being analyzed, how is it collected, frequency)*

PIP Population

Baseline Condition:

Root Cause Analysis:

Improvement Goal:

Intervention Strategy: *(Summary of recommendations, overall plan, how the plan addresses the RCA, cultural and linguistic appropriateness, evidence to support-clinical, research, PDSA, other)*

Intervention Actions: *(Planned Action, Start Date, Action Results – including discussion of barriers & how addressed, Complete Date, Responsible Person, tools or methods used, Status)*

Verification Plan: *(Method to verify effectiveness, data to track, who is responsible, frequency of reporting, # or % of study eligible enrollees reached by each intervention)*

Verification Results: *(objective indicators)*

Next Steps: *(Plan for sustaining and monitoring improvements. Indicate whether the interventions will be Adopted, Adapted, or Abandoned.)*



MODEL FOR IMPROVEMENT

DATE 1.29.2016

Objective for this PDSA Cycle: *Review Total Cost Information for Community Health Worker (CHW) Clients*

Is this cycle used to develop, test, or implement a change? *Test*

What question(s) do we want to answer on this PDSA cycle? *Have the Total Plan Costs for Super-Utilizing Members engaged with the CHW decreased since May, 2013? Has PrimaryHealth reached the target of a 5% reduction in total plan costs?*

Plan:

Plan to answer questions: Who, What, When, Where

PrimaryHealth will measure outcomes for SuperUtilizer Members who are/were engaged in case management with the community health worker from May 2013 forward. Generally speaking, "Super Utilizers" are members with high patterns of utilization resulting in significant medical costs. To be considered for the caseload in this project, the member must also have modifiable risk factors that contribute to the high pattern of utilization. Modifiable risk factors include poor disease control, social and environmental risk factors, and poorly controlled or undiagnosed mental health conditions. SuperUtilizer has been redefined during this cycle as a member with >\$10,000 in total plan costs in the 12 month pre-engagement period.

For members who engage with the CHW, PrimaryHealth will measure historical health plan utilization costs in the 12 months before engagement with a Community Health Worker. If costs exceed \$10,000, they will be included in the primary measurement in Data Set One.

CHWs have also engaged members with lower utilization patterns who have potential for future patterns of high utilization due to poor disease control, social and environmental risk factors, and poorly controlled or undiagnosed mental health conditions, but who do not meet the total cost criteria for "super utilizer." Some of these members are represented in Data Set Two, which includes members who reach \$10,000 in plan costs anytime in the 12 month pre-engagement period through the first 12 months of engagement. Members who receive CHW services but do not reach \$10,000 in total plan costs, as outlined in Data Sets One or Two will be excluded from the total cost analysis.

There is no continuous or historical eligibility for inclusion on the measure.

Plan for collection of data: Who, What, When, Where

In the previous cycles, PrimaryHealth began to review CHW outcome data in the following manner. Member profiles were built with monthly utilization data, which was transposed into an excel spreadsheet. Data was aggregated starting in Jan 2012 and monthly thereafter. The data was organized by CHW. Members with total costs less than \$10,000 were excluded and monitored in a separate file. Data was extracted from Inteligenz on a monthly basis to maintain current profiles. The data was organized into a run chart and analyzed. Analysis demonstrated what appeared to be a decrease in median costs. In general, the challenges raised questions as to the validity of the data.

In reviewing the data in early PDSAs, the following challenges were identified:

- 1. Eligibility Gaps create challenges in reviewing both baseline and ongoing data: 5 of 17 (29%) of Super Utilizers appear to have had an eligibility gap > 2 mos in 2012. This contributed to a significant gap in accurate 2012 baseline data. In comparison, only 3/17 members (17.6%) had an eligibility gap >2 mos in 2013. The median utilization was reviewed with a baseline period of Jan 12-May-13 (\$24,200) and also with a baseline period of Jan*

2013-May 2013 (\$34,900). Shortening the baseline eliminated many of the eligibility gaps and resulted in a higher baseline in median expenses.

2. Members were not enrolled onto the caseload at the same time, but on an ongoing basis, often following a high dollar event or hospitalization. This makes review of aggregate monthly data challenging. Individual profiles often offer some additional clarity in reviewing the data.

PrimaryHealth changed the measurement plan in order to place a tighter control of the potential extrinsic or programmatic factors affecting the data. The measurement plan was further defined and refined in this cycle.

During the previous, an influx of new members meeting the study criteria were added to the table, nearly doubling the total number of clients represented. During the validation process, it was discovered that there was confusion between the two analysts regarding the study population. Analysis/spot checking of the data set showed that individuals were included when costs reached \$10,000 at any time during the pre/post engagement period. The measure was clarified, and a second data set was added to the study. These groups of high utilizers have been clarified below as Data Sets One, Two, and Three-or super and moderate utilizers.

Data is being collected and organized on an ongoing basis into a table in a similar manner to what is described above, utilizing total plan cost data contained in the Inteligenz analytics system.

Data Set One: Super Utilizers- Members that have costs >\$10,000 during the 12 month pre-engagement period and > 3 mo of engagement with a CHW will be transposed onto a spreadsheet. Rather than being organized by date, the data will be aligned according to engagement date with the program. Twelve months of data will be reviewed prior to engagement, and cost data will be collected on an ongoing basis following engagement. The total plan costs of all members will be added and divided by the number of eligible members for that month.

Data Set Two: Moderate High Utilizers: Individuals with costs not that did not reach \$10,000 in the pre-engagement period, but went on to reach \$10,000 by month +12 were reviewed as a separate category. Similar to Set One, rather than being organized by date, the data will be aligned according to engagement date with the program. Twelve months of data will be reviewed prior to engagement, and cost data will be collected on an ongoing basis following engagement. The total plan costs of all members will be added and divided by the number of eligible members for that month.

Data Set Three: Combined High Utilizers- All members that have costs >\$10,000 with the 12 month pre engagement period through the 12th moth of engagement and > 3 mo of engagement with a CHW will be transposed onto a spreadsheet (i.e. Super and Moderate Utilizers combined). Again, rather than being organized by date, the data will be aligned according to engagement date with the program. Twelve months of data will be reviewed prior to engagement, and cost data will be collected on an ongoing basis following engagement. The total plan costs of all members will be added and divided by the number of eligible members for that month.

Predictions (for questions above based on plan)

Organizing data in this fashion will determine if the data collection strategy will work, and if targets are met for cost reduction. It will identify trends and outcomes that may vary between utilizer types.

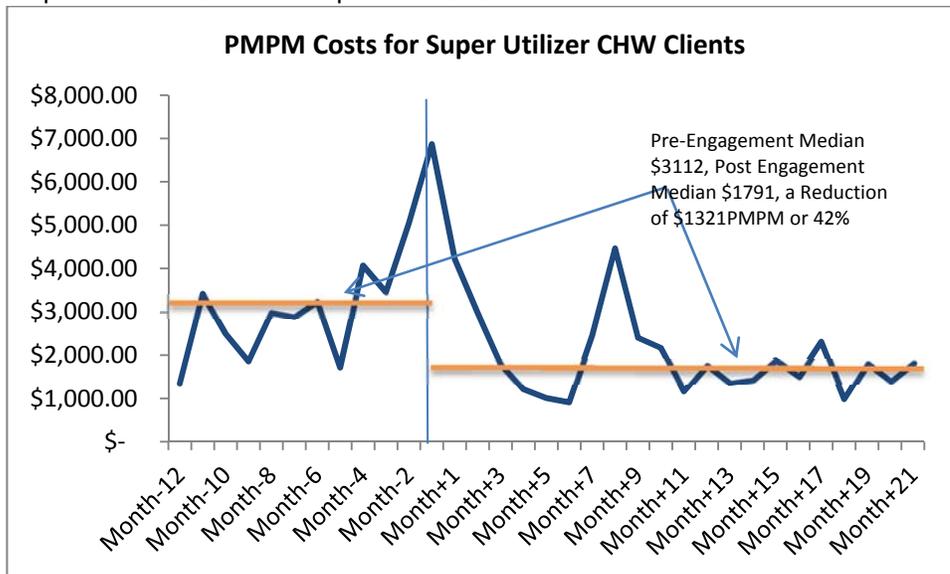
DO: Carry out the change or test; Collect data and begin analysis

Table 1: Outcome Data for Data Sets One and Two

Data Set	# of clients	Pre Engagement Mean	Post Engagement Mean	Difference in \$	% Difference	Pre Engagement Median	Post Engagement Median	Difference in \$	% Difference	Statistical Tests	Data points
#1: Super Utilizer: >\$10,000 in pre-engagement	21	3280	1952	1328	40%	3112	1791	1321	42%	Unpaired t test =Two tailed P value of 0.0044, which is considered to be very statistically significant	33
#2 Super Utilizer Expanded: >\$10,000 threshold in mos -12 through +12	42	1973	1653	320	16%	1872	1535	337	18%	Unpaired t test=Two tailed P value of 0.2950, not statistically significant	35

Data Set One:

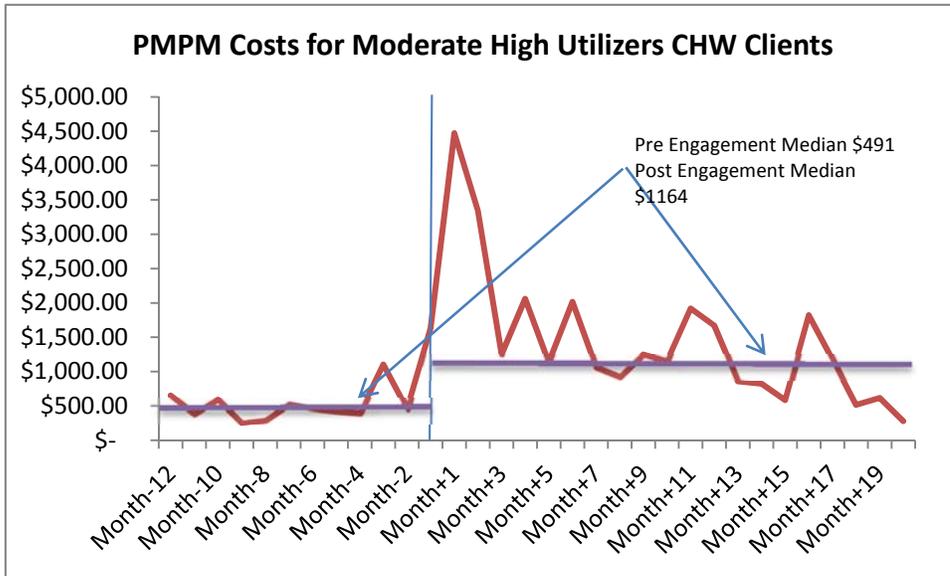
Graph 1: PMPM Costs for Super Utilizer CHW Clients



A total of 21 clients met the criteria for inclusion in the measurement. Data is represented through post engagement month 21. Greater than 6 members must be present in the sample for the data to be included.

Data Set Two:

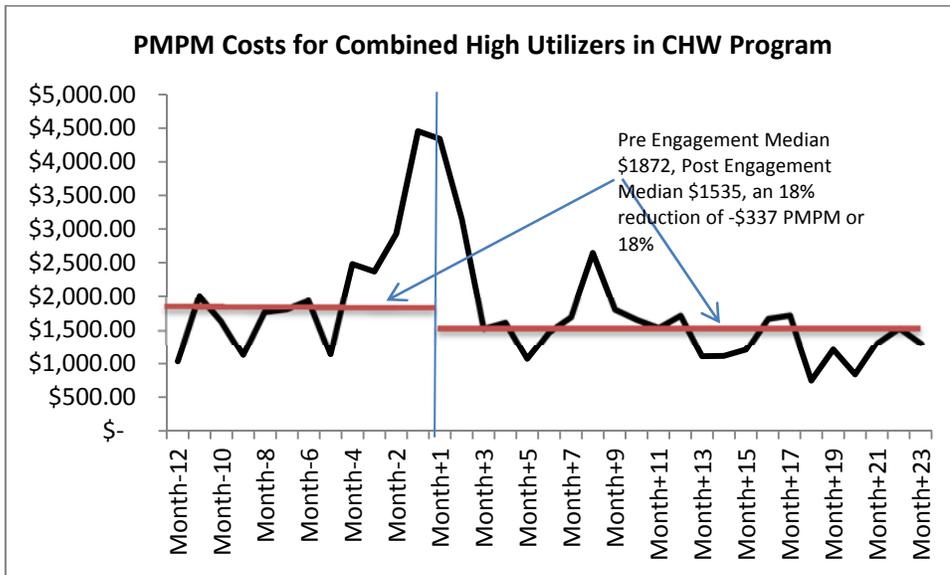
Graph Two: PMPM Costs for Moderate High Utilizers



A total of 21 clients were classified as “moderate” high utilizers. Data is represented through post engagement month 21. Greater than 6 members must be present in the sample for the data to be included.

Data Set Two:

Graph 3: Combined High Utilizers



A total of 42 clients met the criteria for inclusion in the measurement. Data is represented through post engagement month 21. Greater than 6 members must be present in the sample for the data to be included. Greater than 6 members must be present in the sample for the data to be included.

Study:

Complete analysis of data; compare learning to each prediction

Data Set One: Super Utilizers

The graph now includes 33 data points, 12 months of pre-engagement data and 21 months of post engagement data. Post-engagement data was included so long as more than 6 clients remained in the sample. Additional outreach clients have been added to the study as they meet the criteria for inclusion. A total of 21 clients are currently included.

When pre and post intervention medians are calculated, there is a difference of \$-1321 in the post intervention period (Pre \$3112ppm and Post \$1791ppm). This represents a 42% decrease from the pre-engagement median. The means were also compared. There was a decrease of \$1328 in the post engagement mean.

Compared to the previous data set, which showed a 48% decrease from the pre-engagement median, savings PMPM are slightly less.

An unpaired t test was used to compare the pre and post engagement data sets. The two tailed P value was 0.0044, which is very statistically significant. Compared to the previous quarter, statistical significance of the intervention is higher.

Analysis of this data shows signs that the CHW intervention may be successful in significantly lowering the median costs of super utilizers.

Data Set 2: Moderate Utilizers

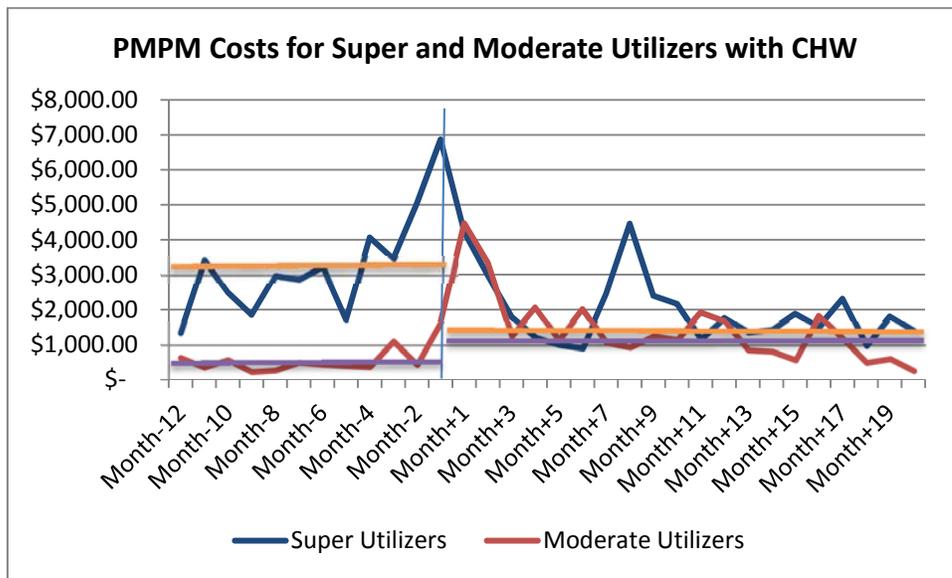
The graph now includes 35 data points, 12 months of pre-engagement data and 23 months of post engagement data. Post-engagement data was included so long as more than 6 clients remained in the sample. Additional outreach clients have been added to the study as they meet the criteria for inclusion. A total of 21 clients are currently included.

When pre and post intervention medians are calculated, there is a difference of \$+663 PMPM in the post intervention period (Pre \$491ppm and Post \$1164ppm). This represents a 135% increase from the pre-engagement median.

This is similar to the findings in the last data set.

Analysis of this data shows signs that the moderate utilizers had a spike in utilization, particularly in months -1 through +3. However, the overall post engagement median remains lower than the super utilizer group (See Graph 4 Below). When asked, the CHW shared that this group is comprised of individuals referred during an imposing or recent health crisis, such as a new chronic disease or acute hospitalization in a person with previously low utilization. CHW intervention does not completely remove the financial risk or ongoing increase in costs, yet it may be successful in significantly lowering costs of high utilizers over time, thus never reaching the high cost patterns of our traditional super utilizers.

Graph 4: Comparison of Super and Moderate High Utilizers



Data Set 3:

The graph now includes 35 data points, 12 months of pre-engagement data and 23 months of post engagement data. Post-engagement data was included so long as more than 6 clients remained in the sample. Additional outreach clients have been added to the study as they meet the criteria for inclusion. A total of 42 clients are currently included.

When pre and post intervention medians are calculated, there is a difference of \$-337 in the post intervention period (Pre \$1872 pmpm and Post \$1535pmpm). This represents a 18% decrease from the pre-engagement median. The means were also compared. There was a decrease of \$320, or 16% in the post engagement mean.

An unpaired t test was used to compare the pre and post engagement data sets. The two tailed P value was 0.2950, which is not statistically significant.

Analysis of this data still shows signs that the CHW intervention may be successful in lowering the median costs of super utilizers in the expanded set.

When comparing this measurement to the previous quarter, the decrease in costs went from a median reduction of 25% to 18%. The data was reviewed to determine a potential cause. One client was identified with significant costs in the post engagement period. This client, a new paraplegic, had two months of very high costs, related to hospitalizations and rehab. The costs for the single member appear to be were high enough to skew the data of the entire population.

Compare the data to your predictions and summarize the learning

Based on the data in both data sets, the CHW intervention appears to be effective in reducing the post-engagement costs of super utilizers. There is a more dramatic reduction for individuals who have reached the super utilizer threshold in the 12 months prior to engagement. Engaging potential super utilizers early may have a positive effect on their overall PMPM costs over time.

ACT:

Are we ready to make a change? Plan for the next cycle

More data will need to be collected to determine if these trends continue. The next cycles will focus on collection and analysis of additional data. However, the Community Health Worker success has been sustained through nearly the full life of the initial pilot. While the quantitative data in this PIP represents a measure of success, many qualitative stories also capture the value of the interventions for members and health care providers. CHW will be funded through OHMS (physical health delegate) starting in 2016, as the transformation grant comes to an end. PrimaryHealth will continue to conduct analysis of the CHW effect of overall PMPM costs in the next cycle.