

Quality and Health Outcomes Committee Agenda

September 14, 2015

DHS Building Room 137A-D, Salem, OR

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

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

Clinical Director Workgroup			
Time	Topic	Owner	Related Documents (page#)
9:00 – 9:05	Welcome Consent Agenda	Tracy Muday, Chair	-August QHOC minutes (1-7) -PH Update (8) -P&T committee agenda (9-10) -BH IT training flyer (11)
9:05 – 9:25	Statewide PIP: Clinical directors input	Acumentra	-Survey results (12-13)
9:25 – 9:40	Public Health Modernization	Michael Tynan	-Presentation slides (14-17)
9:40 – 10:00	HERC Update	Cat Livingston	-BHAP agenda (18) -OHAP agenda (19) -August HERC minutes (20-30) -August VbBs minutes (31-50) -Labor Pain CG (51-70)
10:00 – 10:30	Health Systems Update - Organization Chart - Transgender Services - OOH Births	Rhonda Busek	
10:30 – 10:40	BREAK		
10:40 – 10:50	PCPCH Program changes	Nicole Merrithew	
10:50 – 11:00	Clinical Directors: Items from the floor	All	
Learning Collaborative			
11:00 – 12:30	Traditional Health Workers		-Agenda (71-72) -THW Definitions (73) -Presentation Slides (74-84) -DELTA Brochure (85-86)
12:30 – 1:00	LUNCH		
Quality and Performance Improvement Workgroup			
1:00 – 1:10	QPI Updates	Lisa Bui	
1:10 – 1:50	CAHPS Presentation - Data and Improvement Strategies	Rusha Grinstead	-Presentation slides (87-93)
1:50 – 2:15	Statewide PIP	Acumentra	-Survey results (12-13)
2:15 – 3:00	QPI Session Planning	Lisa Bui	

Upcoming October 12 Agenda Highlights:

- OHSU Diabetes Prevention Program
- Statewide PIP: Opioid Management Learning Forum 11:00 a.m. – 3:00 p.m.

Agenda topics and times are subject to change to meet the needs of OHA and QHOC membership.



**Division of Medical Assistance Programs
Quality & Health Outcomes Committee
Meeting Notes**

**August 10, 2015 9:00 a.m. –3:00 p.m.
HSB 500 Summer Street NE Salem, Oregon
Room: HSB 137 A-D**

In Attendance:

Anne Alftine (JCC); Susan Arbor (MAP); Joell Archibald (OHA); Rosey Ball (OHA); Chris Barber (OHA), Sarah Bartelmann (OHA); Sarah Beaudrault (OHA/Public Health); Maggie Bennington-Davis (Health Share), Cara Biddlecom (PHD); Graham Bouldin (Health Share); Bill Bouska (OHA); Lisa Bui (OHA); Mindi Burdick (WVCH); Jim Calvert (Cascade Health Alliance); Barbara Carey (Health Share); Jody Carson (Acumentra); Tawnya Elmore (OHA); Teresa Everson (OHSU/PSH); Ariel Ferguson (OHA); David Fischer (OHA); Mike Franz (PacificSource); Bennett Garner (FamilyCare); Ruth Galster (UHA); Sara Halvik (Acumentra); Walter Hardin (Tuality); Rosanne Harsen (OHA), Jenna Harms (Yamhill CCO); Maria Hatcliffe (PacificSource); Hank Hickman (OHA); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Jenny Kaylor (UHA); Charmaine Kinney (Mult. Co./Health Share); Safina Koreishi (Columbia Pacific); Diana Ledbetter (OHA); Lynnea Lindsey-Pengelly (Trillium); Alison Little (PacificSource); Cat Livingston (HERC); Andrew Luther (OHMS); Karen Lutz (OHA); Laura Matola (AllCare); Laura McKeane (AllCare); Kevin McLean (FamilyCare); Ben Messner (WOAH); Jetta Moriniti (Providence); Tracy Muday (WOAH); Melissa Mumey (OHA); Frias Nazer (CareOregon); Jaime Nino (OHA); Chris Norman (MAP); Coleen O'Hare (Trillium), Alonso Oliveros (Columbia Pacific); Ellen Pinney (OHA); Rose Rice (UHA); Nancy Siegel (Acumentra); Debbie Standridge (UHA); Dayna Steringer (WOAH/Advantage Dental); Anna Stern (WVCH); Ron Stock (OHA); Steve Stolzoff (GOBHI); Priscilla Swanson (Acumentra); Jed Taucher (AllCare); Denise Taray (OHA); Jennifer Valentine (OHA); and Rosemary Zanke (CareOregon)

By phone:

Christine Seals (UHA); Pam Martin (OHA); Kristie DePriest (UHA); Rebecca Ross ((UHA); Ellen Altman (IHN/CCO); Lyle Jackson (Mid-Rogue); Corinne Thayer (ODS Dental); Stuart Bradley (WVCH); Tiffany Dorsey (Kaiser)

Medical Directors Section

Chair: Tracy Muday

9:00-11:00

**TOPIC ITEMS –
UPDATES**

PRESENTATIONS / DISCUSSIONS

**ACTION,
CONTACTS,
HANDOUTS, LINKS**

**Introductions &
Announcements:**

- Introductions were made in the room, and with those on the phone.
- QHOC will not meet in December.

Materials:

- Agenda
- July Meeting Notes
- OHA/PHD Update
- Meeting Packet
- Save the Date Engaging Beneficiaries

**Old Business:
QHOC Charter,
Operationalization
of HERC Policies-
Lisa Bui**

Charter:

- No feedback or changes discussed. Charter adopted.

HERC Policies:

- Recognized the need for HERC-HSD to meet to discuss the operationalization of HERC policies. Group has met once and developing team charter and workplan.

Materials:

- QHOC Charter

**Health Systems
Updates**

Kim Wentz:

- Language access- goal is to bring in to Federal compliance;
- OHA/OEI training: Translation and Interpreting Services Requirements for Clients with Limited English Proficiency- Friday August 14, 2015 1-2:30 and Thursday September 10, 2015 1-2:30;

Action item:

- Distribute flyer electronically on trainings in Portland

<p>Statewide PIP- Acumentra</p>	<p>Opioid Management: Discussed-</p> <ul style="list-style-type: none"> ▪ Who is the target population for this PIP?- entire population recommended; ▪ Discussion on metrics and which ones to use. Do we measure all three? 1) Percentage of patients on opioid doses >120mg Morphine Equivalent Dosage (MED) per day, 2) Proportion of patients with overlapping prescriptions for an outpatient opioid and a benzodiazepine, 3) Percentage of adolescents and adults, previously naïve to opioid pain reliever (OPR) utilization, who became chronic users of opioid pain relievers. A straw poll was taken with Metric #1 the favored metric to use. There was a tie between 2 and 3; ▪ Minnesota Metric- population based study; ▪ Discussed definition and agreement; ▪ More research on reporting possibilities; 	<p>Materials:</p> <ul style="list-style-type: none"> ▪ Opioid Management Statewide PIP- Clarifying Questions ▪ Proposed measure draft specifications <p>Action item:</p> <ul style="list-style-type: none"> ▪ Acumentra to develop and send survey monkey for CCO vote for one metric selection
<p>HSD Update - (continued)</p>	<p>Chris Norman:</p> <ul style="list-style-type: none"> ▪ Adjusting to new name of Health Systems Division; ▪ Recruiting for a Chief Health Officer for HSD; ▪ In the reorganization new managers have been named, but not all; ▪ There have been changes in time and frequency of other CCO related workgroups; ▪ ICD-10 in testing and working on Social Security numbers. 	<p>Action Item:</p> <ul style="list-style-type: none"> ▪ Send CCOs an updated Org chart.
<p>HERC Update- Cat Livingston</p>	<ul style="list-style-type: none"> ▪ HERC is looking for a CCO medical director to volunteer their time and expertise for the EbGS committee. Contact Cat if 	<p>Materials:</p> <ul style="list-style-type: none"> ▪ HERC and VbBS Agendas for 8/13/2015 meetings ▪ CG: Out-of-hospital birth

	<p>interested;</p> <ul style="list-style-type: none"> ▪ Discussed agenda items for the August 13, 2015 HERC meeting; ▪ Changed the Coverage Guidance process by defining questions ahead of time; ▪ Treatment of ADHD for children; ▪ Bio-marker test; ▪ Hypnotherapy; ▪ Stents; ▪ Gender Dysphoria- guideline modifications, procedures, age limitations. Discussed surgical codes and some language changes. Comments are welcome but responses must be in by Thursday. OHSU is hiring a surgeon that can perform reassignment surgery; 	<ul style="list-style-type: none"> ▪ Treatment of ADHD in Children ▪ Coronary Artery Calcium Scoring ▪ Carotid Endarterectomy ▪ Coronary CT Angiography ▪ Cervical Cancer Screening ▪ CBG Monitoring ▪ Diagnosis of Sleep Apnea in Adults ▪ Induction of Labor ▪ Breast MRI after Diagnosis of Breast Cancer ▪ Neuroimaging for Headache ▪ PET CT for Breast Cancer Staging & Surveillance ▪ Recurrent Acute Otitis Media ▪ Self-Monitoring of Blood Glucose ▪ Vertebroplasty, Kyphoplasty, & Sacroplasty ▪ Gender Dysphoria Medication Prescribing Issues ▪ Age Limitations for Gender Dysphoria Treatments ▪ Gender Dysphoria Mental Health Provider Amendments ▪ Surgical Therapy for Gender Dysphoria
<p>P&T Update- Roger Citron</p>	<p>Topics from July 30, 2015 Oregon Drug Use Review/P&T Committee were:</p> <ul style="list-style-type: none"> ▪ DUR activities; ▪ DUR –Old/New business; ▪ Preferred Drug List 	<p>Action Item:</p> <ul style="list-style-type: none"> ▪ Send the group the link for the Oregon Drug Use Review/P&T Committee July 30, 2015
<p>Items From the Floor</p>	<ul style="list-style-type: none"> ▪ Dr. Muday requested an update of Health Systems staffing with regular updates going forward; 	

	<ul style="list-style-type: none"> ▪ Future discussion on the intent of the reorganization requested with Rhonda Busek and Karen Wheeler 	
	Learning Collaborative: Provider Vitality- John Christensen	11:00-12:30
	<ul style="list-style-type: none"> ▪ Burnout; ▪ Continuum of Professional Health; ▪ Reciprocity between professional and organizational health; ▪ Landscape of clinician well-being; ▪ Physician morale; ▪ Doctors' attitudes about their profession; ▪ U.S. physician burnout relative to U.S. population in 2012; ▪ U.S. physician burnout relative to U.S. population; ▪ RAND study 2013; ▪ The positive path ahead; ▪ Convergence of positive trends; ▪ Positive psychology; ▪ Evidence on happiness; ▪ Positive Organizational Scholarship; ▪ A deviance continuum; ▪ High functioning organizational cultures; ▪ From Triple to Quadruple Aim; ▪ Group Health experience; ▪ Menu of organizational initiatives; ▪ Implications of health professional well-being for organizations; ▪ Strengthening clinician vitality; 	<p>Materials:</p> <ul style="list-style-type: none"> ▪ Personal and Organizational Well-Being (hand-out & pwp) ▪ Mid-Career Burnout in Generalist and Specialist Physicians ▪ Meeting the Imperative to Improve Physician Well-being: Assessment of an Innovative Program ▪ Health Professional Well-Being Reflection Questions ▪ Development of Health Professional Well-Being Programs in Oregon ▪ Evaluation

	QPI Segment of QHOC	1:00-3:00
<p>Welcome/ QPI Updates- Chris Barber & Lisa Bui</p>	<p>Chris Barber:</p> <ul style="list-style-type: none"> ▪ Chris was honored and recognized for her service to the state and to the CCOs. <p>Lisa Bui:</p> <ul style="list-style-type: none"> ▪ Justin Hopkins will now be managing Quality Assurance. He provided a little background information on himself; ▪ Asked for introductions around the room and over the phone; ▪ PIP Quarterly reports have been sent and received. Review and feedback hopeful for by Labor Day; 	
<p>Statewide PIP: Draft Measure Specifications- Acumentra</p>	<p>There was a question on which measures to use- All three or just one or any other combination.</p> <p>There was a list of clarifying questions that this group needed to address. Attendees assembled into smaller groups to discuss those questions. In addressing the question on how, what, and who to measure, the groups shared their responses:</p> <ul style="list-style-type: none"> ▪ Group 1- Metric #2 is a good driver and metric #3 will take longer and will be harder to capture data; ▪ Group 2- Unanimously agreed on metric #3 to be used; ▪ Group 3- Metric #2 was the favored one. This group felt that over the month this would be the best. 	<p>Materials:</p> <ul style="list-style-type: none"> ▪ Opioid Management Statewide PIP- Clarifying Questions ▪ #1: Percentage of patients on opioid doses > 120mg Morphine Equivalent Dosage (MED) per day, ▪ #2: Proportion of patients with overlapping prescriptions for an outpatient opioid and a benzodiazepine, ▪ #3: Percentage of adolescents and adults, previously naïve to opioid pain reliever (OPR) utilization, who became chronic users of opioid pain relievers;

<p>Hearing Process- Tressa Perlicek & Hearings Team</p>	<p>The Hearings Team joined this meeting to answer a list of questions that the CCOs had in regard to the Hearing process. One by one, the questions were answered by various members of the team. There were 11 questions in all that were answered.</p> <p>Tressa provided her contact information: tressa.i.perlicek@state.or.us</p> <p>503-917-5028</p>	<p>Hand-out(s):</p> <ul style="list-style-type: none">▪ DMAP questions for appeals and hearings▪ DMAP General Rules▪ 183.415 Notice of right to hearing▪ 410-120-1280- Billing▪ 410-120-1860- Contested Case hearing Procedures▪ 410-141-3262- Requirements for CCO Appeal▪ 410-141-3264- Contested Case Hearings▪ 431.154▪ Oregon.gov page where you find rulebooks▪ Contested Case Proceedings▪ Appeal and hearings flow chart▪ OHP Client Agreement to Pay for Health Services
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Quality and Health Outcomes Committee Public Health Division updates – September 2015

Updates

ScreenWise Provider Orientation: Effective September 2015, the Breast and Cervical Cancer (BCCP), WISEWOMAN and Genetics Programs are now collectively known as ScreenWise, with the mission to reduce breast and cervical cancer, cardiovascular disease and other diseases by promoting early detection, risk factor screening, risk reduction support, and access to treatment. To introduce this rollout, ScreenWise staff conducted a series of Provider Orientation Webinars, which are available at: <https://public.health.oregon.gov/HealthyPeopleFamilies/Women/HealthScreening/BreastCervicalCancerScreening/Documents/ScreenwiseProviderOrientation.pdf>

Nonmedical Exemptions for Immunizations: Under Senate Bill 895 (2015), religious exemptions signed before Oregon implemented a new nonmedical exemption process in 2014 are no longer valid. Parents who signed a religious exemption for their child prior to March 1, 2014 must now: 1). Provide documentation of immunization, or 2). Complete the nonmedical exemption process. Information for healthcare providers about this change is available at: <http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/GettingImmunized/Documents/SchSB895FAQprov.pdf>.

Resources

State of Breast Cancer: The Community Profile: Over the past year, ScreenWise (formerly BCCP/WISEWOMAN and Genetics) supported its funding partner Komen Oregon and SW Washington in drafting the Komen Community Profile Report, a statewide breast health needs assessment conducted by Komen every four years. The following link provides access to the report, including qualitative and quantitative data, a fact sheet and a summary of the breast cancer burden in OR and SW Washington: <http://komenoregon.org/mission/communityneed.aspx>



Oregon Drug Use Review / Pharmacy & Therapeutics Committee

Thursday, September 24, 2015 1:00 - 5:00 PM

Clackamas Community Training Center
29353 SW Town Center Loop East
Wilsonville, OR 97070

MEETING AGENDA

NOTE: Any agenda items discussed by the DUR/P&T Committee may result in changes to utilization control recommendations to the OHA. Timing, sequence and inclusion of agenda items presented to the Committee may change at the discretion of the OHA, P&T Committee and staff. The DUR/P&T Committee functions as the Rules Advisory Committee to the Oregon Health Plan for adoption into Oregon Administrative Rules 410-121-0030 & 410-121-0040 as required by 414.325(9).

I. CALL TO ORDER

- A. Roll Call & Introductions R. Citron (OSU)
- B. Conflict of Interest Declaration R. Citron (OSU)
- C. Approval of Agenda and Minutes B. Origer (Chair)
- D. Department Update D. Weston (OHA)

II. DUR ACTIVITIES

- A. Oregon State Drug Reviews K. Sentena (OSU)
 - 1. "Treating UTIs with the Tried and True"
 - 2. "New Hypertension Guidelines: Do Blood Pressure Goals Need to Change with Age?"

III. DUR OLD BUSINESS

- A. Initial Pediatric SSRI High Dose Prior Authorization Criteria T. Williams (OSU)
 - 1. Revised Criteria
 - 2. Public Comment
 - 3. Discussion of Clinical Recommendations to OHA

IV. PREFERRED DRUG LIST NEW BUSINESS

- A. Asthma and COPD Class Updates K. Sentena (OSU)
 - 1. Asthma and COPD Class Updates
 - 2. Public Comment
 - 3. Discussion of Clinical Recommendations to OHA

- B. Diabetes Class Updates K. Sentena (OSU)
 - 1. Non-insulin Diabetes Agents Class Updates
 - 2. Public Comment
 - 3. Discussion of Clinical Recommendations to OHA

- C. Drug Class Literature Scans A. Gibler (OSU)
 - 1. Oral Multiple Sclerosis Drugs
 - 2. Growth Hormones
 - 3. Inflammatory Bowel Agents
 - 4. Alzheimer's Agents
 - 5. Public Comment
 - 6. Discussion of Clinical Recommendations to OHA

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|---|--|
| <ul style="list-style-type: none"> D. Sacubitril/Valsartan New Drug Evaluation <ul style="list-style-type: none"> 1. Sacubitril/Valsartan (Entresto™; LCZ696) NDE 2. Public Comment 3. Discussion of Clinical Recommendations to OHA
 E. Ivabradine New Drug Evaluation <ul style="list-style-type: none"> 1. Ivabradine (Corlanor®) NDE 2. Public Comment 3. Discussion of Clinical Recommendations to OHA
 F. Influenza Class Update <ul style="list-style-type: none"> 1. Influenza Antiviral Class Update 2. Public Comment 3. Discussion of Clinical Recommendations to OHA | <p>A. Gibler (OSU)</p>
<p>A. Gibler (OSU)</p>
<p>A. Gibler (OSU)</p> |
| <p>V. DUR NEW BUSINESS</p> | |
| <ul style="list-style-type: none"> A. Modafinil/Armodafinil Drug Use Evaluation <ul style="list-style-type: none"> 1. Drug Use Evaluation 2. Public Comment 3. Discussion of Clinical Recommendations to OHA
 B. Tetracyclines Drug Use Evaluation <ul style="list-style-type: none"> 1. Drug Use Evaluation 2. Public Comment 3. Discussion of Clinical Recommendations to OHA
 C. Low Dose Quetiapine Policy Evaluation <ul style="list-style-type: none"> 1. Policy Evaluation 2. Public Comment 3. Discussion of Clinical Recommendations to OHA
 D. Clinical Review of Existing Prior Authorization Criteria <ul style="list-style-type: none"> 1. Tesamorelin for injection 2. Becaplermin topical gel 3. Public Comment 4. Discussion of Clinical Recommendations to OHA | <p>K. Ketchum (OSU)</p>
<p>T. Williams (OSU)</p>
<p>K. Ketchum (OSU)</p>
<p>A. Gibler (OSU)</p> |

VI. EXECUTIVE SESSION

VII. RECONVENE for PUBLIC RECOMMENDATIONS

VIII. ADJOURN

WEBINAR FOR BEHAVIORAL HEALTH INFORMATION SHARING



You are invited to an Oregon Health Authority Webinar: “Understanding Privacy Laws for Physical and Behavioral Health Information Sharing.”

**Tuesday, September 29
11 a.m.-12:30 p.m.**

[Register for the webinar here](#)

Background: The Oregon Health Authority (OHA) is developing a strategy to support integrated care and services through the electronic sharing of behavioral health information between providers. This is a critical step in supporting the coordinated care model, and realizing the goal of better health, better care and lower costs for everyone. OHA created the Behavioral Health Information Sharing Advisory Group to spearhead this work.

In February 2015, the advisory group sent a survey to providers throughout Oregon. The survey aimed to help OHA understand the challenges and barriers providers and coordinated care organizations (CCOs) face when sharing patient health information, including behavioral health diagnoses and treatment. Survey findings and an overview of federal and state laws that impact information sharing will be the primary focus of this webinar.

Stakeholders are an important part of the process to help create solutions that improve electronic information sharing. The advisory group communicates with and solicits feedback from stakeholders throughout this process. This webinar is the next opportunity for our stakeholders to contribute to the process.

The webinar will include:

- Overview of Behavioral Health Information Sharing Advisory Group
- Background and overview of 42 CFR Part 2, HIPAA and state laws
- Working with 42 CFR Part 2 to share information between providers
- Impact of electronic health records(EHR)/health information exchange on 42 CFR Part 2

If you are unable to participate in the webinar, a recording will be posted on the [Behavioral Health Information Sharing Advisory Group website](#) shortly after. If you have any questions about how to participate, please contact the following OHA policy leads:

- Veronica Guerra at Veronica.Guerra@state.or.us or by phone at 503-915-3411
- Melissa Isavoran at Melissa.Isavoran@state.or.us or by phone at 503-559-7886

SurveyMonkey results for statewide PIP on opioid management

At the August Quality and Health Outcomes Committee (QHOC) meeting, Medical Directors and Quality Managers discussed the three metrics for the statewide performance improvement project (PIP) on opioid management that had garnered the most support in previous discussions. The three metrics are:

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

#2: Proportion of patients with overlapping outpatient prescriptions for an opioid and a benzodiazepine

#3: Percentage of adolescents and adults, previously naïve to opioid pain reliever utilization, who became chronic users of opioid pain relievers (“Minnesota metric”)

Following the QHOC meeting, Acumentra Health and OHA sent a survey to CCOs asking them to vote on a single metric for the statewide PIP, submit any comments, questions or concerns, and indicate whether or not the CCO would need technical assistance with data analysis.

The results as of September 4, 2015 are as follows:

- 15 out of 16 respondent

Metric	# of votes	Comments
≥ 120 MED dosage per day	8	<p>“This one is most in line with work we were already planning. . . we may have a bit more control over this indicator.”</p> <p>“>120 MED has high impact for both decreased mortality and total numbers of people affected.”</p> <p>“Without knowing the actual prevalence of these metrics, it is very hard to vote. They need to represent a significant portion of our population or the PIP will be less than effective.”</p> <p>“No single metric will achieve complete success in reducing the unsafe use of opioid medications. . . . there are deficiencies with each of the proposed PIP metrics. . . . Our largest concern is inaccurate data based on MED calculation for the 30 day period. “ Concern was expressed that CCOs who have already been working on this issue could be penalized if improvement is measured by % of change, and the CCO proposed using a target baseline threshold instead.</p>

<p>Opioid and benzodiazepine co-prescription</p>	<p>2</p>	<p>Five CCOs were interested in this measure as their second choice, but expressed concern about data collection and analysis.</p> <p>This metric “has the greatest potential for safer use of opioids. However, CCOs have no control over the use of BZDs as the state has carved out these agents. There is no timely access to fill history or ability to limit BZDs by the CCOs. Without change to the state regulation, this measure is impossible for CCOs to manage.”</p> <p>“Provider education on new prescribing rules. What to expect with 711 data.”</p>
<p>Naïve to chronic opioid use</p>	<p>5</p>	<p>“one respondent felt there are likely few providers that achieve significant numbers to allow statistical analysis for #3 unless this runs for a long time.”</p> <p>In addition to metric #1, “if people would like to expand, we could address new chronic opioids.”</p> <p>“Does the metric account for multiple pain conditions or does it focus on a single diagnosis. Additionally, the length of the time proposed (45 days) is too short for appropriate pain management, specifically for post-operative patients who often need 1-2 months of pain medication for recovery.”</p>

In terms of technical assistance, several CCOs wanted assistance in identifying specific members and getting clear and specific technical specifications and instructions on data collection. As noted above, several CCOs expressed a need for assistance with collecting 7-11 drug data. One CCO wanted assistance with accessing data on out-of-pocket prescriptions.

Modernization of Oregon's Public Health System

Quality and Health Outcomes Committee



Why modernize Oregon's public health system?

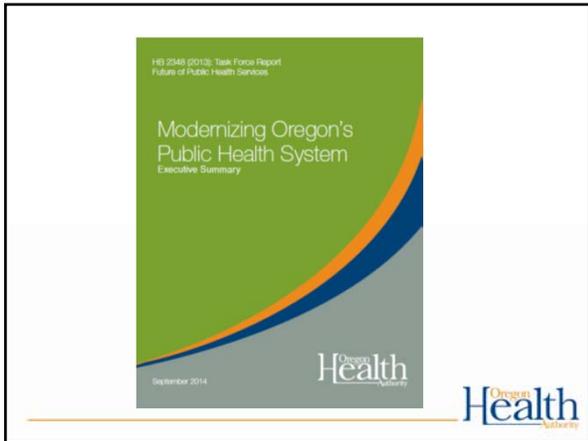
- Public health has traditionally provided a safety net for individuals without health insurance, and due to the Affordable Care Act, Oregon's uninsured rate has plummeted.
- Without needing to provide health care for a substantial number of uninsured individuals, public health can focus on developing policies and programs that can sustain lifelong health for everyone.
- A focus on policies and programs that can help everyone be healthy will yield cost and time savings for the health care delivery system.
- Investments in public health vary from county to county, leading to disparities in services.
- Oregon's public health system relies heavily on federal categorical grants, which do not always meet the unique needs of our state.

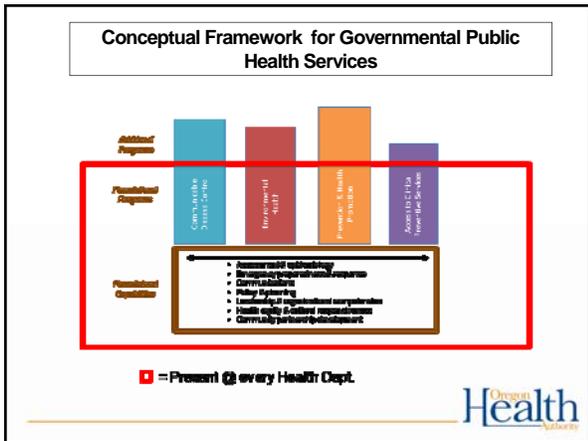


Task Force on the Future of Public Health Services

- HB 2348 (2013) called for the creation of a task force to study and develop recommendations for a public health system for the future.
- Between January and September 2014, the Task Force on the Future of Public Health Services met to develop a framework for modernizing Oregon's public health system.
- In September 2014, the *Modernizing Oregon's Public Health System* report was submitted to the legislature with a specific set of recommendations.







House Bill 3100 (2015)

- Legislators used the recommendations from the *Modernizing Oregon's Public Health System* report to introduce House Bill 3100, which was approved by the legislature in July 2015.
- House Bill 3100 operationalizes many of these recommendations over the period of 2015-2017. Specifically, the bill:
 - Adopts the foundational capabilities and programs for governmental public health.
 - Changes the composition and role of the Public Health Advisory Board beginning on January 1, 2016.
 - Requires the Oregon Health Authority's Public Health Division and local public health authorities to assess their current ability to implement the foundational capabilities and programs; and requires the Public Health Division to submit a report on these findings to the legislature by June 2016.
 - States that local public health authorities shall submit plans for implementing the foundational capabilities and programs no later than December 2023.

Access to Clinical Preventive Services

HB 3100 defines Access to Clinical Preventive Health Services as the assessment of public access to:

- Immunizations;
- Prenatal care;
- Screening for preventable cancers and other diseases;
- Screening for sexually transmitted infections;
- Evaluation of and treatment for tuberculosis and related latent tuberculosis infections;
- Cost-effective preventive care; and
- Laboratory services.



Access to Clinical Preventive Services

Provides an opportunity to utilize public health data to better plan for the provision of health care across a jurisdiction.

- Public health departments can refer to health care.
- Public health departments can help monitor access to care among specific sub-populations, and support engaging underserved populations in care.
- When needed, communities may determine that certain services should be provided by public health (e.g., HIV and STD screening; family planning).



What does modernization mean for CCOs?

- CCOs will be able to count on a core level of public health service in every jurisdiction. This means:
 - CCOs will be better equipped with timely and comprehensive data on the health of their population in order to inform robust community health assessments and community health improvement plans;
 - Local jurisdictions will be prepared to respond to natural disasters and other threats;
 - CCO members will be better protected from the threat of emerging communicable diseases like measles, meningococcal disease or Ebola; and
 - Chronic diseases can be better prevented by CCO members having access to tobacco-free public spaces, healthy foods and safe places to play and be active.



What will happen now?

- In order for everyone in Oregon to have access to these foundational public health protections, between July 2015 and June 2016:
 - A new governance structure for Oregon’s public health system, the Public Health Advisory Board, will be appointed by the Governor;
 - Clear, measurable definitions for the Foundational Capabilities and Programs for public health will be developed using national research and feedback from stakeholders;
 - State and local health departments will assess the extent to which they currently provide the foundational capabilities and programs and will determine costs to fully implement them;
 - Local health departments will determine the most appropriate governance structure for the jurisdiction they serve, so they can successfully implement the foundational capabilities and programs;
 - With communities and partners, state and local health departments will develop plans to implement the foundational capabilities and programs, based on the findings from their assessments.



What will happen now?

Activity	Timeline
Draft measurable definitions of each foundational capability and program	July-September 2015
New Public Health Advisory Board is appointed by the Governor	January 2016
Public Health Division and local public health authorities assess ability to implement foundational capabilities and programs	January-March 2016
Administrative rules are filed in accordance with House Bill 3100	May 2016
Assessment findings and implementation costs are reported to the Oregon legislature	June 2016
Public Health Division and local public health authorities plan for implementation of the foundational capabilities and programs	Beginning July 2016



How can I stay involved?

- Keep in touch with the Oregon Health Authority’s Public Health Division and your local public health authority.
- Provide us with your ideas and feedback:
 - www.healthoregon.org/modernization
 - publichealth.policy@state.or.us
 - (971) 673-1222



AGENDA
BEHAVIORAL HEALTH ADVISORY PANEL (BHAP)
September 16, 2015
9:00-11:00 AM

Wilsonville Training Center, Room 210

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

#	Time	Item	Presenter
1	9:00	Call to Order	David Pollack
2	9:05	Purpose of Meeting	Darren Coffman
3	9:10	Prioritized List issues 1) Integration of medical and mental health lines for child abuse and neglect 2) Guideline notes with differential treatment of children by age (GN 20, 25, 28, 42, 45) 3) SOI 3 INTEGRATED CARE 4) New line for substance abuse and acute substance intoxication and/or withdrawal	Ariel Smits
4	10:30	Coding/reimbursement issues with integrated care	Denise Taray
5	10:45	Other Business	David Pollack
6	10:55	Public Comment	
7	11:00	Adjournment	David Pollack

AGENDA
ORAL HEALTH ADVISORY PANEL (OHAP)
September 22, 2015
Wilsonville Training Center, Room 210
8:00 – 10:00 am

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

#	Time	Item	Presenter
1	8:00 AM	Call to Order & Introductions	Bruce Austin
2	8:05 AM	Purpose of Meeting	Ariel Smits
3	8:10 AM	<ol style="list-style-type: none"> 1. 2016 CDT code placement 2. Placement of CDT codes on the Prioritized List and on another list 3. Denture code placement review 4. Guideline for crowns 	Ariel Smits
4	9:15 AM	Medicaid dental access issues	Bruce Austin
5	9:30 AM	Update on restoration of benefits for adults -dentures -crowns -interval for scaling and root planing	Bruce Austin
6	9:45 AM	Dental metrics?	?
7	9:55 AM	Public Comment	
8	10:00 AM	Adjournment	Bruce Austin

Minutes

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
August 13, 2015

Members Present: Som Saha, MD, MPH, Chair; Beth Westbrook, PsyD; Wiley Chan, MD; Vern Saboe, DC (teleconference-left early); Irene Crowell, RPh; Susan Williams, MD; Derrick Sorweide, DO.

Members Absent: Leda Garside, RN, MBA; Mark Gibson; Gerald Ahmann, MD, PhD.

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

Also Attending: Robyn Liu, MD, Adam Obley, MD, and Valerie King, MD, Center for Evidence-based Policy; Jesse Little, OHA Actuarial Services Unit; Kim R. Wentz, MD, MPH, and Laurie Theodorou, OHA Health Systems Division; Aiesha Moore, Aerocrine; Pam Keuneke, Providence; Joanne Rogovoy, March of Dimes; Kerry Kostman Bonilla, AstraZeneca; Bruce Croffy, FamilyCare; Ashlen Strong, Health Share; Courtney Johnston, COHO; Mellony Bernal, OHA Public Health Division; Jen Gilbert, Jonathan Modie, OHA Communications; Emily McLain, Nico Quintana, Basic Rights Oregon; Phillip L. Santa Maria, Avanir; Sharron Fuchs; Jeana Colabianchi, Pharm D, Sunovion; Maros Ferencik, SCCT; Teresa Everson, Will Nettleton, MD and Cristina Fuss, OHSU.

Call to Order

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

Minutes Approval

[Meeting Materials](#), page 4

MOTION: To approve the minutes of the 3/12/2015 meeting as presented. CARRIES 7-0.

Director's Report

Membership:

- Darren Coffman noted today is the first official meeting for recently confirmed Commissioner Dr. Derrick Sorweide. He is an osteopathic physician, a former family practice physician, is an Army Major, teaches at Western University of Health Sciences and is the current president of the Osteopathic Physicians & Surgeons of Oregon (OPSO).

MOTION: To seat Sorweide on the Health Technology Assessment Subcommittee. CARRIES: 7-0.

- Coffman noted the Governor’s office anticipates a Senate confirmation hearing in September to fill the vacant dental position.
- Recently, the EBGs CCO representative, Kattie Leuken, resigned.

Legislative update:

- Palliative Care and Quality of Life Interdisciplinary Advisory Council
 - Denise Taray will be lead staff
- Task Force on Researching the Medical and Public Health Properties of Cannabis
 - HERC Staff were initially tasked with staffing this group but found out this week staffing will come from elsewhere
- Report on diagnosis and treatment of Lyme disease
 - Ariel will be lead staff for this report to an interim legislative committee

Staff/organizational updates:

- Coffman introduced Dr. Kim Wentz, the new medical assistance program medical director. That organization has been renamed the “Health Systems Division.” HERC is now under Health Policy and Analytics Division, Clinical Services Improvement Unit. Jeanene Smith, CMO, is leaving state service.
- Coffman invited Val King to introduce Center for Evidence-based Policy staff. Adam Obley will take over Robyn Lui’s role, with Craig Mosbaek and Aasta Thielke acting as research assistants.

Coverage Guidance Topic: Planned out-of-hospital birth

[Meeting Materials](#), pages 26-197

No recommendation reached at the VbBS meeting held earlier in the day, therefore this topic was tabled until a future meeting.

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

[Meeting Materials](#), pages 198-271

Ariel Smits reported the VbBS met earlier in the day, August 13, 2015.

Gender dysphoria discussion:

Smits brought VbBS’s recommendations forward:

- Clarify which mental health provider appropriate for assessments/referrals
- Re-affirm no age limitations
- Do not specify provider type restrictions for gender dysphoria medication prescribing
- Issues tabled until the next meeting:
 - Changes to many surgery codes were tabled until a future meeting, including procedures for penile and testicular implants and chest surgery

Saha began the discussion by mentioning the onslaught of emails and phone calls staff received over a Fox news story in July. Most of them came from non-Oregon residents. What most struck Saha is that

we did not receive a single negative feedback/comment from someone who has gone through this as a patient or a parent. Every testimony from a patient, parent or provider implored the Commission to stick with the original decision.

Smits stated the new recommendations are based on the [World Professional Association for Transgender Health](#) (WPATH) guidelines. Williams pointed out that these guidelines have extensive requirements related to gender dysphoria training and experience, rather than limits on a particular type of provider degree type. Westbrook shared some concern with the language in the meeting materials regarding mental health professions. Smits stated VbBS adopted WPATH guidelines which specifically outlines necessary training (e.g. clinical training in psychiatry, mental health counselling, nursing or family therapy with specific training in behavioral health and a minimum of master's level degree or equivalent in a clinical behavioral health field by an accredited institution with continuing education in gender dysphoria).

Saha broached the issue of medical age of consent. He stated there is confusion over "age of procedure," when and who should be able to get it. In the case of gender dysphoria, it is disadvantageous clinically to wait until secondary sex characteristics are fully developed. There is no good clinical rationale to require patients to be 18 years old. Further, having heard from providers, advocates and patients, it is rare when the parents are not involved. It is not feasible to make parental involvement mandatory since this is a stigmatized condition where sometimes patients become estranged from their family and their parents don't approve. That becomes an issue of discriminating against people who have basically been disowned by their parents. It is a false idea that a child could just walk in and say "do this to me." There is a long list of criteria to meet, primary care doctor approval, multiple mental health evaluations, surgeon approval – plenty of adults involved in the discussion. A child is never making this decision alone, ever.

In Oregon, the age of medical consent is 15. This commission does not have the authority to change this state law. Without parental consent, a 15 -17 year old can have brain surgery, breast augmentation, or terminate a pregnancy. This policy has far more safeguards to help ensure a child isn't reaching a wrong decision than in the case of other surgeries.

Westbrook felt, for pre-surgery criteria, we should be even more cautious with minors, encouraging the group to consider adding criteria for a doctoral level person to complete any testing, especially a psycho-sexual developmental piece. Smits countered there are additional referrals required (1 for chest/breast surgery, 2 for genital surgery) from a provider with master's level or higher credentials.

Wentz said there is a shortage of child mental health care providers. Further, she mentioned there are currently ten active OHP discrimination cases pending over lack of appropriate care for transgender individuals; five are mental health cases. Hodges added the providers may be available in the community but may not be currently contracted by CCOs. Smits said Kaiser Permanente wrote her, objecting to any deviation from WPATH since doing so would cause them to treat their Medicaid patients differently, and potentially discriminately, than their "commercial" population. Saha wondered if the world-wide guidelines agree on this level, is changing anything necessary? Wentz added, if you ask for more scrutiny *only* for transgender patients you are discriminating on the basis of gender and you cannot do this in implementation. Further, Hodges shared there was an abundance of compelling testimony heard at VbBS to leave the 15-17 year-old coverage in place. Livingston said it may be in a patient's best interest to begin college as their identified gender.

Public comment:

Maura Roach, Basic Rights Oregon, urged the Commission to align with the world standard guidelines, WPATH, and to accept the VbBS recommendations.

Nico Quintana of Basic Rights Oregon testified that the lowest barriers possible for care should be adopted due to the marginalized nature of the transgender community, and their high risk of violence and suicide.

Census was reached to accept the VbBS proposal to modify the mental health evaluation sections to refer to the WPATH version 7 guidelines. The number of referrals required for chest/breast surgery was reduced from 2 to 1 to conform to WPATH guidelines, resulting in the following guideline.

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

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

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

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

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

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

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

Other VbBS report items:

Smits presented recommendations on other topics, but there was no discussion:

- Add certain procedure codes to the covered gender dysphoria line to better include all procedure codes for procedures previously approved for this line; remove 2 inappropriate codes from this line
- Make various straightforward coding changes
- Modify the left ventricular assist device guideline to allow destination therapy
- Modify the continuous blood glucose monitoring guideline to specify that recurrent hypoglycemia is defined as 3 or more events in the previous 6 months
- Adopt various straightforward guideline corrections

MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances, as stated. See the VbBS minutes of August 13, 2015 for a full description. Carries: 6-0. (Absent: Saboe; Abstained: 0)

Coverage Guidance Process Redesign

[Meeting Materials](#), pages 273-285

Jason Gingerich reminded the group they had granted permission to change the literature search process and GRADE table format at a previous meeting. He reviewed the staff's proposed changes to the coverage guidance process including: 1) additional research prior to releasing the initial draft of the guidance, and 2) a brief 7-day comment period focused on insuring that the literature search strategy returns the correct information to guide the HERC's decision. He also presented examples of the new GRADE tables which will provide more quantitative information about key outcomes. There was minimal discussion.

Coverage Guidance Topic 2-Year Review

[Meeting Materials](#), pages 286-302

Livingston led the discussion with help from Adam Obley, MD, of the Center for Evidence-based Policy. The new process now calls for the identification of Population, Intervention, Comparator, Outcomes (PICO) and Key Questions (KQ) for each topic, followed by posting for public comment for 7 days and a review of the literature search results at the September EbGS & HTAS meetings.

The Commission discussed the scope documents and made the changes shown in Appendix A.

- **Treatment of ADHD in Children (See Appendix A)**
- **Coronary Artery Calcium Scoring (See Appendix A)**

Public comment:

Maros Ferencik, MD, cardiologist and associate professor at OHSU, Board member of Society of Cardiovascular Computed Tomography. His stated conflict is that he is a practicing cardiologist who performs these tests and is a grant recipient for American Heart Associate to study coronary CTs. Dr. Ferencik said the current scope document partially mixes diagnostic uses with the test's preventive and prognostic value. He said the PICO should focus on the role of calcium scoring in predicting cardiovascular events and improving classification of the risk. Further, CACS should be compared to other tests or screening that lead to risk classification. She said that in certain cases adding a calcium score can help rule out further testing

- **Carotid Endarterectomy (See Appendix A)**
- **Coronary CT Angiography (See Appendix A)**

Public comment:

Cristina Fuss, MD is the section chief for cardiothoracic Imaging in the department of Diagnostic Radiology at OHSU. No conflicts declared. She said that studies have proven diagnostic accuracy and therefore the usefulness of this test is excellent. It does indeed prevent invasive tests in many cases and can help shorten the length of hospital stays. She said that in certain cases adding calcium score can help rule out further testing.

Maros Ferencik, MD spoke to urge the group to consider effects of radiation on the population. Also stressed the need to look at negative and positive effects of incidental findings.

At this point, with many more scope documents yet to review, Saha called a halt to reviewing the scope documents, as time for the topic had elapsed. He would like these discussions to take place at the subcommittee level in the future. Coffman and Gingerich added such a process change could result in a two-month delay. For this iteration, the scoping documents for all of the topics will be posted for public comment. The four reviewed at HERC today may then go on to a literature search, incorporating changes reflecting public comments as appropriate. The remainder will go to their originating subcommittee for additional discussion before proceeding with the literature search. After a literature search is conducted the subcommittee will review the results to see if revisiting the topic is warranted. Staff will work on a more stream-lined process for future topics.

Coverage Guidance Topic: Biomarker Tests of Cancer Tissue for Prognosis and Potential Response to Treatment

[Meeting Materials](#), pages 303-368

Dr. Robyn Liu, Center for Evidence-based Policy, reviewed the evidence resulting in the draft coverage guidance recommended by HTAS. Livingston reviewed the GRADE table and box language and the proposed changes to the Prioritized List recommended by VbBS. There was no discussion.

MOTION: To approve the proposed coverage guidance for Biomarker Tests of Cancer Tissue as recommended by HTAS. Carries 6-0.

MOTION: To approve the proposed guideline and coding changes for the Prioritized List as recommended by VbBS. Carries 6-0.

HERC APPROVED COVERAGE GUIDANCE

BIOMARKER TESTS OF CANCER TISSUE FOR PROGNOSIS AND POTENTIAL RESPONSE TO TREATMENT

Oncotype DX is recommended for coverage in early stage breast cancer when used to guide adjuvant chemotherapy treatment decisions for women who are lymph node negative (*strong recommendation*).

The following genetic tests of cancer tissue are recommended for coverage (*strong recommendation*):

- BRAF gene mutation testing for melanoma
- Epidermal growth factor receptor (EGFR) gene mutation testing for non-small-cell lung cancer
- KRAS gene mutation testing for colorectal cancer

The following genetic tests of cancer tissue are not recommended for coverage (*weak recommendation*):

- MammaPrint, ImmunoHistoChemistry 4 (IHC4), and Mammostrat for breast cancer
- Prolaris and Oncotype DX for prostate cancer
- BRAF, microsatellite instability (MSI), and Oncotype DX for colorectal cancer
- KRAS for lung cancer
- Urovysion for bladder cancer
- Oncotype DX for lymph node-positive breast cancer

The use of multiple molecular testing to select targeted cancer therapy is not recommended for coverage (*weak recommendation*).

Changes to the Prioritized List of Health Services:

1) Coding changes:

- a. Add S3854 (Gene expression profiling panel for use in the management of breast cancer treatment) to Line 195 (breast cancer).
 - i. Advise the Health Systems Division to remove S3854 from Ancillary Codes File
- b. Place 81275 (KRAS) on Line 161 (colon cancer)
 - i. Advise the Health Systems Division to remove 81275 from the Diagnostic File
- c. Place 81210 (BRAF) on Line 233 (malignant melanoma)
 - i. Advise the Health Systems Division to remove 81210 from Diagnostic File
- d. Add the following to the Services Recommended for Non-coverage Table (all represented by nonspecific CPT codes unless otherwise indicated)
 - MammaPrint
 - ImmunoHistoChemistry 4 (IHC4)
 - Mammostrat
 - Microsatellite instability (MSI)
 - Urovysion

- Prolaris
- Multiple molecular testing (81504)

2) Adopt a new Guideline Note:

GUIDELINE NOTE 148, BIOMARKER TESTS OF CANCER TISSUE

Lines 161, 188, 195, 233, 266, 274, 333

The use of multiple molecular testing to select targeted cancer therapy (CPT 81504) is included on the Services recommended for non-coverage table.

For breast cancer, Oncotype Dx testing (CPT 81519, HCPCS S3854) is included on line 195 only for early stage breast cancer when used to guide adjuvant chemotherapy treatment decisions for women who are lymph node negative. Oncotype Dx is not included on this line for lymph node-positive breast cancer. Mammaprint, ImmunoHistoChemistry 4 (IHC4), and Mammostrat for breast cancer are included on the Services recommended for noncoverage table.

For melanoma, BRAF gene mutation testing (CPT 81210) is included on line 233.

For lung cancer, epidermal growth factor receptor (EGFR) gene mutation testing (CPT 81235) is included on line 266 only for non-small cell lung cancer. KRAS gene mutation testing (CPT 81275) is not included on this line.

For colorectal cancer, KRAS gene mutation testing (CPT 81275) is included on line 161. BRAF (CPT 81210) and Oncotype DX are not included on this line. Microsatellite instability (MSI) is included on the Services recommended for noncoverage table.

For bladder cancer, Urovysion testing is included on Services recommended for noncoverage table.

For prostate cancer, Oncotype DX is not included on line 333 and Prolaris is included on the Services recommended for noncoverage table.

The development of this guideline note was informed by a HERC coverage guidance. See [website](#).

Advisory Panels Update

Coffman said the three advisory panels to help VbBS with a variety of issues have been revitalized and will meet in September and October. Membership has been updated to ensure current CCO/DCO representation on the Behavioral Health Advisory Panel, Oral Health Advisory Panel, and Genetics Advisory Panel.

Best Practices, Evidence-based Toolkits

Livingston said there is a need for a way for HERC to make a statement on effectiveness and appropriateness of services that do not fit within the current constructs of the Prioritized List. These would be strategies for population health management on topics such as obesity, chronic pain, and tobacco use for services not traditionally billed as medical services. The product might be a stand-alone document and/or could be embedded in the Prioritized List.

Saha agreed there is a need to break down barriers between medical care and public health in support of our biggest stake holder, the CCOs. Discussion centered on the scope of the new venture, whether a task force should be convened for each topic or if adopting another group's practices was desired. Staff will bring back options at the next meeting in October, possibly focused on tobacco cessation.

2016 Biennial Review

Livingston asked for permission to convene a task force on obesity management which would include a wide variety of providers including primary care, CCO representatives, and endocrinology. This will take a look at HTAS recommendations on surgical indications as well as a comprehensive look at non-surgical approaches.

MOTION to create a task force on obesity management. CARRIES: 6-0.

Next Steps

I was determined that the next VbBS/HERC meeting date needs to be moved to October 1st or 22nd. Staff will poll the members for availability by email and confirm the date and location as soon as able.

Adjournment

The meeting was adjourned at 4:30 pm.

Treatment of ADHD in Children

Populations

Children 6 years of age or older diagnosed with ADHD, or
Children under 6 years of age deemed at-risk for ADHD

Interventions

Parent behavior training, teacher consultation, pharmacotherapy (methylphenidate, amphetamine salts, non-stimulant medications, atypical antipsychotics) other pharmacologic treatments, psychosocial and behavioral interventions

Comparators

Usual care, no intervention

Outcomes

Critical: Academic achievement, measures of social functioning

Important: Measures of impulsiveness, grade retention, growth restriction

Outcomes considered but not selected for GRADE table: Measures of inattention, overactivity, non-specific harms

Key Questions

KQ1: What is the effectiveness of pharmacologic, behavioral, and psychosocial interventions for children with ADHD?

1a. Does effectiveness vary based on patient characteristics?

KQ2: Is there comparative effectiveness evidence for interventions for children with ADHD?

KQ3: What is the effectiveness of interventions for children under 6 years of age deemed at-risk for ADHD?

KQ4: What is the evidence of harms associated with the interventions for ADHD in children?

Coronary Artery Calcium Scoring

Populations

Asymptomatic adults with coronary heart disease (CHD) risk, adults with acute chest pain with normal EKG and negative cardiac enzymes, adults with chronic stable chest pain

Intervention

Coronary artery calcium scoring (CACS)

Comparators

No further risk stratification, other forms of risk stratification (including serial monitoring (EKG, troponins), exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography, clinical risk prediction tools

Outcomes

Critical: All-cause mortality, major adverse cardiovascular events

Important: Incidental findings, avoidance of invasive procedure

Outcomes considered but not selected for GRADE table: Length of stay

Key Questions

KQ1: What is the comparative effectiveness of CACS in improving outcomes for asymptomatic patients with CHD risk or patients with chest pain (either acute chest pain with normal EKG and negative cardiac enzymes or chronic stable chest pain)?

KQ2: What is the cost-effectiveness of CACS?

KQ3: What are the harms of CACS?

Coronary CT Angiography

Population

Adults with acute chest pain or chronic stable chest pain

Intervention

Coronary CT angiography (CTA)

Comparators

Usual care (including no additional testing, exercise EKG, stress echocardiography, stress myocardial perfusion scanning, coronary angiography; serial monitoring with EKG/troponin)

Outcomes

Critical: All-cause mortality, Major Adverse Cardiac Events (MACE)

Important: Contrast-induced nephropathy, avoidance of invasive procedures

Outcomes considered but not selected for GRADE table: radiation exposure; need for revascularization procedure

Key Questions

KQ1: What is the comparative effectiveness of coronary CTA for improving outcomes among adults with chest pain?

1a. Are there patient characteristics that modify the utility?

KQ2: What are the harms of coronary CTA (including incidental findings)?

KQ3: What are the comparative costs and/or cost-effectiveness of coronary CTA?

Coronary Endarterectomy

Populations

Adults with carotid stenosis with or without recent symptoms of cerebral ischemia

Intervention

Carotid endarterectomy

Comparators

Optimal medical therapy, carotid stenting

Outcomes

Critical: All-cause mortality, cerebrovascular accidents

Important: Transient ischemic attacks, development/progression of vascular dementia, quality of life

Outcomes considered but not selected for GRADE table: Need for reintervention

Key Questions

KQ1: What is the comparative effectiveness of carotid endarterectomy for treatment of symptomatic or asymptomatic carotid stenosis?

1a. What degree of carotid stenosis predicts clinical utility of carotid endarterectomy?

KQ2: What are the harms of carotid endarterectomy?

KQ3 Under what circumstances should carotid endarterectomy be covered for asymptomatic patients (i.e. when stenosis is found as an incidental finding?)

**Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on August 13, 2015**

For specific coding recommendations and guideline wording, please see the text of the 8-13-2015 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/15)

- Add several procedure codes to the covered gender dysphoria line to better include all procedure codes for procedures previously approved for this line; delete 2 inappropriate codes from this line
- Delete several tests for genetic changes in tumors to the Services Recommended for Non-Coverage Table and add several others to covered cancer lines in accordance with the recommendations in the coverage guidance for biomarker tests of cancer tissue
- Add and delete several straightforward coding changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- No age restrictions were added for gender dysphoria services
- No restrictions on prescriber type were added for gender dysphoria medications
- No change was made to non-coverage of exhaled nitric oxide testing for asthma

RECOMMENDED GUIDELINE CHANGES (effective 10/1/15)

- Edit the left ventricular assist device guideline to allow destination therapy
- Edit the gender dysphoria guideline to have the mental health evaluation sections refer to the WPATH version 7 guidelines. The number of referrals required for chest/breast surgery was reduced from 2 to 1 to conform to WPATH guidelines.
- Edit the continuous blood glucose monitoring guideline to specify that recurrent hypoglycemia is defined as 3 or more events in the previous 6 months
- Add a new guideline based on the new coverage guidance for biomarker tests of cancer tissue
- Make various straightforward guideline corrections

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
August 13, 2015
8:00 AM – 1:30 PM

Members Present: Kevin Olson, MD, Chair; David Pollack, MD; Susan Williams, MD; Irene Croswell, RPh; Holly Jo Hodges, MD.

Members Absent: Laura Ocker, LAc; Mark Gibson.

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

Also Attending: Jenn Burleton and Kate Kauffman, TransActive Gender Center; Jim Mudd, MD, Amy Kerfoot, Amy Perkin, Dr. Christina Milano, Teresa Everson, Will Nettleton, MD and Julie Hanna, OHSU; Dr. Carter, private practice ND; Nico Quintana, Gig Cassel, Phoenix Singlet, Aaron Smith, Curtis Espinoza, Neola Young, Khalil Edwards, Abby Hoover, Nancy Haque, Basics Rights Oregon; Kazuaki Jindai, MD, VA/OHSU;; Bruce Croffy, FamilyCare; Megan Bird, MD, Legacy Health; Jess Guerriero, Lifeworks, NW; Adam Maxey, COHO; Karen L. Campbell, Jane Stephen and Chris Doyle, Allergan; Mellony Bernal, Jessie Little, Deborah Weston, Brian Nieubuurt, Kim Wentz, MD, Oregon Health Authority; Aiesha Moore, Acrocrine; Angela Carter, EQUI Institute; Ashlen Strong, Health Share; Rene Taylor, Dixun; Regina Eckles, WVP/WRICH.

➤ **Roll Call/Minutes Approval/Staff Report**

The meeting was called to order at 8:10 am and roll was called. Minutes from the May, 2015 VbBS meeting were reviewed and approved.

Kim Wentz, MD, MPH was introduced as the new medical director for the Oregon Medicaid program. Smits reviewed the Errata document for changes to the Prioritized List which were done as corrections since the last meeting.

A new obesity task force is proposed for creation to review a variety of treatments, including medications and surgical interventions. Staff requested feedback on the type/specialty of providers to be invited to join this task force. There was no input.

Smits noted that the Oral Health Advisory Panel, Behavioral Health Advisory Panel, and Genetics Advisory Panel are all meeting in the next one to two months and asked for any topic suggestions for these groups. There were none.

Topic: Straightforward/Consent Agenda

Discussion: There was no discussion about the consent agenda items. Staff clarified that code placements recommended in the document titled “Codes Without Line Placement for January 1, 2016” should take effect on October 1, 2015.

Recommended Actions:

- 1) Add CPT 55720 and 55725 (Prostatotomy, external drainage of prostatic abscess, any approach; simple and complicated) to line 209 SUPERFICIAL ABSCESSSES AND CELLULITIS
 - o Advise Health Systems Division (HSD), formerly DMAP, to remove 55720 from the Ancillary File and 55725 from the Diagnostic File
- 2) Add ICD-10 Q54.4 (Congenital chordee), Q55.64 (Hidden penis), and Q55.69 (Other congenital malformation of penis) to line 667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY and keep on line 438 HYPOSPADIAS AND EPISPADIAS
- 3) Add ICD-10 Q55.62 (Hypoplasia of penis) to line 438 HYPOSPADIAS AND EPISPADIAS and keep on line 667 GENITOURINARY CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
- 4) Add G90.50 (Complex regional pain syndrome I, unspecified) to lines 297 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT and 381 DYSFUNCTION RESULTING IN LOSS OF ABILITY TO MAXIMIZE LEVEL OF INDEPENDENCE IN SELF-DIRECTED CARE
- 5) Remove G90.50 (Complex regional pain syndrome I, unspecified) from line 612 DISORDERS OF SOFT TISSUE
- 6) Advise HSD to add W94.31xx (Exposure to sudden change in air pressure in aircraft during descent) to the Informational Diagnosis File
- 7) Add S16.1xxA (Strain of muscle, fascia and tendon at neck level, initial encounter) to line 407 CONDITIONS OF THE BACK AND SPINE
- 8) Add 69710 (Implantation or replacement of electromagnetic bone conduction hearing device in temporal bone) to the Services Recommended for Non-Coverage Table
- 9) Add 90378 (Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
- 10) Add 90460-90461 (Immunization administration through 18 years of age via any route of administration, first and subsequent) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
- 11) Add 90644 (Meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza B vaccine (Hib-MenCY), 4 dose schedule, when administered to children 2-15 months of age), 90653 (Influenza vaccine, inactivated, subunit, adjuvanted), 90664-90668 (Influenza virus vaccine, pandemic formulation), 90672 (Influenza virus vaccine, quadrivalent, live, for intranasal use) and 90739

- (Hepatitis B vaccine, adult dosage (2 dose schedule), for intramuscular use) were line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
- 12) Modify Guideline Notes 31 and 39, and Diagnostic Guideline D17 as shown in Appendix A
 - 13) Modify the medical back pain guideline scheduled for inclusion on the January 1, 2016 Prioritized List as shown in Appendix B
 - 14) Add hypnotherapy (CPT 90880) to the Services Recommended for Non-Coverage List
 - Advise HSD to remove CPT 90880 from the Ancillary File
 - 15) Add diagnostic codes for abnormal vaginal pap smears (ICD-9 795.1x / ICD-10 R87.62x) to line 291 CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS
 - Advise HSD to remove 795.1x/R87.62x from the Diagnostic Workup File.
 - 16) Add CPT 57420 (Colposcopy of the entire vagina, with cervix if present) and 57421 (with biopsy(s) of vagina/cervix) to line 291 CANCER OF VAGINA, VULVA, AND OTHER FEMALE GENITAL ORGANS
 - Advise HSD to remove 57420 and 57421 from the Ancillary File
 - 17) Modify the new guideline for wearable cardiac defibrillators as shown in Appendix A

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 5-0.

➤ **Topic: Left Ventricular Assist Device (LVAD) as Destination Therapy**

Discussion: Smits introduced the summary of this topic and the staff recommendations. Dr. James Mudd from the OHSU Heart Failure Clinic gave a short presentation in favor of the staff recommendations and answered questions from the subcommittee members. He reported that patients receiving LVADs for cardiac transplant frequently do not receive a heart due to extreme limitations of organs available, and therefore LVADs are essentially serving as destination therapy for these patients. He argued that LVADs are a treatment for end stage heart failure, regardless of the choice of being placed on the transplant list. He reported that LVAD candidates undergo the same evaluation process as transplant patients in the OHSU program.

There was some discussion about whether the current guideline spoke to replacement of LVADs if a patient lived long enough to reach the device life limit. Dr. Mudd reported that current devices do not appear to have a life span which requires replacement in this extremely ill patient population with limited life expectancy. Some devices are replaced due to device failure. There was discussion about what happens when patients decide to elect hospice/palliative care. Dr. Mudd indicated that OHSU's program, as well as other programs that he is aware of, require a palliative care consult prior to LVAD

placement and an informed consent discussion with the patient about the option of hospice rather than LVAD. When and if a patient elects to choose hospice or is near the end of life, the LVAD can be turned off.

The decision was to cover LVAD for all indications, and adoption of the guideline modifications.

Recommended Actions:

- 1) Modify Guideline Note as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 5-0.

➤ **Topic: Gender dysphoria**

Discussion: The four separate staff recommendation documents were reviewed. Staff referred to the voluminous amount of written testimony which has been received on this topic and which is available on the HERC website.

The first item discussed regarded the mental health requirements in the guideline. Hodges read an extensive suggested change proposed by one of the plan mental health providers. The subcommittee discussed the staff proposed changes to the mental health provisions and had concern for the proposed change that a provider be “knowledgeable.” The term “knowledgeable” was considered difficult to define. Would providers need to submit documentation of training or credentials? There was discomfort with requiring anything that would be considered credentialing, as this is supposed to be the purview of the CCOs. There was additional discussion about whether the person doing the referral for surgery needed to be a mental health professional who is not the patient’s personal counselor or treating psychiatrist. Requiring an additional consult was considered to be a possible barrier due to the mental health provider shortage in the state. However, the subcommittee members wanted to ensure that the evaluation was as thorough and unbiased as possible. In regards to the type and extent of an evaluation, the subcommittee felt that partially reversible interventions such as cross-sex hormone therapy should have a lower bar than irreversible interventions such as surgery. In addition, the majority of the subcommittee felt that all surgical interventions should have two referral letters. *[Note: the number of referrals for chest/breast surgery was reduced from 2 to 1 by HERC that afternoon to align with WPATH guidelines]*

The next topic discussed was possible limitations to the providers who could prescribe puberty suppression medications and/or cross sex hormone therapy. There was a clarifying question about whether naturopaths could prescribe these medications (yes). There was general concern that the group of providers should be large enough to ensure access but should have limits placed if there was a need for improved quality.

There was a general sense, however, that provider type for prescribing was an implementation question to be answered by HSD and the CCOs rather than by HERC.

Discussion then changed to the proposed surgical coding/guideline changes. Dr. Megan Bird from Legacy testified as an expert to assist with coding questions. Dr. Bird also testified that Washington Medicaid has recently changed their surgical coverage for gender dysphoria, and now cover mastopexy and penile implants. She suggested that HERC staff review this coverage. Dr. Bird also supplied 4 additional CPT codes for consideration that were not included in the meeting materials.

The last discussion item on this topic was regarding the possibility of age restrictions for various treatments for gender dysphoria. The subcommittee members were against adding any restrictions.

At this point, public testimony was heard. Dr. Christina Milano from OHSU testified that the current mental health requirements were limiting access to hormone therapy. She feels that an adequately trained PCP can prescribe cross sex hormone therapy if this provider is appropriately trained and competent in transgender health. She recommended following WPATH guidelines and considering carefully any deviations from WPATH. She also spoke to the issue of requiring providers to show documentation of being “knowledgeable,” testifying that it was difficult for providers to show adequate documentation.

Amy Penkin, LCSW from OHSU discussed who should be a “qualified mental health professional.” She felt that many providers are not yet licensed but are eligible. Many providers have the required degree, but are working on hours of patient care to qualify for licensure, and would be able to make these types of evaluations.

Dr. Megan Bird from OHSU testified that she encouraged alignment with WPATH, which is a conservative organization with appropriate care guidelines. She argued against age restriction. She feels that there are multiple safeguards for persons under 18 getting surgery—4 total evaluations (primary care, surgeon, 2 mental health) prior to surgery. She also testified about an ethics consult being available if needed. Hodges asked Bird about evidence that surgical outcomes being better or worse under age 18 (no evidence available).

Pollack voiced concern about possible poor care if there are not stringent requirements for the mental health evaluation. Milano replied that as a consultant, she finds most providers are very hesitant to prescribe rather than over-eager and felt that stringent requirements were not necessary. Olson asked about the number of providers available for these mental health services. Milano replied that there is no comprehensive registry, so the actual number of providers available and trained to do these evaluations is not known; however, there is lots of discussion amongst the various plans about who is trained and available. In her personal experience, she finds few providers outside the

Portland metro area. Bird noted that for surgical providers, the surgeon must show evidence of experience/training to obtain privileges to do a procedure at a hospital. There was discussion about the argument that PCPs provide care for other mental health issues other than gender dysphoria (depression, anxiety, PTSD, etc). Olson replied that there is a large body of evidence regarding best practices for these other mental health considerations, but standards are still being determined for gender dysphoria. Wentz noted that there was an access and implementation issue for HSD with the current guideline, with multiple complaints to the state about lack of access/providers.

Nico Quintana of Basic Rights Oregon testified that the lowest barriers possible for care should be adopted due to the marginalized nature of the transgender community, and their high risk of violence and suicide.

Kate Kauffman, a therapist, testified in opposition to age of consent changes. She feels that the current guideline ensures youth under 18 have a rigorous evaluation.

Dr. Carter, a naturopath active in transgender care, testified in favor of maintaining lower barriers to care. Many providers are competent to prescribe cross sex hormones and other therapy (like naturopaths).

At this point, the subcommittee resumed discussion of the four sets of staff recommendations. The first discussion was about the mental health requirements. For the specific question of changing "qualified" to "licensed," the subcommittee reviewed the testimony that pre-licensed providers may be able to perform these evaluations, and that physical health providers could, with training, perform them as well. There was discussion about the ability of pre-licensed providers to do these evaluations well, as they by definition have less experience. The response was that in many cases, a pre-licensed provider might have more training and/or experience than their supervising provider in the specifics of trans-gender evaluation and care. King read out selections from the current WPATH guideline section on mental health providers to show the extent of the description on who should provide mental health care. The subcommittee members felt that the WPATH guidelines were more extensive and comprehensive than any guideline HERC could write, and the decision was made to simply require a mental health evaluation provided in accordance to WPATH version 7 guidelines.

There was minimal additional discussion on limiting provider types. The subcommittee decided to not specify any type or training for a provider of puberty suppression medications or cross sex hormone therapy.

Staff suggested that rather than extensively discuss the surgical suggestions, that the proposed CPT code changes which had been vetted by experts be accepted (other than the mastopexy code). Additionally, the electrolysis code was added with the proposed guideline wording changes. Further discussion of mastopexy/breast augmentation and

penile implants was tabled until the next meeting and staff was directed to find Washington state coverage and guidelines on surgery. Bird will also provide staff with other surgical guidelines for breast surgery.

There was minimal further discussion on possible age limitations. Williams reminded the group that there was a lot of public sentiment in opposition to surgery prior to age 18 in addition to the unanimous support for it from those giving testimony today. The decision was to add no age limits.

Recommended Actions:

- 1) Modify Guideline Note 127 as shown in Appendix A
 - No changes recommended to the guideline to specify provider type or training for prescribing any type of medications used in gender dysphoria
- 2) Remove CPT 19301 (Lumpectomy) and 19302 (Mastectomy, partial; with axillary dissection) from line 413 GENDER DYSPHORIA
- 3) Add the following CPT codes to line 413 GENDER DYSPHORIA
 - 19318 (Reduction mammoplasty)
 - 19350 (Nipple/areola reconstruction)
 - 53415-53430 (Urethroplasty)
 - 54120 (Amputation of penis, partial)
 - 55150 (Resection of scrotum)
 - 55866 (Laparoscopy, surgical prostatectomy)
 - 56620 (Vulvoplasty, simple, partial)
 - 57295-57296 (Revision (including removal) of prosthetic vaginal graft)
 - 57426 (Revision (including removal) of prosthetic vaginal graft)
 - 58152 (Total abdominal hysterectomy)
 - 58660-58661(Laparoscopic oophorectomy)
 - 58940 (Oophorectomy, partial or total, unilateral or bilateral)
- 4) Add electrolysis (CPT 17380) to line 413 GENDER DYSPHORIA with guideline note modifications restricting use to surgical site preparation
- 5) Discussion of coverage of mastopexy/breast augmentation, penile implants, and scrotal implants was tabled to the next VbBS meeting
- 6) Discussion of any requirements for qualifications of surgeons was tabled to a future discussion
- 7) No age restrictions for any service were adopted

MOTION: To recommend the code and guideline note changes as discussed. CARRIES 5-0.

➤ **Topic: Temporary prostatic stents**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Vertebral fracture assessment**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Optic neuritis**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Trochanteric bursitis**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Exhaled nitric oxide testing for asthma**

Discussion: Smits introduced the summary document and staff recommendation for continuation of non-coverage. There was some discussion about the lack of requests from providers for coverage and the lack of claims received for this service. The subcommittee members felt that there was a community consensus to not use this test in the management or diagnosis of asthma.

Recommended Actions:

- 1) No change in current non-coverage of exhaled nitric oxide testing

➤ **Topic: Nose repair**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Coverage of perforations of the ear drum with hearing loss**

Discussion: Tabled until the next VbBS meeting

➤ **Topic: Continuous glucose monitoring guideline**

Discussion: Smits introduced the summary document and staff recommendations for modifications to this guideline. Rene Taylor, a registered dietician representing Dexcom (a device manufacturer), testified about studies showing the poor prognostic

implications of having had hypoglycemia in the prior 6 months. She reviewed literature showing serious impact of hypoglycemia on risk of hospitalization or future episodes of hypoglycemia.

There was discussion regarding how to define recurrent hypoglycemia. The subcommittee decided that recurrent was 3 or more events. The time for these events was debated and it was determined that these events should have occurred in the prior 6 months.

There was also discussion about the suggested modification to require reassessment at 6 month intervals. The criteria that needed to be met for reauthorization of the continuous glucose monitor were debated. It was decided to not adopt wording regarding reassessment and to direct HTAS to specifically address the criteria for continuing use during their review of the continuous glucose monitoring devices scheduled for this fall. If HTAS does not provide clarification on criteria for how frequently to review and criteria for continuing use, then VbBS will take up this topic again to determine these.

Recommended Actions:

- 1) Modify Guideline Note 108 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 5-0.

➤ **Topic: Acute peripheral nerve injury guideline**

Discussion: Tabled until the next VnBS meeting

➤ **Topic: Botulinum toxin injections for migraine and bladder conditions**

Discussion: Smits outlined the need for guidelines for migraine and bladder indications for botulinum toxin injections. Karen Campbell from Allergan offered to answer subcommittee questions.

The main discussion centered on what is the definition of “positive response” for these therapies. The Center for Evidence-based Policy has reviewed botulinum toxin and has a definition in their report on what was considered “improvement,” which Valerie King volunteered to research. The P&T Committee may also have specific criteria for what they consider “positive response.” HERC staff will work with CEbP and P&T, and review literature to help determine what the best definition of improvement should be.

Recommended Actions:

- 1) Staff will contact P&T and CEbP staff and determine what criteria were used for “positive response” in the PA criteria and studies of CGM and bring back this topic to a future meeting

➤ **Topic: Coverage Guidance—Biomarkers**

Discussion: Dr. Robyn Liu reviewed the evidence and public comment for the Draft Coverage Guidance Biomarker Tests of Cancer Tissue for Prognosis and Potential Response to Treatment. Livingston reviewed the GRADE table and box language and the proposed changes to the Prioritized List. There was a brief discussion on the rapidity of evolution of these diagnostic tests. The proposed coding changes and new guideline note were accepted.

Recommended Actions:

- 1) Add S3854 (Gene expression profiling panel for use in the management of breast cancer treatment) to Line 195 (breast cancer)
 - i. Advise the Health Systems Division to remove S3854 from the Ancillary File
- 2) Place 81275 (KRAS) on Line 161 (colon cancer)
 - i. Advise the Health Systems Division to remove 81275 from the Diagnostic File
- 3) Place 81210 (BRAF) on Line 233 (malignant melanoma)
 - i. Advise the Health Systems Division to remove 81210 from Diagnostic Procedures File
- 4) Add the following to the Services Recommended for Non-coverage Table (all represented by nonspecific CPT codes unless specified)
 - i. Mammaprint
 - ii. ImmunoHistoChemistry 4 (IHC4)
 - iii. Mammostrat
 - iv. Microsatellite instability (MSI)
 - v. Urovysion
 - vi. Prolaris
 - vii. Multiple molecular testing (81504)
- 5) Adopt a new Guideline Note as shown in Appendix C

MOTION: To approve the recommended changes to the Prioritized List based on the draft biomarkers coverage guidance scheduled for review by HERC at their August 13, 2015 meeting. CARRIES 5-0.

➤ **Topic: Coverage Guidance—Planned Out-of-hospital births**

Discussion: Dr. Valerie King presented the evidence review and summarized the changes as a result of the public comment period. There were a series of clarifying questions about the evidence and the changes made, as well as the Oregon public health records data and the mortality rate among OOH births in Oregon. It was clarified that 6 out of the 8 deaths reported in that data would not meet current nor draft coverage guidance criteria for coverage. Livingston reviewed the GRADE table and the box language and raised the concern of needing to clarify what exactly is required for coverage to be recommended, if each high risk criteria needs to be ruled out. Further discussion was curtailed due to the ending of the meeting.

Recommended Actions:

This topic will be readdressed at the October 2015 VbBS meeting.

➤ **Public Comment:**

No additional public comment was received.

➤ **Issues for next meeting:**

- Coverage of breast augmentation and penile implants for gender dysphoria
- Botulinum toxin injections for migraine and bladder conditions
- Vertebral fracture assessment
- Trochanteric bursitis
- Nose repair
- Optic neuritis
- Temporary ureteral stents
- Coverage of repair of eardrum perforations in cases of hearing loss
- Acute peripheral nerve injury guideline
- Stem cell transplant for neuroblastoma
- Dysfunction line review
- Tobacco cessation coverage
- Tobacco use and elective surgery
- Craniofacial anomalies and obstructive sleep apnea

➤ **Next meeting:**

After a brief poll of those present, most could attend October 1, 2015, rather than the previously scheduled October 8, at location to be determined.

➤ **Adjournment:**

The meeting adjourned at 1:30 PM.

DIAGNOSTIC GUIDELINE D17, PRENATAL GENETIC TESTING

The following types of prenatal genetic testing and genetic counseling are covered for pregnant women:

1. Genetic counseling (CPT 96040, HPCPS S0265) for high risk women who have family history of inheritable disorder or carrier state, ultrasound abnormality, previous pregnancy with aneuploidy, or elevated risk of neural tube defect.
2. Genetic counseling (CPT 96040, HPCPS S0265) prior to consideration of chorionic villus sampling (CVS), amniocentesis, microarray testing, Fragile X, and spinal muscular atrophy screening
3. Validated questionnaire to assess genetic risk in all pregnant women
4. Screening high risk ethnic groups for hemoglobinopathies (CPT 83020, 83021)
5. Screening for aneuploidy with any of five screening strategies [first trimester (nuchal translucency, beta-HCG and PAPP-A), integrated, serum integrated, stepwise sequential, and contingency] (CPT 76813, 76814, 81508-81511)
6. Cell free fetal DNA testing (CPT [81420](#), 81507) for evaluation of aneuploidy in women who have an elevated risk of a fetus with aneuploidy (maternal age >34, family history or elevated risk based on screening).
7. Ultrasound for structural anomalies between 18 and 20 weeks gestation (CPT 76811, 76812)
8. CVS or amniocentesis (CPT 59000, 59015, 76945, 76946, 88235, 88267, 88280, 88291) for a positive aneuploidy screen, maternal age >34, fetal structural anomalies, family history of inheritable chromosomal disorder or elevated risk of neural tube defect.
9. Array CGH (CPT 81228, 81229) when major fetal congenital anomalies are apparent on imaging, or with normal imaging when array CGH would replace karyotyping performed with CVS or amniocentesis as in #8 above
10. FISH testing (CPT 88271, 88275) only if karyotyping is not possible due a need for rapid turnaround for reasons of reproductive decision-making (i.e. at 22w4d gestation or beyond)
11. Screening for Tay-Sachs carrier status (CPT 81255) in high risk populations. First step is hex A, and then additional DNA analysis in individuals with ambiguous Hex A test results, suspected variant form of TSD or suspected pseudodeficiency of Hex A
12. Screening for cystic fibrosis carrier status once in a lifetime (CPT 81220-81224)
13. Screening for fragile X status (CPT 81243, 81244) in patients with a personal or family history of
 - a. fragile X tremor/ataxia syndrome
 - b. premature ovarian failure
 - c. unexplained early onset intellectual disability
 - d. fragile X intellectual disability
 - e. unexplained autism through the pregnant woman's maternal line
14. Screening for spinal muscular atrophy (CPT 81401) once in a lifetime
15. Screening those with Ashkenazi Jewish heritage for Canavan disease (CPT 81200), familial dysautonomia (CPT 81260), and Tay-Sachs carrier status (CPT 81255)
16. Expanded carrier screening only for those genetic conditions identified above

The following genetic screening tests are not covered:

1. Serum triple screen
2. Screening for thrombophilia in the general population or for recurrent pregnancy loss
3. Expanded carrier screening which includes results for conditions not explicitly recommended for coverage

The development of this guideline note was informed by a HERC coverage guidance. See <http://www.oregon.gov/oha/herc/CoverageGuidances/Prenatal%20Genetic%20Testing.pdf>

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines ~~86~~,102,267

Ventricular assist devices are covered ~~only in the following circumstances: 1) as a bridge to cardiac transplant; 2) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or, 3) as a bridge to recovery;~~ or, as destination therapy.

~~Ventricular assist devices are not covered for destination therapy.~~

~~Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.~~

~~Long-term VADs are covered for indications 1 and 2. Long-term VADs are defined as a VAD that is implanted in a patient with the intent for the patient to be supported for greater than a month with the potential for discharge from the hospital with the device. Temporary or short term VADs are covered for indications 1 and 3. Short term VADs are defined as a VAD that is implanted in a patient with the intent for the patient to be supported for days or weeks with no potential for discharge from the hospital with the device.~~

When used as destination therapy, patients must

- 1) have chronic end-stage heart failure (New York Heart Association Class IIIB or IV end-stage left ventricular failure) for more than 60 days, AND
- 2) not be a candidate for heart transplantation, AND
- 3) meet all of the following conditions:
 - a. Have failed to respond to optimal medical management, including beta-blockers and ACE inhibitors (if tolerated) for at least 45 of the last 60 days, or have been balloon pump dependent for 7 days, or IV inotrope dependent for 14 days; and
 - b. Have a left ventricular ejection fraction (LVEF) <25%; and
 - c. Have demonstrated functional limitation with a peak oxygen consumption of <14 ml/kg/min unless balloon pump or inotrope dependent or physically unable to perform the test.
- 4) Have adequate psychological condition and appropriate external psychosocial support for prolonged VAD support
- 5) Have adequate end organ function

GUIDELINE NOTE 31, COCHLEAR IMPLANTATION

Line 331

Patients will be considered candidates for cochlear implants if the following criteria are met:

- A) [Severe to p](#)rofound sensorineural hearing loss in both ears (defined as 71dB hearing loss or greater at 500, 1000 and 2000 Hz)
- B) Receive limited useful benefit from appropriately fitted hearing aids, defined as a speech discrimination score of <30% on age appropriate testing for children and as scores of 40% or less on sentence recognition test in the best-aided listening condition for adults
- C) No medical contraindications
- D) High motivation and appropriate expectations (both patient and family, when appropriate)

Bilateral cochlear implants are included on this line. Simultaneous implantation appears to be more cost-effective than sequential implantation.

GUIDELINE NOTE 39, ENDOMETRIOSIS AND ADENOMYOSIS

Line 400

- A) Hysterectomy, with or without adnexectomy, for endometriosis may be appropriate when all of the following are documented (1-4):
 - 1) Patient history of (a and b):
 - a) Prior detailed operative description or histologic diagnosis of endometriosis
 - b) Presence of pain for more than 6 months with negative effect on patient's quality of life
 - 2) Failure of a 3-month therapeutic trial with both of the following (a and b), unless there are contraindications to use:
 - a) Hormonal therapy (i or ii):
 - i) Oral contraceptive pills or patches, progesterone-containing IUDs, injectable hormone therapy, or similar
 - ii) Agents for inducing amenorrhea (e.g., GnRH analogs or danazol)
 - b) Nonsteroidal anti-inflammatory drugs
 - 3) Nonmalignant cervical cytology, if cervix is present
 - 4) Negative preoperative pregnancy test result unless patient is postmenopausal or has been previously sterilized
- B) Hysterectomy, with or without adnexectomy, for adenomyosis may be appropriate when all of the following are documented (1-~~6~~ 5):
 - 1) Patient history of dysmenorrhea, pelvic pain or abnormal uterine bleeding for more than six months with a negative effect on her quality of life.
 - 2) Failure of a six-month therapeutic trial with both of the following (a and b), unless there are contraindications to use:
 - a) Hormonal therapy (i or ii):
 - i) Oral contraceptive pills or patches, progesterone containing IUDs, injectable hormone therapy, or similar
 - ii) Agents for inducing amenorrhea (e.g., GnRH analogs or danazol)
 - b) Nonsteroidal anti-inflammatory drugs
 - 3) One of the following (a or b):
 - a) Endovaginal ultrasound suspicious for adenomyosis (presence of abnormal hypoechoic myometrial echogenicity or presence of small myometrial cysts)
 - b) MRI showing thickening of the junctional zone > 12mm
 - 4) Nonmalignant cervical cytology, if cervix is present

- 5) Negative preoperative pregnancy test unless patient is postmenopausal or has been previously sterilized

GUIDELINE NOTE 108, CONTINUOUS BLOOD GLUCOSE MONITORING

Line 8

Services related to real-time continuous blood glucose monitoring (for long-term use) or retrospective glucose monitoring (for short-term use) are included on Line 8 only when insulin pump management is being considered, initiated, or utilized and only when the patient has at least one of the following despite compliance with treatment:

- HbA1c levels greater than 8.0% ~~(despite compliance with treatment)~~, or
- ~~a history of~~ recurrent hypoglycemia with at least three events in the past six months.

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

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 413

[*Note: The changes shown in **boldface italics** were approved by HERC later in the day to align with WPATH guidelines*]

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

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

1. have persistent, well-documented gender dysphoria
2. have the capacity to make a fully informed decision and to give consent for treatment
3. have any significant medical or mental health concerns reasonably well controlled
4. have a comprehensive mental health evaluation provided in accordance with Version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (www.wpath.org). ~~thorough psychosocial assessment by a qualified mental health professional with experience in working with patients with gender dysphoria.~~

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

1. have persistent, well documented gender dysphoria

2. have completed twelve months of continuous hormone therapy as appropriate to the member's gender goals unless hormones are not clinically indicated for the individual
3. have completed twelve months of living in a gender role that is congruent with their gender identity unless a medical and a mental health professional both determine that this requirement is not safe for the patient
4. have the capacity to make a fully informed decision and to give consent for treatment
5. have any significant medical or mental health concerns reasonably well controlled
6. for breast/chest surgeries, have one referral from a mental health professional provided in accordance with version 7 of the WPATH Standards of Care.
7. for genital surgeries, have two referrals from ~~qualified~~ mental health professionals ~~with experience in working with patients with gender dysphoria who have independently assessed the patient. Such an assessment should include the clinical rationale supporting the patient's request for surgery, as well as the rationale for the procedure(s)~~ provided in accordance with the version 7 WPATH Standards of Care.

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

GUIDELINE NOTE 49, WEARABLE CARDIAC DEFIBRILLATORS

Lines 73,103,115,193,286,350

Wearable cardiac defibrillators (WCDs; CPT 93745, HCPCS E0617, K0606-K0609) are included on these lines for patients at high risk for sudden cardiac death who meet the medical necessity criteria for an implantable cardioverter defibrillator (ICD) as defined by the CMS 2005 National Coverage Determination but are unable to have an ICD implanted due to medical condition (e.g. ICD explanted due to infection with waiting period before ICD reinsertion or current medical condition contraindicates surgery). WCDs are not included on these lines for use during the waiting period for ICD implantation after myocardial infarction, coronary bypass surgery, or coronary artery stenting.

GUIDELINE NOTE XXX NON-INTERVENTIONAL TREATMENTS FOR CONDITIONS OF THE BACK AND SPINE

Line 407

Patients seeking care for back pain should be assessed for potentially serious conditions (“red flag”) symptoms requiring immediate diagnostic testing, as defined in Diagnostic Guideline D4. Patients lacking red flag symptoms should be assessed using a validated assessment tool (e.g. STarT Back Assessment Tool) in order to determine their risk level for poor functional prognosis based on psychosocial indicators.

For patients who are determined to be low risk on the assessment tool, the following services are included on this line:

- Office evaluation and education,
- Up to 4 total visits, consisting of the following treatments: OMT/CMT, acupuncture, and PT/OT. Massage, if available, may be considered.
- First line medications: NSAIDs, acetaminophen, and/or muscle relaxers. Opioids may be considered as a second line treatment, subject to the limitations on coverage of opioids in Guideline Note YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.

For patients who are determined to be medium or high risk on the validated assessment tool, the following treatments are included on this line:

- Office evaluation, consultation and education
- Cognitive behavioral therapy. The necessity for cognitive behavioral therapy should be re-evaluated every 90 days and coverage will only be continued if there is documented evidence of decreasing depression or anxiety symptomatology, improved ability to work/function, increased self-efficacy, or other clinically significant, objective improvement.
- Medications, subject to the limitations on coverage of opioids in Guideline Note YYY OPIOID PRESCRIBING FOR CONDITIONS OF THE BACK AND SPINE. See evidence table.
- The following evidence-based therapies, when available, are encouraged: yoga, massage, supervised exercise therapy, intensive interdisciplinary rehabilitation
- A total of 30 visits per year of any combination of the following evidence-based therapies when available and medically appropriate. These therapies are only covered if provided by a provider licensed to provide the therapy and when there is documentation of measurable clinically significant progress toward the therapy plan of care goals and objectives using evidence based objective tools (e.g. Oswestry, Neck Disability Index, SF-MPQ, and MSPQ).
 - 1) Rehabilitative therapy (physical and/or occupational therapy), if provided according to GUIDELINE NOTE 6, REHABILITATIVE SERVICES. Rehabilitation services provided under this guideline also count towards visit totals in Guideline Note 6
 - 2) Chiropractic or osteopathic manipulation
 - 3) Acupuncture

These coverage recommendations are derived from the State of Oregon Evidence-based Guideline on the Evaluation and Management of Low Back Pain available here:

<http://www.oregon.gov/oha/herc/Pages/blog-low-back-non-pharmacologic-intervention.aspx>

Intervention Category*	Intervention	Acute < 4 Weeks	Subacute & Chronic > 4 Weeks
Self-care	Advice to remain active	●	●
	Books, handout	●	●
	Application of superficial heat	●	
Nonpharmacologic therapy	Spinal manipulation	●	●
	Exercise therapy		●
	Massage		●
	Acupuncture		●
	Yoga		●
	Cognitive-behavioral therapy		●
	Progressive relaxation		●
Pharmacologic therapy (Carefully consider risks/harms)	Acetaminophen	●	●
	NSAIDs	●(▲)	●(▲)
	Skeletal muscle relaxants	●	
	Antidepressants (TCA)		●
	<i>Benzodiazepines</i> **	●(▲)	●(▲)
	<i>Tramadol, opioids</i> **	●(▲)	●(▲)
Interdisciplinary therapy	Intensive interdisciplinary rehabilitation		●
<ul style="list-style-type: none"> ● Interventions supported by grade B evidence (at least fair-quality evidence of moderate benefit, or small benefit but no significant harms, costs, or burdens). No intervention was supported by grade "A" evidence (good-quality evidence of substantial benefit). <p>▲ <i>Carries greater risk of harms than other agents in table.</i></p>			

NSAIDs = nonsteroidal anti-inflammatory drugs; TCA = tricyclic antidepressants.

*These are general categories only. Individual care plans need to be developed on a case by case basis. For more detailed information please see: <http://www.annals.org/content/147/7/478.full.pdf>

**Associated with significant risks related to potential for abuse, addiction and tolerance. This evidence evaluates effectiveness of these agents with relatively short term use studies. Chronic use of these agents may result in significant harms.



GUIDELINE NOTE ~~XXX-148~~, BIOMARKER TESTS OF CANCER TISSUE

Lines 161, 188, 195, 233, 266, 274, 333

The use of multiple molecular testing to select targeted cancer therapy (CPT 81504) is included on the Services recommended for non-coverage table.

For breast cancer, Oncotype Dx testing (CPT 81519, HCPCS S3854) is included on line 195 only for early stage breast cancer when used to guide adjuvant chemotherapy treatment decisions for women who are lymph node negative. Oncotype Dx is not included on this line for lymph node-positive breast cancer. Mammaprint, ImmunoHistoChemistry 4 (IHC4), and Mammostrat for breast cancer are included on the Services recommended for noncoverage table.

For melanoma, BRAF gene mutation testing (CPT 81210) is included on line 233.

For lung cancer, epidermal growth factor receptor (EGFR) gene mutation testing (CPT 81235) is included on line 266 only for non-small cell lung cancer. KRAS gene mutation testing (CPT 81275) is not included on this line.

For colorectal cancer, KRAS gene mutation testing (CPT 81275) is included on line 161. BRAF (CPT 81210) and Oncotype DX are not included on this line. Microsatellite instability (MSI) is included on the Services recommended for noncoverage table.

For bladder cancer, Urovysion testing is included on Services recommended for noncoverage table.

For prostate cancer, Oncotype DX is not included on line 333 and Prolaris is included on the Services recommended for noncoverage table.

The development of this guideline note was informed by a HERC coverage guidance. See [website](#).

HEALTH EVIDENCE REVIEW COMMISSION (HERC)

COVERAGE GUIDANCE: NITROUS OXIDE FOR LABOR PAIN

DRAFT for EbGS Meeting Materials 9/3/2015

HERC Coverage Guidance

Nitrous oxide for labor pain is recommended for coverage (*weak recommendation*).

Note: Definitions for strength of recommendation are provided in Appendix A GRADE Element Description

PLAIN LANGUAGE SUMMARY

[Staff will insert lay language summary once the coverage guidance has been reviewed by subcommittee]

RATIONALE FOR GUIDANCE DEVELOPMENT

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

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

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

EVIDENCE OVERVIEW

Clinical background

Annually, approximately 45,000 births occur in Oregon (Oregon Health Authority, 2015) and childbirth pain is a major concern among women (Likis et al., 2012). Pain relief is most commonly delivered through epidural anesthesia in the United States, with 61% of women who had singleton births through vaginal delivery electing an epidural anesthesia (Centers for Disease Control and Prevention, 2011; Likis, et al., 2012). For women interested in other types of pain relief or in delaying the timing of an epidural, there are several options including inhaled nitrous oxide (N₂O, also known as "laughing gas"), other

inhaled anesthetic gases, opioids, paracervical or pudendal block, transcutaneous electrical nerve stimulation, hydrotherapy, sterile water injections, and psychoprophylaxis (Likis et al., 2012).

Inhaled nitrous oxide is a non-invasive form of pain relief. Commonly used in dentistry, nitrous oxide provides a diminished sense of pain and provides some antianxiety effects (Likis et al., 2012). In comparison to epidural anesthesia, women using nitrous oxide for pain management retain their full mobility. Individuals experience the maximum effect of nitrous oxide 30 to 60 seconds after inhalation. The effects of nitrous oxide wear off quickly and other types of pain management methods can be used in a relatively short time period after the use of nitrous oxide (Likis et al., 2012).

In the Portland-Metro region, an epidural adds an additional \$1,050 to \$2,400 to the cost of a hospital birth (Providence Health Services, 2015). The use of nitrous oxide costs significantly less with estimates ranging from \$15 to \$100 per patient.

Indications

Inhaled nitrous oxide can be used in the first or second stages of labor and is indicated for pregnant women in labor intending a vaginal birth. Nitrous oxide can also be used in the third stage of labor to assist with managing pain that may occur during immediate postpartum procedures (e.g., perineal repair, manual placenta removal).

Technology description

Inhaled nitrous oxide is widely used for childbirth pain relief outside of the United States and is a common form of non-invasive pain relief during childbirth (Klomp, van Poppel, Jones, Lazet, Di Nisio & Lagro-Janssen, 2012). Nitrous oxide is a non-flammable, tasteless, odorless gas that is self-administered on demand by laboring women through a mouth piece or facemask (Collins, Starr, Bishop, Baysiner, 2012; Klomp et al., 2012). Inhaled nitrous oxide is typically administered as a 50% nitrous oxide / 50% oxygen combination. It can be administered at this concentration using a blender device (e.g., Nitronox®) or as a premixed gas (e.g., Entonox®). Entonox® is not currently available in the U.S., but appropriate types of blender equipment are available for hospital and out-of-hospital use.

Key questions

The following key questions (KQ) guided the evidence search and review described below. For additional details about the review scope and methods please see Appendix B.

KQ1: What are the effects on mode of birth, use of neuraxial (e.g. epidural) analgesia and maternal satisfaction when nitrous oxide is used for labor analgesia?

KQ2: What are the maternal and fetal/neonatal harms of nitrous oxide used for labor pain?

Evidence review

Two systematic reviews (SR) (Klomp et al., 2012; Likis et al., 2012) identified in the core source search address the use of nitrous oxide for pain management during labor. Both SRs were of good methodological quality. The AHRQ SR (Likis, 2012; Likis, 2014) was selected as the index SR and is the

primary evidence source for this coverage guidance because it is more comprehensive and matches the scope of the HERC’s key questions better. In addition, the Cochrane SR (Klomp, 2012) did not add eligible studies or other information which were not included in the AHRQ SR. For further details on the methods of this evidence review please see Appendix B. The included study characteristics for the AHRQ SR are outlined below in Table 1.

Table 1. Overview of Index Systematic Review

Citation	Total Studies Included	Included Studies Specifically Addressing Coverage Guidance Scope
Likis et al (2012, 2014) [AHRQ SR]	59 studies (13 RCTs, 7 crossover RCTs, 4 non-randomized clinical trials, 14 prospective cohorts, 1 retrospective cohorts, 3 case series, 4 case-control studies, 11 cross sectional studies, and 2 trend studies)	<ul style="list-style-type: none"> • 14 studies (5 RCTs; 8 prospective cohorts 1 case-series) for fetal/neonatal harms • 3 studies (2 prospective cohort studies, 1 cross-sectional study) for mode of delivery • 10 studies (7 RCTs; 2 prospective cohorts; 1 cross-sectional study) for maternal adverse effects • 2 studies (both cross-sectional studies) for use of neuraxial (e.g. epidural) anesthesia

Evidence from additional sources

No additional evidence sources were included in this review. A MEDLINE® (Ovid) search based on the search strategy of the AHRQ SR did not locate any additional eligible studies.

EVIDENCE SUMMARY

The AHRQ SR (Likis, 2012) included a total of 59 studies reported in 58 publications (13 RCTs, 7 crossover RCTs, 4 non-randomized clinical trials, 14 prospective cohorts, 1 retrospective cohorts, 3 case series, 4 case-control studies, 11 cross sectional studies, and 2 trend studies) to answer five key questions on the following issues: 1) effectiveness for pain (21 studies); 2) comparative effectiveness for women’s satisfaction with their birth experience and pain management (9 studies); 3) effect on mode of birth (6 studies); 4) maternal and fetal/neonatal adverse effects (49 studies); and 5) health system factors influencing the use of nitrous oxide (no studies). Key Questions 2, 3 and 4 are directly applicable to this coverage guidance.

Most of the studies in the full AHRQ SR included comparator interventions that are not of interest for this guidance (comparators included other inhaled anesthetic gasses, most of which are not used in the U.S., alternative concentrations of N2O; parenteral opioids and non-pharmacologic techniques not widely available or used in the U.S.). Many of the studies used different concentrations of N2O compared to the 50% N2O/50% oxygen mix that is used in most labor and delivery settings in countries such as the United Kingdom (U.K.) and which is the concentration used in U.S. settings that have

adopted it for obstetric use. Most included studies did not report on populations or outcomes of interest for this guidance (e.g. pain scores, occupationally exposed workers). Some populations of interest (e.g. women in the third stage of labor requiring procedural analgesia such as for manual placental removal) were not explicitly included among the studies identified in the AHRQ SR. No study directly addressed or was designed to address whether use of N2O reduces the use of neuraxial (e.g. epidural) analgesia; we were only able to address this outcome descriptively. None of the included studies that did address the questions of interest for this evidence review were conducted in the U.S., although all were conducted in developed countries with modern maternity care systems. However, differences in health systems, provider training, hospital routines and patient expectations may limit the applicability of these studies to the U.S. context.

Although pain was not selected as a key outcome for this guidance, for background context, the AHRQ SR found that N2O is less effective than epidural anesthesia for measures of pain in labor, but that the evidence was insufficient to determine the effectiveness compared with other, non-epidural pain management interventions. The studies are limited because of poor quality, use of varying outcome measures, and inconsistency. The review found no studies that met inclusion criteria and studied the systems factors related to using N2O for management of labor pain, including provider preferences, availability, settings and resource utilization.

Critical Outcome: Fetal/neonatal adverse effects

The AHRQ SR (Likis, 2012) noted that while 49 studies reported on maternal, fetal, neonatal, or occupational harms associated with N2O use in labor, that 16 of these were conducted prior to 1980 when it was usual practice to combine N2O with other sedative, tranquilizing and anesthetic agents. Although N2O is transmitted via the placenta to the fetus, it is also quickly eliminated via maternal circulation and neonatal respiration. Twenty-nine studies included fetal or neonatal harms as outcomes. The SR found no significant differences between any comparison groups in Apgar scores at either one or five minutes after birth. Eight studies reported umbilical cord blood gasses. There was one study that compared infants of women using 50% N2O/50% oxygen to epidural anesthesia. It found that 7% of the N2O group had Apgar scores less than or equal to seven at one minute after birth compared to 6% of infants of women who used epidurals. At five minutes, the proportions with low Apgar scores were 1% and 4%, respectively (p values not reported). There was a statistically significant finding in one study of lower arterial cord blood gasses among infants of primiparous women who used N2O plus meperidine (a parenteral opioid) compared to those who used an epidural (pH 7.21 vs. pH 7.29, p<0.01). Use of meperidine alone has been associated with lower umbilical cord gasses and so it is not clear whether this finding can be attributed to N2O use or only to use of meperidine. The AHRQ SR was unable to analyze neonatal intensive care unit admission because of the varying definitions of intensive care across countries and lack of reporting of this outcome.

Only one study included in the AHRQ SR compared neonatal neurobehavioral outcomes among infants of women using N2O and who used other methods of labor pain management, including epidurals, opioids, TENS, and non-pharmacologic methods. This study reported no significant differences between groups in neonatal adaptive capacity scores (NACS).

Critical Outcome: Mode of birth

Six studies in the AHRQ review compared the mode of birth among women who used N2O to women who used other methods of pain relief and determined that there was insufficient evidence, primarily due to poor quality studies and inconsistent results. However, only three studies compared the intervention and comparator of interest for this guidance. One prospective cohort study from Ireland, published in 1987, enrolled primiparous women in an academic hospital. Twenty women used N2O and 50 women used epidural anesthesia. Other comparison groups in the study used TENS or parenteral opioids. Another prospective cohort study from Finland, published in 1994, included 210 women (27% primiparas) using N2O and 82 women (71% primiparas) using epidural anesthesia. This study also found higher rates of vaginal birth among women using N2O. No analysis of the results by parity was provided in the AHRQ SR. These two studies found the following proportions of women with vaginal, assisted vaginal (vacuum or forceps), Cesarean, or vaginal breech births as described in Table 2 below. No statistical testing of differences between pain management groups were reported in either study.

Table 2. Mode of Birth According to Pain Management Approach

Mode of Birth	Nitrous Oxide*	Epidural*
Vaginal	60%/95%	26%/80%
Assisted	35%/2%	62%/11%
Cesarean	0%/3%	6%/9%
Breech	5%/NR	6%/NR

NR: not reported

* The first percentage in each cell represents the Irish study and the second percentage is from the Finnish study.

One cross sectional study conducted in the U.K. and published in 1982 also reported the mode of birth. This U.K.-based study included women (51.4% primiparous) who had vaginal births and found that women who used N2O (n=128) were more likely to have a spontaneous vaginal birth and less likely to have an assisted vaginal birth compared with women who used epidural anesthesia (n=423) or women who used an epidural and N2O together (n=38). Proportions who had a vaginal birth for each of these three groups were 93.7%, 48.7%, and 60.5% and for assisted vaginal birth the proportions were 6.3%, 51.3%, and 39.5%.

Consistent with reported mode of birth outcomes, three of these studies (two prospective cohort studies and one cross sectional study) also reported shorter duration of labor for women in the N2O groups compared to the epidural groups. The reported duration of labor in the N2O groups ranged from a mean of 5.2 hours +/- 1.7 (standard deviation [S.D.]) to 6.7 +/- 3.0 hours. The reported range among women using epidural anesthesia was 7.7 +/- 2.4 hour to 10.8 +/- 4.9 hours.

Important Outcome: Maternal adverse effects

Most harms reported by studies included in the AHRQ SR were unpleasant side effects of N2O such as nausea, vomiting, dizziness and drowsiness. Some commonly reported adverse effect outcomes (e.g.

nausea and oxygen desaturation) are reported often among women in labor regardless of pain management strategies used. Studies did not have adequate power to detect rare outcomes. Eight studies of women receiving N2O as the sole pain management agent report rates of nausea from 0% to 28%. Four of these studies also reported vomiting with a range of 0% to 14%. Four studies of women using N2O as the sole analgesia agent reported dizziness or lightheadedness, with rates ranging from 3% to 23%. Four studies reported drowsiness or sleepiness with sole use of N2O and proportions ranged from 0% to 67%.

Important Outcome: Maternal satisfaction

Nine studies in the AHRQ SR evaluated women's satisfaction with their birth experience or pain management, although most were of poor quality and reported varying outcome measures, making it difficult to synthesize results. However, the AHRQ authors concluded that there was low strength of evidence to support the equivalence or superiority of N2O relative to maternal satisfaction outcomes. Among the three studies that specifically evaluated use of 50% N2O / 50% oxygen compared with epidural anesthesia, two studies (two prospective cohorts) evaluated women's satisfaction with labor pain management at various points in time between one hour and three days post-delivery. They both reported that women who used N2O were somewhat less satisfied with the adequacy of pain relief for N2O compared to epidural anesthesia. Satisfaction scores ranged from 60% to 90% for the N2O group and 98% to 100% for the epidural group in the prospective cohort study. Because N2O is not assumed or designed to achieve the same degree of pain relief as epidural anesthesia this is not considered by the AHRQ researchers to be as robust of an outcomes as is women's assessment of whether they would use the method again. One prospective cohort study conducted in Ireland found that 80% of women who used N2O would request the method again in a subsequent pregnancy compared with 88% of women who used an epidural. In a cross-sectional study performed in Sweden that evaluated this outcome, 69.9% of women who used N2O would request it in another pregnancy compared to 45.3% of women who used an epidural.

Important Outcome: Use of neuraxial analgesia in labor

The AHRQ SR did not report on this outcome. However, the two cross sectional studies (one from the U.K. and one from Sweden) that reported outcomes for groups of women choosing N2O and epidural anesthesia, respectively, do give some information on the methods that women choose when both choices are freely available. The U.K. based study, published in 1982, included only women who had a vaginal birth and approximately half were primiparous. Of 1000 women, about 13% used N2O, 42% used epidurals, and 4% used both methods. Other methods used in this study included parenteral opioids, pudendal or regional anesthetic blocks, no pharmacologic pain management, and combinations of these methods. The Swedish cross-sectional study, published in 1996, gathered data on women who had used N2O, epidural, local anesthesia, acupuncture, hydrotherapy, and breathing techniques as their primary pain management technique. About 79% of women used N2O and 34% used epidural (categories were not mutually exclusive and thus some women who started with N2O may have also used epidurals or other techniques).

OTHER DECISION FACTORS

Resource Allocation

The cost of N2O for labor is low (\$15 to \$100 per patient). The major cost is for the delivery equipment, which is borne by the facility or provider. The costs of the comparator intervention are relatively high (\$1,050 to \$2,400 per patient per epidural in the Portland metropolitan area). Use of N2O is associated with lower rates of assisted vaginal birth and cesarean delivery which would potentially result in significantly lower intrapartum costs. For some women who use both N2O and an epidural during the same labor, anesthesia costs of care could increase over use of an epidural alone. However, this combination may still result in higher vaginal birth rates and thus lower total costs of care. The literature review found that the length of labor was consistently shorter (about 2 to 4 hours shorter) among women using N2O analgesia compared to women using epidural anesthesia such that increased use of N2O may also result in somewhat shorter length of stay on labor and delivery units.

Values and preferences

Some women and clinicians have a strong preference to avoid or delay neuraxial anesthesia and would potentially desire an intervention that may decrease their risk of assisted vaginal delivery or cesarean section. If N2O were available in Oregon facilities, many women would likely try it. Most women would not be concerned about potential harms because there do not appear to be adverse fetal/neonatal harms and women who experience adverse effects themselves can stop using N2O and their symptoms would resolve. Its quick onset would also be desired by women who are waiting for an epidural in labor and who would use it as a bridging technology. However, other women may strongly prefer neuraxial anesthesia (epidural) because of its greater effect in reducing labor pain, so the net assessment is that values and preferences would be highly variable.

Other considerations

There is currently no specific CPT code for N2O use in labor except for an anesthesia-specific code. Benefit plans may need to consider alternative payment methodologies and/or innovative mechanisms to encourage use by providers. Facilities and clinicians may have to invest in equipment and staff training to implement N2O for labor pain. Facilities may experience shorter length of stay on labor and delivery units with increased use of N2O that may result in higher bed availability and/or decreased staffing needs in some hospitals.

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DRAFT

GRADE-INFORMED FRAMEWORK

The HERC develops recommendations by using the concepts of the Grading of Recommendations Assessment, Development and Evaluation (GRADE) system. GRADE is a transparent and structured process for developing and presenting evidence and for carrying out the steps involved in developing recommendations. There are several elements that determine the strength of a recommendation, as listed in the table below. The HERC reviews the evidence and makes an assessment of each element, which in turn is used to develop the recommendations presented in the coverage guidance box. Estimates of effect are derived from the evidence presented in this document. The level of confidence in the estimate is determined by the Commission based on assessment of two independent reviewers from the Center for Evidence-based Policy. Unless otherwise noted, estimated resource allocation, values and preferences, and other considerations are assessments of the Commission.

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ Confidence in Estimate	Resource allocation	Values and Preferences	Other considerations
Fetal/neonatal adverse effects <i>(Critical outcome)</i>	No significant differences in Apgar scores at 1 and 5 minutes, or umbilical cord gasses after birth when maternal N2O is compared to epidural anesthesia use. ●●●○ <i>(Moderate certainty, based on multiple RCTs and other studies with consistent findings)</i>	Use of N2O is likely to be cost-saving compared to epidural anesthesia. The cost of N2O is low. Use of N2O is associated with lower rates of assisted vaginal birth and cesarean delivery, and shorter length of stay on labor and delivery units.	High variability: Some women would want this additional option because of the reduced risk of caesarean section or assisted delivery. Concerns about harms would be mitigated because they could easily discontinue it and	There is no specific CPT code for this service, other than an anesthesia code, so reimbursement to providers may require use of a non-specific code that may require manual review.

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ <i>Confidence in Estimate</i>	Resource allocation	Values and Preferences	Other considerations
Mode of birth <i>(Critical outcome)</i>	15 to 34 more women per 100 are likely to have a vaginal birth when using N2O compared to those using epidural anesthesia for labor pain. 9 to 27 fewer women per 100 would experience assisted vaginal (forceps/vacuum) birth, and there would be about 6 fewer Cesarean births per 100. ●●○○ <i>(Low certainty based on prospective cohort and cross sectional studies with consistent findings)</i>		consider an epidural if adverse events occur or if analgesia is insufficient. Other women may prefer epidural anesthesia because of its greater effect in reducing labor pain.	
Maternal adverse effects <i>(Important outcome)</i>	Women may experience unpleasant side effects when using N2O. Nausea (0-28%), vomiting (0-14%), dizziness/lightheadedness (3-23%), and drowsiness/sleepiness (0-67%) were commonly reported side effects. Effects dissipated quickly when N2O use is stopped. ●●●○ <i>(Moderate certainty based on multiple RCTs and other studies with consistent findings)</i>			
Maternal satisfaction <i>(Important outcome)</i>	70 to 80% of women who used N2O said they would want to use it in a subsequent pregnancy compared to 45 to 88% of women who would request an epidural again. ●●○○ <i>(Low certainty based on prospective cohort and cross-sectional studies with consistent findings)</i>			

Coverage question: Should nitrous oxide (50% N2O) be recommended for coverage for labor pain management?				
Outcomes	Estimate of Effect for Outcome/ <i>Confidence in Estimate</i>	Resource allocation	Values and Preferences	Other considerations
Use of neuraxial (e.g., epidural) anesthesia <i>(Important outcome)</i>	When multiple pain management methods are available for women 13% to 79% will use N2O, compared to 34 to 42% who will select epidural anesthesia. There is no direct evidence on whether use of N2O changes the use of neuraxial anesthesia. ●○○○ (<i>Very low certainty based on cross-sectional studies with consistent findings</i>)			
Rationale: On balance, there are potential benefits to the use of N2O and no serious harms to its use. Costs are low and variable maternal preferences argue for increased availability of N2O for management of labor pain. Coverage is recommended because of the potential benefits of fewer cesarean and assisted deliveries, the lack of significant harms, maternal preferences, and low costs. The recommendation is a weak recommendation because there are few studies available for benefit outcomes, and the external validity of the data and its applicability in U.S. settings is limited. The confidence in the quality of evidence for most outcomes is low to moderate certainty.				
Recommendation: Nitrous oxide for labor pain is recommended for coverage (<i>weak recommendation</i>).				

Note: GRADE framework elements are described in Appendix A

POLICY LANDSCAPE

Quality measures

No quality measures related to the use of nitrous oxide during labor were identified when searching the [National Quality Measures Clearinghouse](#).

Payer coverage policies

No public or private payer coverage policies¹ were identified for the use of nitrous oxide during labor.

Professional society guidelines

The National Institute for Health and Care Excellence (NICE) found there to be moderate evidence of benefit for the use of nitrous oxide during labor (NICE, 2014). The guideline notes that nitrous oxide can cause nausea and light-headedness for the mother. NICE did not find any evidence of harm to the baby. The use of 50:50 mixture oxygen and nitrous oxide is recommended to be available in all birth settings in the United Kingdom.

The American College of Nurse-Midwives (ACNM) has a Position Statement that supports the increased availability and use of nitrous oxide analgesia (ACNM, 2011).

Coverage guidance is prepared by the Health Evidence Review Commission (HERC), HERC staff, and subcommittee members. The evidence summary is prepared by the Center for Evidence-based Policy at Oregon Health & Science University (the Center). This document is intended to guide public and private purchasers in Oregon in making informed decisions about health care services.

The Center is not engaged in rendering any clinical, legal, business or other professional advice. The statements in this document do not represent official policy positions of the Center. Researchers involved in preparing this document have no affiliations or financial involvement that conflict with material presented in this document.

¹ Washington Medicaid, Aetna, Cigna, Regence Blue Cross Blue Shield, and Moda

APPENDIX A. GRADE INFORMED FRAMEWORK - ELEMENT DESCRIPTIONS

Element	Description
Balance between desirable and undesirable effects	The larger the difference between the desirable and undesirable effects, the higher the likelihood that a strong recommendation is warranted. The narrower the gradient, the higher the likelihood that a weak recommendation is warranted
Quality of evidence	The higher the quality of evidence, the higher the likelihood that a strong recommendation is warranted
Resource allocation	The higher the costs of an intervention—that is, the greater the resources consumed—the lower the likelihood that a strong recommendation is warranted
Values and preferences	The more values and preferences vary, or the greater the uncertainty in values and preferences, the higher the likelihood that a weak recommendation is warranted
Other considerations	Other considerations include issue about the implementation and operationalization of the technology or intervention in health systems and practices within Oregon.

Confidence in the quality of the evidence, across studies, about an outcome

High: The subcommittee is very confident that the true effect lies close to that of the estimate of the effect. Typical sets of studies are RCTs with few or no limitations and the estimate of effect is likely stable.

Moderate: The subcommittee is moderately confident in the effect estimate: The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Typical sets of studies are RCTs with some limitations or well-performed nonrandomized studies with additional strengths that guard against potential bias and have large estimates of effects.

Low: The subcommittee's confidence in the effect estimate is limited: The true effect may be substantially different from the estimate of the effect. Typical sets of studies are RCTs with serious limitations or nonrandomized studies without special strengths.

Very low: The subcommittee has very little confidence in the effect estimate: The true effect is likely to be substantially different from the estimate of effect. Typical sets of studies are nonrandomized studies with serious limitations or inconsistent results across studies.

Strong recommendation

In Favor: The subcommittee is confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences.

Against: The subcommittee is confident that the undesirable effects of adherence to a recommendation outweigh the desirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences.

Weak recommendation

In Favor: The subcommittee concludes that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences, but is not confident.

Against: The subcommittee concludes that the undesirable effects of adherence to a recommendation probably outweigh the desirable effects, considering the quality of evidence, cost and resource allocation, and values and preferences, but is not confident.

DRAFT

APPENDIX B. METHODS

Scope Statement

Populations

Pregnant women intending a vaginal birth in the first and second stages of labor and their fetus/neonate, women in the third stage of labor or immediate postpartum period

Population scoping notes: *Exclude women planning a Cesarean birth*

Interventions

Self-administered nitrous oxide used for labor analgesia or third stage/immediate postpartum management

Intervention exclusions: *Concentration of nitrous oxide blended with oxygen for analgesia other than 50%; non-self-administration of nitrous oxide*

Comparators

Neuraxial analgesia (e.g. epidural, combined spinal/epidural)

Outcomes

Critical: Mode of birth; Fetal/neonatal adverse effects (e.g. low Apgar score, low cord blood gasses)

Important: Maternal adverse effects (e.g. nausea/vomiting, dizziness, loss of consciousness); Use of neuraxial (e.g. epidural) analgesia; Maternal satisfaction

Considered but not selected for the GRADE table: Use of non-neuraxial analgesia

Key Questions

KQ1: What are the effects on mode of birth, use of neuraxial (e.g. epidural) analgesia and maternal satisfaction when nitrous oxide is used for labor analgesia?

KQ2: What are the maternal and fetal/neonatal harms of nitrous oxide used for labor pain?

Search Strategy

A full search of the core sources was conducted to identify systematic reviews, meta-analyses, technology assessments, and clinical practice guidelines using the terms “nitrous oxide,” and “labor pain management.” Searches of core sources were limited to citations published after 2004.

The core sources searched included:

- Agency for Healthcare Research and Quality (AHRQ)
- Blue Cross/Blue Shield Health Technology Assessment (HTA) program
- BMJ Clinical Evidence
- Canadian Agency for Drugs and Technologies in Health (CADTH)

Cochrane Library (Wiley Interscience)
Hayes, Inc.
Institute for Clinical and Economic Review (ICER)
Medicaid Evidence-based Decisions Project (MED)
National Institute for Health and Care Excellence (NICE)
Tufts Cost-effectiveness Analysis Registry
Veterans Administration Evidence-based Synthesis Program (ESP)
Washington State Health Technology Assessment Program

Based on this initial search, the AHRQ report (Lakis, 2012) was selected as the index systematic review.

We also identified another good quality SR from the Cochrane Collaboration in the core source search. The Cochrane SR (Klomp, 2012) included four RCTs that were not included in the AHRQ SR. They were excluded from the AHRQ SR because they were not published in English. In total, five RCTs in the Cochrane SR, compared varying or unspecified concentrations of N2O to oxygen alone or no treatment. Only one of these RCTs evaluated the comparison, relevant to this coverage guidance, of 50% N2O/50% oxygen with epidural anesthesia. This RCT also included a no treatment control group. The Cochrane SR did not present outcomes for the comparison of N2O vs. epidural groups, but only the comparison of the N2O and no treatment groups. We were unable to incorporate the results of the N2O vs. epidural comparison to this evidence report due to this RCT being published in Chinese.

A MEDLINE® (Ovid) search was then conducted to identify systematic reviews, meta-analyses, and technology assessments published after the search dates of the AHRQ report (Lakis, 2012). The search was limited to publications in English published after 2010 (the end search date for the AHRQ SR).

Searches for clinical practice guidelines were limited to those published since 2010. A search for relevant clinical practice guidelines was also conducted, using the following sources:

Australian Government National Health and Medical Research Council (NHMRC)
Centers for Disease Control and Prevention (CDC) – Community Preventive Services
Choosing Wisely
Institute for Clinical Systems Improvement (ICSI)
National Guidelines Clearinghouse
New Zealand Guidelines Group
NICE
Scottish Intercollegiate Guidelines Network (SIGN)
United States Preventive Services Task Force (USPSTF)
Veterans Administration/Department of Defense (VA/DOD)

Inclusion/Exclusion Criteria

Studies were excluded if they were not published in English, did not address the scope statement, or were study designs other than systematic reviews, meta-analyses, technology assessments, or clinical practice guidelines.

APPENDIX C. GRADE EVIDENCE PROFILE

Quality Assessment (Confidence in Estimate of Effect)							
No. of Studies	Study Design(s)	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Factors	Quality
Fetal/Neonatal Adverse Effects (Apgar scores, Cord gasses)¹							
14	5 RCTs; 8 Prospective cohorts; 1 Case-series	High	Consistent	Direct	Imprecise	None	Moderate confidence in estimate of effect ●●●○
Mode of Birth³							
3	2 Prospective cohort; 1 Cross-sectional	High	Consistent	Direct	Imprecise	Moderate magnitude of effect and some evidence of dose-response relationship	Low confidence in estimate of effect ●●○○
Maternal Adverse Effects (Nausea, Vomiting, Dizziness/Lightheadedness, Drowsiness/Sleepiness)²							
10	7 RCTs; 2 Prospective cohorts; 1 Cross-sectional	High	Consistent	Direct	Imprecise	None	Moderate confidence in estimate of effect ●●●○
Maternal Satisfaction³							
4	2 Prospective cohort; 2 Cross-sectional	High	Consistent	Direct	Imprecise	None	Low confidence in estimate of effect ●●○○

Quality Assessment (Confidence in Estimate of Effect)							
No. of Studies	Study Design(s)	Risk of Bias	Inconsistency	Indirectness	Imprecision	Other Factors	Quality
Use of Neuraxial Anesthesia³							
2	2 Cross-sectional	High	Consistent	Indirect	Imprecise	None	Very low confidence in estimate of effect (●○○○)

¹Studies from Tables 9, 10, 11 (AHRQ, 2012). Strength of evidence assessment based on AHRQ SR, Table 12 (AHRQ, 2012).

²Studies from Table 8 (AHRQ, 2012). Strength of evidence assessment based on AHRQ SR, Table 12 (AHRQ, 2012).

³Studies for benefit outcomes selected from AHRQ SR based on HERC review PICO only (neuraxial anesthesia comparator studies only) (AHRQ, 2012). Strength of evidence based on risk of bias assessments included for individual studies in AHRQ SR, Table 6 (AHRQ, 2012) and assessment of other GRADE elements by staff.

DRAFT

APPENDIX D. APPLICABLE CODES

CODES	DESCRIPTION
ICD-9 Diagnosis Codes	
ICD-10 Diagnosis Codes	
ICD-9 Volume 3 (Procedure Codes)	
CPT Codes	
HCPCS Level II Codes	

Note: Inclusion on this list does not guarantee coverage

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
September 14, 2015 11:00 a.m. – 12:30 p.m.

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

Standardization of the Traditional Health Workers in Oregon's Coordinated care System

Session Objectives

Participants will:

- 1) Be able to describe the health outcomes of OHP members who work directly with Traditional Health Worker in Oregon's health systems transformation.
- 2) Identify and discuss promising practices in the CCO Traditional Health Worker models.
- 3) Reflect on opportunities to standardize data collection and reporting of Traditional Health Workers.

1. Introductions and reflection (Summer Boslaugh, Andy Luther, MD, Ty Schwoeffermann) (5 minutes)

2. Presentation: What can we learn from the data collected by the Traditional Health Worker needs assessment? (Kristi Manseth, PhD) (10 minutes)

Kristi Manseth, PhD is the Research Director at Pacific Research and Evaluation and has been the project manager for the Traditional Health Worker Needs Assessment in partnership with Rogue Community College over the past 6 months. She earned her doctorate in Industrial Organizational Psychology from Portland State University in June of 2009, specializes in organizational development, assessment and evaluation, and has several years of experience conducting organizational needs assessments and training evaluations in organizations.

3. Panel discussion: Promising practices of CCO Traditional Health Worker Models (Facilitator: Ron Stock) (40 minutes)

- **Primary Health of Josephine County – Jennifer Johnstun** (*Jennifer Johnstun, Director of Quality, Primary Health of Josephine County*)
- **Health Share of Oregon – Kyna Harris**
Kyna L. Harris is a Project Manager II working on health equity at Health Share of Oregon. Kyna received her Masters of Business Administration from Concordia University in 2007. In 2013, she received her Community Health Worker certification as part of the Urban League of Portland and the Multnomah County Capacitation Center's, "We Are Health Movement African/African-American Community Health Worker Training".

- **Pacific Source Columbia Gorge – Janet Hamada**

Janet Hamada became Executive Director of The Next Door, Inc. (NDI) in September 2007. For 20 years, Janet has managed programs in health promotion, services for youth and community organizing, specializing in working with Community Health Workers. Janet understands that cooperation and collaboration between agencies serving the community is crucial to providing effective, sustainable and affordable services. Janet earned her Bachelor’s Degree in American Studies from Wesleyan University and her Masters in Social Work from the University of Washington.

- **Dental Health Workers –Tony Finch**

Tony Finch, MA, MPH, is the Executive Director of the Oregon Oral Health Coalition. The mission of the statewide coalition is to improve general health through oral health integration for all Oregonians. Finch has a blended background in business, health care, and nonprofit management.

4. Small group discussion – (Facilitator: Ron Stock, MD) (20 minutes)

Groups:

1. Facilitator - Jennifer Jennsen, Community Health Worker, PeaceHealth; presenter – Jennifer Johnstun; recorder – Summer Boslaugh OHA Transformation Center
2. Facilitator – Bianca Fernandez, Community Health Worker, The Next Door; presenter – Janet Hamada, The Next Door; recorder – Ty Schwoeffermann OHA Transformation Center
3. Facilitator – Jesse Remer, Doula, Providence Health; presenter – Tony Finch, Oregon Oral Health Coalition; recorder – Tom Cogswell OHA Transformation Center
4. Facilitator – Shawn Clark, OHA Peer Delivered Services; presenter – Kyna Harris, Health Share of Oregon; recorder – Anastasia Sofranac, OHA Office Equity and Inclusion

Each CCO shares with the group the answers to the following questions:

- a. What is relevant data to collect from the work of THWs in your CCO?
- b. Does your CCO currently collect outcomes data from the THW projects at your CCO? If yes, give examples.
- c. What data collection for the THW workforce would be meaningful across CCOs?

5. Group debrief (Facilitator: Ron Stock) (10 minutes)

- Facilitators share general comments on target interventions and CCO support
- Group to share any other comments, thoughts, barriers

6. Next steps (Summer Boslaugh) (5 minutes)

- a. Announcement – DELTA cohort Anastasia Sofranac OHA Office of Equity and Inclusion
- b. Evaluation

Community Health Workers

- Means a person who has expertise or experience in public health;
 - Works in an urban or rural community, either for pay or as a volunteer in association with a local health care system;
 - To the extent practicable, shares ethnicity, language, socioeconomic status and life experiences with the residents of the community where the worker serves;
 - Assists members of the community to improve their health and increase the capacity of the community to meet the health care needs of its residents and achieve wellness; and residents in receiving the care they need;
 - Provides health education and information that is culturally appropriate to the individual being served;

Peer Support Specialists

- Means a person providing peer delivered services to an individual or family member with similar life experience. A peer support specialist must be:
 - A self-identified person currently or formerly receiving mental health services; or
 - A self-identified person in recovery from an addiction disorder, who meets the abstinence requirements for recovering staff in alcohol and other drug treatment programs; from problem gambling; or
 - A family member of an individual who is a current or former recipient of addictions or mental health services.

Peer Wellness Specialists

- Means an individual who is responsible for assessing mental health service and support needs of the individual's peers. Through:
 - Community outreach;
 - Assisting individuals with access to available services and resources;
 - Addressing barriers to services;
 - Providing education and information about available resources and mental health issues in order to reduce stigmas and discrimination toward consumers of mental health services;
 - To provide direct services to assist individuals in creating and maintaining recovery, health, and wellness.

Personal Health Navigators

- Means an individual who provides information, assistance, tools and support to enable a patient to make the best health care decisions in the patient's particular circumstances and in light of the patient's needs, lifestyle, combination of conditions and desired outcomes.

Birth Doula

- Means a birth companion who provides personal, nonmedical support to women and families throughout a woman's pregnancy, childbirth, and post-partum experience.



Selected Findings from a Statewide Traditional Health Worker Needs Assessment

Needs Assessment Overview

- Background and Primary Objectives
 1. Identify the functions and processes for THWs to determine how they fit into the CCO or primary care model.*
 2. Identify the barriers to integration of THWs into healthcare teams.
 3. Determine how the knowledge and skills of a THW can be integrated into other current employment positions such as medical assistant, certified nursing assistant, and dental assistant.*
 4. Identify the degree to which THWs are integrated into healthcare teams working within Healthy People 2020 areas.*
- Components of Needs Assessment
 1. Statewide Survey (Preliminary results shared today)
 2. CCO Survey
 3. THW Focus Groups

Preliminary Results

- Data are presented for those organizations that are contracted to provide care to a Medicaid or Medicare consumer.

	% Yes	n
All survey participants (n=376)	34.8%	131
Employs THW	61.1%	80
Employs CHW	42.0%	55
Employs PSS	21.4%	28
Employs NAV	13.7%	18
Employs PWS	9.2%	12
Birth Doula	3.1%	4

Functions and Processes (Obj. 1)

Most highly rated tasks (TOP 3) % rating Important/Very Important			
CHW			
		%	n
1	Follow up to referrals	97.8%	43/44
2	Assist clients with transportation needs	92.9%	39/42
3	Case management and coordinating health care needs	91.1%	41/45
PSS			
		%	n
1	Assisting clients with basic life needs such as housing and utilities needs	100.0%	18/18
2	Leading support groups	93.8%	15/16
3	Informal counseling	88.2%	15/17

PWS: Functions and Processes (Obj. 1)

- Most highly rated tasks for PWS
- 100% (n = 4-6) rated the following tasks as Important/Very Important
 - Assisting clients with basic life needs such as housing and utilities needs*
 - Make referrals
 - Case management and coordinating health care needs*
 - Insurance enrollment
 - Leading support groups*
 - Advocacy work

* Indicates overlap with another THW role

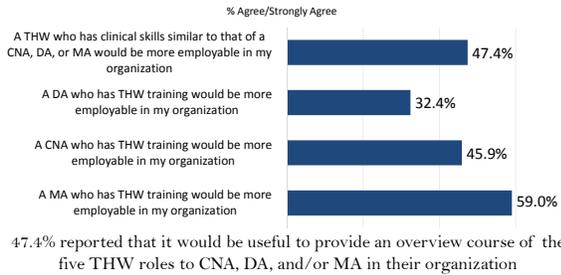
NAV: Functions and Processes (Obj.1)

- Most highly rated tasks for NAV
- 100% (n = 6-7) rated the following tasks as Important/Very Important
 - Assisting clients with basic life needs such as housing and utilities needs*
 - Make referrals*
 - Home visits
 - Assist clients with transportation needs*
 - Follow up to referrals*
 - Assisting with advance directives and end of life care practices
 - Wound care
 - Fall prevention techniques
 - Checking vital signs
 - Basic first aid
 - Mental health first aid
 - Teach classes to children and adolescents
 - Nutrition and exercise programs

* Indicates overlap with another THW role

Integrating the THW Role (Obj. 3)

- Organizations who employ CNAs, DAs, or Mas were asked the following questions (n = 39).



CHW: Populations and Health Areas Served (Obj. 4)

TOP 3 Populations and Health/Disease Areas served by CHWs (n=51)

	Population Served	% (n)	Health/Disease areas served	% (n)
1	Low income populations	43.1% (n=22)	Chronic pain	31.4% (n=16)
2	Rural communities	33.3% (n=17)	Diabetes	27.5% (n=14)
3	Women (pregnant or with child)	29.4% (n=15)	Heart and lung disease	21.6% (n=11)
			Mental health treatment	21.6% (n=11)

PSS: Populations and Health Areas Served (Obj. 4)

TOP 3 Populations and Health/Disease Areas served by PSS (n=24)

	Population Served	% (n)	Health/Disease areas served	% (n)
1	Low income populations*	50.0% (n=12)	Addiction disorders	54.2% (n=13)
2	Rural communities*	25.0% (n=6)	Mental health treatment*	54.2% (n=13)
3	Veterans	25.0% (n=6)	Chronic pain*	20.8% (n=5)

* Indicates overlap with another THW role

PWS: Populations and Health Areas Served (Obj. 4)

TOP 3 Populations and Health/Disease Areas served by PWS (n=9)				
	Population Served	% (n)	Health/Disease areas served	% (n)
1	Low income populations*	44.4% (n=4)	Chronic pain*	55.6% (n=5)
2	Homeless	33.3% (n=3)	Addiction disorders*	44.4% (n=4)
3	Criminal justice system, Rural communities*, Veterans*, Women (pregnant or with child)*	22.2% (n=2)	Mental health treatment*	33.3% (n=3)

* Indicates overlap with another THW role

NAV: Populations and Health Areas Served (Obj. 4)

TOP 3 Populations and Health/Disease Areas served by NAVs (n=13)				
	Population Served	% (n)	Health/Disease areas served	% (n)
1	Low Income Populations*	23.1% (n=3)	Mental health treatment*	23.1% (n=3)
2	Migrant farm workers	15.4% (n=2)	Addiction disorders*	15.4% (n=2)
3	Women (pregnant or with children) *	15.4% (n=2)	Diabetes*	15.4% (n=2)

* Indicates overlap with another THW role

Questions

?

PRIMARYHEALTH OF JOSEPHINE COUNTY

Community Health Worker Pilot

Program Basics

- PrimaryHealth hired our first CHW in May 2013
- PHJC currently supports three FTE for Certified Community Health Workers (CHW)
- The CHW target population has a combination of poorly controlled chronic diseases, complex social/environmental factors, and high (or potentially high) patterns of utilization
- CHW operate out of the health plan office
- Caseload size is about 20
- Services are provided in the home or community setting.

Referral to Community Health Worker

- Referrals to CHW are generated in multiple ways
 - Internal referral from authorizations or case management
 - Community partner or CCO delegate organization
 - PCP or provider referral
 - Analytics (such as ER Utilization Lists or top 1-3% of health plan utilizers)
- Referrals may initially be made verbally, but a referral form is required prior to engagement.

Referral Form

Member name:	Member ID:	Member DOB:
Date of Request:	Referral Source:	
PCCP (PCCP is not Referral Source):	Have outreach activities been discussed with member? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	If yes, in member's interest to outreach services? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Why are you referring this patient? What are the known health related risks to be addressed through outreach?		
What general changes would benefit this member?		
Please List Two Specific Goals you have for this individual.		
1.		
2.		
What interventions have you already attempted for these issues?		
Does member have a history of hypertension, diabetes, tobacco or prior other risks to outreach visit? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> If yes, please specify:		
Chronic condition currently treated: Opioid <input type="checkbox"/> Calcium <input type="checkbox"/> Cold/Flu/Respiratory <input type="checkbox"/> Community Corrections <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Stroke and Disability Services <input type="checkbox"/> Other: _____		
Verbal consultation between the referring caregiver and the outreach specialist is a requirement of our intake process. How would this best be accomplished? Please: <input type="checkbox"/> Member and send time to call. <input type="checkbox"/> Staff present consultation at your office or other location <input type="checkbox"/> Other: _____		
Additional Information:		

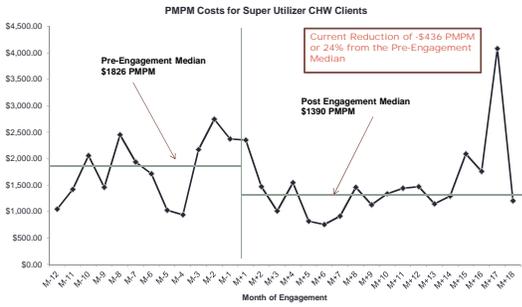
Outcome Data: Why and What

- PrimaryHealth wanted to show that a CHW intervention could have an impact on health plan costs over time.
- Data has been collected for program evaluation purposes (not research).
- PHJC monitors PMPM health plan costs (minus primary care expenses) for members that engage with a CHW for at least 3 months. Costs continue to be monitored even if the intervention with the CHW ends.

Outcome Data: How

- Total costs are collected for 12 months prior to the CHW intervention and every month thereafter.
- Members with low utilization (<\$10,000) are monitored separately from those with high utilization.
- Member data is arranged with the same "0" month for all individuals.
- PMPM costs are calculated with an average of all members eligible that month.
- Pre and Post engagement medians are calculated and compared.

Current CHW Program Data



Oregon Oral Health Coalition

Tony Finch, MA, MPH
 Executive Director
 Oregon Oral Health Coalition
 Tony.Finch@ocdc.net



Oral Health Training for THW/CHW/Promotores

Why engage this workforce?

- Our mission is improve general health through oral health for all Oregonians
- To improve health equity, access, oral health literacy and culturally appropriate services, every level of the workforce should be encouraged to understand and integrate oral and systemic health.

OrOHC's Experience

- First Tooth Training - ECCP
 - Oregon specific training to certify medical providers to receive reimbursement for oral health assessments and prevent treatment (Fluoride Varnish)
 - Non-clinical training – oral health education only for childcare providers, Head Start, community childcare
 - Nearly 4,000 medical/dental providers and childcare providers trained
 - 32 First Tooth Trainers (DCO, CCO, FQHC, County Health Departments)

OrOHC's Experience

- First Tooth Training for migrant and seasonal Head Start
- Piloting Prenatal Oral Health
 - Maternity: Teeth for Two
 - Education and tools for providers and others who engage with mothers during pregnancy
 - Messaging for mothers on the importance of oral health during pregnancy and for the newborn

OrOHC's Experience

- Radiant Smiles Project for K-12
 - Partnered with Oral Health America and Virginia Garcia (FQHC) for a school sealant program in 21 unserved schools in Washington County
- Senior Oral Health Pilot Project
 - Piloting an oral health training for caregivers in Assisted Living Communities (ALC)
 - Collaborating in oral health education for seniors in Senior Community Centers and ALC

Aligning Workforce Training with the Oral Health Strategic Plan

OrOHC facilitated the development of the *Strategic Plan for Oral Health in Oregon: 2015-2020* in collaboration with the OHA and Oral Health Funders Collaborative of Oregon and SW Washington.

Oral Health Training for THW/CHW/Promotores

HB 2024

Authority by rule.

- (2) The Oregon Health Authority, in consultation with coordinated care organizations and dental care organizations in this state, shall adopt rules and procedures for the training and certification of health workers to provide oral disease prevention services and for the reimbursement of oral disease prevention services provided by certified health workers.
- (3) The rules adopted under subsection (2) of this section must prescribe the training required for certification, including instruction on:
 - (a) The performance of dental risk assessments; and
 - (b) The provision of oral disease prevention services.
- (4) The authority shall adopt rules requiring that a certified health worker:
 - (a) Refer patients to dental providers; and
 - (b) Recommend to patients, or to the parent or legal guardian of a patient, that the patient visit a dental provider at least once annually.

Oral Health As An Overarching Theme

Tooth Decay Gum Disease Oral Cancer

How do these 3 oral health issues impact persons in each stage in the life continuum?

Pregnancy Infants and Toddlers K-12 Adults Seniors

Assessment, Education, Referral, and Navigation
to a Medical / Dental Home

Desired Outcomes

Implement the most potent and cost-effective strategies to improve oral health for all Oregonians, while reducing disparities in access and quality.



Health Equity: What is it?

Health equity is attainment of the highest level of health for all people.

Achieving health equity requires **valuing everyone equally** with focused and ongoing societal efforts to

- 1) address avoidable inequalities
- 2) address the **effects of historical and contemporary** socially patterned injustices
- 3) eliminate health disparities



The Department of Health and Human Services

2016 DELTA Structure

- 25 individual cohort members from interdisciplinary backgrounds
- 9-month program with CMEs available
- One *full-day* training per month in various locations throughout Oregon (Jan – Sept)
- National and local trainers and facilitators
- Instruction, group dialogue, small group activities, multimedia, interactive games, etc
- Individual Health Equity Projects
- Evaluation (by & about cohort members)

Applications close Oct 31st



Anastasia Sofranac
 DELTA Coordinator
 OHA - Office of Equity and Inclusion
<http://www.oregon.gov/oha/oei/Pages/DELTA.aspx>
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Anastasia.sofranac@state.or.us

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, call 971-673-1240 or 711 (TTY), or fax 971-673-1128.



Who is this program designed for?

- Community leaders
- Health providers
- Policy makers
- Administrators
- Local health department staff

The project described was supported by Funding Opportunity Number CMS-1G1-12-001 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services and the content provided is solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.



About OHA's Office of Equity and Inclusion

The Office of Equity and Inclusion (OEI) engages and aligns diverse community voices with the Oregon Health Authority to eliminate avoidable health gaps and promote optimal health in Oregon.

For further questions regarding the DELTA program, contact

Anastasia Sofranac
DELTA coordinator

Phone: **971-673-1333**

Fax: **971-673-1128**

Anastasia.Sofranac@state.or.us

Or visit us online at:

www.oregon.gov/oha/oei/Pages/delta.aspx



OFFICE OF EQUITY AND INCLUSION
421 SW Oak St., Suite 750
Portland, OR 97204

OHA 2013 (08/15)

DELTA

Developing Equity Leadership through Training and Action



What is DELTA?

A nine-month professional health equity leadership program with training, coaching and networking for Oregon's health, community and policy leaders. **Eligible for up to 42 CMEs!**



How does the DELTA program address the triple aim?

- Build the capacity and commitment of Oregon's health leaders to eliminate health disparities to increase the quality of care for each individual.
- Assist Oregon health systems in lowering costs through partnerships, collaborative approaches and culturally-competent practices for health equity.
- Increase the availability of care by stimulating leaders to act individually and collectively to address significant challenges and barriers to accessing optimal health in all populations.

The Oregon Health Authority (OHA) works to improve how health care is delivered and paid for. OHA also works to reduce health disparities through OEI to broaden the state's focus on prevention.

How is DELTA delivered?

Local, state and national leaders deliver the trainings in various locations throughout Oregon, depending on the cohort makeup.

Ending health disparities means building the capacity to change systems

After completing the program, graduates:

- Drive equity and inclusion within Oregon's public health and health care systems through individual project work.
- Institutionalize health equity and inclusion strategies in their own health care and public health settings.

When do DELTA sessions occur?

Each cohort meets for one full-day training each month from January to September each year.

How are DELTA cohort members selected?

Applications to join the next DELTA cohort are made available in the fall of each year for the following calendar year. Cohort members are selected based on ability to effect systemic change.



2014 CAHPS Health Plan Survey:
Analysis, and Improvement Strategies

Presented by Rasha Grinstead MS, MPH
Office of Health Analytics
9/14/2015

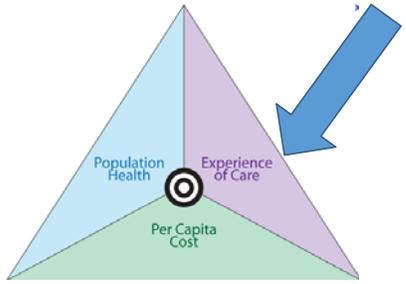


Today

- This is a bullet
- Bullet
- Bullet
 - Bullet
 - Bullet



Part of the Triple Aim

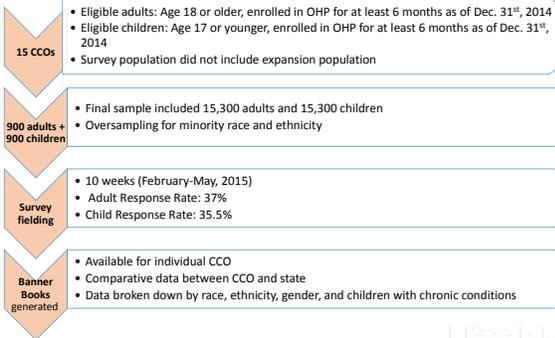


Background

- Tool for organizational change
- Oregon
 - Pilot state
 - Children With Chronic Conditions
 - Dental
 - Multi-lingual reporting
 - Response Rate, Race and Ethnicity breakouts
 - Health Literacy, Cultural Competency Modules
 - Concurrent C&G – PCMH fielding in nearly 40 practices, in three states
 - Enhanced Shared Decision Making and Care Coordination Questions



Methodology



Banner Books

- The banner books are a reference, not a road map.
- Provide standard breakdowns on all questions and the composites and ratings
- Show where there are significant differences within subgroups and the CCO and the state average



Inside the Banner Book

- Brief description of survey
- Response Rate tables
- Measures
- Composites
- Global Ratings
- Comparison of measures & composites to state results
- Breakdown by gender, age, race, ethnicity, health-status, and children with chronic conditions (CCC)
- Survey instruments in English and Spanish



Composite Measures (Adults and Children)

- Getting Needed care **Incentive Measure**
Access to Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Rating Questions **Incentive Measure**
Satisfaction with Care
- Shared Decision Making
- Access to Specialized Services
- Access to Prescription Medicine
- Experience with Personal Doctor
- Coordination of Care (Child Only)
- Family Centered Care: Personal Doctor who Knows Child
- Children with Chronic Conditions **Performance Measure**
- Cultural Competency
- Health Literacy
- Assistance with Smoking Cessation (Adults Only)



Adult







Children

Age

- 25-54 years olds had a harder time accessing needed therapy than those 55 and over.
- Individuals who were 65 and older, reported not having a regular dentist
- 18-24 year olds had a harder time accessing routine care compared to all other adults.

Race/Ethnicity

- Hispanics reported being treated with courtesy and respect by Customer Service less often than non-Hispanics
- Compared to non-Hispanics, parents of Hispanic children got help less often from provider's office getting the therapy their child needed
- Fewer parents of Hispanic children reported that their child's doctor spent enough time with them



Individuals with poor health status

- Adults with poor/fair health status reported less Shared Decision Making in treatment choices with their providers
- Children with poor health status had a harder time accessing treatment or counselling

Children with Special Healthcare Needs

- Compared to children without SHCN, CSHCN had a harder time accessing:
 - needed care, tests, or treatment
 - special medical equipment
 - needed therapy
- Fewer parents of CSHCN reported that their child's doctor was up to date about the care their child receives from other providers

CSHCN had overall poorer mental/emotional health



Identifying System Characteristics Affecting CAHPS measures

- Compare CAHPS data with other sources of information on access and communication/customer service

Example:

- Complaints and Grievances data from OHA
<http://www.oregon.gov/oha/healthplan/Pages/reports.aspx>
- In house customer service complaints and grievances data
- PCPCH data from clinics or other clinic survey data
- Metric Dashboard data
- Community Advisory Council

- Criteria for identifying children with special healthcare needs



- Identifying operational or process characteristics and/or changes within health plan that can impact access

Example:

- What is the patient assignment process for new patients?
- Are pre-visit planning processes used?
- Has the customer service recently undergone training due to organizational change?
- What is the proportion of FQHCs vs. private clinics?
- What kind of EMR system is used?
- Are there provider incentives for things like after hours care?



Success Story! HealthShare Customer Service

- One call resolution strategies: reduced call transfer rate to 17%
- Change in employee behavior to encourage problem-solving skills: Mandatory staff check-in where staff has to recommend solution to issues discussed.
- Enhanced member interaction other than calls: emails, walk-in members who require better understanding of their plans.
- Encouraging new members calls for plan orientation
- Member navigators assist members to navigate plan and establish relationship with PCP.
- Emphasis on organizational prioritization of cultural competency to increase member satisfaction.



For questions

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<http://www.oregon.gov/oha/analytics/Pages/CAHPS.aspx>