HealthInsight OREGON

Statewide PIP on Opioid Safety

Summary of Improvement Strategy Updates, Barriers and Next Steps by CCO

(Based on April 2016 Quarterly Progress Reports)

CCO	Improvement Strategies	Barriers and how they were addressed	Next Steps
AllCare	(From January 2016 report) • **Continued administrative review of all non-cancer opioid prescriptions:** ➢ Opioid MED limit to 90 mg or less (over a 30-day period) for non-cancer pain • **Tracking and Monitoring by pharmacists:** ➢ AllCare clinical pharmacists work with the prescribing provider to taper members on >120 mg ➢ Hired a third clinical pharmacist to identify members who are trending upward on the MED over a 30-day cycle through using MedImpact's data base • **Promotion of non-opioid therapies** ➢ The La Clinica Wellness Program in Jackson County offers alternative supports such as yoga and mindfulness training. ➢ In Josephine County, Cave Junction, AllCare has contracted with Healthy U, a one-stop shop that offers yoga,	• Not listed	• Not listed

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	healthy diet, exercise and stretching classes, mindfulness training. ➢ In Curry County, a registered nurse acts as a liaison between AllCare and the medical community; specifically, to identify community partners that offer alternative treatment modalities. ➢ AllCare is utilizing MedInsight (Milliman software) to identify members diagnosed with low back pain and refer them for physical therapy. • **Community Campaigns:** AllCare will collaborate with Oregon Pain Guidance (OPG) partners (other CCOs, public health departments, hospitals/emergency rooms, and high schools in the communities) to develop a public education campaign. • **Provider education:** AllCare is developing a Provider Education Work Plan that aligns with the OPG. Specific support includes: ➢ outlining available community resources and coordinating identified members to those programs ➢ provide one-on-one support for identified offices under BME investigation ➢ utilizing established protocols, “Get Smart, Don’t Start” on the OPG website and other social media as preventative support and education for prescribing providers ➢ utilizing MedInsight (Milliman software), for early identification providers with worrisome prescribing trends		

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Cascade Health Alliance	• **Pain Committee:** A pain committee consisting of local physical and behavioral health providers, pharmacists, and other members of the CHA team will develop safer and more up-to-date standards of care for chronic pain that can be disseminated and accepted as a community standard. ➢ No action steps this quarter • **Provider outreach:** Modify existing CHA guidelines for management of chronic pain and opioid prescribing to meet the current standard of care. ➢ In Q1 2016, 6 members filled opioid prescriptions >120 mg MED, 4 of which had oncology/end-of-life diagnoses. Letters sent to the 2 remaining members and their providers • **Alternative Treatment Options:** Implement diverse approaches to chronic pain to include cognitive behavioral therapy provided by behavioral health professionals, physical therapy, chiropractic, massage, and acupuncture. ➢ CHA will begin tracking utilization of alternative treatments and of new items to the formulary. • **Existing policies and procedures:** CHA's parent company implemented changes to the formulary and prior authorization processes two years. CHA stated that data	• Data collection has been more of a challenge than anticipated. Intervention implementation was delayed, but not prevented.	• Continue implementation of formulary changes and prior authorization processes • Begin tracking the utilization of alternative treatments and new items added to the formulary • Will conduct a provider survey about the PIP process in June 2016

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	analyses confirms the success of the interventions.		
CPCCO	• Intervention #1: Pain Clinics: CPCCO has expanded its pain clinic model into each of counties served by CPCCO (3 cohorts of graduates in Tillamook County and 2 cohorts of graduates in Columbia County for a total of 119 graduates) • Intervention #2: Changing the prescribing patterns of local providers through clinician education and the cultivation of a shared vision. ➢ Established a target goal of 50mg MED ➢ Developed annual tapering goals, first focusing on the highest risk members ➢ Developing a prior authorization process (target date end of 2018) ➢ Distribute a monthly dashboard and member lists to clinics (data updated quarterly) ➢ Partnering with OHSU to expand medication-assisted treatment within primary care ➢ Clinic Advisory Panel will continue to coordinate and monitor the opioid work and will provide regular progress reports to the community. • Intervention #3: Conducted the North Coast Opioid Summit in April 2016. Participants included representatives from regional clinics, local hospitals, drug courts,	• Difficulty filling available pain clinic openings – CPCCO is working with private insurers to cover pain clinic services for all community members.	• Continue with the pain clinic model, but work on raising community awareness about the service and identifying barriers to member participation • Continue developing or implementing the different strategies listed under Intervention #2 • Evaluate the recent Opioid Summit and make decisions about next steps • Develop outreach strategies to clinics, including a clinic pledge and certification process, provider recognition by CPCCO, and funding of clinic-level pilot projects and programs • Partner with the Public Health Division to lead provider and clinic trainings, including training on the Prescription Drug Monitoring Program.

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	police departments, school staff, and the community.		• CPCCO will host regional quarterly community of practice trainings.
EOCCO	• **Intervention 1: Educate community** ➢ After reviewing data, provider capacity and availability of buprenorphine providers, the Regional Opioid Prescribing Group (ROPG) decided to focus community education in Malheur, Grant, Union, Harney and Umatilla counties. The ROPG will conduct community forums in Hermiston, La Grande, Ontario, and Burns. ➢ The ROPG identified a need for patient resources available to local communities and plans to develop a patient resource library, which could include print materials provided to local libraries, YouTube video library and other electronic resources. • **Intervention 2: Develop "Pain Schools" in EOCCO service area** ➢ No further developments in this area in this quarter. • **Intervention 3: Community Health Worker (CHW) Activities** The ROPG reviewed the EOCCO CHW training program and is developing ways to integrate opioid management into the training.	• Changes in data analytics staffing. EOCCO is working with pharmacy to resolve • Providers lack information and resources needed to manage chronic opioid users. EOCCO, through the ROPG, is developing interventions to address this barrier.	In addition to the next steps discussed under the intervention updates, EOCCO noted that the ROPG will : • Promote the May 2016 pain management conference in Medford, Oregon to the provider network. • Invite Dr. Jim Shames to the June ROPG to discuss the southern Oregon Pain Group program and provider materials. • Recruit a non-physician behaviorist and a physical therapist representative to the ROPG • Distribute alternative pain treatment best practice materials: buprenorphine resources, mind-based resources including a list of regional pain schools, and non-pharmacologic resources. • Internally assess Moda prior authorization processes on buprenorphine due to ROPG recommendations for change requirements.

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	• **Intervention 4: Provider Education** ➢ ROPG is developing four Provider forums, linked with the above described community forums. Based on provider feedback, forum topics include buprenorphine certification training, opioid tapering, and co prescribing opioids and naloxone. ➢ EOCCO will have the following educational presentations at the September 9, 2016 Clinician Summit (presented by peer-to- peer providers): Substance Use Disorder Treatment, Buprenorphine Certification and Prescribing Support, and Changes in Coverage for Treatment of Low Back Pain. The Clinician Summit is open to all EOCCO providers (dental, mental, and medical), staff, and partners and projected to have 100+ attendees. EOCCO is working to get above listed presentations CME accredited. EOCCO is partnering with Union County Center for Human Development to staff a PDMP registration booth for providers to sign up and learn to maximize use. ➢ In March 2016, EOCCO mailed 87 providers lists of members on >120mg MEDD of opioids. Distribution of these lists revealed that providers need best practice information and referral resources in order to act upon lists. Modifications to this intervention will be reviewed under next steps. ➢ EOCCO is tracking buprenorphine rates to demonstrate changing provider		• Consider including data on MEDD prescriptions of >50 and >90 in addition to >120 and to include date on patients prescribed opioids and benzodiazepines.

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	prescribing practices and the effectiveness of provider education		
FamilyCare	• Provider outreach: ➢ Provided specific MED data reports for the entire clinic membership roster to clinic medical directors the CCO's largest clinics beginning in February 2016. Approximately 104 members were identified. ➢ Developing process to integrate a member's concurrent benzodiazepine use into the MED report. Provider notification letters will include a brief synopsis of the issue, useful resources, and a list of provider specific patients that have been prescribe ≥ 90 MED over the last month. • Provider education: ➢ Conducted Part 1 of a 3-part series on alternative pain treatment methodologies. Approximately 50 providers attended. • Engage and evaluate existing comprehensive pain management practices in the community: ➢ Assembled a provider education planning team that includes key community stakeholders. This team will develop education sessions and post-attendance surveys in order to evaluate effectiveness and plan new actions. • On-site visits to top prescribing clinics by medical directors.	• Timing of education sessions: More lead time is needed to effectively market and engage providers. FamilyCare is addressing this barrier by adding an additional one-month lead time to the next session and by promoting the training through a variety of different means. • Non-contracted providers: It is difficult to achieve clinic-oriented outreach when many providers are non-contracted and there is not clinic-affiliation information. FamilyCare is addressing this barrier by having the IT department refine the provider database. Also, the CCO is developing strategies for non-contracted provider outreach.	• Begin sending mail-based notifications to top prescribers, letters will include a brief synopsis of the issue, useful resources, and a list of the prescriber's members that have been prescribed ≥ 90 mg MED over the last month. • Continue providing reports to clinics, adapting elements of the reports to meet individual clinic needs. Also, increase the number of clinics to receive reports. • Continue to offer training on alternative treatment methods. Part 2 is scheduled for 5/13/2016 and Part 3 is scheduled for the end of June. Session content and structure will be modified based on feedback. • Analyze acute prescribing of high dose opioids, focusing on urgent care, emergency department and post-surgical prescribing. Initial data suggests acute prescribing might be more problematic for the CCO

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	➢ No action steps this quarter • Existing interventions: Prior authorization and quantity limits policies and procedures continue to be implemented		• Opioid workgroup will develop a comprehensive program for alternative treatments for chronic pain management. • Continue prior authorization and quantity limits procedures. • Conduct data analyses of metric and interventions to determine effectiveness.
Health Share	Health Share has adopted a Collective Impact Model, which emphasizes achieving improvement through intentionally aligning efforts among diverse organizations rather than imposing a single top-down structure. Below is the Q1 2016 update of the interventions documented in the January 2016 report: **CareOregon** • Technical assistance to "high risk" clinics: ➢ $20,000 scholarship to 11 high prescribing clinics to allow them to send 1 provider champion, 1 behavioral health champion and 1 champion of their choice to 5 Chronic Pain Learning Collaborative sessions between July and October 2016. ➢ Up to $40,000 incentive to clinics for providing status/process/care management data every 6 months and for having clinic behaviorists attend CBT/ACT learning.	• CareOregon ➢ CareOregon had to delay exploring increased access to buprenorphine/naloxone • Providence ➢ Pain Symposium had to be rescheduled to a later date • Tuality ➢ Inadequate reporting from Express Scripts ➢ Poor/limited access to some alternative therapies	• CareOregon ➢ Exploring options on offering additional CME credits in the future ➢ Develop process to increase access to buprenorphine/naloxone ➢ Continue other interventions • Kaiser ➢ Continue interventions • Providence

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	• Expand access to MAT in primary care and specialty addictions settings. ➢ No activity this quarter • Expand access to acupuncture to unlimited services for chronic pain and addiction patients. ➢ Contracted with Working Class Acupuncture to treat 1000+ members ➢ Contracted with Quest and PCA to provide services • Provider education/engagement ➢ Conducted first CME (in partnership with Health Share) in March 2016. Session was filmed and a dissemination process is being developed. **Kaiser Permanente** • Member education/engagement ➢ Developed a standard surgical handout to assist in discussion between providers and members in all surgical specialties. ➢ Distributed handout with CDC guidelines to members in April 2016 ➢ Letters to members on >90 mg MED about developing a taper plan are being sent out every 3 weeks. To date, 502 letters have been mailed. • Provider education/engagement ➢ New opioid starts are reviewed monthly, and recommendations are shared with leadership		➢ Reevaluate Pathways to Treat provider tool in June 2016 ➢ Decrease the number of clinical onsite reviews ➢ Develop a regional case review process ➢ Reschedule Pain Symposium to September 2016 ➢ Continue other interventions • Tuality ➢ Begin analyzing opioid utilization by member, outcomes (utilization and cost) and member demographics ➢ Begin discussions with Pain Management Specialists ➢ Offer case management ➢ Contact members according to an established schedule ➢ Increase collaboration with Health Share and other Health Plan partners regarding new state opioid guidelines ➢ Conduct random urine screens on members on opioids

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	➢ Implementation of taper guidelines: 15% decrease in chronic pain population on opioids > 90 mg MED ➢ Prioritize decrease % of members > 90 mg MED: Metric is reported monthly. 7% decrease in population since February 2016. ▪ Ongoing ➢ 60 mg MED new opioid prescription cap ➢ Each surgical department has developed their own guidelines and standards around prescribing. **Providence** • Member education/engagement ➢ Trial of virtual pain education class April 2016 ➢ Direct member intervention by pharmacist not yet implemented. ➢ Pilot program to provide short course of physical therapy visits is continuing. Providence Rehab saw increased utilization by members with less severe pain. • Provider education/engagement ➢ Pathway to Treat tool continues to be used, but will be reviewed June 2016 ➢ Number of clinic onsite reviews reduced in order to decrease costs. The clinic selection process is to be determined. ➢ Quarterly list of prescribers with members on opioids >120 mg MED		

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	for ≥ 90 consecutive days to be mailed to providers April 2016 ➢ 160 people attended February 2016 CME program ➢ Module on neurophysiology of pain added to employee Internet-based learning center in March 2016 ➢ Provider Pain Symposium rescheduled for September 2016 ➢ Regional Case review of difficult cases process is still being developed • Administrative ➢ Quantity limits for members with a new opioid prescription continue. **Tuality** • Member education/engagement ➢ Mailing to members about titration plan completed by January 2016 ➢ Review terminations of members with pain contracts ➢ Continue to hire staff (QI RN, Care Managers) to improve member engagement • Provider education/engagement ➢ Continue to require pain contract, but in process of reviewing ➢ Continue to identify non-adherent providers ➢ Continue to contact providers about patient issues. • Data ➢ Continue quarterly pharmacy reports on members with high MEDs		

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	➢ Continue to request additional data from Express Scripts • Alternative treatments ➢ Continue to expand alternative treatment provider network, including locations for aqua therapy **Health Share** • Sponsored addictions CME event in March 2016. Attended by 161 people • Convened the Tri-County Opioid Safety Coalition. The group is developing work group structure and priorities.		
IHN	• **Intervention 1:** General public and provider education through the Regional Taskforce and its subcommittees first initiated in August 2015. ➢ **Provider education:** In Quarter #1, 16 Urgent Care providers received education from the IHN Chief Medical Officer, Dr. Ewanchyna; 57 providers were educated through the Regional Taskforce; 8 providers on the Pharmacy & Therapeutics Committee received education; 151 providers attended the CME offering; 20 leaders attended training in managing chronic conditions. ➢ **Public education:** In Quarter #1, 8000 persons were reached through a newspaper article by Dr. Ewanchyna; 70 members received direct education through a class by Dr. Ewanchyna. • **Intervention 2:** Opioid limits:	• **Intervention 1:** None • **Intervention 2:** None	• **Intervention 1:** Maintain interventions • **Interventions 2:** Maintain interventions

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	➢ 87 providers and 964 members were sent letters about the new policy to decrease upper limit of prescription opioid quantities from 360 to 240 cap/tabs per 30 days on oral dosage forms of all formulary opioid products and opioid combination products (not including liquid preparations). • **Intervention 3:** Member education ➢ Pharmacy team will identify members who may need targeted education In Quarter #1, the above intervention had not been implemented.	• **Intervention 3:** IHN has not developed the report to identify the target member population for this intervention.	
JCC	JCC has been working towards reducing chronic opioid prior to the start of the Statewide PIP. Existing interventions include: • Implementing tapering plans for members on chronic doses above 120 MED. • Piloting a Pain Resilience Program (discontinued). • Supporting monthly Oregon Pain Guidance Group meetings. • Providing behavioral health specialist support to top prescribers and clinics. • Holding a weekly Opiate Case Review. **New Interventions:** <u>JCC-specific interventions</u>: • **Intervention 1 (Improve internal data resources)**:		• Continue existing strategies

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	➢ Use additional claims data to identify subgroups of opiate users and refine outreach to providers based on primary characteristics (for example, high numbers of prescribers, depression, addiction.)	• **Intervention 1** ➢ JCC is in the process of reconciling discrepancies between internal and OHA data.	• **Intervention 1** – Adopted. JCC is moving forward with quarterly data updates
	• **Intervention 2 (Outreach and MED policy)** Improve provider engagement and education; increase provider use of bio-psycho-social supports; and improve patient education and safety. ➢ Ambulatory Care Pharmacist met with four different clinics and approximately 18 providers to provide assistance in managing members with chronic pain. As a result, the JCC Pharmacist has received more taper plans. ➢ JCC Pharmacist is developing policies and procedures to help guide CCO opioid work.	• **Intervention 2** ➢ PCPs tend to refer chronic opioid members to pain specialists rather than managing the members' care themselves. This results in fragmented (and decreased quality of) care.	• **Intervention 2 –** Continue quarterly outreach to providers and clinics with the most patients. The JCC Pharmacist will begin several new interventions: incorporating new data into member lists; conduct a retrospective analysis of members identified as achieving MED goal; and providing tapering technical assistance to providers
	<u>Regional Collaborative interventions</u> • **Intervention 3 (Coordination and collaboration between CCOs)** Develop coordinated strategies around community and provider education, treatment modalities and medication-assisted treatment among four CCOs with overlapping membership. ➢ Implementation has not yet started	• **Intervention 3** ➢ Implementation has been delayed due to lack of time, long distances between stakeholder and different operating structures. The group has developed communication plans and decision-making strategies that should mitigate these risks.	• **Intervention 3** – Following development of infrastructure, begin implementing interventions.

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PSCS - CO	• **Intervention #1a**: Promote safer prescribing practices: limit opioid dosing threshold to < 120 mg MED ➢ PSCS is focusing primarily on members on ≥ 120 mg MED for 30 consecutive days or more. ➢ In the process of reconciling internal and OHA data on members on ≥ 120 mg MED in order to better identify target population. ➢ Completed demographic analyses of target population, as well as analyses of members with ≥ 4 providers, and members on buprenorphine/naloxone and buprenorphine HCL. ➢ 14% of providers (200) have signed a letter endorsing opioid reduction. ➢ Conducted a Grand Rounds on MAT in April 2016. ➢ Increase of 16.5% in prescriber accounts in Deschutes County from August 2015 to March 2016 following roll out of Provider Endorsement Letter in December 2015, the Reduce Prescription Drug Abuse Summit in October 2015 and several Grand Rounds (all prior to start of Statewide PIP). • **Intervention #1b**: Promote safer prescribing practices: reduce co-prescribing of opioids and benzodiazepines ➢ A list of members co-prescribed benzodiazepines and opioids is being developed.	• Definition of target population is delayed because the issue of whether or not to include members on buprenorphine has not been decided. • Creation of mailing processes has taken longer than expected due to multiple pre-approval processes and the need to create new processes to accommodate new technology, such as PreManage/Emergency Department Information Exchange (EDIE) for emergency department providers. • Need to collaborate efforts of multiple entities around the PDMP in order to not burden providers with multiple requests for their time.	**Intervention #1**: • Finalize data analysis process and begin distributing accurate lists of members on ≥ 120 mg MED re-generating old reports if revisions are necessary. • Develop process to identify members who are co-prescribed opiates and benzodiazepines. Provide lists of these members to providers on a monthly basis. • Develop new communication processes, including, communication plan with customer services, case management and behavioral health department follow-up, tracking system in collaboration with project manager and process to update the PreManage EDIE system for ED providers. **Intervention #2:** • Conduct PDMP training in May 2016 • Conduct direct education of and assistance to providers • If Deschutes County Health receives grants to improve PDMP usage, new grant hire

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	• **<u>Intervention #2</u>**: Increase PDMP enrollment and usage ➢ Deschutes County Health Department has requested a grant to engage and enroll providers in the PDMP. Award announcement is pending. ➢ Revised the PDMP reporting format from percent of enrolled prescribers to total number of PDMP registered users after consulting with OHA analyst ➢ Continue to implement pharmacy PA process that requires attestation of PDMP enrollment		will work collaboratively with PSCS.
PSCS - CG	**Interventions implemented before the start of the Statewide PIP:** • Persistent Pain Education classes • Implementation of prescription quantity limits, requiring prior authorization (PA) for MED ≥ 120 mg **New interventions**: <u>Q1 2016 Update</u> • **Charter a Pain and Opioid Treatment Work Group in the Gorge**: The Pain and Opioid Treatment (POT) Work Group conducted its first meeting in early February 2016. The group created a charter and a mandate: advise the Clinical Advisory Panel (CAP) and PacificSource on clinical policies or coverage related to opioids and pain, and to disseminate CAP-approved recommendations to providers and to members.	• The POT identified the following as barriers to a successful community strategy: ➢ Limited access to Suboxone prescribers ➢ Limited treatment options for chronic pain members who have "below the line" diagnoses ➢ Competing demands and priorities for PCPs affects participation in workgroup ➢ Strong member resistance to decreasing opioid limits ➢ Providers lack experience with difficult patient conversations • Definition of target population is delayed because the issue of whether or not to include members on buprenorphine has not been decided.	• The POT Work Group will meet monthly and develop interventions in accordance with their charter, including PDMP education and assistance to providers. • Develop process to notify members on ≥ 120 mg MED and their prescribing providers about new policies and procedures. • Develop new communication processes including: communication plan with customer services, case management and behavioral health department follow-up, tracking system in collaboration with project manager, and process to

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	• **Promote safer prescribing practices, including adherence to a ≥ 120 mg MED opiate limit**: In the process of reconciling internal and OHA data on members on ≥ 120 mg MED in order to better identify the target population. ➢ Completed demographic analyses of target population, as well as analyses of members with ≥ 4 providers, and members on buprenorphine/naloxone and buprenorphine HCL. • **Promote safer prescribing practices, including avoidance of polypharmacy**: ➢ List of members taking benzodiazepines is being developed. • **Increase PDMP enrollment and usage** ➢ Develop a PDMP training ➢ Continue to track PDMP data, but modify analyses from percent of prescribers enrolled to total numbers of PDMP registered users. Data will be used to evaluate intervention effectiveness.	• Creation of mailing processes has taken longer than expected due to multiple pre-approval processes and the need to create new processes to accommodate new technology, such as PreManage/EDIE for emergency department providers. • Need to collaborate efforts of multiple entities around the PDMP in order not to burden providers with multiple requests for their time.	update the PreManage EDIE system for ED providers. • Conduct PDMP training in May 2016. • Develop process to identify members who are co-prescribed opiates and benzodiazepines. Provide lists of these members to providers on a monthly basis. • Continue refining data analysis process.
PHJC	For purposes of the Statewide PIP, three local CCOs (PrimaryHealth, Jackson Care Connect, and AllCare) will collaborate on PIP interventions. • **Intervention #1: Community Education Campaign** ➢ Raise public awareness about opiate safety, treatment expectations and treatment modalities for chronic pain.	• Lack of time/busy schedules: It has been difficult to schedule several workgroup and advisory group meetings involving a balance of CCO representatives. A monthly workgroup schedule has been developed that will allow timely sharing of information with the monthly advisory group meeting.	• Since the work of three of the workgroups (provider education, unified roll out of benefit changes, pain review committee) is closely aligned and interconnected, combine the groups into a single work group - “Provider Interface Campaign.”

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	➢ Educate CCO members about treatment options for chronic pain. ➢ Align community and member messages as much as possible. • **Intervention #2**: **Provider Education** ➢ Provide and/or support education to providers about CCO policies, benefit coverage, resources, tools, and best practices. • **Intervention #3: Alternate Therapy Coverage** ➢ Review CCO coverage of different treatment modalities by each CCO, including availability. ➢ Align coverage of treatment options among the regional CCOs. ➢ Identify gaps in coverage and address barriers. ➢ Provide education to providers about options. • **Intervention #4**: **Unified Roll Out of Interventions** ➢ Implement coordinated benefit changes (towards 90 mg MED) ➢ Create consistently worded member notifications, such as NOAs ➢ Share resources, best practices and methodologies around opiate reviews, member identification, vendor strategies, weaning strategies, etc.	• Lack of timely communication: Lack of communication norms affected efficient coordination between the workgroups and the advisory group. This barrier was addressed by the development of agreements around timely sharing of workgroup minutes and internal review of activities prior to promotion outside of the project. • Lack of clarity around charter and scope of work: definition of scope of work for each group (including decision-making and representation) has been time-consuming and delayed further progress. Approval by the advisory group will help the workgroups move forward with work. • Lack of clarity about the relationship between the individual CCO PIP groups and the Oregon Pain Guidance Group. Clarity about the working relationship between the different stakeholders is necessary before work can proceed. The Advisory Committee developed guidelines and agreements, including an agreement that the individual PIP groups would align with OPG when appropriate, but not necessarily on every issue.	• Implementation of benefit changes is tentatively set for October 2016. • Rename the “alternate treatment modalities: work group to the “pain management modalities” workgroup as it shifts the perspective of the work to a more balanced approach to all types of treatment. • Scope of work and strategies have remained the same, but participants in different work groups have changed in order to ensure balanced and appropriate representation. • Formation of an internal PHJC work group to develop program-specific strategies.

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	• **Intervention #4: Pain Committee** ➢ Develop a centralized multi-disciplinary pain review committee to act as a local resource. • **Intervention #5: Medication-Assisted Treatment (MAT)** ➢ Develop consistent policies, coverage, guidelines and expectations of MAT providers among all CCOs ➢ Identify gaps in MAT coverage and address any gaps In the first quarter, none of the above interventions had yet been implemented. The focus of this quarter has been on building the regional infrastructure necessary to implement coordinated strategies.		
TCHP	• **Intervention 1**: Adoption of the CDC Guidelines for Prescribing Opioids for Chronic Pain ➢ Interventions delayed due to changes to the computer systems platform and lack of outreach staff. • **Intervention 2:** Offer and assist with physical therapy or acupuncture access for managing chronic pain. ➢ Teams continue to assist members in accessing other treatment modalities ➢ Trillium is in the process of developing tracking and monitoring tools	• Changes in a new computer systems platform have delayed the ability to identify the study population and distribute identified members to providers. The systems transition is expected to be completed 6/1/2016. • Lack of staffing to perform the additional task of outreach to the identified members has delayed intervention implementation. Care coordination staff workflows are being adjusted. • Tracking and monitoring results not available. Data from Living	• Continue existing interventions • A formal letter of adoption of the guidelines will be sent to the providers and provided in other formats to encourage the new prescribing methods. • An internal team consisting of physical health, and behavioral health medical directors and a pharmacist will manage the outreach campaign in conjunction with provider services. • Study-eligible members will be identified and attempts to

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	• **Intervention 3**: Offer and assist with access to behavioral medicine interventions for managing chronic pain. ➢ Five additional community health clinic sites began regular screening for depression with PHQ-9 ➢ "Our data shows excellent interventions that are extremely individualized for each member, with warm hand off to additional services as needed." • **Intervention 4**: Offer and assist with Living Well with Chronic Pain classes. ➢ Care coordination staff continue to assist members' access these classes. ➢ Tracking and monitoring results due 4/30/2016.	Well with Chronic Pain expected by 4/30/2016.	decrease their opioid dosages will be tracked.
UHA	• The Pain Committee, which includes physical health providers, mental health providers, Medicaid Plan Pharmacist, appropriate staff members, and the Medical Director, continues to monitor opioid policy, guidelines and adherence. • Ongoing prior authorization process • Ongoing implementation of new opioid medication guidelines • Ongoing provision of education and CME • Ongoing case reviews conducted as needed	• The CCO Pain Committee has made a commitment to clear communication to physicians and providers involved in this quality improvement effort. Sometimes to overcome misunderstanding of the intent, it has become necessary for the Committee Chair and CCO Pharmacist to meet one-on-one with the individual provider to clarify the intent in relation to their patient's care. While this might not be considered a barrier, it is an effort to reduce a possible barrier on the part of any understanding or misunderstanding by the provider. The UHA Clinical Pharmacist	• The Pain Committee is focusing on decreasing the numbers of members on opioid prescriptions exceeding 90 mg and their providers, using current strategies.

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	• Ongoing offering of support to those providers and clinics that have large drug-seeking patient populations UHA observed that the data collected over the past several years indicates that the CCO's interventions have resulted in a decreased number of members on opioid medications, including this past month. Current data indicate that UHA is meeting the target it set for decreasing number of members on opioid medications exceeding 90 mg. Current statistical reports reflect that UHA has fewer OHP members on opioid medications during the past month.	reports that the one-on-one meetings are going well.	
WOAH	<u>Workgroups</u> • Since November 2015, Coos Bay and North Bend police departments, law enforcement, physical and mental health providers, addiction treatment providers, public health, WOAH, and community members have been meeting monthly to discuss prescription drug abuse in the community. • Heroin Work Group ➢ Heroin Town Hall meeting is scheduled for May 19, 2016, and discussion will include an update of the group's activities • OHA Back Pain Reorganization Task Force.	• Delay in receiving member-specific data has delayed member and provider outreach efforts • Having multiple stakeholders involved with efforts around opioid prescribing has meant more time spent on ensuring that efforts are not duplicative, competing or confusing.	• Continue NBMC quarterly education events • Continue participation in different task forces and workgroups. • Work with NBMC to present a pain symposium in August 2016 • Develop a process to increase access to naloxone • Implement outreach strategies

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	➢ The WOAH Medical Director attends meetings of the Task Force, which is responsible for setting guidelines on opioid use and payment for alternative treatment modalities. • Opioid Collaborative Group: WOAH is working with AllCare, PrimaryHealth of Josephine County, Jackson Care Connect and the Oregon Pain Guidance group to develop region-wide educational materials, guidelines and prescribing practices. • OHA Opioid Prescribing Task Force ➢ WOAH Director of Pharmacy Services is attending meetings. <u>WOAH interventions</u> • Policy and guidelines ➢ Will contact each member on opioid doses greater than 90 mg MED and their provider to assist with implementing opioid tapers and non-opioid treatments. ➢ Developing a process for increasing access to naloxone. ➢ Implemented formulary changes to allow increased access to non-opioid alternative treatments for chronic pain. • North Bend Medical Center (NBMC), with the support of WOAH: ➢ Continued to conduct quarterly provider education programs open to all providers		• WOAH does not yet have intervention implementation results/data to determine if any of the interventions should be modified, adapted or abandoned.

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	in Coos and Curry counties. The April 5, 2016 event focused on diversion and trends in opioid and illicit drug use. ➢ Will sponsor a pain symposium in spring 2016 • WOAH (Director of Pharmacy and Medical Director) will attend the Jackson County Pain Symposium in 2016 and will promote the symposium to WOAH providers. • Using grant money, public health has hired a staff member to promote utilization of the PDMP and coordinate development and implementation of safe opioid prescribing practices in Coos, Curry, and Josephine counties. ➢ A meeting to discuss next steps is scheduled for April 29, 2016.		
WVCH	• In July 2015, the WVCH Pharmacy Committee approved and adopted the implementation of the following pre-authorization (PA) criteria for new non-cancer related opioid prescriptions over 120 mg per day. ➢ Member must be receiving treatment for an OHP-funded condition ➢ Requested medication must be included on formulary ➢ Member must have tried and failed alternative formulary options ➢ The member must not have a history of suicide attempts in the past two years	• Resistance by some physicians to using a pain contract. WVCH stated that the Pharmacy and Therapeutics Committee will develop strategies to address this barrier.	• Continue the existing interventions

CCO	Improvement Strategies	Barriers and how they were addressed	Next Steps
	➢ Member must have tried and failed medication doses under 120 mg per day ➢ Member must be evaluated by a pain management specialist ➢ Member must have an established pain treatment agreement with provider ➢ The WVCH Medical Director may make exceptions to criteria if medically appropriate. • The WVCH Pharmacy Committee applied the following quantity limits to the formulary: ➢ 6-month taper for long-acting opioids ➢ 2-month taper for short-acting opioids • Removal of pre-authorization criteria for physical and occupational therapy for those members tapering off opioids and receiving an evaluation from pain management specialists. WVCH reported a 3.86% decrease (improvement) in both of the study indicators from baseline to 2016 year-to-date. The CCO attributed the improvement to the implementation of the prior-authorization intervention, citing a 20% decrease in opioid claims from first quarter 2015 to first quarter 2016.		

CCO	Improvement Strategies	Barriers and how they were addressed	Next Steps
YCCO	• **Intervention 1 - Sharing CCO and provider-level trending data.** ➢ 41 members were identified in the first quarter with names and MED level shared with practices to promote awareness. ➢ Trending data is showing an overall decline in the study indicator. As a result of the slow decline, member data will continue to be refined to represent different MED levels for all members receiving chronic opioid prescriptions. • **Intervention 2 - Implementation of community prescribing guidelines/ Provider education on system resources** ➢ YCCO distributed a survey to providers about the new prescribing guidelines, knowledge of persistent pain treatment resources and experience of the YCCO Persistent Pain Program. ➢ Survey results indicated that only 48% of clinics or individual providers had adopted the prescribing guidelines and that almost all of the respondents were familiar with various alternative, non-opioid treatments (and the majority utilized those treatments). ➢ There were fewer respondents (16) to the Pain Program survey, and only half of those indicated that their patients benefited from the program as a whole. • **Intervention 3 - Provider Presentations** ➢ YCCO conducted one-time presentations to promote awareness. YCCO reported that results from the presentations were	• A key barrier that impacted all interventions was the lack of CCO clinical leadership. An interim provider volunteered to help, but had limited time as he also maintained a pediatric practice and is the County Health Officer. A Medical Director for the CCO was hired and will begin work in Q2. • A second barrier that impacted interventions 2 and 3 is lack of provider availability. It is difficult to engage providers who have busy schedules and prioritize patient care.. Scheduling events early morning, lunch hour, and evenings and using in-clinic staff to distribute surveys was the best way to overcome this barrier.	**Intervention 1 - Sharing CCO and provider level trending data – Adapted.** Opioid reporting data will track more than MED levels greater than 120 and include all chronic users with the ability to separate and compare by other thresholds 90, 60, 30 MED **Intervention 2 - Community prescribing guidelines/ Provider education on system resources – Adapted.** YCCO will review and update the prescribing guidelines and develop a comprehensive promotion and dissemination plan. YCCO will survey providers again in 12 months in order to evaluate the effectiveness of planned interventions on provider knowledge and use of chronic pain resources. Also, YCCO will make modifications to the Persistent Pain Program based on the survey results. **Intervention 3 - Provider Presentations – Abandoned.** Additional provider communication and promotion will be done at the annual pain summit and through small group meetings with providers.

CCO	Improvement Strategies	Barriers and how they were addressed	Next Steps
	mostly qualitative (i.e., discussion and feedback from all prescribers – not just primary care) about issues and barriers related to the stopping or limiting opioid prescribing. The feedback will be used to develop future interventions. • **Intervention 4 – Alternative Payment (APM).** In January 2016, YCCO implemented the Alternative Payment Model (APM), where add-on payments of $1 per member per month were given to practices that did not have any members on greater than 120 mg MED for non-cancer pain management. ➢ Eight practices, representing 67% of the YCCO membership, applied and were awarded APM: Strategy 4 dollars. • **Intervention 5 – Community Coordination** ➢ The Opioid Guide Path Committee met twice during the first quarter and discussed law enforcement training and interventions; Naloxone pilot in Adult Behavioral Health; alternative treatments; opioid reduction strategies within ortho/fracture practices; and reviewed current data.		**Intervention 4, Alternative Payment (APM) – Adopted.** YCCO will continue to evaluate APM strategies on a quarterly basis with payments awarded to practices that meet minimum criteria for base and add-on payments.