Quality and Health Outcomes Committee

March 14, 2016

HSB Building Room 137A-D, Salem, OR

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

Parking: Map ◦ Phone: 503-378-5090 x0

Clinical Director Workgroup			
Time	**Topic**	**Owner**	**Related Documents (page#)**
9:00 – 9:15	**Welcome / Introductions** **-Consent Agenda** **-Announcements**	Mark Bradshaw Lynnea Pengelly	-Meeting Minutes *(1 – 14)* -PH Update *(15 – 16)* -BHI RFP for APM Grant Funds *(17)* -National CLAS Standards Webinar *(18)* -CCO BH Directors Meeting *(19 – 28)*
9:15 – 9:20	**Legislative Update**	Brian Nieubuurt	
9:20 – 9:30	**General Updates**	Lisa Bui	-Opioid Prescribing Workgroup -Waiver Renewal Concept *(29 – 32)*
9:30 – 10:00	**HERC Update**	Cat Livingston	-HERC Materials *(33 – 49)*
10:00 – 10:25	**Hepatitis C High Cost Drugs**	Jim Rickards	-CMS Letter Release No. 172 *(50 – 53)* -OHA Hepatitis C Letter *(54 – 55)*
10:25 – 10:30	**EPSDT**	Kim Wentz	
10:30 – 10:35	**April LC Planning for MAT**	Acumentra	- Medication-Assisted Treatment *(56)*
10:35 – 10:50	**Equity and Inclusion Coaches**	Anastasia Sofranac	- Coach Matrix *(57)* - TA Provider Biographies *(58 – 67)*
10:50 – 11:00	**BREAK**		
Learning Collaborative Session			
11:00 – 12:30	**Transgender Health**	Panel	-Agenda (68 – 69) -Presentation slides *(70 – 97)*
12:30 – 1:00	**LUNCH**		
Quality and Performance Improvement Workgroup			
1:00 – 1:10	**Introductions/ Update**	Jennifer Johnstun	
1:10 – 1:20	**Learning Collaborative Topic Brainstorm**	Jennifer Johnstun	
1:20 – 1:40	**Statewide PIP: Opioid**	Acumentra	-Reducing Prescribing of High Morphine Equivalent Doses *(98 – 123)* -Standard 8 Themes *(124 – 125)*
1:40 – 2:45	**3 x 3 Peer Learning**	All	
2:45 – 3:00	**Items from the Floor**	All	
3:00	**Adjourn**		

Upcoming Topics:

- BH Crisis
- Psych meds for kids
- EPSDT

Chair contact info: mark.bradshaw@allcarehealth.com
OHA contact info: lisa.t.bui@state.or.us

MEETING NOTES	Quality & Health Outcomes Committee (QHOC) February 8, 2016 Website: http://www.oregon.gov/oha/healthplan/Pages/CCO-Quality-and-Health-Outcomes-Committee.aspx

Chair- Mark Bradshaw (All Care)

Co-Chair- Jennifer Johnstun (Primary Health)

Attendees: (*in person or by phone*)

Anne Alftine (JCC); Gary Allen (Advantage Dental); Susan Arbor (MAP); Joell Archibald (OHA); Bruce Austin (OHA); Joseph Badolato (FamilyCare); Sarah Bartlemann (OHA); Maggie Bennington-Davis (Health Share); Tara Bergeron (Tuality); Graham Bouldin (Health Share); Stuart Bradley (WVCH); Mark Bradshaw (All Care); Lisa Bui (OHA); Amy Burns (AllCare); Jim Calvert (Cascade Health Alliance); Barbara Carey (Health Share); Christine Castle (CareOregon); Kathy Cereghino (Kaiser); Roger Citron (OHA/HSD); Laurence Colman (GOBHI); Colleen Connolly (Trillium); Eric Davis (JD Health); Linda Fanning (Acumentra); Ruth Galster (UHA); Bennett Garner (FamilyCare); Jim Gaudino (OHSU); Sarah Hallvick (Acumentra); Walter Hardin (Tuality); Rosanne Harksen (OHA), Jenna Harms (Yamhill CCO); Maria Hatcliffe (PacificSource); Theresa Heidt (YCCO); Hank Hickman (OHA); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Bridget Kiene (American Cancer Society); Charmaine Kinney (Mult. Co./Health Share); Safina Koreishi (Columbia Pacific); Lynnea Lindsey-Pengelly (Trillium); Cat Livingston (HERC); Laurie Lockert (HMA); Andrew Luther (OHMS); Laura Matola (All Care); Laura McKeane (AllCare);Sharon Merfeld (Primary Health); Jetta Moriniti (Providence); Tracy Muday (WOAH); Chris Norman (MAP); Nicole Okane (Acumentra); Laureen Oskochil (Acumentra); Paolo Paz (Tuality); Erica Pettigrew (OHSU); Ellen Pinney (OHA); Jordan Rawlins (Moda/EOCCO); Rose Rice (UHA); Belinda Sauer (OHA); Stefan Shearer (YCCO); Cheryl Shen (HealthShare); Jeanene Smith (HMA); Debbie Standridge (UHA); Dayna Steringer (WOAH/Advantage Dental); Anna Stern (WVCH); Steve Stolzoff (GOBHI); Ralph Summers (PacificSource); Priscilla Swanson (Acumentra); Denise Taray (HERC); Jaclyn Testani (CPCCO); Corinne Thayer (ODS); Jennifer Valentine (OHA); Anna Warner (WOAH); Mark

Whitaker (Providence); UZ Winterzak (HealthShare); and Amarissa Wooden (NBMC) **By phone:** Ellen Altman, Kevin Ewanchyna, Lyle Jackson, Jed Taucher, Melinda West, JCC, UHA	
CLINICAL DIRECTORS SESSION	
1. Introductions & Announcements	
Introductions/ Announcements	▪ Introductions were made around the room and from the phone. ▪ This a last chance to be a part of the Back Pain Workgroup. Interested parties need to contact Lisa Bui; ▪ Public Health update includes a "leading causes of death" report.
Review of January Notes	
Behavioral Health Directors Meeting Update- Lynnea Lindsey-Pengelli	January 11, 2016 meeting: ▪ Discussion on need to give regular reports at the QHOC meeting; ▪ Certified Community Behavioral Health Certification (CCBHC) statewide planning process; ▪ Integration of behavioral health; ▪ Psychiatric consultation codes; ▪ Update on USDOJ status; ▪ Applied Behavioral Analysis- multiple concerns about implementation; ▪ Agreement between CCOs when high need youth transfer across CCOs.

Metrics Update- Sarah Bartlemann	▪ The 2015 Mid-year CCO metrics report was published January 20, 2016; ▪ The January dashboard was released January 27th for September 1, 2014 to August 31, 2014. There will not be a February dashboard to allow time to make the conversion to ICD-10; ▪ OHA will be providing quarterly files to CCOs with data from the ALERT immunization registry; ▪ All CCOs have submitted their Year # Data proposals; ▪ PCPCH enrollment update; ▪ Colorectal Roundtable- Wednesday April 20, 2016 9-3 at the Multnomah Athletic Club;
Metrics Targeted TA Prioritization- Anona Gund	During the recent Transformation Center's strategic planning interviews with CCO stakeholders, three metrics were selected to be the focus of conversation on the informal conference calls being held. Each of the three metrics came with challenges. Medical Directors and select attendees voted on those challenges that were of highest priority. The results are: Childhood Immunizations- 1. Missed opportunities to vaccinate (sick visits etc.). 2. Identifying reasons for low rates (clinic level). 3. Sharing rates between providers and CCO. Tobacco Reduction- 1. Patient awareness of cessation benefits. 2. Provider training to treat tobacco dependency.

	3. Identifying or tracking tobacco use. Adolescent well-care visit- 1. Missed opportunities to provide well care visits. 2. Culture shift to value and prioritize annual visits. 3. Leveraging of and coordination with school-based health centers.
P & T Update- Ted Williams	Discussed: ▪ CMS has sent a letter and it is expected that OHA will respond next week; ▪ Materials from P & T are posted on their website with new information on treating Stage II HIV; ▪ Discussed drug and alcohol changes; ▪ Changes to PA criteria; ▪ Clinical changes need to be placed on the QHOC agenda; ▪ Behavioral health input is needed in the P & T committee meeting;
HERC Update- Cat Livingston	Topics discussed at the HERC meeting held January 14, 2016: ▪ Retired three guidelines on the management of back pain; ▪ Discussed code movements; ▪ Nitrous Oxide use for labor pain management; ▪ Indications for Proton beam therapy; ▪ Elective surgery and tobacco cessation; ▪ Digital breast tomosynthesis for breast cancer screening; ▪ Fecal microbiota transplantation for clostridium difficile infection; ▪ Genetic testing to guide use of anti-depressant medications;

	▪ Interventions to reduce the harms of tobacco during pregnancy; ▪ Gastrointestinal motility tests; ▪ Timing of long acting reversible contraceptive placement; ▪ Percutaneous interventions for low back pain; ▪ Sacral nerve stimulation for non-obstructive urinary retention; ▪ Non-invasive testing for liver fibrosis in chronic hepatitis C infection; ▪ Ultrasound-enhanced catheter-directed thrombolysis for pulmonary embolism; ▪ Continuous glucose monitoring in diabetes mellitis- 2015 rescanning summary; ▪ In discussion of dementia/autism, what causes morbidity, traumatic brain injury/mental health had to find treatment.	
Transformation Center: Clinical Innovators Program- Emilee Coulter-Thompson & Dr. Safina Koreishi	▪ Goals and benefits; ▪ 2016-2017 call for applications; ▪ Changes for 2016-17 cohort; Dr. Safina Koreishi shared her experience in this program and encouraged participation. Applications are due by April 15, 2016.	
Clinical Items From the Floor	Jennifer Valentine discussed and provided copies of OHA Accountable Health Communities overview and an MOU Request Form for CMMI AHC	
TOPIC	**DISCUSSION**	**ACTION ITEM(S)**
Back Pain Workgroup	Last chance to join this workgroup	**<u>Action Item:</u>** Contact Lisa Bui if interested.

P & T Update	Discussed the P & T website	**Action item:** Re-send the link to this website.
Other		**Action Item:** Send out Mark Bradshaw's e-mail address
JOINT LEARNING SESSION (1.5 hrs.)		
	Non-Opioid Treatment Options	
Quality and Performance Improvement Session (2.5 hrs.)		
Introductions		
QPI Update and Introductions- Jennifer Johnstun and Lisa Bui	▪ Discussed the PIPs- what measures are the CCOs sronger/weaker on? ▪ Reach out to Tressa Perlicek and Ann Brown about grievances and complaints ▪ Statewide PIP data for February will come out in March EQRO Update: ▪ Onsite visits are occurring; ▪ Looking at compliance and follow-up of last two years of findings. Transformation plans : ▪ QUAPI in March 2016.	
Metrics	The afternoon agenda for today's meeting will be blended. There will be a round table discussion on the following: ▪ Contraceptive ▪ Immunization ▪ Tobacco	

	Attendees broke up into smaller groups to discuss all three topics. In the first break-out, groups discussed what worked and what activities helped to promote results. A spokesperson from each group reported out on this. In the second break-out session, people were asked to mix a bit and discuss the barriers encountered in delivering the metrics. There was another large group discussion with reporting out this information.
Next Meeting	
Monday, March 14, 2016 9:00 am - 3:30 pm *HSB Conference Room 137 A-D* Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: Map Office: 503-378-5090 x0	

MEETING NOTES	Quality & Health Outcomes Committee (QHOC) November 9, 2015 Website: http://www.oregon.gov/oha/healthplan/Pages/CCO-Quality-and-Health-Outcomes-Committee.aspx

Chair- Tracy Muday (WOAH)

Co-Chair- Barbara Carey (Health Share)

Attendees: (*in person or by phone*)

Cynthia Ackerman (AllCare); Anne Alftine (JCC); Susan Arbor (MAP); Joell Archibald (OHA); Bruce Austin (OHA); Joseph Badolato (FamilyCare); Sarah Bartlemann (OHA); Shannon Beatty (Medimmune); Sara Beaudrault (OHA); Amanda Blodgett (CHA); Kim Blood (WVCH); Summer Boslaugh (OHA); Bill Bouska (OHA); Mark Bradshaw (AllCare); Stacy Brubaker (JCC); Lisa Bui (OHA); Mindi Burdick (WVCH); Jim Calvert (Cascade Health Alliance); Barbara Carey (Health Share); Jody Carson (Acumentra); Christine Castle (Metro); Darren Coffman (HERC); Laurence Colman (GOBHI); Joel Daven (UHA); Kristi DePreist (UHA); Trevor Douglass (OHA); Kevin Ewanchyna (IHN/CCO);Wade Fox (CMO); Mike Franz (PacificSource); Ruth Galster (UHA); Bennett Garner (FamilyCare); Jim Gaudino (OHSU); David Geels (WOAH); Sara Hallvik (Acumentra); Walter Hardin (Tuality); Rosanne Harksen (OHA), Jenna Harms (Yamhill CCO); Maria Hatcliffe (PacificSource); Hank Hickman (OHA); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Charmaine Kinney (Mult. Co./Health Share); Cynthia Lacro (EOCCO); Ron Lagergan (FamilyCare); Alison Little (PacificSource); Cat Livingston (HERC); Andrew Luther (OHMS); Laura Matola (AllCare); Sharon Merfeld (OHMS); Ben Messner (WOAH);Crystal Metvas (CareOregon); Jetta Moriniti (Providence); Tracy Muday (WOAH); Chris Norman (MAP); Coleen O'Hare (Trillium); Nicole Okane (Acumentra); Paolo Paz (Tuality); Ellen Pinney (OHA); Jordan Rawlins (Moda/EOCCO); Rose Rice (UHA); Amit Shah (CareOregon); Ellen Singer (Kaiser); Amit Shah (CareOregon); Debbie Standridge (UHA); Dayna Steringer (WOAH/Advantage Dental); Anna Stern (WVCH); Ron Stock (OHA); Steve Stolzoff (GOBHI); Priscilla Swanson (Acumentra); Denise Taray (OHA); Jed Taucher (AllCare);Jaclyn Testani (Columbia Pacific); Corinne Thayer (ODS); Melanie Tong (Washington Co.);

Jennifer Valentine (OHA); Laura Walker (PacificSource); Anna Warner (WOAH); Kim Wentz (OHA); and Mark Whitaker (Providence) **By phone:** Ellen Altman, Lyle Jackson, Lynnea Lindsey-Pengelly, Leslie Clement, Kaiser Permanente	
CLINICAL DIRECTORS SESSION	
1. Introductions & Announcements	
Introductions/ Announcements	▪ Introductions were made in the room, and with those on the phone. ▪ There will not be a December QHOC meeting. ▪ Will need to select a new Chair for this meeting for 2016.
Review of September Notes	Notes from the October QHOC meeting were reviewed and approved.
2. Program Reports (Reports are given by the staff representatives of each program)	
Public Health: Syphilis Screening- Katrina Hedberg	▪ Purpose of presentation; ▪ Rates of early syphilis by sex and year; ▪ Syphilis in women, Oregon, 200-2015; ▪ Congenital syphilis, Oregon, 2000-2015; ▪ Congenital syphilis, case histories; ▪ Self reported risk factors among female early syphilis cases; ▪ CDC, ACOG Prenatal syphilis screening recommendations; ▪ OHA recommendation;

	▪ Most effective step to reduce syphilis transmission; ▪ Rates of early syphilis by year.
Other:	Opioid Performance Project: ▪ Additional information coming; ▪ Statewide Opiate prescribing guidelines. Rhonda Busek introduced Varsha Chauhan as the new Chief Health Systems Officer. Varsha provided some backround information and vision for OHA.
Back Guideline discussion:	Back condition coverage and the Oregon Health Plan: Implementation delay: ▪ Implementation delay; ▪ The approved changes to OHP's coverage for back conditions; ▪ Why did HERC undertake this process? ▪ The history of OHP coverage of treatments for back conditions; ▪ The process for HERC's decision. Resource: HERC website: www.oregon.gov/OHA/OHPR/Pages/HERC/
HERC Update- Cat Livingston:	▪ MRI Guidelines updated- clarification in February; ▪ VbBS: Genetic committee GAP (Genetic Advisory Panel reviewed new genetics CPT codes. This panel is seeking CCO involvement. Contact Cat Livingston if interested; ▪ Pre-conception testing- how to combine with prenatal testing; ▪ There is plenty of panel testing going on; ▪ Looking at language that encourages most cost effective test; ▪ New codes- some are integrated; ▪ Drs. Gary Allen and Alison Little have joined on HERC's committee; ▪ Temporary prostatic stents- on recommended code movement;

	▪ Gender dysphoria guideline changes; ▪ Proton beam therapy guideline changes; ▪ Multi-sector interventions is a new section on the prioritized list.	
TOPIC	**DISCUSSION**	**ACTION ITEM(S)**
Technical Assistance Projects- Acumentra, OHIT, and ORPRN	**Acumentra:** Improving Behavioral Health for Older Adults- ▪ A community-based approach; ▪ Goals; ▪ Key strategies and interventions; **OHIT:** Oregon Medicaid Meaningful Use Technical Assistance Program- ▪ Purpose; ▪ Provider eligibility; ▪ Flow of activities; ▪ Next steps/request for CCOs; ▪ Menu of services; **ORPRN:** Healthy Hearts Northwest (flyer)	
HSD Updates	Kim Wentz:	**<u>Action Item (Hank):</u>**

	▪ Discussed and shared document on an out-of-hospital birth survey. This will be sent out electronically; Chris Norman: ▪ Working on a provider guide/survey for CCO directors; ▪ Rates- CCO leadership connection;	Send an electronic copy of OOH Births survey to medical directors.
Clinical Directors Items from the floor	▪ Discussion on fining providers refusing to see non-immunized children; ▪ Alison Little, Tracy Muday, and Mark Bradshaw nominated for Chair for 2016. Dr. Bradshaw accepted.	
JOINT LEARNING SESSION		
Childhood Immunizations	▪ Agenda ▪ "Strategies to Improve Childhood Immunization Rates ▪ "Childhood Immunization Status (Combo 2) ▪ "Enrollment Delay for Vaccines for Children Clinics ▪ "Evidence-based Strategies for Improving Childhood Immunization Rates"	
	Quality and Performance Improvement Session (2 hrs)	
QPI Update - Introductions	▪ This is the last QHOC meeting of the year. December's meeting cancelled; ▪ Jennifer Johnstun was nominated as the Chair for 2016. She accepted.	
2016 Schedule of Activities- Acumentra	▪ Proposed 2016 EQRO schedule; ▪ 2016 External Quality Review activities;	

	▪ ISCA training will be in Eugene at the Valley River Inn;
Standard 8 Reporting Template- Acumentra	**Report Monitoring Tool-** reviewed and discussed. **PIP Review Tool:** ▪ FORMAL OPENING/FORMAL CLOSING; ▪ Requires a signed signature to open a PIP; ▪ Folks were asked their preference between version 1 or 2. Version 1 was the overall preference;
Statewide PIP: Metric Specifications & Data Review- Jon Collins and Sara H.	Discussed percentage of patients on opioid doses ≥120mg Morphine Equivalent Dosage (MED) per day. Comments were: ▪ What is the denominator? ▪ Excludes palliative care/end of life care; ▪ Helpful to have all of the codes by data; ▪ The goal is for improvement. It was suggested to send out a poll on the information shared.
Statewide PIP: Next Steps- Acumentra	▪ Survey Monkey sent out. Some CCOs did not send back; ▪ Discussed what February training should cover; ▪ Discussion on what information/topics would be helpful.
Next Meeting	
Monday, January 11, 2016 9:00 am - 3:00 pm *HSB Conference Room 137 A-D* Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: Map Office: 503-378-5090 x0	

PUBLIC HEALTH DIVISION
Office of the State Public Health Director
Kate Brown, Governor

Oregon Health Authority

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

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

Data and Reports

Youth's Experience of Care: Findings from Youth Listening Sessions in Jackson and Umatilla Counties: The Oregon Public Health Division, Adolescent and School Health Program held youth listening sessions in Jackson and Umatilla Counties in the fall of 2015 to inform program development. Youth provided their perspective on:

- Why they do and do not access preventive health services, and
- Recommendations for improving health care for youth.

The report is available here: https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/Pages/Resources.aspx. Please direct questions to Liz Thorne, MPH. Adolescent Health Policy & Assessment Specialist at elizabeth.k.thorne@state.or.us or 971-673-0377.

Resources and Updates

LGBTQ Meaningful Care Conference: The LGBTQ Meaningful Care Conference will be held March 25th. As a day-long LGBTQ cultural competency training event for healthcare and social service professionals, the Meaningful Care Conference aims to promote LGBTQ cultural competency in health care and social services, share current best practice applications of LGBTQ cultural competency in health care and social services, and to develop and diversify networks of LGBTQ culturally competent health care and social service providers. Registration information is available here: www.oregonlgbtqhealth.org/mcc

Interested in additional training information and resources from the Northwest AIDS Education Training Center (AETC)? Join their listserve here: http://visitor.r20.constantcontact.com/manage/optin?v=001jQVlpaFBJw8kZ04aZ5PlSokhddeXlR2hdvxPEk5a2QM6_qSTTkCLifhSrp3pqNZ8zsofF2qwxNHFj67bdVF_oQfX-D_tBjq0ILC6qh-NFW0%3D.

Competitive Funding Opportunity: Sustainable Relationships for Community Health: The Oregon Public Health Division, Health Promotion and Chronic Disease Prevention section will be releasing a competitive funding opportunity called Sustainable Relationships for Community Health (SRCH). Once the opportunity has been released, it can be found on the State of Oregon Procurement Information Network (ORPIN) as opportunity #4170.

> **Purpose:** Supports partners to delineate organizational roles for optimizing delivery of 1) cessation support and 2) either chronic disease self-management programs or colorectal cancer screening. Recipients conduct an assessment of current practices, attend a series of

institutes, and develop agreements between consortium members to improve referral and supports. HPCDP anticipates three institutes, with the first one held in the summer of 2016.
Funding period: Spring 2016 through June 2017.
Eligible applicants: Consortia consisting of county local public health agencies, CCOs and additional members such as clinical partners, and organizations providing supportive community-based services.
For further information: Please contact the sole point of contact as listed on the funding opportunity information.

Collaboration between Health Care and Public Health: The new free publication *Collaboration Between Health Care and Public Health* (National Academies Press) describes national, state, and regional partnerships focused on payment reform, specific disease initiatives (hypertension, asthma), public-health/hospital collaborations, and initiatives focused on building a culture of health. This resource is available here: http://www.nap.edu/download.php?record_id=21755#

Webinar: Exploring Comprehensive Diabetes Prevention & Care in Oregon: The Oregon Public Health Division and Q Corp's Patient-Centered Primary Care Institute will host a webinar on March 16, 2016 from 8-9:30am on "Exploring Comprehensive Diabetes Prevention & Care in Oregon." This webinar, to be presented by Don Kain (OHSU Schnitzer Diabetes Health Center), Tracy Carver (Acumentra Health) and Sarah Worthington (Deschutes County Health Services), will articulate how the National Diabetes Prevention Program, Diabetes Self-Management Education (DSME) and the Stanford Diabetes Self-Management Program (DSMP) can be employed to support clinical care in improving the health of Oregonians at high risk for developing type 2 diabetes, as well as those who have diabetes. For more information and to register go to: http://pcpci.org/resources/webinars/exploring-comprehensive-diabetes-prevention-and-care-in-oregon.

Immunization Resources: The Oregon Immunization Program has released additional tools for CCOs and clinics in support of the childhood immunization status incentive measure at the clinic level. Resources are available at:
https://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/ImmunizationProviderResources/Pages/AFIXResourceCCO.aspx

Resources are available on the following topics:

- ALERT IIS report tip sheets
- CDC AFIX Site Visit Questionnaire
- CDC Quality Improvement Action Steps
- CDC AFIX Site Visit Questionnaire Answer Guide

Request for Grant Proposals (RFGP):
Behavioral Health Alternative Payment Models

Project Overview and Background

Behavioral and Physical Health Integration (BPHI) initiatives are occurring throughout Oregon and nationally. However, most are being sustained through temporary or partial funding strategies. There is general agreement that a comprehensive, impactful integrated care model requires an Alternative Payment Model (APM) that is not constrained by the limitations of encounter-based reimbursement. Clinical care models for BPHI have evolved and become more defined. Funding models for sustaining and spreading BPHI need to be aligned with the care model and implemented as soon as possible.

This funding opportunity is aimed at accelerating APM implementation that supports more advanced BPHI practices. The Oregon Health Authority (OHA) is offering up to three selected healthcare payers and/or purchasers an opportunity to receive funding for implementation of an APM specifically designed for integrated care.

Funding may be used to support:

- Resources to determine which existing integrated care model components should be included in the APM;
- Development of a data set to be used to analyze costs associated with the integrated care model and care delivery performance outcomes, including total cost of care across the spectrum of care services;
- Identification of an APM methodology that is sustainable for purchasers, payers and providers; and/or
- Initial implementation of an APM.

Eligible Organizations: All Oregon healthcare purchasers or payers are eligible.

The Agency anticipates awarding funding to up to three Proposers as a result of this RFGP.
The total amount of awards available is up to $300,000.00.

For more information and to apply:

- Visit http://orpin.oregon.gov/open.dll/welcome and search for **OHA-4173-16**
- Date of Issue: March 7, 2016
- Closing Date: April 12, 2016
- Contact Heather Mowry at 971-673-0514 or heather.j.mowry@state.or.us with any questions

Upcoming Webinar: Fundamentals of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care

Please join the U.S. Department of Health and Human Services Office of Minority Health for the first webinar in a series on the *National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)*.

Culturally and linguistically appropriate services means that services are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels and communication needs. Implementing culturally and linguistically appropriate services helps individuals and organizations respond to the demographic changes in the U.S.; reduce health disparities; improve the quality of services; meet legislative, regulatory and accreditation mandates; gain a competitive edge in the market place; and decrease the likelihood of liability. The *National CLAS Standards* provide a blueprint for individuals and health and health care organizations to best serve our nation's increasingly diverse communities through culturally and linguistically appropriate services.

Attendees will learn about culturally and linguistically appropriate services and the *National CLAS Standards.*

For additional resources on the *National CLAS Standards*, please visit: www.thinkculturalhealth.hhs.gov.

Webinar: Fundamentals of the *National CLAS Standards*
March 17, 2016 at 3 pm ET

Featured Speaker:

J. Nadine Gracia, MD, MSCE
Deputy Assistant Secretary for Minority Health
Director, Office of Minority Health
U.S. Department of Health and Human Services

Register here: https://attendee.gotowebinar.com/register/1124444526228357633

After registering, you will receive a confirmation email containing information about joining the webinar.

CCO Behavioral Health Directors Meeting Agenda
Monday March 14, 2016
1:00 – 3:00 pm
Barbara Roberts Human Services Building: 500 Summer Street NE-Salem/Room 456
Conference Line: 1-888-251-2909 Participant Code: 3324049 Host code: 3345

CCO Behavioral Directors				
All Care Health Plan: Mark Bradshaw Shelby Sanford	Mark.Bradshaw@allcarehealth.com Shelby.Sanford@allcarehealth.com		Pacific Source Central OR/Gorge: Mike Franz Ralph Summers	Mike.Franz@pacificsource.com Ralph.Summers@pacificsource.com
Cascade Health Alliance: Stan Gilbert	sgilbert@kbbh.org		Primary Health: Karla McCafferty Shelly Uhrig	kmccafferty@optionsonline.org suhrig@optionsonline.org
Columbia Pacific: Douglas Luther	lutherd@careoregon.org		Trillium Community Health Plan: Bruce Abel Lynnea Lindsey-Pengelly	bruce.abel@co.lane.or.us DrLinPen@TrilliumCHP.com
Eastern Oregon: Todd Jacobson Laurence Colman	todd.jacobson@gobhi.net Laurence.colman@gobhi.net		Umpqua Health Alliance: Janet Holland	jholland@chaoregon.org
Family Care: Bennett Garner Ron Lagergen	BennettG@familycareinc.org RonL@familycareinc.org		Western Oregon Advanced Health David Geels Erin Porter	David.geels@chw.coos.or.us portere@curryCH.org
Health Share: Cheryl Cohen	cheryl@healthshareoregon.org		Willamette Valley Comm Health Scott Tiffany	scott@mvbcn.org
Intercommunity Health Network: Karen Weiner Sandy Minta	kweiner@samhealth.org sminta@samhealth.org		Yamhill CCO Theresa Heidt Seamus McCarthy	heidtt@co.yamhill.or.us smccarthy@yamhillcco.org
Jackson Care: Stacy Brubaker	brubaksj@jacksoncounty.org			
Guests:				

Item #	Time	Agenda Item	Lead	Action	Due Date
	1:00-1:15p	Review/discussion of agenda/additions; disc related to QHOC			
	1:15-1:30p	Review of outstanding items: - Model agreement between CCOs to Improve transition of youth in Wraparound teams – next steps - Gender dysphoria – updates - CCBHC update	Karen Weiner Lynnea Lindsey-Pengelly Bruce Abel		
	1:30-2:00p	PRTS/ Intensive Treatment Services – discussion on current availability of intensive services given recent loss of beds; cost trends for residential treatment. Discussion of efforts by the HSD with Justin Hopkins and Karen Wheeler	HSD- Justin Hopkins/Karen Wheeler		
	2:00-2:30p	Billing/Procedure code clarification/round table discussion with Mitch Elovitz, Medicaid Policy Analyst. Topics: use/limits of telephonic delivery; CCOs not using all Medicaid listed services; options for psychiatric consult codes; etc.	Mitch Elovitz		
	2:30-3pm	Current Olmstead efforts in Oregon	Rick Wilcox		

Next Meeting – Date	Time	Location
April 11th 2016	1-3pm	Barbara Roberts Human Services Building/Rm. 456

2/8/16 - BH Directors Meeting

Attendance: Ralph Summers(Pacific Source), Bruce Abel (Trillium), Todd Jacobson (EOCCO), Cheryl Cohen (Health Share), Bennett Garner (Family Care), Laurence Colman (EOCCO), Ron Lagergen (Family Care), Theresa Heidt (Yamhill)

On Phone: Stan Gilbert (CHA), Shelby, Stacey, Scott Tiffany (WVCH)., Karen Weiner (IHN).

Guests: Emily Watson (OHA).

1. Review/Discussion of Agenda/ Additions: Discussion related to QHOC:
   - Opioid PIP was discussed at QHOC, next month will be a discussion on MET which would be a good conversations for the BH Directors to be part of…about 4-5 BH Directors will be attending. They will report back to this group.
   - BH availability for pain clinic's, seems to be an issue as per QHOC meeting. CCOs may want to consider approach re integrating services within the pain clinics.
     - Frequency of no shows by enrollees is important causing lack of continuity of care and engagement, and risking viability of programs.
     - Agreement that we want to support the development of pain clinics and alternative to medication.
     - Focus on members seeking services, their trauma histories, SUD issues, culture of poverty, and related issues to strengthen our uniform approach.
2. Model Agreement between CCO's re continuity of care for high needs/WRAP youth:
   - Discd process as spelled out in Karen Weiner's region. (See Handout)
   - Need to identify best CCO reps that can develop plan/collaborate on transition together
   - When transferring care, the CCO of the sending Region contacts the receiving CCO representative, which starts the process of transferring information.
   - In the past there was an agreement that the receiving CCO would accept the ISA, but this is no longer the case- this does not have to leave the member in limbo.
   - Regions with multiple CCOs can present additional challenges- as not always clear which CCO will gain particular member - needs further discussion
   - Wrap site Lead meeting is happening quarterly and this process document provided by Karen will be a topic of conversation. The next site lead meeting is scheduled in April 2016.

- Add topic of having OHA/HSD being more proactive in notifying CCO's of pending transfers.
- This could include Chris Norman and Rhonda Busek because they would probably have a better solution to remedying a proactive notification of pending transfers

- **Next Steps:**

  a.. Develop list of current contacts/leads within each CCO that may take on task of flushing out specifics and possible point when actual transfers occur.

  b.. See if site leads can develop the specifics at their quarterly meeting – ultimately the BH Directors formalize a MOU

  .

3. Use of "Rendering Provider" on now required on CMS-1500/HICF claims (Bruce Abel)
   - Each provider now needs a NPI and MAP number. This is particularly important to SUD providers/programs that have traditionally not had to comply with this standard.
4. ABA Update (Bruce Abel)
   - All day training in Lane County on March 18, 2016. Handout has been distributed. If you have not received, please contact Bruce Abel.
   - Registration information will be sent out. Video conferencing may also be option.
   - Discussion of possible use of variances to meet requirements for BCBA, Assistance, Interventions, Technicians. Consensus was that variances wouldn't be allowed.
   - Access to care: ABA is based on the "Community Standard", not routine MH standards as stipulated in OAR's for emergent/urgent/routine care. May allow use of wait list of services.

5. Adult residential early Adopter Update (Todd Jacobson & Karen Weiner) – what is working/not
   - UR reviews. (Working)
   - Current allocation amounts for Admin costs (Adequate, with HSD ability to add on $)
   - Potentials when Capitation amounts start in July of 2017. (TBD)
   - Adult Foster Home issues. (Not Working)
   - Timely provider payments (still problem at times with some improvement in past months).

6. CCBHC updates – All:
   - Bruce provided a general overview of the Innovative Centers presentation on CCBHC.

- National presenters were in attendance, but the outcome was that Mike Morris and his team has a lot of work ahead of them which has to be accomplished prior to CCO/CMHP actions.
- Good news is that we apparently are no further ahead or behind where other State recipients of these funds are.
- Emily Watson update: State is going to need feedback from advisory group before they will be able to move ahead (eg: WANTSA, website). Steering/advisory committee are meeting.
    - Need to decide on Geographic Regions – Rural vs Urban designation for the application. Also issues re Payment, Contracting, DCOs, plus FQHC connections.
    - AMH Optimistic that Oregon will be capable of meeting the deadline for submission this coming October.
    - The CCBHC will also be Behavioral Health Homes – though isnot completely finalized.

7. Review of progress on Gender Dysphoria treatment, et al. (Lynnea Lindsey-Pengelly)
    - Lynnea absent. This will be the Topic of conversation at the next QHOC meeting in March.
    - Clarification on what constitutes an evaluation needs to be clarified, but currently the stipulation is that the professional is a QMHP.
        - No specialized billing codes other than the typically CPT or HCPC used for assessment. Cheryl will send out info she has.

8. Development of Psychiatric consult codes – contd disc from previous meeting (All)
    - Benefit of having Professional Consultation for member who may not be enrolled in MH. Can extend psychiatric expertise to PCPs and others via consult with PCPs w/o patient presence.
        - Could allow both psychiatric provider and MH LMP to encounter/ document efforts. Would not require formal enrollment in MH.
        - Need to determine what coding options may be available, and what specifics may be required including provider type.
        - This is a primary concern of PCP's and the consultation they receive and from whom? (Wanting a Psychologist rather than a QMHP).
    - Psychiatric consultation being applied as recommended has controversy attached to it. Move cautiously and respectfully in this area.

Oregon Health Plan
Coordinated Care Organization Intensive Care Managers List

November 2015

AllCare CCO, Inc.		740 SE 7TH ST GRANTS PASS OR 97526-3102	
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Tammy Solem, RN Care Coordinator	503-416-8055	solemt@careoregon.org	
Eastern Oregon Coordinated Care Organization, LLC		601 SW 2ND AVE PORTLAND OR 97204	
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Nicole Fenimore, RN	800-592-8283	nicole.fenimore@modahealth.com	
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Todd Jacobson, LCSW, CHC	800-493-0040	todd.jacobson@gobhi.net	
FamilyCare, Inc.		825 NE MULTNOMAH ST STE 1400 PORTLAND OR 97232-2598	
Mackenzie Petersen	503-488-3602	mackenziep@familycareinc.org	
Kathy Helm	503-471-2148	kathyh@familycareinc.org	
Health Share of Oregon		2121 SW BROADWAY STE 200 PORTLAND OR 97201-3181	
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Melinda Bishop, RN	503-681-1784	melinda.bishop@tuality.org	Tuality
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Kim Perry, RN	541-706-5120	kim.perry@pacificsource.com	
Department Manager Tricia Gardner, RN, LCSW	541-385-5315 x5111	patricia.gardner@pacificsource.com	
Behavioral Health Customer Service	541-382-5920 800-431-4132	bh@pacificsource.com	Fax: 541-330-4910
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Patti Wilson	541-471-4208	pattiw@ohms1.com	
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Care Coordination Team	541-762-9090	carecoordination@trilliumchp.com	541-434-1072
Umpqua Health Alliance			1813 W HARVARD AVE STE 206 ROSEBURG OR 97471-2754
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Rebecca Ross, LPN Grievance and Appeals Coordinator	541-673-1462	rross@architravehealth.com	
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Oregon Health Plan
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Debbie Root, RN	503-455-8046	droot@yamhillcco.org	

Oregon Health Plan
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Physician Care Organization Exceptional Needs Care Coordinator/Dental Care Organization Case Management Coordinator

Kaiser Foundation Health Plan of the Northwest (PCO)		500 NE MULTNOMAH ST STE 100 PORTLAND OR 97232-2031	
Jayna Plasse	503-721-3721	jayna.r.plasse@kp.org	
Danell Weese	503-721-4741	danell.s.weese@kp.org	
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Lynsey Krausse	360-975-7641	lkrausse@accessdentalplan.net	Fax: 360-573-4022
Advantage Dental Services, LLC (DCO)		442 SW UMATILLA AVE STE 200 REDMOND OR 97756-7039	
Rosa Pedraza	866-268-9631	casemanagement@advantagedental.com	Fax: 541-504-3907
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CareOregon Dental (DCO)		315 SW 5TH AVE STE 900 PORTLAND OR 97204-1739	
Cathleen Olesitse	503-416-4939	olesitsec@careoregon.org	
Family Dental Care (DCO)		8070 SW HALL BLVD STE 200 BEAVERTON OR 97008-6419	
FDC Customer Service	866-875-1199		TTY: 800-471-7944
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Michele Chaer	503-644-1110	michele.chaer@familydentalcareinc.com	Fax: 503-641-6431
Managed Dental Care of Oregon, Inc. (DOC)		3000 MARKET ST NE STE 222 SALEM OR 97301-1897	
MDCO Member Services	800-538-9604 503-581-1407	memberservices@mdcodental.com	Fax: 503-581-0043
ODS Community Health, Inc. (DCO)		601 SW SECOND AVE PORTLAND OR 97204	
ODS Customer Services	800-342-0526	ohpdentalcoordinator@modahealth.com www.modahealth.com	Fax: 503-765-3297 Relay: 711

Oregon's Waiver: Proposed renewal and amendments to Oregon's 1115 Demonstration Waiver with the Centers for Medicare and Medicaid Services

Goals of the Demonstration or "waiver"

Since Oregon's existing five-year 1115 Demonstration Waiver (or "Waiver") with the Centers for Medicare and Medicaid Services (CMS) ends in June 2017, Oregon is developing a renewal application to continue its highly successful health system transformation work. Since 1994, the Oregon Health Plan (OHP) Demonstration has provided the state's most vulnerable residents with high-quality, evidence-based health care while containing spending growth, saving the federal and state government more than $33.9 billion over the life of the waiver.

Oregon's current 2012 demonstration waiver helped transform the delivery system to one of coordinated care, with 16 coordinated care organizations (CCOs) now delivering the vast majority of physical, oral and behavioral health services to OHP members. Today, approximately 90% of OHP members are enrolled in a CCO. Oregon was with the first wave of states that expanded Medicaid eligibility under the Affordable Care Act. Since 2014, the impact of our delivery system reform reaches over 1.1 million Oregonians, or approximately 25% of Oregon's population. Additionally, Oregon has one of the lowest rates of uninsured with nearly 95% of Oregonians now enrolled in health care coverage. This new system of health care delivery has led to better health, better care and lower per capita costs, saving the federal and state government over $1.7 billion (and saving the federal government over $1.4 billion) by the end of the current waiver in 2017. Because of the success of the current demonstration to transform the health system, Oregon is in a position, with targeted federal investment, to take health system transformation to the next level. Oregon will continue its coordinated care model that was developed during the current demonstration period, and will expand areas such as furthering integration of behavioral health and improving social determinants of health, while continuing to maintain a sustainable rate of growth of health care costs.

In the last five years, Oregon developed a transformed Medicaid system, including:

- Passed bi-partisan legislation in 2011 and 2012 to establish a new integrated and coordinated approach to deliver Medicaid health care services throughout Oregon;
- Stood up 16 Coordinated Care Organizations (CCOs), covering the entire state geographically;
- Enrolled approximately 90% of all Medicaid enrollees into CCOs and this new model of care, including the vast majority of the nearly 450,000 newly eligible Medicaid enrollees under the Affordable Care Act;
- Integrated new services and budgets into CCOs for services that were not part of the old managed care plans. These new services and budgets include behavioral health, oral health, non-emergency medical transportation, addiction services, and children's wrap around services.
- Developed a successful, robust measurement and public reporting process to align incentive metrics, and 5% of CCO budgets are now paid based on meeting incentive targets.

The impact of Oregon's efforts to transform Medicaid is also driving transformation efforts in other markets and has become a core component of the Oregon health care story. Last year the Oregon Legislature passed bipartisan legislation for a public process to develop and align metrics across all state

programs. Supported by the Comprehensive Primary Care Initiative, we have seen multi-payer collaboratives come together to support patient-centered primary care homes. Legislation now being considered would create a work group and process to determine how to better integrate Emergency Medical System providers into transformation efforts and support their work to reduce emergency department visits. Elements of the coordinated care model have been included in the state's public employee health care program.

The success of this system is already showing. Current health system transformation has been a success in keeping costs below the national rate of growth for health care expenditures (see graph). While holding costs down below the national rate of growth, data from Oregon's robust quality measurement program show significant improvements in quality, access, and health (for a full report of health system transformation: www.oregon.gov/oha/Metrics/Pages/index.aspx). Highlights include:

- **Decreased emergency department visits.** Emergency department visits by people served by CCOs has decreased 23% since 2011 baseline data.
- **Decreased hospital admissions for short-term complications from diabetes.** The rate of adult patients (ages 18 and older) with diabetes who had a hospital stay because of a short-term problem from their disease dropped by 32% since 2011 baseline data.
- **Decreased rate of hospital admissions for chronic obstructive pulmonary disease.** The rate of adult patients (ages 40 and older) who had a hospital stay because of chronic obstructive pulmonary disease or asthma decreased by 68% since 2011 baseline data.
- **Patient-centered Primary Care Home (PCPCH) enrollment continues to increase.** Coordinated care organizations continue to increase the proportion of members enrolled in a patient-centered primary care home. PCPCH enrollment has increased 61% since 2012. Additionally, primary care spending continues to increase, which means more health care services are happening within primary care settings rather than other settings such as emergency departments.

These improvements translate directly into better health for Medicaid enrollees and savings for the Centers for Medicare and Medicaid Services (CMS). The state has already extended the elements of the coordinated care model to public employees and is planning to expand the model to more Medicare and Medicaid dual-eligible beneficiaries. As more people are covered through coordinated care plans, the benefits spread across the state and create critical momentum for Oregon and CMS to achieve mutual reform goals. More and more Oregonians – beyond the Oregon Health Plan — are receiving care through this transformed system. Right now, about 94 percent of Oregon's providers serve OHP members at their primary practice site. When these providers transform their model of care, these changes reach not only OHP members, but also benefit patients across a provider's practice.

With this renewal and amendment, Oregon, with a shared commitment with the federal government, seeks to build on our success with the coordinated care model to meet the following key goals across the next five years:

1. Build on transformation of Oregon's Medicaid delivery system with a stronger, expanded focus on integration of physical, behavioral, and oral health care through a performance driven system with the goal of improving health outcomes and continuing to bend the cost curve;
2. Improve the social determinants of health and health equity across all low-income, vulnerable Oregonians with the goal of improving population health outcomes;
3. Commit to ongoing sustainable rate of growth that includes the 2% test, a federal investment at risk for not meeting that target, and an integrated budget that promotes increased spending on health related services and advances the use of value based payments;
4. Establish supportive partnerships with CMS to expand the coordinated care model by implementing innovative strategies for providing high-quality, cost-effective, person-centered health care for Medicaid and Medicare dual eligible members.

I. Strategies

Strategies for consideration as part of the waiver renewal to achieve these key goals include:

Build on transformation, including integration

- Expand the integration of behavioral health services through partnerships with counties, corrections, and community-based programs.
- Invest to continue success and support for the Hospital Transformation Performance Program that furthers goals of transformation, ensures sustainable funding, and aligns care coordination across the delivery system.
- Refine and advance the coordinated care model through a robust measurement program; expanded Patient-Centered Primary Care Home program; quality incentive payments; expanded HIT infrastructure and Transformation Center.
- Promote a recovery-based model of care and strengthen substance use diversion services along the continuum of care by requesting a Substance Use Disorders Waiver in 2017.

Improve social determinants of health and health equity

- Increase access to housing and housing supportive services for vulnerable populations.
- Partner with the Oregon Early Learning Council to provide in-home mental health screening and referral services to families with young children.
- Ensure access to health care services for American Indians and Alaska Natives.
- Expand the use of traditional health care workers within the delivery system.

Commit to sustainable rate of growth

- Advance the integrated budget and rate development strategies to promote the use of flexible services, social determinant investments, and value-based payments.

Expand the coordinated care model

- Promote better coordination and improve health outcomes for those Medicare and Medicaid dual eligible members.
- Increase the health care workforce in underserved areas and in behavioral health settings using evidenced-based, best practices for recruiting and retaining workforce.

II. Financing Initiatives

Oregon will request an amendment to the 1115 Demonstration Waiver to authorize targeted federal financial participation to support taking health system transformation to the next level and to provide a financial incentive for meeting the 2% test annually. These programs are vital to the success of advancing health system transformation to improve social determinants of health, such as access to housing and investing in a more robust behavioral health system for Oregon's most vulnerable residents. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not. The state will ramp down the federal investment as we realize additional savings from health system transformation.

III. Next Steps

Oregon will be submitting a request to renew the current 1115 Demonstration Waiver and requests the following commitments from CMS and federal partners:

- Commitment to reach high level agreement on the waiver renewal by this summer and finalize the waiver renewal in 2016.
- Continue the program in its current form for another five years, including an extension of targeted federal investment to maintain sustainability and continue to limit the growth of health care costs. Most of the savings accrue to the federal government and the investment is recouped through those savings.
- Make some clarifications and provide additional flexibility within the waiver on issues that were always part of the design but that we want to take to the next level, including:
    - Advance integrated budget concept to promote more flexible services (i.e. non-medical services that promote health) and community health investments that target improvements in social determinants of health including transitional housing and housing supports and services.
    - Flexibility to provide better coordination and outcomes for Medicare and Medicaid dual eligible members (particularly disabled members with complicated health conditions).
    - Support to continue to promote primary care and improve workforce and access in underserved areas, including access for American Indians and Alaska Natives.
    - Provide expanded behavioral health and substance use diversion services.

For questions about the Waiver renewal process or content, please contact:
Lori Coyner by email at Lori.A.Coyner@State.OR.US.

MINUTES

Evidence-based Guidelines Subcommittee

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
February 4, 2016
2:00-5:00pm

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

Members Absent: None

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

Also Attending: Adam Obley, MD, Val King MD, MPH, and Craig Mosbaek (OHSU Center for Evidence-based Policy), Patricia Mulcahy (Osiris Therapeutics), Joe Shreck (Allergan), Erica Pettigrew (OHSU), Jessie Little (OHA Actuarial Services Unit).

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1. CALL TO ORDER

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

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2. MINUTES REVIEW

No changes were made to the November 5, 2015 minutes. The minutes were approved 5-0.

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3. STAFF REPORT

Coffman reported that subcommittee member Vern Saboe is transitioning to a different subcommittee. He will be leaving the HERC and EbGS and joining the Value-based Benefits Subcommittee. In addition, Kim Tippins, a naturopath and acupuncturist will be joining this subcommittee as well as HERC, pending Senate confirmation. He asked the members to think about additional potential members as quorum is easier with a larger group.

He noted that there is a new task on the agenda to score potential topics. EbGS will have the opportunity to give feedback on staff recommendations for topic scoring. This scoring is used to guide topic selection by the HERC.

4. Review of Public Comment – Draft Coverage Guidance on Skin Substitutes for Chronic Skin Ulcers

Obley reviewed the public comment disposition from the meeting materials with the exception of the comments about number of applications.

When Obley reviewed the comments on OASIS, Livingston explained that at the previous meeting the subcommittee had recommended coverage of this product for diabetic foot ulcers, based on erroneous information staff provided at the meeting. Therefore staff changed the recommendation to a recommendation for noncoverage prior to posting the document for public comment. However, during public comment, additional evidence came to light, leading to a staff recommendation to cover OASIS for diabetic ulcers as a weak recommendation.

Based on the Cazzell study submitted for public comment, the subcommittee agreed to accept the staff recommendation for coverage of OASIS for diabetic foot ulcers.

Livingston reviewed the responses to comments about the number of applications. She highlighted staff's acknowledgment in the document that the costs will vary by patient and application and that costs can't easily be estimated at the population level. Gingerich reviewed the revised table on the number of applications. He explained that staff has removed the maximum cost figures from the right column of the table, based on the public comment and the fact that the proposed maximum number of applications was based on different factors for different products (in some cases they were coverage maximums from other payers; in others they were statements by the FDA or reported numbers of applications from studies). The studies seem to indicate that the appropriate number of applications may vary by product, and it's difficult to propose a maximum number of applications based on an average from a study. In addition, the cost (at least in traditional Medicare) varies significantly by setting of care.

Chan asked why the costs for some products were the same as other products in some settings of care but different in other settings. Gingerich explained that it was because they are classified differently on the Medicare web site, but he didn't know the reason for the different pricing.

Because of the lack of consistent criteria, staff did not propose application limits in the coverage guidance box. After some discussion of the fairness of the applications table and the inclusion of resource information in the GRADE table, and the appropriate place to present the table, the subcommittee affirmed the decision not to include quantity limits in the draft coverage guidance recommendations but to request that staff add the revised application table as a new appendix to the coverage guidance, as it may be useful to payers. Staff will add a sentence indicating that the cost table did not affect the coverage guidance recommendations, and highlighting at the bottom of the appendix that the costs are for a single application. Staff will also add an additional explanation to the resource allocation section of the coverage guidance narrative.

Chan asked about the comparison between 3 sheets of Dermagraft to 8 sheets of OASIS. If this is for venous leg ulcers (VLUs), it is incongruous since Dermagraft is not recommended for VLU. Livingston and Obley clarified that this was for diabetic foot ulcers (DFU), not for VLU. Staff will clarify this in the coverage guidance.

Livingston reviewed the other changes made since the last meeting, shown as revisions in the meeting materials.

Chan invited public comment. Patricia Mulcahy from from Osiris Therapeutics offered her comments. She discussed Grafix, referencing the Lavery study and reporting the results. Grafix is true placental membrane and contains proteins and growth factors. She said that Grafix is a game changer because it is the first product to preserve placental tissue. Providers and various health plans are starting to cover it. She said other products aren't anything new, their research is from two decades ago, whereas Grafix is a leading edge technology. It is also available in 4 sizes and was reviewed by NICE in 2015.

Obley reported that the Lavery study was reported in the coverage guidance. It was deemed to be a poor-quality trial. There was uncertainty about sequence generation and allocation concealment in the trial as well as inadequate blinding. It had a fair number of people who failed screening as well as some who dropped out in the run-in period. There was variable offloading and a small difference in wound size between groups. There were twice as many dorsal wounds in the Grafix group as the control group and these wounds are known to heal more readily. Chan thanked her for her testimony and suggested that Osiris needs to conduct higher-quality trials in order to show efficacy for the product.

Livingston asked Dr. White-Chu, the ad hoc expert to the subcommittee on this topic, if she had any comments. She said that in the future it may be important to categorize these products according to the growth factors present, as comparative trials of products with different factors may not be the correct comparison. The science isn't there yet but the subcommittee may want to consider this is a few years. Stecker said that technologies like this may require more frequent scanning than other topics. Coffman said that the standard scanning interval is two years but if someone presents new compelling evidence we can take a topic up earlier. Livingston said we received new evidence on an additional product just this week. The new product will not be considered at this time, since the Commission can't be in a constant state of review and there are effective alternatives. The subcommittee determined that rereview would occur at 2 years time unless there was compelling evidence of a superior technology than currently recommended treatments, -that may initiate an earlier review.

After additional discussion, a motion was made to approve the draft coverage guidance with the addition of the revised applications table and other changes as discussed, then forward the draft to HERC for review. Motion approved 5-0.

DRAFT COVERAGE GUIDANCE

Skin substitutes for chronic venous leg ulcers and chronic diabetic foot ulcers are recommended for coverage *(weak recommendation)* when all of the following criteria are met:

1. Product is recommended for the type of ulcer being treated (see table below)
2. FDA indications and contraindications are followed, if applicable
3. Wound has adequate arterial flow (ABI > 0.7), no ongoing infection and a moist wound healing environment
4. For patients with diabetes, Hba1c level is < 12.
5. Prior appropriate wound care therapy (including but not limited to appropriate offloading, multilayer compression dressings and smoking cessation counseling) has failed to result in significant improvement (defined as at least a 50 percent reduction in ulcer surface area) of the wound over at least 30 days
6. Ulcer improves significantly over 6 weeks of treatment with skin substitutes, with continued significant improvement every 6 weeks required for coverage of ongoing applications
7. Patients is able to adhere to the treatment plan

The following products are recommended/not recommended for coverage as shown below. All recommendations are weak recommendations.

Product	Diabetic foot ulcers	Venous leg ulcers
Dermagraft	Recommended	Not recommended
Apligraf	Recommended	Recommended
OASIS Wound Matrix	Recommended	Recommended
Epifix	Not recommended	Not recommended
Grafix	Not recommended	Not recommended
Graftjacket	Not recommended	Not recommended
Talymed	Not recommended	Not recommended
Theraskin	Not recommended	Not recommended
Other skin substitutes	Not recommended	Not recommended

The use of skin substitutes is not recommended for coverage of chronic skin ulcers other than venous leg ulcers and diabetic foot ulcers (e.g. pressure ulcers) *(weak recommendation).*

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5. Scope statements

Obley reviewed the scope statements for proposed topics.

Digital Breast Tomosynthesis for Breast Cancer Screening

The subcommittee changed the intervention to "Digital breast tomosynthesis (3-D mammography) in conjunction with standard digital mammography" as this is the most commonly-used intervention and the one supported by advocates. Obley said there is data about digital breast tomosynthesis alone from other countries.

They also removed no screening and MRI for breast cancer screening as comparators as traditional mammography is the more likely real-world alternative for patients and Obley didn't believe there would be any evidence on this.

The subcommittee then discussed a public comment saying that impact on morbidity and mortality were unfair outcomes, and that other outcomes should be invasive cancer detection rate, cancer detection rate, and positive predictive value (PPV) for recall/biopsy. Chan suggested to keep the outcomes of morbidity and mortality as in some cases a positive finding does not mean that what is detected with one test behaves in the same way clinically as what would be detected with another test. Little and Stecker, however, supported the public comment since standard of care includes mammography and it's unlikely that a differential outcome on morbidity and mortality between the two interventions would be detectable. Obley noted that the benefit of standard mammography is of marginal benefit for younger women (for whom this intervention is most touted as they tend to have denser breasts). Given that he thought it would be a reasonable option to require an impact on mortality/morbidity, he acknowledged that there is unlikely to be any data showing an effect on distal clinical outcomes. After discussion the subcommittee decided to leave the morbidity and mortality outcomes as critical but acknowledged that the decision would need to be made based on diagnostic test characteristics.

Little asked whether any other negative outcomes should be included. Obley said that initially there had been concerns about radiation exposure but that newer technology had eliminated that concern. Livingston asked whether the cancer detection rate outcome should be stratified based on whether the cancer was invasive. After discussion the group eliminated the limitation to invasive, and Obley said he would break out detection of invasive versus other cancers where reported.

Positive predictive value (PPV) for recalls and biopsies was added as an outcome considered but not selected, as this was suggested in public comment. This would be reported in diagnostic test characteristics but not in the GRADE table. The group replaced "operating characteristics" with "diagnostic test characteristics" throughout the document. The subcommittee discussed how to handle high risk populations, eliminating MRI as a comparator and clarifying under key question 2 that baseline risk should be within an average risk population. They also requested that a separate coverage guidance should be developed to guide screening with various imaging modalities in high-risk populations such as women with BRCA mutations or prior ductal carcinoma in situ. They changed the title to Digital Breast Tomosynthesis for Breast Cancer Screening in Average Risk Women.

Fecal Microbiota Transplantation for Clostridium difficile Infection
The subcommittee asked that probiotics be moved before the combination treatments to clarify that it could be used in combination with other interventions.

Genetic Tests for Selection of Antidepressant Therapy
Obley noted that this topic was recommended by a test manufacturer and reviewed the scope statement. Westbrook said she talked to someone about this test who expressed concern that the only studies on this product are conducted by the manufacturer. Obley agreed that there is heavy

manufacturer involvement in the studies, but they are published in peer-reviewed literature. Westbrook expressed concern about continued testing and the associated cost for minimal gain when a good clinician might be able to do better. Stecker asked how the topic got such a high score. Livingston reviewed the scoring in the meeting materials. King noted that Medicare and the Veteran's Administration cover this test, and so it may be a good time to review the evidence before coverage becomes more widespread. Based on this the subcommittee raised the score for variation/controversy from 1 to 2, raising the score to 48. The subcommittee discussed that total health care costs are a key question, but were listed as an outcome considered but not selected. They then removed this outcome from the list of outcomes considered but not selected but left it as a key question.

Interventions to Reduce the Harms of Tobacco During Pregnancy
The subcommittee discussed whether it was appropriate for the subcommittee to weigh in on policy interventions over which HERC has no control, such as the tobacco excise tax. Stecker proposed eliminating interventions over which CCOs do not have control. Livingston said that plans may be interested in engaging with policy work. Little asked whether the document can be taken and used at the legislature. Stecker said that personally, he would support such policy changes, but they are beyond the mandate of the committee. After discussion, the subcommittee agreed to keep the scope broad, but separate the recommendations for evidence-based nonclinical interventions and direct them to the appropriate audiences.

Gastrointestinal Motility Tests
Obley reviewed the scope statement and noted a duplicate outcome. Livingston suggested that patient-reported symptoms be downgraded from Urgent to Important. The subcommittee discussed the definition of usual care (no diagnostic testing other than physical exam) and eliminated "usual care" as a comparator. The issue is that guidelines recommend testing for gastroparesis because of the potential harms of medication for this condition, but some clinicians believe they can diagnose this condition without radiologic testing. After discussion, the subcommittee changed the comparators to "empiric therapy, diagnosis based on clinical criteria/assessment tools, other listed interventions." They also added key question #4 "Do these tests have additional clinical utility over using clinical assessment without invasive testing?" Obley confirmed that time to symptom resolution would be captured by the scope as amended.

Timing of Long-Acting Reversible Contraceptive Placement
Little asked whether there was controversy about this not related to religious affiliation. Livingston explained that sometimes there is no separate reimbursement for LARC or to pay for the placement if it is done immediately postpartum, so providers are reluctant to absorb the cost of the device and placement. There is also controversy about the rate of expulsion. Stecker asked why patient satisfaction was excluded. King said that discontinuation is the most important marker for patient satisfaction. After discussion the subcommittee removed patient satisfaction from the list of outcomes considered but not selected. Westbrook asked whether this would affect out-of-hospital birth. King said it is done after outpatient abortion, but she found no studies about placement after out-of-hospital birth.

Percutaneous Interventions for Low Back Pain
The subcommittee suggested that the topic name be changed to Corticosteroid Injections for Low Back Pain. Livingston explained that VbBS requested this review to update the topic based on the new AHRQ report following discussion at its January meeting. Scope will be limited to epidural steroid injections. This would be a new coverage guidance and a disclaimer would need to be placed on the previous coverage guidance that the part about steroid injections had been superseded. Based on public

comment, the subcommittee added the Alexander technique as a comparator, and clarified that change in utilization of comparators included opioids and surgery as examples.

Staff noted that the rescanning summary for Recurrent Acute Otitis Media in Children was included for reference in the scoring process. Obley briefly reviewed this document's conclusions.

The subcommittee briefly reviewed the scoring. Livingston explained the changes to the scoring methodology, which were made recently and will be presented in more detail to HERC in March. Stecker asked about the purpose of EbGS reviewing the topic scoring. He suggested the subcommittee either do the scope statements and not look at scoring, score the topics first, or score the topics while scoping each topic. Livingston said that the scoring could come first. Coffman said that the idea was for staff to suggest the scores and for EbGS to review the scoring, then for topics to be addressed in priority order. Little said if a topic scores low it's a poor use of subcommittee time to scope the topic. The subcommittee discussed changing the prevalence to zero for fecal microbiota transplants, but elected not to as it would not make much of a difference.

Chan suggested making the delineation of the scores for prevalence more standardized, and noted that on the variation row, the scores 0 and 3 include language about standard of care but the other scores do not. Staff will take this into account as these are brought to HERC.

After additional discussion the subcommittee voted to approve the scope statements and scoring as amended (4-0, Waldman absent).

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6. ADJOURNMENT

The meeting was adjourned at 5:00 pm. The next meeting is scheduled for April 7, 2016 from 2:00-5:00 pm at Clackamas Community College, Wilsonville Training Center, Rooms 111-112, 29353 SW Town Center Loop E, Wilsonville, Oregon 97070

MINUTES

Health Technology Assessment Subcommittee

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
February 18, 2016
1:00-4:00pm

Members Present: Som Saha, MD, MPH (Chair Pro Tempore); Chris Labhart; Gerald Ahmann (by phone), MD; Leda Garside, RN, MBA; Mark Bradshaw, MD

Members Absent: Jim MacKay, MD, ; Derrick Sorweide, DO

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

Also Attending: Adam Obley, MD, Val King MD, MPH & Craig Mosbaek (OHSU Center for Evidence-based Policy), Joanie Cosgrove (MedTronic), Linli Pao.

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1. CALL TO ORDER

Saha called the meeting to order at 1:10 p.m.

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2. MINUTES REVIEW

Minutes from the December 10. 2015 meeting were reviewed and approved 5-0.

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3. STAFF REPORT

Coffman provided information on various items:

- Tim Keenen has resigned from the committee as his clinical schedule does not allow participation on Thursdays. He has recommended a recently-retired osteopathic physician to replace him.
- The rescanning report on Vertebroplasty, Kyphoplasty and Sacroplasty was taken directly to HERC after an email to members, and no update is currently planned on this topic.
- The topic of Viscosupplementation for Osteoarthritis of the Knee had been recommended for a new review after the 2014 monitoring process after a new report became available. The report recently became available but staff review indicated that the report is unlikely to change the current recommendation for noncoverage. A more comprehensive rescanning report will occur later this year as a part of the regular monitoring process.
- The April HTAS meeting as cancelled in order to give staff time to prepare for the Obesity Task Force meetings happening this spring.
- Staff has developed a plan for cancer genetics topics, which is a rapidly-evolving field. The HERC will follow guidelines from the National Comprehensive Cancer Care Network (NCCN) where

they make a clear recommendation. Where the recommendation is not clear, the HERC will consider taking up the topic. This will help make best use of HERC resources in keeping up-to-date with this evolving field. Bradshaw suggested that the subcommittee consider mental health-related genetics topics as well. Coffman said that the EbGS is looking at genetic testing related to antidepressant selection.

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4. COVERAGE GUIDANCE: Metabolic and Bariatric Surgery

Obley reviewed public comment on Metabolic and Bariatric Surgery, which consisted of a single comment offering "applause." Livingston noted that CCO medical directors have raised concerns about costs. Coffman said that after the coverage guidance is approved any changes will be implemented in January, 2018 as a part of the biennial review so that costs can be incorporated into rates.

Dr. Bruce Wolfe, appointed expert for this topic, spoke in favor of fewer barriers to access for patients desiring this surgery. He noted that, for instance, smoking rates are usually about 20 percent at intake in this population, then 0 percent at surgery due to the requirements, then they rise to 20 percent again at followup. Adequate pre-operative weight loss is hard to define. Labhart noted that tobacco cessation is a big priority for CCOs this year due to metrics. After brief discussion the subcommittee referred the draft coverage guidance to HERC, without making any changes by a vote of 5-0.

DRAFT HERC Coverage Guidance

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

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

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

Metabolic and bariatric surgery is not recommended for coverage in:

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

Children and adolescents *(weak recommendation)*

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5. SCOPE STATEMENTS FOR COVERAGE GUIDANCES

Genetic Testing of Thyroid Nodules. Obley reviewed the scope statement. Saha asked about harms

from testing be mentioned as an outcome, but not in key questions. Obley said the harm would be from neck dissections and thyroidectomies which did not reduce mortality. He said the harms could show up in mortality or be reported as harms, and could be covered under key question 3 (b) as a change in outcomes or management plans. No changes were made.

Noninvasive Testing for Liver Fibrosis in Chronic Hepatitis C Patients. Obley reviewed the draft scope statement.Saha expressed concern that with the outcomes as written even a bad test could receive favorable results if the information produced by the test didn't have good value. Obley said that from what he has seen so far, these noninvasive tests are better at the higher stages of liver fibrosis. He suggested adding hepatitis-related morbidity and progression. The subcommittee also made testing-related adverse events an important (not critical) outcome and re-ordered the listed outcomes. Bradshaw expressed concern that providers might do this test too frequently in an effort to qualify a patient for treatment. The subcommittee also discussed removing quality of life as an outcome but left it in.

Prostatic Urethral Lifts The subcommittee discussed the fact that there was only one critical outcome. After discussion, Saha said that even if an outcome may not be a major public health issue, it could be a critical outcome in terms of making the decision on a particular service. After discussion, the subcommittee changed the outcomes, adding procedural complications, long-term harms and making urinary incontinence and erectile dysfunction examples of harms).

Sacral Nerve Stimulation for Non-obstructive Urinary Retention Obley reviewed the draft scope statement. There was brief discussion but no changes were made to the statement.

Ultrasound-Enhanced Catheter Directed Thrombolysis for Deep Vein Thrombosis (DVT) Saha questioned whether pulmonary embolism should be moved to a critical outcome. Some are very serious, some aren't. The subcommittee changed the outcome to symptomatic pulmonary. Saha asked how often thrombolysis is used. Obley said at least at OHSU he doesn't believe the procedure is performed locally for pulmonary embolism, but it is being done for DVT, albeit not the catheter-directed, ultrasound-enhanced approach studied here.

Ultrasound-Enhanced Catheter Directed Thrombolysis for Pulmonary Embolism (PE) The subcommittee corrected an error in key question 2(d), changing the outcome to presence of DVT (not PE), and elevated recurrent pulmonary embolism to a critical outcome.

The subcommittee voted 5-0 to refer the scope statements for these 4 topics to HERC, as amended.

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6. TOPIC SCORING/PRIORITIZATION

Livingston reviewed the topic scoring sheet and explained that the first 8 rows are added, then the meaningful coverage guidance row is a multiplier. She also explained that some of the scoring sheet has been revised to better capture the key concepts.

For Ultrasound-Enhanced Catheter-Directed Thrombolysis for DVT, the subcommittee discussed prevalence. The population who might need this procedure is extremely small, but for those patients the

disease burden would be high. The subcommittee discussed lowering the prevalence score to 0 and raising the disease burden to 3. This would result in the same score so no changes were made.

Saha asked whether the group should consider a report on all catheter-directed thrombolysis. Due to the DRG billing methodology, plans may never even make a decision on this service. Based on the low score, the subcommittee decided to recommend HERC not consider this topic, and made the same recommendation for the Ultrasound-Enhanced Catheter-Directed Thrombolysis for PE. This recommendation was approved by a vote of 5-0.

The subcommittee then reviewed the scoring for the remaining topics. All the other topics scored much higher. Gingerich said that the Continuous Glucose Monitoring and Sleep Apnea Diagnosis in Adults are rescan topics, which the subcommittee discussed previously.

Discussion turned to the multiplier row on the scoring sheet. Saha expressed concern that there could be good topics which might be eliminated due to lack of implementation levers. Gingerich gave the example of transitional care for patients with heart failure, which is an important topic that is difficult for plans to address with coverage policy. There was an extensive discussion about the changing nature of implementability given the changing structure of CCOs. Saha proposed that this scoring system should only be applied to clinical topics and not to other topics that a plan may use extra funds for, services which occur outside the typical clinical encounter. The group proposed developing a new product and/or process for multisector interventions. They discussed that the review of evidence of clinical and non-clinical interventions ought to happen simultaneously, as there would be a benefit to addressing a topic from multiple angles. Final recommendations could include a coverage guidance for clinical interventions and evidence-based strategies for non-clinical recommendations.

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5. ADJOURNMENT

The meeting was adjourned at 3:20 pm. The next meeting is scheduled for April 21, 2016 from 1:00-4:00pm in Room 111-112 of the Wilsonville Training Center of Clackamas Community College.

Potential topics	
Digital Breast Tomosynthesis (3D Mammography) for Breast Cancer Screening in Average Risk Women	EbGS
Fecal Microbiota Transplants for C. difficile	EbGS
Gastrointestinal Motility Tests	EbGS
Genetic Testing of Thyroid Nodules	EbGS
Genetic Tests for Selection of Antidepressant Therapy	EbGS
Interventions to Reduce Tobacco Use During Pregnancy	EbGS
Percutaneous Interventions for Low Back Pain	EbGS
Recurrent Acute Otitits Media in Children	EbGS
Timing of Long-Acting Reversible Contraceptive Placement	EbGS
Continuous Glucose Monitoring In Diabetes Mellitus	HTAS
Noninvasive Testing for Liver Fibrosis in Chronic Hepatitis C Patients	HTAS
Prostatic Urethral Lift for Treatment of Benign Prostatic Hypertrophy	HTAS
Sacral Nerve Stimulation for Non-Obstructive Urinary Retention	HTAS
Sleep Apnea Diagnosis in Adults	HTAS
Ultrasound-Enhanced, Catheter-Directed Thrombolysis for Deep Vein Thrombosis	HTAS--not recommended for adoption
Ultrasound-Enhanced, Catheter-Directed Thrombolysis for Pulmonary Embolism	HTAS--not recommended for adoption

AGENDA
VALUE-BASED BENEFITS SUBCOMMITTEE
March 10, 2016
8:30am - 1:00pm
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
A working lunch will be served at approximately 12:00 PM
All times are approximate

I. Call to Order, Roll Call, Approval of Minutes – Susan Williams **8:30 AM**

II. Staff report – Ariel Smits, Cat Livingston, Darren Coffman **8:35 AM**
- **A.** Errata

III. Straightforward/Consent agenda – Ariel Smits **8:40 AM**
- **A.** Straightforward table
- **B.** Rosacea
- **C.** Vitamin A deficiencies

IV. 2018 Biennial Review – Ariel Smits **8:45 AM**
- **A.** Merging newborn lines

V. Previous discussion topics – Ariel Smits **9:00 AM**
- **A.** Diaphragmatic hernia
- **B.** Intracranial stenting and angioplasty for atherosclerosis
- **C.** Balloon dilation of intracranial vasospasm

VI. Guidelines – Ariel Smits **9:30 AM**
- **A.** Hormone requirements for chest surgery in the gender dysphoria guideline/other gender dysphoria issues
- **B.** Acupuncture for tobacco cessation—Erica Pettigrew
- **C.** Hyperbaric oxygen

VII. New discussion topics – staff **10:15 AM**
- **A.** Pectus excavatum and pectus caravatum—with Dr. Kim Ruscher
- **B.** Retractile testicles
- **C.** Remote imaging for screening and management of retinopathy of prematurity
- **D.** Implantable cardiac loop recorders
- **E.** Electric tumor treatment fields for initial treatment of glioblastoma
- **F.** Introduction to issues regarding services for autism and dementia

VIII.	**Coverage guidances – Cat Livingston** **A.** Skin substitutes for chronic skin ulcers (EGBS) **B.** Metabolic and bariatric surgery (HTAS)	**11:30 AM**
IX.	**Public comment**	**12:55 PM**
X.	**Adjournment – Susan Williams**	**1:00 PM**

Breast/Chest Surgery Requirements for Gender Dysphoria
Other Coverage Concerns for Gender Dysphoria

Questions:

1) Should the gender dysphoria guideline be modified to remove the requirement for 1 year of cross sex hormone therapy prior to breast/chest surgery?
2) Should laser hair removal be a covered treatment for pre-operative site preparation?
3) What is the HERC policy regarding revisions to previous gender dysphoria related surgeries?
4) Should smoking cessation be required prior to genital surgery for gender dysphoria?
5) Do we need to add PT procedure codes to the gender dysphoria line to allow pre- and post-procedure therapy for vaginoplasty?
6) Should other procedures requested by patients be considered for addition to the gender dysphoria line?

HERC staff recommendations:

1) Modify the gender dysphoria guideline as shown below
    a. Removes hormone requirement prior to female-to-male type chest/breast surgeries
        i. Consistent with other insurance carriers and WPATH guidelines
    b. Modifies the requirement for hormone (estrogen) therapy prior to mammoplasty, allowing for "any contraindication" which could include intolerance of the medication or medical conditions which preclude use
        i. Alternate: remove any requirement for estrogen therapy prior to mammoplasty
    c. Removes the requirement for a year of living as the desired gender prior to breast/chest surgery
        i. Consistent with other insurance carriers and WPATH guidelines
    d. Clarifies when surgical revisions are a covered service
    e. Add requirement for smoking cessation prior to genital surgeries
        i. Evidence of improved outcomes; agrees with Dr. Dugi's recommendations
2) Add laser hair removal for surgical site preparation (CPT 17110, 17111) to line 317 GENDER DYSPHORIA
    a. 17110: Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
    b. 17111: 15 or more lesions
    c. Modify the guideline note as shown below regarding hair removal
3) Add pelvic physical therapy to line 317 GENDER DYSPHORIA
    a. 97001 Physical therapy evaluation

b. 97002 Physical therapy re-evaluation
c. 97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
d. 97140 Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
e. 97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
f. Modify the guideline note as shown below to specify use only for pre- and post-operative therapy for included genital surgery.

GUIDELINE NOTE 127, GENDER DYSPHORIA

Line 317

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. for genital surgeries, 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. for genital surgeries, 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 version 7 of the WPATH Standards of Care.
8. For genital surgeries, be abstinent from tobacco products for 6 weeks prior to surgery, to be confirmed by urine cotinine testing.

Electrolysis (CPT 17380) and laser hair removal (CPT 17110, 17111) are ~~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~~ These procedures are not included on this line for facial or other cosmetic procedures or as pre-surgical preparation for a procedure not included on this line.

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

Revisions to surgeries for the treatment of gender dysphoria are only covered in cases where the revision is required to address complications of the surgery (wound dehiscence, fistula, chronic pain, etc.). Revisions are not covered solely for cosmetic issues.

Pelvic physical therapy (CPT 97001, 97001, 97110, 97140, and 97530) is included on this line only for pre- and post-operative therapy related to genital surgeries also included on this line.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and CHIP Services

NOVEMBER 5, 2015

MEDICAID DRUG REBATE PROGRAM NOTICE **Release No. 172**

For State Technical Contacts

ASSURING MEDICAID BENEFICIARIES ACCESS TO HEPATITIS C (HCV) DRUGS

The Centers for Medicare & Medicaid Services (CMS) remains committed to Medicaid beneficiaries continuing to have access to needed prescribed medications, a commitment we know that states share. The purpose of this letter is to advise states on the coverage of drugs for Medicaid beneficiaries living with hepatitis C virus (HCV) infections. Specifically, this letter addresses utilization of the direct-acting antiviral (DAA) drugs approved by the Food and Drug Administration (FDA) for the treatment of chronic HCV infected patients.

Rules Regarding Medicaid Drug Coverage

Coverage of prescription drugs is an optional benefit in state Medicaid programs, though all fifty (50) states and the District of Columbia currently provide this benefit. States that provide assistance for covered outpatient drugs of manufacturers that have entered into, and have in effect, rebate agreements described in section 1927(b) of the Social Security Act (the Act) under their Medicaid fee-for-service (FFS) programs or Medicaid managed care plans are required to comply with the requirements of section 1927(d)(1) and (2) of the Act.

Section 1927(d)(1) of the Act provides that a state may subject a covered outpatient drug to prior authorization, or exclude or otherwise restrict coverage of a covered outpatient drug if the prescribed use is not for a medically accepted indication as defined by section 1927(k)(6) of the Act, or the drug is included in the list of drugs or drug classes (or their medical uses), that may be excluded or otherwise restricted under section 1927(d)(2) of the Act.

Section 1927(k)(6) of the Act defines the term “medically accepted indication” as any use of a covered outpatient drug which is approved under the Food Drug And Cosmetic Act (FFDCA), or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in section 1927(g)(1)(B)(i).

When establishing formularies, states must ensure compliance with the requirements in section 1927(d)(4), including the requirements of section 1927(d)(4)(C) of the Act. Under this provision, a covered outpatient drug may only be excluded with respect to the treatment of a specific disease or condition for an identified population if, based on the drug's labeling, or in the case of a drug the prescribed use of which is not approved under the FFDCA, but is a medically accepted indication based on information from the appropriate compendia described in section 1927(k)(6), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

Accordingly, to the extent that states provide coverage of prescription drugs, they are required to provide coverage for those covered outpatient drugs of manufacturers that have entered into, and have in effect, rebate agreements described in section 1927(b) of the Act, when such drugs are prescribed for medically accepted indications, including the new DAA HCV drugs.

CMS is aware that, given the costs of these new DAA HCV drugs, states have raised concerns about the budgetary impact to their Medicaid programs and beneficiary access to needed care. The agency shares these concerns. However, the recent launch of multiple DAA HCV drugs in the marketplace is creating competition in this class that may result in downward pressure on the prices of these drugs. This competition may enhance the ability of states to negotiate supplemental rebates or other pricing arrangements with manufacturers to obtain more competitive prices for both their FFS and managed care programs, thereby reducing costs. CMS encourages states to take advantage of such opportunities.

To that end, manufacturers have a role to play in ensuring access and affordability to these medications. CMS has sent a letter to the manufacturers of these DAA HCV drugs, asking them to provide information regarding any value-based purchasing arrangements they offer for these drugs so that states might be able to participate in such arrangements.

Permissible Limitations to Medicaid Drug Coverage

CMS is concerned that some states are restricting access to DAA HCV drugs contrary to the statutory requirements in section 1927 of the Act by imposing conditions for coverage that may unreasonably restrict access to these drugs. For example, several state Medicaid programs are limiting treatment to those beneficiaries whose extent of liver damage has progressed to metavir fibrosis score F3, while a number of states are requiring metavir fibrosis scores of F4[1].

[1] The metavir scoring system is used to assess inflammation and fibrosis by histopathological evaluation of a liver biopsy of patients with hepatitis C. The stages, indicated by F0 through F4, represent the amount of fibrosis or scarring of the liver. F0 indicates no fibrosis while F4 represents cirrhosis; a chronic degenerative liver disease state in which normal liver cells are damaged and are then replaced by scar tissue. For more information about liver fibrosis please read Ramon Batallar and David A. Brenner, Liver fibrosis Journal of Clinical Investigation. 2005 Feb 1; 115(2): 209–218 by visiting http://www.ncbi.nlm.nih.gov/pmc/articles/PMC546435/

Certain states are also requiring a period of abstinence from drug and alcohol abuse as a condition for payment for DAA HCV drugs. In addition, several states are requiring that prescriptions for DAA HCV drugs must be prescribed by, or in consultation with specific provider types, like gastroenterologists, hepatologists, liver transplant specialists, or infectious disease specialists in order for payments to be provided for the drug.

While states have the discretion to establish certain limitations on the coverage of these drugs, such as preferred drug lists and use of prior authorization processes,[2] such practices must be consistent with requirements of section 1927(d) of the Act to ensure appropriate utilization.

As such, the effect of such limitations should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections. States should, therefore, examine their drug benefits to ensure that limitations do not unreasonably restrict coverage of effective treatment using the new DAA HCV drugs.

CMS encourages states to exercise sound clinical judgment and utilize available resources to determine their coverage policies. These resources include pharmacy and therapeutics (P&T) committees, drug utilization review (DUR) boards, and comparative analysis of the costs to treat HCV patients in light of the efficacy of these newer regimens in terms of cure rates, when compared to those of preexistent therapies. Additionally, CMS notes the availability of guidelines for states to refer to regarding testing, managing, and treating HCV put forth by the American Association for the Study of Liver Diseases (AASLD), the Infectious Diseases Society of America (IDSA), and the International Antiviral Society-USA (IAS-USA), which can be found at http://www.hcvguidelines.org/full-report-view. CMS also suggests that states consider implementing programs that provide patients on HCV treatment with supportive care that will enhance their adherence to regimens, thereby increasing the success rates.

Coverage under Medicaid Managed Care Plans

CMS is also concerned that in many states, Medicaid managed care organizations (MCOs) or other managed care arrangements' conditions for payment for DAA HCV drugs appear to be more restrictive than coverage under the states' fee-for-service (FFS) programs. Furthermore, in states with multiple MCOs or arrangements, the conditions for payment for DAA HCV drugs often differ between various plans.

CMS reminds states that the drugs under the approved state plan must be available to individuals enrolled in Medicaid managed care arrangements. As with their FFS program, states are urged to carefully monitor the DAA HCV drug coverage policies of their MCOs to ensure enrollees have appropriate access. States have the option to include these drugs in the managed care contracts and capitation rates or to "carve out" the drugs used in the treatment of chronic HCV

[2] In accordance with section 1927(d)(5) of the Act, a state plan may establish a prior authorization program as a condition of coverage or payment for a covered outpatient drug; however, the program must provide responses by telephone or other telecommunication device within 24 hours of a request for prior authorization, and, except for those drugs restricted or excluded from coverage pursuant to section 1927(d)(2) of the Act, provide for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation.

infections from managed care contracts and capitation rates and instead provide access to these drugs through FFS or other arrangements.

Consistent with the regulation at 42 CFR §438.210, services covered under Medicaid managed care contracts (with MCOs, prepaid inpatient health plans, and prepaid ambulatory health plans) must be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services for beneficiaries under FFS Medicaid. While managed care plans may place appropriate limits on DAA HCV drugs using criteria applied under the state plan, such as medical necessity, the managed care plan may not use a standard for determining medical necessity that is more restrictive than is used in the state plan.

CMS notes that managed care plans are permitted to use other utilization controls provided that the services, as controlled under the health plan's policies, can be reasonably expected to achieve their purpose. However, states should carefully monitor utilization controls and the HCV coverage policies of their managed care plans to ensure that the organizations are providing appropriate access to covered services and benefits consistent with 42 CFR §438.210.

CMS recognizes the challenges of defining policies in the face of new and innovative drug treatments. It will monitor the policies and conditions states impose for the coverage of DAA HCV drugs to ensure compliance with the requirements of the Act and access to effective, clinically appropriate, and medically necessary treatments for beneficiaries. CMS will monitor state compliance with their approved state plans, the statue, and regulations to assure that access to these medications is maintained.

CMS shares with states the common goal of ensuring access to quality care for Medicaid beneficiaries. Given the complexities that have arisen with the introduction of the DAA HCV drugs, CMS will continue to work with State Medicaid agencies to continue providing and improving care to persons infected with chronic HCV infections. If you have any questions, please contact John M. Coster, Ph.D., R.Ph., Director of the Division of Pharmacy, at John.Coster@cms.hhs.gov.

/s/

Alissa Mooney DeBoy
Acting Director
Disabled and Elderly Health Programs Group

Health Policy and Analytics Division
Kate Brown, Governor

Oregon Health Authority
500 Summer St. NE, 5th Floor, E54
Salem, OR 97301

Date

CCO
Address
Address

Dear CCO Medical Directors and Pharmacy Directors:

On November 5, 2015, Centers for Medicare & Medicaid Services (CMS) issued Release No. 172 concerning Medicaid beneficiary access to direct acting antiviral (DAA) treatments of hepatitis C (HCV). CMS expressed concern that in many states, Medicaid managed care plans' "conditions for payment for DAA HCV drugs appear to be more restrictive than coverage under the states' fee-for-service (FFS) programs." The Release suggests greater restriction may violate 42 CFR §438.210. The release explains this federal regulation requires any services covered by the managed care plan "be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid." The regulation further sets requirements on the managed care plan definition of "medically necessary services." CMS, through the release, explains that a "managed care plan may not use a standard for determining medical necessity that is more restrictive than is used in the state plan." The Oregon Health Authority carefully reviewed federal law in light of Release No. 172, and understands the concerns raised apply to Oregon's CCOs.

Release No. 172 specifically addresses coverage limitations based on metavir fibrosis scoring, a required period of abstinence from drug and alcohol abuse, and prescribing by, or in consultation with, a specific provider type. I am attaching the current coverage criteria for DAA HCV drug coverage in FFS OHP. Effective January 1, 2015, the Oregon Pharmacy and Therapeutics (P&T) Committee approved DAA coverage for metavir fibrosis scores F3 and F4, along with clinical indications as attached. This coverage determination was based on medical evidence available at the time that showed DAA agents are medically appropriate, safe and effective for these fibrosis stages. The coverage recommendation was also based on the "Community Standard" recommended by the Hepatitis C Advisory Committee. In addition, evidence showed that waiting to treat until stage F4 would result in both poorer clinical outcomes and decreased efficacy of DAAs.

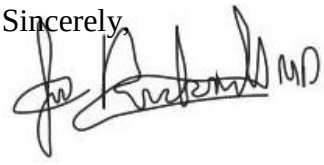
On January 28, 2016, the P&T Committee recommended additional changes to clarify coverage and expand coverage for certain clinical indications including transplant patients and HIV coinfection. Their recommendation, which I have attached, will go into effect February 12, 2016 if approved. Current and historic PA criteria is available in the Oregon Medicaid PA Criteria section of the Pharmaceutical Services Program policy page, available at http://www.oregon.gov/oha/healthplan/Pages/pharmacy-policy.aspx. As new agents come to market and as new medical evidence becomes available, our P&T will periodically review medical evidence to ensure appropriate access to DAA HCV agents.

Release No. 172 urges states to "carefully monitor the DAA HCV drug coverage policies of their MCOs to ensure enrollees have appropriate access." Please assist me in meeting this obligation by sending your

CCO's current coverage criteria for DAA HCV drugs and by updating coverage in whatever ways are necessary to comply with federal Medicaid law.

Thank you for your commitment to the health and wellbeing of Oregonians. We look forward to collaborating to achieve the triple aim for all OHP beneficiaries.

Sincerely,



Dr. Jim Rickards, MD, MBA
Chief Medical Officer, Oregon Health Authority

cc: Lynne Saxton, OHA Director
Lori Coyner, State Medicaid Director
Dr. Varsha Chauhan, MD, Chief Health Systems Officer Leslie Clement, Health Policy and Analytics Division Director

Encl: Medicaid Drug Rebate Program Notice, Release No. 172, CMS, November 5, 2015 FFS Hepatitis C DAA coverage criteria, effective January 1, 2016 (current) Revised FFS Hepatitis C DAA coverage criteria, effective February 12, 2016

Draft Learning Collaborative sessions on Medication-Assisted Treatment

Monday April 11th 11:00 AM – 12:30 PM. Salem, OR

- Provide an overview of best practices for Opioid Treatment Programs (OTP) and Medication-Assisted Treatment (MAT). Discuss innovative programs.
- Describe the role of medications in the treatment opioid addiction. Discuss the management of chronic pain in substance use disorders.
- Provide a summary of OTP, MAT and naloxone distribution programs in Oregon

Monday June 13th 11:00 AM – 12:30 PM. Salem, OR

- How CCOs can support and encourage providers in becoming MAT prescribers and in utilizing existing OTPs and MAT prescribers?
- CCOs' responsibilities in tracking and monitoring of programs and prescribers
- The State's role in monitoring OPTs, MAT and naloxone prescribers

If you have specific questions or concerns that you would like speakers to address, please send them to: PIPTeam@acumentra.org by March 17th.

Health Equity and Inclusion Technical Assistance Coach Highlights

	CHIP Implementation	Community engagement	Cultural Competency (providers/ clinicians)	Cultural competency (organizations/ employees)	General training/TA	Leadership development	Strategic planning	Health literacy	Real+D data collection	Workforce Diversity	Language specialty/ community focus/ other
Asian Health & Service Center			✓	✓	✓				✓	✓	Chinese, Korean, Vietnamese
Figure 8 Knot Consulting LLC			✓	✓	✓	✓		✓			
Interface Network Inc		✓	✓	✓	✓	✓	✓	✓			Latino, gender issues, needs assessments
John Lessen			✓	✓	✓	✓					
Lutheran Community Services				✓	✓					✓	15+ languages, immigrants, refugees, mental health
Oregon Public Health Institute	✓	✓	✓	✓	✓		✓	✓			Maasai, Swahili, immigrants, refugees, maternal child health

Equity and Inclusion (E&I) Coaches| Individual TA Provider Biographies

Asian Health & Service Center (AHSC)

Holden Leung, MSW
Chief Executive Officer
Holden has management and consultant experience in both government and non-profit sectors for over 30 years.

Christine Lau, MA, CADCI
Chief Operating Officer,
Christine has accumulated both clinical and operational management experience for over 20 years.

Gemma Kim, LCSW, RN
Clinical Care Specialist
Gemma has over 20 years of experience in clinical and social work.

Vananh Nguyen, MPH
Project Coordinator
Vananh is a first-generation Vietnamese American who has experiences in acculturation and enculturation.

Figure 8 Knot Consulting LLC

April D. Lewis
Co-owner and trainer/consultant
April has more than 20 years' experience in cultural agility, diversity, and intercultural organizational development. Her fun, dynamic, and charismatic style engages audiences with her knowledge, skills, sense of humor, and her passion for combining humor with learning.

Carol D. French
Co-owner and trainer/consultant
Carol's background is in education where she served as a counselor, instructor, and diversity trainer. She has had years of experience in curriculum development, and her interactive training style was developed and refined in classrooms and on ropes courses where she operated with humor, fun, and the philosophy that learning is best when it is experiential and involves the whole person.

Interface Network Inc.

Colleen Puentes
Senior Diversity Trainer and Equity Specialist
Colleen has over 20 years of training and facilitation experience in addressing cultural competency, cross-cultural communication, diversity, inclusion and service equity and adult learning and literacy. She is an energetic facilitator and trainer experienced in cross-cultural conflict resolution, workplace climate assessment, conducting focus groups, service equity and customer service and inclusive leadership. Today the workforce is more diverse than ever and is constantly changing. Colleen is committed to assisting organizations to create work environments that are equitable, productive and inclusive for all internal and external customers. She has worked throughout Oregon with public agencies, hospitals, clinics, hospice care providers, medical staff and volunteers in reducing healthcare disparities and improving service delivery for culturally, ethnically and linguistically diverse populations.

Colleen has taught in the education departments of San Jose State University and Western Oregon University and has extensive experience in education program evaluation. She has a Bachelor of Science Degree in Speech Communications from Oregon State University, a Multiple Subject teaching credential from Santa Clara University and a Master's Degree in Education Administration from Santa Clara University. Colleen also earned a Certificate of Language Acquisition Development from California. Colleen lives in Salem, Oregon with her husband and four children.

Esther Puentes
Owner and president of Interface Network Inc.
Esther has worked successfully with the private and public sectors in providing technical assistance, training, needs assessments and information gathering through focus groups, surveys, questionnaires and cultural audits. She has extensive knowledge and experience in professional development and training a productive work force. She is passionate about providing equal access and assisting organizations in developing and implementing service equity plans. She has spent the last twenty-eight years providing training and consulting services for diverse markets at local, national and international levels.

Esther has extensive experience in outreach to the Latino and other diverse communities, teambuilding, developing and facilitating needs assessment and information gathering processes targeting Latino communities, strategic planning, interpersonal communication, gender issues, training of trainers, English language instruction, and diversity action plans for private businesses, public agencies and community-based organizations. The following is a sampling of agencies she has worked with: City of Salem, State of Oregon, US Department of Education, Department of Labor, AID for International Development, Oregon Health Authority, OHA Office of Equity and Inclusion, Redevelopment Agency for the City of San Jose, Oregon Human Development Corporation, Oregon Dispute Resolution Commission, Salem Health, Willamette Valley Medical Center, Incite Inc. and Swinerton Incorporated.

	Esther has a Bachelor of Arts Degree in Liberal Arts/Education from San Jose State University in California, and a Master's Degree in Bicultural Education from San Jose State University. She also holds a teaching credential from the state of California. She is a former Board of Director for the Oregon Higher Education Board and the Chairperson of the Oregon Youth Authority Hispanic Advisory Council. She is currently a board member of the Marion Polk Food Share. Esther lives in Salem, Oregon with her husband.
	**Marin Arreola** **Owner and president of Advanced Economic Solutions Inc.** Marin has over 20 years of experience developing and implementing economic, business, health and workforce development programs to better serve culturally and socially diverse communities throughout Oregon and California. Marin has worked with the Oregon Health Authority, Salem Health, Willamette Valley Medical Center, Oregon Business Development Department, Department of Human Services and the Governor's Office of Business and Equity to name a few. Marin is energetic and passionate about developing and implementing culturally and linguistically appropriate health care programs that lower disparities in healthcare in diverse communities. He implemented an evaluation model known as "Social Return on Investment" to effectively measure the success of health, economic and workforce development programs that focused on diverse communities. Additionally, Marin has served on many commissions and boards that seek to better serve culturally and socially diverse communities in Oregon and California. Marin majored in Political Science at California Polytechnic State University with a minor in International Affairs. He has an Entrepreneurship Development Management Certificate from Silicon Valley Economic Development Corporation and an Economic Development Planning Certificate from International Economic Development Council. Marin is a current board member of the Friends of Pimpollo, Garten Services and the Salem Area Chamber of Commerce as well as a member of Mayor Ana Peterson's International Council. Marin Arreola has been married for 19 years, has four children and resides in Salem.
John Lenssen and Associates, LLC	
	**John Lenssen** John Lenssen works with agencies, schools and organizations on issues of equity, leadership, culture, communication, conflict, bias, and organizational change. He is an adjunct faculty member at the University of Oregon, Portland State University, and Lewis and Clark College, teaching graduate courses in leadership, social justice, communication, health equity, violence prevention, conflict resolution, and cultural competency. He previously served as the Team Leader for the Access and Equity Team at the Oregon Department of Education where he also served as the state coordinator for the Safe and Drug-Free Schools and Communities Program. He has also served as an administrator with the Educational Opportunities Program at Oregon State University and the Office of Minority Affairs at the University of Washington. He is a former community college instructor and head start teacher. He currently serves as chair of the Oregon Leadership Network, is a Board Member for Sojourn Theatre, and is an advisor to the Salem Keizer Coalition for Equality. He consults and collaborates with Stir Fry Seminars in Berkeley, with Education and Training Consultants, Inc. in Oregon, and Workplace Solutions in New York.

Lutheran Community Services

Pierre Morin
Clinical Director/Trainer
Born in Switzerland, Dr. Morin was trained as a physician with specialty in tropical medicine, psychosocial and rehabilitation medicine in Europe. He later obtained a PhD in Interdisciplinary Studies, with a focus in Health Psychology. He has overseen many community health projects in Europe, Africa and the USA. He is trained in the Living Well with Chronic Conditions Model. For all his professional life he has been involved in community and minority physical and mental health. He is also trained as a mediator and group facilitator and has years of experience working with culturally diverse groups. Dr. Morin is multi-lingual and bi-cultural.

Susanne Steinmann
Project Coordinator/Trainer
Born in Switzerland, Susanne is bi-cultural and multilingual. She has over 20 years of experience teaching in cross-cultural settings. She has a PhD in Geography, an MA in Teaching with ESL focus and in International Development. She has spent many years abroad in Africa, the Middle East and Europe engaging in community-based research and teaching, and offering participant-based consulting services and trainings with a range stakeholders including diverse refugee and immigrant groups, program staff, and policy makers in the wider community. In recent years, she has administered and managed numerous LCSNW programs serving refugees and immigrants in Portland. She Speaks English, Arabic, and German.

Mohammed Maraee
Project Assistant/Trainer
Born in Iraq and spending many years in Jordan, Mohammed offers a wealth of experience with organization and system change. He is an expert in evaluating outcome data, creating system changes, quality assurance and management consultation, and organizational evaluation. Mohammed is multi-lingual.

Assefash Melles
Trainer
Born in Ethiopia, Assefash is a clinical counselor who partners with social service organizations to facilitate growth in individuals and groups by creating sustainable, culturally relevant service models which promote self-sufficiency in addressing physical, social and psychological wellness.
Ms. Melles is multi-lingual.

	**Olga Parker** **Trainer** Born in Russia, Olga Parker is a clinical counselor who is an expert in conducting ongoing outreach on available mental health services and other social services to members of Eastern European immigrant population. She also provides Gatekeeper training/education to members of local community that provide services to Eastern European immigrant populations. Olga is bi-lingual (English/Russian) and bi-cultural.
	**Lul Abdulle** **Trainer** Born in Somalia, Lul has over 14 years' experience in coordinating community based events and workshops, forming support groups and working to build strong communities within refugee and immigrant population groups. She is a professional translator/interpreter in social service, medical, legal and educational settings. Lul is also multilingual and speaks Somali, Somali Bantu, Arabic, Swahili and Italian.
	**Sasha Verbillis-Kolp** **Trainer** Sasha is a clinical social worker with a focus on global mental health, international development and forced migration studies. Recently, she served as the evaluation coordinator for the Pathways to Wellness project where she helped develop the Refugee Health Screener-15 (RHS-15), a mental health screening tool used to detect trauma, depression and anxiety symptoms in refugees. She provides consultation and technical assistance to health sites implementing mental health screening for refugees. Currently, as a Program coordinator she focuses on community-level interventions for refugees that promote emotional health and well-being through alternative therapies. These include adjustment support groups, activities which incorporate traditional arts and urban agriculture and peers support services. As a clinician she provides culturally appropriate clinical assessment and treatment planning. She frequently lectures on refugee health disparities, cross-cultural treatment approaches and psycho-social interventions. She is chair of a Task Force for Refugee Emotional Health in the Portland area, and serves as an Oregon representative to the American Association of Refugee Health Coordinators- Refugee Emotional Wellness Work group.
	Dalia Baaderani **Trainer** Born in Lebanon, Dalia has served as a school counselor and mental health therapist in multiple settings. She is currently finishing a PhD. Her research interest focus on mental health as perceived by Muslim Americans, counseling issues among refugees in the U.S., Post-Traumatic Stress Disorder (PTSD) & Emotional Intelligence, prevention advocacy, and culturally adapted interventions. She speaks Arabic and English.

	**David Ochan** **Trainer** Born in Uganda and lived in Kenya, David serves as the Coordinator for the Minority Aids Initiative. He is an expert cross-cultural communicator and has innate ability to connect across a range of individuals on difficult subjects. He was well-known in Africa for his musical public health messages. He speaks 7 different languages.
	**Raumene Rahatzad** **Trainer** Born in the United States with Iranian parents, Raumene has had a lifelong interest in other cultures. He graduated with honors in International/Intercultural Studies with a focus on the Middle East and later completed his Master's Degree in Couples, Marriage and Family Counseling from Portland State University. He has spent significant time abroad in Jordan and later as a Fulbright Scholar in Azerbaijan. He is often sought to provide training on working with Muslim clients. He is bi-lingual in Farsi.
	**Massarra Eiwaz** **Trainer** Born in Iraq and living Syria for five years, Massarra came to U.S. with her family in 2008. She has several years of experience in medical research as well as working with refugees and immigrants to promote well-being. Massarra obtained her B.S. in Psychology at Lewis & Clark College. Today, she is a Case Manager for the *Pathways to Wellness* program. She is bi-lingual in English and Arabic.
	**Daya Shakya** **Trainer** Born in Nepal, Daya has a wide breadth of experience working as an Education Specialist with the School Advocacy for Refugee Newcomers program as well as working as a Peer Mentor with the *Pathways to Wellness* program. Daya has a degree in Linguistics from the University of Oregon. He has provided healthcare and social service interpretation for the Bhutanese community since 2008. He speaks English, Neplai, Newah, Hindi, and Tibetan.
	**Aline Ndemeye, Trainer** Born in Rwanda and moving to the U.S. twelve years ago, Aline has become an expert at working across cultures. She works as the Case Manager for the Intensive Case Management program under Refugee Reception and Placement. Aline has a degree Community Health from Portland State University. She has many years of experience advocating for minority and refugee women's health and serving as a facilitator with the African Women's Coalition. Aline speaks five different languages – French, Spanish, Swahili, Kinyarwanda and English.

Oregon Public Health Institute (OPHI)

Liz Baxter, MPH
Executive Director
Liz has more than three decades of experience in health and health policy, and has been influential in reframing Oregon's policy debate to emphasize health rather than simply medical care. She brings extensive experience leading cross-system collaborations (with internal and external partners) to improve health outcomes for community members with chronic health conditions, focusing on patient experience of care and strategic initiatives to improve care to community members.

Liz has led innovative projects to improve care and services, as well as national research and demonstration projects to improve outcomes for at risk patients and community members. Liz is a trained facilitator. Though not a clinician, Liz is respected by medical leaders across Oregon and the nation for her ability to bridge the language of health, health care and public health. She has led work supporting development of the Community Advisory Councils throughout Oregon. Liz received her Master's in Public Health from Portland State University, where she has also taught courses on federal and state health reform. She also currently sits on the boards of Mackenzie River Gathering Foundation and Oregon Health Decisions.

Steve White, MURP
Healthy Community Planning and Health Impact Assessment
Steve White, MURP, is a project manager for OPHI's Health Impact Assessment (HIA) and Healthy Community Planning initiatives. His work focuses on assessing and improving the connection between the built environment and health through the use evidence-based strategies for educating and working with diverse stakeholders to include public health into decision-making processes. Steve has completed multiple HIAs on plans and projects in the housing, land use and transportation sectors, and has conducted research on active transportation, housing and food access issues. Steve also provides training and technical assistance nationally.

Steve received his Masters in Urban and Regional Planning from the Nohad A. Toulan School of Urban Studies and Planning at Portland State University, and has received facilitation training through the Institute of Cultural Affairs' Technology of Participation program. Prior to joining OPHI, Steve worked on a GIS project to assess and improve food access in Portland and conducted research on active transportation behavior and Safe Routes to School programs.
Steve is adept at explaining key public health concepts and strategies to people in different sectors, as well as helping public health practitioners understand concepts, policies and practices related to the built environment.

	**Dawn Robbins** **Worksite Wellness** Dawn has worked for more than 20 years in health and communications. Through the Wellness@Work movement, Dawn works with a wide array of partners to create a culture of health in all worksites, both public and private. A journalist by training, Dawn has written articles and several toolkits, including the Wellness@Work toolkit. Prior to coming to OPHI in 2012, Dawn worked on several public health initiatives. In 2002, she founded the nationally recognized initiative: Make It Your Business: Insure a Tobacco-Free Workforce. In 2007, a toolkit she developed supported the creation of tobacco-free living in psychiatric facilities across the nation. Since then, her work has focused on creating a culture of health in worksites of all sizes and types.
	**Steffeni Mendoza Gray,** **City Engagement and Partnerships Manager** Steffeni manages the HEAL Cities Campaign. She has over 25 years of professional experience in executive non-profit management positions and government relations for local government with a focus on social justice and equity. She has worked with elected officials, business leaders, non-profit organizations and key stakeholders in cities, counties, and tribes throughout Oregon to adopt and implement culturally-appropriate policies that improve education, workforce development, economic development opportunities, and health equity for underserved communities. Steffeni has served, and continues to serve, on numerous public and private sector policy advisory committees and task forces, particularly in the areas of work/family issues, community development, economic development, urban design and planning, civic engagement, business development, education and public health advocacy. Steffeni has a Bachelor's degree in Architecture from the University of Oregon. The Oregon Business Magazine selected her as one of Oregon's Top 50 Business Leaders in 2004. She is also a Senior Fellow of the American Leadership Forum of Oregon.
	**Emily Henke,** **Policy Manager** Emily joined OPHI as in 2014, after completing her Master of Public Health at Portland State University with a focus on health management and policy. Emily began her public health work in 2010 as an outreach worker for the Oregon Healthy Kids program, an experience that motivated her to broaden her health policy knowledge and develop program planning skills in order to increase access to better health for all Oregonians. At OPHI, Emily's work focuses on the intersection of healthcare and public health and the transformation of the healthcare system. She works on several projects, including the Consumer Confidence Project, the Oregon Healthiest State Initiative, and OPHI's health impact assessment work. She is passionate about system change and improvement, and about listening to community and consumer voices as Oregon transforms its health system.

	**Karli Thorstenson, MPH** **Program Coordinator** Karli has over seven years of experience working in policy, systems, and environmental change to improve community health. She works to utilize new and traditional media to engage the public to think differently about health and adopt individual and environmental changes to improve healthy eating and active living. Karli works on several OPHI projects including HIAs, healthy community planning, the HEAL Cities Campaign, and the Wellness@Work movement. She has managed community meetings gathering input on the immunizations and how local health districts can identify new revenue streams to support their work as more people across the state gain insurance coverage. Karli also leads OPHI's communications efforts, which includes translating policy jargon into language that professionals and lay community members can understand. Karli received her Master's in Public Health at the University of Arizona with an emphasis in Health Promotion.
	**Zeenia Junkeer, ND** **Maternal and Child Health** Zeenia has more than six years of experience working with diverse populations in clinical and community settings, including international work focused on improving health outcomes for women, children, and families while supporting local capacities in the areas of food security, education, and community health work. Her training as a Naturopathic physician is the foundation for her passion for whole food nutrition, preventive programs and practices, and culturally appropriate work within communities disproportionately affected by poverty, marginalization, and oppression. As the Maternal and Child Health project lead, Zeenia facilitates the Right from the Start Coalition, which works to bring together key partners in child care, public health, research, and advocacy to collaboratively identify and implement effective strategies for promoting healthy weight in child care settings. A focus of this work is to engage and outreach to diverse populations of providers so all children can have access to the resources, knowledge, and programs offered at the state and local levels.
	**Edna Nyamu, CHW** **ORCHWA Coordinator** Edna is the Coordinator for Oregon Community Health Workers Association (ORCHWA). Edna received her Bachelor of Science in Health Care Administration from Concordia University in Portland Oregon. Edna is a certified Community Health Worker and also a certified Child Development Associate (CDA) and has worked extensively with children as a teacher aide at Crossroads Christian School in Portland. She is an active volunteer at Tuality Community Hospital helping patients in the admission and dismissal department. Edna speaks three languages, English, Maasai, and Swahili; in-addition, she does Swahili language interpretation. Edna clearly understands other cultures and has been working closely with immigrant, refugees, and people of color. Edna is also a member for the Commission for Traditional Health workers (THWs) in Oregon.

	**Celia Higueras, MPH** **Warriors of Wellness Project Manager** Raised in Chile, Celia received her BA in sociology degree from Lewis and Clark College. She has worked with community health workers in Portland, New York City and Santiago on issues ranging from gender violence, to nutrition, to chronic disease control with the elderly. Celia is dedicated to improving health and decreasing disparities using community involvement, culturally competent care and popular education. Celia manages the Warriors of Wellness (WOW) project, a model in which healthcare systems can contract with community health worker programs to address the social determinants of health of their patient population. The WOW project is formed by a multicultural collaborative of community based organizations throughout the Portland metro area.
	**Pattie Carlin, MBA** **Operations and Finance Manager** Pattie has over ten years of experience in nonprofit administration, working with diverse groups of dedicated individuals helping people improve their lives. She spent six years working on a federal grant to revolutionize mental health services for children and families, giving her firsthand knowledge of the power of information, advocacy, and dedication to make positive change. Pattie provides daily operational support for OPHI and has been instrumental in creating and implementing workplace policies and procedures and organizational development. Her knowledge and experience in financial management, development, and board relations ensures OPHI runs smoothly and has effective statewide impact.

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.

Statewide CCO Learning Collaborative:

Quality and Health Outcomes Committee Meeting
500 Summer Street NE, Salem, OR 97301, Room 137 A-D
March 14, 2016 11:00 a.m. – 12:30 p.m.

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

Transgender Health

Session Objectives
Participants will:

1) Understand the basics of transgender health and the clinical environment
2) Understand current research related to transgender health
3) Understand the physical and mental health needs of the transgender individual and the corresponding benefit considerations

1. **Introduction and reflection** (Summer Boslaugh, Lynnea Lindsey-Pengelly, PhD, MSCP) (5 minutes)

2. **Transgender Health and Evolving Health Care Coverage Developments in Oregon** (80min total) (Christina Milano, MD and Jess Guerriero, LCSW)
   - **Transgender 101** (15min)
   - **Physical Health Needs of the Transgender Individual and Corresponding Benefit Updates** (20min)
   - **Mental Health Needs of the Transgender Individual and Corresponding Benefit Updates** (20min)
   - **Open Q&A** (25min)

   Christina Milano, MD is a family physician, and has spent the last decade as a PCP at OHSU Richmond Clinic in SE Portland and on the inpatient family medicine teaching service at OHSU. She is also the medical director of CareOregon Metro, serving 160,000 Health Share members in the Tri-County area. She specializes in providing family planning and related procedures to women of all ages, the care of transgender patients (including hormone therapy), and in the post-hospital care of complex medical patients. She is a co-founder of OHSU's Transgender Health Program.

   Jess Guerriero is a social worker with a second graduate degree in Gender and Cultural Studies from Simmons College. Following Simmons, Jess interned/ worked at Fenway Health and the Sydney Borum Health Center, which are both community health centers geared towards LGBTQI-identified individuals. There, Jess carried a caseload of children, adolescents, and adults who were coming to terms with their transgender identities and in some cases, navigating medical transitions. Jess also ran a support group for parents of trans youth and established an independent consulting business to help schools, businesses, and providers implement policies that were more trans-inclusive. Jess now works in Quality Management at LifeWorksNW, and serves as an internal trainer at LifeWorks NW on LGBTQI-related topics, is the chair of the Transgender Care Workgroup, and is an active member of the Diversity Resource Crew.

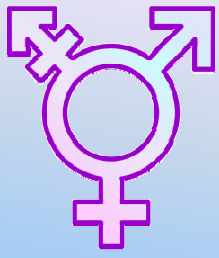
3. **Next steps** (Summer Boslaugh) (5 minutes)
   - May 9, 2016 QHOC meeting: Approaches to Achieving the Tobacco and Immunization Metrics
   - Evaluation

Transgender Health Resources

- **Provider tools:** Trans Health Provider Tool Kit compiled as part of the FamilyCare / Health Share training November, 2015. https://www.familycareinc.org/explore/trans-health-provider-tool-kit

- **Providers with training/experience with transgender individuals:** Basic Rights Oregon is a member of a task force of providers, organizations and advocates, who not only look at the transgender health care in the Oregon Health Plan, but transgender health care generally. Members of the group last year constructed a list of providers, which is currently being updated. This list is managed by Neola Young, who has consulted with Basic Rights Oregon, and Jazz McGinnis at Outside In working with community members and partners. https://oregontranshealth.files.wordpress.com/2015/01/oregon-health-plan-trans-healthcare-providers5.pdf

- **Oregon Health Plan benefits:** Basic Rights Oregon keeps several documents on their website. http://www.basicrights.org/resources/



Providing High Quality Care for the Transgender Patient

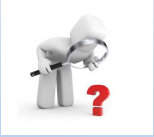
March 14, 2016 QHOC Collaborative

Christina Milano, MD, Jess Guerriero, MA, MSW

Outline

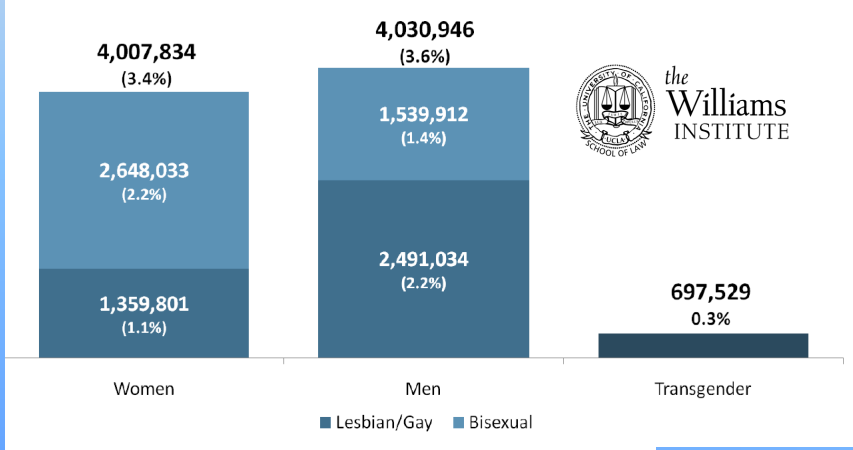
- Transgender Care as Emerging Focus
- Transgender : Terms, Identity vs Diagnosis
- Transgender Health in Primary Care
- Considerations in Mental Health
- Transgender Hormone Therapy
- Surgery/Subspecialty Referrals/Electrolysis
- Discussion re: Acess/Benefits/CCO Alignment
- We have nothing to disclose

Why has care of the Transgender patient emerged as a critical area of focus recently?



Reason #1: Epidemiologic

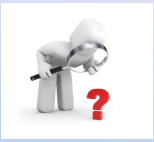
Figure 5. Percent and number of adults who identify as LGBT in the United States.



the Williams INSTITUTE

Gary J. Gates, Williams Distinguished Scholar

April 2011

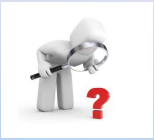


Reason #2:
Recent changes in Oregon

Oregon Insurance Division Bulletin INS 2012-01

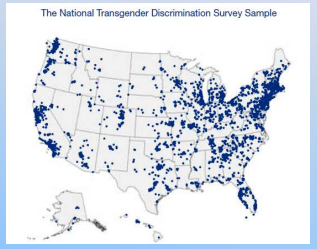
Oregon Department of Business and Consumer Services (DBCS) mandates that health insurance sold and purchased in Oregon:

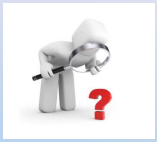
- must provide coverage and cannot deny coverage of treatments for transgender policy holders if the same treatments are covered for other policy holders
- may not have riders that categorically exclude all transgender patients.
- must heed the statewide mandate for coverage of mental health service regardless of gender status
- may not deny relevant treatment or screening based on patient designation of male or female gender (ie, a person cannot be denied an ovarian cancer screening on the basis that they identify as male)



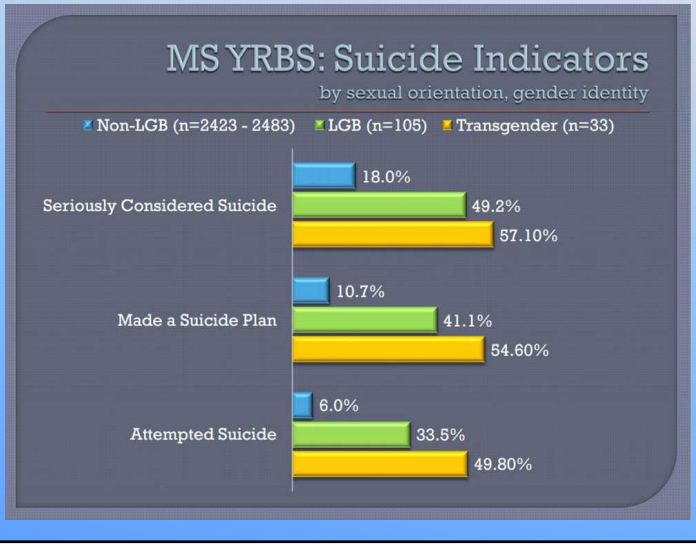
Reason #3:
Injustice at Every Turn,2011

- 70 question survey, 7500 respondents from all 50 states.
- **Health outcomes for all respondents show effects of social and economic marginalization**, including much higher rates of HIV infection, smoking, drug and alcohol use and suicide attempts (48%) than the natl avg.





Reason #4:
The experience of TG Youth



Orienting to the topic

Photo: http://cache.boston.com/resize/bonzai-fba/Globe_Photo/2011/12/11/1323581924_9814/539w.jpg

TERMS 101

Sexual Identity:
referring to who you are attracted to

Lesbian

Gay

Bi-Sexual

Queer

Gender Identity:
referring to an internal feeling of being: male, female, a mix of both, or neither

Transgender

(AVP, 2015)

TERMS 101: Language Matters

Transgender vs Cisgender

Affirmed Male, Affirmed Female

Trans Man, Trans Woman

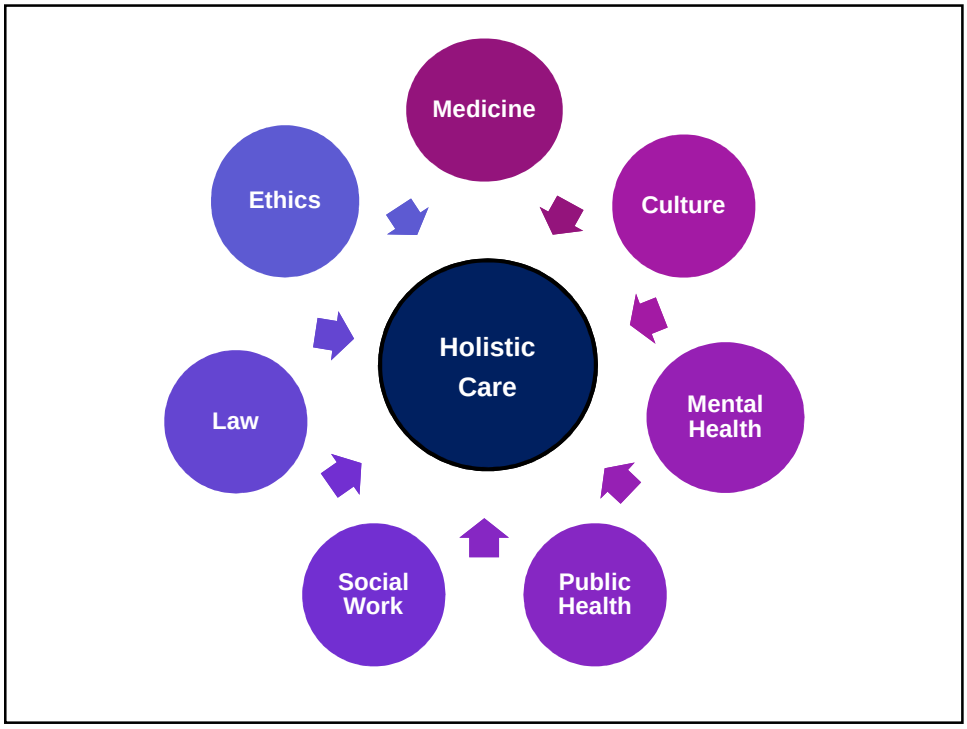
FTM, MTF

Note: Transgender is used as an **adjective**, not a noun or a verb: "a transgender person" vs. "a transgender" or "a transgendered person"

DIAGNOSIS V. IDENTITY

- When we're looking at diagnosis, we are focusing on the idea of dysphoria
- Dysphoria means the pain associated with a felt incongruence between body and identity, and body and how the rest of the world sees us
- When diagnosing, we are looking at the impact dysphoria has on areas of functioning and how treatment might relieve dysphoria and improve functioning

- While dysphoria might be part of experiencing a transgender identity, simply identifying as transgender is not a disorder and not diagnosable
- In fact, when I'm working with new clinicians, I tell them to not diagnose gender dysphoria unless a person meets criteria AND is seeking medical treatment
- As we approach diagnosis and treatment, we have to mindful about the role of stigma in the treatment relationship and trans people's overall experiences



Suggestions for improving the clinic environment

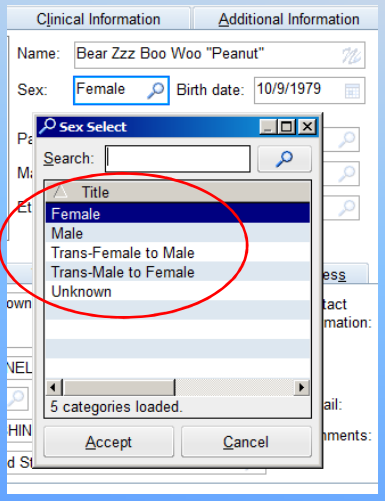
Suggestions for improving your practice

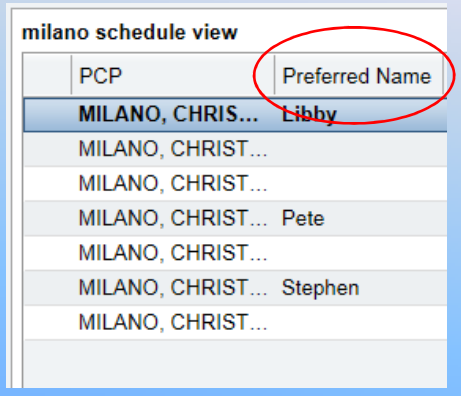
- Consider the patient experience from initial phone call to receipt of a bill, and everything in between.
- Initial call/request to Est Care – include TG care whenever offering selection of options
- Pre-arrival to clinic; use appt notes; Huddle is KEY!
- Initial intake forms: include "chosen" or "preferred" name, not just legal; multiple options under gender, including free-text option; same with "preferred pronoun"; "any unique health care prevention needs?"

Suggestions for improving your practice

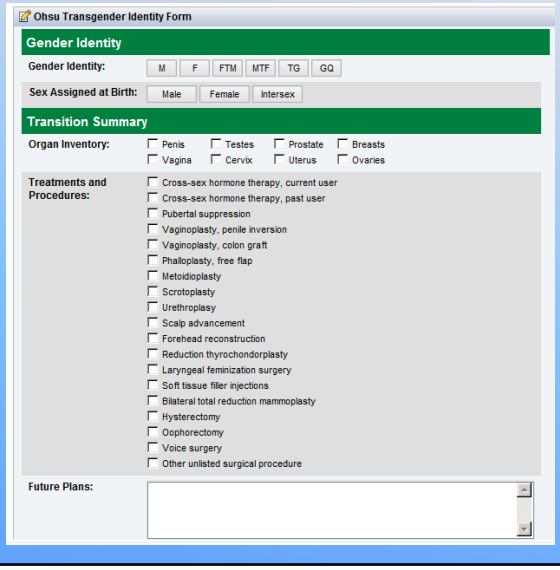
- Consider your EHR: where will you document gender status; how will you communicate with the patient about this; how will staff communicate in presence of and in regards to pt
- Consider routine workflows and how they may differ for TG pts: ie, HCM scrubs
- Consider BATHROOMS: Are they gender neutral?
- Create a list of what services you can offer and the protocols you are following (requirements for hormone initiation, frequency of visits, referral contacts)

Suggestions for improving your practice: OCHIN





Suggestions for improving your practice: EPIC



Suggestions:
OHSU TGHP as a Resource

Diversity & Inclusion

Transgender Health Program

Mission

The OHSU Transgender Health Program provides safe, comprehensive, affirming health care for the transgender and gender-nonconforming communities. The OHSU Transgender Health Program will endeavor to improve the community's overall well-being through education, research, and leadership that responds to the health care needs of transgender and gender nonconforming people.

The Goal of Hormone Therapy…

…for transgender people is to improve their ***quality of life*** by facilitating their transition to a physical state that more closely represents their sense of themselves

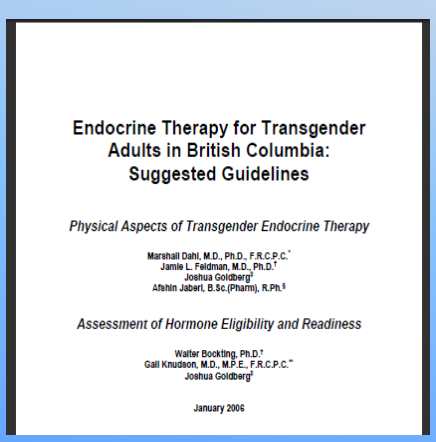
Practice Guidelines

WPATH (formerly "Harry Benjamin International Gender Dysphoria Association")

The World Professional Association for Transgender Health, Inc.
a nonprofit organization

Practice Guidelines

Canada, 2006



Endocrine Therapy for Transgender Adults in British Columbia: Suggested Guidelines

Physical Aspects of Transgender Endocrine Therapy

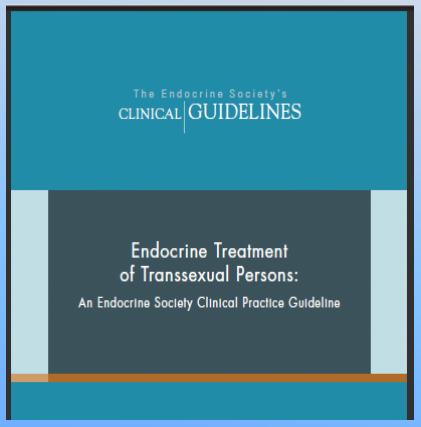
Marshall Dahl, M.D., Ph.D., F.R.C.P.C.[1]
Jamie L. Feldman, M.D., Ph.D.[2]
Joshua Goldberg[3]
Afshin Jaberi, B.Sc.(Pharm), R.Ph.[4]

Assessment of Hormone Eligibility and Readiness

Walter Bockting, Ph.D.[5]
Gail Knudson, M.D., M.P.E., F.R.C.P.C.[6]
Joshua Goldberg[3]

January 2006

The Endocrine Society, 2009



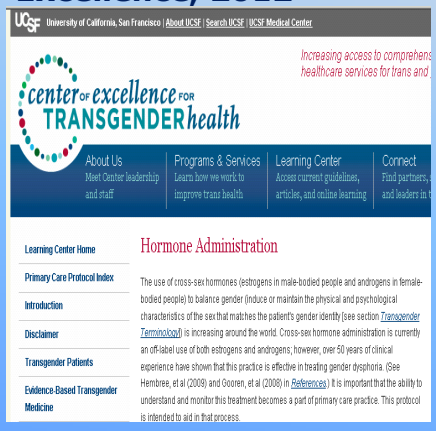
The Endocrine Society's CLINICAL GUIDELINES

Endocrine Treatment of Transsexual Persons:

An Endocrine Society Clinical Practice Guideline

Practice Guidelines

UCSF Center for Excellence, 2012



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Increasing access to comprehens
healthcare services for trans and

center of excellence for TRANSGENDER health

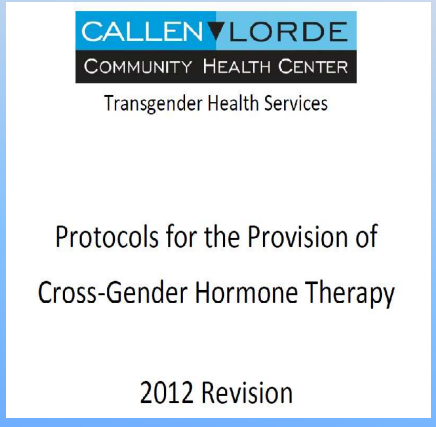
About Us — Meet Center leadership and staff
Programs & Services — Learn how we work to improve trans health
Learning Center — Access current guidelines, articles, and online learning
Connect — Find partners, and leaders in t

Learning Center Home
Primary Care Protocol Index
Introduction
Disclaimer
Transgender Patients
Evidence-Based Transgender Medicine

Hormone Administration

The use of cross-sex hormones (estrogens in male-bodied people and androgens in female-bodied people) to balance gender (induce or maintain the physical and psychological characteristics of the sex that matches the patient's gender identity [see section Transgender Terminology]) is increasing around the world. Cross-sex hormone administration is currently an off-label use of both estrogens and androgens; however, over 50 years of clinical experience have shown that this practice is effective in treating gender dysphoria. (See Hembree, et al (2009) and Gooren, et al (2008) in References.) It is important that the ability to understand and monitor this treatment becomes a part of primary care practice. This protocol is intended to aid in that process.

Callen Lorde CHC, NYC, 2012



CALLEN LORDE COMMUNITY HEALTH CENTER

Transgender Health Services

Protocols for the Provision of Cross-Gender Hormone Therapy

2012 Revision

Is Outside Letter from QMHP Necessary for Hormone Tx?

- Can be readily bypassed if prescribing clinician meets WPATH criteria for conducting assessment themselves (*health professional who has appropriate training in behavioral health and is competent in the assessment of gender dysphoria*)
- Patient is ELIGIBLE to initiate Hormone Therapy if:
  - Able to make a reasoned and informed decision
  - Adequately Informed of benefits and risks
- Patient is READY to initiate Hormone Therapy if:
  - Has engaged in extensive self-directed reflection with consolidation of gender identity
  - Has access to peer counselling/support
  - Has engaged in discussion with personal circle of friends/loved ones

Unique Considerations for the Pediatric Patient

- Early Referral to Pediatric Endocrinology partners is critical, even if child has several years before onset of puberty
- Pubertal blockade (ie, Lupron) is most effective when initiated at 1st sign of emerging secondary sex characteristics (pubic hair, testicular growth)
- Pediatric Endocrinology involvement is necessary for prescribing of pubertal blockade; transition hormones can be managed by PCP
- Do not underestimate value to a family of having a Transgender affirming and safe primary care environment!

Mental Health Considerations

Mental Health Assessment for Medical Transitions

- MHA and ongoing counseling can provide much of this information, but specific assessment is often needed
- Primary purposes:
  - Ensures that client has accurate information and reasonable expectations
  - Establishes medical necessity for insurance coverage
  - Helps identify unmet needs that will ensure client's satisfaction with medical procedure
  - Gives medical provider information to ensure quality care

Assessment Topics: Gender History

- How client has experienced their gender over time
- What traits, experiences, feelings, thoughts helped the client understand their gender identity
- How families, schools, workplaces, communities have responded to the client
- What thoughts, feelings, experiences the client has had in regards to societal responses
- What goals the client has for their gender expression, including what medical procedures they seek

Assessment Topics

Gender Dysphoria Checklist

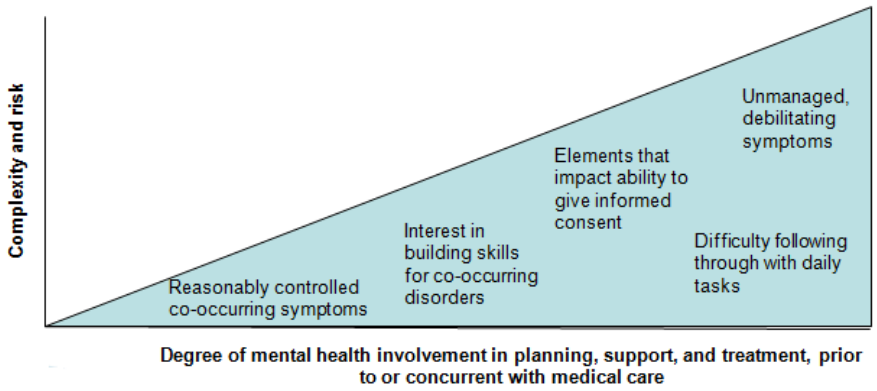
Please rate your level of distress or discomfort in the following areas on a 1-10 scale

Body Dysphoria
Looking at your body, feeling the way clothes fit, allowing others to see your body
1———2———3———4———5———6———7———8———9———10
How does it show up for you:

Social Dysphoria
Being misgendered, others' comments or questions about your gender, being able/unable to "blend in"
1———2———3———4———5———6———7———8———9———10
How does it show up for you:

Psychological Dysphoria
Thinking about your gender, feelings of blame/shame, hope/hopelessness for your future
1———2———3———4———5———6———7———8———9———10
How does it show up for you:

Emotional/Behavioral Exploration



Assessment Topics: Expectations

What do you expect to change once you get this procedure?

Reasonable Expectations	Unrealistic Expectations
Improved self-image	All anxiety will go away
Increased confidence	People will love me more
Closer intimacy with others (sometimes)	Won't have depression
Gradual change of features (HRT)	Pick and choose effects (HRT)
Lessening of anxiety, depression (associated w/ dysphoria)	My problems will be solved
More hope for the future	I'll be able to work/do school once I transition
I'll be more of the person I'm supposed to be	I'll have transitioned within a month

Assessment Topics: Family and Social Supports

- Who is on the client's support team?
- How motivated are these people to support this process?
- Does the client want us to engage family, children, school, or work to help with social support?

Assessment Topics: Support Plan

- Does the client have a reasonable plan for pre- and post-care, and can follow through on long-term maintenance?
- Does the client have stable housing (if healing time is needed)?
- Does the client have the ability to take time off of work or school ?
- Is client aware of the psychological changes associated with the procedure, and the medications used in the procedure?
- Does the client have the ability to stop use of drugs or medication that would threaten effectiveness of the procedure, and can they handle any withdrawal effects?
- If client has negative experiences with medical facilities/staff, have plans been made to address their experience?
- Does the client have the information needed of the next steps in the process?

Considerations

- Master's level clinicians under the supervision of licensed clinicians and licensed master's level clinicians should be able to write letters of support that meet OHP requirements (and PCPs)
- Currently, oregontranshealth.com is managing a self-selected list of providers who provide a wide array of trans-related health services
  - Providers/resources remain heavily Portland-centric
  - OHSU Transgender Health Program is also serving as a switchboard for care requests
  - Ideally, all counties/CCO-covered areas would have representation on the list

- Although many of the OHP covered services are medically-related, Gender Dysphoria is an above-the-line covered diagnosis for behavioral health services and could be the only diagnosis carried by an individual seeking mental health services
- There is a huge access issue with not enough providers to accommodate requests for assessment and not enough geographical diversity in available providers
  - Delays in treatment may result in increased depression, anxiety, dysphoria, and suicidal ideation for patients seeking medical intervention
  - State-wide training, peer consultation, and resource networks could help address the backlog, while also ensuring we provide quality care

Surgery and Subspecialty Referrals

***not currently mandated for OHP coverage**

- **Top/chest surgery**
- Mastectomy and chest reconstruction
- Breast augmentation/lift
- **Bottom/lower surgery**
- Vaginoplasty
- Orchiectomy
- Metoidioplasty
- Phalloplasty (fall 2016)*
- Hysterectomy
- Oophorectomy
- **Facial surgery/facial feminization***
- **Fertility Consultation/preservation***

Hair Removal

- Electrolysis currently mandated for coverage only in surgically-related areas
- Electrologists DO have DMAP numbers
- HERC updates as of 3/10/16: …

Topics for Discussion

- How have CCOs operationalized new covered benefits for Gender Dysphoria?
- Are there standards or policies from other CCOs in place, specifically for review of requests?
- What options exist if there are not enough contracted providers to deliver services?
- How can benefits be coordinated across disciplines?

Thank you!

APPENDIX:
Hormone Therapy Details

Initiating hormone therapy

- Baseline Labs, H&P
  -Female Affirming: **CBC, CMP, Testosterone, Estradiol**, Prolactin, Lipids, TSH
  -Male Affirming: **CBC, CMP, Testosterone, Estradiol,** Lipids, TSH
- Relative Contraindications prior to treatment:
  Female Affirming: H/o hypercoaguability, estrogen sensitive neoplasm (esp pituitary adenoma), ESLD
  Male Affirming: Unstable CAD, untreated Polycythemia
- Considerations: active Tobacco use, active pyschosis, active Substance Use
- Address irreversible and reversible effects through consenting process (*Handout*)
- Address timeline of expected changes (*Handout*)

Timeline of Expected Effects

Appendix: Masculinizing Effects in FTM Clients Receiving Testosterone

EFFECT	ONSET (MONTHS)	MAXIMUM (YEARS)
Skin oiliness/acne	1-6	1-2
Facial hair	6-12	4-5
Androgenic hair loss (scalp)	6-12	
Increased muscle mass	6-12	2-5
Fat redistribution	1-6	2-5
Cessation of menses	2-6	
Clitoral enlargement	3-6	1-2
Vaginal atrophy	3-6	1-2
Deepening of voice	6-12	1-2

Appendix: Feminizing Effects in MTF Clients Receiving Estrogen and Anti-Androgen

EFFECT	ONSET (MONTHS)	MAXIMUM (YEARS)
Decrease in muscle mass and strength	3-6	1-2
Softening of skin	3-6	unknown
Decreased erections	1-3	3-6
Breast growth	3-6	2-3
Decreased testicular volume	3-6	2-3
Decreased sperm production	Unknown	>3
Voice changes	none	

Adapted from The Endocrine Society Clinical Practice Guidelines, 2009

Testosterone risks

- Inc'd Hyperlipidemia/lowered HDL
- Polycythemia (use male reference ranges for evaluating RBC indices!)
- Metabolic syndrome risks
- Hypertension
- Aggression
- Excessive libido
- Acne
- Male pattern baldness (androgenic alopecia)
- Infertility (consider egg storage)

Testosterone risks (cont)

- Headaches
- Bone loss (if not on adequate testosterone, esp post oophorectomy)
- Worsens breast/uterine cancer
- liver dysfunction
- Pelvic pain or cramping
- Spotting (atrophic endometrium typical)
- Injection site issues (pain, lumps, allergic rash, infection)
- Risk to cis-female partner with exposure to topical gels or creams
- NOT an reliable form of CONTRACEPTIVE!

Estrogen Risks

- Venous thromboembolism (with oral estrogen, ethinyl estradiol, smokers, hypertension)
- May worsen: CAD, cerebrovascular disease, macroprolactinoma, migraines, hypertension, hypertriglyceridemia, gallstones, liver dysfunction (transaminases >3x)
- Infertility
- Few reported cases of breast, prostate cancer but no increased overall cancer mortality

Spironolactone Risks

- Renal dysfunction, especially in older patients (monitor BUN, creatinine, urine albumin)
- Hyperkalemia
- Hyponatremia
- Drug interactions with ACE inhibitors and ARB's (hyperkalemia)
- Hypotension
- Erectile dysfunction
- Infertility

Example Dosing Chart:

B. For Transgender men (FTM): The usual regimen is testosterone. Initiate at Starting Dose, titrate to Therapeutic Dose at subsequent visits based on response and lab results (see following section).

TESTOSTERONE:

Preferred Regimen:

Injectable Testosterone	Starting Dose	Typical Therapeutic Dose	Route,Frequency[§]	Amt
Testosterone cypionate 200mg/mL[§§]	50mg (0.25cc)	100mg (0.5cc)	IM, Weekly	1cc-10cc Vial

Alternate Regimen:

Transdermal Testosterone	Starting Dose	Typical Therapeutic Dose	Route,Frequency	Amt
Testosterone gel 1% (Androgel, Testim)*	2.5-5mg	5-10mg	Topical, Daily	30 packets
Testosterone patch (Androderm)	5mg	5mg	TransDerm, Daily	30 patches

§ Some providers recommend administering injectable testosterone subcutaneously.
§§ Commercially available testosterone cypionate is usually suspended in cottonseed oil and is easier to draw up and inject. Testosterone enanthate is also an option, however, and is compounded with sesame oil.
*Low-dose transdermal testosterone may be insufficient to stop menses, consider addition of depot medroxyprogesterone (DepoProvera).

Example Dosing Chart:

For Transgender women (MTF): The usual regimen is an estrogen + anti-androgen. Initiate at Starting Dose, titrate to Therapeutic Dose at subsequent visits based on response and lab results (see following section).

ESTROGENS:

Preferred Regimen:

Oral Estrogen	Starting Dose	Typical Therapeutic Dose	Route,Frequency§	Amt
Estradiol (Estrace)	1.0 mg BID	6.0 mg total (Divided BID)	PO, BID	QS
Injectable Estrogen	Starting Dose	Typical Therapeutic Dose	Route,Frequency§	Amt
Estradiol Cypionate 5mg/ml	2.5 mg (0.5cc)	5mg (1.0cc)	IM or SQ, q2wks	1cc-10cc
Estradiol Valerate 20mg/ml	10 mg (0.5cc)	15mg-20mg (1.5-2.0cc)	IM or SQ, q2wks	1cc-10cc

Alternate Regimen:

Oral Estrogen	Starting Dose	Typical Therapeutic Dose	Route,Frequency	Amt
Premarin	1.25mg BID	2.5 mg BID	PO,BID	QS
Transdermal Estrogen	Starting Dose	Typical Therapeutic Dose	Route/Frequency	Amt
Estradiol Patch *	0.05-0.1 mg	0.2-0.4mg	TransDerm, q3-4d	QS

* Transdermal estrogen may be preferred in some circumstances, e.g. age over 45, history of venous thromboembolic disease or cardiovascular risk factors. Although most patches are applied twice weekly, this may differ by product. Goal is to provide an initial dose of 50-100 mcg transdermal estradiol daily.

§ Some providers recommend administering oral estradiol sublingually or injectable estradiol subcutaneously.

Medication/Supplies Considerations

- Explore pharmacy readiness in your area
- A trans-friendly pharmacy in Portland: Stroehecker's Pharmacy in SW
- Typical injectable supplies (Testosterone):

Equipment	Amount
1cc syringes	#20
18G 1" needles for drawing up medication	#20
22-25G x 1.5" needles for administration (pt preference will vary)	#20
Alcohol prep pads	#100
Sharps Container	#1

Managing and monitoring hormone therapy

- Follow-up in 1, 3, 6, 12 months
- Review BP, side effects, emotional/physical changes, sexuality, weight, and quality of life (risk behaviors if indicated)
- Surveillance labs per guidelines
- Titrate medications per guidelines
- Continue HCM care relevant to natal gender

The Endocrine Society's CLINICAL GUIDELINES

TABLE 16. Monitoring of FTM transsexual persons on cross-hormone therapy

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 2–3 months until levels are in the normal physiologic male range:*
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured mid-way between injections. If the level is >700 ng/dl or <350 ng/dl, adjust dose accordingly.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection.
   c. For transdermal testosterone, the testosterone level can be measured at any time after 1 week.
   d. For oral testosterone undecanoate, the testosterone level should be measured 3–5 hours after ingestion.
   e. Note: During the first 3–9 months of testosterone treatment, total testosterone levels may be high although free testosterone levels are normal due to high sex hormone binding globulin levels in some biological women.
3. Measure estradiol levels during the first 6 months of testosterone treatment or until there has been no uterine bleeding for 6 months. Estradiol levels should be <50 pg/ml.
4. Measure CBC and liver function tests at baseline and every 3 months for the first year and then 1–2 times a year. Monitor weight, blood pressure, lipids, fasting blood sugar (if family history of diabetes) and hemoglobin A1c (if diabetic) at regular visits.
5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.
6. If cervical tissue is present, an annual pap smear is recommended by the American College of Obstetricians and Gynecologists.
7. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

* *Adapted from Refs. 83, 85*

The Endocrine Society's CLINICAL GUIDELINES

TABLE 15. Monitoring of MTF transsexual persons on cross-hormone therapy

1. Evaluate patient every 2–3 months in the first year and then 1–2 times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 months.
   a. Serum testosterone levels should be <55 ng/dl.
   b. Serum estradiol should not exceed the peak physiologic range for young healthy females, with ideal levels, 200 pg/ml.
   c. Doses of estrogen should be adjusted according to the serum levels of estradiol.
3. For individuals on spironolactone, serum electrolytes particularly potassium should be monitored every 2–3 months initially in the first year.
4. Routine cancer screening recommended in non-transsexual individuals (breasts, colon, prostate).
5. Consider BMD testing at baseline if risk factors for osteoporotic fracture are present (e.g., previous fracture, family history, glucocorticoid use, prolonged hypogonadism). In individuals at low risk, screening for osteoporosis should be conducted at age 60 or in those who are not compliant with hormone therapy.

Managing and monitoring hormone therapy: Example

Feminizing Hormones:

- Serum Testosterone assessment: Goal is to suppress Total Testosterone to <55 ng/dL
- Serum Estradiol assessment: Goal is to maintain levels in "healthy female range" but <200 pg/mL
- *Recommended Management*: Oral Estradiol: titrate up or down by 1 mg/week, max dose 6mg/day, divided into BID doses. Oral Spironolactone: titrate up or down by 50mg/week, max dose 400mg/day.
- Repeat Lab: q4-6 weeks until stable in range

Managing and monitoring hormone therapy: Example

Masculinizing Hormones:

- Serum Testosterone assessment: Goal range 270-1200 ng/dL; can test mid-dose *or* trough; amenorrhea is critical for most patients
- Serum Estradiol assessment: Goal is to suppress estradiol to <50 pg/mL and/or to achieve amenorrheic state
- *Recommended Management*: Injectable: titrate up or down by 10mg/week
- Repeat Lab: q4-6 weeks until stable in range

Oregon Statewide Performance Improvement Project on Opioid Safety: Reducing Prescribing of High Morphine Equivalent Doses

Prepared by Acumentra Health

February 17, 2016

Standard 1: Study Topic

Standard 1 establishes the importance of the study topic in general; presents local data to demonstrate that the topic applies to a large or high-risk portion of the Medicaid population and will have a significant impact on enrollee health, functional status, or satisfaction; and demonstrates that a systematic selection and prioritization process, that includes opportunities for input by enrollees and providers, was used in choosing the topic.

Status of PIPs in Oregon

The Oregon Health Authority's (OHA) contract with Coordinated Care Organizations (CCOs), as negotiated with the Centers for Medicare and Medicaid Services (CMS) requires CCOs to conduct three performance improvement projects (PIPs) and one focus study that target improving care in at least four of seven quality improvement areas. OHA determined that one of the PIPs would be conducted as a statewide collaborative on the integration of physical health and behavioral health, and in accordance with the 2012 CMS PIP protocol. The first statewide PIP (2013–2015) addressed diabetes monitoring in people with schizophrenia or bipolar disorder. The second statewide PIP focuses on improving the safety of prescription opioid management.

The external quality review organization, Acumentra Health, is responsible for facilitating and documenting the 10 PIP validation standards adapted from federal guidelines. The CCOs are responsible for developing interventions that meet the needs of their local communities and documenting their efforts in quarterly reports to OHA.

Topic Overview

Opioid abuse and misuse is a major public health problem in the United States. Federal and state health agencies, medical provider organizations, health care researchers, and the Veterans Administration have been galvanized to address the opioid epidemic in response to public testimonies, provider concerns, and alarming national statistics. When compared to other countries, the United States comprises only 4.6% of the world's population, yet the country uses 99% of the world's supply of hydrocodone and 83% of the world's oxycodone.[1]

Data collected at a national level reveals that from 1999 through 2006, opioid-analgesic deaths increased about 18% on average. The rate stabilized from 2006 to 2011, then began to decline in

[1] Report of the International Narcotics Control Board for 2007. https://www.incb.org/documents/Publications/AnnualReports/AR2007/AR_07_English.pdf. Accessed January 12, 2016.

2012.[2] A recent report by the Centers for Disease Control and Prevention (CDC) indicates that the decline has not been sustained. Data show that although overdose deaths due to natural and semisynthetic opioids (which include most of the prescribed opioid pain relievers) remained similar from 2012 to 2013, there was a 9% increase from 2013 to 2014.[3]

Overdose and death are not the only adverse effects of the abuse and misuse of prescription opioids. The CDC estimated that prescription opioid abuse costs (i.e., lost workplace productivity, medical treatment, and criminal justice costs), were approximately $55.7 billion in 2007.[4]

Studies by Washington State and New York State demonstrated that the Medicaid population is disproportionately affected by the opioid epidemic. In Washington, a Medicaid enrollee was 5.7 times more likely to die due to prescription opioid overdose than a person not enrolled in Medicaid.[5] A similar increased death rate among Medicaid enrollees was observed in New York State from 2003 to 2012.[6] In response to the particular vulnerability of the Medicaid population, CMS issued a bulletin describing Medicaid pharmacy benefit management and naloxone provision strategies states could employ to reduce opioid-related overdose deaths.[7]

As part of a national initiative to address the opioid problem, the CDC awarded 16 states (including Oregon) grants to assist those states in their efforts to prevent opioid misuse and overdose. In addition, the CDC will issue opioid prescribing guidelines for primary care providers in early 2016. Although there are published state, regional, and professional guidelines and resource guides, the CDC guidelines will be the first set of standards on the topic of prescription opioids from a federal agency. Among other recommendations, the CDC is expected to propose that providers limit opioid dosages to ≤ 90 mg/day morphine equivalent dosage (MED). Other guidelines (Washington State, Medicare) have established a target of < 120 mg/day MED.

Oregon

Statewide, Oregon had the highest rate of nonmedical uses of prescription opioids for people 18 years and older in 2011–2012, according to the National Survey on Drug Use Health. Oregon tied for second place in 2012–2013.[8]

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[2] Chen, LH, Hedegaard, H, Warner, M. Drug-poisoning Deaths Involving Opioid Analgesics: United States, 1999-2011. NCHS Data Brief, No. 166, September 2014. http://www.cdc.gov/nchs/data/databriefs/db166.pdf.
[3] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report (MMWR). Increases in Drug and Opioid Overdose Deaths – United States, 2000-2014. December 18, 2015. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm64e1218a1.htm?s_cid=mm64e1218a1_e. Accessed January 12, 2016.
[4] Centers for Disease Control and Prevention. Injury Prevention & Control: Prescription Drug Overdose. http://www.cdc.gov/drugoverdose/data/overdose.html. Accessed February 17, 2016.

[5] Coolen P, Lima A, Savel J, et al. Overdose deaths involving prescription opioids among Medicaid enrollees—Washington, 2004-2007. *Morb Mortal Wkly Rep.* 2009; 58:1171-1175.
[6] Sharp MJ, Melnik TA. Poisoning deaths involving opioid analgesics-New York State, 2003-2012. *Morb Mortal Wkly Rep.* 2015; 64:377-380.
[7] Centers for Medicare & Medicaid Services. CMCS Informational Bulletin: Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction. https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-02-02-16.pdf. Accessed February 17, 2016.
[8] National Survey on Drug Use Health. Available at: http://www.icpsr.umich.edu/icpsrweb/ICPSR/series/64

Data collected by state and federal agencies reveal the extent of the opioid epidemic in Oregon:

- In 2013, the number of deaths due to drug overdose exceeded that of motor vehicles among people 25 to 64 years of age. Half of the drug overdose deaths were related to prescription drugs, and over 70% of the prescription drug overdoses involved opioids.[9]
- The rate of opioid hospitalizations in Oregon increased from 2.6 per 100,000 in 2000 to 10.0 per 100,000 in 2013, according to the Oregon Public Health Division (PHD).[10]
- Unintentional and undetermined prescription opioid poisoning death rates followed a similar trend, increasing from 1.4 per 100,000 in 2,000 to 6.5 per 100,000 in 2006. In 2012, the rate was 4.2 per 100,000.[11]
- The PHD reported that while the prescription drug poisoning/overdose death rates in 2013 and 2014 had declined to approximately 4.0 per 100,000, the 2013 rate was still 2.8 times higher than in 2000.[12]
- Recent data from the CDC showed an increase in all drug overdose deaths in Oregon: from 11.3 deaths per 100,000 persons in 2013 to 12.8 deaths per 100,000 persons in 2014. Since the CDC data do not distinguish between deaths due to heroin and those due to natural and semisynthetic opioids (associated with the more commonly prescribed opioid pain relievers), further analyses are needed to determine if there is consistency between the national and state data.

In terms of the Medicaid population, an exploratory data analysis for this PIP by the OHA Office of Health Analytics demonstrated that out of 170,000 adults 18 years and older on Medicaid, 35,749 individuals (21% of the total population) received 6 or more prescriptions for opioid pain relievers in calendar year 2014. The percentage of the CCO adult population receiving 6 or more prescriptions ranged from 8.0% to 31.1% per CCO.

Recognizing the alarming trend in prescription opioid misuse and abuse, the State of Oregon and health professionals/organizations have taken steps to address the problem, including but not limited to:

- The Oregon Legislature established a Prescription Drug Monitoring Program (PDMP) in 2009. The PDMP, which became operational in 2011, is a tool intended to assist health care providers in providing better patient care by helping providers identify risks associated with controlled drug dispensing and use.
- In 2011, the managed care organization, Doctors of Oregon's Coast South (DOCS) selected the topic of opioid prescribing for a PIP after reviewing alarming pharmacy data. Opioid prescribing continued to be a focus for improvement even after DOCS merged with other partners to create Western Oregon Advanced Health (WOAH) CCO.

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[9] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.
[10] See note 9 above.
[11] Oregon Health Authority, Center for Prevention & Health Prevention. Injury & Violence Prevention section. Drug Overdose Deaths, Hospitalizations, Abuse & Dependency among Oregonians. http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Documents/oregon-drug-overdose-report.pdf. Accessed February 17, 2016.
[12] Oregon Health Authority, Public Health Division. Injury and Violence Prevention Program. Prescription Drug Poisoning/Overdose in Oregon. http://www.orpdmp.com/PDO_2015v04242015.pdf. Accessed February 17, 2016.

- In 2011, Dr. Jim Shames, Medical Director of Jackson County Health and Human Services, along with several CCOs (AllCare, Jackson Care Connect) and interested health care professionals, formed the Oregon Pain Group (OPG) in order to address the growing negative impact of prescription opioids in Southern Oregon. OPG has identified and developed patient and provider materials and guides (including an Opioid Prescribers Guideline), hosts annual pain conferences, and maintains a website for healthcare professionals and patients (http://www.oregonpainguidance.com/).
- In 2012 and 2013, the Prescription Drug Task Force, appointed by Governor John Kitzhaber, hosted meetings for stakeholders interested in developing and implementing a prescription drug strategy. Interested stakeholders formed the Oregon Coalition for Responsible Use of Meds (OrCRM), whose mission is to "prevent overdose, misuse and abuse of amphetamines and opioids, both prescription and illicit."[13]
- In 2014, the Healthy Columbia Willamette Collaborative convened a workgroup to develop opioid prescribing standards. The workgroup included representatives from four Portland metro area public health departments (Clackamas County; Clark County, WA; Multnomah County; and Washington County), safety net clinics, two CCOs (FamilyCare and Health Share of Oregon), local hospitals, and professional organizations. After nearly a year's work, the workgroup released the Portland Metro Regional Safe Opioid Prescribing Standards in December 2015.
- After conducting reviews of the existing research on back pain treatments, including surgery and opioids, the OHA Health Evidence Research Commission presented a revised back pain guideline to the Quality Health Outcomes Committee meeting in February 2015. Key changes in the treatment of back pain included limiting coverage on the prescription of opioids and adding coverage for non-opioid therapies such as physical therapy, chiropractic, acupuncture, and massage. The new guidelines were scheduled for implementation on January 1, 2016, with implementation now delayed.
- In 2015, the Oregon Public Health Division (PHD) received a Prescription Drug Overdose Prevention for States grant from the CDC. The purpose of the grant is to assist states in enhancing their PDMPs and working with communities, health systems and providers to develop and implement interventions to prevent prescription drug overdose. As part of this effort, the PHD developed a toolkit to help CCOs develop a more comprehensive approach to reducing opioid overdose and misuse (https://public.health.oregon.gov/PreventionWellness/SubstanceUse/Opioids/Documents/reducing-opioid-overdose-cco-guide.pdf

Topic Selection and Prioritization

At the April 2015 Quality Health Outcomes Committee (QHOC) meeting, Quality Improvement Directors and Managers divided up into small groups in order to begin preliminary discussions about topics for the second statewide PIP (start date July 1, 2015). The following topics garnered the most support: opioid management; maternal medical home; tobacco prevalence and cessation; one key question: effective contraceptive care; and assessments for children in DHS

[13] Oregon Coalition for Responsible Use of Meds. http://orcrm.org. Accessed January 12, 2016.

custody. Following the discussion, Lisa Bui, a Quality Improvement Director at OHA, sent an online survey to all the CCOs asking them to rank the above list according to their top three preferences.

Acumentra Health encouraged, but did not require, CCOs to solicit stakeholder input. It is not clear what, if any, influence enrollees had in the topic prioritization process. The overwhelming majority of CCOs selected the topic of opioid management as their first preference. The selection of opioid management as a topic for the second Statewide PIP received final approval by the OHA Quality Council in June 2015.

Standard 2: Study Question

Standard 2 presents a study question that provides a clear framework for data collection, analysis, and interpretation. The study question should refer to the proposed intervention, a study population (denominator), what is being measured (a numerator), a metric (e.g., average, percentage), and a direction of desired change.

All participating CCOs conduct the PIP with the same topic, indicators, and objectives, but may have different interventions. Consequently, the definitions of the interventions in the study questions are not defined.

Two study questions were developed after finalization of the study metric:

> Study question #1: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥ 120 mg MED on at least one day within the measurement year?*
>
> Study question #2: *Will local interventions by CCOs decrease the percentage of Medicaid enrollees who filled prescriptions totaling ≥ 90 mg MED on at least one day within the measurement year?*

Standard 3: Study Population

Standard 3 provides a brief description of the study population; lists all inclusion and exclusion criteria for the study population, including enrollment criteria; and provides definitions and data sources, including codes and calculations. If a sample is selected, the sampling methods will be described.

This PIP targets adult and adolescent members who have at least one prescription for an opioid pain reliever filled within the measurement year. The study includes all qualified members, and does not require sampling.

Study Population (denominator) Inclusion Criteria and definitions

- *Oregon Health Plan (OHP) enrollment (Medicaid/CHIP-enrolled):* Enrolled in Medicaid or CHIP at the time of service. The study population includes enrollees with dual eligibility in Medicaid and Medicare and enrollees in CHIP who meet the rest of the study criteria.

- *Continuous enrollment*: The 2015 HEDIS specifications define enrollment as continuous enrollment with only one enrollment gap allowed of no more than 45 days during the measurement year.
- *Adults and adolescents*: Medicaid enrollees ≥ 12 years on the final day of the measurement year. Data will be analyzed and reported according to the following stratifications: 12–17, 18+, and total.
- *Opioid pain reliever:* All medications that are covered under the OHA "therapeutic class 40: narcotic analgesics. Using the therapeutic class to define "opioids" allows for year to year variation as codes and medication formulations change. Cough and cold medications are "under the line" (i.e., not covered by OHA) and are not included in the definition. A table of the individual codes for drugs in this class is available as a separate document from Acumentra Health or the OHA Office of Health Analytics.

Denominator Exclusion Criteria

- *End of life care/palliative care/hospice*: The use of high doses of opioids under these circumstances is appropriate, and members who are identified as meeting this criterion according to relevant medical claim codes will be excluded from the study denominator. See Attachment A for a list of the relevant codes.

Standard 4: Study Indicator

Standard 4 provides a definition of the numerator (what is being measured) and the denominator; defines key terms; describes the target goal; discusses the basis for adopting the indicator as a valid proxy for enrollee outcomes, satisfaction, or quality of care; lists all inclusion and exclusion criteria for the numerator (what is being measured), including enrollment criteria; and provides definitions and data sources, including codes and calculations.

Statewide PIP metric: Percentage of OHP enrollees aged 12 years and older who filled prescriptions for opioid pain relievers of at least ≥ 120 mg MED on at least one day, and the percentage of enrollees with at least ≥ 90 mg MED on at least one day during the measurement year.

Metric selection

Following the topic confirmation, Acumentra Health conducted a literature review and identified a list of potential metrics for a Statewide PIP on the management of opioid prescription drugs. The list was reviewed by the OHA Office of Health Analytics department, several members of the Acumentra Health Prescription Drug Monitoring Program (PDMP) research team and the Healthy Columbia Willamette Collaborative opioid monitoring workgroup. The documents were discussed by the medical directors at the July 2015 QHOC meeting, and were evaluated in more depth by the Quality and Performance Improvement (QPI) workgroup in the afternoon QHOC session. The QPI workgroup selected the following three metrics for further consideration:

1. Percentage of individuals on opioid doses ≥120 mg MED per day

2. Proportion of individuals with overlapping prescriptions for opioids and benzodiazepines
3. Percentage of adolescents and adults, previously naïve to opioid pain reliever utilization, who became chronic users of opioid pain relievers (this metric is utilized by the Minnesota Department of Human Services and is referenced in this report as "the Minnesota metric.")[14]

Following the QPI workgroup, Acumentra Health, OHA and OHA Health Analytics met to discuss the metric specifications for each of the three metrics and developed a list of clarifications that needed to be presented to the larger group for final decisions. A handout of issues needing clarification along with a table of individual with opioid prescriptions for calendar year 2014 (analyzed according to CCO, age and 6+ prescriptions) was distributed at the September 2015 QHOC meeting. Discussions at the Medical Director or QPI sessions produced no consensus on metric selection. Copies of the three metric technical specifications along with a list of pros/cons gathered from past discussions were emailed to CCO medical directors and QI managers, along with a survey asking each of the 16 CCOs to submit a single vote for one of the three metrics. These are the survey results:

- Metric #1 – 9 votes
- Metric #2 – 2 votes
- Metric #3 – 5 votes

This information, along with feedback from the Oregon Public Health Division and the CCO Pharmacy Directors workgroup, was presented to OHA leadership. At OHA leadership's request, Health Analytics conducted data analyses of each of the CCOs' Medicaid populations using the Minnesota Metric eligibility criteria in order to determine the metric's feasibility. The analyses demonstrated that four CCOs had numerators of less than 40, and another two CCOs had numerators less than 50. Although OHA leadership was interested in the Minnesota metric, the small study populations presented a barrier to implementation, as was demonstrated in the first Statewide PIP on diabetic monitoring in the SPMI population. Instead, OHA leadership selected the ≥120 mg MED metric as the Statewide PIP metric and decided to investigate other avenues for a metric focused on naïve to chronic users, such as review by the OHA Scoring and Metrics Committee.

Once a decision was made to monitor the management of opioid pain relievers by measuring a dosing threshold, concerns were raised about the dosing threshold level itself. Although experts agree that there is a dose-related risk for overdose and adverse effects[15], they have not achieved consensus on a dosage limit performance measure. The CDC has invited subject matter experts and the public to review and comment on a draft Guideline for Prescribing Opioids for Chronic Pain. The draft CDC guidelines recommend a dosing threshold of ≤ 90 mg MED per day.[16] The 2015 edition of Washington State Interagency Guideline on Prescribing Opioids for Pain

[14] Schiff, J. Analysis of Opioid Utilization CYs 2011-2014, Minnesota Department of Human Services, Office of the Medical Director. August 20, 2015.
[15] Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain. 3rd Edition, June 2015. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.
[16] Centers for Disease Control and Prevention. Draft CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016. http://www.regulations.gov/#!documentDetail;D=CDC-2015-0112-0002. Accessed January 12, 2016.

included a recommendation from the 2010 edition that prescribers avoid prescribing opioids >120 mg/day MED without first consulting with a trained pain specialist. Citing studies from the literature,[17,18] the Washington State Guideline emphasizes that "there is no completely safe opioid dose."[19]

Data provided by OHA Office of Health Analytics revealed that CCOs that had been working on prescribing opioid issues for several years had significantly lower percentages of members on ≥120 mg MED per day than those organizations just beginning work in this area. Experienced CCOs expressed concern that given the lower percentages, it would be difficult to demonstrate improvement over a short period of time. After discussing additional pros and cons of different dosage levels at the November QHOC meeting, Acumentra Health surveyed CCOs as to their study metric dosage threshold preference. Each of the sixteen CCOs was asked to select only one option. The results of the survey are as follows (PacificSource–Central Oregon and PacificSource–Columbia Gorge voted as one plan):

- ≥ 90 mg MED – 7
- ≥ 100 mg MED – 1
- ≥ 120 mg MED – 7

Several CCOs that supported the ≥ 120 mg MED threshold, noted that they had already begun educating providers and implementing interventions based on that threshold assumption. The survey results, along with CCO comments, were presented to the OHA Quality Directors Committee meeting. The committee decided that this PIP should measure both the 90 mg and the 120 mg thresholds.

The study metric for the statewide PIP on opioid safety is:

- Percentage of OHP enrollees aged 12 years and older with opioid prescriptions for ≥ 120 mg and for ≥ 90 mg MED per day.

CCO Level

While data will be collected on both numerators (≥ 120 mg and ≥ 90 mg MED/day) at the statewide level, CCOs have the option of collecting data internally on either or both of the metrics. Because CCOs differ significantly in terms of study baseline rates (percentage of members with opioid doses ≥ 120 mg MED/day or ≥ 90 mg MED/day) and existing implementation strategies, target goals will be established at the CCO level.

Study Numerators

Numerator inclusion criteria and definitions:

[17] Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med.* 2010. Cited in Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition, June 2015.
[18] Fulton-Kehoe D, Garg RK, Turner JA, et al. Opioid poisonings and opioid adverse effects in workers in Washington State. *Am J Ind Med*. 2013. Cited in Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain, 3rd Edition, June 2015.
[19] See note 15.

- Study eligible (meet the denominator definitions)
- *90 mg and 120 mg MED per day:* Daily MED is calculated as drug strength multiplied by quantity divided by days' supply, multiplied by the conversion factor identified by the CDC (the table of morphine equivalent conversion factors is available as a separate document from Acumentra Health of OHA Office of Health Analytics). MED will be first calculated per prescription, and then summed for patient total.

  Any enrollee with opioid prescriptions for ≥ 90 mg and ≥ 120 mg MED will be included in the numerators.

Standard 5: Data Collection and Data Analysis Plan

Standard 5 describes data collection and data validation procedures, including a plan for addressing errors and missing data, and presents a clear data analysis plan, including time frames for the measurement and intervention periods and an appropriate statistical test to measure differences between the baseline and remeasurement periods.

Data Collection

OHA

OHA uses an encrypted system of web-based electronic mailboxes to receive Medicaid claims and encounter data from CCOs. This system ensures that data transfers are consistent with HIPAA confidentiality provisions. The state then uses the Medicaid Management Information System (MMIS) claims adjudication engine to process the CCO encounter data.

From MMIS, data is transferred to the Decision Support Surveillance and Utilization Review System (DSSURS), where it is organized to facilitate reporting and other data extraction. The Office of Health Analytics pulls data from DSSURS, applies the continuous enrollment and exclusion criteria, and then calculates the study indicator for the measurement periods and for monthly reports to each CCO.

CCO level

CCOs are expected to track the study indicator internally. OHA has offered all CCOs technical assistance around collecting data and applying the technical metric specifications.

Data Verification and Validation

OHA

At the end of the remeasurement period, OHA allows for a 90-day period to receive all CCO claims (a 90-day period to collect and process claims is routine practice). OHA then calculates the study data and posts member-level data on each CCO's secure FTP sites. CCOs are asked to review the information and send any revisions/questions to the designated OHA contact, who works with the Office of Health Analytics to evaluate the CCO queries.

CCO level

Quality management personnel at each CCO are responsible for reviewing and comparing OHA monthly reports against their own data reports in order to reconcile any discrepancies. Before submitting data to the state, CCOs perform automated edits and validation checks to ensure completeness and correctness of submitted claims. Currently, there is no contractual requirement for the CCOs to perform an encounter data validation process in accordance with the CMS standards for encounter data validation.

Study Time Periods

- **Baseline measurement:** January 1, 2014 – December 31, 2014
- **First remeasurement:** January 1, 2016 – December 31, 2016
- **Second remeasurement:** January 1, 2017 – December 31, 2017

CCOs, OHA, and Acumentra Health agreed on the date range for the first remeasurement period based on the expected start date for intervention implementation for many of the CCOs. A non-consecutive baseline measurement period was selected because a longer period of time would allow those CCOs that have already been working on the study topic for several years more opportunity to demonstrate improvement in the study indicator.

The study results for each study indicator at the statewide level will be tested for a statistically significant difference between baseline and remeasurement periods using a probability level of $p \leq .05$. A chi-square test is appropriate for the categorical data that will result from the indicators.

Standard 6: Study Results

Standard 6 presents results according to the data analysis plan, including the study indicator, the original data used to compute the indicator, and a statistical test to measure differences between the baseline and remeasurement periods; and discusses any other data analyses for factors that may affect the study results.

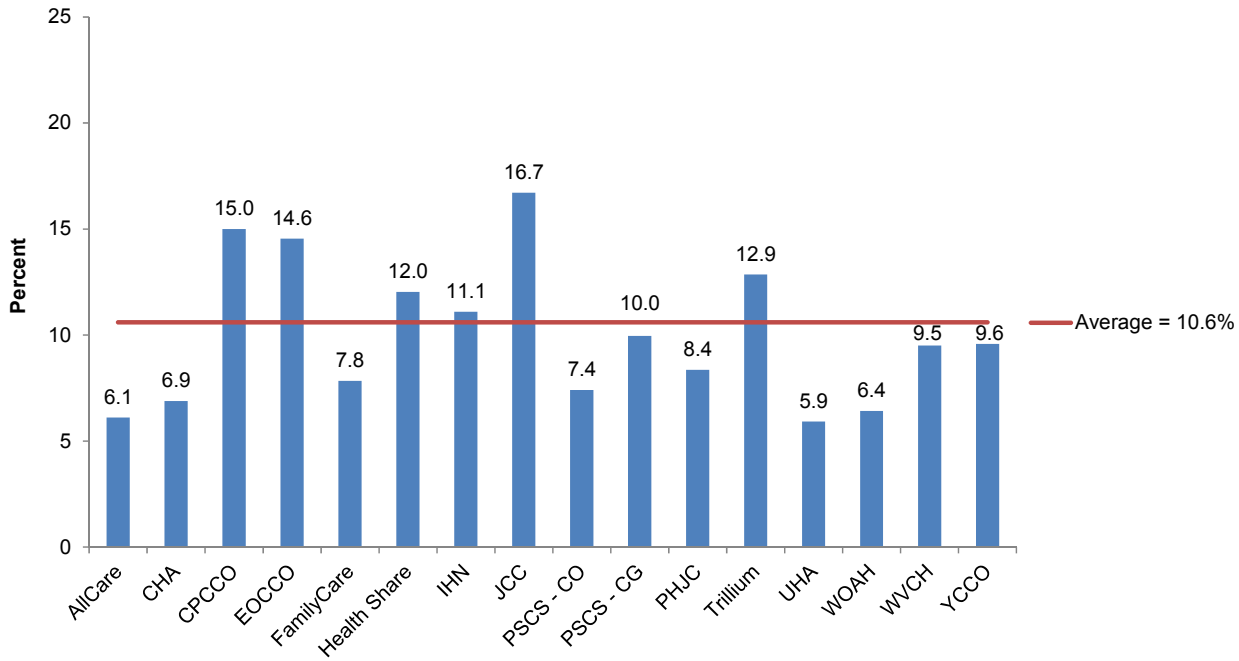
Table 1 shows the baseline and results of the first measurement for the ≥ 120 mg MED metric.

Table 1. Aggregated statewide results: Percentage of OHP enrollees aged 12 years and older who filled opioid prescriptions for at least ≥ 120 mg MED on at least one day during the measurement year.

Study Indicator	Baseline January 1 – December 31, 2014	First remeasurement
Numerator	11,945	
Denominator	112,768	
Calculated indicator	10.6%	

Below is a graph illustrating the baseline rates for this metric among the 16 CCOs (Figure 1).

Figure 1. Percentage of enrollees aged 12 years and older who filled opioid prescriptions for at least ≥ 120 mg MED on at least one day during the baseline measurement year per CCO.



In response to CCO interest in targeting chronic users of high amounts of prescription opioids, OHA analyzed individual CCO baseline (calendar year 2014) study data according to 30-day consecutive use at ≥ 120 mg MED. Below is a graph that illustrates the range among CCOs (Figure 2).

Figure 2. Percentage of enrollees with at least one opioid prescription for ≥ 120 mg MED in the baseline measurement year with ≥120 mg MED/day for 30 days or more.

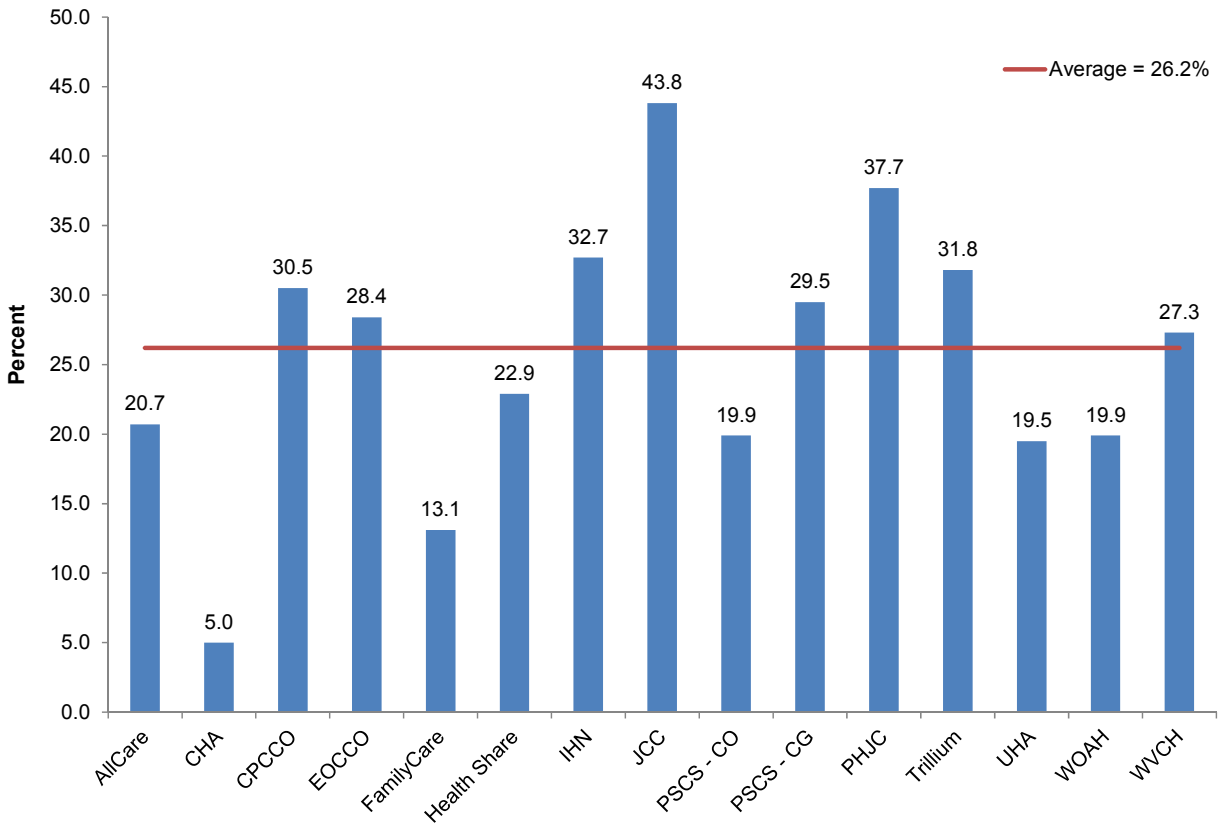


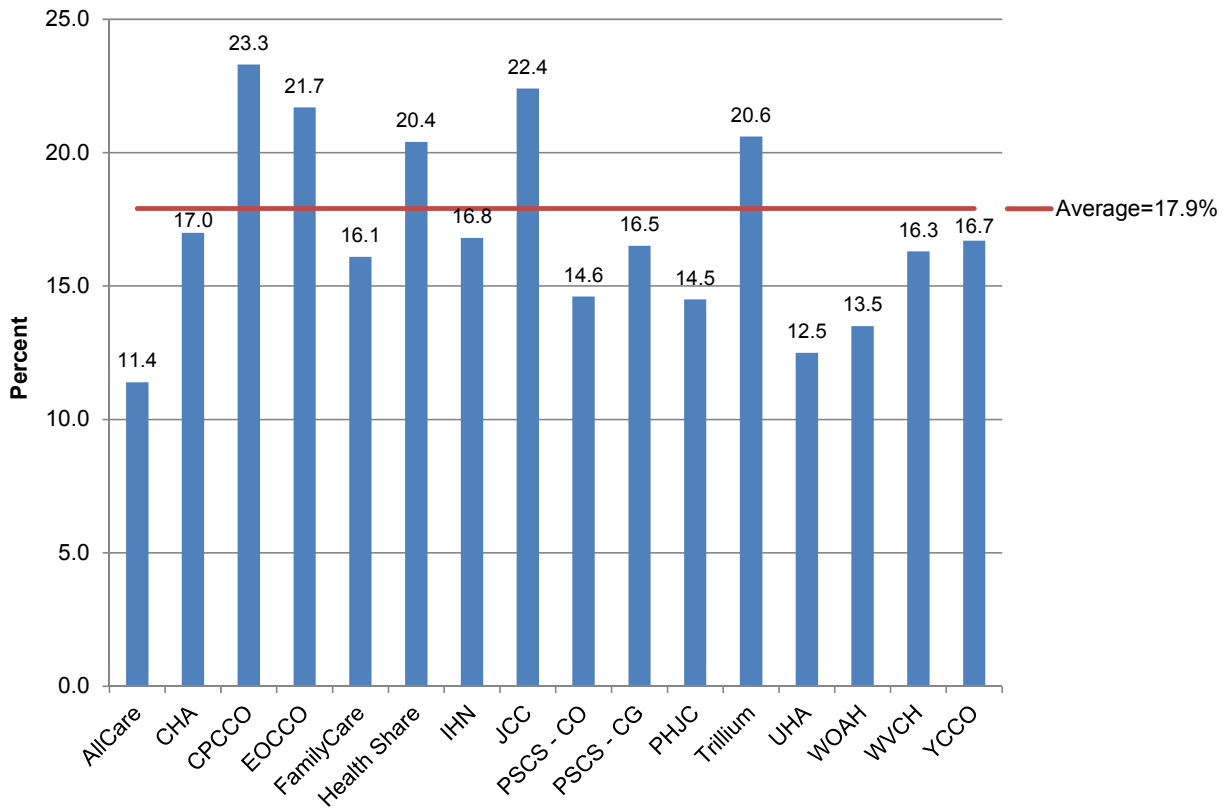
Table 2 shows the baseline and results of the first remeasurement for the ≥ 90 mg MED metric.

Table 2. Aggregated statewide results: Percentage of OHP enrollees aged 12 years and older who filled opioid prescriptions for at least ≥ 90 mg MED on at least one day during the measurement year.

Study Indicator	Baseline January 1 – December 31, 2014	First remeasurement
Numerator	20,235	
Denominator	112,768	
Calculated indicator	17.9%	

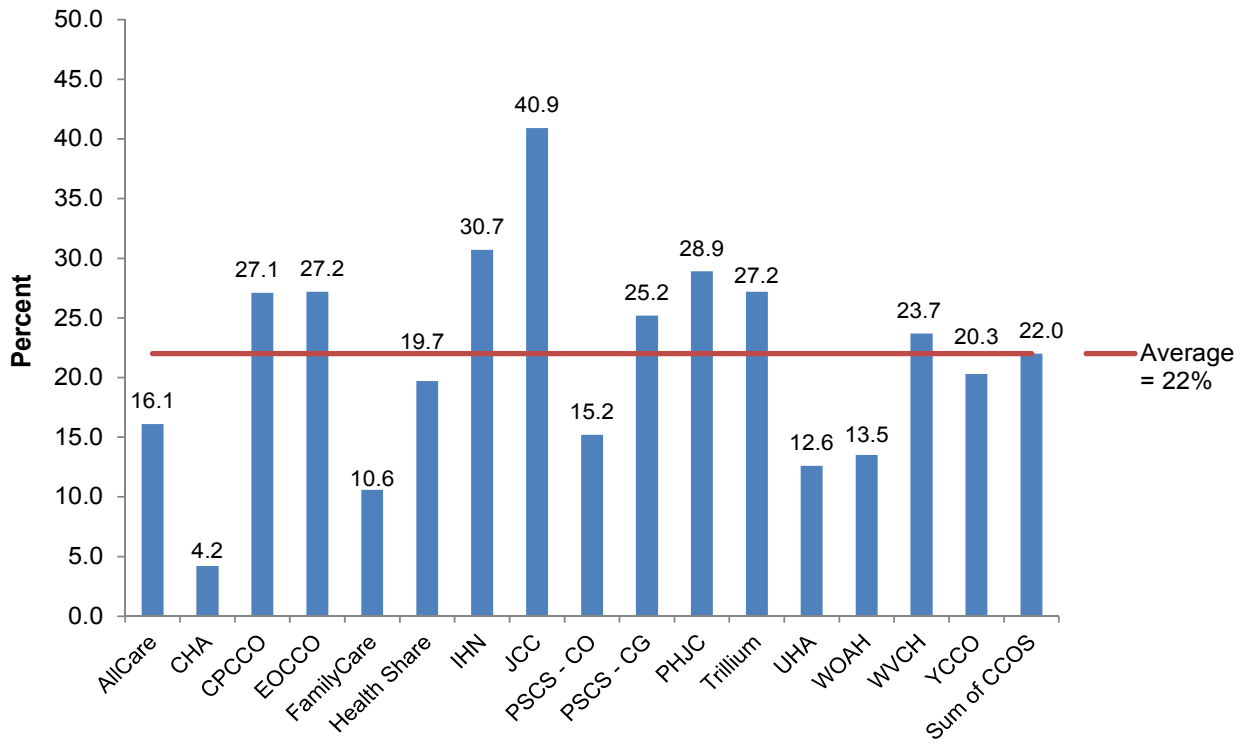
Figure 3 illustrates the range of baseline rates for this metric among the 16 CCOs.

Figure 3. Percentage of OHP enrollees aged 12 years and older who filled opioid prescriptions for at least ≥ 90 mg MED on at least one day during the baseline measurement year per CCO.



OHA also analyzed the baseline 90 mg MED metric data in order to determine the number and percentage of members on this dosage for consecutive 30 days or more. Figure 4 illustrates the range among CCOs.

Figure 4. Among study members with at least one opioid prescription for ≥ 90mg MED/day in the baseline measurement year, the percentage who had ≥ 90mg MED/day for 30 days or more.



Study numerator and denominator data for both study metrics according to CCO are in Attachment B.

Additional analyses

Demographic analyses of the statewide study denominator and chronic high user numerator populations indicate that Latino/Hispanic, Asian, and Race/ethnicity unknown enrollees are underrepresented in the numerator, while Caucasian/White enrollees are overrepresented. The complete analysis can be found in Attachment D.

CCOs have been encouraged to conduct additional analyses of their own data in order to better understand their study populations and improve performance tracking and monitoring.

Standard 7: Interpretation of Results

Standard 7 lists any changes to the study design and discusses the effect of those changes on the comparability of data and interpretation of results; describes any factors that threaten the internal or external validity of the study; discusses whether the intervention was implemented as planned; describes any improvement in enrollee health, functional status, or satisfaction and accomplishment of target goals; discusses how the intervention influenced the results; discusses lessons learned during the PIP process; draws a conclusion about the study results based on the above factors; and describes next steps for the study.

Possible confounding factors:

- Other organizations (see Standard 1) will be implementing interventions as part of their own strategies to address opioid misuse and abuse, independent of the CCO-initiated interventions, which could have contribute to a decrease in the first remeasurement study indicator results.
- The delay in the implementation of the OHA back pain guidelines (scheduled for January 1, 2016) disrupted CCOs' plans to develop and fund non-opioid therapies.
- On December 14, 2015, the CDC released a draft of the first national guidelines on prescribing opioids for pain (the finalized version is pending at the time of this report).[20] The draft guidelines and media attention surrounding their release could influence provider prescribing practices, separate from any local CCO-initiated interventions.

Standard 8: Improvement Strategies

Standard 8 describes and documents the implementation of the intervention(s) and discusses the basis for adopting the intervention; how the intervention can be reasonably expected to result in measurable improvement; the cultural and linguistic appropriateness of the intervention; a tracking and monitoring plan (providing evidence of how the intervention was or will be implemented as planned); barriers encountered during implementation of the intervention and how they were addressed; and how the intervention will be adapted, adopted, or abandoned.

Each CCO has been tasked with developing, implementing, and documenting an improvement strategy to address the overarching, statewide study topic of integrating physical and mental health care through improving the safety of opioid management. Because they differ significantly in terms of geography, level of integration, history addressing this topic, and population size, the CCOs were advised to develop strategies for this PIP in a manner that met the needs of their local communities. Acumentra Health provided the CCOs with the criteria and scoring matrix for this standard, as well as ongoing technical assistance.

OHA required that CCOs submit quarterly reports documenting their progress on the Statewide PIP, beginning with the January 2016 quarterly report.

[20] The CDC. Draft CDC Guideline for Prescribing Opioids for Chronic Pain. http://www.cdc.gov/drugoverdose/prescribing/guideline.html.

Standard 9: Repeated Measurement of the Study Indicator

Standard 9 provides study results for two measurement periods, including the study indicator, original data used to compute the indicator, and a statistical test of group differences; provides any other data analyses for factors that may affect the study results; and discusses how the intervention, consistency of methodology, and any confounding factors affected the study results in the second remeasurement period.

This standard will not be completed until after the second remeasurement.

Standard 10: Sustained Improvement

Standard 10 discusses whether or not goals were met and sustained; whether improvement in the study indicator, as well as in enrollee health, functional status, or satisfaction was achieved; discusses lessons learned for the PIP and the system as a whole; and reports next steps.

This standard will not be completed until after the second remeasurement.

Statewide PIP, Attachment A: Denominator Exclusion Codes

Diagnoses and CPT codes related to: end-of-life care, palliative care, or hospice care		
DX		
V66	Convalescence and palliative care	
V667	Encounter for palliative care	
Z515	Encounter for palliative care	
CPT		
4350F	Cnslng Provided Symp Mngmnt	Counseling Provided On Symptom Management, End Of Life Decisions, And Palliation (Dem)
4553F	Pt Asst Re End Life Issues	Patient Offered Assistance In Planning For End Of Life Issues (Als)
99377	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 15-29 Minutes Per Month
99378	Hospice Care Supervision	Physician Supervision Of Patient Hospice Services, 30 Minutes Or More Per Month
D9110	Tx Dental Pain Minor Proc	Palliative (Emergency) Treatment Of Dental Pain-Minor Procedures
G0065	Physician Supervision Of A Hospice Patient	Physician Supervision Of A Hospice Patient
G0151	Hhcp-Serv Of Pt,Ea 15 Min	Services Performed By A Qualified Physical Therapist In The Home Health Or Hospice Setting, Each 15 minutes
G0152	Hhcp-Serv Of Ot,Ea 15 Min	Services Performed By A Qualified Occupational Therapist In The Home Health Or Hospice Setting, Each
G0153	Hhcp-Svs Of S/L Path,Ea 15mn	Services Performed By A Qualified Speech-Language Pathologist In The Home Health Or Hospice Setting,
G0154	Hhcp-Svs Of Rn,Ea 15 Min	Direct Skilled Nursing Services Of A Licensed Nurse (Lpn Or Rn) In The Home Health Or Hospice Setting

G0155	Hhcp-Svs Of Csw,Ea 15 Min	Services Of Clinical Social Worker In Home Health Or Hospice Settings, Each 15 Minutes
G0156	Hhcp-Svs Of Aide,Ea 15 Min	Services Of Home Health/Hospice Aide In Home Health Or Hospice Settings, Each 15 Minutes
G0157	Hhc Pt Assistant Ea 15	Services Performed By A Qualified Physical Therapist Assistant In The Home Health Or Hospice Setting
G0158	Hhc Ot Assistant Ea 15	Services Performed By A Qualified Occupational Therapist Assistant In The Home Health Or Hospice Set
G0182	Hospice Care Supervision	Physician Supervision Of A Patient Under A Medicare-Approved Hospice (Patient Not Present) Requiring
G0337	Hospice Evaluation Preelecti	Hospice Evaluation And Counseling Services, Pre-Election
G8768	Doc Med Reas No Lipid Profle	Documentation Of Medical Reason(S) For Not Performing Lipid Profile (E.G., Patients With Palliative
G8892	Doc Med Reas No Ldl-C Test	Documentation Of Medical Reason(S) For Not Performing Ldl-C Test (E.G. Patients With Palliative Goal
G9380	Off Assis Eol Iss	Patient Offered Assistance With End Of Life Issues During The Measurement Period
G9381	Doc Med Reas No Offer Eol	Documentation Of Medical Reason(S) For Not Offering Assistance With End Of Life Issues (Eg, Patient
G9382	No Off Assis Eol	Patient Not Offered Assistance With End Of Life Issues During The Measurement Period
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
G9433	Death, Nhres, Hospice	Death, Permanent Nursing Home Resident Or Receiving Hospice Or Palliative Care Any Time During The M
HC100	Omap: Nf Hospice Care	Omap: Nf Hospice Care
Q5001	Hospice Or Home Hlth In Home	Hospice Or Home Health Care Provided In Patient'S Home/Residence
Q5002	Hospice/Home Hlth In Asst Lv	Hospice Or Home Health Care Provided In Assisted Living Facility
Q5003	Hospice In Lt/Non-Skilled Nf	Hospice Care Provided In Nursing Long Term Care Facility (Ltc) Or Non-Skilled Nursing Facility (Nf)
Q5004	Hospice In Snf	Hospice Care Provided In Skilled Nursing Facility (Snf)

Q5005	Hospice, Inpatient Hospital	Hospice Care Provided In Inpatient Hospital
Q5006	Hospice In Hospice Facility	Hospice Care Provided In Inpatient Hospice Facility
Q5007	Hospice In Ltch	Hospice Care Provided In Long Term Care Facility
Q5008	Hospice In Inpatient Psych	Hospice Care Provided In Inpatient Psychiatric Facility
Q5009	Hospice/Home Hlth, Place Nos	Hospice Or Home Health Care Provided In Place Not Otherwise Specified (Nos)
Q5010	Hospice Home Care In Hospice	Hospice Home Care Provided In A Hospice Facility
S0255	Hospice Refer Visit Nonmd	Hospice Referral Visit (Advising Patient And Family Of Care Options) Performed By Nurse, Social Work
S0257	End Of Life Counseling	Counseling And Discussion Regarding Advance Directives Or End Of Life Care Planning And Decisions, W
S0271	Home Hospice Case 30 Days	Physician Management Of Patient Home Care, Hospice Monthly Case Rate (Per 30 Days)
S5150	Unskilled Respite Care /15m	Unskilled Respite Care, Not Hospice; Per 15 Minutes
S5151	Unskilled Respitecare /Diem	Unskilled Respite Care, Not Hospice; Per Diem
S9126	Hospice Care, In The Home, P	Hospice Care, In The Home, Per Diem
T2042	Hospice Routine Home Care	Hospice Routine Home Care; Per Diem
T2043	Hospice Continuous Home Care	Hospice Continuous Home Care; Per Hour
T2044	Hospice Respite Care	Hospice Inpatient Respite Care; Per Diem
T2045	Hospice General Care	Hospice General Inpatient Care; Per Diem
T2046	Hospice Long Term Care, R&B	Hospice Long Term Care, Room And Board Only; Per Diem

Statewide PIP, Attachment B: Baseline Measurement Period Results

Among OHP enrollees aged 12 years and older who had at least one prescription for an opioid pain reliever, the percentage who filled prescriptions totaling ≥ 120mg morphine equivalent dose (MED) on at least one day within the measurement year. Measurement year: 1/1/2014 – 12/31/2014.									
CCO	**deno: 12–17 y/o**	**num: 12–17 y/o**	**rate: 12–17 y/o**	**deno: 18+ y/o**	**num: 18+ y/o**	**rate: 18+ y/o**	**deno: Total**	**num: Total**	**rate: Total**
ALLCARE	331	6	1.8%	6240	396	6.3%	6571	402	6.1%
CHA	95	7	7.4%	1167	80	6.9%	1262	87	6.9%
CPCCO	209	7	3.3%	3792	593	15.6%	4001	600	15.0%
EOCCO	431	10	2.3%	5512	855	15.5%	5943	865	14.6%
FAMILYCARE	621	10	1.6%	11,058	906	8.2%	11679	916	7.8%
FFS	497	4	0.8%	8638	894	10.3%	9136	898	9.8%
HEALTH SHARE	1538	40	2.6%	26,218	3301	12.6%	27752	3340	12.0%
IHN	480	10	2.1%	7820	911	11.6%	8299	921	11.1%
JCC	240	7	2.9%	3488	616	17.7%	3728	623	16.7%
PSCS - CO	475	8	1.7%	6993	545	7.8%	7468	553	7.4%
PSCS - CG	82	1	1.2%	1143	121	10.6%	1225	122	10.0%
PHJC	68	0	0.0%	1391	122	8.8%	1459	122	8.4%
TRILLIUM	665	14	2.1%	12,861	1726	13.4%	13526	1740	12.9%
UHA	189	3	1.6%	3711	228	6.1%	3900	231	5.9%
WOAH	144	3	2.1%	2986	198	6.6%	3130	201	6.4%
WVCH	643	10	1.6%	9313	937	10.1%	9956	947	9.5%
YCCO	242	6	2.5%	2627	269	10.2%	2869	275	9.6%
SUM OF CCOs	**6453**	**142**	**2.2%**	**106,320**	**11804**	**11.1%**	**112768**	**11945**	**10.6%**

"deno" = denominator; "num" = numerator; "Total" = ages 12-17 plus ages 18+
Data extraction date: 12/28/2015, Office of Health Analytics, OHA
Note: Physician-assisted opioid injection claims do not have days of supply, or quantity of dispensed units. Therefore, MED cannot be calculated and these claims are not included in denominator calculation.

Among OHP enrollees aged 12 years and older who had at least one prescription for an opioid pain reliever, the percentage who filled prescriptions totaling ≥ 90mg MED on at least one day within the measurement year.

Measurement year: 1/1/2014 – 12/31/2014

CCO	deno: 12–17 y/o	num: 12–17 y/o	rate: 12–17 y/o	deno: 18+ y/o	num: 18+ y/o	rate: 18+ years old	deno: Total	num: Total	rate: Total
ALLCARE	331	7	2.1%	6240	739	11.8%	6571	746	11.4%
CHA	95	13	13.7%	1167	202	17.3%	1262	215	17.0%
CPCCO	209	16	7.7%	3792	915	24.1%	4001	931	23.3%
EOCCO	431	32	7.4%	5512	1258	22.8%	5943	1290	21.7%
FAMILYCARE	621	40	6.4%	11058	1846	16.7%	11679	1886	16.1%
FFS	497	25	5.0%	8638	1574	18.2%	9135	1599	17.5%
HEALTH SHARE	1538	89	5.8%	26218	5560	21.2%	27756	5648	20.4%
IHN	480	21	4.4%	7820	1372	17.5%	8300	1393	16.8%
JCC	240	12	5.0%	3488	824	23.6%	3728	836	22.4%
PSCS - CO	475	26	5.5%	6993	1063	15.2%	7468	1089	14.6%
PSCS - CG	82	2	2.4%	1143	200	17.5%	1225	202	16.5%
PHJC	68	1	1.5%	1391	210	15.1%	1459	211	14.5%
TRILLIUM	665	39	5.9%	12861	2744	21.3%	13526	2783	20.6%
UHA	189	6	3.2%	3711	480	12.9%	3900	486	12.5%
WOAH	144	7	4.9%	2986	414	13.9%	3130	421	13.5%
WVCH	643	27	4.2%	9313	1593	17.1%	9956	1620	16.3%
YCCO	242	16	6.6%	2627	462	17.6%	2869	478	16.7%
SUM OF CCOs	**6453**	**354**	**5.5%**	**106320**	**19882**	**18.7%**	**112773**	**20235**	**17.9%**

"deno" = denominator; "num" = numerator; "Total" = ages 12-17 plus ages 18+

Data extraction date 12/28/2015, Office of Health Analytics, OHA.

Note: Physician-assisted opioid injection claims do not have days of supply, or quantity of dispensed units. Therefore, MED cannot be calculated and these claims are not included in denominator calculation.

Statewide PIP, Attachment C: Chronic High Opioid Users

Percentage of patients on opioid doses ≥ 120mg Morphine Equivalent Dosage (MED) per day for 30 consecutive days or more. Measurement year: 1/1/2014 – 12/31/2014.

CCO	deno: 12–17 y/o	num: 12–17 y/o	rate: 12–17 y/o	deno: 18+	num: 18+	rate: 18+	deno: total [1]	num: total	rate: total	120 MED metric num[2]	rate: ≥ 30d in 120 mg MED population [3]
ALLCARE	331	0	0.0%	6240	83	1.3%	6571	83	1.3%	402	20.7%
CHA	95	0	0.0%	1167	4	0.3%	1262	4	0.3%	87	5.0%
CPCCO	209	0	0.0%	3792	183	4.8%	4001	183	4.6%	600	30.5%
EOCCO	431	1	0.2%	5512	245	4.4%	5943	246	4.1%	865	28.4%
FAMILYCARE	621	0	0.0%	11,058	120	1.1%	11679	120	1.0%	916	13.1%
FFS	498	0	0.0%	8638	258	3.0%	9136	258	2.8%	898	28.7%
HEALTH SHARE	1538	0	0.0%	26,214	766	2.9%	27752	766	2.8%	3341	22.9%
IHN	480	0	0.0%	7819	301	3.8%	8299	301	3.6%	921	32.7%
JCC	240	0	0.0%	3488	273	7.8%	3728	273	7.3%	623	43.8%
PSCS - CO	475	0	0.0%	6993	110	1.6%	7468	110	1.5%	553	19.9%
PSCS - CG	82	0	0.0%	1143	36	3.1%	1225	36	2.9%	122	29.5%
PHJC	68	0	0.0%	1391	46	3.3%	1459	46	3.2%	122	37.7%
TRILLIUM	665	0	0.0%	12,861	554	4.3%	13526	554	4.1%	1740	31.8%
UHA	189	0	0.0%	3711	45	1.2%	3900	45	1.2%	231	19.5%
WOAH	144	0	0.0%	2986	40	1.3%	3130	40	1.3%	201	19.9%
WVCH	643	0	0.0%	9313	259	2.8%	9956	259	2.6%	947	27.3%
YCCO	242	0	0.0%	2627	63	2.4%	2869	63	2.2%	275	22.9%
Sum of CCOs	**6453**	**1**	**0.0%**	**106,315**	**3128**	**2.9%**	**112,768**	**3129**	**2.8%**	**11946**	**26.2%**

"deno" = denominator; "num" = numerator; "Total" = ages 12-17 plus ages 18+

Data extraction date: 12/28/2015, Office of Health Analytics, OHA

Note: Physician-assisted opioid injection claims do not have days of supply, or quantity of dispensed units. Therefore, MED cannot be calculated and these claims are not included in denominator calculation.

[1] Among enrollees with at least one opioid prescription in the measurement year (study denominator), the percentage of people who had ≥120mg MED/day for 30 days or more.

[2] Number of enrollees with opioid prescriptions of ≥120mg MED/day for at least one day during the measurement year (study metric #1 numerator).

[3] Among enrollees with at least one day of ≥120mg MED/day (study numerator #1), the percentage of chronic high users (≥ 30 days at 120mg MED).

Percentage of patients on opioid doses ≥ 90mg Morphine Equivalent Dosage (MED) per day for 30 consecutive days or more. Measurement year: 1/1/2014 – 12/31/2014

CCO	deno: 12–17 y/o	num: 12–17 y/o	rate: 12–17 y/o	deno: 18+ y/o	num: 18+ y/o	rate: 18+ y/o	deno: Total	num: Total	rate: Total [1]	90MED metric num [2]	rate: ≥30d in 90mg MED pop[3]
ALLCARE	331	0	0.0%	6240	120	1.9%	6571	120	1.8%	746	16.1%
CHA	95	0	0.0%	1167	9	0.8%	1262	9	0.7%	215	4.2%
CPCCO	209	0	0.0%	3792	252	6.6%	4001	252	6.3%	931	27.1%
EOCCO	431	1	0.2%	5512	350	6.3%	5943	351	5.9%	1290	27.2%
FAMILYCARE	621	0	0.0%	11,058	200	1.8%	11,679	200	1.7%	1886	10.6%
FFS	498	0	0.0%	8638	412	4.8%	9136	412	4.5%	1599	25.8%
HEALTH SHARE	1538	0	0.0%	26,214	1114	4.2%	27,752	1114	4.0%	5648	19.7%
IHN	480	0	0.0%	7819	427	5.5%	8299	427	5.1%	1393	30.7%
JCC	240	0	0.0%	3488	342	9.8%	3728	342	9.2%	836	40.9%
PSCS - CO	475	0	0.0%	6993	166	2.4%	7468	166	2.2%	1089	15.2%
PSCS - CG	82	0	0.0%	1143	51	4.5%	1225	51	4.2%	202	25.2%
PHJC	68	0	0.0%	1391	61	4.4%	1459	61	4.2%	211	28.9%
TRILLIUM	665	0	0.0%	12,861	756	5.9%	13,526	756	5.6%	2783	27.2%
UHA	189	0	0.0%	3711	61	1.6%	3900	61	1.6%	486	12.6%
WOAH	144	0	0.0%	2986	57	1.9%	3130	57	1.8%	421	13.5%
WVCH	643	0	0.0%	9313	384	4.1%	9956	384	3.9%	1620	23.7%
YCCO	242	0	0.0%	2627	97	3.7%	2869	97	3.4%	478	20.3%
SUM OF CCOS	**6453**	**1**	**0.0%**	**106,315**	**4447**	**4.2%**	**112,768**	**4448**	**3.9%**	**20235**	**22.0%**

"deno" = denominator; "num" = numerator; "Total" = ages 12-17 plus ages 18+

Data extraction date: 12/28/2015; Last two columns on the right calculated by Acumentra Health 1/20/2016.

Note: Physician-assisted opioid injection claims do not have days of supply, or quantity of dispensed units. Therefore, MED cannot be calculated and these claims are not included in denominator calculation.

[1] Among enrollees with at least one opioid prescription in the measurement year (study denominator), the percentage of people who had ≥ 90mg MED/day for 30 days or more.

[2] Number of enrollees with opioid prescriptions of ≥ 90mg MED/day for at least one day during the measurement year (study metric #2 numerator).

[3] Among enrollees with at least one day of ≥ 90mg MED/da (study numerator #2), the percentage of chronic high users (≥ 30 days at 90mg MED).

Statewide PIP, Attachment D: Study Demographics

Number of enrollees 12+ years and older who had least one prescription for an opioid pain reliever filled within the baseline measurement year by race and ethnicity.					
Denominator	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of denominator**
African American	162	4589	46	4797	4.25%
American Indian or Alaskan Native	122	1414	24	1560	1.38%
Asian	120	1566	23	1709	1.52%
Caucasian/White	4943	80,800	1326	87,069	77.21%
Native Hawaiian/Pacific Islander	27	248	0	275	0.24%
Hispanic	25	0	18	43	
Other Race or Ethnicity	874	1826	37	2737	2.43%
Unknown	4611	9827	140	14,578	12.93%
Total	**10,884**	**10,0270**	**1614**	**112,768**	

Percentage of denominator who are Hispanic = 9.65%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Number of enrollees in the study baseline denominator with at least 30 consecutive days or more with ≥ 120 mg MED/day by race and ethnicity.					
Numerator: ≥ 120mg MED/day for 30 days or more	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of numerator**
African American	2	90	0	92	2.94%
American Indian or Alaskan Native	4	51	0	55	1.76%
Asian	0	10	0	10	0.32%
Caucasian/White	61	2609	18	2688	85.91%
Native Hawaiian/Pacific Islander	0	5	0	5	0.16%
Hispanic	0	0	0	0	0.0%
Other Race or Ethnicity	20	25	1	46	1.47%
Unknown	40	191	2	233	7.45%
Total	**127**	**2981**	**21**	**3129**	

Percentage of denominator who are Hispanic = 4.10%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Number of enrollees in the study baseline denominator with at least 30 consecutive days or more with ≥ 90 mg MED/day by race and ethnicity.					
Numerator: ≥ 90mg MED/day for 30 days or more	**Hispanic/ Latino**	**Non-Hispanic/ Non-Latino**	**Unknown**	**Cross Ethnicity**	**% of numerator**
African American	3	156	1	160	3.60%
American Indian or Alaskan Native	5	69	0	74	1.66%
Asian	0	12	0	12	0.27%
Caucasian/White	94	3689	25	3808	85.61%
Native Hawaiian/Pacific Islander	0	5	0	5	0.11%
Hispanic	0	0	0	0	0.0%
Other Race or Ethnicity	20	45	2	73	1.64%
Unknown	40	257	3	316	7.10%
Total	**127**	**4233**	**31**	**4448**	

Percentage of total denominator who are Hispanic = 2.86%.

Data extraction date: 12/28/2015, Office of Health Analytics, OHA.

Statewide PIP on Opioid Safety - Standard 8 Themes

Acumentra Health has identified general themes based on the January 2016 quarterly reports provided by each CCO. Aggregated examples are listed below for root cause analysis, improvement strategies and tracking and monitoring plans.

Questions related to this document should be directed to the Acumentra Health PIP Team at PIPTeam@acumentra.org.

I. Root Cause Analysis

Prescribing-related issues that influence opioid management

1. Changes in standards and beliefs, and slow pace of change in practice
2. Historical precedents, such as promotion of long-term opioid use for chronic pain
3. Lack of provider awareness of opioid profile of own patient population
4. Excessive amounts of opioids prescribed after surgery and in dental settings

Member-related issues that influence opioid management

1. Use of multiple providers and pharmacies, addiction, and dependence inhibit patient change
2. Inadequate understanding regarding opioids
3. Social and environmental factors, such as chronic and co-morbid conditions including mental health

Barriers to greater use of non-opioid treatments

1. Clinic guidelines may still focus on opioids
2. Lack or underuse of non-opioid treatments, availability of services, trained providers, and lack of reimbursement
3. Lack of coordination between alternative providers, physical health providers, and CCOs

Impacts of various system issues (medical record, data collection, decision support)

1. Providers not creating pain contracts, and lack of integrated systems between providers
2. Few administrative controls on prescribing
3. Data collection (e.g., lack of timely and actionable data available to providers)
4. Lack of guidelines, lack of implementation, and outdated guidelines

II. Improvement Strategies

Interventions supporting providers

1. Provide educational activities; for example, symposia, CMEs, and forums about topics, such as drug diversion and drug seeking, familiarization with and use of guidelines, and PDMP use
2. Provide technical assistance through medical director consultation, academic detailing, and provider notification of identified patients

Interventions to support use of non-opioid alternative treatments

1. Expand use of physical therapy, acupuncture, community classes, massage, behavioral health, medication-assisted treatment, substance abuse disorder treatment, etc., through increases and improvements in contracting, coverage, referrals, and access.
2. Educate providers and patients, collectively and individually, about the availability and benefits of alternative treatment, and promote the use of alternative treatments.

Member/public interventions

1. Implement community activities, such as education campaigns and forums
2. Create and distribute member communications, such as topic-specific handouts, website features, and newsletters
3. Target high-use members with letters that focus on opioid risks and management guidelines

Systems and medication interventions

1. Develop and implement pre-authorization processes
2. Implement opioid-prescribing limits
3. Implement standardized tapering tools
4. Collaboration: pharmacists and others work with providers to identify and work with members, using care coordination, and case and chart review
5. Assemble workgroups with providers and CCO and community representatives to collaborate on guidelines and policies

III. Tracking and Monitoring Plans

1. Collect and monitor internal or OHA-provided study indicator data
2. Collect data on numbers of letters, contacts, academic detailing, and technical assistance to providers
3. Track and monitor non-opioid services and programs (availability, attendance, outcomes). Numbers and feedback of providers and members participating in education efforts; for example, forums and direct-to-member pieces such as targeted letters, newsletters, and website article posts.
4. Track and monitor percent of prescribers enrolled in PDMP; conduct and report interviews with successful users of the PDMP
5. Utilize workgroups to analyze data and assess interventions