Oregon Health Authority

Quality and Health Outcomes Committee
AGENDA

MEETING INFORMATION
Meeting Date: April 10, 2017
Location: HSB Building Room 137A-D, Salem, OR • **Parking**: Map ◦ Phone: 503-378-5090 x0
Call in information: Toll free dial-in: 888-278-0296 Participant Code: 310477
All meeting materials are posted on the QHOC website.

Time	Topic	Owner	Materials
Clinical Director Workgroup			
9:00 a.m.	**Welcome / Announcements**	Mark Bradshaw	-Speaker's Contact Sheet *(2)* -Meeting Notes *(3 – 9)* -Metrics Update *(10 – 11)* -Public Health Update *(12)*
9:10 a.m.	**P&T Update**	Roger Citron	P&T Website
9:20 a.m.	**Oral Health Strategy**	Bruce Austin Tony Finch	-Presentation *(13 – 21)*
9:40 a.m.	**QHOC Planning**	Mark Bradshaw	-Potential Options *(22)* -Survey Results *(23 - 24)* -QHOC Charter *(25 – 26)*
10:00 a.m.	**HERC Update**	Cat Livingston	-HERC Materials *(27 – 54)*
10:30 a.m.	**Food Insecurity**	Brian Frank Lynn Knox	-Food Insecurity Screening *(55 – 58)*
10:45 a.m.	**BREAK**		
Learning Collaborative			
11:00 a.m.	**Statewide PIP – Year 1**		-Agenda *(59)* -Presentation *(60 – 73)*
12:30 p.m.	**LUNCH**		
Quality and Performance Improvement Session			
1:00 p.m.	**QPI Update – Introductions**	Jennifer Johnstun Lisa Bui	
1:15 p.m.	**Complaints & Grievances** • **OHA FAQ** • **Clarifications Discussion** • **Next Steps**	Allison Tonge Ann Brown	-Presentation *(74 – 80)*
2:30 p.m.	**QAPI check in**		
2:45 p.m.	**Items from the floor**	All	

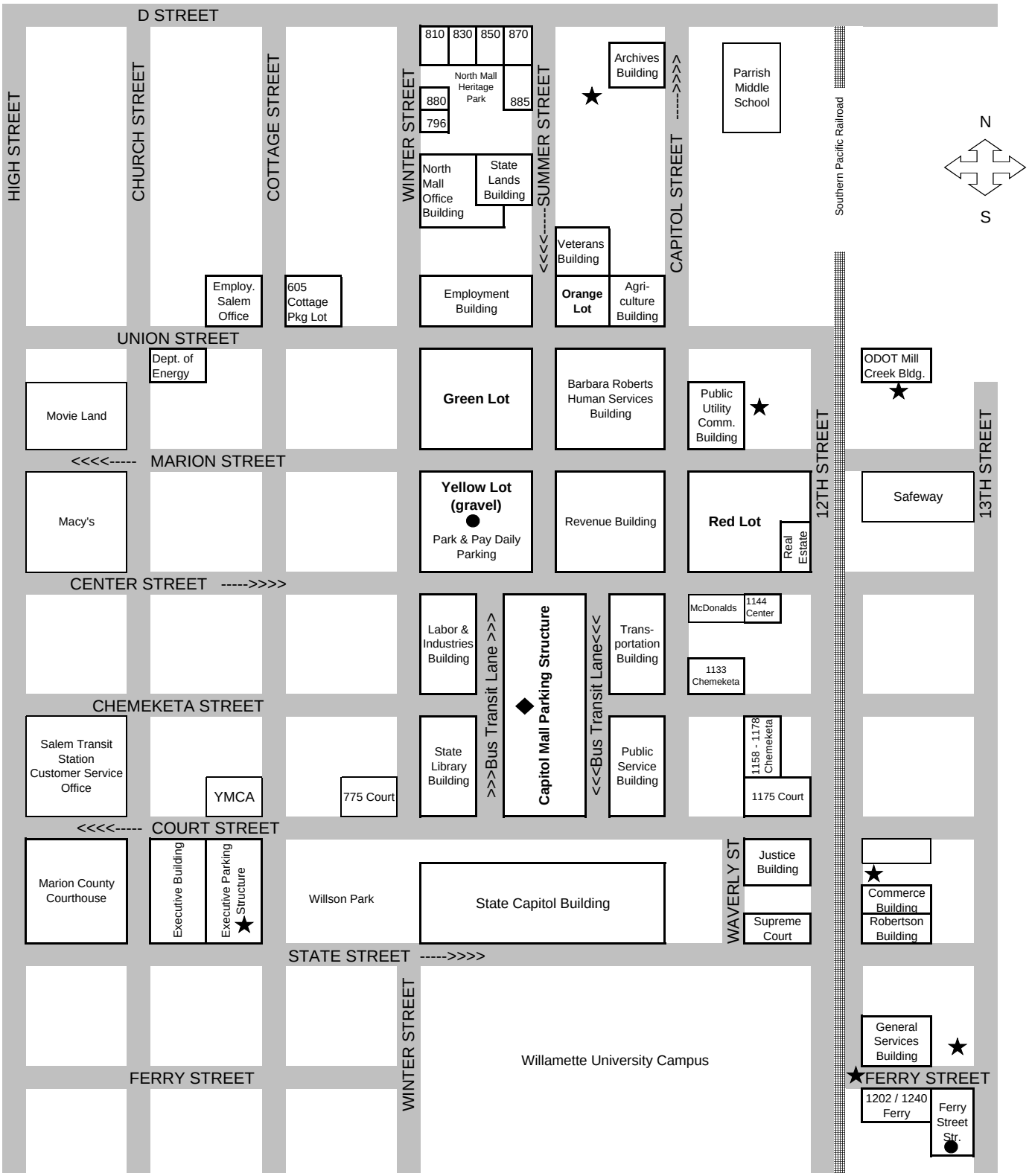
Upcoming May QHOC: Trauma Informed Care

Due to space issues for May, we will be in the Commission Conference Room (1st floor) at the Oregon Department of Fish and Wildlife. Address: 4034 Fairview Industrial Dr SE, Salem, OR 97302.

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

Topics may be subject to change due to availability

SALEM CAPITOL MALL AREA



★ **State of Oregon Meters - OK to use Agency issued one-day permit**

◆ **Capitol Mall Structure Meters - OK to use Agency Issued one-day permit**

● **Yellow Lot & Ferry Structure Rooftop Visitor Spaces - OK to use Agency issued one-day permit**

Daily_permit.xlsx - 5/01/14

SPEAKER CONTACT SHEET
QHOC – April 2017

AGENDA TOPIC	SPEAKER	CONTACT INFO
P&T Updates	Roger Citron	Roger.a.citron@state.or.us
Oral Health Strategy	Bruce Austin	Bruce.w.austin@state.or.us
	Tony Finch	Tony.finch@ocdc.net
HERC Update	Cat Livingston, MD, MPH	catherine.livingston@state.or.us
Food Insecurity	Brian Frank	frankb@ohsu.edu
	Lynn Knox	lknox@oregonfoodbank.org
Statewide PIP – Year 1	Sara Hallvik	shallvik@healthinsight.org
Complaints & Grievances	Allison Tonge	Allison.m.tonge@state.or.us
	Ann Brown	Ann.l.brown@state.or.us
QHOC CHAIRS		
Medical	Mark Bradshaw, MD	mark.bradshaw@allcarehealth.com
Behavioral Health	Athena Goldberg	athena.goldberg@allcarehealth.com
Oral Health	Dayna Steringer	dsteringer@live.com
Quality	Jennifer Johnstun	jen@ohms1.com
OHA LEADS		
Medical	Kim Wentz, MD	kim.r.wentz@state.or.us
Behavioral Health	Royce Bowlin, MS, CPRP	royce.a.bowlin@state.or.us
Oral Health	Bruce Austin	bruce.w.austin@state.or.us
Quality	Lisa Bui	lisa.t.bui@state.or.us

QHOC Website:
http://www.oregon.gov/oha/hpa/csi/Pages/Quality-and-Health-Outcomes-Committee.aspx

Questions:
OHA.qualityquestions@state.or.us or call Lisa Bui at 971-673-3397

Quality & Health Outcomes Committee (QHOC)

March 13, 2017 Meeting Notes

Chair- Mark Bradshaw (All Care)

Co-Chairs- Jennifer Johnstun (Primary Health)

Attendees: (*in person*) Susan Arbor (OHA/HSD); Maggie Bennington-Davis (HealthShare); Tara Bergeron (Tuality); Cara Biddlecom (OHA/PH); Amanda Blodgett (CHA); Stuart Bradley (WVCH); Mark Bradshaw (All Care); Stephani Bratsche (PacificSource); Lisa Bui (OHA/TC); Barbara Carey (Health Share); Roger Citron (OHA/OSU); Cheryl Cohen (Health Share); Ruth Galster (UHA); Athena Goldberg (AllCare); Walter Hardin (Tuality); Jenna Harms (Yamhill CCO); Hank Hickman (OHA/HSD); Holly Jo Hodges (WVP/WVCH); Todd Jacobsen (GOBHI); Jennifer Johnstun (Primary Health); Safina Koreishi (Columbia Pacific); Lynsey Krause (Access Dental); Alison Little (PacificSource); Cat Livingston (HERC); Andrew Luther (OHMS); Laura Matola (AllCare); Laura McKeane(AllCare); Kevin McLean (FamilyCare); Tracy Muday (WOAH); Brian Nieubuurt (OHA); Chris Norman (OHA); Colleen O'Hare (Trillium); Bhavesh Rajani (Yamhill CCO); Nancy Siegel (HealthInsight); Debbie Standridge (UHA); Dayna Steringer (DK Strategies); Anna Stern (WVCH); Ralph Summers (PacificSource); Melanie Tong (Washington Co.); Jennifer Valentine (OHA); Kim Wentz (OHA/HSD); Melinda West (Access Dental); John Wilson (AllCare); Amarissa Wooden (WOAH/NBMC

By phone: Ellen Altman (IHN/CCO); Katie Beck (OHA); Bruce Croffy (UHA); Tiffany Dorsey (Kaiser); Robin Faber; Kerrie Fowler (UHA); Matthew Hough (JCC); Cynthia Lacro (EOCCO); LeeLee Thames (EOCCO); Eryn Womack (IHN/CCO)

Quality & Health Outcomes Committee (QHOC)

March 13, 2017 Meeting Notes

CLINICAL DIRECTORS SESSION	
Introductions/ Announcements	**Announcements:** Mark Bradshaw: ▪ Topic of food insecurities moved to April QHOC meeting. ▪ Be sure to sign in as the sheet was put out late.
Legislative Update- Brian Neiubuurt	▪ The Legislative Session began February 1st; ▪ Discussed the budget cap battle; ▪ Two bills have passed – HB 558 and SB2526; ▪ Other bills discussed- HB 2122, HB 233, HB 236, HB2300, and HB2627; ▪ Policy rules have to be out by April 18, 2017.
PH Modernization- Safina Koreishi & Cara Biddlecom	▪ Public Health modernization updates; ▪ The public health system, now, and in the future; ▪ The public health advisory board; ▪ Statewide Public Health modernization plan; ▪ Opportunities for shared responsibility and collective impact to improve health;

	▪ Local public health modernization meetings; ▪ Attendees at meetings; ▪ AIMHI statewide meeting;
QHOC Planning- Mark Bradshaw	▪ Discussed the charter; ▪ Need for regular focused time for Medical directors; ▪ Webinar capability; ▪ Options for restructure of time – 9:00-10:00 Medical Directors, 10:00-11:00 Updates, 11:00-12:00 Learning Collaborative; ▪ Mental health has a meeting in the afternoon. OHA attendance not consistent; ▪ Medical Directors meeting without OHA present- if OHA is not present, there is no dialogue; ▪ Not enough CCO-OHA, CCO-CCO; ▪ The size of the meeting and group is a problem.
HERC Update- Cat Livingston	VbBG: ▪ HERC sent back vasectomy, will rethink in May ▪ Discussed collistectomy; ▪ Highlights- genetics for mental health disorders- decided not to cover;

	▪ Breast reduction- macromastia is not covered; ▪ MRI's for MS- limited reasons for this; ▪ Future look at non- specific pain conditions; ▪ Prioritization of novel treatments with marginal clinical benefit, low cost effectiveness and/or high cost; ▪ Coverage guidance for breast cancer screening; EGBS: ▪ Scope statements for HERC- Multisector Intervention, Salpingectomy for Ovarian Cancer, Urine drug testing, Corticosteroid low back pain (get input to Dr. Livingston by April 1st.); HTAS: ▪ Breast cancer screening for women with above average risk for breast cancer; ▪ Continuous Glucose Monitoring; ▪ Genome expression profiling for breast cancer; VbBS: ▪ Smoking cessation and elective surgery; ▪ Vaping and chew tobacco- does this guideline need editing? ▪ Confirmatory lab values? Bring back to next meeting.

LARC and Back Implementation Check-in- Kim Wentz	▪ Any difficulties to report? None reported; ▪ Any successes? None reported; ▪ Any other benefit information to share? None reported.
JOINT LEARNING COLLABORATIVE SESSION	
	OHIT: EDIE/PreManage
QUALITY AND PERFORMANCE IMPROVEMENT SESSION	
QPI Update and Introductions-	▪ Reminder: QAPI due March 16th; ▪ Focus on training for all on measurement.
Measurement Training- Colleen Reuland	This discussion began with a Pre-survey on metrics measurement use and knowledge. ▪ Agenda ;

	▪ Primary objective to be helpful; ▪ Metrics are an integral part of improvement; ▪ Model for improvement ▪ OHA PIP progress report; ▪ Key strategies OPIP uses when working with partners to create effective aim statements; ▪ Measures are a critical part of a "SMART" aim statement- Specific, Measureable, Achievable, Realistic, Time specific; ▪ Example measure; ▪ Key questions for designing improvement strategies with associated metrics; ▪ Importance of measurement plan as you design an Improvement Plan; ▪ Types of metrics to gauge improvement; ▪ Important factors to consider as you operationalize metrics; ▪ Run chart anatomy; ▪ How to create a baseline and monitor changes; ▪ Pulling it all together; ▪ Tools that can help you design improvement efforts that align with the aim and sound metrics- Driver Diagrams & logic Model; ▪ Keys to using these models: Identify specific strategies used to achieve the aim; ▪ Metrics demonstrating intervention effectiveness; ▪ Fictitious example of a PIP;

	A group exercise was conducted to specify metrics related to QI efforts focused on a current issue of Opioid safety. ▪ Clarifying measurement plan; ▪ Key to designing improvement strategies with associated measurements;
NEXT MEETING: April 10, 2017	*Salem - HSB Conference Room 137 A-D* Toll free dial-in: 888-278-0296 Participant Code: 310477 Parking: Map Office: 503-378-5090 x0

Metrics Update for QHOC

April 2017

CCO Metrics

Metrics & Scoring Committee

The Metrics and Scoring Committee met March 17 to hear presentations and begin discussions on alternative patient experience measures from the CAHPS survey, and dental metrics. Staff from OHA have been asked to provide additional information and recommendations regarding alternate CAHPS survey questions that could be incentivized.

The upcoming April 21 meeting will include a review of the mid-year CCO metrics report, and the start of discussions aimed at narrowing down the list of potential 2018 CCO incentive measures. Meeting information is available online at: http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx.

CCO Metrics Dashboards

Calendar year 2016 results for claims-based CCO incentive measures will be released in the dashboard no later than April 29th. Any validation questions from CCOs must be sent to OHA at metrics.questions@state.or.us by May 31, 2017.

Health Plan Quality Metrics Committee

Committee members have been appointed and staff have scheduled the first meeting for Thursday, April 13, 2017. Former Metrics and Scoring Committee members (and current members of the Hospital Metrics Advisory Committee) Maggie Bennington-Davis and Jeff Luck are among the appointees. A full roster, as well as meeting schedule and materials, are available at: http://www.oregon.gov/oha/analytics/Pages/Quality-Metrics-Committee.aspx

Hospital Performance Metrics Advisory Committee

The Committee met by phone on March 16 to review the details of the Hospital Transformation Performance Program (HTPP) one year extension granted by CMS in January. The full list of eleven CMS-approved incentive measures and benchmarks for the 2017 measurement period are overleaf:

Measure	Year 4/2017 Benchmark	Improvement Target Floor
1. All-cause readmissions	90th percentile HTPP Year 1 (8.0%)	MN method with 3 *percent* floor
2. EDIE	90th percentile HTPP Year 2 (30.1%)	MN method with 2 percentage point floor
3. Follow-up after hospitalization	90th percentile HTPP Year 2, hosp only rate (80.2%)	MN method with 3 percentage point floor
4. CLABSI	SIR of 0.50 or lower	MN method with 3 *percent* floor
5. CAUTI	SIR of 0.75 or lower	MN method with 3 *percent* floor
6. SBIRT	Brief Screen: 90th percentile from HTPP year 2 rate for brief screens (83.5%) Full Screen: 90th percentile from HTPP year 2 rate (71.3%)	MN method with 3 percentage point floor
7. Adverse drug events due to Opioids	2.0%	N/A (no improvement target)
8. Excessive anticoagulation due to Warfarin	2.0%	N/A (no improvement target)
9. Hypoglycemia in inpatients receiving insulin	3.0%	MN method with 1 percentage point floor
10. HCAHPS – discharge	National 90th percentile, April / May 2016 (91.0%)	MN method with 2 percentage point floor
11. HCAHPS – medication	National 90th percentile, April / May 2016 (73.0%)	MN method with 2 percentage point floor

The original proposal to CMS included three new measures beginning in HTPP Year 4 / 2017:

- *C-difficile*
- C-sections / unexpected newborn complications; and,
- Safe opioid prescribing in the emergency department.

While these measures are **not** eligible for incentive payments for 2017, OHA is encouraging hospitals to track and voluntarily report data on these measures to OHA. Voluntarily reported data may be used as baseline or in benchmarking for potential future quality incentive payments.

For more information

Please contact us at metrics.questions@state.or.us

PUBLIC HEALTH DIVISION
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Quality and Health Outcomes Committee
Public Health Division updates – April 2017

County Health Rankings – In March, the Robert Wood Johnson Foundation released the annual *County Health Rankings*. The annual R*ankings* provide a snapshot of how health is influenced by where we live, work, learn and play. Communities can use this information to identify solutions that make it easier for people to be healthy in their neighborhoods, schools and workplaces. Oregon *County Health Rankings* maps, data and summary reports are available at: http://www.countyhealthrankings.org/app/oregon/2017/overview.

Oregon Quit Line brochures available - The Oregon Health Authority, Public Health Division has a limited number of printed promotional materials available for the Oregon Tobacco Quit Line. Posters and palm cards are available in Chinese, Korean, Vietnamese, Spanish, Russian and English. Please contact Nancy Goff (nancy.m.goff@state.or.us) if you are interested.

Oregon WIC receives national attention - The Center on Budget and Policy Priorities, in cooperation with the National WIC Association, gathered information on WIC practices and procedures to examine how WIC clinics can streamline processes of applying for and maintaining WIC eligibility. Oregon WIC was highlighted six times for best practices in the following areas:

- Streamlining eligibility processes
- Use of technology
- Collaboration with CCOs
- Head Start partnerships
- 211 screening and referral partnership

The full report is available at: http://www.cbpp.org/research/modernizing-and-streamlining-wic-eligibility-determination-and-enrollment-processes

Strategic Plan for Oral Health in Oregon: 2014-2020

Progress Report

April 3, 2017

OREGON ORAL HEALTH COALITION

Improving general health through oral health for all Oregonians

Strategic Plan for Oral Health in Oregon

Plan History

In 2013, oral health providers, experts and advocates came together to develop a *Strategic Plan for Oral Health in Oregon*. They identified three priority areas and set goals for improving statewide oral health:

- *Infrastructure*
- *Prevention and Systems of Care*
- *Workforce Capacity*

Strategic Plan for Oral Health in Oregon
2016 Progress Report

This biennial progress report is based on input from stakeholders representing a wide variety of organizations.

Objectives

- Assess the current status of oral health improvement in each priority area.
- Recognize success and innovation.
- Identify work yet to be done.

Strategic Plan for Oral Health in Oregon
2016 Progress Report

Highlights

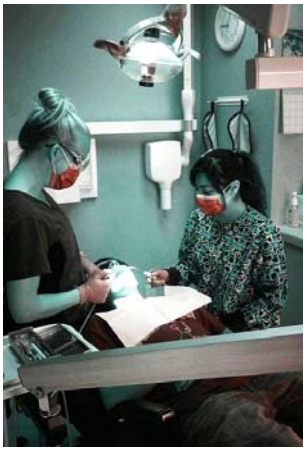
- Statewide health system transformation has increased access to oral health care.
- Exceptional commitment of Oregon's oral health advocates is a major strength.
- Innovative projects around the state have improved care.
- Concerted efforts are building oral health capacity.
- Many opportunities exist to work together more effectively.

Strategic Plan for Oral Health in Oregon
2016 Progress Report

Highlights

- Timely information sharing remains challenging due to a limited integration of medical and dental records.
- Progress has been made on integration of dental-medical-behavioral services, but more is needed.
- Despite expansion of adult Medicaid benefits, care for underserved adults — particularly seniors — remains inadequate.
- There are limited examples of fostering cultural competence in oral health professions.

Strategic Plan Priority Areas
Infrastructure



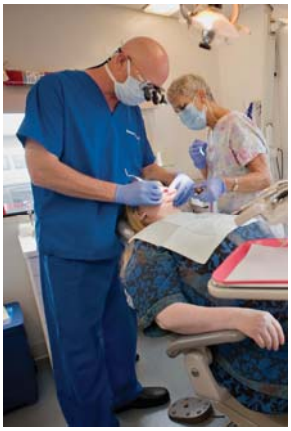
Objectives

Oregon's oral health infrastructure supports health system transformation priorities and delivers better care, better health and lower costs.

Key Accomplishments

- Oregon now has a state dental director, which has led to a new era of cross-divisional collaboration on oral health.
- Oral health is one of seven priorities in the State Health Improvement Plan (SHIP), which recommends:
  - Increasing community water fluoridation
  - Providing sealants in schools
  - Ensuring an adequate supply of oral health professionals
  - Increasing preventive care for children
  - Including oral health in chronic disease prevention and management

Strategic Plan Priority Areas
Infrastructure



Key Accomplishments

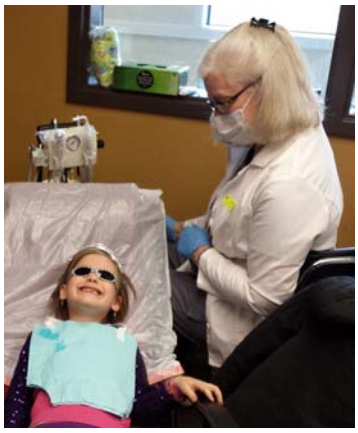
- Legislative actions have expanded dental access.
- CCOs are integrating oral health and have identified oral health as a priority in their communities.
- Oral health coalition network has increased, which broadens the oral health stakeholder base and serves as a common voice for advocacy.
- Federally qualified health centers (FQHCs) and school-based health centers (SBHCs) have expanded access to oral health services.
- Hospital database implemented to track emergency department visits for nontraumatic dental pain.

Strategic Plan Priority Areas
Infrastructure

Recommendations

- Reimbursement and payment models should incentivize oral health integration, care coordination and access.
- Oregon's health care advocates and workforce should coordinate data collection and sharing across organizations and agencies.
- Full integration of electronic health records should be promoted to support dental-medical-behavioral care coordination.
- CCOs and DCOs should continue to working together to take advantage of opportunities to integrate Oregon's system of care together.

Strategic Plan Priority Areas
Prevention and Systems of Care



Objectives

Oregonians understand that oral health is inseparable from overall health, and evidence-based prevention strategies are implemented across every Oregonian's lifespan

Key Accomplishments

- Current water fluoridation programs have been defended and sustained.
- Preventive services for pregnant women have increased substantially, improving access to care.
- Preventive services for children have increased statewide, including screening and sealant programs in schools and community settings.

Strategic Plan Priority Areas
Prevention and Systems of Care

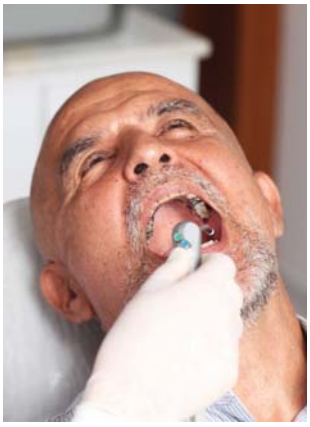
Key Accomplishments

- Innovative programs developed.
- Safety-net dental services for uninsured adults have been sustained.
- Several initiatives are underway to integrate oral health with chronic disease prevention and management.
- Oral health education programs have been developed and integrated into many existing health education programs.

Strategic Plan Priority Areas
Prevention and Systems of Care

Outcome Measures	Baseline	Current
Populations residing in communities with optimally fluoridated water	22.6%	22.2%
Pregnant women who had their teeth cleaned within the previous year	53.2%	58.3%
Individuals who have received First Tooth training	3,046	4,398
8th graders with decay experience	70.1%	68.7%
11th graders with a dental visit in the previous year	74.5	74.9
Adults 18 and older with a dental visit in the previous year	63.8%	67%

Strategic Plan Priority Areas
Prevention and Systems of Care



Recommendations

- Sustain long-term communication and advocacy efforts for community water fluoridation.
- Expand models of care for adolescents, seniors and people with special needs and chronic diseases.
- Foster engagement and inclusion with groups and advocates who serve communities of color.
- Actively engage in statewide efforts to reduce childhood obesity and tobacco use.

Strategic Plan Priority Areas
Workforce Capacity

Objectives

Oregon has an equitable distribution of oral health professionals who can meet the lifelong oral health needs of all Oregonians.

Key Accomplishments

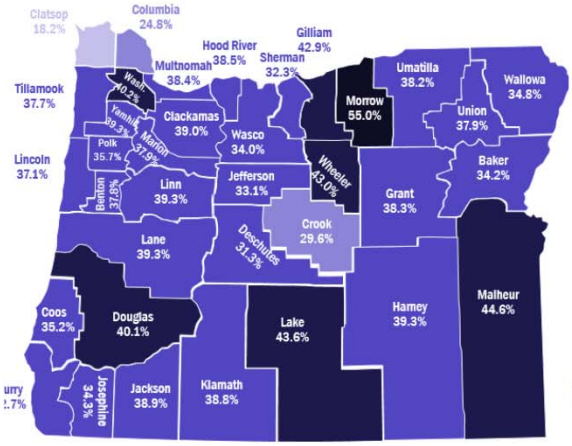
- Expanded practice dental hygienists (EPDHs) have **tripled** in number and are serving in non-dental settings such as schools, Head Start programs and community health clinics.
- Workforce capacity is expanding through pilot projects that are testing new models of care:
  - Dental health aide therapists (DHATs) are targeting underserved Native communities.
  - EPDHs are being trained to place interim therapeutic restorations (ITRs).

Strategic Plan Priority Areas
Workforce Capacity

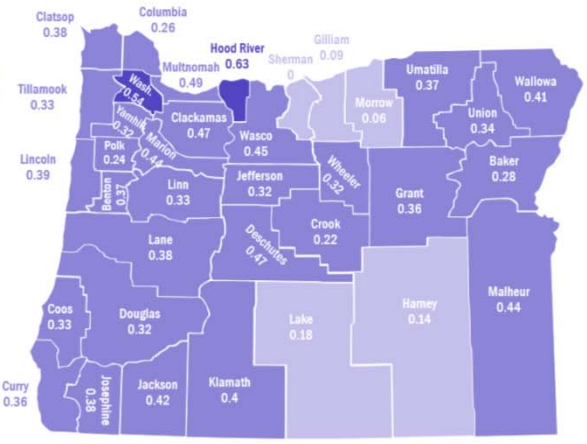
Key Accomplishments

- HB 2024 created rules and procedures for training traditional health workers (THWs) to provide oral health education and navigation.
- Community-based rotations for dental students have increased in length and increasingly include interprofessional education.
- Dental programs now include more cultural competence training.
- Mobile dental services reached several thousand adults and children who otherwise might not have access to dental care.

Strategic Plan Priority Areas
Workforce Capacity

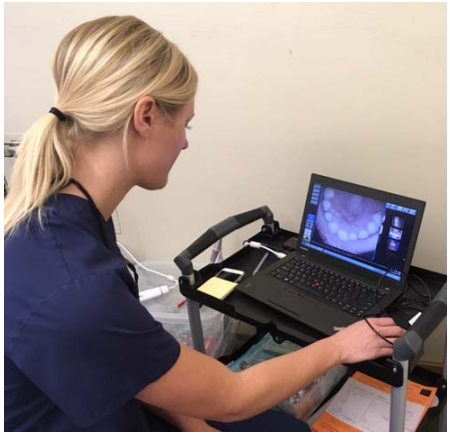


OHP Utilization



Dentists Per 100 population

Strategic Plan Priority Areas
Workforce Capacity



Recommendations

- Support efforts to attract, train and retain a culturally diverse workforce.
- Address impending workforce shortages (esp. lab technicians and dental assistants).
- Secure additional funding to incentivize providers to work in rural areas.
- Attend to EPDH reimbursement issues that create barriers to expanding their use.
- Recognize and that integration of oral health into Primary Care will increase access, education, prevention and earlier detection of dental disease. (and lower costs!)

Strategic Oral Health Priorities
Summary

- Oral health has much more visibility in Oregon as a priority for overall health.
- Great progress has been made in the priority areas identified in the *Strategic Plan for Oral Health in Oregon*.
- We have lots of community-level momentum to continue working together to improve oral health access.
- We need to continue expanding efforts to address high needs and vulnerable adolescents and adults.
- We need to continue working on medical-dental-behavioral integration to support overall health.

Question	Yes	No	Blank
Does the current schedule meet your needs for interaction with OHA staff?	9	6	1
Does the current schedule meet your needs for interaction with CCOs?	7	8	1
Does the current schedule meet your needs for formal structured vs unstructured time?	6	8	2
Is it important to implement GoToWebinar technology?	12	2	2
Does the current composition meets needs for size of group?	9	6	1
Does the current composition meets needs for role of attendees?	10	5	1
Does the current composition meets needs for presence of non-CCO attendees, and public stakeholders?	10	4	2
Are there additional OHA staff needed?	3	10	3
Need for regular focused medical director time	14	1	2
Liaison and consultation to OHA for clinical and quality aspects of implementing benefits of the OHP?	8	5	3
Outreach from community programs to CCO clinical leadership for policy and implementation issues?	9	3	4
Sharing best practices for quality of care improvement?	10	3	3
Supporting integration of behavioral, physical and oral health?	8	5	3
Coordination of community efforts toward achieving the triple aim?	6	6	4
OHA updates regarding benefits and implementation?	10	3	3
OHA program information, e.g. Public Health, Transformation and staff changes?	8	5	3
Clinical knowledge updates, e.g. pregnancy screening for syphilis?	8	5	3
Discussion of federal and state mandates?	8	5	3

Sample of Comments:

- In terms of interaction with other CCO med dir- we don't really get time in the meetings to do that. I wonder if the learning sessions can be structured more to do that? There isn't really unstructured discussion time at all. Some might be nice, depending on the topic. Also- is the intent mostly informational, or is the intent to get input and feedback? I am not sure.
- The agenda doesn't always include the most "hot" topics that CCOs are dealing with, and doesn't always allow for clinical leaders to compare notes. I think we do that a lot off line, but it would be helpful to be able to do so in the room. I've also wondered if it would be helpful to know the CCO CEO agenda items, so we can coordinate with that level of CCO leadership/OHA as well.

Survey fielded: March 3-13, 2017

- The meetings are good for meeting colleagues. The few relationships I've developed by attending have turned into good resources for my daily work. Unfortunately, not too many medical directors can attend (including me) because of the time commitment to be in Salem for most of a day (and away from time lines in our work.). On the other hand, a webinar format loses the give-and-take that can happen in person.
- I feel there are too many "groups" present at the meeting which makes Director type issues inappropriate to discuss in such a mixed audience. I would prefer a separate meeting with just the CCO directors and the OHP clinical staff
- I would say the agenda does not always warrant the time for dental and BH...
- Make the meeting more focused on the CCOs and their clinicians
- This could be useful. During the lunch time, or afternoon, following the morning meeting. The afternoon sessions generally haven't been that relevant to me specifically as a medical director..
- In general, it seems the meeting has changed over the years, in some ways better but missing some valuable pieces/culture now. It used to be more clinical, seeking input from Medical Directors and other clinical-oriented CCO staff. There has been a shift towards a larger group that is more administrative/process oriented, less content/philosophical. Info is now largely from OHA/State to the CCO's, little in the other
- I think the HERC and P and T updates would be good projected, or in powerpoint, highlighting the important parts.

QHOC Meeting Survey: Part II

Responses to the first survey showed agreement that a smaller, regularly scheduled meeting of just medical directors is needed. Goals would be to focus on implementation of benefits and proposed benefits; increased interaction between CCOs and CCOs providing input to OHA, and a more interactive, less structured format. CCOs would be responsible for agendas and leadership. A charter may be needed. OHA staff would attend in a support capacity. 1-2 individuals from each CCO could attend, so total meeting size would be 16-32, instead of current 50-60.

Please note the option of medical directors meeting from 8-9 am has already been ruled out.

Regarding Possible Formats

Option #1

Every other alternating meeting would be exactly as it is now.

On the other months, 9-10 am would be attended by medical directors only. 10-11:00 would be same as it is now: HERC and PnT updates, PH or TC or legislative updates, etc.

11:00-12:30 would be 30 minutes of learning collaborative on a community best practice, and one hour of updates content that previously would have been presented from 9-10.

Option #2

Every other alternating meeting would be exactly as it is now.

On the other months, 9-11 am would stay the same. 11 – 12:30 would be 30 minutes of learning collaborative on a community best practice, and one hour of the new medical directors only meeting.

Option #3

Every other alternating meeting would be exactly as it is now.

On the other months, 9-12:30 would stay the same. Medical directors would stay for a focused meeting from 1-2 pm.

Option #4

Please suggest a format of your own choosing, if preferred.

CHARTER (Updated 04/10/2017, Approved 8/10/2015)
Oregon Health Authority | Quality and Health Outcomes Committee

Background

Since 1993, the Quality Health Outcomes Committee (QHOC), formerly known as the Medicaid Medical Directors meeting and the Quality and Performance Improvement Workgroups, served as the forum for communication of the clinical and quality aspects of implementation of the Oregon Health Plan (OHP) with statewide health systems serving the Medicaid population. In 2013, in compliance with the 1115 Waiver, QHOC added learning collaboratives to share best practice implementation of the quality incentive measures and overall health transformation.

Purpose

- Provide a forum for community leadership in physical, behavioral, oral, and population health for the Oregon Health Plan population
- Develop community improvement strategies from identified trends in quality and compliance
- Serves a liaison and consultation role to the OHA for clinical and quality aspects of implementation of the Oregon Health Plan, including a focus on clinical guidance, benefits implementation, and quality assurance policies.
- Identify integrated approaches and strategies to improve health outcomes
- Provide a mechanism for community programs to reach Coordinated Care Organization (CCO) clinical leadership for policy and implementation issues that support the quality delivery of health care across the spectrum of care.
- Share best practice to community partners for issues and concerns regarding quality initiatives

Principles

- QHOC promotes integration, efficient working relationships, data driven decision making
- Maximizes the in-person learning experience while also recognizing the commitment of time and resources
- Coordinating clinical community efforts towards achieving the Triple Aim (Better health, better care, and lower cost) is the primary goal

Scope

QHOC brings together clinical leadership from CCOs and their community partners across the state to coordinate and lead quality improvement efforts and support the implementation of innovative health care practices throughout the state.

Membership, Roles & Responsibilities

Project Sponsor(s)	Oregon Health Authority
Leadership:	Mark Bradshaw, QHOC Medical Director Chair
	Athena Goldberg, QHOC Behavioral Health Chair
	Dayna Steringer, QHOC Oral Health Chair
	Jennifer Johnstun, QHOC Quality Program Chair
Members:	• Medical, dental health, behavioral health and quality directors of each CCOs

OHA Staff:	OHA representatives from Health Systems Division, Transformation Center staff and the Office of the Chief Medical Officer
Key OHA Staff Resources:	• Medicaid Medicaid Director • Behavioral Health Director • Quality Improvement Director • Contacts and Compliance Director • Meeting Support Staff
Leadership Responsibilities	• Facilitate meeting • Collaborative agenda development with key OHA staff • Field QHOC member questions and concerns
Leadership Term	QHOC chairs are nominated and voted by the full membership with terms lasting one year with the option of a second year.

Key Responsibilities

Key Responsibilities:

- Review, discuss, provide input on changes, and advice regarding clinical policy implementation for HERC, Pharmacy and Therapeutics Committee, HSD and other relevant OHA programs.
- Support community clinical and population health initiatives and standards
- Sharing best practices and approaches amongst CCOs and with OHA
- Evaluate waiver-required External Quality Review Organization (EQRO) findings and Statewide performance improvement projects status and implementation review
- Quality metrics monitoring and performance improvement plans
- Advise and provide consultation to OHA Quality Strategy review and implementation
- Collaboratively develop and improve best practices for contractual quality expectations reporting between CCOs and OHA; following the Center for Medicare and Medicaid Services' regulations

Key Stakeholders

- Health System Members
- Coordinated Care Organizations
- Community Partners
- Oregon Health Authority
- Center for Medicare & Medicaid Services

Meeting Format

Frequency:	Meetings occur monthly in Salem, Oregon (telecom also available)
Format:	Integrated morning session for clinical leadership with a joint learning collaborative mid-morning with both clinical and quality leaders. Breakout afternoon session for role specific workgroups (behavioral health directors, quality managers)
Materials:	QHOC briefing book is distributed monthly with agenda posted to OHA QHOC website no later than 2 weeks prior to meeting

Charter Review & Modification

Annual Review (at a minimum), beginning July 2015

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
March 9, 2017

Members Present: Som Saha, MD, MPH, Chair; Wiley Chan, MD; Beth Westbrook, PsyD; Mark Gibson; Leda Garside, RN, MBA; Susan Williams, MD; Kim Tippens, ND, MSAOM, MPH; Kevin Olson, MD; Chris Labhart; Holly Jo Hodges, MD; Gary Allen, DMD; Irene Croswell, RPh.

Members Absent: Derrick Sorweide, DO.

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

Also Attending: Jesse Little (Oregon Health Authority); Adam Obley, MD, MPH, Craig Mosbaek (OHSU Center for Evidence-based Policy); Gloria Tapia (Salud); Craig Gonzales (EGS); Carl Stevens, MD (CareOregon).

Call to Order

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

Minutes Approval

MOTION: To approve the minutes of the 11/10/2017 meeting as written. *CARRIES 12-0.*

Director's Report

Subcommittee Membership:
Coffman said Dr. Farris resigned from the Health Technology Assessment Subcommittee (HTAS) in December. He recommended Dr. Kathryn Schabel to replace him on HTAS. Dr. Schabel's CV and Conflict of Interest (COI) declaration were vetted by leadership and approved.

MOTION: Appoint Dr. Schabel to HTAS effective immediately. *Carries: 12-0.*

Dr. Devan Kansagara is an internist and colleague of Dr. Saha, who is recommending to be appointed to participate on the Evidence-based Guidelines Subcommittee (EbGS). His CV and COI were similarly vetted and approved.

MOTION: Appoint Dr. Kansagara to EbGS effective immediately. *Carries: 12-0.*

Potential changes to the opioid use policy:
Coffman asked members for data requests to analyze the impact of the back line changes that went into effect 7/1/16, particularly the guideline on the use of opioids. He said he has already begun working with the OHA Health Analytics manager about the data needed, noting we will be unable to use the All Payers All Claims (APAC) data this time but data from MMIS will serve nicely. Ideas suggested at VbBS included the number of new opioid prescriptions for back conditions, length and average dose of existing opioid prescriptions, change in utilization of emergency services and of alternative therapies for back pain. Discussion is anticipated at the May and August meetings; any changes should be reflected in the October 1, 2017 Prioritized List.

Value-based Benefits Subcommittee (VbBS) Report on Prioritized List Changes
Meeting materials page 128-229

Ariel Smits reported the VbBS met earlier in the day, March 9, 2017, as well as on February 2, 2017. She summarized the subcommittee's recommendations.

February 2, 2017 meeting:
RECOMMENDED CODE MOVEMENT (effective 10/1/2017)

- Add several dental procedures to covered lines
- Make various straightforward coding changes
- Add procedure codes for fecal microbiota transplant to a covered line with a new guideline to clarify coverage
- Add procedure codes for cholecystectomy to the pancreatitis line and delete from the intestinal ileus line
- Add limited coverage for tympanostomy tubes and adenoidectomy for high-risk children with hearing loss due to chronic otitis media older than age 5, with coverage limited through age 7 in the chronic otitis media with effusion guideline
- Add adenoidectomy procedure codes to the covered line for hearing loss in children age 5 and under to clarify coverage

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2017)

- Revise the dental guideline regarding wisdom tooth extraction to clarify coverage
- Edit the guideline defining significant injuries to joints to include meniscal injuries
- Add a new guideline to define cholecystitis

2018 BIENNIAL REVIEW CHANGES (effective 1/1/2018)

- Merge two lines with injuries to major blood vessels; move codes from a third line to the new line to consolidate all diagnosis and treatment codes for major blood vessel injuries

March 9, 2017 meeting:
RECOMMENDED CODE MOVEMENT (effective 10/1/2017)

- Add several non-specific pain diagnoses to a non-covered line
- Make multiple straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2017)

- Add a new guideline specifying that pharmacogenetics testing is not covered for any psychiatric disorder
- Edit the pharmacist medication management guideline to remove the requirement for a provider to refer the patient and for the pharmacist to collaborate with the referring provider
- Add a new guideline specifying that breast reduction for macromastia is not covered for the comorbid condition of neck or back pain
- Edit the elective surgery and smoking guideline to specify that tobacco replacement, including vaping, is allowed. Other guidelines which require longer periods of smoking cessation prior to specific procedures were modified to specify that any type of nicotine use (including vaping, smokeless tobacco, and nicotine replacement therapy) were not allowed.
- Edit the MRI for MS guideline to allow MRIs in limited clinical situations
- Edit the preventive services guideline to specify blood lead screening coverage

Biennial Review (Effective 1/1/2018)

- Create two new lines for treatments with marginal clinical benefit or low cost-effectiveness along with two guideline notes and a statement of intent. Further work will is required to further refine these lines and guidelines at the next few VbBS meetings.

Additional discussion took place on the topic of cholecystitis. Smits said VbBS recommends not covering gallbladder removal for pain/biliary colic only until there are certain objective finding such as evidence of inflammation, ultrasound findings characteristic of cholecystitis or a gallbladder ejection fraction <35%.

Saha noted that this treatment course goes against what he learned in medical school and asked for the evidence. Smits said the studies she found show a group of people with those symptoms will proceed to complications but there are no worse outcomes of morbity or mortality to wait to perform the surgery until complications arise. Pain is not covered until there is a complication. She said she found one study of 75 patients where one person in the *waiting group* died and 14 of the 40 required hospital admission. Further, the area expert who was consulted on this issue recommended biliary colic coverage before complications.

Saha summed up his thoughts about the only study found by stating the *surgery group* (received surgery within 24 hours of first bout of biliary colic) experienced no complications while the *waiting group* had 14 (of 40) serious complication admissions and 1 death. A laparoscopic gallbladder removal seems very safe compared to a complicated, potentially open procedure for a perforated gallbladder with pancreatitis. These are not simple complications, they are catastrophes. He struggled to find a valid reason to wait.

Smits said the initial staff recommendation was to allow surgery for recurrent (more than 1 episode) of biliary colic. Chan offered his support for this. Hodges objected saying there is no way to know if the patient will ever have a third bout of biliary colic and pain, and even in the presence of gallstones, there may not be causation.

Dr. Carl Stevens, CareOregon Medical Director, said the standard test in the ED is to perform a bedside ultrasound to confirm Murphy's sign. His CCO is allowing surgery for patients who we think it would be

risky for them to undergo emergent gallbladder removal, such as a patient with diabetes or immunosuppressed patients.

MOTION: To return the topic of gallbladder surgery to VbBS to do more investigation. *Carries: 11-1 (Hodges opposed)*

Biennial report: Novel Treatments
Coffman said this is the last meeting before the biennial review is completed where we can add, create or delete lines. He asked the members to consider a proposal to add two new lines. For many years, this Commission has had explicit statutory authority to prioritize treatments, including drugs, based on cost-effectiveness as well as clinical effectiveness. Historically HERC has not used cost-effectiveness to regularly determine placement on the Prioritized List other than to occasionally not pair a treatment with a condition when another treatment is found to be more cost-effective.

For the biennial review, staff propose a new guideline on novel treatments with marginal clinical benefit or low cost-effectiveness. In additional to utilizing the line items and guideline notes for medical and surgical therapies, this would create a specific mechanism for prioritizing outpatient drugs, durable medical equipment and supplies, and certain other ancillary services that do not currently appear on the Prioritized List below the funding line. This is potentially cost-saving but may cause opposition on a variety of fronts.

The proposal would add one statement of intent, two new lines and two guideline notes as follows, with the higher of the two new lines prioritized at line 500 and the lower new line appearing as the last line of the list:

> STATEMENT OF INTENT 3, THERAPIES WITH MARGINAL CLINICAL BENEFIT OR LOW COSTEFFECTIVENESS
>
> Line 500
> CONDITION: CONDITIONS FOR WHICH CERTAIN TREATMENTS RESULT IN MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS TREATMENT: MEDICAL AND SURGICAL TREATMENT
>
> Line YYY (~666)
> CONDITION: CONDITIONS FOR WHICH CERTAIN TREATMENTS HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS TREATMENT: MEDICAL AND SURGICAL TREATMENT
>
> GUIDELINE NOTE AAA, TREATMENTS WITH MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS FOR CERTAIN CONDITIONS
>
> GUIDELINE NOTE BBB, TREATMENTS THAT HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS

Coffman noted that the proposal would not immediately populate the lines; it would create these lines in order to populate them at future meetings. He noted HERC is statutorily forbidden from doing drug class reviews; that job falls to OHA's Pharmacy & Therapeutics (P&T) Committee. Once P&T completes a review, HERC would be notified. HERC will review their study to determine appropriate prioritization, which would appear as a narrative listing of condition and prescription drug pairings within the new

guideline notes. Coffman also said this process could be used as a more transparent home for non-drug treatments such as those currently on the Services Recommended for Non-Coverage Table, which VbBS would like to review in May towards that end.

Cost-effectiveness discussion:
Livingston directed the members to pages 222-229 in the meeting packet, pointing out Figure 1.9 as a diagram always included in the Biennial Report to the Legislature but never used. Parts of it are unclear and other parts are incorrect. Staff recommends deleting Figure 1.9 from the upcoming biennial report in its entirety.

Coffman said further discussion on whether to define a threshold for what constitutes low cost-effectiveness for new line 500 can occur at the May meetings.

MOTION: To accept the staff recommendation to create two new lines, one statement of intent and two new guideline notes in order to prioritize novel treatments as discussed and delete Figure 1.9 from the biennial report. *CARRIES: 12-0.*

MOTION: To accept the VbBS recommendations on Prioritized List changes not related to coverage guidances or called out separately as stated above. *See the VbBS minutes of 2/2/2017 & 3/9/2017 for a full description. Carries: 12-0. Westbrook noted her objection against the recommendation on MRIs for MS, but was in favor of all other aspects of the vote.*

Coverage Guidance Topic: Digital Breast Tomosynthesis (3D Mammography) for Breast Cancer Screening in Average-Risk Women
Meeting materials page 231

Drs. Humphrey (could not attend) and Thomas (*via teleconference*) were appointed ad hoc experts for this topic and helped inform the process.

Obley presented an overview of the evidence. Though the breast cancer death rate has declined steadily over the past 15 years, 12% of women will develop invasive breast cancer during their lifetime. The decline in mortality can be attributed to better screening efforts, decreased use of hormone therapy post-menopause and improved treatment.

Digital breast tomosynthesis (DBT), approved by the FDA in 2011 and sometimes referred to as three-dimensional (3-D) mammography, involves producing multiple x-ray images of thin breast sections, compared to one image from conventional digital mammography (DM). DBT seeks to improve mammography by improving cancer detection and reducing the false-positive rate.

This scope of this coverage guidance looks at a population of women between 40 and 74 years referred for screening and *excludes* women with a history of breast cancer, certain BRCA mutations, Cowden and Li-Fraumein syndrome, certain familial breast cancer syndromes, high-risk lesions, and previous large doses of chest radiation therapy before age 30. Interventions compared are standard 2-D mammography with or without computer-aided diagnosis.

Outcomes judged include:
- All-cause mortality (critical outcome)
- Breast cancer morbidity (critical outcome)

- Test performance characteristics (important outcome)
- Cancer stage at diagnosis (important outcome)
- Recall rate/false-positive test results (important outcome)

Comments collected through the official 30-day public comment period included the addition of new observational trials and comments on recall, and a request to change how all-cause mortality is framed, wanting instead to be subject to the normal evidentiary standards of screening tests.

HTAS reviewed evidence including four recent, high-quality systematic reviews of observational trials of DBT and DM compared to DM alone, six observational trials published since that last systematic review, and three economic analyses published recently. No randomized controlled trials of DBT have been published, although several are currently underway.

Obley explained evidence for DBT is limited to observational studies, most of which have methodological limitations and inadequate follow-up periods. Some conclusions include:

- Effects of DBT on all-cause mortality, breast cancer morbidity, and breast cancer stage at diagnosis are unknown
- Two studies with adequate follow-up to ascertain interval cancer rates reached differing conclusions
- One study showed increased sensitivity and similar specificity
- One study showed identical sensitivity and improved specificity
- Low-quality evidence showed mixed results that DBT+DM improves cancer detection rates
- Low-quality evidence that DBT+DM reduces recall rates, particularly when limited to U.S.-based studies
- There are no meta-analytic estimates available for any of the outcomes, except for women with dense breasts

Guidelines reviewed:

- U.S Preventive Services Task Force (2016):
    - Grade "I" statement for DBT, concluding that there was insufficient evidence to assess the benefits and harms of DBT
    - Grade "I" statement for adjunctive or supplemental screening, including DBT, for women with dense breasts
- Current evidence is insufficient to assess effectiveness of DBT:
    - American Congress of Obstetricians and Gynecologists
    - American Cancer Society
    - American College of Physicians
    - American Academy of Family Physicians
- National Comprehensive Cancer Network: recently added, "consider tomosynthesis"
- American College of Radiology: DBT is no longer investigational and has demonstrated improvement in outcomes compared to DM

Shaffer then read through the rationale (page 290) as well as the proposed coverage guidance recommendation from HTAS.

- It is likely that DBT decreases recall rates as compared with DM alone, based on observational studies performed in the US

- We have low confidence that DBT improves cancer detection rates
- We are not confident that any improvement in cancer detection rates with DBT, if clearly demonstrated, would result in cancers being detected at earlier stages and leading to earlier intervention that improves clinical outcomes
- Adding DBT to standard DM adds cost, and we are not confident that DBT is cost-effective, based on current analysis
- Randomized controlled trials are currently underway that should help with greater understanding of the risks and benefits of DBT+DM, including the critical issue of whether DBT improves clinical outcomes
- The recommendation against coverage is a weak recommendation because further evidence could change the recommendation

Saha added that the current evidence does not show that earlier breast cancer detection leads to better outcomes. There are such studies underway, which will be examined when it is available.

Dr. Thomas, the appointed expert stated that she disagreed with the recommendation for non-coverage.

MOTION: To approve the proposed coverage guidance for Digital Breast Tomosynthesis (3D Mammography) for Breast Cancer Screening in Average Risk Women as presented. *Carries 10-2 (Garside, Tippens opposed).*

Approved Coverage Guidance:

HERC Coverage Guidance

Digital breast tomosynthesis for breast cancer screening in average risk women is not recommended for coverage *(weak recommendation).*

MOTION: To approve the VbBS recommendation to not cover DBT, which results in no change to the Prioritized List. *CARRIES: 10-2 (Garside, Tippens opposed).*

Coverage Guidance Monitoring (Rescan) Process
Meeting materials page 307-376

Livingston said this section may seem confusing because HERC recently stopped the rescan process and moved to a passive monitoring process, but these topics were already in progress. As a result of rescans of the literature conducted by CEbP on these topics, HERC staff recommends the following for these coverage guidances:

Rescanned & Reaffirm:

- Imaging for Low Back Pain
- Nonpharmacologic Interventions for Treatment-Resistant Depression
- Indications for Hyperbaric Oxygen Therapy for Chronic Wounds and Burns

- Artificial Disk Replacement
    - may reconsider an update when the Washington HTA report is published
- Hip Resurfacing
- Lumbar Discography
- Viscosupplementation for Osteoarthritis of the Knee
- Osteoporosis Screening by Dual-Energy X-ray Absorptiometry (DXA)
- Osteoporosis Monitoring by Dual-Energy X-ray Absorptiometry (DXA)
- Hip Procedures for Femoroacetabular Impingement Syndrome
- Treatment of Obstructive Sleep Apnea in Adults

Retire:

- Prenatal Genetic Testing (not practical to rescan with new process)

Update currently in progress:

- Low Back Pain: Minimally Invasive and Non-Corticosteroid Percutaneous Interventions

Passive Monitoring (no rescan conducted):

- Chronic Otitis Media with Effusion in Children
    - VbBS is recommending a guideline note change for a minor change to OHP coverage
- Low Back Pain: NonPharm-Noninvasive
    - Moved from "reaffirm" category
    - New AHRQ review on the horizon
- Low Back Pain: Pharmacologic and Herbal
    - New AHRQ review on the horizon
- Planned Cesarean Section
- Routine Ultrasound in Pregnancy
- Neuroimaging for Dementia
- Knee Arthroscopy in Patients with Osteoarthritis
- Upper Endoscopy for Gastroesophageal Reflux Disease (GERD)

MOTION: To affirm the coverage guidances and update the status of the other topics as recommended. *CARRIES 12-0.*

Review of Proposed New Coverage Guidance & Multisector Intervention Topics

Obley reviewed scopes and scoring for each proposed new topic, stating some of these topics may later be bumped by higher-priority topics. All topics involve coverage guidances unless otherwise specified as a multisector intervention (MSI) report.

- Colon cancer screening modalities (page 379) ; Score: 21
    - Labhart said this screening is on the CCO metrics means thousands of dollars if his county if the quota is not met
- Prevention of unintended pregnancy (MSI) (page 381) ; Score: 23
- Opportunistic salpingectomy for ovarian cancer prevention (page 383) ; Score: ~~13~~ 19
    - Recommended as a replacement of tubal ligation/sterilization

    - Public comment: Dr. Carl Stevens, CareOregon Medical Director, commented that he routinely denies this procedure for payment citing an ACOG statement that cancer isn't prevented
    - Saha recommended this topic be reviewed sooner and to increase its score to equal the score of urine drug testing (from 13 to 19)
- Urine Drug Testing (page 385) ; Score: 19
    - Public comment: Dr. Carl Stevens, CareOregon Medical Director, commented that the urine opioid test interpretation can be difficult. If diversion is an important outcome of the test, experts must be employed. He suggested adding a question about central interpretation since the primary care physician may not have the specialized training and experience to do so.
- Acellular Dermal Matrix for Breast Reconstruction (page 387); Score: 12
- CardioMEMS for heart failure monitoring (page 390) ; Score: 16
- Gene Expression Profiling for Breast Cancer (page 391); Score: 17
- Gene Expression Profiling for Prostate Cancer (page 392); Score: 21
- Hepatic Artery Infusion Pump chemotherapy (page 393) ; Score: 12

Not scoped:

- Planned Out-of-Hospital birth (not scoped); Score 19
    - There is new evidence and requests to re-review coming from multiple fronts
- Recurrent Otitis Media
    - This is a legacy topic. Obley noted the coverage guidance includes the recommended use of chronic suppressive antibiotic therapy, which is no longer recommended by the American Academy of Pediatrics.

Prioritization of Coverage Guidance Topics

This is simply a vote to reaffirm the prioritization resulting from the scoring of the topics just reviewed, though discussion was conducted on breaking ties. EbGS and HTAS will take up topics in the following order (including legacy topics), although staff was granted permission to skip to the next topic to avoid reviewing two particularly difficult topics at the same time.

EbGS	HTAS
Prevention of unintended pregnancy (MSI)	Colon cancer screening modalities
Urine drug testing	Gene expression profiling for prostate cancer
Opportunistic salpingectomy for ovarian cancer prevention	Gene expression profiling for breast cancer
Planned out-of-hospital birth	Acellular dermal matrix for breast reconstruction
CardioMEMS for heart failure monitoring	Prostatic urethral lifts for the treatment of benign prostatic hypertrophy
Recurrent otitis media	Hepatic artery Infusion pump chemotherapy
Gastrointestinal motility tests	Sacral nerve stimulation
	Genetic testing of thyroid nodules

MOTION: To approve the scope statements as amended and the topic rankings as adjusted. CARRIES: 12-0.

Other Business

Coffman gave a brief overview of legislative happenings and mandate bills. There is a bill that would allow PT/OT to be done with the use of a horse (hippotherapy) that is currently excluded for payment by administrative rule. He commented this therapy uses standard PT and OT billing codes, as the horse is akin to another piece of therapy equipment. Another bill is for immediate placement of LARCs postpartum, which we have a guideline note requiring coverage for OHP, so that bill seems unnecessary.

Regarding the Prioritized List, there is some talk about moving the funding level up 25-50 lines. However, the waiver does not allow for changing the funding level, so this would require a waiver amendment.

Public Comment

There was no public comment at this time.

Adjournment

Meeting adjourned at 4:30 pm. Next meeting will be from 1:30-4:30 pm on Thursday, May 18, 2017 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon.

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on March 9, 2017

For specific coding recommendations and guideline wording, please see the text of the 3/9/2017 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/2017 unless otherwise noted)

- Add several non-specific pain diagnoses to a non-covered line
- Make multiple straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2017)

- Edit the preventive services guideline to specify blood lead screening coverage
- Add a new guideline specifying that pharmacogenetics testing is not covered for any psychiatric disorder
- Edit the pharmacist medication management guideline to remove the requirement for a provider to refer the patient and for the pharmacist to collaborate with the referring provider
- Add a new guideline specifying that breast reduction for macromastia is not covered for the comorbid condition of neck or back pain
- Edit the elective surgery and smoking guideline to specify that nicotine replacement, including vaping, is allowed. Other guidelines which require longer periods of smoking cessation prior to specific procedures were modified to specify that any type of nicotine use (including vaping, smokeless tobacco, and nicotine replacement therapy) are not allowed.
- Edit the MRI for multiple sclerosis guideline to allow MRIs in limited clinical situations

BIENNIAL REVIEW (Effective 1/1/2018)

- Create two new lines for treatments with marginal clinical benefit or low cost-effectiveness along with two guideline notes and a statement of intent. Further work is required to further refine these lines and guidelines at the next few VbBS meetings.

VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
March 9, 2017
9:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; David Pollack, MD; Susan Williams, MD; Mark Gibson; Irene Croswell, RPh; Holly Jo Hodges, MD; Vern Saboe, DC; Gary Allen, DMD.

Members Absent: None

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

Also Attending: Jesse Little (Oregon Health Authority); Jay Halaj, Ph.D. (Allevia Health); Leo Yasinski (Merck).

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

  The meeting was called to order at 9:10 am and roll was called. Minutes from the February 2, 2017 VbBS meeting were reviewed and approved.

  Staff asked members for requests for information on data to analyze the impact of the back line changes, particularly the opioid and back conditions guideline. Coffman noted that he has already begun working with OHA Analytics about the data needed. Ideas from staff and leadership include tracking initiation of new opioid prescriptions for back conditions, evaluation of length and average dose of established opioid prescriptions, change in utilization of ER and of alternative therapies for back pain. This discussion is anticipated to go over two meetings, May and August.

  <u>Public Testimony</u>
  Jay Halaj with Allevia Health, representing the manufacturer of Alpha Stim for cranial electrical stimulation (CES). Dr. Heather Kahn from Grants Pass has previously submitted literature to HERC staff regarding the utility of CES. Mr. Halaj testified to the utility of this device in terms of the treatment of pain, depression, anxiety, etc. Patients stop using medications such as opioids or SSRIs due to the utility of the device. Mr. Halaj indicated that he will be coming in May with practitioners to further testify regarding the utility of this therapy. CES is inexpensive, with no side effects. He previously sent staff additional literature to review and offered additional information for the Commission to review.

  Pollack requested additional information about what this technology involved. Mr. Halaj described CES as an electrical device that stimulates cranial nerves. CES is indicated for depression, anxiety and insomnia. The same instrument is also used locally for pain. Allen

asked about coverage for major insurance plans. Mr. Halaj indicated that CES is not covered by most insurers, which he argued is due to pharmaceutical company pressure, rather than lack of evidence of effectiveness. Hodges asked about how this is billed. The answer was that there are several billing codes used for this technology.

- **Topic: Straightforward/Consent Agenda**

Discussion: Smits and Livingston reviewed the topics on the consent agenda. There were clarifying questions only.

Recommended Actions:

1) Add P29.0 (Neonatal cardiac failure) to line 102 HEART FAILURE
    a. Remove P29.0 from line 2 BIRTH OF INFANT
2) Add 33475 (Replacement, pulmonary valve) to line 74 CONGENITAL PULMONARY VALVE ANOMALIES
3) Add 00102 (Anesthesia for procedures involving plastic repair of cleft lip) to line 305 CLEFT PALATE AND/OR CLEFT LIP
4) Remove S0265 (Genetic counseling, under physician supervision, each 15 minutes) from the Services Recommended for Non-Coverage Table
    a. Advise Health Systems Division (HSD) to add S0265 to the Diagnostic Procedures File
5) Remove 87338 (Infectious agent antigen detection by immunoassay technique, (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], immunochemiluminometric assay [IMCA]) qualitative or semiquantitative, multiple-step method; Helicobacter pylori, stool) from line 60 ULCERS, GASTRITIS, DUODENITIS, AND GI HEMORRHAGE
    a. Advise HSD to add 87338 to the Diagnostic Workup File
6) Add 92002-92014 (Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program) to line 212 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT
7) Add 12011-12018 (Repair of wound of the face, ears, eyelids, nose, lips, and/or mucous membrane) to line 233 FRACTURE OF FACE BONES; INJURY TO OPTIC AND OTHER CRANIAL NERVES
8) Remove 77338 (Multi-leaf collimator (MLC) device(s) for intensity modulated radiation therapy (IMRT), design and construction per IMRT plan) from line 160 CROMEGALY AND GIGANTISM
9) Remove H0048 (Alcohol and/or other drug testing: collection and handling only, specimens other than blood) from lines 4, 66, 59 and 614
    a. Advise HSD to add H0048 to the Diagnostic Procedures File
10) Add T1016 (Case management, each 15 minutes) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
11) Add R13.1 (Oral dysphagia) to line 350 NEUROLOGICAL DYSFUNCTION IN COMMUNICATION CAUSED BY CHRONIC CONDITIONS

12) Add Z72.0 (Tobacco use) to line 5 TOBACCO DEPENDENCE
13) Add 92526 (Treatment of swallowing dysfunction and/or oral function for feeding) to lines 19 FEEDING PROBLEMS IN NEWBORNS, 153 FEEDING AND EATING DISORDERS OF INFANCY OR CHILDHOOD, 599 TONGUE TIE AND OTHER ANOMALIES OF TONGUE
14) Add 30020 (Drainage abscess or hematoma, nasal septum) to line 210 SUPERFICIAL ABSCESSES AND CELLULITIS
15) Add 31645 (Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with therapeutic aspiration of tracheobronchial tree, initial (eg, drainage of lung abscess)) to line 428 COMPLICATIONS OF A PROCEDURE USUALLY REQUIRING TREATMENT
16) Add J98.09 (Other diseases of bronchus, not elsewhere classified) to line 62 BRONCHIECTASIS
17) Add 43300-43312 (Esophagoplasty (plastic repair or reconstruction), cervical or thoracic approach; with or without repair of tracheoesophageal fistula) to line 231 RUPTURED VISCUS
18) Add 43241 (Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube or catheter) to line 46 INTUSSCEPTION, VOLVULUS, INTESTINAL OBSTRUCTION, HAZARDOUS FOREIGN BODY IN GI TRACT WITH RISK OF PERFORATION OR OBSTRUCTION
19) Add ICD-10 P22.1 (Transient tachypnea of newborn) to line 2 BIRTH OF INFANT and remove from line 11 RESPIRATORY CONDITIONS OF FETUS AND NEWBORN
20) Add 99460-99463 (Initial and subsequent hospital care for normal newborns) to all newborn lines with possible minor conditions:
    a. 11 RESPIRATORY CONDITIONS OF FETUS AND NEWBORN
    b. 21 SYNDROME OF "INFANT OF A DIABETIC MOTHER" AND NEONATAL HYPOGLYCEMIA
    c. 22 OMPHALITIS OF THE NEWBORN AND NEONATAL INFECTIVE MASTITIS
    d. 27 INTRACRANIAL HEMORRHAGES; CEREBRAL CONVULSIONS, DEPRESSION, COMA, AND OTHER ABNORMAL CERERAL SIGNS OF THE NEWBORN
    e. 31 DRUG WITHDRAWAL SYNDROME IN NEWBORN
    f. 36 HEMATOLOGICAL DISORDERS OF FETUS AND NEWBORN
    g. 45 HYPOCALCEMIA, HYPOMAGNESEMIA AND OTHER ENDOCRINE AND METABOLIC DISTURBANCES SPECIFIC TO THE FETUS AND NEWBORN
    h. 106 HEMOLYTIC DISEASE DUE TO ISOIMMUNIZATION, ANEMIA DUE TO TRANSPLACENTAL HEMORRHAGE, AND FETAL AND NEONATAL JAUNDICE
    i. 149 ANEMIA OF PREMATURITY OR TRANSIENT NEONATAL NEUTROPENIA
    j. 296 ADRENAL OR CUTANEOUS HEMORRHAGE OF FETUS OR NEONATE
    k. 648 EDEMA AND OTHER CONDITIONS INVOLVING THE SKIN OF THE FETUS AND NEWBORN
21) Add CPT 45384 and 45385 (Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s)) to line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS
22) For the January 2018 Biennial Review Prioritized List:
    a. Remove CPT 35207 (Repair blood vessel, direct; hand, finger) from line 82 INJURY TO MAJOR BLOOD VESSELS

b. Remove ICD-10 S27.9XXA, S27.9XXD (Injury of unspecified intrathoracic organ) from line 82 and add to line 84 INJURY TO INTERNAL ORGANS
c. Remove ICD-10 S45.301A, S45.301D, S45.302A, S45.302D, S45.309A, S45.309D, S45.311A, S45.311D, S45.312A, S45.312D, S45.319A, S45.319D, S45.391A, S45.391D, S45.392A, S45.392D, S45.399A, S45.399D (injury of superficial vein at shoulder and upper arm level) from line 82 and add to line 212 DEEP OPEN WOUND, WITH OR WITHOUT TENDON OR NERVE INVOLVEMENT

23) Modify Guideline Note 106 as shown in Appendix A

MOTION: To approve the recommendations as stated in the consent agenda. CARRIES 8-0.

- **Topic: Biennial Review: Prioritization of Novel Treatments**

Discussion: Coffman introduced the topic. The prioritization of pairings of high cost or low efficacy treatments is a long standing issue for the HERC. Coffman reviewed the staff proposal is to create two new lines for high cost/low efficacy treatments, one line around line 500 for treatments with some evidence of benefit, but higher cost than other efficacious therapies and one line at the bottom of the list for treatments that are ineffective or where harms outweigh benefits.

Hodges asked about whether guideline notes alone would be adequate to deal with this issue. Coffman replied that only a few guideline notes have been used in this manner. HERC staff have been working with Department of Justice on this proposal. Prescription drugs and other ancillary services, services not normally addressed by the Prioritized List, can be tied to these lines as well as services with CPT codes. The OHA Pharmacy and Therapeutics (P&T) Committee can include prior authorization criteria for fee-for-service to deny coverage for a prescription medication as not being on a covered line on the List.

Hodges requested that all procedures on the Services Recommended for Non-Coverage (SRNC) table be placed on these lower lines to make their noncoverage explicit and available for the plans and the public to see. The SRNC table is currently only available to the public through use of the searchable list tool. Coffman said the SRNC table includes some experimental therapy that cannot be on the List, so staff would need to review the SRNC table prior to making recommendations for adding entries to the new high cost/low efficacy guidelines and can bring back to the next meeting.

Coffman said this meeting is the last meeting to create new lines and that the proposal would not necessarily populate the lines. VBBS/HERC would create these lines and then can populate them later.

Olson expressed concern that adding these lines would allow pairing through the co-morbidity rule. Coffman said guideline note language could be crafted to address potential

co-morbid conditions. Olson wanted to make sure the unintended consequences are considered.

Coffman noted that 3 years ago the HERC approved a guideline with many of these features, which was never implemented. P&T was going to make a list of high cost/low efficacy drugs and the guideline would point to this. This never happened, and now is not considered to be the best policy. P&T would still conduct the evidence reviews on medications, to inform the HERC decisions for inclusions on these lines. P&T has the ability to look at costs, which are not publically discussable. P&T can then inform HERC when they feel that a drug has too high a cost to be cost-effective.

Gibson stated that the objective in creating these two new "baskets" would improve clarity to our constituents. The decision today would not populate the lines, and the items for these lines could be approved by the HERC in the future. He suggested initially only approving the staff recommendation for creation of two new lines.

Pollack asked what would happen for a treatment of a condition with no other treatments available. The answer was that if the treatment was not sufficiently effective or very high cost, then it might be included on these new lines.

Livingston said this is a framework to make the HERC intent clear, and to explicitly define experimental, marginal benefit, etc.

Coffman then reviewed the statement of intent. There is now language in statute that statements of intent are part of the Prioritized List, and are therefore an effective way to convey the HERC's intent. Statements of intent can be modified at any time. Hodges said in her experience, statements of intent are useful for the CCOs. Olson said there needs to be consistency in the definition of marginal benefit or cost effectiveness. Upon further discussion, Gibson felt all the changes reflected in the proposal could move forward, with the ability to make modifications at future meetings as necessary.

At the May meeting there will be further discussion about the definition of cost-effectiveness and how to apply this definition. Potential services, focusing initially on those in the SNRC table, to populate the guideline notes will also be discussed.

Recommended Actions:

1) Create two new lines at line 500 and as the last line
    a. Line 500 CONDITION: CONDITIONS FOR WHICH CERTAIN TREATMENTS RESULT IN MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS; TREATMENT: MEDICAL AND SURGICAL TREATMENT
    b. Line YYY CONDITION: CONDITIONS FOR WHICH CERTAIN TREATMENTS HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS; TREATMENT: MEDICAL AND SURGICAL TREATMENT
2) Adopt two new guidelines as shown in Appendix C

a. Will bring guidelines back to begin to fill in content at future meetings

3) Adopt a new statement of intent as shown in Appendix C

MOTION: To approve the new lines, new guidelines and new statement of intent as presented. CARRIES 8-0.

- **Topic: Pharmacogenetics Testing for Medications for Psychiatric Disorders**

Discussion: Smits reviewed the summary document. Pollack commented that for certain populations of patients (e.g. those who have failed multiple medications, patients with multiple side effects) this testing might be justified. However, this population is not clearly defined. Overall, Pollack agrees that this technology is not ready for clinical use. He also raised a concern about the lack of support and infrastructure for genetic counseling in the state.

Recommended Actions:

1) Adopt a new diagnostic guideline as shown in Appendix B

MOTION: To approve the new guideline as presented. CARRIES 8-0.

- **Topic: Pharmacist medication management guideline**

Discussion: Smits reviewed the staff summary document. There was minimal discussion.

Recommended Actions:

1) Modify Guideline Note 64 as shown in Appendix A

MOTION: To approve the guideline change as presented. CARRIES 8-0.

- **Topic: Breast Reduction for Macromastia as Treatment for Neck and Back Pain**

Discussion: Smits reviewed the summary document. Olson said breast reduction was not a covered service for macromastia until the back line changes made it a possible co-morbid condition treatment; therefore the proposed guideline does not take away a long standing benefit from the OHP population. Williams noted that there was evidence of effectiveness, but that this evidence was low quality. She proposed adding wording to the proposed guideline to reflect this, such as “high quality” evidence. Saboe asked what the cost-effectiveness was of breast reduction. The answer was that no study on this was found in the staff review.

Recommended Actions:

1) Adopt a new guideline as shown in Appendix B

MOTION: To approve the modified guideline. CARRIES 8-0.

- **Topic: Elective Surgery Guideline and Electronic Cigarettes**

Discussion: Livingston introduced the summary on this topic. Pollack asked if this topic included marijuana use. Smits answered that limited evidence to date does not find that casual marijuana use has an impact on surgical outcomes for bariatric surgery. Data for other types of elective surgery is lacking. Hodges argued that the previous guideline wording was "smoking" and that her CCO interpreted this as including marijuana. The proposed modification would remove marijuana from the restrictions.

Allen stated that he was not in favor of allowing smokeless tobacco or vaping prior to elective surgery. Olson stated he was thinking along the same lines because of a perception of inconsistency. Pollack expressed concerned for unintended consequences for patients switching addictions. Williams noted that the evidence did not indicate either way. Gibson noted that smokeless tobacco can cause cancer and is otherwise harmful; more restrictive guidelines are appealing, but he felt that the first proposed staff option was the most consistent with the evidence. Williams argued in favor of staff option 2, as the evidence does not indicate that it is completely harm-free to use smokeless tobacco and e-cigarettes prior to surgery.

The subcommittee looked at the Ancillary Guideline proposed under option 1 and suggested adding wording to clarify that the guideline was about tobacco use and vaping prior to elective surgical procedures rather than "smoking cessation" if vaping and smokeless tobacco was going to be allowed.

There was a motion to approve option 1 to exclude e-cigarettes and smokeless tobacco from the elective surgery guideline (i.e. allow their use), that was seconded. It was voted down aby a 3-4 vote.

There was discussion that HERC did not want to appear to endorse or encourage vaping or smokeless tobacco due to their negative public health effects. However, there is no evidence published about the effect of vaping or smokeless tobacco on elective surgical outcomes.

There was discussion about the goal of this guideline—whether it was to reduce tobacco product use or improve outcomes of elective surgeries. The decision was that the goal was to reduce complications of surgical procedures and therefore reduce overall costs and improve outcomes.

There was a motion to approve option 2 which would disallow the use of e-cigarettes or smokeless tobacco one month prior to surgery. It was seconded, but failed to pass on a 3-4 vote.

Pollack then made a motion to revisit option 1. Subcommittee members agreed that smoking is understood to include marijuana.

There were questions raised about why there are 6 month abstinence requirements for certain surgeries such as spinal fusion. Williams clarified because of the need to get bone growth; the nicotine interferes with bone growth. Other spinal procedures involve removing bone spurs or taking pressure off, but these don't need bone growth for surgery to be successful. Smits clarified that the elective surgical guideline would only apply to surgeries other than those specified to require six-months of cessation. The guidelines with 6 month requirements were also approved.

Recommended Actions:

1) Modify Ancillary Guideline A4 as shown in Appendix A
2) Modify guideline notes 8, 100, 112, and 158 as shown in Appendix A

MOTION: To approve the guideline modifications as presented [Option 1 for Ancillary Guideline A4]. CARRIES 4-3 (Williams, Saboe, and Croswell opposed; Olson abstaining).

- **Topic: Non-specific Pain Diagnoses**

Discussion: There was no discussion about this topic.

Recommended Actions:

1) Add ICD-10 G89.21 (Chronic pain due to trauma), G89.28 (Other chronic postprocedural pain) and G89.29 (Other chronic pain) to line 533 FIBROMYALGIA, CHRONIC FATIGUE SYNDROME, AND RELATED DISORDERS
    a. Advise HSD to remove ICD-10 G89.21, G89.28 and G89.29 from the Undefined Diagnosis File
2) Staff will consider creation of a new line for the 2020 Biennial Review allowing coverage of limited treatments for chronic pain conditions. This may require the creation of a taskforce.

MOTION: To approve the recommendations as presented. CARRIES 8-0

- **Topic: MRI for MS Monitoring**

Discussion: Smits reviewed the summary document. The staff proposal was to allow MRIs for patients with multiple sclerosis (MS) with certain symptoms or for monitoring for

patients at high risk for certain medication complications. Olson noted the question of whether MS patients should receive MRIs in certain clinical situations or as a standard yearly test will never be decided with an RCT. Because this is considered standard, he doubts that there will ever be a RCT looking at MRIs with patients randomized to no MRIs, so better evidence is unlikely to be generated. The current proposal will not allow yearly monitoring of asymptomatic patients. The subcommittee members agreed that the current evidence does not support yearly MRIs for asymptomatic patients with MS.

Gibson said it is not right that neurologists are discharging patients from their practice because they cannot get this test. Williams noted that she could relate to the neurologists' frustration that they can't adequately care for their patients.

Hodges said the proposed guideline would be useful for the pharmacy directors of the CCOs to know when to approve an MRI for an MS patient through the exception process which improve consistency across OHP.

Recommended Actions:

1) Modify Diagnostic Guideline D10 as shown in Appendix A.

MOTION: To approve the guideline modification as presented. CARRIES 8-0.

- **Public Comment:**

  No additional public comment was received.

- **Issues carried forward for next meeting:**
  - Cranial Electrical Stimulation
  - Marginal Benefit/Low Cost-Effectiveness Guidelines for Inclusion of Specific Therapies

- **Next meeting:**

  May 18, 2017 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

- **Adjournment:**

  The meeting adjourned at 1:00 PM.

Appendix A
Revised Guideline Notes Effective 10/1/17

ANCILLARY GUIDELINE A4, SMOKING CESSATION AND ELECTIVE SURGICAL PROCEDURES

Smoking cessation is required prior to elective surgical procedures for active tobacco users. Cessation is required for at least 4 weeks prior to the procedure and requires objective evidence of abstinence from smoking prior to the procedure.

Elective surgical procedures in this guideline are defined as surgical procedures which are flexible in their scheduling because they do not pose an imminent threat nor require immediate attention within 1 month. Reproductive, cancer-related and diagnostic procedures are excluded from this guideline.

The well-studied tests for confirmation of smoking cessation include cotinine levels and exhaled carbon monoxide testing. However, cotinine levels may be positive in nicotine replacement therapy (NRT) users, smokeless tobacco and e-cigarette users (which ~~is not a~~ are not contraindications to elective surgery coverage). In patients using ~~NRT~~ nicotine products aside from combustible cigarettes the following alternatives to urine cotinine to demonstrate smoking cessation may be considered:

- Exhaled carbon monoxide testing ~~(well-studied)~~
- Anabasine or anatabine testing (NRT or vaping)

Certain procedures, such as lung volume reduction surgery, bariatric surgery, erectile dysfunction surgery, and spinal fusion have 6 month tobacco abstinence requirements. See Guideline Notes 8, 100, 112 and 159.

DIAGNOSTIC GUIDELINE D10, MRI IN MULTIPLE SCLEROSIS

MRI is a diagnostic test for multiple sclerosis and should not be used for routine monitoring of disease.

MRI may be considered in the following circumstances:

1) Suspected drug failure in the setting of clinical relapse in patients with objective changes in neurological status or documented new clinical symptoms such as urinary urgency or cognitive changes
2) Evaluation of a clear objective progression in clinical symptoms in patients with previously relapsing disease to rule out ongoing inflammatory disease when conversion to secondary progressive MS is suspected
3) Patients who require enhanced pharmacovigilance, including
    a. Yearly monitoring for patients treated with natalizumab who are JCV seropositive

b. One MRI for patients who switch from natalizumab to other therapeutics (including fingolimod, alemtuzumab and dimethyl fumarate) one year after the switch from natalizumab

GUIDELINE NOTE 8, BARIATRIC SURGERY

Lines 30,589

A) Bariatric surgery is included under the following criteria:Age ≥ 18
B) The patient has
   1) a BMI ≥ 35 with co-morbid type II diabetes for inclusion on Line 30 TYPE 2 DIABETES MELLITUS; OR
   2) BMI >=35 with at least one significant co-morbidity other than type II diabetes (e.g., obstructive sleep apnea, hyperlipidemia, hypertension) or BMI >= 40 without a significant co-morbidity for inclusion on Line 589
C) No prior history of Roux-en-Y gastric bypass or laparoscopic adjustable gastric banding, unless they resulted in failure due to complications of the original surgery.
D) Participate in the following four evaluations and meet criteria as described.
   1) Psychosocial evaluation: (Conducted by a licensed mental health professional)
      a) Evaluation to assess potential compliance with post-operative requirements.
      b) Must remain free of abuse of or dependence on alcohol during the six-month period immediately preceding surgery. No current use of any nicotine product or illicit drugs and must remain abstinent from their use during the six-month observation period. Testing will, at a minimum, be conducted within one month of the surgery to confirm abstinence from illicit drugs. Tobacco and nicotine abstinence to be confirmed in ~~active smokers~~ users by negative cotinine levels at least 6 months apart, with the second test within 1 month of the surgery date.
      c) No mental or behavioral disorder that may interfere with postoperative outcomes[1].
      d) Patient with previous psychiatric illness must be stable for at least 6 months.
   2) Medical evaluation: (Conducted by OHP primary care provider)
      a) Pre-operative physical condition and mortality risk assessed with patient found to be an appropriate candidate.
      b) Optimize medical control of diabetes, hypertension, or other co-morbid conditions.
      c) Female patient not currently pregnant with no plans for pregnancy for at least 2 years post-surgery. Contraception methods reviewed with patient agreement to use effective contraception through 2nd year post-surgery.
   3) Surgical evaluation: (Conducted by a licensed bariatric surgeon associated with program[2])

a) Patient found to be an appropriate candidate for surgery at initial evaluation and throughout period leading to surgery while continuously enrolled on OHP.
b) Received counseling by a credentialed expert on the team regarding the risks and benefits of the procedure[3] and understands the many potential complications of the surgery (including death) and the realistic expectations of post-surgical outcomes.

4) Dietician evaluation: (Conducted by licensed dietician)
a) Evaluation of adequacy of prior dietary efforts to lose weight. If no or inadequate prior dietary effort to lose weight, must undergo six-month medically supervised weight reduction program.
b) Counseling in dietary lifestyle changes

E) Participate in additional evaluations:
1) Post-surgical attention to lifestyle, an exercise program and dietary changes and understands the need for post-surgical follow-up with all applicable professionals (e.g. nutritionist, psychologist/psychiatrist, exercise physiologist or physical therapist, support group participation, regularly scheduled physician follow-up visits).

[1] Many patients (>50%) have depression as a co-morbid diagnosis that, if treated, would not preclude their participation in the bariatric surgery program.

[2] All surgical services must be provided by a program with current certification by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), or in active pursuit of such certification with all of the following: a dedicated, comprehensive, multidisciplinary, pathway-directed bariatric program in place; hospital to have performed bariatrics > 1 year and > 25 cases the previous 12 months; trained and credentialed bariatric surgeon performing at least 50 cases in past 24 months; qualified bariatric call coverage 24/7/365;appropriate bariatric-grade equipment in outpatient and inpatient facilities; appropriate medical specialty services to complement surgeons' care for patients; and quality improvement program with prospective documentation of surgical outcomes. If the program is still pursuing (MBSAQIP) certification, it must also restrict care to lower-risk OHP patients including: age < 65 years; BMI < 70; no major elective revisional surgery; and, no extreme medical comorbidities (such as wheel-chair bound, severe cardiopulmonary compromise, or other excessive risk). All programs must agree to yearly submission of outcomes data to Division of Medicaid Assistance Programs (DMAP).

[3] Only Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding and sleeve gastrectomy are approved for inclusion.

GUIDELINE NOTE 64, PHARMACIST MEDICATION MANAGEMENT

Included on all lines with evaluation & management (E&M) codes

Pharmacy medication management services must be provided by a pharmacist who has:

1) A current and unrestricted license to practice as a pharmacist in Oregon

~~2) Services must be provided based on referral from a physician or licensed provider or health plan.~~

3) Documentation must be provided for each consultation and must reflect ~~collaboration~~ communication with the patient's primary care ~~physician or licensed~~ provider. Documentation should model SOAP charting; must include patient history, provider assessment and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; and must be retained in the patient's medical record and be retrievable

GUIDELINE NOTE 100, SMOKING AND SPINAL FUSION

Lines 51,154,205,259,351,366,406,482,532,561

Non-emergent spinal arthrodesis (CPT 22532-22634) is limited to patients who are non-smoking and abstinent from any nicotine product for 6 months prior to the planned procedure, as shown by negative cotinine levels at least 6 months apart, with the second test within 1 month of the surgery date. Patients should be given access to appropriate smoking cessation therapy. Non-emergent spinal arthrodesis is defined as surgery for a patient with a lack of myelopathy or rapidly declining neurological exam.

GUIDELINE NOTE 106, PREVENTIVE SERVICES

Line 3

Included on this line are the following preventive services:

1. US Preventive Services Task Force (USPSTF) "A" and "B" Recommendations in effect and issued prior to January 1, 2016:
   http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/
   a. USPSTF "D" recommendations are not included on this line or any other line of the Prioritized List
2. American Academy of Pediatrics (AAP) Bright Futures Guidelines:
   http://brightfutures.aap.org. Periodicity schedule available at http://www.aap.org/en-us/professional-resources/practice-support/Periodicity/Periodicity%20Schedule_FINAL.pdf.
   a. Screening for lead levels is defined as blood lead level testing and is indicated for Medicaid populations at 12 and 24 months. In addition, blood lead level screening of any child between ages 24 and 72 months with no record of a previous blood lead screening test is indicated.
3. Health Resources and Services Administration (HRSA) Women's Preventive Services - Required Health Plan Coverage Guidelines:
   As retrieved from http://www.hrsa.gov/womensguidelines/ on 1/1/2017.
4. Immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP):
   http://www.cdc.gov/vaccines/schedules/hcp/index.html

Appendix A
Revised Guideline Notes Effective 10/1/17

GUIDELINE NOTE 112, LUNG VOLUME REDUCTION SURGERY

Line 288

Lung volume reduction surgery (LVRS, CPT 32491, 32672) is included on Line 288 only for treatment of patients with radiological evidence of severe bilateral upper lobe predominant emphysema (ICD-10-CM J43.9) and all of the following:

A) BMI ≤31.1 kg/m2 (men) or ≤32.3 kg/m 2 (women)
B) Stable with ≤20 mg prednisone (or equivalent) dose a day
C) Pulmonary function testing showing
    1) Forced expiratory volume in one second (FEV 1) ≤ 45% predicted and, if age 70 or older, FEV 1≥ 15% predicted value
    2) Total lung capacity (TLC) ≥ 100% predicted post-bronchodilator
    3) Residual volume (RV) ≥ 150% predicted post-bronchodilator
D) PO 2, ≥ 45 mm Hg on room air (PO 2, ≥ 30 mm Hg if 1-mile above sea level)
E) Post-rehabilitation 6-min walk of ≥ 140 m
F) Non-smoking and abstinence from any nicotine product for 6 months prior to surgery, as shown by negative cotinine levels at least 6 months apart, with the second test within 1 month of the surgery date.

The procedure must be performed at an approved facility (1) certified by the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission) under the LVRS Disease Specific Care Certification Program or (2) approved as Medicare lung or heart-lung transplantation hospitals. The patient must have approval for surgery by pulmonary physician, thoracic surgeon, and anesthesiologist post-rehabilitation. The patient must have approval for surgery by cardiologist if any of the following are present: unstable angina; left-ventricular ejection fraction (LVEF) cannot be estimated from the echocardiogram; LVEF <45%; dobutamine-radionuclide cardiac scan indicates coronary artery disease or ventricular dysfunction; arrhythmia (>5 premature ventricular contractions per minute; cardiac rhythm other than sinus; premature ventricular contractions on EKG at rest).

GUIDELINE NOTE 159, SMOKING AND SURGICAL TREATMENT OF ERECTILE DYSFUNCTION

Line 526

Surgical treatment of erectile dysfunction is only included on this line when patients are non-smoking and abstinent from any nicotine product for 6 months prior to surgery, as shown by negative cotinine levels at least 6 months apart, with the second test within 1 month of the surgery date.

Appendix B
New Guideline Notes Effective 10/1/17

DIAGNOSTIC GUIDELINE DXX, PHARMACOGENETICS TESTING FOR PSYCHIATRIC MEDICATION MANAGEMENT

Pharmacogenetics testing for management of psychiatric medications is not a covered service.

GUIDELINE NOTE XXX, BREAST REDUCTION SURGERY FOR MACROMASTIA

Line 563

Breast reduction surgery for macromastia is not covered as a treatment for neck or back pain resulting from the macromastia due to lack of high quality evidence of effectiveness.

Appendix C
New Statement of Intent and Guideline Notes Effective 1/1/18

STATEMENT OF INTENT 3, THERAPIES WITH MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS

It is the intent of the Commission that therapies that exhibit one or more of the following characteristics generally be given low priority on the Prioritized List:

i. Marginal or clinically unimportant benefit
ii. Very high cost in which the cost does not justify the benefit
iii. Significantly greater cost compared to alternate therapies when both have similar benefit
iv. Significant budget impact that could affect the overall Prioritized List funding level

Where possible, the Commission prioritizes pairings of condition and treatment codes to reflect this lower priority, or simply does not pair a procedure code with one or more conditions if it exhibits one of these characteristics.

As codes for prescription drugs, durable medical equipment & supplies, certain adjunctive procedures and other ancillary services are not typically included on the Prioritized List and are not always billed in conjunction with diagnosis codes, it is more difficult to indicate the importance of these services through the prioritization process. Through evidence reviews conducted by one of its subcommittees, the Pharmacy and Therapeutics Committee, or other reputable sources and based on these reviews, HERC prioritizes such services regarded as having low importance when prescribed for certain conditions on Line 500 or Line YYY and lists the relevant condition/treatment pairings in Guideline Notes AAA or BBB.

GUIDELINE NOTE AAA, TREATMENTS WITH MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS FOR CERTAIN CONDITIONS

The following treatments are prioritized on Line 500 for the conditions listed here:

CONDITION	TREATMENT
<Note: to be populated at future meetings>	

Appendix C
New Statement of Intent and Guideline Notes Effective 1/1/18

GUIDELINE NOTE BBB, TREATMENTS THAT HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS

The following treatments are prioritized on Line YYY, CONDITIONS FOR WHICH CERTAIN TREATMENTS HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS, for the conditions listed here:

CONDITION	TREATMENT
<Note: to be populated at future meetings>	

WHY ADDRESS FOOD INSECURITY IN A CLINIC OR HOSPITAL?

- ✓ 27.3% of Oregon children and their families are food insecure, which increases risks for developmental, academic and emotional problems, and a weakened immune system.
- ✓ 71% of Oregon Medicaid patients exhibit signs of food insecurity according to a Health Authority survey
- ✓ Diet related disease is the driver for 86% of U.S. health care costs according to the CDC
- ✓ Food insecurity significantly increases likelihood of adult chronic disease, & depression. However, 60 % of people over 60 eligible for SNAP (Food Stamps), don't get this support.
- ✓ Family or personal crisis precipitating food insecurity happens to all types of people and may be well-hidden.
- ✓ Screening for food insecurity provides valuable information for clinicians, improving diagnosis and treatment.
- ✓ Incomes have been flat or declined in the last 20 years, while food prices have soared over 65% yet many people don't know the resources available to them.
- ✓ Screening and intervention is recommended by the American Academy of Pediatrics, Primary Care Association, AARP, the American Diabetics Assoc. and is now an OHA performance improvement measure.

HOW SHOULD WE DO IT ?

- ✓ There are two simple, nationally validated food insecurity screening questions. They are best administered in writing. You can add them to patient check-in materials, or include them in a broader assessment. We provide best practices and options for incorporating the screening into your workflow.
- ✓ Together, we can develop on-site projects to alleviate food insecurity; free produce distributions, cooking classes, gardening help, store-based smart shopping tours, produce Rx systems, clinic or hospital food pantries.

HOW DO WE RESPOND TO PATIENTS WHO SCREEN POSITIVE ?

- ✓ The Oregon Food Bank provides a one-page, EHR compatible, constantly-updated resource and education handout in many languages to include in an after visit summary. Free training is offered for staff, interns or volunteers who will help patients screening positive to connect to resources the day they are screened.
- ✓ Track screenings & results with the most commonly used ICD- 10 codes. Both Epic and OCHIN Epic have now embedded the two screening questions into their data sets.

"We love this screening & intervention because our patients love it! We feel steps have been taken to improve the situation when patients leave the clinic!" - Kate Norman, clinic manager, Women's Health Assoc.

FOR MORE INFORMATION CONTACT: Lynn Knox, 503-853-8732 or lknox@oregonfoodbank.org

OREGON FOOD BANK

Screen for Food Insecurity

Suggested Questions: (any patient answering either question with a 1 or 2 response is considered food insecure)

For each statement, please tell me whether the statement was "often true, sometimes true, or never true" for your household:

A. "Within the past 12 months we worried whether our food would run out before we got money to buy more." 1. *often true* 2. *sometimes true* 3. *never true* 4. *don't know, or refused*

B. "Within the past 12 months the food we bought just didn't last and we didn't have money to get more." 1. *often true* 2. *sometimes true* 3. *never true* 4. *don't know, or refused*

NOT ENOUGH FOOD FOR YOUR FAMILY?
NEED HELP COOKING/SHOPPING FOR HEALTHY FOOD ON A BUDGET?

Food Assistance

SNAP/Oregon Trail Card (formerly known as Food Stamps)

- http://www.oregon.gov/dhs/assistance/pages/foodstamps/foodstamps.aspx or call Oregon 211*

WIC – For pregnant women or children under 5 years old

(Women, Infants, and Children Supplemental Nutrition Program)

- Lane County WIC
  http://www.lanecounty.org/departments/hhs/pubhlth/pages/lcph_wic.aspx or call
  541-682-4202

Summer Meals for Kids

- FOOD for Lane County http://www.foodforlanecounty.org/en/programs_services/summer_food_program/ or call
  541-343-2822

Food Boxes

- FOOD for Lane County
  http://www.foodforlanecounty.org/en/programs_services/emergency_food_pantry_system/ or call 541-343-2822

Farmer's Market- Many accept SNAP & WIC vouchers. With Double Up Food Bucks, you can get a $10 match on fruits and vegetables.

- Oregon Farmer's Market
  http://www.oregonfarmersmarkets.org/market-finder/ (find market near you that takes
  SNAP/WIC and list SNAP match programs)

Food, Nutrition and Gardening Education

Gardening Classes and Resources-

- FOOD for Lane County https://foodforlanecounty.org/go-learn-more/other-programs/gardens/
  or call 541-343-2822
- OSU Lane County Extension
  http://extension.oregonstate.edu/lane/ or call 541-344-5859

Nutrition, Cooking and Food Budgeting classes-

- FOOD for Lane County Nutrition Education Program https://foodforlanecounty.org/go-learn-more/other-programs/#nutrition or call 541-343-2822
- OSU Extension Lane County Nutrition Education Program
  http://extension.oregonstate.edu/fch/healthy-eating-physical-activity
  or call 541-344-5859

Low-cost, Healthy Recipes-

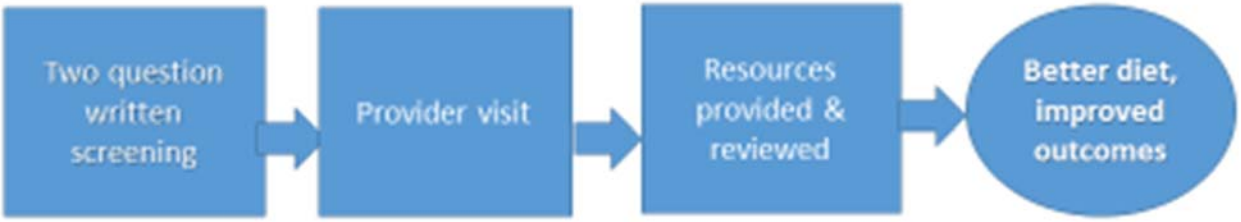
- https://www.foodhero.org/

***What is 211?** 211 is a free multi-lingual phone or online service in most areas of the United States for the purpose of providing quick and easy access to information about health, human services and employment assistance. They constantly update local information. Professional Information and Referral Specialists work with callers to assess their needs, determine their options and provide appropriate programs/services, give support, intervene in crisis situations and advocate for the caller as needed.

FLEXIBLE IMPLEMENTATION

1. Stand Alone: Add questions in writing to check-in or give to patients in exam room. Share results with clinician. Provide food insecure patients with resource handout and have someone review it with them and connect to new resources.

2. Integrated: Questions added to comprehensive health assessment with resource information & supported follow-up for the food insecure.



Statewide CCO Learning Collaborative: Statewide PIP on Opioid Safety – Current Study Results

Quality and Health Outcomes Committee Meeting
Human Services Building, 500 Summer St NE, Salem, OR, Rm 137A-D
April 10, 2017
11:00 a.m. – 12:30 p.m.

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

Opioids

Session Objectives

At the end of the session, participants will have a better understanding of:

- the limitations and considerations when interpreting Statewide PIP results
- conclusions regarding the Statewide and CCO-level PIP baseline and current measurement results
- next steps for this PIP

1. **Introductions and reflection** (Nicole O'Kane) (5 minutes)

2. **Presentation of results** (Nicole O'Kane, Sara Hallvik) (25 minutes)
   - Review of study metric definitions
   - Limitations and considerations
   - Statewide PIP baseline and current measurement results: statistical tests, time series graphs
   - Q & A

3. **Small group discussion** (20 minutes)
   - Sharing conclusions about individual CCO results
   - Interpretation of decreased denominator
   - Additional opioid measures
   - Which interventions seemed to be the most effective

4. **Small group report out to larger group** (10 minutes)

5. **Large group discussion** (20 minutes)
   - Next steps (continue, modify, abandon)

6. **Wrap up** (Nicole O'Kane) (10 minutes)
   - Closing
   - Evaluation

Oregon Statewide Performance Improvement Project (PIP) on Opioid Safety: Results and Interpretation

Nicole O'Kane, PharmD
Sara Hallvik, MPH

Agenda

1. Introductions
2. Presentation of results
3. Small group discussion
4. Small group report out
5. Large group discussion
6. Wrap up

Session Objectives

At the end of the session, participants will have a better understanding of:

1. the limitations and considerations when interpreting Statewide PIP results
2. the conclusions regarding the Statewide and CCO-level PIP baseline and current measurement results
3. next steps for this PIP

Reducing Prescribing of High Morphine Equivalent Doses

- CCOs are working within their communities to address the opioid epidemic and decrease opioid-related harms
- Measures selected for performance monitoring:
  - Percentage of OHP enrollees aged 12 years and older with opioid prescriptions for ≥ 120 mg and for ≥ 90 mg Morphine Equivalent Dose (MED) per day

Denominator Definition

- Denominator: Any OHP enrollee, age 12+ as of the last day of the measurement year, who meets continuous enrollment criteria, with at least one OHA-paid prescription for an opioid filled in the measurement year. Inclusive of dual eligible population.

Denominator Exclusions

- Neoplasm-related pain, end-of-life care, palliative care or hospice care in the measurement year or in the year prior to the measurement year
- Any opioid prescription not paid for by OHA (e.g., cough suppressant)

Numerator Definition

- Numerator: Enrollees in the denominator with one or more days with an MED ≥ 120 mg or ≥ 90 mg

Supplemental Measures

- Enrollees in the denominator on ≥ 120 mg or ≥ 90 mg MED for 30 consecutive days or more

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

Limitations and Considerations

- Narrowly-focused metrics
- Many state and national interventions
- Some interventions preceded baseline
- OHA back pain guideline implemented during PIP (July 2016)

Limitations and Considerations (continued)

- Non-contiguous measurement periods
- Cash payments not captured
- Statewide average does not reflect wide range among CCOs
- Members tapered off high doses still appear in measurement year period

Statewide PIP Results

Denominators

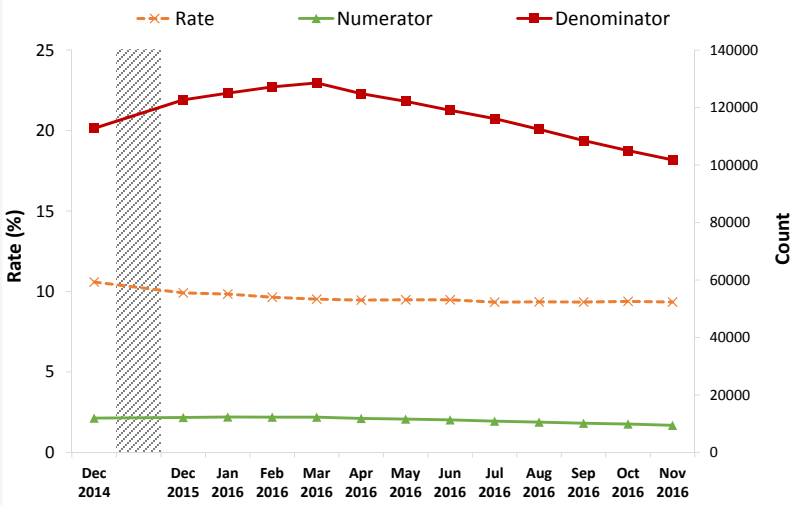
Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	6,453	5,672	4,545
18 +	106,375	117,004	97,255
Total	112,768	122,676	101,800

120 mg MED Numerator

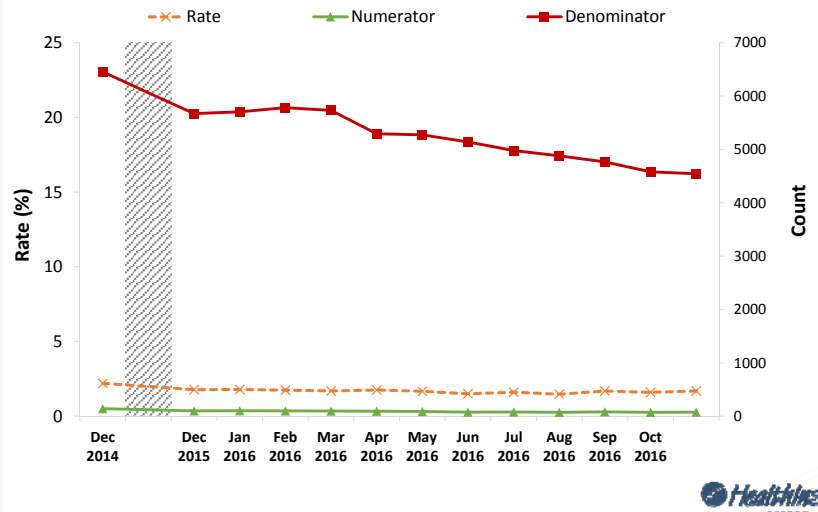
Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	142 (2.2%)	101 (1.8%)	77 (1.7%)
18 +	11,803 (11.1%)	12,059 (10.3%)	9,441 (9.7%)
Total	11,945 (10.6%)	12,160 (9.9%)	9,518 (9.3%)

$\rho \leq .001$

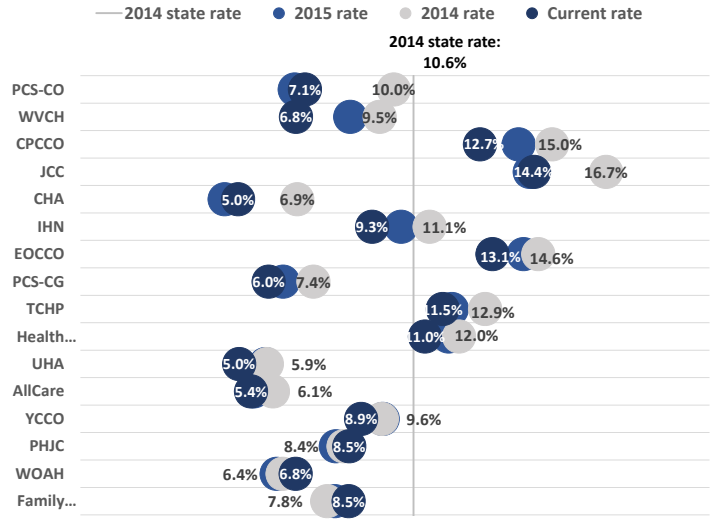
Any day >=120 mg MED, Total



Any day >=120 mg MED, ages 12-17



Any day >= 120 mg MED, total



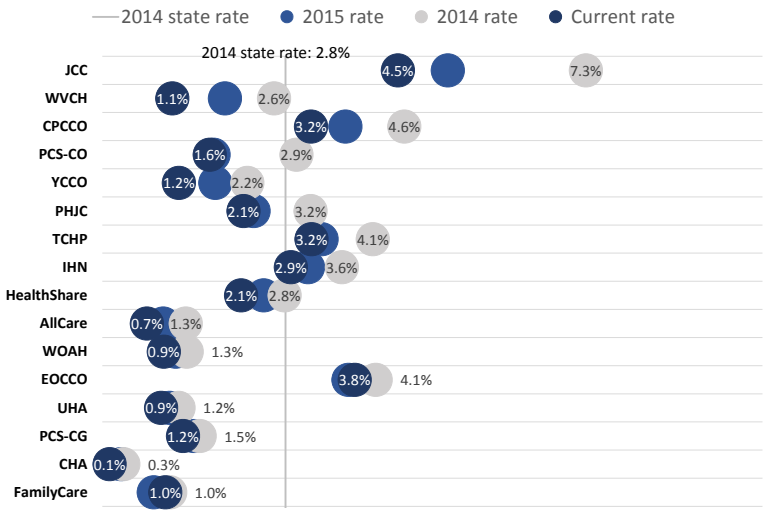
Lower is better

120 mg MED, consecutive 30+ days

Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	1 (0.0%)	1 (0.0%)	0 (0.0%)
18 +	3,128 (2.9%)	2,761 (2.4%)	2,019 (2.1%)
Total	3,129 (2.8%)	2,762 (2.3%)	2,019 (2.0%)

$\rho \leq .001$

Consecutive 30 + days >= 120 mg MED, total

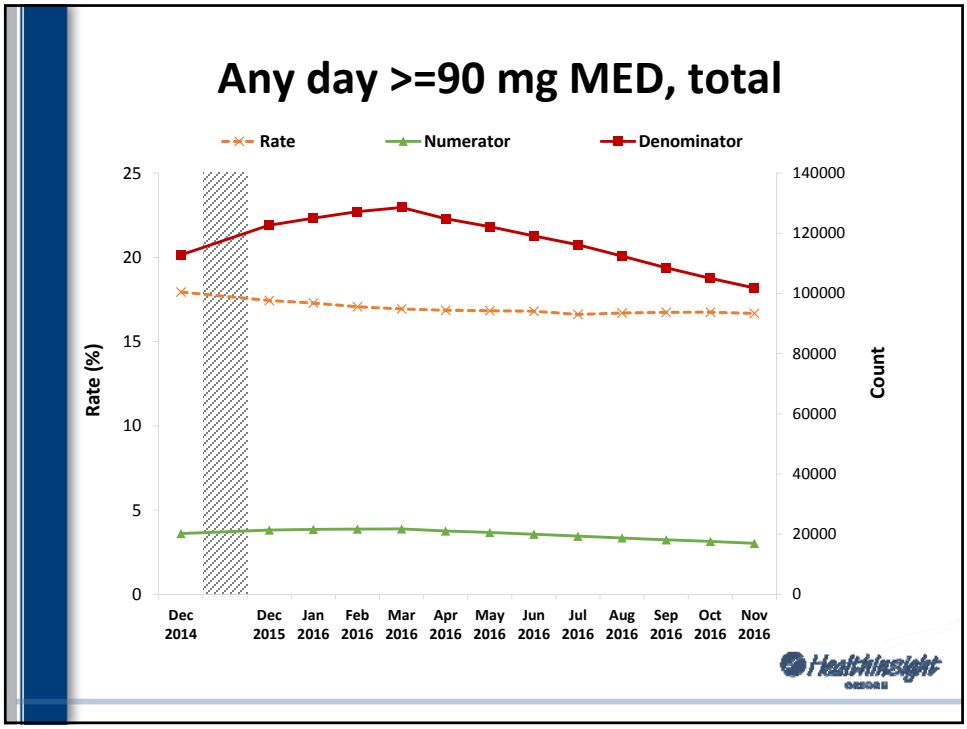


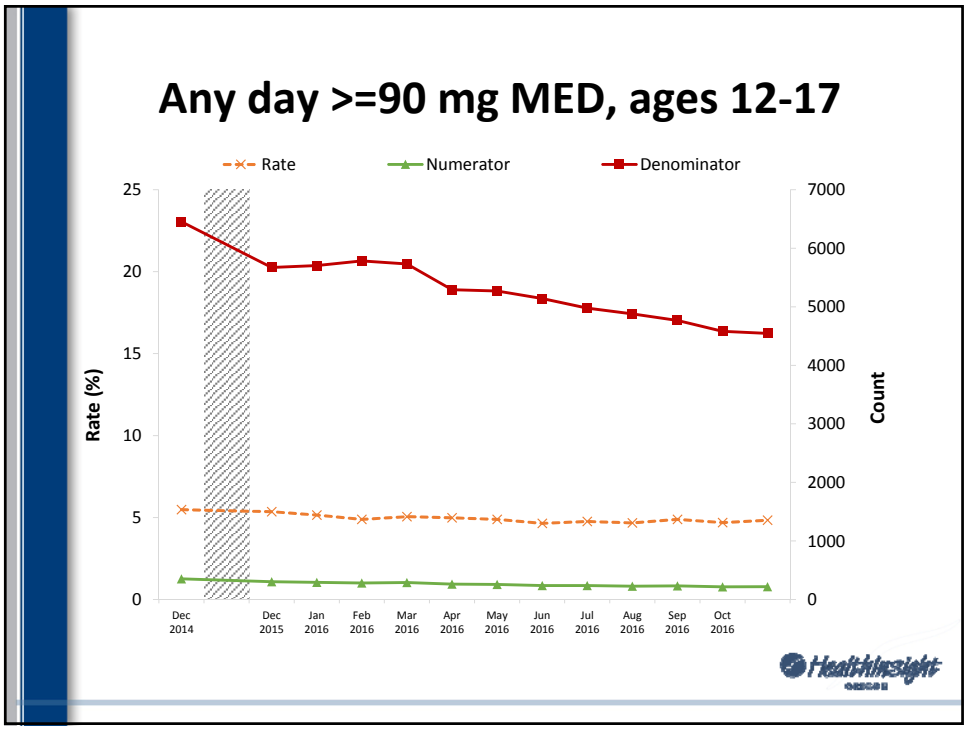
Lower is better

90 mg MED Numerator

Age	CY 2014	CY 2015	12/1/2015 – 11/30/2016
12-17	354 (5.5%)	304 (5.4%)	220 (4.8%)
18 +	19,881 (18.7%)	21,093 (18.0%)	16,754 (17.2%)
Total	20,235 (17.9%)	21,397 (17.4%)	16,974 (16.7%)

$\rho \leq .001$


Any day >=90 mg MED, total
Rate
Numerator
Denominator
Rate (%)
Count
25
20
15
10
5
0
140000
120000
100000
80000
60000
40000
20000
0
Dec 2014
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Aug 2016
Sep 2016
Oct 2016
Nov 2016
HealthInsight


Any day >=90 mg MED, ages 12-17
Rate
Numerator
Denominator
Rate (%)
Count
25
20
15
10
5
0
7000
6000
5000
4000
3000
2000
1000
0
Dec 2014
Dec 2015
Jan 2016
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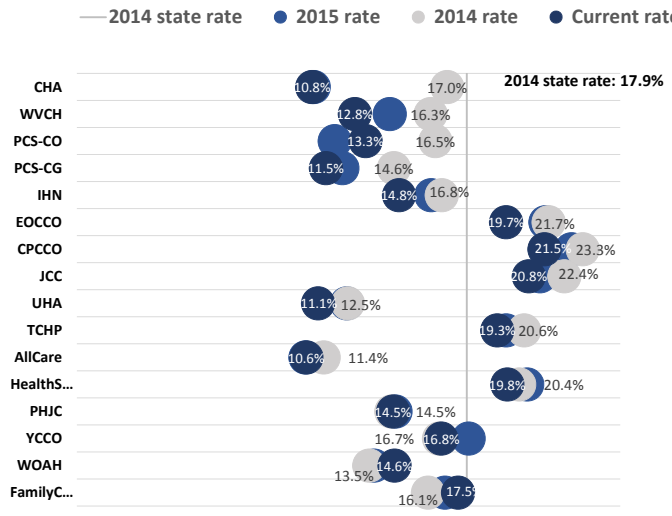
Mar 2016
Apr 2016
May 2016
Jun 2016
Jul 2016
Aug 2016
Sep 2016
Oct 2016
HealthInsight

Any day >= 90 mg MED, total



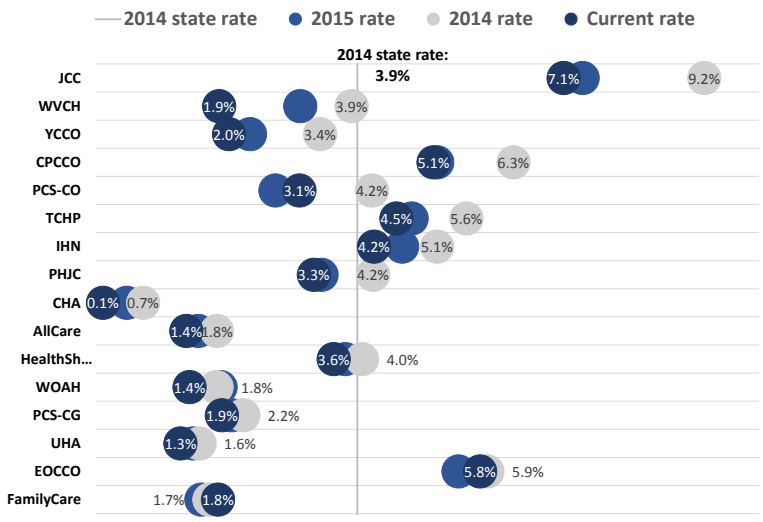
Lower is better

90 mg MED, consecutive 30+ days

Age	CY 2014	CY 2015	12/1/2015 – 11/30/16
12-17	1 (0.0%)	1 (0.0%)	0 (0.0%)
18 +	4,447 (4.2%)	4,195 (3.6%)	3,239 (3.3%)
Total	4,448 (3.9%)	4,196 (3.4%)	3, 329 (3.2%)

$\rho \leq .001$

Consecutive 30 + days >= 90 mg MED, total



Lower is better

Summary

- Significant decrease in metrics from baseline (1.24% points on 120 mg MED; 1.27% points on 90 mg MED)
- Decrease in number of people with any prescription for opioids
- Greater decrease in patients age 12-17 with a high dose than patients age 18+
- Wide variation among CCOs at baseline and in improvement

Thank you.

Questions?

Small Group Discussion

1. Conclusions about individual CCO results
2. Interpretation of decreased denominator
3. Additional opioid measures
4. Which interventions appear to be more effective?

GRIEVANCE
REPORTING PROCESS

CCO Contract
EXHIBIT I

April 2017

Exhibit I

Exhibit I – Grievance System

Contractor shall establish internal Grievance procedures under which Members, or Providers acting on their behalf, may challenge any Action. Contractor shall maintain its Grievance System in accordance with this exhibit, OAR 410-141-3260 through 410-141-3266, and 42 CFR 438.400 through 438.424.

1. Grievance System

Contractor shall have a system in place for Members that includes a Grievance process, an Appeal process and access to a Contested Case Hearing.

CMS Requirements
Grievance System

Subpart D—Quality Assessment and Performance Improvement

§ 438.228 Grievance systems.

(a) The State must ensure, through its contracts, that each MCO and PIHP has in effect a grievance system that meets the requirements of subpart F of this part.

Subpart F—Grievance System

§ 438.402 General requirements.

(a) *The grievance system.* Each MCO and PIHP must have a system in place for enrollees that includes a grievance process, an appeal process, and access to the State's fair hearing system.

Oregon Definitions
GRIEVANCE –OR- COMPLAINT

OAR 410-141-0000(26) "*Grievance*" means a member's complaint to a PHP, CCO or to a participating provider about any matter other than an action.

OAR 410-141-0260(1)(c) *Complaint* – A Division member's or Division member's representative's expression of dissatisfaction to a PHP or to a practitioner about any matter other than an action, as "action" is defined in this section.

Dissatisfaction

CFR §438.400 Statutory basis, definitions, and applicability

Grievance means an expression of dissatisfaction about any matter other than an action. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

Exhibit I Record Keeping Requirements

8. Documentation and Quality Improvement

a. Contractor shall document all Grievances and Appeals using the Grievance Log and Summary Workbook available on the Contract Reports Web Site in accordance with the instructions included on each report and shall submit it to OHA Contract Administration Unit 45 days following the end of each calendar quarter. Contractor shall monitor the Grievance Reports internally on a monthly basis for completeness and accuracy.

Exhibit I Record Keeping Requirements

b. Contractor shall maintain a record, in a central location for each Grievance and Appeal included in the Grievance Forms. The record shall include, at a minimum:

- Notice of Action;
- If filed in writing, the Appeal or Grievance;
- If an oral filing was received, documentation that the Grievance or Appeal was received orally;
- Records of the review or investigation;
- Notice of resolution of the Grievance or Appeal; and
- All written decisions and copies of all correspondence with all parties to the Grievance or Appeal.

Exhibit I Reporting Requirements

d. Contractor shall review and analyze the Grievance System, including all Grievances and Appeals. The analysis of the Grievance System shall be forwarded to the Quality Improvement committee as necessary to comply with the Quality Improvement standards as follows:

- Review of completeness, accuracy and timeliness of documentation;
- Compliance with written procedures for receipt, disposition, and documentation and
- Compliance with applicable OHP rules

Current State of Grievance Reporting

- This overview is about the data collection and reporting of complaints and the grievance log and grievance summary. We will not be covering the appeals and hearings process.
- There are new CMS rules that are requiring us to update the states OARs, which will not necessarily affect the complaints process, but will affect the appeals, and hearings process.
- We're still working on the OARs – there will be RACs over the summer that CCOs can participate in.

FAQ's regarding complaint data collection

Q. Where is the link to the grievance summary sheet and logs?

A. The link to the CCO Contract Forms website for the data collection forms is located here: http://www.oregon.gov/oha/healthplan/Pages/cco-contract-forms.aspx

Q. When were the most recent changes to the grievance summary and log made?

A. The current documents are dated October 1, 2015.

Q. Are reports based on closed (resolved) date and not received date?
A. Reports are based on the number of complaints received per quarter. Complaints not resolved in the same quarter should be marked with a "Y" in the "Pending" column of the Grievance Log.

Q. Will you be adding NEMT as its own column?
A. NEMT is captured under Access and is also a service type and can be captured in other categories as is appropriate.

Q. Do we still report MH and Dental and 1 Phone Call Resolution?
A. Complaint log and report has three columns to capture Mental and Dental Health and 1 Phone Call resolution. The issue and resolution for 1 phone call resolution continue to be required on the log.

Q. When is the grievance summary and logs due to OHA?
A. The grievance summary and logs are due to OHA 45 days after the end of each quarter.

Q. Can we add columns for different delegates?
A. Please do not add columns. The data you submit should reflect the total number of complaints received by the CCO. This helps OHA collect the data in a standardized way to consolidate the CMS report.

Q. For the Y/N columns, do you want "Y" or "Yes"?
A. Please enter "Y".

Questions that have been submitted, but have not been addressed yet:

- ✓ Questions about changing from reporting complaints when they are received, to when there is resolution.
- ✓ How can second opinions be tracked through the grievance process.
- ✓ What is the difference between QSb, CRj and CRk on the Grievance Summary form.
- ✓ What is the length of time a member has to file a grievance after an event. Can this timeframe be aligned with the Medicare 60 day limit after the event.