MEETING INFORMATION
Meeting Date: April 8, 2019
Location: HSB Room 137 A-D, 500 Summer Street, NE, Salem, OR
Parking: Map Phone: 503-378-5090 x0
Call in information: Toll free dial-in: 888-278-0296 Participant Code: 310477
Webinar: https://attendee.gotowebinar.com/rt/4303958396461018881
All meeting materials are posted on the QHOC website.

Clinical Director Workgroup 10:00 a.m. – 11:00 a.m.			
Time	**Topic**	**Owner**	**Materials**
10:00am	Welcome / Announcements	Andy Luther	Speaker's Contact Sheet (Packet Page 2) March Meeting Notes (Packet Pages 3-8) PH Update (Packet Pages 9-13)
10:10am	Medicaid Benefits and Health Improvement [Recent/Upcoming Changes, Challenges, Opportunities] o HERC discussion (Packet Pages 14-58) o Pharmacy discussion o Key clinical topics roundtable o Diabetes Prevention Program billing setup update o Provider Enrollment Update		
10:40am	Legislative Update	Jeannette Taylor	
10:50am	Break		
Learning Collaborative 11:00 a.m. – 12:30 p.m.			
11:00am	Viral Hepatitis C in Oregon		(Packet Pages. 59-67)
12:30pm	LUNCH		
Quality and Performance Improvement Session 1:00 pm – 3:00 p.m.			
1:00pm	Welcome / Announcements	Carla Munn Lisa Bui	
1:10pm	Quality and Compliance WORK SESSION		

Upcoming Topics:

AGENDA TOPIC	SPEAKER	CONTACT INFO
HERC Update	Cat Livingston, MD, MPH Ariel Smits, MD, MPH	catherine.livingston@state.or.us ariel.smits@state.or.us
P&T Update	Roger Citron	roger.a.citron@state.or.us
Provider Enrollment Update	Todd Howard	todd.a.howard@state.or.us
DPP Billing Setup Update	Nathan Roberts	nathan.w.roberts@state.or.us
Legislative Update	Jeanette Taylor	jeannette.t.taylor@state.or.us
Learning Collaborative	Dana Hargunani, MD Ann Thomas Dayna Morrison Kent Benner Lauren Meyers Lisa Nelson Martyna Witowska Renee Yandel Robert Barns Trevor Douglass, DO	dana.hargunani@state.or.us trevor.douglass@state.or.us
QHOC Chairs		
Medical	Andy Luther, MD	andrew.luther@primaryhealthfamily.com
Behavioral Health	Athena Goldberg, LCSW	athena.goldberg@allcarehealth.com
Oral Health	Laura McKeane	laura.McKeane@allcarehealth.com
Quality	Carla Munn	cmunn@wvchealth.org
QHOC Leads		
Medical	Renae Wentz, MD	kim.r.wentz@state.or.us
Behavioral Health		
Oral Health	Bruce Austin, DMD	bruce.w.austin@state.or.us
Quality	Lisa Bui	lisa.t.bui@state.or.us

QHOC Website:
http://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Health-Outcomes-Committee.aspx

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

QHOC
March 11, 2019
10:00 a.m. – 3:00 p.m., HSB 137 A-D
500 Summer Street NE, Salem, OR 97301

Meeting Notes

Attendance	
Advanced Health	Anna Warner
AllCare	Kelley Burnett, Athena Goldberg, Jake Mazzola, Richard Williamson
Cascade Health Alliance	David Shute, Cord Van Ryper
Columbia Pacific	
Eastern Oregon	
Health Share	Maggie Bennington-Davis
InterCommunity Health Network	Arik Olson, Kevin Ewanchyna
Jackson Care Connect	
PacificSource Community Solutions	Mike Franz, Alison Little, Sherri Sturks
Primary Health of Josephine County	Andy Luther
Trillium Community Health Plan	Coleen Connolly
Umpqua Health Alliance	F. Douglas Carr, Tanveer Bokhari
Willamette Valley Community Health	Carla Munns, Holly Jo Hodges, Lisa Parks, Jeanne Savage
Yamhill Community Care	Tyler Hartman, Bhavesh Rajani, Jenn Jackson
Capitol Dental Care	
Willamette Dental	Dayna Steringer
CareOregon	
Providence	Kristin Garrett
Tuality Health Alliance	Kristen Jeannis, Bobbie Mellor
Washington County	Andy Wallace
OHA	Ariel Smits, Cat Livingston, Sarah Dobra, Renae Wentz, Lisa Bui, Tracy Muday, Roger Citron, Ann Brown, Tressa Perlichek, Dana Hargunani, Deborah Larkins
Attendance via Phone/Webinar	Barbara Boardman, Darin Brink, Briona Campbell, Barbara Carey, Fritz Darling, Kelly DeLany, Renee Doan, Tiffany Dorsey, Donna Erbs, Ann Ford, Anona Gund, Christine Hartmann, Shellie Holk, Cyndi Kallstrom, Sara Kleinschmit, Kristen Lacijan-Drew, Cynthia Lacro, Lara Nina, Laura Matola, Ruth McBride, Laura McKeane, Christi Melendez, Caryn Mickelson, Yuberca Pena, Vannessa Ramirez, Jim Rickards, Alissa Robbins, Jill Roe, Bonnie Thompson, Del Webb, Courtney Whidden, Sara Beaudrault, Charmane Kinney, Lisa Krois, Michelle Martinez, Jennifer Johnstun

PHARMACY DISCUSSION *(Page 11 in packet)*

- Next P&T meeting is scheduled for Thursday, March 21st. March agenda
- Link to January P&T Recommendations

- Link to searchable web application, where the PDL placement and associated PA criteria can be accessed

HERC DISCUSSION *(Pages 12-61 in packet)*

- Newly Covered Conditions (effective 2020)
  - Hydradenitis suppurativa
  - SI joint fusion
- Code Movement
  - Add failure to thrive in children to covered line
  - Add DPP codes to obesity lines
  - Magnetic sphincter augmentation for GERD on line 660
- New Guidelines
  - Transoral incisionless fundoplication for treatment of GERD
- Upcoming Topics of Interest
  - Pulmonary rehabilitation
  - Impella devices for percutaneous mechanical circulatory support
  - Tonsillectomy guideline
  - Venous and arteriovenous malformations
  - Injections for plantar fasciitis
  - Non-invasive testing for liver fibrosis
  - Coverage guidance: knee OA interventions
  - Need input on
    - How to cover screening for ophthalmologic drug complications
    - Changes to requirements for endometrial ablation
  - Chronic Pain Task Force recommendations
    - Nonpharmacologic therapy for chronic pain syndrome, fibromyalgia
    - Opioid guideline/opioid tapering
      - Chronic pain syndrome, fibromyalgia
      - Back pain
  - Alternative proposals being discussed
  - Option to make no changes for chronic pain
    - Back opioid guideline will still be updated

EbGS next meeting is scheduled for 4/4/2019. Discussion topics include planned out-of-hospital birth – Evidence; community health workers- public comment.

HTAS next meeting is scheduled for 4/18/2019. Discussion topics include extended stay centers – Public Comment; and Spinal cord stimulators

- Future topics include:
  - Biologic matrix for breast reconstruction
  - Telephone and email consultation
  - Massage therapy
  - Incontinence procedures
  - Lower extremity chronic venous disease
  - Lymphedema issues
- For CCO awareness:
  - New USPSTF recommendation on preventive treatment for peripartum mood disorders

ENROLLING PRESCRIBING PROVIDERS:

Update on status of enrolling prescribing providers was given by Todd Howard, manager of HSD Provider Enrollment unit. A formal deadline has yet to be determined but is anticipated in mid to late summer 2019. A new MMIS edit to allow existing prescriptions but deny new prescriptions is in development. A monthly update communication will be sent to the QHOC and CCO Operations Collaborative groups. Provider outreach efforts will continue.

OREGON BACK PAIN STUDY: *(Pages 62-71 in packet)*

Cristi Pinela and Maria Danna from HealthInsight Oregon presented on Oregon Back Pain Study. The goal of the study is to investigate whether Oregon's Medicaid policy on opioid prescribing and nonpharmacologic therapies for back pain is effective in reducing opioid use and opioid-related harms among Medicaid patients with back pain. CCO administrator interviews will be conducted Feb-Mar 2019 then again in winter 2021. Discussion will be around CCO approach to implementation, communications, aspects implemented, challenges and barriers, beneficial and harmful aspects, support for the policy, recommendations for future policy design and implementation. HealthInsight team member will contact Medical and Pharmacy Directors to set interview dates.

SUD WAIVER:

Update given by Joanna Johnson and Dana Peterson from Health Systems Division. OHA is applying for a Medicaid SUD waiver, asking the federal government for more flexibility. If approved, the waiver would allow OHA to improve Oregon's SUD treatment system in three ways: Expand system supports, increase access to services, and establish standards of care.

SUD Waiver Project Timeline:

<u>March 2019</u>

Draft application development continues

April 2019
Submit draft application to CMS
Begin tribal consultation process
Post draft application for public comment
May 2019
Public notice process ends
Tribal consultation process continues
June 2019
Tribal consultation process ends
Revise draft application based on tribal and public comment
Submit final application to CMS

What is FFS?

Presentation by Jamal Furqan. FFS is the Oregon Health Plan population that is not enrolled with a CCO or managed care plan; where providers are paid directly by OHA for all or specific categories of their health services. The FFS delivery system consists of many more payment methodologies than just fee schedule claims payments.

STATE HEALTH IMPROVEMENT PLAN: *(Pages 72-80 in packet)*

Presentation by Christy Hudson, OHA Policy and Partnerships team

What is a State Health Improvement Plan?

- Identifies our state's health priorities
- Addresses unjust and unacceptable disparities
- Tool for collective impact with cross-sector partners
- Key strategic document for Oregon Health Authority's, Public Health Division
- Required for Public Health Accreditation

2015-2019 SHIP: Health System Strategies

- Incentive metrics
- Comprehensive healthcare benefits
- Health care environments
- Standards of care
- Screening guidelines
- Provider training

Vision for 2020-2024 SHIP

Oregon will be a place where health and wellbeing are achievable across the lifespan for people

of all races, ethnicities, disabilities, genders, sexual orientations, socioeconomic status, nationalities and geographic locations.

2020-2024 Priorities

- Institutional bias
- Adversity, trauma and toxic stress
- Economic drivers of health (including issues related to housing, living wage, food security and transportation)
- Access to equitable, preventive health care
- Behavioral health (including mental health and substance use)

Next Steps

Subcommittees will be formed with inclusion of subject matter experts, cross-sector partners and people with lived experience. The subcommittees are charged with identifying strategies, measures, action steps, and soliciting additional feedback from community. Meetings will be held between April-December.

Quality and Performance Improvement Session:

2019 TQS PROJECT DETAILS DATE MILESTONE *(Page 81 in packet)*

- 11-Mar CCO QHOC update
- 15-Mar 2019 CCO TQS annual submission due
- 8-Apr CCO QHOC update (optional)
- 19-Apr OHA review of CCO TQS
- 13-May CCO QHOC update (optional)
- May-19 OHA written assessment of CCO TQS
- Jun-19 OHA/CCO individual TQS calls
- 31-Jul CCO TQS resubmission due (optional) 1-Aug 2019 CCO TQS submissions posted online Aug-19 2019 CCO TQS global feedback webinar
- 30-Sep 2019 CCO TQS progress report due 1-Oct 2020 CCO TQS guidance documents posted online

2019 Acute Prescribing Statewide PIP: *(Pages 83-84 in packet)*

PIP Metric: New Opioid Patients Days' Supply of First Opioid Prescription
Percent of patients with at least one opioid prescription in one year, who have no opioids prescribed in the prior six months, among patients in the population by days' supply

Baseline 2017 data review

Questions: (Notes from white board)

1. Claims
   - Oral Health/BH/PH
   - Can it be broken out?
2. Exclusion
   - Cancer diagnosis-time based
3. Surgical-1 week before Rx index
4. <3 vs. < 3
   - Member level data
5. If all categories selected for PIP then significantly improvement would be needed across all.
6. Days' supply

Goal: <*3* day supply

   - Won't be 100%

COMPLAINTS AND GRIEVANCES: *(Pages 85-93 in packet)*

- Grievance system reporting current documents are:
  Grievance and Appeal Log Instructions – July 1, 2018
- Grievance and Appeal Log Version 2 – July 1, 2018
- Grievance System Report – July 1, 2018

These documents are located on this website:
http://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx

The published reports are on this website: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/2017-2022-Quarterly-Annual-Reports.aspx

CCOs are currently reviewing updates to the Grievance and Appeal Log

Version 3 of the Grievance and Appeal Log will be posted on the Website April 1, 2019

Reporting cycle with updated Grievance and Appeal Log begins July 1, 2019

APRIL AGENDA TOPICS:

- Metrics update
- Hep C Learning Collaborative

PUBLIC COMMENT: There were no public comments during this meeting.

ADJOURNMENT: Meeting was adjourned at 3:05pm.

Quality and Health Outcomes Committee
Public Health Division updates – April 2019

New public education campaign to prevent the use of prescription opioids

OHA will soon be launching a new behavior change campaign to prevent the use of prescription opioids in Oregon.

OHA teamed up with Brink Communications and Goodwin Simon Strategic Research to conduct groundbreaking research aimed at uncovering how diverse people think about short-term pain and pain management.

OHA is hosting a webinar to give stakeholders an early look at the campaign and the key insights that helped shape OHA's equitable and culturally responsive approach.

Join us for a webinar on **Tuesday, June 18th from 9am – 10:30am.**

The webinar will also include an overview of a new narrative that you can leverage to successfully drive change in your own work.

Click here to RVSP by June 14th. You will receive a follow up email with a calendar invite and webinar details.

For more information, contact Mary Borges at mary.l.borges@state.or.us.

OHA is looking for CCO representation on subcommittees to develop the 2020-2024 State Health Improvement Plan (SHIP)

The OHA Public Health Division is looking for CCO representatives to serve on the subcommittees that are being formed for each of the 5 new SHIP priority areas. In particular, we still need CCO representation for the following priority areas:

- Adversity, trauma and toxic stress
- Economic drivers of health (to include housing, transportation, wage and food insecurity)
- Access to equitable preventive care

Ideally, we are looking for subcommittee members who:

- Have lived or learned subject matter expertise in the topic area
- Have capacity and passion to fully engage in this effort (Monthly 2 hour commitment starting in May – early 2020. Some work in between meetings is expected.)
- Are able to facilitate 2-way communication about this work with your CCO
- Have connection to and/or decision-making authority about CHIP related investments

Interested persons can contact Christy.j.hudson@state.or.us for additional information.

Sustainable Relationships for Community Health (SRCH) RFGP Opportunity

The OHA Public Health Division is getting ready to release a RFGP for the next round of SRCH funding.

Sustainable Relationships for Community Health (SRCH) is a facilitated model for collaboration that brings together leaders from Local Public Health Authorities (LPHAs), Oregon Federally Recognized Tribes, Urban Indian Health Programs, Coordinated Care Organizations (CCOs), Regional Health Equity Coalitions (RHECs), clinics, community-based organizational partners delivering self-management programs (SMPs), and others involved with health system transformation to implement evidence-based interventions and services.

SRCH participants create sustainable effective relationships between community partners to improve preventive and chronic care services, improve health outcomes, reduce healthcare costs, and promote equity.

The RFGP will be released in early May, and the funding period is from July 2019 – June 2020.

For more information, please see the attached document or contact Shira Pope at shira.r.pope@state.or.us.

Upcoming training: Oregon Public Health Assessment Tool

The Oregon Public Health Assessment Tool (OPHAT) is a web-based data query system for community health assessment. It's available at no cost to employees of CCOs or hospitals engaged in community health needs assessment.

Oregon Health Authority will hold a training for new users on:

Thursday, May 16, 2019
1:00-2:00

Register at: https://register.gotowebinar.com/register/8243206196494648323. For more information, contact Nita Heimann at Juanita.a.heimann@state.or.us.

2019 County Health Rankings

In March, the annual County Health Rankings were released. County Health Rankings provide a revealing snapshot of how health is influenced by where we live, work, learn and play. Data by Oregon county show how the factors that influence health and health outcomes vary by where one lives. Oregon data and additional information about the Rankings are available at: http://www.countyhealthrankings.org/.

The Link Between School Attendance and Good Health

The OHA Public Health Division has a memorandum of understanding with the Oregon Department of Education which defines opportunities related to our shared goal of reducing chronic abseentism among Oregon's students. Chronic abseentism refers to missing school for any reason, including both excused and unexcused reasons. Oregon has one of the highest rates of chronic abseentism in the country. The American Academy of Pediatrics recently published a policy paper that outlines specific actions that pediatricians and clinics can take to promote school attendance.

Oregon-specific resources, including posters and signs for your clinic, can be found at https://www.every-day-matters.org/

For more information, contact Rosalyn Liu at Rosalyn.liu@state.or.us.

Sustainable Relationships for Community Health (SRCH) RFGP Opportunity

What is SRCH?

Sustainable Relationships for Community Health (SRCH) is a facilitated model for collaboration that brings together leaders from Local Public Health Authorities (LPHAs), Oregon Federally Recognized Tribes, Urban Indian Health Programs, Coordinated Care Organizations (CCOs), Regional Health Equity Coalitions (RHECs), clinics, community-based organizational partners delivering self-management programs (SMPs), and others involved with health system transformation to implement evidence-based interventions and services.

SRCH participants create sustainable effective relationships between community partners to improve preventive and chronic care services, improve health outcomes, reduce healthcare costs, and promote equity.

What will SRCH teams do?

SRCH will award at least three Recipient teams the opportunity to develop and strengthen relationships, co-design strategies to formalize infrastructure and/or arrangements between health system partners and community-based organizational partners (e.g., closed loop referrals, memorandums of understanding), implement quality improvement processes, and collect, analyze and share data in order to reduce some of the leading causes of death and disability in Oregon.

The SRCH model includes at least three structured in-person institutes, an assigned liaison /coach, monthly technical assistance calls, and quality improvement tools to support co-design, implementation and evaluation of SRCH initiatives.

What are the funding sources for SRCH?

SRCH is funded through a variety of federal grants that focus on reducing the burden of some of the leading causes of death and disability in Oregon, i.e., arthritis, asthma, colorectal cancer, diabetes, and hypertension, and associated risk factors, i.e., tobacco, physical inactivity, poor nutrition, alcohol misuse. Currently, SRCH is not funded by any state or general funds. In past SRCH grants, award amounts have ranged between $70,000 to $120,000.

Who can apply as lead fiscal agent for SRCH?

The lead fiscal agent can be one of the following:

- Local Public Health Authority (LPHA) or organizations administering TPEP and/or ADPEP programs
- Oregon Federally Recognized Tribe
- Urban Indian Health Program that administers an ADPEP or TPEP program

- Coordinated Care Organization (CCO)

What is the timeline for the SRCH RFGP release?

Early May 2019 – SRCH RFGP released

Early June 2019 – SRCH Applications due

June 2019 – SRCH award recipients notified

July 2019 June 2020– SRCH competitive grant period

Key Contact for SRCH:

Shira Pope. MS
Health Systems Policy Specialist
OREGON HEALTH AUTHORITY
Public Health Division
Health Promotion and Chronic Disease Prevention
Desk: 971-673-1052
Shira.r.pope@state.or.us

HERC Update

Cat Livingston, MD, MPH

April 8, 2019

Code movement

- Cover treatment of posterior urethral valve surgery
- Coverage of symptomatic non-brain AVMs
- Coverage of screening ophthalmology visits and testing for patients on high risk drugs

Guideline update

- Liver fibrosis testing changes
- Fewer requirements for endometrial ablation for menorrhagia
- More stringent criteria for tonsillectomy for strep

Upcoming topics of interest

- Impella devices for percutaneous mechanical circulatory support
- Injections for plantar fasciitis
- Counseling to prevent peripartum depression

Upcoming topics of interest

- Chronic Pain Task Force recommendations
  - Nonpharmacologic therapy for chronic pain syndrome, fibromyalgia
  - Opioid guideline/opioid tapering
    - Chronic pain syndrome, fibromyalgia
    - Back pain
  - Alternative proposals being discussed
  - Option to make no changes for chronic pain
    - Back opioid guideline will still need to be updated

EbGS & HTAS

EbGS 4/4/2019

- Planned out-of-hospital birth - Evidence
- Community health workers – Public Comment
- Impella devices – discussion following HERC review

HTAS 4/18/2019

- Extended stay centers – Public Comment

Future Topics

- Biologic matrix for breast reconstruction
- Telephone and email consultation
- Massage therapy
- Incontinence procedures
- Lower extremity chronic venous disease
- Lymphedema issues
- Liver transplant for hepatoblastoma and HCC
- Radiofrequency ablation for knee osteoarthritis
- Spinal cord stimulators (HTAS)

Your feedback?

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on March 14, 2019

For specific coding recommendations and guideline wording, please see the text of the 3/14/2019 VbBS minutes.

RECOMMENDED CODE MOVEMENT (effective 10/1/2019 unless otherwise noted)

- Add the diagnosis code for posterior urethral valves to a covered line and leave it on two other covered lines
- Add procedure codes for treatment of arteriovenous malformations to a covered line
- Add two diagnosis codes to a covered line with a guideline specifying they are to be used for screening for ophthalmologic complications of high-risk medications
- Make various straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2019 unless otherwise noted)

- Adopt a new guideline regarding pulmonary rehabilitation services
- Edit the guideline for menstrual bleeding disorders to exempt endometrial ablation from the requirement to demonstrate a hemoglobin level of less than 11, and to require only a pelvic ultrasound prior to that procedure
- Edit the guideline on noninvasive testing for liver fibrosis for hepatitis C to more broadly refer to testing for chronic liver disease
- Modify the guideline note on viscosupplementation for osteoarthritis of the knee to more broadly address newer interventions for osteoarthritis of the knee including glucosamine/chondroitin, whole body vibration, platelet-rich plasma, and TENS
- Edit two guidelines regarding breast imaging to refer to each other to increase clarity
- Edit the tonsillectomy guideline to reflect updated national expert guidelines
- Add a new guideline regarding when treatment of arteriovenous malformations are covered
- Add a new guideline specifying that shoulder decompression surgery is only covered when used as part of rotator cuff repair
- Make several guideline changes to the guidelines for lines 500 and 660 to help clarify HERC intent
- Make various straightforward guideline note changes

VALUE-BASED BENEFITS SUBCOMMITTEE
Human Services Building, Rooms 137 A-D
500 Summer Street NE
Salem Oregon
March 14, 2019
8:30 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, Vice-Chair; Mark Gibson; Vern Saboe, DC; Gary Allen, DMD; Adriane Irwin, PharmD.

Members Absent: None

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Cat Livingston, MD, MPH; Dana Hargunani, MD; Jason Gingerich; Daphne Peck.

Also Attending: Renae Wentz, MD, and Trilby deJung (Oregon Health Authority); Billy Ray Pitt; Tracy Muday, MD; Kelly Howard; Larry and Wendy Gordon; Barry Schlansky, MD (Kaiser) via phone.

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

  The meeting of the Value-based Benefits Subcommittee (VbBS) was called to order at 8:35 am and roll was called. Minutes from the January 17, 2019 VbBS meeting were reviewed and approved unanimously. Smits reviewed the errata document; there were no questions.

- **Topic: Straightforward/Consent Agenda**

  Discussion: There was no discussion about the consent agenda items.

  Recommended Actions:
  1) Remove ICD-10 Q66.21 (Congenital metatarsus primus varus) from line 359 DEFORMITY/CLOSED DISLOCATION OF JOINT AND RECURRENT JOINT DISLOCATIONS
  2) Add ICD-10 Q66.21 (Congenital metatarsus primus varus) to line 540 DEFORMITIES OF FOOT
  3) Remove CPT 28292 (Correction, hallux valgus (bunionectomy), with sesamoidectomy, when performed; with resection of proximal phalanx base, when performed, any method) from line 356 RHEUMATOID ARTHRITIS, OSTEOARTHRITIS, OSTEOCHONDRITIS DISSECANS, AND ASEPTIC NECROSIS OF BONE
  4) Add ICD-10 R33.8 (Other retention of urine) to Line 327 FUNCTIONAL AND MECHANICAL DISORDERS OF THE GENITOURINARY SYSTEM INCLUDING BLADDER OUTLET OBSTRUCTION
     a. Keep ICD-10 R33.8 (Other retention of urine) on the Diagnostic Workup File
  5) Add the ICD-10 H04.55 (Acquired stenosis of nasolacrimal duct) and H04.56 (Stenosis of right lacrimal punctum) code series to line 393 STRABISMUS WITHOUT AMBLYOPIA AND OTHER DISORDERS OF BINOCULAR EYE MOVEMENTS; CONGENITAL ANOMALIES OF EYE; LACRIMAL DUCT OBSTRUCTION IN CHILDREN
  6) Add CPT 44186 (Laparoscopy, surgical; jejunostomy (eg, for decompression or feeding)) to line 157 CANCER OF COLON, RECTUM, SMALL INTESTINE AND ANUS
  7) Modify Guideline Note 29 as shown in Appendix A

8) Modify the first clause of Diagnostic Guideline D1 as shown below
    a. Genetic tests are covered as diagnostic, unless they are listed below in section ~~F1~~ E1 as excluded or have other restrictions listed in this guideline…
9) Modify Guideline Note 36 as shown in Appendix A *[note: further revisions to this guideline discussed below]*
10) Add references to guideline notes 6, 64, and 65 to the new SI joint surgery line approved for the Biennial Review list effective 1/1/2020
11) Add references to guideline notes 64 and 65 to the new line for hidradenitis suppurativa approved for the Biennial Review list effective 1/1/2020

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 6-0.

- **Topic: 2020 Biennial Review – Reprioritization of Certain Chronic Pain Conditions**

Discussion: Dr. Dana Hargunani, CMO of the Oregon Health Authority (OHA), stated that as transparency and integrity are key to the agency's work, OHA is requesting that the subcommittee table the discussion of this topic at this time, as potential conflicts of interest of a contracted medical consultant to HERC, Cat Livingston, recently became known. These potential conflicts involve two studies evaluating HERC's past decisions on the treatment of back pain that have been part of the discussions of the the Chronic Pain Task Force. This will give time for an independent review of the policy options in front of VbBS to ensure they are the appropriate options to be considered in light of the potential conflicts of interest. Further discussion could then occur at a special session of VbBS and HERC within the next month, if possible, and no later than the currently scheduled May 16th meeting if it was determined the biennial report to the legislature could still be transmitted in a timely fashion. Dr. Hargunani indicated that she will conduct a full review of the conflict of interest process to prevent this from happening in the future.

At this time, Vern Saboe, declared a potential conflict of interest. He is a paid consultant for a Kaiser Permanente study funded by a grant from the Patient Centered Outcomes Research Institute (PCORI) to evaluate the effects of the 2016 changes in OHP coverage of nonpharmacologic treatments for low back and spine pain and their impact on opioid prescribing. Written statements from both Dr. Livingston and Dr. Saboe on the potential conflicts of interest will be provided to HERC.

There was a brief discussion of making the public testimony time more immediately clear in the public notice and other meeting materials when it is taken for a specific topic rather than at the general public testimony time at 12:55 pm for topics not on the agenda.

Public testimony:

- Tracy Muday, MD: member of the Chronic Pain Task Force (CPTF) testified. The CPTF recommendation has been modified through the committee process. The goal was to add therapies to reduce the risk of harms. The evidence of benefit of these therapies are low, and there are unintended consequences of harm with reprioritizing these conditions. There is misunderstanding of the aims and scope of the process, among the public and even the task force members. Thoughtful, well intentioned people have pointed out the potential of harms of

the current proposal. These harms outweigh the benefits of the therapies, which themselves have low evidence.

- Kelly Howard: chronic pain patient testified. This process has been very difficult for patients to determine what is going on, and to understand the language used. Adding the alternative treatments under discussion is a great idea, but they are generally not very helpful. Concerned about removing opioid therapies. Baffled by VbBS attitude toward scientific literature. Evidence is low to very low for the therapies proposed to be added, but adding options is beneficial. However, evidence of opioid benefit, which is higher quality, was discounted. There are not studies of opioids longer than 3 months she acknowledged. Concerned about the ethics of tapering all chronic pain patients from their opioids. A lot of prejudice and bigotry about pain patients on opioids being "addicts." There is a difference between physiologic dependence and addiction.
- Shelley Latin: testified about concerns that the CPTF was "one-sided" and did not contain objective views about the best treatments for chronic pain patients. There should never be forced tapers; this is a medical decision between a doctor and patient. There has been a mountain of testimony about prominent pain physicians that tapers are harmful, including the testimony of Beth Darnell. She went to the Stanford pain program personally. She feels that the alternative treatments are not a replacement for opioids, which is supported by evidence. There is also inadequate infrastructure to provide these alternative treatments across the state, particularly places such as eastern Oregon. Please consider Dr. Darnell's offer to be included in her EMPOWER study.
- Larry Gordon: testified that Beth Darnell was an excellent addition to the committee and that he agreed with the previous testimony. Concerned that no one is on any of the task force/ committees that represents the chronic pain community. His wife is an example of the unintended consequences of forced tapering. Her family physician was afraid of the CDC guidelines and losing his license, so he abandoned her and sent her to another physician who did not know her. She is disabled and in chronic pain. She was sent to a pain specialist, who tapered her off her opioids. This was devastating to her and she wanted to commit suicide. The Department of Health and Human Services did a report on the CDC guidelines, and stated that these guidelines were not to be used for local jurisdictions to write laws or mandates. This policy will result in chronic pain patients being abandoned by their doctors. The doctors treating these patients should not be at risk for losing their license. Consider mitigating the unintended consequences.

Recommended Actions:

1) This topic was tabled until either a special VbBS/HERC meeting in April or the scheduled May meeting

- **Topic: Pulmonary rehabilitation**

Discussion: Smits reviewed the summary document. Hodges asked for clarification regarding whether the number of sessions of pulmonary rehabilitation should be limited to 36 visits per year or per lifetime. Gingerich noted that OHP cannot put in lifetime per the ACA. The question was raised regarding whether this is an overused treatment. Hodges noted that some CCOs are seeing overuse. Smits pointed out that repeat programs are limited in the last sentence of the guideline.

The subcommittee accepted the guideline note as proposed. The intent of VbBS is that coverage is limited to 36 lifetime sessions unless there is lung reduction surgery or lung transplant.

Recommended Actions:

1) Add pulmonary rehabilitation HCPCS codes to lines with chronic pulmonary disease diagnoses
    a. HCPCS codes:
        i. G0237 (Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring))
        ii. G0238 (Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring))
        iii. G0239 (Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring))
        iv. S9473 (Pulmonary rehabilitation program, non-physician provider, per diem)
        v. Note: G0424 (Pulmonary rehabilitation, including exercise (includes monitoring), one hour, per session, up to two sessions per day) is already on the lines below
    b. Lines:
        i. 9 ASTHMA
        ii. 58 BRONCHIECTASIS
        iii. 223 OCCUPATIONAL LUNG DISEASES
        iv. 234 ADULT RESPIRATORY DISTRESS SYNDROME; ACUTE RESPIRATORY FAILURE; RESPIRATORY CONDITIONS DUE TO PHYSICAL AND CHEMICAL AGENTS
        v. 241 CONDITIONS REQUIRING HEART-LUNG AND LUNG TRANSPLANTATION
        vi. 283 CHRONIC OBSTRUCTIVE PULMONARY DISEASE; CHRONIC RESPIRATORY FAILURE
2) Adopt a new guideline note as shown in Appendix B

MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0.

- **Topic: Non-invasive testing for liver fibrosis guideline**

Discussion: Livingston reviewed the summary document. Dr. Barry Schlansky was introduced as a content expert. He is the Chief of Hepatology at Kaiser and clinical assistant professor at OHSU and an Investigator at Kaiser Center for Health Research.

There were questions about the availability of proprietary versus non-proprietary blood testing. Schlansky discussed that non-proprietary tests are excellent and are readily available.

Members requested adding the specific proprietary and nonproprietary tests within the guideline note itself, for clarity.

The conversation turned to magnetic resonance elastography (MRE). One member suggested Line 500 was appropriate for MRE given the cost-effectiveness and thus perhaps the exceptions process could be used for allowing MRE in limited circumstances. However, Schlansky clarified that FibroScan® fails in 20% of patients, which was not a rare circumstance. If one is concerned about a patient without a reliable FibroScan, the choices are MRE or liver biopsy. When compared to the cost and potential complications of a liver biopsy, MRE is a reasonable choice.

Livingston asked about the clinical impact of patients in whom ultrasound-based screening are ineffective, such as due to obesity. The reason for this is that if cirrhosis is diagnosed, monitoring would then be with ultrasound, which was previously not an effective strategy. Schlansky discussed that evidence for HCC screening is based on a single RCT in China that has not been replicated in western populations because of equipoise. Therefore, the data is not based on an American population, which is very different than Chinese population. Most are thin and have hepatitis B. US is not as accurate at finding liver nodules in the setting of obesity. The strategy for follow-up of these patients would be to introduce CT alternating with ultrasound.

Wentz raised the concern about potential overuse of liver biopsy and the group then discussed the importance of having safer and cheaper alternatives. There was a clarifying question about what is the denominator of those we are getting screening with non-invasive liver testing. Schlansky discussed that there is a movement towards doing screening in those who are higher risk (obesity, diabetes, age over 50). He discussed some therapeutic options for fatty liver disease such as bariatric surgery, pioglitazone and vitamins. Livingston stated that as currently written, the proposed coverage policy is only for those with chronic liver disease, not for screening in an asymptomatic, but high-risk population.

Members discussed the importance of trying to ensure that access to services across the state is uniform. It can take a long time to get an answer on an exception request. In contrast, a concern was raised that to be more consistent with the evidence, noncoverage of MRE might be more appropriate.

Members debated the two options and ultimately a vote to move option 2 forward, which allows coverage of MRE in very specific circumstances, as an alternative to a medically-indicated liver biopsy.

Recommended Actions:

1) Retire the Coverage Guidance *Noninvasive Liver Testing for Liver Fibrosis in Patients with Hepatitis C.*
2) Modify Guideline Note 76 as shown in Appendix A.

MOTION: To approve the staff recommendations as amended, with coverage of magnetic resonance elastography in specific circumstances. CARRIES 6-0.

- **Topic: Endometrial ablation requirements for menstrual bleeding disorders**

Discussion: Smits reviewed the summary document. Wentz asked about the failure rate of endometrial ablation. Smits noted that there is a failure rate, but it is small. Hodges commented that the rate in her experience is small and when patients do continue to have bleeding after endometrial ablation, the bleeding is still lighter and more manageable.

Recommended Actions:

1) Modify Guideline Note 44 as shown in Appendix A

MOTION: To recommend the guideline note changes as presented. CARRIES 6-0.

- **Topic: Posterior urethral valves**

  Discussion: Smits reviewed the summary document. There was no discussion.

  Recommended Actions:
  1) Add CPT 52400 (Cystourethroscopy with incision, fulguration, or resection of congenital posterior urethral valves, or congenital obstructive hypertrophic mucosal folds)) to line 87 CONGENITAL ANOMALIES OF GENITOURINARY SYSTEM

  MOTION: To recommend the code change as presented. CARRIES 6-0.

- **Topic: Breast MRI for breast cancer screening in breast cancer survivors**

  Discussion: Smits reviewed the summary document. Hodges noted that breast MRI CPT coding has changed recently, and computer aided diagnosis (CAD) is now included in the only CPT code available for billing breast MRI with contrast (without contrast still can be billed without CAD but is less frequently indicated than contrast MRI). The subcommittee struck the CAD reference from three locations in the diagnostic guideline note. It is the intent of VbBS that CAD should not be covered for breast MRI when and if coding for breast MRI without CAD again becomes available due to lack of benefit and possible harms of CAD.

  Recommended Actions:
  1) Modify diagnostic Guideline D6 as shown in Appendix A
  2) Modify GN26 as shown in Appendix A

  MOTION: To recommend the guideline note changes as presented. CARRIES 6-0.

- **Topic: Indications for adenotonsillectomy/tonsillectomy**

  Discussion: Smits reviewed the summary document. Hodges asked whether a link to the ENT society article could be put into the tonsillectomy guideline; Smits replied that typically single articles are not referenced in guideline notes. Smits will ensure that the article citation is included in the minutes:

  Mitchell, RB et al. Clinical Practice Guideline: Tonsillectomy in Children (Update). Otolaryngology–Head and Neck Surgery 2019, Vol. 160(1S) S1–S42. https://journals.sagepub.com/doi/pdf/10.1177/0194599818801757

  Irwin pointed out that the number of episodes of strep infection should be modified with “or more” to indicate that the number of episodes is a minimum.

  Recommended Actions:
  1) Modify Guideline Note 36 as shown in Appendix A

  MOTION: To recommend the guideline note changes as amended. CARRIES 6-0.

- **Topic: Embolization of vascular malformations**

  Discussion: Smits reviewed the summary document. There was no discussion.

  Recommended Actions:
  1) Add CPT 37242 (Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (e.g., congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)) to line 305 DISORDERS OF ARTERIES, OTHER THAN CAROTID OR CORONARY
  2) Add a new guideline to line 305 as shown in Appendix B

  MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0.

- **Topic: Injections for plantar fasciitis**

  Discussion: This topic was tabled to the May, 2019 VbBS meeting at the request of the Oregon Podiatry Association.

- **Topic: Screening for ophthalmologic complications of high-risk drugs**

  Discussion: Smits reviewed the summary document. Hodges requested that the ICD-10 code for high risk medication use be added to line 360 as well, as many ophthalmologists use that code for these types of screening. HERC staff identified that code as ICD-10 Z79.899 (Other long-term (current) drug therapy), which is currently on the Diagnostic Workup File. Livingston noted that H36 was the code used by many private insurers in this situation.

  Recommended Actions:
  1) Add ICD-10 H36 (Retinal disorders in diseases classified elsewhere) to line 360 CHORIORETINAL INFLAMMATION
  2) Add ICD-10 Z79.899 (Other long-term (current) drug therapy) to line 360 CHORIORETINAL INFLAMMATION
     - Advise HSD to keep ICD-10 Z79.899 on the Diagnostic Workup File
  3) Adopt a new guideline note for line 360 as shown in Appendix B

  MOTION: To recommend the code and guideline note changes as amended. CARRIES 6-0.

- **Topic: Shoulder decompression surgery for shoulder impingement syndrome**

  Discussion: Smits reviewed the summary document; there was no substantial discussion.

  Recommended Actions:
  1) A new guideline was added to lines 356,417,441 as shown in Appendix B

MOTION: To recommend the guideline note changes as presented. CARRIES 6-0.

- **Topic: Guideline note 172/173 modifications**

Discussion: Smits reviewed the summary document. There was no discussion.

Recommended Actions:

1) Remove CPT 88120 and 88121 (Cytopathology, in situ hybridization (eg, FISH), urinary tract specimen with morphometric analysis, 3-5 molecular probes) from line 271 CANCER OF BLADDER AND URETER
2) Modify GN 27 as shown in Appendix A
3) Modify GN 172 as shown in Appendix A
4) Modify GN 173 as shown in Appendix A

MOTION: To recommend the code and guideline note changes as presented. CARRIES 6-0.

- **Topic: Coverage Guidance—Newer interventions for osteoarthritis of the knee**

Discussion: Obley reviewed the evidence and policy background for the newer interventions for osteoarthritis of the knee. Livingston reviewed the other GRADE domains and the EbGS recommendations for noncoverage.

Members discussed these interventions as having few harms, but evidence of ineffectiveness. There was a suggestion posited that if something doesn't work, but has few harms, perhaps it has a role. An example was given of battlefield acupuncture. Others pointed out that in order for something to be covered, it would need to have evidence of benefit, not just lack of harm. The importance of harnessing the placebo was raised. Evidence of a placebo effect is possible to obtain. However, the evidence for TENS did not compare TENS to a non-sham TENS arm, therefore there was not proof of an effective placebo effect. Members agreed to adopt the suggested guidelines changes as recommended.

Recommended Actions:

1) Modify Guideline Note 104 as shown in Appendix A
2) Advise HSD to move A9270 (Non-covered item or service) from the Ancillary File to Excluded File

MOTION: To approve the recommended changes to the Prioritized List based on the draft Coverage Guidance on Newer Interventions for Osteoarthritis of the Knee scheduled for review by HERC at their March 14, 2019 meeting. CARRIES 6-0.

- **Public Comment:**

No additional public comment was received.

- **Issues for next meeting:**

- Reprioritization of certain chronic pain conditions
- Injections for plantar fasciitis

- **Next meeting:**

  May 16, 2019 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112. *Note: a special meeting to discuss the chronic pain reprioritization topic may be held in April, 2019.*

- **Adjournment:**

  The meeting adjourned at 12:50 PM.

DIAGNOSTIC GUIDELINE D6, BREAST CANCER SCREENING IN ABOVE-AVERAGE RISK WOMEN

Annual screening mammography and annual screening MRI ~~without computer-aided detection (CAD)~~ are covered only for women at above-average risk of breast cancer. This coverage, beginning at 30 years of age, includes women who have one or more of the following:

- Greater than 20% lifetime risk of breast cancer
- BRCA1 or BRCA2 gene mutation, or who have not been tested for BRCA but have a first-degree relative who is a BRCA carrier
- A personal history or a first-degree relative diagnosed with Bannayan-Riley-Ruvalcaba syndrome, Cowden syndrome, or Li-Fraumeni syndrome
- Other germline gene mutations known to confer a greater than 20% lifetime risk of breast cancer

For women with a history of high dose chest radiation (≥ 20 Gray) before the age of 30, annual screening MRI ~~without computer-aided detection (CAD)~~ and annual screening mammography are covered beginning 8 years after radiation exposure or at age 25, whichever is later.

For women with both a personal history and a family history of breast cancer which give a greater than 20% lifetime risk of breast cancer, annual mammography, annual breast MRI ~~without computer-aided detection (CAD)~~ and annual breast ultrasound are covered.

For women with increased breast density, supplemental screening with breast ultrasound, MRI, or digital breast tomosynthesis is not covered.

Breast PET-CT scanning and breast-specific gamma imaging are not covered for breast cancer screening.

For surveillance for a treated breast cancer, see Guideline Note 26 BREAST CANCER SURVEILLANCE.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 26, BREAST CANCER SURVEILLANCE

Line 191

A) History and physical exam is indicated every 3 to 6 months for the first three years after primary therapy, then every 6-12 months for the next 2 years, then annually thereafter.
B) Mammography is indicated annually, and patients treated with breast conserving therapy, initial mammogram of the affected breast should be 6 months after completion of radiotherapy.
C) No other surveillance testing is indicated

For ongoing screening for a new breast cancer, see Diagnostic Guideline D6 BREAST CANCER SCREENING IN ABOVE-AVERAGE RISK WOMEN.

GUIDELINE NOTE 27, SLEEP APNEA

Line 203

CPAP is covered initially when all of the following conditions are met:

- 12 week 'trial' period to determine benefit. This period is covered if apnea-hypopnea index (AHI) or respiratory disturbance index (RDI) is greater than or equal to 15 events per hour; or if between 5 and 14 events with additional symptoms including one or more of the following:
    - excessive daytime sleepiness defined as either an Epworth Sleepiness Scale score>10 or daytime sleepiness interfering with ADLs that is not attributable to another modifiable sedating condition (e.g. narcotic dependence), or
    - documented hypertension, or
    - ischemic heart disease, or
    - history of stroke;
- Providers must provide education to patients and caregivers prior to use of CPAP machine to ensure proper use; and
- Positive diagnosis through polysomnogram (PSG) or Home Sleep Test (HST).

CPAP coverage subsequent to the initial 12 weeks is based on documented patient tolerance, compliance, and clinical benefit. Compliance (adherence to therapy) is defined as use of CPAP for at least four hours per night on 70% of the nights during a consecutive 30-day period.

Mandibular advancement devices (oral appliances) are covered for those for whom CPAP fails or is contraindicated.

Surgery for sleep apnea in adults is not included on this line (due to lack of evidence of efficacy). Surgical codes are included on this line only for children who meet criteria according to Guideline Note 118 OBSTRUCTIVE SLEEP APNEA DIAGNOSIS AND TREATMENT FOR CHILDREN.

Hypoglossal nerve stimulation for treatment of obstructive sleep apnea is not included on this line due to insufficient evidence of effectiveness and evidence of harm.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 29, TYMPANOSTOMY TUBES IN ACUTE OTITIS MEDIA

Line 389

Tympanostomy tubes (CPT 69433, 69436) are only included on this line as treatment for:

A) recurrent acute otitis media (three or more well-documented and separate episodes in six months or four or more well-documented and separate episodes in the past 12 months with at least one episode in the past six months) in patients who have unilateral or bilateral middle ear effusion at the time of assessment for tube candidacy, or
B) patients with complicating conditions (immunocompromised host, meningitis by lumbar puncture, acute mastoiditis, sigmoid sinus/jugular vein thrombosis by CT/MRI/MRA, cranial

nerve paralysis, sudden onset dizziness/vertigo, need for middle ear culture, labyrinthitis, or brain abscess).

Patients with craniofacial anomalies, Down's syndrome, cleft palate, permanent hearing loss of 25dB or greater independent of otitis media with effusion, and patients with speech and language delay may be considered for tympanostomy if unresponsive to appropriate medical treatment or having recurring infections (without needing to meet the strict "recurrent" definition above).

Removal of retained tympanostomy tubes requiring anesthesia (CPT code 69424) or as an office visit, is included on Line 422 as a complication, pairing with ICD-10-CM H74.8.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 36, ADENOTONSILLECTOMY FOR INDICATIONS OTHER THAN OBSTRUCTIVE SLEEP APNEA

Lines 42,47,368,548

Tonsillectomy/adenotonsillectomy is an appropriate treatment for patients with:

A) ~~Five~~ Seven or more documented attacks of strep tonsillitis in a year or ~~3~~ 5 or more documented attacks of strep tonsillitis in each of two consecutive years or 3 or more documented attacks of strep tonsillitis per year in each of the three consecutive years where an attack is considered a positive culture/screen and where an appropriate course of antibiotic therapy has been completed; or

B) ~~Peritonsillar abscess requiring surgical drainage~~ A history of two or more peritonsillar abscesses OR when general anesthesia is required for the surgical drainage of a peritonsillar abscess and tonsillectomy is performed at the time of the surgical drainage; or,

C) Unilateral tonsillar hypertrophy in adults; unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy.

ICD-10-CM J35.1 and J35.3 are included on Line 368 only for 1) unilateral tonsillar hypertrophy in adults and 2) unilateral tonsillar hypertrophy in children with other symptoms suggestive of malignancy. Bilateral tonsillar hypertrophy and unilateral tonsillar hypertrophy in children without other symptoms suggestive of malignancy are included only on Line 548.

See Guideline Note 118 for diagnosis and treatment of obstructive sleep apnea in children.

GUIDELINE NOTE 44, MENSTRUAL BLEEDING DISORDERS

Line 420

Endometrial ablation or hysterectomy for abnormal uterine bleeding in premenopausal women may be indicated when all of the following are documented (A-C):

A) Patient history of (1, 2, 3, 4, and 5):
   1) Excessive uterine bleeding evidence by (a, b and c):

a) Profuse bleeding lasting more than 7 days or repetitive periods at less than 21-day intervals
b) Anemia due to acute or chronic blood loss (hemoglobin less than 10 or hemoglobin less than 11 g/dL if use of iron is documented) for hysterectomy. No documented hemoglobin level is required for endometrial ablation procedures.
c) Bleeding causes major impairment or interferes with quality of life

2) Failure of hormonal treatment for a six-month trial period or contraindication to hormone use (oral contraceptive pills or patches, progesterone-containing IUDs, injectable hormone therapy, or similar)
3) No current medication use that may cause bleeding, or contraindication to stopping those medications
4) Endometrial sampling performed
5) For hysterectomy, no evidence of treatable intrauterine conditions or lesions by (a, b or c):
   a) Sonohysterography
   b) Hysteroscopy
   c) Hysterosalpingography

   For endometrial ablation, a pre-operative ultrasound should be performed

B) Negative preoperative pregnancy test result unless patient has been previously sterilized
C) Nonmalignant cervical cytology, if cervix is present

~~**GUIDELINE NOTE 76, DIAGNOSTIC TESTING FOR LIVER FIBROSIS TO GUIDE TREATMENT OF HEPATITIS C IN NON-CIRRHOTIC PATIENTS**~~

~~*Line 199*~~

~~Given that a fibrosis score of ≥F2 is the threshold for antiviral treatment of Hepatitis C, the following are included on this line:~~

~~Imaging tests:~~

- ~~Transient elastography (FibroScan®)~~
- ~~Acoustic radiation force impulse imaging (ARFI) (Virtual Touch™ tissue quantification, ElastPQ)~~
- ~~Shear wave elastography (SWE) (Aixplorer®)~~

~~Blood tests (only if imaging tests are unavailable):~~

- ~~Enhanced Liver Fibrosis (ELF™)~~
- ~~Fibrometer™~~
- ~~FIBROSpect® II~~
- ~~FibroSure® (FibroTest®) or ActiTest®~~

~~If a fibrosis score of ≥F3 is the threshold for antiviral treatment of Hepatitis C, one or more of the following are included on this line:~~

~~Imaging tests:~~

- ~~Transient elastography (FibroScan®)~~
- ~~Acoustic radiation force impulse imaging (ARFI)~~
- ~~Shear wave elastography (SWE)~~

~~Magnetic resonance elastography is included on this line for ≥F2 or ≥F3 only when at least one imaging test (FibroScan, ARFI, and SWE) has resulted in indeterminant results, a second one is similarly indeterminant, contraindicated or unavailable, and MRE is readily available.~~

~~The following tests are not included on this line (or any other line):~~

- ~~Real time tissue elastography~~
- ~~Hepascore (FibroScore)~~

~~Noninvasive tests are covered no more often than once per year.~~

~~The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.~~

GUIDELINE NOTE 76, DIAGNOSTIC TESTING FOR LIVER FIBROSIS TO GUIDE MANAGEMENT IN CHRONIC LIVER DISEASE

Line 199

The following tests are included on this line because of their ability to effectively distinguish F4 from lower levels of fibrosis:

Non-proprietary blood tests such as:

- Platelet count
- Hyaluronic acid
- Age-platelet index
- AST-platelet ratio
- FIB-4
- FibroIndex
- Forns index
- GUCI
- Lok index

Imaging tests:

- Transient elastography (FibroScan®)
- Acoustic radiation force impulse imaging (ARFI) (Virtual Touch™ tissue quantification, ElastPQ)
- Shear wave elastography (SWE) (Aixplorer®)

The following tests are not included on this line (or any other line):

- Real time tissue elastography
- Proprietary blood tests (such as):
  - EL

- Fibrometer
- FibroTest
- Hepascore
- FIBROSpect II

Noninvasive tests for liver fibrosis are only indicated for initial assessment or when monitoring progression from F3 to F4, no more than annually.
Magnetic resonance elastography is included on this line for patients when ALL of the following apply:

- In whom at least one imaging test (FibroScan, ARFI, and SWE) has resulted in indeterminant results, a second one is similarly indeterminant, contraindicated or unavailable
- The patient is suspected to have aggressive disease/advanced fibrosis (e.g. in NAFLD based on older age, diabetes, obesity, high FIB-4, or APRI)
- Cirrhosis is not identified on routine imaging (ultrasound, CT)
- A liver biopsy would otherwise be indicated, but MRE would be an appropriate alternative

Repeat MR elastography is not indicated.

GUIDELINE NOTE 104, ~~VISCOSUPPLEMENTATION~~ NEWER INTERVENTIONS FOR OSTEOARTHRITIS OF THE KNEE

Lines 430,461

The following treatments are not included on this line for osteoarthritis of the knee:

- Whole body vibration
- Glucosamine/chondroitin (alone, or in combination)
- Platelet rich plasma
- Viscosupplementation
- Transcutaneous electrical stimulation (TENS)

CPT 20610 and 20611 are included on these lines only for interventions other than viscosupplementation for osteoarthritis of the knee.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

GUIDELINE NOTE 172, INTERVENTIONS WITH MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS FOR CERTAIN CONDITIONS

Line 500

The following interventions are prioritized on Line 500 CONDITIONS FOR WHICH INTERVENTIONS RESULT IN MARGINAL CLINICAL BENEFIT OR LOW COST-EFFECTIVENESS:

Procedure Code	Intervention Description	Rationale	Last Review
~~95250-95251~~	~~Retrospective (professional) continuous glucose monitoring~~	~~Limited evidence of clinical utility~~	~~August, 2017~~

GUIDELINE NOTE 173, INTERVENTIONS THAT ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS

Line 660

The following Interventions are prioritized on Line 660 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS:

Procedure Code	Intervention Description	Rationale	Last Review
~~64568~~	~~Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator for hypoglossal nerve stimulation for treatment of obstructive sleep apnea~~	~~Insufficient evidence of effectiveness and evidence of harm~~	~~May, 2018~~
~~79445~~ ~~C2616~~ ~~S2095~~	~~Radiopharmaceutical therapy, by intra-arterial particulate administration for use in treating cancers other than primary hepatocellular carcinoma or colorectal cancer metastatic to the liver~~ ~~Brachytherapy source, non-stranded, yttrium-90, per source in treating cancers other than primary hepatocellular carcinoma or colorectal cancer metastatic to the liver.~~ ~~Transcatheter occlusion or embolization for tumor destruction, percutaneous, any method, using yttrium-90~~	~~No evidence of effectiveness~~	~~March, 2018~~

	~~microspheres, in treating cancers other than primary hepatocellular carcinoma or colorectal cancer metastatic to the liver~~		
81232~~, 81246~~	5-fluorouracil/5-FU and capecitabine drug metabolism	Insufficient evidence of effectiveness	November, 2017
~~90869~~	~~Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment~~	~~No evidence of effectiveness~~	~~December, 2012~~
~~95012~~	~~Nitric oxide expired gas determination~~		~~August 2015~~

GUIDELINE NOTE XXX, PULMONARY REHABILITATION

Lines 9,58,223,234,241,283

Pulmonary rehabilitation is included on these lines only for patients with all of the following (1-4):

1) Moderate to severe chronic pulmonary disease with dyspnea with exertion that reduces their ability to perform activities of daily living despite appropriate medical management
2) Moderate to severe pulmonary disability defined as either
    a. A maximal pulmonary exercise stress test under optimal bronchodilatory treatment which demonstrates a respiratory limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20 ml/kg/min, or about 5 metabolic equivalents (METS); *or*
    b. Pulmonary function tests showing that either the forced expiratory volume in one second (FEV1), forced vital capacity (FVC), FEV1/FVC ratio, or diffusion capacity for carbon monoxide (DlCO) is less than 60 % of that predicted
3) Physically able, motivated and willing to participate in the pulmonary rehabilitation program and be a candidate for self-care post program
4) No contraindications to pulmonary rehabilitation, including unstable cardiac disease, locomotor or neurological difficulties precluding exercise, significant cognitive or psychiatric impairment, or housebound due to the severity of disease.

Pulmonary rehabilitation is only covered for:

1) A multidisciplinary program with includes supervised exercise therapy, patient education, and smoking cessation (if applicable).
2) Up to 36 total sessions.

Repeat pulmonary rehabilitation programs should be limited to those patients who have had a subsequent lung reduction surgery or lung transplantation.

GUIDELINE NOTE XXX, EMBOLIZATION OF ARTERIAL MALFORMATIONS

Line 305

Vascular embolization or occlusion of arterial or arteriovenous malformations is included on this line only for Schobinger Class 3 or 4 lesions.

GUIDELINE NOTE XXX, SCREENING FOR OPHTHALMOLOGIC COMPLICATIONS OF HIGH-RISK MEDICATIONS

Lines 360, 632

ICD-10 H36 (Retinal disorders in diseases classified elsewhere) and/or Z79.899 (Other long term (current) drug therapy) are included on Line 360 only for ophthalmologic examinations and testing to screen for complications of high-risk medications. ICD-10 H36 is included on Line 632 for all other indications.

GUIDELINE NOTE XXX, SHOULDER DECOMPRESSION SURGERY

Lines 356,417,441

CPT 29826 is only included on these lines as a component of rotator cuff repair surgery. CPT 29826 is not included on this line for pairing with shoulder impingement syndrome or adhesive capsulitis of shoulder.

MINUTES

HEALTH EVIDENCE REVIEW COMMISSION
Human Services Building
500 Summer Street NE, Rooms 137A-D
Salem, Oregon
March 14, 2019

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, Vice-Chair; Mark Gibson; Leda Garside, RN, MBA; Angela Senders, ND (by phone); Gary Allen, DMD; Lynnea Lindsey, PhD; Leslie Sutton (by phone); Adriane Irwin, PharmD; Michael Adler, MD (arrived at 1:45 pm); Kevin Cuccaro, DO (by phone).

Members Absent: Devan Kansagara, MD

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

Also Attending: Dana Hargunani, MD, Renae Wentz, MD, MPH, and Trilby de Jung (Oregon Health Authority); Adam Obley, MD, MPH and Craig Mosbaek (OHSU Center for Evidence-based Policy); Shelley Latin (by phone for testimony); Andrea Middleton, Kelsey Johnson, Xiynan Pang, Samantha Hendrickson, Kim Castro, Stacey McGarr, Alyssa Jacobs and Anna Avgi (OHSU); Laura Jeffcoat (Abbvie); Cherry Amabisca; Joseph Gramer; Sarah Rohrs, Allen Amabisca; Allan Chino, PhD; Kathy Spain; Amara M and Wendy Sinclair (Oregon Pain Action Group, Alliance for the Treatment of Intractable Pain); Sandy Anderson; Richard Ashby; Carissa Lungo; Ginevra Lipton and Jordan Swearingen (Frida LLC); Steven Hicks.

Call to Order

Kevin Olson, Chair of the Health Evidence Review Commission (HERC), called the meeting to order; roll was called.

Minutes Approval

MOTION: To approve the minutes of the 1/17/2019 meeting as presented. CARRIES 10-0. *(Absent: Adler)*

Director's Report

Coffman announced that Devan Kansagara has been re-appointed through February 2022.

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

Reprioritization of Certain Chronic Pain Conditions
Meeting materials, pages 162-221

Dr. Dana Hargunani, Oregon Health Authority's (OHA's) Chief Medical Officer, addressed the Commission about a change in the agenda. The previously announced reprioritization of certain chronic pain conditions will not be discussed. She said OHA leadership regard integrity and transparency as core values. OHA leadership recently learned that the contracted medical consultant to HERC, Dr. Livingston, may have a potential conflict of interest as she is a paid co-investigator for two ongoing research studies. The two studies Dr. Livingston is involved in are evaluating the work that HERC did previously around back pain. These include a Patient-Centered Outcomes Research Institute (PCORI) study and a study funded by the National Institute for Drug Abuse. Based on this information, OHA leadership requested VbBS table the chronic pain topic discussion and any deliberations at this morning's meeting. While the topic is tabled, OHA leadership will take the time to seek independent review of the policy recommendations presented to ensure that there was no impact of a potential conflict of interest. Dr. Livingston will be submitting a written disclosure to OHA and HERC of her relationship to the studies. In addition, Hargunani will complete a top-to-bottom review of conflict of interest processes as it relates to staff, consultants and members of HERC to ensure this does not happen in the future. Hargunani apologized for the delay and said she intends for VbBS and HERC to convene before the next scheduled May meeting to move this discussion forward for the biennial review of the Prioritized List.

Olson said April 25th might be a potential meeting date to meet before May, if a quorum can be met. Staff will be in touch in the coming days. Olson urged the public in attendance and on the phone to sign up for Gov-delivery on HERC's website to be electronically notified when the next meeting is scheduled.

Though the Commission did not discuss the chronic pain topic, public comment was accepted.

Public comments:

Sarah Rohrs declared no conflicts of interest. She testified about her husband's intractable pain and the forced-taper he is currently undergoing. She talked about illicit drug overdoses and how tapering chronic pain patients does not affect that statistic.

Shelley Latin, an attorney from Pendleton, Oregon, testified. She declared no conflicts of interest. She said that forced taper decisions should remain in the hands of doctors and never legislated by regulation. She said the composition of the Chronic Pain Task Force was biased towards wanting to reach a particular outcome, ignoring the mountain of public testimony, including Dr. Beth Darnall's offer of her Empower study. She said the issue is too important to wait another two years. She said there is no reason to limit opioid prescriptions while adding alternative services.

Cherry Amabisca declared no conflicts of interest. She said over the last 15 years she has taken care of five friends and family members who have complex medical conditions who are also on opioids. She questioned the task force's use of evidence when recommending a force-taper to zero. She said there is no evidence that any of the 154 Oregonians who died of prescription opioid overdoses in 2017 included any Medicaid patients, nor evidence that alternative treatments work. She said you will do harm to chronic pain patients who also have anxiety if you force them to choose between their pain medications and benzodiazepines.

Amara M. declared no conflicts of interest. She said she is the co-founder of the Oregon Pain Action Group and Alliance for the Treatment of Intractable Pain. She testified about being abandoned as a pain patient and her experience with Guideline Note 60 implementation. She expressed her frustration with the Back Lines Reconfiguration Task Force process.

Allan Chino, PhD, a clinical psychologist who served two terms on the Oregon Pain Management Commission, is past-president of the American Academy of Clinical Psychology and former-director of the Psychological Association, declared no conflicts of interest. He urged the Commission to reject mandatory forced-tapers and to embrace individual, patient-centered treatment plans. He further urged the members to read Dr. Sean Mackey's submitted testimony letter.

Joseph Gramer, a Salem resident and disabled chronic pain person, declared no conflicts of interest. He said his quality of life is now compromised by a forced taper of pain medicine that was already within the CDC dosage guidelines and that had been effective for years.

Wendy Sinclair, founder of the Oregon Pain Action Group and works with the Alliance for the Treatment of Intractable Pain. She commented about the back and neck guideline note stated that when it was passed the public was not given an opportunity to comment or research the evidence. She testified about her personal experience with chronic pain and opioid medication. Sinclair said she submitted the full version of Sean Mackey's letter to the Commission today.

Note: Coffman clarified that all of the meetings prior to the decisions on the back and neck guideline were open to the public, as are all of the Commission's meetings.

Sandy Anderson, a State of Oregon employee, declared no conflicts of interest. She said she has been a chronic pain patient for the last 25 years and receives benefit from opioid medication, well under the CDC MME suggested guideline. She said she thinks ending opioid coverage would put many more people on disability or cause suicides.

Richard Ashby, a chronic pain patient who declared no conflicts of interest. He is on a forced-taper. He stated he has tried all the alternative treatment his insurance will pay for to no effect. He said people are talking about getting street drugs and committing suicide.

Ginevra Lipton, MD, medical director of the Frida Center in Portland, specializes in treating fibromyalgia. She is a fibromyalgia patient herself and declared no conflicts of interest. She applauded the Commission's efforts to make fibromyalgia a covered service along with expanding access to alternative and complementary care. She said she agrees that opioids are imperfect tools to manage chronic pain but until we have better tools, imperfect tools are better than nothing. She also expressed concern with the number of alternative and complementary care providers who will accept OHP.

Steven Hicks, an Oregon resident, declared no conflicts of interest. He said he is evidence of how the opioid epidemic has greatly diminished his life and the life of his family. Since he has been force-tapered off opioids, his family's responsibilities to care for him have greatly increased. He expressed how difficult it is to be completely dependent on others for his care. He said he is here representing others who are too hurt to come to the meeting.

Olson said the testimony has influenced the work of the subcommittee and assured the audience members that their voices are being heard.

Ariel Smits reported the VbBS met earlier in the day, 3/14/2019, and on 1/17/2019. She summarized the subcommittee's recommendations for both meetings.

Recommendations from 1/17/2019:
Meeting materials, pages 42-106

RECOMMENDED CODE MOVEMENT (effective 10/1/2019)
- Add the diagnosis code for failure to thrive in children to a covered line
- Delete the procedure codes for procalcitonin and fecal calprotectin testing from an uncovered line and suggest for addition to the Diagnostic Procedures File
- Make various straightforward coding changes
- Add the Diabetes Prevention Program (DPP) codes to the obesity line

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2019)
- Make various straightforward guideline note changes
- Modify the guideline on human donor breast milk for high-risk infants
- Modify the DPP guideline and overweight and obesity guideline to enable coverage of the DPP program for obesity, along with other various straightforward changes

BIENNIAL REVIEW CHANGES (effective 1/1/2020)
- Create a new line above the funding line for hidradenitis suppurativa with a new guideline
- Create a new line above the funding line for minimally invasive surgery for sacroiliac joint dysfunction

Recommendations from 3/14/2019:
Meeting materials, page 107-161

RECOMMENDED CODE MOVEMENT (effective 10/1/2019)
- Add the diagnosis code for posterior urethral valves to a covered line and leave on two other covered lines
- Add procedure codes for treatment of arteriovenous malformations to a covered line
- Add two diagnosis codes to a covered line with a guideline specifying they are to be used for screening for ophthalmologic complications of high-risk medications
- Make various straightforward coding changes

RECOMMENDED GUIDELINE CHANGES (effective 10/1/2019)
- Adopt a new guideline regarding pulmonary rehabilitation services
- Edit the guideline for menstrual bleeding disorders to exempt endometrial ablation from the requirement to demonstrate a hemoglobin level of less than 11, and to require only a pelvic ultrasound prior to that procedure
- Edit two guidelines regarding breast imaging to refer to each other to increase clarity
- Edit the tonsillectomy guideline to reflect updated national expert guidelines
- Add a new guideline regarding when treatment of arteriovenous malformations are covered
- Add a new guideline specifying that shoulder decompression surgery was only covered when used as part of rotator cuff repair
- Make several guideline changes to the guidelines for lines 500 and 660 to help clarify HERC intent
- Make various straightforward guideline note changes

MOTION: To accept the VbBS recommendations of 1/17/2019 on *Prioritized List changes* not related to coverage guidances, as stated. See the VbBS minutes of 1/17/2019 for a full description. Carries: 11-0.

MOTION: To accept the VbBS recommendations of 3/14/2019 on *Prioritized List changes* not related to coverage guidances, as stated. See the VbBS minutes of 3/14/2019 for a full description. Carries: 11-0.

Coverage Guidance Topic: Newer Interventions for Osteoarthritis of the Knee

Meeting materials, pages 223-309

Obley presented an overview of the evidence. Livingston then read through the remainder of the GRADE Table (page 271) as well as the proposed coverage guidance from the Evidence-based Guidelines Subcommittee (EbGS).

There was minimal discussion.

MOTION: To approve the proposed coverage guidance for Newer Interventions for Osteoarthritis of the Knee as presented. Carries 11-0.

Approved Coverage Guidance:

HERC Coverage Guidance

Whole body vibration

Whole body vibration is not recommended for coverage (*strong recommendation*).

TENS

TENS is not recommended for coverage (*strong recommendation*).

Glucosamine-chondroitin

Glucosamine-chondroitin is not recommended for coverage (*weak recommendation*).

Glucosamine alone is not recommended for coverage (*strong recommendation*).

Chondroitin alone is not recommended for coverage (*weak recommendation*).

Platelet-rich plasma

Platelet-rich plasma is not recommended for coverage (*weak recommendation*)

MOTION: To approve the proposed guideline and coding change for the Prioritized List as proposed. Carries 11-0.

Changes for the Prioritized List of Health Services:

1) Accept Guideline Note 104 as follows:

GUIDELINE NOTE 104, NEWER INTERVENTIONS FOR OSTEOARTHRITIS OF THE KNEE

Lines 430,461

The following treatments are not included on this line for osteoarthritis of the knee:

- Whole body vibration
- Glucosamine/chondroitin (alone, or in combination)
- Platelet rich plasma
- Viscosupplementation
- Transcutaneous electrical stimulation (TENS)

CPT 20610 and 20611 are included on these lines only for interventions other than viscosupplementation for osteoarthritis of the knee.

The development of this guideline note was informed by a HERC coverage guidance. See https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Evidence-based-Reports.aspx.

2) Advise HSD to move HCPCS code A9270 (Non-covered item or service) from the Ancillary File to the Excluded File

Member Discussion

Members discussed the public comments received during the meeting. There was a consensus that it is difficult to remain neutral hearing such passionate and oftentimes misplaced anger. Many, if not most of those providing comment have conditions for which opioids should be and are covered by the Prioritized List and may be seeing impacts from broader efforts to reduce opioid prescribing that have nothing to do with Guideline Note 60. The PowerPoint which was included in the packet that was not able to be discussed attempts to clarify the proposal, which as it stands now would expand opioid coverage for currently nonfunded conditions. Staff will work with OHA communications to try to explain this more clearly.

Others discussed that it is tricky to know when a potential conflict of interest or bias might exist. Hargunani clarified there are clear state policies and agency policies about conflicts of interest and when they must be disclosed if related to a financial conflict and staff can make sure that training is provided on that issue. She wanted to make it clear that the issues that were brought forward today did not have anything to do with bias.

Public Comment

There was no other public comment at this time.

Adjournment

The meeting adjourned at 4:00 pm. The next meeting is scheduled for 1:30-4:30 pm on Thursday, May 16, 2019 at Clackamas Community College Wilsonville Training Center, Rooms 111-112, Wilsonville, Oregon but members will be polled to confirm availability for a possible meeting in late April. Public notice will be provided as soon as possible if a meeting is to be held sooner.

March 24, 2019

Contacts: Allyson Hagen, 503-449-6457, allyson.hagen@state.or.us (media inquiries)
Daphne Peck, 503-373-1985, herc.info@state.or.us (meeting information or accommodation)

HERC's Health Technology Assessment Subcommittee meets April 18 in Wilsonville

What: A public meeting of the Health Evidence Review Commission's Health Technology Assessment Subcommittee

When: Thursday, April 18**,** 1-2 p.m.

Where: Five Oak Building – OEI conference Room 7th Floor | 421 SW Oak, Portland OR 97204. The public also may attend via a listen-only conference line (888-204-5984, participant code 801373).
Webinar Registration Link:
https://attendee.gotowebinar.com/rt/5185517132218583299

Agenda includes: Review of public comment on Extended Stay Centers: Patient characteristics and appropriate procedures

For more information about the meeting, visit the committee's website at https://www.oregon.gov/oha/HPA/DSI-HERC/Pages/Meetings-Public.aspx. The meeting agenda and materials will be available one week before the meeting.

# # #

Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are:

- Sign language and spoken language interpreters
- Written materials in other languages

- Braille
- Large print
- Audio and other formats

If you need help or have questions, please contact Daphne Peck at 503-373-1985, 711 TTY or herc.info@state.or.us at least 48 hours before the event. Written comments are also welcome at herc.info@state.or.us.

Health Evidence Review Commission (HERC)

Coverage Guidance: Newer Interventions for Osteoarthritis of the Knee

Approved 3/14/2019

HERC Coverage Guidance

Whole body vibration

Whole body vibration is not recommended for coverage (*strong recommendation*).

TENS

TENS is not recommended for coverage (*strong recommendation*).

Glucosamine-chondroitin

Glucosamine-chondroitin is not recommended for coverage (*weak recommendation*).

Glucosamine alone is not recommended for coverage (*strong recommendation*).

Chondroitin alone is not recommended for coverage (*weak recommendation*).

Platelet-rich plasma

Platelet-rich plasma is not recommended for coverage (*weak recommendation*)

Note: Definitions for strength of recommendation are in Appendix A. *GRADE Table Element Descriptions*.

Rationales for each recommendation appear below in the GRADE table.

GRADE Table

Should whole body vibration be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	Insufficient evidence	The machines for home use range from $100 to $250 to thousands of dollars. Clinic-based treatments would be low to moderate expense depending on what is charged and the frequency of treatments.	Patients would likely prefer noninvasive interventions. Whole body vibration appears to be popular based on its widespread availability for home purchase, but the physical experience of doing this intervention might not be universally appealing (e.g., for older adults who are unsteady on their feet). We would expect moderate variability in values and preferences.	The improvement in intermediate-term function did not meet the threshold of minimal clinically important difference.
Long-term function *(Critical outcome)*	Insufficient evidence			
Intermediate-term pain *(Important outcome)*	No significant difference between exercise programs with whole body vibration and exercise and strength-training programs alone SMD -0.20 (95% CI -1.12 to 0.71) ●●○○ *(Low confidence, based on 4 RCTs, n = 180)*			
Intermediate-term function *(Important outcome)*	Improved in exercise programs with whole body vibration compared to exercise and strength-training programs alone SMD -0.26 (95% CI -0.45 to -0.06) ●●○○ *(Low confidence, based on 4 RCTs, n = 180)*			
Harms *(Important outcome)*	Adverse events were rare and did not differ significantly between active and control groups ●●○○ *(Low confidence, based on 4 studies, n = 180)*			

Balance of benefits and harms: We have low confidence that whole body vibration improves intermediate-term function but not to a clinically significant degree, and it is similar to exercise and strength-training programs in terms of pain. There appear to be few adverse events.
Rationale: We recommend against coverage because of the low evidence for a lack of clinically significant improvement in outcomes, moderate cost, and moderate variability in values and preferences. It is a strong recommendation because there is no evidence of clinically significant improvement, and there are alternative treatments for this condition. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.

Recommendation: Whole body vibration is not recommended for coverage (*strong recommendation*).

Should transcutaneous electrical nerve stimulation (TENS) be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	Insufficient evidence	TENS is generally an inexpensive intervention (although very expensive models are available). If it were effective, its low price would make it very appealing.	Patients would prefer simple, inexpensive, noninvasive treatments for knee osteoarthritis that improve pain and function. Some patients have preferences for or against nonallopathic treatments, which leads to moderate variability in values and preferences.	
Long-term function *(Critical outcome)*	Insufficient evidence			
Intermediate-term pain *(Important outcome)*	No significant difference between TENS and sham control Pooled estimates not provided ●●○○ *(Low confidence, based on 2 RCTs, n = 650)*			
Intermediate-term function *(Important outcome)*	No significant difference between TENS and sham control Pooled estimates not provided ●●○○ *(Low confidence, based on 2 RCTs, n = 650)*			
Harms *(Important outcome)*	Adverse events were rare and did not differ significantly between active and sham control groups ●●○○ *(Low confidence, based on 2 studies, n = 650*			

Balance of benefits and harms: We have low confidence that TENS appears to have no benefits in terms of intermediate-term pain and function, has no harms, and insufficient evidence for long-term outcomes.

Rationale: Given that there is evidence that TENS is ineffective, even though it is inexpensive and patients may be willing to try it, coverage is not recommended. It is a strong recommendation because available evidence supports inefficacy rather than clinical benefit. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.

Recommendation: TENS is not recommended for coverage for osteoarthritis of the knee (*strong recommendation*).

Should glucosamine-chondroitin be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	No significant difference between glucosamine-chondroitin and placebo control SMD -0.73 (95% CI -4.03 to 2.57) ●●●○ *(Moderate confidence, based on 3 RCTs, n = 466)*	Glucosamine-chondroitin is an inexpensive daily supplement. Its low cost would increase its favorability.	Patients would prefer simple, inexpensive, noninvasive treatments for knee osteoarthritis that improve pain and function. A daily supplement would likely be acceptable to many patients, so we would expect low variability of values and preferences.	A separate systematic review with serious limitations raised questions about whether the individual components were more effective than the combination. Individual patient data meta-analysis showed that glucosamine alone has no effect. Because this is an over-the-counter supplement, product quality may vary significantly.
Long-term function *(Critical outcome)*	No significant difference between glucosamine-chondroitin and placebo control SMD -0.45 (95% CI -2.75 to 1.84) ●●●○ *(Moderate confidence, based on 3 RCTs, n = 466)*			
Intermediate-term pain *(Important outcome)*	Improved with glucosamine-chondroitin compared to placebo control Pooled estimates not provided ●●○○ *(Low confidence, based on 3 RCTs, n = 881)*			
Intermediate-term function *(Important outcome)*	Improved with glucosamine-chondroitin compared to placebo control Pooled estimates not provided ●●○○ *(Low confidence, based on 3 RCTs, n = 881)*			
Harms *(Important outcome)*	Adverse effects were rare and did not differ significantly between active and control groups ●●●○ *(Moderate confidence, based on 6 studies, n = 4,195)*			

Balance of benefits and harms: We have moderate confidence that glucosamine-chondroitin has no effect on long-term pain or function, but have low confidence that it improves intermediate-term pain and function (although the estimates include mixed effect sizes with regards to clinical significance). There appear to be no harms.

Rationale: We recommend against coverage because of moderate-quality evidence of no benefit in long-term pain and function, and it is unclear that the intermediate-term benefit is clinically significant given the mixed effect sizes. The low cost and low variability in patient preferences temper the recommendation against, and the combination of these factors and the possible clinically significant intermediate effect lead to a weak recommendation against coverage. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.
Recommendation: Glucosamine-chondroitin is not recommended for coverage (*weak recommendation*).

Should glucosamine alone be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	No significant difference between glucosamine and placebo control SMD -0.05 (95% CI -0.22 to 0.12) ●●●○ *(Moderate confidence, based on 3 RCTs, n = 1,007)*	Glucosamine alone is a very inexpensive daily supplement. Its low cost would increase its favorability.	Patients would prefer simple, inexpensive, noninvasive treatments for knee osteoarthritis that improve pain and function. A daily supplement would likely be acceptable to many patients, so we would expect low variability of values and preferences.	Because this is an over-the-counter supplement, product quality may vary significantly.
Long-term function *(Critical outcome)*	No significant difference between glucosamine and placebo control Pooled estimates not provided ●●○○ *(Low confidence, based on 3 RCTs, n = 1,007)*			
Intermediate-term pain *(Important outcome)*	Insufficient evidence			
Intermediate-term function *(Important outcome)*	Insufficient evidence			
Harms *(Important outcome)*	Adverse effects were rare and did not differ significantly between active and placebo control groups ●●●○ *(Moderate confidence, based on 6 studies, n = 4,195)*			

Balance of benefits and harms: We have low to moderate confidence that glucosamine alone is ineffective for long-term pain and function; there is insufficient evidence for other outcomes. There appear to be no significant adverse effects.
Rationale: Despite patients' willingness to take a supplement and the supplement being low cost and not harmful, the available evidence suggests glucosamine alone is an ineffective intervention. Therefore, we make a strong recommendation against coverage. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.
Recommendation: Glucosamine alone is not recommended for coverage (*strong recommendation*).

Should chondroitin alone be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	No significant difference between chondroitin and control Pooled estimates not provided ●●●○ *(Moderate confidence, based on 3 RCTs, n = 1,889)*	Chondroitin alone is a very inexpensive daily supplement. Its low cost would increase its favorability.	Patients would prefer simple, inexpensive, noninvasive treatments for knee osteoarthritis that improve pain and function. A daily supplement would likely be acceptable to many patients, so we would expect low variability of values and preferences.	Because this is an over-the-counter supplement, product quality may vary significantly.
Long-term function *(Critical outcome)*	No significant difference between chondroitin and control Pooled estimates not provided ●●○○ *(Low confidence, based on 2 RCTs, n = 1,267)*			
Intermediate-term pain *(Important outcome)*	Improved with chondroitin compared to control Pooled estimates not provided ●●○○ *(Low confidence, based on 2 RCTs, n = 974)*			
Intermediate-term function *(Important outcome)*	Insufficient evidence			
Harms *(Important outcome)*	Adverse effects were rare and did not differ significantly between active and control groups ●●●○ *(Moderate confidence, based on 6 studies, n = 4,195)*			

Balance of benefits and harms: Chondroitin alone has no benefit for long-term pain or function, but we have low confidence that it improves intermediate-term pain. There do not appear to be significant adverse effects.
Rationale: This is a low-cost, apparently safe, and acceptable intervention that improves intermediate-term pain but has no long-term impact. There is less evidence to support it than glucosamine and chondroitin in combination. Therefore, we make a recommendation against coverage; it is a weak recommendation because further evidence could support intermediate-term improvements in pain and function. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.
Recommendation: Chondroitin alone is not recommended for coverage (*weak recommendation*).

Should platelet-rich plasma be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Long-term pain *(Critical outcome)*	Improved with platelet-rich plasma compared to control MD 6.0 on WOMAC pain score (95% CI not provided, p < 0.05) ●●○○ *(Low confidence, based on 1 RCT, n = 30)*	Platelet-rich plasma injections are relatively expensive, ranging from hundreds to thousands of dollars.	Patients would generally prefer noninvasive interventions. However, a single minimally invasive intervention would likely be appealing if it offered long-term relief and had few risks. We would expect low variability in patient preferences.	The one study evaluating long-term pain and function was industry-funded but well designed.
Long-term function *(Critical outcome)*	Improved with platelet-rich plasma compared to control MD 24.0 on WOMAC function score (95% CI not provided, p < 0.05) ●●○○ *(Low confidence, based on 1 RCT, n = 30)*			
Intermediate-term pain *(Important outcome)*	Improved with platelet-rich plasma compared to controls Pooled estimates not provided ●●○○ *(Low confidence, based on 5 RCTs, n = 439)*			
Intermediate-term function *(Important outcome)*	Insufficient evidence			

Should platelet-rich plasma be recommended for coverage for osteoarthritis of the knee?

Outcomes	Estimate of Effect for Outcome/ *Confidence in Estimate*	Resource Allocation	Values and Preferences	Other Considerations
Harms *(Important outcome)*	Adverse events were rare and did not differ significantly between active and control groups ●●○○ *(Low confidence, based on 3 studies, n = 215)*			

Balance of benefits and harms: There is low confidence that platelet-rich plasma injections yield improvements in intermediate-term pain and long-term pain and function with no increased risk of adverse effects.
Rationale: We do not recommend coverage for platelet-rich plasma for osteoarthritis of the knee because the data supporting long-term efficacy are based on a single, small, industry-funded trial and there is low confidence in intermediate-term improvements on pain (however, this assessment appears to be based on studies with mixed results), and also moderate resource allocation. For such a common condition, which is relatively straightforward to research, further research is necessary to support use of platelet-rich plasma prior to covering it. The recommendation is weak because there would likely be low variability in patient values and preferences and further evidence could change the recommendation. Because of the prevalence of this condition and the ease of studying this intervention, we would require at least moderate-quality evidence of benefit in order to recommend coverage.
Recommendation: Platelet-rich plasma is not recommended for coverage (*weak recommendation*)

Note: GRADE table elements are described in Appendix A. A GRADE Evidence Profile is in Appendix B.

Coverage Guidance Topics

Health Technology Assessment Subcommittee:

4/18/2019 Extended Stay Centers Guideline

6/20/19 Spinal Cord Stimulators for Chronic Back Pain
New Topics

Evidence-based Guidelines Subcommittee

4/4/2019 Community Health Workers
Planned Out-of-Hospital Birth
Temporary Percutaneous Mechanical Circulatory Support with Impella Devices

6/6/19 Planned Out-of-Hospital Birth
Multisector Interventions to Reduce the Frequency of Asthma Exacerbations
New topics

Statewide CCO Learning Collaborative Agenda: Viral Hepatitis C in Oregon

Quality and Health Outcomes Committee Meeting
Barbara Roberts Human Services Building
500 Summer Street NE, Salem, OR 97301, Room 137 A-D
April 8, 2019, 11:00 a.m. – 12:30 p.m.

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

Viral Hepatitis C in Oregon
Session Goals: Share examples of best practices of caring for the needs of individuals with Viral Hepatitis C (HCV) from clinics and providers across the state, with a focus on known barriers to treating HCV in Oregon.

1. **Opening reflection** (Dana Hargunani, Chief Medical Officer, OHA) (5 minutes)

2. **The scope and disease burden of HCV in OR** (Ann Thomas, Public Health Physician, OHA) (10 minutes)

3. **Break out to small groups for focused discussions** (15 minutes each; total of 45 minutes)
    a. Provider Education and Resources for Implementing HCV treatment in Oregon (Dayna Morrison)
    b. Treatment of Hepatitis C: Best Practices to Streamline Therapy (Kent Benner)
    c. Expanding the Hepatitis C Prescriber Network and Number of Members treated for HCV (Lauren Myers)
    d. Patient Treatability: Providing Low Barrier Treatment for Complex Patients (Lisa Nelson and Martyna Witkowska)
    e. Harm Reduction Strategies: Case Management, Syringe Exchange and Peer Support Specialists (Renee Yandel and Robert Barnes)

4. **Strategies for communicating Oregon Health Plan (OHP) benefit coverage of HCV treatment to providers: Q&A** (Dana Hargunani and Trevor Douglass, Oregon Prescription Drug Program & Pharmacy Purchasing Director, OHA) (10 minutes)

5. **Next steps and wrap-up** (Trevor Douglass) (10 minutes)

Statewide CCO HCV Learning Collaborative: Subject Matter Expert Professional Biographies

Dayna K. Morrison is the program manager for the Oregon AIDS Education and Training Center (AETC) and brings 20 years of experience working with people living with HIV/AIDS in Oregon and abroad. She has coordinated the LGBTQ+ Health Coalition of the Columbia-Willamette since 2010. In this role she represented LGBTQ+ voices in Health Equity Workgroups through the Oregon Health Authority and served as a stakeholder advisor to Cover Oregon. Previous professional positions include Director of HIV Services at Quest Center for Integrative Health, and Program Coordinator for the CDC Global AIDS Program.

Kent Benner is a physician at The Oregon Clinic, Liver Clinic since 2001. He has been caring for patients with liver disease and specifically treating HCV patients since the late 1980's. He has been an advocate for expanding treatment for HCV patients on the Oregon Health Plan (OHP) since initial approval of interferon/ribavirin therapy.

Lauren Myers is a Physician Assistant in the Department of GI and Hepatology at Oregon Health and Science University, she directs the Hepatitis C treatment program at OHSU. Lauren has been primary faculty for the Hepatitis C and Liver Care ECHO through OHSU to educate community providers to treat Hepatitis C and help build community Hepatitis C treatment programs. She completed her PA training at Yale University in 2008 and has been practicing in both Liver Transplant and Hepatology.

Lisa Nelson has a Doctorate of Pharmacy from Oregon State University and a Bachelor in Chemistry and Biomedical from Southern Oregon University. She has been practicing pharmacy in various settings over the past 9 years. She worked for a year at the Veterans Affairs Medical Center in the inpatient and ambulatory care setting and split her time at OHSU working in drug information and policy for 2 years and rheumatology for 3 years. She is currently working at Central City Concern where she splits her time treating patients as the main Hepatitis C Clinical Pharmacist and supports the main pharmacy workflow the other half of her time.

Martyna Witkowska has a Master of Public Health from the University of Queensland in Brisbane and a Bachelor of Social Work from RMIT University, Melbourne, Australia. She has extensive experience in infectious disease risk reduction in People Who Inject Drugs, including as HIV/HCV prevention coordinator at the Cascade Aids Project, HIV Prevention Coordinator at Clackamas County, and Community Health Worker in Melbourne, Australia. She is currently the Coordinator of the HCV Treatment Program at Old Town Clinic, Central City Concern working with marginalized, low income communities.

Renee Yandel has been with HIV Alliance since joining as a volunteer in 1999. Prior to her appointment as Executive Director in 2015, Yandel worked with the agency as Program Director, Housing Coordinator, Client Services Director, and Case Manager. As Program Director, Yandel oversaw: 1) the development of an innovative dental program that now provides low-cost comprehensive dental services to people living with HIV/AIDS in twenty-one counties in Oregon, 2) a groundbreaking pharmaceutical program for people living with HIV/AIDS, and 3) a Hepatitis C prevention and care program in Lane County. In this position Yandel was also responsible for the education, prevention, and care programs which made up roughly 90% of the agency's revenue, staff and activities. Yandel has been with agency since it only served one county, and played a key role in expanding the agency's care coordination and nursing case management program for people living with HIV/AIDS to twelve additional counties in Oregon.

Robert Barnes is certified by the American Board of Internal Medicine as an Infectious Disease Specialist and with the American Board of Preventative Medicine in Hyperbaric Medicine. Prior to his recent retirement, Dr. Barnes was a PeaceHealth provider in the Division of Infectious Disease and Hyperbaric Medicine for 10 years. Previously, he served as the Medical Director for Virginia Mason Health Systems Employee Occupational Health, the Director for the Clinical Research Department and an Infectious Disease Specialist at Madrona Medical Group in Washington State. Among other positions, Dr. Barnes served on the Board of Directors as the Medical Director for AID Atlanta and was in the US Public Health Service and US Navy Reserve. Dr. Barnes joined HIV Alliance as its Medical Director in 2019.

VERSION 1.0

FEBRUARY 22, 2019

CCO Challenges and Barriers to Connecting Clients with Viral Hepatitis C to Care: Survey Results

IN RESPONSE TO JAN. 9, 2019 REQUEST

CCO CHALLENGES AND BARRIERS TO CONNECTING CLIENTS WITH VIRAL HEPATITIS C TO CARE: SURVEY RESULTS

OHA and OLC last met January 9, 2019. OLC representatives asked OHA to survey CCOs to better understand the barriers and challenges they face in connecting eligible clients with Hepatitis C to care. OHA conducted an informal survey of CCOs, and all 15 CCOs responded. Below are the responses, organized by category, followed by next steps in response to these findings.

SURVEY RESPONSES

A. CRITERIA CHANGES AND DOCUMENTATION:

1. As criteria changes, it allows for a larger population of patients to receive treatment, which results in a larger expenditure financially and additional workload for our reviewers.
2. As new criteria are developed by OHA, it takes time to move through the criteria updating process.

B. MESSAGING AND EXPANDING PRESCRIBER NETWORK:

1. At the beginning of 2018 we had challenges communicating new criteria with providers that prescribe Hep C treatment.
2. Increasing local PCP education and participation in treating patients with Hep C.
3. Limited number of providers who are well versed and comfortable in treatment protocol.
4. Not all patients who were eligible were receiving treatment due to providers' lack of knowledge around new criteria/state mandates. As providers have become more aware of the updated criteria, we have seen an increase in requests.
5. Providers do not always submit PA for a recommended treatment regimen as specified in criteria.
6. The primary care provider is unaware of prescribing/point of care specialist.
7. Providers often do not draw a week 24-viral load if previous draws showed an undetectable number.
8. Some local providers are reluctant to continue patient follow-up and case management past end of treatment (specifically 48-week labs). [commenter may have meant 24-week labs]

C. MESSAGING AND IDENTIFYING PATIENTS AND INITIATING TREATMENT:

1. Identifying members for treatment (lack of screening and/or members/providers requesting treatment).
2. Members not wanting treatment.

3. Members postponing treatment.

D. CARE MANAGEMENT:

1. Member ability to comply with treatment due to housing issues, communication, transportation needs, etc.
2. Members eligibility ending mid-treatment.
3. Members frequently avoid case management calls and do not return voicemails.
4. Members not keeping their scheduled appointments and getting their necessary follow-up viral loads drawn.
5. Reaching members when they do not update their demographics.
6. Reaching the member and enrolling them in case management in a timely manner. This can be challenging for members who are homeless, do not have a phone, or we do not have correct contact information for.
7. Submission of follow-up labs has been a challenge. Requires multiple outreach attempts by CCO.

E. OHA/CCO COMMUNICATION

1. Please provide a communication pathway for HCV programmatic changes or feedback. Specifically related to: clinical questions for criteria, HERC, or P & T; Risk Corridor questions about financials, non-clean claims; operational questions about case management, data elements.
2. The large and detailed nature of the required data elements do not allow for flexibility in accepting authorization requests. Can create delays in the process.
3. There is a disconnect between collecting case management information for reporting purpose and the information needed to make prior authorization coverage decision. It has added administrative burden for both providers and CCOs.

F. CCO SPECIFIC CHALLENGES AND MISC.

1. Consistent tracking of paid claims due to change in system within the past year.
2. The case management protocols do not take into account the varied time of each treatment.
3. Access to specific fibrosis staging tests is sometimes needed to determine the appropriate regimen, and these can be a challenge in some rural areas. This can lead to unnecessary drug costs if prescribers opt for a longer course than would have been chosen if more definitive stage and cirrhosis status were known.

4. Challenging to complete required steps within the 24-hour PA turnaround time. Ideally, CCOs could pend PA requests for a more reasonable time to allow time for coordination. This would decrease CCO denial rates.

G. CHALLENGES THAT SHOULD IMPROVE AFTER MARCH 1:

1. Coverage of Hep C DAA coverage for members with less than F2 fibrosis score and without additional conditions that may allow for coverage.
2. Prior authorization review of Hep C treatment using the most recent criteria for patients with suspected current or past substance use disorder. Can be difficult to determine coverage decision if provider does not clearly document if the member is currently enrolled in a treatment program.
3. PCPs not using the correct lab and fibrosis staging tests supported by the HERC and in the Hep C criteria.
4. Provider participation in lab results, tracking and full completion.
5. Providers do not always agree with what is needed for pre- and post-authorization. Can delay treatment if the information is part of criteria.
6. Required documentation not being submitted by the provider with prior authorization request.
7. Required lab tests and fibrosis staging not being submitted with prior authorization request. More of a challenge when PCP submitting request versus Specialist.
8. Risk Corridor: not all cases fit squarely into criteria. The challenges arise when the CCOs feel vulnerable to risk corridor payment when unique cases do not follow criteria exactly.

NEXT STEPS

1. **Learning Collaborative at April QHOC** to focus on best practices in expanding treatment access for HCV and overcoming barriers. Agenda still in development. OHA will share the final agenda with OLC once available.
2. **Continue collaboration with our Oregon Public Health Division** colleagues to expand provider networks, awareness, and capacity, particularly in rural areas.
3. **Communication strategy gearing up to March 1 expansion**, to include reaching out to Oregon Medical Association, Oregon Nurses Association, Oregon Chapter of the American College of Physicians, Oregon Academy of Family Physicians, and Oregon Society of Physician Assistants.
4. **HCV Project Echo.** OHA, OHSU and others will continue to explore potential funding sources. Approximately $100k is required to fund a 3rd cohort. If funding is found, the 3rd cohort could start in June and focus on concurrent SUD treatment and harm reduction approaches.

5. **CDAF/ASTHO 2019 Viral Hepatitis Disease Progression Modeling** is a grant-funded project to develop an HCV disease progression model that will support efforts to eliminate HCV in Oregon. The Oregon Public Health Division will lead, with participation and support from Health Policy and Analytics Division. [Launch March 2019]
6. **Oregon Hepatitis C Screening Initiative** within the Oregon Public Health Division works to increase hepatitis C testing and detection. Through this work, staff also identify barriers to testing and detection. [Ongoing]
7. **Continue improved CCO communication**. Explore the opportunity to identify a primary point of contact within OHA for CCOs related to HCV.
8. **Contact the CCOs who raised area-specific concerns**. [DONE or in process]

Action Planning

Project/Topic learned about today	Questions or next steps for follow-up

Resources

Oregon Hepatitis C Screening Initiative is a project within the Oregon Public Health Division to increase HCV testing and detection of HCV infections across different settings.

Hepatitis C Online is a free educational web site from the University of Washington. The site is a comprehensive resource that addresses the diagnosis, monitoring, and management of hepatitis C virus infection. Free CME contact hours and CNE credits are offered throughout the site. Pharmacology CE for advanced practice nurses is also available for many activities.

American Association for the Study of Liver Diseases Fundamentals of Liver Disease – Hepatitis C. The overall goal is to improve patient care by increasing learner competence and confidence in both proper patient identification and assessment and increasing learner performance in therapeutic options and on-treatment management strategies for patients. Patient outcomes will be improved as a result of the improvements in more providers understanding these key components in the management and care of patients with liver diseases.

University of Liverpool HEP Drug Interactions provides a clinically useful, reliable, comprehensive, up-to-date, evidence-based drug-drug interaction resource, freely available to healthcare workers, patients and researchers.

Clinician Consultation Center Hepatitis C Management is a national hotline for clinician-to-clinician advice on hepatitis C mono-infection and co-infection management. Clinicians receive expert advice on screening and treating hepatitis C, from testing to treatment.

Oregon Aids Education & Training Center (AETC)

- Oregon providers can contact the Oregon Aids Education & Training Center (AETC) medical director, Melissa D. Murphy, MD via phone or email for clinical consultation and questions on topic related to HIV, STIs, and hepatitis A, B, and C. Providers can reach Melissa by calling (971)200 - 5266 or by emailing melissa@oraetc.org.

- Training events can be requested by local public health, health systems, clinics, and providers and range from one-on-one brief information sessions to small group discussions to large conferences. To request an event, please use our training request form: https://www.oraetc.org/contact.

- Preceptorships are available in Portland, Oregon through the AETC at Multnomah County's HIV/HCV Health Services Center for hepatitis C treatment (both mono and HIV co-infected) and can include a practice change/systems component to support health system implementation of hepatitis C workflows, policies, and quality improvement. Contact Toni Kempner RN, ACRN, CCRC, MSN/Ed, Clinic Manager, to learn more: toni.kempner@multco.us