Oregon Health Authority

Quality and Health Outcomes Committee
AGENDA

MEETING INFORMATION
Meeting Date: November 4, 2019
Time: 10:00am-3:00pm
Location: HSB Room 137 A-C, 500 Summer Street, NE, Salem, OR
Call in information: Toll free dial-in: 888-278-0296 Participant Code: 310477
Webinar: https://register.gotowebinar.com/rt/4303958396461018881
All meeting materials are posted on the QHOC website.

Clinical Director Workgroup 10:00 a.m. – 12:30 p.m.			
TIME	**TOPIC**	**OWNER**	**MATERIALS**
10:00 a.m.	Welcome/Introductions	Andy Luther, MD	Speakers Contact Sheet Pg.2 October Meeting Notes Pg. 3-12
10:10 a.m.	General Updates	Lisa Bui	TC TA Document Pg. 13-16
10:20 a.m.	HERC Update	Cat Livingston, MD, MPH Ariel Smits, MD, MPH	Materials Pg. 17-26
10:35 a.m.	Ombuds Program	Sarah Dobra	Presentation Pg. 27-30
11:00 a.m.	Medicaid Update	Lori Coyner	
11:30 a.m.	ORPRN Technical Assistance	Dr. Brigit Hatch Caitlin Dickinson	Presentation Pg. 31-40
12:00 p.m.	Oregon HIV / Hepatitis	Todd Korthuis Ann Thomas	Presentation Pg. 41-49
12:30 p.m.	**Lunch**		
Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.			
1:00 p.m.	Welcome / Announcements	Lisa Bui Jennifer Johnstun	
1:10 p.m.	Statewide PIP Update	Lisa Bui	Materials Pg. 50-86
1:40 p.m.	Ombuds Program	Sarah Dobra Ellen Pinney	Presentation Pg. 87-93
2:40 p.m.	Items from the Floor	All	
3:00 p.m.	Adjourn		

REMINDER: No December 2019 meeting.

Everyone is welcome to the meetings. For questions about accessibility or to request an accommodation, please call 971-304-6236 or write OHA.qualityquestions@dhsoha.state.or.us. Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language, please call 971-304-6236 or write OHA.qualityquestions@dhsoha.state.or.us.

NOV. 2019 QHOC SPEAKERS CONTACT INFORMATION

AGENDA TOPIC	SPEAKER	CONTACT INFO
Welcome/Announcements	Andy Luther, MD	andrew.luther@primaryhealthfamily.com
General Updates	Lisa Bui	lisa.t.bui@dhsoha.state.or.us
HERC Update	Cat Livingston, MD, MPH Ariel Smits, MD, MPH	catherine.livingston@dhsoha.state.or.us ariel.smits@dhsoha.state.or.us
Ombuds Program	Sarah Dobra	sarah.e.dobra@dhsoha.state.or.us
Medicaid Update	Lori Coyner	lori.a.coyner@dhsoha.state.or.us
ORPRN PINPOINT and ANTECEDENT	Dr. Brigit Hatch Caitlin Dickinson	adamusb@ohsu.edu summerca@ohsu.edu
Oregon HIV / Hepatitis	Todd Korthuis Ann Thomas	korthuis@ohsu.edu ann.r.thomas@dhsoha.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	Jennifer Johnstun	jennifer.johnstun@primaryhealthfamily.com
QHOC LEADS		
Medical	TBD	
Behavioral Health	TBD	
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

Quality Health Outcomes Committee (QHOC)
October 14, 2019
MEETING NOTES

In-Person Attendees	Amarissa Wooden (Advanced Health); Anna Warner (Advanced Health); Tracy Muday (Advanced Health); Cynthia Ackerman (AllCare); Laura Matola (AllCare); Carl Stevens (CareOregon); Amy Carl (EOCCO); Courtney Whidden-Rivera (EOCCO); Jim Richards (EOCCO); Wendy Chavez (GOBHI); Barbara Carey (Health Share); Bobby Martin (Health Share); Graham Bouldin (Health Share); Maggie Bennington-Davis (Health Share); Andy Luther (PrimaryHealth); Jennifer Johnstun (PrimaryHealth); Allison Little (PacificSource); Elke Towey (PacificSource); Sherri Sturko (PacificSource); Kristin Garrett (Providence); Colleen Connolly (Trillium); Kristan Jeannis (Tuality); Katrina McPherson (Tuality); Doug Carr (Umpqua Health Alliance); Tanveer Bokhari (Umpqua Health Alliance); Jeanne Savage (WVCH); Holly Jo Hodges (WVP Health Authority); Bhavesh Rahjani (Yamhill CCO); Jackson Ross (Yamhill CCO); Tyler Hartman (Yamhill CCO); Lissette Rivera (CCC Bridges to Health); Megan Ochoa
Webinar/Phone Attendees	Jameson Baird (Umpqua Health Alliance); Barbara Boardman (IHN CCO); Susan Boldt (Cascade Health Alliance); Bill Bouska (Samaritan Health); Devin Brown; Kelley Burnett (AllCare); Briona Campbell (Providence); Lisa Castle (Advanced Health); Carissa Cousins (ABC House); Tania Curiel (ODS); Fritz Darling (IHN CCO); Kristi DePriest (IHN CCO); Renee Doan (Moda); Tiffany Dorsey (Kaiser); Esther Escobar (Tuality); Kevin Ewanchyna (IHN CCO); Linda Fanning (Comagine); Susann Finnegan (Yamhill CCO); Ann Ford (Options Online); Mike Franz (PacificSource); Nick Gross (EOCCO); Kristine Hartmann (HSAG); Whitney Hausotter (Umpqua Health Alliance); Shellie Holk (CareOregon); Melissa Isavoran (HSAG); Jennifer Jackson (Yamhill CCO); Tamara Johnson (Options Online); Charmaine Kinney (Multnomah Co.); Karen Keomuangtai (GOBHI); Kristen Lacijan-Drew (Health Share); Nina Lara (PrimaryHealth); Andrew Lee (Capital Dental); Kimberley Lee (CareOregon); Michelle Martinez (Trillium); Ruth McBride (PrimaryHealth); Cally McCool (Cascade Health Alliance); Laura McKeane (AllCare); Norm Navarro (Providence); Cathleen Olesitse (CareOregon); Yunerca Pena (Willamette Dental); Tammy Pierce (Gobhi); Bhavesh Rajani (Yamhill CCO); Robin Scherdnik (Willamette Dental); David Schute (Cascade Health Alliance); Michael Woods (Samaritan Health)
OHA Staff	Nate Cimino; Estela Gomez; Cyndi Kallstrom; Laura Kreger; Alissa Robbins; Sarah Wetherson; Jenny Nones; Roger Citron; Dana Hargunani; Dean Sidelinger; Cat Livingston; Ariel Smits; Lisa Bui; Jaime Nino; Jennifer Valentine; Lisa Krois; Valerie Stewart; Sara Kleinschmit; Rex Larsen; Wes Rivers

WELCOME/ANNOUNCEMENTS

Welcome and announcements was done by Dr. Andy Luther. Roll call was done in the room but not via phone. Phone/webinar attendance is tracked by webinar registrations. A majority of the committee membership was in attendance.

PUBLIC HEALTH DIVISION UPDATES

Oregon Immunization Program Update: AFIX is becoming IQIP

The Immunization Quality Improvement for Providers Program (IQIP) is replacing the Assessment Feedback Incentives and Exchange Program (AFIX) as Oregon's statewide immunization quality improvement program. Like AFIX, IQIP is a national quality improvement program sponsored by the CDC with a focus on improving immunization rates and workflows at the practice level. IQIP promotes and supports the implementation of provider-level strategies designed to increase on-time vaccination of children and adolescents.

IQIP
IMMUNIZATION QUALITY IMPROVEMENT FOR PROVIDERS

IQIP Key Strategies:

- Schedule the next immunization visit before the patient leaves the office
- Use ALERT IIS functionality to improve clinical practice
- Give a strong recommendation for vaccines

IQIP is a 12 months process where Oregon Immunization Program quality improvement specialists and VFC providers identify QI strategies to increase vaccine uptake by enhancing immunization workflow.

Site Visit	2- and 6-month check-ins	12-month follow-up
• Discuss workflow • Review immunization coverage • Select QI strategies • Develop QI plan	• Review QI strategy progress • Update QI plan	• Review QI strategy progress • Review immunization coverage • Start a new IQIP cycle

Important notes for CCOS

- Adolescent assessment cohort has changed from 13-17-year-olds to 13-year-olds to match the CCO incentive measure/HEDIS adolescent imm combo 2 (1 Tdap, 1 MCV, 2 HPV by 13th birthday);
- Increased emphasis on workflow analysis and improvement;
- Strong focus on connecting with community partners such as with LPHAS.

If you'd like more information please reach out to the VFC Helpdesk at 971-673-4VFC or email rex.a.larsen@state.or.us.

2020-20204 State Health Improvement Plan (SHIP) Subcommittees begin to meet

Subcommittees for each of the new 2020-2024 SHIP priority areas have been formed and are now meeting monthly to develop goals, strategies and measures for implementation with a

health equity framework. CCOs and CACs are represented on each subcommittee. Subcommittees also include representatives from the Public Health Division, local and tribal public health, regional health equity coalitions, state agencies, community-based organizations, health and human service providers, academia and people with lived experience. We hope to have a final plan developed and launched summer of 2020. All subcommittee meetings are open to the public and remote meeting options are available. For additional information, visit heathoregon.org/2020ship or contact publichealth.policy@state.or.us.

A new way to refer to WIC

The Oregon WIC program has kicked off a simple, online way to refer pregnant, breastfeeding women, infants and children under 5 years, who are OHP- eligible. Please share this information with health care providers and others who serve this population.

Online referrals take four easy steps:

1. Go to www.healthoregon.org/wic,
2. Click the "WIC Interest Form" button (image),
3. Select "I am a referring organization",
4. Type your clinic name, your patient's name and contact. That's it! Someone from WIC will follow up with your patient within 48 business hours. *If you are in Clackamas, Deschutes or Multnomah County, you can link directly to their referral sites.*

WIC medical documentation forms, reports and research, breastfeeding resources and more are available on WIC's Medical Providers page. For additional information, contact Cheryl Alto at cheryl.l.alto@state.or.us.

STATE EPIDEMIOLOGIST AND STATE HEALTH OFFICER

Dean Sidelinger, MD, MSEd was introduced as the new State Epidemiologist and State Health Officer. Prior to joining the Oregon Health Authority, Dr. Sidelinger served as the Child Health Medical Officer and Interim Deputy Public Health Officer for the County of San Diego Health and Human Services Agency (HHSA). In this role, he helped provide strategic direction for HHSA programs that impacted children and public health through the County's vision, Live Well San Diego, to help all County residents be healthy, be safe, and thrive. He worked across programs in behavioral health, child welfare, early childhood, eligibility operations, and public health.

RESPONSE TO THE OUTBREAK OF SEVERE RESPIRATORY INJURIES

Dr. Sidelinger gave an update on the response to the outbreak of severe respiratory injuries. As of October 8, 2019: 1,299 cases nationally including 26 deaths. 9 Oregon cases, including 2

deaths. Governor Brown has issued an executive order NO. 19-09 directing state agencies to take immediate action to address the vaping public health crisis.

Goals of Executive Order are to increase access to FDA approved cessation methods (including nicotine replacement therapy) and substance use disorder prevention services and encourage all Oregon insurance providers identify and remove barriers (i.e. prior authorizations, co-pays) to accessing nicotine replacement therapy and other cessation support.

Oregon's response includes:

- Sale ban on flavored vaping products (OHA and OLCC)
- Consumer warnings and ingredient disclosures
- Provider reporting
- Remove and remediate barriers to cessation supports including FDA-approved cessation products
- Statewide prevention and education campaign
- Legislative proposals to:
  - Ban flavored vaping products permanently
  - Disclose ingredients to consumers
  - Increase regulatory oversight
  - Clarify OHA's authority when there is a public risk
- Governor's Vaping Public Health Workgroup

For those who need help quitting vaping, help is available, including:

- Oregon Quit Line:
  - 800-QUIT-NOW (800-784-8669), http://www.quitnow.net/Oregon
  - Español: 855-DEJELO-YA (855-335356-92), https://www.quitnow.net/oregonsp/
- This Is Quitting: http://www.thisisquitting.com/ or text DITCHJUUL to 88709 (text-based resource for youth and young adults to quit vaping)
- Oregon's Drug and Alcohol Helpline: Call 800-923-4357 or Text RecoveryNow to 839863.
- SAMHSA National Help Line: (substances other than nicotine): 800-662-HELP

OHA TRANSFORMATION CENTER TECHNICAL ASSISTANCE (TA) FOR CCOS

Information on upcoming OHA Transformation Center Technical Assistance (TA) opportunities was included in the meeting packet.

HERC UPDATE

VbBS/HERC

2020 CPT codes

- Preperitoneal pelvic packing
- Implantable delivery devices
- Fat grafting
- Dry needling Oncology
- Computerized dynamic posturography
- Sacriiliac and genicular nerve injections and destruction
- Myocardial strain imaging using speckle tracking derived assessment
- Remote physiologic monitoring
- Cardiac PET

2020 CDT codes

- Straightforward

2020 HCPCS codes

- Coverage guidance: Community health workers for patients with chronic disease
- Telephone and email consult guidelines
- Peer support for physical conditions
- Diagnostic spinal injections
- Y90 embolization and mapping
- Fall prevention
- Vitamin D screening
- Vestibular rehabilitation & falls prevention
- Bone marrow transplant for sickle cell disease
- Helmets for positional plagiocephaly in infants

- Breast reconstruction revisions for previous cosmetic procedures
- Umbilical hernias with non-intestinal obstruction
  - TENS like therapies
  - Female genital mutilation repair
  - Chronic lower extremity venous disease
  - Intracardiac echocardiogram
  - Fetal myelomeningocele repair

BHAP

- Yoga and acupuncture for PTSD and anxiety
- Autism wraparound services
- Counseling to prevent peripartum mood disorders
- Neuropsychological status exam and neuropsychological testing evaluation services

GAP

- Non-prenatal, non-cancer genetic testing guideline
  - Cytochrome P450 genetic testing
  - Microarray analysis
  - Clarification of whole exome sequencing coverage
- Prenatal genetic testing guideline
  - CF genetic testing code
- Cancer genetic testing guideline
  - NCCN reference updates
  - CALF genetic testing for myeloproliferative disease
  - Hereditary breast cancer-related disorders genomic sequence analysis panels

EbGS 9/12/2019

- Planned out-of-hospital birth – Risk factor review continued

EbGS 12/5/2019

- Planned out-of-hospital birth – release for public comment

- MSI – Increase colorectal, breast and cervical cancer screening

P&T UPDATE

September P&T Committee OHA Approved Recommendations were approved on October 3rd and are posted online at https://www.oregon.gov/oha/HSD/OHP/Therapeutics/OHA%20Recommendations%2C%20approved%2010-03-2019.pdf

Oral Muscle Relaxants Literature Scan: Make no changes to the PMPDP based on efficacy and safety and no further review or research needed at this time. After comparative cost consideration in executive session, make methocarbamol preferred.

Herpes Simplex Virus Literature Scan: Make no changes to the PMPDP based on efficacy and safety and no further review or research needed at this time. After comparative cost consideration in executive session, make valacyclovir preferred.

Insulin Class Update: Make no changes to the PMPDP based on efficacy and safety and no further review or research needed at this time. After comparative cost consideration in executive session, make insulin glulisine (Apidra) pens and vials preferred**,** make insulin regular, human U-500 (Humulin) pen preferred**,** make Humalog Mix 75/25 and 50/50 KwikPens preferred**,** remove the prior authorization (PA) requirement for these pens and make insulin detemir (Levemir) vials preferred.

Hepatitis C, Direct-Acting Antivirals Literature Scan: Update the PA criteria to move the request for baseline RNA level to question #2 when asking about diagnosis (i.e. through positive detection of HCV viral load) and simply ask whether the patient has complications of cirrhosis and no longer require "clinical, radiologic or laboratory evidence". After comparative cost consideration in executive session, make Zepatier non-preferred and update Recommended Regimens to reflect Mavyret's new indication for an 8-week treatment duration for treatment-naïve patients with compensated cirrhosis.

Tobacco Smoking Cessation Literature Scan: Update the PA criteria to implement an age limit for varenicline (17yo+)**.** Make no changes to the PMPDP based on efficacy and safety and no further review or research needed at this time. After comparative cost consideration in executive session make no changes to the PMPDP.

Drugs for Duchenne Muscular Dystrophy Literature Scan: Update the PA criteria to include updated FDA-approved age (≥ 2yo) and assessment of immunization status prior to initiation of treatment with deflazacort**;** modify recommended vaccinations to specify 2 MMR and 2 varicella vaccinations**;** clarify which mutations are amenable to exon 51 skipping.

Opioid Class Update: Update the PA criteria to add dihydrocodeine MME to conversion chart listed in Short-acting Opioid (SAO) PA criteria, add sickle cell disease and severe burn injury as an exclusion to PA criteria, add concomitant benzodiazepine/CNS depressant use as an assessment to PA criteria, remove taper plan requirement for back and spine based on updated HERC guidance, retire Codeine PA and add a question about use of codeine and tramadol to the SAO PA criteria to insure appropriate use in patients < 19yo based on FDA safety alerts and add a note recommending against pediatric use for tramadol in dosing table. Modify question on PDMP to verify prescribing is appropriate instead of a single provider and add PEG score to the list of examples documenting improvement. Make no changes to the PMPDP based on efficacy, safety, or comparative cost.

Tafamidis New Drug Evaluations: Modify the Drugs for Transthyretin-Mediated Amyloidosis (ATTR) PA criteria to ensure appropriate use of tafamidis. Designate Vyndaqel and Vyndamax as non-preferred medications in the Amyloidosis Agents class.

Spinal Muscular Atrophy Class Update and New Drug Evaluation: Implement the proposed PA criteria for Zolgensma, revise the Spinraza PA criteria to assess Zolgensma use, add language to the Spinraza renewal criteria regarding "stabilization in a meaningful manner". After comparative cost consideration in executive session, make Zolgensma preferred and make Spinraza non-preferred.

Bone Metabolism Drugs Class Update and New Drug Evaluation: Modify the Bone Metabolism Agents PA criteria to ensure appropriate use of romosozumab, and maintain romosozumab (Evenity) as a non-preferred agent on the PMPDP. After comparative cost consideration in executive session make no changes to the PMPDP.

Drugs for Fabry Disease Class Review: Designate agalsidase beta (Fabrazyme) and migalastat (Galafold) as non-preferred agents on the PMPDP. Implement the proposed PA criteria for the Fabry disease treatments to ensure appropriate use according to FDA-approved indications.

The November P&T Committee Draft Documents are posted at https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/meetings-agenda. Comments on draft documents accepted until 10/16/2019. Agenda and final documents will be posted on 10/22/2019. Meeting scheduled on 11/21/2019 from 1:00 – 5:00pm @ DXC Building.

LEARNING COLLABORATIVE: ASSESSMENTS FOR CHILDREN IN DHS CUSTODY

The session objective was to share strategies from around the state that support the achievement of physical, dental and mental health assessments of children in DHS custody in the first 60 days. *Presentation slide deck is included in the meeting packet.*

TQS UPDATE

2020 guidance document, template and FAQ are posted to the TQS website. There is no subcomponent section on the template. TQS webinar series is also posted to the website.

PERFORMANCE IMPROVEMENT PROJECT UPDATE

CCO specific PIP summary is posted to the OHA QI webpage. This will be updated quarterly.

2019 – 2022 Statewide PIP

CCO annual report due on January 31, 2020 and will cover CMS PIP Protocol Steps 1 through 6 (Statewide PIP design only – no study indicator results will be submitted).

Discussion on timing of baseline and measurement for the statewide PIP.

Proposed schedule:

- July 31, 2021: Steps 1 through 8 (including baseline study indicator results for CY 2020 and QI activities, including barrier analysis and improvement strategies)
- July 31, 2022: Steps 1 through 8 (including study indicator results and QI activities through CY 2021 for Remeasurement 1)
- July 31, 2023: Steps 1 through 8 (including study indicator results and QI activities through CY 2022 for Remeasurement 2)

The measurement periods for the Statewide PIP would be as follows:

- Baseline measurement: January 1, 2020 – December 31, 2020
- Remeasurement 1: January 1, 2021 – December 31, 2021
- Remeasurement 2: January 1, 2022 – December 31, 2022

Discussion resulted in follow up with HSAG and CCOs to reflect on baseline timing for improvement and measurement achievement. The statewide PIP focuses on integration, however, CCOs are also evaluated on improvement is "real improvement" as defined in Step 9 of the protocol. Follow up information will be sent to CCOs with discussion at November QHOC.

METRICS QUALITY IMPROVEMENT: CHILDHOOD IMMUNIZATION METRIC

Sarah Kleinschmidt, Rex Larsen and Wes Rivers presented on childhood immunization metrics. Whiteboard notes from group discussion are below.

CHILDHOOD

Strategies

- Real time data (EMR)
- Alert → missed opportunities reporting
- Boost Oregon resources
- Maternal vaccination
- Sending CDC Imme schedule and maternity packets

- Sending birthday cards – Imme gap

Barriers

- Vaccine hesitancy
  - # of shots per visit

Missed opportunities

- Easier to address at younger age (before sexual health discussions begin)
- Media campaign
- Local cancer society collaboration

ADOLESCENT

Strategies

- Postcards-reminders
- Provider champion/HPV
- Public health partnership
- Workflows/scrubbing/callbacks
- SBHC- opportunity for measure alignment KPM
- Outreach to clinic leadership/faith-based community
- Messaging cancer prevention
- 2 series vs 3

Barriers

- Conservative community challenges (local challenges)
- Data abstracting
- AWC measure sunsetting (potential)

PUBLIC COMMENT

There was no public comment during this meeting.

ADJOURNMENT

Meeting was adjourned at 3:05pm.

NEXT MEETING

November 4, 2019
10:00am-3:00pm

OHA Transformation Center Technical Assistance (TA) for CCOs

TA index

Metrics TA

Diabetes: HbA1c poor control

Webinar – Peer-to-peer learning for CCOs

What: The Transformation Center invites CCO staff to a webinar focused on the Diabetes: HbA1c poor control incentive metric. The webinar features representatives from Columbia Pacific and Trillium CCOs, who will share how they share data with clinics, use their incentive dollars to improve diabetes programs, improve care through learning collaboratives, and their other keys to success with this metric. Sara Kleinschmit from OHA's metrics team will also give an outline of the metric and be available for your questions.

When: December 12, 2019, noon to 1 p.m.

Webinar registration: https://attendee.gotowebinar.com/register/1947677498131011852

Questions? Please contact Sarah Wetherson (Sarah.E.Wetherson@dhsoha.state.or.us)

Tobacco cessation

Free, quick online tobacco cessation counseling training (with CME) – available through November 30

What: This short online course will improve your care team's ability to help patients quit tobacco. The course focuses on brief tobacco intervention and motivational interviewing techniques.

Who: All members of the care team committed to supporting their patients to quit tobacco.

When: The course is available through November 30, 2019. It is self-paced and takes approximately 45 minutes. The course can be started, paused and resumed later as needed.

CMEs: This training has been reviewed and is accepted for up to 1.0 prescribed credit from the American Academy of Family Physicians (AAFP). For other licensing boards that may not pre-approve continuing education credits (for

example, the Board of Licensed Professional Counselors and Therapists), please submit the certificate of participation to your accrediting body.

Access the training: https://tcrc.rapidlearner.com/3462253711

Questions? Contact Anona Gund (Anona.E.Gund@dhsoha.state.or.us or 503-381-1104)

Tobacco cessation 5 A's guide – available in English and Spanish

What: This brief Tobacco Cessation 5 A's Guide is now available in English and Spanish. This guide provides brief, clear steps for any care team member to deliver the 5 A's tobacco cessation intervention.

Who: All members of the care team committed to supporting their patients to quit tobacco.

Access the guide:

1. English: https://apps.state.or.us/Forms/Served/le2877.pdf
2. Spanish: https://apps.state.or.us/Forms/Served/ls2877.pdf

Questions? Contact Anona Gund (Anona.E.Gund@dhsoha.state.or.us or 503-381-1104)

Screening, brief intervention and referral to treatment (SBIRT)

The OHA Transformation Center is partnering with the Oregon Rural-based Practice Research Network (ORPRN) for the Screening, Brief Intervention and Referral to Treatment (SBIRT) CCO incentive metric. This technical assistance, designed for clinics, is a 3-year study funded through the Agency for Healthcare Quality and Research. The project, referred to as ANTECEDENT (pArtNership To Enhance alcohol screening, treatment anD intervention) is designed to address unhealthy alcohol use in primary care. Clinics are invited to participated in free technical assistance (see flier: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/ORPRN-SBIRT-Antecedent-Pinpoint.pdf).

Questions? Contact Alissa Robbins (Alissa.Robbins@dhsoha.state.or.us) or contact the program directly at ANTECEDENT@ohsu.edu)

Non-metrics TA

CCO 2.0: Moving Forward Together

Event save-the-date

What: This one-day event will provide CCO leadership and staff with an overview of capacity-building support and guidance from OHA relating to CCO 2.0 focus areas. The event will also provide opportunities for CCO and OHA staff to discuss the vision for the next five years of health system transformation in Oregon. Key topics to be discussed at the event include:

- Behavioral health
- Oral health integration
- Social determinants of health and equity, including: Community advisory councils, community health assessments & community health improvement plans, health-related services, and housing
- Sustainable costs
- Value-based payment
- Other ways to support this work, including through health information technology, will also be discussed

When: March 17, 2020, 8:30 a.m.- 4 p.m.

Where: Salem Convention Center

Who: CCO leadership, CCO staff representing event topic areas, CAC coordinators, other staff identified by the CCO, OHA leadership, and OHA staff representing CCO 2.0 topic areas. OHA expects to be able to accommodate approximately 15-17 staff per CCO at this event. CCOs: Please work with your Innovator Agent to identify appropriate staff for this event.

Cost: No charge to attendees.

Registration: Event registration will open in November on the OHA Transformation Center's website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-2-0-Moving-Forward-Together.aspx

Questions? Please contact Tom Cogswell at Thomas.Cogswell@state.or.us or 971-304-9642.

CHAs and CHPs

CCO Guidance: Community Health Assessments and Community Health Improvement Plans

In 2020, based on CCO 2.0 recommended policies and updated Oregon Administrative Rules, CCOs will be required to have a shared CHA/CHP with local public health authorities, hospitals, other CCOs and tribes that share service areas. To support that change, *CCO Guidance: Community Health Assessments and Community Health Improvement Plans* provides guidance to CCOs regarding how OHA defines a "shared" CHA/CHP and when their next CHA/CHP deliverable is due. Access the guidance document here: https://www.oregon.gov/oha/HPA/dsi-tc/CHACHPTechnicalAssistance/CCO-Guidance-CHA-CHP.pdf

Questions? Please contact Anona Gund (Anona.E.Gund@dhsoha.state.or.us or 503-381-1104).

Children's health complexity

Using data on children's health complexity

What: The Transformation Center is partnering with the Oregon Pediatric Improvement Partnership (OPIP) to provide supports and technical assistance to CCOs focused on using children's health complexity data. (This data is provided to CCOs by OHA's Office of Health Analytics in partnership with OPIP).

When: TA hours are now available to CCOs, and a recorded webinar providing an overview of TA opportunities is available on the Transformation Center website. ***Update:*** An additional webinar will be provided to accompany the upcoming data release. Details will be posted on this page when registration opens.

Data release (Health Analytics): Round 2 of the children's health complexity data and reports has been delayed so further testing and validation can occur to explain some of the variations seen between cycle 1 and 2 results. Challenges remain in collecting, consolidating and validating the amount of data involved in producing the health complexity score across many data sets. There is no new estimated release date but OHA remains highly committed to producing health complexity scores that are as accurate as possible. More will be known after the first round of validation is completed.

Questions? Contact Liz Stuart (Elizabeth.M.Stuart@dhsoha.state.or.us or 503-891-9335).

See more details here.

Health-related services

Health-related services guidance and resources

What: OHA's health-related services (HRS) guidance and resources are all available on the OHA HRS website (https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Health-Related-Services.aspx).

Questions? Contact the OHA HRS team (Health.RelatedServices@dhsoha.state.or.us)

Transformation and quality strategy

2020 TQS template, guidance documents and technical assistance

The 2020 Transformation and Quality Strategy (TQS) reporting template, guidance documents and technical assistance opportunities are now available on the Transformation Center's website: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

Webinars will cover updates to this year's requirements and review areas commonly missed last year. Office hours are scheduled to answer questions. See this overview of TA available: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2020-TQS-technical-assistance-schedule.pdf

Questions? Contact Anona Gund (Anona.E.Gund@dhsoha.state.or.us or 503-381-1104)

Value-based payment

VBP roadmap and technical guide for CCOs

The Value-based Payment (VBP) Technical Guide for CCOs is now available to help clarify CCO 2.0 VBP requirements: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Technical-Guide.pdf

The OHA VBP roadmap has also been updated (September 2019): https://www.oregon.gov/oha/HPA/dsi-tc/Documents/OHA-CCO-VBP-Roadmap.pdf

Questions? Contact Lisa Krois (Lisa.Krois@dhsoha.state.or.us or 503-551-1346)

Transformation Center technical assistance updates

For updates, sign up for the Transformation Center's events, resources and learning opportunities distribution list.

AGENDA
VALUE-BASED BENEFITS SUBCOMMITTEE
11/14/2019
8:00am - 1:00pm
Clackamas Community College
29373 SW Town Center Loop E,
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
A working lunch will be served at approximately 12:00 PM
All times are approximate

I. Call to Order, Roll Call, Approval of Minutes – Kevin Olson **8:00 AM**

II. Staff report – Ariel Smits, Cat Livingston, Darren Coffman **8:05 AM**
- **A.** Errata

III. Straightforward/Consent agenda – Ariel Smits **8:10 AM**
- **A.** Consent table
- **B.** Abnormal pap smear coding cleanup

IV. Advisory Committee Reports **8:15 AM**
- **A.** Oral Health Advisory Committee
    - A. 2020 CDT code review
- **B.** Behavioral Health Advisory Committee
    - A. Wrap around services for autism
    - B. Neuropsychological Status Exams and Neuropsychological Testing
    - C. Counseling to prevent peripartum mood disorders
- **C.** Genetics Advisory Committee
    - A. Recommended changes to the non-prenatal, non-hereditary cancer genetic testing guideline
        1. CALR testing
    - B. Recommended changes to the prenatal genetic testing guideline
    - C. Recommended changes to the hereditary cancer genetic testing guideline

V. 2020 code review **9:00 AM**
- **A.** 2020 CPT code review
    - A. Straightforward code placements
        1. Consent code table
            - A. Includes BHAP reviewed codes
    - B. Codes requiring discussion
        1. Fat grafting
        2. Dry needling
        3. Implantable drug delivery devices

4. Preperitoneal pelvic packing
5. Sacroiliac nerve procedures
6. Genicular nerve procedures
7. Oncology
8. Computerized dynamic posturography
9. Myocardial strain imaging using speckle tracking derived assessment
10. Cardiac PET
11. Remote physiologic monitoring

C. Reviews involving new and existing codes
1. Telephone and email consult guidelines

B. 2020 HCPCS code review

VI. Break **10:30 AM**

VII. Previous discussion items **10:45 AM**

A. Chronic lower extremity venous disease
B. Vestibular rehabilitation

VIII. New discussion items **11:15 AM**

A. Breast reconstruction revisions for previous cosmetic procedures
B. Umbilical hernias with non-intestinal obstruction
C. Repair of female genital mutilation
D. Intracardiac echocardiogram
E. Yttrium 90 embolization
F. Vitamin D screening
G. USPSTF Recommendation Update for GN106
H. Frequency specific microcurrent therapy and similar TENS-like therapies
I. Low level laser therapy
J. Fetal myelomeningocele repair

IX. Public comment on topics not listed above **12:55 PM**

X. Adjournment – Kevin Olson **1:00 PM**

AGENDA

HEALTH EVIDENCE REVIEW COMMISSION

Clackamas Community College
Wilsonville Training Center, Rooms 111-112
29353 SW Town Center Loop E
Wilsonville, Oregon 97070
November 14, 2019
1:30-4:30 pm
(All agenda items are subject to change and times listed are approximate)

#	Time	Item	Presenter	Action Item
1	1:30 PM	Call to order	Kevin Olson	
2	1:35 PM	Approval of minutes (August 8, 2019)	Kevin Olson	X
3	1:40 PM	Director's report	Darren Coffman	
4	2:00 PM	Value-based Benefits Subcommittee report	Ariel Smits Cat Livingston	X
5	2:30 PM	Community Health Workers for Patients with Chronic Disease • Multisector intervention report	Adam Obley Cat Livingston	X
6	3:15 PM	Temporary Percutaneous Mechanical Circulatory Support with Impella Devices • Coverage guidance • Prioritized List changes approved in August	Cat Livingston	
7	4:15 PM	Public comment for topics not on the agenda above	Kevin Olson	
8	4:20 PM	Next steps • Schedule next meeting – January 16, 2020 Wilsonville Training Center, rooms 111-112	Kevin Olson	
9	4:30 PM	Adjournment	Kevin Olson	

Note: Public comment will be taken on each topic per HERC policy at the time at which that topic is discussed.

Highlights

Genetic Advisory Panel
Conference Call hosted at:
Five Oak Building
Transformation Center Conference Room, Suite 775
421 SW Oak, Portland, Oregon
October 23, 2019
9:00-11:00 am

Members Present: Karen Kovak; Sue Richards, PhD; Cary Harding, MD; Jaellah Thalberg; Carl Stevens, MD; Nicoleta Voian; Supriya Raina-Hukku

Staff Present: Ariel Smits, MD, MPH; Jason Gingerich

Also Attending: Devki Saraya, Myriad

The meeting was called to order at 9 AM. Roll was called. This is an advisory panel to the HERC Medical Director in preparing meeting materials for deliberation by the Value-based Benefits Subcommittee at their 11/14/19 meeting and a quorum is not necessary as no votes are taken. The highlights from the 2018 GAP meeting were reviewed and no changes were suggested.

Staff report

Smits reported to the Panel regarding topics requested for follow up at the 2018 meeting that are not on the current agenda. Both cell free fetal DNA (NIPS) for non-high-risk women and whole exome sequencing are the topics of Washington HTA reports due to be completed soon. HERC staff plan on addressing these topics at the 2020 GAP meeting, informed by these HTA reports. GAP members were comfortable with this approach, but requested that HERC staff send them the HTA reports when they become available.

Prioritized List issues

1. 2020 CPT codes related to cancer oncology: Smits reviewed the summary document. There was minimal discussion, and no changes were suggested to the staff recommendations.

2. Non-prenatal, non-cancer genetic testing guideline: Smits reviewed the summary document for both cytochrome P450 testing and for the other suggested changes to the guideline. There was minimal discussion regarding the suggested changes around cytochrome P450 testing. Stevens requested that HERC staff draft up wording for GN173 regarding non-coverage for genetic testing for antidepressant therapy. On further evaluation, HERC staff members felt that this topic should be re-reviewed and brought to the 2020 GAP meeting for discussion.

   The GAP members discussed the question regarding microarray testing. Diagnostic Guideline D1 places more restrictions on CPT 81229, but this test has become the standard for microarray testing, and 81228 is only rarely used. GAP members recommended that the section in D1 regarding CPT 81228 and 81229 have the additional restrictions for 81229 removed. As the entries for 81228 and 81229 with then be the same, the GAP recommended merging these sections.

   GAP members discussed the request for clarification on trio testing (of the affected individual and both parents) for whole exome sequencing. The members indicated that trio testing is preferred if both parents are available, as it is only slightly more costly but has a much better diagnostic rate.

   GAP members identified the CALR testing issue as actually relating to the non-prental, non-cancer genetic testing guideline. The staff proposal to add the CPT code for CALR testing (CPT 81219) to the Diagnostic List was not recommended. The members noted that this test should not be done as a separate test, but rather as part of a panel. Several gene panels include CALR, and testing for this gene alone should be added to line 662/GN173.

   a. Actions:
      i. HERC staff will re-review genetic testing for antidepressant therapy and draft a proposed guideline for the 2020 GAP meeting.
      ii. Staff will make the proposed changes to Diagnostic Guideline D1 for review at the November 2019 VbBS/HERC meeting
      iii. Staff will revise the CALR testing topic to reflect the recommendation to add to Line 662/GN173.
         1. Note: staff on later review recommended line 502/GN172 as a better placement. This will not change the GAP recommendation for non-covage

3. Prenatal genetic testing guideline: Smits first introduced the cystic fibrosis testing issue. The GAP members felt that prenatal genetic testing guideline should have all the CPT codes for possible CF testing (CPT 81220-81224) included, and HERC staff should review the ACOG guidelines on this testing and consider putting in a reference to ACOG in Guideline D17. The additional CPT codes allow for variant testing if a relative has a known CF mutation. Additionally, other types of CF testing might be recommended based on certain ultrasound findings.

The GAP then discussed CF testing in Diagnosotic Guideline D1. They recommended adding a mention of CPT 81221 to the first entry under CF diagnostic testing for completeness. They also recommended adding CPT 81221-81224 to the second entry regarding carrier testing, to allow for testing for family members of persons with known mutations or if the partner with whom pregnancy is contemplated is a carrier with a known mutation. HERC staff was directed to work on wording for D1 to reflect this discussion and send to the GAP for further possible input. On review of the ACOG guideline, HERC staff determined that no further changes were required to Diagnostic Guideline D1.

The only other preposed change to diagnostic Guideline D17 was to remove wording regarding screening for thrombophilia for recurrent pregnancy loss, as this was not a prenatal test.

a. Action:
    i. HERC staff will edit Diagnostic Guideline D1 CF carrier testing to allow broader types of testing in certain clinical circumstances and send to the GAP for further possible input

4. Hereditary cancer genetic testing guideline: Smits reviewed the summary document. The NCCN reference updates were noted without discussion. There was discussion about the entry for hereditary breast cancer panel testing. The GAP felt that the CCO question was based on confusion regarding the guideline wording. Revised wording was suggested that clarifies that the patient has to meet NCCN guidelines as eligible for testing, rather than the testing had to meet NCCN guidelines.

    a. Action: HERC staff will edit Diagnostic Guideline D25 as suggested by GAP for consideration at the VBBS/HERC in November 2019

Other issues: Members brought up an issue not on the agenda that needs correction: two CPT codes for generic genetic tests are being used quite a bit for panels of various genes. These are both appropriate codes in certain clinical situations but currently are on line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS, and need to be moved to the Diagnostic Procedures List with a recommendation for manual review. These codes are CPT 81479 (Unlisted molecular pathology procedure) and 81599 (Unlisted multianalyte assay with algorithmic analysis). HERC staff looked into this issue further after the meeting and determined that both of these codes had been on the "Suspend for Review" file at some point. Subsequently, CPT 81479 was mentioned in DIAGNOSTIC GUIDELINE D25, HEREDITARY CANCER GENETIC TESTING with the entry "Hereditary breast cancer-related disorders genomic sequence analysis panels (CPT 81432, 81433, 81479) are only included for patients meeting the criteria for hereditary cancer syndrome testing per NCCN guidelines." The entry in GN173 lists these codes are on line 662 only for certain tumor testing, not for all indications. HERC staff will need to look into this issue further prior to recommending a solution.

Public comment: A typo was pointed out in the prenatal genetic testing guideline. The correct CPT code for spinal muscular atrophy testing is CPT 81329. HERC staff will correct this error in the errata.

There was also a question raised about re-review of expanded carrier screening. This topic was reviewed by GAP at their 2018 meeting and recommended for coverage. However, VbBS did not approve this recommendation, due mainly to concerns about how the additional information would be interpreted or used. The public member asked how to go about getting this topic re-reviewed, and Smits recommended sending any new literature, guidelines, or other new material to HERC staff for review and consideration for placement on a future VbBS agenda.

The meeting was adjourned at 10:30 AM.

MINUTES

Behavioral Health Advisory Panel
Clackamas Community College
Wilsonville Training Center, Room 111
Wilsonville, OR
October 7, 2019
1:00 pm--3:00 pm

Members Present: Lynnea Lindsey, PhD Chair; Kathy Savicki, LCSW

Members Absent: Gary Cobb; Eric Davis, MSW, CADC III, PSS; MSCP; Sheldon Levy, PhD; Nimisha Gokaldas MD.

Staff Present: Darren Coffman; Ariel Smits, MD, MPH; Jason Gingerich

Also Attending: Laurie Theodorou, LCSW, Donny Jardine, and Nat Jacobs (OHA); Kevin Mintz (Multnomah County); Keith Cheng, MD (CareOregon); Tracy Zent and Morgan Pitchford (Oregon Recovery); Lorne Bulling (COHO); Rita Bierek (OMA); Doreen Crail (Central City Concern).

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1. CALL TO ORDER

Lynnea Lindsey called the meeting to order at 1:05 PM. Note that this advisory body to the Medical Director of the Health Evidence Review Commission on issues to take forward to the Value-based Benefits Subcommittee does not require a quorum to meet.

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2. PRIORITIZED LIST ISSUES

1) 2020 Health and behavior assessment CPT codes: The members agreed with the HERC staff recommended placements for the new CPT codes. Lindsey noted that the new health and behavior assessment codes include a longer, 30-minute initial time interval, as CMS has noted that most previous billings were for two 15-minute visits. Also, the new CPT codes are planned to have a higher RVU. 97129 was briefly discussed. Savicki suggested considering adding this code to the schizophrenia line; Lindsey disagreed, noting that this would open the code up quite a bit. The recommendation is to place 97129 on the lines with current code 97127 as suggested by HERC staff and readdress if and when a provider requests a review.

2) Straightforward behavioral health coding changes: Staff presented behavioral health line standardization, including categorizing each line as inpatient or outpatient. The BHAP members discussed the need for inpatient consults for some conditions when a patient is hospitalized for a physical health condition. Lindsey will provide the CPT codes that her group uses for inpatient consults, and staff will draft up a proposal to add these CPT codes to the appropriate lines. Keith Cheng from Legacy testified that autism should have ER codes added, otherwise, patients will be seen in the ER and the billings will be made under different diagnoses, which will be a problem. The BHAP members felt that several lines should be considered for possible addition of inpatient

code or inpatient consults, including the lines for PSYCHOLOGICAL FACTORS AGGRAVATING PHYSICAL CONDITION (line 252), mild depression (line 203) and anxiety (line 414).

a. Action item: Lindsey will work with her team to determine CPT codes for inpatient consults and provide them to HERC staff. These codes will be considered for addition to the three lines identified above

3) Autism wraparound services: there was a robust discussion on this topic. Savicki felt that adding wraparound services to the autism line would be complicated. These services are used only for the highest complexity of children, and are only cost effective for complex kids when it keeps them out of higher levels of care. Opening these services to children with milder forms of autism would not be as cost effective and would put a strain on the delivery system.

Nat Jacobs, from the OHA Child and Family Behavioral Health group, testified that she oversees the wraparound program. The request for pairing autism with wraparound services was brought to her by several communities. Autism is the only serious condition affecting children not currently covered by the wraparound program. Not covering wraparound services can lead to non-coordinated care. Only children who are involved in two different child systems (e.g. foster care and medically fragile) qualify for wraparound services. Many kids with autism are already getting these services under other diagnoses; therefore, Jacobs does not anticipate a large number of new children qualifying for these services. Jacobs also testified that there are specific rules around which clients qualify for wraparound services, meaning that low needs children with autism will not qualify. She did not feel that adding wraparound services to the autism line would strain the delivery system.

Lindsey raised concerns about the cost of wraparound services, and how such costs should be distributed amongst the various systems (education, medical, mental health, etc.).

Keith Cheng from Legacy testified that children can get more appropriate services earlier with the wraparound program, which will prevent downstream costs from having these children require higher levels of care, get involved with corrections, etc.

Theodorou testified that adding wraparound services for autism will break down silos in the system, and possibly save costs across the system.

Jacobs noted that in addition to the two HCPCS codes identified by staff for wraparound services, HCPCS H2014, H0038 and T1016 should be added to the autism line as these codes are also used for wraparound services provision.

BHAP recommended adding wraparound services (using all 5 identified HCPCS codes) to the autism line. HERC staff will draft a more robust summary for the November VbBS/HERC meetings.

4) Neuropsychological status exam/Neuropsychological testing evaluation services: the BHAP members felt that both neuropsychological status exam CPT codes and neuropsychologist testing evaluation service CPT codes should be covered as diagnostic. Lindsey noted that such testing would still need to be medical necessary. The members discussed limiting these services with a guideline that would include only covering when "there is a lack of diagnostic clarity," "when symptoms are not explained by an alternative diagnosis," and/or "when the intended use of the

testing results is to develop a care plan." Theodorou felt that a guideline would be very helpful, in addition to making these codes diagnostic.

The BHAP recommendation is to recommend that both neuropsychological status exams and neuropsychological testing evaluation services be added to the Diagnsotic Procedures File with a new diagnostic guideline.

a) Action item: BHAP members and HERC staff will reach out to experts and the CCOs for assistance in writing the requested new guideline and will circulate this guideline via email to BHAP members prior to the November VbBS/HERC meetings.

5) Yoga and acupuncture for PTSD and anxiety disorders: Smits reviewed the summary document. Laura Ocker, LAc testified that she has treated many patients with these conditions and finds acpuncture to be beneficial for a variety of anxiety conditions. Ocker noted that acupuncture is hard to study, as acupuncture services involve a variety of treatments, such as lifestyle advice and motivational interviewing, as well as acupuncture needle placement.

Lindsey noted that Medicare does not cover acupuncture or yoga for mental health issues. She expressed concern with coverage of yoga for these conditions, given the lack of licensure and oversight for yoga providers. Savicki commented that yoga and/or acupuncture might help divert patietns from psychiatric services and need for psychiatric medication. She noted that the evidence that medication helps PTSD is poor. Savicki also felt that adding these services would add tools for OHP patients dealing with these conditions.

The BHAP felt that they did not have the expertise to fully analyze the evidence for acupuncture and yoga for PTSD/anxiety and deferred further discussion to the VbBS.

6) Counseling to prevent peripartum mood disorders: Smits reviewed the summary document. Lindsey noted that the health and behavior assessment codes are intended for just this circumstance—counseling when there is a physical health issue but no diagnosed mental health issue. The BHAP members strongly felt that psychotherapy codes should not be added to line 1 PREGNANCY. The public members present also felt that psychotherapy codes should not be paired with pregnancy or postpartum diagnoses. Lindsey remarked that the health and behavior assessment codes are already present on line 1 and 3. The BHAP members felt that a modification of the proposed guideline would be useful.

a) Action item: HERC staff to revise the proposed guideline for counseling to prevent peripartum mood disorders and circulate to BHAP members via email prior to taking to VbBS/HERC.

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3. PUBLIC COMMENT

No additional public comment was received.

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4. ADJOURNMENT

The meeting was adjourned at 2:45 pm.

Oregon Health Authority
Ombuds Program

Integral to Oregon Health Plan (OHP) client service and leadership understanding of Oregon Health Plan and Medicaid access and quality trends

QHOC Community Presentation

What is an Ombudsperson???

OMBUDSMAN

The word “ombudsman” is Swedish, and it means someone whose role is to respond to complaints about government.

Two type: Impartial and Advocacy

- OHA Statue sets our Ombuds program up as an **advocacy program**

2

Why does the Oregon Health Authority have an Ombuds Program?

Oregon Revised Statute (ORS) 414.712 requires OHA to have one

Scope

The Oregon Health Authority shall provide:

- Ombudsman services for
  - Oregon Medicaid recipients
- An ombudsman shall serve as a recipient's *advocate* whenever there are concerns about
  - access to, quality of or limitations on care

Noteworthy Elements

- Recipients must be informed of availability
- Under the OHA Director's supervision and control
- Reports to the Governor and the Oregon Health Policy Board quarterly

Oregon Health Authority

3

Members come first: Monitoring complaints improves individual & overall system care

Ombuds walk alongside Oregon Health Plan members, step into their shoes to understand their care challenges

Reconnect member with those equipped to meet their needs: CCO, care coordinators, providers, community

Elevate member voice & experience to inform policies, programs, and operations

Partner with OHA, contractors, DHS and community to support improved health and improved patient experience

The OHA Ombuds Program is here to serve members

Oregon Health Authority

4

How do OHP Members get to the Ombuds program?

Many different doors:

- All CCO's required to include Ombuds contact information on *Notices of Complaint Resolution.*
- Advocacy organizations, Oregon Law Center & government officials
- Referred to program by
  - CCOs
  - Providers
  - OHA/ DHS staff

Oregon Health Authority

5

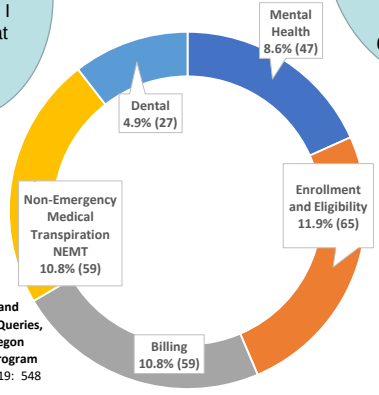
What sort of complaints does the Ombuds program receive?

My NEMT provider didn't pick me up on time. My doctor's office is going to fire me because I've missed so many appointments as a result.

I received a medical bill and have been sent to collections. I thought that this was covered.

My child is in mental health crisis and has been in the emergency department for the past 10 days. Help me!

My dentures don't fit. I've been told I can't get new ones.



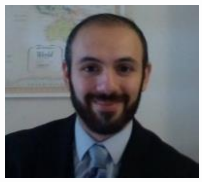
Top Oregon Health Plan and Medicaid Related Concerns, Queries, and Complaints to the Oregon Health Authority Ombuds Program
January 1, 2019 - June 30, 2019: 548 Total Concerns

Oregon Health Authority

6

Our Team

Awab Al-Rawe



Jaime Niño

Cate Drinan

Ellen Pinney

Libbie Rascon

Sarah Dobra

Contact Us

877-642-0450

OHA.OmbudsOffice@dhsoha.state.or.us

Oregon Health Authority

Questions, Collaboration Opportunities, & Contact Information

?

The Ombudsprogram is reaching out to all CCO's to strengthen collaboration with member service, grievance & care teams

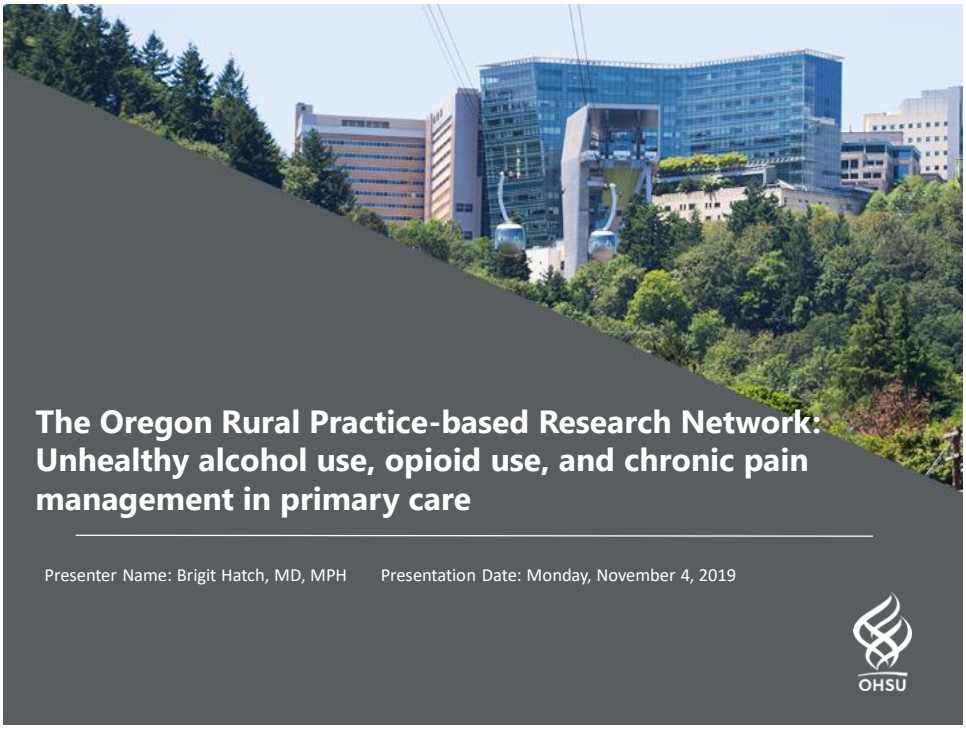
Contact Us

877-642-0450

503-947-2346

OHA.OmbudsOffice@dhsoha.state.or.us

Oregon Health Authority



The Oregon Rural Practice-based Research Network: Unhealthy alcohol use, opioid use, and chronic pain management in primary care

Presenter Name: Brigit Hatch, MD, MPH Presentation Date: Monday, November 4, 2019

OHSU

Presentation Outline

1. ORPRN and research partners
2. Unhealthy alcohol use (ANTECEDENT)
3. Chronic pain management and opioid use (PINPOINT)
4. Participation in both projects
5. Brief takeaway

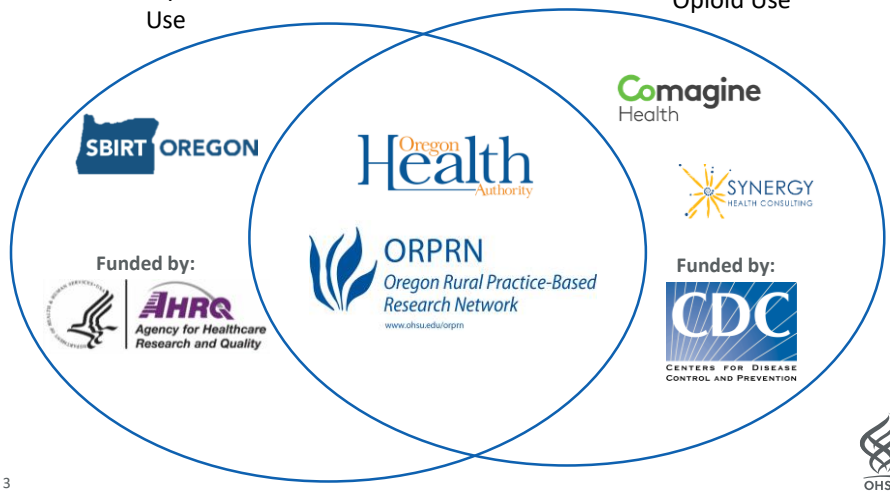
2

OHSU

Research Partners

ANTECEDENT
Unhealthy Alcohol Use

PINPOINT
Chronic Pain Management & Opioid Use



3

OHSU

What is ORPRN?

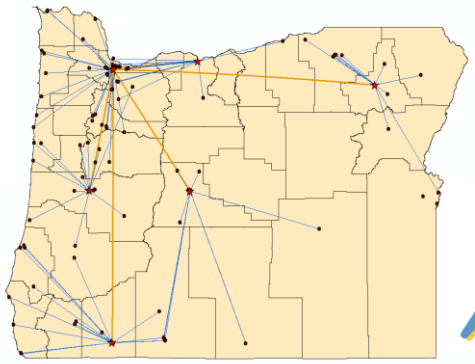
ORPRN's mission is to improve health outcomes and equity for all Oregonians.

4

OHSU

ORPRN Network

RAVE
Rural Adolescent Vaccine Enterprise



Project ECHO

CPC+
Comprehensive Primary Care Plus

CASCADE

HEALTHY HEARTS NORTHWEST
Improving practice together

Accountable Health Communities

Practice Facilitators (PERCs)

- Who are they?

Trained ORPRN practice facilitators, based throughout Oregon.


Portland


Bend


Medford


Portland


La Grande


Portland

- What do they do?
  - Build the internal capacity of primary care clinics, and support them in reaching improvement goals
  - Foster lasting relationships while using their skills to meet clinics' unique needs

Why practice facilitation?

Primary care clinics are

2.76 times more likely

to adopt evidence-based guidelines through practice facilitation.[1]

[1]Baskerville, N. B., Liddy, C., & Hogg, W. (2012). Systematic review and meta-analysis of practice facilitation within primary care settings. *The Annals of Family Medicine*, *10*(1), 63-74.

ANTECEDENT

pArtNerships To Enhance alCohol scrEening, treatment, anD intErveNTion

Addressing unhealthy alcohol use in Oregon

Unhealthy Alcohol Use in the US

- **4th** leading cause of death in the United States
- **88,129** alcohol-attributable deaths due to excessive alcohol use (2006-2010)
- **2.1 million** people misused opioids and were binge drinkers (2012-2014)
- **$249 billion** spent for excessive alcohol consumption (2010)

Source: Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI); Centers for Disease Control and Prevention
Esser et al / Am J Prev Med 2019;57(2):197–208.

9

OHSU

10

OHSU

What is ANTECEDENT?

- Addresses screening and interventions for unhealthy alcohol use
- Aligned with the CCO incentive metric for SBIRT
- Free for clinics and will be tailored to meet clinics' needs
- 15 months of support to improve data reporting, clinical workflows, and integrating SBIRT into routine care

11

OHSU

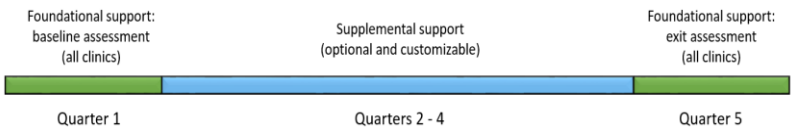
What to Expect from ANTECEDENT?

Foundational support (required):

- Baseline and exit assessments
- Access to SBIRT Oregon intervention and e-screening tools

Supplemental support (optional):

- Monthly quality improvement coaching for up to 12 months (MOC part IV credit available)
- Access to webinars, office hours, motivational interviewing training, and academic detailing
- Health IT support for SBIRT tracking and reporting



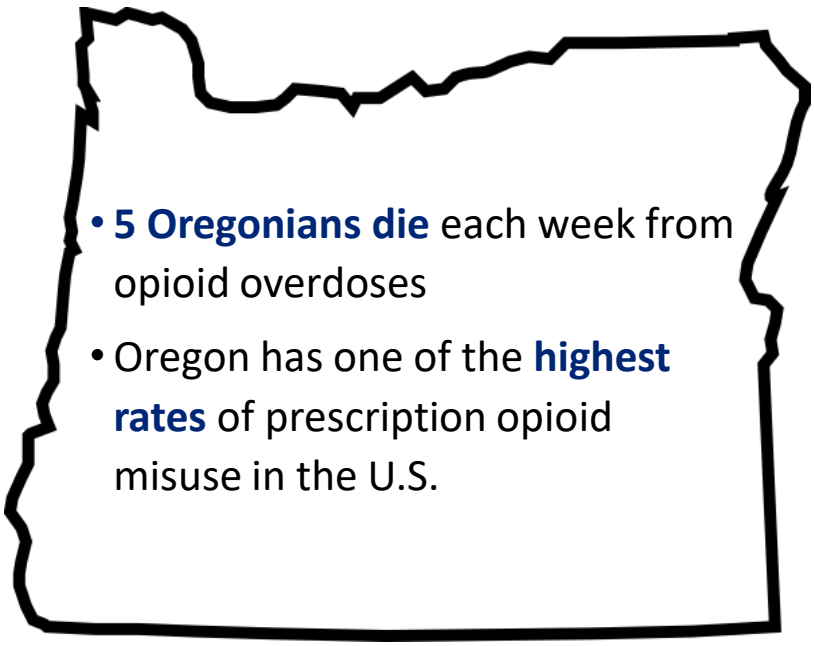
12

OHSU

PINPOINT

PaIn aNd oPiOId maNagemenT

Addressing chronic pain and opioid use in Oregon



Source: Oregon Health Authority

What is PINPOINT?

- PINPOINT addresses chronic pain management and the opioid epidemic in Oregon
- Participation in PINPOINT is free for clinics and will be tailored to meet your clinic's needs
- 15 months of support to improve chronic pain management and opioid prescribing practices

15

OHSU

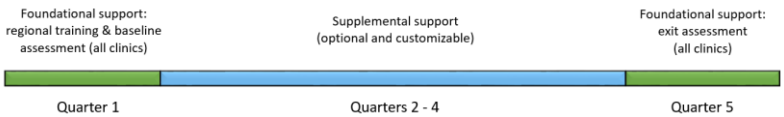
What to Expect from PINPOINT

Foundational support (required):

- Baseline and exit assessments
- Regional quality improvement training (lunch and CME credit included)

Supplemental support (optional):

- Monthly quality improvement coaching for up to 12 months (MOC Part IV credit available)
- Engagement with a quarterly learning collaborative
- Access to Oregon ECHO Network opioid prescribing tele-mentoring program
- Academic detailing (e.g. expert consultation, HIT support, etc.)

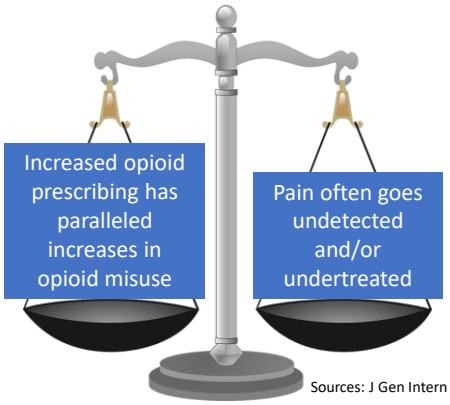


16

OHSU

ANTECEDENT & PINPOINT in Primary Care

Primary care clinicians are often the **only** medical professionals that patients with an alcohol or opioid use disorder encounter.



Screening rates for risky drinking with:

- standard instruments (13%)
- brief intervention (18%)
- use of MAT (1.3%)

are **very low** in primary care settings.

Sources: J Gen Intern Med 2011;26:951–2.; J Prim Care Community Health 2011;2:37– 44.

Participation in Both Projects

- ANTECEDENT and PINPOINT are designed for clinics to engage in both concurrently – **dual enrollment is strongly encouraged!**
- The timeline for both projects are aligned with 2020 metric reporting
  - ANTECEDENT:
    - Flexible start dates from February 2020 – February 2021
  - PINPOINT:
    - Flexible start dates from May 2020 - August 2020

The Bottom Line

- Through ANTECEDENT and PINPOINT, our team will provide the support you need to:
  - ❖Provide high quality patient-centered care
  - ❖Achieve the OHA SBIRT incentive metric
  - ❖Train clinical staff and providers to conduct this work sustainably
  - ❖Make an impact on addiction health in Oregon

Contact

For more information about ANTECEDENT, contact:
ANTECEDENT@ohsu.edu

For more information about PINPOINT, contact:
summerca@ohsu.edu

ORPRN
Oregon Rural Practice-Based Research Network
www.ohsu.edu/orprn

Oregon-HOPE

Oregon HIV/Hepatitis and Opioid Prevention and Engagement

QHOC Meeting, November 4, 2019

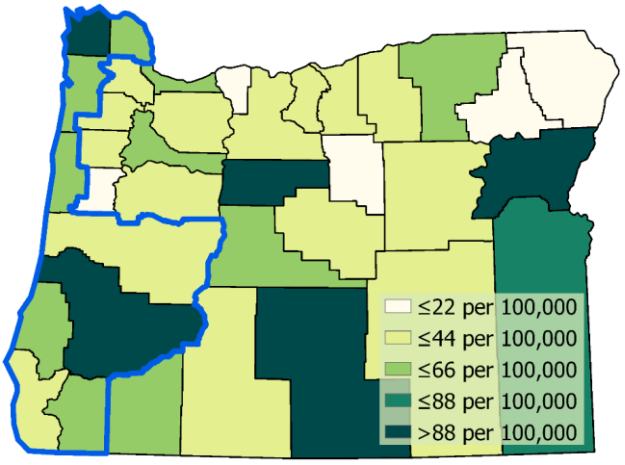
1

Presentation Objectives

- Provide background on pilot project in Lane and Douglas counties that has been successful in recruiting out-of-services people who inject drugs to receive HCV screening and engage in SUDs treatment
- Ask for support from CCOs
  - Brainstorm about processes to ensure that telehealth services for HCV treatment and MAT are covered by CCOs
  - CCO support for peer services so that upcoming project can be scaled up from 5 counties to additional north coast counties

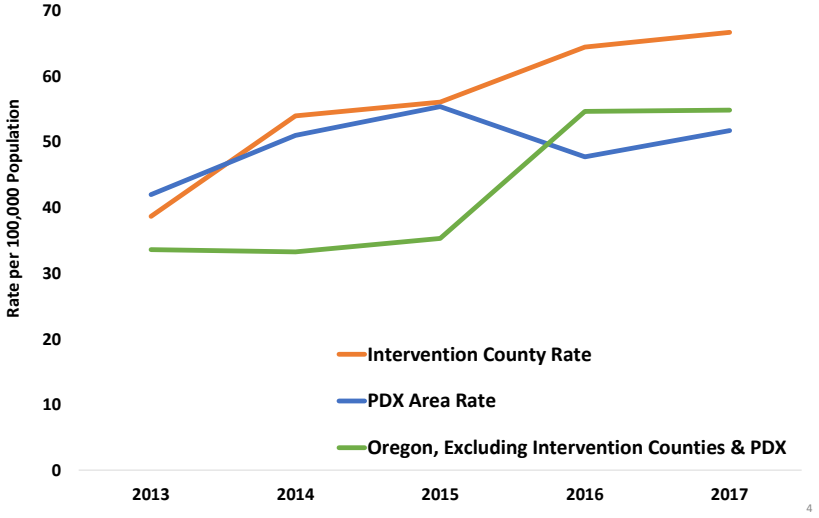
2

Statewide Rates of chronic HCV in persons < 30
2013-2017



3

Chronic HCV cases in persons < 30 years
87% increase in intervention counties



4

OR-HOPE Multi-level Interventions

Community Level

- Community action teams

Provider Level

- Buprenorphine waiver trainings
- Addiction Medicine and HCV ECHO
- HOPE curriculum with AETC

Patient/Individual Level

- Syringe exchange, mobile outreach
- Peer support specialists providing HCV/HIV testing, naloxone, fentanyl test strips, sterile syringes, linkage to treatment

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Pilot Peer Intervention

Who are they?

- Lived experience with SUD
- Completed Peer Support certification
- Supported by HIV Alliance

Joanna

Larry

What do they do?

- **Build relationships**
- Harm reduction "gift bags"
- Rapid HCV/HIV/syphilis testing
- CCO registration
- Link to treatment
- Transportation
- Housing assistance

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SUD Initiation & Engagement

18% of peer-outreach clients engaged in substance use disorder treatment within 3 months.

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New: Peer-facilitated Telemedicine HCV Treatment

8

TeleHCV Innovation

- Gaps:
  - Rural areas lack HCV prescribers
  - HCV elimination requires reaching people who use drugs
- Opportunities:
  - Telemedicine can expand services to rural areas
  - Community-based peer support specialists can engage and retain people with HCV

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Benefits to CCOs

- Opportunity to streamline care and save costs
  - Peers expand the reach of CCOs
  - Cost-efficient support for care engagement
- Help meet CCO 2.0 Incentive Metric:
  - "Initiation & engagement in substance use treatment"

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Tele-HCV Study Design

- Participants with HCV randomized to peer-facilitated telehealth vs. referral to local HCV prescribers
- Data collection
  - Survey & UDS: baseline, 4, 8, and 12 weeks post tx
  - HCV labs: baseline and 12 weeks post tx
- Outcomes
  - Primary: HCV sustained viral response 12 weeks post tx
  - Secondary: 1) HCV treatment Initiation; 2) HCV treatment completion 3) Perceived stigma; 4) Treatment satisfaction; 5) Harm reduction engagement, and 6) Substance use.

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Inclusion / Exclusion

Inclusion Criteria:

1) Age > 18
2) Past 90 day injection drug use
3) Hepatitis C RNA positive
4) Seeking treatment for HCV

Exclusion criteria:

1) Laboratory evidence of decompensated cirrhosis (Childs Pugh B or greater)
2) History of hepatic decompensation, ascites, or encephalopathy
3) Pregnant/breastfeeding

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Tele-HCV Process

- Participants enrolled with local CCO
- Peer facilitate confirmatory HCV screening and evaluation labs (standing order)
- Peer link participants to tele-HC provider session to review labs and assess for decompensated cirrhosis
- Telemedicine provider sends prescription for HCV directing acting antivirals (DAA) to local pharmacy
- Peers assist participant in picking up medication and encourage treatment adherence.

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Recommended Lab Work-up

If HCV rapid antibody+:

-HCV RNA

-HIV Ag/Ab

-HBV sAg, sAb, cAb

-HAV Ab, Total

-Complete Metabolic Panel

-Platelets

-INR

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Safety

- FDA black box warning for liver decompensation during treatment for patients with *decompensated cirrhosis;* demonstrated safe compensated cirrhosis
- Childs-Pugh scoring performed by HCV clinician in telemedicine visit
  - Current/past history of ascites or encephalopathy
  - Physical exam adds little negative predictive value for decompensated cirrhosis

Simel DL. The Rational Clinical Examination: Evidence-Based Clinical Diagnosis New York, NY: McGraw-Hill; 2009.

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OR-HOPE Informs Dissemination

- OHA launching a CDC-funded pilot using peer services for HCV outreach in Eastern Oregon
  - Klamath, Malheur, and Umatilla
  - Hospital-based peers providing HCV screening and linkage
  - Will create Business Associate Agreements between hospitals and SUDs/HCV tx providers
- TeleHCV potential sustainable model for rural areas lacking HCV prescribers

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Question

- Clarify HCV telemedicine reimbursement, standardization between CCOs?
- How to reimburse providers outside of the CCO catchment area?
- CCO support for outreach peers to
  - Engage people in community with harm reduction strategies
  - Support enrollment or re-engagement of people with CCO systems of care
  - Set engagement in substance use treatment and medical care as goals for CCO members

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Contact Oregon HOPE

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Option #1: CY2020 Baseline Measurement Period

Year	PIP Activities	Report Due for Validation	Report Content for Validation	CMS PIP Protocol Evaluated for Validation	Reference Documents (Page Numbers)
2019	Study Design	January 31, 2020	Statewide PIP *design only – no study indicator results*	Steps 1-6	– CMS Protocol (Pgs. 4-12) – HSAG Validation Tool (Pgs. 2-7)
2020	Baseline Measurement year	July 31, 2021**	Including baseline study indicator results for CY 2020 and QI activities, including barrier analysis and improvement strategies	Step 1-8	– CMS Protocol (Pgs. 4-12, 12-14) – HSAG Validation Tool (Pgs. 2-7, 8-9)
2021	Remeasurement 1: Interventions	July 31, 2022**	Including Remeasurement 1 study indicator results and QI activities through CY 2021	Step 1-9*	– CMS Protocol (Pgs. 4-12, 12-14, 15) – HSAG Validation Tool (Pgs. 2-7, 8-9, 10)
2022	Remeasurement 2: Interventions / Adjustment	July 31, 2023**	including study indicator results and QI activities through CY 2022	Step 1-9/10*	– CMS Protocol (Pgs. 4-12, 12-14, 15, 15-16) – HSAG Validation Tool (Pgs. 2-7, 8-9, 10, 11)

**In Step 9 and 10, each CCO's PIP will be evaluated for demonstrating statistically significant improvement over the baseline study indicator results at each remeasurement. The related evaluation elements in HSAG's PIP validation tool are critical elements, which means those evaluation elements can drive the overall validation status (Met, Partially Met, or Not Met) assigned to each CCO's PIP.*

*******Pending 2021 CCO contract language change*

Option #1 Pros:

- CCOs will be able to target 2021 (Remeasurement 1) interventions toward appropriate members, based on baseline data
- CCOs will receive HSAG's validation feedback on QI activities before the end of the Remeasurement 1 period, earlier in the PIP process
- The measurement periods and PIP activities align with the data-driven process outlined in the CMS PIP protocols and HSAG's PIP validation process

Option #1 Cons:

- CCOs will need to consider the best timing to initiate interventions, given that for the July 31, 2022 validation report (and any subsequent annual validations), each CCO's PIP will be evaluated on whether statistically significant improvement was demonstrated over the baseline measurement; CCOs may choose to wait until 2021 to initiate interventions

Option #2: CY2019 Baseline Measurement Period

Year	PIP Activities	Report Due for Validation	Report Content to be Validated	CMS PIP Protocol Evaluated for Validation	Reference Documents (Page Numbers)
2019	Study Design and baseline measurement year	January 31, 2020	Statewide PIP *design only – no study indicator results*	Steps 1-6	– CMS Protocol (Pgs. 4-12) – HSAG Validation Tool (Pgs. 2-7)
2020	Remeasurement 1: Interventions	July 31, 2021**	Including baseline study indicator results for CY 2019 and Remeasurement 1 study indicator results for CY 2020; Including QI activities, barrier analysis and improvement strategies, for baseline and Remeasurement 1	Step 1-9*	– CMS Protocol (Pgs. 4-12, 12-14) – HSAG Validation Tool (Pgs. 2-7, 8-9)
2021	Remeasurement 2: Interventions / Adjustment	July 31, 2022**	Including study indicator results and QI activities through CY 2021 for Remeasurement 2	Step 1-9/10*	– CMS Protocol (Pgs. 4-12, 12-14, 15) – HSAG Validation Tool (Pgs. 2-7, 8-9, 10)
2022	Remeasurement 3: Interventions / Adjustment	July 31, 2023**	Including study indicator results and QI activities through CY 2022 for Remeasurement 3	Step 1-9/10*	– CMS Protocol (Pgs. 4-12, 12-14, 15, 15-16) – HSAG Validation Tool (Pgs. 2-7, 8-9, 10, 11)

**In Step 9 and 10, each CCO's PIP will be evaluated for demonstrating statistically significant improvement over the baseline study indicator results at each remeasurement. The related evaluation elements in HSAG's PIP validation tool are critical elements, which means those evaluation elements can drive the overall validation status (Met, Partially Met, or Not Met) assigned to each CCO's PIP.*

****Pending 2021 CCO contract language change***

Option #2 Pros:

- CCOs can initiate interventions in 2020 without impacting baseline study indicator results

Option #2 Cons:

- OHA will need to re-assign members for the CCO 2.0 service area transition for two measurement periods, baseline (2019) and Remeasurement 1 (2020)
- CCOs will not have complete baseline results until mid-2020 (middle of Remeasurement 1 period); without complete member-level data, CCOs may not be able to identify appropriate members for most effectively targeting interventions
- CCOs to submit *both* baseline and Remeasurement 1 study indicator results for the 7/31/21 annual validation report. CCOs will report 2 years of study indicator results (baseline and Remeasurement 1) on 7/31/19 and therefore, CCOs would not be able to apply HSAG's annual validation feedback on QI activities until the Remeasurement 2 period (no opportunity for HSAG to provide annual validation feedback prior to the Remeasurement 1 period)

OMB Approval No.
0938-0786

EQR PROTOCOL 3: VALIDATING PERFORMANCE IMPROVEMENT PROJECTS (PIPs)

A Mandatory Protocol for External Quality Reviews (EQR)

Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations
Protocol 2: Validation of Measures Reported by the MCO
Protocol 3: Validation of Performance Improvement Projects (PIPs)
Protocol 4: Validation of Encounter Data Reported by the MCO
Protocol 5: Validation and Implementation of Surveys
Protocol 6: Calculation of Performance Measures
Protocol 7: Implementation of Performance Improvement Projects (PIPs)
Protocol 8: Focused Studies
Appendix V: Information Systems Capabilities Assessment (ISCA)

Department of Health and Human Services (HHS)
Centers for Medicare & Medicaid Services (CMS)

Protocol 3
Version 2.0

September 2012

Table of Contents

PURPOSE AND OVERVIEW OF THE PROTOCOL

This mandatory protocol is used to determine whether a health care quality performance improvement project (PIP) was designed, conducted, and reported in a methodologically sound manner. The purpose of a PIP is to assess and improve the processes and outcomes of health care provided by an MCO. Protocol 3 specifies procedures for EQROs to use in assessing the validity and reliability of a PIP.[1] Protocol 3 specifies how to conduct the following three activities:

1. Assess the study methodology;
2. Verify PIP study findings; and
3. Evaluate overall validity and reliability of study results.

Results of the MCO's PIPs may be reported in the annual Secretary's Report on the Quality of Care for Children in Medicaid and CHIP or the annual Secretary's Report on the Quality of Care for Adults in Medicaid. These reports are released every September and information that is not available from a State's EQR report may be so noted in the reports. Both reports will be available on the CMS Medicaid website. States are strongly encouraged to have EQROs include PIP outcome and trending information reported in the EQR technical report. This will enable the Secretary to include results and lessons learned from State intervention strategies to improve care as part of that annual reporting process.

Additionally, States may incorporate specific PIPs as part of their State quality strategy, required by Section 1932(c)(1) of the Social Security Act, to align with the HHS National Quality Strategy for Quality Improvement in Health Care. When doing so, soliciting input from participating MCOs/PIHPs in the identification of PIP topics and methodologies may be helpful so that relevant clinical, administrative and population-based improvement efforts are addressed as part of the State's overall strategy to improve health care delivery and outcomes of the people it serves.

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Activity 1 includes reviewing the following steps:

1. Review the selected study topic(s);
2. Review the study question(s);
3. Review the selected study indicators;
4. Review the identified study population;
5. Review sampling methods (if sampling used);
6. Review the data collection procedures;
7. Assess the MCO's Improvement strategies;
8. Review the data analysis and interpretation of study results;
9. Assess the likelihood that reported improvement is "real" improvement; and
10. Assess the sustainability of documented improvement.

The EQRO will review the PIP design and implementation using documents provided by the MCO, which may be supplemented with MCO staff interviews. In addition, the MCO, on an ad

[1] This protocol relies heavily on a guidebook produced by the National Committee for Quality Assurance (NCQA) that identifies key concepts in quality improvement (QI) studies. Please see References at the end of this protocol for a list of references that were used to develop this protocol.

hoc basis, may supplement information obtained through hardcopy, electronic submission, or interviews.

The EQRO should follow the 10 steps below and answer the questions posed in each. The answers should be recorded on a standardized PIP Validation Worksheet (see Attachment A).

Step 1: Review the Selected Study Topic(s)

In this step, the reviewer determines the appropriateness of the selected study topic(s). The topic(s) should address the overarching goal of a PIP, which is to improve processes and outcomes of health care provided by the MCO.

Criteria
The PIP should target improvement in either clinical or non-clinical services delivered by the MCO. Study topics must reflect MCO enrollee characteristics including demographics, prevalence of disease, and the potential consequences of disease. The project may focus on patterns of over or under utilization that present a clear threat to health or functional status. The State may select the MCO's study topic(s). Topics may also be selected based on enrollee input.

The topic should address a significant portion of the enrollees (or a specified sub-portion of enrollees) and have the potential to significantly impact enrollee health, functional status, or satisfaction. The topics should reflect high-volume or high-risk conditions of the population served. High-risk conditions may occur for infrequent conditions or services. High risk also exists for populations with special health care needs, such as children in foster care, adults with disabilities, and the homeless. Although these individuals may be small in number, their special health care needs place them at high risk.

The CMS suggests that States consider PIPs which address some of the national health priorities CMS has identified, (e.g., in 2011, Partnership for Patients, Million Hearts Campaign, pediatric oral health, and childhood obesity).

Recommended Sources of Supporting Information

- Data about enrollees:
    - Health risks;
    - Utilization of clinical or non-clinical services;
    - Demographics (Age, sex, race, ethnicity, language); and
    - Disability or functional status
    - Geographic location of membership
- Utilization, diagnostic, and outcome information on:
    - Outpatient and inpatient encounters, services, and procedures;
    - Medications and devices;
    - Diagnoses; and
    - Adverse incidents (such as deaths, avoidable admissions, or readmissions)
- Standardized local, State, or national measures when appropriate and available
- Data from other outside organizations, such as Medicaid or Medicare fee-for-service data; data from other health plans; and local or national public health reports on conditions or risks for specified populations; data from health information exchange technology – including registries.
- Data from surveys, grievance and appeals processes, disenrollment, and requests to change providers

- Data on appointments and provider networks (e.g., access, open and closed panels, and provider language spoken)
- Data from certified electronic health record (EHR) technology as described in Appendix V: Information System Capabilities Assessment
- Data from previous EQRO focused surveys

Assessment
To determine appropriateness of the study topic:

A. Review the documentation justifying the study topic using the potential data sources listed above.
    1. Did the State require the PIP topic, goal and/or study methodology?
    2. Were specific MCO or State enrollee demographic characteristics and health risks considered?
    3. Is the topic consistent with demographic and epidemiologic information of the current enrollees?

B. Did the MCO consider input from enrollees who are users of, or concerned with specific areas such as mental health or substance abuse?

C. The PIP, over time, should address a broad spectrum of enrollee care and services. Does the PIP address:
    1. Children with special health care needs?
    2. Preventive care?
    3. Acute and chronic condition care?
    4. High-volume and high-risk services (even if they are low frequency)?
    5. Specialized care received from centers such as burn, transplant, and cardiac surgery centers?
    6. Continuity or coordination of care when received from multiple providers and multiple episodes of care?
    7. Appeals and grievances?
    8. Access to and availability of care?

Step 2: Review the Study Question(s)

In this step, the reviewer determines the appropriateness and adequacy of the study (questions). The study question(s) identifies the focus of the PIP and establishes the framework for data collection, analysis, and interpretation.

Criteria
The study question(s) should be clear, simple, and answerable. In addition, they should be stated in a way that supports the ability to determine whether the intervention has a measurable impact for a clearly defined population.

An example of a vague study question is:

- ✕ "Does the MCO adequately address psychological problems in patients recovering from myocardial infarction?"

  In this example, it is not clear how "adequately address" will be assessed. Furthermore, "psychological factors" is not specific.

A clearer study question is:

- ✓ "Does the intervention reduce the likelihood that patients with myocardial infarction will develop severe emotional depression during hospitalization?"

Potential Sources of Supporting Information:

- QI study documentation
- Relevant clinical literature
- Enrollee focus groups/surveys
- Enrollee/provider representatives on Quality Committees

Step 3: Review the Identified Study Population

Measurement and improvement efforts must be system-wide.

Criteria
The PIP must clearly identify the 'system' or population, also referred to as the universe. Once the population is identified, the MCO will determine whether to study data for the entire population or a sample of that population. A representative sample of the identified population is acceptable (see Step 5).

Potential Sources of Supporting Information
Data on the MCO's enrolled population as well as enrollee counts relevant to the study topic and measures. This includes:

- Demographic information from the MCO's enrollment files
- The MCO's utilization and outcome information such as:
  - Services
  - Procedures
  - Admitting and encounter diagnoses
  - Adverse incidents (e.g., deaths, avoidable admissions, readmissions)
  - Patterns of referrals
  - Authorization requests
- Other databases, as needed (e.g., pharmacy claims data to identify patients taking a specific medication(s) during a specific enrollment period).

Assessment
Review the study description and methodology to determine if the study clearly identified the study population. Consider the following questions:

A. How was the "at risk" population defined?
B. Are all individuals clearly defined in terms of the identified study question(s) and relevant indicators?
C. Is the entire study population or a sample used? If the organization is able to collect and analyze data through an automated data system, it is possible to study the whole population? If the data must be collected manually, sampling may be more realistic.
D. Did the definition of the study population include requirements for the length of the study populations' members' enrollment in the MCO? The required length of time will vary depending on the study topic and study indicators.
E. If the entire population was studied, did the data collection approach capture all enrollees to whom the study question applied?

F. If a sample was used, go to Step 5. If the entire population was studied, skip Step 5 and go to Step 6. If HEDIS® measures and sampling methodology is used, go to Step 7.

Step 4: Review the Selected Study Indicators

A study indicator is a measurable characteristic, quality, trait, or attribute of a particular individual, object, or situation being studied. Indicators may be quantitative or qualitative and continuous or discrete. Discrete or categorical indicators have a limited number of possible categories (e.g., an individual has/has not received a flu shot in the last 12 months). In contrast, continuous indicators have unlimited possible values within the limits the indicator range, (e.g., age, blood pressure, temperature). Data collected on a continuous indicator such as blood pressure can be used for a discrete indicator, (e.g., an enrollee's blood pressure is/is not below a specified level).

Criteria
Each PIP should have one or more measured indicator to track performance and improvement over a specific period of time. All measured indicators should be:

- Objective; and
- Clearly defined; and
- Based on current clinical knowledge or health services research; and
- Enrollee outcomes (e.g., health or functional status, enrollee satisfaction); or
- A valid indicator of these outcomes.

The number and complexity of measures may vary depending on:

- The study question(s);
- The complexity of existing practice guidelines for a clinical condition; and
- Availability of data and resources to gather data

Potential Sources of Supporting Information

- Clinical and non-clinical practice guidelines
- Administrative data
- Medical records

Assessment
The EQRO will review the project documentation to determine if appropriate measures are used. Examples of measures currently existing within the public health community or the managed care industry include NCQA's Healthcare Effectiveness Data Information Set (HEDIS®) or measures that are developed by CMS and AHRQ (such as the Pediatric or Adult Core Measures). The MCO may also develop measures based on current clinical practice guidelines or health services research. When an MCO develops its own measures, it must document the basis for its adoption. Consider the following questions:

A. Did the study use objective, clearly defined, measurable, time-specific indicators?

B. Do the measures capture changes in health status, functional status, or enrollee satisfaction?

C. Do the measures have any of the following key characteristics:

- related to identified health care guidelines relevant to the study question?
- an important aspect of care or operations that made a difference to the MCO's/ beneficiaries?
- data available through administrative, medical records or another readily accessible source?
- limitations on the ability to collect the data skew the results?
- require explicit or implicit criteria (Note that the specificity of the criteria used to determine compliance with a measure must be considered)?
- if relevant, a strategy to ensure inter-rater reliability?

Notes to Reviewers
For the purpose of this protocol, "outcomes" are defined as changes in patient health, functional status, or satisfaction resulting from the PIP. For a PIP with a clinical focus, measures should include change in health status or functional status or process of care proxies for these outcomes. Standardized performance measures addressing outcomes may be limited because health outcomes are influenced by factors outside of the organization's control, such as poverty, genetics, and environment. For these reasons, quality measures do not always need to be outcome measures.

Process measures, while acceptable, must offer strong clinical evidence that the process being measured is meaningfully associated with outcomes. This determination should be based on published guidelines, including citations from randomized clinical trials, case control studies, or cohort studies. At a minimum, the PIP should be able to demonstrate a consensus among relevant practitioners with expertise in the defined area who attest to the importance of a given process. It will be important that MCOs note within their PIP external validity threats which could affect the results of the outcome measures.

While enrollee satisfaction is an important outcome of care in clinical areas, improvement in satisfaction should not be the only measured outcome of a clinical project. Some improvement in health or functional status should be addressed. For projects in non-clinical areas, the use of health or functional status measures is preferred, but not required, when addressing access or availability of services. Enrollee satisfaction alone may be sufficient for some non-clinical projects.

Step 5: Review Sampling Methods

In this step, the reviewer determines the appropriateness and validity of the PIP's sampling methods. A sample is a statistical subset of a population that represents the entire population. There are several types of sampling methods that are appropriate for different types of PIPs.

Criteria
Appropriate sampling is necessary to ensure valid and reliable information. Please refer to Appendix II of the EQR Protocols for an overview of sampling methodologies applicable to PIPs. MCOs that use HEDIS® measures should also use HEDIS® sampling methodology, which is considered valid and reliable.

Potential Sources of Supporting Information
Data on enrollee characteristics relevant to health risks or utilization of clinical and non-clinical services including:

- Age;
- Sex;
- Race/ethnicity;
- Language; and
- Functional status.

Utilization information includes:

- Diagnostic and outcome information such as:
  - Procedures,
  - Admitting and encounter diagnoses,
  - Adverse incidents (such as deaths, avoidable admissions, readmissions),
  - Patterns of referrals, and
  - Authorization requests;
- Other information as needed, such as pharmacy claims data to identify patients taking a defined number of a specific medication(s) during a specific enrollment period.

Assessment
Review the study description and methodology. Consider following questions:

A. Did the methods
   1. Calculate the required sample size?
   2. Consider and specify the true or estimated frequency of the event?
   3. Identify the confidence level to be used?
   4. Identify an acceptable margin of error?

B. Are valid sampling techniques used?

Sampling
Statistical sampling methods apply two basic methodologies- probability sampling and non-probability sampling. General information about using various types of sampling methods is provided in Appendix II of the EQR Protocols.

Probability sampling is also known as random sampling, which means leaving the selection of population units totally to chance and removing biased selection of study subjects. An example would be a study of how many women received a cervical cancer screening during a specified year by randomly selecting 100 of the 1,000 women members of the MCO. Types of probability sampling include:

- Simple Random Sampling;
- Systematic Random Sampling;
- Stratified Random Sampling; and
- Cluster Sampling.

Non-Probability sampling uses specific characteristics of the study subject. An example would be a study of the performance of a group practice by sampling all the patients that were seen in that office on a specific day. Types of non-probability sampling include:

- Judgment Sampling;
- Convenience Sampling; and
- Quota Sampling.

Step 6: Review the Data Collection Procedures

In this step, the reviewer determines the validity of the procedures the MCO uses to collect the data that inform the PIP measurements. Study results are dependent on accurate and valid data that are collected appropriately.

Criteria
Data collection procedures must ensure that the data used to measure performance are valid and reliable. Valid data measure what is intended to be measured, while reliable data produces consistent results. To ensure both validity and reliability, the data collection plan should specify:

- The data to be collected;
- The data sources;
- How and when the data are to be collected;
- Who will collect the data; and
- Instruments used to collect the data.

To ensure the collection of valid and reliable data, the MCO should develop collection specifications appropriate to the type of data needed. Procedures for collecting data from automated data systems will be different from procedures for visual inspection of medical records or other primary source documents. However, both types of data collection require the following to ensure the data are consistently extracted and recorded:

- Qualified Personnel:
  Data collection personnel have the conceptual and organizational skills to abstract the data. The specific skills will vary depending on the nature of the data and the degree of professional judgment required. For example, experienced clinical staff, such as registered nurses, should be used to extract the appropriate data from medical records to support a judgment about whether clinical criteria are met. In contrast, trained medical assistants or medical records clerks may collect data if the abstraction involves verifying the presence of a diagnostic test report.

- Inter-Rater Reliability:
  The number of data collection staff used for a given project affects the reliability of the data. A smaller number of staff promotes inter-rater reliability; however, it may also increase the amount of time it takes to complete this task. The PIP should also consider and address intra-rater reliability (i.e., reproducibility of judgments by the same abstractor at a different time).

- Guidelines for Obtaining and Recording the Data to ensure consistent interpretation among and between data collection staff. This is particularly important when there are multiple reviewers collecting data. Appropriately qualified data collection staff (e.g., registered nurse, certified coder, etc.) should have access to a glossary of terms for each project before data collection begins. The data collection staff should be provided with clear and succinct written instructions, including an overview of the study, specific instructions on how to complete each section of the form or instrument, and general guidance on how to handle situations not covered by the instructions.

Potential Sources of Supporting Information

- List of sources of data used in the study.
- If medical record review or other manual data collection is used to produce study data:

    - data recording forms; and
    - instructions to data collectors.
- If automated data collection is used, an algorithm showing the steps in the production of quality indicators and other relevant data collection.
- When assessing non-clinical services such as health care access or cultural competency or care coordination, a study may utilize information on how the MCO is structured and operates.

Assessment
Two processes may be used to assess data collection procedures:

1. Reviewing the study's approach to data collection (discussed in this step); and
2. Conducting a verification sample of the study's findings (discussed in Activity 2 of this protocol).

Consider the following questions to determine the appropriateness of the PIP's data collection procedures:

A. Does the study design clearly specify how the data are to be collected?

   Accurate measurement depends on clear and concise definitions of data elements. When descriptive terms are used (e.g., high, low, or normal), numerical definitions must be established for each term. The units of measure (e.g., pounds, kilograms, etc.) must also be specified.

B. Does the study design clearly specify the sources of data?

   Data sources vary and depend upon the selected topic and indicators. The topic and indicators will reflect clinical and research considerations and the available MCO data sources. Sources can include:
   - Beneficiary medical records;
   - Tracking logs;
   - Encounter and claims systems;
   - Provider interviews;
   - Beneficiary interviews; and
   - Surveys.

C. Does the study design specify a systematic method of collecting valid and reliable data that represents the entire population relevant to the study (sampling adequacy)?

D. What is the type of data collected (automated vs. manual)?

   Automated Data Collection: Evaluating an automated data collection methodology emphasizes the system that stores the data and should focus on an estimation of the degree of completeness of the automated data used for the PIP study indicators.[2] For example:
   - Inpatient data: Did the data system capture all inpatient admissions?

[2]The accuracy of automated data is also a concern, but validation of this is beyond the scope of this protocol.

- Primary care data: Did primary care providers submit encounter data for all encounters?
- Specialty care data: Did specialty care providers submit encounter data for all encounters?
- Ancillary services data: Did ancillary service providers submit encounter or utilization data for all services provided?
- EHR data: Was patient clinical, service, or quality metrics data retrieved from certified electronic health record technology?

Manual Data Collection: This may be the only feasible option for MCOs and selected topics and emphasizes who and how the data are abstracted. The beneficiary medical record is the most frequently used data source. Other manual systems include clinical tracking logs, registries, complaint logs, and manual claims. When evaluating manual data collection, consider the following:

- Is qualified staff collecting the data?
- Does the staff have the requisite clinical knowledge and skills, including good conceptual skills, organization skills, thoroughness, and strong documentation skills?
- Does the data collection tool provide reliable and accurate data collection over the time periods studied?
- Is the data collection instrument(s) used for manual data collection clear and promote inter-rater reliability?

E. Does the study design prospectively specify a data analysis plan that reflects the type of data being collected (i.e., qualitative, quantitative data, or both)?

Qualitative data describes characteristics or attributes by which persons or things can be classified (e.g., sex, race, poverty level, or the presence or absence of a specific disease). Calculation of proportions and calculation of rates are the two most common qualitative measures.

Quantitative data are concerned with numerical indicators such as height, weight and blood levels. The methods by which the data are analyzed and presented will vary by type of data. Quantitative data require, at a minimum, simple descriptive statistics such as measures of central tendency (i.e., mean, median, or mode) and measure of variability (i.e., range or standard deviation).

F. Are data collected on the entire population or a sample?

G. Is the PIP comparing these results to those of previous or similar studies? If so, the data analysis plan should evaluate the comparability of the studies and identify the appropriate statistical tests.

H. Is the PIP comparing the performance of an individual MCO, a number of MCOs, or different provider sites? Comparing the performance of multiple entities involves greater statistical design and analytical considerations than those required for a study of a single entity, such as a MCO.

Step 7: Review Data Analysis and Interpretation of Study Results

In this step, the reviewer determines the accuracy of the MCO's plan for analyzing and interpreting the PIP's results. Accurate PIP data analysis is critical because the MCO will implement changes in treatment and operations based on the results of a PIP.

Criteria
The review examines the appropriateness of, and the adherence to, the statistical analysis techniques defined in the data analysis plan. Interpretation and analysis of the study data should be based on continuous improvement philosophies and reflect an understanding that most problems result from failures of administrative or delivery system processes. Interpreting the data should involve developing hypotheses about the causes of less-than-optimal performance and collecting data to validate the hypotheses.

Potential Sources of Supporting Information
- Baseline project indicator measurements
- Repeat project indicator measurements
- Industry benchmarks
- Analytic reports of PIP results by the MCO

Assessment
Examine the calculated plan performance on the selected measures. To review the data analysis and results of the study, consider the following:

A. Is the analysis of the findings conducted in accordance with the data analysis plan?

B. Are numerical results and findings presented in an accurate, clear, and easily understood manner?

C. Does the analysis identify:

- Initial and repeat measurements of project outcomes?
- Realistic and unambiguous targets for the measures?
- The statistical significance of any differences between the initial and repeat measurements?
- Factors that influence the comparability of initial and repeat measurements?
- Factors that threaten the internal or external validity of the findings?

D. Does the analysis of the study data include an interpretation of the extent to which its PIP is successful and what follow-up activities are planned as a result?

Step 8: Assess the MCO's Improvement Strategies

In this step, the reviewer determines the appropriateness of the strategy for achieving true improvements. Real, sustained improvements result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.

An improvement strategy is defined as an intervention designed to change behavior at an institutional, practitioner, or beneficiary level. The effectiveness of the intervention activity or

activities is determined by measuring the MCO's change in performance, according to predefined quality measures.

Criteria
Interventions are key to a PIP's ability to bring about improved health care outcomes. Appropriate interventions must be identified and/or developed for each PIP to assure the likelihood of effecting measurable change.

If repeat measures indicate that quality improvement actions were not successful (i.e., did not achieve significant improvement), the problem-solving process should begin again with data analysis to identify possible causes and propose and implement solutions. If the quality improvement actions were successful, the new processes should be standardized and monitored.

Potential Sources of Supporting Information

- Current project baseline data
- Previous project data (if available)
- Results of clinical and literature research
- Project evaluation results completed by evaluators

Assessment
To assess the MCO's Improvement Strategies, consider the following questions:

A. Are the interventions related to causes/barriers identified through data analysis and quality improvement processes?

   1. Interventions should be based on a root cause analysis of the problem the PIP addresses. It is expected that interventions associated with improvement on quality indicators will be system interventions (i.e., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives to improve performance). Interventions that might have some short-term effect, but that are unlikely to induce permanent change (such as a one-time reminder letter to physicians or beneficiaries) are insufficient.

   2. An MCO is not required to demonstrate conclusively (e.g., through controlled studies) that a change in an indicator is the effect of its intervention; it is sufficient to show that an intervention occurred that might reasonably be expected to affect the results. Nor is the MCO required to undertake data analysis to correct for secular trends (e.g., changes that reflect continuing growth or decline in a measure because of external forces over an extended period). The MCO should be able to demonstrate that its data have been corrected for any major confounding variables with an obvious impact on the outcomes. The MCO's interventions should reasonably be determined to have resulted in measured improvement.

B. Are the interventions sufficient to be expected to improve processes or outcomes?

C. Are the interventions culturally and linguistically appropriate? For example, a mailing in English at 12th grade level to members of a predominately Chinese language population would not be appropriate. More information on culturally and

linguistically appropriate services may be found at the following website: http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15.

Step 9: Assess the Likelihood that Reported Improvement is "Real" Improvement

In this step, the reviewer determines the likelihood that the results of the PIP are accurate. It is important to determine if a reported change represents "real" change or is a result of a short-term event unrelated to the intervention, or simply random chance. Therefore, the EQRO must assess the probability that a reported improvement is a true improvement.

Criteria
"Real improvement" can be assessed in several ways, but is most confidently assessed by calculating the degree to which an intervention is statistically "significant". This protocol requires the EQRO to assess the extent to which any change in performance reported is statistically significant; however, it does not specify a specific level of statistical significance that must be met. States may establish a required level of statistical significance for findings to be accepted as valid. The EQRO should state in its final report which findings do not meet the required level of statistical significance.

Potential Sources of Supporting Information
- Baseline and repeat measures on quality indicators
- Tests of statistical significance calculated on baseline and repeat indicator measurements
- Benchmarks for quality specified by the State Medicaid agency or found in industry standards

Assessment
Review documents to determine the extent to which improvement occurred. Through repeated measurement of the quality indicators selected for the project, meaningful change in performance relative to the performance observed during baseline measurement must be demonstrated. The repeat measurement should use the same methodology as the baseline measurement, unless the baseline data was collected for the entire population at risk; the repeat measurement may then use a reliable sample. Performance using the identified indicators can be measured by collecting information on all individuals, encounters or episodes of care to which the indicator is applicable (a census) or by collecting information on a representative subset of individuals, encounters, providers of care, etc. Consider the following questions:

A. Are there any documented improvements in processes or outcomes of care?

B. Does the improvement in performance appear to be the result of the planned quality improvement intervention?

C. Is there any statistical evidence that any observed performance improvement is true improvement?

Step 10: Assess Sustainability of the Documented Improvement

Real change is the result of changes in the fundamental processes of health care delivery and is most valuable when it offers demonstrable sustained improvements. In contrast, a spurious "one-

time" improvement can result from unplanned accidental occurrences or random chance. This step in the protocol is to determine if the real change is sustainable.

Criteria
Improvement must demonstrate repeated improvements or the likelihood of repeated improvements.

Potential Sources of Supporting Information

- Baseline and first repeated measurements on quality indicators
- Additional measurements on quality indicators made after the first repeat measurement

Assessment
Review of the re-measurement documentation is required to assure the improvement on a project is sustained. Consider the following question:

A. Is sustained improvement demonstrated through repeated measurements over comparable time periods?

Measurements of the outcomes are repeated after the first measurement following implementation of the intervention. Because of random year-to-year variation, population changes, and sampling error, performance on any given measure may decline in the second measurement. However, when all measurements for a given review are taken together, this decline should not be statistically significant.

ACTIVITY 2: VERIFY STUDY FINDINGS (OPTIONAL)

This activity is optional because verifying actual PIP study findings is a resource intensive activity that may not be feasible. If the PIP uses HEDIS® measures that have been certified by a third party, this step may not be needed. However, guidelines for conducting this optional activity are provided here.

Criteria
In addition to reviewing the methodology and findings of a PIP, States may request the EQRO verify the actual data produced to determine if the initial and repeated measurements of the quality indicators are accurate. This activity may not be feasible to perform for every (or even some) PIPs. Verification activities can provide added confidence in reported PIP results as they provide greater evidence that the findings are accurate and reliable. Therefore, this activity is included in this protocol as an optional activity that a State may elect to have the EQRO conduct on an ad hoc basis when the State has special concerns about data integrity.

Potential Data Sources Needed for Verification Activities:

- Current project data and findings
- Depending upon the source of the PIP data:
  - MCO administrative data
  - Beneficiary interviews and surveys
  - An assessment of the MCO's Information System (see Appendix V)

Assessment

The key focus in this activity is validating the processes through which data needed to produce quality measures were obtained, converted to information, and analyzed. Assessing the algorithm together with the integrity of the MCO's information system and encounter data will provide a strong indication of the accuracy of the MCO's reported quality measures. The algorithm for converting the information and analyzing it is verified in Activity 2, Step 6 of this protocol. The methods used to verify how the data were collected depends on whether the data are obtained through review and abstraction of medical records or produced through an automated information system.

Verification of quality measures produced through medical record review can be achieved by conducting a re-abstraction of a small subset (validation sample) of the reviewed records. Data retrieval and analysis should be conducted on a small scale, with the validation sample following the same abstracting rules as the original study. Statistical correlations will be made between the validation sample and the original study data. A wide variety of statistical methods can be applied to assess the degree of correlation between the study and validation measures. Two recommended methods are the Pearson correlation coefficient for continuous data (e.g., age, income, etc) and the Kappa statistic for categorical data (e.g., gender, race, etc.).

Verification of data obtained though MCO-automated information system is a reflection of three phenomena:

1. Soundness of the algorithm used to produce quality measures from its information system;
2. Integrity (completeness and accuracy) of the MCO's information system at capturing enrollee information; and
3. Accuracy of the information translated from source documents (e.g., an enrollee's medical record) into automated data in the MCO's information system.

These three activities can be performed by one or more of the following methods:

- Review the assessment of the MCO's information system and any validations of MCO encounter data that the State has produced as described in Appendix V.
- Review the results of another Protocol or EQR activity (e.g., validating encounter data, validating performance measures, or assessing an MCO's compliance with standards for MCO information system specified by the State Medicaid agency or other organization such as a private accrediting organization.
- Review the MCO's own recently completed assessment of the MCO's information system and validation of its encounter data from the MCO, the State Medicaid agency, or other organization identified by the MCO.
- In the event that no current evaluation of an MCO's information system or encounter data exists, the State may choose to contract this important function to fulfill this requirement to validate its MCO PIPs.

ACTIVITY 3: EVALUATE AND REPORT OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS

Following the completion of Activity 1 and Activity 2, the EQRO will assess the validity and reliability of all findings to determine whether or not the State has confidence in the MCO's reported PIP findings. As studies always have weaknesses, the EQRO will need to accept threats to the accuracy of the PIP, and determine PIP generalizability as a routine fact of QI activities.

The EQRO will report findings to the State. The PIP validity report should include the description of the PIPs that were validated and the findings of the EQRO's validation review. Because determining threats to validity, reliability, and PIP design is sometimes a judgment call, the EQRO can report a level of confidence in its findings. Examples of levels that can be reported to the State include:

- High confidence in reported MCO/ PIP results;
- Confidence in reported MCO/ PIP results;
- Low confidence in reported MCO PIP results; or
- Reported MCO PIP results not credible.

The EQRO and the State must include the actual results of the PIPs in the final EQRO technical report for submission to CMS.

REFERENCES

Quality Improvement System for Managed Care (QISMC)

Health Care Quality Improvement Studies in Managed Care Settings: A Guide for State Medicaid Agencies (National Committee for Quality Assurance (NCQA))

A Health Care Quality Improvement System for the Medicaid Managed Care, A Guide for States (Health Care Financing Administration (HCFA))

Framework for Improving Performance, From Principles to Practice (Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

1990-2000 Standards for Health Care Networks (SHCN) (JCAHO)

NCQA 1997, 1998, and 1999 Standards for Accreditation of Managed Care Organizations and NCQA 1999 Standards for Accreditation of Managed Behavioral Healthcare Organizations (MBHO)

Peer Review Organizations (PRO) 4th and 5th Scope of Work (SOW) (CMS)

*Please see EQR Protocols Appendix I for information about how these references were used to develop PIP protocols.

END OF PROTOCOL

State of Oregon 2019 PIP Validation Tool
<PIP Topic>
for <Plan Name>

Demographic Information	
Plan Name: **<Plan Name>**	
Project Leader Name: _____	Title: _____
Telephone Number: _____	Email Address: _____
PIP Title: ***<PIP Topic>***	
Submission Date: _____	

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
I.	**Select the Study Topic(s): The study topic should be selected based on data that identify an opportunity for improvement. The goal of the project should be to improve processes and outcomes of healthcare. The topic may also be specified by the State. The study topic:**		
C*	1. Was selected following collection and analysis of data. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Has the potential to affect member health, functional status, or satisfaction. The scoring for this element will be ***Met*** or ***Not Met.***	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step I

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
II.	**Define the Study Question(s): Stating the study question(s) helps maintain the focus of the PIP and sets the framework for data collection, analysis, and interpretation. The study question:**		
C*	1. Was stated in simple terms and in the recommended X/Y format. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step II

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
III.	**Define the Study Population: The study population should be clearly defined to represent the population to which the study question and indicators apply, without excluding members with special healthcare needs. The study population:**		
C*	1. Was accurately and completely defined and captured all members to whom the study question(s) applied. ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step III

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
IV.	**Select the Study Indicator(s): A study indicator is a quantitative or qualitative characteristic or variable that reflects a discrete event or a status that is to be measured. The selected indicator(s) should track performance or improvement over time. The indicator(s) should be objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research. The study indicator(s):**		
C*	1. Was well-defined, objective, and measured changes in health or functional status, member satisfaction, or valid process alternatives.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the basis on which the indicator(s) was developed, if internally developed.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IV

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
V.	**Use Sound Sampling Techniques: (If sampling was not used, each evaluation element will be scored Not Applicable [NA]). If sampling was used to select members in the population, proper sampling techniques are necessary to provide valid and reliable information on the quality of care provided. Sampling methods:**		
	1. Included the measurement period for the sampling methods used (e.g., baseline, Remeasurement 1).	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included the title of each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Included the population size for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	4. Included the sample size for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	5. Included the margin of error and confidence level for each study indicator.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Described the method used to select the sample.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	7. Allowed for the generalization of results to the study population.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step V

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
7	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VI.	**Reliably Collect Data: The data collection process must ensure that the data collected on the study indicator(s) was valid and reliable. Validity is an indication of the accuracy of the information obtained. Reliability is an indication of the repeatability or reproducibility of a measurement. Data collection procedures include:**		
	1. Clearly defined sources of data and data elements collected for the study indicator(s). ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	2. A clearly defined and systematic process for collecting baseline and remeasurement data for the study indicator(s). ***NA*** is not applicable to this element for scoring.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. A manual data collection tool that ensured consistent and accurate collection of data according to indicator specifications.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. The percentage of administrative data completeness following allowable claims lag and the process used to calculate the percentage.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VI

Total Evaluation Elements

Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
4	0	0	0	0

Critical Elements

Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VII.	**Analyze Data and Interpretation of Study Indicator Results: Clearly present the results for each study indicator. Describe the data analysis performed, the results of the statistical analysis, and a narrative interpretation for each study indicator. Through data analysis and interpretation, real improvement, as well as sustained improvement, can be determined. The data analysis and interpretation of the study indicator outcomes:**		
C*	1. Included accurate, clear, consistent, and easily understood information in the data table.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Included a narrative interpretation of results that addressed all requirements.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	3. Addressed factors that threatened the validity of the data reported and ability to compare the initial measurement with the remeasurement.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VII

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
VIII.	**Improvement Strategies and Interventions: Interventions were developed to address causes/barriers identified through a continuous cycle of data measurement and data analysis. The improvement strategies were developed from an ongoing quality improvement process that included:**		
C*	1. A causal/barrier analysis with a clearly documented team, process/steps, and quality improvement tools.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	2. Barriers that were identified and prioritized based on results of data analysis and/or other quality improvement processes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	3. Interventions that were logically linked to identified barriers and have the potential to impact study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	4. Interventions that were implemented in a timely manner to allow for impact of study indicator outcomes.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	5. An evaluation of effectiveness for each individual intervention.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
	6. Interventions that were continued, revised, or discontinued based on evaluation data.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step VIII

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
6	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
3	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
IX.	**Assess for Real Improvement: Real improvement or meaningful change in performance is evaluated based on study indicator(s) results.**		
	1. The remeasurement methodology was the same as the baseline methodology.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	
C*	2. There was statistically significant improvement over the baseline across all study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step IX

Total Evaluation Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*
2	0	0	0	0

Critical Elements				
Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Evaluation Elements		Scoring	Comments
Performance Improvement Project Validation			
X.	**Assess for Sustained Improvement: Sustained improvement is demonstrated through repeated measurements over comparable time periods.**		
C*	1. Repeated measurements over comparable time periods demonstrated sustained improvement over the baseline across all study indicators.	☐ *Met* ☐ *Partially Met* ☐ *Not Met* ☐ *NA*	

Results for Step X

Total Evaluation Elements					Critical Elements				
Total Evaluation Elements**	*Met*	*Partially Met*	*Not Met*	*NA*	Critical Elements***	*Met*	*Partially Met*	*Not Met*	*NA*
1	0	0	0	0	1	0	0	0	0

* "C" in this column denotes a *critical* evaluation element.
** This is the total number of *all* evaluation elements for this step.
*** This is the total number of critical evaluation elements for this step.

Table B-1—2019 PIP Validation Tool Scores for <PIP Topic> for <Plan Name>										
Review Step	**Total Possible Evaluation Elements** (Including Critical Elements)	**Total *Met***	**Total *Partially Met***	**Total *Not Met***	**Total *NA***	**Total Possible Critical Elements**	**Total Critical Elements *Met***	**Total Critical Elements *Partially Met***	**Total Critical Elements *Not Met***	**Total Critical Elements *NA***
I. Select the Study Topic(s)	2					1				
II. Define the Study Question(s)	1					1				
III. Define the Study Population	1					1				
IV. Select the Study Indicator(s)	2					1				
V. Use Sound Sampling Techniques	7					2				
VI. Reliably Collect Data	4					2				
VII. Analyze Data and Interpret Study Results	3					1				
VIII. Improvement Strategies	6					3				
IX. Assess for Real Improvement	2					1				
X. Assess for Sustained Improvement	1					1				
Totals for All Steps	**29**					**14**				

Table B-2 PIP Validation Overall Score for <PIP Topic> for <Plan Name>	
Percentage Score of Evaluation Elements *Met**	**%**
Percentage Score of Critical Elements *Met***	**%**
Validation Status***	***<Met, Partially Met, or Not Met>***

* The percentage score for all evaluation elements *Met* is calculated by dividing the total *Met* by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*. The Not Assessed and Not Applicable scores have been removed from the scoring calculations.

** The percentage score for critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

*** Validation Status: See confidence level definitions below.

EVALUATION OF THE OVERALL VALIDITY AND RELIABILITY OF PIP RESULTS
HSAG assessed the validity and reliability of the results based on CMS validation protocols and determined whether the State and key stakeholders can have confidence in the reported PIP findings. Based on the validation of this PIP, HSAG's assessment determined the following:
Met:* High confidence/confidence in reported PIP results. All critical evaluation elements were *Met,* and 80 to 100 percent of all evaluation elements were *Met* across all steps.** ***Partially Met:* Low confidence in reported PIP results. All critical evaluation elements were *Met,* and 60 to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met. ***Not Met:* All critical evaluation elements were *Met,* and less than 60 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met.***
Validation Status ☐ ***Met*** ☐ ***Partially Met*** ☐ ***Not Met***

Excerpts from CMS Guidance for EQR Validation of Performance Improvement Projects

From Medicaid.gov https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html:

Important EQR-Related Definitions

- EQRO is an organization that meets the competence and independence requirements set forth in 42 CFR 438.354, and performs external quality review, other EQR-related activities as set forth in 42 CFR 438.358, or both.
- Validation means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.
- Quality as it pertains to external quality review, means the degree to which an MCO or PIHP increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

EQR-Related Activities and Protocols

The EQR process consists of three mandatory and five optional EQR-related activities. Each of these EQR-related activities has a corresponding EQR protocol which provides detailed instructions on how to complete the activity.

From EQR Protocol 3: Validating Performance Improvement Projects (PIPs)

PURPOSE AND OVERVIEW OF THE PROTOCOL (pg. 3)

This mandatory protocol is used to determine whether a health care quality performance improvement project (PIP) was designed, conducted, and reported in a methodologically sound manner. The purpose of a PIP is to assess and improve the processes and outcomes of

health care provided by an MCO. Protocol 3 specifies procedures for EQROs to use in assessing the validity and reliability of a PIP.

Step 8: Assess the MCO's Improvement Strategies (pgs. 13-14)

In this step, the reviewer determines the appropriateness of the strategy for achieving true improvements. Real, sustained improvements result from a continuous cycle of measuring and analyzing performance, and developing and implementing system-wide improvements. Actual improvements depend on thorough analysis and implementation of appropriate solutions.

An improvement strategy is defined as an intervention designed to change behavior at an institutional, practitioner, or beneficiary level. The effectiveness of the intervention activity or activities is determined by measuring the MCO's change in performance, according to predefined quality measures.

Criteria

Interventions are key to a PIP's ability to bring about improved health care outcomes. Appropriate interventions must be identified and/or developed for each PIP to assure the likelihood of effecting measurable change. If repeat measures indicate that quality improvement actions were not successful (i.e., did not achieve significant improvement), the problem-solving process should begin again with data analysis to identify possible causes and propose and implement solutions. If the quality improvement actions were successful, the new processes should be standardized and monitored.

Potential Sources of Supporting Information

• Current project baseline data

• Previous project data (if available)

• Results of clinical and literature research

• Project evaluation results completed by evaluators

Assessment

To assess the MCO's Improvement Strategies, consider the following questions:

A. Are the interventions related to causes/barriers identified through data analysis and quality improvement processes? 1. Interventions should be based on a root cause analysis of the problem the PIP addresses. It is expected that interventions associated with improvement on quality indicators will be system interventions (i.e., educational efforts, changes in policies, targeting of additional resources, or other organization-wide initiatives to improve performance). Interventions that might have some short-term effect, but that are

unlikely to induce permanent change (such as a one-time reminder letter to physicians or beneficiaries) are insufficient.

Step 9: Assess the Likelihood that Reported Improvement is "Real" Improvement

In this step, the reviewer determines the likelihood that the results of the PIP are accurate. It is important to determine if a reported change represents "real" change or is a result of a short-term event unrelated to the intervention, or simply random chance. Therefore, the EQRO must assess the probability that a reported improvement is a true improvement. Criteria "Real improvement" can be assessed in several ways, but is most confidently assessed by calculating the degree to which an intervention is statistically "significant". This protocol requires the EQRO to assess the extent to which any change in performance reported is statistically significant; however, it does not specify a specific level of statistical significance that must be met. States may establish a required level of statistical significance for findings to be accepted as valid. The EQRO should state in its final report which findings do not meet the required level of statistical significance.

Potential Sources of Supporting Information

• Baseline and repeat measures on quality indicators

• Tests of statistical significance calculated on baseline and repeat indicator measurements

• Benchmarks for quality specified by the State Medicaid agency or found in industry standards

Oregon Health Authority
Ombuds Program

Integral to Oregon Health Plan (OHP) client service and leadership understanding of Oregon Health Plan and Medicaid access and quality trends

QHOC Data Presentation

Today's Presentation

1. Provide overview of Ombuds complaints & concerns process
2. Discuss Ombuds data tracking & use
3. Highlight shared member access to & quality of care issues and themes

2

Why does the Oregon Health Authority have an Ombuds Program?

Oregon Revised Statute (ORS) 414.712 Requires OHA to have one

Scope

The Oregon Health Authority shall provide:

- Ombudsman services for
  - Oregon Medicaid recipients
- An ombudsman shall serve as a recipient's *advocate* whenever there are concerns about
  - access to, quality of or limitations on care

Noteworthy Elements

- Recipients must be informed of availability
- Under the OHA Director's supervision and control
- Reports to the Governor and the Oregon Health Policy Board quarterly

Oregon Health Authority

3

How do OHP Members get to the Ombuds program?

Many different doors:

- All CCO's required to include Ombuds contact information on *Notices of Complaint Resolution.*
- Advocacy organizations, Oregon Law Center & government officials
- Referred to program by
  - CCOs
  - Providers
  - OHA/ DHS staff

Oregon Health Authority

4

Ombuds Intake and Service Process Overview

The Ombuds program considers each caller an engaged client. Engaged clients:

- Are actively involved in efforts to improve their health
- Want to be part of their own care team
- Offer insights into how OHA efforts to improve health, improve care and lower cost are experienced by those we serve.

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Ombuds Complaint & Concerns Process Overview

Ombuds walk alongside Oregon Health Plan members, step into their shoes to understand their care challenges

Reconnect member with those equipped to meet their needs: CCO, care coordinators providers, DHS, community

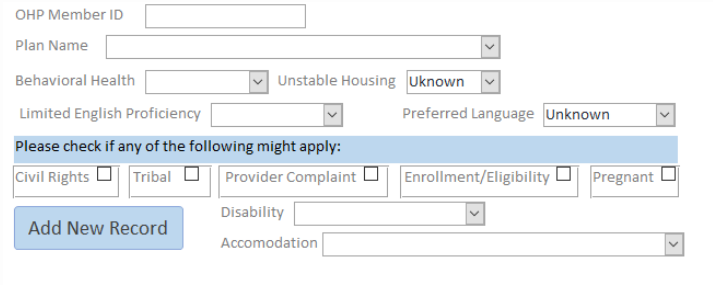
Elevate member voice & experience to inform policies, programs, and operations

Partner with OHA, contractors, DHS and community to support improved health and improved patient experience

6

Ombuds Data Tracking & Use

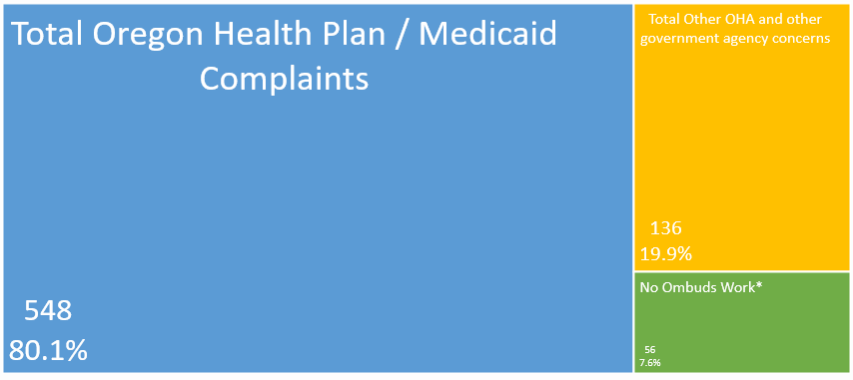
- Data to know who we are serving and their needs
- Data to inform member care & understand how to best support their needs
- Data identifies systems issues impacting member access & quality



7

Ombuds Data Tracking & Use

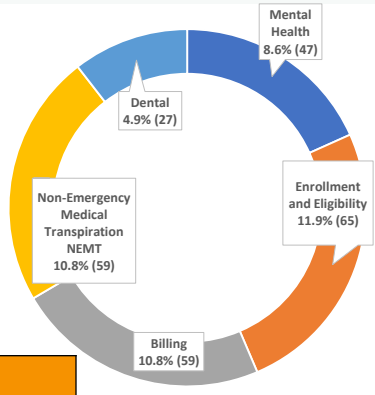
Concerns, Queries, and Complaints to the Oregon Health Authority Ombuds Program
January 1 - June 30, 2019: 740 Total Program Queries



3rd Q 2019: Approximately 200 Ombuds queries per month, representing 300+ distinct concerns

8

Ombuds Data Tracking & Use



Top Oregon Health Plan and Medicaid Related Concerns, Queries, and Complaints to the Oregon Health Authority Ombuds Program January 1, 2019 - June 30, 2019: 548 Total Concerns	Total	Percentage
OHP Enrollment and Eligibility	65	11.9%
Billing	59	10.8%
Non-Emergency Medical Transpiration (NEMT)	59	10.8%
Mental Health *	47	8.6%
Dental	27	4.9%
** Access to services, quality of service, 1915i in-home supports, Continuity of Care request, and other mental health related concerns*		

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Highlight shared member access to & quality of care issues and themes

Data Purpose/ Use

- Hear from members/ understand member needs
- Every caller who makes it through to us is a voice for others who do not
- Ombuds Reports to the Governor and the Health Policy Board are intended to call out system themes, not specific CCOs

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The Ombuds Program and Compliance

- The Ombudsprogram does NOT have a compliance function.
- The Ombuds Program believes in the importance of a healthy, universally understood complaint process as a tool for identifying agency or contractor problem areas.
- The Ombudsprogram does inform leadership and Innovator Agents when trends related to a specific service area are identified.

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Themes for Collaborative Conversation

Care Transition Challenges

- Medicaid – Medicare transition challenges.
- Delays in enrolling in new CCO after address updates.

Access to Care Challenges

- Mental health capacity
- Dentures issues
- Accessing care/ case management

Administrative Challenges

- The power of a well-written complaint letter
- Complaint process vs. Issues resolution
- Notices of Action – member understanding of content

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Questions, Collaboration Opportunities, & Contact Information

?

We are reaching out to all CCO's to strengthen these collaborations with complaints & care teams

Contact Us

877-642-0450

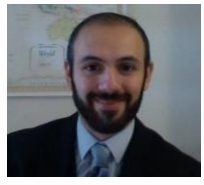
503-947-2346

OHA.OmbudsOffice@dhsoha.state.or.us

Oregon Health Authority

Our Team

Awab Al-Rawe



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Oregon Health Authority