QUALITY & HEALTH OUTCOMES COMMITTEE

Monday, September 13, 2021

10 a.m.–12:30 p.m.

Zoom Call-in Info:

1-669-254-5252 / Meeting ID 160 583 5048/ Passcode 658434

Tips for participating in the meeting

Please remain muted when not speaking

- Zoom: Use the microphone icon to mute/unmute
- Phone: Use *6 to mute/unmute if double muted

When possible, use the “raise hand” function in Zoom under reactions to:

- Be recognized prior to speaking
- Participate in a vote

State your name prior to speaking

- This ensures all listeners can follow the conversation

Agenda

Clinical Director Work Group 10 a.m.–12:30 p.m.			
TIME	**TOPIC**	**OWNER**	**MATERIALS (page #)**
10:00 a.m.	**Welcome/announcements**	Holly Jo Hodges Lisa Bui	TC TA handout (3–6) Benchmark glide path memo (7–17)
10:10 a.m.	**COVID-19: Vaccine update** • **Fall vaccination planning** • **Booster planning, school** • **EOT metric technical Q&A** • **Home-based COVID testing** • **Hospital decompression**	Dawn Mautner Kristen Dillon Stacey Schubert Kate Lonborg	Presentation slides EOT measure specs (18–22) EOT measure FAQ (23–26)
10:55 a.m.	**HSD update** • **Community birth update**	Dawn Mautner	Presentation slides
11:05 a.m.	**Break**		
11:15 a.m.	**Family Connects universally offered home visiting**	Cate Wilcox	Presentation slides
11:40 a.m.	**HERC update**	Ariel Smits	Presentation slides HERC minutes (27–30) VbBS minutes (31-63)
11:55 a.m.	**P&T update**	Roger Citron	Presentation slides
12:10 p.m.	**IIBHT update**	Chelsea Holcomb Beth Holliman	Presentation slides
12:20 p.m.	**Items from the floor**		
12:30 p.m.	**Lunch**		
Quality and Performance Improvement Session 1–3 p.m.			
1:00 p.m.	**QPI introductions/announcements**	Jenna Harms Lisa Bui	Presentation slides
1:10 p.m.	**TQS peer sharing** • **Panel** • **Breakout**	Lisa Bui	Presentation slides
2:45 p.m.	**Items from the floor**	All	
3:00 p.m.	Adjourn		

Announcements

- Metrics & Scoring meeting Sept. 17
  - Benchmark glide path recommendations (also in packet)
    - https://www.oregon.gov/oha/HPA/ANALYTICS/MetricsScoringMeetingDocuments/Benchmark-Glide-Path-Recommendation.pdf
  - M&S public comment period – written comment must be submitted 48 hours prior and/or in-person “virtual” comment on meeting day

COVID-19 vaccine updates

COVID-19 vaccine updates

- Fall vaccination planning and implementation
    - Booster planning, model for school vaccinations
- EOT metric technical Q&Q
- In-home COVID testing
- Hospital decompression

COVID Vaccination Planning and Implementation – Fall 2021

Kristen Dillon, MD, FAAFP

Senior Advisor, COVID Response and Recovery Unit

September 13, 2021

Oregon Health Authority

Context – Pandemic Response

What needs done

- Case investigation and contact tracing
- Vaccination
- Testing
- Monoclonal antibody treatment
- Clinical care and community support for COVID patients

Available to do it

- LPHAs
- Physical health clinics
- Dental, PT, other clinics
- Pharmacies
- OHA Field Ops
- Health Systems
- Hospitals
- Community-Based Organizations

Forecast – COVID-19 Vaccination

NOW -

- Third doses for people with compromised immune systems, 3% of adults
- Strong CDC recommendation for vaccination for pregnant people
- Increased demand due to vaccine requirements from work, school, and others
- “Booster” doses for the general population are not an authorized use and violate the agreement that providers enter with CDC in order to receive vaccine

LATE FALL - Vaccination for children under age 12:

- Current Planning Assumption - Ages 5-11 in November
- Current Planning Assumption - Ages 6 months to 4 years in January
- About 500,000 children in Oregon in these age groups.

FALL - Booster vaccine doses:

- Pfizer has submitted complete data, but the FDA and CDC review process will likely not be complete by Sept 20 because the first FDA review meeting is not until 9/17:
  - It’s unknown if FDA and CDC will authorize booster doses
  - Any recommendation might be for subgroups or for the general population
  - Review and endorsement by CDC Director and Western States Group typically occur within a few days
- Moderna and J&J have not filed complete study data with FDA

Framework - Planning and Implementation

- Equity
  - Prioritize resources to achieve equity
  - Monitor performance
- Access – responsive
  - Locations easy to find and reach
  - Include evenings and weekends
  - Walk-in and scheduled
- Access – capacity
  - Grounded in primary care and pharmacies
  - Formats prioritized to achieve equity (i.e. long term care, BIPOC populations, in-home, worksite, schools)
- Demand/Vaccine Confidence
  - Robust work by OHA ongoing
  - May need to resume prioritization for vaccination slots
  - Community partners have new support and capacity
- Supply
  - Currently identifying assumptions and risks
  - Recommend maintaining a 3-4 week supply on hand
- Systems
  - Communications
  - Policy
  - IT

Framework - Schools

Why

Schools are a crucially important opportunity to achieve public health and equity goals for our young people and their families.

How

- CRRU and ODE are partnering to build a "playbook" for schools that want to provide or host vaccination services
  - Based on experience of districts and partners that already succeeded at this with H1N1 or COVID vaccinations
- Currently, OHA steers schools to their Local Public Health Authority as starting point if they need help offering vaccinations

What

- Catch-up for ages 12+ now
- Start ages 5-11 in November or later
- Large-Scale Vaccination Events
  - Are Effective
  - Partnership of School – host and outreach – with Vaccinator
  - The Vaccinator (pharmacy, clinic, or Local Public Health Authority) comes on-site, either during or outside school hours
  - Including families has been successful
- Small-Scale Ongoing Services
  - 75% of Oregon's School-Based Health Centers have enrolled as pandemic vaccinators

Framework – Prioritization and Timeline

Urgent

- Long-term care facilities (Skilled Nursing Facilities are all covered at this time)
- Health care workforce
- Primary series for unvaccinated and partially vaccinated people

Short-term

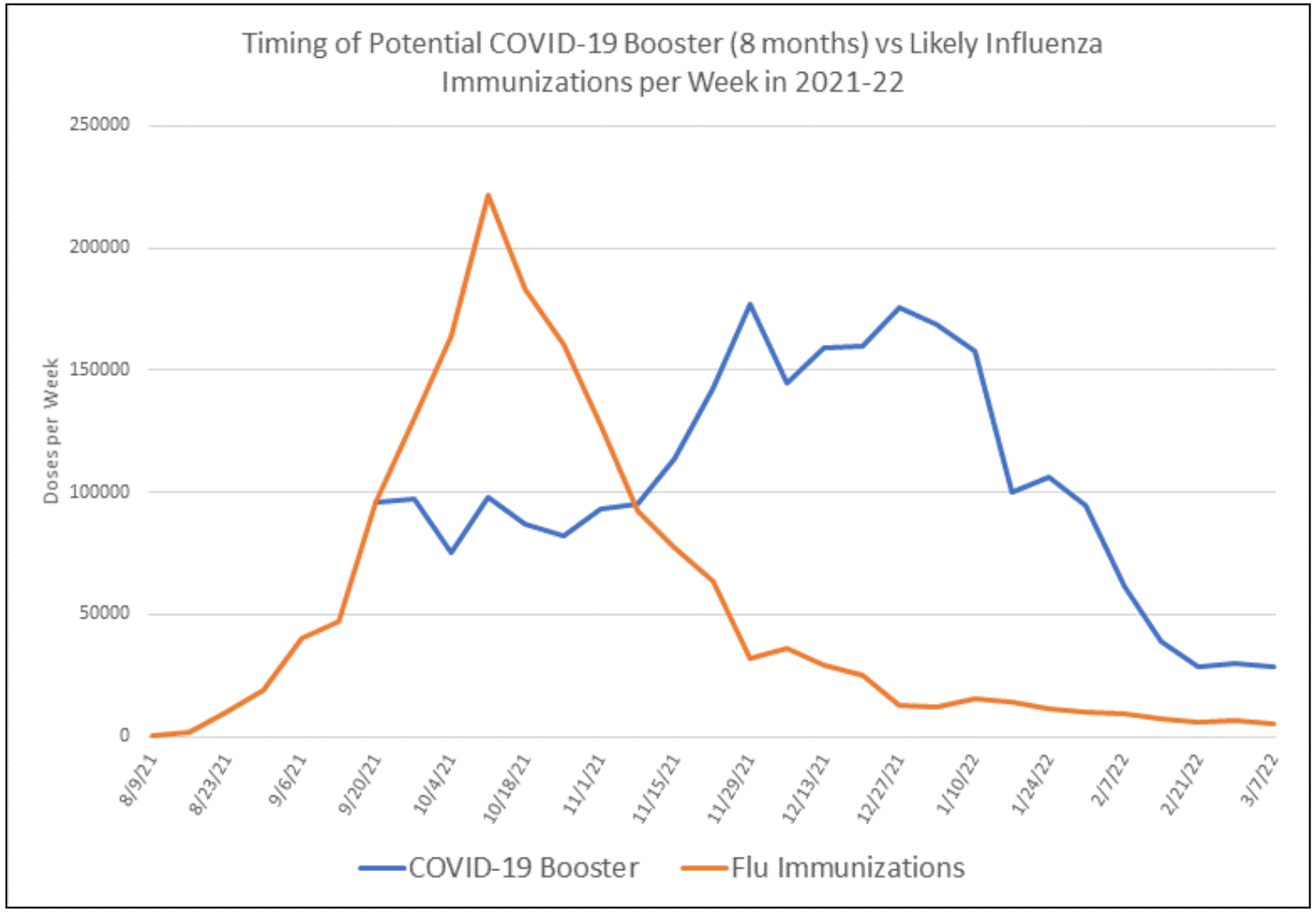
- OHA will provide project management support for vaccination planning and implementation at the regional level
- Meet needs for equity and capacity across all populations and vaccination formats in the coming months

Long-term

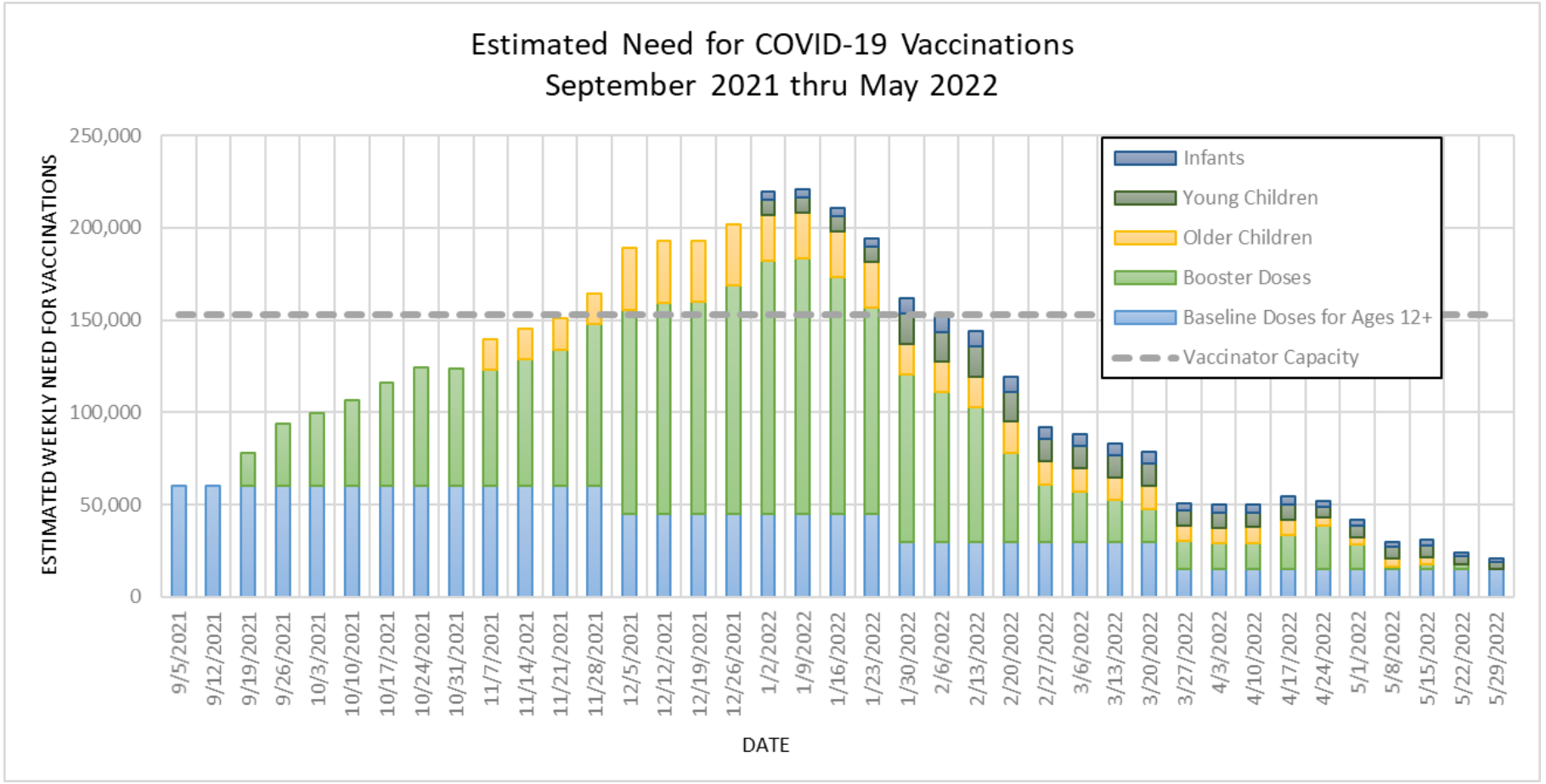
- Continue to move COVID-19 vaccination into typical settings

Oregon Health Authority

Projections – Fall Vaccinations



Projections – COVID Vaccinations Statewide



"Vacinator Capacity" is an estimate of capacity in pharmacies, clinics and similar sites. It uses the highest administration weeks in April 2021 but removes mass vaccination sites, public health, and hospitals from the totals.

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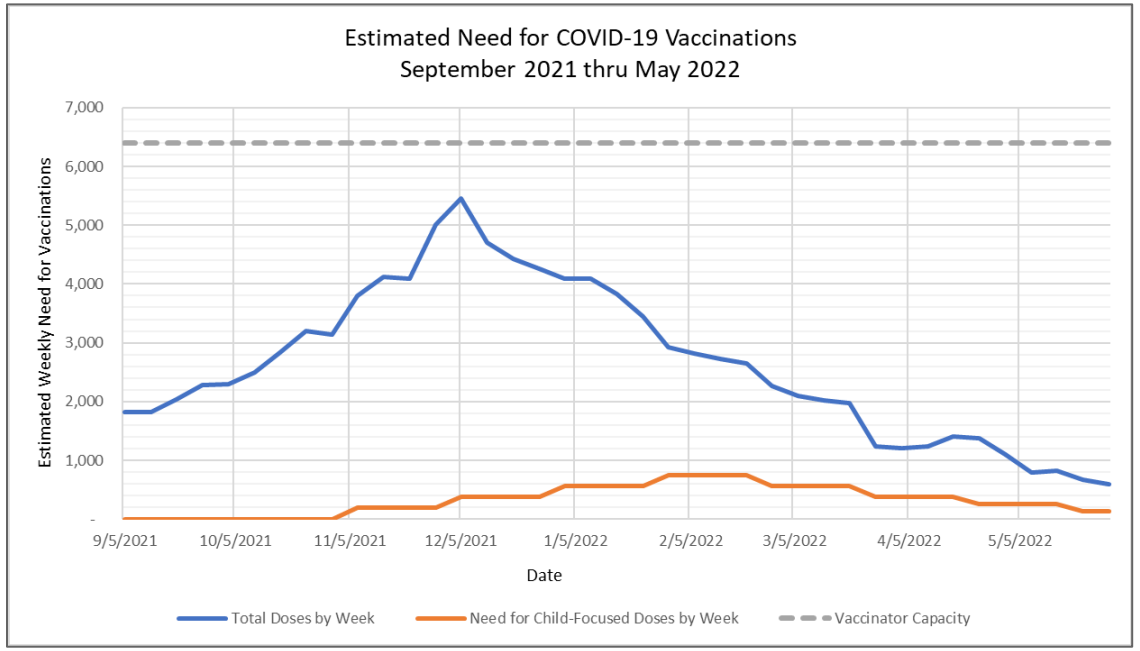
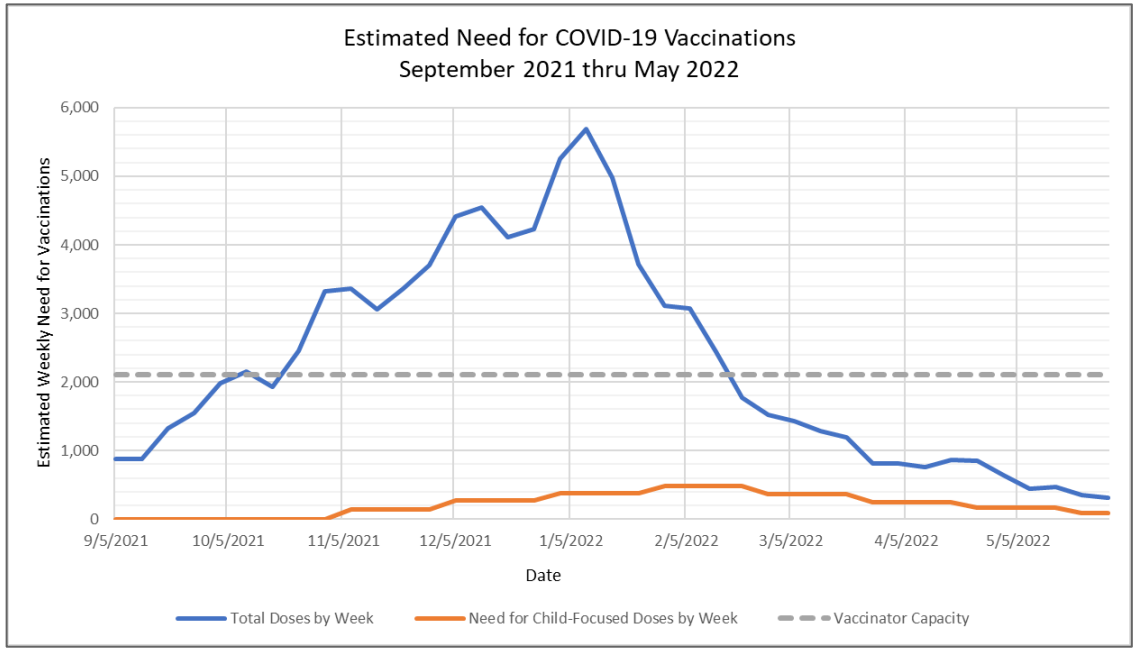
Projections – COVID Vaccinations Regionally

County X



County Y



"Vacinator Capacity" is an estimate of capacity in pharmacies, clinics and similar sites. It uses the highest administration weeks in April 2021 but removes mass vaccination sites, public health, and hospitals from the totals.

What roles can CCOs play in success this fall?

- Outreach and facilitation of vaccination for members
  - Immunocompromised or unvaccinated
  - Ages 12-39
  - Needing in-home or special services
- Activating your provider network to be vaccinators
  - Technical Assistance, Incentives, Coordination
- Sharing your workforce – support your staff's enrolling in SERV-OR and local Medical Reserve Corps and volunteer teams for mass vaccination services
- What else?

Thank You

Oregon Health Authority

EOT metric technical Q&A

Stacey Schubert

Kate Lonborg

In-home COVID testing

Dawn Mautner, MD

Hospital decompression

Dawn Mautner, MD

HSD updates

Dawn Mautner, MD

HSD updates

- Community birth updates

BREAK

PLEASE MUTE YOUR PHONE OR DROP OFF THE CALL

Do not put your phone on hold.

It is better if you drop off the call and rejoin if needed.

Oregon Universally Offered Home Visiting (UoHV) Initiative: Family Connects Oregon

QHOC

September 13, 2021

Cate Wilcox, MPH

Maternal and Child Health Manager

Public Health Division

Oregon Health Authority

Oregon Universally offered Home Visiting Initiative

What is it?

An initiative to strengthen families by offering a voluntary home visit by a nurse shortly after the birth of every child.

Why?

The birth of a child is a big change for **any** family, and most families welcome and need support of some kind, whether that is an answer to a question about breastfeeding or getting connected to a local community resource.

Connecting all families in need to preventative services is the route to community level change, and a cost-effective investment in long-term population health outcomes.

Goals of the Universally offered Home Visiting Initiative

✓**Create and strengthen community level systems of care** for families of newborns

✓**Offer support** to all new parents in Oregon (regardless of risk and insurance status)

✓**Increase access** to community services and supports

✓**Promote collaboration and coordination** across Oregon's early childhood and home visiting systems

✓**Improve health outcomes** for families across the life-course

2019 Legislative Session: SB 526 & POP 401 (Governor's Budget)

SB 526 and Policy Option Package (POP) 401 were passed in the 2019 Legislative Session, establishing the Universally offered Home Visiting (UoHV) program and providing funding for OHA's budget.

SB 526

- **Goal:** To help families give their children a healthier start in life.
- Consists of 2 mandated components:
  - ✓ Directs OHA to design and implement a voluntary universal statewide home visiting program for families with newborns up to six months of age
  - ✓ It requires commercial health benefit plans to offer this service to their members.
- Oregon will be the first state to offer a universally offered home visiting program for all newborns and their families, including families with adopted or foster newborns BY 2026.

POP 401

- OHA budget includes $7.6 million ($4.69 million GF) for the 19-21 biennium to design and begin implementation of a universally offered newborn home visiting service, specifically:
  - ✓ state level infrastructure to implement and maintain the initiative
  - ✓ evaluation, data and technical assistance support
  - ✓ local implementation and Medicaid services
- OHA will begin offering the service to Oregon Health Plan members in 18 early adopter counties in July 2020; commercial plans will roll on in January 2021 due to their rate

Oregon Health Authority

The Family Connects Model

A newborn population health model and systems building strategy with nurse home visits at the center

Evidence Based

- Completed two randomized control trials and 1 quasi-experimental trial
- Recognized by HRSA/MIECHV as an evidence-based model

University Based

- Ongoing Rigorous evaluations
- Non-competitive and value add focused

The Family Connects Model

FOR ALL

Helping all families regardless of income or background

THREE WEEKS

Visits are scheduled around 3 weeks after a baby's birth

NO COST TO RECIPIENTS

As an eligible recipient, you will not be charged

REGISTERED NURSE

All visits are made by highly trained nurses

Oregon Health Authority

Program Components

How Families Experience the Family Connects Model

Pre-natal

Messaging from primary care and prenatal services: “You’ll be visited in the hospital by a nurse who can also visit you in your home for a check-up.”

Birth

Messaging from Family Connects: “Would you like an opportunity to participate in a free check-up at home in a few weeks?”

Home Visit

About 3 weeks post-birth, a RN visits home for 1.5-2 hours:

- Maternal and child health screening
- Education about newborn care, childcare plans, parent child-relationship, managing of infant crying
- Family and home strength, need, and risk assessment, family safety, community safety, household safety, history with parenting
- Parent well being, substance use, parent emotional support
- Referrals to identified interventions; eligibility assessed during home visit for right fit

Warm Hand Off

Follow Up:
For most families, in weeks following visit, telephone contact is enough. Follow up 2nd and 3rd visits are offered as needed for additional assessment or to ensure community connections

Post Visit Connection Call (PVC):
Families receive a phone call 4 weeks post-visit to check on community connections and make additional connections as new needs arise

Common Referral Examples by Matrix Factor

Matrix Domain	Matrix Factor	Referral Example
Support for Health Care	1. Maternal Health	OB/Primary Care Provider
	2. Infant Health	Pediatrician
	3. Health Care Plans	Health plan enrollment
Support for Infant Care	4. Child Care Plans	Child Care Referral Agency
	5. Parent-Child Relationship	Early Head Start, Healthy Families
	6. Management of Infant Crying	PURPLE Crying education
Support for a Safe Home	7. Household Safety/Material Supports	Housing Authority
	8. Family and Community Safety	Social Worker, DV Shelter
	9. History with Parenting Difficulties	Parent Child Interaction Therapy
Support for Parent(s)	10. Parent Well-Being	Mental Health Services
	11. Substance Use in Household	Substance Use Counseling
	12. Parent Emotional Support	Parent Support Groups

Evaluation Results

- 94% of families served had 1+ need for education and/or community resources
- Families experienced more connections to community resources at 6 months
- More positive parenting behaviors with their infant (e.g., nurturing touch, reading) at 6 months
- 28% less clinical anxiety reported by mothers at 6 months
- Higher quality home environments (e.g., safety, books, toys, and learning materials) at 6 months
- 39% reduction in CPS investigations at age 60 months
- Reductions in disparities of White and Black participant families
  - Maternal anxiety disorder gap reduced by 89%
  - Child abuse investigations gap reduced by 28%
  - Infant emergency medical care gap reduced by 14%

Return on Investment

For every $1 spent, $3.17 were saved.

- 50% less total infant emergency medical care (ED visits + overnights in hospital) at age 12 months

- 37% less total infant emergency medical care (ED visits + overnights in hospital) at age 24 months

UoHV Phased Rollout

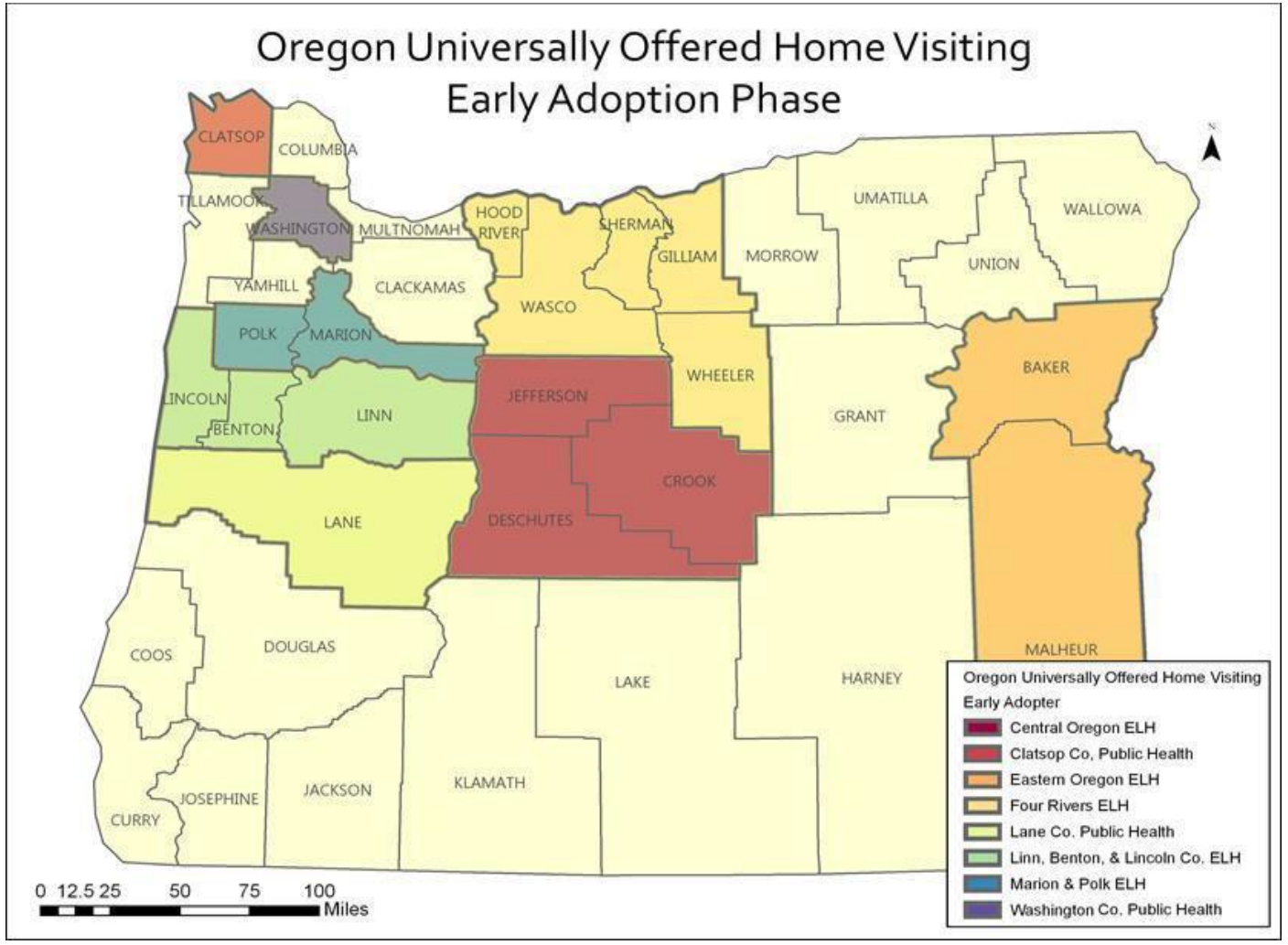
OHA PROJECT PHASE	Pre-Initiation Phase	Phase 1	Phase 1	Phase 2	Phase 3
CALENDAR YEAR	July 2018 – June 2019	July 2019 – June 2021	July 2021 – June 2023	July 2023 – June 2025	July 2025 – June 2027

OHA PROJECT PHASE 1 EXTENDED

UoHV Initiative Early Adopter Cohort Communities

The Early Adopter Cohort Communities are led by the following agencies:

- ✓ Clatsop County Public Health
- ✓ Early Learning Hub Linn, Benton, & Lincoln Counties at Linn-Benton College
- ✓ Early Learning Hub of Central Oregon (High Desert ESD)
- ✓ Eastern Oregon Early Learning Hub
- ✓ Four Rivers Early Learning and Parenting Hub
- ✓ Lane County Public Health
- ✓ Marion and Polk Early Learning Hub, Inc.
- ✓ Washington County Public Health Division



Early Adopter Launch Timelines

May 2021

- Marion County
- Benton County
- Linn County
- Lincoln County

June 2021

- Washington County

September 2021

- Central Oregon (Deschutes, Crook, Jefferson counties)

Early 2022

- Eastern Oregon (Malheur and Baker counties)
- Four Rivers (Hood River, Wasco, Sherman, Gilliam, Wheeler counties)
- Lane County

Building State-level Infrastructure

- Hired initial state level personnel
  - Nurse consultant, health systems integration specialist, evaluation and data analyst, administrative support
- Oregon Administrative Rules
  - Finalized and effective September 2020
- Contracted with Family Connects International
  - Model fidelity assurance, training and technical support
- Steering Committee – established to provide input to the project
- Contracted with Portland State University – to provide program evaluation

Health Plan Integration

Commercial Health Benefit Plans

- Developed a cost-based reimbursement rate, working on credentialling and contracting of service providers (LPHAs initially)

Medicaid

- Currently a carve-out FFS program
- Working with OHA Health Systems Division to integrate this benefit into the CCO benefit package
- Starting slow with CCO coordination and collaboration until the program has more experience and larger service area.

Questions?

oregon.uohv@dhsoha.state.or.us

HERC Update

Ariel Smits, MD, MPH

September 13, 2021

Oregon Health Authority

COVID Coding Update

COVID Coding Update

1) Line 3 PREVENTION SERVICES WITH EVIDENCE OF EFFECTIVENESS

    1) CPT 0013A: 3rd dose of Moderna

2) Line 399 INFLUENZA, COVID-19 AND OTHER NOVEL RESPIRATORY VIRAL ILLNESS

    1) HCPCS M0240 (Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses)

    2) HCPCS M0241 (Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring in the home or residence, this includes a beneficiary's home that has been made provider-based to the hospital during the covid-19 public health emergency, subsequent repeat doses)

VBBS/HERC Meeting Update

August VBBS/HERC meeting

- 2022 ICD-10-CM codes placed
  - Table on website
- Added coverage for COVID antibodies for additional hospitalized patient indications
- Breast cancer index coverage expanded to node positive patients
- PET scans
  - Increased coverage to include limited breast cancer indications
  - Added coverage pre-Aduhelm Alzheimer treatment
  - Restructured guideline for clarity
- Updated Preventive Services guideline to reflect new USPSTF CRC screening age of 45

August VBBS/HERC meeting

- Smoking cessation and elective surgery
  - Added exception for “bloodless surgery”
  - Added wording clarifying that **consultation** is covered while smoking
- New guidelines added for rhinoplasty and septoplasty
- Added coverage for radiofrequency ablation for uterine fibroids
- Added coverage for radiofrequency water vapor ablation of prostate for LUTS
- Added coverage for thrush
- Added coverage for deep brain stimulation for refractory epilepsy

October VBBS Topics

- 2022 CPT/HCPCS codes
- Treatments not reviewed in past 5 years with no recommendation for change:
  - Wireless capsule endoscopy: esophagus and colon
- Minimally invasive treatments for spinal conditions
  - Interspinous/interlaminar process spacer devices
  - Minimally invasive lumbar decompression for spinal stenosis
- Clarification of when neuropsychological testing is covered prior to epilepsy surgery
- Vitiligo

October VBBS Topics continued

- Diabetic monitoring
  - Continuous glucose monitoring for type 2 DM
  - Diabetic test strips
- Acquired penile complications
- Neurectomy for wrist arthritis
- Chronic disease self-management
- Cranial electrical stimulation
- Ankle arthrodesis

Advisory Panels

GAP

- September 29, 2021
- Genetics related 2022 CPT codes
- Prenatal/preconception genetic testing
  - Update guidelines to remove family history prior to testing for preconception and prenatal testing
  - Expanded carrier screening
- Whole genome sequencing

Advisory Panels (continued)

OHAP

- October 6, 2021
- 2022 CDT codes
- Non-restorative caries treatment
- Porcelain crowns
- Expand orthodontia to include handicapping malocclusion

Advisory Panels (continued)

BHAP

- October 18, 2021
- 2022 CPT codes related to behavioral health care
- Nightmare disorder
  - Add to the PTSD line
- Adjustment disorders line update
  - Removes restrictions on Z63.4 (Disappearance and death of family member) and Z71.89 (Other specified counseling) as only secondary diagnoses
- Screening for ACEs

EbGS Update

Next meeting September 9, 2021

High Frequency Chest Wall Oscillation Devices

- Coverage recommendation was for only CF
- Review of public comments
  - Request for increased coverage for bronchiectasis and children with complex medical needs

PANDAS/PANS/AE

- Initial evidence review

Your feedback or issues

HERC.info@dhsoha.state.or.us

Ariel.Smits@dhsoha.state.or.us

Drug Use Research & Management (DURM) Program

OSU Oregon State University College of Pharmacy

Roger Citron, RPh

Oregon Health Authority

August P&T Committee
OHA Approved Recommendations

https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

Approved August 10, 2021

Oncology Policy Updates

- Add the following new FDA-approved antineoplastic agents to Table 1 in the Oncology Agents prior authorization (PA) criteria:

  Rybrevant™ (amivantamab-vmjw); Truseltiq™ (infigratinib); and

  Lumakras™ (sotorasib)

https://www.orpdl.org/durm/PA_Docs/oncology.pdf

Amondys 45™ (casimersen)
New Drug Evaluation

- Update the Duchenne Muscular Dystrophy PA criteria to include casimersen

https://www.orpdl.org/durm/PA_Docs/duchennemusculardystrophy.pdf

Benlysta® (belimumab)
Prior Authorization Update

- Update the PA criteria for belimumab to include the expanded FDA indication for adults with active lupus nephritis

https://www.orpdl.org/durm/PA_Docs/Belimumab.pdf

Sodium-glucose Cotransporter-2 (SGLT-2) Inhibitors Class Update

- Make no changes to the PMPDP based on clinical evidence

- Update the PA criteria as proposed and no longer require PA for preferred SGLT-2 inhibitors

- After comparative cost consideration in executive session:

  Make no changes to the PMPDP

Other Dyslipidemia Drugs Class Update and New Drug Evaluation

- Make Evkeeza™ (evinacumab) non-preferred and require PA to limit use to patients with homozygous familial hypercholesterolemia (HoFH) requiring additional LDL-lowering on maximally tolerated lipid-lowering therapies

- After comparative cost consideration in executive session:

  Make no other changes to the PMPDP

Overactive Bladder Class Update and New Drug Evaluation

- Make no changes to the PMPDP based on clinical evidence

- After comparative cost consideration in executive session:

  Make solifenacin succinate tablets preferred on the PMPDP

Asthma Biologics
Drug Effectiveness Review Project (DERP) Summary

- Make no changes to the PMPDP based on clinical evidence
- Create a PMPDP class entitled “Biologics for Severe Asthma” to include: benralizumab, dupilumab, mepolizumab, omalizumab and reslizumab
- Modify the “Monoclonal Antibodies for Severe Asthma” PA criteria to include expanded indications, apply to all drugs in new class as well as provider administered claims
- After comparative cost consideration in executive session:

  Make no changes to the PMPDP

Phosphate Binders Literature Scan

- Make no changes to the PMPDP based on clinical evidence
- No longer require PA for preferred non-calcium products
- After comparative cost consideration in executive session:

  Make sevelamer carbonate tablets preferred on the PMPDP

HIV Class Update and New Drug Evaluation

- Make no changes to the PMPDP based on clinical evidence

- After comparative cost consideration in executive session:

  Make no changes to the PMPDP

October P&T Committee Meeting

- Meeting scheduled to be held 10/07/2021
- Agenda and Final Documents were posted on 9/07/2021
- https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/meetings-agenda

P&T Committee Vacancies

- The OHA will be appointing to the Committee:
    - 2 physicians (MD or DO); 1 pharmacist; and 1 public member
    - Need to be actively practicing
- Terms are for 3 years and there are 6 P&T meetings annually

https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

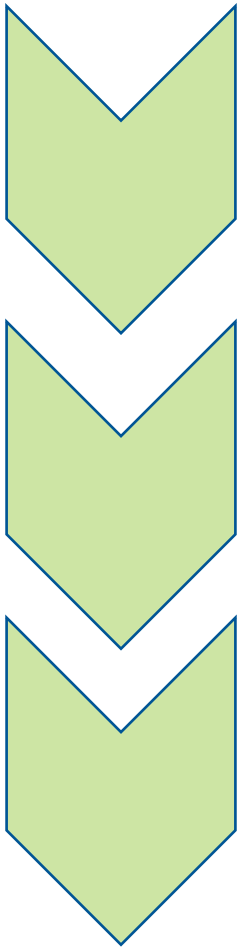
Thank You

Oregon Health Authority

Intensive In-Home Behavioral Health Treatment (IIBHT) Updates

Oregon Health Authority

IIBHT Timeline



- Fall 2019: Legislative Session
- March 2020 State Plan Amendment Approved

- Aug. 2019- April 2020 Develop Medicaid and Program Rules
- Feb/May 2020 OHA Stakeholder Webinar Series

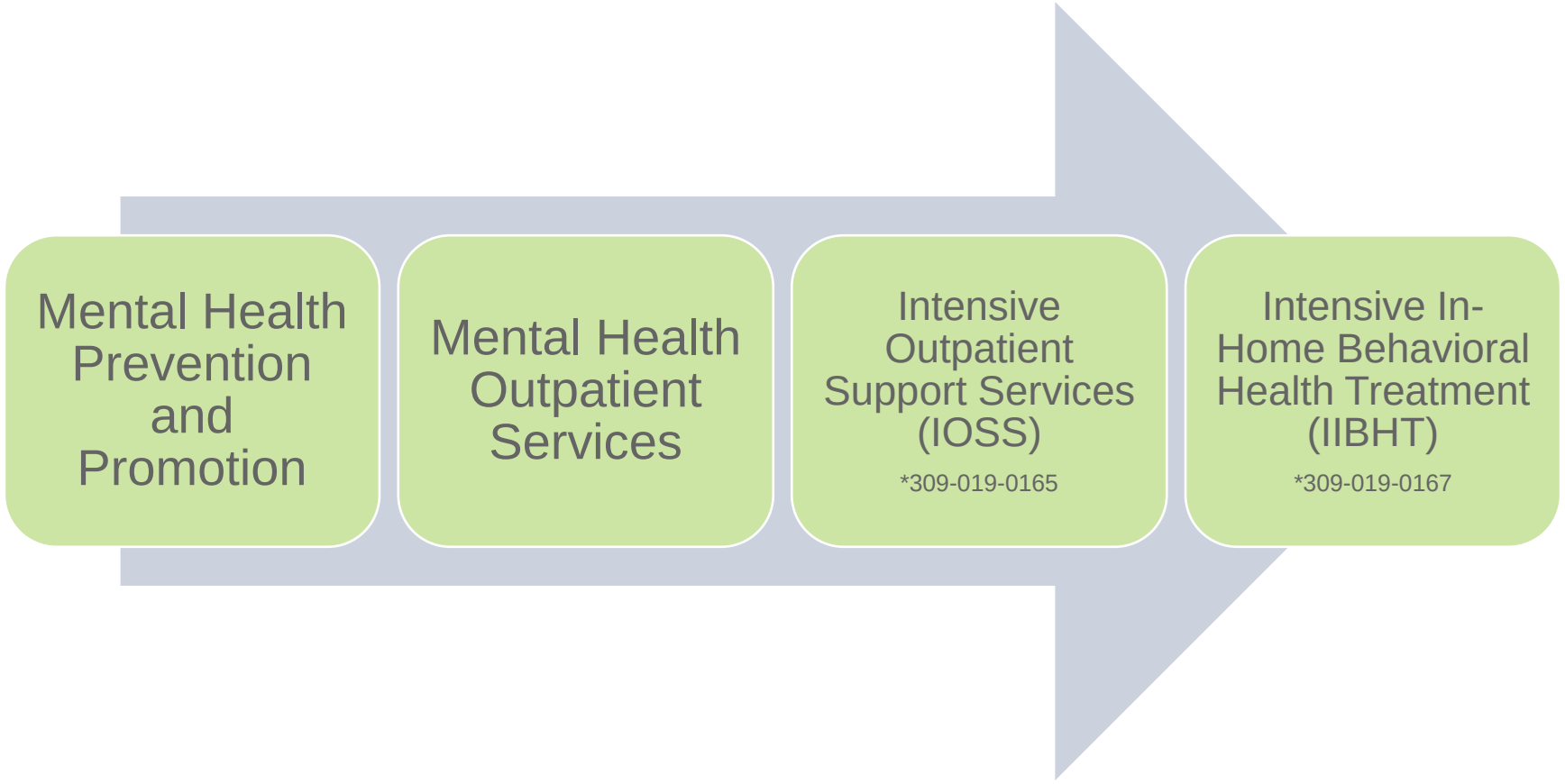
- April 2020 Rules Advisory Committee
- May 2020 Notice of Proposed Rulemaking
- July 2020 OAR Posted

IIBHT Launches

Open Card
July 2020

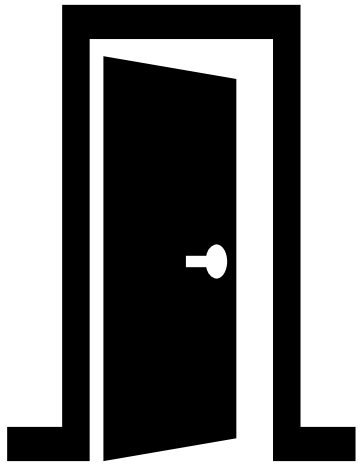
CCO
Jan. 2021

Outpatient Mental Health Continuum of Care



Accessible and Inclusive Care

- ✓ Bridge the gap between residential care and clinic-based outpatient
- ✓ Provide a community-based alternatives available for youth with complex needs
- ✓ Offer a universal model and access across the entire state of Oregon
- ✓ Increased access to higher levels of care, reduce wait time
- ✓ Access to MH services can be difficult for youth with co-occurring I/DD or SUD



IIBHT Certified Providers

Total: 27

1. The Child Center
2. The Next Door
3. Center for Human Development
4. Wallowa Valley Center for Wellness
5. Youth Villages
6. Columbia Community Mental Health
7. Lifeways- Umatilla
8. Lifeways- Malheur
9. New Directions NW
10. Adapt
11. Trillium Youth and Family
12. Catholic Community Services
13. Options of Southern Oregon

IIBHT Certified Providers (cont.)

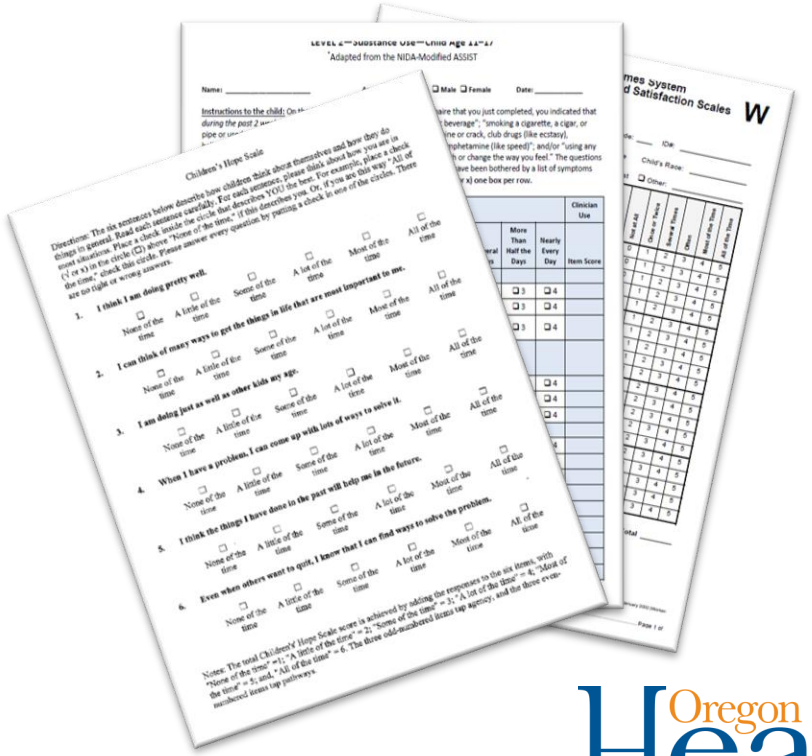
14. Best Care- Cook
15. Best Care- Jefferson
16. Deschutes Behavioral Health
17. Symmetry
18. Community Counseling Solutions
19. Options Counseling
20. Kairos
21. Yamhill County Health and Human Services
22. Tillamook Family Counseling
23. Coos Health and Wellness
24. Clatsop Behavioral Health
25. Klamath Basin Behavioral Health
26. Lake Health District

Pending: Lincoln County Health and Human Services

OHSU
Data Evaluation and Technical Assistance (DEATA) Team

OHSU is leading the statewide quality improvement and outcomes monitoring project.

REDCap
Research Electronic Data Capture



Oregon Health Authority

Redcap Enrollment Data updated 090721

34 Total Youth

27 Open Cases

6 Discharges

Youth by Provider

- ✓ Best Care (4)
- ✓ Center for Human Development (4)
- ✓ Coos Health and Wellness (6)
- ✓ Adapt (6)
- ✓ Lifeways (2)
- ✓ Options for Southern Oregon (9)
- ✓ Yamhill County (1)
- ✓ Youth Villages (2 Open Card Youth)

Youth by Payer

- ✓ Advanced Health (6)
- ✓ Eastern Oregon CCO (6)
- ✓ Jackson Care Connect (6)
- ✓ Umpqua (6)
- ✓ Pacific Source-Central (4)
- ✓ All Care (3)
- ✓ *Open Card (3) **tentative data*

IIBHT Training Updates

OHA Training	Description	Total Attendees Jan-July 31, 2021
IIBHT Foundations	The pre-requisite training for all other IIBHT trainings. Includes history of IIBHT, an overview of the model and team members, best practices in service delivery, and an overview of quality improvement and professional development	114
REDCap DataBase	A required training for all data collection and entry staff. Includes an overview of the data collection measures and a step-by-step REDCap tutorial.	55
IIBHT Clinician Specific Training	An in-depth training on the clinical requirements for IIBHT. Includes a detailed look at the IIBHT clinician workflow, evidence-based therapeutic interventions, and best practices for special populations and cross-systems collaboration. Also includes psychiatry role on the team and all information specific to clinical supervision. 10 CEU Available.	34
Peer Delivered Services, Skill Training and QMHA	An in-depth look at the roles filled by family and youth/young adult peer service providers and skills trainers, as applied in the IIBHT program. Includes working on cross-disciplinary teams that have a strong clinical focus and provides information for QMHA level providers on the IIBHT team.	45

IIBHT Learning Collaboratives

1st and 3rd Fridays
9-10 a.m.
Click here to join the meeting

Get the latest program information from OHA

Connect with peers and leadership across the state

Troubleshoot challenges in service delivery

Get data and quality improvement updates from OHSU

Contact Information

Beth Holliman, LPC

Intensive Community Based Services Coordinator

Beth.Holliman@dhsoha.state.or.us

503 820-1197

IIBHT Website: https://www.oregon.gov/oha/HSD/BH-Child-Family/Pages/IIBHT.aspx

Items from the floor

Lunch

PLEASE MUTE YOUR COMPUTER/PHONE OR DROP OFF THE CALL

Do not put your phone on hold.

It is better if you drop off the call and rejoin if needed.

QUALITY PERFORMANCE IMPROVEMENT (QPI) SESSION

Monday, September 13, 2021

1–3 p.m.

Zoom Call-in Info:

1-669-254-5252 / Meeting ID 160 583 5048/ Passcode 658434

Tips for participating in the meeting

Please remain muted when not speaking

- Zoom: Use the microphone icon to mute/unmute
- Phone: Use *6 to mute/unmute if double muted

When possible, use the “raise hand” function in Zoom under reactions to:

- Be recognized prior to speaking
- Participate in a vote

State your name prior to speaking

- This ensures all listeners can follow the conversation

QPI Updates

Statewide 1115 Integration PIP

- Social emotional health measure value set being completed. Cross walk between social emotional health measure and statewide PIP MH Access Monitoring measure will be conducted.
- Any edits to MH Access Monitoring value sets will be discussed and informed here at QHOC.

SUD statewide PIP development to begin late 2021.

- What meeting structures do we want to support this development work?
- QHOC time or alternate monthly meeting?

DRAFT

Statewide SUD PIP development timeline

May	• (2021) Inform CCOs
Fall 2021	• Brainstorm topic, Select topic
Spring 2022	• Define study aim, Define population; develop metric
Summer 2022	• (2022) Metric viability review; develop metric specifications
Fall 2022	• Develop summary document
Jan	• (2023) PIP projects begin

Oregon Health Authority

Transformation and quality strategy (TQS): Peer learning session

Tech helpful hints

If you called in by phone AND joined by computer do the following:

On your computer

1. From Zoom control panel, select the arrow by the Mute/Unmute button.
2. Select “Switch Phone to Audio”.

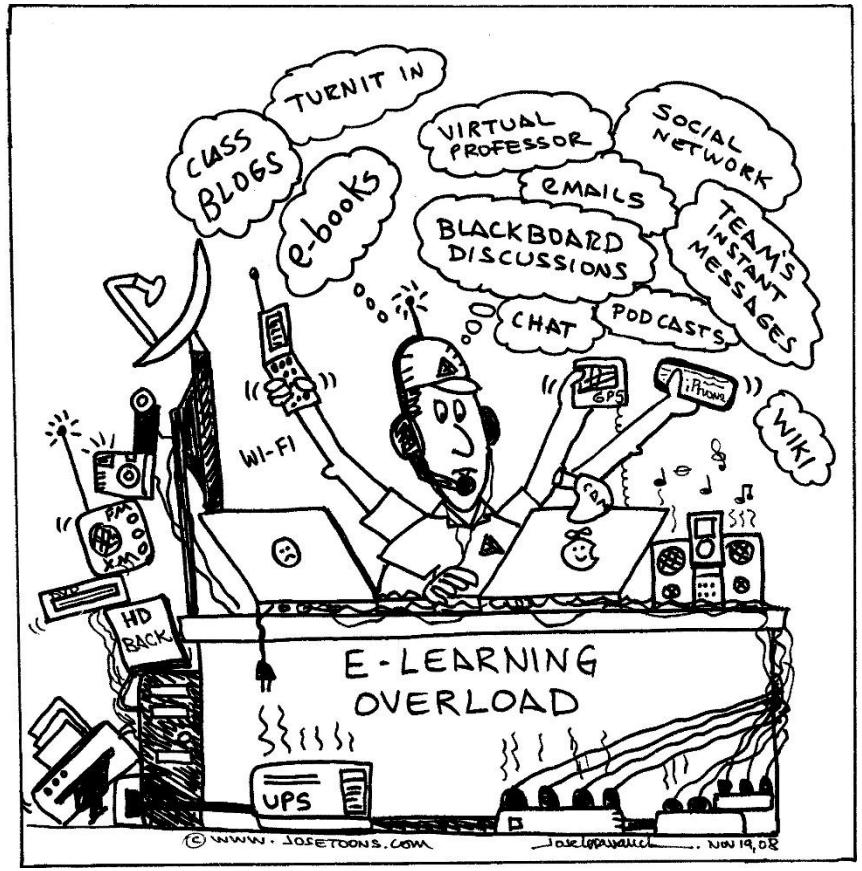
On your phone type in the #code#.

1. The code is the unique participant ID that is listed when you click the switch to Phone audio button.

Doing the above will combine your computer and phone as one zoom user.

Agenda

Peer learning overview instructions	5 minutes
Panel	30 minutes
Panel Q&A	10 minutes
Transition to breakout room	2 minutes
Breakout Session	20 minutes
Transition to breakout room	2 minutes
Breakout Session	20 minutes
Wrap up	10 minutes



Oregon Health Authority

TQS panel presentation

Three projects will be presented by CCOs for component areas that had consistent opportunities for learning amongst CCOs.

- **Access: Timely –** Timely Hospital Follow Up for FBDE Members (IHN, Caleb Larson)
- **Utilization Review –** Implementing Medicaid Efficiency and Performance Program (Health Share of Oregon, Kristen Lacijan-Drew)
- **SPMI, BHI –** Behavioral Health Neighborhood (Yamhill, DeAnn Carr)

Timely Hospital Follow-up for FBDE Members

Component Focus: Access
Timely

InterCommunity Health Network CCO

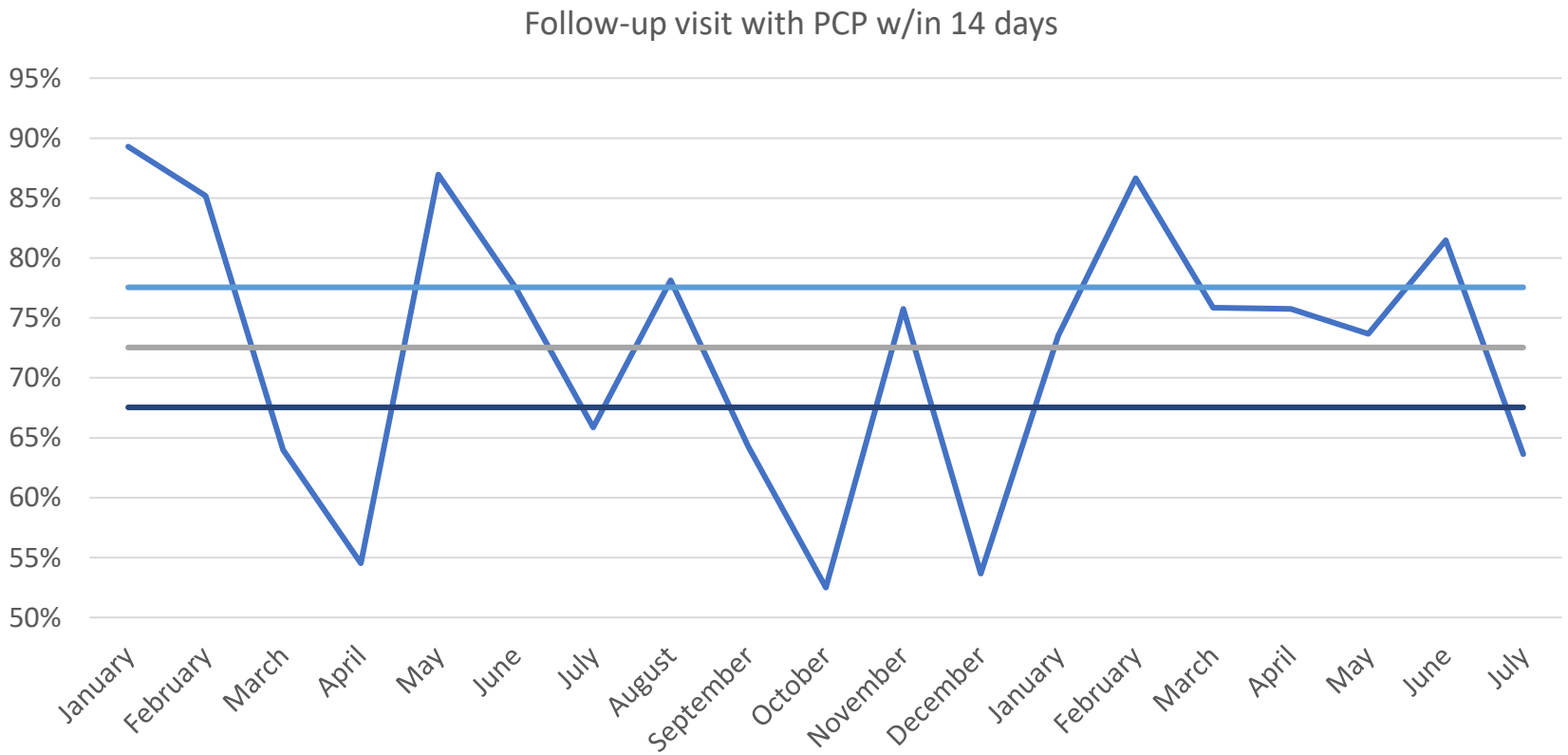
Summary

- Focused Population: Full Benefit Dual Eligible and Special Needs Plan Population
- Project: To ensure timely hospital follow-up for acute hospitalization
- Component: Access - Timely

InterCommunity Health Network CCO

Current State Analysis

High variation in process outcomes



InterCommunity Health Network CCO

Deep dive into the Data

Evaluating the complexities within reporting

Focus on establishing accurate and timely reporting

Work sessions with clinical concurrent team to identify opportunities

Developing data driven decisions

InterCommunity Health Network CCO

Observed opportunities for improvement

- Turnover in staffing, and limited hiring pool is creating limited nurse capacity to conduct concurrent review and outreach
- Limited availability of PCP hospital follow-up appointments
- Lack of education awareness of hospital staff to set-up follow-up appointment before discharge
- Members relationship with PCP
- Communication of discharge from out of area facility

InterCommunity Health Network CCO

Next steps

- Provider outreach
- Assess the Interdisciplinary Care Team barriers
- Hospital staff engagement in work flow improvement
- Hospital staff education development

InterCommunity Health Network CCO

Health Share TQS Utilization Review project: “Implementing Medicaid Efficiency and Performance Program (MEPP)”

- Combination MEPP and TQS deliverable
- Included our three MEPP episodes: Substance Use Disorder (SUD), Diabetes, and Pregnancy
- Themes for today’s presentation:
    - Monitoring over and under utilization
    - Action steps based on monitoring
    - Logistics of combining two deliverables

health share

Key Project Theme: Monitoring Over and Under Utilization

Under-utilization:

- Described WHAT we monitor: primary care, dental, behavioral health utilization
- Described WHERE monitoring occurs: Clinical Advisory Panel, Behavioral Health Advisory Council, Quality Health Outcomes Committee

Over-utilization:

- Through MEPP (below) and participation in the OHLC Reducing Ineffective Care Workgroup

MEPP Specific:

- SUD: Initiation and Engagement in Treatment (IET) (especially among members with Alcohol Use Disorder), Medication for Opioid Use Disorder, number of value-based payments.
- Diabetes: A1c metric, Diabetes Integration Project implementation, Oral health integration project implementation.
- Pregnancy: Members served by doulas, the number of doulas of color, members served by Project Nurture, *C-section rate*.

health share

Action Steps based on Monitoring

Overall: Utilization Review Workgroup pivoted to existing governance structure: Clinical Advisory Panel, QHOC, MEPP analysis

MEPP Specific Action Steps:

- MAT expansion strategies (plan partner specific), increase value-based payment structures, develop regional AUD strategy.
- Diabetes: Oral health integration project- focus on stabilization of existing programs. Diabetes Integration Project- continue to develop tools/workflows.
- Pregnancy: Expand Project Nurture services, increase value-based payment structures, increase doulas of color.

health share

Logistics of Combining Two Deliverables

- Continuation/expansion of last year's project, utilization review, which already included Prometheus (MEPP).
- Two sections: Overall over- and under-utilization and MEPP specific.
- Milestones focused on MEPP.
- Included all the MEPP requirements (i.e., summarize changes to each intervention, progress on milestones, updated narrative about cost estimates, etc.) within the TQS format.

Monitoring activity 1a for improvement: Continued implementation of ongoing action plan items

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Multiple SUD, Diabetes, and Pregnancy activities are in process.	Continued activity implementation in 2021.	12/2021	Continued activity implementation in 2021.	12/2021

Monitoring activity 1b for improvement: Completion of the outstanding action plan items

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Four MEPP milestones were either partially met or not met in 2020.	All MEPP milestones are met.	12/2021	All MEPP milestones are met.	12/2021

health share

QUESTIONS?

Feel free to reach out for more information:

lacijank@healthshareoregon.org

Behavioral Health Neighborhood

Yamhill Community Care Organization

Oregon Health Authority

Baseline Statement

- High service utilizers (e.g. 5 ED visits/12 months, total cost of care > $1k/12 months etc.) constitute about 5% of YCCO patients yet consume 50% of overall costs.

Background

A high percentage of these patients have mental health issues, substance abuse issues, or both.

Many of these members also have other comorbidities such as diabetes, hypertension, and obesity.

The social determinants of health (SDOH) of Health and Health Care is a determinant area that disproportionately impact individuals with behavioral health challenges.

Development Work

2016

YCCO partnered with consultants to develop an Integrated Complex Care (ICC) model

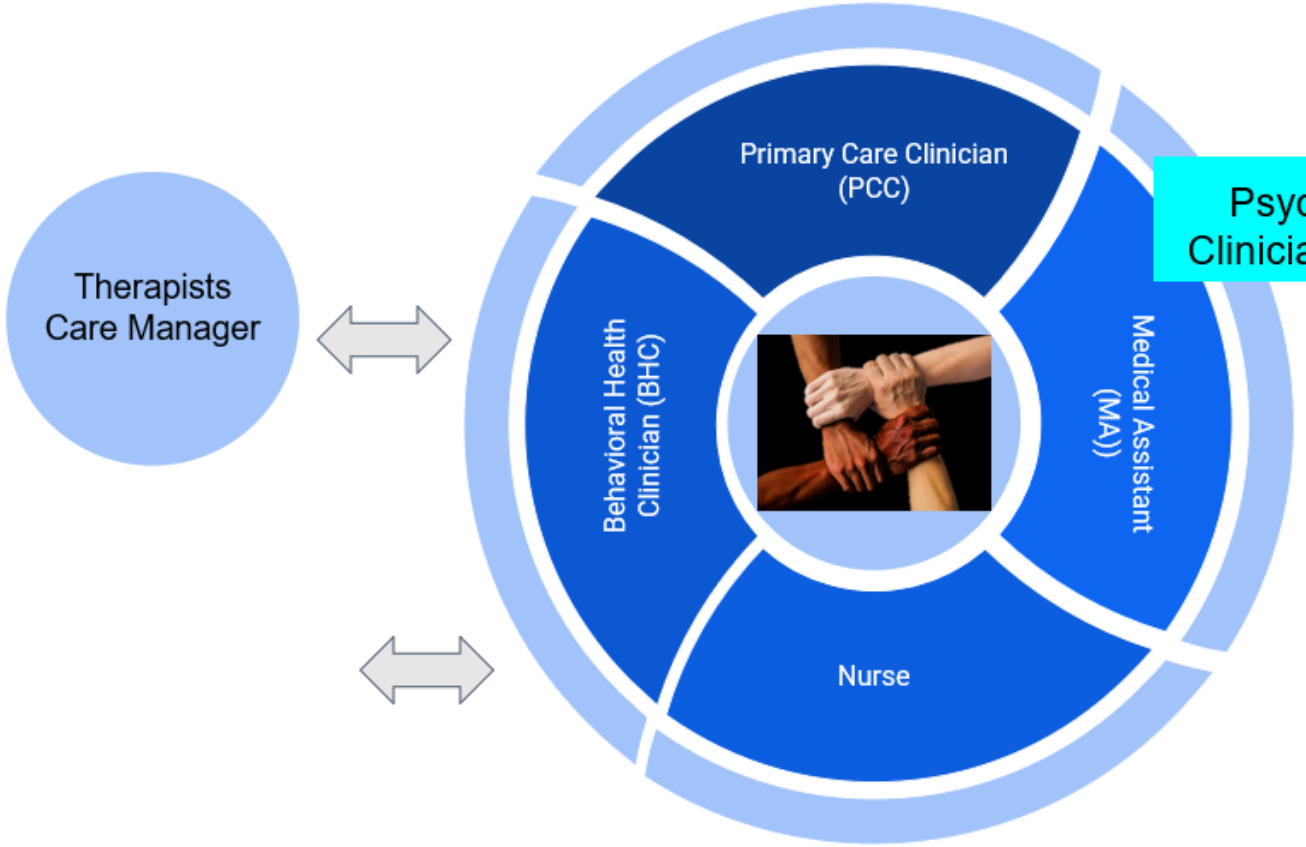
2018

ICC work developed into the Behavioral Health Neighborhood model in 2018.

2019

The structures of the BH Neighborhood were put in place in 2019.

Behavioral Health Neighborhood Model



"Grow-our-own" excellent BHC workforce (psychologist residents)

Increase BHC FTE in both clinics

Assign FT BHC to 2-3 primary care teams

Build care management push reports

Leverage Premanage

Support PCC/BHC services by providing Psychiatric, clinician-advisor services (YCCO members)

Build collaborative relationships between YC-HHS therapists and PC BHCs

PMC Physicians Medical Center PC

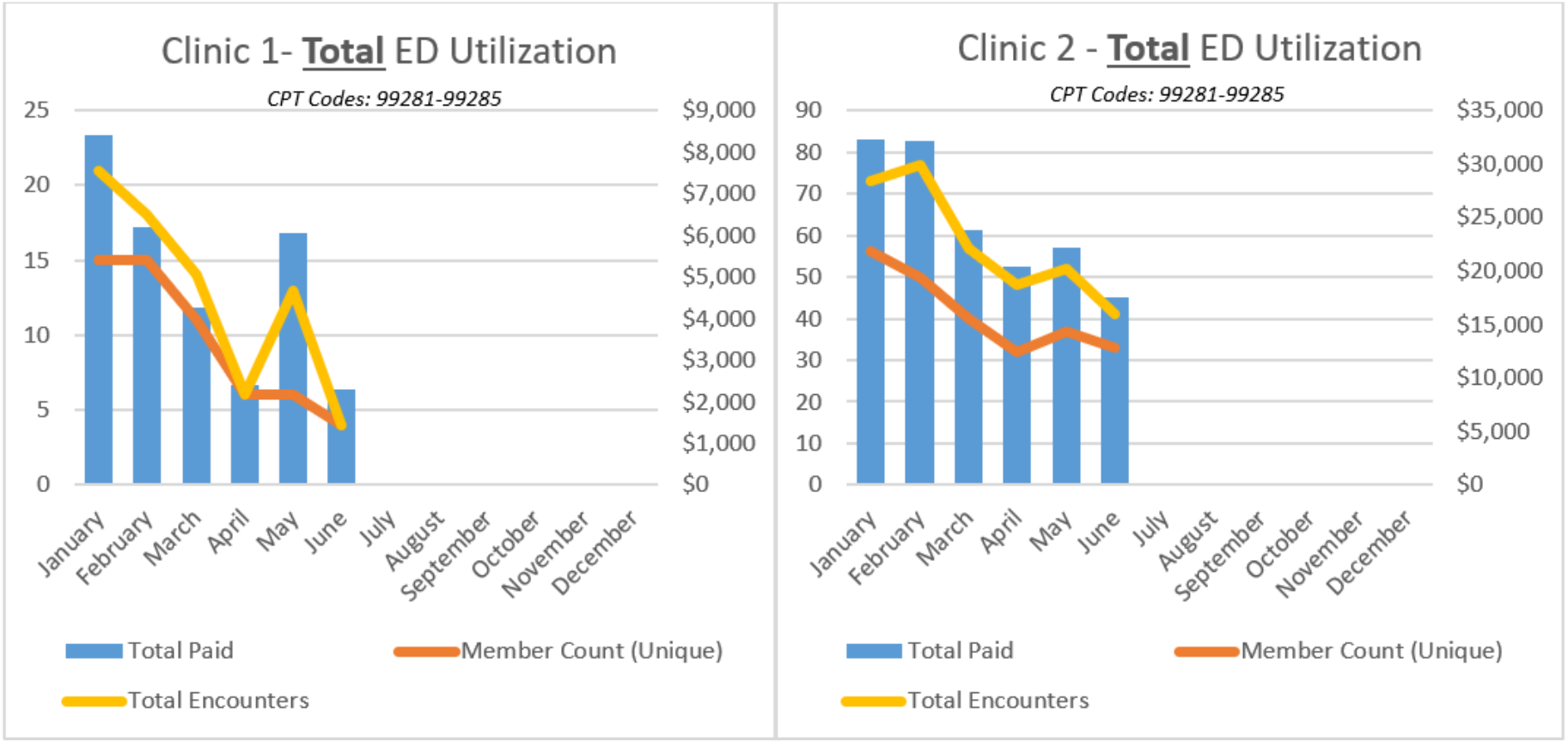
Virginia Garcia Memorial HEALTH CENTER

Oregon Health Authority

Process

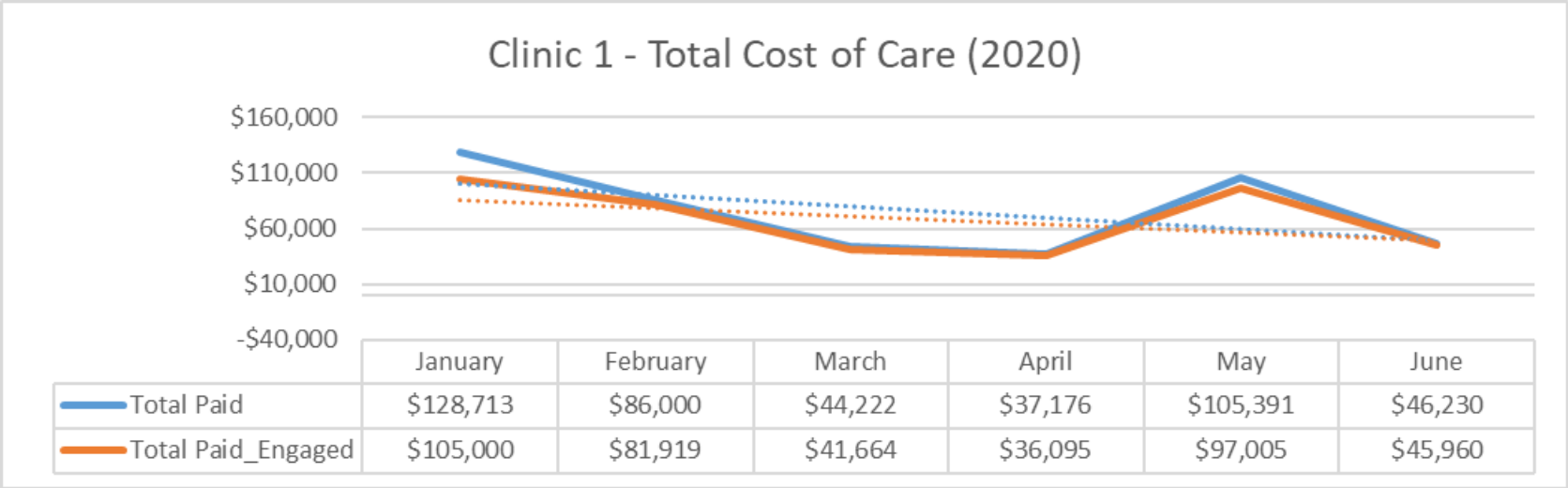
- YCCO generates members lists for the clinics
- The clinics reach out to members and enroll members in the BH Neighborhood cohort
- Care Plans and member information shared between providers via The Collective Platform

Impacts of the Program
ED Utilization

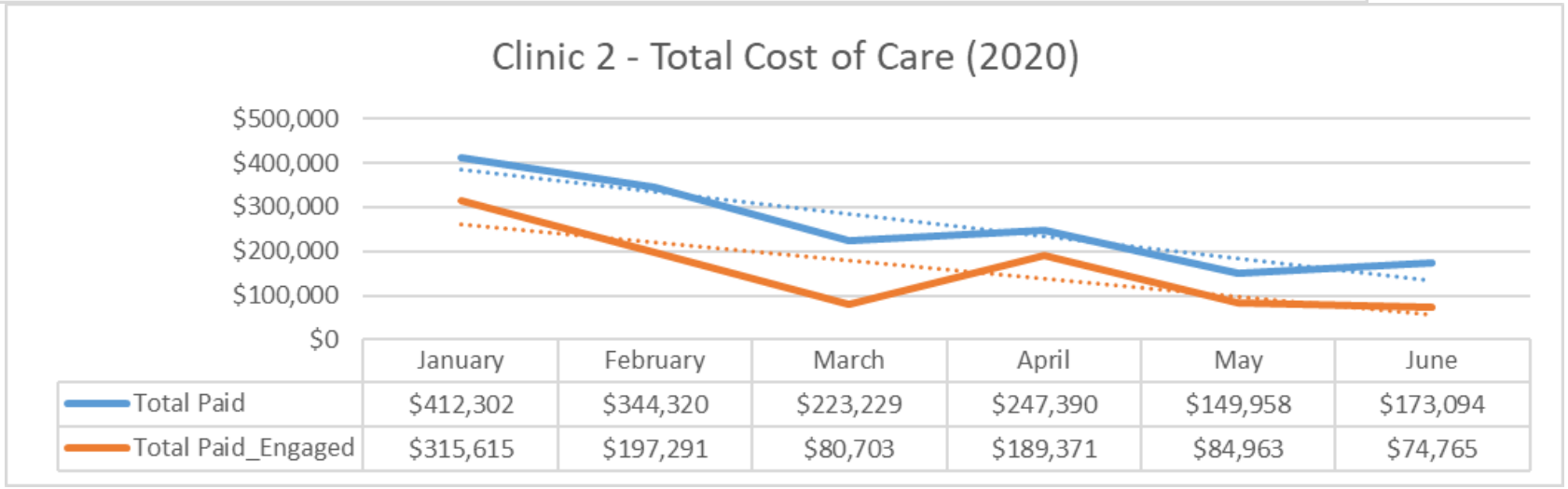


Impacts of the Program

Total Cost of Care



	January	February	March	April	May	June
Total Paid	$128,713	$86,000	$44,222	$37,176	$105,391	$46,230
Total Paid_Engaged	$105,000	$81,919	$41,664	$36,095	$97,005	$45,960



	January	February	March	April	May	June
Total Paid	$412,302	$344,320	$223,229	$247,390	$149,958	$173,094
Total Paid_Engaged	$315,615	$197,291	$80,703	$189,371	$84,963	$74,765

TQS panel Q&A

TQS breakout discussion

✓Each breakout room will have two CCO projects to discuss.

✓Begin with a brief project summary by each CCO point of contact for the two assigned breakout room projects.

✓Open discussion amongst breakout room participants and CCO points of contacts

Tips for peer learning

Mental presence is needed

We all have a piece in “making the picture”

Active listening is required

No stupid questions or bad ideas

Everyone has a voice

Ask clarifying questions

Keep the goal present: learning, sharing

Avoid going into the weeds as group

Adapted from Aecumen.com

Zoom Breakout Room	CCO	TQS topic (TQS component)	CCO point of contact
1	Advanced Health	**Oral Health Integration for Members with Diabetes** (Oral Health Integration)	Amanda McCarthy
1	PacificSource PS-CO PS-CG PS-Lane PS-Marion, Polk	**Diabetes: Inter-professional Care Collaboration between Primary Care and Dental Providers** (Oral Health Integration)	Michelle Zuiderweg
2	AllCare	**Health Equity, African American PCP visits** (Health Equity Data & Cultural Responsiveness)	Stick Crosby
2	Health Share	**Equity Driven Best Data Practices** (Health Equity Data)	TBD
3	CPCCO	**Baseline Assessment: Anonymous Consumer** (CLAS [Culturally Linguistic Accessible Services])	Maranda Varsik
3	EOCCO	**TQS Language Access Plan project** (Access: Cultural Considerations)	Courtney Valenzuela
4	JCC	**Medication for Addiction in Primary Care Payment Model** (Behavioral Health Integration)	Julia Jackson, Darian Dale
4	Yamhill	**Behavioral Health Neighborhood** (SPMI, Behavioral Health Integration)	DeAnn Carr
5	CHA	**Food Hub: Mill Addition Neighborhood, Klamath Falls** (Social Determinants of Health Equity)	Cally McCool
5	Trillium Lane Tri-County	**Cultural Competency Training** (Health Equity: Cultural Responsiveness)	Tina Potter
6	IHN	**Wellness to Smiles** (Oral Health Integration)	Caleb Larson
6	Umpqua	**Grievance and Appeal System: Access and Provider Interaction** (Grievance & Appeal)	Lindsey Birch

TQS resources

- 2021 CCO submissions and assessments
  - https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy.aspx
- 2022 webinar and office hours schedule (TA starts in October)
  - https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx
- 2022 guidance documents will be posted Oct. 1

- OHA TQS leads:
  - Lisa Bui: Lisa.T.Bui@dhsoha.state.or.us
  - Anona Gund: Anona.E.Gund@dhsoha.state.or.us
  - Veronica Guerra: Veronica.Guerra@dhsoha.state.or.us


Thank You

Items from the floor