Oregon Health Authority
Quality and Health Outcomes Committee
AGENDA

MEETING INFORMATION
Meeting Date: February 10, 2020
Location: HSB Room 137 A-D, 500 Summer Street, NE, Salem, OR
Parking: Map Phone: 503-378-5090 x0
Call in information: Toll free dial-in: 888-278-0296 Participant Code: 310477
Webinar: https://attendee.gotowebinar.com/register/7360859116154118923
All meeting materials are posted on the QHOC website.

Clinical Director Workgroup 10:00 a.m. – 11:00 a.m.			
Time	**Topic**	**Owner**	**Materials (page#)**
10:00 a.m.	**Welcome / Announcements**	Holly Jo Hodges	-Speaker's Contact Sheet (2) -Public Health Update (3-4) -TC TA for CCOs (5-10)
10:05am	**HIT Strategic Updates**	Susan Otter	-Presentation slides (11-14) -Health IT Strategic Plan (15-18)
10:15am	**HERC**	Cat Livingston Ariel Smits	-Presentation slides (19-21) -HERC minutes (22-40)
10:45am	**P&T**	Roger Citron	-Presentation slides (41-48)
Learning Collaborative 11:00 a.m. – 12:30 p.m.			
11:00 a.m.	**Kindergarten Readiness Learning Collaborative**		Presentation slides (50-76)
12:30pm	**LUNCH**		
Quality and Performance Improvement Session **1:00 pm – 3:00 p.m.**			
1:00 p.m.	**Welcome / Announcements**	Jenna Harms Lisa Bui	
1:05pm	**Updates** **- TQS**	Lisa Bui	
1:20 pm	**CCO Performance Improvement Project**	All	Presentation slides 76-83 PIP matrix
2:45	**Items from the floor**	All	

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.

OHA contact info: lisa.t.bui@state.or.us

Topics may be subject to change due to availability

SPEAKER CONTACT SHEET
QHOC – February 2020

AGENDA TOPIC	SPEAKER	CONTACT INFO
HERC Update	Cat Livingston Ariel Smits	catherine.livingston@dhsoha.state.or.us ariel.smits@dhsoha.state.or.us
P&T Update	Roger Citron	roger.a.citron@dhsoha.state.or.us
HIT Strategic Updates	Susan Otter	Susan.otter@dhsoha.state.or.us
Kindergarten Readiness	Dana Hargunani	Dana.hargunani@dhsoha.state.or.us
CCO Performance Improvement Projects	Lisa Bui	lisa.t.bui@dhsoha.state.or.us
QHOC Chairs		
Medical	Holly Jo Hodges, MD	tbd
Behavioral Health	Athena Goldberg, LCSW	athena.goldberg@allcarehealth.com
Oral Health	Laura McKeane	laura.McKeane@allcarehealth.com
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Behavioral Health	TBD	
Oral Health	Bruce Austin, DMD	bruce.w.austin@dhsoha.state.or.us
Quality	Lisa Bui	lisa.t.bui@dhsoha.state.or.us

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

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

Quality and Health Outcomes Committee
Public Health Division updates – February 2020

Public health modernization funding for communicable disease prevention and response
Local public health authorities (LPHAs), tribes and tribal partners and OHA Public Health Division are using a 2019 legislative investment of $15.6 million in public health modernization to expand interventions to prevent and respond to communicable disease threats.

The majority of funding, about $10.3 million, has been allocated to local public health authorities for interventions that address each community's priorities for communicable disease prevention. Across the state LPHAs are working closely with health care providers to provide training on evidence-based methods of disease control, to improve information-sharing on communicable disease risks and to improve timely reporting of reportable diseases. Some CCOs participate in regional partnerships that implement regional strategies to prevent and respond to communicable diseases, addressing areas including childhood and adolescent immunizations, sexually transmitted infections and HIV, and infection prevention in long-term care facilities. A description of LPHA regional partnerships is available at:
https://www.oregon.gov/oha/PH/ABOUT/TASKFORCE/Documents/2019-Regional-Partnerships.pdf.

About $1.2 million will go to federally recognized tribes, the Urban Indian Health Program and the Northwest Portland Area Indian Health Board. They are using funds to identify opportunities for modernizing tribal health services and to ensure everyone in tribal communities has access to public health protections.

Funds retained by OHA Public Health Division are being used to improve data systems needed to quickly identify and respond to acute and communicable disease outbreaks, and to improve how population health data are collected and reported. These investments benefit public health and health care systems and are a needed resource for community organizations and other agencies working to improve health outcomes. Funding also supports new efforts to prevent and respond to emerging environmental health threats.

Additional information is available at: www.healthoregon.org/modernization. Or contact Sara Beaudrault at (971) 645-5766 or sara.beaudrault@state.or.us.

State Health Improvement Plan for 2020-24

Oregon is on track to have a new State Health Improvement Plan this July. Subcommittees are currently meeting to develop goals, outcome indicators, and strategies for the five priority areas:

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

The draft plan will be completed in March and will be going out for a period of community engagement and partner feedback in April. CCOs will have an opportunity in April to provide input on the draft plan.

Additional information is available at healthoregon.org/2020ship.

OHA Transformation Center Technical Assistance (TA) for CCOs

TA index

Metrics TA 1
Adolescent immunizations 1
Diabetes: HbA1c poor control 1
Tobacco cessation 2
Screening, brief intervention and referral to treatment (SBIRT) 3
Well-child visits (ages 3–6) 3
Non-metrics TA 3
Behavioral health 3
CCO 2.0: Moving Forward Together 4
CHAs and CHPs 4
Health-related services 5
Transformation and quality strategy 5
Transformation Center technical assistance updates 5

Metrics TA

Adolescent immunizations

Webinar – Introduction to the adolescent immunization metric

What: In this webinar, OHA staff will share:

- Background on why the Metrics and Scoring Committee included adolescent immunizations in the 2020 measure set;
- An overview of the measure specifications and information on CCOs' current performance;
- How to partner with Oregon's Immunization Quality Improvement for Providers program (IQIP; formerly AFIX), a collaborative approach to improving clinic-level immunization programs; and
- An overview of vaccine resources available and additional technical assistance planned so far.

When: February 25, 2:30-3:30 p.m.

Register here: https://attendee.gotowebinar.com/register/8581164192047593228

Diabetes: HbA1c poor control

Webinars – Diabetes metric support

Recordings and slides for previous webinars in this series are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Diabetes.aspx

Three webinars will be presented by Dr. Andrew Ahmann, director of the Harold Schnitzer Diabetes Health Center and recipient of the 2018 Outstanding Physician Clinician in Diabetes Award from the American Diabetes Association.

A systems approach to improving diabetes care

- **Watch recording:** https://attendee.gotowebinar.com/recording/588660238218139656

- Audience: Quality improvement staff and diabetes/chronic disease care coordinators at CCOs, Tribal health systems and other health systems

Working with pharmacists on a diabetes care team – no-cost CME available until February 2021

- **Recording:** Will be available soon at https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Diabetes.aspx
- Audience: Primary care physicians, specialty physicians, physician assistants, nurse practitioners, pharmacists
- **Accreditation:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of OHSU School of Medicine and Oregon Health Authority. The OHSU School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.
- **Credit:** OHSU School of Medicine designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Patient education and engagement in diabetes care– no-cost CME available until February 2021

- **February 28, 2020, noon–1 p.m.**
- **Webinar registration:** https://attendee.gotowebinar.com/register/1321879457698122765
- Audience: Primary care physicians, specialty physicians, physician assistants, nurse practitioners, pharmacists
- **Accreditation:** This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of OHSU School of Medicine and Oregon Health Authority. The OHSU School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.
- **Credit:** OHSU School of Medicine designates this live activity for a maximum of 1 *AMA PRA Category 1 Credits*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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

Tobacco cessation

Free, quick online tobacco cessation counseling training (with CME)

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 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. Additionally, the PINPOINT Collaborative is a separate technical assistance opportunity supporting clinics to address chronic pain management and opioid prescribing. 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)

Well-child visits (ages 3–6)

Supporting kindergarten readiness webinar series

Materials and recordings from previous webinars in this series are posted here (more to come): https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Well-Child-Visits.aspx

- Introduction to the kindergarten readiness CCO incentive measures
- Reach Out and Read early literacy program
- How Washington State increased well-child visits
- Well-child visit peer sharing: EOCCO Child Wellness Campaign, IHN gap reporting and closure, and PacificSource provider engagement

Questions? Please contact Adrienne Mullock (adrienne.p.mullock@dhsoha.state.or.us).

Non-metrics TA

Behavioral health

Technical assistance webinar series to support 2020 CCO contract requirements

CCO staff and Oregon Health Plan providers are invited to participate in technical assistance for behavioral health requirements in the 2020 CCO contracts. This webinar series is hosted by the OHA Transformation Center and presented by OHA's Child and Family Behavioral Health Team. See full details here, including recordings and materials from previous webinars in the series: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Behavioral-Health-TA.aspx

Audience: CCO behavioral health staff, behavioral health providers, primary care providers and other service providers, depending on webinar topic

Children's system of care webinars (recordings and slides available at the link above)

- **Local system of care 101**
- **CCO 2.0 system of care reporting requirements and deliverables**

Early childhood mental health in CCO 2.0 (recordings and slides for past webinars available at the link above)

- **Early childhood mental health in CCO 2.0: foundations and expectations**
- **Evidence-based dyadic behavioral health treatments in Oregon: strategies for CCOs to ensure access**
- **Evidence-based dyadic behavioral health treatments in Oregon: strategies for clinics and providers to ensure access**
  - February 11, 1-2 p.m.
  - Register here: https://attendee.gotowebinar.com/register/8782403406458737165
- **Early childhood mental health assessment, billable diagnoses and reimbursement: strategies for CCOs**
  - February 18, 1-2 p.m.
  - Register here: https://attendee.gotowebinar.com/register/1789513851849895949
- **Early childhood mental health assessment, diagnosis and reimbursement: information for OHP providers and clinics**
  - February 25, 1-2 p.m.
  - Register here: https://attendee.gotowebinar.com/register/9042497280055680269

Questions? Please contact Summer Boslaugh (summer.h.boslaugh@dhsoha.state.or.us or 503-753-9688).

CCO 2.0: Moving Forward Together

Event registration

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.

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. CCOs: Please work with your Innovator Agent to identify appropriate staff for this event.

Cost: No charge to attendees.

Registration: Event registration is open: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/CCO-2-0-Moving-Forward-Together.aspx

Draft agenda: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/CCO%202.0%20MFT%20Agenda%20v10.docx

Questions? Please contact Tom Cogswell at Thomas.Cogswell@dhsoha.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).

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

CCO staff are invited to participate in technical assistance for developing the 2020 Transformation and Quality Strategy (TQS). The 2020 template, guidance documents and more details are available here: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx

2020 TQS webinars (recordings and slides available at the link above)

- Overview: updates and global feedback
- Behavioral health integration and serious and persistent mental illness
- Social determinants of health & equity
- CLAS standards and health equity
- Access and dual eligible members

Office hours (conference line for all: 866-390-1828; participant code: 4628003)

- February 19, 11:30 a.m.-noon: https://attendee.gotowebinar.com/register/5633805622461657090
- March 4, 11:30 a.m.-noon: https://attendee.gotowebinar.com/register/2789416320405151234

Audience: CCO transformation staff, quality staff and subject area leads, depending on webinar topic
Questions? Contact Anona Gund (Anona.E.Gund@dhsoha.state.or.us or 503-381-1104)

Transformation Center technical assistance updates

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

Well-child visit (ages 3-6) needs assessment registration responses

From clinics and referring organizations

What do you see being the top barriers preventing families with children ages 3-6 from attending their well-child visit? (open-ended)

- Transportation (14)
- Perceived value (13)
- Appointment times/availability (12)
- Busy schedules/other priorities (7)
- Clinic not having correct contact info (2)
- Long time between appointments – forget (2)
- Avoiding/fear of immunizations (2)
- Other
  - Fear of judgment
  - Need childcare
  - Sick kids
  - Lack of recall for appointments
  - Parents not taking responsibility
  - Lack of care coordination

What strategies have you implemented to encourage families with children ages 3-6 to attend their well-child visit? (open-ended)

- Phone outreach, follow-up calls, reminders, recalls (12)
- Parent education, talk about importance (5)
- Partnerships, community partners ask about medical visit at recertification (4)
- Coordinate with or share information about non-emergent medical transportation (4)
- Incentives, swag night (4)
- Text messaging (3)
- Extended hours (2)
- Pre-scheduling at end of each appointment (2)
- Other
  - Community health worker
  - Send paperwork in advance
  - Mail letters reminding parents to schedule

From CCOs (also some clinic/hospital partners)

What do you see being the top barriers preventing families with children ages 3-6 from attending their well-child visit? (open-ended)

- Transportation (7)
- Access, clinic scheduling (7)
- Perception/education of value (6)
- Parent time available, work schedule (4)
- Conflicting social needs, stability, homelessness (2)
- Not a priority after immunizations completed (2)
- Other
  - Changing culture
  - Parents forget
  - Unable to get a hold of families
  - Parents unengaged
  - Mixed messages from providers about the importance

What strategies have you implemented to encourage families with children ages 3-6 to attend their well-child visit? (open-ended)

- Reminder calls, phone outreach (5)
- Incentives, swag events (3)
- Help set up transportation (3)
- Texts (2)
- Educate on importance, wellness campaign (2)
- Other
  - Mobile clinic
  - Mailed reminders
  - ASQ
  - Extended hours
  - Align with what’s required from school programs

Your input: Oregon's health IT strategies

Oregon's Health IT Oversight Council (HITOC) is revising Oregon's strategic plan for health IT for 2021 and beyond.

Where are Oregon's strategies working well? Where do we need to change course? HITOC wants your input!

1

What is Oregon's health IT strategic plan?

- OHA is transforming the health care system; the core of those efforts is the coordinated care model
- The coordinated care model relies on health IT to succeed
- Coordinating health IT efforts at the state level is important because there are so many moving parts
- HITOC is charged with creating a statewide strategic plan for health IT in Oregon

2

2

How does health IT support the coordinated care model?

Health IT helps...	
Consumers/patients, their families, and their caregivers	Get access to their own health information and participate in their care
Providers	Securely gather, store, and share patients' clinical data so the care team can work together to provide care
Providers	Track and report on quality measures, which support efforts to hold the health care system accountable for delivering high-quality care
CCOs, health plans, and providers	Analyze data to identify disparities and identify patients who need more care to allow targeted efforts to improve health

3

3

Health IT Progress: Key Areas

- Providers are using EHRs/EMRs at high rates overall
- Health information exchange options have grown significantly
- Health IT supports value-based payment
- Health IT can help address social determinants of health
- See handout for details about how HITOC's work supports goals

4

4

Health IT goals/areas

Goal/Area	Description
Goal 1: Share Patient Information Across the Care Team	Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.
Goal 2: Use Data for System Improvement	Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.
Goal 3: Patients Can Access Their Own Health Information and Collaborate in Their Care	Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers
Emerging Area: Health IT supports social determinants of health and health equity	

Conversation starters for your input

Considering the goals/areas on the previous slide:

- How is this going for you today?
- What would achieving this goal look like?
- Where are you experiencing impacts?
- What has been most helpful?
- Where are the biggest challenges/barriers?
- What are the right roles for state, providers, CCOs/health plans, and others?
- What changes would have the biggest positive impact? Biggest negative impact?

Process and input opportunities

- Join a listening session in person or by phone. Register at go.usa.gov/xpzy2.
- Submit a written comment (Feb. 1 – Apr. 30) at go.usa.gov/xpzVt
- Stay up to date at our website, go.usa.gov/xpeQc

Oregon Health Authority

Key Resources

- 2017-2020 Strategic Plan for Health IT go.usa.gov/xpzEt
- Health IT Oversight Council (HITOC) Overview go.usa.gov/xpzEK
- Office of Health IT Overview go.usa.gov/xpzEz
- Health IT Roles (HITOC, HIT Commons, and more) go.usa.gov/xpzEJ
- 2019 Data Report to HITOC (draft) go.usa.gov/xpzEh

The Oregon Health Authority and Health IT: Strategic Plan 2021 Update

What is Oregon's strategic plan for health IT?

OHA is transforming the health care system, and the core of those efforts is the coordinated care model. The coordinated care model relies on health IT to succeed. Coordinating health IT efforts at the state level is important because there are so many moving parts. Therefore, the Oregon legislature charged HITOC with creating a statewide strategic plan for health IT for everyone in Oregon.

Health IT helps…

Consumers/patients, their families, and their caregivers: Access their own health information and participate in their care

Providers: Securely gather, store, and share patients' clinical data so the care team can work together to provide care; track and report on quality measures, which supports efforts to hold the health care system accountable for delivering high-quality care

CCOs, health plans, and providers: Analyze data to identify disparities and find patients who need more care to allow targeted efforts to improve health

Oregon and Health IT: Quick Orientation

Providers are using EHRs/EMRs at high rates overall. Electronic health records or electronic medical records (EHR/EMR) support patient care and patient access to their own information (via patient portals); the data they gather supports care coordination, value-based payment, and population management.

Status: Overall EHR adoption rate is higher than the national average, number of providers using more advanced EHRs is growing, "digital divides" remain

Health information exchange options have grown significantly. HIE securely moves health information between organizations, supporting care coordination, value-based payment, and population management.

Status: EDie/PreManage (Collective platform) have been a standout success, national networks provide access to care summaries, regional HIEs and other efforts support CCOs and communities, no single tool can meet all needs, "digital divides" remain

Health IT supports value-based payment. CCOs and providers need health IT tools and processes to manage value-based payment arrangements.

Status: CCOs have developed Health IT Roadmaps that include plans for health IT and value-based payment which will support major growth in value-based payment arrangements under CCO 2.0; most CCOs, health plans, and providers will need to develop new health IT capacity to manage value-based payment

Health IT can help address social determinants of health. Health IT tools can support social needs assessments, risk scoring, and connect health care with social services.

Status: Providers are exploring using health IT to assess social needs; work is underway to explore options for community information exchange, connecting health care providers with social services; this area raises new challenges with technology, privacy, and care coordination

Gathering your input: health IT goals and question prompts

HITOC wants to hear your input on what strategies are going well and where Oregon needs to change course. **Please look at the health IT goals below and reflect on how things are going.** The optional question prompts below can help you organize your input, but you are not required to use them.

Goal 1: Share patient information across the care team. Oregonians have their core health information available where needed, so their care team can deliver person-centered, coordinated care.

Goal 2: Use data for system improvement. Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

Goal 3: Patients can access their own information and engage in their care. Individuals and their families access, use, and contribute their clinical information to understand and improve their health and collaborate with their providers.

Emerging area: Health IT supports social determinants of health and health equity.

Optional question prompts (all questions can be applied to all goals)

1. How is this going for you today?
2. What would achieving this goal look like?
3. Where are you experiencing impacts?
4. What has been most helpful?
5. Where are the biggest challenges/barriers?
6. What are the right roles for state, providers, CCOs/health plans, and others?
7. What changes would have the biggest positive impact? Biggest negative impact?

Submitting your input

- Register for a listening session (in person/webinar): go.usa.gov/xpzy2
- Submit written comment (Feb. 1 – Apr. 30). We encourage written comments!: go.usa.gov/xpzVt
- Make a public comment at a HITOC meeting: go.usa.gov/xpJT8

Listening session content will be geared toward the audience listed. All listening sessions are open to the public, and everyone is welcome. We want to hear from people across Oregon and encourage you to participate in whatever way that works best for you: in person, phone, or webinar.

Session Name	Date/Time/Location
Technology Partner Listening Session	2/11/2020, 1-4 PM Portland
Oral Health Listening Session	2/25/2020, 2-5 PM Portland
CCO Listening Session	3/4/2020, 1-4 PM Salem
Consumer Listening Session	3/10/2020, 1-4 PM Portland
Behavioral Health Listening Session	4/16/2020, 1-4 PM Portland
General Listening Session	4/21/2020, 1-4 PM Portland

Oregon's health IT goals advance health system transformation goals

Health System Transformation Policy Priority	Health IT Goal/Area
Increase access to health care	Goal 1: Share patient information across the care team
Enhance care coordination	Goal 1: Share patient information across the care team
Pay for outcomes and value	Goal 2: Use data for system improvement.
Measure progress	Goal 2: Use data for system improvement.
Improve health equity	Emerging area: Health IT supports social determinants of health and health equity
Shift focus upstream	Emerging area: Health IT supports social determinants of health and health equity

Strategies for Oregon's health IT goals

Goal 1: Share patient information across the care team. Oregonians have their core health information available where needed, so their care team can deliver person-centered, coordinated care.

- Electronic health records (EHR/EMR)
  - Medicaid EHR Incentive Program go.usa.gov/xpzPn
  - *Complete: Oregon Medicaid Meaningful Use Technical Assistance Program* go.usa.gov/xpzPd
- Electronic health information exchange (HIE)
  - EDie/PreManage (Collective platform), including Medicaid Subscription bit.ly/2Quu6NJ
  - Prescription Drug Monitoring Program Integration initiative bit.ly/2FodEbn
  - Oregon Provider Directory and Flat File Directory go.usa.gov/xpzPz
  - HIE Onboarding Program go.usa.gov/xpzPJ
  - Network of networks for statewide HIE go.usa.gov/xpzPS
  - *Planned: Behavioral Health Information Sharing Toolkit (42 CFR Part 2)*
  - *Complete: Expanding Interoperability - ONC Cooperative Agreement*
- Behavioral Health and Health IT Workplan: go.usa.gov/xpzPE
- Shared Governance: HIT Commons public/private partnership bit.ly/37CNJsD
- CCO 2.0 EHR and HIE support requirements go.usa.gov/xpJDR

Goal 2: Use data for system improvement. Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

- Goal 1 work on EHRs and HIE is foundational
- Clinical Quality Metrics Registry go.usa.gov/xpumR

- Health IT Roadmaps for CCOs (ensuring health IT in place for value-based payment arrangements and population health efforts) go.usa.gov/xpJDR

Goal 3: Patients can access their own information and engage in their care. Individuals and their families access, use, and contribute their clinical information to understand and improve their health and collaborate with their providers.

- Goal 1 work on EHRs and HIE is foundational
- CCO 2.0 Year 2 requirement for health equity plans: patient engagement with health IT go.usa.gov/xpJWc (p. 71)
- HITOC exploration of barriers and opportunities from consumer perspectives go.usa.gov/xpJWp (June 2019 HITOC)
- *Complete: State Innovation Model (SIM) grant for OpenNotes*

Emerging area: Health IT supports social determinants of health and health equity.

- HIT Commons: Exploration of Oregon Community Information Exchange (CIE) bit.ly/2QOiaW1
- Potential for EHRs to track demographic data to help identify disparities (ONE system tracks this data for OHP members) go.usa.gov/xpJWp (October 2019 HITOC)
- Clinical Quality Metrics Registry future capacity to track patient-level data go.usa.gov/xpumR
- Oregon Provider Directory captures demographic information go.usa.gov/xpJWp (October 2019 HITOC)
- Exploration of connection between health IT and health equity go.usa.gov/xpJWp (October 2019 HITOC)

Key Resources

- 2017-2020 Strategic Plan for Health IT
- Health IT Oversight Council (HITOC) Overview
- Oregon Health IT Programs and Partnerships
- Health IT Roles (HITOC, HIT Commons, and more)
- 2019 Data Report to HITOC

Stay Connected

You can find more information about the strategic plan update at our website: go.usa.gov/xpeQc

Program Contact

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Get involved with Oregon Health IT

Office of Health Information Technology: HealthIT.Oregon.gov

Join the listserv: bit.ly/2VYgoDB

HERC Update

Ariel Smits, MD, MPH
Cat Livingston, MD, MPH
February 10, 2020

1

VbBS/HERC

- January 2020 meeting
  - Bone marrow transplant for sickle cell disease
  - Neuropsychological testing guideline
  - Chronic lower extremity venous disease/Compression stockings
  - Delete pharmacist prescribing guideline
  - Intracardiac echocardiogram
  - Frequency specific microcurrent therapy and similar TENS-like therapies
  - Fetal myelomeningocele repair
  - iStent Inject
  - Spinal cord stimulators
  - Yoga and acupuncture for PSTD and anxiety
  - Yttrium 90 embolization mapping
  - Vitamin D screening

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Impella – Coverage Guidance

GUIDELINE NOTE 195, TEMPORARY PERCUTANEOUS MECHANICAL CIRCULATORY SUPPORT WITH IMPELLA DEVICES

Line 69

Temporary percutaneous mechanical circulatory support with Impella devices is included on Line 69 only in the three following circumstances:

During percutaneous coronary intervention (PCI) in patients with ST-Elevation Myocardial Infarction (STEMI) without cardiogenic shock, and

- Ejection fraction (EF) <30%, and
- Patient has complex left main or last remaining conduit disease

During PCI in patients with non-ST-Elevation Myocardial Infarction (NSTEMI) without cardiogenic shock when all of the following conditions are met:

- A heart team discussion determines the patient needs revascularization with coronary artery bypass graft (CABG) or PCI
- A cardiothoracic surgeon is consulted and agrees the patient is inoperable (i.e., is not willing to perform CABG but agree revascularization is indicated)
- Patient has complex left main or last remaining conduit disease
- EF < 30%

In patients with cardiogenic shock who may be candidates for left ventricular assist device (LVAD) (destination therapy) or transplant (bridge to transplant) AND an advanced heart failure and transplant cardiologist agrees that Impella should be used as a bridge to decision for LVAD or transplant. Appropriate effort should be made to consult with an advanced heart failure and transplant cardiologist, but coverage is appropriate in circumstances where consultation cannot reasonably be obtained without endangering the patient's life and the treating physician believes the patient meets the criteria above.

Temporary percutaneous mechanical circulatory support with Impella devices is not included on this or any other line for elective high-risk PCI for patients with stable coronary artery disease.

Oregon Health Authority

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EbGS Update

EbGS 2/6/2020

- Planned out-of-hospital birth – public comment review
- MSI – Multicomponent interventions to increase colorectal, breast and cervical cancer screening

4

4

Issues in development

- MRI of the knee
- Female genital mutilation repair
- Diagnostic spinal injections
- Zio patch
- Pre-operative testing
- Teleconsultation guideline fix
- Compression stockings
- Peripheral nerve ablation
- Bone grafts
- Back guideline update
  - Surgery
  - Non-pharmacologic therapy
  - Opioids
- Acupuncture for cancer-related pain

Oregon Health Authority

Your feedback or issues

Value-based Benefits Subcommittee Recommendations Summary
For Presentation to:
Health Evidence Review Commission on January 16, 2020

For specific coding recommendations and guideline wording, please see the text of the 1/16/2020 VbBS minutes.

RECOMMENDED CODE MOVEMENT (changes to the 10/1/2020 Prioritized List unless otherwise noted)

- Add several diagnosis codes for chronic lower extremity venous disease to a covered line with a new guideline
- Delete the procedure code for intracardiac echocardiograms from an uncovered line and recommend addition to the Diagnostic Procedures File
- Move vitamin D testing codes from the Diagnostic Procedures File to specific lines
- Add the procedure code for fetal myelomeningocele repair to a covered line
- Add an additional procedure code for aqueous shunts to the covered glaucoma line
- Delete the procedure codes for spinal cord stimulators from one covered line with no appropriate diagnoses
- Make various straightforward coding and guideline changes

ITEMS CONSIDERED BUT NO RECOMMENDATIONS FOR CHANGES MADE

- Acupuncture and yoga were not added as treatment for post-traumatic stress disorder or anxiety

RECOMMENDED GUIDELINE CHANGES (changes to the 10/1/2020 Prioritized List unless otherwise noted)

- Add a clause allowing an exception for pre-operative testing prior to epilepsy surgery to the neuropsychological testing guideline
- Add a new guideline specifying when treatment of chronic lower extremity venous disease is covered
- Delete the pharmacist prescribing guideline
- Expand the guideline note entry for TENS to apply to all similar therapies that include the same CPT code
- Edit the guideline on Yttrium 90 therapy for hepatocellular carcinoma to clarify that pre-treatment mapping is covered but not pre-treatment embolization
- Edit the fetal surgery guideline to include fetal myelomeningocele repair
- Edit the guideline regarding aqueous shunts to remove the brand name reference
- Add a new guideline specifying when spinal cord stimulators are covered

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VALUE-BASED BENEFITS SUBCOMMITTEE
Clackamas Community College
Wilsonville Training Center, Rooms 111-112
Wilsonville, Oregon
January 16, 2020
8:00 AM – 1:00 PM

Members Present: Kevin Olson, MD, Chair; Holly Jo Hodges, MD, MBA, Vice-chair (via phone); Vern Saboe, DC (via phone); Gary Allen, DMD (via phone); Kathryn Schabel, MD; Brian Duty, MD (arrived 8:10), Adriane Irwin, PharmD.

Members Absent: None.

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

Also Attending: Michael Collins (Warm Springs Tribe); Shauna Williams (Glaukos); Billy Ray Pitt (Sirtex); Trisha Wong, MD, Eneida Nemecek MD, Rochelle Williams-Belizaire, and Stefan Sang (OHSU), Joevantae Thompson; Jennifer Batchela, Robyn Tyran, and Mary Hlady (Providence); Dawn Mautner (OHA), Andrei Sdrulla (OHSU); Laura Ocker (OCOM); Rosa Schnyer (University of Texas; via phone).

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

  The meeting was called to order at 8:00 am and roll was called. A quorum of members was present at the meeting. Minutes from the November 14, 2019 VbBS meeting were reviewed and approved.

  Smits noted the errata document was available for review; there were no questions regarding any of the errata. She also noted that the back lines review might be delayed from March as the AHRQ reviews have been delayed.

  Gingerich introduced Mike Collins as a new HERC member who will likely be added to VbBS at today's HERC meeting. He also noted that the planned discussion of conflict of interest forms has been delayed from today's HERC meeting to March, 2020.

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- **Topic: Straightforward/Consent Agenda**

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

Recommended Actions:

1) Add CPT 99490 (Chronic care management services) and HCPCS G2058 (Chronic care management services) to lines 346 CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS, 361 SCOLIOSIS, 529 CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS, 661 MISCELLANEOUS CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
2) Remove ICD-10-CM M40.0 codes (Postural kyphosis), M40.4 (Postural lordosis) and M40.5 (Lordosis, unspecified) from lines 402 CONDITIONS OF THE BACK AND SPINE and 529 CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS
   a. Add ICD-10-CM M40.0, M40.4 and M40.5 to line 659 MUSCULOSKELETAL CONDITIONS WITH NO OR MINIMALLY EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY
3) Remove CPT 81225 (CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (eg, drug metabolism), gene analysis, common variants (eg, *2, *3, *4, *8, *17)) from line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS and recommend that HSD add the code to the Diagnostic Procedure File
4) Modify the entry regarding P450 testing in section D of DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE as shown in Appendix A.
5) Remove CPT 93792-93793 (INR) monitoring) from all current lines on the Prioritized List and advise HSD to add to the Diagnostic Procedures File
6) Remove ICD-10-CM Z79.01 (Long term (current) use of anticoagulants) from all current lines on the Prioritized List and advise HSD to add to the Diagnostic Workup File

MOTION: To approve the recommendations stated in the consent agenda. CARRIES 5-0. *(Absent: Duty)*

- **Topic: Bone marrow transplant for sickle cell disease**

Discussion: Smits introduced the summary document and answered clarifying questions from members.

Testimony was heard from:
Eneida Nemecek MD, bone marrow transplant director at OHSU, who also works with the national bone marrow registry. She described the clinical course of sickle cell disease. She noted that as fetal hemoglobin decreases as kids age, they get more and more symptoms such as excruciating pain. They have repeat hospitalizations, and the spleen fails so they get increased infection. The many complications result in a shortened life expectancy. A new coverage recommendation for bone marrow transplant (BMT) was approved by CMS recently. If a patient has a matched sibling donor, then the recommendation is to have a BMT as early as possible. If there is no matched sibling, then organ damage criteria are used to determine when to consider transplant.

Tricia Wong MD, director of Sickle Cell program at OSHU. This is a quality of life issue. The Arnold study used pediatric data only and did not capture cost savings of adults who can be more

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productive and have lower health costs for a long period. She agrees with the proposed requirements that the patient have severe disease and a matched sibling donor for now. She believes that data will be forthcoming about non-sibling transplants and less-symptomatic patients and will be coming back to ask for expanded coverage.

Schabel asked the experts what they felt about the HERC staff-proposed guideline criteria. Nemecek felt that the data is there for matching sibling donors at any age. She testified that she does not know of evidence for transplants after age 40, so she agrees with 40-year age limit in cases with no matched sibling. She also agreed patients should be required to meet study inclusion criteria related to organ damage (she offered to provide this criteria). No one recommends BMT for patients over the age of 40. She would not recommend limiting coverage to sibling matched donors as the research is rapidly changing. She noted that CMS has approved sibling HLA-matched transplant at any age. Wong recommended including coverage for patients with non-sibling matched donors if done as part of a registered trial. Essentially, the experts recommended requiring no complications if there is a sibling match and the patient is under age 40; they recommend requiring patients to meet the complications criteria from an ongoing study if they have a non-sibling match and the patient is under age 40. They did not recommend coverage of BMT for patients over age 40.

Irwin asked for a clarification of the CMS criteria. Nemecek stated that CMS approves all kids (under age 15) with a matched sibling so their guidance is just for ages 15 and above and sibling or non-sibling matched donor. There is also a half-matched protocol (allowing coverage for patients with strokes and adults with many symptoms).

Olson asked about gene therapy. Nemecek replied that gene therapy is experimental and must be done in a clinical trial. Wong noted that gene therapy was recently approved for thalassemia—she will bring this to HERC in the future.

Rochelle Williams-Belizaire from the OHSU Knight Cancer Institute testified. There is evidence to support BMT for sickle cell disease. She has an 18-month-old son with the condition, who has already been in the hospital twice. Her son has a matched sibling, and the family plans BMT for her toddler.

Joevantae Thompson, a sickle cell disease patient testified. He had frequent pain and hospitalizations before his transplant in August 2019. Now he has no pain. He is 17.

Nemecek summarized that she feels coverage should include patients of any age who have a matched sibling donor. If a patient does not have a matched sibling donor, then a patient should be eligible for BMT under the criteria of registered trial (she recommended not being detailed about end organ damage as criteria for trials are changing). Schabel asked whether the donor should be related or a sibling. Nemecek replied that they need to simply be related.

The VbBS generally agreed with adding coverage for BMT for sickle cell disease, and asked staff to work with experts to fine tune the guideline and bring back to the March 2020 VbBS meeting.

Recommended Actions:
1) HERC staff to work with experts on the proposed new guideline wording and bring this topic back to a future VbBS meeting

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- **Topic: Neuropsychological testing guideline**

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

Recommended Actions:

1) Modify Diagnostic Guideline D26 as shown in Appendix A

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

- **Topic: Chronic lower extremity venous disease (CLEVD)/compression stockings**

Discussion: Smits introduced the summary document. Schabel noted that in the case of a non-healing ulcer, compression stockings can be harmful and are not indicated. She also noted that patients with various lower extremity conditions also frequently have neuropathy, and compression stockings can be dangerous in that situation.

Testimony:
Robyn Tyran, a physical therapist with Providence, testified that high compression stockings can be harmful, but there are medical compression devices which have Velcro wraps and better skin protection. These devices also have higher compliance.

The members requested that the proposed guideline note replace "compression stockings" with "medical compression garments" to allow the use of these more effective devices.

Tyran then gave a presentation, requesting that compression garments be covered for all levels of venous insufficiency to prevent downstream complications. She noted that untreated venous insufficiency leads to a downward spiral in health and function. She presented a flowchart of treatment recommendations from Eberhardt et al. She requested that compression garments be covered at the first symptom, before any imaging is done to look for venous reflux. She noted there is level 1 evidence for compression stockings for treatment of post-thrombotic syndrome, prevention of progression of occupational leg syndromes, and in management of lymphedema.

Jennifer Batchela, also a physical therapist from Providence, testified that the biggest barrier to compliance with compression garments is the cost of the garments. Providing coverage for these garments would help to overcome this barrier. She noted that fit and skin issues can affect compliance with use.

Tyran noted that there will be no studies of compression garments against non-treated controls, as not offering compression would be unethical. The studies that are published essentially compare compliant patients with non-compliant patients, which is not a random comparison.

Hodges noted that gradient compression stockings are coded with an HCPCS "A" code (the series used for durable medical equipment (DME)) and covered based on criteria in Oregon Administrative Rules (OAR). Staff noted that they will need to check with the Health Systems Division regarding the OARs for DME such as compression stockings.

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It was noted that superficial thrombophlebitis, which was proposed for coverage in the new guideline, is actually on line 516 and those ICD-10-CM codes were not proposed to be moved to the covered line. The members suggested substituting “recurrent cellulitis resulting from chronic venous disease” in that portion of the new guideline. There was also a suggestion to make medical treatment of CLEVD a separate section in the guideline from the surgical treatment.

Olson noted that the discussion regarding compression garments went beyond the topic at hand, which was coverage for chronic lower extremity venous disease. The group agreed that the modified guideline and coding change recommendations were adequate for their intent to widen coverage slightly for chronic lower extremity venous disease. There was also discussion that if varicose veins resulted in significant bleeding, then surgical treatment should be covered. The members suggested changing that entry in the guideline to say “clinically significant bleeding” to reflect that it cannot be a small amount of bleeding, but something that might affect health. Massive bleeding would be covered as an exception without any other requirements.

The group requested that HERC staff work with the physical therapy group and HSD staff regarding coverage of compression garments for non-CLEVD indications, such as edema from heart disease, liver disease, obesity, or other causes. Staff was also directed to explore coverage of compression garments for less severe CLEVD.

Recommended Actions:

1) Add varicose veins with other complications to line 379 CHRONIC ULCER OF SKIN and keep on line 519 POSTTHROMBOTIC SYNDROME/639 VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR OTHER MAJOR COMPLICATION
    a. ICD10 I83.89 (Varicose veins of lower extremities with other complications)
    b. ICD10 I87.09 (Postthrombotic syndrome with other complications of lower extremity)
2) Adopt a new guideline note to line 379 as shown in Appendix B
3) Modify the line title of line 379 to CHRONIC ULCER OF SKIN; VARICOSE VEINS WITH MAJOR COMPLICATIONS

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

- **Topic: Delete pharmacist prescribing guideline**

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

Recommended Actions:

1) Delete GN64 as shown in Appendix A

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

- **Topic: Intracardiac echocardiogram**

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

Recommended Actions:
1) Remove CPT 93662 (Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure) from line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS
2) Modify Guideline Note 173 as shown in Appendix A
3) Advise HSD to add CPT 93662 to the Diagnostic Procedure File

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

- **Topic: Frequency specific microcurrent therapy and similar TENS-like therapies**

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

Recommended Actions:
1) Modify the GN173 entry for CPT 97014 (Application of a modality to 1 or more areas; electrical stimulation (unattended)) as shown in Appendix A

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

- **Topic: Yttrium 90 embolization mapping**

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

Recommended Actions:
1. Do not add **CPT 37242** *Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; arterial, other than hemorrhage or tumor (eg, congenital or acquired arterial malformations, arteriovenous malformations, arteriovenous fistulas, aneurysms, pseudoaneurysms)* **to Line 315**
2. Modify Guideline Note 185 as shown in Appendix A.

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

- **Topic: Vitamin D screening**

Discussion: Livingston reviewed the summary document. There was a brief discussion about the change in vitamin D recommendations for fall prevention.

Recommended Actions:
1) Advise HSD to remove 82306 *Vitamin D; 25 hydroxy* and 82652 *Vitamin D; 1, 25 dihydroxy*, from the Diagnostic File
2) Add 82306 to the following lines:

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- 24 ENDOCRINE AND METABOLIC DISTURBANCES SPECIFIC TO THE FETUS AND NEWBORN
- 55 COMPLICATED STONES OF THE GALLBLADDER AND BILE DUCTS; CHOLECYSTITIS
- 102 POISONING BY INGESTION, INJECTION, AND NON-MEDICINAL AGENTS
- 117 NUTRITIONAL DEFICIENCIES
- 151 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM
- 195 ACUTE PANCREATITIS
- 224 DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND; DISORDERS OF CALCIUM METABOLISM
- 227 INTESTINAL MALABSORPTION
- 239 SHORT BOWEL SYNDROME - AGE 5 OR UNDER
- 248 METABOLIC BONE DISEASE
- 250 CHRONIC PANCREATITIS
- 259 CANCER OF ENDOCRINE SYSTEM, EXCLUDING THYROID; CARCINOID SYNDROME
- 288 OSTEOPETROSIS
- 293 ANOMALIES OF GALLBLADDER, BILE DUCTS, AND LIVER
- 307 CIRRHOSIS OF LIVER OR BILIARY TRACT; BUDD-CHIARI SYNDROME; HEPATIC VEIN THROMBOSIS; INTRAHEPATIC VASCULAR MALFORMATIONS; CAROLI'S DISEASE
- 334 ALCOHOLIC FATTY LIVER OR ALCOHOLIC HEPATITIS, CIRRHOSIS OF LIVER
- 339 CHRONIC KIDNEY DISEASE
- 352 URINARY SYSTEM CALCULUS

3) Add 82652 *Vitamin D; 1, 25 dihydroxy* to the following lines

- 224 DISORDERS OF PARATHYROID GLAND; BENIGN NEOPLASM OF PARATHYROID GLAND; DISORDERS OF CALCIUM METABOLISM
- 151 DISORDERS OF MINERAL METABOLISM, OTHER THAN CALCIUM
- 248 METABOLIC BONE DISEASE
- 352 URINARY SYSTEM CALCULUS

3) Add R82.994 Hypercalciuria (currently in the Diagnostic Workup File) to Lines 224 and 352

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

- **Topic: Fetal myelomeningocele repair**

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

Recommended Actions:

1) Add HCPCS S2404 (Repair, myelomeningocele in the fetus, procedure performed in utero) to line 1 PREGNANCY
2) Modify GN2 as shown in Appendix A

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

- **Topic: iStent Inject**

Discussion: Smits reviewed the summary document. There was minimal discussion. Hodges requested that the CPT codes for the procedure be added to the guideline.

Recommended Actions:
1) Add CPT 0376T (Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion) to line 139 GLAUCOMA, OTHER THAN PRIMARY ANGLE-CLOSURE
2) Add HCPCS C1783 (Ocular implant, aqueous drainage assist device) and L8612 (Aqueous shunt) to line 139
3) Modify Guideline Note 184 as shown in Appendix A

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

- **Topic: Spinal cord stimulators**

Discussion: Smits introduced the summary documents regarding both spinal cord stimulators for conditions of the back and spine and for complex regional pain syndrome.

Testimony was heard from Dr. Andrei Sdrulla, from the anesthesia department at OHSU. CRPS is uncommon and therefore few clinical trials. 50-100 Oregonians have this condition. Patients have severe neuropathic pain, and have no other treatment options. Patients with CRPS have significant disability and poor quality of life. Anything we can do to help would be worthwhile. Adding coverage for spinal cord stimulators would not a high budget item as small handful of patients a year would get SCS. SCS technology has developed greatly over time. Four different manufacturers make devices with different technology. There is a need to correctly maintain the device as well. Study heterogeneity is high due to different devices and different levels of maintenance. Older trials have high complications rates; newer devices and techniques have much lower complication rates. The Deere study had much lower complication compared to the Kemler study (an earlier study). In Deere—both arms did very well. Complication rate were reasonable. Do not put as much weight on the older studies. His experience in that these devices work well in certain patients and can be life changing. CRPS can often be mislabeled. He also noted that you cannot do sham control for SCS, so inherently get low quality studies.

Members asked what other treatments exist for CRPS. The answer was some medications, physical therapy.

Duty asked what percent of patients getting a test SCS qualify for permanent placement with CRPS. Sdrulla responded that 65-80% of CRPS patients qualify for permanent placement, which is higher than with failed back surgery syndrome.

Sdrulla noted that dorsal root ganglion (DRG) stimulation is very technically difficult, few surgeons in Oregon are doing this.

Olson noted that CRPS patients could access SCS through the exception process. Duty noted this process could be quite onerous. Hodges stated that she did not see problems with CRPS patients getting approved for SCS through the exceptions process at her CCO.

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Gingerich noted that 251 pts on OHP had paid claims for CRPS in 2018.
Saboe asked what is the cost of the procedure? Livingston reported that she found costs of $32,882 for Medicare (hospitalization, procedure, device, $5,000-$21,000 yearly maintenance cost) in a brief internet search.

Schabel requested that the clause stating that coverage for SCS placement would not be covered if a patient had a contraindication be struck from the proposed guideline, as no surgeon would operate on a patient with a contraindication.

Irwin asked about the diagnostic criteria for CRPS. Sdrulla answered: pain out of proportion to the stimulus or after normal healing. There are criteria that include symptoms and exam findings.

There were two votes. The vote to accept the staff coding changes and guideline note modifications excluding the sentence regarding CRPS was approved unanimously. The vote to include wording excluding CRPS from coverage was 4 ayes to 2 nays.

Recommended Actions:

1) Remove all spinal cord stimulator CPT and HCPCS codes from line 361 SCOLIOSIS
    a. CPT 63650, 63655, 63685
    b. HCPCS C1767, C1778, C1816, C1820, C1822, C1823, C1897
2) Add the new guideline shown in Appendix B to lines
    a. 292 NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS NEUROLOGICAL DYSFUNCTION IN POSTURE AND MOVEMENT CAUSED BY CHRONIC CONDITIONS
    b. 346 CONDITIONS OF THE BACK AND SPINE WITH URGENT SURGICAL INDICATIONS
    c. 529 CONDITIONS OF THE BACK AND SPINE WITHOUT URGENT SURGICAL INDICATIONS
3) Delete the coding specification regarding spinal cord stimulators from line 292 as this exclusion for CRPS will be addressed in the new guideline note.
    a. "~~Spinal cord stimulation (63650-63688) is not included on this line when paired with ICD-10-CM-CM category G90.5 Complex regional pain syndrome/reflex sympathetic dystrophy."~~

MOTION: To recommend the code, coding specification, and guideline note changes as presented. CARRIES 4-2 (Opposed: Schabel, Irwin)

- **Topic: Yoga and acupuncture for PTSD and anxiety**

Discussion: Smits introduced the summary document.

Testimony was heard from Laura Ocker, LAc and Rosa Schnyer, LAc (via phone).

Schabel asked the experts about ongoing research efforts in this area. Schnyer replied that the Department of Defense (DOD) is actively collecting data on acupuncture for PTSD among veterans. Duty asked what the DOD protocol was. Schnyer replied that she did not know the details of that research.

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Ocker noted that acupuncture can have variable time of benefit and may improve the effectiveness of other treatments such as medications.

Schabel suggested that the CCOs could develop and use local resources rather than having the coverage required. There was consensus that this was the best approach at this time. There was no recommendation to make a change to the current lack of pairing of acupuncture and yoga with PTSD and anxiety at this time.

➢ **Public Comment:**

No additional public comment was received.

➢ **Issues for next meeting:**

- Bone marrow transplant for sickle cell disease

➢ **Next meeting:**

March 12, 2020 at Clackamas Community College, Wilsonville Training Center, Wilsonville Oregon, Rooms 111-112.

➢ **Adjournment:**

The meeting adjourned at 12:54 PM.

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Appendix A
Revised Guideline Notes

DIAGNOSTIC GUIDELINE D1, NON-PRENATAL GENETIC TESTING GUIDELINE

A) Genetic tests are covered as diagnostic, unless they are listed below in section E1 as excluded or have other restrictions listed in this guideline. To be covered, initial screening (e.g. physical exam, medical history, family history, laboratory studies, imaging studies) must indicate that the chance of genetic abnormality is > 10% and results would do at least one of the following:
   1) Change treatment,
   2) Change health monitoring,
   3) Provide prognosis, or
   4) Provide information needed for genetic counseling for patient; or patient's parents, siblings, or children

B) Pretest and posttest genetic counseling is required for presymptomatic and predisposition genetic testing. Pretest and posttest genetic evaluation (which includes genetic counseling) is covered when provided by a suitable trained health professional with expertise and experience in genetics.
   1) "Suitably trained" is defined as board certified or active candidate status from the American Board of Medical Genetics, American Board of Genetic Counseling, or Genetic Nursing Credentialing Commission.

C) A more expensive genetic test (generally one with a wider scope or more detailed testing) is not covered if a cheaper (smaller scope) test is available and has, in this clinical context, a substantially similar sensitivity. For example, do not cover CFTR gene sequencing as the first test in a person of Northern European Caucasian ancestry because the gene panels are less expensive and provide substantially similar sensitivity in that context Related to diagnostic evaluation of individuals with intellectual disability (defined as a full scale or verbal IQ < 70 in an individual > age 5), developmental delay (defined as a cognitive index <70 on a standardized test appropriate for children < 5 years of age), Autism Spectrum Disorder, or multiple congenital anomalies:
   1) CPT 81228 and 81229, Cytogenomic constitutional microarray analysis: Cover for diagnostic evaluation of individuals with intellectual disability/developmental delay; multiple congenital anomalies; or, Autism Spectrum Disorder accompanied by at least one of the following: dysmorphic features including macro or microcephaly, congenital anomalies, or intellectual disability/developmental delay in addition to those required to diagnose Autism Spectrum Disorder.
   2) CPT 81243, 81244, 81171,81172 Fragile X genetic testing is covered for individuals with intellectual disability/developmental delay. Although the yield of Fragile X is 3.5-10%, this is included because of additional reproductive implications.
   3) A visit with the appropriate specialist (often genetics, developmental pediatrics, or child neurology), including physical exam, medical history, and family history is covered. Physical exam, medical history, and family history by the appropriate specialist, prior to any genetic testing is often the most cost-effective strategy and is encouraged.

D) Related to other tests with specific CPT codes:
   1) Certain genetic tests have not been found to have proven clinical benefit. These tests are listed in Guideline Note 173, INTERVENTIONS THAT HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS FOR CERTAIN CONDITIONS; UNPROVEN INTERVENTIONS

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Appendix A
Revised Guideline Notes

2) The following tests are covered only if they meet the criteria in section A above AND the specified situations:
   a) CPT 81205, BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (eg, Maple syrup urine disease) gene analysis, common variants (eg, R183P, G278S, E422X): Cover only when the newborn screening test is abnormal and serum amino acids are normal
   b) Diagnostic testing for cystic fibrosis (CF)
      i) CFTR, cystic fibrosis transmembrane conductance regulator tests. CPT 81220, 81221, 81222, 81223: For infants with a positive newborn screen for cystic fibrosis or who are symptomatic for cystic fibrosis, or for clients that have previously been diagnosed with cystic fibrosis but have not had genetic testing, CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220) is covered. If two mutations are not identified, CFTR full gene sequencing (CPT 81223) is covered. If two mutations are still not identified, duplication/deletion testing (CPT 81222) is covered. These tests may be ordered as reflex testing on the same specimen.
   c) Carrier testing for cystic fibrosis
      i) CFTR gene analysis of a panel containing at least the mutations recommended by the American College of Medical Genetics* (CPT 81220-81224) is covered once in a lifetime.
   d) CPT 81224, CFTR (cystic fibrosis transmembrane conductance regulator) (eg. cystic fibrosis) gene analysis; introm 8 poly-T analysis (eg. male infertility): Covered only after genetic counseling.
   e) CPT 81225~~6~~-81227, 81230-81231 (cytochrome P450). Covered only for determining eligibility for medication therapy if required or recommended in the FDA labelling for that medication. These tests have unproven clinical utility for decisions regarding medications when not required or recommended in the FDA labeling for that medication (e.g. psychiatric, anticoagulant, opioid medications, etc.).
   f) CPT 81240. F2 (prothrombin, coagulation factor II) (eg, hereditary hypercoagulability) gene analysis, 20210G>A variant: Factor 2 20210G>A testing should not be covered for adults with idiopathic venous thromoboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; or for determining the etiology of recurrent fetal loss or placental abruption.
   g) CPT 81241. F5 (coagulation Factor V) (eg, hereditary hypercoagulability) gene analysis, Leiden variant: Factor V Leiden testing should not be covered for: adults with idiopathic venous thromoboembolism; for asymptomatic family members of patients with venous thromboembolism and a Factor V Leiden or Prothrombin 20210G>A mutation; or for determining the etiology of recurrent fetal loss or placental abruption.
   h) CPT 81247. G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; common variant(s) (eg, A, A-) should only be covered
      i) After G6PD enzyme activity testing is done and found to be normal; AND either
         (a) There is an urgent clinical reason to know if a deficiency is present, e.g. in a case of acute hemolysis; OR

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Appendix A
Revised Guideline Notes

(b) In situations where the enzyme activity could be unreliable, e.g. female carrier with extreme Lyonization.

i) CPT 81248. G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; known familial variant(s) is only covered when the information is required for genetic counseling.

j) CPT 81249. G6PD (glucose-6-phosphate dehydrogenase) (eg, hemolytic anemia, jaundice), gene analysis; full gene sequence is only covered
   i) after G6PD enzyme activity has been tested, and
   ii) the requirements under CPT 81247 above have been met, and
   iii) common variants (CPT 81247) have been tested for and not found.

k) CPT 81256, HFE (hemochromatosis) (eg, hereditary hemochromatosis) gene analysis, common variants (eg, C282Y, H63D): Covered for diagnostic testing of patients with elevated transferrin saturation or ferritin levels. Covered for predictive testing ONLY when a first degree family member has treatable iron overload from HFE.

l) CPT 81332, SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (eg, alpha-1-antitrypsin deficiency), gene analysis, common variants (eg, *S and *Z): The alpha-1-antitrypsin protein level should be the first line test for a suspected diagnosis of AAT deficiency in symptomatic individuals with unexplained liver disease or obstructive lung disease that is not asthma or in a middle age individual with unexplained dyspnea. Genetic testing of the anpha-1 phenotype test is appropriate if the protein test is abnormal or borderline. The genetic test is appropriate for siblings of people with AAT deficiency regardless of the AAT protein test results.

m) CPT 81329, Screening for spinal muscular atrophy: is covered once in a lifetime for preconception testing or testing of the male partner of a pregnant female carrier

n) CPT 81415-81416, exome testing: A genetic counseling/geneticist consultation is required prior to ordering test

o) CPT 81430-81431, Hearing loss (eg, nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel: Testing for mutations in GJB2 and GJB6 need to be done first and be negative in non-syndromic patients prior to panel testing.

p) CPT 81440, 81460, 81465, mitochondrial genome testing: A genetic counseling/geneticist or metabolic consultation is required prior to ordering test.

q) CPT 81412 Ashkenazi Jewish carrier testing panel: panel testing is only covered when the panel would replace and would be similar or lower cost than individual gene testing including CF carrier testing.

* American College of Medical Genetics Standards and Guidelines for Clinical Genetics Laboratories. 2008 Edition, Revised 7/2018 and found at http://www.acmg.net/PDFLibrary/Cystic-Fibrosis-Population-Based-Carrier-Screening-Standards.pdf.

DIAGNOSTIC GUIDELINE D26, NEUROBEHAVIORAL STATUS EXAMS AND NEUROPSYCHOLOGICAL TESTING

Neurobehavioral status exams (CPT 96116 and 96121) and neuropsychological testing services (CPT 96132 and 96133) are only covered when all of the following are met:

1) Symptoms are not explained by an existing diagnosis; AND

DRAFT

Appendix A
Revised Guideline Notes

2) When the results of such testing will be used to develop a care plan.

OR when neuropsychological testing is done as part of the pre-operative evaluation prior to epilepsy surgery.

GUIDELINE NOTE 2, ~~FETOSCOPIC~~ FETAL SURGERY

Line 1

Fetal surgery is only covered for the following conditions: repair of urinary tract obstructions via placement of a urethral shunt, repair of congenital cystic adenomatoid malformation, repair of extralobal pulmonary sequestration, repair of sacrococcygeal teratoma, ~~and~~ therapy for twin-twin transfusion syndrome, and repair of myelomeningocele.

Fetoscopic repair of urinary tract obstruction (S2401) is only covered for placement of a urethral shunt. Fetal surgery for cystic adenomatoid malformation of the lung, extralobal pulmonary sequestration and sacrococcygeal teratoma must show evidence of developing hydrops fetalis.

Certification of laboratory required (76813-76814).

~~**GUIDELINE NOTE 64, PHARMACIST MEDICATION MANAGEMENT**~~

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

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

1) ~~A current and unrestricted license to practice as a pharmacist in Oregon.~~
2) ~~Documentation must be provided for each consultation and must reflect communication with the patient's primary care provider. Documentation should model SOAP charting; must include patient history, provider assessment and treatment plan; follow up instructions; be adequate so that the information provided supports the assessment and plan; and must be retained in the patient's medical record and be retrievable.~~

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

Line 662

The following Interventions are prioritized on Line 662 CONDITIONS FOR WHICH CERTAIN INTERVENTIONS ARE UNPROVEN, HAVE NO CLINICALLY IMPORTANT BENEFIT OR HAVE HARMS THAT OUTWEIGH BENEFITS:

Procedure Code	Intervention Description	Rationale	Last Review
~~93662~~	~~Intracardiac echocardiography during therapeutic/diagnostic intervention~~		

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Appendix A
Revised Guideline Notes

Procedure Code	Intervention Description	Rationale	Last Review
97014, 97032, 0278T, E0720, E0730, G0283	Transcutaneous electrical nerve stimulation (TENS), frequency specific microcurrent therapy, microcurrent electrical stimulation, and all similar therapies; Scrambler therapy; Cranial electrical stimulation; all similar transcutaneous electrical neurostimulation therapies	No clinically important benefit (CES) or insufficient evidence of effectiveness (all other) for chronic pain; insufficient evidence of effectiveness for all other indications	January 2020

GUIDELINE NOTE 185, YTTRIUM 90 THERAPY

Line 315

Yttrium 90 therapy is only included on this line for treatment of hepatocellular carcinoma (HCC) and only when recommended by a multidisciplinary tumor board or team in the following circumstances:

A) Downsizing tumors in patients who could become eligible for curative treatment (transplant, ablation, or resection), OR
B) Palliative treatment of incurable patients with unresectable or inoperable tumors that are not amenable to ablation therapy and
   1) who have good liver function (Child-Pugh class A or B) and
   2) good performance status (ECOG performance status 0-2), and
   3) who have intermediate stage disease with tumors > 5 cm OR advanced stage HCC with unilateral (not main) portal vein tumor thrombus.

Pretreatment mapping is included on this line, however, pre-treatment embolization is not included on this line due to insufficient evidence of effectiveness.

GUIDELINE NOTE 184, ANTERIOR SEGMENT AQUEOUS DRAINAGE DEVICE INSERTION

Line 139

Anterior segment aqueous drainage device ~~(e.g. iStent©)~~ insertion (e.g. CPT 0191T, O376T or HCPCS C1783, L8612) is only included on this line when done at the same time as cataract removal and when the two procedures are billed together as a bundled service.

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Appendix B
New Guideline Notes

GUIDELINE NOTE XXX, TREATMENT OF CHRONIC LOWER EXTREMITY VENOUS DISEASE

Lines 379,519,639

Medical treatment of chronic lower extremity venous disease with major complications (skin ulceration, recurrent cellulitis or clinically significant bleeding) is included on line 379, including medical compression garments.

Surgical treatment of chronic lower extremity venous disease is only included on line 379 when

1) The patient has had an adequate 3-month trial of conservative therapy and failed; AND
2) Ultrasound findings of severe axial venous reflux (>1 second in the greater or small saphenous vein or accessory saphenous vein; AND
3) The patient has one of the following:
    a. Non-healing skin ulceration in the area of the varicose vein(s), OR
    b. Recurrent episodes of cellulitis associated with chronic venous disease OR
    c. Clinically significant bleeding from varicose vein(s).

Otherwise, these diagnoses are included on lines 519 or 639.

GUIDELINE NOTE XXX SPINAL CORD STIMULATOR THERAPY

Lines 292, 346, 529

A spinal cord stimulator trial is included on lines 292 and 346 only when a patient meets all of the following criteria:

1) The patient has moderate to severe (>5 on the VAS pain scale) neuropathic pain and objective neurologic impairment with documented pathology related to pain complaint (i.e. abnormal MRI). Neurologic impairment is defined as objective evidence of one or more of the following:
    a. Markedly abnormal reflexes
    b. Segmental muscle weakness
    c. Segmental sensory loss
    d. EMG or NCV evidence of nerve root impingement
    e. Cauda equina syndrome
    f. Neurogenic bowel or bladder
    g. Long tract abnormalities; AND
2) The patient has failed 12 or more months of other treatment modalities (e.g. pharmacological, surgical, physical therapy, cognitive therapy, and activity lifestyle modification); AND
3) The patient has had an evaluation by a mental health provider (e.g., a face-to-face assessment with or without psychological questionnaires and/or psychological testing) which revealed no evidence of an inadequately controlled mental health problem (e.g., alcohol or drug dependence, depression, psychosis) and the patient receives written clearance from the mental health provider for device placement.

Implantation of a spinal cord stimulator is included on lines 292 and 346 when the trial criteria above are met and the patient experienced significant pain reduction (50% or more) with a 3 to 7 day trial of percutaneous spinal stimulation.

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Appendix B
New Guideline Notes

Spinal cord stimulation (CPT 63650-63688) is not included on line 292 when paired with ICD-10-CMcategory G90.5 Complex regional pain syndrome/reflex sympathetic dystrophy.

Otherwise, spinal cord stimulation therapy is included on line 529.

Health Evidence Review Commission (HERC)

Coverage Guidance: Temporary Percutaneous Mechanical Circulatory Support with Impella Devices

Approved 1/16/2020

HERC Coverage Guidance

Elective high-risk PCI

Temporary percutaneous mechanical circulatory support with Impella devices is not recommended for coverage for patients receiving elective high-risk PCI (weak recommendation).

Acute Coronary Syndrome (ACS) without cardiogenic shock

Temporary percutaneous mechanical circulatory support with Impella devices is recommended for coverage (*weak recommendation*) during PCI in ST-elevation myocardial infarction (STEMI) without cardiogenic shock when the following conditions are met:

- the patient has complex left main or last remaining conduit disease
- ejection fraction (EF) <30%

Temporary percutaneous mechanical circulatory support with Impella devices is recommended for coverage (*weak recommendation*) in non-ST-elevation myocardial infarction (NSTEMI) without cardiogenic shock when all of the following conditions are met:

- A heart team discussion determines the patient needs revascularization with coronary artery bypass graft (CABG) or PCI
- A cardiothoracic surgeon is consulted and agrees the patient is inoperable (i.e., is not willing to perform CABG but agrees revascularization is indicated)
- Patient has complex left main or last remaining conduit disease
- Ejection fraction (EF) < 30%

Cardiogenic shock

Temporary percutaneous mechanical circulatory support with Impella devices is recommended for coverage (*weak recommendation*) only for patients with cardiogenic shock who might be candidates for left ventricular assist device (LVAD) (destination therapy) or transplant (bridge to transplant), AND an advanced heart failure and transplant cardiologist agrees that Impella should be used as a bridge to a decision for LVAD or a transplant. Appropriate effort should be made to consult with an advanced heart failure and transplant cardiologist, but coverage is recommended in circumstances where consultation cannot reasonably be obtained without endangering the patient's life and the treating physician believes the patient meets the criteria above.

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

Rationales for each recommendation appear below in the GRADE table.

Drug Use Research & Management (DURM) Program

Roger Citron, RPh

1

November P&T Committee OHA Approved Recommendations

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

Approved November 26, 2019

2

Antifungals Class Update

- Make no changes to the PMPDP based on clinical evidence
- After comparative cost consideration in executive session:
  - make no changes to the PMPDP

https://www.orpdl.org/drugs/index.php

3

Anticoagulants Class Update

- Make no changes to the PMPDP based on clinical evidence
- After comparative cost consideration in executive session:
  - make no changes to the PMPDP

4

Rifamycin
New Drug Evaluation

- Designate rifamycin as non-preferred on the PMPDP based on clinical evidence
- Add rifamycin to the rifamaxin clinical PA criteria and add a question to approve only if there is a contraindication to azithromycin and fluoroquinolones

5

Amikacin
New Drug Evaluation

- Designate amikacin liposome inhalation suspension as non-preferred on the PMPDP based on clinical evidence
- Implement the proposed PA criteria after amending to:
  - modify question #4 to confirm the patient has been adherent for the past 6 months to a 3-drug regimen

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

6

Drugs for Gaucher Disease Class Review

- Create a PMPDP class for lysosomal storage disorder drugs
- Designate miglustat as non-preferred based on FDA labeling as second-line therapy
- Designate eliglustat as non-preferred based on need for additional enzymatic testing
- Implement the proposed PA criteria for all targeted therapies for Gaucher disease
- Refer requests for Type 3 patients to the Medical Director for review
- After comparative cost consideration in executive session:
  - make taliglucerase alfa preferred
  - make all other agents for Gaucher disease non-preferred

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

7

Amifampridine New Drug Evaluations

- Create a PMPDP class for Lambert-Eaton Myasthenic Syndrome (LEMS) agents
- Implement the proposed PA criteria for amifampridine

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

- After comparative cost consideration in executive session:
  - make amifampridine (Ruzurgi®) preferred
  - make amifampridine (Firdapse®)non-preferred

8

Cholic Acid
New Drug Evaluation

- Designate cholic acid as non-preferred on the PMPDP based on clinical evidence
- Implement the proposed PA criteria after amending to:
  - modify initial approval to 3 months
  - include assessment of liver function tests (LFTs) in the renewal criteria

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

Substance Use Disorder Literature Scan and Prior Authorization Update

- Make no changes to the PMPDP based on clinical evidence
- Remove the PA requirement for all opioid use disorder (OUD) products, except for the dose limit of 24 mg buprenorphine per day for transmucosal products

  (In response to House Bill 2257 form the 2019 legislative session)
- After comparative cost consideration in executive session:
  - make buprenorphine injection (Sublocade™) preferred
  - change buprenorphine sublingual tablets, disulfiram tablets, buprenorphine/naloxone film (Bunavail®) from non-preferred to voluntary non-preferred
  - Designate new products coming to market voluntary non-preferred until P&T review

Antidepressant Use in Children Drug Use Evaluation (DUE)

- Implement the proposed safety edit for initiation of tricyclic antidepressant (TCA) therapy in children younger than the FDA-approved minimum age limit with the goal of preventing off-label use, but automatically approve requests for:
  - children with prescriptions identified as being written by a mental health specialist, or
  - children with ongoing TCA therapy, or
  - children with a recent trial of a SSRI

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

- Implementing a retrospective DUR safety net program to identify patients with denied claims and no subsequent follow-up in order to minimize interruptions and delays in therapy

11

Dupilumab Prior Authorization Update

- Update the PA criteria to:
  - include chronic rhinosinusitis with nasal polyposis as an FDA-approved indication when prescribed as add-on therapy to standard of care
  - change “inhaled” steroid in question #15 to “intranasal” and specify the duration of the required steroid course for step therapy (2 or more courses administered for 12 to 26 weeks)

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

12

February P&T Committee Agenda & Materials

https://pharmacy.oregonstate.edu/drug-policy/oregon-pharmacy-therapeutics-committee/meetings-agenda

Meeting scheduled on 2/6/2020 from 1:00 – 5:00pm @ DXC Building

P&T Committee Updates for 2020

- Meetings will continue to be held on the first Thursday of even numbered months:
  - 4/2/2020; 6/4/2020; 8/6/2020; 10/1/2020; and 12/3/2020
- P&T Committee Appointments
  - OHA has reappointed a physician and pharmacist and newly appointed another physician to three year terms
  - Application: https://www.oregon.gov/OHA/HSD/OHP/Pages/PT-Committee.aspx

Questions?

Statewide CCO Learning Collaborative Agenda

Quality and Health Outcomes Committee Meeting
Barbara Roberts Human Services Building
500 Summer Street NE, Salem, OR, 97301, Room 137 A-D
February 10, 2020
11:00 a.m.–12:30 p.m.

Conference line: 888-278-0296
Participant code: 310477#

Supporting Kindergarten Readiness in Oregon

Session objective: Provide background on The Health Aspects of Kindergarten Readiness multi-year measurement strategy and share tactics from around the state related to what the health sector can do to better prepare children for kindergarten, including achieving the two 2020 incentive measures that support kindergarten readiness:

1) Well-child visits for 3–6-year-olds; and
2) Preventive dental visits for ages 1–5

1. **Health Aspects of Kindergarten Readiness Background and Metrics Level Setting** (35 minutes)
   - Dana Hargunani, Chief Medical Officer, Oregon Health Authority
   - Sara Kleinschmit, Policy Advisor, Health Policy and Analytics Division, OHA

2. **Engaging and working with community providers, PacificSource Central Oregon** (10 minutes)
   - Andrea Ketelhut, QIM Program Manager
   - Therese McIntyre, Population Health Strategist for Central Oregon and The Columbia Gorge

3. **Child Wellness Campaign, Eastern Oregon CCO** (20 minutes)
   - Courtney Whidden-Rivera, Supervisor of Medicaid Quality Improvement
   - Kali Paine, Health Promotion and Quality Improvement Specialist

4. **Facilitated discussion panel for Q&A** (20 minutes)

5. **Next steps and wrap-up** (OHA) (5 minutes)

Health Aspects of Kindergarten Readiness Measurement Strategy

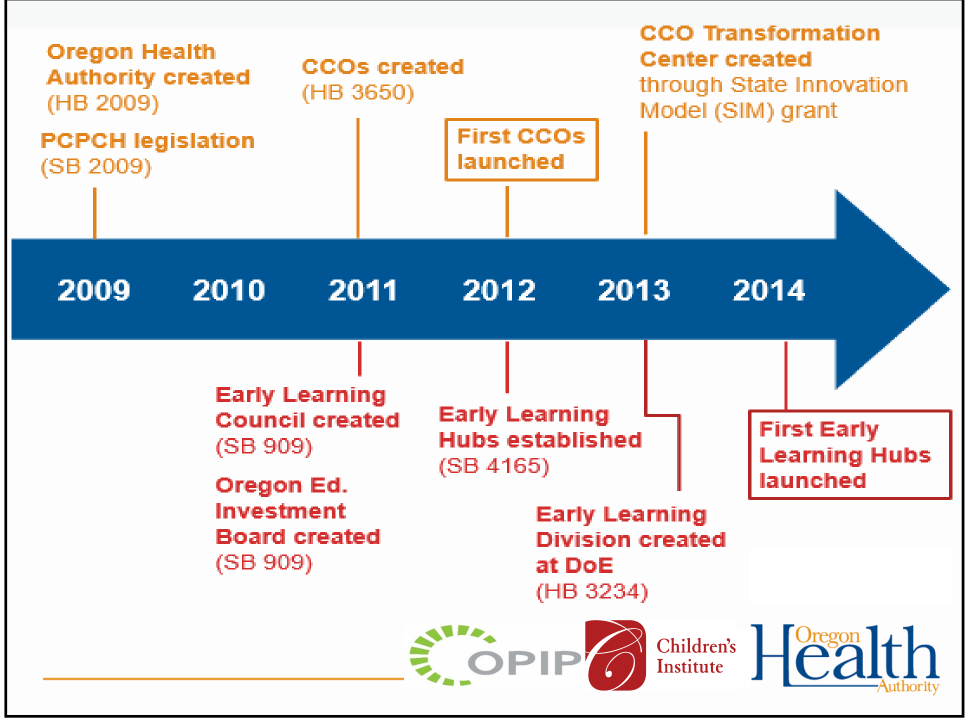
Dana Hargunani, MD, MPH
Sara Kleinschmit, MSc

1

Presentation outline

1. Measure development history
2. Measurement strategy
3. Specifications for 2020 kindergarten readiness measures
4. Implementing the strategy

2



3

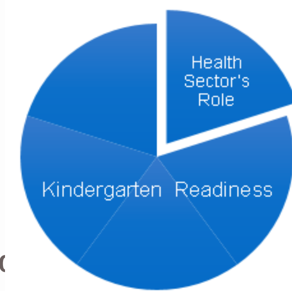
History: Consideration of health sector role in kindergarten readiness in Oregon

- **2014-2015:** the Child and Family Well-being Measures Workgroup developed initial measurement recommendations for child and family well-being, including kindergarten readiness
- **2015-2017:** the Metrics and Scoring [M&S] Committee remained engaged on the topic of developing a kindergarten readiness metric
- **May 2017:** the M&S Committee voted to sponsor a KR metric technical workgroup, launching an innovative partnership between OHA and the Children's Institute
- **March–November 2018:** Health Aspects of Kindergarten Readiness Technical (HAKR) workgroup convenes

4

Workgroup Charge

What is the health sector's role and responsibility for achieving kindergarten readiness for Oregon's children?



Recommend one or more health system quality measures that:

- Drive health system behavior chance, quality improvement, and investments that meaningfully contribute to improved kindergarten readiness
- Catalyze cross-sector collective action necessary f achieving kindergarten readiness
- Align with the intentions and goals of the CCO metrics program

5

Workgroup Composition

- Workgroup members included:
  - CCO representatives
  - Pediatric care providers
  - Early learning hub and early learning program representatives
  - Behavioral health and oral health expertise
  - Health care quality measurement expertise
  - Representatives of families and CYSHCN
- Workgroup convened by **Children's Institute** and the **Oregon Health Authority**, with support from consultants:
  - Colleen Reuland, Oregon Pediatric Improvement Partnership
  - Diana Bianco, Artemis Consulting

Oregon Health Authority

6

6

Workgroup Process

March – May 2018

- Reviewed background, including family focus group findings
- Developed conceptual framework for health aspects of kindergarten readiness
- Developed measure criteria

June – August 2018

- Identified priority areas of focus
- Reviewed and assessed existing metrics that could be implemented in near-term
- Discussed interest in new metrics for development

Sep – Nov 2018

- Narrowed options to 13 priority metrics
- Explored options for measurement proposals
- Built consensus on measurement strategy proposal and implementation options

Working Definition of Kindergarten Readiness

All children arrive at kindergarten with the skills, experiences, and supports to succeed.[1]

- **Supports** include assistance and services to families that promote family stability and functioning.
- **Succeed** refers to children making progress toward educational goals set by families and schools. Goals should be tailored to the individual child to optimize educational experience and outcomes.

[1] Early Learning Council Strategic Plan 2015

Oregon Health Authority

Conceptual Framework for Health Aspects of Kindergarten Readiness

Domains that Impact a Child's Kindergarten Readiness by Population of Focus for the Metric[1]	Domains of Specific Health Care Services and Experiences				CCO System-Level: Cross Sector Collaboration
	Promotion, Prevention & Screening/Early Detection	Follow-Up to Address Risks Identified	Care Coordination and Integration	Family-Centered Care Optimizing Interactions, Partnership, & Engagement	
Children 0-6					
Child Physical, Perceptual, Motor Development (Includes nutrition, vision, and dental)[2]					
Child Social-Emotional Well-Being[2]					
Child Cognitive, Language and Literacy Development[2]					
Family Function and Capacity[3]					
Children with Special Health Needs:					
Management and treatment of SHN(s)					
Family Capacity and Supports to Manage SHN					
Parent/Caregiver:					
Pre-Natal Health: Mother					
Health Shown to Impact a Child's Kindergarten Readiness: Parent/Caregiver					

[1]HAKR Workgroup Definition of Kindergarten Readiness: All children enter kindergarten with the skills, experiences, and supports to succeed.

[2] Domains aligned with the constructs of kindergarten readiness outlined by the National Education Goals Panel: Domains of Early Development and Learning, Head Start Early Learning Outcomes Framework: Central Domains, Oregon Early Learning and Kindergarten Guidelines, and the Developmental Foundations of School Readiness for Infants and Toddlers Report.

[3] Adapted from Connecting Child Health and School Readiness by Charles Bruner and the Build Initiative.

Developed by the Oregon Pediatric Improvement Partnership for the HAKR Technical Workgroup convened by Children's Institute and OHA.

9

Health Aspects of Kindergarten Readiness Measure Criteria

Required Criteria for Metrics Proposed for Phase 1 (Fall 2018 to Metrics and Scoring for CCO Incentive Metric)

- **Meets CCO Incentive Metric Attributes:** Reportable at the CCO-level in a 12-month time period.
- **Technical Specification Reliability and Validity**: Produces reliable and valid results. A version of the metric has been piloted within a sector of the health care system (e.g. state-, system- or practice-level).
- **Feasible:** The data for calculating the measure are feasible to collect and with large enough denominators to produce reliable results.
- **Attainable:** It is reasonable to expect improved performance on this metric in a 12-month time period. If a clinical process, evidence exists that it can be feasibly and meaningfully implemented. CCO has some degree of control over the health practice or outcome being measured.

Criteria to Assess Individual Metrics:

- **Evidence-Based or Aligned with Clinical Recommendations**: Measures align with clinical recommendations and, where possible, are based on an existing body of evidence demonstrating a significant impact on child health.
- **Outcome-Related to Domains of Kindergarten Readiness (KR):** Addresses actual outcomes, or there is evidence that what is being measured has a strong association with or predicts a positive outcome associated with Kindergarten Readiness (e.g., more young children being read to as a predictor of greater kindergarten readiness).*
- **Actionable:** The intended users can understand the results of the metric, how the corresponding care relates to a promotion of kindergarten readiness, and what should be improved.
- **Engages Health System:** Promotes the health system's awareness, engagement, and role in ensuring children are ready for kindergarten.
- **Understandable to Families**: Successfully communicates to families of young children the health system's role in ensuring that children are ready for kindergarten.
- **Family Priority:** Measures aspects of health care of importance to families.
- **Family-Centered:** Promotes family-centered care and support of parents/caregivers in fostering optimal child health and development, and encourages collaborative communication between families and healthcare providers.
- **High Impact on KR:** Drives investments in areas with a significant and positive impact on a young child's kindergarten readiness.
- **Addresses Social Determinant:** The metric drives the health care system to play a role in addressing social determinants of health.
- **Promotes Cross-Sector Collaboration:** Measures aspects of health care that require cross-sector collaboration to meet the needs of young children.
- **Able to Identify Inequities**: The measure highlights disparities by race, ethnicity, culture, gender, language, geography or other child and family risk factors.
- **Promotes a Focus on Addressing Inequities:** Drives health care systems to provide services that are equitable and culturally competent.
- **Transformative towards KR**: Drives priority areas for transformative health system behavior change.

Criteria if a Composite Measure is proposed:

- Composite metric is parsimonious and limited in number of individual components.
- Includes metrics which, in combination, measure the desired outcome by addressing the array of services that impact a child's kindergarten readiness.
- Includes metrics that utilize various data sources.
- Includes measures with the most transformative potential to drive health system change and stimulate cross-sector collaboration

10

10

Health Aspects of Kindergarten Readiness Priority Areas

Domains that Impact a Child's Kindergarten Readiness by Population of Focus for the Metric [1]	Domains of Specific Health Care Services and Experiences				
	Promotion, Prevention, & Screening/Early Detection	Follow-Up to Address Risks Identified		Care Coordination and Integration	Family-Centered Care
Children 0-6	• Info. about how to support development at home • Bundle measure of a high-quality well-visit				• Patient engagement
Child Physical, Perceptual, Motor Development [2]	• Vision screening • Hearing Screening	• Access of WIC	• Follow-up to developmental screening [4,5] • Referral coordination overall		• Ask about concerns • Spend enough time with families • Access to translation services • Culturally relevant and responsive services
Child Social-Emotional Well-Being [2]	• Screening for Social/Emotional Development	• Internal behavioral health • Specialty infant and early childhood mental health and dyadic therapies		• Coordination and integration with PH and BH	
Child Cognitive, Language, & Literacy Dev [2]	• Literacy development				
Family Function and Capacity [3]	• Maternal depression screening in child's visits • Screening for ACES, SDOH, toxic stress, resilience	• Follow-up supports for families identified with risks and needs for supports			
Children with Special Health Needs:	Metrics for this population overall [4]				
Management and treatment of SHN(s)					
Family Capacity and Supports to Manage SHN					
Parent/Caregiver:					
Pre-Natal Health: Mother	• Low birthweight • Early deliveries, full-term • Teen pregnancy rate • Screening for risks, strengths				
Parent/Caregiver Health	• Depression screening	• Mental health services for			

11

Centering Family Voice

How do health services support school readiness?

- Take time to build trust, listen to families, and ask about concerns
- Provide comprehensive prenatal and postpartum care, and parental health services (especially mental health)
- Monitor child development, provide timely immunizations, and ensure proper nutrition
- Make referrals to needed health, early learning and family support services

12

Centering Family Voice

How can health services continue to improve to support school readiness?

- Spend more time with families to develop trusting relationships
- Share expertise, information, and guidance about supporting learning at home
- Identify and communicate developmental concerns earlier, provide referrals to needed services, and follow up
- Increase local access to health services (especially in rural areas)
- Approach health care holistically across the life span, and support parents and caregivers in pediatric care

13

Workgroup Proposal

The role of the health sector is to provide family-centered and integrated services, and to work collaboratively with other sectors to ensure children are physically, socially, and emotionally healthy in preparation for kindergarten.

- A comprehensive approach to improving kindergarten readiness includes:
    - an array of measures to drive progress in all domains of kindergarten readiness
    - sufficient resources
    - greater capacity for services and system-building
- Kindergarten readiness must continue to be a statewide priority; measures applied through the CCO Quality Incentive Program should be just one of many coordinated and mutually reinforcing efforts to improve kindergarten readiness.

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14

Measurement Strategy

Multi-year measurement strategy that aims to drive health system behavior change and investments that contribute to improved kindergarten readiness and cross-sector collaboration.

- Kindergarten readiness is complex and the domains are interrelated. There is no one measure that captures all of the health aspects of kindergarten readiness.
- The proposal balances the workgroup's long-term vision for transformative work on kindergarten readiness with current momentum and sense of urgency.
- It includes metrics that are feasible to implement within the next few years, and drives toward the development of future metrics necessary for progress toward kindergarten readiness.

15

Health Aspects of Kindergarten Readiness

Multi-year measurement strategy:

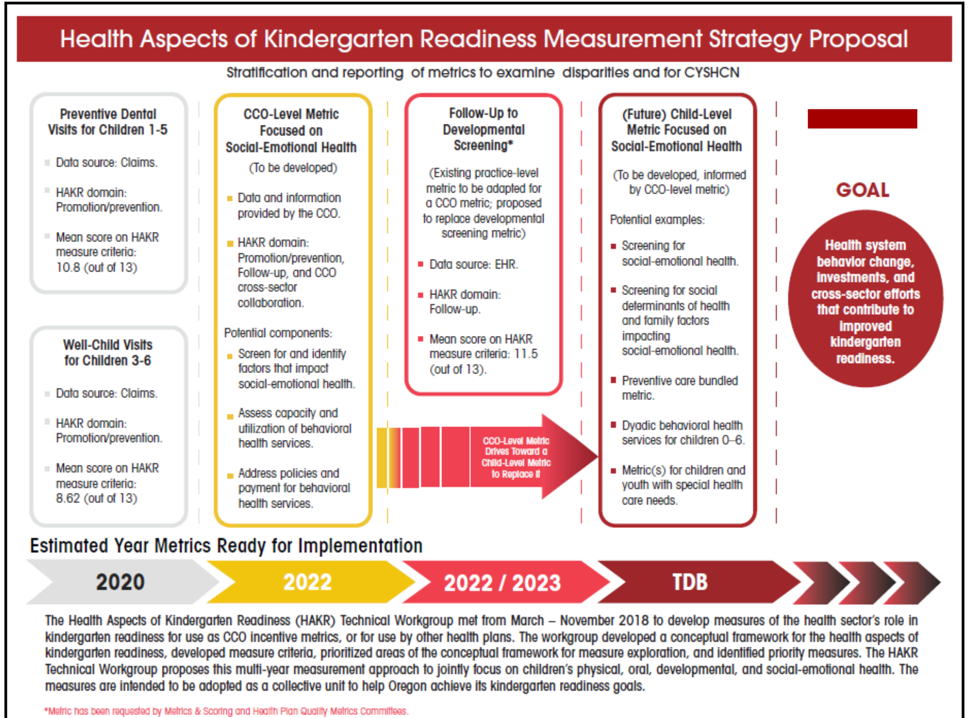
Two metrics adopted for 2020 CCO incentive measure set:

1. Well-child visits for children 3-6 years old
2. Preventive dental visits for children 1-5 years olds

Adopt a CCO-level attestation metric focused on children's social-emotional health once specifications are finalized (i.e., for the 2021 or 2022 CCO incentive measure set).
~ Currently under development ~

Replace the existing developmental screening metric with a new follow-up to developmental screening metric in 2022 or 2023.
~ Currently being tested ~

16



17

Health Aspects of Kindergarten Readiness

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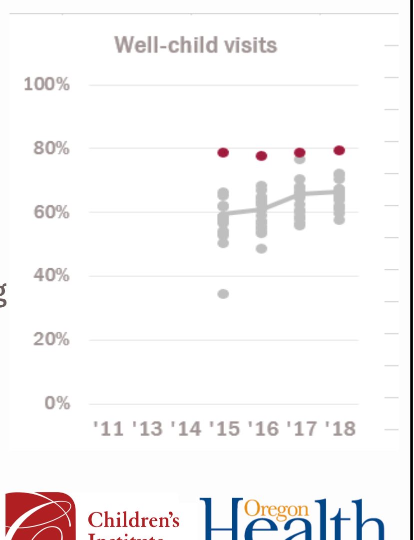
~ Currently being tested ~

18

Well-Child Visits

- Room for improvement: Data shows Oregon lower than (Medicaid) 25th percentile nationally, which is 66.18%.
- Measure aligns with Bright Futures clinical recommendations related to well-child visit periodicity.
- Access to primary care is first step in ensuring access to developmental screening and follow-up supports needed to ensure children are ready for kindergarten.
- Communicates to families that preventive care, received annually through age six, is important.



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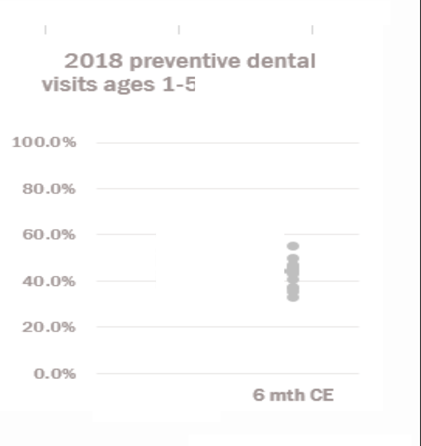
Preventive Dental Visits

- The 2017 Oregon Smile Survey found that 49% of children ages 6-9 had a cavity (30% with treated decay and 19% with untreated decay).
- Tooth decay is one of the most prevalent chronic conditions of childhood and can lead to problems with eating, speaking, playing, and learning.
- In 2013, Oregon ranked last out of 50 states regarding children having at least one preventive dental visit during the year.



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Well-child Visits for Ages 3-6

- **Overview:** Percentage of children ages 3 - 6 that had one or more well-child visits with a PCP during the year
- **Data Source:** MMIS/DSSURS
- **Continuous Enrollment Criteria:** 12 months with one allowable 45 day gap
- **Benchmark:** 78.5% (2019 National Medicaid 75th percentile)

21

21

Preventive Dental Visits

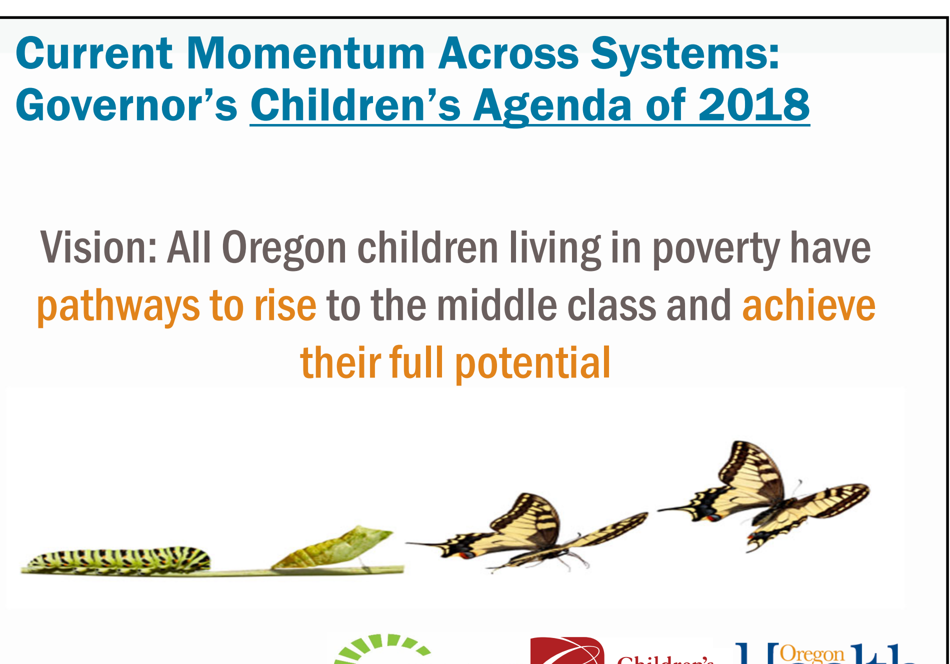
- **Overview:** Percentage of children ages 1-5 / 6-14 who received preventive dental services from a dental provider in the year
- **Data Source:** MMIS/DSSURS
- **Continuous Enrollment Criteria:** Continuously enrolled with the CCO for at least 180 days in the measurement year
- **Benchmark:** Ages 1-5: 45.4%; ages 6-14: 65.5% (CCO 75th percentile from 2018). **must meet both components to achieve measure

22

22

Current Momentum Across Systems: Governor's Children's Agenda of 2018

Vision: All Oregon children living in poverty have pathways to rise to the middle class and achieve their full potential



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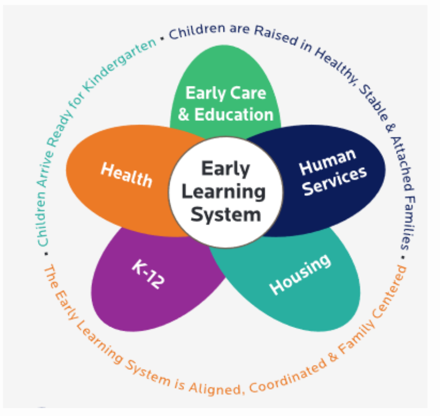
Current Momentum Across Systems

Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023, launched

- **System Goal 1**: Children Arrive Ready for Kindergarten
- **System Goal 2**: Children are Raised in Healthy, Stable, and Attached Families
- **System Goal 3**: The Early Learning System is Aligned, Coordinated, and Family Centered



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Current Momentum Across Systems: Goals of CCO 2.0

- Improve the behavioral health system and address barriers to access to and integration of care

- Increase value and pay for performance

- Focus on social determinants of health and health equity

- Maintain sustainable cost growth and ensure financial transparency

Questions?

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Working with Community Providers to Promote Best Practice

27

Promoting Provider Health Plan Engagement

- ✓Monthly meetings with providers to include Quality, Risk Assessment, and Care Management staff
  - These meetings offer a chance to provide information and updates, review quality data and understand clinic barriers
- ✓Quarterly all provider meetings
  - Started in the Columbia Gorge and will be standing up in Central Oregon this year
  - Opportunity to help spread best practice in the community

28

Promoting Provider Health Plan Engagement
cont.

- ✓Provide timely monthly data on performance
  - Review data on a consistent basis
- ✓Provide monthly gap lists in a timely and consistent way
- ✓Assist with EHR reporting if possible

29

Promoting Provider Health Plan Engagement
cont.

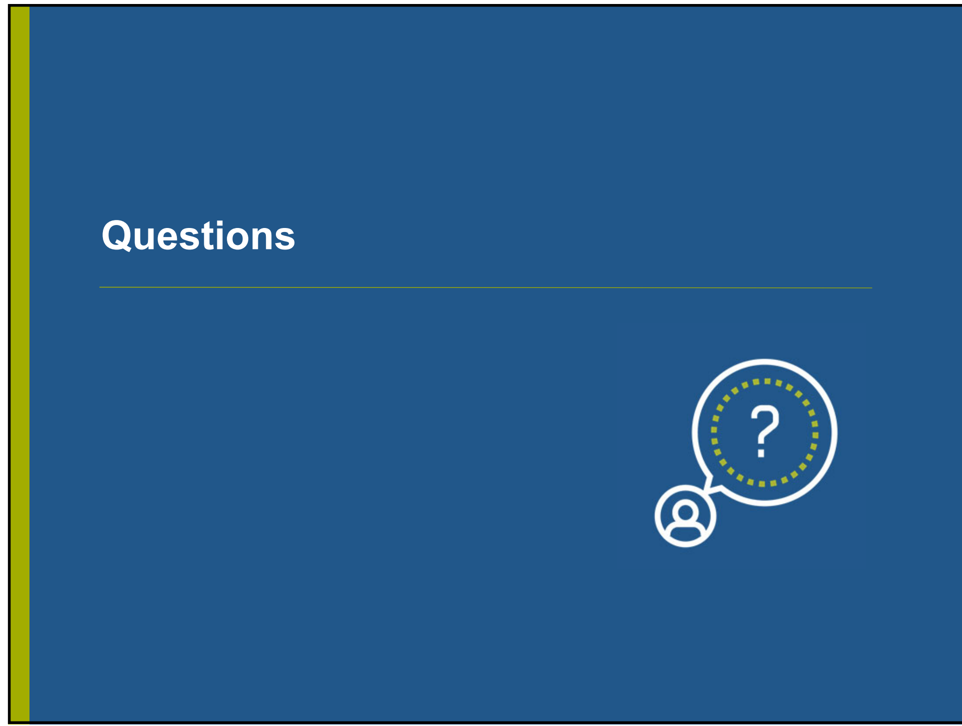
- ✓Provide opportunities for deep dives on new metrics
  - Suggest workflow changes and provide patient facing educational materials
- ✓Research best practice/successful communities and share with providers
- ✓Host community workshops on metrics and/or related topics

30

Final Thoughts

- ✓Build relationships with community providers
- ✓Understand where your goals intersect
- ✓Help providers understand cross functionality of any new workflows they may need to implement
- ✓Connect to the community (non-profits, health departments, other government agencies)
- ✓Focus on health outcomes

31



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33

34

Child Wellness Mailing Campaign

35

Project Overview

- Comprehensive patient education initiative on routine child health recommendations
- Follows patients from birth to age 12
- Tied to past and present CCO incentive measures:

2020 Measures:

- Childhood Immunization Status
- Well-Child Visits
- Preventive Dental Services
- Immunizations for Adolescents

Past Measures:

- Adolescent Well-Care Visits
- Developmental Screenings
- Dental Sealants

36

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36

Why This Project?

- Implemented similar campaign for Commercial group ages 0-21 in March 2019
  - Reached 33,000+ patients
- Addresses barriers to child wellness:
  - Demonstrates value
  - Educates parents
  - Streamlines multiple sources of information

37

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37

EOCCO Stakeholders

External:

- Patients
- Patients' parent/guardians
- Providers

Internal:

- EOCCO Quality Improvement & Operations
- Marketing
- Document Services
- Analytics

38

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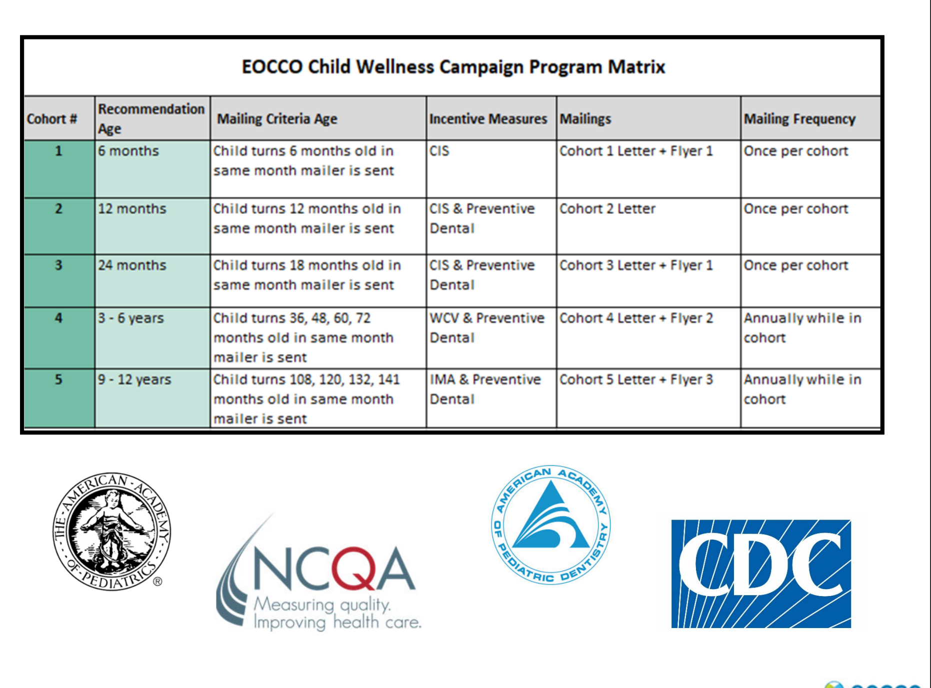
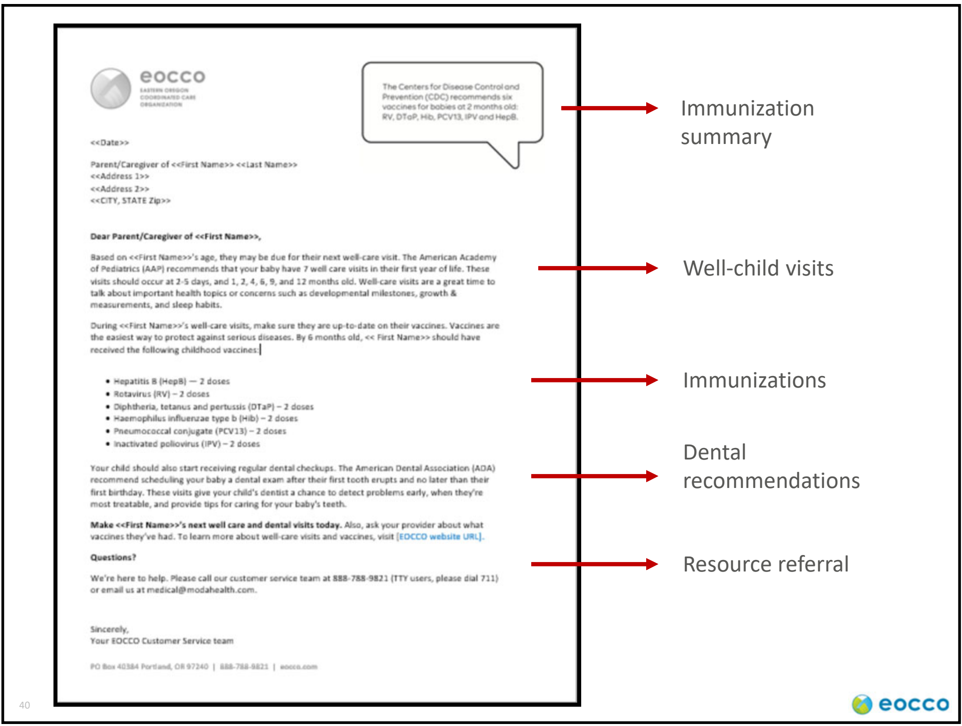


EOCCO Child Wellness Campaign Program Matrix

Cohort #	Recommendation Age	Mailing Criteria Age	Incentive Measures	Mailings	Mailing Frequency
1	6 months	Child turns 6 months old in same month mailer is sent	CIS	Cohort 1 Letter + Flyer 1	Once per cohort
2	12 months	Child turns 12 months old in same month mailer is sent	CIS & Preventive Dental	Cohort 2 Letter	Once per cohort
3	24 months	Child turns 18 months old in same month mailer is sent	CIS & Preventive Dental	Cohort 3 Letter + Flyer 1	Once per cohort
4	3 - 6 years	Child turns 36, 48, 60, 72 months old in same month mailer is sent	WCV & Preventive Dental	Cohort 4 Letter + Flyer 2	Annually while in cohort
5	9 - 12 years	Child turns 108, 120, 132, 141 months old in same month mailer is sent	IMA & Preventive Dental	Cohort 5 Letter + Flyer 3	Annually while in cohort

39



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EASTERN OREGON COORDINATED CARE ORGANIZATION

<<Date>>

Parent/Caregiver of <<First Name>> <<Last Name>>
<<Address 1>>
<<Address 2>>
<<CITY, STATE Zip>>

Dear Parent/Caregiver of <<First Name>>,

Based on <<First Name>>'s age, they may be due for their next well-care visit. The American Academy of Pediatrics (AAP) recommends that your baby have 7 well care visits in their first year of life. These visits should occur at 2-5 days, and 1, 2, 4, 6, 9, and 12 months old. Well-care visits are a great time to talk about important health topics or concerns such as developmental milestones, growth & measurements, and sleep habits.

During <<First Name>>'s well-care visits, make sure they are up-to-date on their vaccines. Vaccines are the easiest way to protect against serious diseases. By 6 months old, << First Name>> should have received the following childhood vaccines:

- Hepatitis B (HepB) — 2 doses
- Rotavirus (RV) – 2 doses
- Diphtheria, tetanus and pertussis (DTaP) – 2 doses
- Haemophilus influenzae type b (Hib) – 2 doses
- Pneumococcal conjugate (PCV13) – 2 doses
- Inactivated poliovirus (IPV) – 2 doses

Your child should also start receiving regular dental checkups. The American Dental Association (ADA) recommend scheduling your baby a dental exam after their first tooth erupts and no later than their first birthday. These visits give your child's dentist a chance to detect problems early, when they're most treatable, and provide tips for caring for your baby's teeth.

Make <<First Name>>'s next well care and dental visits today. Also, ask your provider about what vaccines they've had. To learn more about well-care visits and vaccines, visit [EOCCO website URL].

Questions?

We're here to help. Please call our customer service team at 888-788-9821 (TTY users, please dial 711) or email us at medical@modahealth.com.

Sincerely,
Your EOCCO Customer Service team

PO Box 40384 Portland, OR 97240 | 888-788-9821 | eocco.com

40

Childhood Wellness eocco.com

Give your baby a *healthy* start

Make sure your child is up to date on all of their vaccines. Book a well-care visit today.

Child preventive care is how you can help protect your baby from preventable diseases, as well as see how they are developing. Here are a few things that your child needs and what to look for in the first two years of life.

What your child needs

- Ten well-care visits at 2-5 days old, 1 month old, and 2, 4, 6, 9, 12, 15, 18 and 24 months old
- One developmental screening per year
- Some or all doses of these vaccines: hepatitis B (HepB); rotavirus (RV); diphtheria, tetanus and pertussis (DTaP); haemophilus influenzae type b (Hib); pneumococcal conjugate (PCV13); inactivated poliovirus (IPV); annual influenza (IIV); measles, mumps, rubella (MMR); varicella (VAR); hepatitis A (HepA)
- Know that it's just as important to finish a vaccine series as it is to start it. Make sure your child gets all recommended doses of their vaccines.

What to watch for

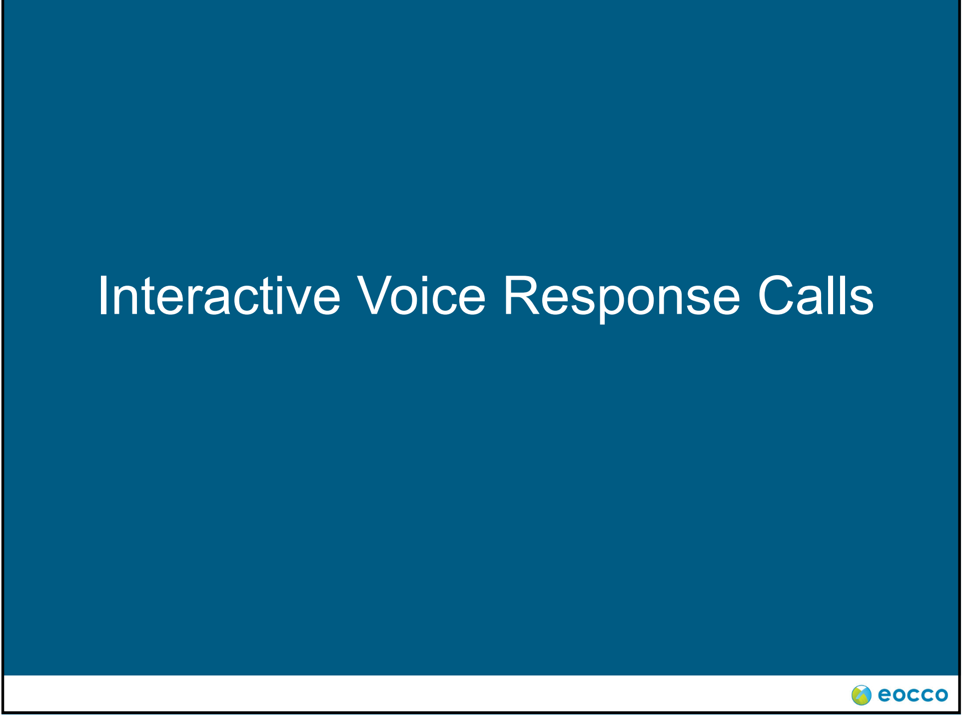
- By their first year, they may copy gestures, sit up without help, drink from a cup and say words like "mama," "dada" or "hi"
- By 18 months, they may show affection, point to specific items and walk alone
- By two years, they may play with other children, sort shapes and colors, and say short sentences

Book a well-care visit with your baby's provider and talk to them about how to keep your child healthy between 0 and 2 years old.

Questions?

We're here to help. Please call the EOCCO's customer service team toll-free at **888-788-9821**. TTY users, please dial 711.

eocco EASTERN OREGON COORDINATED CARE ORGANIZATION



West Collaboration

- Interactive voice response (IVR) campaign adds additional patient touch point to mailings
- IVR calls will deliver messaging similar to Child Wellness mailings
  - Childhood immunizations
  - Well-child visits

43

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43

IVR Program Overview

- Automated calls in English & Spanish to parents of EOCCO patients ages 5 months to 2 years
- Calls triggered by missed immunization dose, determined by claims and ALERT registry
- Barriers addressed:
  - Reaches previously unengaged parents
  - Additional communication channel
  - Refers to additional resources

44

44

45

Data and Training

- Provider progress reports
  - Clinic rate on claims based metrics
  - Prior year performance comparisons
  - Outreach rosters
- Metric training
  - Clinic visits and provider training
  - EOCCO resource guide with metric strategies:
    - Manage registry & recall process
    - Convert sick visits into wellness exams
    - Hold well-child visit events or designated clinic days

46

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46

Materials and Resources

- Distribute child wellness campaign flyers to clinics
  - Focus on parent education
- Community benefit reinvestment initiatives (CBIR)
  - Opt-in project for kindergarten readiness and childhood immunizations
  - Encourage collaboration between PCP clinics, health departments, & dental practices
  - Suggested strategies:
    - Awareness campaigns & information sharing
    - Implement evidence-based practices

47

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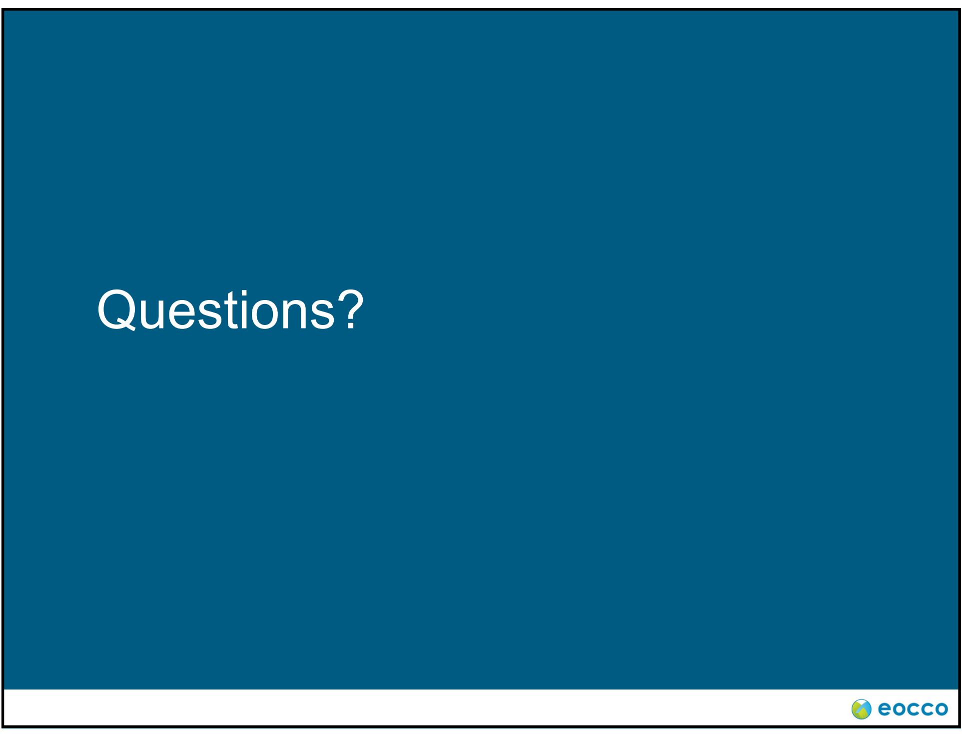
47



48

49

50

Presenter contacts and bios

- **Andrea Ketelhut** (Andrea.Ketelhut@pacificsource.com) is the quality incentive metric program manager for PacificSource Central Oregon. Andrea has over 20 years working in the health care industry with a background in operations and quality. She has been with PacificSource for just over 4.5 years, working on the Medicaid line of business.
- **Therese McIntyre** (Therese.McIntyre@pacificsource.com) is a population health strategist for PacificSource Central Oregon and Columbia Gorge. Therese has worked in health care and public health for over 30 years. Her prior experience, before joining PacificSource, includes five years building a population health program at a Central Oregon federally qualified health center.
- **Kali Paine** (Kali.Paine@modahealth.com) is a health promotion and quality improvement specialist with Eastern Oregon Coordinated Care Organization. Her background is in health promotion program planning, and since joining EOCCO she has led efforts to create a comprehensive child wellness outreach campaign with phone, mail and online components. She hopes to expand EOCCO's reach to further impact child health in Oregon.
- **Courtney Whidden-Rivera** (Courtney.Whidden@modahealth.com) is the supervisor of Medicaid quality improvement with Eastern Oregon Coordinated Care Organization. Prior to joining EOCCO, she spent several years working in quality improvement in a rural health clinic. She brings her passion for nutrition and serving rural populations into her work every day and looks forward to improving member health in 2020.

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51

51

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52

52

Quality Performance Improvement (QPI) QHOC session

Lisa Bui, Quality Improvement Director, OHA
Jenna Harms, QHOC QPI Chair

76

Agenda

- Provide overview of Performance Improvement Project (PIP)
  - Purpose
    - QA/QI, Why, What
  - PIP Accountability
    - PIP Reviews and Technical Assistance
  - PIPs
    - CMS 115 waiver focus areas
  - Common PIP Questions
  - Resources

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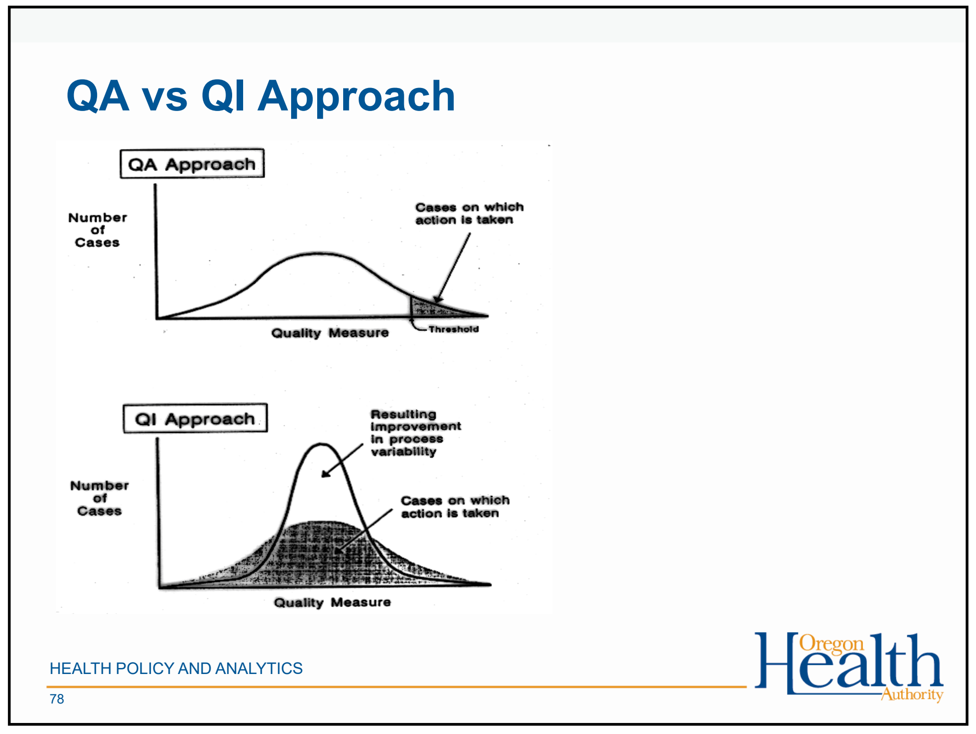
77

77

QA vs QI Approach



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78

78

QA vs QI

	Quality Assurance	Quality Improvement
Goal	Meet standard	Improvement
Focus	Individual Processes	Systems – not fault finding
Attitude	Reactive	Proactive
Source of information	P&P SOP Audit	Dashboards Program reports Surveys
Responsibility	Individuals Managers	Teams Directors
Outcomes	Process/activity change Behavior change	Performance feedback (weakness or strength) Peer learning
Accountable to	Regulation	Organization
Escalation to	Compliance team QI team	Executive Branch

79

Why have a PIP?

The purpose of a PIP is to:

- To continuously improve for achieving positive health outcomes while reducing health disparities.
- To conduct a project which supports meeting the Triple Aim.
- Assess and improve the processes and outcomes of health care provided by an [CCO].[1]
- The intent of performance improvement is to improve the quality of care provided to enrollees. [2]

1 CMS EQR Protocol #3
2 CFR Parts 431, 433, 438, 440, 457 and 495

What is in a PIP?

PIPs are a lever of quality to:

- Improve quality of care
- Improve in clinical and non-clinical areas
- Follow quality improvement science

PIPs are projects that include:

- Barrier, problem statement
- Interventions to reduce barriers and improve care
- Measures that track progress
  - Measures include outcome measure & intervention measures

What else is in a PIP?

CFR activities for PIP

Federal Rules outlines key actions[1]:

(i) Measurement of performance using objective quality indicators.

(ii) Implementation of interventions to achieve improvement in the access to and quality of care.

(iii) Evaluation of the effectiveness of the interventions based on the performance measures.

(iv) Planning and initiation of activities for increasing or sustaining improvement.

1 CFR Parts 431, 433, 438, 440, 457 and 495

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82

Accountability: How are PIPs accountable?

Compliance Functions

- Requirements set in Code of Federal Regulations

  (e.g. CFR 438.330, 438.366)
- CMS provides guidance to External Quality Review Organizations (EQRO) to conduct review of plans' PIPs.

Improvement Functions

- Assessment of study methodology;
  - Assessment of "real improvement"
- Verify PIP study findings;
- Evaluate overall validity and reliability of study results.
- Reviews are posted to the web as part of the EQRO Annual Report of the state and plan.

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83

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PIP Reviews and Technical Assistance

- The three CCO specific PIP quarterly reports are reviewed by an OHA contractor to help determine prioritization of technical assistance needs.
  - Lisa Bui, OHA Quality Improvement Director and/or OHA subject matter experts are accountable for the technical assistance provided to CCOs.
- Current OHA contractor is HSAG. These reviews are not compliance reviews but does draw upon the expertise of HSAG in quality principles.
- Technical assistance will begin scheudled with individual CCOs will begin in Spring 2020.

HEALTH POLICY AND ANALYTICS

OHA 1115 Waiver Quality Focus Areas

Eight Foci of Quality

- Reducing re-hospitalizations
- Addressing population health issues (such as diabetes, hypertension and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and state programs.
- Reducing utilization by “super-utilizers”
- Integration of health: physical health, oral health, and/or behavioral health
- Ensuring appropriate care is delivered in appropriate settings
- Improving perinatal and maternity care
- Improving primary care for all populations
- Addressing social determinants of health

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CCO PIPs

Statewide PIP
- One PIP topic
- Integration Focus Area from 1115 waiver *required
- Follows CMS validation protocol; design to implementation
- Topic is selected collaboratively between CCO and OHA
- OHA runs performance measure for validation
- Statewide PIP usually runs for minimum of three years

CCO Specific PIP
- Three PIP topics
- Topic to be more “rapid cycle” improvement
- **CCOs** select focus area for each PIP topic
- **CCOs** select performance measure and develop data monitoring reports
- **CCOs** select performance measure targets

HEALTH POLICY AND ANALYTICS

86

86

Common Questions

Can a PIP be about an incentive metric?

- Yes - Incentive Metric Alignment is ok.
- Improvement work can be through incentive measures and performance measures as part of PIPs

What is a focus study?

- A focus study, generally speaking, is more exploratory. For example a feasibility study or pilot study. Environmental scan, “Plan” stage of PDSA more extensive.

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87

87

Common Questions: How To End a PIP?

- In the quarterly progress report include the final report out of interventions, measurement and the "Quarterly Status" of Abandon or Adopt (see Figure 1 below)
- Include a new PIP notification form with the progress report for the PIP that's ending or no later than 30 days from quarterly submission.
- Email progress report on due date

Figure 1: PIP Progress Reporting Template

Quarterly Status:	☐ Continue / Monitor ☐ Adapt/Revise ☐ Abandon (drop and move to alternate PIP) ☐ Adopt/systematize interventions

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For more information:

- Questions: OHA.qualityquestions@dhsoha.state.or.us
- Resources:
  - OHA Quality Improvement https://www.oregon.gov/oha/HPA/DSI/Pages/Quality-Improvement.aspx
  - CMS PIP Protocol https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf
  - Code of Federal Regulations (CFR), Part 438, Subpart E. https://www.medicaid.gov/medicaid/managed-care/guidance/final-rule/index.html
  - Medicaid Waiver Evaluation 2012-2017 https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf

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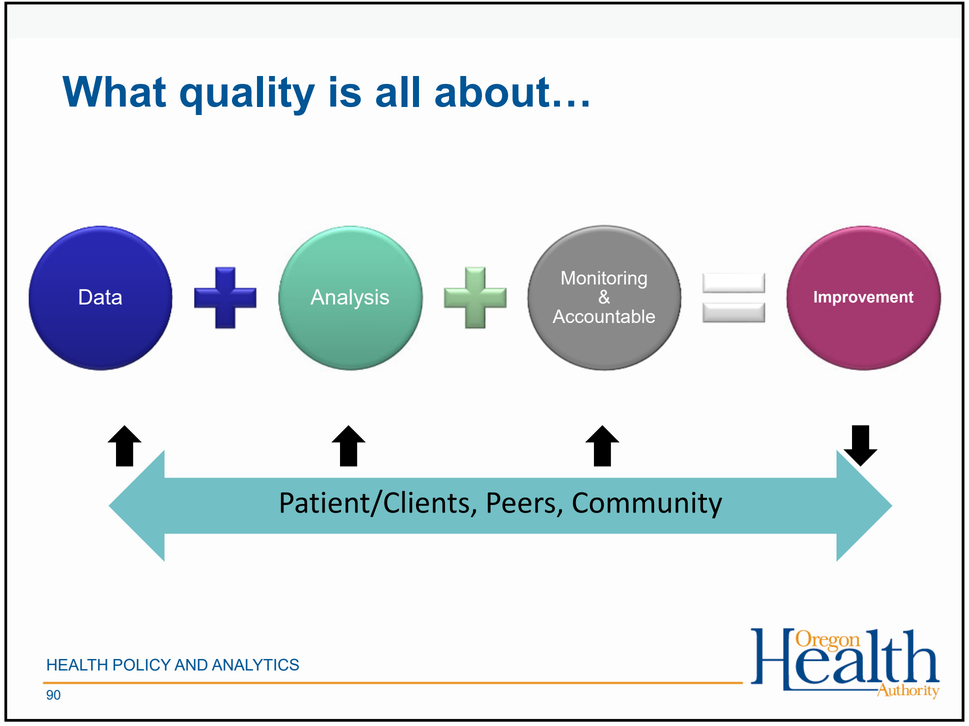

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91