

Summary table of CCO statewide PIP interventions based on October 2016 quarterly reports

CCO	Pharmacy Benefit Structure	Guidelines	Provider-Focused Interventions	Member-Focused Interventions
	Limits imposed on covered benefits. Includes prior authorization; dosage, quantity, or duration limits; etc.	Includes adoption, modification, or dissemination of guidelines	Includes: provider incentives (alternative payment methodology), academic detailing, monitoring/feedback to clinicians or clinics, summits and workshops, safe prescriber pledges, prescriber information dissemination, policy requiring prescribers to submit a taper plan for high-dose pts, PDMP utilization encouragement.	Includes information dissemination to members (brochures, newsletters), community education campaigns and forums, individual patient letters/monitoring/case management
AllCare *	Report pending.	Report pending.	Report pending.	Report pending.
CHA	Initiated formulary standards ( $\geq$ 120mg MED for longer than 27 days) in 2014	Modified guidelines to 90mg MED on July 2016		
CPCCO		50mg MED limit	<ul style="list-style-type: none"> <li>* PCPs asked to sign a safe prescriber pledge *</li> <li>Conducted provider trainings for 4 out of 9 health systems *</li> <li>Quarterly dashboards distributed to larger clinics *</li> <li>Provide "top prescriber" lists to clinics *</li> <li>Medical leadership is meeting with ED and specialty practices to discuss opioid prescribing *</li> <li>Planning Opioid Summit for Spring 2017</li> </ul>	* Regional Opioid Steering Coming Is working on a regionally-cohesive education strategy that includes messages modified to better suit the needs of individual counties
EOCCO	<ul style="list-style-type: none"> <li>* Moda pharmacy resident is developing an Opioid tapering program</li> <li>* Letters will be sent to providers who have members that need to be started on tapering plans.</li> <li>* Pharmacy claims data from October 2016- January 2017 will be compared to data from February/March 2017 in order to identify members as fully-tapered, partially-tapered or no change)..</li> </ul>	Will finalize new guidelines by 2017	<ul style="list-style-type: none"> <li>* Conducted a Clinician's Summit , but the majority of the 105 attendees were administrative staff; The next Summit will clearly focus and be marketed to prescribers. *</li> <li>* At the recommendation of the ROPG, EOCCO will develop materials on ACE screening , advice on how to manage "difficult to taper" members and information on peer group resources that will be included with provider taper letters.</li> </ul>	<ul style="list-style-type: none"> <li>* Will conduct community forums in 4 communities from Jan-May 2017 *</li> <li>* Working with Greater Oregon Behavioral Health Inc. (GOBHI) and Local Community Advisory Councils (LCACs) to help engage members in community forums</li> <li>* Working with Regional Community Advisory Council Chair to recruit LCAC assistance with updating and managing the country resource guides.</li> </ul>

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FamilyCare	<ul style="list-style-type: none"> <li>* Immediate release opioid formulation are subject to quantity limits (QL)</li> <li>* Extended release opioids are subject to both Prior Authorization (PA) and QL.</li> <li>* In process of re-evaluating the PA and QL and move towards more aggressive utilization management.</li> </ul>	Has selected a ≥ 90mg MED limit policy	<ul style="list-style-type: none"> <li>* Plan to provide providers and clinics with reports on members on ≥ 90mg MED by the end of 2016. Provider letters will include a brief synopsis of the issue and useful resources.</li> <li>• 50 dental providers attended continuing education session on the PDMP , risk stratification and alternative medications presented by the FamilyCare Medical Director and Pharmacists.</li> <li>* Continuing to recruit a community provider partner for a Project ECHO pilot (combining continuous medical education with partnering with specialist mentors)</li> <li>*On-site visits with top prescribers delayed until new Program Manager is up-to-speed.</li> </ul>	
Health Share CCO				

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Health Share-Care Oregon			<ul style="list-style-type: none"> <li>* Technical assistance to “high risk” clinics:</li> <li>* Persistent Pain Learning Collaborative: 11 participating clinics completed the fourth collaborative session on 10/19/16.</li> <li>* Hosting ACT training in early 2017 for clinic behaviorists</li> <li>* 5th Collaborative scheduled for next spring</li> </ul>	

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Health Share-Kaiser	<ul style="list-style-type: none"> <li>* 60mg MED new opioid prescription cap</li> <li>* Restrictions on new starts for all long-acting opioids</li> <li>* Working to implement regulations allowing pharmacists to prescribe naloxone.</li> </ul>	<ul style="list-style-type: none"> <li>* Patients need to be on tapering plans and/or below 90mg MED by end of 2016.</li> <li>*Agreement with all surgical departments to avoid prescribing opioids beyond 45 days post-surgery.</li> </ul>	<ul style="list-style-type: none"> <li>* Continue to reinforce recommendations for restrictions on new starts for long-acting opioids, set expectations for all providers that patients need to be on tapering plans and/or below 90mg MED by end of 2016 and "establish high priority measure tied to incentive." (the number of patents above 90mg MED has decreased by 31% since January2016)</li> <li>* *Support Team Onsite Resource for Management of Pain (STORM), a team of pharmacists, a nurse, and a social worker, assist primary care clinicians with tapering,.</li> <li>* STORM/Pain Services clinician and pharmacist provide 2-4 hours of opioid training to new clinicians.</li> <li>each surgical department/chief set a two-week supply for prescribing opioids with by department or by surgery.</li> <li>* Preference lists are being created based on surgery department specific prescribing agreements.</li> <li>* Reports tracking prescribing beyond 45 days post-surgery have been created. Reporting mechanisms back to departments are in process..</li> <li>* Dashboards for specialty care have been created</li> </ul>	<ul style="list-style-type: none"> <li>* Letters to members on &gt;90mg MED: 1353 letters have been mailed to date. Approximately 700 patients who received letters have decreased their doses, with an additional 200 taking steps to decrease (taper plan, TJR surgery, etc. Trainings have been implemented for back office staff and RNs to help develop skills and tools for outreach.</li> </ul>

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Health Share-Providence		<ul style="list-style-type: none"> <li>* Set a benefit limit of 30 therapy visits for all members rather than develop a process to identify which members should only get 4 visits</li> </ul>	<ul style="list-style-type: none"> <li>* Pathway to Treat tool for providers goes to the October Pharmacy and Therapeutics Committee for approval.</li> <li>* Clinic onsite review program (CORP) of charts for pain contract documentation: QI RN recommended that RN review chart documentation for providers who were identified in the 2015 CORP as not meeting the standard of care for treating opioid dependency related to the use of a pain contract.</li> <li>* Provider Pain Symposium implemented in September 2016 with 140 attendees. Discussion topics included tapering plans.</li> <li>* Regional Case review of difficult cases process has not been implemented.</li> <li>* In July 2016, letters were mailed to 70 members using 3 or more pharmacies, 3 or more prescribers and their providers. Another mailing is planned for the end of October.</li> </ul>	<ul style="list-style-type: none"> <li>* Virtual pain education classes conducted once a month. Surveys show that 16/20 respondents felt that an online class was more convenient than attending in-person. On a scale of 1-5 (1=poor; 5=excellent), respondents gave the class a 4.25 over all rating, information usefulness - 4.15; instructor skill - 4.79; and likelihood to recommend class to others - 4.05</li> <li>* Live classes have been modified to integrate an interactive use of a worksheet that can be used as a shared decision making tool. Patients are encouraged to bring the worksheet to their care team for further discussion.</li> <li>* Plan on having pharmacist conduct education to members based on quarterly reports. Not yet implemented.</li> <li>* In July 2016, letters were mailed to 70 members using 3 or more pharmacies, 3 or more prescribers and their providers. Another mailing is planned for the end of October.</li> <li>* Members on &gt;120mg MED are4 reviewed by a multidisciplinary team, which develops pain treatment and tapering of opioid plans.</li> </ul>

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Health Share-Tuality		* Guidelines for providers in treating acute and chronic pain, including requirement of pain contract.	<ul style="list-style-type: none"> <li>* Conducted face-to-face meetings with providers regarding opioid prescribing changes and back pain coverage. Providers "have shown some resistance to meeting" with staff. Unsure of the reason for the resistance.</li> <li>* Attended PAINWeek conference in September 2016</li> <li>* In the process of adding information to PreManage system regarding individual member's pain contract, beginning with those members that are under case management.</li> <li>* Conducted training with case managers and Medical Director on PreManage system.</li> <li>* Medical Director is developing a letter to providers about current and upcoming MED level guidelines.</li> </ul>	* Case management. member outreach, random urine drug scree, identification of terminated members with pain contracts and monitoring of patient dosage/utilization interventions have been suspended due to staffing issues. Currently working with case managers "to grow this interest again." An additional case manager has been hired.

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IHN	<p>* Decreased prescription opioid upper limit (QL) from 360 to 240 caps/tabs per 30 days on oral dosage forms of all formulary opioid products and combination products since May 2016. However, internal data demonstrated that the current QL was not effective and did not have a large impact.</p> <p>* Starting November 15, 2016, the following modifications will be implemented: QL will be revised from 240 to 180 cap/tabs per 30 days; QL criteria will be more stringent and will include tapering plan language; a "soft-stop" drug utilization review message for &gt;90 mg MED will be implemented at point of sale. This will be used to educate members about working with their providers to develop a taper plan; and QL exceptions will be set at two 3-month approval periodic to promote tapering.</p>		<p>* Pain video from plenary sessions on Opioid Safety was made available to providers. 40+ new providers viewed the video in the third quarter.</p> <p>* The Medical Director, Dr. Ewanchyna, made presentation on opioid prescribing guidelines to six family medicine residents.</p> <p>* 45 providers attended a CME on having difficult conversations in opioid reduction.</p> <p>* In August, a IHN physician wrote an article on the OHA Guideline Note 60: for Physician News, which reaches 500+ providers.</p> <p>* The Medical Director offered a provider education session on "Myths of opioid benefits and fallacies of opioid addiction."</p> <p>* 5 clinics recruited to pilot projection improving pain outcomes, and the Patient, provider and therapy referral care pathway. Provider pre-survey was collected from 4 of the clinical groups.</p> <p>* 12 clinics are enrolled in a pilot project on pain management with PCPCH providers. The focus is on improving an understanding of pain, decreasing provider fears, increasing provider confidence in diagnosing chronic pain and improving adherence to back pain treatment guidelines.</p> <p>*Created Opiate Tapering flashcards for clinics. The flashcards outline the reasons for tapering, provide a identification, summarize consistencies with recommendations, list available resources and provides a conversion table on to calculate MED.</p> <p>* A CME for providers is planned for February 2017.</p> <p>* Quarterly list of prescribers with members on opioids &gt;120mg MED for ≥90 consecutive days to be sent to providers in mid-July 2016</p>	<p>* Implemented a new PainWise website in September 2016. The website is a public resource crated by a joint task force, including health care partners located throughout Benton, Lincoln and Linn counties.</p> <p>* In discussion about how to provide education about tapering to the member during the authorization process.</p> <p>* In discussion about sending letters to members on ≥ 120mg MED and not on a tapering plan</p>

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JCC *	* In Q4 2016, CareOregon will make changes to their pharmacy benefit to support community efforts to shift prescribing practices. Changes include: implementing a quantity limit based on MED for short-acting formulary opiates; and implementing a PA required for all formulary extended-release opiates.	* Aligning policy with 3 other CCOs in regional collaborative. Collaborative is evaluating new 90mg MED limit, implemented 10/1/16.	* JCC pharmacist continues to bring benefit information, request feedback on provider and member experiences and solicit questions at regular meetings with clinical leadership. * Continue to offer support at a systems level and technical assistance as needed; technical assistance provided to one prescriber at this time. * Sent co-branded (logos of all of the regional collaborative CCOs) letters to providers about the collaborative and guidelines. * As part of collaborative, developed co-branded video on "living with Chronic Pain." Video will be made available November 2016, and there are discussion about posting the video on the Oregon Pain Guidance website as well as on YouTube	* Working on adding the finalized cross-walk of benefits to regional collaborative CCO websites. * Co-branded member letters were sent to all members age 15 and above. Letters discussed the new state and federal guidelines on opioid prescribing and new coverage of alternative treatments now being offered by health plans. *Co-branded letters will be sent out to all members who exceed the recommended opiate MED. The letters will state that their provider has been notified and been asked to submit a taper plan, and members should discuss the plan with their provider.

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PSCS-CO			<p>* On 7/14/16, mailed 71 letters to members prescribed <math>\geq</math> 120mg MED in the previous 2 months for 30 days or more and to their prescribing providers and to their PCPs (if not the prescribing provider). On 8/25/18, mailed letters to additional 8 members and their PCPs. At the time of this report, less than 10% of providers responded with either tapering plans or request for approval of current medication dose. Once the Quality Improvement (QI) Coordinator position is filled, follow up calls will be made to prescribers.</p> <p>* Above letters also asked providers to provide a rationale if they were co-prescribing opioids and benzodiazepines. 1 rationale was received. QI Coordinator vacancy resulted in lack of follow up.</p> <p>*Sponsored a Benzodiazepine Conference in September 2016.</p> <p>* Above letters also requested that providers attest to PDMP enrollment.</p> <p>* Partnering with Deschutes County Health Department, which has received a grant to hire a PDMP Coordinator through September 2016. PDMP Coordinator joined the Safe Prescribing Team, which makes presentations to individual practices and clinics. To date: 4 locations, 6 providers, 22 delegates and dentists at the statewide dental conference registered. Additional clinics are being scheduled. High prescribers are the focus of outreach efforts.</p> <p>* A PacificSource' dental partner, Advantage Dental, contractually requires their dentists to sign up for the PDMP.</p> <p>* Identified need to address ED prescribing (probably utilizing the Pre-Manage/EDIE system). In progress, no intervention implementation at this time.</p> <p>* Participated in Grand Rounds: "Opioid Tapering" on 10/17/16</p> <p>* Sponsored a Chronic non-cancer pain 101 provider workshop on 9/23/16</p>	<p>* On 7/14/16, mailed 71 letters to members prescribed <math>\geq</math> 120mg MED in the previous 2 months for 30 days or more and to their prescribing providers and to their PCPs (if not the prescribing provider). On 8/25/18, mailed letters to additional 8 members and their PCPs. At the time of this report, less than 10% of providers responded with either tapering plans or request for approval of current medication dose. Once the Quality Improvement (QI) Coordinator position is filled, follow up calls will be made to prescribers.</p>

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PSCS-CG		<p>* Pain and Opiate Treatment Advisory Group (POTAG) has reviewed multiple guidelines and has recommended that the CCO Clinical Advisory Panel endorse the Oregon Pain Guidance, CDC guidelines and OHA Advancing Pain Management in Oregon.</p>	<p>* POTAG reviewed and approved use of the Providence Pain education program and tool kit. Proposal for funding of training of program and toolkit is in progress.</p> <p>* On 7/14/16, mailed 19 letters to members prescribed ≥ 120mg MED in the previous 2 months for 30 days or more and to their prescribing providers and to their PCPs (if not the prescribing provider). At the time of this report, less than 10% of providers responded with either tapering plans or request for approval of current medication dose. Once the Quality Improvement (QI) Coordinator position is filled, follow up calls will be made to prescribers.</p> <p>* Above letters also asked providers to provide a rationale if they were co-prescribing opioids and benzodiazepines. 1 rationale was received. QI Coordinator vacancy resulted in lack of follow up.</p> <p>* Above letters also requested that providers attest to PDMP enrollment.</p> <p>* Planning to use the Pre-Manage/EDIE system to alert ED physicians about opiate use. No interventions implemented yet.</p>	<p>* On 7/14/16, mailed 19 letters to members prescribed ≥ 120mg MED in the previous 2 months for 30 days or more and to their prescribing providers and to their PCPs (if not the prescribing provider). At the time of this report, less than 10% of providers responded with either tapering plans or request for approval of current medication dose. Once the Quality Improvement (QI) Coordinator position is filled, follow up calls will be made to prescribers.</p> <p>* Investigating whether or not to implement separate intervention to address members utilizing multiple providers.</p>

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PHJC *		<p>As part of Regional Collaborative:                      * Agreement to opioid limit of ≤90mg MED                      * Providers have 30 days after notification to develop taper plans                      * All taper plans will be due by 1/1/17</p>	<p>As part of Regional Collaborative efforts:                      * In the process of finalizing a training video that includes information on opiate education, having difficult conversations and peer perspectives. The video will be distributed to CCOs 11/1/16 and is appropriate for CCO staff, clinic staff and community partner organizations.                      * Jennifer Johnstun, PHJC, presented Regional Initiatives at the South West Oregon Opiate Summit in October 2016. Summit attended by 300 people from multiple sectors.                      * In October 2016, sent out co-branded letters to all providers and pharmacists on the standardized policy and guidelines on opioid limits and tapering.                      * Co-branded letters to providers a with list of members on high doses, and need to develop taper plans within 30 days will be sent out 11/1/2016.                      * Co-branded tapering form will be available on all CCO websites                      * Provider toolkit was completed in October 2016, shared at the SW Opiate Summit and will be posted to CCO websites.                      * Training conducted at Grants Pass Clinic on opiate prescribing difficult conversations and CCO benefit changes with participation from 15 primary care providers (PCPs) and representatives from Asante ER. There was positive provider feedback about the training.</p>	<p>As part of Regional Collaborative efforts: :                      * Sent co-branded member letters to all members aged 15 and older on 10/31/16 about new opioid guidelines and policy.                      * In November 2016, will send a co-branded letter to members who need to be on taper plan. PHJC identified approximately 40 members who will be receiving notices.                      * In December 2016, will send Notice of Action (NOA) to members without taper plans</p>
TCHP		* Adopted the CDC guidelines from OHSU by the Clinical Advisory Panel	* Shared guidelines with providers through distribution of laminated reference documents for prescribing.	

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UHA	^ Developed Opioid Medication Guideline in 2012, including authorization process and refill policy * The Pharmacy and Clinical Engagement departments continue to review prior authorization processes.	*Developed Opioid Policy in 2012	* Offer ongoing education and support to providers	

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WOAH *	Outside of the Regional Collaborative, WOA: * Changed formulary to allow for improved access to naloxone.		<p>As part of Regional Collaborative with JCC, AllCare and PHJC:</p> <ul style="list-style-type: none"> <li>* Sent co-branded letters to providers and pharmacists about the new standardized policies</li> <li>* Completed a training video</li> <li>* Drafted a standardized Taper Agreement that was approved by OHA</li> </ul> <p>Outside of the Regional Collaborative, WOA:</p> <ul style="list-style-type: none"> <li>* Is working with Lines for Life as part of a PDO grant to conduct an Opioid Summit on the Oregon Coast on 10/27/16. Intensive marketing efforts targeted local providers, pharmacists and community organizations. Preliminary registration indicates approximately 250 attendees.</li> <li>* Supported North Bend Medical Center and Bay Area Hospital in conducting a Pain Symposium on 8/27/16. Workshops included information on opioid prescribing guidelines, opioid tapers, psychotherapeutic interventions for pain, OHP benefit changes for back pain, emerging drugs of abuse and prescription drug abuse and diversion. Although numbers were not available, WOA reported that the Symposium was "very well attended."</li> <li>* Supports the North Bend medical Center's quarterly provider education events on opioids. The July presentation was on urine drug screen toxicology and interpretation.</li> <li>* Is working with a pharmacist in Curry County to implement pharmacist prescribed naloxone</li> <li>* Developed a dashboard that indicates members' daily MED levels, prescribed medication, days' supply, number of pills and fill date. Dashboard will be modified to exclude members on hospice or palliative care, and include a filter for buprenorphine. The dashboard is "available for use."</li> </ul>	<p>As part of Regional Collaborative with JCC, AllCare and PHJC:</p> <ul style="list-style-type: none"> <li>* Drafted a standardized letter to members about changes to benefits around opioids. Approved by OHA.</li> <li>* Working to identify members who will need taper notices in November 2016</li> </ul>

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WVCH		<ul style="list-style-type: none"> <li>* Providers expected to treat current patients on their panel, and not discharge pain patients to another provider.</li> <li>* WVCH members on ≥ 240mg MED will be switched to Suboxone.</li> </ul>	<ul style="list-style-type: none"> <li>* In 4th quarter 2016, will send out letters to providers about OHP guidelines.</li> <li>* Developing an interactive training for providers on how to talk with members about tapering off opioids or switching to Suboxone.</li> </ul>	<ul style="list-style-type: none"> <li>* In 4th quarter 2016 will send out letters to members about OHP guidelines.</li> <li>* Planning community interventions for 2017. Options include a one-day community forum on treating and living with chronic pain, utilizing radio ads from the Oregon Pain Guidance group, developing CCO website to provide member education and distribute educational videos to clinics.</li> </ul>
YCCO	* CareOregon Pharmacy updated the reporting structure to include the State 7-11 carve out drug encounters	<ul style="list-style-type: none"> <li>* Approved the adoption of the Community Prescribing Guidelines.</li> <li>* Worked with the Oregon Pain Guidance Group to customize logos and the resource guide.</li> <li>* Will finalize resource guide and distribute at a community event in November 2016.</li> </ul>	<ul style="list-style-type: none"> <li>* Will collect list of specialty providers, with an initial focus on Orthopedics, OB and pain specialists, and conduct survey similar to one used with primary care providers to evaluate use of the PDMP.</li> <li>* Continue to implement quarterly review of alternative payment methodology (APM) add-on payments. 4 of 8 practices awarded APM received add-on payments related to opioids.</li> <li>* Medical Director and Wellness Center Behaviorist visited 7 clinics to introduce the new Medical Director, discuss emergency department utilization, pain management for patients and the new OHP back pain guidelines.</li> <li>* Third Annual Pain Summit scheduled for November 15, 2016. Speakers/topics include local ED, pharmacy, Behavioral Health and Pain Programs</li> <li>* "Meet and Greet" program to bring behavioral health and PCPs together to discuss how to better integrate, collaborate and coordinate patient care scheduled for 10/20/16</li> </ul>	* Planning a member communication about the low back pain guidelines and changes to plan coverage. Will

\* AllCare, Jackson Care Connect (JCC), Primary Health of Josephine County (PHJC) and Western Oregon Advanced Health (WOAH) have developed and implemented PIP interventions as members of a Regional Collaborative

Summary tab1

CCO	Alternative Therapies	MAT	Other
	Includes expanding list of approved therapies (e.g., acupuncture, massage, yoga), expanding coverage for therapies already on list (e.g., physical therapy), conducting pain classes, etc.	Efforts to increase MAT access. Includes removal of prior authorization, provider recruitment, member education, etc.	Includes drug take-backs, community needs/resources assessment, Regional Collaboratives, efforts to improve data infrastructure, naloxone expansion efforts
AllCare *	Report pending.	Report pending.	Report pending.
CHA	In the process of identifying alternative providers and developing short-term contracts		
CPCCO	* Working on improving referrals to and marketing for chronic pain classes	* Working with OHSU to develop a Hub-and-Spoke model to deliver MAT * As of 10/1/16 - no PA needed for nasal Narcan * Ambulatory Care pharmacist is working with CareOregon to cover Naloxone co-prescribing for high risk opioid patients. * Collaborating with law enforcement and fire departments in each county to train and provide first responders with naloxone	* Formed the Regional Opioid Steering Committee to help coordinate interventions and plan strategies. The Committee will focus on opioid addiction prevention and safety; treatment options for opioid addiction and community education about chronic pain and opioids * Working with one outpatient pharmacy to expand access to safe medication disposal to other facilities.
EOCCO	* Developing a physical therapy benefit allowance guideline by January 2017, that will be posted to the EOCCO website and made available to Moda staff and members. * The Regional Opioid Prescribers Group (ROPG) will meet with the Center for Human Development and a community behavioral health provider to discuss resources and communication between mental health providers across eastern Oregon. * ROPG will address pain schools as an agenda topic in their next meeting * Will post alternative treatment best practices on the EOCCO website. * Will add Assertive Community Treatment (ACT) as a covered service	* Presentation at the Clinician summit on buprenorphine. * Will post alternative treatment handouts from the Summit to its website. * Continue to collect data on buprenorphine prescriptions on a quarterly basis.	* Collecting data on members with >90mg MED and >50mg MED

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FamilyCare	<p>* Once the opioid dashboard is completed, will evaluate existing comprehensive pain management practices. * Broad plan to build collaborative partnerships, facilitate pilot programs and reassess network contracting, but no specific interventions have been developed. * Full administration of alternative therapy benefit for back and spinal conditions is affected by coordination of service issues.</p>		<p>* Educate internal on ATM benefit changes * Developed MED and acute-to-chronic coding and will implement Q4 2016 or Q1 2017</p>
Health Share CCO		<p>* Implementing a large-scale chemical dependence program, that includes development and implementation of Buprenorphine Dyads (program originated by CareOregon), a HUB and Spoke model with Central City Concern (CCC) and CODA, and incentivizing MAT at the OTP locations.</p>	<p>* Participate in the Tri-county Opiates Task Force, which includes Health Share CCO staff, four physical health plan partners, and Paul Lewis, MD.            * Conduct quarterly meetings of the PIP workgroup, which includes quality improvement stakeholders from each physical plan partner, to discuss their PIP work and get feedback.            * Analyze OHA data on a monthly basis and develop a dashboard (including rates for each metric over time, providers with the largest number of patients on &gt;90mg MED over 30 days, number of members on &gt;90mg MED, number of members on &gt;120mg MED, etc.) to send to each risk adverse entity (RAE)</p>

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Health Share-Care Oregon	<p>* Expand access to acupuncture to unlimited services for chronic pain and addiction patients., including working with Working Class Acupuncture on a pilot program, as well as contracting with Quest and PCA.</p> <p>* Because of some barriers with the Working Class acupuncture pilot, looking at adopting a similar program with the Health Resilience Team from Population Health.</p>	<p>* The pharmacy has been partnering with key high-volume buprenorphine prescribers in the network to fast-track access to most commonly used buprenorphine formulations.</p> <p>* Transitioned responsibility for developing and implementing Buprenorphine Dyads (partnering PCPs and Chemical Dependency providers in starting members on buprenorphine treatment). However, CareOregon will provide primary care support for model being developed by Health Share.</p> <p>* Made naloxone available without prior authorization, which increases the number of high opioid use chronic pain patients who are protected from overdosing.</p> <p>* Clinical champions (not necessarily CareOregon) are conducting education sessions in major Metro clinics about how to prescribe naloxone, how to use the patient education videos, etc.</p>	<p>* Collecting process metrics fast part of Pain Learning Collaborative work is deferred until next steps are determined.</p>

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Health Share-Kaiser		* Pharmacy is developing processes for pharmacists to prescribe naloxone.	* Established an opioid oversight board that includes primary and specialty care. Board makes recommendations, reviews progress and provides direction on how to decrease opioid prescribing. * Investigating adding a performance measure on co-prescribing of opioids and benzodiazepines.

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Health Share-Providence	<p>* Set a benefit limit of 30 therapy visits for all members rather than develop a process to identify which members should only get 4 visits starting July 1, 2016.</p> <p>* Providence Medical Group (PMG) has 3 clinics conducting pain groups through behavioral health. Curriculum is consistent with pain education classes.</p>	<p>* Provided education and training to PMG primary care providers about buprenorphine prescribing in order to increase the number of providers who can prescribe buprenorphine in their clinic offices. At this time, two providers per clinic will receive training and certification.</p>	

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Health Share-Tuality			<p>* Every month, QI coordinator reviews a pharmacy reports (monthly and quarterly) that identifies members on high dose opioids, the number of pharmacies they used and the number of prescribers they saw.</p> <p>* Trying to improve reporting by working with ESI to add additional fields, such as medication type, dosage level, MED and length of time member has been taking the medication.</p> <p>* Continuing to improve the case management log</p>

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IHN	<p>* Developed an Alternative Resources toolkit, which includes a list of alternative therapy options, available services and a description of the referral process, for a new PainWise website. *Implemented Living Well with Chronic Pain class in September 2016.</p> <p>* Implemented Samaritan Good Move program, an 8-week evidenced based program for people with chronic pain.</p> <p>* Implemented ACT beyond Pain program for people struggling with chronic physical and emotional pain.</p>	<p>* PainWise Taskforce is discussing how to recruit more MAT providers. CME planned for 2017 will include a session on MAT.</p> <p>* In September 2016, the Albany Police Department completed training on using Narcan. All squad cars now carry Narcan.</p>	<p>* 2, 207 employees completed opioid training during Q3 2016.</p>

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JCC *	<ul style="list-style-type: none"> <li>* Finalized a cross walk of benefits among all of the CCOs in the regional collaborative and distributed the list as part of a provider toolkit at the SW Oregon Opioid Summit.</li> <li>*Will be discussing access to alternative therapies at upcoming workgroup meetings.</li> <li>• Will be discussing access to alternative therapies at upcoming workgroup meetings.</li> </ul>	<ul style="list-style-type: none"> <li>* CCO leadership spoke with local A&amp;D service providers in order to gain insight and understanding of various philosophies of different service providers, their limitations and challenges.</li> <li>* Working on identifying gaps and barriers in providing MAT services.</li> <li>* In process of developing community best practice guidelines for buprenorphine prescribing.</li> <li>* MAT workgroup met and discussed examples of models of care and is considering a regional approach to providing treatment services.</li> <li>* The JCC pharmacist will be contacting the Oregon State Pharmacists Association and the Oregon Board of Pharmacy to facilitate a training for pharmacists in southern Oregon about the new naloxone laws for pharmacists. No pharmacies contracted to JCC have yet developed processes to dispense naloxone.</li> </ul>	<ul style="list-style-type: none"> <li>* Pharmacy team has revised the internal opioid data report to improve tracking of excluded members and 7/11 drugs</li> <li>*Created video for clinic staff; final version is being reviewed and edited.</li> <li>* Working on building an actionable opiate data report and discussing how to use information to inform coordination of care interventions.</li> <li>* Will use opiate data report to complete an equity analysis in conjunction with the regional collaborative.</li> <li>* Drug take back interventions have been met with resistance, partly due to costs. The JCC pharmacist will discuss a successful model with the FQHC pharmacy and both hospital Director of pharmacy.</li> </ul>

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PSCS-CO		* A task force was convened by the CCO Behavioral Health Medical Director to look at increasing access to MAT. No interventions implemented yet.	* Participate in the Pain Standards Task Force. Members include a representative from the PDMP, the Deschutes County Health Department, PDMP project Coordinator, PacificSource Pharmacy and multiple departments/team, Substance Used Disorders programs, contracted Alternative Care Providers and St. Charles Emergency Department. * 15 disposal sites are available in the CCO area. "Campaigns have occurred to increase awareness of sites." * Data collection and analyses are being revised to more accurately identify the target populations (members and providers).

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PSCS-CG		<p>* POTAG has discussed MAT</p> <p>*One Community Health has obtained a SAMHSA grant to establish a substance use treatment and MAT program in their clinics.</p> <p>* One Gorge physician is taking training to be able to be certified in buprenorphine prescribing; another physician, who has received certification, is anticipated to begin prescribing later this year.</p>	<p>* Participate in the Opiate Treatment Advisory Group (POTA), which includes a representative from the PDMP, PacificSource Pharmacy and multiple other departments/teams, Substance Use Disorders programs, contracted alternative care providers, Providence and Mid-Columbia emergency departments</p> <p>* County prevention coalition has disposal events and promotes disposal on the health department website.</p> <p>* Data collection and analyses are being revised to more accurately identify the target populations (members and providers).</p>

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PHJC *	<p>As part of the Regional Collaborative:            * The pain management modalities workgroup created a benefit crosswalk of all of the four plans, that has been incorporated into the provider toolkit.</p> <p>Outside of its collaborative work, PHJC:            * Is helping to sponsor, "New Pathways," a weekly program which combines cognitive behavioral techniques and movement to address chronic pain. PHJC and AllCare CCOs have made recommendations for curriculum revisions which have been accepted and are being incorporated. Current program attendance is low, but PHJC will monitor.            * Has identified access as a risk and has appointed a staff to assist with alternative medicine referrals.            * Has begun the contracting process with two chiropractors.            * Is in the process of identifying acupuncture and massage therapy providers to contract with.            * Has reviewed and refined contract language and benefit structure.</p>	<p>As part of the Regional Collaborative:            * Workgroup has held several meetings to examine different models, and is currently identifying a best practice model.            * Working with Project ECHO to develop a program on integration of MAT and addictions medicine available to PCPs.            * PIP data leads held a meeting with the PDMP about getting access to information of buprenorphine prescribing.</p>	<p>* Through a fellowship with the OHA Council of Clinical Innovations, Jennifer Johnstun, PHJC, has been able to develop materials, coordinate efforts and provide a consistent presence for the Regional Collaborative.            * The provider education group of the Regional Collaborative plans to conduct a data analysis of members using opiates.            * PHJC approved \$25,000 to support the work of the Oregon Pain Guidance group.</p>
TCHP	<p>* Staff have not incorporated alternative therapies into their care management due to lack of staff and ongoing training.            * Increase access to behavioral health interventions for managing chronic pain has not been implemented due to lack of staff and ongoing staff training.            * Offer and assist with Living Well with Chronic Pain class. 8 members signed up for the class in Q2, with 5 graduating..</p>		

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UHA			* Formed a Pain Committee that include physicians, mental health providers, pharmacists, CCO staff and the Medical Director. The committee meets monthly and reviews data and plans to decrease opioid prescriptions.

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WOAH *		<p>Outside of the Regional Collaborative, WOA</p> <ul style="list-style-type: none"> <li>* Is working with ADAPT to bring an Opioid Treatment Program (OTP) to Coos County in early 2017</li> <li>* Sent the Director of Pharmacy to attend naloxone trainings and attend Naloxone Workgroup.</li> <li>* Supporting partners to improve access to office-based opioid treatment (one local FQHC has received a grant to develop an office-based opioid treatment program; another clinic is expected to begin treatment "for some patients" next quarter..</li> </ul>	<p>As part of Regional Collaborative with JCC, AllCare and PHJC:</p> <ul style="list-style-type: none"> <li>* Requested data from PDMP for the region.</li> <li>* Data and reporting group developed measurement plan</li> </ul> <p>Outside of the Regional Collaborative, WOA:</p> <ul style="list-style-type: none"> <li>* Participated (in the person of the Director of Pharmacy Services) in the OHA Opioid Prescribing Task Force</li> <li>* Facilitates a Community Opioid Guidance Group to ensure communication and alignment and to avoid duplicating efforts among all community partners. Will begin regular meetings in October 2016 after a summer break.</li> <li>* Participated in a local law enforcement sponsored "Heroin Town Hall" to discuss prescription and illicit drug abuse.</li> <li>* Participated in a monthly group, that includes law enforcement, community organizations, substance use treatment providers, medical providers, pharmacists, media, peer support programs and others, to work on issues such as safe disposal of drugs, training first responders in naloxone administration, supporting drug abuse prevention programs and the development of a sobering center that would connect people to addiction treatment programs.</li> <li>* Participated in a North Bend Police Department community education event on substance abuse on 10/20/16. Over 20 people from different sectors attended.</li> <li>* Participates in monthly meetings of Coos County Community Drug Take Back and Disposal workgroup. The goal of the group is to establish 3 drug disposal sites by the end of 2017 and to sponsor a drug take back day in February 2017.</li> </ul>

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WVCH		<ul style="list-style-type: none"> <li>* Planning to give providers training on how to coach patients and families on obtaining Naloxone prescription training and certification.</li> <li>* Planning a CME course on assisting providers in getting a x-waiver in order to prescribe Suboxone.</li> <li>* Working with three provider groups to work in collaboration with A&amp;D treatment programs.</li> </ul>	* Formed a task force, Treating Back Pain and Opioid Prescribing, that includes Medical Directors, the Director of the Pain Clinic, Clinicians, a neurosurgeon, alternative medicine representatives, as well as other stakeholders. The Taskforce meets monthly.
YCCO			* Monthly meetings of the Opioid Guidedpath Committee, which discusses topics such as the prescribing guideline implementation, clinic visits, the Pain Summit event, Control Substance Quality Oversight Committee recruitment.

\* AllCare, Jackson as well as on an individual CCO basis