Central Oregon Health Council

Provider Engagement Panel
PacificSource Community Solutions – Board Room 4th Floor
2965 NE Conners Ave, Bend OR 97701

Agenda: March 14, 2018 from 7:00am-8:00am

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 7:00-7:05 **Introductions -** Divya Sharma
   - Approve Consent Agenda
2. 7:05-7:30 **Duals –** Kristen Dillon
3. 7:30-7:45 **Access to Care – info gathering for Board -** Donna
4. 7:45-8:00 **QHOC Report –** Alison Little
   - Attachment: QHOC report

Consent Agenda:

- **Approval of the draft minutes dated February 14, 2018 subject to corrections/legal review**

Written Reports:

- **RHIP Workgroup Updates**
- **CCO Dashboard**

MINUTES OF A MEETING OF

THE PROVIDER ENGAGEMENT PANEL OF

CENTRAL OREGON HEALTH COUNCIL

HELD AT PACIFICSOURCE

2965 CONNERS AVENUE, BEND, OREGON

February 14, 2018

A meeting of the Provider Engagement Panel (the ***"PEP"***) of Central Oregon Health Council, an Oregon public benefit corporation (the ***"Corporation"***), was held at 7:00 a.m. Pacific Standard Time on February 14, 2018, at PacificSource in Bend, Oregon. Notice of the meeting had been sent to all members of the Panel in accordance with the Corporation's bylaws.

Members Present: Divya Sharma, MD, Chair

Gary Allen, DMD (call-in)

Michael Allen, DO

Muriel DeLaVergne-Brown, RN, MPH

Alison Little, MD

Sharity Ludwig

Jessica Morgan, MD

Laura Pennavaria, MD

Dana Perryman, MD

Robert Ross, MD

Members Absent:	Jovanna Casas, PharmD
	Lacey Sheppard, LCSW
Guests Present:	Kristen Dillon, PacificSource
	Eric Maddox, Reliance HIE
	Wade Miller, Central Oregon Pediatrics Associates
	Donna Mills, Central Oregon Health Council
	Ann Ottoson, *
	Kelsey Seymour, Central Oregon Health Council
	Jimmy Tchalmeian, Reliance HIE

Dr. Sharma served as Chair of the meeting and Ms. Seymour served as Secretary of the meeting. Dr. Sharma called the meeting to order and announced that a quorum of directors was present and the meeting, having been duly convened in accordance with the Corporation's bylaws, was ready to proceed with business.

WELCOME

Dr. Sharma welcomed all attendees to the meeting. Introductions were made around the room.

CONSENT AGENDA

MOTION TO APPROVE: Dr. Little motioned to accept the November minutes; Dr. Michael Allen seconded. The minutes were unanimously approved.

RELIANCE HIE UPDATE

Mr. Maddox announced that the Health Informatin Exchange (HIE) has now launched in Central Oregon. He noted Reliance's goal is to have generated interest or secured contracts at clinics and hospitals in every county in Oregon by the end of the year. Dr. Pennavaria asked about surrounding states. Mr. Maddox replied that Washington, California, Alaska, Nevada, Arizona and others are also in the process of joining.

as releasing the information in April to allow plenty of time for the transition, blocking visit times in June and the week prior to the exclusion date, and putting articles in the local paper. She shared that the transition took approximately two years to take hold and now it is generally seen as the norm. Ms. Ludwig suggested that this information should be placed on the Bend La Pine School District website because all of their sports registration is handled online.

The group noted that they are unaware of any provider group in the region who is opposed to this transition, though they are uncertain of how this may affect Mountain Medical, which provides free sports physicals. Ms. Mills agreed this clinic should be engaged in this process and an effort should be made to help them achieve their aims.

QHOC REPORT

Dr. Little shared the notes from the January QHOC meeting. She noted that presentations were seen regarding the use of flex funds for supportive housing, oral health integration, and All Care in California regarding integration. In the HERC update, Dr. Little shared that coverage guidance on low back pain was approved, and guidance is still being discussed regarding urine drug testing. She shared that long-acting Buprenorphine implants are now below the line, and massage therapy visits now count toward physical therapy visits. She noted that a contentious decision for treatment centers to offer or refer to MAT has a delayed implementation until July. She shared that the chronic pain task force has begun questioning why back pain is the only chronic pain area with guidelines, and not other things such as fibromyalgia; she estimated they will spend the rest of the year developing new recommendations.

ADJOURNMENT

There being no further business to come before the PEP, the meeting was adjourned at 7:55 am Pacific Standard Time.

Respectfully submitted,

_____

Kelsey Seymour, Secretary

OHA Quality and Health Outcomes Committee (QHOC) February 12, 2018
Salem, 500 Summer Street, NE, Conference room: HSB 137 A-D

Meeting Packet

QHOC Website

Clinical Director Workgroup
9:00 am – 11:00 am

Topic	Summary of Discussion Impacted Departments	Materials/Action Items

Welcome/ Announcements	• Presenter: Maggie Bennington-Davis
	• New CMO at OHA: Dana Hargunani, MD, MPH
	• Public Health Updates:
	  ○ Newborn Screening Care Coordinators Information Session: OHA and OHSU are sponsoring an information session regarding newborn screening and birth anomalies on Wednesday, February 28th in Portland. Register here.
	  ○ Colorectal cancer screening web-based learning collaborative for CCOs: TA available for CCOs with a focus on disparities through population outreach.
	  ▪ Available to CCOs and clinic partners.
	  ▪ Application can be found here.
	  ○ New Resource: Implementing Comprehensive Diabetes Prevention Programs: Guide for CCOs.
		Speaker's Contact Sheet (1)
		Meeting Notes (2-7)
		PH Update (8-9)
		Information Session (10)

P&T Updates	• Presenter: Roger Citron • November and January P&T Committee meetings update: • **November Meeting**:	P&T Website

	○ Committee looked to adopt a new drug policy, whereby any drug that costs $5,000 or more would require PA ○ Biosimilar policy: these are ending up being more expensive than the brand names due to rebates ○ Duchenne Muscular Dystrophy: update PA criteria, discussion of clinical recommendations to OHA ○ Low Dose Quetiapine: update prior authorization criteria to only apply to <50mg; more efficient process ○ Multiple Sclerosis Class Update: PA criteria changed to reflect guideline note that progressive MS is not covered; • **January meeting**: ○ Re-appointed members and selected new Chair, Tracy Cline, and Vice Chair, Karen Michelson ○ PA criteria modified for COPD ○ Hep-C: PA criteria reviewed for people who inject drugs ▪ Risk corridor CCO should be following: all members with HIV and Hep-C are eligible for treatment ▪ Eliminating insulin resistance as an extra hepatic manifestation • **Next meeting**: March 22nd	
PDMP	• Presenter: Drew Simpson: Program Coordinator PDMP • PDMP integrated into EHR • Increase in utilization and queries; although number of registered users stagnated at approx. 50% • Medical Directors are now able to register for PDMP accounts for the purpose of overseeing operations.	Presentation (11-14)

	- Can have both a clinical and medical director account - Delegate use is allowed; Medical Director must be a licensed physician - PDMP use alone is not a driver for changing prescribing practice - Subcommittee formed to review prescriber history in aggregate to determine TA needed - PDMP now includes dispensed Naloxone and patient phone number - Interstate data sharing: actively pursuing agreements with States (currently with Idaho and soon Washington) - Prescriber dashboard (Threshold matrix) - Delivery end of February - Upcoming changes: - HB4143 mandatory registration possible - Procuring a new system: request input from stakeholders (consider how you would like this system improved) - PDMP Gateway to integrate PDMP with health IT systems (EHRs, HIEs, etc.) soft launch of summer 2017: - Current cost is on the organization ($50 per subscriber to integrate system into EHR) - Early adopters: - EDIE utility- PDMP data pushed through EDIE alerts to ED providers. Only hospitals with integrated EDIE into their EHR may receive PDMP data in notification. - Reliance eHealth Collaborative and Intercommunity Health Network CCO are working on implementation	

	○ Establishment of Statewide Subscription under HIT Commons: ▪ In process of establishing a public-private partnership to leverage the EDIE utility to drive down cost for practices that want to integrate PDMP within their EHR ○ HIT Commons to support statewide subscription (PDMP Gateway) ▪ Looking to launch subscription in early May ○ PDMP notifications will be through EDIE at hospital locations (currently 9 hospitals participating)	
HERC Update	• Presenter: Cat Livingston & Ariel Smits • January HERC Meeting: ○ Changed cataract guidelines: remove visual acuity as a criteria and replace with effects of vision on ADLs. ○ New Guideline for implantable cardiac defibrillators ○ Statement of intent for PH emergencies: on hold ○ Added wording on IT band Syndrome: limited coverage ○ Add the procedure code for fractional exhaled nitric oxide to the diagnostic file with a new guideline specifying it is only covered for the diagnosis of asthma, not management of asthma ○ No yttrium 90 for liver cancer ○ Catheter directed thrombolysis for DVT- not covered • Coverage Guidance:	HERC Materials (15-67)

	○ Affirm placement of Prolaris on Line 660 and add Oncotype DX and Decipher to Line 660 ○ Deep brain stimulation for Parkinson's disease: added to line 250 Parkinson's Disease; removed for epilepsy ○ Sleep apnea: home sleep testing is a recommended first line test ○ Tobacco smoking cessation and elective surgery: ▪ Smoking cessation is required for at least 4 weeks prior to elective surgical procedures for active tobacco users ▪ If pt. has cancer, then surgery will be covered regardless of smoking status ○ Low back pain: minimally invasive and non-corticosteroid percutaneous interventions mostly not covered ○ Topics under development: ▪ CardioMEMS for heart failure monitoring ▪ Gene expression profiling for breast cancer ▪ Urine drug testing: discussion on urine drug testing limits for SUD ▪ Gene expression profiling for prostate cancer • HERC Retreat: ○ Discussing health-related services and how to provide additional guidance: ▪ Currently exploring housing ▪ Send additional ideas to HERC ○ Evaluating effectiveness of HERC policies • Chronic Pain Task Force:	

	○ Chronic non-back pain: what is not working? Send feedback to task force. ○ Considering therapies to cover for chronic non-back pain (PT, chiro) • March HERC agenda: ○ Fixing acne placement (all acne moved to covered line, mistake, GN specifies, will be corrected in October) ○ Vaccine issues- shingrix- currently covered on FFS, coverage not required by CCO until it appears in MMWR (at direction of CDC director); coverage encouraged. ○ Auricular acupuncture: code has to be used by a licensed professional ○ Bi-annual review topics on dermatology and Sinus lines ○ Exondys- under legal review, update in April ○ Ocrevus for MS- looking at guideline note that says not covered	
Hep A Update	• Presenter: Patrick Luedtke & Ann Thomas • Recent outbreaks of HEP-A in California • Incidence has declined overtime in US due to vaccine ○ Highest incidence among age groups 20 to 40 • Cases of Hep-A hospitalizations have increased • Risk factors: predominantly MSM, homeless or illicit drug users, person-person spread through contact with fecal-contaminated environments • Cases of Hep-A in OR, 2017 (n=23) ○ 40% travelers to foreign country or household member of traveler • Recommendations and Supply: ACIP Recommendations: ○ Travelers to high or intermediate risk countries	Presentation (68-78)

	○ MSM ○ Illicit drug use ○ Chronic liver disease ○ Clotting factor disorder Additional recommendations: ○ Homeless ○ Service providers for high-risk populations ○ EMT, public safety • Supply: ○ Ig- very limited supply, and recent dose increase ○ Adult vaccine- only one of two manufacturers ▪ Supply limited in both public and private markets • OHA responses (so far): ○ Purchased 1700 doses from GSK. Distributed except for 600 doses ○ Outreach to high-risk populations ○ Updated standing order is ready to post if/when we have an outbreak. • Hep-A Outbreak Prevention: ○ Leverage current relationships: clinical community, media, safety net entities & systems, high risk persons ○ Raise outbreak awareness; assist in identifying high risk persons; promote high risk vaccination; encourage timely disease reporting; public service announcements; media interviews; media toolkit; promote key messages; peer outreach worker; needle exchanges; homeless organizations: direct outreach at tent camps & homeless sites; coordination: county jails & FQHCs; culturally appropriate communications	

	• What remains to be done?
	  ○ Secure adequate supply of vaccine
	  ○ Ensure sufficient staff support
	  ○ Improve immunization rates before outbreak
	  ○ Increase disease reporting	

2019 Statewide PIP	• Presenter: Lisa Bui
	• Current high dose opioid PIP will end 12/31/2018
	  ○ OHA will provide dashboards for 50 MED and 90 MED in 2018
	• New PIP period will be 1/1/2019-12/31/2020
	  ○ Must be in the Integration focus area, per 1115 waiver
	• 2018 topic suggestions:
	  ○ Oral health integrations
	  ○ Care coordination across provider areas
	  ○ Substance abuse disorder treatment
	  ○ Pregnancy/babies
	  ○ SBIRT
	  ○ Trauma informed care
	  ○ Population/kids
	  ○ Pediatric prescriptions for kids
	  ○ Kindergarten readiness
	  ○ Post-partum care
	  ○ Complex care coordination
	• Can we stay on the Opioid topic?
	  ○ Focus on acute to chronic
	  ○ Co-prescribing: concern over small population size of CCOs
	  ○ Cannot continue to focus solely on chronic use
	• Suggestion: Care coordination between physical and behavioral health
	• Suggestion to have a more focused look at the topic areas
		Presentation (79-80)

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Learning Collaborative 11:00am-12:30pm		
Topic	**Summary of Discussion**	**Materials/Action Items**

Oral Health Learning Collaborative	• Presenter: Bruce Austin, DMD
	• Session objective: share strategies from around the state that could inspire or help other CCOs with integrating oral health to better serve their populations.
	• Fundamentals of Oral Health Integration: AllCare CCO's Perspective (Laura McKeane)
	  ○ CCO and Pediatric office work to streamline referrals for procedures for infants
	  ○ Facilitate referrals to oral surgeon's office
	• Oral Health in the Medical Office:
	  ○ 1st office with integrated oral health assessments in primary care setting
	  ○ Use OrOHC's training materials for providers/staff
	  ○ Provide 'Key Messages' for providers
	  ○ Develop a formal dental referral process
	  ○ Follow-up and support: CCO is working with support staff and members
	  ○ Obstacles: EHR differences; reimbursement; CCO Staff support
	• Enhancing Tobacco Cessation (Willamette Dental Group)
	  ○ Dental Quality Metric: Tobacco
	  ▪ High rate of screening for tobacco use but low rates of formal tobacco cessation
	  ▪ Leveraged EHR to improve tobacco program
	  ▪ Improve patient education materials	

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	▪ Completed a baseline survey of providers (dentists, hygienist, and care advocate) ▪ Implementing a pre and post survey of study results o Making the Case ▪ Dental providers are in a unique position to screen for chronic diseases in populations that may not otherwise seek medical care. o What are dentists/staff doing to decrease the rates of tobacco use? ▪ Modeled off the NYU system ▪ Use a screening tool in EHR ▪ Clinical decision support tool within EHR based on screening of patient ▪ Referrals to state quit lines ▪ NYU dispensed NRT directly • Linking Primary Care with Dental Services (CareOregon) o Listening to feedback from PCPs, EDs, Patients, CAC, Customer Service Reps o Diverse network models in OR o Low overall dentist participation in Medicaid o Initial strategies: ▪ Member ID Cards include DCO info. ▪ Promoting the dental benefit at the CCO level and in collaboration with dental plan partners ▪ Navigation brochure ▪ Provider Portal • PA page within the portal	

	• PCPs can use existing referral or authorization workflows to establish internal process • Removes the challenges of dental plan identification and navigation to dental services from provider offices ▪ CareOregon internal processing: • System creates a list of requests overnight • DCO assignment is added • Received by dental staff member the following morning ○ Future: bidirectional functionality for dentists to connect the patient to a PCP • Oral Health Integration TA ○ The transformation Center is offering each CCO up to 10 hours of oral and physical health and/or behavioral health integration TA, focused on one topic area. ○ Submit requests by May 15, 2018, with TA hours completed by November 30, 2018.	
Quality and Performance Improvement Session 1:00 pm – 3:00 pm		
Topic	**Summary of Discussion**	**Materials/Action Items**
Welcome/ Announcements	• Presenters: Carla Bennett, Lisa Bui • New CMO: Dana Hargunani, MD, MPH • **TQS** Updates: ○ Office hours continue through February ○ May submit a sample TQS project for review	ISCA updates (115-118)

	○ FWA component and how information is submitted ▪ Still TBD on how to submit information requested in the Guidance Doc ▪ Look at FWA example ○ Cover every component/subcomponent at least once and as many times as necessary ○ Up to CCO on how much information to submit to OHA ○ Do not need to submit a work plan! • 2018 Information Systems Capabilities Assessment (ISCA)- Colleen Gadbois ○ Broken into 11 sections ○ New format for reporting ○ REDCap and 2018 ISCA Protocol tool questions match	
CCO NOA Oral Health Work Session	• Focus on readability and understandability of NOAs for oral health • Use most recent Adverse Benefit Determination/NOA templates- recently updated January 1, 2018 • Includes denial language, reason for denial • Use short sentences and less than 3 syllables • Look at readability analyzer on readability request form • Examples: ○ Your dental chart shows your teeth and gums are not healthy enough for dentures. ○ Based on your current dental health we would not expect the dental device to work well. ○ A crown on this tooth is not covered for members under age 16. ○ This tooth is not showing any symptoms. The OHP only covers the extraction of teeth with	Dental Dictionary (119-144) Writing for Medicaid Audience (145-148) Readability Samples (149) Medicaid Terms (150)

	medical cause. There is no infection, severe tooth pain, or extreme swelling.	

Items from the floor	All
	• 2019 PIP, OHA will:
	  ○ Look at data
	  ○ Determine feasibility per protocol
	• Voting on topics:
	  ○ Acute to chronic (Minnesota Method)
	  ○ Benzos co-prescribing
	  ○ Trauma-informed care
	  ○ Care coordination (PH and BH)
	• Continue discussion in March	

March upcoming topics:

- Social Determinants of Health Framework – Medicaid Advisory Committee (MAC)

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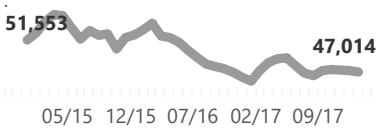
Central OR CCO

Coordinated Care Organization (Medicaid) 03/05/2018

PacificSource Community Solutions

MEMBER COUNTS

FEB 2018 — **47,014** Members — **20,375** children — **26,638** adults



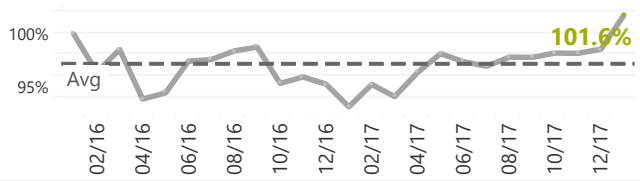
AVG MEMBERSHIP (YEAR TO DATE FROM FINANCE)

COST OF CARE

= Budget

		Actual PMPM	Difference from Budget
Medical Excl. Cap	12/17	$113.39	($5.93)
	01/18	$114.63	$1.31
Dental	12/17	$23.12	$3.13
	01/18	$24.65	$0.22
Pharmacy	12/17	$65.05	$5.64
	01/18	$69.08	($3.34)
Capitated BH, PCP, Hosp	12/17	$177.50	($10.96)
	01/18	$199.68	($32.25)
TOTAL EXPENSES	12/17	$393.41	($14.46)
	01/18	$423.40	($37.65)

Expenses & Claims Over Revenue (YTD)



FOCUS ON: ED & PCP UTILIZATION

Emergency Dept & Primary Care Utilization by Member Race / Ethnicity

		% w/ PCP Visit		% w/ ED Visit		# ED Visits per 100 PCP Visit..		% of Pop.
Caucasian	2015	61%	Avg 60%	25%	Avg 24%	24	Avg 24	73%
	2016	60%		24%		25		
	2017	60%		24%		24		
Hispanic / Latino	2015	60%	Avg 62%	23%	Avg 23%	23	Avg 23	12%
	2016	61%		22%		23		
	2017	64%		24%		23		
Native American / Alaskan Native	2015	44%	Avg 45%	29%	Avg 29%	44	Avg 43	2%
	2016	44%		31%		45		
	2017	46%		29%		40		
Unknown	2015	48%	Avg 49%	16%	Avg 16%	19	Avg 19	12%
	2016	47%		15%		19		
	2017	53%		18%		19		
All Others	2015	59%	Avg 58%	23%	Avg 20%	21	Avg 19	1%
	2016	57%		20%		20		
	2017	59%		17%		17		

* Number of ED visits for every 100 primary care visits. Lower is often better.

ACCESS & UTILIZATION

(1/2016 to 02/2018, paid thru 02/2018; no completion factor applied)

RATE Per Member Per Year

Behavioral Health (BH)	2016	2.4
	2017	2.8
	2018 YTD	2.1
Dental	2016	1.0
	2017	1.1
	2018 YTD	0.7
Primary Care (PCP)	2016	2.4
	2017	2.5
	2018 YTD	1.9

% OF MEMBERS (Unique Mems)

Behavioral Health (BH)	2016	14%
	2017	18%
	2018 YTD	9%
Dental	2016	34%
	2017	35%
	2018 YTD	9%
Primary Care (PCP)	2016	58%
	2017	59%
	2018 YTD	23%
Any Claim	2016	77%
	2017	79%
	2018 YTD	47%

NEMT

#SERVICES (ALL TYPES)

Members since 1/2017:

4,018 NEMT

356 SUD RES

SUD RES & DETOX

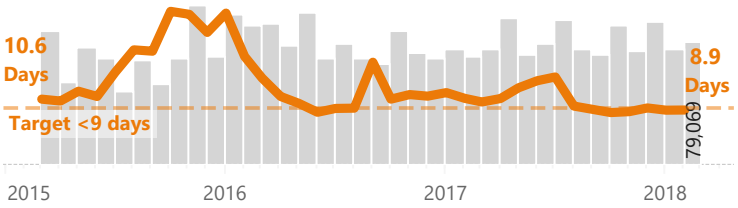
MEMBERS

OPERATIONS

(03/2015 to 02/2018)

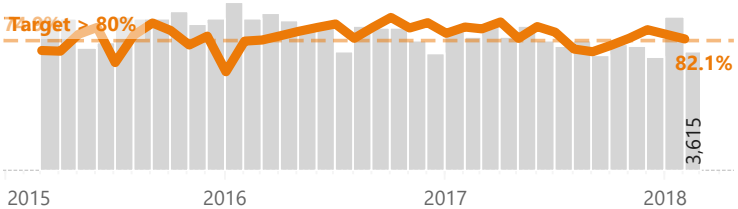
CLAIMS TURNAROUND TIME (DAYS)

Bars = # Claims **Line = Avg Turnaround Time (Days)**



CALL SERVICE LEVELS

Bars = Call Volume **Line = % Calls Answered w/in 30 seconds**



DEFINITIONS

Avg	Average
BH	Behavioral Health (mental health, substance abuse and addictions)
Cap	Capitation
Den	Dental Services
Detox	Detoxification Services. When expressed with Substance Use Disorder Residential (SUD RES) these are detoxification services provided in the residential setting.
General Administrative Expense (G&A)	Expenses related to the administration of the plan including, but not limited to, staff salary and benefits, telephone, depreciation, software licenses, utilities, compliance, etc.
Hosp	Hospital (when listed under "Capitated" label, only includes capitated inpatient services)
Medical Claims Expense	Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).
Mems	Members
MH/CD	Mental Health / Chemical Dependency
Misc	Miscellaneous Services not otherwise categorized.
MM	Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.
NEMT	Non-Emergent Medical Transport
Net Income	Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.
PCP	Primary Care Provider
PMPM	Per member per month
Premium Taxes & OMIP	State mandated taxes collected on a per member per month (PMPM) or % of premium basis.
QIM	Quality Incentive Measure program by Oregon Health Authority for Coordinated Care Organizations.
Rx	Prescription
SPMI	Severe and persistent mental illness. Members of all ages are included if diagnosed at any time with a condition outlined by OHA and USDOJ as SPMI. This includes certain depression diagnoses. Identification of members based on Medicaid CCO claims.
SUD	Substance Use Disorder
SUD RES	Substance Use Disorder Residential Treatment
Total Revenue	Premiums collected for insurance, net of HRA costs. Premiums for Oregon Health Plan recipients are received from the state of Oregon
Underwriting Income	Income after Operations and other activities not directly related to continuing operations.
Utilization	Use of a good or service
YTD	Year to date. For this dashboard, Financial YTD is based on the calendar year beginning January 1st.

***BCCP** & SPECIAL NEEDS RATE GROUP NOTE: As of 2017, Special Needs Rate Group (Rate Group X) is no longer a grouping by OHA. Starting in 2017, OHA used Rate Group X to classify Breast Cancer and Cervical Cancer Program members (BCCP).

NOTE: As of 4/2017, all financial PMPMs and cost bucketing comes from the Finance Department and no longer uses Actuarial bucketing. This means that costs, revenues and expenses are all presented on an ***paid date*** basis, regardless of what year they were incurred.