2018

Clinician and Staff Summit

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EASTERN OREGON
COORDINATED CARE
ORGANIZATION

2018 EOCCO Clinician and Staff Summit Agenda

September 20, 2018 • Eastern Oregon Trade and Event Center

8:30 – 9:00	**Registration/Refreshments**
9:00 – 9:05	**Welcome and Introductions** *Dr. Chuck Hofmann*
9:05 – 9:50	**Plenary Session 1** **Quality Measure Update** *Sean Jessup*
10:00 – 10:45	**Breakout Session 1** **Providers: Tips to Increase Contraceptive Use in 15-17 Year Olds** *Dr. Sarah Laiosa*
	Staff: Weighing in on the Children and Adolescent Nutritional Assessment Measure *Courtney Whidden*
11:00 – 11:45	**Plenary Session 2** **The ED-MI Incentive Measure – Tips for Success** *Bonnie Thompson*
12:00 – 12:45	**Lunch Session: Healthy Mouths, Healthy People** *Elizabeth Gordon, ODS Community Health and Dr. Gary Allen, Advantage Dental*
1:00 – 1:45	**Breakout Session 2** **Providers: Panel Session: EOCCO Models for Integrating Behavioral Health into PCPCHs** *Dr. Kim Humann, Moderator; Dr. Rachel Morenz, and Dr. Brian Sandoval as panelists*
	Staff: Arcadia Update – Lessons Learned *Josh Cabana*
2:00 – 2:45	**Breakout Session 3** **Providers: EOCCO Online Pain School Project** *Mark Altenhofen*
	Staff: Using Data/Registries to Assess Clinical Quality Measures *Sarah Patterson*
3:00 – 3:45	**Plenary Session 3** **Panel Session: The SPACE Trial – Is This What We've Been Waiting For?** *Dr. Chuck Hofmann, Moderator; Dr. Joel Rice, Dr. Liz Waters, and Dave Ebel (PT) as panelists*
4:00	**Adjourn**

ACCREDITATION:

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of St. Charles Health System and the Eastern Oregon Coordinated Care Organization (EOCCO). St. Charles Health System is accredited by the Oregon Medical Association to provide continuing medical education for physicians.

St. Charles Health System designates this Live Activity for a maximum of 5.25 *AMA PRA Category 1* credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

EOCCO Incentive Measure Updates

Sean Jessup

Disclosure statement

- I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation.
  - Company: Moda Health, Inc./EOCCO
  - Relationship: Director of Medicaid Programs
- To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review for best evidence.

Learning objective

- Summarize EOCCO's overall quality measure performance

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EOCCO structure

- **Ownership**
  - Moda Health (29%)
  - Greater Oregon Behavioral Health, Inc. (29%)
  - Good Shepherd Hospital (10%)
  - Grande Ronde Hospital (10%)
  - St. Alphonsus Hospital (10%)
  - St. Anthony's Hospital (10%)
  - Eastern Oregon IPA (1%)
  - Yakima Valley Farm Workers (1%)
- **17 Member Governing board**
- **Community advisory council's**
  - 12 Local Community Advisory Council's (LCAC's)
  - 1 Regional Community Advisory Council (RCAC)
- **Clinical Advisory Panel (CAP)**

Keys to financial success

- **Operating within the global budget framework**
  - 3.4% fixed rate of growth per year
- **Implement Value Based Payment (VBP) models**
  - Shared savings/alternate payment methodologies
- **Meet CCO quality measures**
- **Re-investments into providers the community and new programs**
  - Significant Primary Care investments

2016 statewide quality pool distribution

- 2016 quality pool funding available:
  - $179 Million
  - 27.4 Million in challenge pool funding

Number of quality measure targets met	Number of CCO's	Percent of quality pool funds earned
At least 14	7	100%
12-13	7	80%
11	2	70%

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2017 statewide quality pool distribution

- 2017 quality pool funding available:
  - $178 Million
  - $2.4 Million in challenge pool funding

2017 CCO performance

Number of quality measure target met	Number of CCOs	Percent of quality pool funds earned
At least 13	14	100%
11	2	70%

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2013-2017 EOCCO quality measures met and percent of funding received

- 2013 $2.4 Million (2% of premium)
  - Received $1.9 Million-80% of available funding
- 2014 $6 Million (3% of premium)
  - Received $6.8 Million-100% of available funding
- 2015 $10 Million (4% of premium)
  - Received $10.2 Million-100% of available funding
- 2016 $11.5 Million (4.25% of premium)
  - Received $10.1 Million-91% of available funding
- 2017 $12 Million (4.25% of premium)
  - Received $12.1 Million-101% of available funding

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Quality performance over time

EASTERN OREGON CCO-2017 Quality Measure Results					
Incentive Measure	2014 Final Rate	2015 Final Rate	2016 Final Rate	2017 Target Rate	2017 Final Rate
Adolescent well care visits	23.9%	25.5%	34.3%	37.3%	37.8%
Alcohol and drug misuse: SBIRT	5.5%	8.8%	16.1%	15.0%	15.3%
Emergency department utilization*	54	54.4	53.4	51.8	52.9
CAHPS Access to care	84.8%	82.3%	81.7%	83.7%	80.7%
CAHPS Satisfaction with care	83.3%	87.4%	84.7%	86.7%	86.8%
Cigarette smoking prevalence**	N/A	N/A	31%	30%	24.2%
Colorectal cancer screening***	35.3%	36.0%	40.9%	43.9%	44.8%
Controlling high blood pressure**	52.2%	59.1%	63.9%	66.9%	67.0%
Dental sealants	4.9%	14.4%	18.6%	20.0%	24.6%
Depression screening and follow up plan**	17.4%	33.0%	52.1%	52.9%	57.3%
Developmental screening in the first 36 months of life	35.9%	44.7%	54.3%	57.3%	62.6%
Diabetes HbA1c Poor Control *&**	21.6%	26.4%	26.5%	23.5%	30.0%
Effective contraceptive use	32.6%	39.7%	45.1%	48.1%	50.3%
Childhood Immunization Status Combo 2	N/A	N/A	70.6%	72.9%	77.8%
Follow up after hospitalization for mental illness	63.6%	70.9%	72.7%	75.7%	83.8%
Assessments for Children in DHS custody	68.8%	51.0%	73.0%	76.0%	83.2%
PCPCH Enrollment	61.0%	73.5%	85.1%	60.0%	68.9%
Timeliness of prenatal care***	96.9%	91.4%	93.1%	91.0%	92.9%

*Lower is better
**Technology Measures
***Chart Review Component

County Level Performance

County	Measures Met	Adolescent Well Care Visits	Childhood Immunizations	Colorectal Cancer Screening	Dental Sealants	Developmental Screening	Effective Contraceptive Use	Ambulatory Care & ED Utilization	Follow Up After Hospitalization for Mental Illness*	Alcohol and Drug Misuse
Baker	6	33.1%	84.0%	41.7%	29.1%	69.1%	54.6%	51.1	100.0%	11.0%
Gilliam	5	50.0%	85.7%	29.6%	32.2%	50.0%	30.3%	37.3	100.0%	8.4%
Grant	2	29.8%	66.7%	25.1%	40.6%	43.3%	44.1%	63.0	100.0%	5.3%
Harney	8	36.5%	79.2%	48.4%	42.5%	90.0%	51.3%	45.8	100.0%	17.2%
Lake	7	36.4%	77.3%	45.1%	32.1%	39.7%	56.9%	40.1	100.0%	18.1%
Malheur	4	36.7%	82.4%	43.6%	23.0%	84.0%	47.0%	55.7	94.7%	13.4%
Morrow	6	46.2%	68.8%	40.5%	24.4%	43.6%	49.6%	50.0	100.0%	24.0%
Sherman	6	42.2%	50.0%	41.9%	30.4%	62.5%	33.3%	32.1	100.0%	17.8%
Umatilla	7	39.5%	79.1%	44.1%	24.0%	47.2%	49.1%	53.6	88.9%	15.1%
Union	5	39.0%	66.7%	39.1%	17.8%	82.8%	48.2%	62.8	100.0%	21.7%
Wallowa	6	47.9%	78.3%	53.7%	16.8%	80.0%	44.7%	30.7	100.0%	7.6%
Wheeler	6	24.0%	50.0%	41.0%	62.5%	80.0%	63.3%	35.1	100.0%	38.5%
EOCCO Rate	7	38.6%	77.3%	42.7%	24.6%	62.8%	49.0%	53.1	95.7%	15.3%
EOCCO 2017 Target Rate		37.3%	72.9%	43.9%	20.0%	57.3%	48.1%	51.8	75.7%	15.0%

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EOCCO quality measure funding reinvestments

- Quality bonus payments to PCP's
- Enhanced PCPCH funding
- Local community advisory council (LCAC) community benefit initiatives
- Dental Care Organization quality funding
- Transformation Grant Community Benefit Initiatives (grants)
- Other Initiatives

Other initiatives and new programs

- **Community Health Worker investments**
  - Training
  - Reimbursement
- **Technology investments**
  - Arcadia
  - PreManage

2017 quality pool funds distribution

Initiative	Percentage
Quality Bonus Payments	30%
Enhanced PCPCH Payments	40%
LCAC Community Benefit Initiatives	6%
Dental Care Organization Distribution	7%
Transformation Grant Community Benefit Initiatives	10%
Other Initiatives	7%

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EOCCO investments in the community through June 2018

- **PCPCH payments:** $27.9 Million
- **EOCCO shared savings/APM:** $28.4 Million
- **EOCCO Community Benefit Initiatives (Grants):** $4.35 Million
- **EOCCO quality measure investments:** $26.6 Million
- **Total re-investments to date:** **$87.25 Million**

EOCCO Cost and Utilization updates

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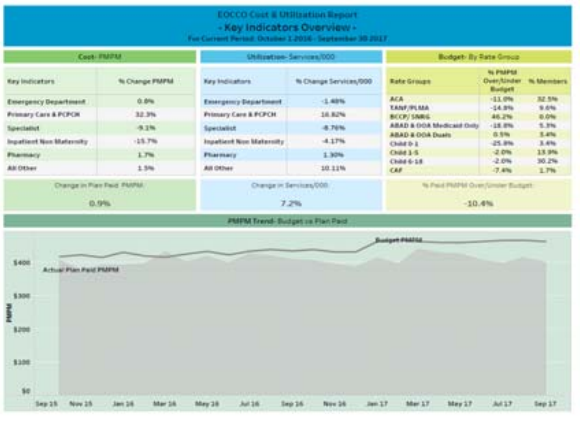

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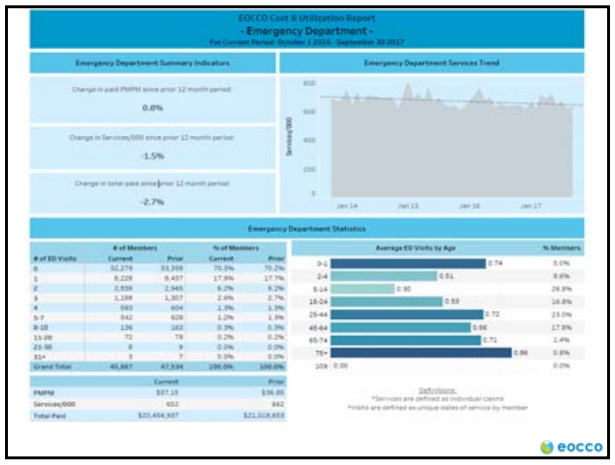
EOCCO Cost & Utilization Report
- Emergency Department -
For Current Period: October 1 2016 - September 30 2017
Emergency Department Summary Indicators
Change in paid PMPM since prior 12 month period:
0.8%
Change in Services/000 since prior 12 month period:
-1.5%
Change in total paid since prior 12 month period:
-2.7%
Emergency Department Services Trend
Services/000
Jan 14
Jan 15
Jan 16
Jan 17
Emergency Department Statistics
# of ED Visits
# of Members
% of Members
Current
Prior
Grand Total 45,887 47,534 100.0% 100.0%
Average ED Visits by Age
% Members
0-1 0.74 5.0%
2-4 0.61 8.6%
5-14 0.30 26.8%
15-24 0.53 16.8%
25-44 0.72 23.0%
45-64 0.66 17.8%
65-74 0.71 1.4%
75+ 0.86 0.8%
10% 0.00 0.0%
Definitions
*Services are defined as individual claims
*Visits are defined as unique dates of service by member
PMPM $37.18 $36.85
Services/000 652 662
Total Paid $20,454,937 $21,018,853
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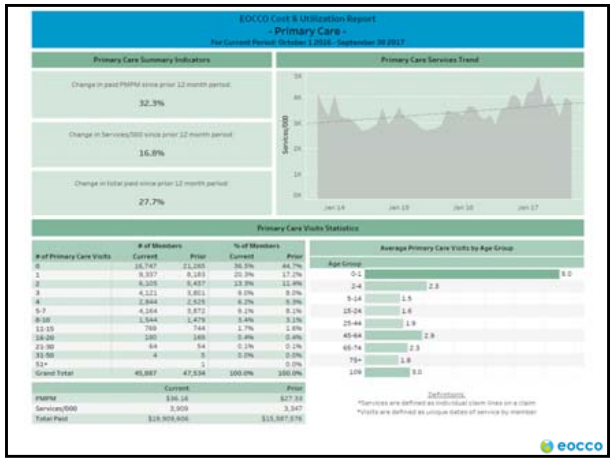
EOCCO Cost & Utilization Report
- Primary Care -
For Current Period: October 1 2016 - September 30 2017
Primary Care Summary Indicators
Change in paid PMPM since prior 12 month period:
32.3%
Change in Services/000 since prior 12 month period:
16.8%
Change in total paid since prior 12 month period:
27.7%
Primary Care Services Trend
Services/000
Jan 14
Jan 15
Jan 16
Jan 17
Primary Care Visits Statistics
# of Primary Care Visits
# of Members
% of Members
Current
Prior
Grand Total 45,887 47,534 100.0% 100.0%
Average Primary Care Visits by Age Group
Age Group
0-1 8.0
2-4 2.8
5-14 1.5
15-24 1.6
25-44 1.9
45-64 2.9
65-74 2.3
75+ 1.8
10% 8.0
Definitions
*Services are defined as individual claim lines on a claim
*Visits are defined as unique dates of service by member
PMPM $36.16 $27.33
Services/000 3,909 3,347
Total Paid $19,909,906 $15,587,576
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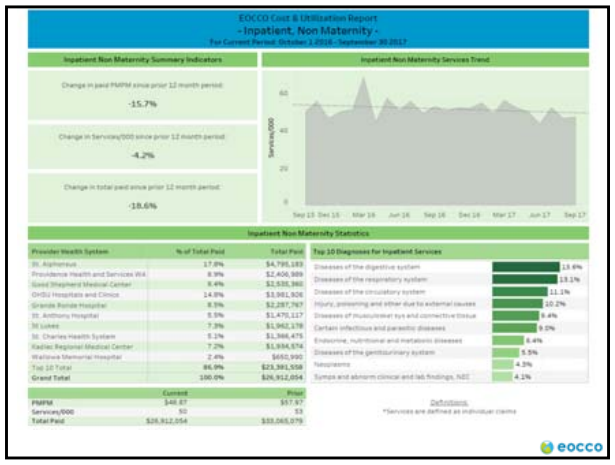
EOCCO Cost & Utilization Report
- Inpatient, Non Maternity -
For Current Period: October 1 2016 - September 30 2017
Inpatient Non Maternity Summary Indicators
Change in paid PMPM since prior 12 month period:
-15.7%
Change in Services/000 since prior 12 month period:
-4.2%
Change in total paid since prior 12 month period:
-18.6%
Inpatient Non Maternity Services Trend
Services/000
Sep 15
Dec 15
Mar 16
Jun 16
Sep 16
Dec 16
Mar 17
Jun 17
Sep 17
Inpatient Non Maternity Statistics
Provider Health System
% of Total Paid
Total Paid
Top 10 Diagnoses for Inpatient Services
Diseases of the digestive system 13.6%
Diseases of the respiratory system 13.1%
Diseases of the circulatory system 11.1%
Injury, poisoning and other due to external causes 10.2%
Diseases of musculoskel sys and connective tissue 6.4%
Certain infectious and parasitic diseases 6.0%
Endocrine, nutritional and metabolic diseases 5.4%
Diseases of the genitourinary system 5.5%
Neoplasms 4.3%
Symps and abnorm clinical and lab findings, NEC 4.1%
Grand Total 100.0% $26,912,054
Definitions
*Services are defined as individual claims
PMPM $40.87 $57.97
Services/000 50 53
Total Paid $26,912,054 $33,065,079
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2018 Incentive Measures

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2018 Incentive Measures

Claims Based Measures

1. Adolescent Well Care Visits
2. Child Immunization Status Combo 2
3. Dental Sealants for Children
4. Developmental Screening
5. ED Utilization
6. ED Utilization for Members Experiencing Mental Illness
7. Effective Contraceptive Use
8. Health Assessments for Children in DHS custody
9. SBIRT

Chart Review Measures

10. Colorectal Cancer Screening
11. Timeliness of Prenatal and Postpartum Care

Clinical Quality Measures

12. Depression Screening and Follow-up
13. Controlling High Blood Pressure
14. Diabetes HbA1c Poor Control
15. Cigarette Smoking Prevalence
16. Weight Assessment and Counseling for Children and Adolescents

CCO Specific Measures

17. PCPCH Enrollment
18. Access to Care (CAHPS)

Quality measures in blue are new or modified for 2018

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Clinical Quality Measures

- OHA continues to add clinical quality measures
  - 2013: 3 clinical quality measures
  - 2019: 6 clinical quality measures
- Arcadia Analytics
  - Clinical quality measure tool
  - 9 clinics currently on-boarded
  - Approximately 36% of our patient population

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Targeted Efforts for 2018

- Educate clinics on the two new measures and changes to existing measures
  - Weight Assessment and Counseling for Children and Adolescents
  - Emergency Department Utilization for Members Experiencing Mental Illness
- Integrate Alcohol and Drug Screen (SBIRT) into clinic EHRs for 2019
- Increased emphasis on measures that were challenging to meet in 2017
  - Adolescent Well Care
  - Effective Contraceptive Use
  - Diabetes and Hypertension
  - Emergency Department Utilization

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2018 Strategies

- Clinic visits
- Reoccurring conference calls with clinic managers
- County level clinic staff meetings
- Provider and county progress reports
- Arcadia
- PreManage

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2018 quality pool funds distribution

- Board approved methodology
- Funds will be received 6/30/19

Initiative	Percentage
Quality Bonus Payments	30%
Quality Bonus Payments	30%
Enhanced PCPCH Payments	40%
LCAC Community Benefit Initiatives	6%
Dental Care Organization Distribution	7%
Transformation Grant Community Benefit Initiatives	10%
Other Initiatives	7%
Total	**$11.8 Million (estimated)**

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Questions?

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Effective Contraception Utilization

Sarah Laiosa, DO

Family Physician

Contract Medical Director, EOCCO

Disclosures

Contract Medical Director, EOCCO

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Objectives

- Illustrate how to best address contraception with adolescents
- Cover modes of contraception considered effective for this measure
- Delineate the codes used for monitoring the ECU incentive measure by EOCCO

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Sarah Laiosa, DO

Contract Medical Director, EOCCO

High Country Health and Wellness, Provider and Medical Director

Harney District Hospital, ER and OB provider

Harney County Hospice Medical Director

Harney County Public Health Medical Director

Harney County Physician Medical Examiner

Harney District Hospital EMS Medical Director

Harney County Dispatch Medical Director

Designated Medical Professional, Child Abuse Examiner, Prosecution Expert Witness, Harney County DHS

Adjunct Faculty, OHSU, Family Medicine Department, Cascades East Family Medicine Residency Program, Klamath Falls

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Measured Population

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Effective Contraception Measure

Numerator: Women aged 15-50 using effective contraception as defined by the Oregon Health Authority (OHA)

Denominator: All women aged 15-50 as of December 31 of the measurement year who were continuously enrolled in a CCO for the 12 month measurement period. Exclusions to follow.

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Exclusions

- Hysterectomy (Z90.710)
- Bilateral Oophorectomy (Z90.722)
- Natural Menopause (N95.1)
- Premature Menopause (E28.319)
- Currently Pregnant
- Pregnant During Measurement Year
- Female Infertility (N97.0, N97.1, N97.2, N97.8, N97.9)
- Congenital Abnormalities of Female Organs (Q50.02, Q51.0)

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Not Excluded, But Should Be?

- Women whose partner have vasectomy
- Women who are not sexually active
- Women who are actively trying to become pregnant
- Women who do not have sex with men

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Bilateral Tubal Ligation

In previous years, a code for surveillance of tubal would need to be submitted annually, however the Oregon Health Authority (OHA) has changed this such that any woman who has a claim for tubal in their records (since 2002) will always show as compliant for this measure.

“Women who had claims indicating female sterilization would count as a numerator hit in the measurement year, as well as the subsequent years. OHA will compile a ‘female sterilization permanent numerator table’ using all the OHP claims history (which dates back to 2002), and give numerator credits to the CCO that the member is continuously enrolled with during the measurement year."

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What Is Effective Contraception?

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ECU Per the OHA

- Tubal
- Implant
- IUD
- Depo Provera
- OCPs
- Contraceptive Ring
- Contraceptive Patch
- Diaphragm

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Adolescent Sexual Activity

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Best Practices

"Best practices in adolescent anticipatory guidance and screening include a sexual health history, screening for pregnancy and sexually transmitted infections, counseling, and if indicated, providing access to contraceptives."

AAP, "Contraception for Adolescents", October 2014

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Adolescent Sexual Activity

2011:

- 47% of high school students reported ever having sex
- 34% reported having sex in the previous 3 months

Annually:

- 750,000 adolescent girls become pregnant
- 82% of these pregnancies are unplanned
- 59% of these pregnancies end in births
- 14% end in miscarriage
- 27% end in abortion

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Adolescent Contraceptive Use

TABLE 1 Lifetime Use (Ever-Use) of Contraception Among Sexually Experienced Women Aged 15 to 19 Years: United States, 2006 to 2010

Method	% Distribution
Any method[188]	98.9
Injectable	20.3
Pill	55.6
Contraceptive patch	10.3
Contraceptive ring	5.2
Emergency contraception	13.7
Condom	95.8
Female condom	1.5
Periodic abstinence—calendar	15.0
Withdrawal	57.3
Other methods	7.1
Long-acting reversible contraceptives (IUDs and implants)[64]	4.5

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Current Contraceptive Use

TABLE 2 Current Contraceptive Use by Method of Women Aged 15 to 19 Years: United States, 2006 to 2008[102]

Contraceptive Status and Method	% Distribution
Using contraception	28.2
Pill	15.2
Implant, Lunelle, or patch	0.5
3-mo injectable (Depo-Provera)	2.6
Contraceptive ring	1.0
IUD	1.0
Condom	6.4
Withdrawal	1.1
Not using contraception	71.8
Nonsurgically sterile—female or male	0.5
Pregnant or postpartum	3.9
Seeking pregnancy	0.9
Other nonuse:	
Never had intercourse or no intercourse in 3 mo before interview	60.0
Had intercourse in 3 mo before interview	6.5

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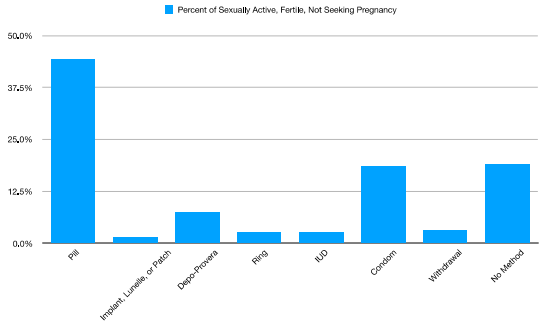
Sexually Active, Fertile, Contraception



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Consent to Treatment

- Family planning/sexual and reproductive health (ORS 109.610, ORS 109.640)
- Minors of any age are allowed to access birth control-related information and services as well as testing and treatment for sexually transmitted infections (STIs) including HIV, without parental consent.
- 66% of parents agree that it is important for adolescents to have private conversations with their physician

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Contraceptive Methods

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Nexplanon

- Implanted in the arm
- Good for 3 years
- Can cause irregular bleeding
- Failure rate <1%
- Insertion takes 1 minute
- Removal can take <5 minutes
- Can be seen on x-ray
- Requires manufacturer training

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IUD

- Several varieties
- Hormonal and non-hormonal
- Failure rate <1%
- Safe in nulliparous women
- Does not increase risk of pelvic inflammatory disease (PID)
- Screening for gonorrhea/chlamydia can be done at time of insertion, treatment without removal is adequate

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Depo-Provera Injection

- Single injection every 13 weeks
- Can be started the same day as the visit, even if pregnancy cannot be definitively ruled out, follow up pregnancy test in 2-4 weeks
- Perfect-use pregnancy rate is 0.2%, Typical-use is 6%
- Irregular bleeding experienced by nearly all, improves over time
- Long return to fertility
- Weight gain?
- Bone density?

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Oral Contraceptive Pills

- Can be started on the day of visit
- Requires back up method for 7 days
- May be decreased in effectiveness by several medications, including antibiotics
- May decrease the effectiveness of medications
- Perfect-use failure of 0.3%, Typical-use failure 9%

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Progesterone-Only Pills

- Generally considered to be less effective than combined oral contraceptives
- More time sensitive than combined oral contraceptives
- Efficacy not studied separately from combined oral contraceptives

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Contraceptive Patch

- Can be placed on the abdomen, upper torso, upper outer arm, buttocks
- 1 patch for each of 3 weeks in a row, then one week off
- Typical-use failure rate: 9%
- 1.6 times higher estrogen exposure than with combined oral contraceptives
- Black box warning for higher risk of VTE (still true?!?)

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Vaginal Ring

- Inserted into vagina, stays in place for 3 weeks, then remove for 1 week
- Efficacy should not be affected by concomitant use of tampons, spermicide, miconazole
- Can be removed for up to 3 hours for intercourse
- Typical-use failure rate: 9%
- Can have same-day start

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Tubal Ligation

- Typically not appropriate in adolescent population, but paid for by EOCCO with appropriate signed consent over the age of 15.

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Coding

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Surveillance Codes

- Tubal Ligation Z30.2
- Implant Z30.46
- IUD Z30.431
- Depo-Provera Z30.42 plus 96372 and J1050 each injection
- Oral Contraceptive Pills Z30.41
- Contraceptive Ring Z30.44
- Contraceptive Patch Z30.45
- Diaphragm Z30.49

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Initiation Codes

- Implant placement **Z30.017** plus **11981** and **J3707**
- IUD counseling visit: **Z30.014**
- IUD placement **Z30.430** plus device codes: ParaGard = **J7300** Liletta = **J7297** Mirena **= J7298**
- Kyleena = **J7296** Skyla = **J7301**
- Depo Provera (injection) **Z30.013** plus **96372** and **J1050**
- Birth control pills **Z30.011**
- Contraceptive Ring **Z30.015**
- Contraceptive Patch **Z30.016**
- Diaphragm plus **Z30.018** plus **A4266** for the device

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Removal Codes

- Implant removal **Z30.46** plus **11981** removal + reinsertion: **Z30.46** plus **11983** plus **J3707**
- IUD removal **Z30.432** plus **58301** removal + reinsertion**:** **Z30.433** plus J code and **58301 and 58300** (and *modifier* ***-51*** *or* ***-59***)

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Resources

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Sources

- https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/Effective%20Contraceptive%20Use%20-%202018.pdf
- “Contraception for Adolescents”, Technical Report. American Academy of Pediatrics. Pediatrics, Volume 134, Number 4, October 2014.
- https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/Documents/minor-rights.pdf

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Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

Courtney Whidden, MS, CHES

Disclosure Statement

- **In-kind financial relationship as it relates to the sponsorship of the event**
  - Company: Moda Health, Inc./EOCCO
  - Relationship: Health Promotion and Quality Improvement Specialist

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Introduction: Courtney Whidden

- Education/Credentials
  - Bachelor of Science in Community Health
  - Master of Science in Nutrition
  - Certified Health Education Specialist
- Work Experience
  - Oregon State University Extension, Nutrition Educator
  - NorthShore Medical Group, Chronic Care Management Program Coordinator
  - Northwest Personal Training, Nutritionist
  - Moda Health, Health Promotion and Quality Improvement Specialist

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Learning Objective

- Explain the importance of documenting nutrition and physical activity counseling for children and adolescents

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Measure Specifications

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Numerator and Denominator

- Numerator 1
  - Patients who had a height, weight, and BMI percentile recorded during the measurement period
- Numerator 2
  - Patients who had counseling for nutrition during a visit that occurs during the measurement period
- Numerator 3
  - Patients who had counseling for physical activity during a visit that occurs during the measurement period
- Denominator
  - All patients ages 3-17 with at least one outpatient visit with a PCP or OB/GYN during the measurement period
    *PCP includes NPs and PAs

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Measure Details

- Clinic rate is an average of the three rates
  - Example
    - BMI: 90/100 = 90%
    - Nutrition Counseling: 30/100 = 30%
    - Physical Activity Counseling: 30/100 = 30%
    - **Average**: (90+30+30) / 3 = **50%**
- Each numerator is calculated independently
- The BMI value, nutrition counseling, and physical activity counseling do not need to occur during the same visit
- **EOCCO Target = 30.4%**

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Example Patient 1

- 7 year old, John Doe has one office visit in the measurement period where his height and weight is recorded, so the BMI is calculated
- John does not receive any counseling for nutrition or physical activity at his office visit
- How he will be counted in the measure
  - BMI: counted in denominator AND numerator
  - Nutrition Counseling: counted in denominator but NOT numerator
  - Physical Activity Counseling: counted in denominator but NOT numerator

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Example Patient 2

- 12 year old, Jane Doe has two office visits in the measurement period and BMI is recorded at both
- Jane receives nutrition counseling at her first visit but receives no physical activity counseling at either visit
- How she will be counted in the measure
  - BMI: counted once in denominator AND once in numerator
  - Nutrition Counseling: counted once in denominator AND once in numerator
  - Physical Activity: counted once in denominator but NOT in numerator

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Exclusions

- Denominator Exclusions
  - Patients who have a diagnosis of pregnancy during the measurement period
  - Patients who were in hospice care during the measurement period
- Numerator Exclusions
  - None

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Clinical Importance of Weight Assessment and Counseling

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The Why Behind the Measure

- The Health Plan Quality Metrics Committee and the Metrics and Scoring Committee are interested in an evidence-based metric to reduce obesity[1]
- A workgroup has formed to work on measure development[1]
- This measure is a building block to that work[1]

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The Importance of Nutrition and Physical Activity Counseling for All

- Nutrition-related health conditions are highly prevalent in the United States yet only 12% of office visits include nutrition counseling[2]
- Adequate nutrition and physical activity are essential for[2,3]
  - Growth and development
  - Reducing the risk of disease
  - Maintaining healthy weight
  - Stabilizing energy
  - Promoting healthy mental health
  - Social development
- Make it a part of your workflow for all Well Child Checks and Adolescent Well Care Exams

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Clinic Workflow Example

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Assessment Tool

- Valid dietary assessment tool designed for use in primary care to identify areas of nutrition concern[3]
  - MA can provide questionnaire and then provider can reinforce healthy behavior
- Assess the average number of servings of vegetables, fruits, whole grains, and protein sources
- Assess the number of servings of sugar-sweetened beverages, fast food, candy, etc.
- Assess the amount of physical activity per week
- Example Tool
  - Bright Futures: Nutrition[3]

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Questionnaire for Parents of Children Ages 1 to 10[3]

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Questionnaire for Parents of Children Ages 1 to 10[3]

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Questionnaire for Adolescents Ages 11 to 21[3]

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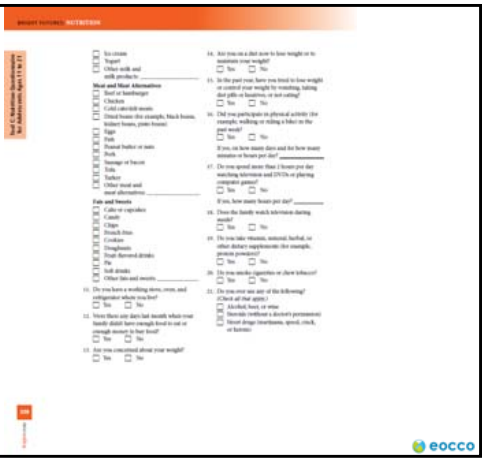
Questionnaire for Adolescents Ages 11 to 21[3]



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Counseling

- Indicators of nutrition risk[3]
  - Food Choices
  - Eating Behavior
  - Food Resources
  - Weight and Body Image
  - Growth
  - Physical Activity
  - Lifestyle
- Direct patient to appropriate resources
- Schedule follow-up if needed or refer to a dietician

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Reporting

Coding

- Bill for the Well Child Check or Adolescent Well Care Exam
- Counseling for Nutrition Grouping Value Set SNOWMEDCT[1]
  - 2.16.840.1.113883.3.464.1003.195.12.1003
- A referral to a dietician counts for nutrition counseling[1]
  - SNOMEDCT codes for patient referral to dietitian (procedure) and referral to community-based dietetics service (procedure), etc.
  - CPT codes for Medical Nutrition Therapy apart from WCC
    - 97802, 97803, 97804

Clinical Quality Measure

- Three rates reported
- Reported annually to EOCCO using clinic EHR data
- This is an NQF endorsed metric developed by the National Committee for Quality Assurance (NCQA)[1]
  - NQF 0024/ CMS 155v6

Questions?

Contact **eoccometrics.com** with additional questions

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References

1. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents. Oregon Health Authority. https://www.oregon.gov/oha/HPA/ANALYTICS/CCOData/Weight-Assessment-Counseling-FAQ.pdf. Published June 1, 2019. Accessed August 24, 2018.
2. Kahan S, Manson JE. Nutrition Counseling in Clinical Practice How Clinicians Can Do Better. *JAMA*. 2017;318(12):1101–1102. doi:10.1001/jama.2017.10434
3. Bright Futures: Nutrition and Pocket Guide. American Academy of Pediatrics. https://brightfutures.aap.org/materials-and-tools/nutrition-and-pocket-guide/Pages/default.aspx. Published 2018. Accessed August 24, 2018.

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The ED-MI Incentive Measure, Tips for Success

Bonnie Thompson, RN, MBA, MSN

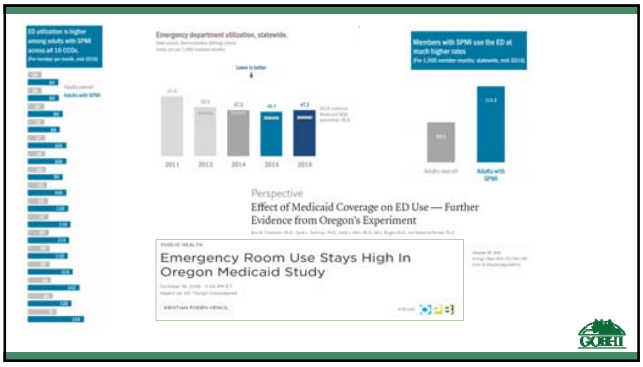
Presenter Information

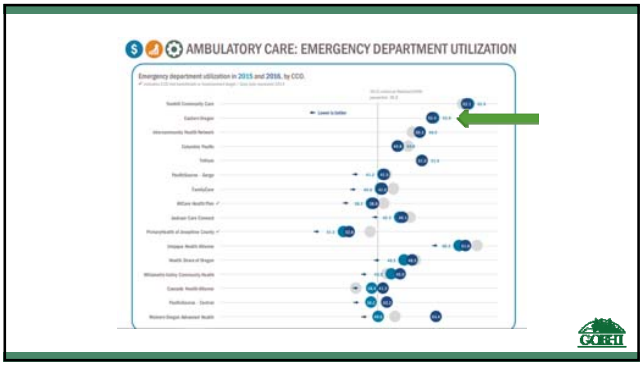
- Bonnie Thompson works for Greater Oregon Behavioral Health, Inc. Her past experience includes working as a Nurse Practitioner in the Emergency Department, Family Practice Clinic and as a the County Designated Mental Health Provider.
- She has no financial relationship with any of the software vendors mentioned in this presentation.

Learning Objectives

- Describe one strategy for reducing emergency department utilization among individuals experiencing mental illness
- Understand the inter-related nature of care needed for individuals experiencing mental illness
- Understand how to utilize community care plans to improve communication and care coordination
- Learn about alternate deliver models to reduce ED utilization

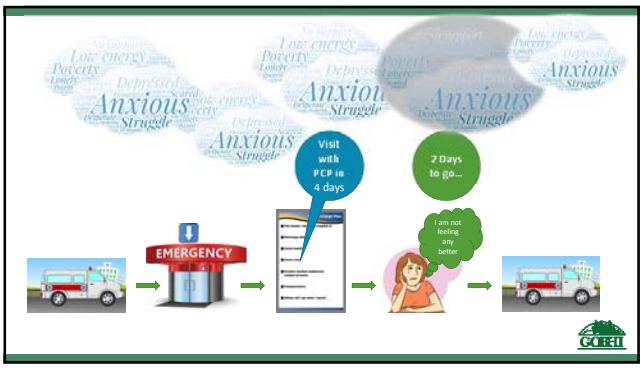

CollectiveMedical TECHNOLOGIES
OREGON HEALTH LEADERSHIP COUNCIL
Future Enhancements
Reducing Preventable Emergency Room Visits
Reducing Emergency Department Overuse: A $36 Billion Opportunity


Emergency department utilization, statewide.
Members with SPMI use the ED at much higher rates
Perspective
Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon's Experiment
Emergency Room Use Stays High In Oregon Medicaid Study

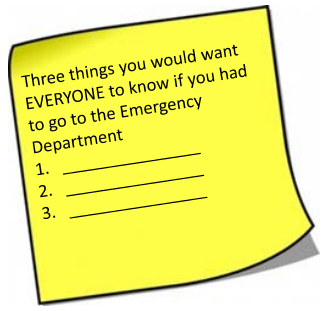

AMBULATORY CARE: EMERGENCY DEPARTMENT UTILIZATION
Emergency department utilization in 2015 and 2016, by CCO.

http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/07/Q4-2017-EDIE-Dashboards-002-1.pdf
http://www.orhealthleadershipcouncil.org/wp-content/uploads/2018/07/2017-EDIE-Annual-Report-002-1.pdf

Creative Community Challenges

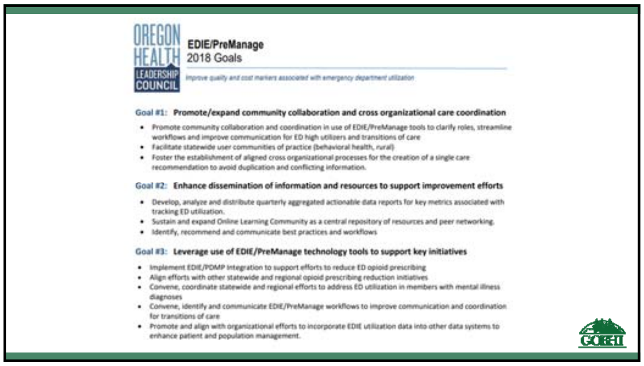


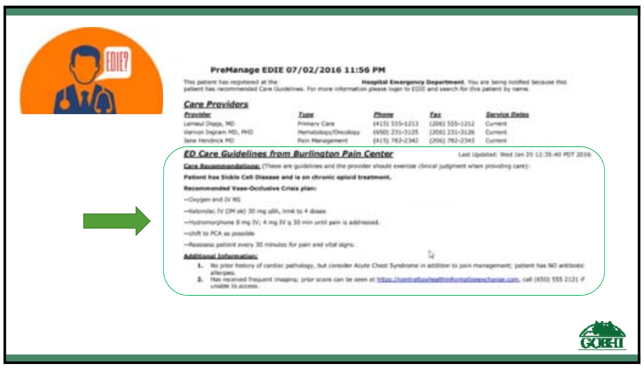
Community Communication

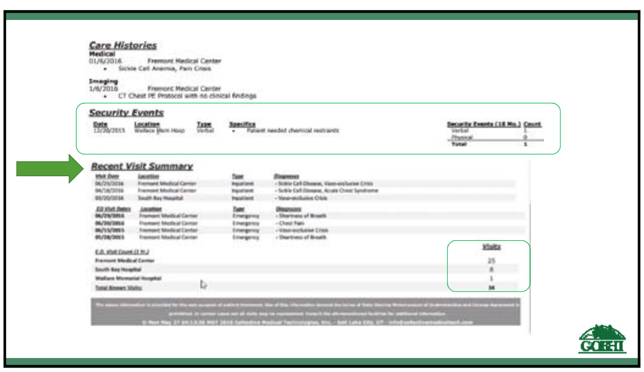


This is EDIE

Every ED Instantly at Your Fingertips


OREGON HEALTH LEADERSHIP COUNCIL
EDIE/PreManage
2018 Goals
Improve quality and cost markers associated with emergency department utilization
Goal #1: Promote/expand community collaboration and cross organizational care coordination
• Promote community collaboration and coordination in use of EDIE/PreManage tools to clarify roles, streamline workflows and improve communication for ED high utilizers and transitions of care
• Facilitate statewide user communities of practice (behavioral health, rural)
• Foster the establishment of aligned cross organizational processes for the creation of a single care recommendation to avoid duplication and conflicting information.
Goal #2: Enhance dissemination of information and resources to support improvement efforts
• Develop, analyze and distribute quarterly aggregated actionable data reports for key metrics associated with tracking ED utilization.
• Sustain and expand Online Learning Community as a central repository of resources and peer networking.
• Identify, recommend and communicate best practices and workflows
Goal #3: Leverage use of EDIE/PreManage technology tools to support key initiatives
• Implement EDIE/PDMP Integration to support efforts to reduce ED opioid prescribing
• Align efforts with other statewide and regional opioid prescribing reduction initiatives
• Convene, coordinate statewide and regional efforts to address ED utilization in members with mental illness diagnoses
• Convene, identify and communicate EDIE/PreManage workflows to improve communication and coordination for transitions of care
• Promote and align with organizational efforts to incorporate EDIE utilization data into other data systems to enhance patient and population management.
GOBHI


EDIE?
PreManage EDIE 07/02/2016 11:56 PM
Care Providers
ED Care Guidelines from Burlington Pain Center
Patient has Sickle Cell Disease and is on chronic opioid treatment.
Recommended Vaso-Occlusive Crisis plan:
Additional Information:
GOBHI


Care Histories
Security Events
Recent Visit Summary
GOBHI

Attributes of a GREAT Care Recommendation

M/BH Providers can write Care Recommendations that comply with applicable state and federal law and provide significant value to ED clinicians by doing one or more of the following:

1. Provide a Care Coordination Note with a simple statement that the patient has complex M/BH needs, is receiving treatment at your clinic, and provide contact information (24-hour "hotline" contacts are especially helpful) for a treating provider or case manager who can consult on providing optimal care for the patient when he or she presents at the ED.
2. Provide a description of the patient's baseline presentation. Some patients with serious psychiatric conditions may appear to be agitated, impaired or erratic even when their condition is well managed. ED providers benefit from having a simple summary of the patient's underlying condition and baseline presentation in many ways. For example, a brief description of diagnosis and baseline presentation may simplify the ED provider's efforts to identify the cause for the ED visit (i.e., in some cases it may relate to medical issues only and not to the underlying psychiatric issue).

Attributes of a GREAT Care Recommendation

4. Where applicable, it can be helpful to ED providers for you to provide recommendations for things to avoid or tips to try in the ED to help provide reassurance to M/BH patients. Some M/BH patients may have specific concerns or fears

1 For more explanation on how to comply with state and federal mental and behavioral health laws when working with EDIE and PreManage, see CMT Whitepaper "How EDIE & PreManage Work with Mental & Behavioral Health Laws." (Note to Draft: currently in development). Please note that neither the guidance in this Toolkit nor the MBH Whitepaper constitute legal advice and you should consult with your own legal counsel on the specifics of state and federal law applied to your clinical context.

Feedback from the ED

- **"Simpler and clearer… Provide essential, brief background and clear, bulleted direction on what to do."**
- "More information on actual medical problems."
- "I want Useful information. Narcotics. Care Plans for chronic illness Radiology studies performed in the last year."
- "Add more care plans and real information."
- **"Some of them seem to use a lot of space to say very little and repeat the same info multiple times.** Condense."
- "Possibly limit number of characters in a care plan."
- "Many times **doctors have told me that information that I have told them about the patient is not in the guideline, but it is--it is just buried in random information."**

Keep It Short and Simple.

Attributes of a GREAT Care Recommendation

One coordinated care plan!

If a care plan already exists please do one of the following:

- Connect with one another and coordinate information to author one care recommendation
- Much of the information can also be shared in the care history section as well

If there isn't one listed or no PCP assigned, by all means create a care plan if it is meaningful.

42 CFR Part 2

- PreManage allows the ability to provide selective MH/BH information—
  - **Do not** include information about services covered by Part 2: psychotherapy notes, etc.,

Cascading Efforts – What you can expect

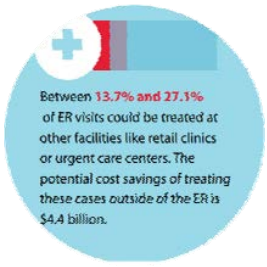
Behavioral Health Care Plans in PreManage

- Each County Mental Health Provider (CMHP) will be entering 10 care plans per month for members with SPMI entered into PreManage
- Target: by the end of 2018 every EOCCO member with an SPMI diagnosis will have a care recommendation entered into EDIE

Stand Up and then Sit Down If…

- You buy all of you music at a record store
- You buy all of your books at a bookstore
- You buy all of your clothes at a clothes store
- You do all of your banking at a bank
- You get all of your healthcare at an office or facility

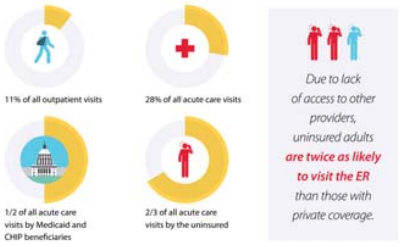
Direct to Patient Care



Weinick RM, Burns RM, Mehrotra A. How Many Emergency Department Visits Could be Managed at Urgent Care Centers and Retail Clinics? Health affairs (Project Hope). 2010;29(9):1630-1636. doi:10.1377/hlthaff.2009.0748.

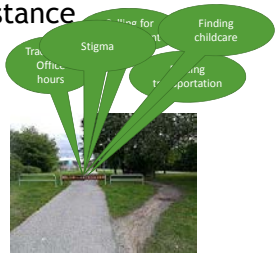
Most studies find that at least
30% of emergency room visits are non-urgent

The 4% of America's doctors who work in emergency medicine provide:



*Due to lack of access to other providers, uninsured adults **are twice as likely to visit the ER** than those with private coverage.*

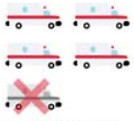
Path of least resistance



Telehealth can reduce overall costs
and keep people out of the hospital

The average estimated cost for a telehealth visit is **just $40 to $50.**

20% of ER visits require follow-up care for similar conditions, while **only 6% of telehealth visits do.**



A study of approximately 1,500 older adults found that telehealth was able to eliminate nearly **1 in 5 ER visits.**

Patient Satisfaction and Engagement

67% felt that tele-health increased satisfaction with their medical care

53% felt that tele-health helped increase their involvement in treatment decisions

https://www.softwareadvice.com/medical/industryview/telemedicine-report-2015/

Sources:

http://www.rand.org/pubs/research_reports/RR280.html
https://projects.propublica.org/emergency/
https://www.cdc.gov/nchs/data/nhss/nhsr090.pdf
https://www.cdc.gov/nchs/fastats/emergency-department.htm
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4156292/#R9
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3412873/
https://www.cms.gov/researchstatistics-data-and-systems/statistics-trends-andreports/nationalhealthexpenddata/downloads/highlights.pdf
https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-andReports/NationalHealthExpendData/Downloads/proj2016.pdf
http://www.connectwithcare.org/wp-content/uploads/2014/12/Medicare-Acute-Care-Telehealth-Feasibility.pdf
http://www.aha.org/content/16/16telehealthissuebrief.pdf
http://www.healthcareitnews.com/news/nyp-weill-cornell-telehealth-program-slashes-ertimes-patients-minor-complaints
http://www.healthcareinformatics.com/article/telemedicine/aurora-health-care-telehealth-use-improving-erpatient flow
https://www.umc.rochester.edu/research/blog/june-2015/is-telemedicine-aviable-alternative-to-ambulance.aspx

Healthy Mouths, Healthy People

Risk Assessment & Prevention
A Systematic Approach

Gary W. Allen, DMD, MS
Vice President of Clinical Services
garya@advantagedental.com

Disclosures

- Employee Advantage Dental
- Minority Owner Advantage Dental

Healthy Mouths, Healthy People
Learning Objectives

Describe:

1. Relationship between oral health and overall health
2. Dental caries as a chronic infectious disease
3. Evidence-based strategies to assess and prevent dental disease

Primary References

- American Academy of Pediatric Dentistry http://www.aapd.org
- American Dental Association Center for Evidence-Based Dentistry https://ebd.ada.org
- Cochrane Oral Health Group https://oralhealth.cochrane.org/
- CDC Division for Oral Health https://www.cdc.gov/oralhealth
- Oral Health in America: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2000 https://profiles.nlm.nih.gov/ps/access/NNBBJT.pdf

Oral Health: The Silent Epidemic

Regina M. Benjamin, MD, MBA, Public Health Rep. 2010 Mar-Apr

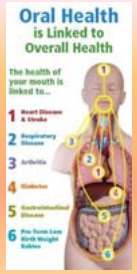
- Dental caries and periodontal disease are among the most common chronic diseases in the United States.
- Dental caries is the most common chronic disease in children: it is about five times as common as asthma.
- Fifty-three million people live with untreated tooth decay in their permanent teeth.
- One-quarter of adults aged 65 years and older have lost all of their teeth due to untreated oral disease.

Oral Health: The Silent Epidemic

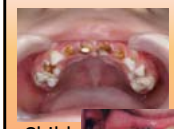
Regina M. Benjamin, MD, MBA, Public Health Rep. 2010 Mar-Apr

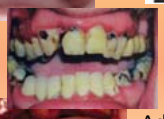
Recent research has indicated possible associations between chronic oral infections and diabetes, heart and lung disease, stroke, and low birthweight or premature births.

In other words, oral health refers to the health of our mouth and, ultimately, supports and reflects the health of the entire body.



Dental Caries: Chronic Infectious Disease





Child

Adult

Older Adult

Abstract

Dental caries is an infectious and transmissible disease. The mutans streptococci (MS) are infectious agents most strongly associated with dental caries. Earlier studies demonstrated that infants acquire MS from their mothers and only after the eruption of primary teeth. More recent studies indicate that MS can colonize the mouths of predentate infants and that horizontal as well as vertical transmission does occur. The purpose of this paper was to demonstrate that these findings will likely facilitate the development of strategies to prevent or delay infant infection by these microbes, thereby reducing the prevalence of dental caries. (Pediatr Dent 2006;28:106-109)

KEYWORDS: MUTANS STREPTOCOCCI, ACQUISITION, TRANSMISSION

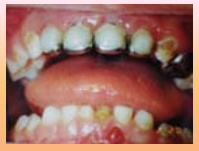
Does drilling & filling work to treat an infection?

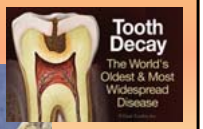
- 40-70% recurrent decay within 1 year after treatment under GA

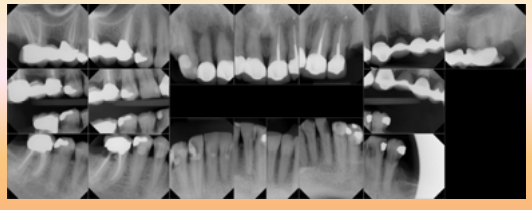
Amin 2004, Zhan 2006, Berkowitz 2011

- 70% of fillings done by dentists are replacements, and 70% of replaced posterior restorations increase the number of surfaces

Anusavice, KJ. J Public Health Dent, 1995







Evidence-Based Strategies to Reduce the Burden of Oral Disease

- Early access & prevention
- Fluoride
- Sealants
- Early referral to treatment for advanced disease

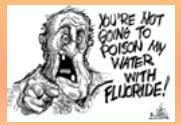
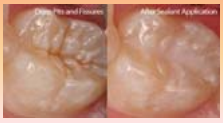


Table 7. Odds Ratio of "High" Caries Risk Assignment at First Dental Visit

Year(s) of Increased Age	Odds Ratio of Caries at First Dental Visit
1 year	2.11
2 years	4.45
3 years	9.39
4 years	19.82

Pediatric Oral Health Research and Policy Center, Aug 2018

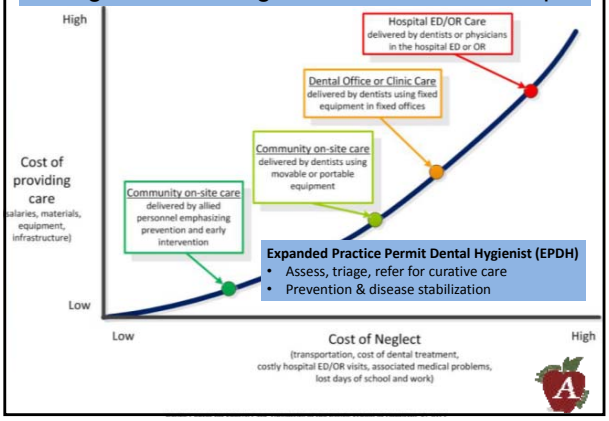


"Children who had their first preventive dental visit by age 1 were more likely to have subsequent preventive visits but were not more likely to have subsequent restorative or emergency visits. Those who had their first preventive visit at age 2 or 3 were more likely to have subsequent preventive, restorative, and emergency visits. The age at the first preventive dental visit had a significant positive effect on dentally related expenditures, with the average dentally-related costs being less for children who received earlier preventive care."

~ Paul S. Casamissimo, DDS, MS, Chief Policy Officer, AAPD

Predictive Model for Caries Risk Based on Determinants of Health Available to Primary Care Providers
Pediatric Oral Health Research and Policy Center, Aug 2018

Taking the Knowledge & Science to the People

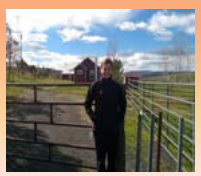


Advantage Dental Community Care Investment in EOCCO Counties

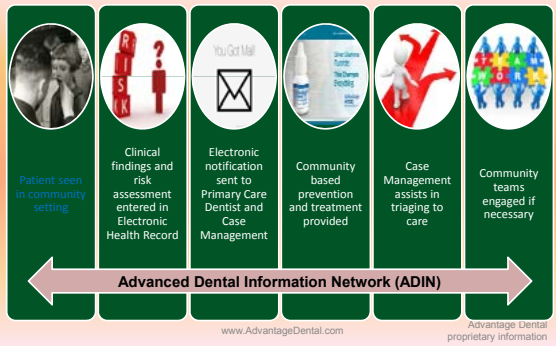
- Integration Coordinator & Director of Community Dental Programs
- Nine EPDHs & two community care dental assistants
- 57 school districts & 108 schools in 11 counties
- WIC, Head Start, Preschools, Teen Parent Program, Lifeways Day Treatment Program, Assisted Living Facilities
- Centralized Case Management
- 10 Advantage Dental Offices & 16 Contracted Provider Offices

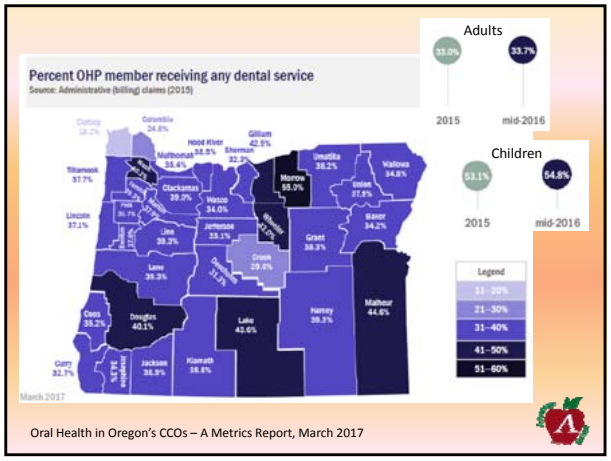
Community Care Team in Action



Connecting the Community





Oral Health in Oregon's CCOs – A Metrics Report, March 2017

Thanks for You Time!

Contact Information

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Advantage Dental

Health *through* Oral Wellness

Elizabeth Gordon, EPDH, M.Ed.
Dental Professional Relations

Disclosure

- **In-kind financial relationship as it relates to the sponsorship of the event**
  - Company: ODS Community Health
  - Relationship: Dental Professional Relations

Learning Objective

- Describe the relationship between oral health and overall health of the individual.

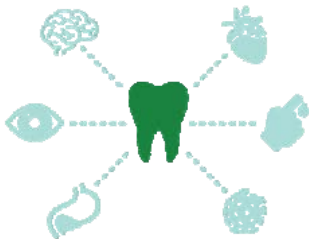
ODS

Health *through* Oral Wellness

- Limited launch date – October 2017
- Expanded to include Oregon Health Plan February 1, 2017

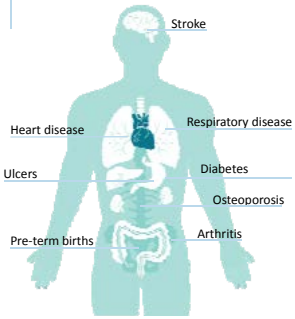
ODS

The total health connection



ODS

The oral/systemic connection



Additionally:

- Cancer
- Dementia/Alzheimer's
- Erectile dysfunction
- Chronic kidney disease
- Cardiovascular disease
- Peripheral artery disease

Impact on medical costs

The CDC estimates roughly 50% of American adults have periodontal disease, yet only 6% have received periodontal services.

Periodontal disease has been correlated to certain chronic conditions and with treatment can demonstrate medical plan savings.

Periodontal Disease		Average savings Per patient/per year	Hospital admissions decrease
&	Diabetes	$2,840	39.4%
&	Coronary Artery Disease	$1,090	28.6%
&	Cerebral Vascular Disease	$5,681	21.2%
&	Pregnancy	$2,433	N/A

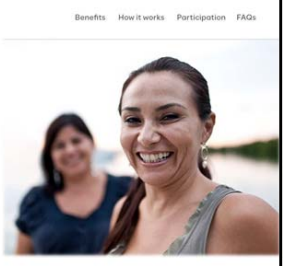
Jeffcoat et al / Am J Prev Med 2014;47(2):166–174 ***Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions***

Health through Oral Wellness

Self-assessment

Better oral health for you

When it comes to oral health, we know some people need more care than others. ODS Community Dental's Health through Oral Wellness® program offers extra benefits and related care to members who have a greater risk for oral diseases.



PreViser

Population oral health manager

Dental benefits today

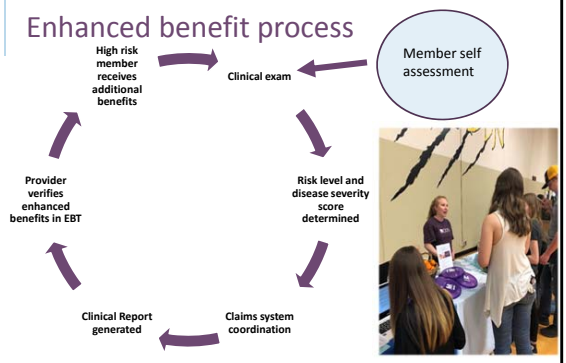
The dental benefit
2 Cleanings per year, $1,500 annual cap, etc.

Increased treatment needs

Increased prevention needs

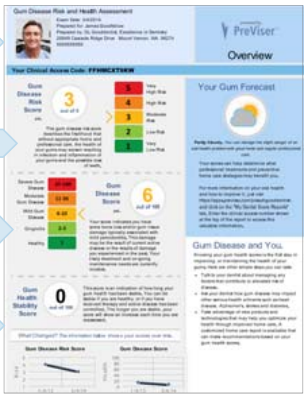
Risk level	Disease description			
	Health or Gingivitis	Mild Periodontitis	Moderate Periodontitis	Severe Periodontitis
Very low risk 1				
Low risk 2				
Moderate risk 3				
High risk 4				
Very high risk 5				

Enhanced benefit process



Clinical report

- Supports dentist/patient relationship
- Risk that disease will initiate or progress
- My current severity of disease
- Am I getting healthier, or deteriorating?



Risk based additional benefits

Risk levels	Enhanced benefit	CDT Codes	Frequency
• Caries risk (3+) • Periodontitis risk (3+) • Periodontal disease severity (4+)	Prophy or periodontal maintenance	D1110, D1120, D4346, D4910	Combination up to 1 per 3 months
	Fluoride varnish or topical fluoride	D1206, D1208	Combination up to 1 per 3 months
	Oral hygiene instruction or nutritional counseling	D1330, D1310	Once per 12 months
	Drugs or medicaments dispensed in the office for home use	D9630	Once per 6 months

Member awareness

You may get extra dental benefits!

The ODS Community Dental **Health through Oral Wellness®** program helps members who are at greater risk for oral diseases.

Bring this card to your next dental appointment.

ODS

Give this card to your dentist!

Place this card in your wallet. Talk about the program the next time you see your dentist.

If they're not registered, ask them to call our provider line at 844-683-4433. Once registered, they can give you an oral health risk assessment. Then, they can let you know if you qualify for extra benefits.

Questions?
We're here to help! Please call ODS Community Dental Customer Service team at 800-342-0636.

ODS

16 March 2, 2018

Dentalytics

Provider engagement in the pursuit of quality

ODS

17 March 2, 2018

Metrics

- Fluoride
- Periodontal maintenance
- Sealants
- Goal = **GREEN**
  - meeting target

ODS

18 March 3, 2018

Successes and momentum

- Since the limited launching in October 2017, we have **779** unique providers registered for the Health through Oral Wellness program.
- **10** of the **20** providers in Hermiston have registered.
- Overall numbers of assessments completed by providers - **6,041**
  - Total number of self-assessments taken by members – **631**
- Dentists and hygienists reporting that the program is valuable because it allows more preventative care to patients in need.
- Feedback includes that providers feel members are more engaged in their health and treatment plans.

ODS

Collaborative Care in EOCCO

Kimberly Humann, MD

GOBHI

Disclosure statement

In-kind financial relationship as it relates to the sponsorship of the event

Company: GOBHI/EOCCO

Relationship: Employed by GOBHI

2

Learning Objective

- Summarize the benefit of behavioral health integration into a PCPCH

3

Principles of Effective Integrated Health Care

1. Patient-Centered Team Care - Collaborative Care Primary care and behavioral health providers collaborate effectively using shared care plans. It's important to remember that colocation does NOT mean collaboration, although it can.
2. 2. Population-Based Care Care -team shares a defined group of patients tracked in a registry to ensure no one "falls through the cracks." Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
3. 3. Measurement-Based Treatment to Target -Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.
4. 4. Evidence-Based Care -Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.
5. 5. Accountable Care- Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

4

Why Behavioral Health Should be Part of the PCMH

5

Six Reasons *Why* Behavioral Health Should be Part of the PCMH

1. High **prevalence** of behavioral health problems in primary care
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**

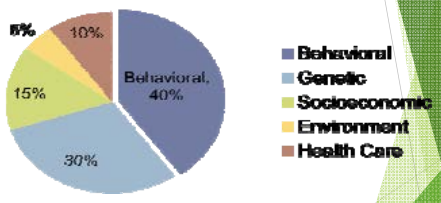
Triple Aim

Behavioral health integration achieves the triple aim.

the map to PCMH success

Prevalence

Leading Determinants of Overall Health are Behavioral[1,2]



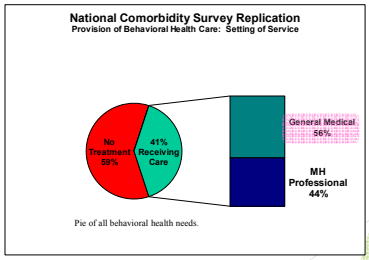
Sources: [1]McGinnis JM et al. JAMA 1993; 270:2207-12. [2]Mokdad AH, et al. JAMA 2004; 291:1230-1245.

7

Patient-Centered Medical Home

1.Prevalence

Primary Care is the 'De Facto' Mental Health System



Wang P et al. *Arch Gen Psychiatry*, 2005; 62

Adapted from Katon, Rundell, Unützer, Academy of PSM Integrated Behavioral Health 2014

Patient-Centered Medical Home

2. Unmet Behavioral Health Needs

- **67% with a behavioral health disorder** do not get behavioral health treatment[1]
- **30-50% of referrals** to behavioral health from primary care don't make first appt[2,3]
- Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients[4] due to:
  - Shortages of mental health care providers
  - Health plan barriers
  - Lack of coverage or inadequate coverage
- **Depression goes undetected** in >50% of primary care patients[5]
- **Only 20-40% of patients improve** substantially in 6 months without specialty assistance[6]

1. Kessler et al., NEJM. 2005;352:515-23.
2. Fisher & Ransom. Arch Intern Med. 1997;9:324-333.
3. Hoge et al., JAMA. 2006;96:1022-1032.
4. Cunningham, Health Affairs 2009; 3:w490:w501.
5. Mitchell et al. Lancet. 2009; 374:609-619.
6. Schulberg et al. Arch Gen Psych. 1996; 53:913-919

Patient-Centered Medical Home
3. High Cost of Unmet BH Needs

•Individuals with behavioral health and substance use conditions **cost 2-3 times** as much as those without[1]

•BH disorders account for **half as many disability days** as "all" physical conditions[2]

•Annual medical expenses--chronic medical & behavioral health conditions combined **cost 46% more** than those with only a chronic medical condition[3]

•**Top five conditions** driving overall health cost[4]

1. **Depression**
2. Obesity
3. Arthritis
4. Back/Neck Pain
5. **Anxiety**

1. Milliman report to the APA, August 2013 available
2. Merikangas et al., Arch Gen Psychiatry. 2007;64:1180-1188.
3. Original source data is the U.S. Dept of HHS the 2002 and 2003 MEPS.
4. Loeppke et al., J Occup Environ Med. 2009;51:411-428.

Patient-Centered Medical Home
4. Lower cost when BH is treated

- **Medical use decreased 15.7%** for those receiving behavioral health treatment while controls who did not get behavioral health medical use increased 12.3%[1]
- Depression treatment in primary care for those with diabetes resulted in **$896 lower** total health care cost over 24 months[2]
- Depression treatment in primary care $3,300 lower total health care cost over 48 months[3]
  - This resulted in a **return of $6.50 for every $1 spent**
- Multi-condition collaborative care for **depression** and **diabetes** saved **$594 per patient** over 24 mos.[4]

1. Chiles et al., Clinical Psychology. 1999;6:204–220.
2. Katon et al., Diabetes Care. 2006;29:265-270.
3. Unützer et al., American Journal of Managed Care 2008;14:95-100.
4. Katon et al. Arch Gen Psych. 2012;69:506-514

Patient-Centered Medical Home
4. Lower cost when BH is treated

IMPACT Collaborative Care for **Depression** Reduces Costs

Cost Category	4-year costs in $	Intervention group cost in $	Usual care group cost in $	Difference in $
IMPACT program cost		522	0	522
Outpatient mental health costs	661	558	767	-210
Pharmacy costs	7,284	6,942	7,636	-694
Other outpatient costs	14,306	14,160	14,456	-296
Inpatient medical costs	8,452	7,179	9,757	-2578
Inpatient mental health / substance abuse costs	114	61	169	-108
Total health care cost	**31,082**	29,422	32,785	**-$3363**

Savings

12

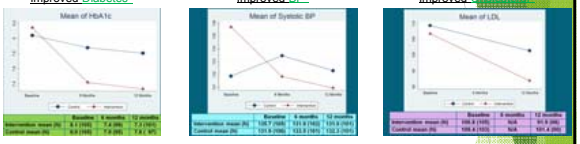
Unützer et al., American Journal of Managed Care 2008;14:95-100

Patient-Centered Medical Home

5. Leading to Improved physical health outcomes

- When treated in harmony with mental health, **chronic physical health improves significantly**[1]

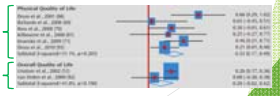
Improved Diabetes[1] | Improved BP[1] | Improved Cholesterol[1]



Overall **quality of life** and **physical health** improve consistently[2]

Physical health

Quality of life



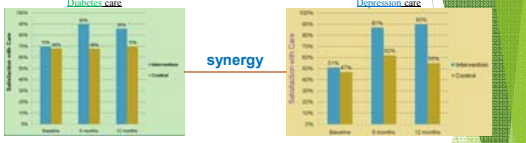
1. Katon et al. NEJM 2010;363:2611-2620
2. Woltmann et al. AJP 2012;169:790-784

Patient-Centered Medical Home

6. Improved patient satisfaction

- After 12 months of care, multi-condition collaborative care **improved patient satisfaction** in depression **AND** diabetes care[1]

Diabetes care | synergy | Depression care



Patient testimonial on integrated care:

"...the staff at Marillac Clinic actually cared about what I had to say- they were there to help when I needed it - not just medical help, but counseling - and the medications needed to get well. They helped me learn how to care for myself -I understood how to accept myself from the kindness in their eyes."

Past patient of Marillac Clinic, Grand Junction, Colorado

14

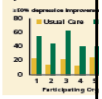
1. Katon et al. NEJM 2010;363:2611-2620

Reasons PCPs Love Collaborative Care

"I practiced for 16 years without it and I will never go back"
primary care physician, UW Neighborhood Clinic

1. **Gold Standard of Depression Care**
   Collaborative Care is the best approach to treating depression, as proven by 79 randomized controlled trials published in a 2012 Cochrane Review. Why practice anything less?
2. **Better Medical Care**
   Collaborative Care has been linked to better medical outcomes for patients with diabetes, cardiovascular disease, cancer, and chronic arthritis pain.
3. **Access to experts**
   Care managers and psychiatric consultants expand the treatment options available and support the care provided by PCPs. From providing psychotherapy when clinically indicated to supporting pharmacotherapy, these experts support you as the primary clinical decision maker.
4. **Help with Challenging Patients**
   Many of your most challenging patients likely have un-treated or under-treated mental health conditions. Care managers do the follow-up and behavioral intervention tasks a busy PCP doesn't have time for, tasks that can make a big difference for your patients.
5. **It Takes a Team**
   Collaborative Care uses a population-based, treat-to-target approach similar to care for chronic medical conditions. Knowing when a proactive change in care is needed makes sure that none of your patients fall through the cracks.

Results of the landmar… study (1 of the 79 trial… Cochrane Review) sho… Collaborative Care pa… twice as likely to expe… significant improvem… though 70% of usual … were prescribed an an… by their PCP.



Think co-locating a be… health specialist or ha… referrals enough? T… The organization circ… Masters-level, co-locat… behavioral health clin… practicing within the … clinic using a referral … Collaborative Care sti… twice as well!

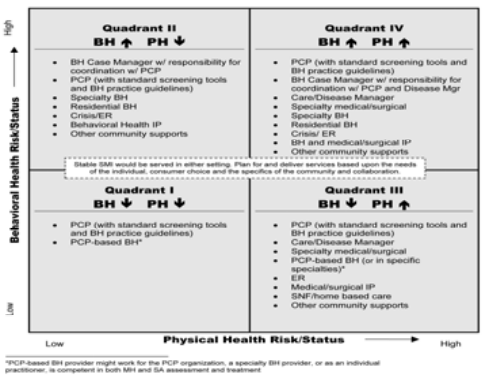
AIMS CENT…
UNIVERSITY of WASHIN…

Review: Six Reasons *Why* Behavioral Health Should be Part of the PCMH

1. **High prevalence** of behavioral health problems in primary care
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction**
7. **BONUS! Collaborative care *IS* a m**

the map to PCMH success

The Four Quadrant Clinical Integration Model



Implementation Tasks

- Complete environmental scan
- Determine program's capacity and "filters"
- Establish administrative and clinical leadership "buy-in"
- Decide whether to rent or own BH staff
- Determine staffing pattern and BH tasks
- Define BH specialist skills

Stepped Care Levels

1. Basic education: info sharing & referral to self-help resources
2. Clinicians provide psycho-educational & motivational support
3. BH specialists use specific practice algorithms
4. Referral to external specialty or higher level BH providers

Clinical Tasks

- Triage
- Comprehensive assessment
- On-site treatment
- Referral
- Consultation
- Care monitoring & condition management
- Treatment/medication optimization
- **The key is balanced management of these tasks!**

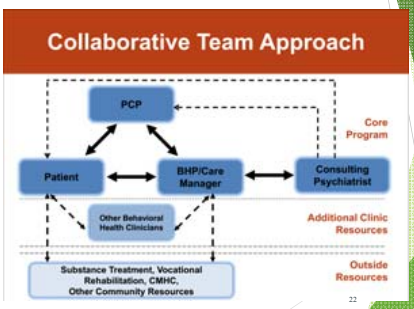
Staffing The Model

- Behavioral health professional (Masters or higher)
- Psychiatric provider (for diagnostic and tx insights, not just for meds)
- Non-BH personnel trained to provide specific support functions

Patient-Centered Medical Home

7. Collaborative care *is* a medical home

Collaborative care *optimizes* all behavioral health resources



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http://uwams.org

Selected Resources

- AHRQ Academy for Integrating Behavioral Health and Primary Care: http://integrationacademy.ahrq.gov/
- AIMS CENTER: http://aims.uw.edu/
- Center for Integrated Primary Care: http://www.umassmed.edu/cipc/
- Collaborative Family Healthcare Association: www.cfha.net
- Evolving Models of Behavioral Health Integration in primary Care. Milbank Memorial Fund 2010. http://www.milbank.org/
- Lexicon for Behavioral Health and Primary Care Integration. AHRQ 2013: http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
- National Alliance on Mental Illness. Integrating Mental Health & Pediatric Primary Care Resource Center: http://www.nami.org
- SAMHSA/HRSA Center for Integrated Health Solutions: http://www.integration.samhsa.gov

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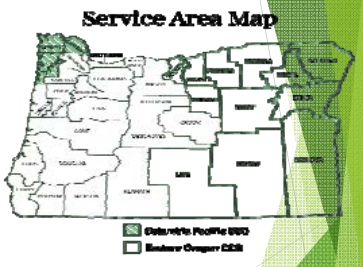
Sites in Action

- **Columbia River Community Health Services:** Boardman, OR (Morrow County)
- **Valley Family Health Care:** Ontario, OR (Malheur County)
- **Wallowa Valley Center for Wellness:** Enterprise, OR (Wallowa County)



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Overview of teams

- Behavioral health care managers: licensed clinical social workers, chronic care management nurse/pharmacist
- Psychiatric consultant: MD, PMHNP
- Primary care providers: between 4-6 at each site (PAs, NPs, MD/Dos)

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Workflow

- Similar between sites, with slight variations
- PCP: identifies provisional diagnosis, prescribes, involved in evolution of treatment
- BH Care Managers: engages, educates, refines diagnosis, and drives treatment plan through warm handoffs from PCPs, scheduled visits (from 20-60 minutes), phone follow-up, strategically using screeners, registry management to track treatment to target
  - Use evidence based brief psychotherapy interventions in individual or group form: Problem Solving Treatment, Behavioral Activation, CBT, Interpersonal Psychotherapy, MI

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Example Registry

4) Be aware that at least one PHQ-9 score must be entered for a given record in order for that record's GAD-7 scores to display properly in the Caseload

			Treatment Status					PHQ-9				GAD-7	
			The most recent contact was over 1 month (30 days) ago The next follow-up contact is past due					The last available PHQ-9 score is at target (>5 or 50% decrease from initial score) The last available PHQ-9 score is more than 30 days old				The last available GAD-7 score is at target (>5 or 50% decrease from initial score) The last available GAD-7 score is	
View Record	Treatment Status	Name	Date of Initial Assessment	Date of Most Recent Contact	Date Next Follow-up Due	Number of Follow-up Contacts	Weeks in Treatment	Initial PHQ-9 Score	Last Available PHQ-9 Score	% Change in PHQ-9 Score	Date of Last PHQ-9 Score	Initial GAD-7 Score	Last Available GAD-7 Score
View	Active	Albert Smith	8/19/2017	11/8/2017	12/6/2017	5	16	19	18	-5%	11/8/2017	13	10
View	Active	Susan Test	4/9/2017	11/24/2017	12/8/2017	10	35	22	15	-32%	11/24/2017	18	14
View	Active	Joe Smith	9/9/2017	12/4/2017	12/18/2017	6	13	15	8	-47%	12/4/2017	11	✓ 4
View	Active	Bob Dolittle	9/26/2017	12/5/2017	12/19/2017	3	10	22	19	-14%	12/5/2017	11	10
View	Active	Nancy Fake	12/8/2017	12/8/2017	12/22/2017	0	0	No Score	No Score			No Score	No Score

Disclaimer | Patient Tracking | Caseload Overview

Ready

Workflow continued

- Psychiatric Consultant:
  - Indirect consultation: meets with BH Care Manager for 1 hour weekly to review patients on registry who:
    - Need diagnostic clarification
    - Not improving (haven't had 50% decrease in symptoms over 10-12 weeks with treatment plan already in place)
    - Difficult cases (like pregnancy, medically complex)
  - Direct consultation: sees 1-2 patients per week, if team decides necessary to guide treatment plan

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The Treatment Target

- Patient Improves with 50% decrease in symptoms/PHQ9<10
  - Monitor for stability for 3 months with decrease contacts from team (about 1 contact per month)
  - Form relapse prevention plan and remove from registry's active caseload

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Collaboration with Community Mental Health Program

- Some patients who do not improve will be referred to the CMHP for longer term psychotherapy, pharmacotherapy, and/or other recovery resources
- Crisis services
- Some patients at the CMHP who reach stability may be referred back to primary care

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Community of Practice: Learning from other BH Care Managers

- Vidyo lunch-hour meeting 2x/month with BH Care Managers from the active sites and any others in region who would like to join
- Brief didactic material
- Opportunity to discuss and get support about work flow issues, difficult cases, etc.

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Preliminary Qualitative Data from PCPs at start of CRCHS Program

- Prior to program, impression that many barriers to getting patient mental healthcare and not enough supply to meet need of these patients
- A couple months into program, impression of increasing capacity to care for mental health conditions in-clinic and in-coordination with other community providers
- Positive feedback about using screeners as diagnostic and treatment guides, as long as done before start of appointment

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Behavioral Health Integration at YVFWC

Brian E. Sandoval, Psy.D.
Clinical Director, Primary Care Behavioral Health
Yakima Valley Farm Workers Clinic

PCBH Staffing

Washington
- 10 BHCs, 9 clinics

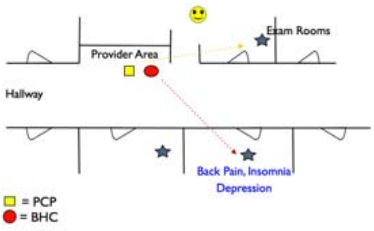
Oregon
- 6 BHCs, 5 clinics

* = Current BHC
* = BHC open position

The PCBH Consultant Model

PCBH is:

- Routine Primary Care
- Part of PCMH team
- Consultative
- Result of clinical and population need



Adapted from Serrano (2009)

Key Features		
PCBH		CoCM
Horizontal Integration	**Type**	Vertical Integration
Access/Reach/ ⬇Barriers	**Function**	Care Mgmt. via Registry
PCP consult, brief visits	**Method**	Psychiatry Consult/PST
Constantly "Enrolled"/Accessible	**Duration**	Enrolled for 6 months
Enhance PC/PCMH	**Goal**	Improve Mgmt. of target condition (e.g. depression)

Year in Review: 2017 Data

Unique Patients Served:
14,891

Average Pop. Penetration:
15%

Penetration Range:
4% - 24%

PCBH Program Metrics

- **General Productivity**
  - Goal: 10-12 FTF Visits/Day
  - **Actual: 10 visits/day**
- **Program Adoption**
  - Population Penetration (Total Unique BHC / Total Unique Medical)
  - **Goal**: End of 1st year: 5%
    Year 2-3: 7%-10%
    Year 3-4: 10%-12%
    Year 4-5: 12%-15%
    Year 6+: 20%
  - **2017 Average = 14%, Range = 11%-24%**
- **Clinical Measures**
  - PHQ9 - 44.3% improvement*
  - GAD7 - 50.3% improvement**
  - Utilization – Decrease in 2 visits/patient for highest 100 medical utilizers

*Defined as ≥ 5 points pre/post for PHQ-9 scores (Kroenke et al., 2001)
**Defined as ≥8 points pre/post for GAD-7 scores (Spitzer et al., 2006)

PRIMARY CARE BEHAVIORAL HEALTH PROGRAM
we are family

Depression Screening and Follow up (OHA/CCO/UDS)

Org Wide

UDS Quality Measures Status Update 7-30-2017		YVFWC 2016 UDS	HRSA Benchmark	2017 UDS YTD	2017 UDS YTD	2017 UDS YTD	Variance prior month
Preventive Care							
76B	Patients screened for depression and follow-up	36.6%	>51%	83.3%	83.6%	83.8%	0.2%

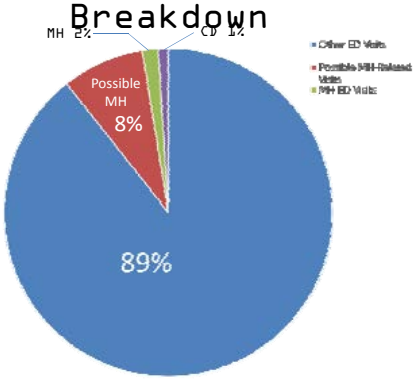
Clinic	Depression screening
Sunnyside Immediate Care	1.8%
Granger Immediate Care	1.9%
Pacific Peds	39.8%
Unify Community Health West Central	49.9%
Mountainview Womens Health	55.4%
Coastal Family Health Center	59.2%
Clatskanie School Based	63.3%
Mid-Valley Medicine	66.5%
Lancaster at Lancaster	67.9%
Yakima Medical-Dental Clinic	68.1%
Lancaster Family Health Center	72.7%
Community Health Center Clatskanie	73.4%
Lincoln Avenue	79.2%
Rosewood Family Health Center	79.2%
Unify Community Health on Mission	80.0%
Salud Medical Center	83.6%
Unify Community Health Northeast	83.9%
Toppenish Medical Dental	85.3%
Grandview Medical Dental Clinic	90.5%
Mirasol Family Health Center	93.5%
Family Medical Center	96.2%
Valley Vista Medical Group	97.2%
Miramar Health Center	97.4%
All YVFWC Clinics (OR & WA)	83.8%
YVFW OR Clinics (only)	82.1%
HRSA Benchmark	51.0%

NO BHC

ED Diagnoses

MENTAL HEALTH		
Diagnosis	**Visit Count YTD**	**Approx Annual Visits**
Anxiety D/O (e.g. Panic, GAD, PTSD)	366	732
Depression	127	254
Suicidality	95	190
Total	**588**	**1176**
CHEMICAL DEPENDENCY	368	736
SIGNS/SYMPTOMS of possible MH concern		
Unspec/Generalized Abdominal Pain	648	1296
Chest pain	551	1102
Headache	448	896
Epigastric Pain	368	736
Low back pain	276	552
Migraines	208	416
Chronic Pain	194	388
Dizziness	144	288
Palpitations/tach	103	206
Shortness of breath/Dyspnea	82	164
Insomnia	15	30
Total	**3037**	**6074**

ED Visit Reason Breakdown



Highest Utilizers of ED

Treating/tracking patients with MH conditions is paramount!

COORDINATED CARE HIGH ED UTILIZERS		
YTD ED VISITS ≥ 8	(Range 8-22, Median 9)	
N = 29		
	Count	Percentage
MH Diagnosis	25	86.2%
Seen BHC	16	55.2%
Missed opportunities	9	31.0%
No MH and seen BHC	2	6.9%

Continuing Initiatives

- Depression/SBIRT Protcols and Tracking
- ED Pilot Testing and Iteration
- TeleBHC Optimization
- Focus on Retention
- Continue to “be” primary care

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Using Data Registries to Assess Clinical Quality Measures

Sarah Patterson, CHES

Disclosure

- In-kind financial relationship as it relates to the sponsorship of the event.
  - Company: Moda Health / EOCCO
  - Relationship: Health Promotion & Quality Improvement Specialist

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Learning Objective

- Describe how to utilize data and registries to outreach to patients for preventative health services.

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Clinical Quality Measures

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Clinical Quality Measures

- Depression Screening and Follow-up
- Controlling High Blood Pressure
- Diabetes HbA1c Poor Control
- Cigarette Smoking Prevalence
- Weight Assessment and Counseling for Children and Adolescents
- **2019**: Screening Brief Intervention Referral to Treatment (SBIRT)

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Patient Registry Options

- Provider Progress Report
  - Outreach rosters for multiple measures
- Arcadia Analytics
  - Outreach rosters for all measures
  - Patient Registry
- Electronic Health Record specific report
  - Data pulled from EHR with lab data

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Provider Progress Report

Members Currently Eligible for Diabetes Measure
EOCCO Incentive Measures - Clinic Name
Reporting Period: Services Incurred 1/1/2018-7/31/2018 as of 7/31/2018

Assigned PCP	Subscriber Id	First Name	Last Name	Birth Date	Gender	Address	City	Zip Code	State	Phone Number	Last Visit	Upcoming Appt
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		
Last Name, First Name	XXXXXXXX	First	Last	XX/XX/XX	F	XXXX XXXXXX XXXXX	XXXXXX	XXXXX	OR	XXX-XXX-XXXX		

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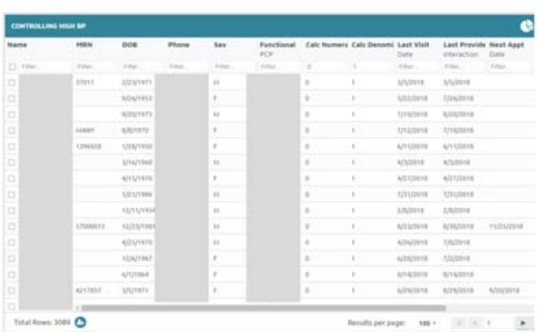
Arcadia Analytics



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Registry Tracking

- Monthly registry tracking spreadsheet
- Keep the registry length manageable
- Allow for friendly competition between teams
- Provide awards or incentives to staff

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Billing for Chronic Care Management (CCM)

- Originally for Medicare only, now expanded to Medicaid
- CCM billing requirements
  - Physician or qualified health care professional
  - At least 20 minutes per month
  - Patient must have 2+ chronic conditions to last at least 12 months
  - Chronic condition must place patient at risk of death, acute exacerbation, decompensation, or functional decline
  - Comprehensive care plan established, implemented, revised, or monitored
  - Patient consent

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Clinic Examples

- Population health management tool
- Clinic specific workflows

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Disclosure Statement

- No conflicts of interest to report.

Learning Objective

- Recognize that opioids did not provide improved pain-related function compared to non-opioids in a recent randomized study of patients with severe chronic back pain or hip and knee osteoarthritis.
- Recognize that opioids did produce more adverse medication related symptoms compared to non-opioids in the same study.
- Recognize possible reasons why opioid treatment is not supported in the treatment of moderate to severe chronic back pain or hip and knee osteoarthritis pain.
- Explain the effects of opioid versus non opioid medications on pain management

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain

The SPACE* Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

JAMA, 2018;319(9):872-882

*Strategies for Prescribing Analgesics Comparative Effectiveness

Study Design

Clinical Characteristics of Eligible Patients

- Minneapolis VA System
- Moderate to Severe Chronic (pain nearly every day for 6 or more months) back pain or hip or knee osteoarthritic pain
- Patients on benzodiazepines and/or long-term opioids excluded
- Patients with substance abuse disorder excluded
- Average age 57 yrs Opioid Group, 60 yrs Nonopioid Group
- 78 patients with back pain and 42 patients with hip or knee osteoarthritis pain in each group
- 13% women in each group
- 88% white in Opioid Group, 86% in Nonopioid Group

Randomization

- Stratified by primary pain diagnosis to ensure balanced numbers (120 in each group)
- Following randomization, pharmacy staff, patient, and provider informed of group assignment

Study Design (con't)

Interventions

- Opioid Prescribing Strategy
  - Step 1: Hydrocodone/APAP, Oxycodone, or Morphine IR
  - Step 2: Oxycodone or Morphine SA
  - Step 3: Transdermal Fentanyl
  - If no response by MED 60, rotation to a different opioid before dose escalation
  - Fewer than 15% of patients had an average MED of 50 or more
  - Maximum MED = 100
- Nonopioid Prescribing Strategy
  - Step 1: APAP + NSAID
  - Step 2: Step 1 + TCA/Gabapentin/Topical capsaicin/lidocaine
  - Step 3: Step 1 + Pregabalin/duloxetine/tramadol (13 patients)

Study Design

Outcome Measurements

- Primary Outcomes
  - Pain-related functions (7 item Brief Pain Inventory interference scale)
  - Pain intensity (4 item Brief Pain Inventory severity scale)
  - Adverse Outcomes checklist of 10 medication-related symptoms
- Secondary Outcomes
  - Quality of Life (Veterans RAND 12 item Health Survey – VR-12)
  - Pain Related Physical Function (11 item Roland-Morris Disability Questionnaire – RMDQ)
  - Patient Health Questionnaire – PHQ-8
  - Generalized Anxiety Disorder measure – GAD-7
  - Patient-Reported Outcomes Measurement Information System (PROMIS) sleep disturbance short form
  - Migraine Disability Assessment (MIDAS) Questionnaire
  - Arizona Sexual Experience Scale (ASEX)
  - Multidimensional Fatigue Inventory Scale (MFI)

Results

Pain Related Function

- Most patients in both Groups improved but there were no significant differences between the two groups over 12 months

Pain Intensity

- Significantly better in the Nonopioid Group over 12 months

Adverse Outcomes

- Significantly more medication-related outcomes in the Opioid Group over 12 months

Results

Pain Related Function

- Most patients in both Groups improved but there were no significant differences between the two groups over 12 months

Pain Intensity

- Significantly better in the Nonopioid Group over 12 months

Adverse Outcomes

- Significantly more medication-related outcomes in the Opioid Group over 12 months

Non-pharmacologic Treatments

Patient-reported co-interventions during the study year*

Treatment, n (%)	Opioid group (n=106)	Non-opioid group (n=105)
Acupuncture	7 (7)	9 (9)
Biofeedback	1 (1)	2 (2)
Chiropractic or osteopathic manipulation	24 (23)	15 (14)
Homeopathy or naturopathy	2 (2)	2 (2)
Hypnosis	0	0
Nutritional advice of counseling	11 (10)	13 (12)
Massage	20 (19)	25 (24)
Mental health counseling or therapy	15 (14)	14 (13)
Personal training or supervised exercise therapy	18 (17)	19 (18)
Physical therapy	39 (37)	25 (24)
Injections in spine, such as epidurals or facet blocks	9 (9)	8 (8)
Injections in the knee, hip, or other joints	29 (28)	23 (22)
Surgery for spine (neck or back)	1 (1)	1 (1)
Surgery for knee or hip, such as arthroscopy or joint replacement	3 (3)	8 (8)

*Non-pharmacological therapies were allowed and not managed by the study.
Patients were asked "In the past 12 months since you started the study, have you seen a provider or practitioner for any of the following therapies to manage pain?" Numbers are those responding "yes, during the past year."

Notes:

Notes: