

## Medicaid Innovation Accelerator Program Webinar

### Reducing the Reliance on Opioids for Pain Management

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ROXANNE DUPERT-FRANK (CMS): (Slides 1-4) Thank you for attending. I'd like to introduce Dr. Lisa Patton. Dr. Patton is a clinical psychologist and a behavioral health and disparities development lead at IBM Watson Health. Dr. Patton has more than 20 years of experience in behavioral health services, research and evaluation. Prior to joining IBM Watson Health, Dr. Patton worked for two agencies within the Department of Health and Human Services. In her last role in the federal government, Dr. Patton served as the Division Director for Evaluation, Analysis and Quality within the structure for behavioral health care statistics and quality. Dr. Patton assisted with the first round of opioid state targeted response grants and directed the initial award of a national evaluation for this grant. Dr. Patton served on the national quality forums, national opioid stewardship workgroup, the serious mental illness workgroup, and recently co-chaired a social determinants of health data integration workgroup for the National Quality Forum and the Centers for Disease Control. She currently coaches' states related to enhanced understanding of opioid data and works with IBM Watson Health to identify innovative solutions to the opioid epidemic.

DR. LISA PATTON: (Slide 5) We're very excited to have this next hour to hear from the state of Oregon. The work of the next hour or so will be to take a look at strategies that state Medicaid agencies are using to address the reliance on opioid pain treatment, something that we know states and communities around the country are grappling with on a daily basis. We're also going to take some time to think about common barriers to the adoption of non-opioid pain management methods, shifting the conversation around pain tolerance and what that means across the U.S. Then we'll have some time to hear from a couple of speakers from Oregon around their opioid initiative and to hear about some of the great work they're doing on the provider toolkit front that the Oregon Health Authority created for its coordinated care organization (CCO). We're excited to bring you this panel and look forward to this important discussion.

(Slide 6) A brief agenda for this afternoon:

- We'll hear from a couple folks from Oregon
- Background on issues we're facing around pain management
- Questions and answers
- Key takeaways

(Slides 7-8) About our speakers, we have Dr. Ariel Smits from Oregon. She is the Medical Director for the Oregon Health Evidence Review Commission, which helps set policy for Oregon Medicaid. She is board-certified in family medicine and preventive medicine/public health. She continues to see patients at Oregon Health and Sciences University. Dr. Smits graduated from Washington University in St. Louis School of Medicine in 1999.

We also have her colleague, Lisa Bui, who serves on the Oregon Health Authority Quality Improvement as its director. In this role, she supports quality improvement efforts across the agency along with the coordinated care organizations across the state. Lisa has experience in multiple health settings including federally qualified health centers in terms of delivering integrated care, so physical, behavioral and oral health services. She is also a Specialty Practice Administrator at the Oregon Health and Science University. Lisa serves as the point person along with Dr. Hedberg, the Acting State Public Health Officer and the state's epidemiologist on related opioid initiatives. She also directly oversees the statewide Performance Improvement Project on Opioid Safety that you're going to hear more about today.

(Slide 9) I'm going to walk through the background on changing culture and perceptions around non-opioid pain management, and much of the work you're going to hear about today has been amassed through literature reviews, opioid summits, different conversations with state agencies and communities that are engaged in this work. We've looked at what the private sector's doing on these issues, as well as the tremendous federal push to address common barriers to the adoption of non-opioid alternative pain treatment. We're really trying to cull the best practices to share with you today.

(Slide 10) Part of what we know in looking across the literature and talking with a wide range of stakeholders on these issues is that there seems to be an ongoing lack of understanding of chronic pain as a disease. What we hear across the board from providers and consumers and their families is that in many instances, patients being treated for pain can be stigmatized. They can feel that their very real pain concerns are not heard or that they are in some way put into the category of drug-seeking or in other ways not having their pain management well-addressed. There is a need for a patient-centered approach. There is a need for more understanding of where patients are, how they want to manage their chronic pain, and in terms of health literacy around different options for pain management. What we know is that pain tolerance is individual, it's subjective. So, if we think about our own pain experiences, those of our families and those around us, some people have higher pain tolerance and report pain at higher levels, and so it's very important to understand what that person's individual experience of pain is and how that can be most effectively treated.

So more data is needed on symptoms, treatment methods that have the most impact for a wide range of chronic pain conditions, and how again we can best treat that individual from where they are in terms of being at risk for opioid use disorder (OUD) or having other risk factors that might affect opioid misuse in the long term and might lead to a need to really delve into non-opioid pain management. We also want to know more about how pain affects a person's activity level, sleep, mood and stress, so really comprehensive care. How do we take a look at the data available or amass additional data to really understand that holistic view of the person and where pain management affects their quality of life?

(Slide 11) Additional barriers we've looked at are limited access to alternative pain treatment options. We talked a bit on the last slide about the experience of the patient or client seeking pain treatment for perhaps a chronic condition and may be frustrated, may feel like their needs are not being heard. But at the same time, we know that there may not be strong referral networks for alternative pain treatment options, that providers may not be available to meet the patient need. We talk a lot in behavioral health and healthcare in general about workforce shortages. HERC does a lot of work around that area. We hear about it a lot from our federal partners in this work and also from communities and states that are being heavily impacted on being able to readily meet patient need.

Prior authorizations for pain treatment need to be more flexible to allow for targeted treatment in these areas. I already mentioned the lack of a referral network. That's the workforce strategy, the workforce capacity to fill those needs, particularly in rural areas. Engaging in different alternative types of treatment. How do we use telehealth in this area? There are lots of different aspects of this work that are still in need of research and a lot of it is about leadership and considerations of different workforce challenges that we're facing.

The VA has done some work to bring chiropractic clinics into their systems and co-locate some of that. There's still a great need for looking at integrated care options for patients experiencing chronic pain, and how do we make that care accessible for people who may have limited mobility issues or don't feel comfortable in getting out frequently during the week to get to doctor's appointments. Transportation may be an issue. So how do we integrate care and make it truly accessible for people experiencing chronic pain?

(Slide 12) A couple more points about barriers. I feel I'm talking a lot about barriers. Patient providers and payers may lack knowledge regarding the benefits of nonpharmacologic treatment options, so there may be a sense, we heard this from a number of provider groups, that they don't feel particularly well-equipped to talk about nonpharmacologic pain treatments, and they really want to be able to alleviate that person's pain who's in front of them, and they want to do that quickly and readily. So, part of the issue is sharing better materials around that, better educating providers, as well as patients and payers about what those treatments look like and how to access them. It's often been the case that non-pharmacotherapy options have been the last line of treatment after everything else has failed. So, we want to try to think of those treatments a little earlier in the process and bring them more to the forefront of treatment planning.

(Slide 13) I'll move on now to shifting the conversation around pain tolerance. If you think about yourself, your family and others in your lives, as a culture we have not been particularly tolerant of pain. We like to avoid pain and that's obviously understandable. But at the same time, in thinking about pain management we know that non-opioid pain treatment doesn't have the immediate effectiveness of a pill, but our usual expectation is we don't have any pain or that it is immediately alleviated. So, part of what we want to do with this work is shift the conversation to what is manageable pain? How do we move into talking about pain as something that's a message to our bodies that we can distract ourselves from in other ways, that we can manage with some nonpharmacologic treatment, and how do we begin to shift that conversation so that people, while not at unacceptable levels of pain, will be able to find a balance between what that tolerable pain is and where they really are in their other treatments?

(Slide 14) In terms of thinking about the approaches states can take to combat the reliance on opioids for pain management, we talked with a lot of states and providers around the CDC guidelines for opioid prescribing that were based in 2016, the shift in those guidelines and concerns about that balance between over-prescribing and under-prescribing, and ensuring that pain management is adequate, and again that pain is at a tolerable level for our clients or patients. But again, we want to begin to shift that conversation and some of our states are at the forefront of that work. You're about to hear from Oregon about that in terms of considering nonpharmacologic opioid therapy as a first line of treatment for chronic pain rather than reaching immediately for opioids. We're going to talk more about that.

(Slide 15) Promoting the provision of non-opioid pain management therapies, part of the work we've done in looking across the landscape of stakeholder engagement and what seems to work, what's the literature show us, where are the findings—acupuncture, chiropractic services, cognitive behavioral therapy and other forms of physical therapy have been found to work really effectively as non-opioid pain management techniques. Again, these are conversations to be had, referral resources, networks to be gathered, and really a shift in thinking for providers and consumers of pain management. Again, providing provider training and technical support so to share this information with our provider communities. We have an aging provider population who may not have heard a lot about some of these techniques during their medical school education or their medical education in general. So, sort of retraining and rethinking about some of these additional types of services that may be effective in non-opioid pain management are some directions that we would like to be moving toward.

(Slide 16) We're going to take a poll of everybody to find out what steps your state has taken to shift perspectives around chronic pain treatment. When you think about the variety of actions you all have been able to take as a state, have you used provider trainings? Provider toolkits? Patient education? Media campaigns or other strategies? We'll open that poll now. Looks like over 50% of the group have engaged in provider training so that's great. It would be great to hear your observations around the provider training and the response to that when we get to our Q&A and to hear what you've seen with those provider trainings in terms of engagement, who's engaged, thinking around that. It already looks like provider toolkits and patient education have been used by a large group as well.

(Slide 17) Now our Oregon team.

DR. ARIEL SMITS: (Slides 18-19) There will be a background of Oregon's opioid initiative. Basically, what we want you to learn from this is to kind of understand the framework and what levers we've been using in the state of Oregon for our opioid initiative. We use coordinated care organizations here, which our CCOs are the local partners that sort of administer our Medicaid program on the ground. They have a lot of leeway in their local communities to use different resources and to kind of understand what we require of them for their improvement projects. We require them to take part in a performance improvement project, would we have called PIPs. And they share sort of best practices amongst themselves and understand what kind of barriers or interventions they've been able to do for opioids there, and then understand the next steps.

(Slide 20) The scope of the problem in Oregon, we're like many other states, a lot of nonmedical use of prescription opioids. Probably about 5% of our population were doing nonmedical use of prescriptions. They had a lot of hospitalizations for overdose with OUD, etc., which was quite a cost expense for us. We also had 115 deaths in 2017, which is the last year we had data for pharmaceutical opioid overdoses. This doesn't include sort of the unlisted overdoses that might have started with a prescription opioid use. Then 20% of Oregonians have used illicit drugs in the past, now have a pretty high rate of methamphetamine use, which is kind of an emerging problem, that combined with opioids. So definitely we identify this as a major issue we wanted to address with our various strategies we were going to go forward with.

(Slide 21) We first looked at what we were doing in terms of allowing Medicaid coverage. One thing we really wanted to increase was our non-opioid therapies for chronic pain. Especially for back conditions we weren't covering a lot of other things other than prescription opioids. We wanted to increase the

availability of chiropractic and acupuncture and physical therapy and behavioral health and all those other types of pain treatments. Hopefully this would reduce the amount of opioids that people would need and would reduce the harms from OUD, etc. We also were trying to increase the use of naloxone and medication-assisted therapy (MAT) for folks who did have OUD to cut down on some of the impact that was having on folks. Then we tried to reduce the number of pills prescribed and various strategies that we could go into more detail about. We would use data to target and evaluate all of our interventions.

(Slide 22) Oregon is a little bit of a different system in terms of our Medicaid program. We use prioritized lists. We also have an intractable pain law passed in 1995. We didn't actually implement our PDMP until about 10 years ago. I think we would assign some other states with that. We now have been implementing and trying to make it a more robust system. Then moving forward, we'll get our Oregon preferred drug list, and some of the drugs aren't there, as well as convening statewide opioid prescribing groups that did a lot of work starting with the CDC prescribing guidelines and then trying to come up with Oregon-specific guidelines for acute and chronic opioid prescribing. That work has continued.

(Slide 23) We've also done a SAMHSA-funded Oregon Tapering Project, which we've been working on trying to come up with Oregon-specific opioid tapering guidelines and trying to improve people's access to naloxone or MAT or alternative therapies, etc., when they're trying to do the tapering. Then we've been expanding again our PDMP mandating that previous need to enroll. Our governor has put together an Oregon Epidemic Taskforce to try to come up with more of a comprehensive strategy for assessing the problem, and that is work that's been going on in the last year or so. Then we've come up with Oregon Acute and Chronic Prescribing Guidelines. We've also worked with our dental partners to come up with dental prescribing guidelines and then we convened an Oregon Tapering Taskforce and hopefully we'll have their work done within this year.

(Slide 24) We have made some progress. We have expanded our coverage for non-opioid therapies for back and neck pain. We've added coverage for chiropractic and acupuncture, cognitive behavioral therapy. We've added coverage for things like yoga, although we've had some issues with the CCOs and payment for that, but we've been trying to expand to others with evidence-based treatments for pain, getting away from opioids. The Oregon Pain Management Commission has developed an educational module that new providers are required to do, but existing providers do have access to improve their pain education. We've increased our opioid treatment programs to try to reduce harm from opioids, which expands back up to naloxone and MAT. We've done various strategies to try to increase our X-waivered prescribers as well as to try to increase the number of patients each X-waivered prescriber is taking care of.

(Slide 25) Then with our prescribing guidelines and our PDMP expansions and enhancements, we've been really trying to reduce the number of pills in circulation, because we know even if a patient is prescribed medication appropriately for them having the pills in circulation can lead to nonprescribed uses. So, we have made progress. The latest data we have is 2017 but we've been pretty happy to see our pharmaceutical opioid overdose deaths have been declining since about 2016, which has been great. Our heroin overdoses have been staying steady. Lately we've been seeing an uptick in synthetic direct mail in fentanyl. I'm sure that's a problem other states are facing as well.

Then I briefly alluded to this, but methamphetamines are becoming kind of a rising problem in our state. I think this is what's happening in other states around the country as well. Lisa, did you want to take over?

LISA BUI: (Slide 26) One of the approaches Oregon has taken is, again, we can't do it alone. The opioid epidemic is really something that within our agency, the Oregon Health Authority has taken a strong approach of working across our agency, which includes our Medicaid agency, our public health agency, as well as our behavioral health arm. We have everyone kind of all on deck, along with our actual Medicaid plans, our CCOs, trying to create initiatives that build upon each other to obviously reduce the risk and overdose deaths.

(Slide 27) I'm going to touch on a few key specific strategies that were broadly mentioned in the strategies that Dr. Smits mentioned. I'm going to speak to the reducing opioid overdose misuse and dependency, a guide for our CCOs. I'll give a little bit of background and then I'll speak specifically around our PIP.

This toolkit was developed as part of, as we said again, the broad agency initiative, the OHA Opioid Initiative. What we found was having some of the very different information put together for our Medicaid plans that would align to the four priorities the agency had picked under the OHA initiative, as well as the priorities of the opioid community that are here in Oregon. So, we have several different community partners who are also helping address this. The toolkit was developed quite early on. The most recent version that is on the web link is February 2018, but I believed we developed it and released it as early as in the 2016 time period when we started the statewide PIP.

In there you'll see those four priorities around data, the reduced harms, reduced pills. What we tried to do was put in there the information from a variety of resources, not just with any agency, but also from national resources such as the CDC guidelines, the information about buprenorphine and MATs. That's kind of our one-stop shop for our CCOs just have the information in one place.

(Slide 28) The next thing I'll talk about is a little more of the meat of the conversation here, which is really the Medicaid plans or CCOs plans in Oregon and their approach for their PIP. The basic overview is the statewide PIP is where all our Medicaid plans, our CCOs in Oregon, including our fee for service, work on a topic. We work on developing that topic and topic selection, etc., all for a year. And ultimately in 2015 we selected chronic opioid use, and it began in January 2016. All the plans are required to participate in the statewide PIP. It is required as our 1115 waiver. So, it does follow the CMS PIP protocol. It's also validated through our state external review question organization (ERQO) for this statewide PIP.

The CCOs are working within their communities to address the activities but we have one specific measure for the PIP so that's what we'll speak to as far as the data that I'm showing you is the outcome measure that I selected for the PIP. The CCOs can select their own internal measures and their own interventions that meet their community needs to drive towards the overall outcome measure that we're looking for.

(Slide 29) I'm going to highlight some of the interventions. Again, we started at the time when we had 16 CCOs and we ended up with 15, but again we're covering close to one million individuals, and there are several different initiatives that occurred throughout this 2- to 3-year PIP, but here are some high-level ones. The common themes have been, again, like we just saw in the earlier poll was outreach and education of providers and members. One approach to that, parts of our state, our southern Oregon

contingency, which included five different plans, they decided to group together and come up with a collaborative communication. So even though they're working in the same region or service area, they decided that for the same community, the providers, the patients, the hospital systems, etc., it would be best to have a common group to work for. So again, whether that's different standards in prescribing, they didn't have to understand that. So, they banded together. All five of those basically made a community collaboration for the whole entirety of the PIP. They developed standard provider letters with co-branding of all five of those CCOs and then they also developed patient communication. That was one specific initiative that came out of this.

Some of the other specific provider education and trainings, again very common: safe prescribing; evidence-based non-opioid treatments and about access to that, and just communication to those providers of the availability and the coverage specifically related to that guideline that Dr. Smits spoke to. Then one other thing common across our CCOs is what they called either high utilizers or high prescriber reports. So, a lot of the CCOs, whether they use OHA data or their own claims data, disseminated high prescriber reports. They did this in actually a very leader champion model in which they would designate a medical director or champion of the CCO to go out to various different practices with those high prescribers reports and actually have a conversation with the providers in regards to what their patient populations are looking like and have a conversation about it instead of necessarily just emailing it.

One of the challenges we'll address is did the providers actually let the CCO come in and talk about that? The answer was yes. He just kept coming back. So that is part of the lessons learned that we'll discuss as well. Then one specific CCO in our metro region, which is again a significant part of our population of Medicaid, they focused on MAT expansion and specifically around the waiver providers and naloxone distribution as well.

(Slide 30) Here's the metrics and this is what you'll see if you Google statewide PIP for OHA. This is the one metric that gets validated again by ERQOs. We landed on 120 MED (morphine equivalent doses) at the state, then as we added a third year to this, we made the metric to be in alignment with CDC guidelines of the 15-week equivalent. One thing about this monthly reporting is that the CCOs receive from OHA the actual data. So, every month OHA's data analytics department creates this report that gives their performance. It also has the detail to the rolling 12 months of the individual members who have met those criteria as far as the metric goes. So, the information, if in fact the CCO doesn't have the analytics capability, has been coming from OHA so that they can use it to help inform their quality improvement initiatives. So, every month since 2016 they've been getting this report through the calendar year of 2018.

(Slide 31) Now the good stuff. Here are the results of the data. The chronic opioid PIP again ended from a measurement perspective in calendar year 2018 so we have 2016, 2017, 2018 data. What I'm showing on this particular chart is the greater than equal to 90 MED of morphine and equivalents across our CCOs. Again, Oregon is commonly using this kind of chart and display of data, and yes, we do deidentify it, so we do show it by plan, and we do that across various different quality metrics, not just a statewide PIP metric. So, what you will see is the performance of each CCOs including our fee for service population for this metric.

You will see that there are 90 NNE days for a consecutive 30 days, so that's the lighter blue. That basically means the patient is on the medication for that dosing for a consecutive 30 days. Then what you see in the darker blue is the MME for any day, just somewhere in the reporting period they had the 90.

(Slide 32) This is another way to display the data. This one specifically shows, and we did report the data in three different categories. We had 12-17 years of age, then 17 and older, and then all age groups. So, this is greater equals 12 so basically all age groups above 12. What you'll see with this dot display is the darker color—if you aren't in color—but it's dark blue, that's the 2018 rate. So that is the end of this PIP and the performance of each CCO as far as the any day 90 MED calculation. The lightest gray or color on the chart is the 2014 rates, so that was our baseline measurement year that we're using for reporting at the time of the start of the PIP. You can see there's been quite a significant level of reductions across all plans with some really remarkable reductions over the period of the PIP.

Back to Dr. Smits. She will speak to specifically a breakout of our Medicaid population related to our back guideline and again this is a subpopulation of individuals who were on opioids but had a back condition that basically had a benefit for alternative therapies.

DR. ARIEL SMITS: (Slide 33) We have an interesting system for deciding on coverage policies for Medicaid. We have what we call the prioritized list, and this links diagnoses and treatment. We cover some that we call above the line and we don't cover others that are below the funding line set by the legislature.

When we were looking initially at some of our opioid prescribing issues, we realized that we had unintentionally kind of forced people with back issues to get opioids because all the other treatments were below the line. So, we put together a taskforce and based on their recommendations we moved all of these folks above the line to get the alternative therapies that I discussed earlier. That actually rolled out in 2016. Before that we had about 6.5% of patients had one claim for back pain and were getting opioids and you can see others continued at about that rate.

(Slide 34) Then once we implemented the back-pain guidelines we were trying to see if they were making any difference, so we looked at a growth of other types of therapy. We had added coverage for CBT, which is usually provided by our psychiatric community. That didn't really increase much part of that because of our issues with a lot of access to mental health, unfortunately. But we did see quite an uptick in PT and OT and then acupuncture as well as in chiropractic care. These were all things we were trying to promote both through changing the back guidelines as well as all or the other types of things Lisa was referring to that the CCOs were doing.

(Slide 35) This is just another way to look at the same data. Not only were we seeing more claims but more frequent claims for the things we were trying to promote with the changes that we were making, the PT, OT, acupuncture, chiropractic, etc. Lisa, want to take this? It's a little bit more about the PIPs.

LISA BUI: (Slide 36) Basically, the general summary is yes, we have seen an increase in alternative therapy, specifically for our back-pain population. As far as the PIP goes, and again there are several metrics, again greater than equal to 120, greater than equal to 90, greater than equal to 50 MEDICATION across very different populations and sizes. Again, 12, 17, 17 and over. And for any day prescription, and then consecutive 30 days at that dosing. Across all of those metrics that I just briefly went over that we've had



decreases, some having again more significant decreases, specifically the any day. What you'll see across all those charts, and we can give you even more, we only highlighted a few today of those particular PIP metrics, but you can pretty much see the reduction. We have tried to look at our prescribing patterns across not just our Medicaid as a result of some of the PIP work but across all of Oregon, but we do have some of that data across all prescribing on our OHA opioid website. The difficulty is we cannot specifically extract on our PDMP Medicaid population. But we do see a similar trend in reduction of prescribing of opioids that mirrors what we're seeing in the Medicaid population.

(Slide 37) The lessons learned:

- Like we highlighted at the very beginning that really for this particular topic, this is all hands on deck. There are interventions that go across the community, across the health systems. There are policy levers across state agencies and even federal. There is a role for everyone to play and we have found that to be very helpful across our OHA opioid initiative to have those conversations and those convening meetings to figure out the roles and clarifications and common messaging.
- That's again in that second bullet point, common messaging. It has helped in our communities to say there are the Oregon prescribing guidelines. There are the benefits to the prioritized lists, support the Medicaid. These prescribing guidelines are for the state of Oregon. They're practiced across the state. So as far as the health system and/or provider units go there isn't just one thing, this is the way we're doing it. No, this is the way Oregon's doing it. You'll get the same message across different prescribers is the hope.
- The other thing we've learned is that you need the data. Oftentimes, and we heard this through some of our PIP quarterly reporting on this, was that giving the data is important but also continuing that education and having the information readily available for those on the ground, whether in the hospital or emergency department, or the primary care providers, that having the analytics or dashboards readily available for them so that they can help develop those interventions is key.

(Slide 38) So where is Oregon going next? Like I stated, the 2016, 2017, 2018 chronic opioid PIP technically ended in December 2018. We have continued in the opioid arena for our next statewide PIP, which began in January 2019. We are staying in opioids but working specifically in acute settings. While we have guidelines specific to the emergency department, opioid prescribing and guidelines for oral health and dental prescribing for opioids, which is again both in acute settings and common areas, we are working for specifically the spread and adoption of those guidelines and also other areas like potentially postsurgical. So, we are currently in the study design phase of that and we're working through the development of that particular metric and then we'll go from there.

As far as the broader opioid initiative, as mentioned we are currently working on Oregon opioid taper guidelines. This taskforce was convened in March 2019. We are still actively in those convenings and we hope to have, in later fall, that guideline for again dissemination across Oregon providers and health systems.

The other thing we're trying to look at within our opioid initiative is actually broadening it to try and think about the behavioral health system specifically around SUD and the approaches, strategies and levers we want to do to address potentially the uptick we're starting to see in the fentanyl, as well as methamphetamines. So, we're going to be bringing the behavioral health folks even further into this work. They've been involved but we're going to be going even farther down that road.

Then obviously like we discussed, what are the levers we want to start to invoke for the illicit drug use medication?

(Slide 39) This last slide is pretty much resources:

- The [healthOregon.org/opioids](http://healthOregon.org/opioids) website has an interactive data dashboard. It is regularly updated depending on the data source, sometimes as early as quarterly. It also has community information. Basically, that includes provider resources, patient resources, etc., and that's not just Oregon-specific, but some national. Again, we found it helpful to have all the information in one place. What you'll also see is the various guidelines that have come out of Oregon, like the chronic opioid, the acute prescribing, the oral health dental prescribing, and then we also have a neonatal abstinence population special prescribing guidelines.
- You have the link for Oregon's prescription drug monitoring program, which actually is housed within the Oregon Health Authority under our public health agencies so that does make collaboration and data use a little bit easier.
- Then you have the statewide PIP website. I will be updating that shortly to include the information for the acute prescribing, but all the information on there is currently the chronic opioid use one.
- Then if you want to learn more about the Health Evidence Review Commission and how OHA structures it benefits, specifically that would be the Commission website.
- (Slide 40) Finally, you have contact information for any question about any of the related work around opioids in Oregon. I'm happy to connect you to various different partners here in our agency or in the community.

DR. LISA PATTON: (Slide 41) A couple observations and questions and then we'll open to questions. One frustration we hear across the board from larger health plans, states and organizations trying to get information out to providers is that as you were describing you have that high-prescribing report that may go out, and it sounds like you have a very strong model for you, you're actually implementing some action around that high prescribing. So, if you're a point person who's going out, are there particular action steps they're taking with high prescribers? Materials you all have developed to really help that high prescriber change that behavior? Is there something very concrete you've done on that front?

Then one other observation from states and organizations thinking to find a way forward on this, using that high rate of back pain, we're hearing a lot that really delving into a specific chronic pain condition like back pain and focusing on that large swath of population coming in for those types of issues has been a really effective way, and I think your data spoke to that. So how is that high prescriber intervention going?

DR. ARIEL SMITS: I'll take the higher prescriber reporting. One of the things that helped our CCOs to go out to their provider groups is number one, we all agreed on what the metric should be. So, we had to pick one metric for the PIP for validation and so that was very key and a robust conversation among the plans in OHA. Once we landed on that metric and we adopted the metric specifications, it seems very fundamental but it was really a little bit easier in that after the metric specifications were developed, and again OHA provides the data, then we also had our analytics top team talk to whatever CCO analytics team they wanted, and they mirrored within their data the same specifications, because they had a little bit more real time data. It had a common voice.

So again, when you're going out to a provider group it's like here's your high prescriber report, it's pretty much what you also see on our opioid website, just specific to your particular panel. One of the providers had let me know when he was heading out it was when he had the actual information that was down to the member or patient level, that is where the value of the conversation was when he walked through the door. So, saying here are your rates, that's great and all. But when they got to the member and had the communication of what's going on with this particular patient, that was what allowed them to further the conversations with those particular provider practices. So, I think not just reporting rates and numbers out to those practices but bringing it down to the member level and having conversations about key people that you want to address. Obviously, you're not going to be able to talk about every patient but that was the engagement piece for the providers.

DR. LISA PATTON: Very helpful. As I said we're really hearing across the board that those really concrete action steps are where people are trying to get, so sounds like you all have done that. In 2014, I believe the Pharmacy Quality Alliance had an NQF-endorsed measure that got to that MED of 120, right? Then the CDC came out with the guidelines in 2016 at 90 MED. In talking with states during that time frame, many states had been pushing to get down to the 120 or even 110 or 100, so there was some reluctance by states to try to push even further to 90. You all have taken on getting even lower to the 50 MED. Could you talk about that transition, approach and feedback you got on that shift in conversation?

LISA BUI: So, when the statewide PIP was getting adopted it was very simultaneous to the chronic opioid guidelines and when the CDC guidelines were coming out. I remember it vividly because we were like oral health, if we just would have waited a couple months the CDC guidelines would have come out and we would have just prevented long, robust conversations about what MED level. Because we talked 120, 250, 100, we talked various different levels.

But then the chronic opioid guidelines group discussed it and then the CDC guidelines came out. Then our CCO group, who again discussed and planned the PIP, we basically went in alignment with Oregon, which was around the 90. What we found was when we looked at our baseline data and looked at our populations, we had to have enough population size for everyone to work with, but there wasn't enough that the plans felt that if we just gave them 90 to focus in the area, there were too many members, too many things to look at. So, they said if we could start at the 120 that was preferred.

Now some who had been working in this area around opioids since as early as 2008, some of our plans had been working in this arena, they went straight to the 90, because they already addressed individuals who were over 120. They hadn't necessarily gotten down to 90. So that's why the initial measurement development, we did 120 and 90. When we saw the outcomes after the first year or so of this PIP and developing the collaborations and communication and all those other things we talked about, we were trying to figure out if we were going to switch topics or go to a different one. Then we as a group really just felt that we're going to continue that momentum and we're going to go with full alignment to the CDC, which is the 50 MEDx, which is how at that time chronic long-term opioids were being addressed. That's where ultimately that third year measurement came in.

The discussion with our Ombuds staff and with complaints and grievances and other things we were seeing, that had tapered off as far as we weren't hearing that so much in the third year of the PIP. So, the group really felt we could go down to the 50. Other questions about that?

DR. LISA PATTON: No, that's great. Very helpful feedback. I believe Ariel was talking about alternative pain treatment and some issues around the mental health, behavioral health access and yoga. Could you talk a little bit more about that and where you might see more purple approaches?

DR. ARIEL SMITS: We had a variety of issues. For behavioral health, the CBT aspect specifically for back pain, we have a chronic issue with access to mental health, behavioral health for pretty much any referral, so that was a starting issue. We also found a diagnosis code that was psychological issues caused by chronic health issues that we thought therapists and people could use. It's an ICD-10 code. I'm probably not quoting it exactly. But it would allow them to bill even if the patient didn't have depression or anxiety or some other specific code, they felt they were comfortable using for CBT. That solved one problem because they didn't know how to bill. But we still have this issue where a lot of mental health providers aren't comfortable dealing with someone whose main issue is a pain condition rather than more of a mental health condition. That's been kind of an ongoing push-pull with our behavioral health community trying to make them more comfortable with this type of intervention and dealing with this population. That's been a little bit of an ongoing work in progress.

Similarly, for yoga, that was actually a little bit of a unique situation. Our CCOs have money they can use that's not in their medical spend. They use initiatives they see in their community so they might fund a farmer's market or someone to go to the Y and work out. They can do things like that with their discretionary funds, so they were actually paying for yoga punch cards and things like that with their discretionary funds. Then we made it a mandatory coverage and found a CPT code that was like group exercise that we thought they could use for it that became an issue in terms of where does the money come from? Does it come from this sort of nonmedical discretionary or does it come from their medical spend? I think we finally got that all straightened out and it's kind of whatever way you want to get there, so if the CCOs want to continue to pay for punch cards or have a provider they give—of course then a yoga provider doesn't have a Medicaid number to bill so they have to have a physical therapist or physician or somebody who's the billing provider. So, it's lots of issues to work through once you start trying to broaden out beyond historical medical structures.

DR. LISA PATTON: Yeah, and I think you make a very good point about the potential lack of comfort with traditional mental health or behavioral health providers working with pain. Because we talk so much and even did today about where's the comfort levels for medical professionals dealing with opioids and pain and pain management. Even being able to establish tapering plans or weaning plans comfortably and a lot of the workforce challenges. That's just a different angle that we might not typically think about.

(Slide 42) Other questions or comments? [none] A huge thanks to Oregon for this great presentation. You have Lisa's contact information to learn more about her work. Please complete evaluation form following this presentation. Anything else from our host? [silence]

[end of tape]