BEGIN: 12:00PM

ADJOURN: 1:30PM

CCO COMMUNITY ADVISORY COUNCIL MEETING

Lane County Mental Health Building, Room 198
December 17th, 2012
12:00pm-1:30pm

AGENDA

Present

CAC Members

David Parker, Chair
John Radich, Vice-Chair
Tony Biglan
Lezlee Craven
Tara DaVee
Nancy Golden
Val Haynes
Dawn Helwig
Rick Kincade
Marianne Malot
Roxie Mayfield
LM Reese

Staff

Lindsey Adkisson, Lane County Public Health

Guests

Dr. John Sattenspiel, Trillium
Kim Durst, Trillium
Debi Farr, Trillium
Cass Skinner, Trillium
Karen Gaffney, Lane County Health & Human Services
Jennifer Webster, Lane County Public Health
Brian Johnson, Lane County Public Health
Lillian Parker
Charles Biggs

CAC Members Absent

Renae Freeman
Karen Gillette
Marcela Mendoza
Charene Reavis
Jessica Rice
Susanna Sammis

1. **Call Meeting to Order**

2. **Public Comment**
    a. Heather Brown – written comment (see attachment)

3. **Introductions and Welcome**
    a. Introductions
    b. "Get to Know You" Activity

4. **CAC Business**
    a. The group approved the November CAC minutes.

5. **Announcements**
    a. Lindsey announced to the group that Ellen Syverson was hired by Lane County Public Health to serve as the full-time staff support person to the CCO Community Advisory Council and Rural Advisory Council. Ellen will join the group at the January meeting and slowly transition into the role Lindsey has been filling in the interim. Members should continue to use Lindsey as the primary staff contact until given further direction.

6. **Liaison Reports**
    a. Governing Board report
        i. LM Reese and Nancy Golden reported on the following topics of interest from the last Governing Board meeting:
            1. Inclusion/coverage of midwifery services:
                a.The Board discussed the importance of focusing on providing services that are based on evidence of high quality
                b. Group that testified in support of midwifery services was asked to provide more evidence on effectiveness for the Trillium Board.
            2. The question: How do we help support people who use the Emergency Room instead of primary care physicians?
                a. The Board discussed the importance of relationships between primary care physicians and patients
                b. A CAC member brought up an example of how many of the families she works with are assigned to a dentist but often don't know who they are assigned to.
                c. Dr. Sattenspiel noted to the group that Trillium requires that the providers they contract with provide "medical triage" when needed. However, they have not set-up any sort of on-call nursing unit to receive calls all of the time.
                d. The group discussed the gap in education for consumers around what it means to be assigned to a doctor.
                e. Dr. Sattenspiel explained that an important objective is to re-educate consumers to use their primary medical

home as a first contact rather than Trillium or the Emergency Department.

3. Panel discussion on dental care hosted by Trillium.
    a. CAC members heard very little opposition from the 69 people that attended.
    b. There was a shared understanding that that this is an important issue by no formal resolution or agreement came out of the event.
    c. Debi Farr is assembling a workgroup that has representation from each of the dental care organization as well as Trillium Board members.
    d. David Parker asked for regular updates to the CAC on this issue.

b. CAP Report
    i. Rick Kincade updated the CAC on the Clinical Advisory Panel business.
    ii. The CAP has assembled workgroups to address issues such as pain management, musculoskeletal issues, diabetes, behavioral health, etc.
    iii. The goal of the workgroups is to dive into the data to understand where there may be opportunity to provide better care.
    iv. They will be also focusing on quality measures for public reporting.
    v. They will also be focusing on addressing how chemical dependency fits into the primary care medical home to ensure consumers the right level of care and support they need.
    vi. Rick explained that there has been a lot of misunderstanding and misinformation in the medical community.

c. RAC Report
    i. Lezlee Craven reported that the Rural Advisory Council had had their first meeting in early D

7. Trillium Newsletter

a. Debi Farr shared with the group the Trillium Newsletter and asked for feedback.
b. What did CAC members like about the newsletter?
    i. Likes electronic to make it more versatile – can send it on and copy it
    ii. It's eye catching – colorful, simple to read
    iii. Articles are short
    iv. Preventative – try to give people tips to stay healthy
c. What do you want to see changed?
    i. Want more short interactive articles that could engage kids
    ii. Would be good to have online – especially for kids
    iii. Have guest writers that are young people
    iv. Font needs to be a little bigger
    v. Have a "Kids Health Corner"
    vi. Needs to refer to web address
    vii. Should start publishing evidence-based practices in non-scientific language
    viii. Myth busters section
    ix. Include local data, local information

x. Need to assess comprehension- make sure it is at a 4th grade reading level
xi. Be mindful of different cognitive levels (words and pictures)
xii. Be aware of ethnic/cultural differences
xiii. Include an article from a consumer to discuss how to be healthy/opportunities they've encountered in the community
xiv. An ability to not only push information out but also pull information in – what are the things that are going on in the community and how are we addressing them

d. What health information would you like to see added?
   i. Talk about things that kids deal with, that teens deal with, that adults deal with
   ii. When should I go to the ER?
   iii. Each population group has different needs – a large number of people have a lot of small things – how do you engage people into wellness?
   iv. Depression
   v. How to combat negative stress, life, etc. – local support groups – following Acceptance Commitment Therapy
      1. Bruce and Tony will draft an article

8. Durable Medical Equipment

a. Kim Durst and Dr. John Sattenspiel from Trillium addressed the group regarding Durable Medical Equipment
b. LM and Tara shared their personal experiences and frustrations with current policies around how to access needed medical equipment
c. Members believed that these policies caused the equipment/services to cost more in the long-run
d. Dr. Sattenspiel explained that the rules and procedures are put in place to manage the health of an entire community. He said that often the needs of the specific individuals get lost.
e. For rules and procedures around Durable Medical Equipment coverage, Trillium uses the Oregon Administrative Rules. When there aren't rules, Oregon uses Medicare rules to guide decision making.
   i. Trillium uses additional algorithms to make these decisions (see attached).
f. The CCO will pay for things that are deemed necessary and cost effective.
g. There is a need to fix the system – the role of the CCO is to help a community balance the healthcare rights of consumers.
h. Question from one CAC member: At what point does someone get to speak with a person when they have something that they feel should be covered?
   i. There is a large volume of OHP members that Trillium must work with so it is difficult.
   ii. There needs to be a system where clients can speak to a human being – volunteer nurses, etc. to get more information.
i. Problem: population cost effectiveness vs. individual cost effectiveness

j. The group agreed that a workgroup should be convened to discuss this issue further. CAC members should submit their names to Lindsey or David to be a part of this ad hoc workgroup.

9. Continuous Improvement

a. David and John framed the conversation on Durable Medical Equipment as an example of the CAC's need for a process on how to deal with issues that arise from CAC members.
b. Everything can't be discussed at the monthly meetings because there isn't time. It would make the most sense for these issues to be given to a workgroup to look at, research, and provide a recommendation to be voted on by the whole CAC.
c. The Continuous Improvement form is a way for members to submit things that they would like to see improved in healthcare delivery. The form also allows the CAC to track what issues are addressed and what aren't.
d. The group will talk more about this at the January meeting.

10. Adjourn

a. **Next meeting:** January 28th

Attachment 1. Public Comment

Dear Lindsey,
Thank you for taking the time to read this. I am a doula working in Lane County and hired by pregnant women to assist in their pregnancy, birth, and postpartum care. I have had many clients who want a homebirth but instead end up with a birth center or hospital birth because the insurance plan doesn't allow them one and they cannot afford to pay out of pocket.
Homebirth is safe and significantly cheaper than a hospital birth, however if the Oregon Health Plan doesn't cover it, OHP will be leaving poverty stricken women without any options. I don't want to see more choices being taken away from women who are already struggling. Homebirth shouldn't just be for the rich, the right to birth where you choose is very important. I have seen birth trauma effect the mother even years after giving birth. On the flip side of that, I have also seen an empowered birth lift women to a point where they gain self confidence and strength. Hospital birth can be great for those who feel safe and well taken care of in that setting, but for others it can be scary as they just want the comfort of their home and the presence of a trusted midwife.
Please help make sure that women on your plan still have options and feel free to share my letter with anyone who may help make that decision.

Thank you,
Heathir Brown, C.D.

Attachment 2. LM Governing Board Report

Report from the CCO/DCO'S meeting December 11, 2012

I attended the meeting on December 11 between the CCO /DCO'S held at the Trillium building. I heard very little opposition to the integration of the DCO'S into the CCO. I think for the most part all the dentist want to work with the CCO.
We had 69 sign in beside Trillium staff.

Respectfully submitted

L. M. Reese

Attachment 3. Trillium Newsletter and Feedback Form

ISSUE 3 | VOLUME 12 | 2012

Trillium Community Health Plan

Member

ADDRESSING THE NEEDS OF INDIVIDUAL MEMBERS AND PLANTING THE SEEDS FOR FUTURE HEALTHCARE

MANAGE YOUR DIABETES

By National Centers for Chronic Disease Control, CDC

FINDING PEOPLE WITH EARLY SIGNS OF DIABETES. Many people avoid the long-term problems of diabetes by taking good care of themselves.

DISCUSS HOW YOUR SELF-CARE PLAN IS WORKING FOR YOU EACH TIME YOU VISIT YOUR HEALTH CARE TEAM.

Work with your health care team to reach your ABC goals (A1C, Blood Pressure, and Cholesterol). In addition, use this self-care plan:

▶ Use a diabetes meal plan. If you do not have one, ask your health care team about one.

▶ Make healthy food choices such as fruits and vegetables, fish, lean meats, chicken or turkey without the skin, dry peas or beans, whole grains, and low-fat or skim milk and cheese.

▶ Keep fish, lean meat and poultry portion to about 3 ounces (or the size of a deck of cards). Bake, broil, or grill it.

▶ Eat foods with more fiber such as whole grains, cereals, breads, crackers, rice, or pasta.

▶ Get 30 to 60 minutes of physical activity on most days of the week. Brisk walking is a great way to move more.

CONTINUED ON PAGE 2

Trillium
Community Health Plan
It's beautiful what we cover

Trillium Member Newsletter

1-If you receive this newsletter in the mail, do you read it?

Yes____ No____

2-If the answer is no, would you read it online?

Yes_____ No_____

3-What do you like about the newsletter?

_____

4-Do you find the health information useful?

Yes_____ No_____

5-What is missing from the newsletter?

_____

6-How could the newsletter be improved?

_____

7-What health information would you like to see added?

_____

Attachment 4. Trillium Information on Durable Medical Equipment

What is Durable Medical Equipment (DME)?:

Equipment, furnished by a durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) provider or a home health agency that can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a client in the absence of an illness or injury and is appropriate for use in the home. Some examples include wheelchairs, crutches and hospital beds. Durable medical equipment extends to supplies and accessories that are necessary for the effective use of covered durable medical equipment (OAR 410-122-0010 (4))

Where is DME used?:

For purposes of purchase, rental and repair of durable medical equipment (DME) that is used primarily as a supportive measure to support a client's basic daily living activities, home is a place of permanent residence, such as an assisted living facility (includes the common dining area), a 24-hour residential care facility, an adult foster home, a child foster home or a private home. This does not include hospitals or nursing facilities or any other setting that exists primarily for the purpose of providing medical/nursing care. Separate payment will not be made to DME providers for equipment and medical supplies provided to a client in their home when the cost of such items is already included in the capitated (per diem) rate paid to a facility or organization. (OAR 410-122-0010 (5))

How long should DME last?:

Reasonable useful lifetime (RUL) of durable medical equipment (DME) is no less than five years; Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment; (OAR 410-122-0184 (c)(i)(ii))

What is the process for getting DME from Trillium?:

It all starts with a discussion with your primary care physician (PCP).

- During the discussion it is decided that you need some equipment or supplies for a medical condition that you have.
- A prescription is written with what is needed, for how long and why (your diagnosis)?
- The prescription is called in, faxed or taken to a local DME vendor. Trillium contracts with many vendors in Lane County to ensure choice to the members.
- The DME vendor reviews the needs and is familiar with the rules and works on getting the supporting information needed to have a prior authorization (PA) processed. The most common problems that are often encountered at this stage are getting a covered diagnosis based on the prioritized list, or lack of supporting documentation from the PCP.

- The DME Vendor also has a responsibility of being timely when they receive the prescription. They know that they need to get the equipment out as soon as possible. For some equipment there can be some delays as they need to do a home visit or measure a member for the equipment.
- Once all the needed information is gathered the DME Vendor will submit to the Health Plan (in this case CCO). They submit by fax and/or electronically.
- The faxes and electronic submissions are received by Trillium Durable Medical Equipment Benefit Specialist (DBS) and they process the PA. The DBS have decision algorithms (Internal Process Guides) to follow for the equipment and supplies. Most items are processed as approved at this level. If they are not able to get to an approval on a decision path, they forward to a DME Nurse. If the DME Nurse is not able to get to an approval, the PA is sent to an internal Care Coordinator who is familiar with the member just prior to going to the Medical Director for final review. (Please review attachment A)
- Once a PA arrives in the building, by rule we have 14 days to process. If it is urgent, then it must be processed in 72 hours.
- Once the decision is made a fax is sent to the PCP and Vendor to process the order.
- If a denial occurs, reference to why criteria was not met is added for the Member , PCP and Vendor to review.

How does Trillium make decisions on DME?

Oregon Health Authority provides the rules for Durable Medical Equipment and Medical Supplies for the CCO plan for Medicaid decisions.

Rules for Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) for Medicaid are located at:
http://arcweb.sos.state.or.us/pages/rules/oars_400/oar_410/410_122.html

If there is not a rule available, then it diverts to rules under Medicare.

Medicare rules are listed under Noridian.

Noridian is our region's Medicare Administrative Contractor or MAC. We are in Region D.

The rules are referred to as Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs)
LCDs and NCDs are located at:
https://www.noridianmedicare.com/dme/%3f

12/17/12 KED

410-122-0184

Repairs, Maintenance, Replacement, Delivery and Dispensing

(1) Indications and Limitations of Coverage and/or Medical Appropriateness: The Division of Medical Assistance Programs (Division) may cover reasonable and necessary repairs, servicing, and replacement of medically appropriate, covered durable medical equipment, prosthetics and orthotics, including those items purchased or in use before the client enrolled with the Division:

(a) **Repairs:**

(A) To repair means to fix or mend and to put the equipment back in good condition after damage or wear to make the equipment serviceable;

(B) If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, no payment will be made for the amount of the excess;

(C) Payment for repairs is not covered when:

(i) The skill of a technician is not required; or

(ii) The equipment has been previously denied; or

(iii) Equipment is being rented, including separately itemized charges for repair; or

(iv) Parts and labor are covered under a manufacturer's or supplier's warranty;

(D) Code K0739 must not be used on an initial claim for equipment. Payment for any labor involved in assembling, preparing, or modifying the equipment on an initial claim is included in the allowable rate;

(b) **Servicing:**

(A) Additional payment for routine periodic servicing, such as testing, cleaning, regulating, and checking of the client's equipment is not covered. However, more extensive servicing which, based on the manufacturers' recommendations, is to be performed by authorized technicians, may be covered for medically appropriate client-owned equipment. For example, this might include, breaking down sealed components and performing tests that require specialized testing equipment not available to the client;

(B) Payment for maintenance/service is not covered for rented equipment. The Division may authorize payment for covered servicing of capped rental items after six months have passed from the end of the final paid rental month. Use the corresponding Healthcare Common Procedure Coding System (HCPCS) code for the equipment in need of servicing at no more than the rental fee schedule allowable amount;

(C) Up to one month's rental will be reimbursed at the level of either the equipment provided; or, the equipment being repaired, whichever is less costly;

(D) Maintenance and servicing that includes parts and labor covered under a manufacturer's or supplier's warranty is not covered;

(c) **Replacement** - Replacement refers to the provision of an identical or nearly identical item:

(A) Temporary Replacement: One month's rental of temporary replacement for client-owned equipment being repaired, any type (K0462) may be reimbursed when covered client-owned equipment such as a wheelchair is in need of repair. The equipment in need of repair must be unavailable for use for more than one day. For example, the repair takes more than one day or a part has to be ordered and the wheelchair is non-functional;

(B) Permanent Replacement: Situations involving the provision of a different item because of a change in medical condition must meet the specific coverage criteria identified in chapter 410, division 122;

(C) Equipment, which the client owns or is a capped rental item may be replaced in cases of loss or irreparable damage. Irreparable damage refers to a specific accident or to a natural disaster (e.g., fire, flood, etc.). Irreparable wear refers to deterioration sustained from day-to-day usage over time and a specific event cannot be identified. Replacement of equipment due to irreparable wear takes into consideration the reasonable useful lifetime of the equipment;

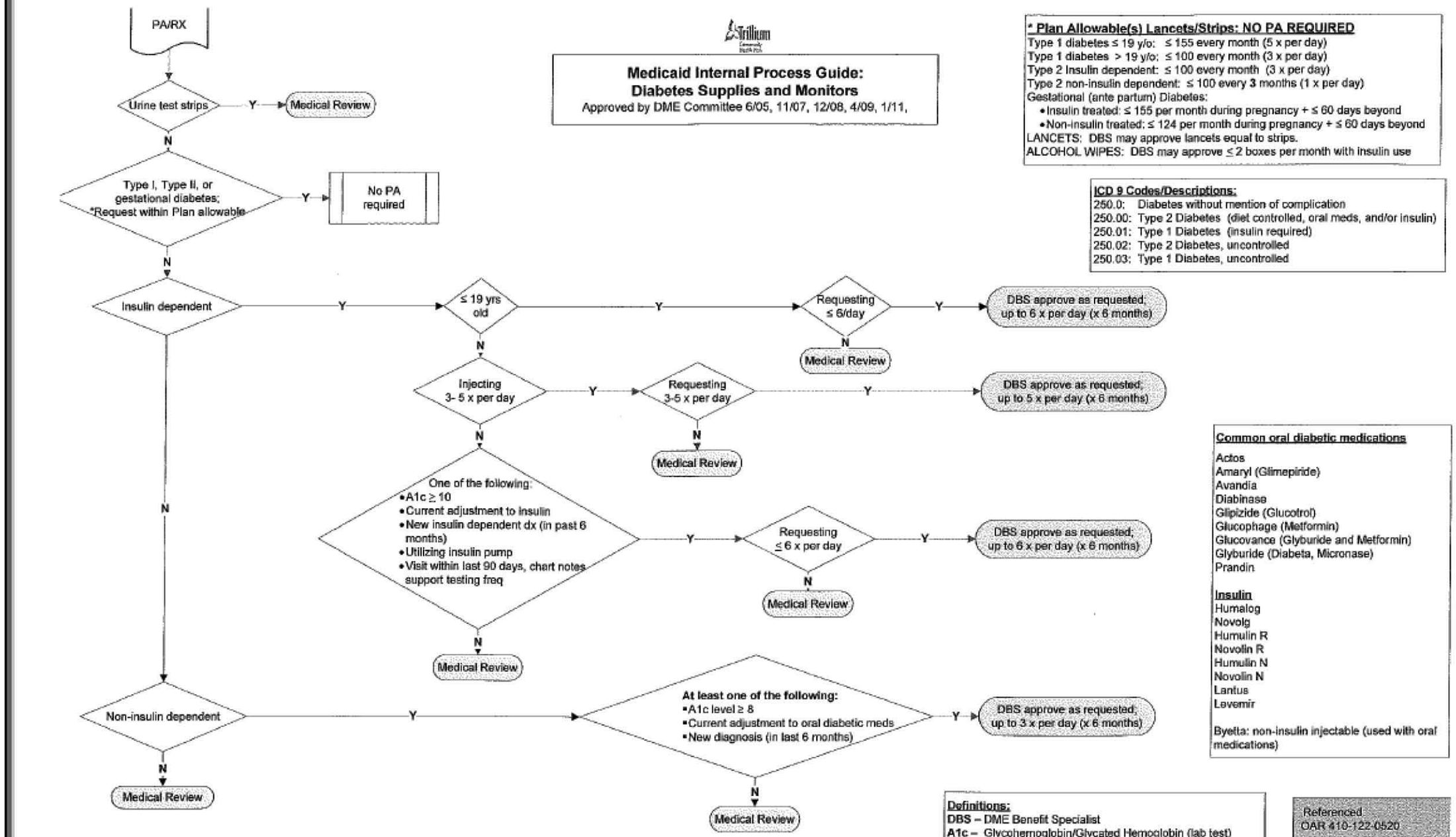
(i) Reasonable useful lifetime of durable medical equipment (DME) is no less than five years;

(ii) Computation of the useful lifetime is based on when the equipment is delivered to the client, not the age of the equipment;

(iii) Replacement due to wear is not covered during the reasonable useful lifetime of the equipment;

(iv) During the reasonable useful lifetime, repair up to the cost of replacement (but not actual replacement for medically appropriate equipment owned by the client) may be covered;

(D) Cases suggesting malicious damage, culpable neglect, or wrongful disposition of equipment may not be covered;



Medicaid Internal Process Guide: Diabetes Supplies and Monitors

Approved by DME Committee 6/05, 11/07, 12/08, 4/09, 1/11,

*** Plan Allowable(s) Lancets/Strips: NO PA REQUIRED**

Type 1 diabetes ≤ 19 y/o: ≤ 155 every month (5 x per day)
Type 1 diabetes > 19 y/o: ≤ 100 every month (3 x per day)
Type 2 Insulin dependent: ≤ 100 every month (3 x per day)
Type 2 non-insulin dependent: ≤ 100 every 3 months (1 x per day)
Gestational (ante partum) Diabetes:
- Insulin treated: ≤ 155 per month during pregnancy + ≤ 60 days beyond
- Non-insulin treated: ≤ 124 per month during pregnancy + ≤ 60 days beyond

LANCETS: DBS may approve lancets equal to strips.
ALCOHOL WIPES: DBS may approve ≤ 2 boxes per month with insulin use

ICD 9 Codes/Descriptions:

250.0: Diabetes without mention of complication
250.00: Type 2 Diabetes (diet controlled, oral meds, and/or insulin)
250.01: Type 1 Diabetes (insulin required)
250.02: Type 2 Diabetes, uncontrolled
250.03: Type 1 Diabetes, uncontrolled

Common oral diabetic medications

Actos
Amaryl (Glimepiride)
Avandia
Diabinase
Glipizide (Glucotrol)
Glucophage (Metformin)
Glucovance (Glyburide and Metformin)
Glyburide (Diabeta, Micronase)
Prandin

Insulin

Humalog
Novolg
Humulin R
Novolin R
Humulin N
Novolin N
Lantus
Levemir

Byetta: non-insulin injectable (used with oral medications)

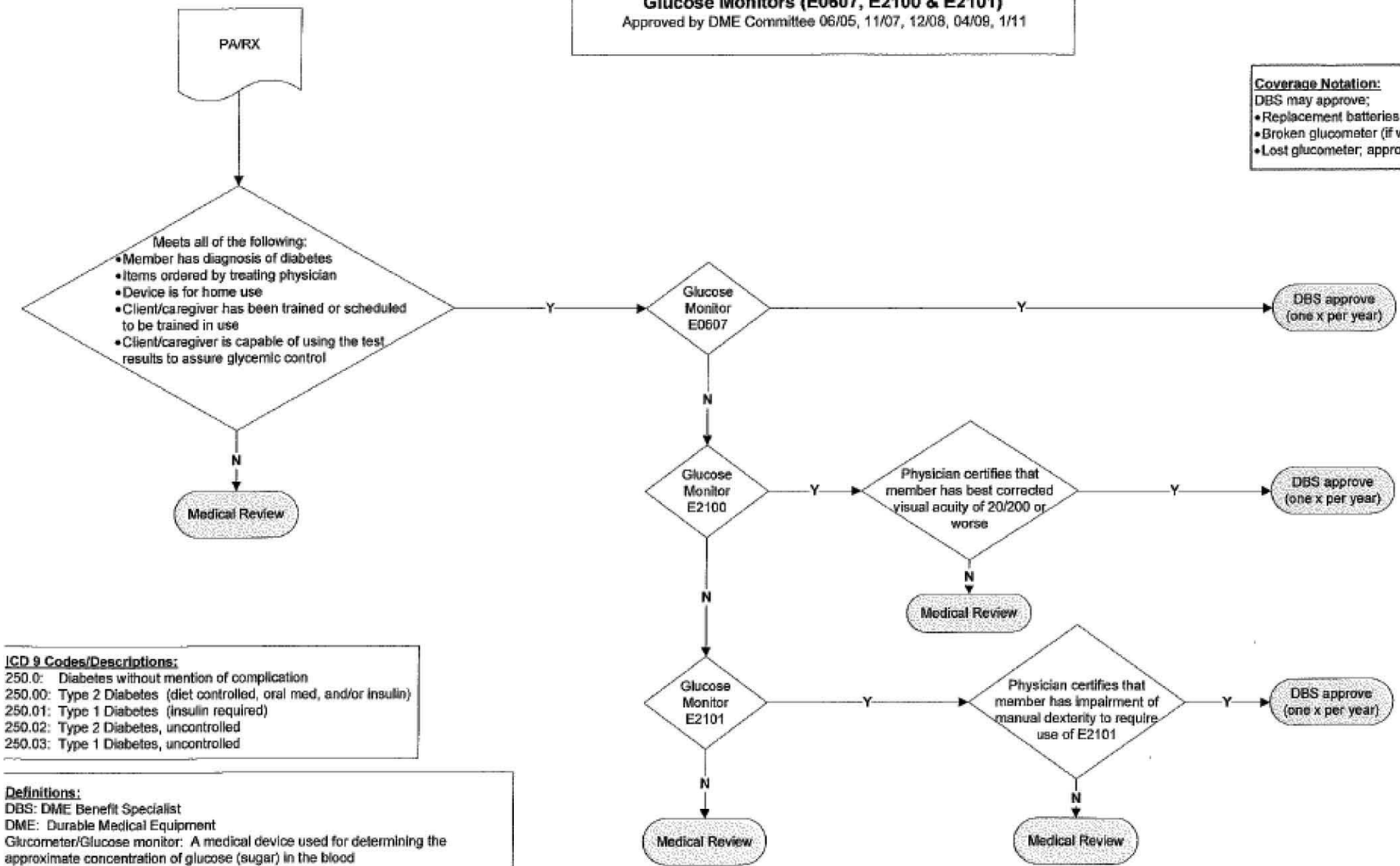
Definitions:

DBS – DME Benefit Specialist
A1c – Glycohemoglobin/Glycated Hemoglobin (lab test)

Referenced:
OAR 410-122-0520

Medicaid Internal Process Guide: Glucose Monitors (E0607, E2100 & E2101)

Approved by DME Committee 06/05, 11/07, 12/08, 04/09, 1/11



Coverage Notation:
DBS may approve;
- Replacement batteries as requested
- Broken glucometer (if warranty no longer valid)
- Lost glucometer; approve 1st loss, medical review for subsequent

ICD 9 Codes/Descriptions:
250.0: Diabetes without mention of complication
250.00: Type 2 Diabetes (diet controlled, oral med, and/or insulin)
250.01: Type 1 Diabetes (insulin required)
250.02: Type 2 Diabetes, uncontrolled
250.03: Type 1 Diabetes, uncontrolled

Definitions:
DBS: DME Benefit Specialist
DME: Durable Medical Equipment
Glucometer/Glucose monitor: A medical device used for determining the approximate concentration of glucose (sugar) in the blood
Glycemic control: Typical levels of blood sugar in a persons with diabetes
Manual dexterity impairment: A condition causing reduced ability to use the hands

Referenced