Using Evidence to Inform Policymaking

Monday, October 23, 2017

Portland Marriott Downtown Waterfront
1401 SW Naito Parkway
Portland, OR
Using Evidence to Inform Policymaking

Monday, October 23, 2017
8:00 a.m. – 4:00 p.m.

Portland Marriott Downtown Waterfront
Meeting Room: Mt. Hood
Portland, OR

TABLE OF CONTENTS

Agenda

Speaker Biographies

Sessions:
- Opening Panel: Using Evidence to Inform Policymaking
- Introduction to Evidence-Informed Health Policy Workshop
- State Models for Evidence-Informed Policymaking
- New and Emerging Evidence

Resources:
- NASHP Resources
- Additional Resources

Hotel Wireless Internet Information:
Complimentary wireless internet access will be available in all meeting rooms at the Portland Marriott Downtown Waterfront. Below is the network and passcode information:
Network: MARRIOTT_CONFERENCE
Code: NASHP

This meeting is supported through a Patient-Centered Outcomes Research Institute Conference Award (EA-5895-CHPD).
# Using Evidence to Inform Policymaking
Portland Marriott Downtown Waterfront Hotel  
Meeting Room: Mt. Hood  
Portland, Oregon

## Learning Objectives:
Participants will 1) understand the range of evidence available for evidence-informed policymaking; 2) get hands-on experience working with evidence in an interactive workshop; 3) explore a range of state models for evidence-informed policy; and 4) gain access to systematic reviews and emerging evidence of relevance to state health policymakers.

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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</table>
| 8:00 – 8:45 am | Registration  
(Breakfast buffet will be available 7:30 – 8:30 a.m. in the foyer on Lower Level 1) |
| 8:45 – 9:00 am | Welcome and Opening Remarks  
- Jane Beyer, JD, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner |
| 9:00 – 10:15 am | Opening Panel: Using Evidence to Inform Policymaking  
Moderator: Jane Beyer, JD, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner  
During this opening panel, participants will hear from a range of organizations which support states with evidence-based policymaking from various approaches. The Patient-Centered Outcomes Research Institute (PCORI) focuses on generating research which incorporates patients’ perspectives and values, the Center for Evidence-based Policy (CEbP) helps states make informed policy decisions based on evidence reviews, while the State Health Access Data Assistance Center (SHADAC) helps states utilize local, state and federal data sources for informed decision making.  
- Greg Martin, Deputy, Chief Engagement and Dissemination Officer, PCORI  
- Pam Curtis, MS, Director, CEbP  
- Lynn Blewett, PhD, Principal Investigator, SHADAC |
| 10:15 – 10:30 am | Break |
| 10:30 – 11:50 am | Introduction to Evidence-Informed Health Policy Workshop, Part I  
Moderator: Pam Curtis, Director, CEbP  
Part I of this workshop will include 1) “What is evidence-informed health policy and why does it matter?” and 2) Evidence Basics, - or “Why are some studies better than others?”  
- Adam Obley, MD, Clinical Epidemiologist, CEbP |
| 11:50 am – 12:10 pm | Break: Pick up lunches from buffet |

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<thead>
<tr>
<th>Time</th>
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<th>Notes</th>
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<tr>
<td>12:10 – 1:30 pm</td>
<td>Introduction to Evidence-Informed Health Policy Workshop, Part II</td>
<td>Pam Curtis, Director, CEbP</td>
<td>Part II of this workshop will include: 1) “How is evidence summarized, graded, and applied to policy-making?”; 2) How to effectively communicate about evidence with legislators; and 3) Interactive case studies allowing for hands-on work reviewing evidence and discussing policy implications for one of the following topics: the effects of insurance coverage on health or the merits of different health system delivery reform models.</td>
</tr>
<tr>
<td>1:30 – 1:45 pm</td>
<td>Break</td>
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<tr>
<td>1:45 – 3:00 pm</td>
<td>State Models for Evidence-informed Policymaking</td>
<td>Gabriel Kaplan, PhD, MPA, Chief, Health Promotion and Chronic Disease Prevention Branch, Colorado Department of Public Health &amp; Environment</td>
<td>This panel will use a moderated Q&amp;A format to give participants an understanding of the range of approaches states have taken to support evidence-informed policymaking. Speakers will demonstrate a variety of models (e.g. legislatively-mandated ones versus more informal approaches) and will also explore how these states involve patients and the public in evidence-informed policymaking.</td>
</tr>
<tr>
<td>3:00 – 3:45 pm</td>
<td>New and Emerging Evidence</td>
<td>Jennifer Johnson, MPH, Director, Division of Public Health Statistics and Performance Management, Florida Department of Health</td>
<td>This session will share recent and upcoming findings from PCORI as well as key findings from recent, vetted systematic reviews which may be of interest to policymakers. A speaker from PCORI will discuss emerging evidence from PCORI’s research portfolio on topics such as Community Health Worker effectiveness. Speakers from HERC and CEbP will share findings from recent systematic reviews of treatment options for low back pain, obesity management strategies, best practices for smoking cessation in pregnancy, and the effectiveness of home versus long-term care settings.</td>
</tr>
<tr>
<td>3:45 – 4:00 pm</td>
<td>Closing Remarks and Adjournment</td>
<td>Jane Beyer, JD, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner</td>
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Jane began her career as a legal services attorney in Tacoma Washington. She served as legal counsel to the Washington State House of Representatives for twenty years, as Washington State’s Medicaid director and, more recently, as Washington State’s Behavioral Health Commissioner. She is currently the Senior Health Policy Advisor to Washington State Insurance Commissioner Mike Kreidler.

Greg Martin, Deputy, Chief Engagement and Dissemination Officer, Patient-Centered Outcomes Research Institute (PCORI)

Greg Martin is the Deputy, Chief Engagement and Dissemination Officer for the Patient-Centered Outcomes Research Institute (PCORI). He assists the Chief Engagement and Dissemination Officer in facilitating the integration of Communications, Engagement, Training, and Dissemination activities across the department and organization-wide among other cross department and PCORI activities. Martin was previously deputy director, Stakeholder Engagement, and responsible for leading PCORI’s state- and local-level engagement with clinicians, policy makers, professional audiences, and the broader healthcare community. An experienced state health policy and state government affairs professional, Martin previously served the American Academy of Family Physicians (AAFP) and National Conference of State Legislatures (NCSL). Martin received his BA in political science from University of Mary Washington in Fredericksburg, Virginia.

Dr. Lynn Blewett, Professor, State Health Access Data Assistance Center, University of Minnesota

Lynn A. Blewett, Ph.D., is Professor of Health Policy at the University of Minnesota, School of Public Health, Division of Health Policy and Management. She directs the State Health Access Data Assistance Center (SHADAC), a multidisciplinary research center that provides data analytics and policy analysis to better understand how policy impacts health insurance coverage, access to need care and population health. She works with state policy analysts and decision makers to better understand data and trends in health care to better inform health policy. She most recently served on the Board of AcademyHealth and Board of Scientific Advisors for the National Center for Health Statistics. She currently serves on the board of Portico HealthNet, a coverage program for the uninsured, and is a member of the National Academy of Social Insurance. Dr. Blewett received her MA in public affairs from the Hubert H Humphrey Institute of Public Affairs and her PhD in health services research and policy from the University of Minnesota School of Public Health.

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Pam Curtis, MS, Director, Center for Evidence-based Policy, Oregon Health & Science University

Pam Curtis is the Center’s co-founder and Director. Ms. Curtis is responsible for the overall effectiveness of the Center as well as maintaining a portfolio of direct state work. She currently serves as the Director of the MED project (the Center’s largest collaborative of states), leads the Center's work in Colorado focused on transforming primary care delivery through payment reform, and leads work in Oregon to develop a longitudinal child data set, integrated across six state agencies. Prior to founding the Center, Ms. Curtis served as a policy advisor to Oregon’s Governor on health and human services issues, as well as elected officials at the state, county and national levels. Ms. Curtis has clinical experience in the fields of substance abuse, behavioral health, and child abuse. Her professional background also includes collaborative governance.

Dr. Adam Obley, Assistant Professor, Department of Medicine, Clinical Epidemiologist, Center for Evidence-based Policy Oregon Health & Science University

Dr. Obley graduated from the University of Kansas, School of Medicine. He completed his residency in Internal Medicine at Oregon Health & Science University where he also served as Chief Resident. Dr. Obley is a Clinical Epidemiologist at the Center for Evidence-based Policy where he works on a wide variety projects applying clinical and health services research to policy development. He is an academic general internist at Oregon Health & Science University, as well as an Assistant Professor of Medicine. He is also a staff physician at the Portland VA Medical Center.

Gabriel Kaplan, Chief of the Health Promotion and Chronic Disease Prevention, Prevention Services Division, Colorado Department of Public Health and Environment

Gabriel Kaplan is the Chief of the Health Promotion and Chronic Disease Prevention Branch in the Prevention Services Division at the Colorado Department of Public Health and Environment. He also oversees the work of the Division’s Health Access Branch. In this role, Dr Kaplan manages 8 public health work units that seek to improve policies around health promotion and prevention, to transform the delivery of care within health systems, and improve the linkages between community-based prevention and the clinical care system. Prior to this, he served as the Director of the Epidemiology, Planning & Evaluation Branch in the same division at CDPHE, where he directed the data analysis and research units that support public health prevention services and interventions. Before joining CDPHE, Dr. Kaplan served as an Assistant Professor of Public Policy at the University of Colorado, Denver’s School of Public Affairs. He also serves as an adjunct assistant professor at the Colorado School of Public Health and is the President-Elect of the National Association of Chronic Disease Directors. Dr. Kaplan has a PhD in public policy analysis and research from Harvard’s JFK School of Government.

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Ellie Garrett, Deputy Director, Office of the Medical Director, Minnesota Department of Human Services

Ellie Garrett, serves as deputy director of the Office of the Medical Director at the Minnesota Department of Human Services. She also teaches a masters-level health policy course at St. Catherine University. Prior to joining DHS, she maintained a national and regional consulting practice focusing on public engagement on health policy issues and worked as the associate director for health policy and public health at the Minnesota Center for Health Care Ethics. There she co-directed the Minnesota Pandemic Ethics Project, the nation’s largest state-sponsored public engagement project about pandemic planning. She is a past-president of the Minnesota Public Health Association and in 2004 received the Albus Justus Chesley Award for distinguished service to public health in Minnesota.

Darren Coffman, Director, Health Evidence Review Commission, Oregon Health Authority

Mr. Coffman is the Director of the Health Evidence Review Commission (HERC) for the state of Oregon. HERC provides evidence-based coverage guidance on health technologies to public and private payers and purchasers in the state. They also administer the Prioritized List of Health Services used to define the benefit package for the Oregon Health Plan, the state’s Medicaid program. Prior to the creation of HERC in 2012, Mr. Coffman served for 15 years as the Director of the Health Services Commission, the predecessor to HERC, with his involvement in Oregon’s pioneering health care prioritization efforts dating back to 1989.

Dr. Gary Franklin, Medical Director, Washington State Department of Labor and Industries; Research Professor, Departments of Environmental Health, Neurology, and Health Services, University of Washington

Dr. Franklin has served as the Medical Director of the Washington State Department of Labor and Industries (L&I) from 1988 to the present, and has more than a 25-year history of developing and administering workers’ compensation health care policy and conducting outcomes research. He is a Research Professor in the Department of Environmental and Occupational Health Sciences, the Department of Medicine (Neurology), and the Department of Health Services, at the University of Washington (UW). He has served as Director or Co-Director of the NIOSH-funded ERC Occupational Health Services Research training program since its inception. Dr. Franklin is also Director of the Occupational Epidemiology and Health Outcomes Program at the UW, which is the most productive program of its kind in the U.S. This program houses and facilitates primary research as well as the secondary use of workers’ compensation data in order to improve medical care and reduce the disability related to occupational injuries and illnesses.

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Sam Austin, Health Policy Analyst, Population Health Institute, University of Wisconsin

Sam Austin leads the Evidence-Based Health Policy Project (EBHPP) at the University of Wisconsin – Madison’s Population Health Institute. The EBHPP works to connect research and expertise from the University and other sources into Wisconsin’s health policymaking process, and encourage an evidence-informed approach to policy in the state legislature. Prior to joining the Institute in 2016, Sam served for eight years as a budget analyst with the Wisconsin Legislative Fiscal Bureau, a non-partisan service agency of the state legislature. In this role, Sam was the lead analyst for state and federal health programs, including Medicaid and multiple public health programs, and staffed the state legislature’s budget-writing committee. Sam received a master’s degree in international public policy at the La Follette School of Public Affairs at UW-Madison.

Jennifer Johnson, Director, Division of Public Health Statistics and Performance Management, Florida Department of Health

Jennifer Johnson is the Director for the Florida Department of Health’s Division of Public Health Statistics and Performance Management and is responsible for the Department’s performance management and continuous quality improvement efforts. From January 2016 through May 2017, she served the Department of Health as the County Health Department Administrator for Jefferson and Madison counties, where she oversaw the provision of local public health services and initiatives. Prior to coming to the Department of Health, she served as the Health and Human Services Staff Director for the Florida Legislature’s Office of Program Policy Analysis and Government Accountability where she supervised policy research and analysis to assist legislative budget and policy deliberations. During her 16-year tenure at OPPAGA, areas of research and evaluation included state and local public health, Florida’s Medicaid program, developmental disabilities, health care regulation, long-term health care, substance abuse and mental health, and child welfare. She holds a Master of Public Health from the University of South Florida and is in the final stages of earning a doctoral degree in Public Administration.

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Using Evidence to Inform Policymaking

Opening Panel: Using Evidence to Inform Policymaking
9:00 – 10:15 a.m.

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Moderator: Jane Beyer, JD, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner

Speakers: Greg Martin, Deputy, Chief Engagement and Dissemination Officer, Patient-Centered Outcomes Research Institute (PCORI)

Pam Curtis, MS, Director, Center for Evidence-based Policy (CEbP)

Lynn Blewett, PhD, MPA, Principal Investigator, State Access Data Assistance Center (SHADAC)

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Using Evidence to Inform Policymaking

Greg Martin
Deputy, Chief Engagement and Dissemination Officer

National Academy for State Health Policy
October 23, 2017

About Us

- An independent research institute authorized by Congress in 2010 and governed by a 21-member Board of Governors representing the entire healthcare community
- Funds comparative clinical effectiveness research (CER) that engages patients and other stakeholders throughout the research process
- Seeks answers to real-world questions about what works best for patients based on their circumstances and concerns
What We Mean by…

“Patient-centeredness”
- The project aims to answer questions or examine outcomes that matter to patients within the context of patient preferences
- Research questions and outcomes should reflect what is important to patients and caregivers

“Patient and stakeholder engagement”
- Patients are partners in research, not just “subjects”
- Active and meaningful engagement between scientists, patients, and other stakeholders
- Community, patient, and caregiver involvement already in existence or a well-thought-out plan

Why Engage?

To influence research to be patient-centered, relevant, and useful
To establish trust and a sense of legitimacy in research findings
To encourage successful uptake and use of research results
Who Are Our Stakeholders?

- Patient/Consumer
- Caregiver/Family Member of Patient
- Patient/Caregiver Advocacy Org
- Hospital/Health System
- Training Institution
- Policy Maker
- Industry
- Payer

Our Engagement Rubric: A Valuable Resource

- Planning the Study: How stakeholders will participate in study planning and design
- Conducting the Study: How stakeholders will participate in the conduct of the study
- Disseminating the Study Results: How stakeholders will help communicate and disseminate study findings

Reciprocal relationships, Co-Learning, Partnership, Trust, Transparency, Honesty
Engagement Rubric: Applicability to Policy

- **Planning the Policy**
  - How stakeholders will participate in policy and program planning and design

- **Drafting the Policy**
  - How stakeholders will participate in drafting and implementing the policy or program

- **Communicating the Policy**
  - How stakeholders will help communicate the policy and program

**Reciprocal relationships**
- Co-Learning
- Partnership
- Trust
- Transparency
- Honesty

Who Are Your Stakeholders?

- Patient/Consumer
- Caregiver/Family Member of Patient
- Hospital/Health System
- Training Institution
- Policy Maker
- Payer
- Industry
- Patient/Caregiver Advocacy Org
- Clinician

Policy Community
Engagement with State Policymakers

State-University Partnership Learning Network
- AcademyHealth project to support ongoing engagement between researchers and state policymakers.

Dementia Methods Pre-Summit
- Multi-stakeholder workshop to identify how best to improve methods to strengthen dementia care research.

National Academy for State Health Policy
- Series of awards to develop tools and knowledge on state policymakers’ access to, and use of, evidence.

Engagement Case Study: Patients

National Multiple Sclerosis Society (NMSS)

1:1 Engagement
Invited to submit CER topics and questions. PCORI selected topic.

Research Prioritization

Targeted PFA
Two releases of tPFA; 12 awards totaling $65 million.

NMSS Engaged in Projects
Discontinuation of Disease Modifying Therapies: NMSS financially supporting study sites

All activities lead to better science and better health outcomes
### Engagement Case Study: Payers

**Medicaid Medical Directors Network (MMDN)**

**1:1 Engagement**
- Proactive outreach to MMDN

**Engagement Awards**
- PCORI awarded funding to support the MMDN to support topic nomination reports, dissemination report, annual MMDN meetings, “open mic” calls to discuss high priority topics

**Research Prioritization**
- Solicited MMDN application to advisory panels. MMDN participation in 11 multi-stakeholder workshops.

**Dissemination and Implementation**
- Active engagement led to high interest among MMDs in disseminating and implementing PCORI findings

*All activities lead to better science and better health outcomes*

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### Engagement Case Study: Clinicians

**American Urological Association (AUA)**

**1:1 Engagement**
- Invited to submit CER topics and questions

**Community Engagement**
- Former AUA Board member and PCORI awardee Dave Penson, MD, participated in Hill Briefing

**Dissemination and Implementation**
- AUA served as key informant on evidence updates developed by PCOR Translation Center. AUA-branded evidence update to be disseminated via AUA to their membership

*All activities lead to better science and better health outcomes*
Engagement Case Study: Purchasers

National Alliance of Healthcare Purchaser Coalitions (NAHPC)

1:1 Engagement
- Proactive outreach to thought leader within purchaser community

Community Engagement
- Actively sought advice and guidance on portfolio, purchaser engagement, dissemination and implementation
- PCORI membership in NAHPC Health Leadership Council
- Sponsorship of Mental Health and Wellbeing Summits featuring PCORI’s mental health portfolio, priming the pump for dissemination of findings

Engagement Awards
- NAHPC identifying existing and emerging PCOR/CER findings highly relevant to the purchaser community, prioritize dissemination and determine implications for purchasers and related stakeholders

All activities lead to better science and better health outcomes

Thank You

Greg Martin
Deputy, Chief Engagement and Dissemination Officer

gmartin@pcori.org
Addressing Policy CHALLENGES with Evidence & Collaboration

October 23, 2017
Pam Curtis
Center for Evidence-based Policy

What We Do

MULTI-STATE COLLABORATIVES
- Self-governing
- Pool resources
- Evidence & data to address policy questions

STATE-SPECIFIC EVIDENCE & DATA
- Evidence synthesis
- Systematic review
- Data analysis & predictive modeling

HEALTH SYSTEMS ENGINEERING
- Process design
- Stakeholder engagement
- Decision-making protocols & tools
- System design & implementation

OTHER
- Training
- Policy analysis
- Multi-sectoral coordination
- Collaboration development
Where We Work

More About the Center

- Synthesize data from multiple sources to inform policy
- Self-governing
- State-initiated
- Get the questions right
- Engagement
Multi-State Collaboratives

- Medicaid Evidence-based Decisions Project (MED)
- Drug Effectiveness Review Project (DERP)
- SMART-D
- Medical Cannabis (under construction)
State Uses

- Coverage determinations
- Management strategies
- Guidelines
- Billing/fees
- Program design
- Other

Sample Uses

- Rational utilization management
- Reduce/avoid financial burdens
- Reduce/avoid loss of benefits
- Programs that best meet needs of target population
- Increased likelihood of achieving results
Example: Sovaldi® Prior Authorization (PA)

- Before PA
  - Average 25 patients/month
  - Est. 60% unnecessary
  - Average cost: $1.6 million
- After PA
  - Average 10 patients/month
  - Necessary & appropriate treatment
  - Average cost: $670,000

Example: State Case Studies

- ALABAMA
  - Policy changes based on durable medical equipment (DME) expense analysis
  - Cost avoidance of $1 million/year
- MISSOURI
  - PA for specific CT & MRI uses
  - Savings > $9.3 million/year
- MINNESOTA
  - Development of process for high tech imaging (HTI) use
  - Stabilized use rate
State-Specific Evidence & Data

- Guided by state-specific questions & needs
- Executive or legislative
- Sample analyses:
  - Evidence synthesis
  - Systematic review
  - Data analysis & predictive modeling
  - Qualitative inquiry
Sample Uses

- Benefit-related decisions
- Coverage-related decisions
- Prioritize use of resources
- Target program impact
- Accountable & effective funding
- Transparent decision-making
- Other

Example: Oregon Health Evidence Review Commission (HERC)

- Real-time continuous glucose monitoring (CGM) recommended:
  - Adults & children with type 1 diabetes, with or without an insulin pump
  - Women with type 1 diabetes who are/plan to become pregnant in next 6 months
- Not recommended:
  - Type 2 diabetes
    - Additional evidence could change recommendation
Example: New York Evidence Based Benefit Review Advisory Committee (EBBRAC)

- Digital Breast Tomosynthesis
  - EBBRAC recommended coverage for screening & diagnosis
  - Department accepted screening, no coverage for diagnosis
- Allergy testing
  - Expanded coverage to included blood allergy testing & oral injection challenge
Health Systems Engineering

- State-specific
- Process design
- Stakeholder engagement
- Decision-making protocols & tools
- System design & implementation
- Technical assistance & consultation

Example: Washington Health Technology Assessment (HTA)

- Assess alignment with statutory & administrative requirements
- Explore public input & program transparency
- Results
  - Five-step process & timeline
  - Process improvements & clarity
  - Increased stakeholder communication
  - Increased public engagement
Example: Texas Health & Human Services Commission

Example: Oregon Foster Care
Example: Oregon Foster Care

All children born in Oregon 2001 – 2010 who entered foster care before age four.

Share of Births Covered by Medicaid (by Mother's Age and Educational Attainment)
### Example: Oregon Foster Care

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Intervention Cost (per child)</td>
<td>$5,000</td>
</tr>
<tr>
<td>Potential Savings (per child)</td>
<td>$100,000</td>
</tr>
<tr>
<td><strong>Expected Effect</strong></td>
<td></td>
</tr>
<tr>
<td>Target population</td>
<td>SNAP+ Teen + Less than High School + Substance Abuse</td>
</tr>
<tr>
<td>How many will be maltreated and enter foster care?</td>
<td>23% 36</td>
</tr>
<tr>
<td>How many could you prevent?</td>
<td>25% 9</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td>$785,000</td>
</tr>
<tr>
<td><strong>Total Savings</strong></td>
<td>$900,000</td>
</tr>
<tr>
<td>Savings-Cost Ratio</td>
<td>1.15</td>
</tr>
</tbody>
</table>

### Other Work
Example: Colorado Multi-Payer Collaborative (MPC)

A shared commitment to increased quality, improved efficiency, higher value, and continuous improvement and diffusion of innovative and successful strategies through increased system accountability, improved health outcomes and experiences for patients and providers, and decreased total cost of care.

- Payment reform & practice transformation
  - Comprehensive Primary Care (CPC) initiative
  - CPC+
  - State Innovation Model (SIM) (behavioral health integration)
- Quality metric alignment
- Data aggregation
Framework for Integration of Whole Person Care


- Clinic
  - Engaged Leadership
  - Supportive of Integration & Change
  - Data-driven Improvement
  - Team-based Care

- Population
  - Empanelment
  - Population Management
  - Community of Care linked to BH & Social Supports

- Practice Functions
  - Population
  - Person

Lessons for States

WHO IS ASKING?
- Self-governing
- State-initiated

WHY ARE YOU ASKING?
- Purpose of question
- Application of answer

WHAT ARE YOU DECIDING?
- Clear questions

WHEN DO YOU NEED ANSWERS?
- Timeline vs. threshold

WHERE TO GET ANSWERS?
- Synthesize data from multiple sources

HOW TO IMPLEMENT?
- Encourage use of evidence
- Process to decide
- Mechanisms for implementation
Pam Curtis, MA
Director
Center for Evidence-based Policy
Oregon Health & Science University
curtispa@ohsu.edu
USING EVIDENCE TO INFORM POLICY MAKING

Lynn A. Blewett, PhD
State Health Access Data Assistance Center
University Of Minnesota, School Of Public Health

INFORMING HEALTH POLICY STARTS WITH:

- The right data
- Getting to the right people
- At the right time

WHAT WE DO

- Conduct health policy research and evaluation
- Translate research
- Leverage federal and state data resources to inform policy
- Support states implementing the ACA and payment/delivery system reform
- Train researchers & policy analysts

RESEARCH AREAS

- Health Insurance
- Access to Care
- Medicaid
- Behavioral Health
- Health Disparities/Safety Net Financing
- Payment and Delivery System Reform
- Monitor & Evaluation of the ACA
STATE DATA TO INFORM POLICY

Accessible On-Line Data Resource

STATE HEALTH COMPARE

Use State Health Compare to create customized reports for state-level health estimates

Data Highlight

Since 2000, U.S. sales of the opioid painkiller oxycodone tripled. In six states—KS, NY, OK, TN, UT, WY—they have grown more than 5 times.
State Health Compare has 50 indicators on a broad range of health topics:

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<td>Coverage Type</td>
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<td>Workers in Establishments that Other Coverage</td>
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<td>People with High Medical Care Cost Burden</td>
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<td>Average Annual ESI Premium</td>
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<td>Employee Contributions to Premiums</td>
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<td>High-Deductible Plans</td>
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<td>Medicaid Expenses as Percent of State Budget</td>
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<td>Costs of Potentially Preventable Hospitalizations</td>
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<td>Adult Binge Drinking</td>
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<td>Adult Obesity</td>
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<td>Adult Smoking</td>
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<td>High School Obesity</td>
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<tr>
<td>High School Smoking</td>
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<td>High School Physical Activity</td>
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<td>Opioid-Related Drug Poisoning Deaths</td>
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<tr>
<td>Sales of Opioid Painkillers</td>
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<table>
<thead>
<tr>
<th>Utilization of Care</th>
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<tbody>
<tr>
<td>Had General Doctor or Provider Visit</td>
</tr>
<tr>
<td>Had Emergency Department Visit</td>
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<tr>
<td>Spent the Night in a Hospital</td>
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<td>Adult Cancer Screenings</td>
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<tr>
<td>Adult Potentially Preventable Hospitalizations</td>
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<td>Child Potentially Preventable Hospitalizations</td>
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<td>Child Vaccinations</td>
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<tr>
<th>Public Health</th>
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<tbody>
<tr>
<td>Weight Assessment in Schools</td>
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<tr>
<td>School Nutrition Standards Stronger than USDA</td>
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<tr>
<td>Schools Required to Provide Physical Activity</td>
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<tr>
<td>Smoke Free Campuses</td>
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<tr>
<td>Cigarette Tax Rates</td>
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<td>Public Health Funding</td>
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<tr>
<th>Social and Economic Factors</th>
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<tr>
<td>Adult Educational Attainment</td>
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<tr>
<td>Children Considered to be Poor</td>
</tr>
<tr>
<td>Income Inequality</td>
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<tr>
<td>Unemployment Rate</td>
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</tbody>
</table>

Data sources: the American Community Survey (ACS), the Current Population Survey (CPS), the Behavioral Risk Factor Surveillance System (BRFSS), the National Health Interview Survey (NHIS), the Healthcare Cost and Utilization Project (HCUP), the Medical Expenditure Panel Survey - Insurance Component (MEPS-IC), and other sources.

Prescription opioid painkiller sales in kilograms per 100,000 people, oxycodone and hydrocodone

<table>
<thead>
<tr>
<th>State: 3 Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxycodone / Hydrocodone: Oxycodone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Data Type: Rate per 100,000</th>
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<tbody>
<tr>
<td>2000 to 2016</td>
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</table>

Graph showing prescription opioid painkiller sales in kilograms per 100,000 people for oxycodone and hydrocodone.
Deep Dive on Opioid-Related Deaths

The Opioid Epidemic: National Trends in Opioid-Related Overdose Deaths from 2000 to 2015

Deep Dive on Opioid-Related Deaths

DATA AND METHODS TO INFORM AND EVALUATE PAYMENT AND DELIVERY SYSTEM REFORM
Data Sources and Methods to Assess Delivery System and Payment Reform

Case studies
In-depth review of advanced payment models for MACPAC; Study of care coordination costs associated with Minnesota Health Care Home for state of Minnesota

Qualitative, semi-structured interviews
Evaluation of the State Innovation Model (SIM) in Minnesota, interviews with SIM organizations about accomplishments, outcomes, and sustainability

Claims data analysis
Use of Minnesota’s All-Payer Claims Database (APCD) to assess the impact of Minnesota’s Medicaid ACO/Integrated Health Partnerships (IHPs) on Total Cost of Care and Quality Outcomes

Surveys
Designed surveys to assess provider and user perceptions of Accountable Communities for Health (ACHs) and e-health interventions under the State Innovation Model (SIM)

State evaluation of MN State Innovation Model – Medicaid ACO using All-Payer Claims Database (APCD) Data

- Trend and difference-in-difference analysis comparing participating and non-participating clinics
- Study Timeframe: 2012-2014
- Key Outcomes
  - Utilization: Primary care, specialist, ED, hospitalizations
  - Total Cost of Care: Standardized based on reported costs
  - Quality: Five optimal care rates used by IHP program

APCD Data on Patients, Diagnosis, Utilization, Costs
Linked with Clinic Data on Quality Indicators
Replicating Medicaid Clinic Attribution Methodology
SHADAC Health Information Exchange User Survey

**Purpose:** To assess impacts of Health Information Exchange (HIE) on:
- Provider workload
- Patient workflow
- Data Privacy and Security
- Services delivery

**Timeframe:** May 2017

**Key Domains:**
- Current use of HIE
- Impact on care quality and providers’ work
- Provider satisfaction with HIE

---

EVIDENCE TO ASSESS IMPACT OF THE AFFORDABLE CARE ACT (ACA) IN KENTUCKY
Impact of the ACA in Kentucky

5 domains of health and healthcare
- Coverage
- Access
- Cost
- Quality
- Health Outcomes

Use of Multiple Data Sources to tell a Comprehensive Story

Mixed-methods study
- **Quantitative:** Federal surveys, state administrative data, Kentucky Health Reform Survey
- **Qualitative:** Focus groups with Medicaid beneficiaries and key actor interviews (*third year not funded*)

Impact of the ACA on Uninsurance: US, KY

*Statistically significant change at 95% level.*

Source: SHADAC analysis of American Community Survey
Products based on multiple data sources

**Medicaid Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C Screening</td>
<td>6,159</td>
<td>7,039</td>
<td>44,065</td>
</tr>
<tr>
<td>Neonatal Births</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Preventive Dental Services</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>3,000</td>
<td>3,000</td>
<td>3,000</td>
</tr>
</tbody>
</table>

Breakout of Substance Use Treatment

**Traditional Income-Based Medicaid Expansion**

<table>
<thead>
<tr>
<th>Race</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Black</td>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
</tr>
<tr>
<td>Other</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

**Disparities in Coverage between Blacks and Whites Eliminated**

**Kentucky Uninsurance Rates by Race/ethnicity**

<table>
<thead>
<tr>
<th>Race/ethnicity</th>
<th>2012</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>13.6%</td>
<td>6.1%*</td>
</tr>
<tr>
<td>White</td>
<td>12.6%</td>
<td>5.3%*</td>
</tr>
<tr>
<td>Black</td>
<td>17.3%</td>
<td>5.5%*</td>
</tr>
<tr>
<td>Asian</td>
<td>16.9%</td>
<td>12.5%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>28.7%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Multiple/other</td>
<td>15.5%</td>
<td>8.2%*</td>
</tr>
</tbody>
</table>

*Statistically significant change at 95% level.

Source: SHADAC analysis of American Community Survey

**Figure 2: Emergency Department Visits in the Past Year by Coverage Type, 2012-2015 (non-elderly Kentuckians)**

**Figure 4: Main Reason to Visit the Emergency Department, 2016 (non-elderly adults)**
LESSONS LEARNED

Goals and messaging

• Balance-controlling message and allowing for independent voice – watch out for the politics and set expectations up front
• Sometimes easier for contractor to convey difficult message, must be grounded in rigorous findings

Communication

• Meet regularly with partners
• Advisory committees for key stakeholders, data holders

Planning—this work takes TIME

• Build in time for back and forth on draft products
• Time for data access – IRB, DUAs, Data Aggregation, Data Releases
Optimal Dissemination

• Use of Multiple formats
  • Some comprehensive in-depth analysis, some higher level overview of key themes
    • Issue Briefs
    • Data Snapshots
    • Full Reports
    • Chart Books
    • Infographics
    • Blogs

• BUT…keep same “look and feel”

• Leverage in-house and partner organization’s communication infrastructure
  • Coordinate a dissemination schedule
  • Roll out pieces over time

• Use Social Media platforms!

Lynn A. Blewett, PhD
Division of Health Policy and Management
University of Minnesota, School of Public Health
blewe001@umn.edu
www.shadac.org
612.624.48032
@lynnblewett
@shadac
Using Evidence to Inform Policymaking

Introduction to Evidence-Informed Health Policy Workshop

Part I: 10:30 – 11:50 a.m.
Part I of this workshop will include 1) “What is evidence-informed health policy and why does it matter?” and 2) Evidence Basics, - or “Why are some studies better than others?”

Part II: 12:10 – 1:30 p.m.
Part II of this workshop will include: 1) “How is evidence summarized, graded, and applied to policy-making?”; 2) How to effectively communicate about evidence with legislators; and 3) Interactive case studies allowing for hands-on work reviewing evidence and discussing policy implications for one of the following topics: the effects of insurance coverage on health or the merits of different health system delivery reform models.

Moderator: Pam Curtis, Director, Center for Evidence-based Policy (CEbP)
Speaker: Adam Obley, MD, Clinical Epidemiologist, CEbP

This meeting is supported through a Patient-Centered Outcomes Research Institute Conference Award (EA-5895-CHPD).
Using Evidence to Inform Policymaking

State Models for Evidence-informed Policymaking
1:45–3:00 p.m.

This panel will use a moderated Q&A format to give participants an understanding of the range of approaches states have taken to support evidence-informed policymaking. Speakers will demonstrate a variety of models (e.g. legislatively-mandated ones versus more informal approaches) and will also explore how these states involve patients and the public in evidence-informed policymaking.

Moderator: **Gabriel Kaplan**, PhD, MPA, Chief, Health Promotion and Chronic Disease Prevention Branch, Colorado Department of Public Health & Environment

Speakers: **Darren Coffman**, Director, Oregon Health Evidence Review Commission (HERC)

**Gary Franklin**, MD, Co-Director, Washington Agency Medical Directors Group

**Ellie Garrett**, JD, Minnesota Health Services Advisory Council

**Sam Austin**, Wisconsin Evidence-based Health Policy Project

*This session will not have presentation slides.*
Using Evidence to Inform Policymaking

New and Emerging Evidence
3:00–3:45 p.m.

This session will share recent and upcoming findings from PCORI as well as key findings from recent, vetted systematic reviews which may be of interest to policymakers. A speaker from PCORI will discuss emerging evidence from PCORI’s research portfolio on topics such as Community Health Worker effectiveness. Speakers from HERC and CEbP will share findings from recent systematic reviews of treatment options for low back pain, obesity management strategies, best practices for smoking cessation in pregnancy, and the effectiveness of home versus long-term care settings.

Moderator: Jennifer Johnson, MPH, Director, Division of Public Health Statistics and Performance Management, Florida Department of Health

Speakers: Greg Martin, Deputy, Chief Engagement and Dissemination Officer, Patient-Centered Outcomes Research Institute (PCORI)
Darren Coffman, Director, Health Evidence Review Commission (HERC)
Adam Obley, MD, Clinical Epidemiologist, Center for Evidence-based Policy (CEbP)
New and Emerging Evidence

Greg Martin
Deputy, Chief Engagement and Dissemination Officer
National Academy for State Health Policy
October 23, 2017

Lots on the way:
1) Uterine Fibroids
2) Contralateral Prophylactic Mastectomy and Breast Cancer
3) Using Technology to Deliver Multi-Disciplinary Care to Individuals with Parkinson Disease in Their Homes
4) Group Exercise to Prevent Walking Difficulty in At-Risk Older Adults
5) Depression Care among Low-Income Patients
6) Preventing Venous Thromboembolism
7) Shared Decision Making in the Emergency Department: Chest Pain Choice
8) Glucose Monitoring in Non-Insulin Treated Diabetes
9) Improving Childhood Obesity Outcomes
10) Peritoneal Dialysis or Hemodialysis for Kidney Failure
11) Reducing Health Disparities in Appalachians with Multiple Cardiovascular Disease Risk Factors
## New and Emerging Evidence

| 12 | Treating Peripheral Arterial Disease |
| 13 | Treatment Choices among Minorities with Lupus |
| 14 | **Intravenous vs. Oral Antibiotic Therapy for Serious Bacterial Infections** |
| 15 | Hospital-PCMH Collaboration within an ACO to Improve Care Transitions |
| 16 | Community Health Worker/Mobile Chronic Care Team Strategy |
| 17 | Transitional Care for Individuals with Serious Mental Illness |
| 18 | Corticosteroids versus Anti-TNF Alpha Therapy for Inflammatory Bowel Disease |
| 19 | Broad vs. Narrow Spectrum Antibiotics for Acute Respiratory Tract Infections in Children |
| 20 | Decision-Support Tool for Adult Consumers with Mental Health Needs and their Care Managers |
| 21 | Navigation for Disadvantaged Women with Depression |
| 22 | Self-Care Management of Cancer Symptoms |
| 23 | Surveillance Imaging Modalities in Breast Cancer Survivors |

## New and Emerging Evidence

| 24 | Literacy-Adapted Psychosocial Treatments for Chronic Pain |
| 25 | Supplemental Oxygen for Pulmonary Fibrosis |
| 26 | Shared Decision Making in Parents of Children with Head Trauma: Head CT Choice |
| 27 | Developmental Trajectories of Children with Cerebral Palsy |
| 28 | Patient-Defined Treatment Success and Preferences in Stage IV Lung Cancer Patients |
| 29 | Chronic Kidney Disease in Zuni Indians |
| 30 | Use of a Web-Portal by Patients with Complex Chronic Conditions |
| 31 | Optimal Patient-Centered Care for US Trauma Care Systems |
| 32 | Promoting Informed Decisions about Lung Cancer Screening |
| 33 | Decision Aid for Therapeutic Options in Sickle Cell Disease |
| 34 | Telehealth Self-Management Program in Older Adults Living with Heart Failure in Health Disparity Communities |
| 35 | Ovarian Cancer Patient-Centered Decision Aid |
New and Emerging Evidence

36) Smoking Cessation Versus Long-Term Nicotine Replacement among High-Risk Smokers
37) A Comparison of Non-Surgical Treatment Methods for Patients with Lumbar Spinal Stenosis
38) Risk Stratification for Improving Primary Care for Back Pain
39) Addressing HIV Treatment Disparities Using a Self-Management Program and Interactive Personal Health Record
40) A Toolbox Approach to Obesity Treatment in Primary Care
41) Mobile Application for Improving Symptoms and Adherence to Oral Chemotherapy in Patients with Cancer
42) Shared Decision-Making Tool for Stent Selection in PCI
43) Navigator Guided e-Psychoeducational Intervention for Prostate Cancer Patients and Their Caregivers
44) Peer-Facilitated Support Group and Cognitive Behavioral Therapy for Hoarding Disorder

Martin
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE

New and Emerging Evidence

45) Long Term Outcomes of Lumbar Epidural Steroid Injections for Spinal Stenosis
46) Decision Making in Localized Prostate Cancer
47) Health Plan Initiative to Mitigate Chronic Opioid Therapy Risks
48) Burnout in Mental Health Care
49) Integrated Care and Patient Navigators for Latinos with Serious Mental Illness
50) Increasing CRC Screening Among Hispanic Primary Care Patients
51) Comparing Effectiveness of Treating Depression With and Without Comorbidity to Improve Fetal Health
52) Community Engagement to Address Depression Outcomes Disparities
53) Advance Care Planning for Perioperative Cancer Patients and Families
54) Behavioral Health Homes for Adults with Serious Mental Illness
55) Decision Aid for Ventricular Assist Device Placement
56) Improving QOL in Latina Breast Cancer Survivors and Their Caregivers

Martin
PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE
Content and Resources Arranged by Topic

Fact Sheets Highlight Activities and Portfolios
Results of PCORI-funded Studies in Peer-reviewed Publications

- At least **60** articles have appeared in leading journals with results from PCORI-funded studies.
- Full text accessible for FREE as part of PCORI’s efforts to make results widely available.

### Featured Articles on Prostate Cancer

- New Evidence on Prostate Cancer Treatment Options
- Findings on Treatment Options for Prostate Cancer

### Journal articles resulting from PCORI-funded research projects

<table>
<thead>
<tr>
<th>Year</th>
<th>Articles</th>
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</thead>
<tbody>
<tr>
<td>FY2014</td>
<td>56</td>
</tr>
<tr>
<td>FY2015</td>
<td>205</td>
</tr>
<tr>
<td>FY2016</td>
<td>190</td>
</tr>
</tbody>
</table>

As of May 2017

Public Reporting of Study Results

- PCORI release of findings
- Peer-reviewed publications that present results of PCORI-funded studies
- Initiatives to promote public access to peer-reviewed literature
- Reporting of results back to study participants
PCORI Public Release of Findings

- Results posted to pcori.org
- Results to be posted within next 90 days
- Results to be posted within next year

Engagement Case Study: Clinicians

American Urological Association

1:1 Engagement

- Invited to submit CER topics and questions
- PCORI funded two projects around prostate cancer decisions

Community Engagement

- Former AUA Board member and PCORI awardee Dave Penson, MD, participated in Hill Briefing

Dissemination and Implementation

- AUA served as key informant on evidence updates developed by PCOR Translation Center.
- AUA-branded evidence update to be disseminated via AUA to their membership

All activities lead to better science and better health outcomes
• Activities to disseminate results from PCORI-funded research on Current Treatments for Localized Prostate Cancer and Symptom-Related Quality of Life include:
  ▪ Evidence Updates for Clinicians and Patients
  ▪ Continuing Medical Education/Continuing Education

Resources for Putting Evidence to Use

Evidence for Decisions

Putting Evidence to Work

In the past, it often took years for new evidence from clinical research to influence health care. And many times, these findings have failed to reach patients and families who could benefit from the information. Disseminating and promoting the uptake of research findings is part of PCORI’s legal mandate to improve the quality and relevance of evidence available to help patients, caregivers, clinicians, employers, insurers, and policymakers make better-informed health decisions.

PCORI’s dissemination activities begin with the translation of all research findings into understandable summaries for posting on our website with the help of the PCORI Translation Center.

Patient version  Clinician version
Treatment of Osteomyelitis in Children

DECISIONAL DILEMMA

- Should we use a catheter for intravenous antibiotics through a PICC line, or should we use oral antibiotics?
  - Children who have been hospitalized for a severe infection (osteomyelitis or complicated pneumonia) require weeks of antibiotic therapy after discharge from the hospital.
  - Antibiotics can be administered at home either orally or intravenously through a peripherally inserted central catheter (PICC).
  - Catheters carry a risk for serious complications in children, but limited evidence exists on the effectiveness of oral therapy.

MAIN PCORI STUDY FINDING

"Given the magnitude and seriousness of PICC complications, clinicians should reconsider the practice of treating otherwise healthy children with acute osteomyelitis, [and] complicated pneumonia...with prolonged intravenous antibiotics after hospital discharge when an equally effective oral alternative exists."

Community Health Workers

- **56 studies** in PCORI’s portfolio involve Community Health Workers (CHW)
  - CHWs are the primary focus of the research in 46 of the studies

![Bar chart showing the distribution of Community Health Workers (CHWs) in various settings: Remote, Home, Clinic, Community, Hospitals.]

---

PCORI Response to the Opioid Crisis

- As of September 2017, PCORI has awarded **$62 MILLION TO FUND 11 CER studies related to opioid use.** These projects will involve **≈11,000 STUDY PARTICIPANTS.**

- **Research on opioid use and pain management is an ongoing priority for PCORI.**

- Applications due Wednesday on delivery of Medication Assisted Treatment (MAT) for pregnant women with substance use disorders.
Opioid Studies Across the Care Continuum

Prevention
3 studies look at preventing inappropriate opioid use from the start, including testing how various tools, strategies, and policies can improve prescribing practices.

Early-Stage and Chronic Use
6 studies, including one large study of veterans, examine ways to decrease inappropriate opioid use and taper long-term use.

Dependence
2 studies evaluate ways to reduce harm among dependent patients. Interventions test medication assisted therapy and non-medication treatments.

Self-Monitoring of Blood Glucose

Effect of Glucose Monitoring on Patient and Provider Outcomes in Non-Insulin Treated Diabetes
This study compared 3 approaches of SMBG in patients with non-insulin-dependent Type 2 diabetes for effects on hemoglobin A1c levels and health-related quality of life at 1 year of follow-up. They found that self-monitoring achieves no significant differences in disease control, hospitalization rates, need to start using insulin, or quality of life — results that augment findings of previous research.

Results of PCORI-Funded Research:
For many with Type 2 diabetes, daily finger stick offers little value.


"Our study results have the potential to transform current clinical practice for patients and their providers by placing a spotlight on the perennial question, ‘to test or not to test?’"

—Dr. Katrina Donahue, Study Investigator

Med.unc.edu Article
**Antipsychotic Use in Foster Children**

- For children diagnosed with DICD and/or ADHD, SGAs probably improve symptoms for which they are usually prescribed, such as aggression and disruptive behavior, but global clinical impressions of the severity of the disorders may not improve. SGAs may also cause adverse effects including weight gain, high triglyceride levels, extrapyramidal symptoms, sedation, and somnolence.

  *(We need a better, clearer way to say this.)*

- PCORI will engage multiple stakeholder audiences—including representatives of the state policy community—to help us
  - Use natural language to communicate the evidence;
  - Develop evidence updates to disseminate the findings; and,
  - Disseminate the evidence updates to right people.

- **STAY TUNED!**

---

**Thank You**

**Greg Martin**  
Deputy, Chief Engagement and Dissemination Officer

gmartin@pcori.org
Management of Obesity

- Prioritized List biennial review topic including:
  - Coverage Guidance on Metabolic & Bariatric Surgery
  - Evidence Review of Pharmacotherapy
  - Evidence Review of Devices
  - Evidence Review of Behavioral Interventions
  - Multisector Interventions Report
- Data project to evaluate utilization and outcomes of bariatric surgery in Oregon Medicaid
Management of Obesity: Context

- Original implementation of bariatric surgery coverage in 2008 covered only people with type 2 diabetes and BMI ≥ 35
- Plan concerns:
  - Cost of expanding coverage
  - Will it be effective in Medicaid population
  - Duration of effect
- Provider concerns
  - This is the only highly effective intervention for obesity

Data/Evidence Results

- Fewer surgeries than might be expected (partly due to supply constraints driven by rates)
- Bariatric surgery effective in a broader population (other comorbidities; BMI ≥ 40)
- Most effective in accredited centers
- Devices/drugs not effective or harms outweigh benefits
- Behavioral interventions effective — intensive is better than non-intensive
Multisector Interventions for Obesity

- CEbP summarized 16 systematic reviews conducted within last 4 years
- 10 member task force reviewed (public health, primary care focus)
- Most studies reported on impact on physical activity and improved nutrition instead of BMI
- Examples of interventions with limited evidence of effectiveness
  - School-based aimed at reducing BMI, esp. with phys. activity focus
  - Family-based group education programs delivered in schools
  - Environmental (e.g., social marketing, cafeteria signs, farmers markets)
  - Community-based (group) & workplace health education
  - Introduction of light rail
  - Sugar sweetened beverage taxes
- Examples of interventions with insufficient evidence of effectiveness
  - Change in WIC policy to allow purchase of food from farmer’s market
  - Financial incentives to change health habits

Management of Obesity: Evidence to Implementation

- Issues were different for each type of intervention:
  - Drugs and devices already noncovered (status quo)
  - Work with actuaries and budget regarding costs of surgery
  - With behavioral services, lack of payment pathways, system support is key barrier
  - Multisector interventions best implemented locally by plans. Difficult to pay for due to Medicaid rules. Some require law change.
Corticosteroid Injections for Low Back Pain

- Coverage guidance process
- Noncoverage began earlier, because of weak evidence and costs associated with imaging needed to determine appropriateness
- Focus on epidural steroid injections for low back pain with radiculopathy
  - No difference in short-term or long-term function
  - Short-term but not long-term reduction in need for surgery
  - Immediate-term benefit in pain did not reach predefined thresholds of a minimum clinically important difference
  - Harms are rare, more costly than alternatives

Coffman

Corticosteroid Injections for Low Back Pain

- Strong advocacy from local providers and national associations
- Arguments about surgical technique, narrowing the study population, observational trials
- Passionate testimony from people who had received these created challenge for subcommittee, resulted in delays
- Difficult decision for subcommittee due to anecdotal testimony, limited other treatment options, opioid use epidemic
- Decision: continued noncoverage
Other Recent Evidence Reviews

• Continuous glucose monitoring in diabetes mellitus (expanded eligible population)
• Breast cancer screening in above-average risk women (expanded screening technologies for this group)
• 3D mammography for breast cancer screening in average risk women (continue noncoverage)
• Timing of long-acting reversible contraceptives (endorsed previously covered service; helped break payer, provider implementation barriers)

Other Recent Evidence Reviews

• Proton beam therapy (added some indications, removed others)
  o Allowances for rare diseases, childhood cancers
• Multisector interventions for tobacco cessation
  o Identified interventions supported by evidence (behavioral interventions, financial incentives, high-feedback ultrasound)
  o Not supported (electronic cigarettes, counseling on secondhand smoke)
• Planned out-of-hospital birth
  o Identified contraindications for PA process
For more information

www.oregon.gov/OHA/HPA/CSI-HERC


New and Emerging Evidence

Adam Obley, MD
Center for Evidence-based Policy, OHSU
October 23, 2017

Non-pharmacologic treatments for low back pain

- High quality systematic review of 114 systematic reviews and randomized control trials covering the following treatments for chronic low back pain
  - Exercise
  - Yoga
  - Tai chi
  - Mindfulness-based stress reduction
  - Psychological therapy
  - Multidisciplinary rehabilitation
  - Acupuncture
  - Massage
  - Spinal manipulation

Non-pharmacologic treatments for low back pain

- Overall, there was low to moderate quality evidence that non-pharmacologic approaches to low back pain result in small to moderate size short-term improvements in pain
  - Exercise, tai chi, yoga, MBSR, CBT, multidisciplinary rehab, acupuncture and spinal manipulation
  - Functional outcomes were more mixed, but many therapies showed small to moderate size short-term improvements


Uncertainties

- Little information on combination therapies
- Most outcomes were short-term
- Most of the results don’t apply to low back pain with radiculopathy (which is common)
- Optimal provider types and settings are not well established
- Comparisons to sham procedures were more likely to show no effect, suggesting the presence of placebo effects
Implications

• Multi-modality approaches to managing chronic low back pain are an essential tool in addressing the opioid epidemic
• Payer policies (including public payers) are starting to include a broad array of non-pharmacologic treatments

Smoking cessation in pregnancy

• Oregon HERC multisector coverage guidance approved in August 2016
• Examined a mix of systematic reviews and randomized control trials covering:
  • Nicotine replacement
  • Behavioral interventions
  • Financial incentives
  • Programs to reduce secondhand smoke exposure
  • Smoke free legislation
  • Tobacco excise taxes
Smoking cessation in pregnancy

• Behavioral interventions and financial incentives appeared to be most effective in promoting cessation during pregnancy
• Smoke free legislation and tobacco excises taxes were associated with fewer adverse perinatal outcomes in observational and modeling studies

Uncertainties

• Most of the trial evidence found positive results for cessation during pregnancy, but perinatal outcomes and long-term smoking cessation was less certain
  • Behavioral interventions were associated with modest reductions in pregnancy complications and low birth weight
• Structure of financial incentives varied
Implications

• HERC recommended coverage for:
  • Behavioral interventions
  • Financial incentives

• HERC stated that evidence supports:
  • Smoke free legislation
  • Increased tobacco excise taxes

Home vs Institutional Long-term Care

• Cochrane systematic review of 10 studies comparing home or foster home care to institutional long-term care for functionally dependent older adults

Home vs Institutional Long-term Care

- Insufficient high quality data to draw any conclusions about the merits of a particular model of care
- Community-based care may be associated with improved quality of life and physical function
- But, community-based care might also be associated with a greater risk of hospitalization


Uncertainties

- Only one older study was done as a randomized trial
- Inconsistent data reporting in the primary studies
- Four of the studies were conducted outside the US
- Variability in the types of home care provided
- Complex interventions in a diverse group of patients
Implications

- The evidence leaves a great deal of uncertainty about the merits of different models of care
- More and better quality studies are needed and should include a broader range of outcomes including health care costs and assessments of caregiver burden
Using Evidence to Inform Policymaking

Monday, October 23, 2017

RESOURCES

This meeting is supported through a Patient-Centered Outcomes Research Institute Conference Award (EA-5895-CHPD).
NASHP Resources


This brief and the accompanying resources provide states with actionable information on evidence-based policymaking including why states should work with evidence, key considerations for developing an evidence-based policymaking process, and strategies for engaging patients and consumers in this work. The information in this brief is based on findings from a 20-month learning collaborative in which NASHP convened multiple agency teams from Alabama, Colorado, and Massachusetts. The learning collaborative focused on developing processes for evidence-based health policymaking with a specific focus on patient-centered outcomes research (PCOR) and comparative effectiveness research (CER).


With support from the Patient-Centered Outcomes Research Institute (PCORI), NASHP created this guide to support the use of various types of research in state policymaking. The purpose of this Roadmap is to guide policymakers in the use of CER and PCOR as well as other research to support the decision-making process. Information for the Roadmap was obtained from several sources, including a national survey of 494 state health policymakers and a series of interviews with a variety of state policymakers including Medicaid, public health, worker’s compensation directors, state employee health benefits directors and others.


This report supplies key background information on CER and PCOR and provides examples of current programs used by state policymakers to support the generation, synthesis, analysis, and implementation of this research in policy decision-making.

This meeting is supported through a Patient-Centered Outcomes Research Institute Conference Award (EA-5895-CHPD).
Additional Resources

1. Center for Evidence-based Policy (CEbP) Key Questions to Assess the Evidence

2. Washington State Agency Medical Directors Group Evidence-based Policy Slide Deck

3. Wisconsin Evidence-based Health Policy Project Factsheet

4. Minnesota Health Services Advisory Council Factsheet

5. Oregon Health Evidence Review Commission (HERC) Resources
Evidence-informed Health Policy

Key Questions to Assess the Evidence

1. What is the quality of the evidence? Was it a case study, randomized controlled trial, or systematic review?

2. Who produced the evidence? Are there conflicts of interest?

3. Do other studies support your position, or are there different results?

4. Who are the other stakeholders on this issue (e.g., providers, consumers, payers, governmental agencies), and would they agree with your interpretation of this study?
For More Information

Adam Obley, MD
Clinical Epidemiologist
Center for Evidence-based Policy
Oregon Health & Science University
obley@ohsu.edu

Pam Curtis, MS
Director
Center for Evidence-based Policy
Oregon Health & Science University
curtispa@ohsu.edu
Evidence-based policy in WA state
NASHP PCOR/CER Learning Collaborative
Sept 22, 2017

• Gary M Franklin, MD, MPH
  Medical Director, WA Dept Labor and Industries
• Dan Lessler, MD, MHA
  Chief Medical Officer, WA Health Care Authority

Co-Chairs, WA Agency Medical Directors Group (AMDG)

WA State Authority for Evidence-Based Decisions

2003-SSB 6088—Established the Prescription Drug Program for all agencies—uses evidence within drug classes to determine preferred drug list
2003-SHB 1299—all agencies to conduct formal assessment of scientific evidence to inform coverage, track outcomes—AMDG authority
2005-Budget proviso—Agencies to collaborate on coverage and criteria (guidelines)—off-label neurontin done 08/2005
2006-Gov request legislation—HB2575/SB6306 to establish WA State Health Technology Assessment Program
2011-ESHB 1311—Public/private collaborative on implementation of evidence-based policies—Bree Collaborative
Agency Medical Directors Group Website

Agency Medical Directors Group:
Participating Agencies

Medical and Health Policy Leaders from:

- Department of Corrections
- Department of Health
- Department of Human and Health Services
- Department of Labor and Industries
- Governor’s office
- Health Care Authority-Medicaid, Public Employees Benefits
- Office of the Insurance Commissioner
### Federal Oversight

<table>
<thead>
<tr>
<th>Required for FDA approval</th>
<th>Drugs</th>
<th>Medical Devices</th>
<th>Surgical Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 prospective, placebo controlled RCTs</td>
<td>“Substantial equivalence” to preexisting device</td>
<td>No approval requirements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Study outcomes</th>
<th>Disease-related endpoints</th>
<th>Engineering performance only</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Published studies with patient-oriented endpoints?</th>
<th>Common</th>
<th>Uncommon</th>
<th>Not Considered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Patient population</th>
<th>Narrowly defined set of conditions (e.g., depression, dementia)</th>
<th>Varies widely (e.g., implantable defibrillators, laparoscopes)</th>
<th>Not Considered</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Post-marketing evaluation?</th>
<th>Sporadic, sometimes high quality</th>
<th>Rare, usually low quality</th>
<th>None</th>
</tr>
</thead>
</table>

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**AMDG Participation in Statewide Evidence-based Medicine Efforts**

- Washington State Prescription Drug Program
- Washington State Health Technology Assessment Program
- Bree Collaborative-Health Care Authority implementation lead
AMDG outputs

• Produce, implement and disseminate evidence-based policies
    • >44,000 hits on AMDG website since Jan, 2016
  --Health technology assessment dossiers
• Convening function
  – RWJ funded task group on technology assessment-
    Ramsey et al, Am J Manag Care 1998; 4: SP188-199
  – AHRQ funded EBM conference for state health policy
    makers-2004-directly led to HB 2575 (2006)
  – Hepatitis C treatment policy
  – WA State Drug Price and Purchasing Prescription
    Summit – June 2016
  – Proposal: State-of-the-art conference on health care
    coordination/collaborative care

Evidence-Based Decision Making for Health Policy Leaders
A Workshop for Washington State Policymakers

Sheraton Tacoma
Tacoma, Washington
December 6-7, 2004

Narrative Agenda

Session 1: Welcome, Workshop Overview and Participant Introductions

Time and Date: Monday, December 6, 2004, 8:30 a.m. – 9:15 a.m.
Franklin et al. *A Comprehensive Approach to Address the Prescription Opioid Epidemic in Washington State: Milestones and Lessons Learned*
American Journal Public Health 2015; 105: 463-69

Unintentional Prescription Opioid Overdose Deaths 1995-2014

37% sustained decline

Source: Washington State Department of Health, Death Certificates

*Does not include heroin or illicit only deaths
# Interagency Guideline on Prescribing Opioids for Pain

Developed by the Washington State Agency Medical Directors’ Group (AMDG) in collaboration with an Expert Advisory Panel, Actively Practicing Providers, Public Stakeholders, and Senior State Officials.

[www.agencymedicaldirectors.wa.gov](http://www.agencymedicaldirectors.wa.gov)

## clinicians
- David Beck – Grays Harbor Clinic
- Randi Beck – Group Health Cooperative
- Malcolm Butler – Columbia Valley Community Health
- Phillip Capp – Swedish Medical Center Family Practice
- Greg Carter – St. Lukes Rehabilitation
- Dianna Chamblin – Everett Clinic
- Pamela Davies – UW/Seattle Cancer Care Alliance Supportive & Palliative Care
- Dermot Fitzibbon – UW/Seattle Cancer Care Alliance
- Andrew Friedman – Virginia Mason Medical Center
- Debra Gordon – Harborview Anesthesiology & Pain Medicine
- Lucinda Grande – Pioneer Family Practice
- Chris Howe – Valley Medical Center
- Ray Hsiao – Seattle Children’s Hospital/UW Department of Psychiatry and Behavioral Sciences
- Gordon Irving – Swedish Pain and Headache Center
- Joseph Merrill – UW/Harborview Medical Center Division of Addictions
- Andrew Saxon – VA Puget Sound Health Care System/Center of Excellence in Substance Abuse Treatment and Education (CESATE)/UW Addiction Psychiatry Residency Program
- Michael Schatman – Foundation for Ethics in Pain Care
- Mark Sullivan – UW Center for Pain Relief/Department of Psychiatry and Behavioral Sciences
- David Tauben – UW Center for Pain Relief/Division of Pain Medicine
- Greg Terman – UW Department of Anesthesiology
- Stephen Thelker – Seattle VAMC Geriatric Research, Education and Clinical Center
- Michael Von Korff – Group Health Cooperative

## health plans
- Ken Hopper – Amerigroup, Washington
- James Luciano & Thomas Paulson – Wellpoint Companies
- Mary Kay O’Neill – Coordinated Care/Bree

## state agencies
- Stephen Hammond - DOC
- Kathy Lofy – Dept of Health
- Gary Franklin, Lee Glass, Nicholas Reul & Hal Stockbridge – Labor and Industries
- Dan Lessler & Charissa Fotinos – Medicaid, State employees benefits

## boards and commissions
- Richard Brantner - MQAC
Summary of 2015 Interagency Guideline on Prescribing Opioids for Pain

All pain phases
- Use non-opioid therapies, such as behavioral intervention, physical activity and non-opioid analgesics.
- Avoid opioids if the patient has significant respiratory depression, current substance use disorder, history of prior opioid overdose or a pattern of aberrant behaviors.
- Assess and document function and pain using a validated tool at each visit where opioids are prescribed.
- Don’t prescribe opioids with benzodiazepines, carisoprodol, or sedative-hypnotics.

Acute phase (0–6 weeks)
- Check the state’s Prescription Monitoring Program (PMP) before prescribing.
- Don’t prescribe opioids for non-specific back pain, headaches, or fibromyalgia.
- Prescribe the lowest necessary dose for the shortest duration.
- Opioid use beyond the acute phase is rarely indicated.

Perioperative pain
- Evaluate thoroughly preoperatively: check the PMP and assess risk for over-sedation and difficult-to-control pain.
- Discharge with acetaminophen, NSAIDs, or very limited supply (2–3 days) of short-acting opioids for some minor surgeries.
- For patients on chronic opioids, taper to preoperative doses or taper within 6 weeks following major surgery.

Subacute phase (6–12 weeks)
- Don’t continue opioids without clinically meaningful improvement in function (CMIF) and pain.
- Screen for comorbid mental health conditions and risk for opioid misuse using validated tools.
- Recheck the PMP and administer a baseline urine drug test (UDT) if you plan to prescribe opioids beyond 6 weeks.

Chronic phase (>12 weeks)
- Continue to prescribe opioids only if there is sustained CMIF and no serious adverse events, risk factors, or contraindications.
- Repeat PMP check and UDT at frequency determined by the patient’s risk category.
- Prescribe in 3–7 day multiples to avoid ending supply on a weekend.
- Don’t exceed 120 mg/day MED without a pain management consultation.

When to discontinue
- At the patient’s request
- No CMIF
- Risks outweigh benefits
- Severe adverse outcome or overdose event
- Substance use disorder identified (except tobacco)
- Aberrant behaviors exhibited
- To maintain compliance with DOH rules or consistency with AMDG guidelines

Considerations prior to taper
- Help the patient understand that chronic pain is complex and opioids cannot eliminate pain.
- Consider an outpatient taper if the patient isn’t on high-dose opioids or doesn’t have comorbid substance use disorder or other active mental health disorder.
- Seek consultation if the patient failed previous taper or is at greater risk for failure due to high-dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or other active mental health disorder.

How to discontinue
- Taper opioids first if patients are also on benzodiazepines.
- Unless safety considerations require a more rapid taper, start with 10% per week and adjust based on the patient’s response.
- Don’t reverse the taper; it can be slowed or paused while managing withdrawal symptoms.
- Watch for unmasked mental health disorders, especially in patients on prolonged or high-dose opioids.

Recognizing and treating opioid use disorder
- Assess for opioid use disorder and/or refer for a consultation if the patient exhibits aberrant behaviors.
- Help patients get medication-assisted treatment along with behavioral therapies.
- Prescribe naloxone (especially if you suspect heroin use) and educate patient’s contacts on how to use it.

Special populations
- Counsel women before and during pregnancy about maternal, fetal, and neonatal risks.
- For children and adolescents, avoid prescribing opioids for most chronic pain problems.
- In older adults, initiate opioids at 25–50% lower dose than for younger adults.
- For cancer survivors, rule out recurrence or secondary malignancy for any new or worsening pain.

Check out the resources at www.AgencyMedDirectors.wa.gov
- Free online CME
- Opioid Dose Calculator
- Videos from Primary Pain Care Conference

Slide 14
Bree Collaborative Opioid Focus Areas

• **Reduce acute opioid use**
  • Focus on adolescents (e.g., after dental procedure, sports injury)-eg,presentation to DQAC on 7/15/2016

• **System Implementation**
  • Longer term goal: incent non-pharmacological alternatives to opioids

• **Improved use and interoperability of the WA Prescription Monitoring Program**

• **Enhance clinician education**
  • Diffuse AMDG guidelines (via WSMA, WSDA, CME)
  • Get desktop tools to clinicians
  • Work with UW to stabilize funding for tele-pain

• **Pilot reportability of overdose events**

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**THANK YOU!**

For electronic copies of this presentation, please e-mail Laura Black: lj12@u.washington.edu

For research questions, please e-mail Gary Franklin: meddir@u.washington.edu
The Evidence-Based Health Policy Project (EBHPP) connects research and expertise from the University and elsewhere into the state health policymaking process, to improve the wellbeing of our state. The project has two core goals:

- Provide public and private sector policymakers with timely, nonpartisan, and high-quality information to support evidence-informed decision-making.
- Increase and the involvement of UW faculty research and teaching in issues of state public policy.

These goals grow from the Wisconsin Idea, that ongoing dialogue between the campus and the Capitol can improve and enhance the work of both. To best apply their work to real world circumstances, researchers need to learn from decision-makers who deliver and fund health care services. Likewise, to craft policies that effectively address urgent problems, policymakers must have timely access to relevant and rigorous evidence, and a framework for translating that evidence into action. Ultimately, increasing the responsible use of research in policy and practice can improve the health of our communities.

**VENUES**

- **Capitol Briefings:** Briefings at the State Capitol provide legislators, staff, state agency employees, and other interested parties with timely information and research. Briefings address priority issues raised in the Legislature, or address broader, ongoing policy issues. These events are open to the public, and include question and answer sessions.
- **Legislative Staff Trainings:** Training sessions for legislators and their staff on resources generated at the University, such as the County Health Rankings and Roadmaps or What Works for Health, that can help build data and evidence into decisions, and into the day-to-day work in the Capitol.
- **Community Conversations:** Public programs held in communities across the state, where local knowledge and expertise is put in the context of the link between the campus, the community, and the state and local policymakers whose decision affect the health of that region.
- **Methods Exchanges:** One-on-one meetings between legislators and researchers on topics of interest. These conversations allow for mutual learning through direct dialogue, directly inform decisions or debate, and pave the way for continued collaboration.

**PARTNERS**

The EBHPP draws on academic, government, and community expertise to help policymakers address Wisconsin’s urgent health challenges. The project is a formal partnership of the UW Population Health Institute, the La Follette School of Public Affairs, and the Wisconsin Legislative Council.

**CONTACT**

Sam Austin, Project Director  
608.265.4851  
svaustin@wisc.edu
Minnesota Medicaid – Office of the Medical Director

The Office of the Medical Director (OMD) supports evidence-based decision-making in multiple ways and with many partners. Two of the more visible ways include staffing the Health Services Advisory Council (HSAC) and leading Minnesota’s participation in the Medicaid Evidence-based Decision-making Project (MED).

HSAC is a 13-member council comprising physicians, other health care providers and a consumer representative. It provides leadership in recommending health care benefit and coverage policies for Minnesota’s public health care programs. The council’s strength is evidence-based coverage policy, in which decisions regarding health care services paid for by public programs are informed by the best available research on their effectiveness and safety. DHS’ Medicaid medical director serves as a non-voting member of HSAC, and OMD’s deputy director staffs the council.

HSAC advises the Department of Human Services (DHS) on a wide range of topics and serves many agency divisions, including mental health, alcohol and drug abuse, disability services and health care. Among other things, it has informed policy on coverage-with-evidence-development for autism services, evaluated the safety and effectiveness of numerous new technologies and advised on patient prioritization criteria for new Hepatitis C treatments. The agency turned to HSAC when it first began addressing the opioid crisis, and the council’s recommendations formed the backbone of a successful legislative initiative and community-based approach to improve care. More information about HSAC (including its charter, legislative mandate and transparency and conflicts of interest policies) can be found on its webpage.

The MED Project is a collaboration among approximately 18 states’ Medicaid agencies and researchers based at Oregon Health Science University’s Center for Evidence-based Policy. MED’s mission is to provide Medicaid policy-makers with the tools and resources they need to make evidence-based decisions. It does so by:

- Producing independent and objective evaluations of clinical evidence to inform decisions made by policy-makers, purchasers, providers, and consumers;
- Sharing best practices and engaging in collaborative problem-solving to accelerate improvements in healthcare outcomes and health system efficiency.

HSAC’s work and Minnesota’s requests for MED assistance are often synergistic. HSAC staff frequently obtains policy analysis and clinical evidentiary reviews from MED to support HSAC’s deliberations.
Links to Oregon Health Evidence Review Commission Resources

Homepage: www.oregon.gov/oha/hpa/csi-herc/
About HERC: www.oregon.gov/oha/HPA/CSI-HERC/Pages/About.aspx
Contact us: HERC.Info@state.or.us

Prioritized List
Overview: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List-Overview.aspx
Methodology: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritization-Methodology.aspx
Current List: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Meetings-Public.aspx
Keyword Searchable List: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Searchable-List.aspx

Coverage Guidances
Completed: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Prioritized-List.aspx
Under development: www.oregon.gov/oha/HPA/CSI-HERC/Pages/Evidence-based-Current-Topics.aspx
Open for comment: www.oregon.gov/oha/HPA/CSI-HERC/Pages/EBR-Open-Comment.aspx

Coverage Guidance and Multisector Intervention Report: Tobacco Cessation During Pregnancy