

**Ohio Department of Job and Family Services (ODJFS)  
Drug Utilization Review (DUR) Board  
Quarterly Meeting  
February 21, 2012**

The quarterly meeting of the ODJFS DUR Board was called to order at 12:02 PM in room East B of the 31st floor of the Riffe Building, 77 S. High St. Columbus, Ohio. David Brookover, RPh presided. The following Board members were present:

Thomas Gretter, MD  
Kevin Mitchell, RPh  
J. Layne Moore, MD  
Lenard Presutti, DO  
Donald Sullivan, RPh, PhD

Also present were Margaret Scott, RPh, DUR Administrator; Jill Griffith, RPh, DUR Director; Pam Heaton RPh, PhD, from the University of Cincinnati College of Pharmacy; and Jon Barley, PhD, Chief, ODJFS Bureau of Health Services Research. Approximately ten observers were present representing pharmaceutical manufacturers.

Reading, Correction & Approval of Previous Minutes:

The November 15th, 2011, DUR Board minutes were approved. (1st K. Mitchell, 2nd L. Moore).

New Business:

DUR Board members signed the Conflict of Interest statement for 2012. A copy of the statement is attached.

John Barley, PhD gave a presentation about the Ohio Medicaid Quality Strategy. A copy of the presentation is attached.

A presentation from the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) regarding a buprenorphine dosing protocol was rescheduled to the May 8<sup>th</sup>, 2012 DUR Board Meeting.

DUR Committee Report:

J. Griffith gave the DUR Committee report.

The December and January DUR Committees re-reviewed 2,030 profiles of patients on duplicate long-acting stimulants. This review was originally completed in November 2010. Thus far, the re-review shows the intervention was successful for 552 patients, meaning a decrease from two or more long-acting products to one. The analysis is still ongoing. The February DUR Committee learned about the Medicaid Quality Strategy from Dr. Barley.

Health Plan Policy:

M. Scott gave the Health Plan Policy report.

Governor Kasich has convened a cabinet-level Opiate Action Team with many subcommittees to combat opiate abuse in Ohio. The various subcommittees are working on education, prescribing guidelines for emergency department practitioners, treatment strategies including buprenorphine dosing guidelines, and law enforcement protocols.

Ohio Medicaid has joined Catalyst for Payment Reform to improve quality and value purchasing in health care. The department is exploring ways to pay for health outcomes.

Medicaid is working on the implementation patient-centered medical homes, including projects for mental health and Medicare/Medicaid dual eligibles.

Unfinished Business:

J. Griffith announced that the DUR annual report has been submitted to CMS.

J. Griffith announced that the 2012 DUR review calendar is on hold pending resolution of data challenges and the successful completion of the Medicaid Information Technology System (MITS) RETRODUR system testing. We are likely able to send out educational information.

The DUR Board discussed ways to incentivize patients to seek care with their primary care doctors rather than in more expensive settings such as the emergency department. The Board discussed directing a recipient mailing to the top utilizers of the emergency room, those patients seeking primary care, well child checks or treatment for ear aches or sore throats from the emergency room. The Board suggested the survey included with this mailer ask questions to try and understand what motivates patients to seek care in the ER and what barriers prevent them from seeking care via their primary care physician.

Announcements:

The third and fourth quarter DUR Board meetings are scheduled for noon on Tuesday, September 11th and Tuesday, November 13<sup>th</sup>, location to be announced.

Adjournment:

David Brookover, RPh adjourned the meeting at 1:05 PM. (1st T. Gretter, 2nd L. Presutti).

Respectfully submitted:

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Jill RK Griffith BS, PharmD, DUR Program Director

A presentation slide with a light blue background and a large, faint, stylized 'C' shape. The title 'Healthcare Transformation' is in red. A yellow box on the right contains the subtitle 'Ohio Medicaid Quality Strategy' and the presenter's name and date. The bottom left features the Ohio Department of Job and Family Services logo.

# Healthcare Transformation

## Ohio Medicaid Quality Strategy

Jon Barley, PhD  
DUR Board Meeting, 2/21/2012

**Ohio** | Department of  
Job and Family Services

## Quality Context

- New Governor
- New Office of Health Transformation
- New Budget addressing the \$8 Billion budget shortfall
- Health Care Reform
- HITECH / EHR / Meaningful Use
- CHIPRA Re-authorization
- MITS

## Ohio's Health System Performance

### **Health Outcomes – 42<sup>nd</sup> overall<sup>1</sup>**

- 42<sup>nd</sup> in preventing infant mortality (only 8 states have higher mortality)
- 37<sup>th</sup> in preventing childhood obesity
- 44<sup>th</sup> in breast cancer deaths and 38<sup>th</sup> in colorectal cancer deaths

### **Prevention, Primary Care, and Care Coordination<sup>1</sup>**

- 37<sup>th</sup> in preventing avoidable deaths before age 75
- 44<sup>th</sup> in avoiding Medicare hospital admissions for preventable conditions
- 40<sup>th</sup> in avoiding Medicare hospital readmissions

### **Affordability of Health Services<sup>2</sup>**

- 37<sup>th</sup> most affordable (Ohio spends more per person than all but 13 states)
- 45<sup>th</sup> most affordable for hospital care and 47<sup>th</sup> for nursing homes
- 46<sup>th</sup> most affordable Medicaid for seniors



Governor's Office of  
Health Transformation

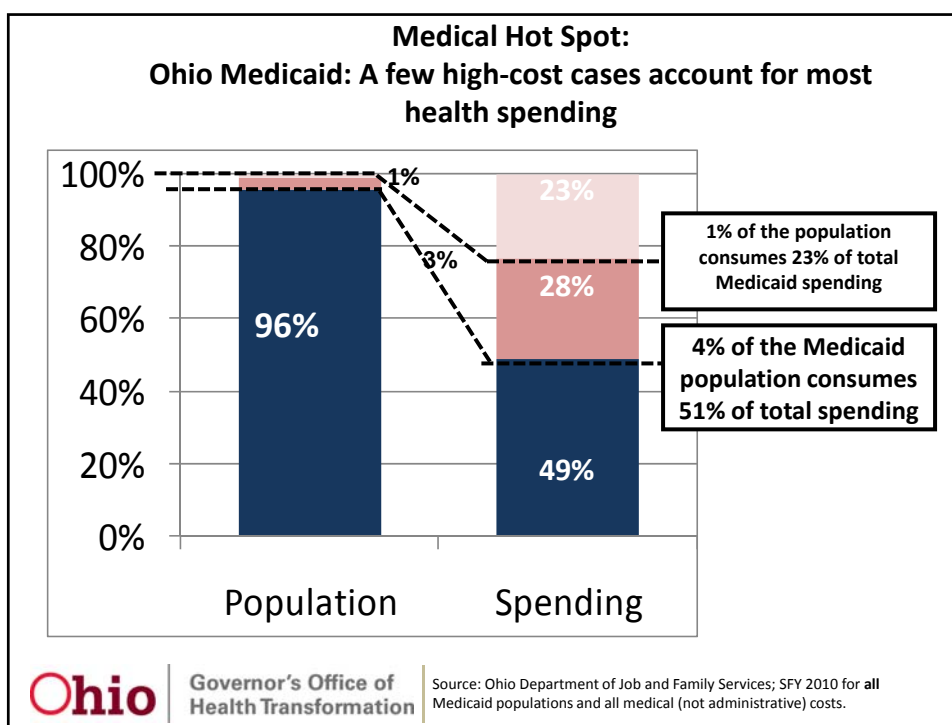
Sources: (1) Commonwealth Fund 2009 State Scorecard on Health System Performance, (2) Kaiser Family Foundation State Health Facts. <sup>3</sup>

Fragmentation	vs.	Coordination
<ul style="list-style-type: none"> <li>• Multiple separate providers</li> <li>• Provider-centered care</li> <li>• Reimbursement rewards volume</li> <li>• Lack of comparison data</li> <li>• Outdated information technology</li> <li>• No accountability</li> <li>• Institutional bias</li> <li>• Separate government systems</li> <li>• Complicated categorical eligibility</li> <li>• Rapid cost growth</li> </ul>		<ul style="list-style-type: none"> <li>• Accountable medical home</li> <li>• Patient-centered care</li> <li>• Reimbursement rewards value</li> <li>• Price and quality transparency</li> <li>• Electronic information exchange</li> <li>• Performance measures</li> <li>• Continuum of care</li> <li>• Medicare/Medicaid/Exchanges</li> <li>• Streamlined income eligibility</li> <li>• Sustainable growth over time</li> </ul>



Governor's Office of  
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SOURCE: Adapted from Melanie Bella, *State Innovative Programs for Dual Eligibles*, NASMD (November 2009)



## Child Hot Spots Top 5% Most Costly Children

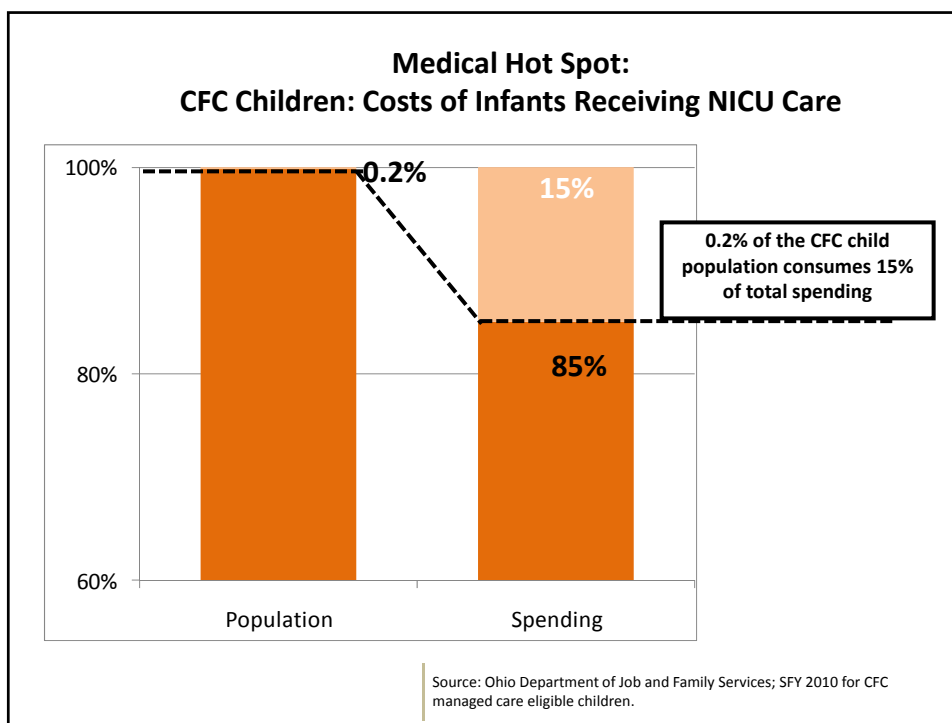
(excluding institutional level of care population)

Compared to all children:

- Top 5% consumes 51% of total costs
- Inpatient rate is 10 times higher for ABD & 8 times higher for CFC than all children
- Average cost is 10 times higher than all children  
(ABD: \$75K vs \$7.4K)(CFC: \$19K vs \$1.8K)

Of the top 5% most costly children:

- 60% ABD & 46% CFC have a behavioral health condition
- 99% ABD & 62% CFC have a manageable condition
- 40% ABD & 50% CFC receive primarily hospital-based care



## Adult Hot Spots Top 5% Most Costly Adults

(excluding institutional level of care population)

### Compared to all Adults:

- Top 5% consumes 35% of total costs
  - Inpatient rate is 7 times higher
  - Average cost is 7 times higher
- (ABD: \$95K vs \$13K)(CFC: \$24K vs \$3.6K)

### Of the top 5%:

- 47% ABD & 42% CFC have a behavioral health condition
- 66% ABD & 38% CFC have a cardiovascular condition
- 86% ABD & 71% CFC have a manageable condition
- 48% ABD & 45% CFC receive primarily hospital-based care

## Most Prevalent Conditions in Costliest 5% Medicaid Populations

(excluding institutional level of care population)

<b><u>CFC Children</u></b> <ul style="list-style-type: none"> <li>•Minor infections</li> <li>•Behavioral health</li> <li>•Minor injuries</li> <li>•Eye-related conditions</li> <li>•Gastrointestinal</li> <li>•Asthma</li> <li>•Neurologic</li> <li>•Congenital</li> <li>•Joint-related conditions</li> <li>•Endocrine system</li> </ul>	<b><u>ABD Children</u></b> <ul style="list-style-type: none"> <li>•Minor infections</li> <li>•Behavioral health</li> <li>•Neurologic</li> <li>•Eye-related conditions</li> <li>•Gastrointestinal</li> <li>•Minor injuries</li> <li>•Congenital</li> <li>•Asthma</li> <li>•Joint-related conditions</li> <li>•Benign tumors</li> </ul>
<b><u>CFC Adults</u></b> <ul style="list-style-type: none"> <li>•Minor infections</li> <li>•Behavioral health</li> <li>•Joint-related conditions</li> <li>•Cardiovascular disease</li> <li>•Minor injuries</li> <li>•Gastrointestinal</li> <li>•Neurological</li> <li>•Eye-related conditions</li> <li>•Endocrine</li> <li>•Asthma</li> </ul>	<b><u>ABD Adults</u></b> <ul style="list-style-type: none"> <li>•Cardiovascular disease</li> <li>•Minor infections</li> <li>•Joint-related conditions</li> <li>•Neurologic</li> <li>•Behavioral health</li> <li>•Gastrointestinal</li> <li>•Minor injuries</li> <li>•Diabetes</li> <li>•Severe infections</li> <li>•Iatrogenic</li> </ul>

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## Most Costly Conditions in Costliest 5% of Medicaid Populations

(excluding institutional level of care population)

<b><u>CFC Children</u></b> <ul style="list-style-type: none"> <li>•Behavioral health</li> <li>•Congenital</li> <li>•Minor infections</li> <li>•Neurologic</li> <li>•Gastrointestinal</li> <li>•Severe infections</li> <li>•Cancer</li> <li>•Minor injuries</li> <li>•Asthma</li> <li>•Pregnancy</li> </ul>	<b><u>ABD Children</u></b> <ul style="list-style-type: none"> <li>•Congenital</li> <li>•Behavioral health</li> <li>•Neurologic</li> <li>•Minor infections</li> <li>•Cancer</li> <li>•Iatrogenic</li> <li>•Severe infections</li> <li>•Gastrointestinal</li> <li>•Asthma</li> <li>•Cardiovascular disease</li> </ul>
<b><u>CFC Adults</u></b> <ul style="list-style-type: none"> <li>•Behavioral health</li> <li>•Gastrointestinal</li> <li>•Pregnancy</li> <li>•Cancer</li> <li>•Cardiovascular disease</li> <li>•Neurologic</li> <li>•Minor injuries</li> <li>•Joint-related conditions</li> <li>•Minor infections</li> <li>•Severe Infections</li> </ul>	<b><u>ABD Adults</u></b> <ul style="list-style-type: none"> <li>•Cancer</li> <li>•Cardiovascular disease</li> <li>•Severe infections</li> <li>•Neurologic</li> <li>•Behavioral health</li> <li>•Gastrointestinal</li> <li>•Iatrogenic</li> <li>•Minor injuries</li> <li>•Minor infections</li> <li>•Diabetes</li> </ul>

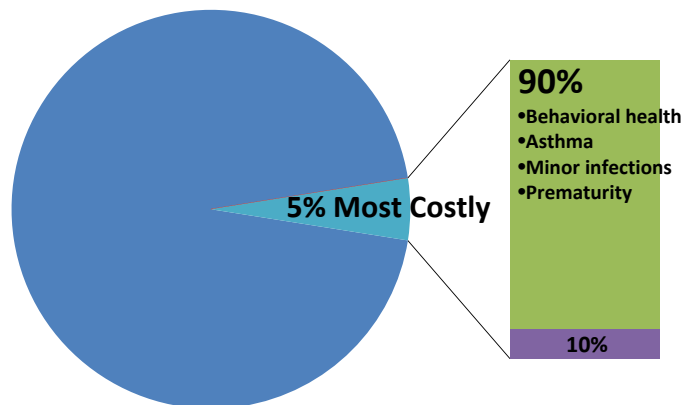
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## OHP's Clinical Focus Areas (excluding institutional level of care population)

- High Risk Pregnancy/Premature Births
- Behavioral Health
- Cardiovascular Disease
- Diabetes
- Asthma
- Upper Respiratory Infections

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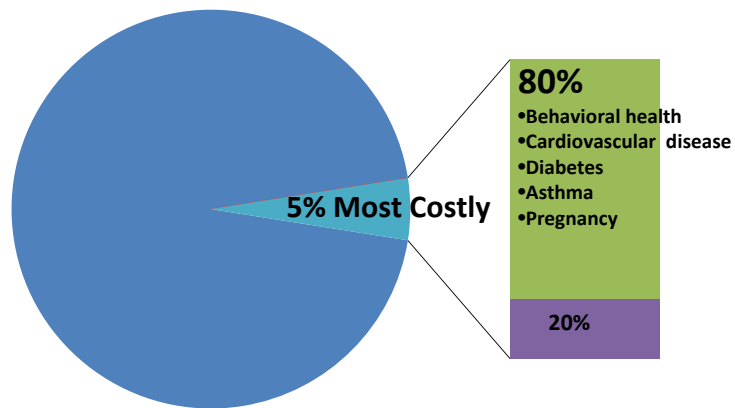
## OHP's Clinical Focus Areas: Most Costly 5% of Medicaid's Child Population (excluding institutional level of care population)



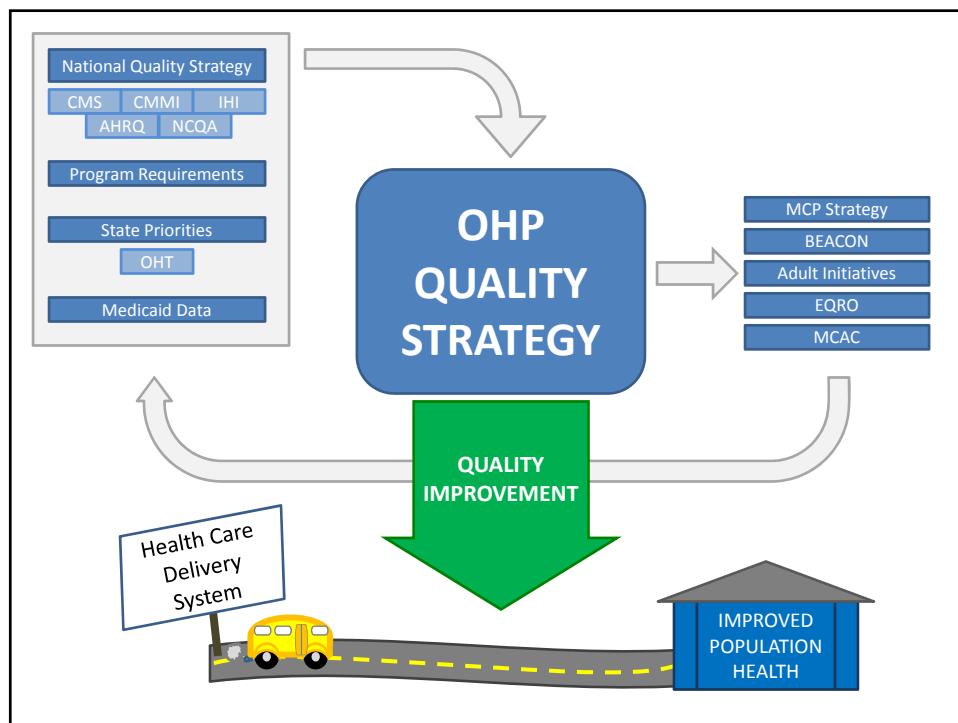
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## OHP's Clinical Focus Areas: Most Costly 5% of Medicaid's Adult Population (excluding institutional level of care population)



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## Quality Strategy Outline

- Aims
  - broad aims used to guide and assess efforts to improve the quality of healthcare
- Priorities
  - used to advance aims base on latest research to rapidly improve health outcomes and increase effectiveness of care
- Goals
  - specific areas to focus on in the next 1 – 3 years
  - includes six clinical focus areas
- Initiatives
  - what OHP is doing to achieve goals

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## Six Clinical Focus Areas

- Data Review (Non LTC population)
  - High Cost Hot Spotters
  - Prevalence
  - Capacity to Impact
  - Adults/Children data separated
- Evaluated/ Ranked based on:
  - Intervention Intensity Needed for Impact
  - Improvable Condition
  - Impact in 18 months
  - Measurability
  - Nationally-Recognized Measures
  - Outcome measures

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## Measures to Hold MCPs Accountable

- Considered all Nationally-Recognized Measures related to the 6 Priority Areas
  - NCQA-HEDIS
  - AHRQ's Core Set of Quality Measures for Adults in Medicaid
  - CHIPRA's core set of Children's Healthcare Quality Measures
  - Meaningful Use Core Measures
- Evaluated Measures directly related to the Clinical Focus Areas – Considered:
  - National Benchmarks
  - Feasibility – data, timing
  - Difficulty – cost, effort
- Selected 25 measures – see handout

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