Council

- **Rick Treleaven, LCSW, Chair**
  Executive Director,
  BestCare Treatment Services
- **Linda Johnson, Vice Chair**
  Community Representative
- **Patti Adair, Commissioner**
  Deschutes County
- **Eric Alexander**
  CEO, Partners in Care
- **Gary Allen, DMD**
  VP, Advantage Dental
- **Paul Andrews, EdD**
  Superintendent,
  High Desert ESD
- **Tammy Baney, Executive**
  Director, Central Oregon
  Intergovernmental Council
- **Seth Crawford**
  Commissioner,
  Crook County
- **Megan Haase, FNP**
  CEO, Mosaic Medical
- **Brad Porterfield, Community**
  Representative, CAC Chair
- **Divya Sharma, MD**
  Central Oregon IPA
  Representative
- **Kelly Simmelink**
  Commissioner,
  Jefferson County
- **Iman Simmons, MPH**
  Senior VP & COO, St. Charles
  Health System (interim)
- **Justin Sivill**
  Executive Director,
  Summit Health
- **Dan Stevens**
  EVP, PacificSource

Central Oregon Health Council

COHC Virtual Board of Directors Meeting
October 14, 2021 • 12:30–3:30
Meeting registration: https://bit.ly/2Mkqvit
Dial-in: See calendar invite for Zoom details to join from a computer
Phones: 1 (669) 900-6833 • Code: 542240567#

Welcome – Rick Treleaven

12:30–12:40 **Introductions and Public Comment – Rick Treleaven**

12:40–12:45 **Action Items and Approve Consent Agenda**..... *vote*

12:45–12:50 **Patient Story – Megan Haase** ..... *info*

Governance

12:50–1:05 **REALD Report – Gwen Jones** ..... *discussion*
Attachment: Report

1:05–2:00 **Board CODEI Training – Ignatius Bau** ..... *discussion*
Attachment: .ppt

2:00–2:05 **Governance Committee – Linda Johnson** ..... *info*

Long-Term Systemic Change

2:05–2:20 **Deschutes County Self-Insured Plan – Kathleen Hinman** ..... *info*
Attachment: .ppt

2:20–2:30 **Strategic Plan Update – Rebeckah Berry** ..... *info*

2:30–2:40 **Combined Meeting – Donna Mills** ..... *discussion*
Attachment: Board–CAC Priority Action Poll

RHA/RHIP

2:40–3:30 **Tri-Annual RHIP Report – COHC Project Managers** ..... *discussion*

Adjourn: Board Executive Session for Personnel Discussion

Consent Agenda

- August 2021 Board Minutes
- June, July & August 2021 COHC Financials
- Form 990
- COHC 2022 Budget

Written Reports

- Executive Director Update
- CCO Directors Report
- August 2021 CAC Minutes
- October Mini-Grant Reports
- CCO Dashboard

The Central Oregon Health Council Board of Directors reserves the right to transition into an executive session at any point during the Board meeting.

MINUTES OF A MEETING OF

THE BOARD OF DIRECTORS OF

CENTRAL OREGON HEALTH COUNCIL

HELD VIRTUALLY VIA ZOOM

August 12, 2021

A meeting of the Board of Directors (the ***"Board"***) of Central Oregon Health Council, an Oregon public benefit corporation (the ***"Corporation"***), was held at 12:30 p.m. Pacific Standard Time on August 12, 2021, online via Zoom. Notice of the meeting had been sent to all members of the Board in accordance with the Corporation's bylaws.

Directors Present: Rick Treleaven, Chair

Linda Johnson, Vice Chair

Patti Adair

Paul Andrews, Ed.D

Tammy Baney

Seth Crawford

Megan Haase, FNP

Brad Porterfield

Divya Sharma, MD

Iman Simmons

Justin Sivill

Dan Stevens

Directors Absent:	Eric Alexander
	Gary Allen, DMD
	Kelly Simmelink
Guests Present*:	Jeff Absalon, St. Charles Medical Group
	Miguel Angel Herrada, PacificSource
	MaCayla Arsenault, Central Oregon Health Council
	Kim Bangerter, Central Oregon Independent Practice Association
	Joan Ching, St. Charles Health System
	Kellie DeVore, PacificSource Lane County CCO Director
	Rebecca Donell, Oregon Health Authority
	Janice Garceau, Deschutes County Behavioral Health
	Sarah Holloway, PacificSource
	Gwen Jones, Central Oregon Health Council
	Andrea Ketelhut, PacificSource
	Therese McIntyre, PacificSource
	Donna Mills, Central Oregon Health Council
	Sara Mosher, COPA
	Leslie Neugebauer, PacificSource
	Erin Fair Taylor, PacificSource
	Katherine Ryan, Lane County
	Emily Salmon, St. Charles Health System
	Kelsey Seymour, Central Oregon Health Council
	Camille Smith, Central Oregon Health Council

Tricia Wilder, PacificSource

Kristen Tobias, PacificSource

Renee Wirth, Central Oregon Health Council

Mr. Treleaven served as Chair of the meeting and Ms. Seymour served as Secretary of the meeting. Mr. Treleaven called the meeting to order and announced that a quorum of directors was present and the meeting, having been duly convened in accordance with the Corporation's bylaws, was ready to proceed with business.

WELCOME

Mr. Treleaven welcomed all attendees to the meeting. Ms. Seymour introduced Ms. Smith who will be taking over her role as Administrative Assistant at the Central Oregon Health Council.

PUBLIC COMMENT

Mr. Treleaven welcomed public comment. No public comment was offered.

CONSENT AGENDA

The consent agenda included the June minutes, the Care Coordination Report endorsed by the Provider Engagement Panel, and the January through May COHC Financials (post-audit).

MOTION TO APPROVE: Ms. Baney motioned to approve the consent agenda; Ms. Johnson seconded. The motion was approved unanimously.

PATIENT STORY

Mr. Andrews shared a story from the Culture of Care program funded by the COHC in 2019. He shared that the 3 care coaches hired by the district provided a training on the Power of Influence, a non-verbal communication workshop. He shared that Crook County requested a deeper training on the subject, and shared an example of an educator who shared their learnings with their teaching assistant in order to work with a child who was displaying non-verbal cues.

STATE OF CENTRAL OREGON HEALTH ECO-SYSTEM

Ms. Simmons shared a presentation on the hospital's current capacity for addressing the coming COVID-19 case rate surge. She noted that with the increased transmissibility of the Delta variant,

herd immunity requires 84-85% of the population to be immune. She add that in addition to a steady influx of patients suffering from COVID-19, Emergency Department visits are up by approximately 1,500 per month. She noted that many Emergency Department visits appear to be a result of delayed care, and encouraged Primary Care to offer same-day visits, and for Urgent Care to advertise their availability. She explained that the hospital nursing staff is down 30% between vacant positions or employees on leave or vacation, and mentioned that nationally an RN shortage is predicted over the coming decades by more than 1.5M nurses. She added that many patients are ready to leave the hospital and are unable to be discharged into the community in a timely manner.

Dr. Absalon shared that St. Charles has been approved for national guard support for the short term, but that there are not likely to be any nurses in that cohort. Ms. Ching noted that many of the arising needs appear to be shared throughout the community.

Commissioner Adair asked if a booster for the COVID-19 vaccine is expected later this year. Dr. Absalon confirmed a booster is anticipated, though the FDA and CDC are still in conversations about it.

Mr. Sivill and Dr. Sharma indicated that previous assistance that the Central Oregon Independent Practice Association (COIPA) has offered in the form of case management has been turned down. He also noted that the delayed care causing the rise in Emergency Department visits is inclusive of the past year's cancelled surgeries. Dr. Absalon added that with so many new residents moving to the area, many people are coming to the ED because they have not established care with a Primary Care Physician (PCP) yet.

Ms. Haase suggested that creative approaches to PCP access might be in order. Ms. Baney noted that the Central Oregon Intergovernmental Council transportation department may be of assistance with providing rides for patients ready to depart the hospital. Ms. Simmons welcomed a discussion to determine which strategies would be most helpful, noting that not all solutions may be appropriate. Mr. Treleaven asked if a meeting could be held in the short-term to discuss the options for solutions as a community. Mr. Sivill requested that the COHC host that discussion. Ms. Simmons indicated that the hospital would be willing to discuss solutions to the problems noted in the presentation, but not an examination of the hospital's understanding of the root causes. Mr. Sivill agreed to participate in

the discussion, but noted that the whole group does not appear to be in agreement over what the root causes are.

Dr. Sharma applauded the Board and guests for working their way through the difficult conversations. Mr. Treleaven suggested that a short-term meeting can address short-term solutions, but also a meeting should be scheduled for a few months from now to discuss long-term solutions to the critical issues that continue to face the growing communities of Central Oregon. Ms. Johnson suggested that both of these meetings contain patient representation; the group agreed this was wise.

ACTION: The COHC Staff will convene a meeting of executives to discuss short-term solutions for the current crisis.

ACTION: The COHC Staff will convene a meeting in a few months to discuss the long-term solutions for the ongoing struggles of Central Oregon communities.

OPERATIONS CHAIR QUALITY INCENTIVE METRIC (QIM) REPORT OUT

Ms. Ketelhut shared that the QIM performance during 2020 is on track to underperform compared to previous years, resulting in a significant financial loss in incentive dollars. She added that there is hope that certain measures can still be attained through focus and coordination, but that 100% payout is unlikely. She added that clinics with larger Medicaid panels must raise their performance in order to make the difference, as smaller clinics simply do not carry the patient load required to move the metrics significantly. She noted that COVID-19 vaccine rates in Central Oregon for patients on the Oregon Health Plan are significantly lower than other regions in Oregon.

Ms. Haase suggested that the Operations Council's QIM Workgroup create goals and commitments for clinics. Ms. Garceau asked clinics to come and share their strategies for high QIM performance with the QIM Workgroup.

Ms. Ketelhut shared that PacificSource is tracking monthly and quarterly targets by clinic. Dr. Sharma suggested that weekly might be more helpful to clinic workers. Ms. Garceau added that some Medicaid providers sometimes appear unaware that the QIM reports exist, and suggested that executives track down who in their clinic is responsible for receiving and distributing these reports.

CCO Q2 2021

Ms. Neugebauer shared the CCO's quarterly report, noting that the SHARE funding went to FUSE under the supervision of the Community Advisory Council for housing voucher work. She noted that one metric in a cautionary stage is hospital readmissions. She added that an access to care survey has been launched and the results will be available later this year.

BOARD SURVEY/COMBINED MEETING FOCUS

Ms. Mills announced that the Board's survey results in preparation for the Combined meeting discussion with the Community Advisory Council (CAC) will be released in conjunction with an agenda on August 19th. She added that at that time the Board will be asked to complete a brief three-question survey in reaction to the results.

Ms. Mills shared that Senate Bill 741 has been signed by Governor Brown.

Ms. Mills announced that the COHC staff has moved to a new office on Emkay in Bend, and that they hope to secure access to a community meeting space in partnership with the Latino Community Association later this year.

Ms. Mills noted that the Connect Oregon pilot has successfully transitioned to PacificSource and engagement with the platform is healthy.

OTHER AGENDA ITEMS

Mr. Treleaven elected to delay the Culturally Linguistically Appropriate Services (CLAS) presentation, the Cost and Utilization Steering Committee (CUSC) update, and the Tri-annual Regional Health Improvement Plan (RHIP) Report Out until a future meeting due to time constraints.

ADJOURNMENT

There being no further business to come before the Board, the meeting was adjourned at 2:10 pm Pacific Standard Time.

Respectfully submitted,

_____

Kelsey Seymour, Secretary

Central Oregon Health Council

READ DATA AND OUR DEMOGRAPHICS

October 2021

Purpose

- Review of READLD
- Review of READLD data collection
- Board of Directors Demographics

What is REALD?

A set of standardized data and questions.

Race
Ethnicity
Language
and
Disability

Must be collected by the Oregon Health Authority, the Department of Human Services and organizations that work with them.

House Bill (HB) 2134

Oregon Administrative Rules (OARs) 943-070-0000 through 943-070-0070

How does REALD help reverse health and social inequities?

Identify and change structural social and health barriers imposed on people.

Better understand ALL the people we work with and serve.

Guide how we create services to meet the cultural and accessibility needs of the people we serve.

Guide how we invest our funds to address health inequities.

Why is it important to the COHC Board?

Central Oregon Health Council

OUR PURPOSE

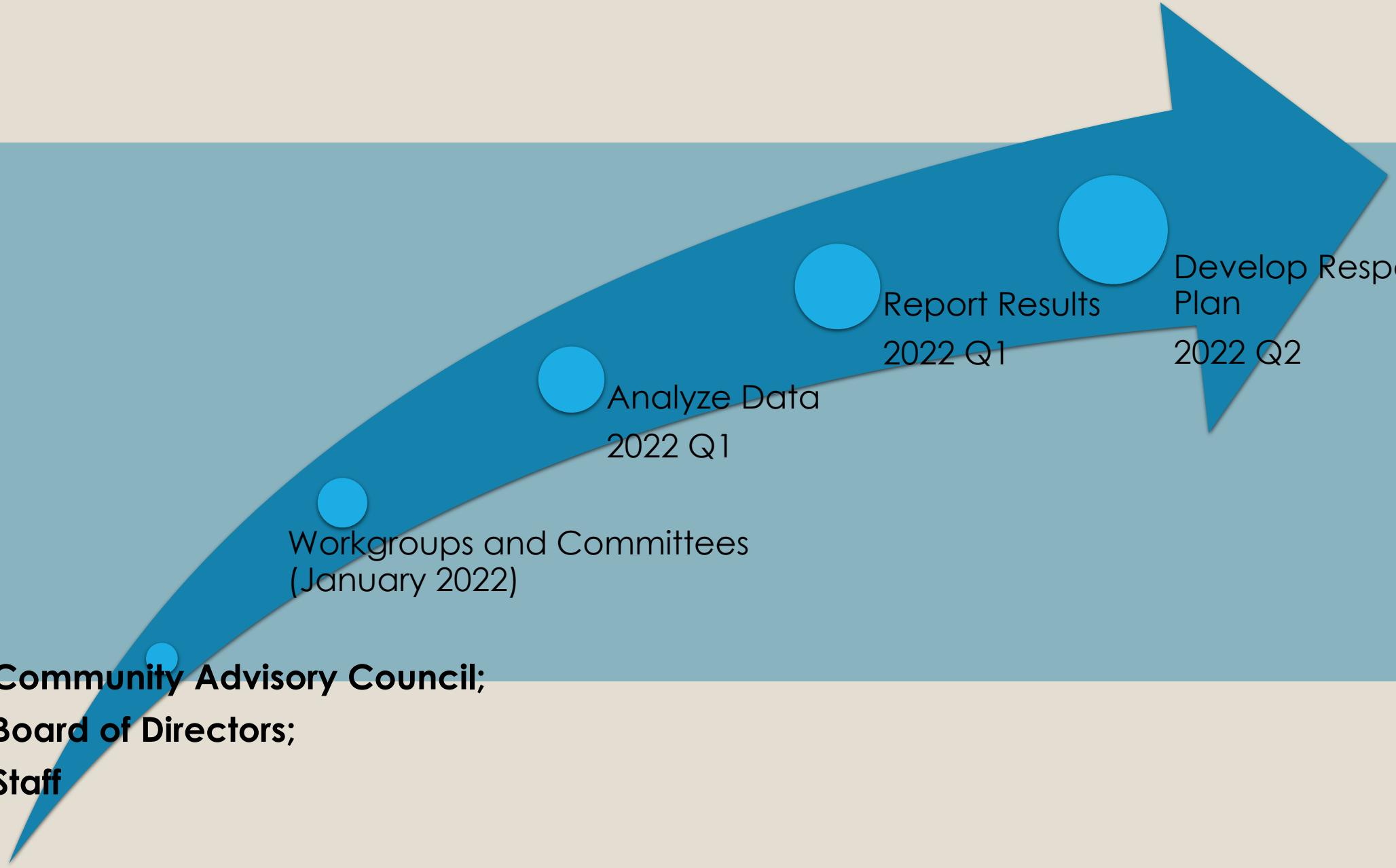
We exist to build an equitable and integrated health ecosystem that improves the health of Central Oregonians through collaboration and partnerships, data-driven decisions, quality improvements, lowered costs, and empowered providers. Our value to the region will exceed the cost of our efforts.

Strategic Plan:

Identifying and Addressing Inequities

- Develop and begin collecting COHC organizational DEI metrics
  - Data
  - Policy
  - Training
- Bolster Community Engagement: Ensure diversity of voices during decision making
- Survey current COHC Board members' demographics

- Understand with whom we currently partner
- Identify gaps in partnerships
- Inform recruitment of future Board members
- Support the use and best practices of REALD data as a tool to improve health inequities
- Respond to partner requests
- Prepare to support partners with resources

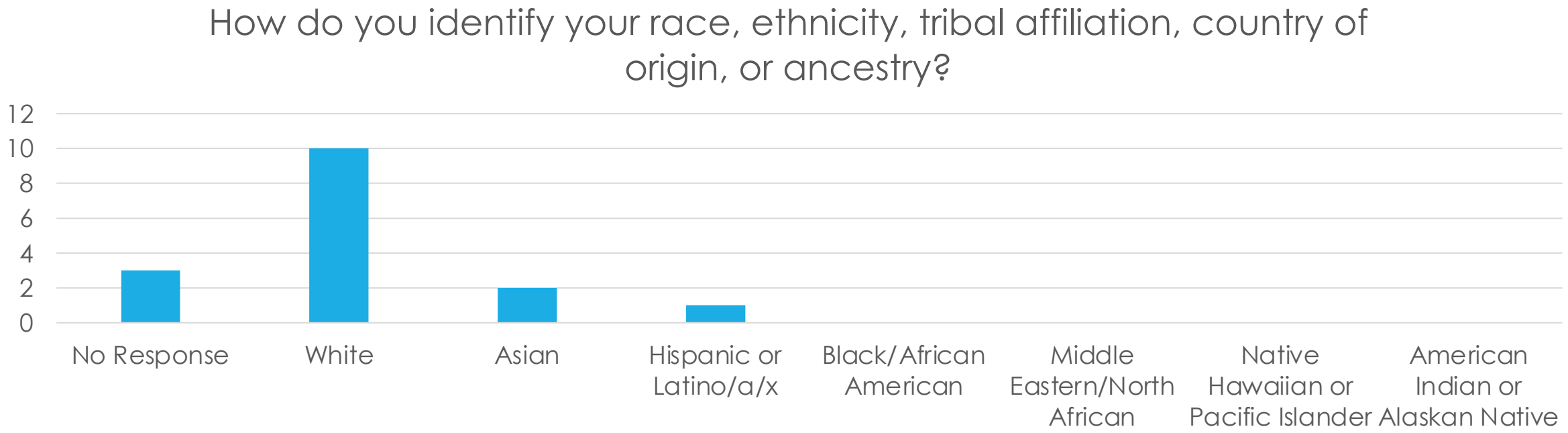


Community Advisory Council;

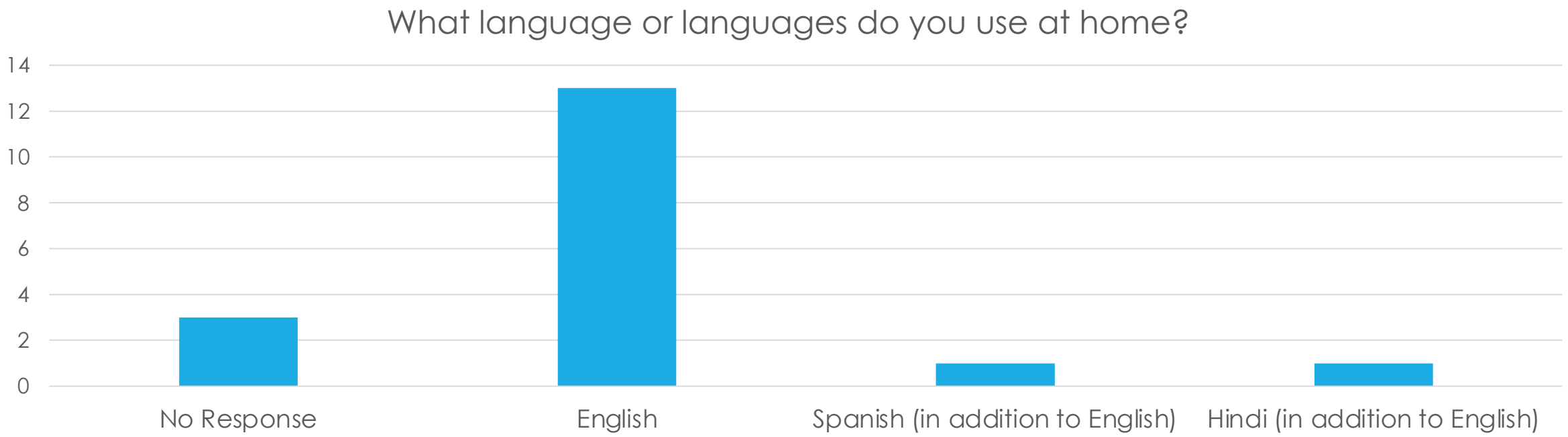
Board of Directors;

Staff

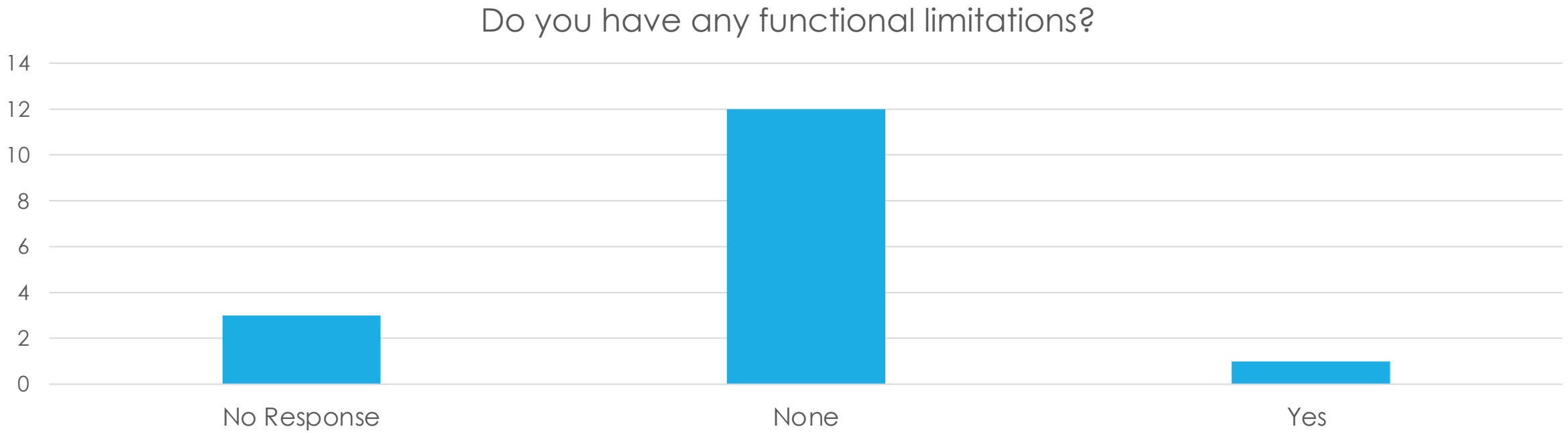
WHO ARE WE?



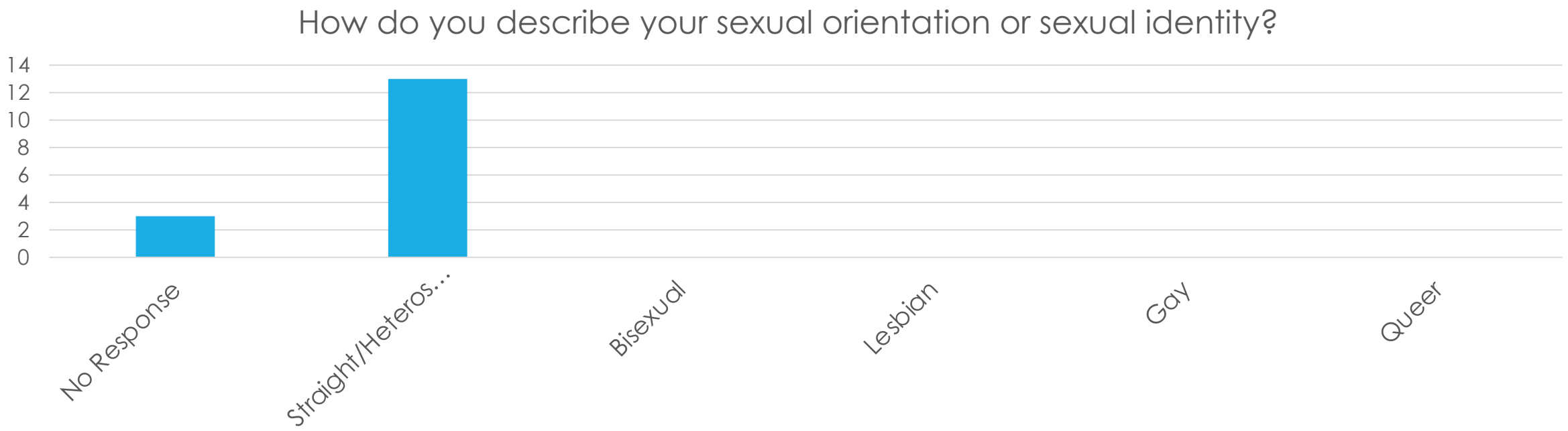
RACE AND ETHNICITY


What language or languages do you use at home?
14
12
10
8
6
4
2
0
No Response
English
Spanish (in addition to English)
Hindi (in addition to English)

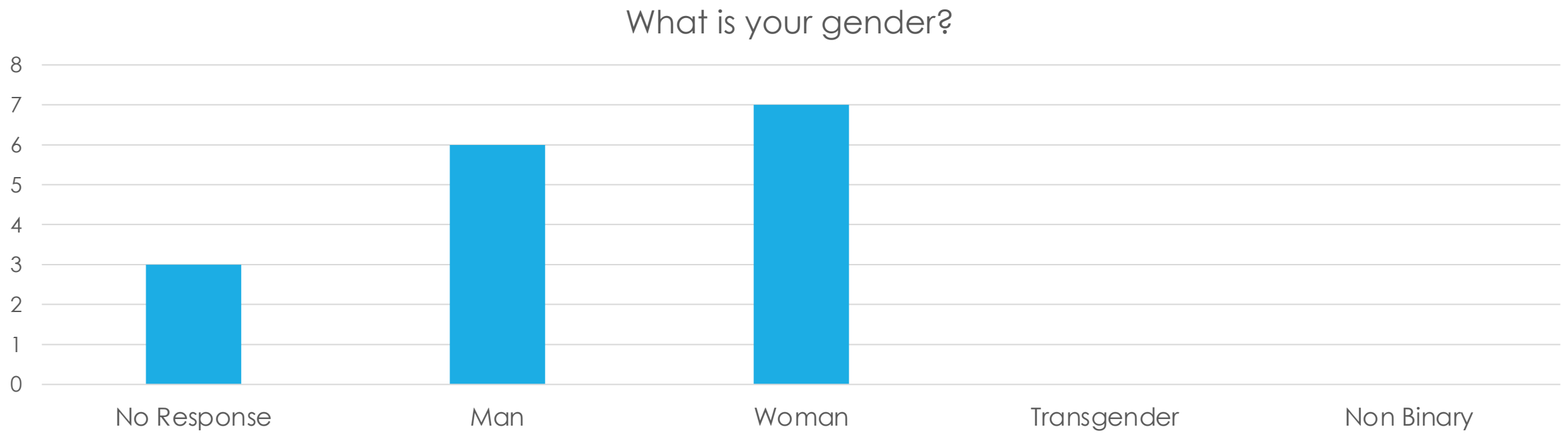
LANGUAGE



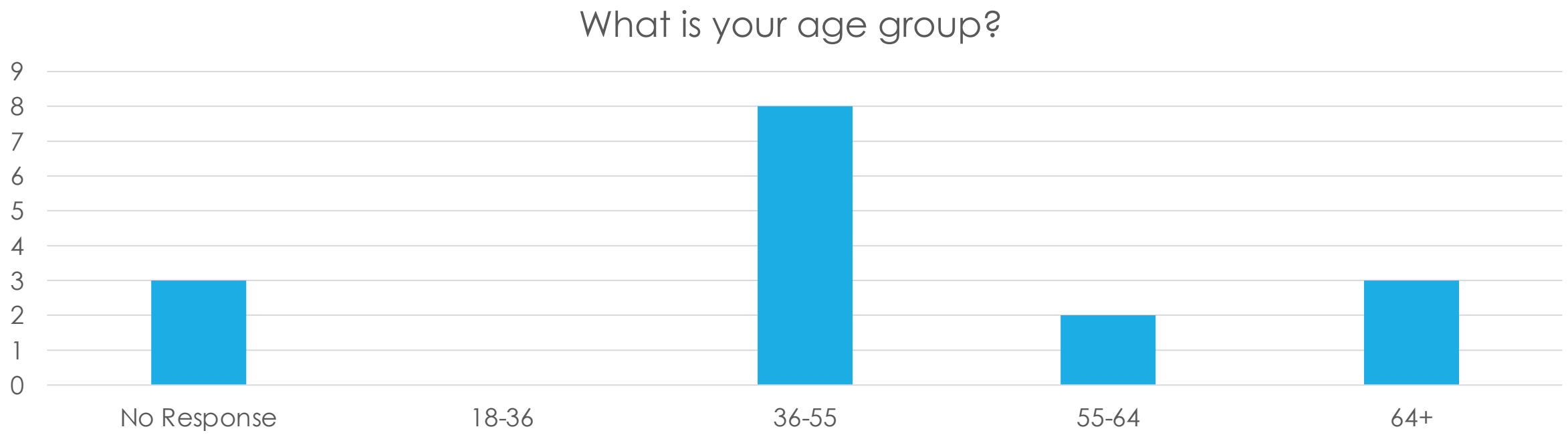
FUNCTIONAL LIMITATIONS



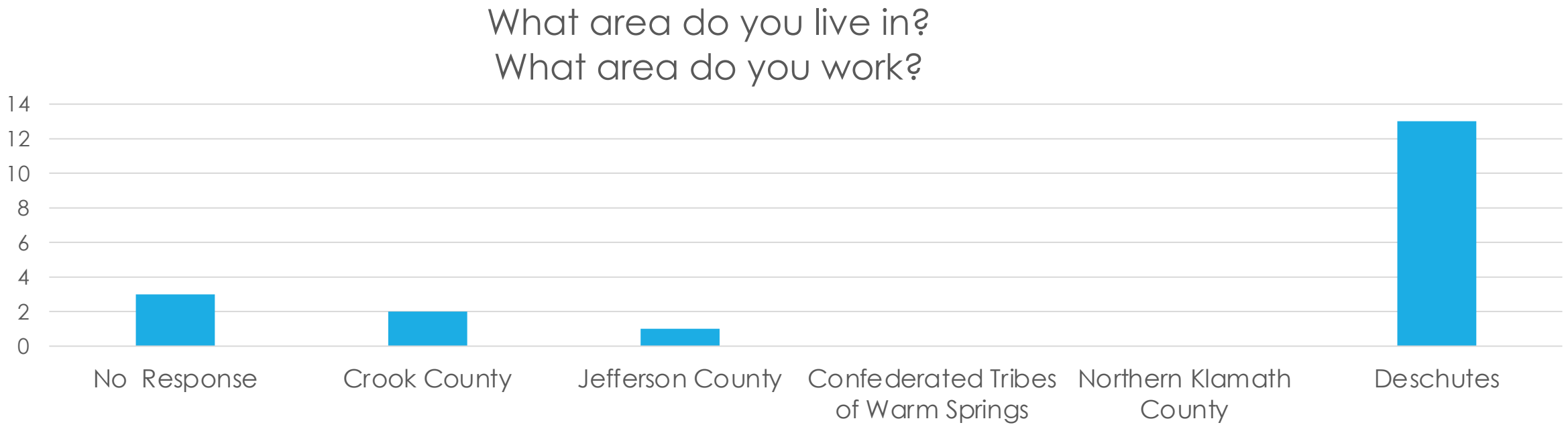
SEXUAL ORIENTATION



GENDER IDENTITY


What is your age group?
9
8
7
6
5
4
3
2
1
0
No Response
18-36
36-55
55-64
64+

AGE



GEOGRAPHY OF RESIDENCE AND WORK

Questions and Reflections

Prioritizing Health Equity

October 14, 2021

Objectives:

✓ To increase understanding of how the Oregon Health Authority has prioritized health equity

✓ To increase understanding of how the federal government and national health care stakeholders are prioritizing health equity

✓ To discuss how the COHC and COHC member organizations could continue to advance health equity

✓ To meet the CCO requirement for training of its governing board on health equity

August 2021

A Message From Governor Kate Brown

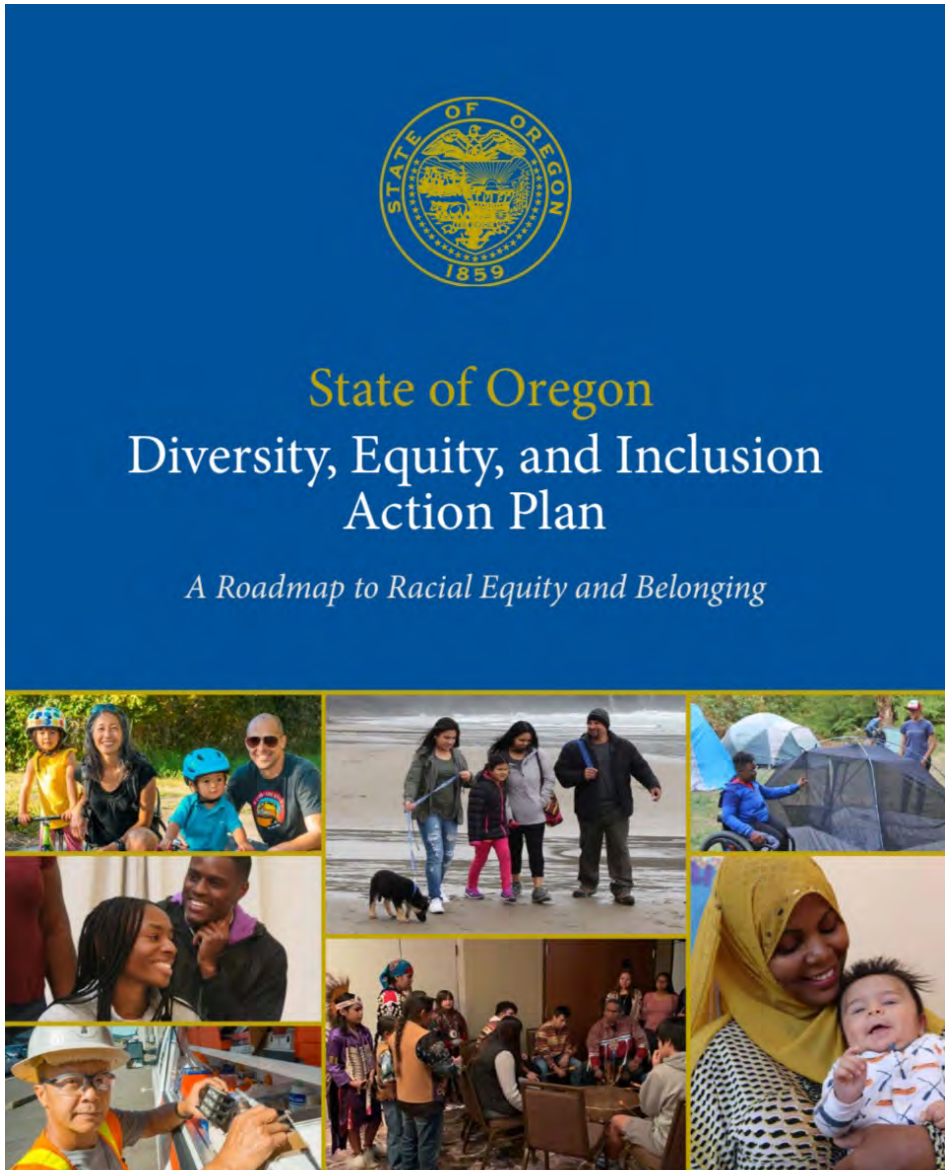
To all state employees,

Thank you for your tireless commitment and dedicated service. I am proud of how we are responding to these challenging times when Oregonians are relying on us.

Every state employee has a higher calling to public service, and now is the exact time to reevaluate and reexamine how to serve everyone in the state to the very best of our abilities.

Over the past year, our most vital needs – health, safety, education, housing, and economic security – have been challenged to the core. Because of systemic racism, racial disparities impact every part of our culture and economy, and the effects of our current struggles are more severe for communities of color and Tribal communities. As Oregon continues to recover from the historic year of a global pandemic, worst-in-a-century wildfires, unprecedented ice storms, and racial reckoning across our nation, we must put racial equity at the forefront of all of our recovery efforts and strategies. Racism is insidious, and racist policies and practices have undergirded the nature of our economy. Getting at these deep roots requires specific attention to ensure we are being proactive to embed anti-racism in all that we do and to minimize the negative, disproportionate outcomes experienced by communities of color.

There is a wide spectrum of understanding about what anti-racism really is. We, as state employees, must do the work of unlearning our internal bias and actively changing the way institutions work. That means acknowledging the history, the root cause, learning, growing, and making a concerted effort to upset and uproot racism wherever it exists.

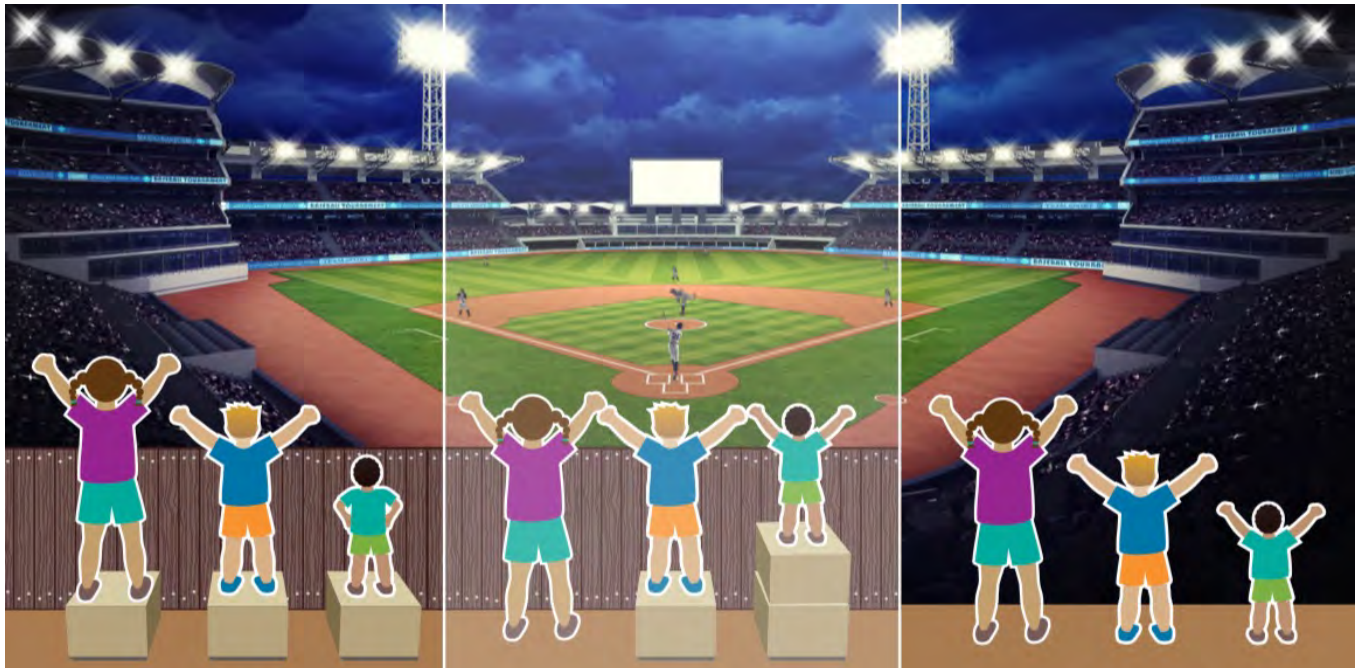


Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- **Recognizing, reconciling and rectifying historical and contemporary injustices.**



Equality

This image depicts EQUALITY. All individuals are being treated equally with the same supports. As shown, not all start from the same position; some have a height advantage. This challenges the assumption that everyone benefits from the same supports.

Equity

This image depicts EQUITY. The people are being treated equitably. It demonstrates that when different individuals are given different supports, it makes equal access possible for all of them.

Liberation

This image depicts LIBERATION. The barriers have been removed and supports are no longer needed. The inequity has been addressed.

Health equity framework

HTO's primary goal is to achieve health equity for BIPOC-AI/AN, people with low incomes, people with disabilities, people who identify as LGBTQ+ and people who live in rural areas. These groups experience major health inequities because Oregon and U.S. systems that determine access to these resources are designed for people who typically identify as white, straight, English-speaking, able-bodied, cis-gendered and male. People at the intersection of more than one affected community, e.g., people who are Black and transgender, find these systems especially oppressive and hard to navigate. People in power positions may not be intentionally racist. However, our systems are racist because of implicit and institutional bias.

OHA's 10-year strategic goal is to eliminate health inequities. This means people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

While health equity is the stated 10-year goal of our agency, the COVID-19 pandemic has shown how far short we are from eliminating health inequity in this state. Communities of color clearly have been disproportionately affected by COVID-19. For example, people who identify as Latino/a, Hispanic, or Latinx account for 32% of confirmed cases in Oregon but only 12% of the population. A crisis has a tendency to expose weakness and where systems fall short, and this pandemic has been no exception.

Kate Brown, Governor

Oregon Health Authority

OHA 2021 Legislative End-of-Session Report

Centering Health Equity

The Oregon Health Authority (OHA) seeks to eliminate health inequities in Oregon by 2030. The vision of health equity that OHA and the Oregon Health Policy Board are working to achieve is:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address the equitable distribution or redistribution of resources and power; and recognizing, reconciling and rectifying historical and contemporary injustices.*

The past year has been profoundly challenging due to the COVID-19 pandemic, wildfires, and ice storms. While every person in Oregon has been affected, it is overwhelmingly clear that some individuals and communities – those that had already been economically or socially marginalized, or who had already suffered greater health difficulties – experienced worse health impacts from these events. For example, Pacific Islander, American Indian/Alaska Native, African American and Black, and Latino/Latina/Latinx and Hispanic populations in Oregon each had more than twice the rate of COVID-19 cases per capita as white non-Hispanic populations.

This reality overlapped with the long overdue racial reckoning, sparked by George Floyd's murder and other cases of violence against Black people, as well as attacks upon democracy at both the state capital and national capital.

Metrics & Scoring Committee Equity Impact Assessment

May 2021

Health Care Workforce Committee Equity Framework

Report to the Oregon Health Policy Board

October 5, 2021

Health Equity Plan Summary

PacificSource Community Solutions

Health Equity Plan Process

CCO Deliverable

A Health Equity Plan is an annual CCO contract deliverable that must be submitted to OHA via Administrative Notice by June 30 of each contract year, beginning in 2020. A Health Equity Assessment, detailed below, is an additional part of a CCO's Health Equity Plan that will be required beginning in 2021.

Focus Area 6 – Organizational training and education

OHA Expectations: The CCO develops an "*Organizational and Provider Network Cultural Responsiveness, Implicit Bias Training and Education Plan*" that includes its governing board, leadership, Community Advisory Council (CAC) and the provider network. (This focus area has special reporting requirements outlined on a separate guidance document) *(CCO Contract Exhibit B Part 3 Patients' Rights, Responsibilities, Engagement and Choice(1) (c); Exhibit B Part 4 Providers and Delivery Systems (4) (b) (5); Exhibit K Part 10 (c) (2) (f) and CCO Contract Exhibit K Part 10 (d))*

OHA's Guiding Principles 2022-2027

Ensure that the 1115 waiver renewal application:

- ✓ Advances **health equity** for OHP plan members
- ✓ Is **economically sustainable** and support goals of containing statewide health care cost growth (aligns with SB 889)
- ✓ Creates a more **person-centered system of heath** (advancing CCO 2.0 goals of more integration, coordination, and spending on health and not just health care)

Overarching Waiver Goal:

Advance Health Equity

To achieve this, our policy framework breaks down the drivers of health inequities into four actionable sub-goals:

Maximizing OHP coverage

Stabilizing transitions to minimize disruptions in care

Encouraging smart, flexible spending for health equity

Focused health equity investments

- ✓ CCOs have greater flexibility in spending through true global budgets.
- ✓ Decisions about **community investments** are held by the community itself.
- ✓ People will get the care and supports they need to **stay healthy**.

Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government

JANUARY 20, 2021 • PRESIDENTIAL ACTIONS

CDC's Efforts to Address Racism as a Fundamental Driver of Health Disparities

As the nation's preeminent public health agency, CDC has a pivotal role: to lead our nation in addressing racism and the resulting health inequities. We will do what we do best by using science to investigate and better understand the intersection of racism and health, and then to take action.

Together with our public health partners, we are working to reduce, and ultimately, eliminate racial and ethnic inequities in health by addressing the structural and social conditions that give rise to them. We are committed to also working further upstream to address racism as the fundamental driver of these inequities.

Innovation At The Centers For Medicare And Medicaid Services: A Vision For The Next 10 Years

Chiquita Brooks-LaSure, Elizabeth Fowler, Meena Seshamani, Daniel Tsai

HealthAffairs

AUGUST 12, 2021 **DOI:** 10.1377/hblog20210812.211558

The Innovation Center should make equity a centerpiece of every model. Models to date have been largely Medicare-oriented, and voluntary models have primarily drawn only those health care providers and organizations with resources and capital to apply and participate, resulting in limited attention to Medicaid and safety net providers. From here on, the Innovation Center will embed equity in every aspect of its models by seeking to include more providers serving low- and modest-income, racially diverse, and/or rural populations; the Innovation Center will aim to ensure everyone has access to providers at the leading edge of transformation. Prioritizing equity across the Innovation Center's portfolio will also help ensure that value- based outcomes are fairly measured and evaluated.

Three core ideas drive our work on health equity:

1. High quality care is equitable care.

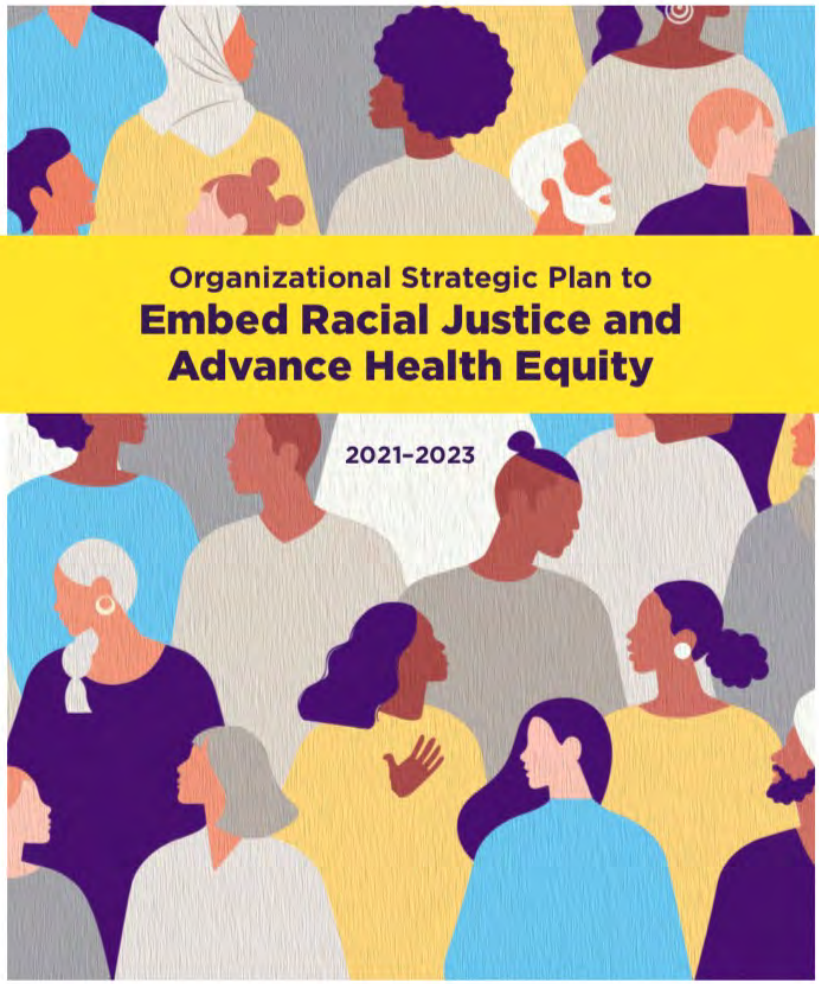
2. No quality without equity.

3. Build equity into all NCQA programs.

Accreditation and Health Equity

Distinction in Multicultural Health Care (MHC) will become Health Equity Accreditation (HEA), with an additional evaluation option, Health Equity Accreditation Plus, starting with the July 2022 surveys.

Two levels of Health Equity Accreditation programs provide a comprehensive framework that organizations can use to elevate and measure health equity goals, deliver culturally and linguistically appropriate services and reduce disparities.



Organizational Strategic Plan to

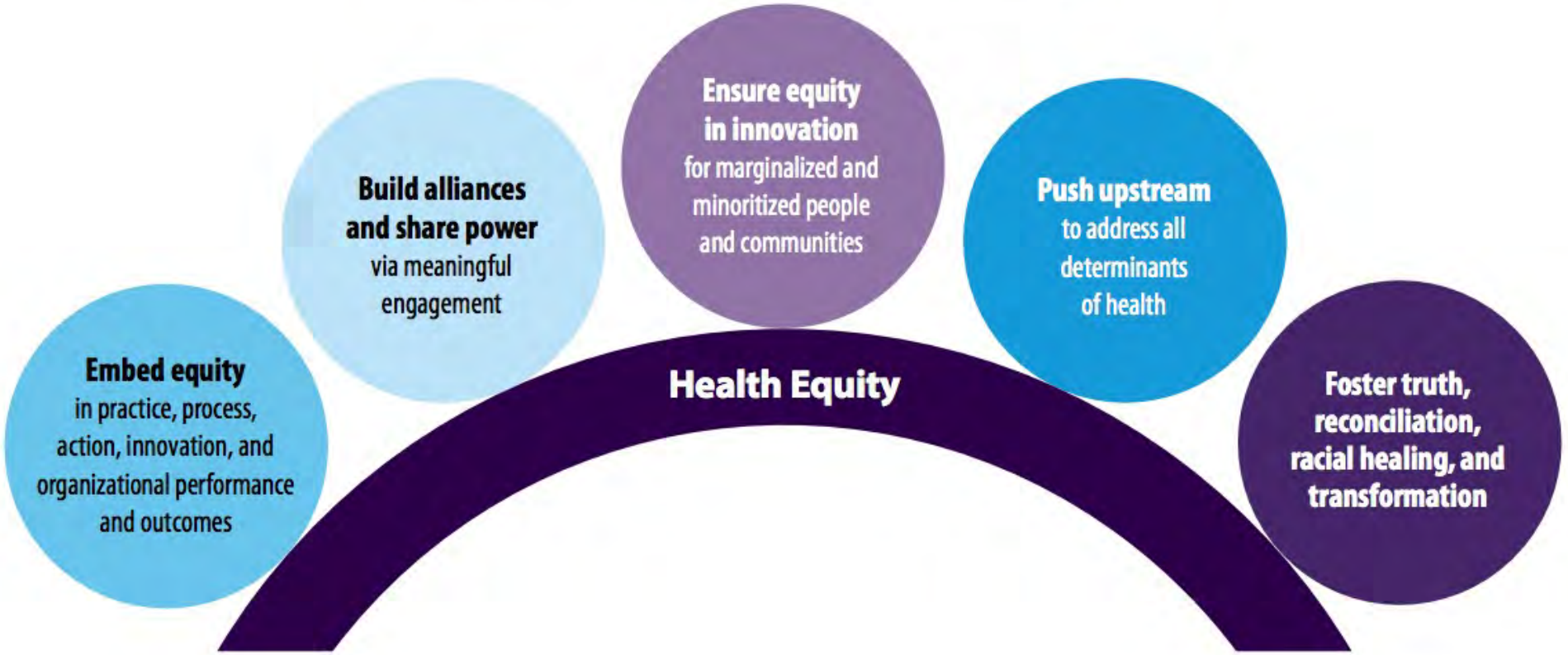
Embed Racial Justice and Advance Health Equity

2021–2023

AMA

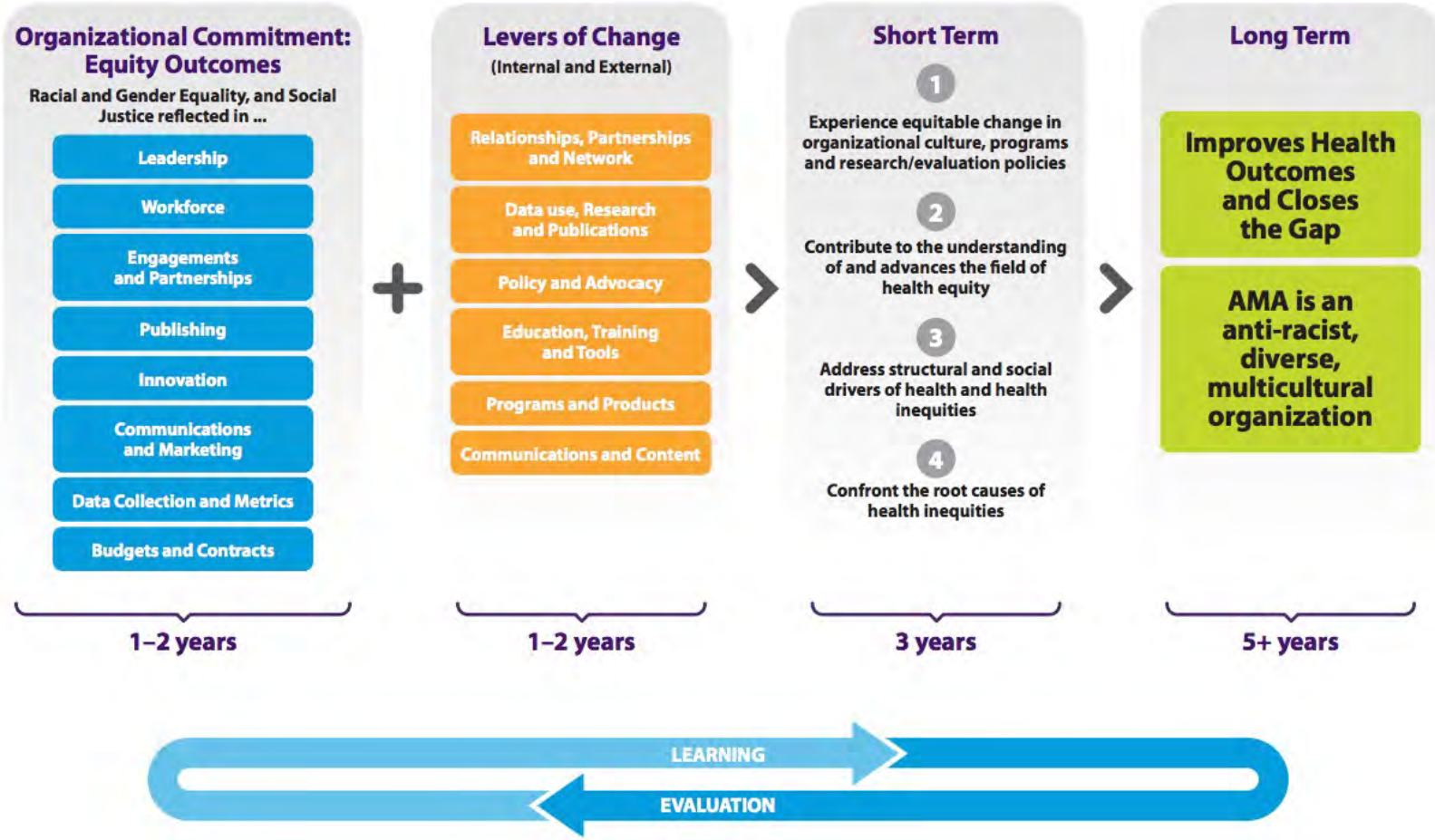
AMERICAN MEDICAL ASSOCIATION

AMA's Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity, 2021–2023



Our logic model for change

Figure 10. AMA's Health Equity Logic Model



- ✓How is your own organization advancing health equity?
- ✓How else could the COHC advance health equity?
- ✓What additional discussion or training on health equity issues would be useful for the COHC Board?

Objectives:

✓ Has this session increased your understanding of how health equity has been prioritized by the Oregon Health Authority?

✓ Has this session increased your understanding of how the federal government and national health care stakeholders are prioritizing health equity?

✓ Has this session identified how COHC and COHC member organizations can advance health equity?

Self-funded Insurance

Deschutes County Employee Health Benefit Plan

Self-Insurance

A self-funded, or self-insured, health plan is one in which the employer assumes the financial risk, and some or all of the administrative burden, for providing health care benefits to its employees.

Self-Insured employers pay for claims out-of-pocket as they are presented instead of paying a pre-determined premium to an insurance carrier for a Fully Insured plan.

Self-Insurance – The Good.

Not subject to certain government regulations or all taxes and fees.

Flexibility with plan design, opportunity to customize to member's unique health care needs.

Access to plan data to be more proactive in plan design.

Only pay for health care costs of own employees.

Maintain control over the reserves and cash-flow.

Self-Insurance – The Bad.

Volatility for smaller organizations or certain demographics.

Exposure to risk, stop-loss insurance needed to cover high cost claim risk.

Employer and Employee contributions to the fund are earmarked.

Administrative burden; requires knowledgeable staff to oversee the plan and vendors.

Self-Insurance at Deschutes County

We are a self-funded government, multi-employer plan.

Stop-loss insurance with a $500K deductible.

Built a well funded reserve to manage risk.

Team of partners to manage the plan.

Estimated 20-25% increase to costs to become fully insured.

	5 Year Average	10 Year Average
Claims Paid	4.1%	3.3%
DOC Clinic	3.4%	2.3%
All Expenses	4.5%	5.4%
Ending Reserve Balance	2.6%	-0.1%
Cost PEPM	0.8%	4.4%

$1625 Per Employee Per Month

Self-Insurance – The Plan.

Managing plan costs through plan design and administrative adjustments.

- Changed TPA – *improved claims oversight.*
- Renegotiated Pharmacy (PBM) and Stop Loss contracts – *added renewal limits.*
- Implemented the Deschutes Onsite Clinic and Pharmacy – a*dded provider capacity.*
- Regularly review demographic and claims data - *invest in outcomes and improved quality of life.*

Self-Insurance – The Plan.

Deschutes Onsite Clinic and Pharmacy

Supports The Triple Aim objectives

- Improve the overall health of employees, dependents and retirees
- Enhance patient experience of care; quality, access, and reliability
- Reduce, or control, the per-capita cost of care

Improved disease management care. Patients benefit from pharmacist, medical providers, and wellness coach all working within the same small building.

Self-Insurance – Hindsight.

What we should have considered.

1. Missed opportunity to make a more dramatic change to our Emergency Room and Urgent Care co-pays when implementing the DOC.
2. Using a composite rate for employee cost-share instead of a tiered rate system.
3. Implementing the initial reserve funding policy at a lower limit.

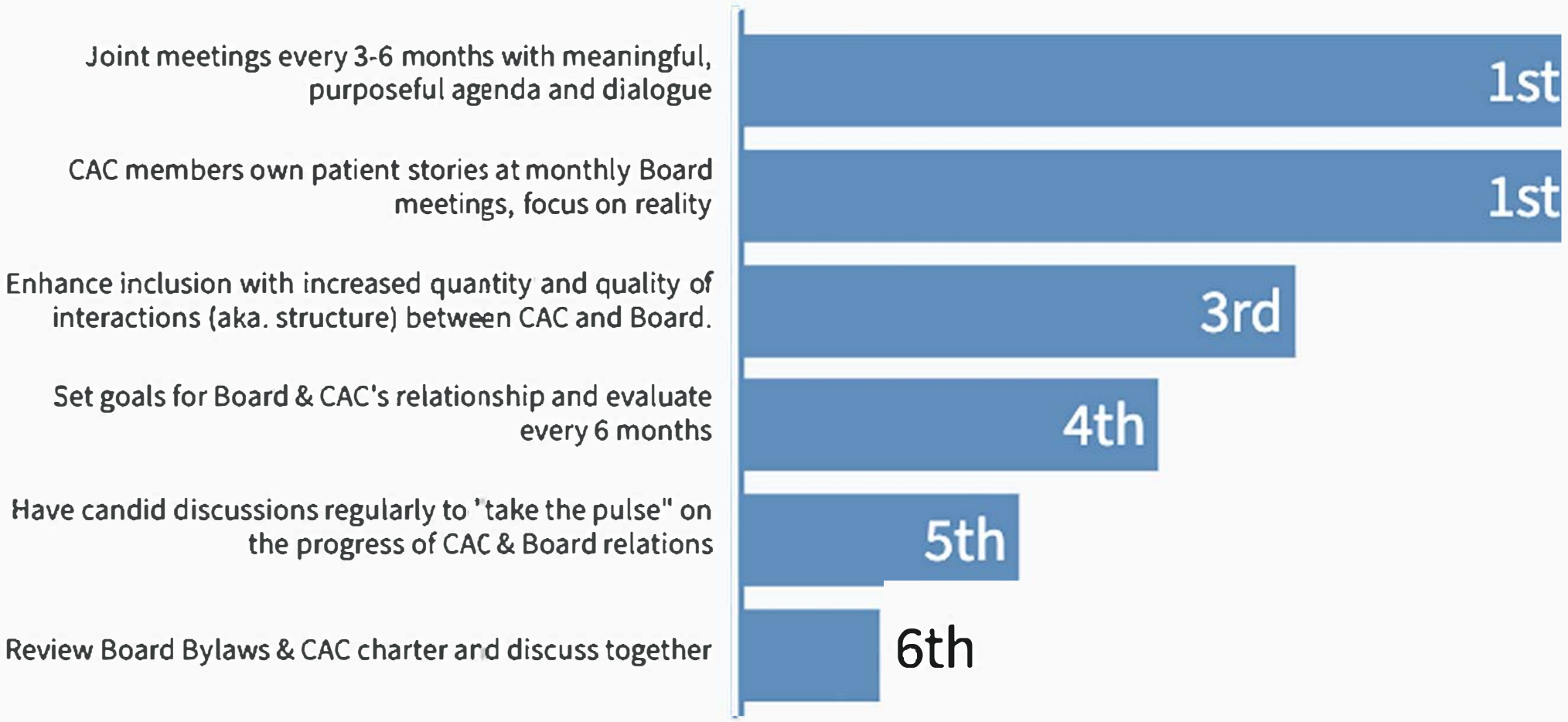
Thank you

County's Goal for Service Delivery –

Maintain strong fiscal practices to support short and long term county needs.

September 2021 Board-CAC Priority Action Poll

Place the following in order of priority



Central Oregon Health Council
Executive Director's Update
October 14, 2021

- Facilitate PEP meeting
- Facilitate Finance meeting
- Multiple stakeholder/community meetings
- EL Hub as ex-officio member
- EL Hub Investment Steering Committee
- Central Oregon Suicide Prevention Alliance Leadership
- COHIE Board Officer – HIE
- System of Care Executive Team member
- Grant software management
- CCO 2.0 alignment and support and training
- Board Governance Committee support
- Manage Cost & Utilization Steering Committee
- Maintain office closure and provide for minimal disruption to staff, committees, workgroups, and community
- Manage Strategic Plan
- Transitioning Unite Us/Connect Oregon to PacificSource
- Manage monthly bookkeeping oversight
- Local Public Safety Coordinating Council – member
- Participated in the Healthcare Congress/American College of Healthcare Executives (ACHE)
- Economic Recovery Plan/CEDS member
- Completed OABHI transition to PacificSource
- New hire effective 8.12.2021 (Kelsey's departure)
- Manage virtual onboarding
- Manage 990 prep
- Budget prep
- Begin OHP contract discussions
- Manage community re-entry (Delta variant)- no progress

Coming up:

- *Back to the Strategic Plan (I hope)*

CCO Director Report
Date: October 2021
To: The Central Oregon Health Council (COHC) Board of Directors
Prepared by: Tricia Wilder, Director, Central Oregon CCO

PACIFICSOURCE COMMUNITY SOLUTIONS (PCS) CENTRAL OREGON CCO UPDATES:

Quality Incentive Measures (QIMs)/Quality Pool
I. Outcome of September Metrics & Scoring Committee Meeting
On its September 17 meeting, the Metrics & Scoring Committee discussed 2021 QIM benchmarks. PacificSource joined fellow CCOs, provider groups, and other interested stakeholders in providing written public comment about the current state of the program and need for Committee reconsideration of 2021 benchmarks given the on-going stressors of the COVID-19 pandemic.

Back in October 2020, the Committee established six COVID-related criteria that would enable revisions to the 2021 QIM performance benchmarks. One of these criteria was related to "county reopening." This criteria was met, triggering a review by the Committee that impacts eight QIM benchmarks.

Ultimately, the Committee approved the following "glide path" approach proposed by OHA with some slight modifications:

- 2021: Benchmarks reset to 2019 Medicaid 25th percentile. No change to improvement targets.
- 2022: Benchmarks set to 2019 Medicaid 50th percentile. Improvement targets will be based upon 2021 performance (without a floor).
- 2023: Benchmarks return to aspirational status, which is typically Medicaid 75th or 90th percentile. Improvement targets based upon 2022 performance with floors.

As such, benchmarks were reset for the following seven QIMs in 2021:

Reset to 2019 National Medicaid 25th Percentile

- Childhood Immunizations
- Adolescent Immunizations
- Diabetes: Poor Control
- Initiation and Engagement of Alcohol and Other Drug Abuse Dependence Treatment

Reset to 2020 CCO 25th Percentile

- Well Child Visits (ages 3-6)
- Oral Evaluation for Members with Diabetes
- Preventative Dental 1-5 and 6-14 (This QIM was decoupled. As long as CCOs meet one age group, the metric as a whole is considered met).

Note: the Committee did not make any changes to the Timeliness to Postpartum Care QIM benchmark.

II. Emergency Outcome Tracking (EOT) COVID-19 Vaccine Measure
As of September 1, the Central Oregon CCO is still performing 3.7% below the overall target in the 16+ age group and also lagging behind in five of the seven race/ethnicity groups. Important to note, the previous month the gap closed by 4% so if this trend continues we will meet the EOT metric for the 16+ age group in October.

Collaborative work between primary care providers and culturally specific community-based organizations continues to be fostered to help meet the seven race/ethnicity group targets. The 12-15 year old age band is also struggling and 9.1 percentage points short from meeting the goal of 42%.

III. Quarter 1 2020 Quality Pool Payout
The COHC's Quarter 1 2020 Quality Pool payout totaled $1,432,518.00. These funds are currently in the process of being released by PCS to the COHC for community distribution.

Redeterminations
When the Public Health Emergency (PHE) was declared in March 2020, the federal government gave states flexibility in determining Medicaid eligibility, and allowed states to keep members enrolled for the duration of the PHE so that people did not lose coverage during the health crisis. As a result, Oregon Health Plan enrollment has grown by approximately 25% since the pandemic began. CMS issued recent guidance to states that will allow states a four-month grace period after the PHE has officially concluded to begin redetermining eligibility for those enrolled in Medicaid. At that point, states will then have 12 months to determine eligibility for their entire enrolled population and to end coverage for those who are no longer eligible. We do not know when the PHE will be declared over, but it is likely to continue until summer 2022, at the earliest. This means that the earliest we may begin to see a reduction in Medicaid membership due to eligibility redetermination will be late 2022 or early 2023, and until then, Medicaid enrollment will remain at an all-time high.

Provider Trainings
There are several on-demand trainings available for providers right now:

- A Motivational Approach to Vaccine Hesitancy
- Motivational Interviewing: Building a Skillset for Patient Engagement & Activation *(12 CME/CEU)*
- Cultural Agility (recorded webinar series) *(9 CME)*

We also have a great fall line-up of live virtual workshops:

- Patient & Family Engagement *(3 AMA PRA Category 1 Credits available)*
    - October 12th & 19th
- Trauma Informed Care – Older Adults in Primary Care (OABHI) *(CME pending approval)*
    - October 14th
- Implicit Bias Virtual Workshop Series *(4.5 AMA PRA Category 1 Credits available)*
    - October 20th, 27th & November 3rd
- Gaining and practicing cultural competency in healthcare *(4.5 AMA PRA Category 1 Credits available)*
    - November 10th, 17th & December 1st
- QPR Suicide Prevention Training *(1 CEU available)*
    - November 18th

Contracted providers can view all of our course offerings by registering at:
https://PacificSource.myabsorb.com?KeyName=Training

COHC Community Advisory Council
Held virtually via Zoom
August 19, 2021

Present
Brad Porterfield, Chair, Consumer Representative
Larry Kogosvek, Vice Chair, Consumer Representative
Conor Carlsen, Consumer Representative
Linda Johnson, Community Representative
Elaine Knobbs-Seasholtz, Mosaic Medical
Theresa Olander, Consumer Representative
Regina Sanchez, Crook County Health Department
Elizabeth Schmitt, Consumer Representative
Ken Wilhelm, United Way of Central Oregon

Absent
Mayra Benitez, Consumer Representative
Natalie Chavez, Jefferson County Public Health
Jolene Greene, Consumer Representative
Tom Kuhn, Deschutes County Health Services
Lauren Kustudick, Consumer Representative
Jennifer Little, Klamath County Public Health
Mandee Seeley, Consumer Representative
Cris Woodard, Consumer Representative

Others Present
MaCayla Arsenault, Central Oregon Health Council
Rebeckah Berry, Central Oregon Health Council
Tania Curiel, Oregon Health Authority
Rebecca Donell, Oregon Health Authority
Buffy Hurtado, PacificSource
Gwen Jones, Central Oregon Health Council
Donna Mills, Central Oregon Health Council
Leslie Neugebauer, PacificSource
Kelsey Seymour, Central Oregon Health Council

Camille Smith, Central Oregon Health Council
Kristen Tobias, PacificSource
Tricia Wilder, PacificSource
Renee Wirth, Central Oregon Health Council

Introductions

- Introductions were made and Brad Porterfield welcomed all attendees.

Public Comment

- Brad welcomed public comment.
- Kristin Tobias noted, in case the flex services presentation didn't happen this meeting due to time constraints, that PacificSource in Central Oregon is out of flex fund dollars for this year. The funds will be replenished in January 2022. If anyone has questions, reach out to Kristin.
- Brad shared that he took his son to the chiropractor and was surprised to learn that OHP does not cover chiropractic services. Leslie Neugebauer responded that PacificSource is aware of the problem and it should be added to emerging issues. Rebecca Donell shared that the OHA Health Evidence Review Committee handles such reviews. Brad noted that it will be pushed to emerging issues.

Approval of the Consent Agenda, Minutes

- Ken Wilhelm motioned to approve the minutes; Linda Johnson seconded. All were in favor and the motion passed unanimously.

Community Health Projects Process Development

- MaCayla Arsenault reviewed the process of awarding Community Benefit Initiative (CBI) monies to the community health projects under consideration via the Letters of Interest (LOIs) the group had received. The 2021 budget is $431,681.98, to be spent by December 31. The group had decided on a two-step process: first requesting LOIs, then determining which they were most interested in funding and asking those organizations to submit full Requests for Proposal (RFPs).
- Theresa Olander wondered why they were not divided into three groups instead of two so they had 10 LOIs to review rather than 15. Gwen Jones explained that not everyone is able to review so approximately four people reviewed each grant, noting that this would be a good discussion for later.
- MaCayla went over the application timeline: On August 23, applicants would be notified or denied. Full applications are due on October 18, with CAC scores due November 1.

Final decisions will be made at the November 18 meeting, with grantees notified on November 22.

- MaCayla discussed the group's narrowed focus on social determinants of health and equity and rural communities, explaining that the scoring spreadsheet was organized by those priorities, with rural areas, Bend/Redmond, and regional service areas broken out, along with the Confederated Tribes of Warm Springs (CTWS), as the CAC had prioritized the tribe being a partner. She shared language in the CCO contract specifying that CCOs must ensure a role for the CAC and tribes in spending decisions.
- Following some discussion, Ken Wilhem confirmed the group's consensus that the final list for RFPs would include the CTWS application.
- After further consideration, Brad made a motion to move forward with four more applications: Warm Springs Community Action Team, REACH, Saving Grace, and the Child Center. The motion passed unanimously.
- Still under budget, the CAC resumed deliberations and came to agreement on five additional projects: Bethlehem Inn, Darlene Urbach Pickleball Courts, Lines for Life, MountainStar, and PAWSitive Choices.
- MaCayla noted that the group had chosen to advance 10 projects for a total ask of $679,334.
- Brad made a motion to approve. Linda confirmed and Ken seconded. There was no opposition.

Emerging Issues Process Update

- Brad is leading the process and is close to moving it through. Gwen sent out an email proposing a small group to review.

Flexible Services

- Brad elected to delay this agenda item until the next meeting due to time constraints.

COVID-19 Final Report for Jefferson County Public Health (Non-RHIP)
"COVID-19 Vaccine Administration and Distribution Grant"

Summary of Results:

- Funding was utilized to support COVID-19 vaccine Points of Dispensing (PODs) in communities throughout Jefferson County.
- Specifically, the funding was utilized to purchase an additional vaccine transport cooler and the additional supplies needed for the clinic (band-aids, cotton balls, disinfectant supplies, etc.).
- PODs were hosted at several locations throughout Madras, Crooked River Ranch, Culver, and Camp Sherman.
- All requested supplies were received.
- Beginning in January 2021, Jefferson County Public Health started providing vaccine outside of the clinic setting.
- These PODs (Points of Dispensing) were set up throughout the community at schools, churches, businesses, community centers, skilled nursing facilities, parks, and fire stations.
- The PODs varied in size form 1,500 attendees down to 10 attendees.
- The PODs and equipment purchased with the COHC grant continue today.
- Additionally, the vaccine transport cooler is now being utilized to provide in-home vaccinations for highly vulnerable individuals and/or caregivers that are unable to leave their homes.
- Supply chains, especially for vaccine related equipment and supplies, were on serious back order. It took an additional 3 months to receive our vaccine cooler.

Quote:

"We have seen numerous people cry tears of joy for receiving the vaccine and take families 'selfies' after the event."
Dr. Michael Baker, Jefferson County Public Health

COVID-19 Final Report for Deschutes County Health Services (RHIP)
"Grandpad Pilot Program"

Reviewed by the Promote Enhanced Physical Health Workgroup

Summary of Results:

- The COHC grant funded the purchase of 7 Grandpad devices.
- Many older adults in our community are not able to access their providers due to isolation, being quarantined, lack of appropriate technology including internet access or physical challenges such as blindness or deafness.
- These barriers make it impossible or extremely challenging to provide them with quality mental health and medical care.
- The Grandpad devices have given our team direct access into client homes or facilities through face to face technology in order to provide vital mental health services to vulnerable older adults during this continuing pandemic.
- The primary result from purchasing the Grandpad devices is to continue to provide vital mental health services during this pandemic that otherwise would not have been available.
- Since starting the Grandpad program we have increased our telehealth capability with older adults from zero to 1100%. Some benefits we have observed are the following:
    - Grandpad's have offered a social lifeline to isolated older adults, allowing them to connect with family and friends.
    - Clients report an increase in self-esteem as they have mastered learning new technology that is often overwhelming or intimidating.
    - Clients report enjoying features of the Grandpad such as the articles, internet access, radio and games. These additional features have allowed clients to enjoy entertainment and provided continued connection to the "outside world".

Quote:

One client reports the following: "I was nervous about using the Grandpad. Technology is usually hard to learn and confusing. I wasn't sure if I could do it. I am happy to say I was able to learn something new and with the help of the Older Adults team I am able to stay connected. I use it to do therapy and I can also talk to my family and friends. When we are on "lock down" it can be depressing, but it helps to know I can reach out to my Older Adults team, family or friends. It's nice to use the features like the radio, articles and I love playing the games. I am grateful for this tool, especially during the pandemic when we have lost so many connections and outlets".

RHIP Mini-Grant Final Report for Central Oregon Locavore

"Central Oregon Locavore Program Support"

Reviewed by the Address Poverty & Promote Physical Health Workgroups

Summary of Results:

- Central Oregon Locavore set out to promote the well-being and belonging of our community members through our WWOLF (Willing Workers on Local Farms) and Edible Adventure Crew programs along with increasing intake of local fruits and vegetables through SNAP usage and sharing recipes.
- We were able to exceed our goal of hosting 4-10 WWOLF and Edible Adventure Crew events.
- Between August 2020 and August 2021, we hosted 11 WWOLF events and 6 Edible Adventure Crews for a total of 17.
- We also developed a partnership with the Oregon Youth Challenge Program to bring at-risk high school youth to farms for a day of volunteering.
- These events included medicinal plant and edible weed walks, blueberry harvesting, apple picking and pressing, and potato gleaning that resulted in hundreds of pounds of potatoes being donated to NeighborImpact.
- We were able to hire a staff person to manage both programs and provide mileage reimbursement for travel to the various sites.
- Additionally, Our SNAP sales increased from an average of $2,500 a month before August 2020 to $4,500 during the grant period.

Quote:

"Having the WWOLF crew out to help with some big projects on the farm really cut down on the time it would normally take to complete those tasks by a ton! Having 14-16 sets of hands instead of 2 really does make for lighter work that is so much more enjoyable. The group was extremely motivated, and many had already volunteered several times together. It really had a community feel. I got to know some familiar faces and met so many new folks from our community." - farmer Gia

Central Oregon Coordinated Care Organization

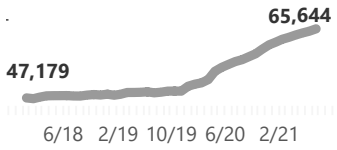
Updated 9/28/2021

PacificSource Community Solutions

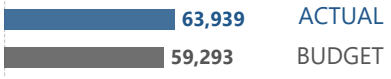
AVERAGE MEMBERS **65,644**

24,110 children

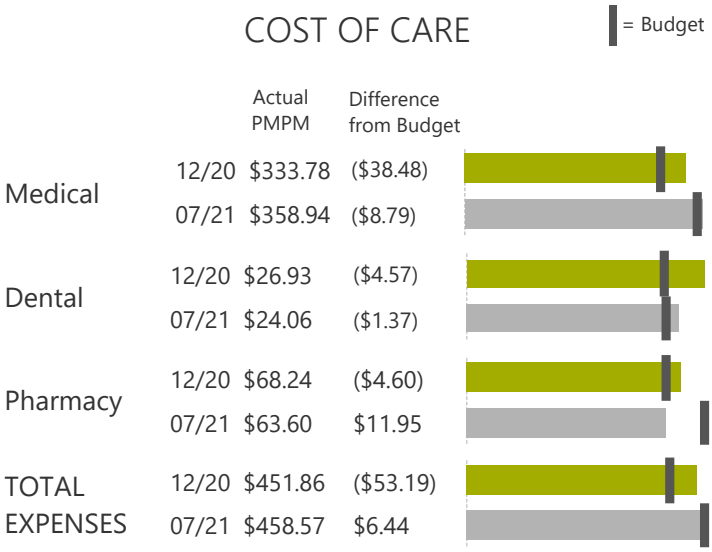
41,534 adults



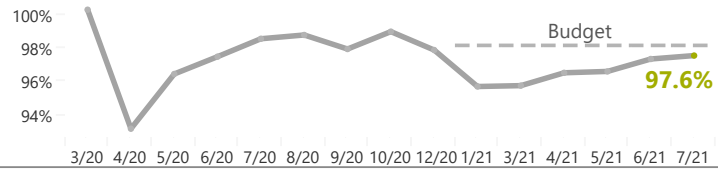
Average Members (Finance YTD)



COST OF CARE



Expenses & Claims Over Revenue (YTD)



FOCUS ON: COVID VACCINATION MEASURE

COVID Emergency Outcome Tracking Measure Ages 16+ as of August 2021

1 *Overall Rate Ages 16+*	# Mem	Rate	Target
Central OR	**39,446**	**43.7%**	**47.4%**

2 *Rate by Race*	# Mem	Rate (Bar) & Target (Line)	# Needed to Meet
Asian	246	67.1%	
Hispanic/Latinx	1,819	49.1%	
African American/Black	184	45.1%	4
White	18,497	45.0%	444
Unknown/Did Not Answer	17,921	41.8%	
American Indian/Alaskan Native	435	40.7%	29
Other	275	40.4%	19
Native Hawaiian/Pacific Islander	69	26.1%	15

42.0% 47.4%

Color Legend

Meeting | *Not Meeting* | *Not Assessed Separately (<50 members or unknown race)*

ACCESS & UTILIZATION

(01/2019 to 08/2021, paid thru 08/2021; no completion factor applied)

		Visits PTMPY	% Members
Behavioral Health	2019	3,253	16%
	2020	3,772	16%
	2021 YTD	3,379	15%
Dental	2019	1,120	32%
	2020	685	24%
	2021 YTD	698	22%
Primary Care	2019	2,182	49%
	2020	1,866	47%
	2021 YTD	1,698	41%
Specialist Office	2019	636	17%
	2020	579	17%
	2021 YTD	565	14%
Emergency Dept	2019	572	20%
	2020	431	17%
	2021 YTD	382	13%
Inpatient Admits	2019	83	4%
	2020	73	4%
	2021 YTD	57	3%

**Visits Per 1,000 Members per Year*

FOCUS ON: COVID VACCINATION MEASURE

COVID Emergency Outcome Tracking Measure Ages 12-15 as of August 2021

3 *Overall Rate Ages 12-15*	# Mem	Rate (Bar) & Target (Line)	# Needed to Meet
12-15 age group	5,178	32.9%	471

42.0%

Central Oregon CCO is not currently meeting requirements for payout

In order to reach full payout, CCOs need to meet three parts of the COVID Emergency Outcome Tracking (EOT) measure:

1. *Overall rate for members aged 16+ must meet the target*
2. *Rates for each race with at least 50 members must meet the target (with partial payment if all groups meet 42%)*
3. *Rates for members aged 12-15 must meet the target*

The EOT Measure uses ALERT vaccination records only

DEFINITIONS

# Needed to Meet	Number of additional members receiving the vaccine to meet the region specific target for full payout
ABAD	Aid to the Blind / Aid to the Disabled
ACA	Affordable Care Act (Medicaid Expansion)
Avg	Average
BH	Behavioral Health (mental health, substance abuse and addictions)
CAF Children	Children in Adoptive, Substitute, or Foster Care
CHIP	Children's Health Insurance Programs
EOT	Emergency Outcome Tracking Measure
Expenses and Claims Over Revenue	Total expenses including claims expense and administrative expenses divided by the total revenue
Medical Claims Expense	Claims-related expenses, including capitation, pharmacy, disease management and network fees, pharmacy rebates (if applicable), health services expenses and IBNR (incurred but not received).
Mems	Members
MM	Member Months. One member month = one person enrolled for a whole month. If a person is enrolled for an entire year, that is equivalent to 12 member months. If a person is enrolled for 2 out of 4 weeks in the month, that is 0.5 member months.
NEMT	Non-Emergent Medical Transport
Net Income	Underwriting Income combined with results of activities not directly related to continuing operations, on an after tax basis.
OAA	Old Age Assistance
PCP	Primary Care Provider
PLM	Poverty Level Medical
PMPM	Per member per month
PTMPY	Per thousand members per year
TANF	Temporary Assistance to Needy Families
Utilization	Use of a good or service
YTD	Year to date. For this dashboard, Financial YTD is based on the calendar year beginning January 1st.

NOTE: All financial PMPMs and cost bucketing comes from the Finance Dept. This means that costs, revenues and expenses are all presented on a ***paid date*** basis, regardless of what year they were incurred.