COHC Virtual Board of Directors Meeting
Thursday, April 14, 2022 • 12:30 pm
Meeting registration: https://bit.ly/2Mkqvit
Dial-in: 1 (669) 900-6833 • Meeting ID: 542 240 567 • Passcode 406760

12:30–12:40 Welcome and Public Comment – Tammy Baney
12:40–12:45 Action Item Update and Consent Agenda ........................................ vote
12:45–12:55 Patient Story – Conor Carlsen ............................................................... info

GOVERNANCE
12:55–1:00 Board Strategic Plan Survey – Gwen Jones ........................................ info

LONG-TERM SYSTEMIC CHANGE
1:00–1:40 Understanding Additional Impacts of the Housing Crisis
  • OSU–Cascades – Carolyn Platt
  • COHC Investments – COHC Staff
  • Next Steps – Tammy Baney .............................................................. info & discussion
1:40–2:10 Project Access Now – Megan Haase and Carly Hood-Ronick ................. info & discussion

RHA/RHIP
2:10–2:30 Data Review: CO Health Data – Rebeckah Berry ........................ info
2:30–2:45 CAC Report – Brad Porterfield ......................................................... info
2:45–2:50 ED Updates – Donna Mills ............................................................... info
2:50 Adjourn

Consent Agenda
  • March 2022 Board Minutes
  • COHC February Financials (pre-audit)
  • Ratify New ED Selection

Written Reports
  • Executive Director’s Report
  • CCO Director Report
  • CCO March Dashboard
  • COHC Board Hydraulics
  • March 2022 CAC Minutes
  • April Mini-Grant Reports

The Central Oregon Health Council Board of Directors reserves the right to transition into executive session at any point during the Board meeting.
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 pm Pacific Standard Time on March 10, 2022, 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**
- Tammy Baney, Chair
- Linda Johnson, Vice Chair
- Gary Allen, DMD
- Brad Porterfield
- Iman Simmons
- Justin Sivill
- Dan Stevens
- Rick Treleaven

**Directors Absent**
- Patti Adair
- Paul Andrews, EdD
- Seth Crawford
- Megan Haase, FNP
- Divya Sharma, MD
- Kelly Simmelink

**Guests Present**
- MaCayla Arsenault, Central Oregon Health Council
- Rebecca Donell, OHA
- Miguel Herrada, PacificSource
- Wendy Jackson, COPA
- Bess Jayme, PacificSource
Ms. Baney served as Chair of the meeting and Ms. Smith served as Secretary. Ms. Baney 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
Ms. Baney welcomed all attendees to the meeting and facilitated introductions.

PUBLIC COMMENT
Ms. Baney invited public comment. No public comment was offered.

CONSENT AGENDA
The consent agenda consisted of the February meeting minutes and COHC’s December and January financials.

MOTION TO APPROVE: Dr. Allen moved to approve the consent agenda; Ms. Johnson seconded. All were in favor and the motion passed unanimously.

ACTION ITEMS
An action item remains open:
- The Executive Director will create a proposal to add two new community representatives to the Board—ON HOLD pending Strategic Plan work at May Board retreat.

CAC PATIENT STORY
Mr. Porterfield gave an update on follow-ups for two patient stories regarding dental and orthodontic care that were previously recounted to the Board. He shared that the CAC planned to meet with representatives from the three dental care organizations in the region contracted with the
CCO as well as representatives from PacificSource and OHA at their next meeting. The CAC would like to build relationships and share patient stories directly with the DCOs.

**JMA 101**

Ms. Mills explained that she and Ms. Neugebauer had set up an annual overview of the JMA and governance structure of the Board, which utilizes a distributed leadership model wherein we look to the community to make investment decisions for our RHIP funding. The Joint Management Agreement, or JMA, was a groundbreaking agreement between the CCO and the Health Council around this community governance model. Oregon Senate Bill 741, passed in 2021, permitted the Health Council to operate in perpetuity, allowed the Central Oregon community to work as a region, and provided for a community arm to the CCO. Under the provisions of the JMA, the Health Council receives a .325 percent operating revenue from the CCO budget, as well as 1 percent for RHIP investments, and agrees to guarantee a 2 percent margin at the end of the year for the CCO. When there is a year-end surplus, 50 percent goes to behavioral health and the remaining 50 percent is divided among providers, COHC, and the CCO. If a 2 percent margin is not achieved, COHC pays a recapture to the CCO, which they have graciously waived for the past two years during the pandemic.

Mr. Stevens commented on how the establishment of the Health Council brought about dynamic change with regional partners coming to the table together to address the metrics and the expectations. He noted that we are all in this together with respect to how the dollars flow—it is our money collectively.

**CCO Initiatives**

Ms. Baney introduced OHA’s presentation by acknowledging that we are experiencing a crisis of homelessness in the tricounty area and asking what the role of the Health Council is in addressing it.

Rebecca Donnell, innovator agent with OHA, reminded the Board about their discussion a few months ago on the public health crisis we have been experiencing during the Covid pandemic and its intersection with homelessness and the impacts on health care access, employment, and food insecurity. She offered to look into how other regions had responded and how the CCO could support connecting people to resources.

Some examples: All Care CCO had established a resiliency fund to get money into the community where it was most needed and to address social determinants of health in Curry, Jackson, Josephine, and southern Douglas Counties—e.g., domestic violence, economic fragility, food insecurity, homelessness—directing funds toward Latinx and tribal communities, people with underlying conditions, senior citizens, veterans, children, and others being impacted by Covid. The aim of the Covid Provider Continuity program at Health Share OR was to administer Medicaid and allow formerly commercial patients to keep their providers so there would be no disruption to families seeking care. Health Share OR also allocated Medicaid flexible service dollars specifically around food insecurity and made sure that area CBOs knew how to access those funds. The Eastern
Oregon CCO used funds to assist those with Covid-19 and unanticipated needs such as housing disruptions.

The Transformation Center at OHA was looking at what CCOs were doing around social determinants of health. One of the most interesting examples Ms. Donnell found in her research was how OHA was using Z codes within the EMR to identify whether people had been vaccinated or not and how to use them to identify those who were unhoused and connect them to other resources in the community such as food and behavioral health.

Ms. Knight-Alvarez, an operations and policy analyst at OHA, was working in the Covid response and recovery unity, where this project started, and one of her tasks became to mitigate Covid among people experiencing homelessness by ensuring access to vaccines. She explained that Z codes, diagnosis codes related to homelessness, were OHA’s best shot at helping homeless people get vaccinated. Using Z codes allowed them to capture data and better track the priority population, apply equity metrics and incentives, mitigate the spread of Covid, and provide transparency and integrity with their Medicaid data. Using the Z codes creatively proved to be very effective.

The Z codes are unique individual codes, so individuals could be coded more than once. For instance, in the point-in-time count, data analysts just see the numbers. Since OHA doesn’t have data sharing with housing organizations, if people have housing issues and are not on OHP, they wouldn’t know. This is a way to identify people experiencing houselessness and at risk in other ways. OHA is hoping to connect in other areas to see if they can share data, such as the Oregon Housing Consumer Report and community action agencies.

Ms. Baney remarked on the incredible tie-in with discussions happening locally—e.g., the by-name list, the point-in-time count—and pointed out the possibility of a crosswalk with individual identifiers. She inquired whether the Board thought they should establish an ad hoc committee or would care to hear more on this issue from the Stable Housing workgroup and suggested she and Ms. Mills discuss it offline. Tee up and talk data. and id where we sit today, where we want to be tomorrow

ACTION: Ms. Baney and Ms. Mills will discuss the data and where to take this conversation before bringing it back to the Board.

VALUE-BASED PAYMENTS

Mr. McGarry, vice president, Provider Network for PacificSource, presented on value-based payments (VBPs). CCOs are required to expand the use of domain-based VBPs (e.g., in particular care domains: hospital care, maternity care, behavioral health, children’s care, and oral health) from 2020 to 2024. Central Oregon has the achievement of establishing a model where providers are part of the model. New arrangements for maternity, behavioral health, and the hospital are to be implemented in 2022, children’s in 2023, and oral health in 2024. New metrics for postpartum care are expected within eight weeks.
Next, they must increase the Learning and Action Network (LAN) VBP framework, which includes four categories: (1) fee for service (FFS), which has no link to quality or value; (2) FFS with bonus of pay for performance; (3) FFS with bonus and/or downside risk tied to quality; and (4) full risk or capitation for a population, tied to quality.

In Central Oregon thus far, VBPs have increased from 20 percent in 2020 to 35 percent in 2021 to 50 percent in 2022. Sixty percent is targeted for 2023 and 70 percent for 2024. Mr. McGarry also explained 2C and 3B contracts. In category 1 VBPs (FFS only), there is no risk withhold, health care budget, surplus/deficit sharing, or quality metric incentives. Category 2 has the conversion factor of QIMs, which is a classic 2C. Category 3, a health care budget including FFS with bonus and downside risk tied to quality metrics performance, is a classic 3B. If there is a deficit, providers have a responsibility to help offset it; if there is a surplus, additional dollars are shared out. For Category 4, there is no budget, no risk withhold, no surplus/deficit sharing—it’s all quality metric incentives.

Under the model we now have in Central Oregon, surplus dollars go to providers and COHC, while QIM performance brings more dollars to multiple different providers (primary care, specialty care, St. Charles, CMHPs, COHC). Via the hospital capitation withhold, St. Charles, CMHPs, and providers have incentives to work together on metrics performance. The model also creates opportunities to fund special community needs such as the Deschutes Stabilization Center and pediatric hospitalist program. The model has yielded spectacular financial results and has opened access to Medicaid/OHP because providers want to be part of it.

**CCO Health Equity Plan**

Mr. Herrada, health equity and diversity strategist for PacificSource, gave an overview of their community-informed five-year plan. He informed the Board that goals and progress measures will change in June but they haven’t received feedback and guidance from OHA yet.

He covered some of their key successes in 2021: PacificSource held staff and provider trainings on the grievance and appeals process to ensure members could give feedback without fear of negative consequences and created a nonretaliation statement to reinforce the message. The CCO allocated resources in each region to support the growth of workforce diversity. Training and learning opportunities were offered to build cultural responsiveness and implicit bias core competencies among CCO leadership and staff. They collected and analyzed data on member experiences with interpreter services to improve equitable language access. They also created plain language materials in multimedia formats to enhance member communications.

New projects for 2022 include standardizing processes to ensure members receive materials in their preferred language; aligning PacificSource’s Language Access Plan with the health equity quality incentive metric and any new interpretation requirements; including cover letters or introductory paragraphs in plain language to explain the purpose of member communications; continuing to develop health equity infrastructure and community partnerships; documenting efforts to develop
systems and processes to advance health equity (e.g., the commitment to advance); and forming true community partnerships. He explained that a lot of effort goes into creating those collaborations and developing trust and noted the opportunity for the Health Council and community partners to support and help develop relationships. He expressed the need to create projects and work with those communities.

Mr. Porterfield commented that expanding workforce diversity depends on raising awareness in youth and young adults and giving them opportunities in the health field, such as a program offered by Volunteers in Medicine. He also suggested offering young people work as scribes, where they could take notes and engage in hands-on learning.

Ms. Mastrangelo shared that their program had been run in conjunction with St. Charles to bring in high school students particularly who might be interested in health careers to give them opportunities and connect them with mentors. They had been unable to offer it for the past two years because of Covid.

Mr. Stevens noted that many organizations have professional development plans for high-potential employees. To advance the DEI workforce development initiative, he wondered whether COHC and the participating organizations could identify individuals and, as a community, partner together to develop and advance their careers—for instance, allow them to rotate through different providers.

Ms. Baney touted the training provided through COIC with East Cascade Works—internships with Warm Springs, Public Works, and Jefferson County Public Health.

Mr. Treleaven explained that his organization had embedded this type of development by paying for training and schooling as the only way to develop a workforce that looks like our communities. He pointed out that many people from marginalized communities do not have role models teaching them how to enter the professional space and we need to think about not just paying for training and opportunities but also creating support networks for people to learn how to navigate this space.

**ADJOURNMENT**

There being no further business to come before the Board, the meeting was adjourned at 2:48 pm Pacific Standard Time.

Respectfully submitted,

Camille Smith, Secretary
Central Oregon Health Council  
Statement of Financial Position  
YTD 2.2022 - Pre Audit

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>General Fund</th>
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<tbody>
<tr>
<td>Checking/Savings</td>
<td></td>
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<tr>
<td>Total Checking/Savings</td>
<td>$18,262,648</td>
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<tr>
<td>COPA - Security Deposit</td>
<td>1,997</td>
</tr>
<tr>
<td>TOTAL ASSETS</td>
<td>$18,264,645</td>
</tr>
</tbody>
</table>

| LIABILITIES & EQUITY | |
| Accounts Payable | $184,890 |
| Payroll Payable (PTO Accrual) | 37,786 |
| RHP 2020-2024 Payable | 8,357,778 |
| Grants Payable | 1,418,772 |
| Net assets without donor restrictions | 8,852,843 |
| Net Income/(loss) | (587,424) |
| TOTAL LIABILITIES & EQUITY | $18,264,645 |

<table>
<thead>
<tr>
<th>Revenue</th>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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<tr>
<td>Operating Revenue</td>
<td>$122,126</td>
<td>$200,000</td>
<td>-39%</td>
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<tr>
<td>Community Impact Funds</td>
<td>$334,710</td>
<td>$450,000</td>
<td>-26%</td>
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<tr>
<td>Grants</td>
<td></td>
<td>8,333</td>
<td>-100%</td>
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<tr>
<td>Interest income</td>
<td>69</td>
<td>16,667</td>
<td>-100%</td>
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<tr>
<td>Total Revenue</td>
<td>$456,904</td>
<td>$675,000</td>
<td>-32%</td>
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| Expenses | |
| Operating Expense | $186,223 | 257,978 | 28% |
| Community Impact Funds* | 858,105 | 750,000 | -14% |
| Total Expenses | 1,044,328 | 1,007,978 | -4% |

| Net Income | | | |
| (587,424) | (32,978) | 1681% |

* Community Impact Funds - Top 4 funded 2022
- High Desert ESD: 125,000
- COCC: 191,548
- Jefferson County: 117,857
- Agricultural Research: 43,500
- Impact Incentive Funds: 372,200
- All other: 8,000

$858,105

**Variance is due to timing of Community Impact Funds revenue and distribution of funds through Grants in different years.

**CCO Financials**

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Central Oregon Health Council
Executive Director’s Report
April 14, 2022

• 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
• Grant software management
• CCO 2.0 alignment and support and training
• Board Governance Committee support
• Maintain office closure and provide for minimal disruption to staff, committees, workgroups, and community
• Manage Strategic Plan
• Manage monthly bookkeeping oversight
• Local Public Safety Coordinating Council member
• Current American College of Healthcare Executives (ACHE)
• Economic Recovery Plan/CEDS member
• Manage virtual onboarding
• Advisory to OHP (CCO) contract discussions
• Manage community re-entry
• Staff recruitment committee and recruiter hire – HIRED NEW ED
• Begin Finance Committee/DEI conversation
• Prepare COHC staff and community for ED transition
• Community Justice team member
• Prepare for May ED assimilation (Board/CAC/staff)
• Strategic Plan update for BOD
• Prepping for CBI/HRS migration from PCS to COHC

Coming up:
• Offboarding
CCO Director Report
Date: April 2022
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:

2022 Social-Emotional Health Quality Incentive Measure (QIM)
PCS continues to work with Health Council and early learning partners to mobilize on the new social emotional health QIM for 0-5 year olds in early 2022 in the following ways:

- Identifying a cross sector community advisory body to provide critical input and direction with partnership from Health Council and Early Learning Hubs as regional experts
- PCS’ Analytics team has staged the Child Health Complexity Data for 0-5 year olds provided by OHA
- Formalized work plan presentation to external advisory body in Q2
- Analyzing existing Asset Maps to determine next steps

Medicaid Redeterminations
The federal government has promised to give states at least 60 days’ notice prior to ending the Public Health Emergency (PHE). It is likely that the PHE will be extended until mid-July 2022. The Oregon Health Authority (OHA) plans to begin Oregon Health Plan (OHP) redetermination efforts within 60 days of the PHE ending, which means eligibility verifications could resume as early as September. The OHA is planning a slow ramp-up, initially focusing on members least likely to lose coverage and members with fewer medical conditions and complexities. The bulk of redeterminations will likely happen in 2023. OHA estimates that 90% of OHP members will have information verified through automated processes, and the remaining 10% of members will go through active renewal. Members will have up to 90 days to respond to requests for more information and will receive two reminder notices. Those who are determined no longer eligible for OHP will receive at least 60 days advance notice prior to loss of coverage.

House Bill 4035 was recently passed in legislative session and in part establishes a process for OHA to create a bridge health plan which could be offered to Oregonians who do not qualify for Medicaid because they earn slightly too much. There are an estimated 55,000 individuals in this group with income falling between 138-200% FPL, and historically this group has “churned” on and off of OHP. The goal of the bridge plan is to provide affordable and accessible coverage while preventing loss of insurance coverage for those who are no longer eligible for OHP due to an increase in income. Currently, the state is establishing a task force to provide guidance to OHA in developing the bridge plan. HB 4035 also directs resources toward creating an orderly transition for the estimated 300,000 Oregonians who may no longer qualify for OHP following the end of the PHE, including funding to support outreach efforts.

Healthier Oregon Program (formerly known as Cover All People)
OHA has provided CCOs with eligibility data including demographic information for current Citizen-Alien Waived Emergency Medical (CWM) members who are likely eligible for Healthier Oregon Program (HOP) membership beginning July 1. Across Oregon, approximately 11,000 members will be eligible. Initially,
HOP will cover individuals aged 19-25 and 55+, approximately totaling 5,000 individuals. A large proportion (65%) of CWM members indicated Spanish as their preferred written and spoken language.

These estimates do not include approx. 4,000 pregnant and postpartum members aged 26+; OHA is reviewing how and whether to enroll these members so as to avoid interruptions in coverage. HOP is subject to $100 million legislative appropriation, which could impact the timeline for enrollment of other coverage groups (adults aged 26-54), although OHA has indicated that January 1, 2023 will likely be the next entry point for enrollment of additional populations.

**Connect Oregon**

Connect Oregon network growth and development continues under the direction of the CCO Director and Community Health Coordinator, via outreach and engagement with key healthcare providers and community-based organizations. A demo of the platform was recently provided to the COHC Behavioral Health RHIP Workgroup to share information about Connect Oregon and the behavioral health screening tool being piloted by the Health Integration Collaborative in Lane County. A second demo of the platform was presented at COHC Operational Council meeting with the goal of sharing success stories, answering questions and to help ensure continued use of the platform. In addition, key partners who have recently joined or become active on the platform include Klamath Community College, Housing Works, Volunteers in Medicine, and Clinic of the Cascades.

**Training and Facilitation Updates**

- The Training & Facilitation Program is hiring!
  - Training & Facilitation Program Coordinator
  - Health Care Interpreter Program Trainer
    - Please spread the word to help PacificSource find the perfect candidate(s)
- Upcoming Trainings
  - **Five Foundational Fridays for Provider Wellness**
    - This five-part series presented by Dr. Amy Stoeber will go beyond self-care to offer real strategies to mitigate health care provider and staff burnout and overwhelm
    - Starts Friday, April 8, 2022 at 12PM and continues every other Friday through June 3, 2022
    - Up to 5 AMA PRA Category 1 Credits™ are pending approval
  - **Ethics Seminar**
    - Paul Cooney is a healthcare attorney who specializes in healthcare litigation. Mr. Cooney is General Counsel for the Oregon Counseling Association and the Oregon Psychological Association. He will present an Ethics Seminar covering a wide range of current issues
    - Friday, April 22, 2022 from 8:00AM to 3:00PM with a break from Noon to 1:00pm
    - Up to 6 AMA PRA Category 1 Credits™ are pending approval
- **Recognizing & Overcoming Unconscious Bias** and **ResCUE Model for Cross Cultural Clinical Care** still available for a limited time!
  - PacificSource is offering providers and their staff the opportunity to take these required trainings free of charge for a limited time.
  - This offer will expire Summer 2022
  - Up to 2 CME/CEU/CDE available
  - Contact trainingopportunities@pacificsource.com to sign up staff today!

**PACIFICSOURCE COMPANY-WIDE UPDATES:**

With the ongoing decline of COVID-19 cases and hospitalizations, PacificSource employees have slowly started returning to our offices and will be more regularly in-person starting in May. There are currently no limitations on external visitors to our offices other than individual comfort levels with in-person meetings. We will continue to offer virtual/hybrid meeting opportunities. We look forward to reconnecting with our external partners! Please connect with the CCO Director for any additional questions.
Central Oregon Coordinated Care Organization

AVERAGE MEMBERS: 69,001

24,787 children
44,214 adults

7/18 4/19 1/20 10/20 7/21

47,179 69,001

Average Members (Finance YTD)

69,285 ACTUAL
69,569 BUDGET

FOCUS ON: SOCIAL EMOTIONAL HEALTH

Behavioral Health
Dental
Pharmacy
TOTAL EXPENSES

Medical
12/21 $374.81 ($19.88)
01/22 $360.92 $2.16
12/21 $21.35 $1.37
01/22 $22.28 $1.70
12/21 $60.78 $16.23
01/22 $63.18 $5.98
12/21 $471.18 ($0.21)
01/22 $425.60 $49.27

COST OF CARE

Actual PMPM Difference from Budget

= Budget

100% Budget
95% 90%

Access & Utilization

(01/2019 to 01/2022, paid thru 01/2022; no completion factor applied)

Visits PTMPY % Members

Behavioral Health
2020 4,350 21%
2021 4,060 22%

Dental
2020 685 24%
2021 767 28%

Primary Care
2020 1,867 47%
2021 1,694 48%

Specialist Office
2020 579 17%
2021 593 18%

Emergency Dept
2020 434 17%
2021 408 18%

Inpatient Admits
2020 73 4%
2021 63 4%

*Visits Per 1,000 Members per Year

FOCUS ON: SOCIAL EMOTIONAL HEALTH

% of Pediatric Members Ages 0 to 5 with Social Indicator

(Internal PacificSource Data Source Algorithms)

Child Poverty 98.7%
Parent Poverty 71.6%
Parent Language Barrier Flag 52.2%
Child Mental Health 23.3%
Parent SUD 22.2%
Parent Mental Health 18.2%
Parent Disability 10.8%
Potential Language Barrier 8.3%
Child Abuse, Neglect, Maltreat. 5.4%
Foster Care History 2.8%
Parent Incarceration 1.5%
Parent Death 0.3%
Child SUD 0.0%

% of Pediatric Members with 3+ Social Indicators 61.0%
### General Definitions and Acronyms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition &amp; Data Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AI/AN</strong></td>
<td>Member selected one of the racial or ethnic identities under the American Indian and Alaska Native section as their primary race.</td>
</tr>
<tr>
<td><strong>Assessment Rate</strong></td>
<td>In January 2022, OHA provided CCOs with Social Emotional Health reach metric data. The assessment rate is the percent of children ages 0 to 5 included in the measure who have had a qualifying assessment. OHA used the enrollment as of December 31, 2021 for this measure and data for assessments from October 1, 2020 to September 30, 2021 for this measurement. For a full list of codes used, see: <a href="https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx">https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx</a>.</td>
</tr>
<tr>
<td><strong>Behavioral Health Visit</strong></td>
<td>The member has had a behavioral health visit in the last 12 months according to the MiPi member profile.</td>
</tr>
<tr>
<td><strong>BH</strong></td>
<td>Behavioral Health (mental health, substance abuse and addictions).</td>
</tr>
<tr>
<td><strong>Black/Afr Am</strong></td>
<td>Member selected one of the racial or ethnic identities under the Black and African American section as their primary race.</td>
</tr>
<tr>
<td><strong>Child Abuse, Neglect, Maltreatment</strong></td>
<td>Based on PCS internal data of ICD-9, ICD-10 diagnosis codes used by providers in claims.</td>
</tr>
<tr>
<td><strong>Child Mental Health</strong></td>
<td>Based on PCS internal data. Child received mental health services or diagnoses according to claims data.</td>
</tr>
<tr>
<td><strong>Child Poverty</strong></td>
<td>Based on PCS internal data. The child poverty social indicator is determined by eligibility rate group of Temporary Assistance for Needy Families (TANF).</td>
</tr>
<tr>
<td><strong>Complex SUD</strong></td>
<td>Based on PCS internal data. Child received substance abuse treatment or diagnoses in claims.</td>
</tr>
<tr>
<td><strong>Complexity Methodology</strong></td>
<td>The second healthiest category in the Pediatric Medical Complexity Algorithm. Members in this category are considered in the mid-tier medical complexity category based on a three year lookback of data on diagnoses and number of body systems impacted by conditions.</td>
</tr>
<tr>
<td><strong>Other PS CCO</strong></td>
<td>Other PS CCO in this CCO Dashboard combines all other PacificSource Medicaid CCO regions other than the CCO of reference for contextual comparisons.</td>
</tr>
<tr>
<td><strong>Parent Language Barrier</strong></td>
<td>Based on PCS internal data. The member’s adult family member has either received interpretation service, has a spoken or sign interpreter need according to REALD, or has indicated a primary spoken language other than English.</td>
</tr>
<tr>
<td><strong>Parental Death</strong></td>
<td>Based on PCS internal data. A child will have this indicator if there is data found indicating a parent is deceased.</td>
</tr>
<tr>
<td><strong>Parental Disability</strong></td>
<td>Based on PCS internal data. Parent is eligible for Medicaid due to a recognized disability.</td>
</tr>
<tr>
<td><strong>Parental Incarceration</strong></td>
<td>Based on PCS internal data. A child will have this indicator if a parent has a history of incarceration according to internally available data.</td>
</tr>
<tr>
<td><strong>Parental Poverty</strong></td>
<td>Based on PCS internal data. The parental poverty social indicator is determined by access of Temporary Assistance for Needy Families (TANF).</td>
</tr>
<tr>
<td><strong>Pediatric Health Complexity Methodology</strong></td>
<td>Pediatric health complexity combines a member’s medical complexity and social complexity to better reflect the member’s health. This reporting uses both pediatric health complexity data from OHA and internal data on medical and social complexity. The member’s final pediatric complexity will reflect the most complex medical and social categories of either data source. In other words, this reporting reflects the maximum complexity of either data source.</td>
</tr>
<tr>
<td><strong>Potential Language Barrier</strong></td>
<td>Based on PCS internal data. The member has received interpretation according to claims/vendor data, or has a spoken or sign interpreter need according to REALD, or the member’s primary spoken language is not English. If the member is between the ages of 0-5, we also incorporate any information on potential language barriers of any adult family member we have access to, including the adults utilization of prior interpretation services, REALD spoken or sign interpreter needed, or a primary language other than English.</td>
</tr>
<tr>
<td><strong>Primary Care Visit</strong></td>
<td>The member has had a primary care visit in the last 12 months according to the MiPi member profile.</td>
</tr>
<tr>
<td><strong>PTMPY</strong></td>
<td>Per thousand members per year.</td>
</tr>
<tr>
<td><strong>REALD Primary Race/Ethnicity</strong></td>
<td>A member can self-select a primary race during their Medicaid enrollment and OHA shares this information with us in the 834 file. This is a higher level category of primary race based on the sections of the REALD form.</td>
</tr>
<tr>
<td><strong>REALD Spoken Language (Group)</strong></td>
<td>A member can report their spoken language during their Medicaid enrollment and OHA shares this information with us in the REALD 834 file. This is a higher level category of both commonly spoken languages to help avoid sharing PHI.</td>
</tr>
<tr>
<td><strong>Service Rate</strong></td>
<td>In January 2022, OHA provided CCOs with Social Emotional Health reach metric data. The service rate is the percent of children ages 0 to 5 included in the measure who have had a qualifying service. OHA used the enrollment as of December 31, 2021 for this measure and data for assessments from October 1, 2020 to September 30, 2021 for this measurement. For a full list of codes used, see: <a href="https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx">https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx</a>.</td>
</tr>
<tr>
<td><strong>Social Emotional Health Reach Metric</strong></td>
<td>As of January 2022, CCOs have a new incentive measure to support health aspects of kindergarten readiness: system-level social emotional health. This metric focuses on identifying and connecting young children (ages 0 to 5 years) with social emotional health needs to services. More information: <a href="https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx">https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Social-Emotional-Health-Metric.aspx</a>.</td>
</tr>
<tr>
<td><strong>Social Indicators</strong></td>
<td>Social Indicators are a component of pediatric health complexity and the look back period for these indicators is the lifetime of the child plus one year prior to birth when available. Final social factors levels reported in health complexity follow the methodology of taking the most complex category of either OHA data or PacificSource data. However, data on individual social factors is only available based on internal data as OHA does not provide that level of granularity in their reporting.</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>The member has had a specialist visit in the last 12 months according to the MiPi member profile.</td>
</tr>
</tbody>
</table>

Note: Financial PMPM costs, revenues and expenses are presented on a paid date basis, regardless of which year they were incurred.
The COHC Board uses a hybrid distributed leadership model. The Board functions as the Health Council in the boardroom. COHC staff are the Health Council at work. The community is the true Health Council, and where the decisions are ultimately made.
CAC Members Present:
Brad Porterfield, Chair, Consumer Representative
Conor Carlsen, Consumer Representative
Elaine Knobbs-Seasholtz, Mosaic Medical
Elizabeth Schmitt, Consumer Representative
Ken Wilhelm, United Way of Central Oregon
Linda Johnson, Community Representative
Mandee Seeley, Consumer Representative
Mayra Benitez, Consumer Representative
Miranda Hill, Klamath County Public Health
Stacy Shaw, Consumer Representative
Theresa Olander, Consumer Representative

CAC Members Absent:
Natalie Chavez, Jefferson County Health
Tom Kuhn, Deschutes County Health Services

COHC Staff Present:
Donna Mills, Central Oregon Health Council
MaCayla Arsenault, Central Oregon Health Council
Gwen Jones, Central Oregon Health Council
Kelley Adams, Central Oregon Health Council
Renee Wirth, Central Oregon Health Council
Camille Smith, Central Oregon Health Council

DCO Representatives Present:
Molly Johnson, Advantage Vice President
Nikki Coe, Advantage Regional Vice President
Nancy Avery, ODS Manager Dental Services
Amy Lawrence, ODS OHP Coordinator
Manu Chaudhry, Capitol Dental Care President
Kristin Soto, Capitol Dental Care General Manager

OHA Representatives Present:
Rebecca Donell, Innovator Agent
Tania Curiel, Regional Outreach Coordinator
Kaz Rafia, Dental Director

PacificSource Representatives Present:
Kristen Tobias, Community Health Coordinator
Tricia Wilder, Director
Buffy Hurtado, Tribal Liaison
Kyle Ash, Dental Director
Heather Simmons, Dental Service Program Manager
Jessica Waltman, Manager Grievance & Appeals
Welcome
• Brad Porterfield welcomed all attendees.

Land Acknowledgement
• Mayra Benitez read the Land Acknowledgement (see March packet for statement).

Guiding Principles & Objectives
• Linda Johnson read the guiding principles and objectives (see March packet for statement).

Introductions
• Kelley Adams led the group introductions.

Small Group Breakout Session
• 10 minutes were set aside at the meeting for CAC members, DCO, OHA, and PacificSource representatives to go into virtual breakout rooms and answer an icebreaker question to get to know each other.

Learning about Each Other’s Experiences and Work
• MaCayla Arsenault shared an overview of the meeting format.
• Mandee Seeley shared a summary of dental and periodontal barriers faced by OHP members.
• Molly Johnson from Advantage Dental presented a general overview of the Medicaid plan and dental delivery system. Advantage Dental just recently hired a periodontist who will be starting at the end of March. Although this periodontist will be located outside of Central Oregon, teledentistry will be available for evaluations and treatment planning. Onsite care and services will be based on patient needs.
• Amy Lawrence from ODS Community Dental focused on the periodontal services and contributing factors of periodontal disease. ODS has a Perio program in place where the dental provider puts in a request or referral to ODS who then puts together a packet of information for the OHP member with an explanation of benefits, educational flyers, and offers a DCO advocate.
• Manu Chaudhry from Capitol Dental Care shared a personal experience of when he was a child. His family was on Medicaid but did not know how to access medical services. His vision, along with OHA, the DCO’s and CCO’s, is to change the structure as well as they can with the support of evidence-based dentistry. Manu’s presentation started with explaining gum disease and that genetics plays a large role in what each person is predisposed to and that social determinants of health also contributes to gum disease. Manu shared the system barriers that are faced by the DCO’s and stated that Capitol Dental Care is sincere and deliberately trying to improve oral health access.

Questions & Answers
• Gwen Jones facilitated the question and answer segment of the meeting.
• Miranda Hill asked the first question to the DCO’s: Why do OHP members have such difficulty being referred to and receiving periodontal care in Central Oregon?
  o The DCO and OHA representatives explained some of the difficulties.
- Limited benefits applicable to periodontists.
- DCO’s have little to no success trying to contract with periodontists is Central Oregon.
- There is only 1 periodontist in Central Oregon that will accept referrals but is out-of-pocket. Therefore, members are referred to a periodontist out of the area.
- Surgical therapy, which is what a periodontist would perform, is not a covered benefit.
- There are only 35 periodontists in the whole state of Oregon (population of 4.2 million people).
- Dental providers work in the perimeters of the OHA guidelines that are set by HERC (Health Evidence Review Commission) on what or what is not covered.
- Reimbursement rates for OHP providers are 33-35% range of commercial rates.

Other questions raised during this discussion were:
- Why is accessing dental services different from someone who has private/commercial insurance versus OHP? Delays in service could result in more dental issues.
- Are there tax breaks for dental providers who provide OHP services?
- How can those of us who are willing to advocate for benefits at the state level get them expanded?

Manu Chaudhry from Capitol Dental asked the question to CAC: How can the DCO’s communicate better for more awareness, more information, so members know how to navigate the system?

The suggestions from the CAC members are:
- Integrating organizations, like local colleges, and the community in general is important for overall health. Public health announcements/awareness especially for dental.
- Health Council, PacificSource, and OHA should put more time and attention into educating members on how to navigate the system.
  - PacificSource confirmed that they have a team who helps members navigate the dental system.
- DCO navigator or advocate for members.
  - Advantage – sends a welcome letter that outlines care and services. The Care Coordination Team works with members to navigate the system and break down barriers to care. Working towards embedding Community Health Workers into practices.
  - ODS – DCO Advocate provides CCO coordination.
  - Capitol – only deals with Medicaid plan and has a Member Services team to provide care coordination to appropriate services.
- Provide training to Community Health Workers and others like Family Access Network to advocate and communicate to OHP members.

Other questions posed during this discussion were:
- Who dictates changes to dental benefit coverage?
  - Decisions are made by HERC (Health Evidence Review Commission) around benefit coverages. Email feedback to HERC: HERC.Info@dhsoha.state.or.us
Who makes the decisions on the reimbursement rates for OHP providers? How can we advocate?

- Kaz Rafia from OHA asked that he be contacted directly, and he can direct to the right people. kaz.rafia@dhsoha.state.or.us

Mandee Seeley asked the second question to the DCO’s: *What are some of the other possible ways to encourage the system to make changes? What would talking to HERC need to look like? What would going to the state need to look like?*

  - Suggestions from the DCO representatives were:
    - There needs to be more dental representation on HERC.
    - Getting providers appropriate reimbursement.
    - Address the barriers that cause OHP members to miss appointments. Medicaid members with social determinants are more likely to miss appointments versus commercial insurance members. This results in providers losing productivity and they do not get reimbursed for that time.

Closing

- Kelley Adams launched a poll for the participants to evaluate the meeting. The overall consensus was that the meeting was very valuable and most would be willing to collaborate again.

- Brad Porterfield opened it up to anyone who would like to share their thoughts on today’s time together.

  - Stacy Shaw asked: Are there federal or state grants available for public health announcements or education to college students to help with navigating the dental system?
    - Kaz Rafia and Rebecca Donell from OHA will look into it to see if there is anything available.

  - Tania Curiel from OHA mentioned that the OHA program to partner with dental plans to provide training for OHP assistors on how to navigate the OHP dental system will continue. It could potentially be expanded to others, like Community Health Workers, to provide cohesive and collaborative training to support the community in navigating the system better.

- Brad thanked everyone for their participation and looks forward to continued conversations.
COVID-19 Final Report for Diversability
“COVID19 Pivot & YAYAA Attendant Care Services”

Summary of Results:
- Our project worked to increase capacity and service to individuals in our community with diversabilities.
- Our intentions consisted of three primary objectives:
  - To increase connections for individuals with diversabilities;
  - To increase the number of individuals we serve, and;
  - To launch our Youth and Young Adult Pivot program to expand Pivot services beyond the intellectual/developmental disability category.
- In the grant time-frame, we accomplished one of the three overall objectives.
- Given the challenging labor climate, we would have enjoyed greater outcomes.
- Between February 1, 2021 and June 18, 2021 our objectives resulted in an overall decrease in our capacity to provide Pivot mentoring services.
- While we successfully launched the Youth and Young Adult Pivot program including individuals with diversabilities who otherwise lacked access to our specialized mentoring services, we are disappointed to have not met our SMART outcomes.
- The outcomes of our SMART objectives include fewer hours or "connections" with individuals by 17.25%, service provision to 12 youth and young adults which was an increase of 2 individuals, and onboarding 2 individuals to our newly launched Youth and Young Adult Pivot program.

Quote:
“We are grateful we are able to sustain our programs that serve our community, providing individuals and families with opportunities to remain healthy and in some cases improve their health. Thank you!”

*Order of projects is by final report submission date           Published April 2022
RHIP Mini-Grant Final Report for DAWNS House
“Emergency Service Site Manager”
Reviewed by the Address Poverty and Stable Housing Workgroups

Summary of Results:

- Dawns House has been operating emergency shelter services since Oct 2019.
- We started these vital services to help fill the gap in the growing number of displaced families finding themselves homeless living in camps with their children.
- The mini grant supported the wrap activities for our on-site emergency service manager, mentor.
- Activities included, intake assessment, then fulfillment of needs such as food, clothing, identification recovery, OHP/SNAP, mental health enrollment and day to day personal assistance and guidance.
- During this time frame our nonprofit transitioned 23 families through our free emergency service units.
- All were assisted with wrap services.

Story:

DAWNS House assisted several families, but a few stood out from the rest. A single father with a 6 year old girl who had recently lost his wife to cancer and ended up homeless on Hunnel Road. During the time this gentleman was here he was able to heal some of his grief and gain employment again. We were able to get him fast tracked in the rapid rehousing program and transitioned into Foxhollow Apt. we then contacted Furnish Hope nonprofit who came in a beautifully furnished their new little home