



COHC Provider Engagement Panel

January 12, 2022

Held Virtually Via Zoom

<https://us02web.zoom.us/j/630619272?pwd=OEEDUnZQMW1PdIBZemwwWDB1WWdQdz09>

Meeting ID: 630 619 272 • Passcode: 775506 • Dial-in: 1-253-215-8782

7:00–7:10 **Introductions – Divya Sharma**

Approve Consent Agenda

Introduction of PacificSource Medical Director Dr. Jeff Davis

7:10-7:55 **2022 Quality Pool Distribution – Andrea Ketelhut, Tricia Wilder, and Leslie Neugebauer**

7:55–8:00 **Wrap-up – Divya Sharma**

Consent Agenda

November Minutes

Written Reports

November QHOC Minutes

December QHOC Minutes

January Final Mini-Grant Reports



**MINUTES OF A MEETING OF
THE PROVIDER ENGAGEMENT PANEL OF
CENTRAL OREGON HEALTH COUNCIL
Held Virtually Via Zoom
November 10, 2021**

A meeting of the Provider Engagement Panel (the “**PEP**”) of Central Oregon Health Council, an Oregon public benefit corporation (the “**Corporation**”), was held at 7:00 am Pacific Standard Time on November 10, 2021, virtually via Zoom. Notice of the meeting had been sent to all members of the Panel in accordance with the Corporation’s bylaws.

Members Present

Divya Sharma, MD, Chair
Gary Allen, DMD
Jessica LeBlanc, MD
Alison Little, MD
Sharity Ludwig
Robert Ross, MD

Members Absent

Carey Allen, MD
Logan Clausen, MD
Matt Clausen, MD
Emily Harvey, MD
Jessica Morgan, MD

Guests Present

Sarah Holloway, PacificSource
Christina Lee, PacificSource
Donna Mills, Central Oregon Health Council
Mike Shirtcliff, DMD, Redmond Dental Group
Camille Smith, Central Oregon Health Council
Tricia Wilder, PacificSource

Dr. Sharma served as Chair of the meeting and Ms. Smith served as Secretary. Dr. Sharma 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

Dr. Sharma welcomed all attendees to the meeting and facilitated introductions.

CONSENT AGENDA

Dr. Sharma asked for a motion to approve the consent agenda.

MOTION TO APPROVE: Dr. Allen motioned to approve the consent agenda; Dr. Ross seconded. All were in favor, and the motion passed unanimously.

QHOC REPORT

Dr. Little presented a report from the OHA QHOC meeting held on October 11. Dr. Allen commented that the most discussed issue was expanding orthodontia, and there was concern about implementation and how to put processes in place to guard against overuse of an expensive benefit. The last part of the meeting was on the Vaccination Learning Collaborative. They polled people on why they would not get vaccinated—the largest reason was “personal decision.” When they gave out cards to educate, the number went up to 90 percent.

Dr. Little also announced that she is retiring and asked whether the panel would like her replacement to continue with the QHOC updates. The group agreed that they like receiving them.

QUARTERLY CARE COORDINATION

Ms. Holloway shared an overview of PacificSource Care Management, noting that the Q3 Care Coordination Report is the same as Q2 in what's included. Programs available include Care and Community Coordination to take care of the social determinants of health addressed by resources in the area. Intermediate Care Management includes physician involvement, and Intensive Care Coordination is longer term, out of CCO 2.0. The Care Management Team includes Member Support Specialists and Care Managers who are all licensed—e.g., nurses, behavioral health clinicians, social workers, and counselors. Care Coordination Data includes the number of members enrolled, screening timeframe, care plan development, progress toward goals, and reassessment triggers. REALD data showed that Central Oregon CCO membership increased by 1,665 for Q3. There were 1,047 members screened for care management services in Q3, with 35 percent eligible for ICC. Central Oregon closed 356 cases in Q3, with 72 open cases remaining. Member Support Specialists did outreach during the heat wave to support shelter access, fans, and AC. They have new outreach strategies such as texting and email campaigns. The report is subject to PEP approval.

Dr. Allen asked about the OHA definition of screening criteria and Ms. Holloway explained that it is up to the CCO—there is no standardized screening tool. They prefer local control, but there is quite a variation from CCO to CCO. As we are a full year into CCO 2.0, it is a good time to look at the others and see what is being done better.

MOTION TO APPROVE: Dr. Sharma asked for a motion to approve the Care Management report. Dr. Allen motioned; Dr. Ross seconded. All were in favor, and the motion passed unanimously.

AiC UPDATE

Ms. Lee presented a quarterly update (August–October) on Advancing Integrated Care. AiC was a 2018–2020 COHC grant–funded project to improve access to behavioral health care and coordination with primary care in Central Oregon. It was transferred to PacificSource in January 2021. They held a round robin with their workgroup a couple of months ago on staffing, the vaccine mandate, and effective networking. Dawn Creach of Creach Consulting has received a new grant to measure timeliness and engagement between specialty and primary care. She is also working to develop a Metrics Advisory Committee. The BestCare Community Engagement Team has worked to embed three people in the Emergency Department. PacificSource is no longer facilitating the workgroup so the issue is where does this work live in the future? Navigators are hungry to connect with one another, and this is a real need for the future.

ACTION ITEM: Ms. Lee will connect with Dawn Creach about the BHCs and the possibilities for a group for them.

VACCINE UPDATE

Dr. Ross gave an update on vaccine efforts in the region. He shared that they haven't seen grant applications for the two-year-old immunizations project and probably would not until December. Dr. Sharma had met with COPA the day before and found that the level of interest in the 5- to 11-year-old vaccines had been great. They had received four times the number of calls in a typical week. Dr. LeBlanc noted that Mosaic had the only walk-in clinic in Central Oregon for that age range, and there had been a lot of excitement the previous couple of days at East Bend.

ADJOURNMENT

There being no further business to come before the PEP, the meeting was adjourned at 8:00 am Pacific Standard Time.

Respectfully submitted,

Camille Smith, Secretary

OHA Quality and Health Outcomes Committee
(QHOC) **11/8/2021**
Zoom Conference ID: 160 050 3391
Passcode: 9088871
Phone: 1-669-254-5252

[Meeting Packet](#)
[Agenda](#)
[QHOC Website](#)
[Slides](#)

Clinical Director Workgroup

10:00 a.m. – 12:00

Topics	Summary of Discussion/Impacted Departments	Materials/ Action Items
Welcome/ Introductions/ Updates	Presenter: Holly Joe Hodges <ul style="list-style-type: none"> See attendee list 	Pgs. 1-2
COVID-19 updates	Presenter: Dawn Mautner <ul style="list-style-type: none"> Case numbers are trending down. COVID-19 long haul coverage guidance: <ul style="list-style-type: none"> Required to cover treatment for conditions due to complications of COVID-19 (OHA is checking whether this applies to commercial insurance as well.) Includes coverage for pharmacological and non-pharmacological treatments. Case by case review to determine medical necessity FDA is reviewing oral anti-body treatment. An evaluation is underway for home-based PCR tests (HERC will be involved). 	Pgs. 3-4
P&T updates	Presenter: Roger Citron <ul style="list-style-type: none"> Oncology Policy Updates: <ul style="list-style-type: none"> Rylaze and Welireg approved by FDA for Table 1 PA criteria. Orphan Drug Update: <ul style="list-style-type: none"> Ryplazim and Rezurock approved by FDA for Table 1 PA criteria. Inhaled Anticholinergics Literature Scan: <ul style="list-style-type: none"> Combivent, Respimat, and Incruse are preferred effective 1/1/2021. Non-Injectable Antiepileptics Literature Scan: <ul style="list-style-type: none"> No changes to PMPDP Biologics for Autoimmune Disorders: <ul style="list-style-type: none"> Class renamed to “Targeted Immune Modulators” PA criteria expanded to include more ages and indications Multiple Sclerosis Oral Agents PA criteria now includes ozonimod for moderate to severe ulcerative colitis. Cosentyx preferred Calcitonin Gene-Related Peptide (CGRP) Inhibitors: <ul style="list-style-type: none"> PA criteria updated to clarify between acute and 	Pgs. 5-19

	<ul style="list-style-type: none"> preventative treatment <ul style="list-style-type: none"> Require providers to assess for uncontrolled hypertension prior to initiation of therapy Recommendations updated for cluster headaches Hepatitis C, Direct-Acting Antiviral Literature Scan: <ul style="list-style-type: none"> PA criteria updated to include new pediatric indications and clerical updates Epclusa non-preferred Discussion underway about Hep-C risk corridor. Pulmonary Arterial Hypertension Updates <ul style="list-style-type: none"> No changes to PMPDP Alzheimer's Disease Class Update: <ul style="list-style-type: none"> Aduhelm non-preferred Renewal criteria modified to prevent continuation of therapy in patients with evidence of microhemorrhage. Donepezil, rivastigmine, memantine, and Namzaric preferred. Topical Antiparasitic Updates: <ul style="list-style-type: none"> Xeglyze non-preferred Soolantral non-preferred Vanalice non-preferred The next P&T meeting is scheduled on 12/2/2021. <ul style="list-style-type: none"> OHA is recruiting for 2 new physicians to join the P&T Committee. <ul style="list-style-type: none"> 3 year terms Be actively practicing 	
Pharmacy Updates	<p>Presenter: Trevor Douglas</p> <ul style="list-style-type: none"> National shortage of pharmacy technicians, causing shortened hours and reduced services. <ul style="list-style-type: none"> No vaccine or testing services. Reduced hours of operation and long waiting lines. BiMart announced it is closing all pharmacies effective 11/11/2021. <ul style="list-style-type: none"> 37 pharmacies will be closing across the state. BiMart should be sending a closing letter to effected clients. Some pharmacies will be acquired by Walgreens <ul style="list-style-type: none"> Eugene, Klamath Falls, Corvallis, Monmouth, Stayton, Prineville, Veneta, Junction City, and La Pine. Sister's location will become designated as Critical Risk Pharmacy. What is being done? <ul style="list-style-type: none"> OHA is working on a response that will be released on 11/22. Walgreens will be coordinating with CCO's and OHA. CCO can provide messaging and resources to effected members. 	Pgs. 20-25
HERC Updates	<p>Presenter: Jason Gingerich</p> <ul style="list-style-type: none"> COVID-19 Issues: <ul style="list-style-type: none"> CMS requiring coverage without limitations for all long-term treatments. Individual review required for treatment not paired. New codes for J&J vaccine 	

	<ul style="list-style-type: none"> ○ More discussion is needed about defining “long-haul” • Behavioral Health Advisory Panel (BHAP) meeting: <ul style="list-style-type: none"> ○ Nightmare disorder added to PTSD line ○ No screening codes added for Aces (CDC currently does not recommend or require it.) ○ New services added to SUD HCPC codes. ○ Selective mutism moved to Generalized Anxiety Line (for severe cases of GAD.) • November VBBS/HERC meeting: <ul style="list-style-type: none"> ○ CPT code placements (see list in slides) ○ Duplicate angioedema line deleted ○ Coverage clarification for pelvic congestion and cyanoacrylate vein ablation. ○ Adding level 3 CPT code for platelet rich plasma ○ Breast MRI guidelines reviewed • Genetic Advisory Panel (GAP)/Oral Health Advisory updates: <ul style="list-style-type: none"> ○ Handicapping malocclusions was suggested to move forward after 1/2022. ○ Opening D0190 code for non-dentist professional screenings ○ GAP recommending coverage for expanded carrier screening (pending approval) • Statement of intent released for role of prioritized list (see slides) • January VBBS meeting: <ul style="list-style-type: none"> ○ Dorsal rhizotomy coverage is being considered. ○ Other topics: actinic keratosis and foot arthrosis • December EGBS meeting: <ul style="list-style-type: none"> ○ High frequency chest oscillation devices ○ Continued discussion on PANDAS/PANS <ul style="list-style-type: none"> ▪ Proposal to cover IVIG and plasmapheresis if recommended by two pediatric subspecialist. 	Pgs. 26-38
Additional Agenda Items (open discussion/issues)	<ul style="list-style-type: none"> • State Hospital issues with long wait lists. <ul style="list-style-type: none"> ○ Only 2 people have been taken off the wait list in the past 2 years. • Ongoing issues with member discharges waiting to go home or to a SNF. <ul style="list-style-type: none"> ○ Legacy has put together a discharge assistance team to coordinate the appropriate level of care. • HEP-C drug and PA process: Concerns over possible future removal of PA. <ul style="list-style-type: none"> ○ Umpqua: PA is needed to assist treatment. Removing PA would be a barrier. ○ Other CCO’s agreed. • OOHB and KEPRO process: <ul style="list-style-type: none"> ○ One QHOC member was recently on a RAC pertaining to licensing of birth centers; CCO do not have standing to participate ○ KEPRO does not provide oversight, they provide voluntary case management. • Collaborative emergency planning and response and statewide disaster planning: <ul style="list-style-type: none"> ○ Questions will be brought back at the next meeting about how to communicate messaging with members (text and 	

	<p>technology issues)</p> <ul style="list-style-type: none"> • Other discussions: <ul style="list-style-type: none"> ○ Dr. Franz- Issues with “ED boarding” minors who need higher levels of care and are seen as a community risk. ○ ICC designation and broadness of terms makes it challenging to provide care coordination. 	
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Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.		
QPI Intro/updates	<p>Presenter: Lisa Bui</p> <ul style="list-style-type: none"> • PIP updates: <ul style="list-style-type: none"> ○ HSAG is working on validating CCO PIPs against protocols. ○ Lisa reached out to schedule annual PIP check-in with CCO’s. • The Special Health Care Needs (SHCN) webinar for TQS will be rescheduled. • MEPP Program and TQS alignment: <ul style="list-style-type: none"> ○ Final Guidance will be posted in December. ○ TQS alignment will be discussed in MEPP guidance. • Questions: <ul style="list-style-type: none"> ○ When will the next MH statewide PIP submission be due? <ul style="list-style-type: none"> ▪ Lisa Bui: July 31st. This year it was postponed until September. 	Pg. 41
2021 Parity Audit and NOABD review	<p>Presenter: Nathan Roberts and Veronica Guerra</p> <ul style="list-style-type: none"> • Discussion and questions about NOABD process: <ul style="list-style-type: none"> ○ AllCare- aging report is monitored. ○ Making sure P&P is solid for new staff. ○ Jenna (Yamhill) – Fewer denials to go through for mental health. Some difficulties with sending extension letter in time. They are working with providers to get the needed information. ○ Mental Health NOADB’s are less frequent than physical health. • Discussion- Three CCO’s scored 100%. What are best practices? <ul style="list-style-type: none"> ○ IHN CCO- Success with embedding behavioral health team into the process. ○ New template structures will help to create better processes next year. 	Pg. 42
SUD Statewide PIP development	<p>Presenter: Lisa Bui</p> <ul style="list-style-type: none"> • The Statewide SUD PIP is being implemented as part of the SUD waiver. • The design phase will occur in January 2022 with validation due in 2023. <ul style="list-style-type: none"> ○ Goals and objectives from the SUD waiver will be discussed in January. 	Pgs. 43

	<ul style="list-style-type: none"> • How do CCOs want to discuss and engage in the design summary process? <ul style="list-style-type: none"> ○ CCOs suggested using QHOC, but having a dedicated time slot for the SUD PIP. ○ Lisa will send info to the BH directors to determine which timeslot works best (1pm or 2pm.) • The SUD PIP might build upon previous work done with the Opioid Statewide PIP. More discussion to come. 	
Items from the floor.	<ul style="list-style-type: none"> • Meeting ended early. 	Pg. 44
Adjourn		

Everyone is welcome to the meetings. For questions about accessibility or to request an accommodation, please call 971-304-6236 or write OHA.qualityquestions@dhsosha.state.or.us. Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language, please call 971-304-6236 or write OHA.qualityquestions@dhsosha.state.or.us.

OHA Quality and Health Outcomes Committee (QHOC)
12/13/2021
Zoom Conference ID: 161 975 3420
Passcode: 645815
Phone: 1-669-254-5252

[Meeting Packet](#)
[Agenda](#)
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[Slides](#)

Clinical Director Workgroup

10:00 a.m. – 12:00

Topics	Summary of Discussion/Impacted Departments	Materials/ Action Items
Welcome/ Announce- ments	<p>Presenter: Holly Jo Hodges, Lisa Bui</p> <ul style="list-style-type: none"> • See attendee list • Medicaid 1115 waiver around transformation was emailed to QHOC participants 7-10 days ago. It is open for public comment. • Jan and Feb meeting is scheduled. The remaining meeting will be scheduled soon. • Holly Jo is stepping down as chair. New chair is Jeanie Savage from Trillium/Health Net. Bhavesh Rajani is stepping down as vice chair. The new vice chair is Douglas Carr from Umpqua. <ul style="list-style-type: none"> • Thank you to the team. 	Pgs. 1-2
COVID-19 Updates	<p>Presenter: Dawn Mautner, Rex Larsen, Melissa Sutton</p> <ul style="list-style-type: none"> • Vaccination progress: <ul style="list-style-type: none"> ○ 73.2% 18 years and older in Oregon have completed the series with 79.4% who have initiated the series. This is significant progress. 24% received an extra dose. ○ Variation by county, from 44% to 85%. Troubling disparity around the state. ○ 12-17 year olds, 65.1% have initiated a series. 5-11 year olds saw steep uptick, 24% in December. • Epidemiologic curve: <ul style="list-style-type: none"> ○ 5th surge. Spike in cases and hospitalizations in Sept; 900 new cases per day on average, but starting to plateau. ○ 20% of cases are pediatric with highest amount of cases in the 5-11 age group. ○ Lowest transmission county is Gillum • Testing update: <ul style="list-style-type: none"> ○ Not doing enough testing since Delta began. Largely due to limited human resources. Percent positivity is improving. • Variant update: <ul style="list-style-type: none"> ○ Wave of variant type: Wild-type variant-> Epsilon->Alpha-> Gamma->Delta. Delta is out competing other variants. It is 3x as transmissible. ○ Omicron (B11529) - high number of mutations (approx. 50). WHO says it is variant of concern. Knowledge is still very limited. Reinfection is more likely. In U.S. 43 cases, 47% were vaccinated or boosted, 19% were unvaccinated. Only one of the 43 cases was hospitalized and only 2 days, no deaths. ○ South Africa saw beta variant that was quickly overtaken by Delta. 	Pgs. 3-21

	<ul style="list-style-type: none"> ○ Omicron surveillance- detected on all continents excluding Antarctica. It has been detected in 22 states. Has not been detected in OR yet. OR is doing extensive genomic sequencing for surveillance including through waste water sequestering across 41 communities. • Traveling- Many counties have instituted travel restrictions. The U.S. is restricting travel from South-Africa for non U.S. citizens or residence. <ul style="list-style-type: none"> ○ CDC has not changed incoming traveler recommendations (testing 3-5 days following travel and self-isolate 5-10 days). <p>-Question regarding in-home testing for travelers. UK has new process, home testing for several days. If positive then isolate.</p> <p>-U.S has different payers with different priorities. Some payers are only paying for symptomatic testing, not exposure testing. OR has a limited amount of self-tests. State should be a front of line for tests, but most seem to go to market for larger profit. FEMA reimbursement for testing resources expires end of year. We have grant funding for this year but not much for home testing. We need more payers to step up.</p> <ul style="list-style-type: none"> • Therapeutics: <ul style="list-style-type: none"> ○ Monoclonal antibody efforts continue. ○ New monoclonal out, is a prophylactic type for those unable to vaccinate. ○ We do not have orals approved or authorized. Efficacy has decreased. More to come. • Vaccinations update: Kristen Dillion <ul style="list-style-type: none"> ○ OR is above national average ○ Approx. 24,000 shots per day <ul style="list-style-type: none"> • Combination of dose type. • Approx. 2500/day for children ages 5-11 to start. Count is about 1200/day as of late. ○ Huge variation across the state. ○ 88.5% of 65 years and older one dose. 65% for extra doses. ○ Concerns with equitable distribution for extra doses- Hispanic population is lowest at 9.5% for boosters, white is highest at 27.4%. ○ Hoping to pick up the pace in offering boosters. Will take till February to reach everyone. ○ OHA is responsible of supply and allocation. <ul style="list-style-type: none"> • See slide 14 for information on ordering. • Adding additional resource to FQHC's ○ Pediatric clinics and community events reporting threats • Future plan- <ul style="list-style-type: none"> ○ Targeting migrant and seasonal workers in February-Spring. ○ Possible April approval for children 2-4 years and 6-23 months. ○ Anticipating a third kind of Pfizer for the toddler population. <p>Participant comment- Studies are showing waning immunity in those</p>	
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	not boosted. Boosted immunity has 75% protection from variant. -Only 35% protection for those not boosted.	
HERC Update	<p>Presenter: Ariel Smits (presentation time was shortened. Please see slides for more details)</p> <ul style="list-style-type: none"> • November VBBS/HERC meeting: <ul style="list-style-type: none"> ○ 2022 CPT codes are posted to the website. ○ 7 or 8 new vaccine codes were excluded because they haven't had a chance to look at them. ○ Codes for Pneumococcal are covered. • November Behavioral Health Advisory Panel (BHAP)/ Genetic Advisory Panel (GAP)/ Oral Health Advisory Panel (OHAP) meeting updates: <ul style="list-style-type: none"> ○ Covering malocclusion ○ Whole genome coverage for very select group- only those under 1 year of age. ○ Expanded carrier screening, refer to guide ○ Added Cyanoacrylate to varicose vein line. ○ Added statement of intent and provided codes • January VBBS meeting: <ul style="list-style-type: none"> ○ January meeting will be cancelled. Will meet in March ○ Topics for discussion are on slide 27 • December EGBS meeting updates: <ul style="list-style-type: none"> ○ High frequency chest wall oscillation devices- expanded coverage. Will go to VBS for guideline and then HERC for approval. ○ PANDAS/PANS <ul style="list-style-type: none"> ▪ Pediatric neuro... received lots of testimony. Child will need to have failed less intensive therapies and will require reassessment every three months. Will take public comment soon. ▪ Tonsillectomy, adenoidectomy, adenotonsillectomy- non coverage of surgical intervention ○ EGBS future topics: <ul style="list-style-type: none"> ▪ Actively looking for topics. Email ideas to Ariel, Jason or Lisa (email addresses on slide 34 ▪ Revising transplant lines 	Pgs. 22-35

Houselessness population and COVID-19	<p>Presenter: Rebecca Knight-Alvarez, Dawn Mautner</p> <ul style="list-style-type: none"> • Definitions of houselessness provided on slide 38. • Vulnerable population. Easier/higher spread and likelihood for severe illness due to crowded living conditions, limited handwashing, higher prevalence of chronic illness, and behavioral health conditions. • Data is likely underrepresented. Several diagnosis codes available but often not used. Providers can help with data by utilizing these codes (see slide 40 for Z codes). <ul style="list-style-type: none"> ○ From data as of 10/25/21, 48.9% vaccinated with at least 1 dose and coded with houselessness. ○ Comparing counts from diagnosis code identified by CCOs to Point in Time survey. Some CCOs are closer than others. Need for improvement. ○ Important for equitable work and to address SDOH. • Possible barriers identified by OHA: <ul style="list-style-type: none"> ○ Limited staffing, unaware of codes, not screening, individuals not coming in for care, clinics capturing housing and SDOH information in internal systems. • Barriers identified by CCO participants: <ul style="list-style-type: none"> ○ Limited number of Z codes that can be applied to any claim. ○ Current claim standard for submission allow 12 lines, but not all EMRs or billing hubs are to the standard. <p>Umpqua provided resource link: https://www.nachc.org/research-and-data/prapare/</p> <p>Rebecca is looking for additional barriers. Email those to Rebecca.knight-alvarez@dhsosha.state.or.us</p>	Pgs. 37-44
Public Approach to HCV in Oregon	<p>Presenter: Ann Thomas</p> <ul style="list-style-type: none"> • Hepatitis C virus (HCV) Data: <ul style="list-style-type: none"> ○ 5-6,000 acute cases per year. There are vaccines for Hepatitis A and B, but not for C. ○ Highest volume in 20-29 year old. <ul style="list-style-type: none"> ▪ Risk factors for acute cases is predominately through IV drug use (62%). ○ Age and gender of chronic HCV cases between 2016-2020 <ul style="list-style-type: none"> ▪ Highest in 55 years and older; 61% males, 39% females ▪ 65 and older, likely asymptomatic. ○ Push to screen/test baby boomers in 2017. Screens jumped by 40,000. <ul style="list-style-type: none"> ▪ Characteristics of persons screened from 2010-2019: 50-69 year olds and 20-39, 52% commercial insurance, 33% Medicaid, 15% Medicare, 59% female, 41% male. ○ Increased interest in treatment. In 2019, coverage expanded, restrictions dropped, and cost went down. Over 4,000 people seeking treatment in 2019. <ul style="list-style-type: none"> ▪ Characteristics of those initiating treatment: ages 50-65+, 28% commercial insurance, 38% Medicaid, 34% Medicare, 60% male, 40% female. • Primary and secondary approach for prevention <ul style="list-style-type: none"> ○ Primary- Prevent new infection- Medicaid Assisted Treatment, Syringe Exchange program, reduce harm and transmission. ○ Secondary- Screen and treat before disease progresses, monitor for liver cancer. 	Pgs. 45-65

	<ul style="list-style-type: none"> ○ Both approaches treat with DAAs to reduce transmission and reduce morbidity and mortality. ○ Highest risk for transmission ages 15-40; moderate risk ages 35-45; highest risk for advance liver disease ages 55-65+. • Targets to eliminate HCV by 2030 (from WHO) <ul style="list-style-type: none"> ○ 80% reduction in new cases; 90% diagnosis of all infections; 65% reduction in liver-related mortality. <ul style="list-style-type: none"> ▪ Continuing with current strategy will likely not meet all targets. ▪ WHO plan A- treatment and harm reduction. Number of infections will go down. ▪ WHO plan B- increase treatment ○ Oregon sees 4-5000 new cases annually. ○ Cases of liver cancer and death are tapering, but treatment of younger adults is lagging behind. <p>-Umpqua shared the following guideline devolved by their Pharmacy Director for PCP treatment of HCV: uha-provider-guidance_-hcv-treatment_12-09-21.pdf (umpquahealth.com)</p> <p>-Participant comment- It has been really hard on CCO to reach targets the last 2 years. Why wasn't the risk corridor adjusted due to the pandemic? – Response- Dropping prior authorizations would help. Using peer recovery specialist to help keep people engaged in treatment. Likely going to PNT committee in Feb. Asking Trevor to outline and send out to the group.</p>	
November Follow up Items	<p>Presenter: Chelsea Holcomb</p> <ul style="list-style-type: none"> • Emergency Preparedness- not addressed during this meeting. • Youth BH crisis/ICC <ul style="list-style-type: none"> ○ Added as prioritized population in CCO 2.0. Part was in response to health complexity data from CCOs. ○ Transformation Center is providing learning sessions. Collaborative starts in January. Third Thursday of every month. <ul style="list-style-type: none"> ▪ Event series is for CCOs. Kepro, and other organizations who are involved in planning or delivering CC/ICC to OHP members. The yearlong collaborative will provide support towards understanding and meeting CCO 2.0 care coordination requirements and facilitate sharing of CC/ICC best practices. ▪ Additional topics will include: <ul style="list-style-type: none"> • CCO contract requirements and OARs related to CC/ICC • CC/ICC staffing models • Care coordination reporting requirements/template • Face to face requirements in rural areas • Best practices for Interdisciplinary Care Team (ICT) meetings and sharing assessment and care plans. ▪ Care Coordination & Intensive Care Coordination (CC/ICC) Virtual Learning Collaborative (office.com) ○ Workforce issue- Chelsea could not address. This is a crisis everywhere. <ul style="list-style-type: none"> ▪ Cannot increase capacity with nurse/staffing shortages. ▪ Only five providers in the state providing child 	No slides

	<p>psychiatric care.</p> <ul style="list-style-type: none"> ○ Local communities organizations should provide wrap around services. ○ QHOC requested specifics clarification around OAR language. Issue identified at November QHOC- ICC designation and broadness of terms makes it challenging to provide care coordination. <ul style="list-style-type: none"> ▪ Per Chelsea, ICC does not need to be offered if there is no need identified. ▪ Intention is to get the care to those who need it. Assessment process is needed to identify those members. ▪ OHA/Chelsea welcomes collaboration and will come to a workgroup to identify the specific concerns and to negotiate a rewrite of the rules if needed. ○ Residential care beds is a crisis. It was before the pandemic. ○ RFP and funding is coming soon. ○ OHA needs CCO's at the table to lend voice and creative ways of addressing this crisis. <ul style="list-style-type: none"> ● Oregon State Hospital <ul style="list-style-type: none"> ○ Long waitlist, continues to be an issue. 	
Items from the floor		

Quality and Performance Improvement Session

1:00 p.m. – 3:00 p.m.

QPI Intro/updates	Presenter: Lisa Bui, Laura Matola <ul style="list-style-type: none"> • Lisa will update slides from this morning's session and will email to the QHOC attendee list. • PIP Public Posting Reminder- <ul style="list-style-type: none"> ○ Lisa sent email regarding public posting of CCO deliverables. CCO's have a redaction period on the eight quarterly PIP reports. Refer to email. • 1115 statewide PIP SUD waiver. <ul style="list-style-type: none"> ○ We are finishing design phase. ○ Due July 2022, step 1-8 protocol. ○ CCO's can measure internally/in-house if desired. Will need to let Lisa know and will need to connect with OHA analytics team. 	Pg. 68
REAL-D and MMIS updates	Presenter: Bob Costa, Kweku Wilson <ul style="list-style-type: none"> • Some changes to REALD standards from passage of HB 4212 <ul style="list-style-type: none"> ○ Need to collect better data, inform, and be able to broaden services ○ Slide 72 provides granular information for the change • ONE system updates include: <ul style="list-style-type: none"> ○ Language questions are updated- <ul style="list-style-type: none"> ▪ 7,000 categories. Will have a filtering approach ▪ Inclusive of sign language needs ○ Added ability to have two or more races. ○ Expansion to the disability category. • ONE Timeline <ul style="list-style-type: none"> ○ March 2022 REALD and paper application (7210 form) ○ April language table • MMIS Timeline <ul style="list-style-type: none"> ○ Summer 2022. Both system updates are of equal importance but MMIS will update second and timeline might change due to other projects and staffing limitations. • Other changes to the ONE system: <ul style="list-style-type: none"> ○ 'Preferred Name' has been identified as an offensive way of asking. They are looking into revising. <ul style="list-style-type: none"> ▪ This field will change from a single field to two fields (first and last name) ○ Fields titles 'Sex' will change to "Gender Identity" • HB 3159 passed and will be reflective in ONE and MMIS. Changes slated for 2023. <ul style="list-style-type: none"> ○ Creation of registry. Registry is specifically for providers. More conversations needed on how to align all of these changes. May change what is being presented today. • HB 2134 - requires OHA to collect and store REALD and demographics from providers but didn't include rules and mandates. HB 4212 requires providers to collect REALD for Covid-19 encounters. Neither bill includes the collection of SOGI (sexual orientation and gender identity). <ul style="list-style-type: none"> ○ Rulemaking advisory committee will convene the beginning of 2022 to finalize collection standards for including SOGI. ○ Development of a registry. Exploring an app. Unique in its capacity to collect. • The Repository draws on ONE data to develop. The registry draws on data from providers and insurers and can be updated by individuals. 	Pgs. 69-81

	<p>The registry will feed the repository. The OHA/ODHS program will feed repository client lists to fill in REALD and SOGI data. The repository may not be information that can be shared with CCO's. Need for more conversation.</p> <ul style="list-style-type: none"> • 2022: <ul style="list-style-type: none"> ○ Cover all People and REALD project- two large projects using the same resources. <ul style="list-style-type: none"> ▪ REALD has July deadline ▪ Requesting more FTE to hurry work along. ▪ Both priority projects. ▪ Budget is not an issue <p>-Participant comment- large percentage of unknown REALD. What are other CCO's doing to collect REALD data?</p> <ul style="list-style-type: none"> ▪ EOCCO- is using EHR and directly through member collections and working with Connect OR. ▪ YCCO uses 834 data and direct member surveys <p>OHA- we are hoping for more complete and quality data by tweaking the questions/how we are asking. We will look at doing a virtual diagram at a future QHOC.</p> <p>Gainwell Technologies is the contractor making the changes to MMIS.</p>	
SUD 1115 Waiver Promer	<p>Presenter: Dana Peterson, Sam Byers</p> <ul style="list-style-type: none"> • Spent a lot of time developing a concept. Got approval for demonstration. Effective 4/8/21 – 3/31/26 • Primary purpose- Increase access to treatment services for OHP members. • Uses 2 authorities: <ul style="list-style-type: none"> ○ Residential and IP treatment and community integration services ○ Will also include help with housing and employment • Amendment added to expand the rehabilitation portion, effective 1/1/2022 <ul style="list-style-type: none"> ○ Will expand continuum of care, provide less restrictions, increase capacity, reduce readmissions, increase engagement, improve transition out of treatment • All activities from outreach to recovery to be implemented by 1/2023 • Impact to CCOs- Second statewide PIP. <ul style="list-style-type: none"> ○ CCOs submit EQR validation form July 2022. ○ January 2023 SUD PIP project will begin. • Questions can go to Dana, email on first slide. Dana is interim. New person will be introduced to the group when time is right. • This is not a substance specific waiver with CMS- access for all regardless of substance of choice. PIP itself could be substance specific but does not need to be. • January QPI session will spend time brainstorming what direction we want to go. • Oregon Health Authority : Substance Use Disorder 1115 Demonstration Waiver : Medicaid Policy : State of Oregon 	Pgs. 82-89

Items from the floor	<ul style="list-style-type: none"> • Clarification on statewide PIP EQR validation date <ul style="list-style-type: none"> ○ July 31st • Lisa is still meeting with CCOs. Once she is done with meetings, she informs OHA Compliance, and then she will follow up individually with CCO via email. 	
Adjourn		

Everyone is welcome to the meetings. For questions about accessibility or to request an accommodation, please call 971-304-6236 or write OHA.qualityquestions@dhsosha.state.or.us. Requests should be made at least 48 hours prior to the event. Documents can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request a document in another format or language, please call 971-304-6236 or write OHA.qualityquestions@dhsosha.state.or.us.

RHIP and COVID-19 MINI-GRANT PROJECT SUMMARIES

Final RHIP Mini-Grant Report for Jericho Road

“Homeless Camp Outreach”

Reviewed by the Address Poverty and Physical Health Workgroups



Summary of Results:

- Jericho Road's Homeless Camp Outreach Program goes directly to camps in the Redmond area to provide fresh water, fuel, food, clothing and to coordinate with other organizations and agencies to assist those people currently forced by conditions to staying in off-grid camps.
- Utilizing our new (donated truck) and pop up tents, tables and support equipment we were able to provide the items listed above plus masks, hand sanitizers and related COVID supplies to the campers.
- Our partners during this time were Mosaic Medical, the Jericho Road shower truck, Volunteer Dental Assistance Van, St. Vincent De Paul, Deschutes County Mental Health Department, Central Oregon Veteran's Outreach and others.
- Working with our partners and in total compliance with COVID protocols from state and local authorities, we were able to provide all the items listed above plus numerous others including pet food and clothing along with tents, propane, sleeping bags and heaters.

Quote:

“During the heat of the summer, we put up tents, provided water and popsicles and showers. We received many comments beyond the customary thank you’s. Some people said it was critically helpful to have us come to them rather than their having to risk leaving what little they had to go to town. Others thanked us for our willingness to help. Two families were successfully moved to more stable living conditions during this time, but the availability of alternative shelter is a constant challenge.”

Final RHIP Mini-Grant Report for Deschutes County Health Services**“Move for Better Health****Reviewed by the Promote Enhanced Physical Health Workgroup****Summary of Results:**

- This pilot program was a collaborative effort between Mosaic Medical and Deschutes County Behavioral Health.
- The program began 6/7/21 and ended on 8/30/21.
- The goal was to see an increase in overall health of participants through tracking movement, blood pressure, and diet.
- We purchased Fitbits, blood pressure cuffs, and scales for clients.
- Two peer support specialists (PSS) ran support groups twice a week with a dual purpose: providing support in client's health journeys and psycho education.
- The PSSs also met with the clients individually weekly, to assist clients in motivation, problem solve and encourage them.
- Curriculum for the 12 week peer lead group was developed.
- Weekly groups included check in, support, and weekly topic.
- Sometimes the PSS presented the topic, and guest speakers were invited as well.
- At the end of the program, we did a post program survey with all clients to ask clients about their perception of their success and meeting goals and to provide feedback to use about the program.
- 100% of participants were offered a smart device or another monitor to track daily steps/movement to increase movement and reduce metabolic syndrome.
- Participant connected (in person, telehealth, and/or phone) with a provider a minimum of 2x per week over the course of 12 weeks for a total minimum of 24 times in a three month period.

Final RHIP Mini-Grant Report for Seed to Table**“Biblioteca en Camino Partnership”****Reviewed by the Physical Health & Upstream Prevention Workgroups****Summary of Results:**

- Seed to Table was invited to collaborate with the Deschutes Public Library Servicios Latinos (DPLSL) to distribute fresh produce to local Latinx communities through an innovative program that sets up community resource distribution points in low-income neighborhoods.
- Through the partnership, produce was distributed in identified low-income neighborhoods, to contribute to a resilient system where diet-related diseases can be prevented through improved access to fresh vegetables while fostering a more welcoming and inclusive Central Oregon.
- In collaboration with other community-based organizations, Biblioteca en Camino served as local access points for thousands of families who experience barriers to essential items, including fresh foods. S2T set up a free farmers market across 8 sites, traveling each Wednesday to the designated neighborhoods.
- Seed to Table, and partners, helped decrease barriers to fresh produce to a total of 53 families with access to free, farm-fresh produce that was fitting within their cultural preferences.
- At each of the 8 sites, 2 to 15 families took home between 100 to 300 pounds of fresh produce. Site participation varied greatly depending on established relationships. A total of 2,400 pounds of veggies were distributed.
- For neighborhoods involved, the program helped overcome the barriers of families feeling unsafe and unwelcome in food banks, libraries, and other public spaces and on fostering relationships with the community by working directly in their neighborhoods.

Story:

I started to unload the Seed to Table truck when I heard many voices behind me. It was a group of neighborhood children who screamed out "the veggies are here!" They all swarmed over with the rollerblades on, eagerly helping set up the produce stand so they could help feed their families. One girl said "I will get all of the vegetables because I would like to try eating more salad, maybe my mom can make chef salad tonight? Oh! What about Cesar dressing... yes she will like that!"

RHIP and COVID-19 MINI-GRANT PROJECT SUMMARIES

COVID-19 Final Report for La Pine Community Health Center (Non-RHIP) “The Patient Healthcare Reminder Project”

Summary of Results:

- We requested \$5,000 from the COHC COVID Mini-Grant Fund to purchase the WELL patient communication platform software.
- La Pine Community Health Center contributed \$1,500 towards the purchase, will pay the on-going monthly fees associated with this program and pay for employee time to setup and monitor the program.
- The benefits of the WELL program through automatic messages sent to our patients during the pandemic have been and are:
 - Keeping low-risk COVID-19 patients from spreading the virus to others and staff.
 - Preventing non-COVID-19 patients from being exposed to the virus.
 - Communicating with all patients to encourage continued medical care follow-up to keep them healthy and avoid becoming ill with a virus.
 - Patients being able to receive and respond to their COVID symptom screening through the automated system which saves staff time.
 - Expanding the capacity of healthcare personnel.
 - We also utilized the WELL automated messaging for a breast cancer screening campaign. Patients were able to click a direct link to contact Central Oregon Radiology Associates and schedule a screening.
- The project has been a complete success. The benefit of WELL to quickly contact patients is significant. It is patient-centered because many patients like texting. It has been especially beneficial during COVID because of the additional responsibilities the pandemic has brought to our staff.
- The program allows us to communicate with our patients in their preferred communication method: telephone, e-mail or texting which improved the number of contacts with patients

Quote:

“The mother of one our patients was contacted to schedule a well-child visit. When she responded using WELL, we were able to schedule her child and two siblings at the same time. This saved staff time and time for the mother.”
Erin Gage Fitzpatrick, Director of Quality Improvement

RHIP and COVID-19 MINI-GRANT PROJECT SUMMARIES

Final RHIP Mini-Grant Report for Commute Options

"Safe Routes to School"

Reviewed by the Promote Enhanced Physical Health Workgroup

Summary of Results:

- The Safe Routes to School (SRTS) project promoted walking and rolling education for student in Central Oregon.
- We installed two traffic gardens during the grant period and reached out to multiple community members for support to extend SRTS Education into our target communities.
- The traffic gardens were used by the surrounding community as a self-guided resource to educate students on how to safely navigate roadways by foot or wheel.
- Through the Traffic Garden planning process, we connected with the Latino Community Association, Out of the Box Art Foundation, and Jefferson County Library.
- One traffic garden was installed adjacent to the Jefferson County Library and the other was installed in a city lot adjacent to Sahalee Park, both in Madras.
- We increased our participation by approximately 150% compared to what our total participation was starting in September 2021, from the 2020/2021 School year events.



Quote:

An article was written up by The Madras Pioneer about the City lot traffic garden - "New Traffic Garden creates haven to teach kids road skills"

"COVID restrictions have limited opportunities for Bennett to have in-person outreach. So, Bennett asked the City of Madras to help create a "Traffic Garden" on the lot at Southeast Seventh and Southeast C streets, a place where children and families can practice their traffic skills on their own."

Final RHIP Mini-Grant Report for La Pine Community Health Center
“Equitable Patient Transportation Access”
Reviewed by the Address Poverty Workgroup

Summary of Results:

- This project served patient transportation needs of South Deschutes County (La Pine) and North Klamath County (Gilchrist/Crescent).
- Transportation is one of the most challenging barriers for patients in these areas. Some patients miss their appointments with their primary medical care provider, behavioral health provider, RN Case Managers, or specialists because they do not have a car, drivers' license, friends, family or any other affordable transportation option.
- Transportation assistance is also needed for same-day, non-emergency transportation for medical services such as prescriptions, X-Rays or urgent care/emergency department issues.
- The assistance includes gas cards, Uber or a taxi to travel to La Pine Community Health Center sites, specialty care or urgent care/emergency department.
- The type of transportation used depends on the needs of the patient.
- The number of requests for the South Deschutes/North Klamath Counties has been increasing every year.
- This project met and tracked the immediate transportation needs of 59 patients for 129 rides including gas cards, vouchers, Uber and taxi to travel to our health care sites, specialty care or urgent care/emergency services.

Story:

We have a patient who lives in the Sunriver area with heart failure and cancer. Her specialists are in Eugene. We provide her (once every 2-3 months) with a gas card to travel to her specialist appointments. Without transportation assistance she might not be able to get the care she urgently needs.

RHIP and COVID-19 MINI-GRANT PROJECT SUMMARIES

RHIP Mini-Grant Final Report for Cascade Peer and Self Help Center

“Cascade Peer and Self Help Center”

Reviewed by the Substance and Alcohol Misuse Workgroup

Summary of Results:

- As Cascade Peer and Self Help Center (CPASHC) had to consolidate their services to the Downtown site from the closed Masonic Lodge site, this project maintained contact with clients who had been referred to Substance Abuse programs and encouraged to maintain their treatment.
- In addition, during this period, some clients were referred to treatment with follow-up.
- In some cases, the initial referral and contact was to be taken for detox and then encouraged to enter treatment after detox.
- The primary referral agencies were Deschutes County Mental Health and Best Care Substance Abuse Program.
- CPASHC was seen as a resource for both entering detox and for treatment referral and support.
- This ongoing support and contact increased the ongoing participation of clients in their treatment.
- There was also coordination with Peer Support Specialists from Deschutes County Mental Health and the staff at Best Care which enhanced support for those needing Substance Abuse treatment.
- The main challenge was with supporting the unhoused clients to maintain their sobriety and treatment.
- While living outdoors many people who are unhoused encounter numerous barriers to their sobriety such as social contact with people who are using, poor environmental conditions such as cold weather, and mental health issues which are unresolved.
- One focus of CPASHC is to continue to maintain relationships with people facing these challenges and being willing to maintain our support.

Story:

One of the most difficult situations was with a man who had been assisted to go for detox several times. He was resisting going to treatment for a long time. Finally, he agreed to go to treatment, and we were able to enroll him in Best Care addiction treatment. With continued support he has been able to stay in treatment and he has expressed much appreciation for how people did not give up on him.