COHC Provider Engagement Panel

Wednesday, March 9, 2022 • 7:00–8:00 am

Held Virtually Via Zoom

https://us02web.zoom.us/j/630619272?pwd=OEdDUnZQMW1PdlBZemwwWDB1WWdQdz09

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

7:00–7:05 **Introductions – Divya Sharma**
Approve Consent Agenda

7:05–7:10 **CCO and Medicaid Update – Jeff Davis**

7:10–7:25 **Challenge Pool Metrics – Sharity Ludwig**

7:25–7:45 **Workforce Provider Development – Cheryl Cohen**

7:45–7:55 **Childhood Immunizations – Rob Ross**

7:55–8:00 **Wrap-up – Divya Sharma**

Consent Agenda

February PEP Minutes

Written Reports

February QHOC Minutes
March Mini-Grant Reports

MINUTES OF A MEETING OF
THE PROVIDER ENGAGEMENT PANEL OF
CENTRAL OREGON HEALTH COUNCIL
Held Virtually Via Zoom
February 9, 2022

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 February 9, 2022, 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
	Logan Clausen, MD
	Matt Clausen, MD
	Jeff Davis, MD
	Emily Harvey, MD
	Jessica LeBlanc, MD
	Sharity Ludwig
	Jessica Morgan, MD
	Robert Ross, MD
Members Absent	Carey Allen, MD
Guests Present	Andrea Ketelhut, PacificSource
	Donna Mills, Central Oregon Health Council
	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.

CONSENT AGENDA

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

QHOC REPORT

Dr. Davis shared that he hadn't yet attended a QHOC meeting and is not sure that QHOC is the best source of the information that has been shared with the group up till now. Although it is important for the CCO medical director to give a report, he will be looking to decide the best venue for obtaining that information.

Dr. Sharma noted that PEP sees value in the information and receives requests from providers for it. The discussion and feedback around rejected below-the-line items and rule changes are helpful.

Dr. Davis explained that there are committees at PacificSource that address that type of information, commenting that from what he could tell QHOC was mostly about Covid. He asked what, big picture, is the focus of the PEP? Regarding January's meeting, he pointed out that the quality pool distribution topic seemed to sit more with Finance and wondered whether deciding QIM percentages was the best use of this committee.

Ms. Mills shared that this was an evolution of QIM payouts and she, Ms. Neugebauer, Ms. Wilder, and Ms. Ketelhut had thought to include PEP in the process, but as they engaged further they concluded that it belongs in Finance.

Dr. Ross voiced that it was important for the group to be informed of changes in coverage and that it changes referral patterns. Dr. Davis responded that there were more refined meetings that bring up those issues.

Dr. Sharma gave a brief overview of the evolution of the Provider Engagement Panel. The state mandated two committees for CCOs—the Community Advisory Council (CAC) and the Clinical Advisory Panel (CAP), which was later changed to the PEP—but their responsibilities were left up to each region. Our region also set up an Operations Council but our sister CCO in the Gorge didn't. Their CAP did delve into the QIMs, but with our Operations Council taking on that duty, CAP's role became more nebulous. At one point, Finance had decided that PEP was going to vet major grants, which the group was excited about, but as the workgroups came into their own, that became their bailiwick. PEP is still evolving, and the question now is how to maximize the valuable resource of the clinical leaders who serve and involve them more actively in making decisions.

Dr. Logan Clausen remarked that, to her, the value of the PEP lies in improving coordination among clinics across the system to address problems, which would be incredibly challenging without multiple providers coming together at the same table.

Dr. Sharma asked whether that was called out in the PEP charter and Ms. Mills stated that she would check, noting that PEP does address issues as they arise in the community and works to determine how better to coordinate in response.

ACTION: Ms. Mills will consult the PEP charter to determine the guidelines for cooperation and action among clinics.

Dr. Davis reminded the group via chat of PEP's responsibilities as listed on the COHC website:
The purpose of the Provider Engagement Panel (PEP) is to support the COHC and its work in the following ways:

- *Review and evaluate projects from a clinical perspective*
- *Coordinate quality committees and set strategic goals*
- *Establish community standards and utilization standards*
- *Promote clinical integration*
- *Serve as a forum for provider perspectives, collaboration, and information exchange*

QUALITY POOL DISTRIBUTION

Ms. Ketelhut shared the data that she had put together for a discussion of quality pool payout distribution, including a dashboard showing 2021 provider performance on the QIMs by measure, with the top ten contributors for each numerator, which was intended to show where the work was being done. She noted that some of the percentages came from her playing with the numbers so she could offer suggestions. After some discussion of the numbers, the group consensus was that decisions on payout distribution belonged with Finance.

Dr. Sharma asked the group to email Ms. Mills with feedback on how to make the meeting of more value—areas where they would like to be involved and topics on which they would like to provide feedback—and whether there should be standing agenda items on clinical issues PEP needs to discuss. She noted that if topics could be identified ahead of time, Ms. Mills could advise whether any workgroups were working on them and PEP could invite a representative to come and present.

ADJOURNMENT

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

Respectfully submitted,

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Camille Smith, Secretary

OHA Quality and Health Outcomes Committee (QHOC)
2/14/2022
Zoom Conference ID: 160 -196-9170
Passcode: 654052
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, Lisa Bui**
	• See attendee list
	• Oregon Resource Allocation Advisory Committee (ORAAC) is accepting applications. The deadline to submit is Friday Feb. 18th.
	• CCO Weekly Update newsletter:
	  ○ CCOs can subscribe to hear updates.
	  ○ January's newsletter included updates on "Guidance about texting and emailing members."
	  ○ February's newsletter included updated about "Provider Operations Manual available for Therapeutics."
		Pgs. 1-4

COVID Updates	**Presenter: Dawn Mautner, Kristen Dillon and Dustin Zimmerman**
	• Omicron surge is decreasing and hospitalizations have been plateauing the past couple of weeks.
	• Booster updates and surge response:
	  ○ Booster shots remain protective against Omicron variant.
	  ○ 56% of eligible adults have received a booster dose.
	  ○ 73% of 65+ age group are vaccinated
	  ○ 96% of Oregon Long-term Care Facilities have had at least one booster clinic for residents. Over 70% of residents have received a booster.
	• Three FEMA mobile vaccine units are supporting efforts.
	• FDA is reviewing data for a vaccine for children under age 5.
	  ○ If approved, the vaccines could begin to get administered as early as 2/21/2022.
	• A new COVID hotline is available for people who test positive and need guidance.
	  ○ 1-800-917-8881
	• OHA's COVID therapeutics team met with three FQHCs to discuss barriers to access. More details to come.
		Pgs. 5- 16

HERC updates	**Presenter: Ariel Smits** • The January VBBS and HERC meeting was cancelled. • New COVID codes are available: ○ 91308, 0081A, and 0081B (see QHOC slides for code descriptions)	Pgs. 16-27

	• March VBBS Meeting topics (carried over from November):
	  o Platelet-rich plasma
	  o Radiofrequency ablation for renal tumors
	  o Pelvic vein congestion
	  o Breast MRI Guidelines
	  o Breast reconstruction after lumpectomy
	  o Newborn home visits.
	  o Coding changes for ligament and tendon injuries
	  o Gait analysis, dorsal rhizotomy, actinic ketatosis
	  o CKD coding for erythropoietin
	• Future topic agendas:
	  o Solid organ transplant lines
	  o Autoimmune encephalitis
	  o BAHA
	• April EBGS virtual meeting:
	  o PANDAS/PAN blue box language (see QHOC slides)
	  o IVIG coverage
	• Ancillary guideline changes: Individual assessment for medical coverage of items, for Early Prevention Screening and Treatment (EPST). Providers need to indicate if the child's specific circumstances warrant if treatment is medically necessary, and make sure patients with special need are not being discriminated against.	

Traditional Health Worker (THW) Learning Collaborative	• Community Health Workers (CHWs) and Chronic Disease Study:
	  o Population: Adults and children with at least 1 chronic condition (asthma, diabetes, hypertension, heart failure, HIV, serious mental illness, and high utilizers)
	  o Interventions – Engagement with CHWs (compared to care without a CHW).
	  o Critical Outcomes – Disease morbidity, ED visits, and medication adherence.
	  o Key Questions - Effectiveness of CHWs in improving outcomes and reducing utilization. What are the harms of CHWs?
	  o Findings: Longer intervention that included using CHWs as part of the care team is associated with greater reductions in utilization.
	  ▪ Evidence shows improvement in outcomes for children with asthma and adults with diabetes and hypertension.
	  ▪ Less evidence to support improved outcomes with patients who have HIV or serious mental illness.
	  o CHW interventions varied across studies and were combined with other interventions such as case management or assertive community treatment.
	• THWs Improve Health Outcomes and Reduce Costs (Summer Boslaugh, OHA Transformation Analyst):
	  o Integrating Doulas:
	  ▪ Higher rates of breastfeeding initiation and lower rates of cesarean deliveries.
	  ▪ Shorter lengths of labor, more cervical dilation,
		Pgs. 30 - 89

	and higher infant Apgar scores. ▪ Women on Medicaid with doula care during labor and delivery resulted in 22% less odds of pre-term birth. ▪ Cost effectiveness analysis indicated potential savings of an average $986. o Personal navigators and improving care for Native Americans: ▪ South Dakota study found that patients undergoing radiotherapy had fewer treatment breaks. ▪ Higher cure rates with fewer referrals out of treatment. o Peer Support Specialist reduces costs of care for individuals with behavioral health care needs. ▪ 71% of people in a program were able to stay out of the hospital in 2009. 54% have not been re-hospitalized. ▪ Involuntary hospitalizations reduced by 32% saving $1.99 million. ▪ $2.28 saved for every $1 spent in a FQHC-based peer support program. o New Mexico Payment Model: ▪ An MCO in New Mexico piloted a payment model in 2005 and gave a PMPM to three clinics that received CHW services. ▪ PMPM provided funding to support CHWs providing a wide range of services and supports. ▪ $4 saved for $1 invested ▪ Fewer ED visits and inpatient admissions ▪ Improved HbAICs and cholesterol levels ▪ 50% increase in breast and cervical cancer screening ▪ 10 other states replicated the model. • Health Equity and THWs (Abdiasis Mohamed, BA, MSW) o CCO 1.0 made minimal progress with integrating THWs in service delivery. o CCO 2.0 Contract requires CCOs to increase the THW workforce by creating a livable and equitable payment system. ▪ Show a return on investment by increasing access to preventative care and access to culturally and linguistically diverse providers. o CCOs are more likely to use fee for service payments with limited scope with doulas. o Most CCOs have value-based payment arrangements for some THW worker type. o Most CCOs have at least some payment engagement with THWs and CBOs. • PCS THW Overview and Strategy (Iris Bickler) o Role of THW Liaisons: ▪ Contracts with clinical and community-based THWs.	

	▪ Ensures members have access to THWs ▪ Support THW workforce development ○ PCS THW payment models: ▪ Fee for service, no codes for Personal Health Navigators ▪ Value-based payments arrangements ▪ Alternative payment models ○ THWs support challenges with payment: ▪ Restrictions to fee for service ▪ CBOs lack contracting experience ▪ Lack of experience with billing for Medicaid (Doulas have no experience billing) • Jackson Care Connect (Cliff Juno, THW Liaison) ○ Guiding Principles for Funding THWs in CBOs ▪ Improve member outcomes and health equity ▪ Long-term payment stability ▪ Transparent and accessible approach ○ Issues and challenges: ▪ Training and certification ▪ OARs and CCO funding complications • HealthShare THW Overview (Maria Tafolla) ○ Host a collaborative with OHSU, Legacy, Kaiser, Providence, and Care Oregon. ○ 601 FTE THW types were reported in their 2021 payment grid. ▪ 42% were CHWs and 41% were Peer Support Specialist. ▪ Funding varied between alternative payment models, grants, fee for service and other methods. ○ Quality Metrics for THWs: ▪ Health Promotion, Community Wellness ▪ Cultural and Linguistic focused ▪ TQS and PIP project for Doulas and Peer Support	
Items from the floor	• n/a	

Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.		
QPI Intro/updates	• No QPI session this month.	n/a
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@dhsoha.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@dhsoha.state.or.us.

COVID-19 Final Report for High Desert Food & Farm Alliance (RHIP)
"Improving Food Access & Sovereignty in Central Oregon"
Reviewed by the Address Poverty & Enhance Self-Sufficiency Workgroup

Summary of Results:

- As part of Improving Food Access and Food Sovereignty in Central Oregon, The Warm Springs Community Action Team (WSCAT) and HDFFA collaborated to improve food security and sovereignty in the tribal community of Warm Springs.
- The WSCAT team identified gaps/barriers for residents and organizations to accessing culturally appropriate food.
- This approach was part of a larger and regional, rural food system assessment conducted by HDFFA in the areas of La Pine, Madras, and Prineville.
- We accomplished the following:
    - WSCAT conducted a food sovereignty assessment with the assistance of HDFFA.
    - WSCAT, HDFFA and Oregon Agricultural Trust (OAT) identified food production opportunities in Warm Springs and presented information about the outcomes and next steps to the tribal council.
    - HDFFA and WSCAT and other tribal members delivered Fresh Harvest Kits.
    - HDFFA conducted surveys of over 100 food pantry clients in Prineville, La Pine and Sunriver.

Quote:

"Given that this project is with Warm Springs members, we are hesitant to share their stories. From HDFFA's perspective, we are excited to partner/work in the rural communities to daylight food access issues and bring more resources."

COVID-19 Final Report for Boys & Girls Club of Bend (RHIP)
"Triple Play: Promoting Physical and Mental Health for Youth in Poverty"
Reviewed by the Address Poverty and Promote Physical Health Workgroups

Summary of Results:

- Through fun and engaging curricula, our Triple Play program delivered health education and programming to promote physical activity and proper nutrition.
- Triple Play: Promoting Physical and Mental Health for Youth in Poverty, focused on healthy habits for the mind, body & soul and provided holistic development for our Club members living in low-income households. A dynamic wellness program to help youth create opportunities to take charge of their personal health and wellness by providing healthy tools to apply to their everyday lives.
- While targeting youth specifically at our East Bend Clubhouse, program staff were able to teach healthy habits to youth who lack support in other areas outside of Club.
- 100% of our members at our East Bend Clubhouse live in low-income housing, often surrounded by negative environmental factors and social/economic barriers, correlating to a higher risk for negative health outcomes in adulthood.
- With the structure of our programming, youth were able to gain confidence despite their socioeconomic backgrounds, by practicing healthy habits of the mind, body and soul.

Quote:

"Triple Play is my favorite program at Club! I wish we could do this program every single day." -4th grade Club member.

This student often has a difficult time engaging in activities with other children, but Triple Play has given him a healthy outlet to develop skills for the mind, body and soul.

COVID-19 Final Report for BendNEXT
"COVID-19 Education and Mask Wearing Campaign"
Reviewed by the Promote Enhanced Physical Health Workgroup

Summary of Results:

- We launched and completed the "Welcome Back" campaign, as described in our grant application, to educate the community on how to follow OHA safety guidelines and promote mask wearing.
- For this campaign, we worked with Central Oregon Daily to produce PSAs, we created social media posts, produced collateral for businesses to educate customers and sent nine different email communications to a list of approximately 4700 unique area users.
- We also produced and distributed 4000 branded masks.
- With the support of the Redmond Chamber, we were able to reach a significant number of individuals, helping them understand how best to safely engage with "reopened" businesses, and provided businesses with valuable resources and collateral.
- Below are details and links to some of the videos and materials we produced:
    - PSA Videos:
        - https://www.youtube.com/watch?v=nTn9ORMqaAs
        - https://www.youtube.com/watch?v=h07HbzkN-mE
        - https://www.youtube.com/watch?v=BhFDP5SS6as
- Social Media: 22 social media posts created, some featured the on-air talent from CO Daily News, county commissioners, and CEOs of the region's chambers of commerce.
- The Welcome Back Toolkit, including display materials and health guidance: https://docs.google.com/spreadsheets/d/16_7ElHmiNjzxxuKHriVLIPadXDaqMMgb3G2UJ0zSNE8/edit#gid=0

Quote:

"We received a number of thanks and comments from business owners, medical professionals and others. A nurse thanked us for encouraging proper hand washing. Other businesses thanked us for supplying masks."

COVID-19 Final Report for Central Oregon Pediatric Associates (COPA)

"PPE Respirators for COVID clinics"

Summary of Results:

- COPA secured reusable and disposable PPE to stay open and see children with respiratory symptoms rather than diverting these visits to the Emergency Department.

- From July 1, 2020, through December 31, 2021, COPA provided >14,900 respiratory visits to children and families across Central Oregon.

- COPA secured enough reusable and disposable PPE to remain open to serve sick children throughout the entire timeframe of the grant.

COVID-19 Final Report for Central Oregon Veterans Ranch (RHIP)
"Veteran Outreach and Community Engagement Project"
Reviewed by the Substance Misuse and Upstream Prevention Workgroups

Summary of Results:

- With support from COHC, we engaged consultants to conduct an organizational assessment, build infrastructure, increase staff capacity, strengthen partnerships, increase veteran engagement, and prepare for hiring of a veteran peer coordinator.
- From April-July 2021, COVR worked with consultants to conduct an organizational assessment and develop a capacity building plan.
- The plan calls for an increase from 5 staff (3.12 FTE) in March of 2021, to 7 staff (6.7 FTE) by the end of 2022.
- New positions hired, thanks in part to this grant, include an Operations & Program Manager and Outreach & Education Coordinator; both are making a huge impact on our services.
- An adjustment was made to our original hiring plan due to our relationship with OHA and the opportunity to secure a contract to hire a Peer Support Specialist in early 2022 (which will be matched by COHC).
- The Outreach & Education Coordinator position (now on staff) meets the original objectives of the Veteran Peer Coordinator.

Story:

A Marine Iraq combat veteran came to COVR for the first time in the Fall of 2020. He had dropped out of college and VA care and was "drifting." He was in a tenuous relationship and his future was uncertain. His first experience was volunteering to help with a seasonal clear out of our Victory Gardens: "I had no idea you guys existed. Now that I do, I'm going to be here every week." He began coming out weekly to volunteer and get training in the COVR hydroponics greenhouse, on the farm property, and soon after joined the Iraq and Afghanistan Veteran Peer Support Group. During the past year, this veteran has gotten certified and hired by Deschutes. Co. as a veteran peer support specialist, got engaged, and is expecting a child.