



COHC Provider Engagement Panel

Wednesday, April 13, 2022 • 7:00–8:00 am

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

- 7:00–7:05** **Introductions – Divya Sharma**
Approve Consent Agenda
- 7:05–7:10** **CCO and Medicaid Update – Jeff Davis**
- 7:10–7:30** **Provider Workforce Development – Cheryl Cohen**
Attachment: Member and Provider Assessment & Workforce Development Priorities
- 7:30–7:55** **Social-Emotional Quality Health QIM – Andrea Ketelhut and Brenda Comini**
- 7:55–8:00** **Wrap-up – Divya Sharma**

Consent Agenda

March PEP Minutes

Written Reports

March QHOC Minutes

April Mini-Grant Reports



**MINUTES OF A MEETING OF
THE PROVIDER ENGAGEMENT PANEL OF
CENTRAL OREGON HEALTH COUNCIL**

Held Virtually Via Zoom

March 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 March 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
Sharity Ludwig
Robert Ross, MD

Members Absent

Carey Allen, MD
Jessica LeBlanc, MD
Jessica Morgan, MD

Guests Present

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

CCO AND MEDICAID UPDATE

Dr. Davis shared that Medicaid membership in Central Oregon had jumped a little over 18,000 in the past year, from 50,950 in March 2021 to 69,140 currently. This was partly due to the federal mandate allowing people to stay on the rolls without reanalysis. There had been rumblings that the federal declaration of disaster may end. The January and February HERC meetings were canceled, and the March meeting was to be held the following day, so there were no updates from that venue.

PacificSource had held a meeting the previous day to update staff on the Oregon legislative session. Bills of note included House Bill 4004 regarding behavioral health provider grants, which directs OHA to give \$130 million to community mental health agencies to help retain workers. House Bill 4035 on Medicaid redeterminations broached the idea of a basic health care program for those who make too much money to qualify for Medicaid (looking at 138 to 200 percent of the federal poverty level). A task force will be established to explore the program.

The Pain Standards Task Force had discussed Narcan co-prescriptions with narcotics. The consensus was that since narcotics are so dangerous, it's important to prescribe Narcan just in case.

CHALLENGE POOL METRICS

After last month's discussion on the purpose of the PEP and the desire of members to engage in system-level action, Ms. Ludwig suggested that the group could focus on ways to impact the challenge pool measures. Any unallocated funds left over from the quality pool payout are rolled into the challenge pool and that money is still possible to obtain. The challenge pool measures set by the Metrics & Scoring Committee for 2022 are CCO system-level social-emotional health (kindergarten readiness); preventive dental or oral health services (ages 1–5, kindergarten readiness, and 6–14); child and adolescent well-care visits (ages 3–6, kindergarten readiness); and meaningful language access to culturally responsive health care services—one focused on the CCO, one on oral health, one on physical health (which can help meet oral), and the last on equity and meaningful language. Ms. Ludwig asked how the group thought we could meet the challenge pool together as a region.

Dr. Logan Clausen responded that it was an interesting thought to target efforts as a community in this way and could be one of the best ways to use this committee, noting that upstream coordination is very helpful.

Ms. Ludwig explained that she did not think they should redirect but they could potentially focus on a more targeted population from different areas of the system, for instance.

Dr. Sharma pointed out that it is important to understand what the measures are and their impact, but they have to make sure they make the other measures. They would not want people to focus on challenge pool measures to the detriment of the main QIMs.

Ms. Mills commented that the Operations Council looks closely at the main QIMs, more so than the challenge pool measures, but the latter often become “real” measures. However, the first effort overall is toward achieving the QIM measures.

Dr. Sharma wondered how the group should be framing the issue to examine it differently and whether it would be helpful for the PEP to hear from the Operations Council regarding how all the member organizations are doing, what efforts they are putting forth, and how the PEP can sync up with those efforts.

CHILDHOOD IMMUNIZATIONS

Dr. Ross shared that the committee on childhood immunizations was funded by the county for three years to work with all their clinics. He assumed they would be following up with COPA, COIPA, St. Charles, and others to clean up their lists.

WORKFORCE PROVIDER DEVELOPMENT

Ms. Cohen was not present this month, so this agenda item was tabled till the April meeting.

WRAP-UP

Ms. Mills asked how everyone felt about moving the meeting to in-person or keeping it in the remote format. It was agreed that the group would prefer to remain virtual.

There was a brief check-in about workplace staffing shortages and the ongoing mask mandate for health care facilities. Dr. Sharma expressed a common hope that the state maintains the masking policy and doesn't leave it to each clinic to decide, so they do not all have to fight that battle with patients.

ADJOURNMENT

There being no further business to come before the PEP, the meeting was adjourned at 7:40 am Pacific Standard Time.

Respectfully submitted,

Camille Smith, Secretary



2022 Central Oregon Member and Provider Assessment & Workforce Development Priorities

April 13, 2022
Cheryl Cohen, LPC, CADC, PWS
Provider Workforce Development Program Manager



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April 13, 2022

Today's Agenda

- Provider Workforce Development Overview
 - Requirements in CCO 2.0
 - The Big Picture
- Assessment: Members & Providers
- 2022 Action Plan Priorities
 - ✓ Priority 1: Healthcare Interpreters (HCI)
 - ✓ Priority 2: Traditional Health Workers (THW)
 - ✓ Priority 3: Behavioral Health (BH)
 - ✓ Priority 4: Internal Infrastructure
- Questions, Input, & Discussion



CCO 2.0 Workforce Development Requirements

As part of the DSN Narrative due each July, CCOs must **assess healthcare provider demographics** and capacity, as well as **member demographics**. Based on that assessment, the CCO must develop and implement an **action plan** to meet member needs for oral, behavioral, and physical health care that is culturally and linguistically appropriate

- Identify and incorporate **culturally and linguistically appropriate service delivery**
- Develop, maintain, and monitor an **appropriate Provider Network for all covered services**
- Ensure **timely access**
- Ensure member access to **certified or qualified healthcare interpreters** in compliance with HB 2359
- The **Provider Directory** must be a single, comprehensive resource for members. It must include:
 - Provider race and ethnicity
 - Provider cultural and linguistic capabilities (including ASL)
 - Certified and/ or qualified healthcare interpreters
 - Provider specialties
 - Whether the provider has completed required cultural competence training
 - Whether the provider offers both telehealth and in-person appointments
- Sexual orientation and gender identity (SOGI) are being added to REALD standards. Once the OHA has a statewide registry (likely 2024), CCOs must identify **REALD + SOGI** demographics and identify health disparities based on those demographics
- Use **data to inform workforce development strategies**
- **Work with local communities**, local and State educational resources, and other OHA resources, including providing financial incentives, to **develop an action plan**

Workforce Priorities: The Big Picture

Outputs

Culturally & Linguistically Responsive Care

- Increased access to certified or qualified healthcare interpreters
- Increased access to Traditional Health Workers
- Implement CLAS
- More providers reflect the cultures & languages of members

Behavioral Health

- BH workforce stabilization
- Improved timely access to mental health and SUD services
- BH pipeline development
- More BH providers reflect the cultures and languages of members

REAL-D Member Demographics

Race

64% White

Primary race unknown
for 1 in 5 members

2% American Indian/
Alaska native

Jefferson County has
more racial and ethnic
diversity

Ethnicity

Across Central
Oregon, 1 in 10
members identify as
Hispanic/ Latinx

In Jefferson County, 1
in 5 members identify
as Hispanic/ Latinx

Age

Average member age
is 28.5 years

42% of members are
under 20 years old

25% of kids are
BIPOC, compared to
16% of adults

Average age higher for
members who speak a
language other than
English or Spanish

Language

94.3% English-
speaking

4.4% Spanish-
speaking. More kids
speak Spanish

1.5% speak English
“Not Well” or “Not at
All”

Unknown English
proficiency for over half
of members

Disability

6.4% of members
have a disability

Sexual Orientation & Gender Identity Demographics



“Without this information, lesbian, gay, bisexual, and transgender (LGBT) patients and their specific health care needs cannot be identified, the health disparities they experience cannot be addressed, and important health care services may not be delivered” -Centers for Disease Control and Prevention (2020)

Social Conditions & Pediatric Health Complexity



- Pediatric members face **social conditions that impact their health**
- Social complexity considers **child and family factors**, including extreme poverty, foster care, parent death, parent incarceration, child and parent mental health services, child and parent substance use services, child abuse or neglect, potential language barrier, and parent disability
- For children in Central Oregon, **29.5% of members have 3+ of these social factors**



Pediatric Health Complexity data can be used to guide improvement strategies

Health Conditions for Members

A PERSON IS SO MUCH MORE THAN THE
NAME OF A DIAGNOSIS ON A CHART.

- SHARON DRAPER -

LIBQUOTES.COM

The Top Four Chronic Conditions are Behavioral Health Conditions



We are unlikely to improve member health and experience in care, manage provider burnout and attrition, or control costs (achieve the Quadruple Aim) without greater focus on behavioral health

Diagnosis	0-19 years	20+ years
Depression	4.7%	17.2%
SPMI	4.7%	11.3%
Substance Use Disorder	0.5%	7.1%
SPMI w/o Major Depression	2.3%	6.3%
Diabetes	0.3%	4.5%
Asthma	1.2%	3.6%

Of members with **4+ ED visits** in the past year, **1 in 3** have an **SPMI diagnosis**

More than half of members living with a physical health condition also have comorbid depression, SPMI, or substance use disorder

BH & PCP utilization is drastically lower among members who speak languages other than English

- Across every risk category, **Spanish-speakers have significantly less BH visits** than English-speakers. There are also **differences in telehealth utilization**, where Spanish-speakers have lower utilization (58%) than English-speakers (67%)
- Increasing access to BH services has led to increased utilization for English-speakers, however we have seen **little to no increase** in the use of BH services for Spanish-speakers
- For adults with a BH diagnoses, 50% of English-speaking members had at least one BH visit in 2020, compared to only 30% of Spanish-speaking members. There were **3.5 times as many BH visits for English-speakers**
- Utilization of **primary care is lower for Spanish-speakers**
- Concepts of mental health and what constitutes “good” emotional health are tied to **culture**

“Latinx and Hispanic communities show similar vulnerability to mental illness as the White population, however, they face disparities in both access to and the quality of treatment. Barriers to care include language services, lack of cultural competence, legal status and fear of deportation, and stigma associated with mental health issues.”

—National Alliance on Mental Illness (NAMI)

Experience in Care: Culture & Language

“Because of my language barrier **they may not take what I would say seriously** or have the patience to understand what I was trying to say”

“I **fear being shamed** for things I fundamentally believe to be positive. I fear not being heard or dismissed and underestimated. I **fear judgement and being misgendered**. I fear that they will not take me seriously”



“**Know about our culture and family dynamic.** If using an interpreter, it’d be nice if they found someone that not only speaks the language but has also had **training** in cultural competency”

“They don’t listen and have **preconceived biases**, and it’s known they treat black people poorly so I have that feeling going in”

Provider Demographics

- What we know
- What we don't know
- Pandemic impacts on workforce

PacificSource Providers: What we know

Overall, PacificSource and other CCOs lack data on provider demographics

Based on current data, **Spanish is the top non-English language** spoken by providers

There are **not enough Spanish-speaking providers** to meet member needs

The majority of Oregon physicians are **White (78.8%)**, followed by Asian (13.4%), Hispanic/Latino (3.4%), Black/African American (1.3%), and American Indian/Alaska Native (0.1%)

The majority of behavioral health providers are **White (90.1%)**, followed by Hispanic/Latino (3.6%), Asian (1.6%), Black/African American (0.9%), and American Indian/Alaska Native (0.4%)

The majority of Oregon dentists are **White (79.2%)**, followed by Asian (13.2%), Hispanic/Latino (3.4%), Black/African American (0.6%), and American Indian/Alaska Native (0.3%)

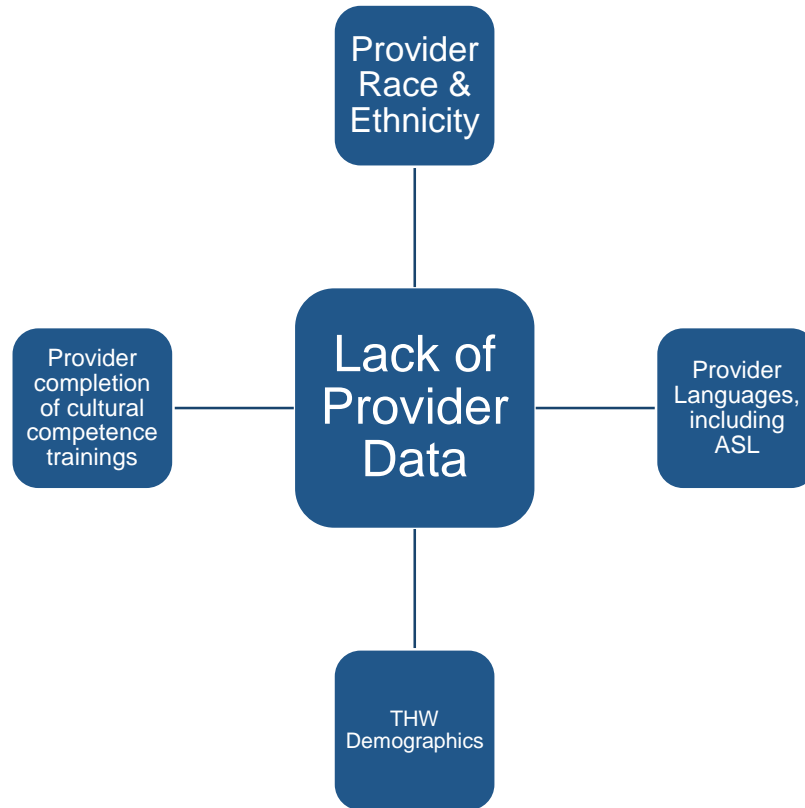
The combined health care workforce is largely **White (82.8%)**.

Use of Health Care Interpreters who are certified or qualified by the OHA is **much higher in Central Oregon (20.2%)** compared to other PacificSource CCO regions (2.6% combined average)

Unlicensed BH providers are **much more racially and ethnically diverse** than licensed BH providers

Provider genders are evenly split, with a slight majority of all provider types being female

Provider Demographics: What we don't know



“Evidence suggests that greater diversity in the healthcare workforce advances cultural competency and increases access to high quality health care. Accordingly, increasing the proportion of underrepresented US racial and ethnic minorities among health care professionals in the workforce may improve quality of care”

- OHA Office of Health Analytics. (2021). *The diversity of Oregon's licensed healthcare workforce*

Pandemic Impacts on the Workforce



“Large numbers of health care workers decided to leave health care at least partly as a result of the stress and burnout occurring during the pandemic, seeking work in other sectors or leaving the labor market altogether”

- JAMA Health Forum, 2022

2022 Central Oregon Workforce Development Priorities

- ✓Language
- ✓Culture
- ✓Behavioral Health
- ✓Infrastructure

Priority 1: Healthcare Interpreters

2022 Activities

New-ish QIM: Certified & Qualified Healthcare Interpreters

2022 CCO metric: In partnership with the Oregon Health Care Interpreter Association (OHCIA), fund training and certification for up to 60 culturally and linguistically responsive Health Care Interpreters who work for vendors contracted with PacificSource

For 2022, the CHIP has a focus on workforce development

In 2022, PS vendor contracts financially incentivize the use of certified or qualified interpreters

Fund & develop internal Healthcare Interpreter Training and Certification Program. Once launched in 2023, this program will prioritize contracted providers first, then HCI vendors



Reminder: Interpreter services are offered two ways- through contracted vendors or through contracted providers who have staff that speak the target language

Priority 2: Traditional Health Workers

2022 Activities

2022 HC metric: Increase member access to community-based THWs

Fund THW foundational and CEU training, prioritizing diverse participants

Advocate that Health Councils integrate THWs into Committees

Educate providers on THW integration, best practices, and the THW Toolkit

For 2022, the CHIP has a focus on workforce development

Develop plans to fill regional THW gaps, in collaboration with providers, training programs, and COCC

Implement two new payment models: Advance PCPCH funding incentives for CHW integration within PCPCH Tier 3.5; Launch community-based THW programmatic payment

Priority 3: Behavioral Health

2022 Activities

Multiple OHA-required plans have a focus on BH workforce and/or BH access. These include: Comprehensive BH Plan (CBHP), Community Health Improvement Plan (CHIP). Additionally, PIPs are focused on BH (mental health access and SUD)

Establish ongoing, regional forums where PacificSource and BH providers collaborate on BH workforce stabilization

BH Provider Training with CME to support licensed or certified BH providers (Topics: CLAS/ Cultural Competency, Trauma Informed Care, Ethics Training, Suicide Risk Assessment)

BH Statewide Workforce Wage & Reimbursement Analysis, in collaboration with Care Oregon

Promote tuition reimbursement, loan repayment, loan forgiveness, and programs for rural BH providers

Pipeline development partnerships with colleges, universities, and training programs- like COCC

CHE Priorities: BH access (Multi-Year Grants), workforce development, integration, diversity and equity

Participate in regional and statewide groups aimed at stabilizing the BH Workforce (with Health Councils, OHA, OCBH, CCO Oregon, etc.)

Participate in or promote OHA-led efforts to reduce administrative burden, including 309 OAR rule revision & suspended reporting requirements

Priority 4: PacificSource Internal Infrastructure

2022 Activities

Improve demographic data collection for both members and providers

Improve demographic data storage for both members and providers

Improve accuracy of utilization data, particularly BH for Latinx and non-English speakers, THWs, & HCI utilization

Offer and expand free provider training; Continue to monitor and report if providers have met OHA-required cultural responsiveness training

Build the PacificSource certified healthcare interpreter training program

Convene cross-departmental BH Crisis Response Workgroup focused on developing a plan of action

Hire CCO BH Director; Spread BH expertise across departments within PacificSource

Workforce Development in Central Oregon: Two Examples

Who's Doing the Work: Central Oregon Behavioral Health Consortium, housed under East Cascade Works. The consortium has 14+ participating provider orgs, plus engagement from COCC, PSU, and OSU

What: Develop a comprehensive, regional strategy to train and build a sustainable BH workforce. This effort is funded by the Healthy Oregon Workforce Training Opportunity (HOWTO) grant through OHSU

Who Benefits from the Work: People in need of high quality BH services; BH providers and provider organizations; local students who want to join the local BH workforce and make a living wage; colleges, universities, and training programs

Desired Outcomes: More BH providers trained and supported to meet the complex needs of those served; Increased access to BH services (especially rural); Improved BH provider recruitment and retention; Increased pipeline development pathways

Contact Person: Adam@ecworks.org

Who's Doing the Work: Central Oregon Community College (COCC), in collaboration with the Health Council, PacificSource, and community groups

What: COCC launched a Community Health Worker (CHW) training program that graduated the first cohort in Fall 2021. COCC is now developing curriculum for a new Peer Support Specialist (PSS) training program

Who Benefits from the Work: People in need of social support or high quality BH services, people with lived experience in recovery who want to join the BH workforce and make a living wage

Desired Outcomes: Increase the number of PSS and CHWs certified to work in Central Oregon; Increase access to peer-delivered services for people with BH conditions; Further integration of THWs in clinical settings

Contact Person: sbaron@cocc.edu

Workforce Priorities: The Big Picture

Outputs

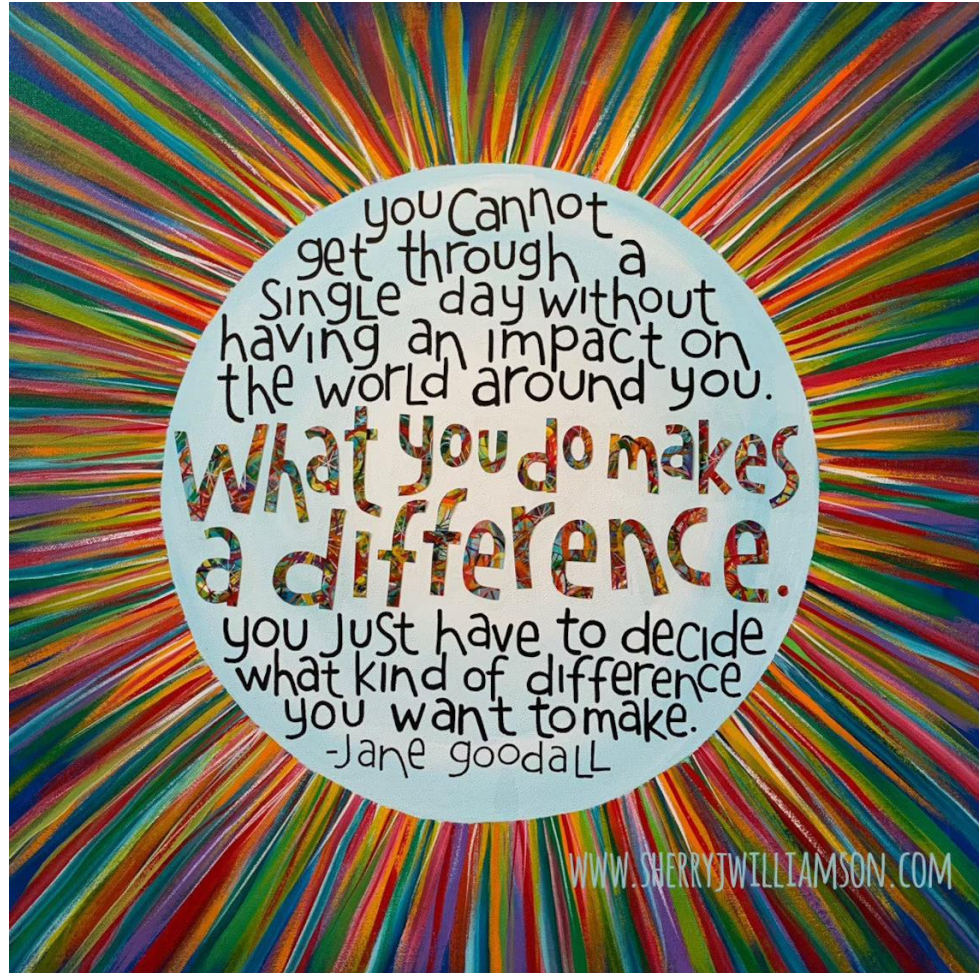
Culturally & Linguistically Responsive Care

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Questions & Discussion Prompt



When you think about the healthcare workforce, what do you think will be most impactful for clients/ patients? Providers?

OHA Quality and Health Outcomes Committee (QHOC)
3/14/2022
Zoom Conference ID: 160 695 606
Passcode: 224545
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	<p>Presenter: Holly Joe Hodges</p> <ul style="list-style-type: none"> See attendee list 	Pgs. 1-4
Oregon State Hospital (OSH)Update	<p>Presenter: Dolores Matteucci and Dr. Walker</p> <ul style="list-style-type: none"> Aid and Assist requires assigned individuals must be admitted within 7 days <ul style="list-style-type: none"> OSH is at maximum capacity with an increase in demand for beds. Expedited admission process for patients who meet criteria for admissions and have exhibited violent behavior that can't be managed in acute psychiatric care. Members with requirements for seclusion and restraint related referrals are reviewed within 24 hours. An additional 16 beds may be available in May or June, but there could be a delay due to workforce issues. Goal to build better coordination across the continuum of care including diversions and timely placement and options to maximize the availability of OSH beds, including expansion for civil admissions. \$130 million housing fund was approved by the legislature. <p><u>CCO Follow-Up</u> Send Lisa Bui two names for points of contact to receive updates from OSH.</p>	Pg. 5
COVID-19 update	<p>Presenter: Dawn Mautner</p> <ul style="list-style-type: none"> Mask mandate has ended in most indoor settings. Masks are still required in healthcare settings. COVID updates are available at https://govstatus.egov.com/OR-OHA-COVID-19 Oregon has entered a recover phase for the pandemic and launched the Reliance in Support of Equity (RISE) plan that includes: <ul style="list-style-type: none"> Protecting Communities most harmed by COVID-19 Protecting people most vulnerable by COVID-19 Expanding access to vital health care and support a thriving workforce. Keeping schools open for student, staff, and family Restoring community cohesion by listening to and 	Pg. 6

	<p>supporting the priorities of local communities.</p> <ul style="list-style-type: none"> • The redetermination process will occur in July and 12 months following the end of the public health emergency. • OHA is taking steps to look at guidelines and cases of long-COVID. 	
HERC Update	<p>Presenter: Arial Smits</p> <ul style="list-style-type: none"> • New COVID codes released: 91309, 0094A, and 87913. <ul style="list-style-type: none"> ◦ New codes include state lab tests for variants. • March VBBS topics: <ul style="list-style-type: none"> ◦ 3 breast MRI guidelines reviewed ◦ Pelvic congestion syndrome is below-the-line (BTL) ◦ Platelet rich plasma is BTL ◦ Breast reconstruction after lumpectomy is above-the-line (ATL) ◦ Actinic Keratosis is not covered. VA study showed group with no treatment that received sunscreen did best. ◦ Polydactyly is covered. ◦ Adenoidectomy can be allowed with the first PE tube. • 2024 Biennial review: <ul style="list-style-type: none"> ◦ Agenesis of the lungs ◦ Dorsal rhizotomy line is being deleted and is being moved to a covered line. (Have to be ages 2-10 and have spastic diplegic cerebral palsy coverage from January 1st). • May VBBS topics: <ul style="list-style-type: none"> ◦ Bilateral BAHA ◦ Orthodontia guidelines review ◦ Coronary CTA ◦ Autologous chondrocyte implantation ◦ Gastric neurostimulators ◦ Ophthalmology review ◦ Adenoidectomy guidelines updates ◦ Temporary urethral stents • Next EGBS meeting is April 7th: <ul style="list-style-type: none"> ◦ PANDAS/PANS ◦ Proposal to cover IVIG and plasmapheresis when recommended by one pediatric subspecialist and PCP or the child has tried and failed at prolonged responses to two less intensive therapies. ◦ Reassessment needed every three months for continued need. ◦ Non-coverage of surgical interventions and long-term antibiotics. ◦ High frequency chest oscillation ◦ Continuous blood glucose monitoring and bariatric surgery 	Pgs. 8 -18
P&T Update	<p>Presenter: Roger Citron</p> <ul style="list-style-type: none"> • Recommendations from last meeting were approved by the director in February. • Oncology Policy Updates: <ul style="list-style-type: none"> ◦ Besremi and Fyarro added to Table 1 with PA criteria. • Parenteral Antipsychotic Literature Scan: 	Pgs. 19 - 30

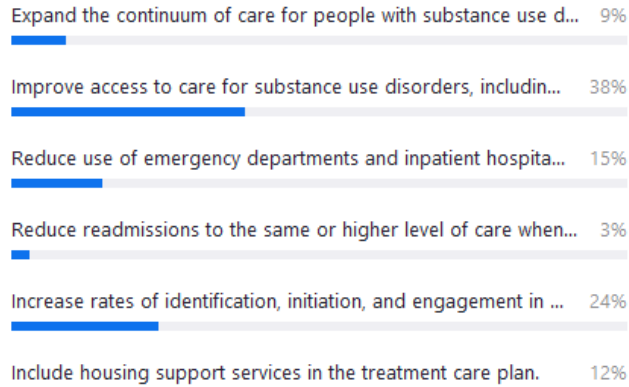
	<ul style="list-style-type: none"> ○ Invega Hafyera preferred • Inhibitors of the Renin-Angiotensin-Aldosterone System (RAAS) Literature Scan: <ul style="list-style-type: none"> ○ Fosinopril, quinapril, and candesartan preferred • Respiratory Syncytial Virus (RSV) criteria updated to correlate with state guidance on season onset. • Oral Antifungals Class Update and New Drug Evaluation (NDE): <ul style="list-style-type: none"> ○ Brexafemme non-preferred • Pompe Disease Class Update and NDE: <ul style="list-style-type: none"> ○ Nexviazyme non –preferred and added to Lysosomal Storage Disorders class. ○ PA criteria updated to include avalglucosidase alfa. • Immunosuppressant Class Update and NDE: <ul style="list-style-type: none"> ○ Saphnelo moved into Targeted Immune Modulators class ○ PA criteria updated for belimumab ○ PA criteria implemented for voclosporin and anifrolumab-fnia. • Oral Glucocorticoids Class Review: <ul style="list-style-type: none"> ○ Class added to the PMPDP and designated at least one oral formulation of each glucocorticoid preferred. ○ Hemady. Alkinidi Sprinkle, Pediapred, Millipred, prednisolone sodium phosphate solution, and prednisolone phosphate disintegrating tablets non-preferred. ○ All other currently available oral formulations preferred. • Next P&T Committee on 4/7/2022. • OHA P&T Committee still has two spots open. 	
Items from the floor	<ul style="list-style-type: none"> • n/a 	

Quality and Performance Improvement Session 1:00 p.m. – 3:00 p.m.		
QPI Intro/updates	Presenter: Lisa Bui <ul style="list-style-type: none"> • MEPP Review for TQS Utilization Review will be completed by consultant in Actuary Services (Shane). • OHA sent an email to CCO Administrators and TQS leads about the 2022 compliance and monitoring review. • Mental Health Access PIP submission/validation is due on 7/31/2022. 	Pg. 34
Statewide SUD PIP development	<ul style="list-style-type: none"> • New Statewide PIP for SUD supports implementation of the SUD 1115 Waiver: • The SUD Waiver is effective April 8, 2021 through March 31, 2026. • Sara Adelhart at OHA will be overseeing the SUD PIP Design and coordinating discussion with CCOs. 	Pgs. 35-48

	<ul style="list-style-type: none"> ○ CCO's to send Sara Adelhart names of contacts from each CCO who need to attend SUD development meetings. • SUD Waiver and State-wide PIP will support new expanded services effective 1/1/2022 such as: <ul style="list-style-type: none"> ○ Expanding the continuum of care for people with substance use disorders. ○ Improving access to care for substance use disorder, including outreach, initiation, treatment, and recovery. ○ Reducing the use of emergency departments and inpatient hospital settings for treatment. ○ Reducing readmissions to the same or higher level of care when the re-admission is preventable or medically inappropriate. ○ Increasing rates of identification, initiation, and engagement in treatment for substance use disorders. ○ Including housing and employment services in the treatment care plan. • The SUD PIP must help reach one of the waiver goals. • Timeline for SUD PIP development: <ul style="list-style-type: none"> ○ April – Topic selection and study question developed. ○ May – Aim statement and PIP metric specification developed ○ June – Metric review and validation ○ July – Design Summary developed ○ August – Design Summary sent to CCOs ○ Sept 1st – CCO's submit and validate Design summary to HSAG. ○ Jan 2023- SUD PIP Implementation begins • CCO External meetings with OHA: <ul style="list-style-type: none"> ○ 2nd Monday during QHOC ○ Fourth week of the month to be scheduled. ○ Send names to sara.adelhart@dhosa.state.or.us to receive calendar invites. • COC Poll Question: - Pick one SUD waiver that you want the SUD PIP to focus on: (See screenshot of combined CCO responses below.) 	
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Untitled Poll

1. For my community, the SUD waiver goal that I want the statewide PIP to focus on: (Single Choice) *



Water Fall Discussion Exercise:

- Question 1: For my community the greatest problem area in SUD is... (A summary of CCO responses from the chat below.)
 - Lack of Access and Stigma
 - Access/ Timely Access
 - Engagement, expanding continuum of care
 - Workflow improvements, relationship building and collaboration with community partners
 - Pilot projects, incentivize X-waiver, grass roots harm reduction
 - SDOH
 - Opiates and the associated ripple effect
- Question 2: For my community, the CCOs most influence in SUD improvement is....
 - Funding for workforce development
 - Access to a continuum of services
 - Workflow improvement
 - Collaboration between various treatment facilities
 - Adequate panel management of SUD providers
 - Increased Access/ Engagement
 - Workforce and integration
 - SUD in primary care and overdoes
- Question 3: For my community, if I could wish all CCOs to work together on SUD it would be on..."
 - Care coordination and closed loop referral
 - Increased access to SUD treatment and system navigation tools.
 - Building the workforce/workforce development
 - Focus on initiation and engagement metric and sharing best practices
 - Community Education

	<ul style="list-style-type: none"> ○ Improve Access ○ Harm reduction ○ Creating a real-time system notifying CCOs and providers when a member has a SUD diagnosis. ○ Community Education on reducing stigma ● General discussion and brainstorming for SUD PIP: <ul style="list-style-type: none"> ○ SUD Peers registered with THW Commission ○ Access to Naloxone ○ Initiation and Engagement (in treatment plan) ○ Incentivizing X-waiver ● Baseline data for the MH access PIP should be available in April after first quarter claims lag. 	
Exhibit I G&A System Dashboard and Reporting Update	<p>Presenter: Carrie Williamson</p> <ul style="list-style-type: none"> ● CCOs submit data on a quarterly basis via excel for grievances, NOABDs issued, and appeals. <ul style="list-style-type: none"> ○ Information in reports is shared with CMS. ● OHA moves information into a dashboard format. <ul style="list-style-type: none"> ○ Drafts are currently being built for the dashboard using PowerQuery and excel. ○ Final versions will have REALD data sets ● OHA is working on streamlining the reporting tool and adding reporting requirements for HB 2517. 	Pgs. 49 – 52
Items from the floor	<ul style="list-style-type: none"> ● Future scheduled Learning Collaboratives: <ul style="list-style-type: none"> ○ Next month – Initiation and engagement metric ○ June- childhood immunizations ● Possible future QPI topics: <ul style="list-style-type: none"> ○ Family Connects ○ TQS and MEPP and Quality and MEPP discussion ○ PIPs – may have presentations in the fall. 	
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

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!”

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 recover, OHP/SNAP, mental health enrolment 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