**CENTRAL OREGON HEALTH COUNCIL**  
**Board of Directors Meeting Agenda**  

**DATE**  
Thursday, August 10, 2023  
**LUNCH**  
12:00 pm  
**MEETING**  
12:30–3:30 pm  
**LOCATION**  
St Charles Prineville | 384 SE Combs Flat Road  

To join via Zoom, register here for the meeting link:  
https://us02web.zoom.us/meeting/register/tZwsdu6trTMiH9zQIsWdA3zRR7flvIH34lG

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Presenter</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>12:30–12:40</td>
<td>Welcome, Public Comment, and Announcements</td>
<td>Tammy Baney</td>
<td></td>
</tr>
<tr>
<td>12:40–12:45</td>
<td>Consent Agenda</td>
<td>Tammy Baney</td>
<td>Vote</td>
</tr>
<tr>
<td>12:45–1:00</td>
<td>Community Update: Crook County on the Move</td>
<td>Donna Barnes</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>1:00–1:20</td>
<td>Psychiatric Residency Program Rural Training Program</td>
<td>Dr. Robert Ross, Dr. Jinnell Lewis</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>1:20–1:35</td>
<td>VIM Report: Diabetes &amp; Behavioral Health Grant</td>
<td>Kat Mastrangelo</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>1:35–2:00</td>
<td>Community Engagement Strategy</td>
<td>Miguel Herrada</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>2:00–2:20</td>
<td>CCO Health-Related Services</td>
<td>Tricia Wilder, Kristen Tobias</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>2:20–2:35</td>
<td>CCO Performance Metrics Q2 2023*</td>
<td>Tricia Wilder</td>
<td>Info</td>
</tr>
<tr>
<td>2:45–3:05</td>
<td>Legislative Update</td>
<td>Rick Blackwell</td>
<td>Info</td>
</tr>
<tr>
<td>2:35–2:45</td>
<td>House Bill 3396, Section 2</td>
<td>Carmen Madrid</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>2:45–2:55</td>
<td>2022 Shared Savings</td>
<td>Rick Treleaven, Carmen Madrid</td>
<td>Info &amp; discussion</td>
</tr>
<tr>
<td>2:55</td>
<td>Adjourn</td>
<td>Tammy Baney</td>
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</tbody>
</table>

*CCO mandated reporting.*
CENTRAL OREGON HEALTH COUNCIL
Board of Directors Meeting Agenda

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Consent Agenda
May & June 2023 Board Minutes
COHC Financials Dec 2022–March 2023

Written Reports
Crook County on the Move
St Charles Residency Programs
OHSU/SCHS Three Sisters Residency
VIM Diabetes & Behavioral Health Grant
VIM Report for 2022 COHC Collins Match
COHC Community Engagement Strategy
Health-Related Services Investment Guidelines
CCO Performance Metrics Q2 2023
Legislative Update June 2023
JMA Update: House Bill 3396
Shared Savings Request
Executive Director’s Report August 2023
CCO Director Report August 2023
CCO Dashboard Q3 2023

The COHC Board of Directors reserves the right to transition into executive session at any point during the Board meeting.
A meeting of the Board of Directors (the “Board”) of Central Oregon Health Council, an Oregon public benefit corporation (the “Corporation”), was held as a hybrid meeting at 12:30 pm Pacific Time on Thursday, May 11, 2023, at the City Council Chambers in La Pine and online via Zoom. Notice of the meeting was sent to all members of the Board in accordance with the Corporation’s bylaws.

Directors

- Tammy Baney, Chair, COIC
- Linda Johnson, Vice Chair, Community Representative
- Patti Adair, Deschutes County Commissioner
- Gary Allen, DMD, Advantage Dental
- Paul Andrews, EdD, High Desert ESD
- Seth Crawford, Crook County Commissioner
- Megan Haase, FNP, Mosaic
- Brad Porterfield, CAC Chair
- Divya Sharma, MD, COIPA
- Kelly Simmelink, Jefferson County Commissioner
- Iman Simmons, St. Charles
- Justin Sivill, Summit Health
- Dan Stevens, PacificSource
- Rick Treleaven, BestCare Treatment

Guests

- Kelley Adams, COHC
- MaCayla Arsenault, COHC
- Lara Bickel, LPB Consulting
- Jeff Davis, MD, PacificSource
- Miguel Herrada, COHC
- Lindsey Hopper, PacificSource
- Gwen Jones, COHC
- Heather Kaisner, DCHS
- Carmen Madrid, COHC
- Carol Martin, COHC
- Kat Mastrangelo, Volunteers in Medicine
- Echo Murray, ODF
- Leslie Neugebauer, PacificSource
- Valerie Nicoll, COPA
- Mike Richards, St Charles
- Emily Salmon, St Charles
- Camille Smith, COHC
- Erin Fair Taylor, PacificSource
- Kristen Tobias, PacificSource
- Tricia Wilder, PacificSource
- Dustin Zimmerman, OHA

Tammy Baney served as Chair of the meeting and Camille Smith served as Secretary. Baney called the meeting to order and announced that a quorum of directors was present, and the meeting, having been duly convened in accordance with the Corporation’s bylaws, was ready to proceed with business.

WELCOME
Baney welcomed all attendees to the meeting and facilitated introductions.

**CONSENT AGENDA**
The consent agenda consisted of the March and April meeting minutes.

**MOTION TO APPROVE:** Linda Johnson moved to approve the consent agenda; Patti Adair seconded. All were in favor and the motion passed unanimously.

**ANNOUNCEMENTS**
Board members were asked to complete their self-evaluation surveys by May 15 in preparation for the Board retreat.

**LOCAL COMMUNITY GUEST**
Echo Murray, who handles dispatch and community education for Walker Range Fire Patrol, informed the Board of the community-based organizations at work in Gilchrist, Crescent, and northern Klamath. She and three others are currently running the Crescent Community Club. Needs in the area include food, insurance for the Saturday Farmers Market, fire mitigation funds to replace SB 762 funding ending June 15, a grant to replace a lost Crescent Municipal well, and transportation, particularly nonemergent medical transportation (NEMT). Murray noted that they were awaiting approval on two vans, which would employ local drivers to connect with transportation in La Pine; they plan to serve veterans and could do grocery runs and the like. Baney offered help from COIC and asked Murray to be in touch. (Note: Baney and Murray connected on May 15.)

**CCO PERFORMANCE METRICS Q1**
Tricia Wilder presented the first quarter performance metrics for the CCO. Three metrics were in the yellow: First, meeting QIM targets, which is expected since all the numbers won’t be in till the fourth quarter. Second, mental health service visits, which were at 63 percent for a 66 percent target. Third, complaints on oral health services, which was close to target; the CCO is focused on improvements.

There was discussion around vaccinations, which were hugely impacted by the pandemic. Deschutes County Public Health and the CCO had collaborated with Boost Oregon. Heather Kaisner planned to reach out to Baney regarding adolescent immunization strategies and to connect Brad Porterfield to the county immunization team and Boost regarding community workshops around the state for the vaccine hesitant. (Note: Kaisner and Porterfield connected on May 15.)

**BOARD RETREAT PREP: STRATEGIC PLAN GUIDANCE**
Baney reminded the Board that the retreat was planned for Thursday, June 8, from 9:30 to 5, starting with an executive session at 9:30. Feedback was requested through the Board self-evaluation survey. A survey to evaluate the performance of the executive director would be sent out the following day and discussed at the executive session. Strategic plan input would be requested from the CAC, and a joint Board–CAC meeting had been set for September. Board members were asked to review the directions and aims of the strategic plan, which were included in the meeting packet, in preparation for the retreat. Healthcare strategy consultant Lara Bickel was introduced as the retreat facilitator.

**PEDAL CLINIC**
Mike Richards shared an update from the PEDAL steering committee, which is working toward a community model similar to the existing pediatric hospitalist model. Clinical and business subcommittees meet biweekly. Thus far, they have conducted a provider survey to identify the most critical services required in the community; engaged Medman Consulting to optimize the program and minimize the financial commitment for sustainability; are creating a draft agreement for the parties in the partnership; and have spent around 25 percent of their funding.

**Behavioral Health Surplus Update**
Gwen Jones gave an update on the $1.4 million in shared savings funds earmarked for behavioral health, which must be distributed by June 30. Three project areas had been identified by a workgroup consisting of Behavioral Health, Substance and Alcohol Misuse, and Stable Housing workgroup and CAC members. Jones requested that the Board consider whether their organizations would be willing to serve as lead agencies and partner on collaborative teams to guide the three project areas.

**RHA Tool Kits**
Carol Martin presented customized RHA tool kits to the Board members in attendance, which include individual QR codes, flyers, posters, and cards for Board members to share with their organizations to drive traffic to the community health survey. Tool kits would be delivered to the remaining Board members.

**Adjoin**
There being no further business to come before the Board, the meeting was adjourned at 2:26 pm Pacific Time.

Respectfully submitted,

___________________________
Camille Smith, Secretary
A meeting of the Board of Directors (the “Board”) of Central Oregon Health Council, an Oregon public benefit corporation (the “Corporation”), was held on Thursday, June 8, 2023, at Aspen Hall in Bend. Notice of the meeting was sent to all members of the Board in accordance with the Corporation’s bylaws.

**Directors**
- Tammy Baney, Chair, COIC
- Linda Johnson, Vice Chair, Community Representative
- Patti Adair, Deschutes County Commissioner
- Gary Allen, DMD, Advantage Dental
- Paul Andrews, EdD, High Desert ESD
- Seth Crawford, Crook County Commissioner
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**Guests**
- Kelley Adams, COHC
- MaCayla Arsenault, COHC
- Lara Bickel, LPB Consulting
- Miguel Herrada, COHC
- Gwen Jones, COHC
- Carmen Madrid, COHC
- Carol Martin, COHC
- Camille Smith, COHC
- Tricia Wilder, PacificSource

Tammy Baney served as Chair of the meeting and Camille Smith served as Secretary. Baney called the meeting to order and announced that a quorum of directors was present, and the meeting, having been duly convened in accordance with the Corporation’s bylaws, was ready to proceed with business.

**Welcome**
Baney welcomed all attendees to the meeting.
**Behavioral Health Shared Savings Proposal**

Gwen Jones shared the progress made on the behavioral health shared savings distribution by the Behavioral Health workgroup and members of the CAC and Substance and Alcohol Misuse and Stable Housing workgroups. The funds will be disbursed in three areas under the guidance of three lead agencies: housing led by FUSE; culturally specific support led by SriPonya; and in-person rural led by Crook County Public Health. Each group will receive $500,000.

Board questions included: can organizations get involved later in the process, what is the definition of success, how will the groups be monitored, and should they submit workplans. It was agreed that the groups would be asked to report back regularly on progress and challenges. The first progress reports would be requested for the August Board meeting.

**MOTION TO APPROVE:** Paul Andrews motioned to approve the updated process with provisos as delineated and Baney called for a vote. All were in favor and the motion passed unanimously.

**Public Comment**

There was no public comment.

**Board Retreat**

Following the completion of the business meeting, the Board recessed to engage in a planned retreat.

**Adjourn**

With no further business to come before the Board, the meeting adjourned at 11:10 am Pacific Time.

Respectfully submitted,

______________________

Camille Smith, Secretary
## Central Oregon Health Council
### Statement of Financial Position
**YTD: DECEMBER 2022 Pre-Audit**

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>General Fund</th>
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<tr>
<td><strong>Checking/Savings</strong></td>
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</tr>
<tr>
<td>Total Checking/Savings</td>
<td>$19,677,520</td>
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<tr>
<td>COPA - Security Deposit</td>
<td>1,997</td>
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<tr>
<td><strong>TOTAL CHECKING/SAVINGS</strong></td>
<td>$19,679,516</td>
</tr>
<tr>
<td><strong>COPA - Security Deposit</strong></td>
<td>1,997</td>
</tr>
</tbody>
</table>

| **TOTAL ASSETS** | $19,679,516 |

<table>
<thead>
<tr>
<th>LIABILITIES &amp; EQUITY</th>
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</thead>
<tbody>
<tr>
<td>Accounts Payable</td>
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<tr>
<td>Payroll Payable (PTO Accrual)</td>
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<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
<td>$19,679,516</td>
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<table>
<thead>
<tr>
<th>Revenue</th>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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<tbody>
<tr>
<td>Operating Revenue</td>
<td>$1,362,222</td>
<td>$1,200,000</td>
<td>14%</td>
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<tr>
<td>Community Impact Funds</td>
<td>3,816,428</td>
<td>2,700,000</td>
<td>41%</td>
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<tr>
<td>Grants</td>
<td>20,500</td>
<td>50,000</td>
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<td>Interest Income</td>
<td>33,507</td>
<td>100,000</td>
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<td><strong>Total Revenue</strong></td>
<td>$5,232,658</td>
<td>$4,050,000</td>
<td>29%</td>
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<thead>
<tr>
<th>Expenses</th>
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<tr>
<td>Operating Expense</td>
<td>1,122,088</td>
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<tr>
<td>Community Impact Funds*</td>
<td>7,417,518</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td>8,539,606</td>
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</table>

| Net Income | $(3,306,948) | $(1,997,867) | 66% |

### Community Impact Funds - Top 4 Funded 2022
- East Cascades Works | 500,000 |
- Boost Oregon | 300,000 |
- Dawn's House | 250,000 |
- Redmond Oasis Village Project | 250,000 |
- Impact Incentive Funds | 2,204,728 |
- All other | 3,912,792 |
| **TOTAL** | $7,447,518 |

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

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<td>NO</td>
<td>NO</td>
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*Operating budget met - 28% below budget*
## Central Oregon Health Council

### Statement of Financial Position

**YTD: January 2023 Pre-Audit**

### ASSETS

<table>
<thead>
<tr>
<th>General Fund</th>
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<tbody>
<tr>
<td>Checking/Savings</td>
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<tr>
<td>Total Checking/Savings</td>
<td>$18,857,498</td>
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<tr>
<td>COPA - Security Deposit</td>
<td>$1,997</td>
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<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$18,859,495</strong></td>
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### LIABILITIES & EQUITY

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<tr>
<th>General Fund</th>
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<tr>
<td>Accounts Payable</td>
<td>$142,313</td>
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<tr>
<td>Payroll Payable (PTO Accrual)</td>
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<td>RHIP 2020-2024 Payable</td>
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<tr>
<td>Grants Payable</td>
<td>$4,919,001</td>
<td>includes Shared Savings 2021 to be paid out by 6/30/2023</td>
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<tr>
<td><strong>Grants Payable</strong></td>
<td><strong>$9,148,888</strong></td>
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<tr>
<td><strong>Net assets without donor restrictions</strong></td>
<td><strong>$9,628,360</strong></td>
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<tr>
<td><strong>Net Income/(loss)</strong></td>
<td><strong>$(78,923)</strong></td>
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<tr>
<td><strong>TOTAL LIABILITIES &amp; EQUITY</strong></td>
<td><strong>$18,859,495</strong></td>
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### Revenue

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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<tbody>
<tr>
<td>Operating Revenue</td>
<td>$ -</td>
<td>$100,000</td>
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<tr>
<td>Community Impact Funds</td>
<td>$ -</td>
<td>$225,000</td>
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<tr>
<td>Grants</td>
<td>$ -</td>
<td>$4,167</td>
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<tr>
<td>Interest income</td>
<td>$1,210</td>
<td>$8,333</td>
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<tr>
<td><strong>Total Revenue</strong></td>
<td><strong>$1,210</strong></td>
<td><strong>$337,500</strong></td>
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### Expenses

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<tr>
<th>Actual</th>
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<tbody>
<tr>
<td>Operating Expense</td>
<td>$80,132</td>
<td>$109,958</td>
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<tr>
<td>Community Impact Funds*</td>
<td>$ -</td>
<td>$308,333</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td><strong>$80,132</strong></td>
<td><strong>$418,292</strong></td>
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### Net Income

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<tr>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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<tbody>
<tr>
<td><strong>Net Income</strong></td>
<td><strong>$(78,923)</strong></td>
<td><strong>$(80,792)</strong></td>
</tr>
</tbody>
</table>

**Community Impact Funds - Top 4 Funded 2023**

No grants funded Jan 2023

Program Funds

All other

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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<tr>
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**Variance is due to timing of Community Impact Funds revenue and distribution of funds through grants in different years.**

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</table>
# Central Oregon Health Council
## Statement of Financial Position
### YTD February 2023 Pre-Audit

### ASSETS

<table>
<thead>
<tr>
<th>Checking/Savings</th>
<th>General Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Checking/Savings</td>
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<tr>
<td>COPA - Security Deposit</td>
<td>1,997</td>
</tr>
<tr>
<td><strong>Total Checking/Savings</strong></td>
<td><strong>$ 19,127,592</strong></td>
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### LIABILITIES & EQUITY

| Accounts Payable | $ 96,172 |
| Payroll Payable (PTO Accrual) | 18,856 |
| RHIP 2020-2024 Payable | 4,195,095 |
| Grants Payable | 4,919,001 |
| **Total Grants Payable** | **$ 9,114,096** |
| **Net assets without donor restrictions** | **$ 9,663,152** |
| Net Income/(loss) | 241,316 |
| **TOTAL LIABILITIES & EQUITY** | **$ 19,127,592** |

### Revenue

<table>
<thead>
<tr>
<th>Operating Revenue</th>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Impact Funds</td>
<td>$ 350,270</td>
<td>$ 450,000</td>
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<td>Grants</td>
<td>-</td>
<td>$ 45,833</td>
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<td>Interest income</td>
<td>$ 3,085</td>
<td>$ 8,333</td>
<td>-63%</td>
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<td><strong>Total Revenue</strong></td>
<td><strong>$ 479,841</strong></td>
<td><strong>$ 704,167</strong></td>
<td>-32%</td>
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### Expenses

| Operating Expense | $ 223,525 | $ 109,958 | -103% |
| Community Impact Funds* | $ 15,000 | $ 308,333 | 95% |
| **Total Expenses** | **$ 238,525** | **$ 418,292** | 43% |

### Net Income

| **Net Income** | **$ 241,316** | **$ 285,875** | -16% |

---

*Community Impact Funds - Top 4 Funded 2023 >$50,000*

| Program Funds | $ 15,000 |
| All other YTD | $ 15,000 |

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

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</tr>
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COHC Board of Directors | 10
August 10, 2023
### ASSETS

<table>
<thead>
<tr>
<th>Description</th>
<th>General Fund</th>
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</thead>
<tbody>
<tr>
<td>Checking/Savings</td>
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<td>Total Checking/Savings</td>
<td>$ 16,284,520</td>
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<tr>
<td>COPA - Security Deposit</td>
<td>$ 1,997</td>
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<tr>
<td>TOTAL ASSETS</td>
<td>$ 16,286,517</td>
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### LIABILITIES & EQUITY

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Accounts Payable</td>
<td>$ 1,540</td>
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<tr>
<td>Payroll Payable (PTO Accrual)</td>
<td>$ 18,856</td>
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<tr>
<td>RHIP 2020-2024 Payable</td>
<td>$ 4,195,095</td>
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<tr>
<td>Grants Payable</td>
<td>$ 1,733,825</td>
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<tr>
<td>Total Grants Payable</td>
<td>$ 5,928,920</td>
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<tr>
<td>Net assets without donor restrictions</td>
<td>$ 9,663,152</td>
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<tr>
<td>Net Income/(loss)</td>
<td>$ 674,049</td>
</tr>
<tr>
<td>TOTAL LIABILITIES &amp; EQUITY</td>
<td>$ 16,286,517</td>
</tr>
</tbody>
</table>

### Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Revenue</td>
<td>$ 259,793</td>
<td>$ 300,000</td>
<td>-13%</td>
</tr>
<tr>
<td>Community Impact Funds</td>
<td>$ 719,426</td>
<td>$ 675,000</td>
<td>-7%</td>
</tr>
<tr>
<td>Grants</td>
<td>$ -</td>
<td>$ 12,500</td>
<td>-100%</td>
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<tr>
<td>Interest income</td>
<td>$ 4,449</td>
<td>$ 25,000</td>
<td>-82%</td>
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<tr>
<td><strong>Total Revenue</strong></td>
<td>$ 983,668</td>
<td>$ 1,012,500</td>
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### Expenses

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<th>Actual</th>
<th>Budget</th>
<th>% Variance</th>
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</thead>
<tbody>
<tr>
<td>Operating Expense</td>
<td>$ 294,620</td>
<td>$ 329,875</td>
<td>11%</td>
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<tr>
<td>Community Impact Funds*</td>
<td>$ 15,000</td>
<td>$ 925,000</td>
<td>98%</td>
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<tr>
<td><strong>Total Expenses</strong></td>
<td>$ 309,620</td>
<td>$ 1,254,875</td>
<td>75%</td>
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### Net Income

<table>
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<th>Description</th>
<th>Actual</th>
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</thead>
<tbody>
<tr>
<td><strong>Net Income</strong></td>
<td>$ 674,049</td>
</tr>
<tr>
<td><strong>(242,375)</strong></td>
<td>-378%</td>
</tr>
</tbody>
</table>

---

*Community Impact Funds - Top 4 Funded 2023 >$50,000*

- Program Funds 15,000
- All other YTD 15,000

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

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**CCO Financials**

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<tbody>
<tr>
<td>P &amp; L Board trigger Yes or No</td>
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<td>NO</td>
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<td>Recapture Board trigger Yes or No</td>
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</tbody>
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COHC Board of Directors | 11
August 10, 2023
A collective impact movement working towards a vibrant and healthy lifestyle for all Crook County residents.
Be Nourished

Community Garden Party
Be Nourished

Share The Bounty reduces waste by redistributing excess garden produce from local home gardeners.
Share The Bounty

HDFFA Fresh Harvest Kit Distribution
Nutrition Security

Working with our partners and community to address needs
Stay Refreshed

Age Friendly Park Benches

A collaborative effort lead by
CC On The Move
CC Parks & Recreation
CC Rotary

With funding from several organizations and
community members.
Let’s Walk Together

A 12-week walking program creating opportunities to increase physical activity, experience ways to create a healthy lifestyle change and enhance community belonging.
Keep Moving
Keep Moving
Group Experiences

Steps Against Melanoma
Group Experiences

Sun Life Farm Hike
Group Experiences

Sun Life Farm Hike
Group Experiences

Superfood Snacks in a Snap
Group Experiences

Online and print resources to explore

Pool exercise

Free classes at the local gym

Local Benefits Walks

Experience Prineville Maps

Crook County On The Move and Crook County GIS have teamed up to create these online experience maps. Let's get outside, stretch those legs and explore our beautiful community!

Scan the QR code or visit our webpage – CrookCountyOnTheMove.org/Explore-Local
Stay Refreshed

Be Well Video Series on YouTube

Thanks to Olive & Blu Photography

Dannie Ramos

Children's Yoga

Hannah Renzi CNM

Meditation

Jodi Kerr
Meandering Maker

#CreateKindnessArt

James Anderson

Qi Gong warmup before walking

Larry Weber

Protect Your Skin in the Winter

COHC Board of Directors | 27 August 10, 2023
Let’s Walk Together Results

106 registered participants
8 hosted groups and P.O.R.K. participation
53 participants logging minutes = 36,279 min (604.7 hours)
Miles walked = 1,517.28 (From Oregon to Texas)

Met new friends, reconnected with old and created a wonderful sense of community among our groups.
Keep Moving

Supporting passions of community members to create healthy lifestyle events and educational opportunities.
Other Opportunities

- Nutrition Security - Regionally & Locally
- Harvest & Heritage event-walking and trolley tours
- ROCRIS (Research in Oregon Communities Review System) - Grants in rural communities
- Children’s activity book to educate early learners about sharing excess food, composting & recycling
- Deschutes Land Trust - Support Ochoco Preserve multi-modal trails connectivity.
- LaPine healthy lifestyle movement

Connecting    Collaborating    Creating Change
Why We Want a Teaching and Research IE “Academic” Institution

“A Town is just a Town until it gets a College, then it is a College Town. A Hospital is just an ordinary Hospital until it has Education and Research—then it is Extraordinary.”
Why SCHS—this IS Strategic Planning

1. Huge population growth, likely to exceed projections
2. Physician shortages—primary care and specialties
3. Address access and social justice issues for indigenous (AI/AN) and rural populations
4. Improve quality, safety, cost of care—address physician culture
5. Solve vexing medical conditions, be part of innovation, not just a recipient
6. Deliver the highest quality, most advanced care to the population
7. Continue to expand educational opportunities (research?) with OHSU
GME as Strategic Imperative

- Community risks of rapid population growth & provider shortages
- AAMC projects a shortage of 220 PCPs in CO by 2025–2030
- Improves access, care quality, mortality rates, outcomes, research/innovation
- Offsets provider turnover and reduces recruitment cost
- Creates steady pipeline of providers vs. dependence on outside recruitment
- CHANGES the CULTURE: happy doctors, happy support staff
St Charles–OHSU High-Level Overview

**OHSU**

- GME provides oversite and support for GME (committees, etc.)
- Expertise on GME program development
- Educational resources for residents and faculty

**St Charles**

- Hires program directors
- Runs programs with OHSU GME oversite
- Claims and collects CMS $
Thus Far

- Rural Training Program (RTP) in Madras: residents are starting in Portland July 2024. Recruiting residents now who arrive in Central OR in August 2025. Full ACGME approval fall 2022

- PD is Dr. Jinnell Lewis—faculty, rotations, design completed

- Supported over last 3 years by HRSA grant and HOWTO state grant

- Proposed psychiatry program 6/22 $500K grant awarded to support PD and coordinator for psychiatry from COHC

- Creates steady pipeline of providers vs. dependence on outside recruitment—for all clinics and specialties—this is a community project
  - Hired PD (Dr. Stanley, OHSU Associate PD, 1/23)
  - Finalizing accreditation application to ACGME—September 23
Oregon Health and Science University (OHSU/SCHS) Three Sisters Residency

**OUR MISSION** OHSU Three Sisters Residency Program aims to provide compassionate, culturally inclusive, full-spectrum training in Family Medicine dedicated to improving access to high-quality healthcare in rural and underserved communities.

**OUR VISION** To create a community of educators and leaders that will transform the delivery of medical care to meet the present and evolving needs of rural and frontier America.

**HOW:** Dr. Rob Ross who is the director of academics and research at St. Charles applied for a HOWTO Grant* and Joe Skariah the OHSU Portland Family Medicine Residency Director applied for HRSA Grant** funding to start this residency program. Dr. Jinnell Lewis, a family medicine physician at St. Charles Madras Family Care since September 2014, was selected as the residency program director.

**WHAT:** 3-year family medicine residency focused on rural family medicine training. Residents are physicians (graduated MD/DO’s) who have completed a 4-year undergraduate degree and 4 years of medical school training.

**WHEN:** Residents complete their intern year at OHSU July 2024-August 2025 then start their last 2 years of residency in Madras August 2025

**WHERE:** Residents will live in Madras and work as physicians in 3 dedicated continuity clinic sites (Warm Springs IHS clinic, Mosaic Medical, St. Charles Family Care) with 1 resident planned at each clinic (2 per clinic total when fully running)

**GOALS:** Improve access to care in rural Oregon and in particular, Central Oregon where there is a large lack of access to primary/preventative care. Community benefits, including a larger pool of potential employees from family/partners of residents, which adds millions of dollars of revenue to the community of Madras.

**NEEDS:** housing within 20 minutes of St. Charles Madras Hospital

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*HOWTO Grant Program is intended to expand health professional training within the state to address current and future shortages in the health care workforce in rural and medically underserved areas of Oregon.

**HRSA awarded over $12.3 billion in grants to improve and expand health care services for underserved people, focusing on the following program areas: Primary Care/Health Centers, Health Workforce Training, HIV/AIDS, Organ Donation, Maternal and Child Health, Rural Health, and other areas.
Diabetes and Behavioral Health Grant

COHC Board of Directors

August 10, 2023

Kat Mastrangelo, Executive Director
Overview

Volunteers in Medicine (VIM) provides healthcare for low-income, uninsured patients who are 96% Latinx / Spanish speaking.

With support from the Central Oregon Health Council, we increased the quality of care for our diabetic and pre-diabetic patients by adding bi-lingual bi-cultural counseling and a bi-lingual, bi-cultural diabetes RN care coordinator (RNCC)
Multi-disciplinary team

• RNCC - lead
• Medical Director
• Counseling
• 3 Endocrinologists *
• 2 ophthalmologists *
• Several PCPs *
• Nutritionist
• Diabetes Nurse Educator *
• Exercise *

*indicates Volunteer
• Patients Served: 385
  • Diabetic patients: 175 (45%)
  • Pre-diabetic patients: 210 (55%)

• A1c >9 Control average = 15.4%

• Patients receiving Mental Health counseling: 48 (12.5%)

VIM’s diabetes population is comparable in size to Summit (213) LaPine (195) and Caldera (98) for their OHP Patients.
Some lessons learned so far:

• PHQ9 on intake: Usually self-reported at a zero or very low. As we worked with the patients, their scores would INCREASE, but this was due to increased understanding of the language and dynamics of their situations. With continued engagement the scores drop over time.

• Reluctance for Counseling: initially hard to get this program started, especially with men. Had much better results with the counselor attending education classes as a resources, the patients could meet and develop rapport her, and would then follow-up for services.
Leveraging your investment
Continuous Blood Glucose Monitoring Project

Funded by Marie Lanfrom Foundation
17 Patients: 7 T1, 10 T2
DATA

STARTING AVG A1C: 10.24
Range 7.7 – 18+

3 MONTH AVG: 8.65
Range 6.4 – 11.1

# HIGHER AFTER 3 MO: 3 of 17 (17.6%)

# LOWER AFTER 3 MO: 14 of 17 (82.3%)
A1C control results (lower is better)

% not in control (A1C > 9)

Initial reading: 65%
2nd reading: 41%
3rd Reading: 15%

Note: COO QIM target is 24.8%. Most recent avg is 26.8% (Range 16.9% – 31%)
CBG monitors are highly effective in providing continuous feedback on blood sugars so that patients can adjust in real time.
Dental care for Diabetic Patients

Funded by the CO Health Quality Alliance (COHQA)
Partnership with Capitol Dental

• This is an ongoing grant

• We had a six-week diabetes wellness class that ran from October 19, 2022 to January 11, 2023 with 19 patients.

• As of the midpoint of the project in February 2023, initial dental care and follow up had been provided for 12 of the 19 patients (those with an A1c>7 and active dental issues) through 34 dental care visits.

• The second half of the project is focusing on follow up with our volunteer diabetes educator and dietician, with the patients receiving food gift cards and continuing to have their A1cs monitored and dental needs provided.

• Participants received electric toothbrushes and water flossers as well as class room instruction on how to use them. Family members could also participate in this part of the program.
Lessons Learned: Dental

- Trusted clinical staff take the lead to assess the need and schedule dental appointments results in good patient acceptance.
- Mental health support for anxious patients was important.
- Dental appointments were approached as a specialty appointment.
- Dental cleanings were an important first step.
- Scheduling follow-up appointments for more extensive care needs is more complicated and access is an issue.
- Training with the electric toothbrushes and water flossers improved patient excitement and usage of the tools.
- More Dental Capacity for high needs patients is needed.
Healthier Oregon Transitions
aka “HOP”
63 diabetic patients have transitioned care because they now have OHP. 14 of these had a1c above 9.
OHP / HOP churn will negatively impact our diabetic patients
Questions
May 12, 2023

Carmen Madrid
Executive Director
Central Oregon Health Council
PO Box 6689
Bend, OR 97708

Re: Report for 2022 COHC Collins Match

Dear Ms. Madrid and Board Members:

In 2022, the Central Oregon Health Council generously supported Volunteers in Medicine Clinic of the Cascades (VIMCC) with a $100,000 match for the grant we received from the Collins Foundation. Your support has helped us provide crucial medical care to Central Oregon residents. I am writing today with an update on our work.

**VIMCC provided medical care to a total of 744 low income, uninsured Central Oregon residents over the past year.** Patients received free of charge primary and specialty medical care, prescription medications, and mental health counseling. We provided 3,230 nurse triage calls, 8,028 visits, and 3,196 prescriptions at no charge to patients.

**We increased outreach, enrollment, and interpreter services** with hires who are bicultural and bilingual thanks to grants from Oregon Health Authority. We retained the new staff with funding from PacificSource, Oregon Community Foundation, Collins Foundation, and Marie Lamfrom Charitable Foundation. These hires bring us closer to the communities we serve to build trusted relationships and further improve care.

**We strengthened our Nurse Telehealth program to better serve our low-income, uninsured Latinx patients.** This program reduces barriers for our patients, increases volunteering by nurses, increases volunteer satisfaction, and diverts patients from unneeded trips to the clinic or ER. Nurses conduct triage for incoming calls, nurse intakes, visit follow up, lab results, ER visits, and patient check-ins via telehealth (we additionally deliver provider visits via telehealth).

Our nurse telehealth program has its roots in the pandemic when volunteer nurses called Covid patients as frequently as daily. The outcomes were that **VIMCC had zero COVID-19 patients in the ICU, zero deaths, and only five hospitalizations**—despite working with a population that would otherwise experience high mortality rates. Today, volunteer nurses call all patients who visit the emergency room (ER) or urgent care, receive lab results, contract COVID-19, or have health questions. Our nurse corps made 3,230 patient calls last year. Patients avoid unnecessary medical visits and receive expedited appointments when care is needed. Thanks to our Nurse Triage program, **our patients have half the ER visits of the general population.**
We retained innovations established during the pandemic. Our telehealth program allowed us to expand services from four to five days per week and after hours. Free-of-charge mail delivery reduces barriers for our patients. Expanded pharmacy staffing ensures no downtime in the pharmacy and more pharmacy support for medical providers and patients.

We continued to improve healthcare delivery. For example, we created a new program that couples diabetes education with no-cost dental care, gift-card supports for healthy food choices, and whole-family engagement. We piloted continuous glucose monitors that allow patients and our RN care coordinator to see real-time blood sugar results for 15 patients. While these units are expensive at $2,000 each, they have been a game changer for diabetic patients who struggle to control their blood sugar levels.

We cultivated a dedicated volunteer corps to provide the majority of our services. Last year, 177 clinic volunteers donated 11,019 hours valued at $730,720. In order to serve our clients who are predominantly Latino and from working-poor, low-income households, 17 Spanish interpreters donated 1,496 hours. Additionally, our 212 off-site medical partners saw 593 patients upon referral to provide no cost or deeply discounted specialty care.

One big development was that changes in Oregon law allowed some of our patients to qualify for Oregon Health Plan (OHP). As proposed in the Collins Foundation grant application, we helped 104 newly eligible patients enroll in OHP. With OHP coverage, these patients moved to other medical providers, but VIMCC continued to work with them extensively to provide navigation services. This was especially important for our patient population where, for many individuals, VIMCC is their first experience with the U.S. healthcare system. With these patients leaving and fewer volunteer medical providers post-pandemic, we saw fewer patients than in prior years, but we are now partnering with the local health system to recruit more volunteers.

Our objectives for the Collins Foundation grant also included recruiting new and upgrade donors through a challenge match. We exceeded the $20,000 Collins match campaign by raising $74,721 from 93 qualifying donors.

Finally, the Collins Foundation grant will help fund implementation of the Willow pharmacy module for our Epic electronic medical records system. Implementation was delayed as we awaited assignment of an Epic specialist from St. Charles Health System, but we now have a specialist, and we will be meeting in June. We are excited that we will be able to tie the medications received into patients’ charts, not only at the VIM clinic but also for our partners.

We are immensely grateful for COHC’s support in helping us build health equity and improved outcomes for uninsured Oregonians. If I can provide any additional information, please feel free to contact me at (541) 585-9005 or kat.mastrangelo@vim-cascades.org.

Sincerely,
Kat Mastrangelo
Executive Director
COHC Community Engagement Strategy

COHC Strategic Direction number Five: Identifying and Addressing Inequities

“Bolster community engagement to ensure diversity of voices during decision-making process”
Diversity, Equity and Inclusion is a Journey

- Staff
- Workgroup M
- Board of Directors
- CODEI
- Workgroup A
- Community Partner
- CAC
- The Oregon Health Policy Board develops the Health Equity Committee.
- Central Oregon Cares is formed, but not able to sustain.
- OHA releases TQS elevating conversation and response to address HE and DEI within health care.
- Central Oregon Diversity, Equity and Inclusion (CODEI) is formed.

2020
- 2020-2024 RHIP elevates health equity.
- World and National Events
  - Structured and intentional COHC staff learning begins.
  - CDC, AMA, APHA and others declare racism a serious public health emergency and threat.

2021
- Health equity review of workgroup investments are initiated.
- Regional health equity reports are added to health data website.
- Equity is integrated into BOD’s and staff job descriptions.
- Initial work begins to align work and vision of HE, DEI and Community Engagement

2022
- COHC DEIJ statement is adopted.
- DEIJ assessment and learning opportunities are initiated.
- Health-equity-related questions are added to investment (grant) design, application, review and decision making.
- Collection and reporting of REALD and SOGI is institutionalized.
Diversity, Equity and Inclusion is a Journey
Why representation and life experience is key to DEIJ oriented decisions?

Values and lived experience

Decision context

Knowledge

Rules

https://i2insights.org/2017/06/20/values-rules-knowledge-and-transformation/
Diversity, Equity, Inclusion and Justice, is more related to a “Value” than to a “Knowledge”.

Beliefs and lived experiences are strongly related to our vision of DEIJ.

DEIJ System change cannot be driven solely from within the organization.

Include people with live experience in the design and the decision process of programs and services that impact their communities.

Right now, only 5% of the workgroups (nine people) are Community members not representing an organization.
Three levels of change:

COHC BOD, workgroups and committees.

Engaging the community and keeping them: Informed, Consulted and Involved.

Need to “touch the hearth of the people”

https://www.fsg.org/resource/water_of_systems_change/
Our goal
The COHC will create the conditions and opportunities for a more significant interaction between the Committees/Workgroups/Board, the CBO’s and Members of underrepresented communities. (Community representatives)
Strategic Direction 1

Develop the idea to build a strategy

Everything is an idea first.

DEIJ will be a priority that is widely understood, acknowledged, and properly resourced to allow all the actors to participate in the COHC decisions.
Strategic Direction 2

Build capacity

*We are the result of our context and opportunities.*

Develop the appropriate operational conditions needed for this style of work to function.

**Actors:** BOD, Workgroups, Committees, Staff, Communities, Tribes, RHEC
Strategic Direction 3

**Empower communities for a meaningful engagement**

*Communities need to be ready to play their role.*

The community members and their leadership need to be empowered to work collaboratively with the COHC workgroups and committees.
How are we going to do it? Future State Metrics

1-Community engagement will be accepted by the Board, workgroups and committees as a main objective for the work led by the COHC and a continuum learning process will be adopted to achieve our goal.

2-The COHC staff will be trained and able to lead and model the transformation needed at workgroups, committees, and communities.

3-COHC Committees and Workgroups will be aware of their need to become a more welcoming space and will develop a plan to integrate inclusive practices, diversity and make space for community feedback into their group.

4-Community representatives, Medicaid members and CBO’s in the region will be informed, consulted, involved, and eventually leading or participating in most decisions that affect the health in their communities.
We need your support as this transformative work begins to develop!

Community Engagement will be adopted and resourced as one of the main strategies by the COHC.

- **Community engagement** will be a goal in the COHC agenda.

- COHC will develop a plan to integrate the topics of HE, DEIJ and Community engagement in the work plan and operations of the COHC.

- Ongoing transformative work...
Final thoughts....
Health-Related Services Investment Guidelines
What are Health-Related Services?

Health-related services (HRS) are non-covered services that supplement covered Oregon Health Plan benefits to improve care delivery and overall member and community health and well-being.

The two types of HRS include Flexible Services and Community Benefit Initiatives.
Services Covered by OHP

What are the services?

- Medical Care
- Dental Care
- Behavioral Health
- Prescriptions (including mail order)
- Non-emergency Medical Transportation

Nurse Case Management and Member Support Services
Members needing extra help have somewhere to turn

Flexible Services
- Emergency housing supports
- Health-related personal items
- Gym memberships
Health-Related Services: Flexible Services

Flexible Services are cost-effective services delivered to an individual OHP member to supplement covered benefits and improve the individuals’ health and well-being. Examples include:

- Weighted blanket
- Gym membership
- Emergency housing assistance
- Utility assistance
- Non-covered medical supplies and durable medical equipment
- Fitness trackers
- Clothing
Health-Related Services: Community Benefit Initiatives

Community benefit initiatives (CBI) are community-level interventions that include – but are not limited to – OHP members and are focused on improving population health and healthcare quality. Examples include:

- Funding active transportation infrastructure improvements (for example, safe routes to school or expanding safe bicycle lane infrastructure) and public transit improvements.
- Preschool and kindergarten readiness programs.
- Community diabetes education programs providing culturally and linguistically appropriate resources.
- Food pantry programs that provide fresh, healthy food to rural communities.
- Projects to improve or develop community parks and playgrounds to increase physical activity.
To **Qualify**, HRS Investments must:

1. Be designed to improve health quality.
2. Increase the likelihood of desired health outcomes.
3. Be directed toward OHP members and provide health improvements to the larger community without additional costs for non-members.
4. Be grounded in evidence-based medicine or widely accepted best clinical practice.
5. Implement, promote, and increase wellness and health activities.
6. Align with the priorities identified by the Regional Health Improvement Plan.
Regional Health Improvement Alignment

The Central Oregon Health Council has six RHIP Workgroups focused on our Priority Areas:

1. Address Poverty and Enhance Self-Sufficiency
2. Behavioral Health: Increase Access and Coordination
3. Promote Enhanced Physical Health Across Communities
4. Stable Housing and Supports
5. Substance and Alcohol Misuse: Prevention and Treatment
6. Upstream Prevention: Promotion of Individual Well-Being
Community Benefit Initiative: HRS Exclusions

1. Projects that are primarily designed to control or contain costs.
2. Activities that can be billed as clinical services.
3. Provider workforce and certification training, including provider credentialing.
4. Broad assessments or research that does not directly improve community health.
5. Advocacy work that does not directly improve community health or healthcare quality.
6. Building new buildings and capital investments in facilities designed to provide billable health services.
7. Member incentives and items and services that could be covered by Flexible Services.
8. Administrative activities to support the delivery of covered services.
9. Projects that are inherently religious.
Questions?

Kristen Tobias
Senior Community Health Coordinator, Central Oregon CCO

kristen.tobias@pacificsource.com
# 2023 CCO Performance Metrics

**Purpose:** Support the Central Oregon Health Council (COHC) Board of Directors in monitoring key performance standards for the Central Oregon CCO.

## Quality and Member Experience

**Objective:** CCO improves care, makes quality care accessible, and eliminates health disparities for members.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2023 Target</th>
<th>Q1 Status</th>
<th>Q2 Status</th>
<th>Q2 Updates</th>
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</thead>
<tbody>
<tr>
<td>Meet minimum Oregon Health Authority Quality Incentive Measure targets to achieve 100% payout.</td>
<td>100%</td>
<td>66%</td>
<td>66%</td>
<td>The CCO is on track to meet the annual QIM targets for both Childhood Immunizations and Adolescent Immunizations by Q3 reporting (pause for applause). Several metrics are trending positively back to pre-pandemic levels. The two metrics that are the most at risk are (1) Postpartum Care and (2) Oral Exam For Patients With Diabetes. 2021 baseline indicator rate for the percentage of members with a mental health service need who received mental health services is 63.4%. 2022 remeasurement year one indicator rate for the percentage of members with a mental health service need who received mental health services is 63.2%.</td>
</tr>
<tr>
<td>Percent of members with a mental health service need who received a mental health service in the measurement year.</td>
<td>66%</td>
<td>63%</td>
<td>63%</td>
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## CCO 2.0 Requirements

**Objective:** CCO meets all CCO 2.0 contract requirements.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2023 Target</th>
<th>Q1 Status</th>
<th>Q2 Status</th>
<th>Q2 Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 60% of provider contracts are in a Value Based Payment arrangement meeting the IAN Framework category of 2C or higher.</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
<td>The CCO is reporting the metric status based on 2021 experience and known upcoming contracting changes. Using the 2021 Internal estimation, PCS estimates 66.2% of CCO payments are 2C or higher. In 2023, the Pharmacy Benefit Manager expenses will move to 2C. Using the 2021 internal estimation, PCS estimates 61.5% of CCO’s payments are 2B or higher. Internal 2022 PAF reporting will be available in the last quarter of 2023.</td>
</tr>
<tr>
<td>Population reach of unique members seen in integrated behavioral health care settings.</td>
<td>10%</td>
<td>13%</td>
<td>14%</td>
<td>16 participating clinics met or exceeded the target and six clinics fell below the target. One clinic opted out of participation due to the clinic closing. Clinics that have not met the target will continue to participate in required technical assistance to support any barriers to reaching the target.</td>
</tr>
</tbody>
</table>

## Financial Stability

**Objective:** CCO ends the year in a positive financial position.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2023 Target</th>
<th>Q1 Status</th>
<th>Q2 Status</th>
<th>Q2 Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve positive net income.</td>
<td>Positive net income</td>
<td>Data for first quarter of 2023 with claims runoff through June shows an ED utilization rate of 379 visits per thousand members per year (PTMYP) which is below the well-managed threshold of 511 visits PTMYP.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Emergency Department utilization is within the well-managed utilization range as defined by Milliman benchmark data source.</td>
<td>Well-managed category threshold or below</td>
<td>The following financials report a year-to-date operating gain of $10.9M, ahead of a budgeted gain of $9.2M. There are $1.4M of negative adjustments from prior year. Membership as of May 31, 2023, was 76,586 actual members compared to a budget of 75,126. The current estimate of the 2023 JMA calculates out to be a shared savings of $4.1M, net of the estimated 2023 SHARE Designation ($1.1M).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Operations

**Objective:** CCO monitors and evaluates operations to ensure optimal performance.

<table>
<thead>
<tr>
<th>Metric</th>
<th>2023 Target</th>
<th>Q4 2022 Status</th>
<th>Q1 2023 Status</th>
<th>Q1 2023 Updates</th>
<th>Q2 2023 Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average number of complaints related to Non-Emergent Medical Transportation (NEMT) services are less than 22% of total</td>
<td>&lt;22% (40/182 total complaints)</td>
<td>20%</td>
<td>22%</td>
<td>There were 217 total complaints in Q1 2023. Of these complaints, 47 were related to NEMT putting the CCO at 22% for Q1 look back. There were 27 complaints related to dental services in Q1 2023. With a total average enrollment of 75,178, the CCO is at .36 complaints related to dental services per 1,000 members. This confirms the prediction made in Q4 2022 that this metric will improve over time. PCS anticipates that the DCOs will continue to meet this metric in the coming quarters as they continue to improve and maintain improvements to access and service efforts.</td>
<td></td>
</tr>
<tr>
<td>Receive ≤.7 complaints/1000 members related to oral health services.</td>
<td>≤0.7% (6/182 total complaints)</td>
<td>0.80%</td>
<td>0.36%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Legislative Update: June 25, 2023

After 40 days of inactivity, the Oregon Senate finally mustered a quorum and passed hundreds of policy bills, all the agency bills that make up the state’s budget and went home hours before the constitutional deadline. Out of the 384 bills that PacificSource tracked this session, only 84 of them made it across the desks of both chambers. Thus, we will not know for certain which measures pass until July 25. There are several bills to bring to your attention, however:

**HB 2446/HB 3396:** As you know, HB 2446 would have extended the current CCO contracts until no later than December 31, 2026. The House Committee on Behavioral Health and Health Care had adopted the measure, though on a party-line vote. In the process of the bill moving from the House to the Senate, we believed that the phrase “no later than” provided a shorter extension period than had been contemplated in the House. We testified solely as PacificSource in the Senate, asking for an amendment for the bill to strike that clause. The Senate Committee on Health Care declined to take up an amendment, due to the concern that any amendments would slow down adoption of the bill.

In the meantime, the Senate was unable to convene because of lack of quorum. For weeks, it seemed as if HB 2446 would not move for the remainder of the session. In the House, another bill – HB 3396 – with the right “relating to” clause (i.e., the subject of the bill that all things must relate to in the text) was amended to extend the existing CCO contracts until December 31, 2026. Most of HB 3396 is part of the broader nurse staffing package that was hammered out between the hospitals, labor and the nurses. PacificSource supported that amendment before the Joint Subcommittee on Capital Construction. Both HB 2446 and HB 3396 would go on to be adopted after the Senate reconvened for business.

When two bills amend the same section or require the same action, a committee must adopt what is known as a “conflict amendment.” Here, because HB 3396 passed later in time, an amendment to the bill deleted sections 1 and 2 of HB 2446, leaving the original bill an empty shell. HB 3396 will thus govern the extension of time granted to the CCO contracts.

**HB 2002:** The same standards that apply to commercial health benefit plans with respect to gender-affirming care also apply to the state medical assistance program – i.e., the Oregon Health Plan – under HB 2002. The only differences between the sections are that there is no mention of cost sharing in the medical assistance program section, and the Oregon Health Authority must monitor CCO compliance with the new requirements. Even though the Department of Consumer and Business Services is required to develop rules to implement the Act that apply to commercial health benefit plans, the Oregon Health Authority has permissive authority to do the same.

**SB 966:** This was one of the Oregon Health Authority’s presession filed concepts, and it dealt with metrics and scoring changes. After much negotiation with CCOs, the bill pared down the changes to the metrics and scoring committee changes. The Act clarifies the existing metrics and scoring subcommittee must adhere to the Public Meeting Law when selecting downstream health outcome and quality measures and health outcome and quality measures. Metrics must be updated to conform with the CMS core set of quality measures. All health measures must be consistent with the 2022-2027 § 1115 demonstration waiver and quality strategies approved by CMS regulation.

The Act also set the downstream metrics for reporting year 2024 from the Health Plan Quality Metrics Committee’s Aligned Measure Menu Set. It established until 2027 the four upstream metrics applicable
to CCOs: (1) health assessments for children in foster care, (2) kindergarten preparedness, (3) language access to culturally responsive health care, and (4) screening for social needs and referrals to address social determinants of health.

OHA will also need to convene a workgroup to study of the CCO quality incentive program to develop recommendations for program changes and subcommittee changes so that the program is primarily focused on addressing health inequities and the structural drivers of health inequities. OHA must work with OHP members and individuals from communities harmed by health inequities. Report is due to the Legislative Assembly by September 15, 2024.

HB 5525: The state’s budget is an aggregate of all the branches’ agencies – the executive branch is by far the largest set of budgets in Oregon. OHA’s budget bill was encapsulated in HB 5525 this session. Some highlights from 5525:

- The General Fund (GF) appropriation to the OHA is $5.6 billion, a 43% GF increase from the 2021-2023 legislatively adopted budget.
- Total agency funds – federal, state and other – are $35 billion.
- Several items included in the “current service level”¹ budget:
  - The Healthier Oregon Plan (HOP) was fully funded to the tune of $576 million. The Joint Ways and Means Committee then made a caseload adjustment reduction of $113 million in HOP due to appropriate caseloads.
  - Increases to account for inflation across all fund types was $517 million.
  - The Oregon State Hospital used GF to backfill from the loss of American Rescue Plan Act funds.
- The 30% average behavioral health rate increase approved by the Emergency Board in 2022 extends into this biennium; funded to $127 million.
- In committee, the Legislative Fiscal Office confirmed that Oregon Health Plan was fully funded, including a 3.4% rate of growth. The full 3.4% rate of growth built into budget, which equated to 6.92% for the biennium.
- $110 million GF went toward redeterminations, the temporary Medicaid expansion and the basic health program: $51 million is to be allocated for the temp expansion; $1.3 million to finish up the blueprint.
- $138 million GF went for implementing the 2022-2027 § 1115 demonstration waiver.
- Finally, approximately $2 million was allocated to replace the federal facilitated marketplace with a state-based exchange (the appropriation for Senate Bill 972).

This update is obviously not a full list of bills that passed affecting, directly or indirectly, the Medicaid system in Oregon. Once the dust completely settles on the session, we will have opportunity to draft a more fulsome report. For questions or concerns, please contact me at (541) 284-7736 or richard.blackwell@pacificsource.com.

¹ Current service level means costs to an agency if programs continued as is, taking into account inflation, salary roll-up costs, program phase-ins and projected caseload increases.
The current JMA (Joint Management Agreement) will currently expire as stated below ‘December 31, 2024’.

With HB 3396 – Section 2 as attached below, this house bill extends existing CCO contracts to expire December 31, 2026.

COHC would like to align the expiration date and continue its existing JMA through December 31, 2026.

2. Extended Term and Termination:

2.1 Extended Term. Subject to the terms and conditions contained in this Amendment and the Agreement, the term of the Agreement is extended for one additional term of six years, commencing on January 1, 2019 and ending on December 31, 2024 (the “Extension Period”), unless sooner terminated or extended as provided in the Agreement and/or this Amendment. Subject to the terms and conditions contained in this Amendment, the Extension Period will be on the same terms and conditions contained in the Agreement.

2.2 For Convenience. Section 7.2 of the Agreement is amended and restated in its entirety as follows:

“7.2 “For Convenience, Either party may terminate this Agreement for convenience upon three hundred sixty-five (365) days’ prior written notice to the other party.”

2.3 Effect of Termination. Section 7.5 of the Agreement is amended to include the following sentence at the end of Section 7.5:

“PCS will remain the CCO for the Region, subject to the terms and conditions contained in the Health Plan Services Contract between PCS and the State of Oregon (acting by and through the Oregon Health Authority) and applicable laws.”
Enrolled

House Bill 3396

Sponsored by Representative RAYFIELD; Representatives DEXTER, EVANS, NELSON, Senator PATTERSON

CHAPTER ..........................................

AN ACT

Relating to health care; creating new provisions; repealing sections 1 and 2, chapter ___, Oregon Laws 2023 (Enrolled House Bill 2446); and declaring an emergency.

Be It Enacted by the People of the State of Oregon:

SECTION 1. (1) As used in this section, “post-acute care settings” includes:
(a) A setting in which a patient receives in-home care services, as defined in ORS 443.305;
(b) A setting in which a patient receives home health services, as defined in ORS 443.014;
(c) Skilled nursing facilities, as defined in ORS 442.015;
(d) Residential care facilities, as defined in ORS 443.400, including assisted living facilities;
(e) Adult foster homes, as defined in ORS 443.705; and
(f) Community hemodialysis providers.
(2) The Joint Task Force on Hospital Discharge Challenges is established, consisting of 22 members appointed as follows:
(a) The President of the Senate shall appoint one member from among the members of the Senate.
(b) The Speaker of the House of Representatives shall appoint one member from among the members of the House of Representatives.
(c) The Governor shall appoint:
(A) Five members representing hospitals, including at least one member representing a rural hospital, as described in ORS 442.470, and one member representing a health system who has expertise in hospice care and home health care;
(B) One member representing nurses who work in acute care settings;
(C) Three members representing health care workers in post-acute care settings;
(D) Three members representing residential care facilities and long term care facilities, including skilled nursing facilities, including one member who has expertise in hospice or home health care;
(E) One member representing commercial insurers that offer health benefit plans;
(F) One member, representing counties, who has expertise in assessing and placing patients discharged from acute care settings into post-acute care settings;
(G) One member representing coordinated care organizations;
(H) One member representing social service providers or federally qualified health centers that serve individuals who are homeless;
(I) One member representing the Oregon Health Authority;
(J) One member representing the Department of Human Services;
(E) One member representing the Governor; and

(L) One member representing outpatient renal dialysis facilities, as defined in ORS 442.015.

(3) The task force shall:

(a) Develop recommendations to address the challenges faced by hospitals in discharging patients to appropriate post-acute care settings, including but not limited to recommendations for:

(A) Streamlining and reducing barriers to training, education, licensure and certification for all classifications of nurses and nursing assistants for work in post-acute care settings while maintaining the quality of the workforce;

(B) Facilitating the timely discharge of patients from hospitals to appropriate placements in post-acute care settings, including by:

(i) Using the Preadmission Screening and Resident Review tool;

(ii) Obtaining medical assistance determinations;

(iii) Improving discharge methodologies; and

(iv) Improving connectivity between hospitals and post-acute care settings for appropriate post-acute care setting placements;

(C) Supporting innovative care models and innovative payment models to increase access to placements in post-acute care settings by patients with complex health needs or who lack stable housing;

(D) Modifying medical assistance and commercial health benefit plan coverage and reimbursement to facilitate appropriate post-acute care setting placements such as by improving benefits for patients in hospitals who are awaiting discharge and increasing reimbursement and benefits for individuals in post-acute care settings;

(E) Increasing available options for and access to community-based placements, including in-home care services, home health care services, adult foster homes, outpatient hemodialysis facilities, hospice care and other potential models of care that may be licensed by the state; and

(F) Opportunities for federal and state partnerships to secure federal resources and the federal approvals needed for such partnerships.

(b) The task force shall consider how each recommendation developed under this subsection relates to the needs of individuals who are experiencing homelessness or who otherwise lack stable housing.

(4) The Legislative Policy and Research Director shall provide staff support to the task force, including but not limited to:

(a) Reviewing strategies that have been successful in other states, including through the use of federal waivers of Medicaid requirements or through demonstration projects under 42 U.S.C. 1315;

(b) Reviewing data and studies related to the challenges faced by hospitals in discharging patients to post-acute care settings;

(c) Reviewing state and federal requirements for licensure, certification and scope of practice for all licensed or certified providers who practice in post-acute care settings;

(d) Reviewing the responsibilities of county and state agencies and the accountability of county and state agencies for conducting clinical assessments and financial assessments of hospital patients who are ready for discharge to post-acute care settings and assisting in the patients’ placements in appropriate post-acute care settings;

(e) Gathering and analyzing data on wages paid to county and state employees with the responsibilities described in paragraph (d) of this subsection, turnover rates of the staff and best practices for hiring and training the staff; and

(f) Gathering and analyzing data provided by hospitals, post-acute care settings and local and state agencies on the main barriers to discharging patients from acute care facilities to appropriate post-acute care settings, including but not limited to:

Enrolled House Bill 3396 (HB 3396-B)
(A) The primary reasons for delays in discharging patients for post-acute care;
(B) The current overall capacity of post-acute care settings;
(C) The current workforce challenges faced by post-acute care settings;
(D) The rates of reimbursement and methodology for reimbursing care for patients in post-acute care settings;
(E) Coordinated care organizations’ rates of reimbursement and methodologies for reimbursing care for patients in post-acute care settings;
(F) The numbers of days patients remain in hospitals after the patients are ready for discharge and the reasons for the avoidable extended stays; and
(G) Data from acute care facilities on patients’ lengths of stays.
(5) The director may contract with third parties that have expertise in acute care discharges and post-acute care settings to support the work of the task force.
(6) The Oregon Health Authority and the Department of Human Services shall provide data and policy analysis to the task force at the direction of the task force chairperson.
(7) A majority of the voting members of the task force constitutes a quorum for the transaction of business.
(8) Official action by the task force requires the approval of a majority of the voting members of the task force.
(9) The task force shall elect one of its voting members to serve as chairperson and another voting member as vice chairperson.
(10) If there is a vacancy for any cause, the Governor shall make an appointment to become immediately effective.
(11) The task force shall meet at times and places specified by the call of the chairperson or of a majority of the voting members of the task force.
(12) The task force may adopt rules necessary for the operation of the task force.
(13) Members of the Legislative Assembly appointed to the task force are nonvoting members of the task force and may act in an advisory capacity only.
(14) Members of the task force who are not members of the Legislative Assembly are not entitled to compensation or reimbursement for expenses and serve as volunteers on the task force.
(15)(a) The task force, at any time, may provide recommendations for administrative changes that do not require legislative action to the Governor and to the interim committees of the Legislative Assembly related to health and human services.
(b) No later than December 15, 2023, to the greatest extent practicable, the task force shall report its recommendations for legislative changes to the interim committees of the Legislative Assembly related to health and human services. The report need not comply with ORS 192.245.
(c) No later than November 15, 2024, the task force shall submit a final report, in the manner provided in ORS 192.245, on the findings and recommendations of the task force, which may include recommendations for legislation, to the interim committees of the Legislative Assembly related to health and human services.

SECTION 2. Notwithstanding ORS 414.590 (2)(a), a contract entered into between the Oregon Health Authority and a coordinated care organization under ORS 414.572 (1) that is in effect on the effective date of this 2023 Act shall be extended to December 31, 2026.

SECTION 2a. If House Bill 2446 becomes law, sections 1 and 2, chapter ___, Oregon Laws 2023 (Enrolled House Bill 2446), are repealed.

SECTION 3. The Oregon Health Authority shall provide grants to support clinical education at hospitals and health care facilities.

SECTION 4. The Oregon Health Authority shall provide grants to employers participating in a labor-management training trust to expand on-the-job training, apprenticeship opportunities and other programs that support the development of health care professionals, including medical technicians, certified nursing assistants and phlebotomists.
SECTION 5. The Oregon Health Authority shall provide grants to the Oregon Center for Nursing to work with Oregon’s public nursing education programs, including the nursing programs at the Oregon Health and Science University and Oregon’s community colleges, to develop programs to recruit and retain nurse educators at public institutions of higher education.

SECTION 6. In addition to and not in lieu of any other appropriation, there is appropriated to the Legislative Policy and Research Committee, for the biennium beginning July 1, 2023, out of the General Fund, the amount of $500,000, which may be expended for carrying out the provisions of section 1 of this 2023 Act.

SECTION 7. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2023, out of the General Fund, the amount of $15,000,000, which may be expended to provide grants under section 3 of this 2023 Act.

SECTION 8. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2023, out of the General Fund, the amount of $5,000,000, which may be expended to provide grants under section 4 of this 2023 Act.

SECTION 9. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2023, out of the General Fund, the amount of $5,000,000, which may expended to provide grants under section 5 of this 2023 Act.

SECTION 10. In addition to and not in lieu of any other appropriation, there is appropriated to the Oregon Health Authority, for the biennium beginning July 1, 2023, out of the General Fund, the amount of $1,517,041, which may be expended to support the task force established in section 1 of this 2023 Act and administer the grant programs in sections 3, 4 and 5 of this 2023 Act.

SECTION 11. (1) Section 1 of this 2023 Act is repealed on January 2, 2025.

SECTION 12. This 2023 Act being necessary for the immediate preservation of the public peace, health and safety, an emergency is declared to exist, and this 2023 Act takes effect on its passage.
Passed by House June 14, 2023

Repassed by House June 25, 2023

Timothy G. Scekereak, Chief Clerk of House

Dan Rayfield, Speaker of House

Passed by Senate June 24, 2023

Rob Wagner, President of Senate

Received by Governor:

M. ......................................................, 2023

Approved:

M. ......................................................, 2023

Tina Kotek, Governor

Filed in Office of Secretary of State:

M. ......................................................, 2023

Secretary of State
Shared Savings: Request for Modification
August 10, 2023

As stated in our JMA, Amendment 1 section 1.3 as highlighted below, ‘(1) fifty percent (50%) of the excess shall be reinvested in behavioral health as the COHC determines;’

With the current emerging needs of our community, a recommendation for discussion to update the language in a way to broaden the investment based on current relevant emerging needs within our community.

Considerations:
1. Our current shared savings from 2022 results, to be received in 2023 is estimated to be close to $5M for the 50% portion for behavioral health.
2. Dollars received in 2023 will need to be spent by March 30, 2024.
3. Is a letter of agreement enforceable for this modification?

Section 5.4 of the Agreement is amended and restated in its entirety as follows:

“The parties agree and acknowledge that payment of CCO Contract dollars shall be allocated and spent according to the following priorities: (i) claims payments; (ii) sub-captitated contract amounts; (iii) CCO required payments and expenses, including but not limited to hospital reimbursement allowances, graduate medical expense, provider taxes, and reinsurance expense; (iv) risk-sharing agreements with providers; (v) administration expenses; (vi) Regional Health Improvement Plan funds, described in Section 5.5; and (vii) margin, described in Section 5.5. Any amounts in excess after such expenditures shall be split as follows: (i) fifty percent (50%) of the excess shall be reinvested in behavioral health as the COHC determines; and (ii) fifty percent (50%) of the excess shall be split as provided in Exhibit 3 with shares allocated to PCS (the “PCS Funds”), provider groups (the “Provider Funds”), and the COHC (the “Shared Savings Portion”). The Shared Savings Portion shall be allocated as provided in the global budget and/or as the COHC determines. The Shared Savings Portion, the PCS Funds, and the Provider Funds shall be determined and paid by September 30th, provided, however, that PCS shall have the right to hold back all or part of the PCS Funds, the Shared Savings Portion, or the Provider Funds until such time as the Medical Loss Ratio (“MLR”) filings are accepted as filed by OHA or, if not accepted, until such time as a settlement is reached with OHA. If any monies are owed to OHA related to the MLR filings, PCS shall first deduct such funds from any amounts in excess of the expenditures noted above and as yet unallocated and unpaid and, if such excess funds were already allocated, then proportionately from the amounts allocated to PCS, the Provider Funds, and the Shared Savings Portion. PCS shall provide the COHC with appropriate financial information to show the calculations that PCS conducted pursuant to Exhibit 3. The COHC, at its expense, may audit the spending of CCO Contract dollars as reported by PCS upon no less than ten (10) days advance written notice to PCS and during normal business hours. COHC is required to spend all Regional Health Improvement Plan and Shared Savings dollars received in a calendar year by no later than March 31 of the following calendar year.”
Executive Director’s Report
August 10, 2023

This report reflects the months of June and July 2023. There was a short business meeting June 8, 2023 due to our annual Board Retreat.

Highlights

1. Behavioral Health Shared Saving Distribution Completed
2. Board Retreat: Strategic Plan Refresh Completed
3. Grant Programs
   a. Community Benefit
   b. Opportunity Grant
4. Community Engagement Strategy

Topics for Discussion to be presented at Board Meeting: August 10, 2023
JMA Amendment
   a. House Bill 3396: Section 2: Extension of CCO Contracts to December 31, 2026
   b. Shared Savings 2022: Amending exiting JMA to extend our contract to December 31, 2026.

Behavioral Health Shared Savings Update

Background:
Shared Savings 2021 Distribution Proposal: Approved to move forward by the Board of Directors.

Shared Savings dollars became available late October 2022 for the 2021 contract year. At this time, the following proposal was open for discussion and approval. We received approval from Pacific Source Community Solutions to extend the distribution date to June 30, 2023 to allow sufficient time for a transparent and equitable distribution process.

Current funding available: $2,449,546.93
Dedicate 1M to Pedal Clinic as a region wide collective need: $1,000,000.00
See attached Pedal Clinic proposal*

Available for distribution: $1,449,546.93

February 2023: Recommendation to move forward with a cross-sectoral strategy investment was approved by the Board of Directors to proceed.

June 2023: Proposal submitted and approved by Board of Directors on funding three lead organizations that will move forward initiatives presented.
Board Retreat: Strategic Plan Refresh

On June 8, 2023, a Board Retreat was conducted for a full day. Its purpose was to review the existing 2020-2024 strategic plan. The seven initiatives of the strategic plan were reviewed to identify accomplishments, areas for clarity, relevance and identified action items. Working with our consultant, Lara Bickel, we will have a summarized report for the board of directors by September 2023 along with the action items for any agreed upon follow up. It was a successful retreat to see board members engaging, celebrating accomplishments as well as identifying opportunities for further discussion.

Grant Programs

Community Benefit Grants

The annual Community Benefit Grant launched in July now receiving applications. CAC (Community Advisory Council) is designated to develop community investments throughout the region. Last year, there were over 73 grant applications which was identified as a challenge. This year, CAC decided to focus on grants focused on the poverty levels within each county and the tribes. CAC also decided to award fewer grants with larger amounts. Final dollar amounts have not been received although estimated to have a total of $1.9M for distribution.

Opportunity Grants ants

The Opportunity Grant launched in June and to date we have received over 75 applications with a total ask close to $5M. This grant was in response to the lack of sustainability of funding for organizations to sustain its programs. It is designed to match existing grants that have been awarded in the past year allowing a grants to be matched up to $200,000 per organization. With all our grants, they go through eligibility requirements and a final regulatory review with our PCS (PacificSource) partners. All grants are also tracked through COHC’s Foundant grant platform with required reporting.

Community Engagement Strategy

Miguel Herrada, spearheading the Community Engagement Strategy briefly presented at the Board Retreat that he will be presenting at the August 10, 2023 Board meeting the strategy in alignment with our AIMS to ‘Bolster community engagement to ensure diversity of voices during decision-making.’ This strategy has been presented to CAC, they have provided feedback and we will continue ongoing discussions with all the workgroups and committees. This AIM is aligned with our strategic initiative of ‘Identifying and Addressing Inequities.” (See Tab 2-Strategic Directions of binders which were distributed at the Board Retreat.)

Topics for Discussion to be presented at Board Meeting: August 10, 2023

1. JMA Amendment
   a. House Bill 3396: Section 2: Extension of CCO Contracts to December 31, 2026
      • Current JMA expires 12/31/2024
• Requesting JMA to align with extension to expire December 31, 2026.

b. Shared Savings:
• Existing language indicates 50% of Shared Savings designated for Behavioral Health
• Request to modify the language for the 50% to direct funding towards addressing emerging issues relevant to Central Oregon

Operations
• Annual financial audit is underway with Jones & Roth as our new auditor for this year.
• Accurate Bookkeeping has finally produced financial statements which have been delayed due to their consistent staffing turnover.
• Ongoing build of SmartSheet continues to centralize work documents and build dashboards for instant reporting available.

Staff
• Staff shortage in July/August due to vacations along with medical leave with two staff. We have since hired two temps to support administrative functions for our grant platform and ongoing operations tasks to be completed.
• Staff is going through procedure documents for stronger workflows and clear accountabilities.
• Staff annual performance reviews completed and performance plans continue to be developed.
• Carol Martin is our temporary administrative staff supporting RHA and other operational projects with the Executive Director. We have now hired Annette Deering to support with RHA, project managers and other operational projects that have not been completed.
• Reviewing potential capacity for 1-2 FTE’s in the fall.

Questions: Please contact Carmen Madrid at carmen.madrid@cohealthcouncil.org
CCO Director Report
Date: August 2023
To: The Central Oregon Health Council (COHC) Board of Directors
Prepared by: Tricia Wilder, Director, Central Oregon CCO

PACIFICSOURCE COMMUNITY SOLUTIONS (PCS) UPDATES:

Medicaid Redeterminations

As redeterminations continue, PCS is working on a few ways to connect with provider partners to conduct outreach to CCO members who may be at risk of losing coverage. PCS has printed business cards urging members to call the Customer Service team to update their contact information. These cards are available to providers and community partners who can help distribute them to CCO members. PCS is also working with provider partners to share information on CCO members who are coming up for renewal, and those who haven’t responded to OHA notices. OHA has recently updated its redeterminations dashboards to include renewals initiated and completed, along with demographic and regional information for these member counts. The dashboards can be found here: https://www.oregon.gov/odhs/agency/pages/oep-one-dashboards.aspx

Healthier Oregon Program (HOP)

Effective July 1, 2023, HOP expanded eligibility to include all adults. This expansion allows more adults who meet qualifications for the Oregon Health Plan (OHP) except for immigration status to gain full OHP benefits. Under the first iteration of HOP, only adults aged 19-25 and 55+ were eligible. More than 12,000 enrolled in HOP during the first year, and under this expansion, approximately 43,000 adults will automatically transition from CWM to OHP. About 11,000 of these members will be enrolled across all PacificSource CCO regions. PCS is working on updating informational documents around HOP and will distribute these once available.

Training & Facilitation Program

Spring was a busy time for the Training & Facilitation Program. We concluded the first Healthcare Interpreter Training Program Cohort. This initial launch was a smashing success; 92% of participants have become Qualified with the State of Oregon and are now listed on the State Registry. We also launched two live webinars on Cultural Responsivity and Implicit Bias with Dr. Tenisha Tevis from Oregon State University. These webinars were well attended, with nearly 500 participants combined. We are working with Dr. Tevis to develop enduring content on these topics.
Upcoming training opportunities:

**August Ethics Series**

Paul Cooney, J.D. will conduct a 3-part series on Ethics this August. Topics will include: Managing difficult clients, information sharing, records, board complaints, treating minors, and mandatory reporting.

Schedule: Thursday’s August 3rd, 10th, and 17th from 9:00 AM to 11:00 AM

Provider Registration Link: [https://PacificSource.myabsorb.com?KeyName=ETHICS23](https://PacificSource.myabsorb.com?KeyName=ETHICS23)

**Culturally Responsive Care for Latinx**

In this online on-demand training, Dr. Ruth Zúñiga and Dr. Daisy Bueno of Raíces de Bienestar discuss culturally responsive care for members of the Latinx population. They will provide insight into the history and culture of the U.S. Latinx community as well as culturally informed tools to discuss and treat mental health concerns.

Provider Registration Link: [https://PacificSource.myabsorb.com?KeyName=Cultural](https://PacificSource.myabsorb.com?KeyName=Cultural)

**Understanding Suicide Prevention & Intervention for Latinx**

In this online on-demand training, Dr. Ruth Zúñiga and Dr. Daisy Bueno of Raíces de Bienestar discuss the increasing rate of suicide among the Latinx community. They will debunk myths and identify risk and protective factors for this population. Workshop participants will learn to identify signs and symptoms of suicide ideation and gain strategies and language to use when asking, talking about, and assessing Latinx patients for suicide risk.

Provider Registration Link: [https://PacificSource.myabsorb.com?KeyName=SuicidePrevention](https://PacificSource.myabsorb.com?KeyName=SuicidePrevention)
Central Oregon Coordinated Care Organization

Updated 6/22/2023

**AVERAGE MEMBERS**
- 75,413 members
- 25,750 children
- 49,663 adults

**COST OF CARE**

<table>
<thead>
<tr>
<th></th>
<th>Actual PMPM</th>
<th>Difference from Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22</td>
<td>$368.13</td>
<td>$2.15</td>
</tr>
<tr>
<td>04/23</td>
<td>$380.92</td>
<td>$1.41</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22</td>
<td>$25.08</td>
<td>($1.12)</td>
</tr>
<tr>
<td>04/23</td>
<td>$25.46</td>
<td>$0.40</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22</td>
<td>$60.99</td>
<td>$11.29</td>
</tr>
<tr>
<td>04/23</td>
<td>$57.67</td>
<td>$6.09</td>
</tr>
<tr>
<td>TOTAL EXPENSES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12/22</td>
<td>$458.33</td>
<td>$26.46</td>
</tr>
<tr>
<td>04/23</td>
<td>$488.43</td>
<td>$6.16</td>
</tr>
</tbody>
</table>

**FOCUS ON: CCO MEMBER SURVEY DATA**

**Getting Care Quickly**
Percent of Central Oregon member surveys between 1/1/2020 and 2/28/2023 responding yes to: “Were you able to get an appointment as soon as you needed?”

<table>
<thead>
<tr>
<th></th>
<th>Provider need</th>
<th>No interpreter need</th>
<th>Interpreter need</th>
<th>No interpreter need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>90.6%</td>
<td>90.5%</td>
<td>93.3%</td>
<td>90.5%</td>
</tr>
<tr>
<td>Oregon</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other PCS</td>
<td>91.2%</td>
<td>89.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>91.1%</td>
<td>90.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Getting Care Quickly by REALD**
Only groups with at least 20 responses are reported

<table>
<thead>
<tr>
<th></th>
<th>Interpreter need</th>
<th>No interpreter need</th>
<th>Interpreter need</th>
<th>No interpreter need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Latino/a/x</td>
<td>88.9% (n=66)</td>
<td>90.5% (n=1,329)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unknown Race</td>
<td>90.6% (n=410)</td>
<td>89.6% (n=275)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>90.6% (n=838)</td>
<td>90.8% (n=1,086)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ACCESS & UTILIZATION**

(01/2021 to 04/2023, paid thru 04/2023; no completion factor applied)

<table>
<thead>
<tr>
<th></th>
<th>Visits PTPMY*</th>
<th>% Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>4,119</td>
<td>24%</td>
</tr>
<tr>
<td>2022</td>
<td>4,059</td>
<td>23%</td>
</tr>
<tr>
<td>2023</td>
<td>3,736</td>
<td>16%</td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>777</td>
<td>30%</td>
</tr>
<tr>
<td>2022</td>
<td>777</td>
<td>30%</td>
</tr>
<tr>
<td>2023</td>
<td>493</td>
<td>12%</td>
</tr>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>1,725</td>
<td>52%</td>
</tr>
<tr>
<td>2022</td>
<td>1,709</td>
<td>50%</td>
</tr>
<tr>
<td>2023</td>
<td>1,627</td>
<td>30%</td>
</tr>
<tr>
<td>Specialist Office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>604</td>
<td>20%</td>
</tr>
<tr>
<td>2022</td>
<td>614</td>
<td>20%</td>
</tr>
<tr>
<td>2023</td>
<td>589</td>
<td>11%</td>
</tr>
<tr>
<td>Emergency Dept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>420</td>
<td>20%</td>
</tr>
<tr>
<td>2022</td>
<td>433</td>
<td>21%</td>
</tr>
<tr>
<td>2023</td>
<td>354</td>
<td>8%</td>
</tr>
<tr>
<td>Inpatient Admits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>65</td>
<td>5%</td>
</tr>
<tr>
<td>2022</td>
<td>62</td>
<td>4%</td>
</tr>
<tr>
<td>2023</td>
<td>49</td>
<td>1%</td>
</tr>
</tbody>
</table>

*Visits Per 1,000 Members per Year

**FOCUS ON: CCO MEMBER SURVEY DATA**

**Provider Communication Composite**
Percent of Central Oregon member surveys between 1/1/2020 and 2/28/2023 responding yes to questions on if the provider was easy to understand, treated the member with respect, and spent enough time. See the notes for more info.

<table>
<thead>
<tr>
<th></th>
<th>Provider Communication Composite</th>
<th>Provider Communication Composite by REALD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>98.0% (n=1,361)</td>
<td>96.4% (n=66)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.0% (n=1,329)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.9% (n=410)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>95.6% (n=275)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>97.6% (n=838)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98.6% (n=1,086)</td>
</tr>
<tr>
<td>Term</td>
<td>Definition &amp; Data Notes</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>AI/AN</td>
<td>Member selected one of the racial or ethnic identities under the American Indian and Alaska Native section as their primary race during the process of Medicaid enrollment. This data is shared by OHA with CCOs in the member enrollment data files.</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>Member selected one of the racial or ethnic identities under the Asian section as their primary race. This includes Asian Indian, Chinese, Filipino/a, Hmong, Japanese, Korean, Laotian, Other Asian, South Asian, and Vietnamese.</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health Visit</td>
<td>The member has had a behavioral health visit (mental health or substance use/addiction treatment) in the last 12 months according to PacificSource claims algorithms.</td>
<td></td>
</tr>
<tr>
<td>BH</td>
<td>Behavioral Health (mental health, substance abuse and addictions)</td>
<td></td>
</tr>
<tr>
<td>Black/Afr Am</td>
<td>Member selected one of the racial or ethnic identities under the Black or African American section as their primary race. This includes African, African American, Caribbean, Other African.</td>
<td></td>
</tr>
<tr>
<td>Interpreter Needed</td>
<td>Member indicated on their REALD form that they need either a spoken or sign interpreter.</td>
<td></td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
<td></td>
</tr>
<tr>
<td>Latino/a/x</td>
<td>Member selected one of the racial or ethnic identities under the Hispanic and Latino/a/x section as their primary race during the process of Medicaid enrollment. This includes Hispanic or Latino/a Central American, Mexican, South American, and Other Hispanic or Latino/a/x.</td>
<td></td>
</tr>
<tr>
<td>Medical Claims Expense</td>
<td>PacificSource Community Solutions surveys a sample of Medicaid members after a recent healthcare visit. The visit may have been in primary care, behavioral health, dental, specialty care, hospital services, NEMT, or other settings. The survey asks members questions about their experience in accessing services, scheduling appointments, interactions with the provider and staff, and more. The survey asks some similar questions as the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but differs from the CAHPS in design and sampling methodology. Therefore, direct comparisons to statewide CAHPS results are not recommended.</td>
<td></td>
</tr>
<tr>
<td>Member Healthcare Access Survey</td>
<td>PacificSource Community Solutions surveys a sample of Medicaid members after a recent healthcare visit. The visit may have been in primary care, behavioral health, dental, specialty care, hospital services, NEMT, or other settings. The survey asks members questions about their experience in accessing services, scheduling appointments, interactions with the provider and staff, and more. The survey asks some similar questions as the standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, but differs from the CAHPS in design and sampling methodology. Therefore, direct comparisons to statewide CAHPS results are not recommended.</td>
<td></td>
</tr>
<tr>
<td>ME/NA</td>
<td>Member selected a primary race of Middle Eastern or North African during the process of Medicaid enrollment. This data is shared by OHA with CCOs in the member enrollment data files.</td>
<td></td>
</tr>
<tr>
<td>NEMT</td>
<td>Non-Emergent Medical Transport</td>
<td></td>
</tr>
<tr>
<td>NH/PI</td>
<td>Member selected one of the racial or ethnic identities under the Native Hawaiian and Pacific Islander section as their primary race during the process of Medicaid enrollment. This includes Guamanian or Chamorro, Micronesian, Other Pacific Islander, Samoan, and Tongan. This data is shared by OHA with CCOs in the member enrollment data files.</td>
<td></td>
</tr>
<tr>
<td>OHA</td>
<td>Oregon Health Authority</td>
<td></td>
</tr>
<tr>
<td>Other Primary Race</td>
<td>Member selected one of the other racial or ethnic identities as their primary race (Middle Eastern/North African) or reported &quot;Other.&quot;</td>
<td></td>
</tr>
<tr>
<td>Other PCS</td>
<td>Other PS CCOs in this CCO Dashboard combines all other PacificSource Medicaid CCO regions other than the CCO of reference for contextual comparisons.</td>
<td></td>
</tr>
<tr>
<td>Point-in-time</td>
<td>Point-in-time methodology anchors a calculation with members enrolled as of a specific date (in this case 4/31/2023) instead of calculating a metric with a more extended length of time.</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>Primary Care Provider</td>
<td></td>
</tr>
<tr>
<td>PCS</td>
<td>PacificSource Community Solutions</td>
<td></td>
</tr>
<tr>
<td>Primary Care Visit</td>
<td>The member has had a primary care visit in the last 12 months according to the MiPi member profile.</td>
<td></td>
</tr>
</tbody>
</table>
| Provider Communication Composite | The provider communication composite provides the percent of responses that indicated "yes" to the following questions:  
"Did your [doctor/dentist/provider] explain things in a way that was easy to understand?"  
"Did your [doctor/dentist/provider] treat you with respect?"  
"Did your [doctor/dentist/provider] spend enough time with you?" |
| PTMPY              | Per thousand members per year                                                                                                                                                                                              |
| REALD              | Race, ethnicity, language and disability (REALD) data. This data is optional for members to provide, is collected by OHA and sent to CCOs in member eligibility data files.                                                      |
| REALD Primary Race/Ethnicity | A member can self-select a primary race during their Medicaid enrollment and OHA shares this information with us in the 834 file.  
This is a higher level category of primary race based on the sections of the REALD form.                                                                 |
| Specialist Visit   | The member has had a specialist visit in the last 12 months according to PacificSource claims algorithms.                                                                                                                  |
| Unknown Primary Race | Member selected unknown, did not answer, declined to answer, or the data was not provided for this member.                                                                                                               |
| Utilization        | Use of a good or service                                                                                                                                                                                                   |
| White              | Member selected one of the racial or ethnic identities under the White section as their primary race.                                                                                                                      |
| YTD                | Year to date. For this dashboard, Financial YTD is based on the calendar year beginning January 1st.                                                                                                                        |

Note: Financial PMPM costs, revenues and expenses are presented on a paid date basis, regardless of which year they were incurred.