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What Is an Oregon Erratics?

Medical stewardship for community-based services

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BEFORE WE START

Disclosures

- I am the founder, medical director, and sole member of Oregon Erratics LLC. I have a direct financial interest in the entity described in this presentation.
- Oregon Erratics anticipates applying for EOCCO Community Benefit Initiative Reinvestment funding. That application is pending or forthcoming as of this presentation.
- Opal Lake Collective, described later, is a related nonprofit entity with which I am affiliated.
- No commercial support was received for this presentation.
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GEOLOGY

The flood came from the east

Glacial Lake Missoula
Western Montana

→

Channeled Scablands
Eastern Washington

→

Wallula Gap
The constriction

→

Lake Condon
Umatilla Basin

→

Willamette Valley
Where rocks stopped

- Wallula Gap could not pass the flood. Water backed up behind it and behind the Gorge, forming temporary Lake Condon across roughly 1,500 square miles of the Umatilla and Dalles basins.
- Lake Condon stood at about 1,200 feet. Downtown Pendleton sits near 1,070. The water was over this ground, repeatedly, and it left ice-rafted stone behind as it fell.

The erratics that became landmarks in Oregon came through Pendleton first.

THE NAME

Out of place on purpose

Ice-rafted erratics

- A boulder carried far from its parent bedrock
- Left in ground whose geology it does not match
- It stays put
- It becomes a landmark people navigate by

Oregon Erratics

- A collaborative medical practice that exists to serve community based organizations
- Structurally out of place, deliberately
- It stays put
- It is useful precisely because of where it sits

SCOPE

It starts with peers

Where we start

- Peer support specialists and peer wellness specialists
- The workforce we know, and the one with the clearest regulatory pathway today
- Recovery services, outreach, and engagement

Where this goes

- The full Traditional Health Worker spectrum, including navigators and community health workers
- A public health nurse training pathway reachable from a rural community
- Same infrastructure, wider workforce

The infrastructure doesn’t care what flavor of Traditional Health Worker it supports,

But we do, because we will not claim competence we haven’t earned.

THE PROBLEM

The work is already happening; The reimbursement is not.

7,824

active Traditional Health Worker registrants in Oregon

THW Registry, May 2026

49%

of THW certifications are peer support specialists

THW Registry, May 2026

69%

of Oregon SUD treatment facilities already offer peer support

Videka et al. 2023 (2017 survey)

CBOs don’t just need workforce; They need sustainable reimbursement.

Videka figures come from 2017 national survey data published in 2023.

THE GATE

The menu has had two items

A Become a licensed behavioral health agency

- Obtain a Certificate of Approval
- Carry the cost, the staffing, and the timeline
- Build and maintain a full compliance apparatus
- Out of reach for a six-person organization

B Stay grant dependent

- Cyclical, restricted, and always ending
- Scope written by the funder, not the community
- Staff turnover follows the funding cycle
- Administration consumed 46% of service-level labor in one costed recovery center

Both answers cost the organization the thing that made it work.

Speer et al. 2025. The authors attribute that administrative load to program oversight plus the work of obtaining and retaining uncertain funding.

WHY A CCO SHOULD CARE

Uncoded work is unmeasured work

1. **No code** — The service generates no claim and no encounter record
2. **No data** — No quality metric credit, no network adequacy contribution, no utilization signal
3. **No visibility** — The intervention keeping a member engaged is invisible to every system that governs your contract

This is not a charity argument. It is a data argument.

SECTION TWO

The middle path

Proportionate, physician-anchored oversight, light enough for a community organization to survive

REGULATORY BASIS

Three rules do the work

1

OAR 309-008-0250(4)(b)

A practice composed exclusively of licensed health care practitioners does not require a Certificate of Approval to bill for THW services. The exemption is independent of payer or funding source.

2

OAR 410-141-3820(3)

Physician-directed THW services are diagnostic services. Medicaid coverage is mandatory regardless of Prioritized List placement.

3

OAR 950-060-0010

Traditional Health Worker supervision may be provided by a licensed health care practitioner. Physicians qualify, but philosophically, peers supervise peers; a joint-credential joint-supervision model needs to be developed.

THE DIVISION

Who holds what

Oregon Erratics holds

- Medical direction and clinical oversight
- Medical necessity documentation
- Licensed practitioner attestation
- Claims submission and compliance
- Audit exposure and regulatory risk

The community organization keeps

- Its name and its independence
- Its people, hired its own way, and kept in the community
- Its culture, local knowledge, and service maps
- Its relationships in the community
- Its way of doing and supervising the work

GOVERNANCE

Nothing about peers without peers

Peers supervise peers. Physicians carry the paperwork and the risk.

- Day-to-day supervision, caseload support, and practice fidelity are held by experienced peers. Medical necessity, documentation, and the claim are held by the physician. Those are different jobs, and they should stay that way.
- CMS confirmed in June 2024 that supervision of peer support may be provided by more experienced peers. This is not a workaround; it’s the design.
- Program scope, hiring, and service design belong to the people doing the work, not to the entity that submits the claim.
- A model that routes peer labor through a physician and calls that leadership has reproduced the problem it claimed to solve.

WORKFORCE

A funded program is a career

1. **A wage, not a stipend**

   A reimbursement pathway turns a volunteer role into a job with a title, a supervisor, and a paycheck that does not end with the grant cycle.

2. **Somewhere for graduates to go**

   Recovery programs produce people qualified to do this work. A funded pathway is where those graduates get hired, in the communities they are from.

3. **Credentialed, not tolerated**

   Certification, documented supervision hours, and billable practice are how a peer becomes a recognized professional inside a health system.

The strongest evidence that a program works is that its graduates can be hired into it.

“We build reimbursement infrastructure, not billing infrastructure.”

We never create a bill for anybody. We build the conditions for legitimate reimbursement of work that is already being done.

WHERE THE PATHWAY ACTUALLY STANDS

The codes, honestly

H0023

Peer outreach, per encounter

LIVE PATHWAY

Pre-diagnostic entry point. Three independent anchors: OAR 410-120-0000 (condition, not confirmed diagnosis); the Colorado Medicaid manual; the CMS FAQ of 5 June 2024.

H0038

Peer support, 15 minutes

PARTIAL

Requires a diagnosis, and crosswalks to a single line in the BHAP code table. A coverage vulnerability, not a solved problem.

T1016

Case management, 15 minutes

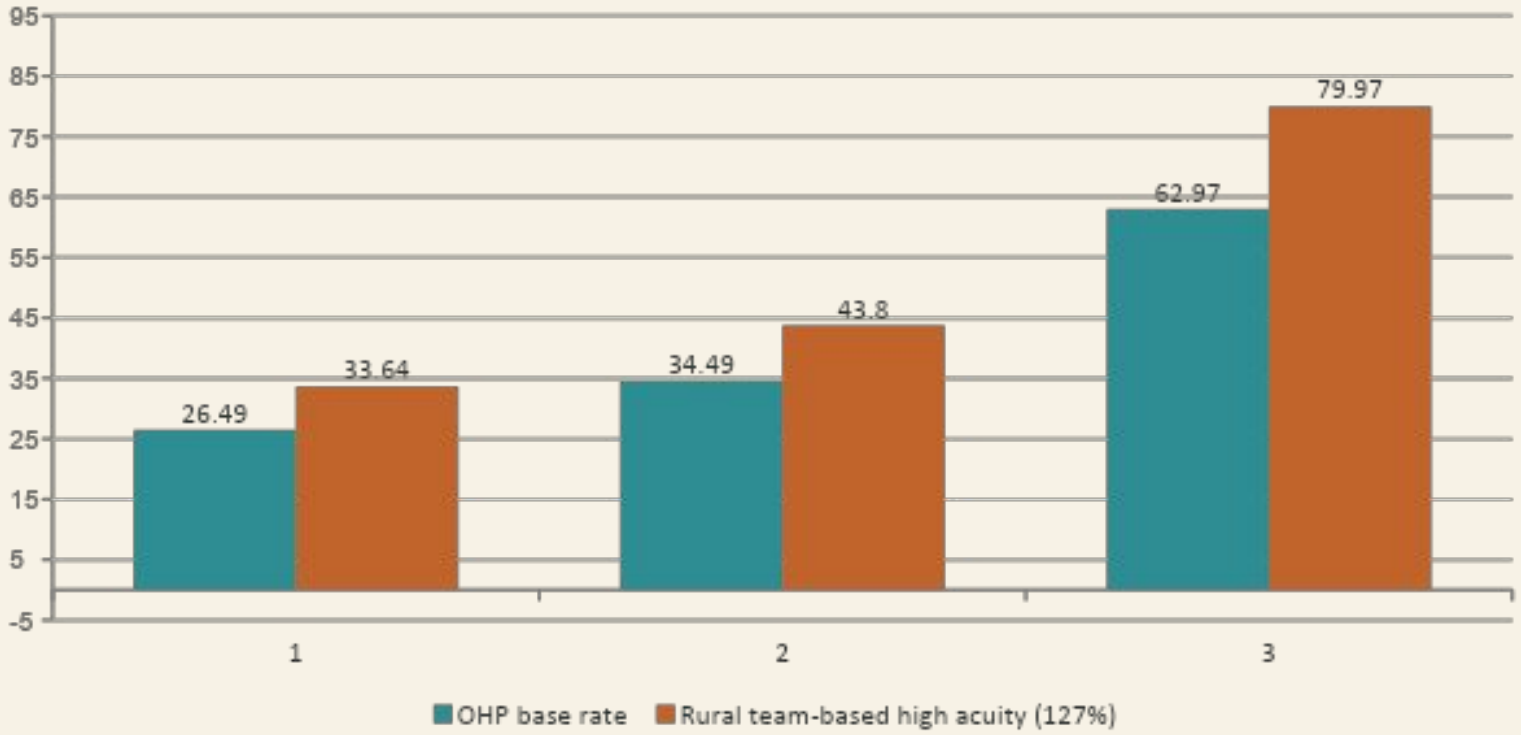
NOT YET

Durable authority under 1915(g) state plan amendment OR-21-0012, but non-viable near term for a private practice because of public-entity match obligations.

And one policy note: H0023 and H0038 do not appear anywhere in the HEDIS MY2026 value set directory; peer work is invisible by design.

RATES

What the pathway is worth



Also available

- 110% of base for qualified directed payment and team-based behavioral health attestation
- Rural directed payment at 127% requires the addiction medicine and case management pillars in place
- Rates confirmed against the current Oregon behavioral health fee schedule

Rates are accurate as of 9/14/2026

COST

What the work costs to deliver

$20-30

per hour, fully loaded, for peer recovery support labor

Speer et al. 2025

63-67%

of total program cost is labor, across both models costed

Speer et al. 2025

46%

of service-level labor went to administration in the standard model

Speer et al. 2025

H0038 pays $26.49 for fifteen minutes. That is not the peer's wage.

It is the wage plus supervision, documentation, compliance, space, training, and every unbillable hour. The first published cost analysis of peer recovery support measured that gap, and most of it is real. Per-participant cost ran $2,824 in the standard center and $5,286 in the grant-expanded model, on active census; however, subsequent studies have demonstrated that cost/QALY is NOT significantly increased by commensurate increases in peer compensation. *Castedo de Martell et al. 2025*

Speer et al., J Subst Use Addict Treat 2025. Per-participant figures use average daily census as the denominator, not annual enrollment. Castedo de Martell et al., A J Drug and Alcohol Abuse, 2025.

COVERAGE

Enrollment assistance is care coordination

Where coverage breaks

- Redetermination paperwork that never arrives
- Release from custody with no active coverage
- An address change during a housing transition
- Documentation demands attached to work requirements

Who absorbs the impact

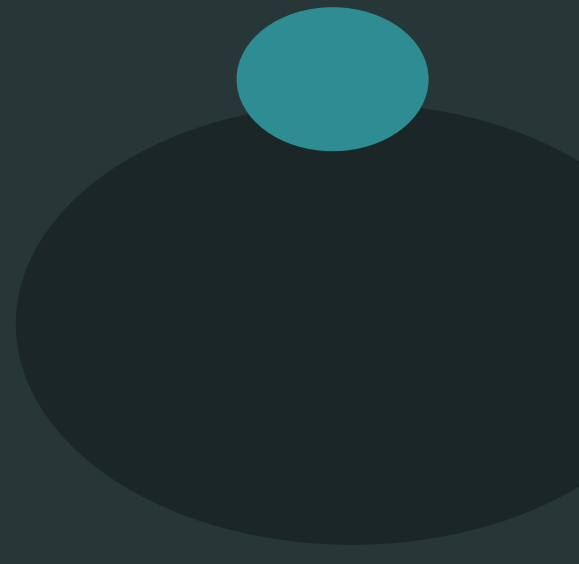
- Critical Access Hospitals, as uncompensated care, immediately and in cash
- The member, as a gap in treatment that is expensive to restart
- The CCO, as a member who disenrolls and returns sicker
- Peers and navigators, who already do this work unbilled

CCO contracts with CMS already require plans to actively support enrollment transition of members. Our hope is to make that job easier, more effective, and community-based.

SECTION THREE

Does it work?

What the evidence says, and what it doesn't say (yet)



EVIDENCE

What the evidence supports

7x

higher hepatitis C cure rates with peer-assisted telemedicine versus referral alone, in rural Oregon

Seaman et al., 2025 (PATH)

5.5x

greater odds of reliable symptom improvement among high-engagement peer participants versus controls

Chinman et al., 2018

0.89

rehospitalizations over nine months with a peer mentor, against 1.53 with usual care

Sledge et al., 2011

$5,899

cost per quality-adjusted life year, health system perspective; $3,422 societal

Castedo de Martell, 2025

The PATH study was done here, in rural Oregon, with this workforce.

Sledge is a small feasibility trial (n=74, one-tailed test, partial industry funding). Verify PATH figures against the published paper before final slides.

HONESTY

What the evidence does not say

- Peer support is well evidenced for engagement and retention. It is not established as an independent driver of medication initiation.
- It is also not disproven. Several null trials were measuring assignment rather than contact: in one, the intent-to-treat result was null while participants who actually engaged with their peer showed five times the odds of improvement.
- Uncoded work generates no data, and no data generates no evidence. Building the coding pathway is how the question finally gets answered.
- What the evidence does support clearly is sustained contact over time. The relationship is the medicine, and dose appears to matter.

We are not going to oversell; we'll let you sit with it and work out your own goals.

That is, more or less, how peer support works.

THE ECONOMICS

The wrong pocket problem

Who pays

The entity funding peer and outreach services carries the cost in the current budget year.

Who saves

Avoided admissions, avoided emergency use, and avoided crisis costs land somewhere else, and later.

The question is not whether it saves money.

The question is whether the entity that saves it is the entity writing the check.

For expansion members, most of that pocket is federal.

SECTION FOUR

Opal Lake Collective

Announcing our partner nonprofit

OPAL LAKE

Why that name

- Opal Lake sits in the Willamette National Forest. My family backpacked there every summer we could.
- It burned in the Beachie Creek Fire in 2020. Access closed.
- The water stayed pristine. Fireweed, thimbleberry, and vine maple are coming back through the char.
- The trailhead is scheduled to reopen in the summer of 2027.

Recovery is not a metaphor we reached for.

It’s just what happened in place.

A US Forest Service photograph of the kind of thing the restoration would look like here. Once it does, obviously.

STRUCTURE

How the two entities relate

Opal Lake Collective

- 501(c)(3), board governed
- Chair: Ariel Lewis, MBA
- Administrative, fiscal, philanthropic

services agreement

Oregon Erratics LLC

- Physician owned medical group
- Licensed practitioners only
- All clinical direction and oversight

The line is deliberate. Administrative and fiscal support flows one way. Clinical direction stays entirely inside the licensed medical group. That separation is what preserves the Certificate of Approval exemption described earlier.

THE ASK

What we are asking for

1

Pilot partners

Community organizations in EOCCO's service area doing peer and outreach work without a reimbursement pathway

2

A conversation

About reinvestment funding and what infrastructure support could look like here

3

Warm introductions

To the organizations already doing this work unpaid, whether or not they know us

4

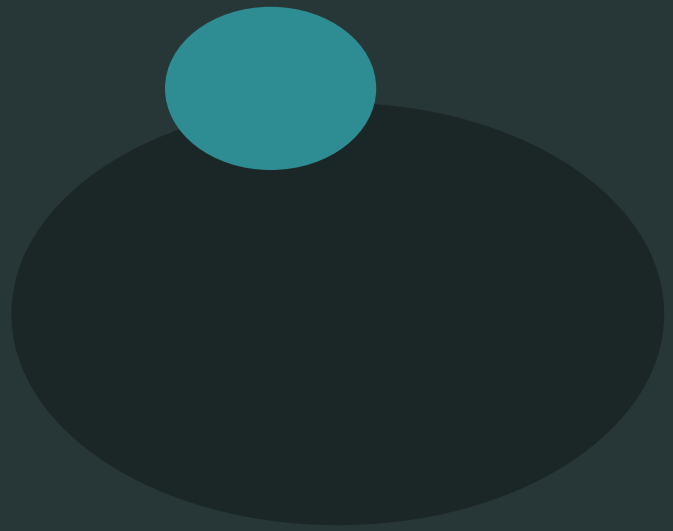
Tell us where it is invisible

The services your members rely on that never generate a code

Questions

Recovery happens in community.

We support the conditions for it to thrive.



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oregonerratics.com

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LEAVE-BEHIND

Sources

- Seaman A, et al. Peer-assisted telemedicine for hepatitis C in rural Oregon (PATH). 2025.
- Speer DD, et al. The costs of peer recovery support services provided through two models within a recovery community center. J Subst Use Addict Treat. 2025;172:209655.
- Castedo de Martell S, et al. Cost-effectiveness of peer recovery support. Am J Drug Alcohol Abuse. 2025.
- Chinman M, et al. Investigating the degree of reliable change among persons assigned to receive mental health peer specialist services. Psychiatr Serv. 2018;69(12):1238-1244.
- Sledge WH, et al. Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. Psychiatr Serv. 2011;62(5):541-544.
- Videka L, et al. Peer support services in behavioral health facilities: secondary analysis from two national surveys. Psychiatr Serv. 2023;74(12):1247-1255.
- Sokol R, Fisher E. Peer support for the hardly reached: a systematic review. Am J Public Health. 2016;106(7):e1-e8.
- CMS. Medicaid and CHIP peer support services FAQ. 5 June 2024. OAR 309-008-0250(4)(b); OAR 410-141-3820(3); OAR 410-120-0000; OAR 950-060-0010.

Rates from the current Oregon behavioral health fee schedule July 2026. THW figures from the Oregon THW Registry, May 2026.