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Thursday, September 16, 2021 | 9:00 AM - 1:00 PM
EOCCO Annual Summit

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EOCCO Summit

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- Teach to the competencies identified by the objectives
- Deliver balanced and objective evidenced-based content
- Present the source and type or level of evidence (i.e., animal study, meta-analysis, etc.)
- Disclose on a slide at the beginning of my presentation any relationship related to (1) the activity's content and/or (2) the activity's supporter(s)
- Notify the Continuing Medical Education office in the event of any changes in relevant financial relationships, and to complete an updated form at that time

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9th Annual EOCCO Summit

9:00am – 9:05am

Welcome and Introductions, Dr. Chuck Hofmann, EOCCO

9:05am – 9:45am

Traditional Health Worker (THW) and Health Care Interpreter (HCI) Training Programs, Kathryn Hart, Kathie Pointer, Oceana Gonzales, Timothy Clark

9:45am – 10:30am

EOCCO Strategies for Behavioral Health Integration into Patient-Centered Primary Care Homes, Dr. Chuck Hofmann, EOCCO

10:30am – 11:15am

EOCCO Grant Programs & the SHARE Initiative, Anne King and Summer Prantl

11:15am – 12:00pm

Counseling on Covid-19 Vaccines to Improve Vaccination Rates, Dr. Ryan Hassan, BOOST Oregon

12:00pm – 12:45pm

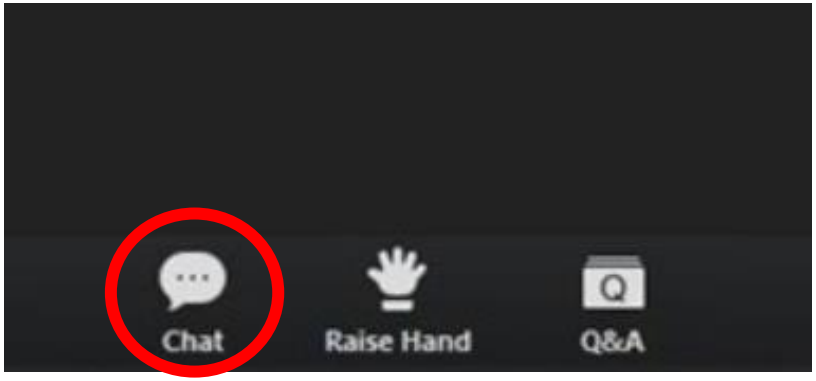
What the Pandemic Has Taught Us About Rural Health Care, Heidi Heitkamp, United States Senator

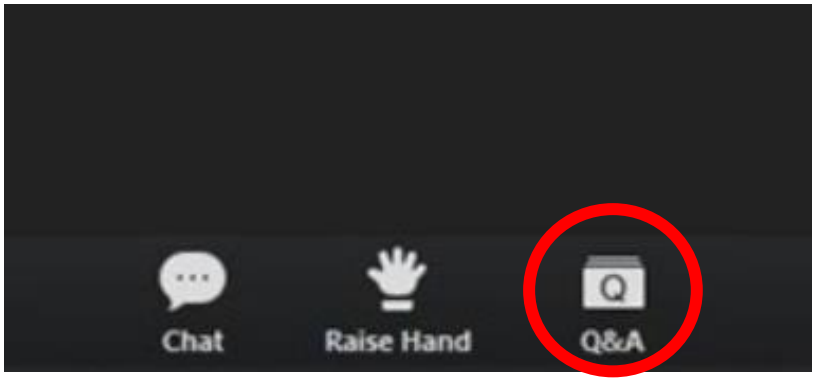
12:45pm

Recap and Adjourn, Dr. Chuck Hofmann, EOCCO

Announcements

- Direct any questions or comments for EOCCO staff or your peers to the chat
- Direct any questions for the speakers to the Q&A
- EOCCO staff will email a post-event evaluation to all attendees
- If you have any questions or concerns after the event, please contact us at EOCCOmetrics@modahealth.com





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Traditional Health Worker (THW) and Health Care Interpreter (HCI) Training Programs

Kathryn Hart, Traditional Health Worker Liaison (EOCCO)

Disclosures and Learning Objectives

- Disclosure Statement:
  - I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation
    - Company: Moda Health, Inc./EOCCO
    - To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendation on structured review for best evidence

- Learning Objectives:
  - Summarize the successes of the CHW training program at OSU
  - Explain the collaboration between EOCCO and OSU for an upcoming HCI training program
  - Engage with Traditional Health Workers across the EOCCO service area

Traditional Health Worker Program

- Traditional Health Workers:
  - Community Health Workers, Doulas, Peer Support Specialists, Peer Wellness Specialists, Personal Health Navigators
  - Trusted individuals from local communities, focus on providing community-centered care

- Goals of the THW Liaison role:
  - Collaborate with provider and community stakeholders to improve regional availability of THW services
  - Support service system improvements

- EOCCO's THW Team:
  - Kathryn Hart (CHW), serves on the OHA Payment Models Subcommittee
  - Sherrie Grieef (PSS), serves on the OHA Traditional Health Worker Commission, behavioral health focus

CHW Training Program Updates

Updates On CHW Training Program

- Enrollment in the CHW entry-level program continues to grow
- 12/18/2020 – 12/18/2022: Approved for Oregon's Eligible Training Provider list (ETPL)

Table 1. Summary of CHW Entry-Level Training Cohorts, Fall 2019-Present		
Term	Location	Total CHW Graduates
Fall 2019	Hermiston	13
Winter 2020	La Grande	11
Spring 2020	Burns – Remote	5
Summer 2020	Remote	14
Fall 2020	Remote	14
Winter 2021	Remote	16
Spring 2021	Remote	29
Summer 2021	**Remote**	**24 (expected Sept. 2021)**

CHW Training Program CEUs

Table 2. Participation in CHW Continuing Education Courses		
CEU Course	**Launched**	**Total Number Completed**
Management of Chronic Health Conditions	2017	14
Poverty & Related Social Determinants of Health	2017	9
Mental & Behavioral Health	2018	18

CHW Training Program Future Directions

- Development of one additional CHW CEU course in partnership with OHSU Oregon Center for Children and Youth with Special Health Needs
  - “Foundations of Cross-Systems Care Coordination for Children and Youth with Special Health Needs and their Families”
  - The goal of the course is to enhance CHW’s ability to work effectively with families with children and youth with special health needs, and as part of the system of care that supports them
  - Pilot launch for Fall 2021

- Developing one THW training
  - “Substance Use Disorders 101”
  - Introductory, online course for anyone who is interested in helping individuals or communities impacted by substance use disorders (SUDs)
    - Covers the basics of SUDs and explains evidence-based models for treatment, recovery, intervention, and prevention of SUDs
    - Free and self-paced course, designed for anyone who wants to help address SUDs in their community
  - Pilot launch for Winter 2022

HCI Training Program Background

Importance to EOCCO

- Alignment with CCO 2.0 contract requirement around language access
- New incentive measure: meaningful language access to culturally responsive health care services
  - Focuses on services provided by certified and qualified interpreters
- Increases the workforce in Eastern Oregon
- Provides standardization and formal credentialling for interpreters
- Approved by EOCCO Board in May of 2021

Health Care Interpreter Training Program

- OSU will develop program
  - Led by Health Management and Policy PhD student who is a Certified Spanish-language HCI in Oregon

- HCI program components
  - Spanish-language specific program
  - “Blended” format: Online self-paced + virtual synchronous + in-person
  - 60-hour training program for Qualified HCI credentialing
  - Region specific pricing model
    - Scholarships will be made available
    - Price to include language proficiency exam cost
  - Apprenticeship program to get 15 practice hours towards Qualification

Traditional Health Worker Panel

Panelists

- **Kathie Pointer**
  - Community Health Worker
  - Saint Alphonsus Medical Center, Baker County
- **Oceana Gonzales**
  - Community Health Worker
  - Valley Family Health Care, Malheur County
- **Timothy Clark**
  - Peer Support Specialist – Adult Addictions
  - Umatilla County Human Services, Umatilla County

Questions

1. Please introduce yourself and your role. How did you become involved with THW work?
2. Can you share a success story from your time as a THW working with EOCCO members?

References and Resources

- References
  - Oregon Health Authority : About Traditional Health Workers : Office of Equity and Inclusion : State of Oregon
  - Community Health Worker Training Program (oregonstate.edu)

- Resources
  - EOCCO THW Learning Collaboratives: Email kathryn.hart@modahealth.com for more information
  - EOCCO CHW Billing Policy: chw_policy.pdf (eocco.com)
  - Upcoming OSU Entry-Level CHW Training Courses: 9/20/2021 to 12/5/2021 or 1/10/2022 to 3/27/2022


Thank you!


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EOCCO Strategies for Behavioral Health Integration Into Patient-Centered Primary Care Homes

Chuck Hofmann, MD, MACP
EOCCO Clinical Consultant

Disclosures

None

Objectives

At the end of this session, attendees should be able to:

- Understand the two evidence-based behavioral health integration care models proposed by EOCCO.
- Understand EOCCO's proposed BHI standards and metrics .
- Understand EOCCO's proposed BHI contracting and payment methods.

CCO 2.0 BH Requirements

- CCOs must be fully accountable for BH benefits
- Members must have provider choice for behavioral health care
- Requires payment for behavioral health services in primary care settings and payment for primary care services in behavioral health care settings

EOCCO Primary Care BH Integration Plan

- Early work authorized in 2019 by EOCCO Board via a 7-member EOCCO BH Integration Subcommittee
- Allows for two evidence-based integration models
  - Primary Care Behavioral Health Home Model
  - Collaborative Care Model
- Creates integration standards
  - Must be state-certified for certain 2020 PCPCH recognition criteria
  - Must have co-located and fully integrated BH provider(s) available for same-day brief interventions and consultations
  - Must have a systematic approach of identifying patients who need care including coordination with local CMHP's

EOCCO Primary Care BH Integration Plan (continued)

- Creates Integration metrics
  - Access and patient identification/intervention measures
  - BH-related CCO quality measures
- Consolidates contracting and payment for BH services provided in a primary care setting
  - Contracting for those BH services will be consolidated through EOCCO/Moda
  - GOBHI will remain responsible for CMHP accountability and will advise on development of care coordination and communication strategies between PCPCHs and CMHPs
  - Includes future implementation of a quality reinvestment program for BH Integration
- Next steps
  - Seek approval of plan by EOCCO Board in October
  - Develop common contract and policies
  - 1/1/22 - Tentative go live date

Approved Evidence-Based Integration Models

- Primary Care Behavioral Health (PCBH) Home Model
  - Behavioral health providers work alongside PCPs and see a limited number of scheduled patients while making ad hoc consultation services readily available
  - Requires a sizeable clinic population

- Collaborative Care Model (CoCM)
  - Care team includes a BH care manager, usually a MSW or an LCSW, who collaborates care between PCPs and the services of a regularly scheduled consulting psychiatrist
  - May be more appropriate for medium sized clinics

Integration Standards

- Clinic must be a state-certified PCPCH meeting 2020 Recognition Criteria 3.C.3 specifications*
  - Same day access to an integrated behavioral health provider
  - Shared electronic medical record system
  - Screening, care coordination, panel management, results monitoring
  - Includes protocol for external psychiatric consultation services
- Clinic must have co-located behavioral health provider/s that:
  - Are available for same-day brief interventions and consultations
  - Have documented two-way communication with referring providers, including exchange of shared treatment plans
  - Participate in pre- and post-visit planning
- Clinic must have a systematic approach for
  - Identifying patients who have a need or may benefit from care
  - Coordinating care with local Community Mental Health Program
  - Engaging patients and their families in identifying needs/decision-making
  - Providing follow-up and care plan adjustment as needed

***See pages 75-76 of OHA 2020 Recognition Criteria Technical Specifications and Reporting Guide**
https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf

Integration Metrics

- Must report on standardized behavioral health reporting measures:
  - Population reach
  - Access to BH encounters
  - Patient identification and intervention methods

- Must report on OHA quality measures with behavioral health components. For 2022, those measures are:
  - Depression screening and follow-up plan
  - SBIRT
  - Initiation and engagement in drug and alcohol treatment
  - Mental health assessments for children in DHS custody

Contracting and Payment

- Contracting for BH services provided in a primary care setting will be consolidated through EOCCO/Moda
  - Clinics will receive BH integration capitation payment contracts through EOCCO
  - Current capitation amounts will be increased in recognition of the costs of providing BH services. These funds will be provided by EOCCO outside of GOBHI's MH budget.
- GOBHI will:
  - Continue to be responsible for CMHP accountability
  - Serve in advisory capacity in developing communication and care coordination strategies between PCPCHs and CMHPs
- Payment system will include future implementation of a quality reinvestment program for BH integration

Questions?

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EOCCO Grant Programs & the SHARE Initiative

Summer Prantl Nudelman

Anne King

Disclosure

Anne King:

I have a relevant financial relationship with a commercial interest whose products or services relate to the content of this educational presentation. I am a consultant to Moda Health/EOCCO for the Grant Programs, and I am a consultant to the Oregon Health Authority for the SHARE program.

Summer Prantl Nudelman:

I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation.

- Company: Moda Health/EOCCO
- To ensure independence and balance of content, current conflicts of interest were resolved by basing recommendations on structured review for best evidence.

Learning Objectives

- Understand the SHARE initiative and how EOCCO is leveraging this requirement to invest in housing for its members and communities.
- Learn about the methods EOCCO uses to improve the health and wellbeing of patients and Eastern Oregon communities through the EOCCO grant programs.

Supporting Health for All through REinvestment (SHARE)

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SHARE Initiative background

Supporting Health for All through REinvestment: the SHARE Initiative was created by Oregon's legislature under House Bill 4018 in 2018

Requires CCOs to spend part of their profits in their communities to address health inequities and SDOH-E

CCO 2.0 aims to:

- Increase strategic, community-aligned SDOH-E spending AND,
- Increase tracking and transparency around this spending

SHARE Initiative background

Require that a portion of CCOs' profits are reinvesting in the community and improve member and community health by requiring reinvestments go toward upstream factors that impact health

SDOH-E spending can have great impact on overall health and well-being of the members we serve

Make strides in addressing SDOH-E and social needs of our members

Requirements and deliverables

Requirements

Contract year annual net income and reserves higher than financial requirements = 200% RBC

- Exempt if EOCCO does not exceed minimum financial requirements in contract year
- For CY 2020 and CY 2021, EOCCO will decide how much of its profits it will contribute to the SHARE Initiative
- For CY 2022, OHA may implement a formula to prescribe how much of EOCCO's net income or reserves will be allocated to the SHARE Initiative.

Requirements

1. Must fall within SDOH-E domains*
   - Economic stability
   - Neighborhood and built environment
   - Education
   - Social and community health
2. Priorities must align with community priorities from Community Health Improvement Plans (CHPs)
   - Common health outcome
   - Common priority population
3. A portion of the funds must go to SDOH-E partners
4. Must designate a role for the Community Advisory Councils

*Must include spending on housing

Spending exclusions

SHARE is not held to the same restrictions as funds within the Medicaid global budget

Funds cannot be HRS or Medicaid covered services or address a medical need

Educational or promotional items and goods for general distribution not focused on health disparities cannot be funded through SHARE

General administrative costs are excluded if

- not directly related to SDOH-E or health disparities
- necessary for regular business operations

Lifecycle of 2020 SHARE Funds

Proposal

Develop 2020 SHARE Initiative Designation (due April 30) and Initiative Spend-down report (due September 30).

Allocate and Spend Funds

Once approved by OHA, EOCCO will have until the end of 2022 to spend the funds

Reporting

EOCCO will be required to report on their mid-year progress beginning in 2022. This will be done through the annual Spend-down Report and the Detailed Spending Report. The final report for 2020 funds will be submitted in 2024.

EOCCO SHARE Designation- CY 2020

The EOCCO Board of Directors designated $310,000 for up to four applications for housing-related projects

Applications were due August 9, 2021 to LCACs

EOCCO SHARE Designation- CY 2020

Suggested topics from EOCCO SHARE RFA:

- Contributions to affordable housing development
- Permanent supportive housing
- Rapid re-housing programs
- Transitional housing
- Shelters
- Asset building
- Building renovations
- Improving accessibility
- Rental assistance
- Individual assistance with housing applications
- Efforts to combat discrimination in housing communities

Next steps

SHARE Decisions

Review Process:

- LCAC review
- CBIR team review
- Grant Committee recommendation
- Board of Directors' funding decision
- Award notice to applicants


QUESTIONS?

EOCCO Community Benefit Initiative Reinvestment (CBIR) Program

Program Components

Opportunities within the grant program include:

LCAC Grants

- Community-driven initiatives championed by LCACs

Opt-in Grants

- Targeted programs grantees can apply to implement

New Ideas Grants

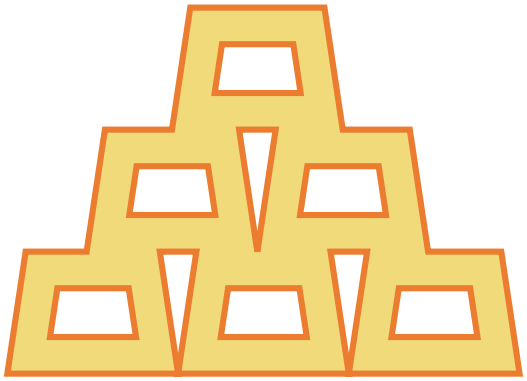
- Groundbreaking ideas with potential for spread to other communities

Public Health Grants

- Initiated and/or championed by Eastern Oregon public health departments

Funds

- A total of **$12,031,654** has been made available to the program to date (2016 to 2021)
- Funds come from achieving CCO quality incentive targets



	Total Allocated- All Years
LCAC	$3,863,160
Opt-In	$5,614,378
New Ideas	$2,161,116
Public Health	$393,000
Total	**$12,031,654**

Programs

LCAC Grants

Community-driven initiatives championed by LCACs

- Amounts based on EOCCO membership within each county
- Focus on Community Health Plan components & consistent with OHA social determinants of health and health equity guidelines
- Most counties have competitive process to select awards

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Programs

Opt-in Grants

Targeted programs grantees can apply to implement

- New models to improve access or reduce barriers to care for EOCCO members
- New programs to engage members in their care
- New ideas to integrate or improve clinical services to members
- Novel workforce initiatives
- Novel models to reduce cost while maintaining the quality of care

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Programs

Public Health Grants

Initiated and/or championed by Eastern Oregon public health departments

- Address incentive measures
- Roots of early childhood trauma and resiliency
- Pre- and post-partum support for at risk and vulnerable populations
- Collect population-level data
- Align CHA with SHIP and CHPs
- Cross-sector collaborations
- Emergency preparedness, accreditation, capacity building, and school-based health centers

Programs

New Ideas Grants

Groundbreaking ideas with potential for spread to other communities

- New models to improve access
- New programs to engage members in care
- New ideas to integrate or improve clinical services to members
- Novel workforce initiatives
- Novel models to reduce cost & maintain quality

Focus areas- Incentive-measures, collaborations, telehealth & broadband, behavioral health integration, health disparities, health-related social needs

Examples of Funded Projects

High County Health and Wellness Center

- Harney County Foster Care Medical Home
  - Supporting training, start up materials, workflow and partnership development to establish the practice as the comprehensive primary care and referral provider for children in foster care in the county.

Examples of Funded Projects

Yakima Valley Farmworkers Clinics- Family Medical Center & Mirasol

- Expansion of capacity to test, treat, and vaccinate for COVID-19
  - Expanded service hours, pop up clinics, and open access for EOCCO patients and community members to testing and COVID-19 vaccine
  - Events in collaboration with local health departments to test and vaccinate community members
  - Patient outreach and education to address vaccine hesitancy, with focused outreach to

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Examples of Funded Projects

Winding Waters Clinic

- Opt-in project- Comprehensive Diabetes Care
  - Address HbA1C Poor Control and Oral Evaluation for Adults with Diabetes Incentive Metric
    - Self-management support strategies
    - Referral to community programs
    - Remote monitoring devices and protocols
    - Primary care-dental communications workflows development
    - Outreach to gap lists
    - Nutrition counseling
    - Group visits

Examples of Funded Projects

Gilliam, Harney, Sherman, Wheeler, Lake, Malheur County LCACs

- Veggie Rx
  - “Prescriptions” distributed to food insecure EOCCO and community members which can be redeemed for fresh fruit and vegetables.

Timeline- 2022 Grants

Early October 2021: RFA release

Through December 2021: Technical assistance

December 17, 2021: Application deadline

January-March, 2022: Application review and Grant Subcommittee and Board of Directors' approval of awards

April 2022: Awards start for truncated 9 month award period

Realigning Grant Timelines- 2023

Opt-In, New Ideas (1st deadline), and Public Health grant periods will be from January through December

- 7/2022 RFA released
- 9/2022 applications due
- 1/2023 projects start
  - ✓ Calendar Year aligns with OHA incentives metrics

LCAC, New Ideas (2nd deadline), and SHARE grant periods will be from July through June

- 12/2022 RFA released
- 3/2023 applications due
- 7/2023 projects start
  - ✓ Fiscal Year aligns with grantee accounting and HRS reporting


QUESTIONS?


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VACCINATION

BOOST OREGON

EDUCATION

Counseling on Covid-19 Vaccines to Improve Vaccination Rates

About Me

Disclosures

I have no disclosures

Land acknowledgment

VACCINATION

BOOST OREGON

EDUCATION

We empower people to make science-based vaccine decisions for themselves, their families, and the community.

We want to answer whatever questions people have about vaccines. We do not tell people what to do. We listen and provide science-based information.

We do not accept donations of any kind from pharmaceutical companies.

Acknowledgement of Historical Trauma

The COVID-19 pandemic highlighted health gaps that existed for hundreds of years. These unfair differences impact Black, Indigenous, and People of Color (“BIPOC”) communities most.

BIPOC communities faced trauma from slavery, being used as test subjects without consent, and abuse in the name of science.

These cruel practices caused understandable distrust in government and medical experts.

Vaccine Confidence

The COVID-19 vaccines offer an important chance to support and protect those who are at the most risk for COVID-19.

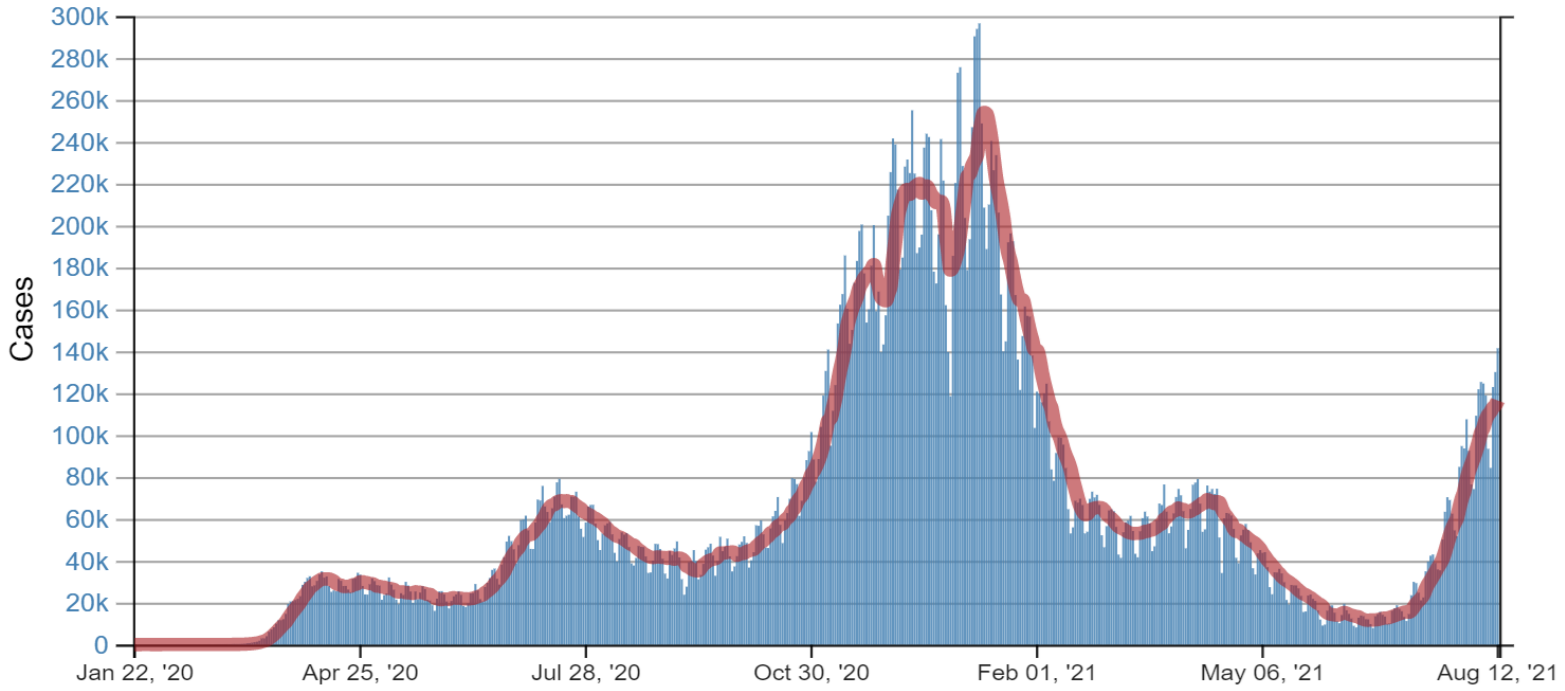
We must commit to addressing the social factors that affect our health and will reduce differences in health outcomes.

Objectives of This Talk

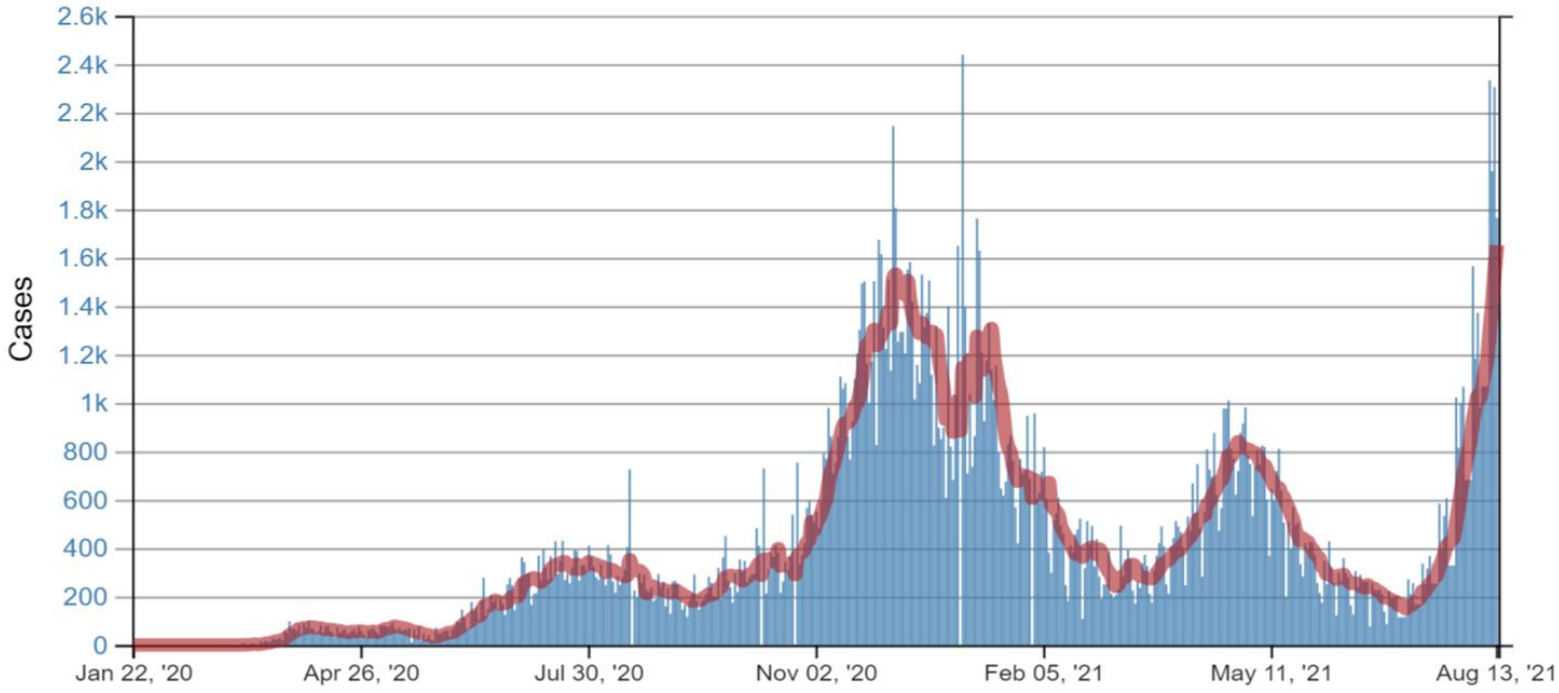
- The current state of COVID-19 in the US
- The effect of vaccination on COVID-19 infections
- Addressing common safety concerns related to COVID-19 vaccines
- How to have productive conversations about vaccines with patients

Where are we now with COVID-19?

Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC



Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



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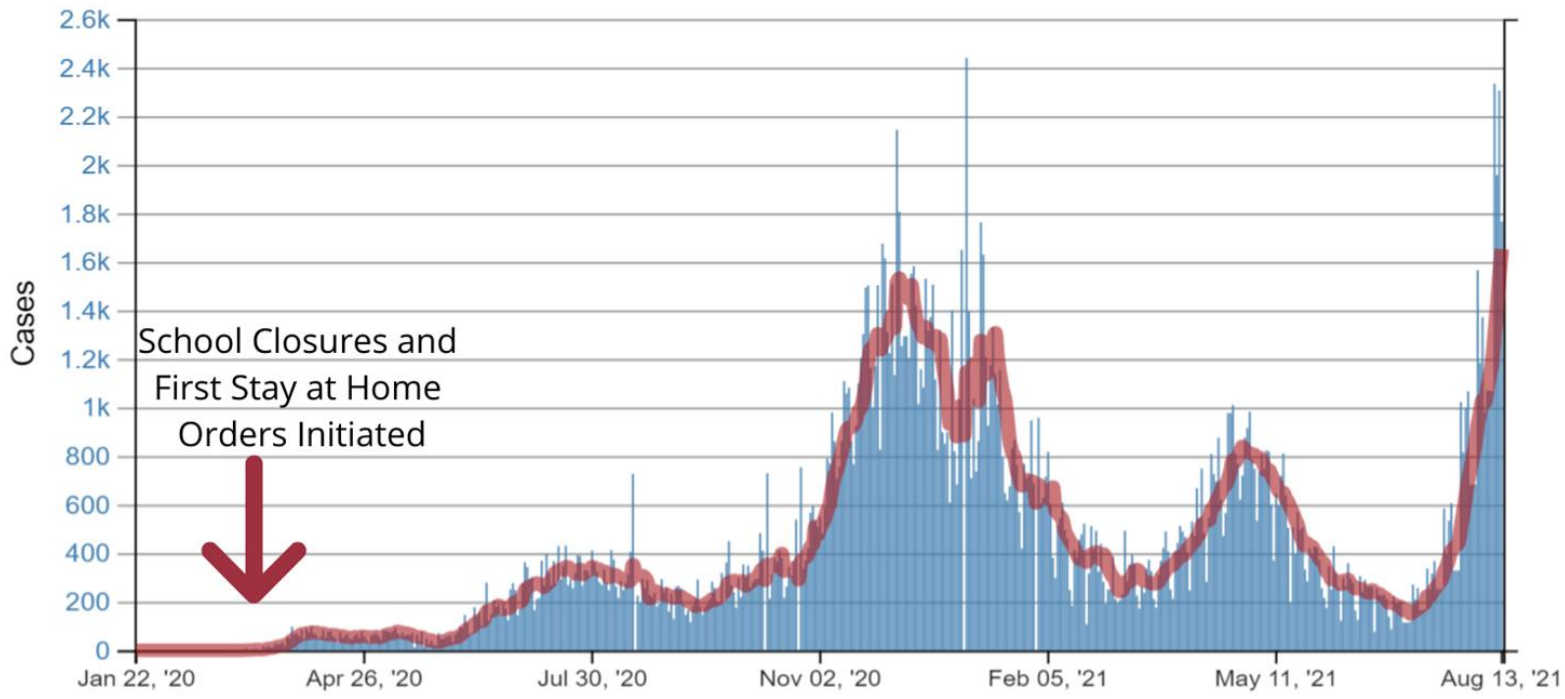
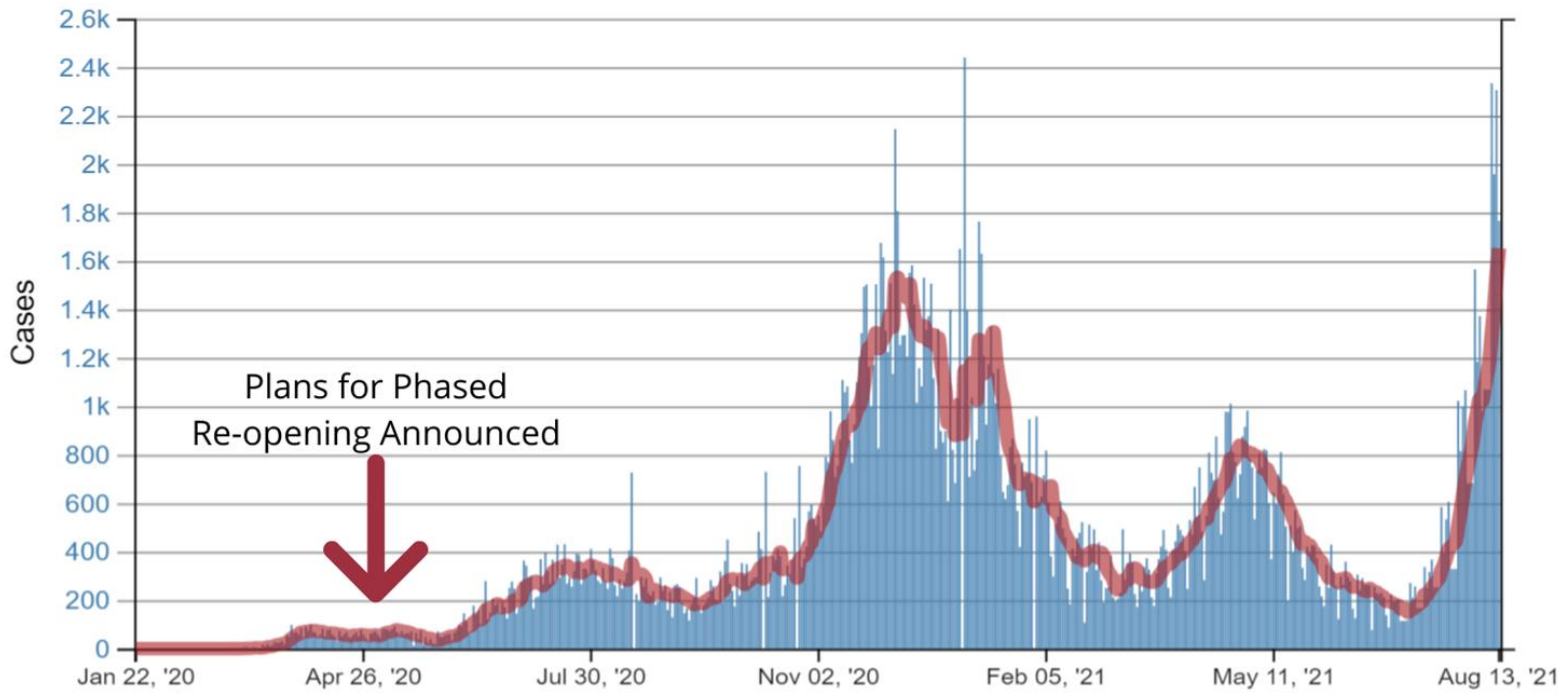
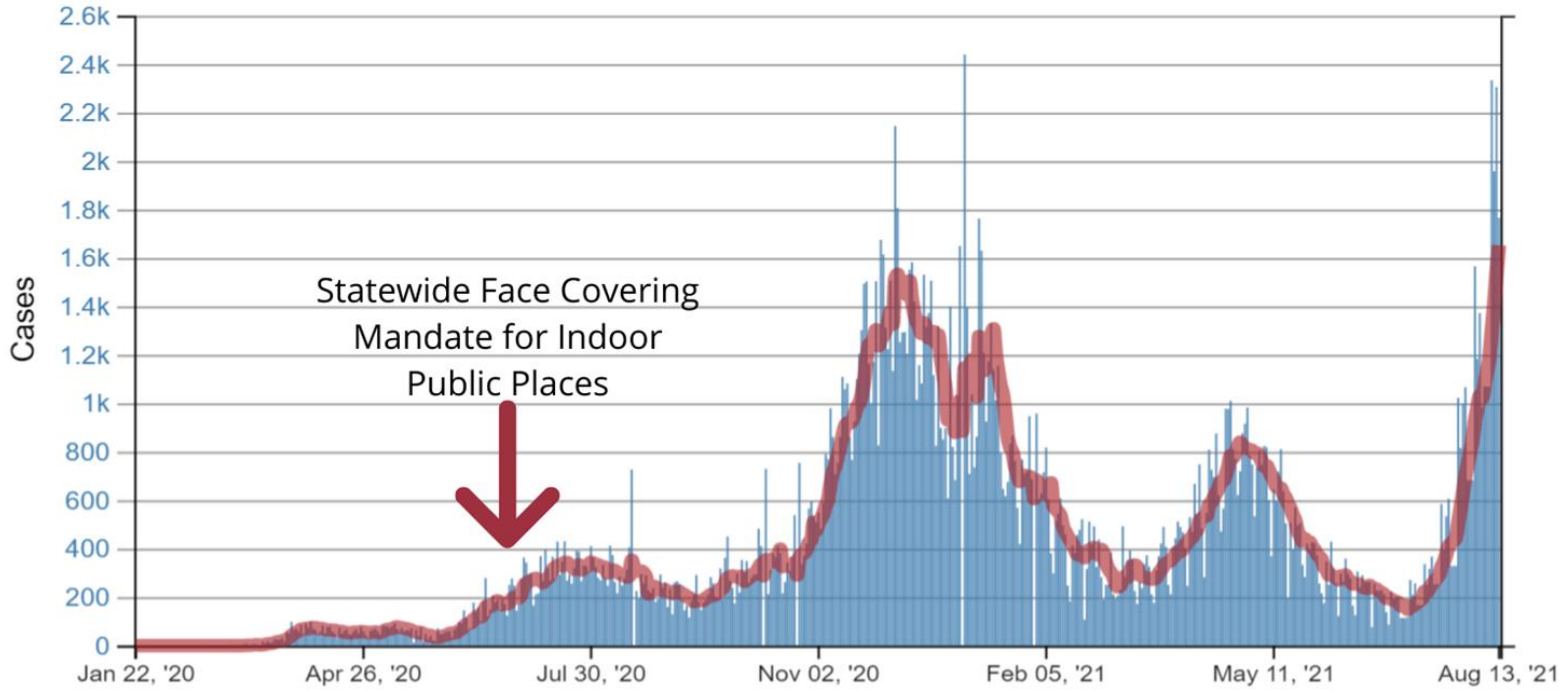


Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



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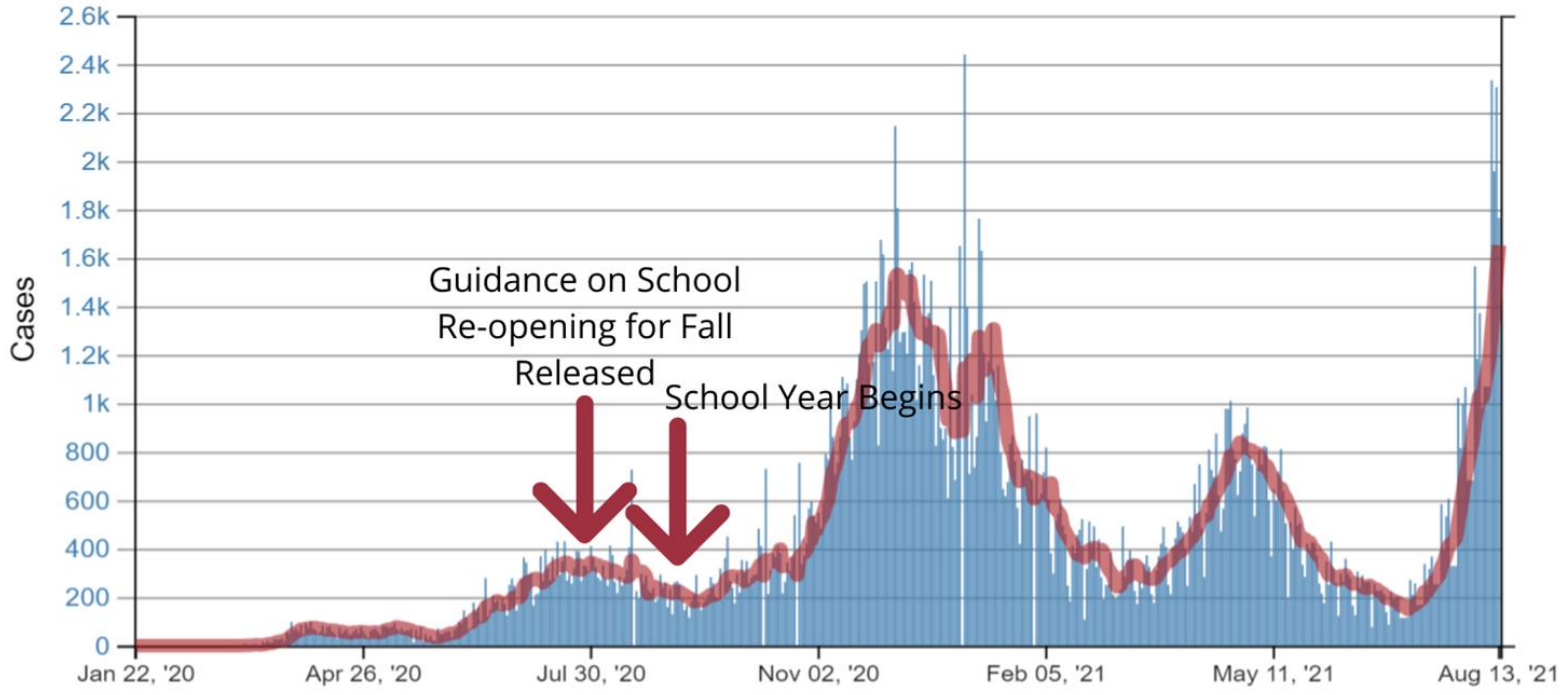

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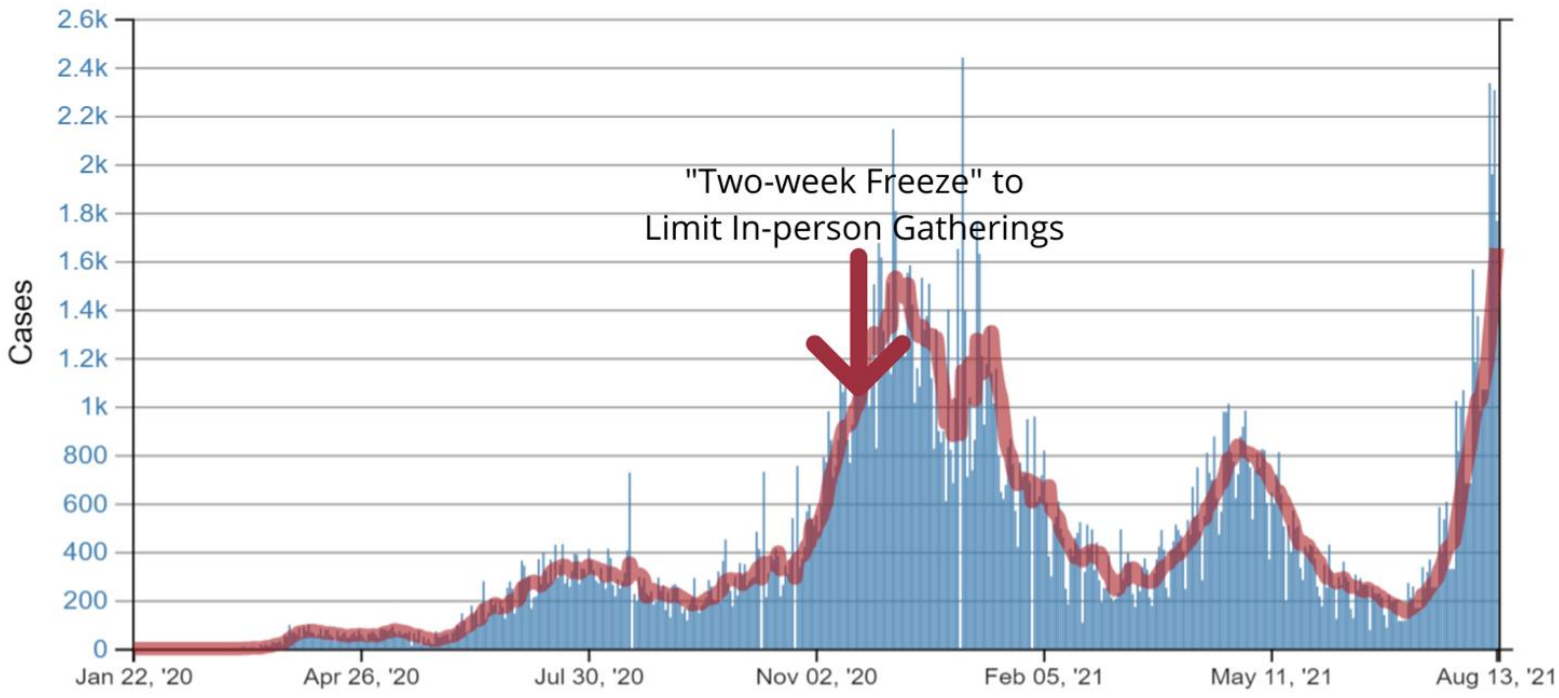

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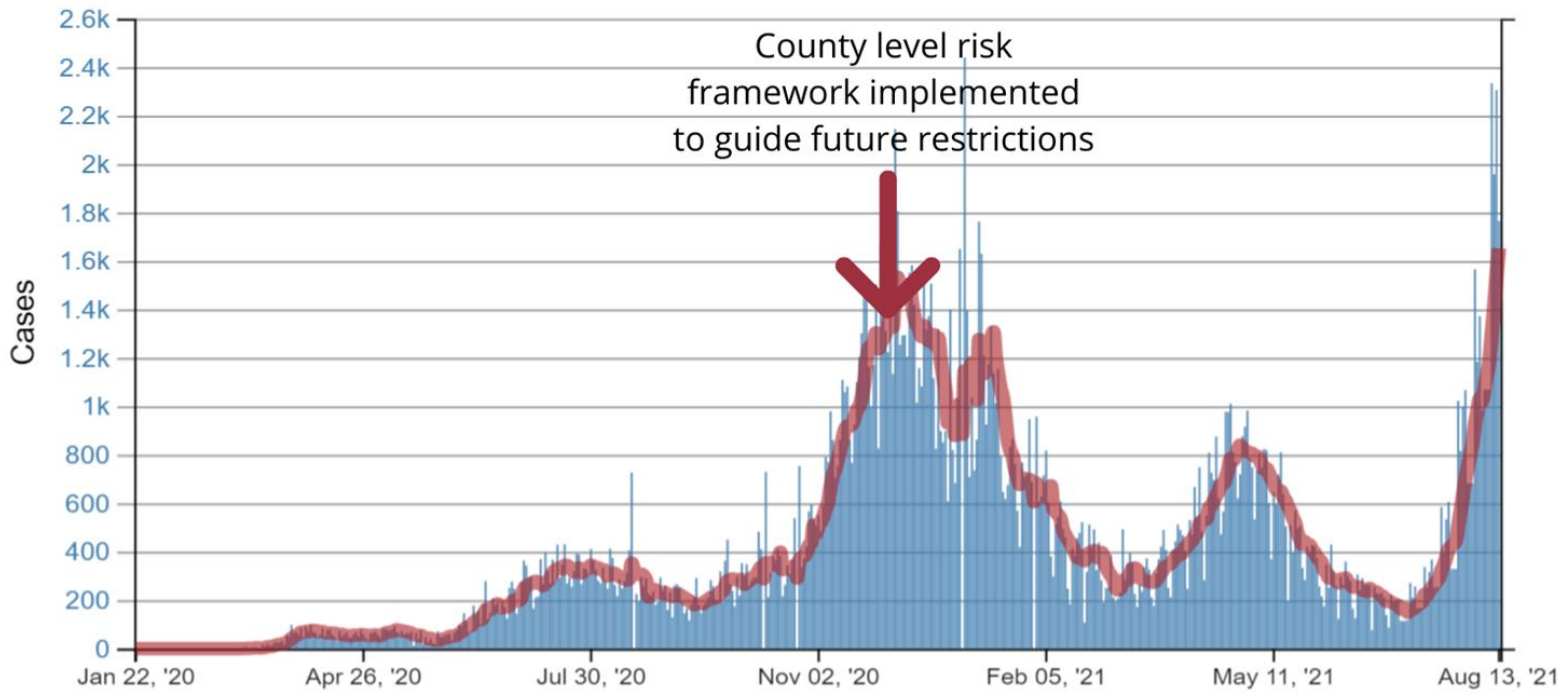
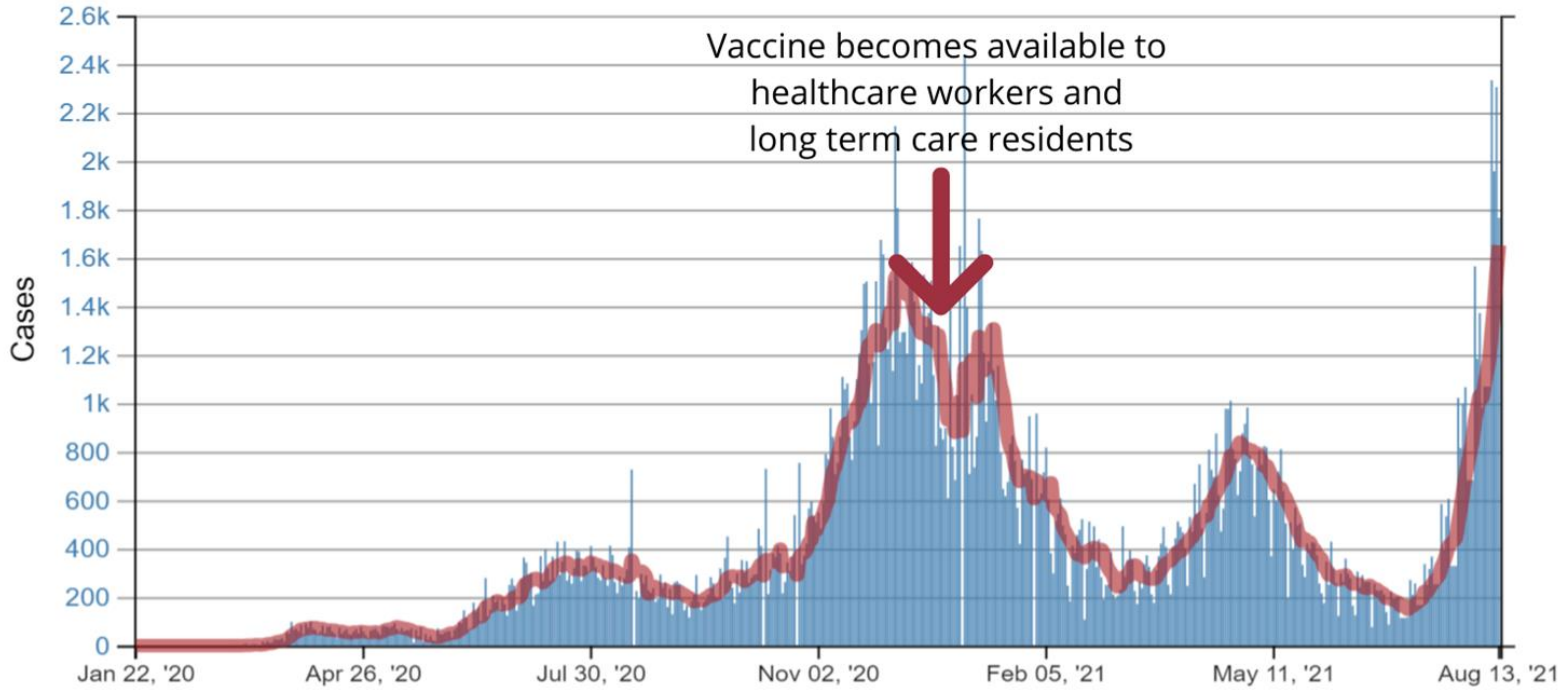
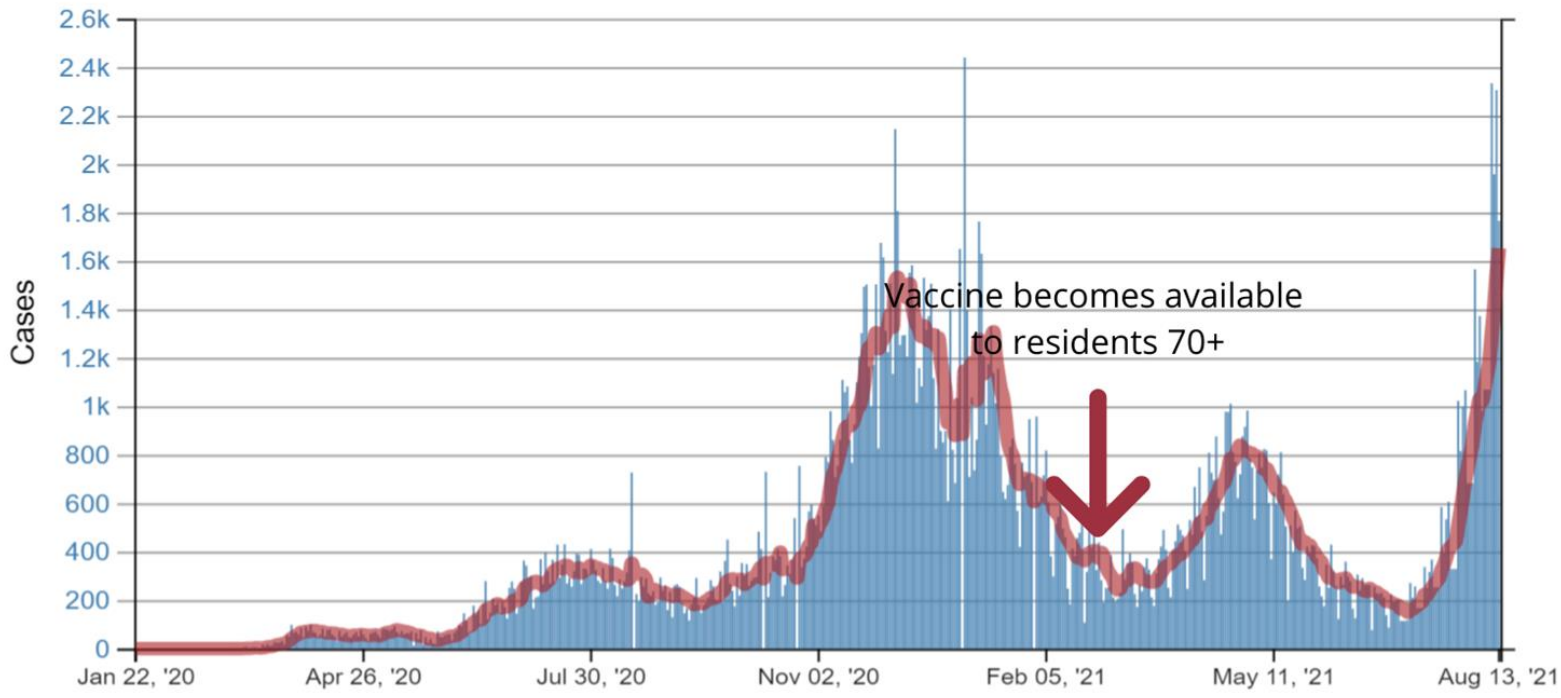


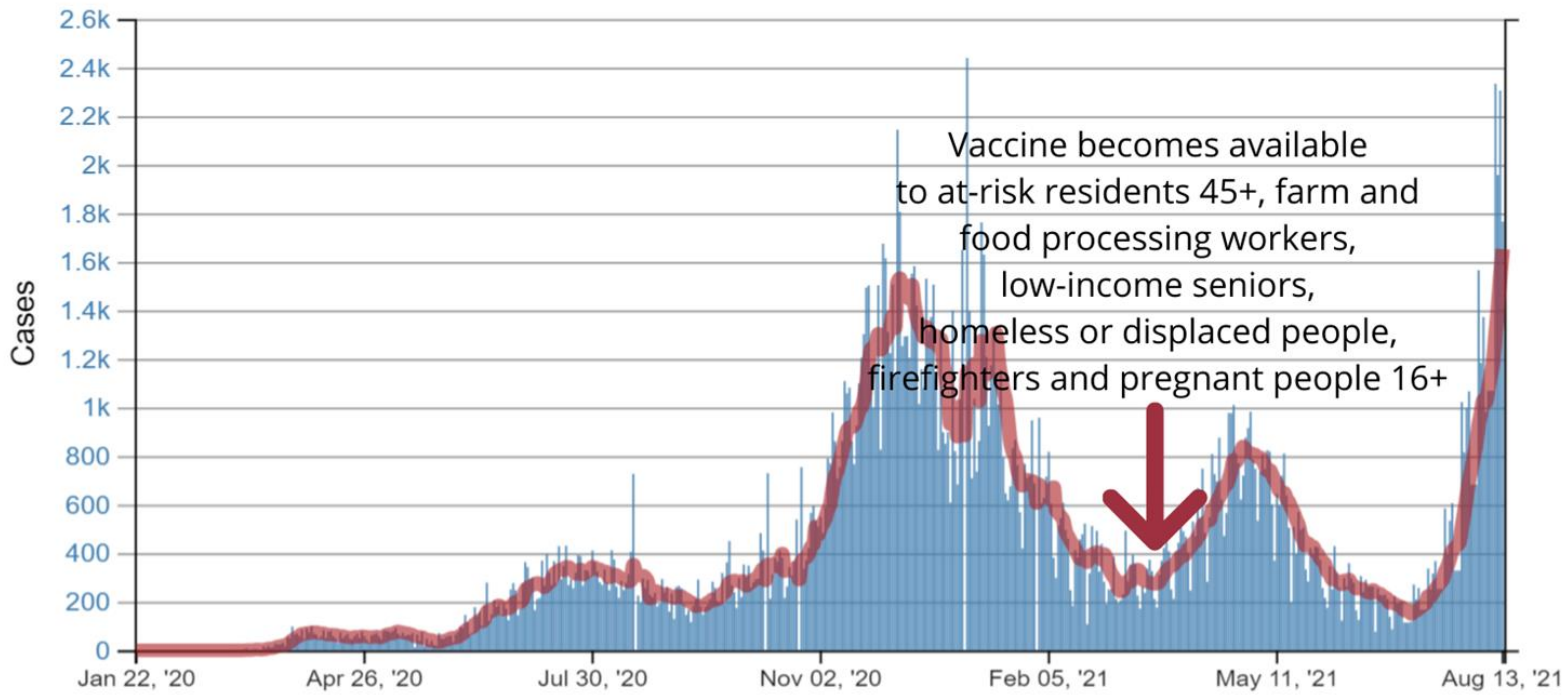
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



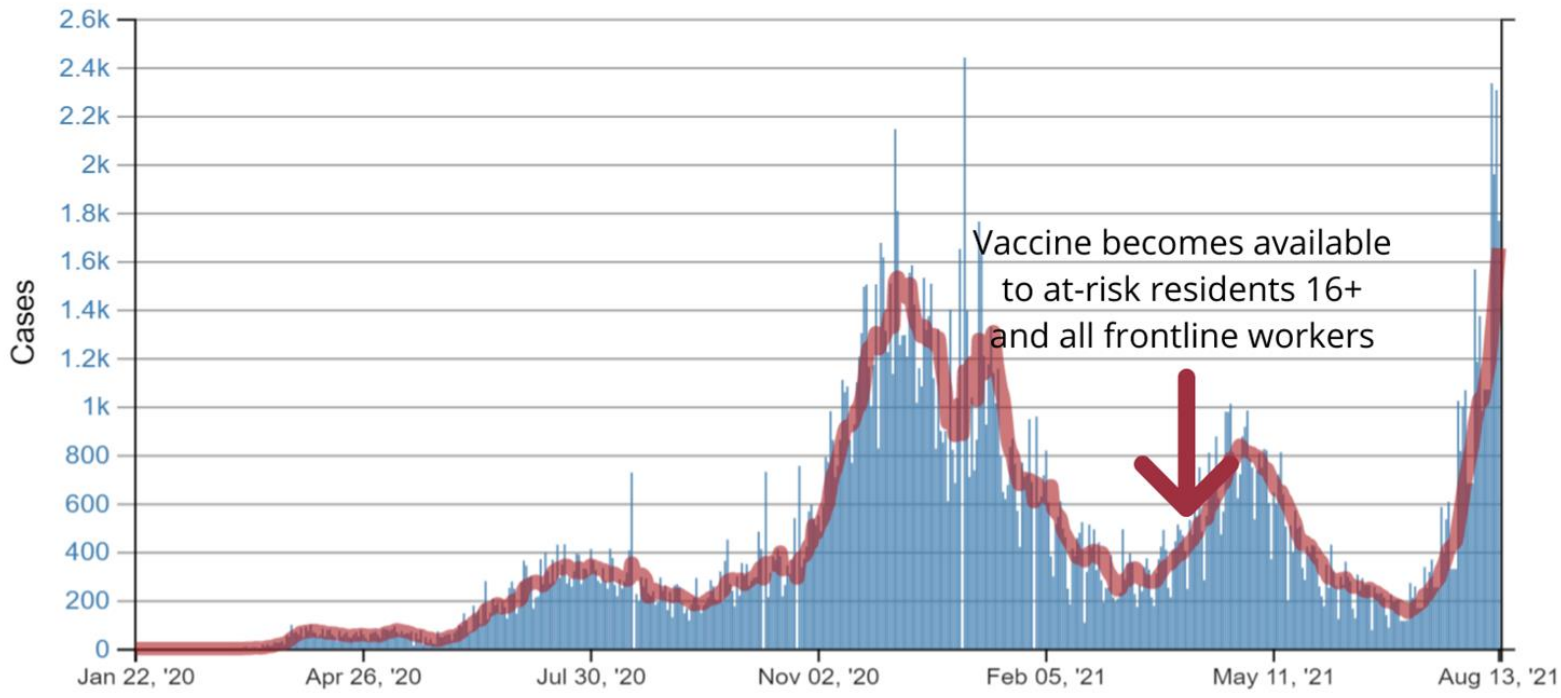
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



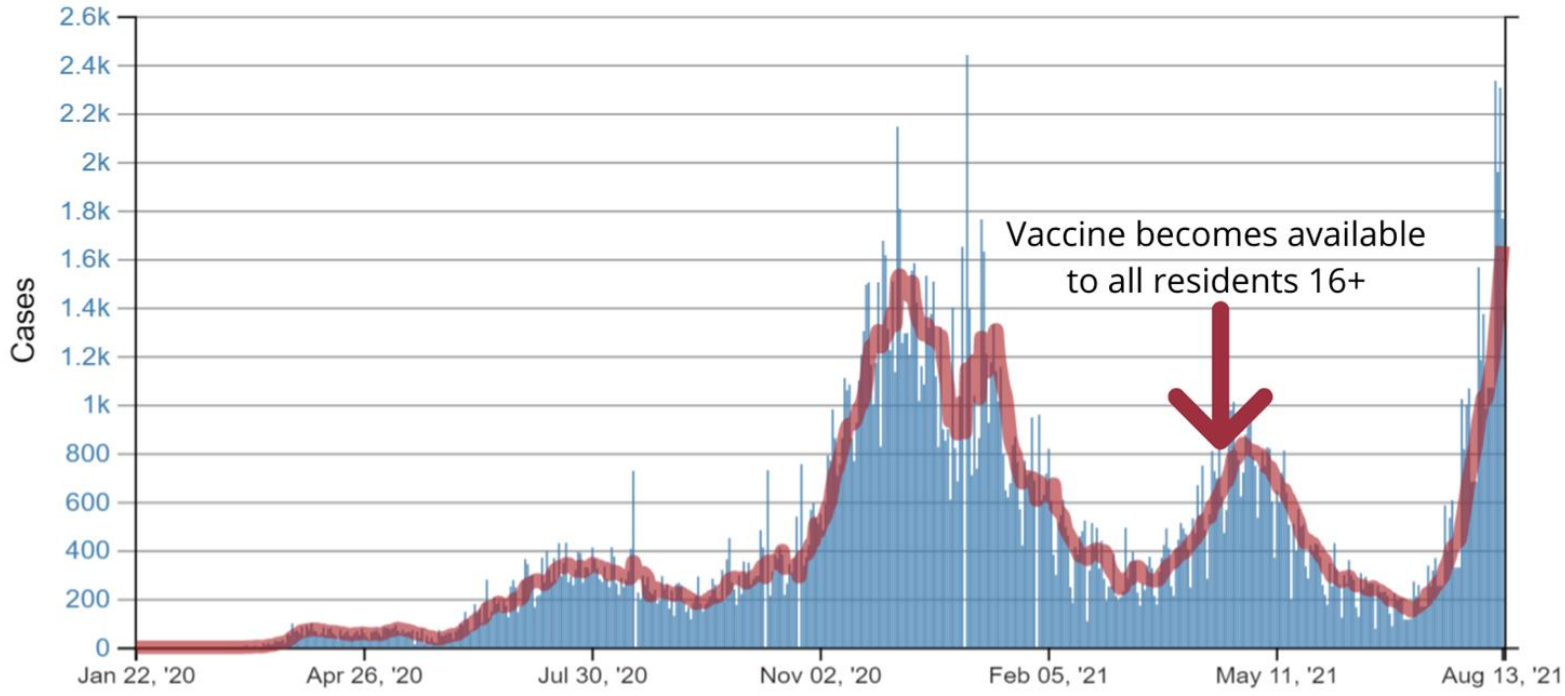
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



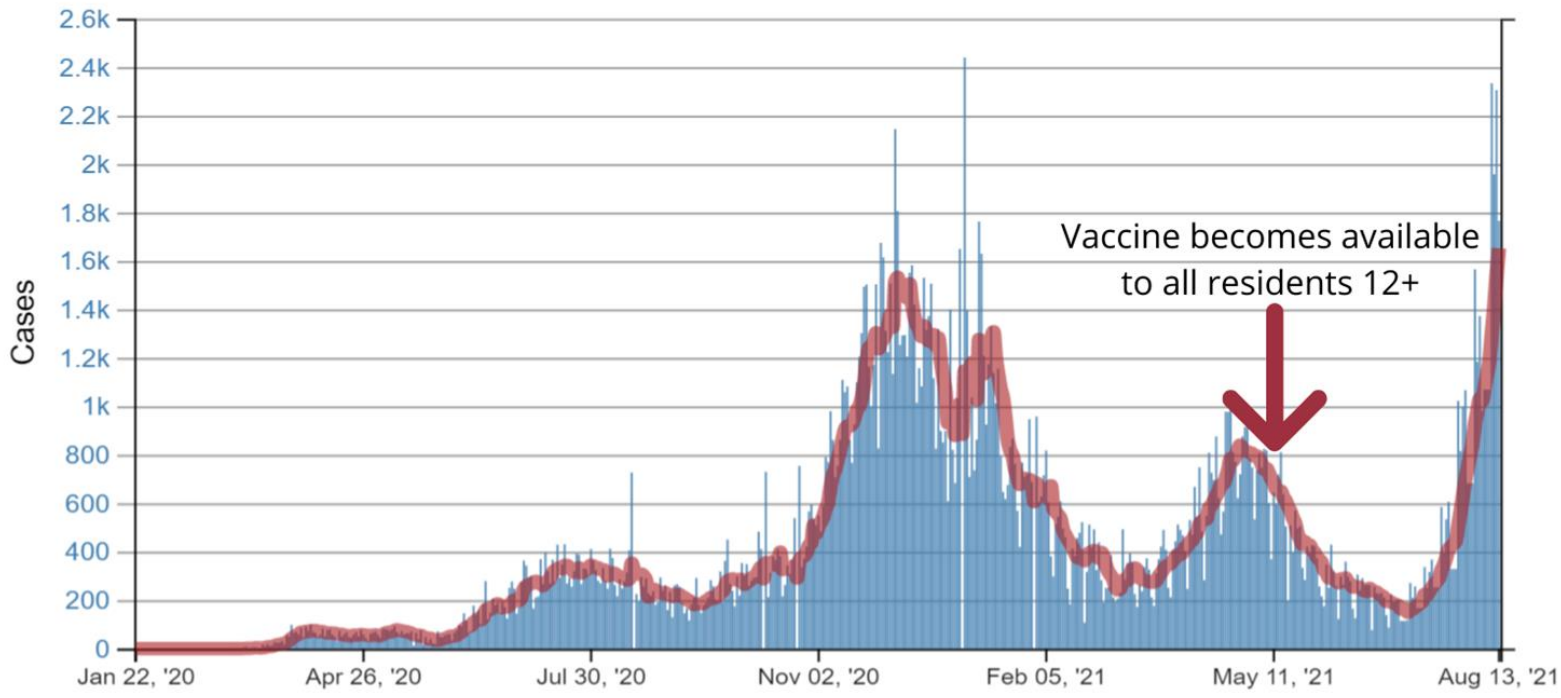
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



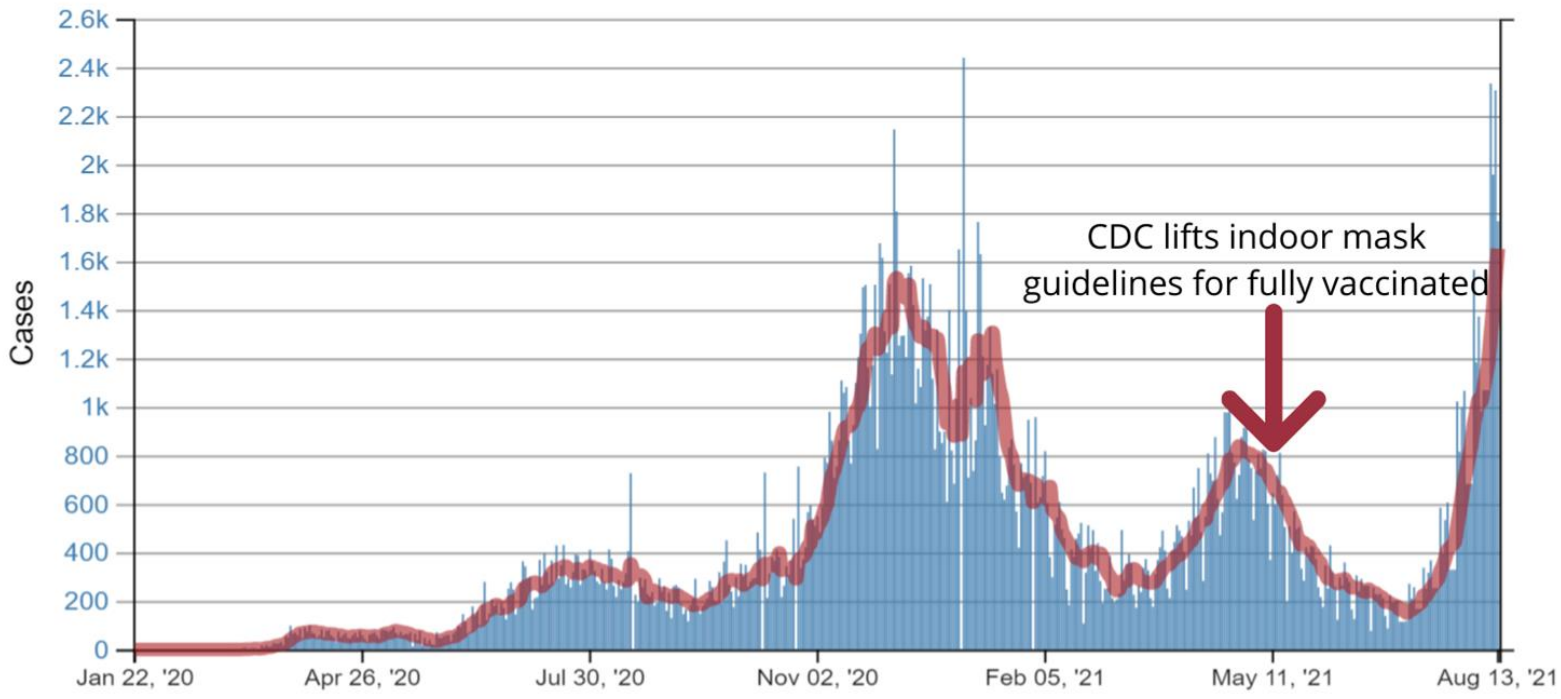
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



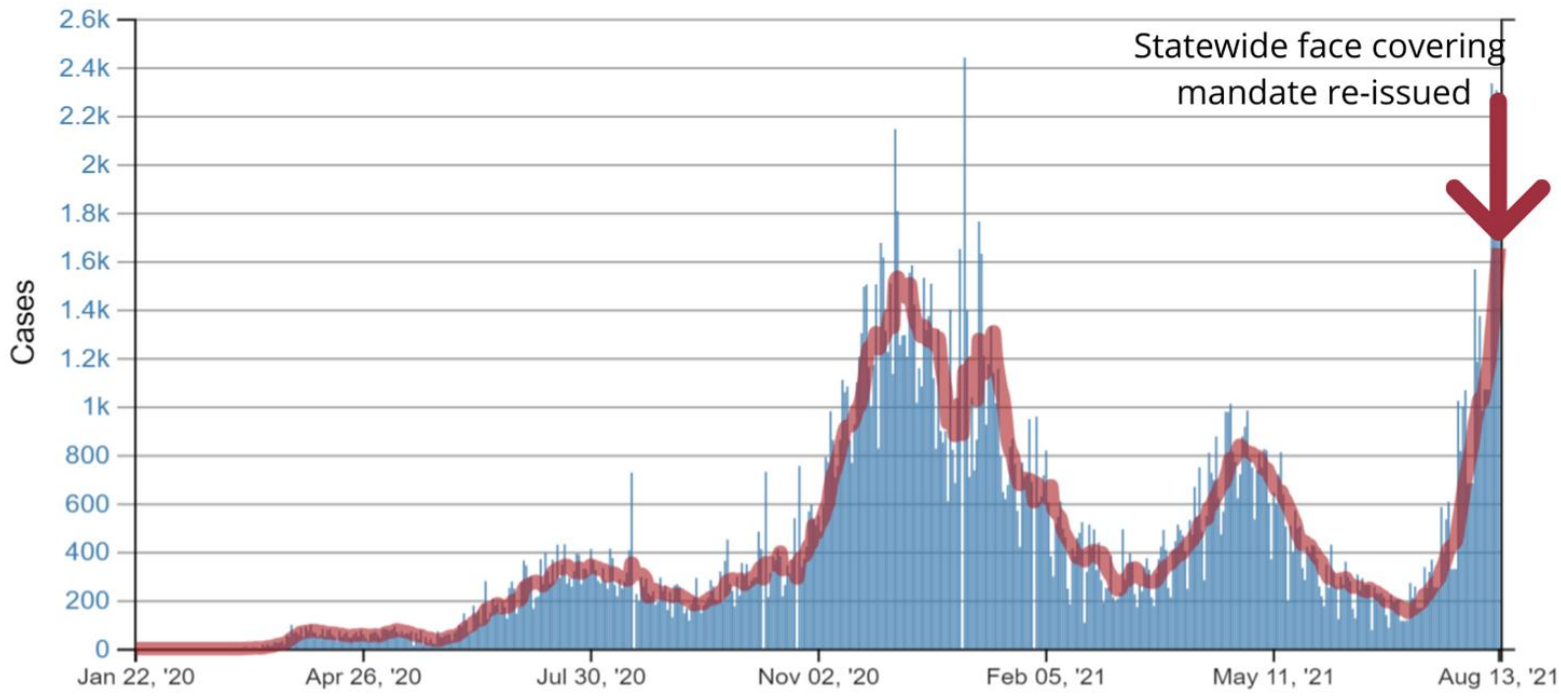
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



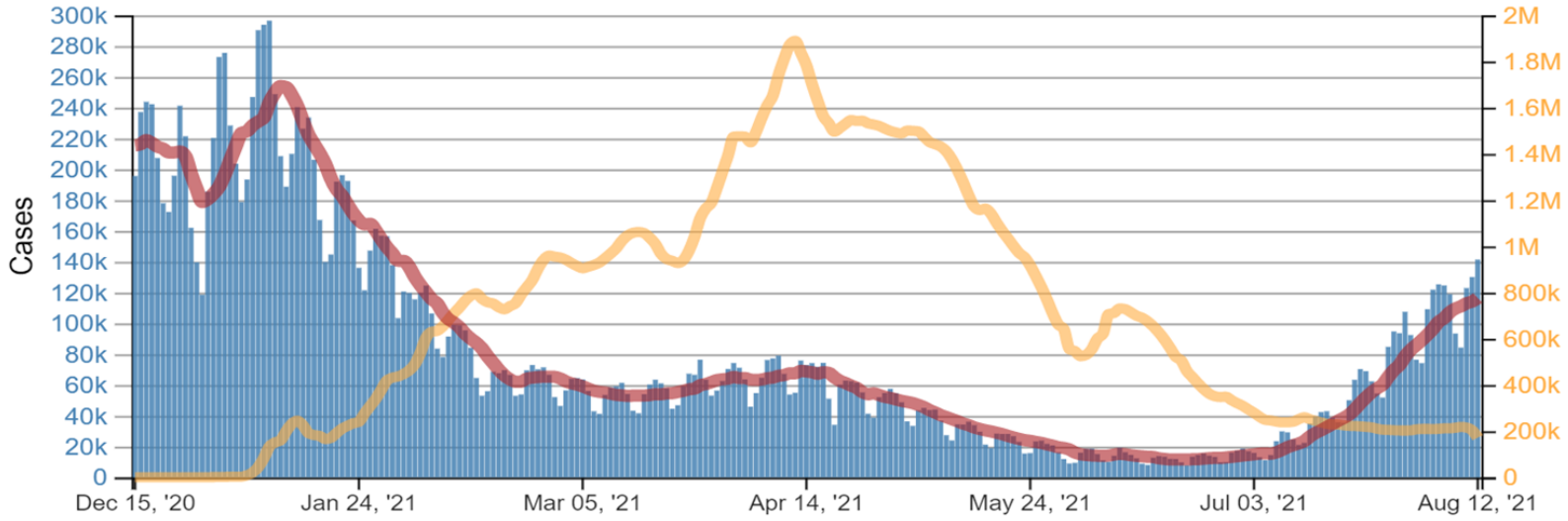
Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC



Daily Trends in Number of COVID-19 Cases in Oregon Reported to CDC

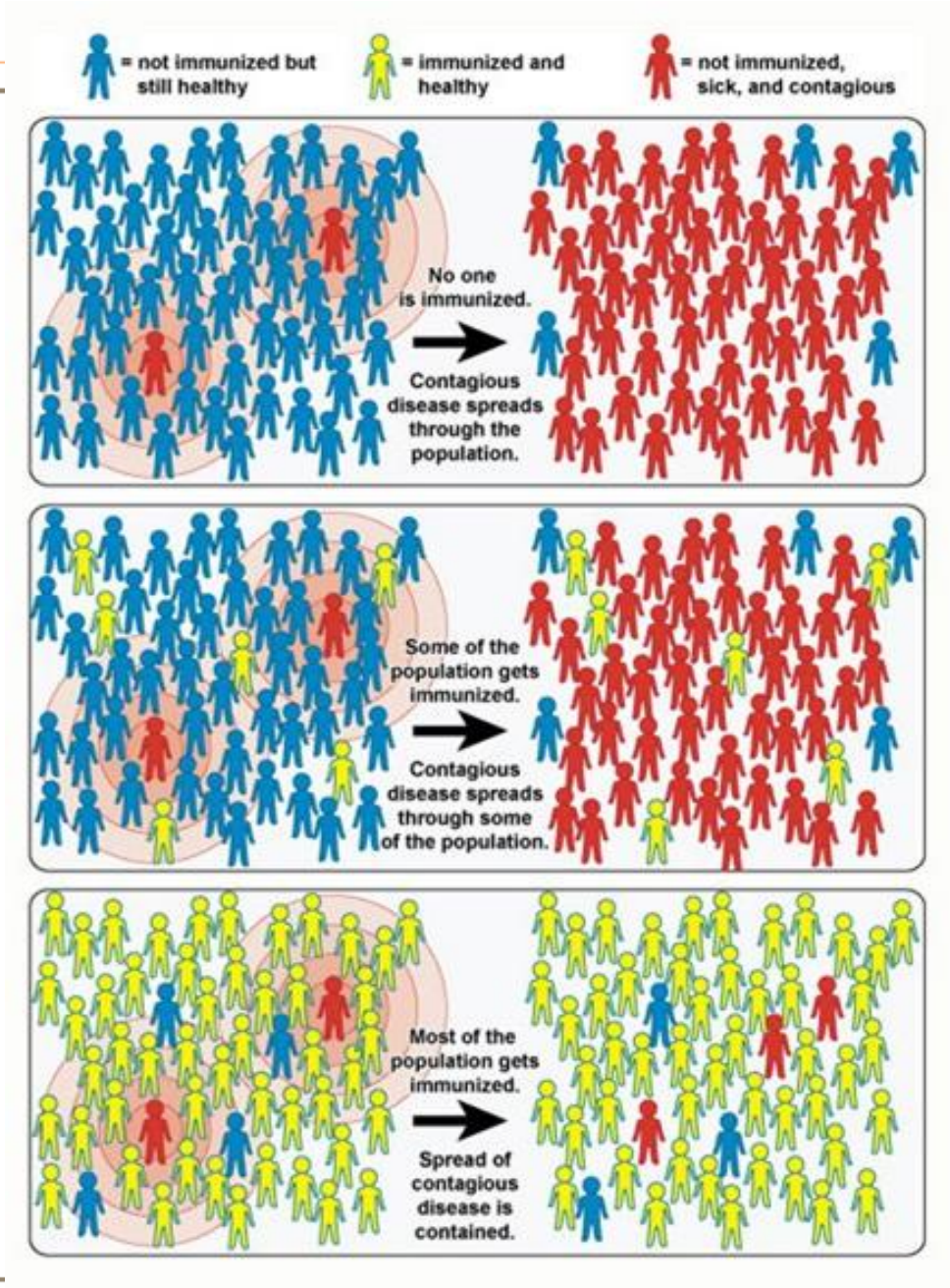


Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC and 7-day Moving Average of the Number of People Fully Vaccinated.



Experiences of Vaccinated and Unvaccinated Individuals Are Changing

- B.1.617.2 is the dominant SARS-Cov-2 strain in the US and is more contagious than the original strains
  - The COVID vaccines in use in the US are very effective against B.1.617.2 and other strains currently circulating in the US.
- COVID-19 infection is decreasing significantly in vaccinated individuals.
  - Unvaccinated people are getting infected at rates similar to the heights of infection seen this past winter
- US COVID infection rates tripled in the first 3 weeks of July
- Unvaccinated people are the vast majority of those people who are in our hospitals and ICUs. Some still must be sent out of state for ICU care if beds are full. (OPB 4June21)



https://www.pbs.org/wgbh/nova/article/herd-immunity/ https://projects.oregonlive.com/maps/vaccination/#eugene-waldorf-school-2470

MASK UP, LATHER UP, SLEEVE UP

CASES ARE RISING.
ACT NOW!

WEAR A MASK

STAY 6 FEET APART

AVOID CROWDS

Masking in Schools

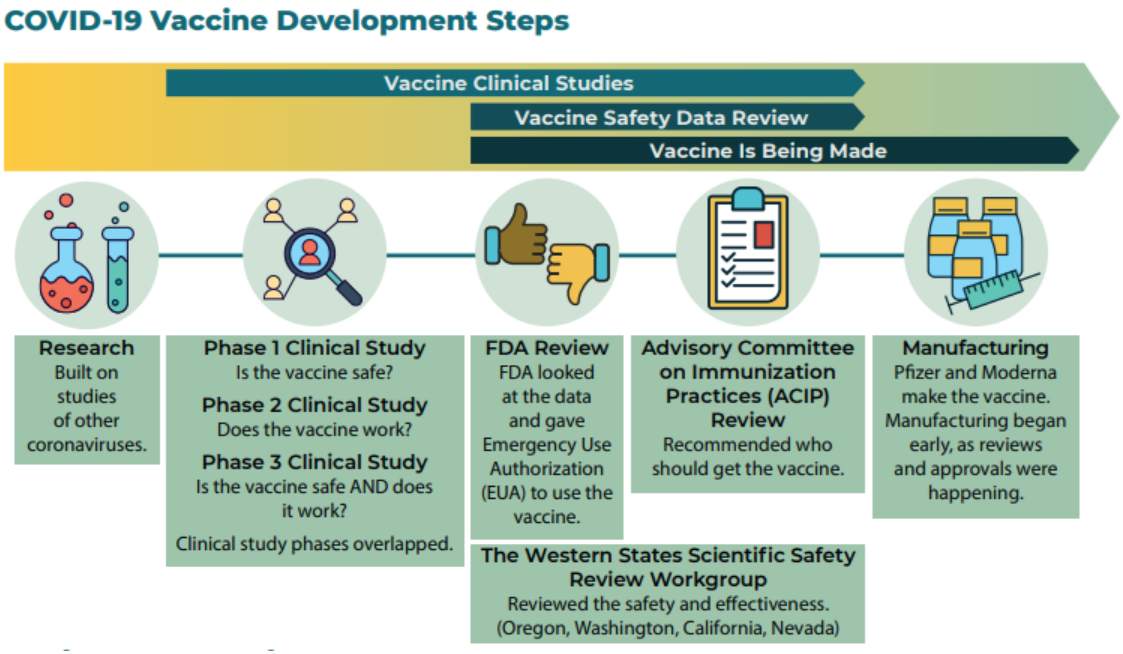
"The Oregon Pediatric Society and the Oregon Academy of Family Physicians strongly advocate for in-person learning in K-12 classrooms, while taking disease-preventing pandemic safety measures."

- The Centers for Disease Control and Prevention recommends that all students, teachers, and staff at K-12 schools should wear face masks, even if they are vaccinated.
- Because children under 12 cannot be vaccinated, and cases of COVID-19 in kids are increasing, masking is the best way to prevent the spread of COVID-19 and other respiratory illnesses.

Development and Monitoring of COVID-19 Vaccines

BOOST OREGON |

Vaccine Development



https://www.nature.com/articles/s41586-020-2798-3/figures/1

COVID-19 Vaccines Followed Same Safety Procedures As Other Vaccines

- COVID-19 vaccines have been through the same safety trials as all other vaccines.
- COVID-19 vaccine development happened quickly because:
  - Researchers had a head-start with their work on SARS and MERS;
  - Thousands of people volunteered for trials;
  - Many COVID-19 cases meant vaccine effectiveness could be tested quickly: and
  - Government and industry prioritized paying for vaccine research and to start making the vaccines while they were being reviewed;
  - So, vaccine could be delivered to people ASAP
- COVID-19 vaccines are reviewed and approved separately in the U.K., the E.U., Israel, and Canada.

Addressing Safety Concerns

Tools Used to Monitor Safety

- Same pre-market safety data as all other vaccines, with 2-years of ongoing follow-up in Phase III clinical trials.

- Same post-market safety monitoring tools:
  - **Vaccine Adverse Event Reporting System (VAERS):** An early warning system to monitor for potential vaccine safety problems. Anyone can report.
  - **Vaccine Safety Datalink (VSD):** A network of 9 healthcare organizations that conducts vaccine surveillance and research.
  - **Clinical Immunization Safety Assessment (CISA) Project:** A collaboration between CDC and 7 medical research centers to conduct clinical research studies about vaccine safety.

- Additional tools for safety monitoring:
  - **V-SAFE:** Smartphone-based tool to monitor side effects.
  - **National Healthcare Safety Network**: Monitors acute care and long-term facilities with reporting to VAERs.
  - **FDA's Biologics Effectiveness and Safety (BEST)** and **Sentinel Initiative**: Contain administrative and claims-based data for surveillance and research.

What About Long Term Side Effects?

- Changes that result in long term side effects should appear within 2 months, and more likely within 2 weeks, of vaccination

- We have no more long term safety data for COVID-19 vaccines than we do for COVID-19 infection

Common mRNA Vaccine Concerns

New and unknown! Could mRNA linger in cells? Integrate into DNA? Cause infertility? Autoimmune disease? What about Antibody Dependent Enhancement (ADE)?

- mRNA vaccines have been tested in clinical trials for influenza, Zika, Rabies, and CMV
- There are also multiple clinical trials for mRNA drugs encoding for cancer-fighting antigens
- Mechanism of action is straightforward, with no probable mechanism for long term side effects
- Vaccine mRNA is destroyed within hours in our cells, never enters the nucleus, and doesn't have a primer sequence for Reverse Transcriptase (which we don't express in our cells anyway)
- If our cells frivolously preserved or integrated into our genome random mRNA strands in our cytosol, we would be able to cure every genetic disease, and be constantly mutating in the face of thousands of viruses injecting their mRNA into humans daily.
- Any side effects caused by the spike protein or the mRNA encoding for it (including ADE) would have been seen with COVID-19 infections and in vaccine recipients already.

The Motivational Interview Approach

General Principles

Don’t try to convince patients to vaccinate!

Convince them that you care about their health, and believe that they are trying stay healthy and safe.

Find out what their closely held beliefs are and speak to those beliefs.

Avoid only refuting wrong ideas; fill the void of a refuted idea with truth.

General Principles

Reinforce positive vaccine acceptance and attitudes.

“I’m so glad to hear you already got your COVID-19 vaccine!”

Step One: Listen

Ask why they have chosen not to vaccinate or delay vaccines, and LISTEN to their response.

Many patients will be hesitant to have the conversation, and will intentionally give vague responses. Follow up: "Please tell me more."

Step Two: Validate and Empathize

We are more likely to listen to others when we feel listened to ourselves.

We are also more likely to be willing to compromise on our deeply held beliefs when we first acknowledge the things about ourselves that make us feel proud

Step Three: Ask Permission to Educate

"I strongly recommend getting all vaccines recommended by the CDC, but I also want to make sure you feel comfortable with the decisions you make about your/your child's medical care. Is it alright if I share some information that others have found helpful?"

Other Ways to Advocate

- Get vaccinated yourself.
- Be a strong voice for evidence-based public health policy.
- Show enthusiastic support for masking in schools and other indoor settings, and ongoing social distancing precautions,

Changing Culture from Fear to Love

Do not tell people what to do.

Provide evidence-based information without judgment.

Do not use fear.

Aim for confident, positive acceptance.

Elicit Positive Emotion

Share stories, especially your own.

Immunization is an act of love.

Important Takeaways

- COVID-19 infections are increasing, especially in unvaccinated populations.
- Because of this, ongoing pandemic precautions will still be required even with increased vaccination efforts.
- There are concerns about mRNA vaccines because they are new, but not unknown.
- Motivational interviewing can be helpful when discussing vaccine decisions with your patients.

References and Further Reading

- Understanding and Explaining mRNA COVID-19 Vaccines | CDC https://www.cdc.gov/vaccines/covid-19/hcp/mrna-vaccine-basics.html
- Oregon COVID-19 Vaccine Planning Update https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/VACCINESIMMUNIZATION/IMMUNIZATIONPROVIDERRESOURCES/COVIDDocuments/Oregon-COVID-Vaccine-Planning-Update-2020-12-04.pdf
- mRNA Vaccines - New Technique, Same Immune Response - NDs For Vaccines https://ndsforvaccines.com/mrna-vaccines-new-technique-same-immune-response/
- AAP Connecting with the Experts: COVID-19 Vaccine (brightcove.net) https://players.brightcove.net/6056665225001/KSSGZDkp6_default/index.html?videoId=6214190718001
- SARS-CoV-2 vaccines in development | Nature https://www.nature.com/articles/s41586-020-2798-3#Fig1

Questions?

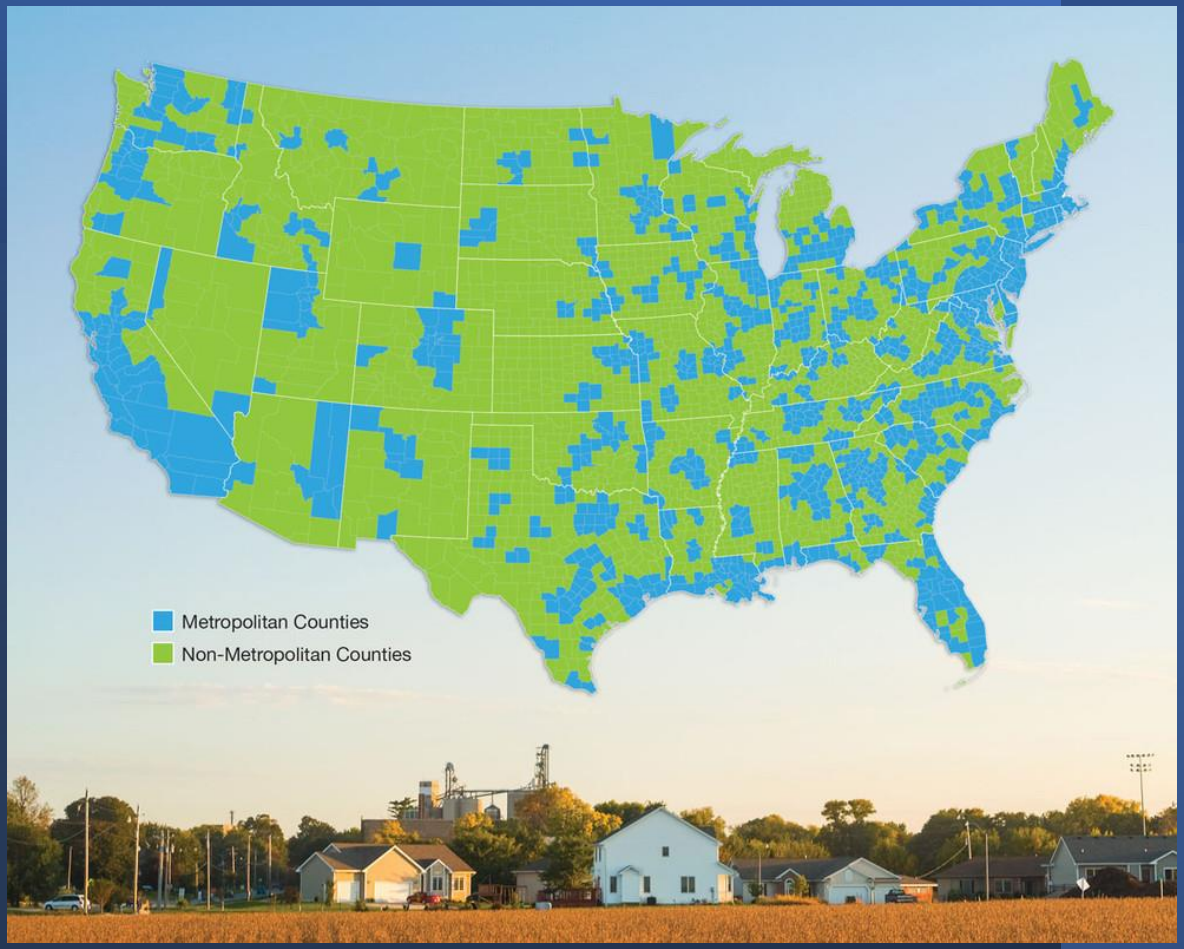
VACCINATION
BOOST OREGON
EDUCATION

www.boostoregon.org
facebook.com/boostoregon
Twitter: @boostoregon
Instagram: @boostoregon


eocco
EASTERN OREGON
COORDINATED CARE
ORGANIZATION

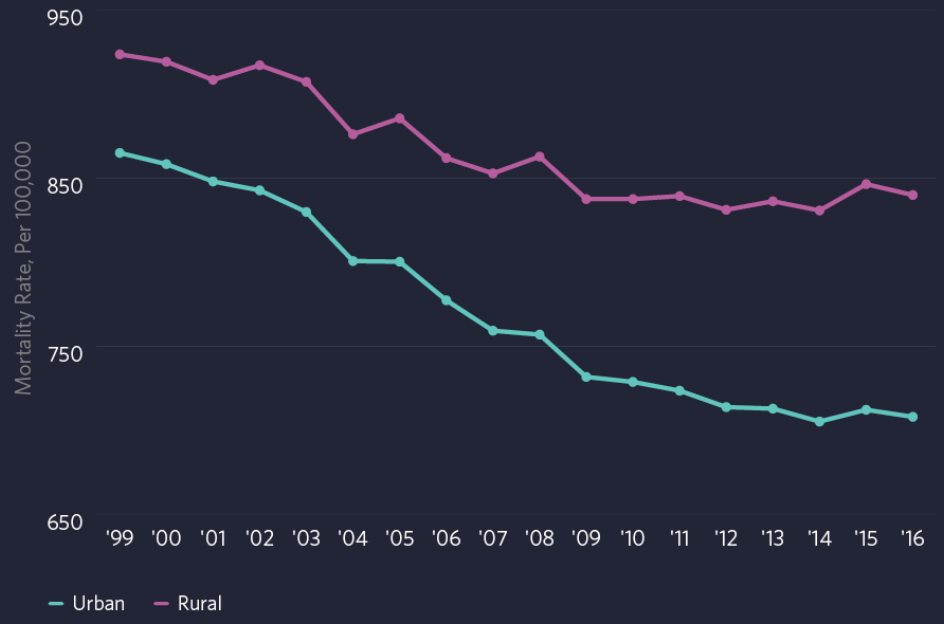
"What the Pandemic has taught us about Rural Health Care"

- HEALTH STATUS OF PEOPLE WHO LIVE IN RURAL AMERICA
- CURRENT STATE OF RURAL HEALTH CARE
- IMPROVING RURAL HEALTH CARE INFRASTRUCTURE
- NEW THREATS TO RURAL HEALTH CARE: ATTITUDES AND PARTISAN POLARIZATION

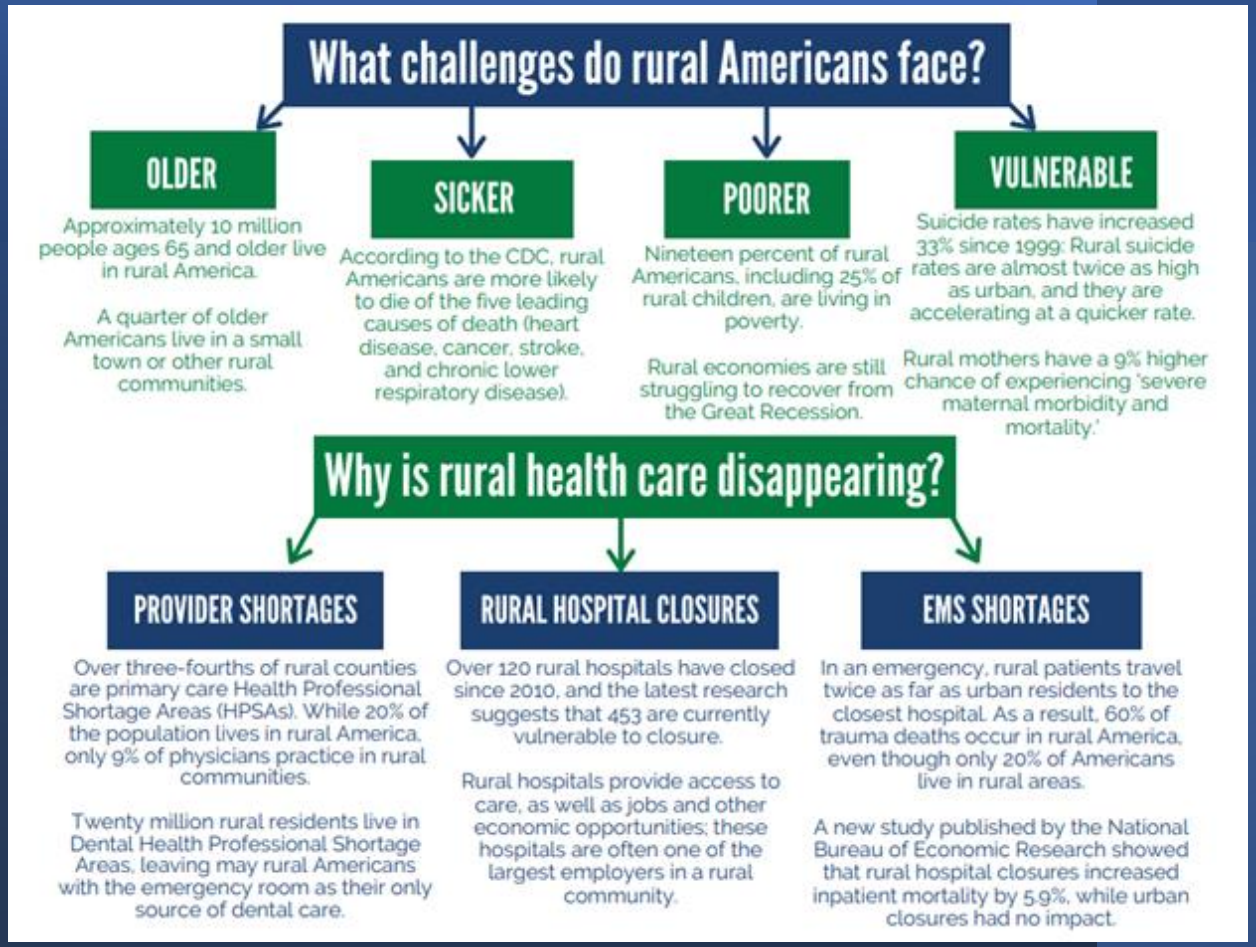

Metropolitan Counties
Non-Metropolitan Counties

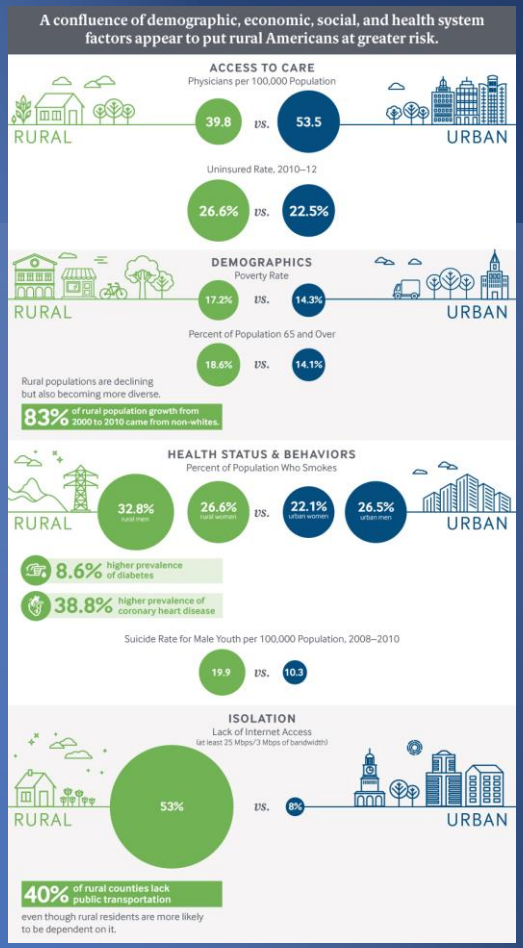
Urban-Rural Mortality

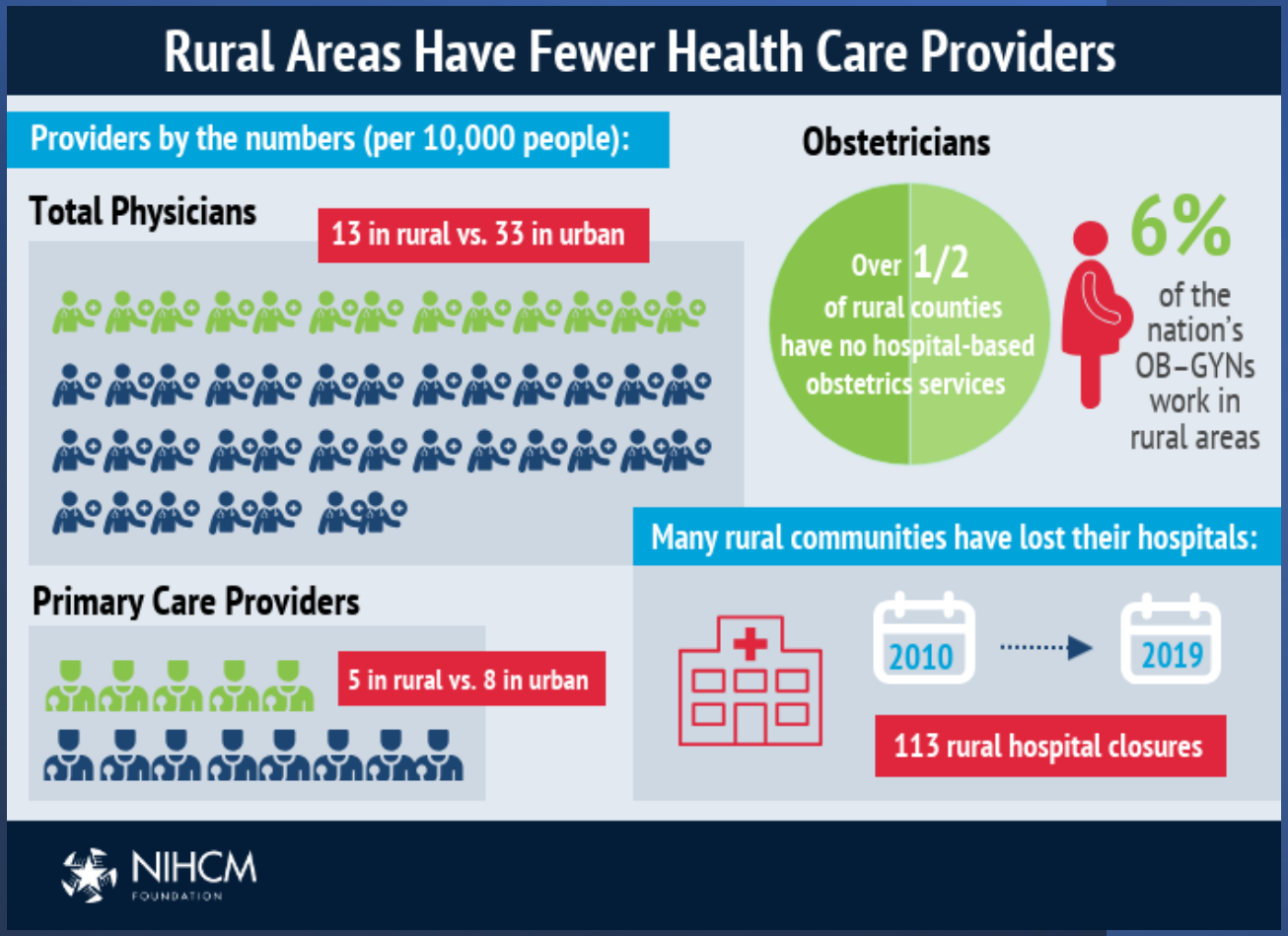
The mortality rate has been higher in rural areas compared to urban areas since at least 1999, but the gap widened after 2009.



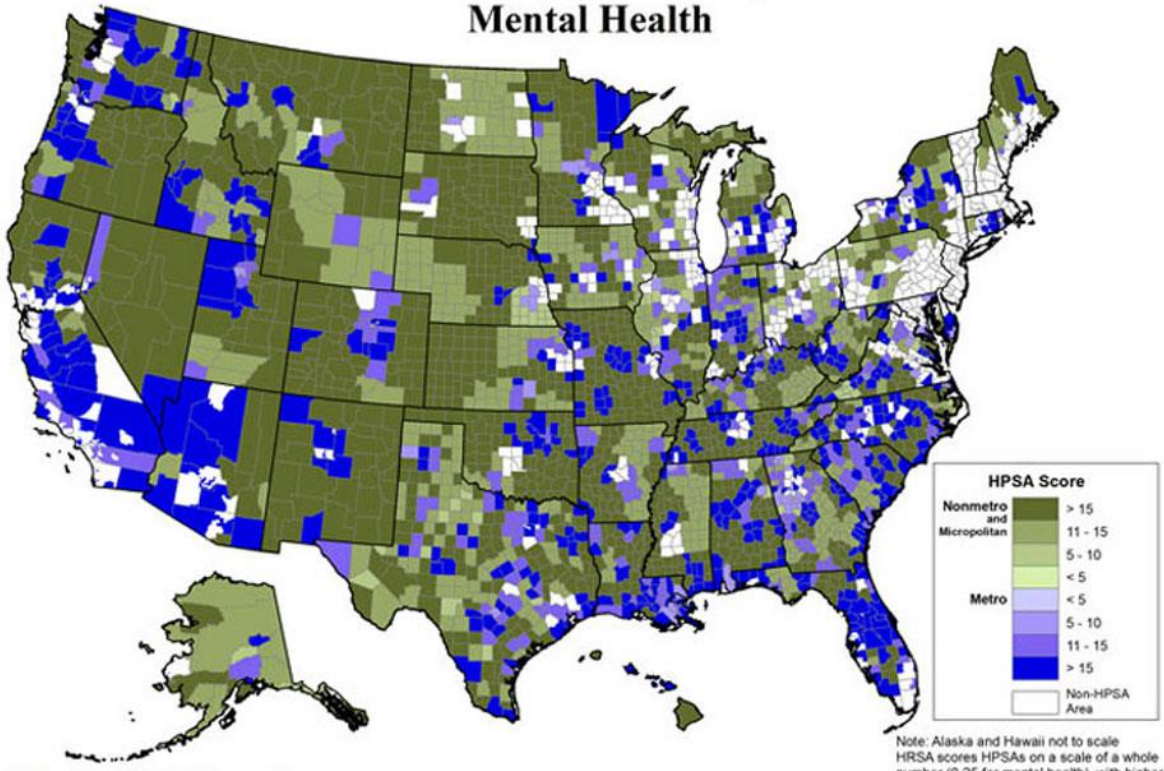
Source: U.S. Centers for Disease Control and Prevention


What challenges do rural Americans face?
OLDER
Approximately 10 million people ages 65 and older live in rural America.
A quarter of older Americans live in a small town or other rural communities.
SICKER
According to the CDC, rural Americans are more likely to die of the five leading causes of death (heart disease, cancer, stroke, and chronic lower respiratory disease).
POORER
Nineteen percent of rural Americans, including 25% of rural children, are living in poverty.
Rural economies are still struggling to recover from the Great Recession.
VULNERABLE
Suicide rates have increased 33% since 1999: Rural suicide rates are almost twice as high as urban, and they are accelerating at a quicker rate.
Rural mothers have a 9% higher chance of experiencing 'severe maternal morbidity and mortality.'
Why is rural health care disappearing?
PROVIDER SHORTAGES
Over three-fourths of rural counties are primary care Health Professional Shortage Areas (HPSAs). While 20% of the population lives in rural America, only 9% of physicians practice in rural communities.
Twenty million rural residents live in Dental Health Professional Shortage Areas, leaving may rural Americans with the emergency room as their only source of dental care.
RURAL HOSPITAL CLOSURES
Over 120 rural hospitals have closed since 2010, and the latest research suggests that 453 are currently vulnerable to closure.
Rural hospitals provide access to care, as well as jobs and other economic opportunities; these hospitals are often one of the largest employers in a rural community.
EMS SHORTAGES
In an emergency, rural patients travel twice as far as urban residents to the closest hospital. As a result, 60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas.
A new study published by the National Bureau of Economic Research showed that rural hospital closures increased inpatient mortality by 5.9%, while urban closures had no impact.


A confluence of demographic, economic, social, and health system factors appear to put rural Americans at greater risk.
ACCESS TO CARE
Physicians per 100,000 Population
RURAL
39.8
vs.
53.5
URBAN
Uninsured Rate, 2010–12
26.6%
vs.
22.5%
DEMOGRAPHICS
Poverty Rate
RURAL
17.2%
vs.
14.3%
URBAN
Percent of Population 65 and Over
18.6%
vs.
14.1%
Rural populations are declining but also becoming more diverse.
83% of rural population growth from 2000 to 2010 came from non-whites.
HEALTH STATUS & BEHAVIORS
Percent of Population Who Smokes
RURAL
32.8%
rural men
26.6%
rural women
vs.
22.1%
urban women
26.5%
urban men
URBAN
8.6% higher prevalence of diabetes
38.8% higher prevalence of coronary heart disease
Suicide Rate for Male Youth per 100,000 Population, 2008–2010
19.9
vs.
10.3
ISOLATION
Lack of Internet Access
(at least 25 Mbps/3 Mbps of bandwidth)
RURAL
53%
vs.
8%
URBAN
40% of rural counties lack public transportation
even though rural residents are more likely to be dependent on it.


Rural Areas Have Fewer Health Care Providers
Providers by the numbers (per 10,000 people):
Total Physicians
13 in rural vs. 33 in urban
Primary Care Providers
5 in rural vs. 8 in urban
Obstetricians
Over 1/2 of rural counties have no hospital-based obstetrics services
6% of the nation's OB-GYNs work in rural areas
Many rural communities have lost their hospitals:
2010
2019
113 rural hospital closures
NIHCM FOUNDATION

Health Professional Shortage Areas
Mental Health

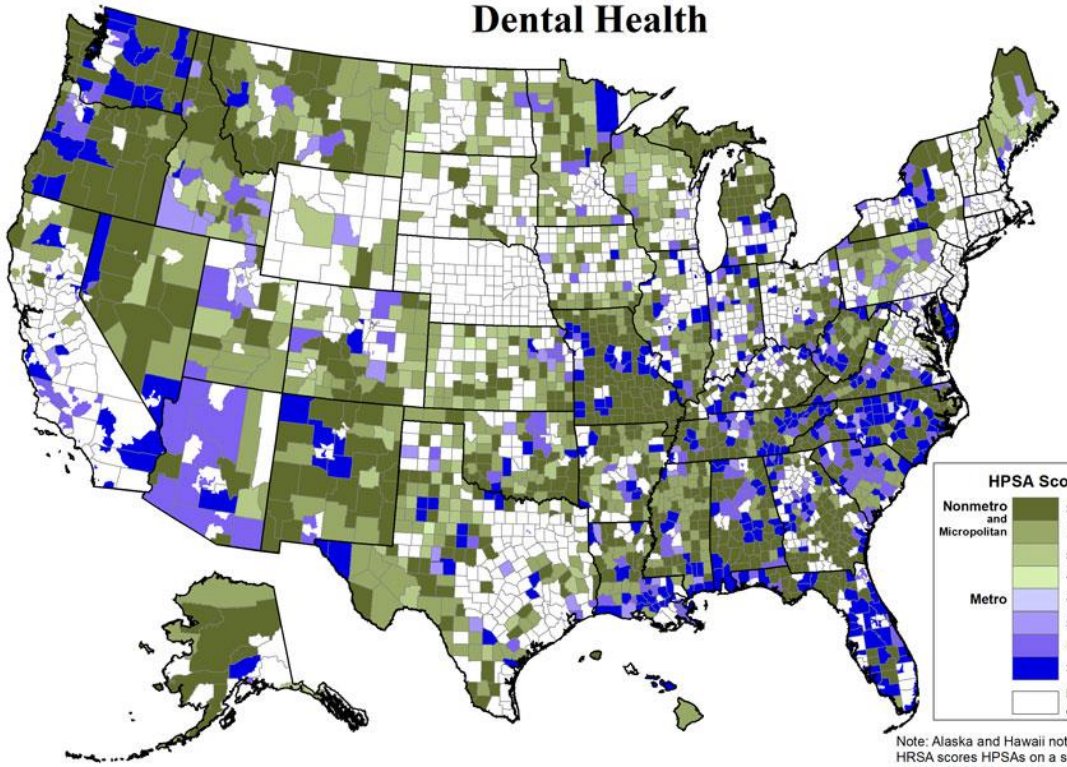


Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-25 for mental health), with higher scores indicating greater need

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, July 2021

RHIhub
Rural Health Information Hub

Health Professional Shortage Areas
Dental Health

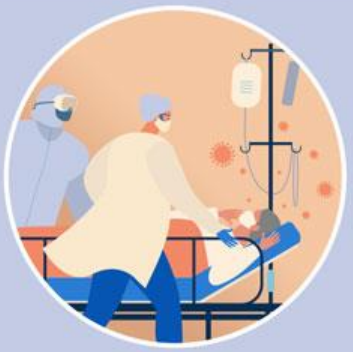


Note: Alaska and Hawaii not to scale
HRSA scores HPSAs on a scale of a whole number (0-26 for dental health), with higher scores indicating greater need

Source(s): data.HRSA.gov, U.S. Department of Health and Human Services, July 2021

RHIhub
Rural Health Information Hub

Underlying Medical Conditions and Severe Illness Among Adults Hospitalized With COVID-19



Of **540,667** adults hospitalized with COVID-19, **nearly 95%** had at least **1 underlying medical condition**.

Hypertension and **lipid metabolism disorders** were the most common underlying medical conditions.

Obesity, diabetes with complications, and **anxiety disorders** were the **strongest risk factors for death** among adults hospitalized with COVID-19.

Original research published in Kompaniyets et al. PCD, July 2021. bit.ly/PCD0123VA

PCD
PREVENTING CHRONIC DISEASE

THE DANGERS OF INFLUENZA (FLU) AND COVID-19 IN ADULTS WITH CHRONIC HEALTH CONDITIONS

93% of adults
hospitalized for flu during the 2019-2020 season had at least one reported underlying medical condition

US adults with chronic health conditions are at high risk for COVID-19 and flu-related complications:

- Exacerbation of chronic health conditions
- Permanent physical decline
- Risk of heart attack or stroke
- Death

34+ million adults
have diabetes and are **3x** more likely to be hospitalized from COVID-19 and die from flu-related complications

30+ million adults
have heart disease and are at **6x** increased risk of heart attack within **7 days** of flu infection

Adults with hypertension
are **3x** more likely to be hospitalized for COVID-19

39+ million adults
have asthma and/or COPD, putting them at greater risk of serious flu-related complications

Adults with asthma
are **1.5X** more likely to be hospitalized for COVID-19

Annual flu vaccination is the best way to protect yourself from flu and serious long-term complications
In the US, there are currently no approved vaccines for COVID-19

NO SHORTAGE OF IDEAS ABOUT IMPROVING RURAL HEALTH CARE INFRASTRUCTURE

BIPARTISAN POLICY CENTER
https://bipartisanpolicy.org/rural-health-task-force/

AMERICAN HOSPITAL ASSOCIATION
https://www.aha.org/system/files/media/file/2021/05/fact-sheet-rural-infrastructure-0521.pdf

RURAL HEALTH INFORMATION HUB
https://www.ruralhealthinfo.org/topics/mental-health/project-examples

Just a few examples and the list goes on……

And improving all aspects of rural health care infrastructure is essential to Improving the quality and quantity of life in rural America.

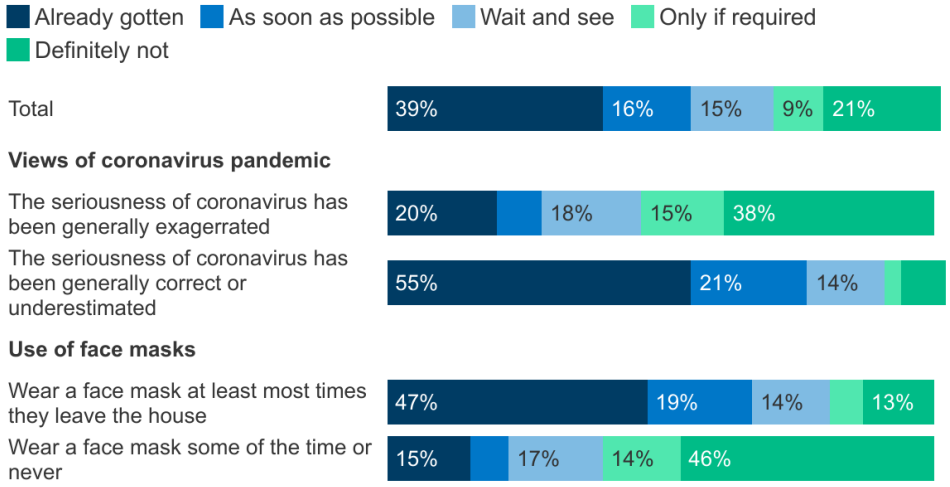
But What the Pandemic
has really taught us about
Rural Health Care is

The long-term consequences of
failing infrastructure is a real and serious
trust gap between many rural patients
and the traditional health care
delivery system

Figure 12

Rural Adults Who Think The Seriousness Of Coronavirus Has Been Exaggerated, Don't Regularly Wear Masks Are More Likely To Say They Definitely Won't Get Vaccinated

Have you personally received at least one dose of the COVID-19 vaccine, or not? When an FDA authorized vaccine for COVID-19 is available to you for free, do you think you will…?



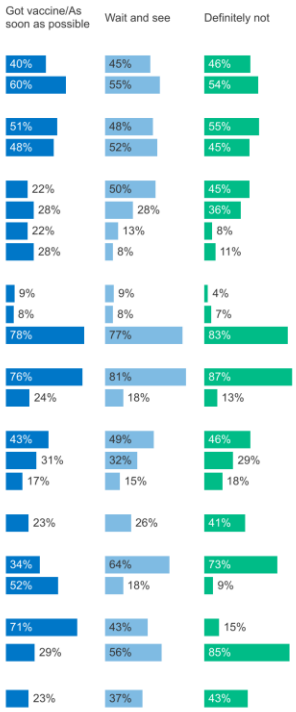
NOTE: Among adults living in rural areas. See topline for full question wording.
SOURCE: KFF COVID-19 Vaccine Monitor: Rural America (March 15-29, 2021)

KFF COVID-19 Vaccine Monitor

Figure 4

Larger Shares Of Rural Adults Who Are "Definitely Not" Going To Get A COVID-19 Vaccine Identify As White Evangelicals And Republicans, Most Also Say They Don't Normally Get Flu Vaccine

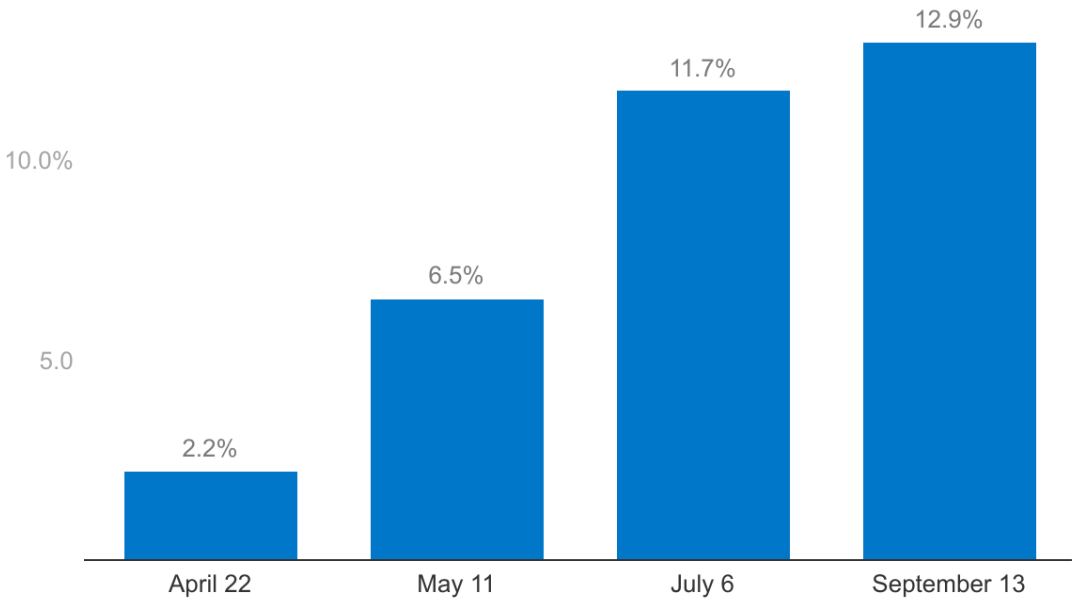
Demographic analysis within each vaccine intention group:



NOTE: Among adults living in rural areas. Party identification includes independents who lean partisan. See topline for full question wording.
SOURCE: KFF COVID-19 Vaccine Monitor: Rural America (March 15-29, 2021)

KFF COVID-19 Vaccine Monitor

The Gap in Vaccination Rates Between Counties that Voted for Biden and Counties that Voted for Trump, April – September 2021

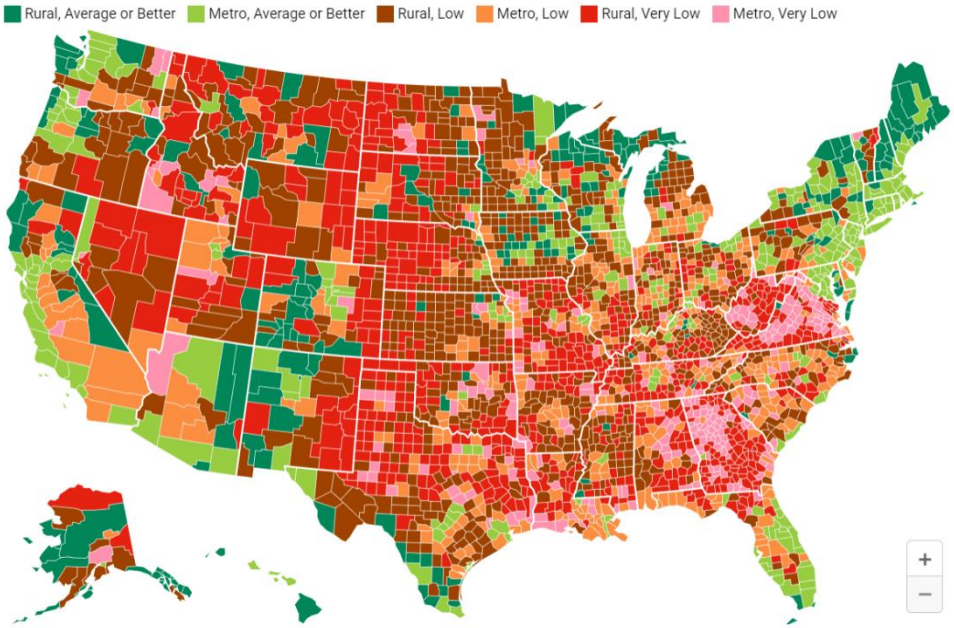


NOTE: Values show percentage-point differences between counties. Data are share fully vaccinated.
SOURCE: KFF analysis of CDC's COVID-19 Integrated County data.

KFF

Rural/Urban Vaccination Rates Compared to National Adjusted Rate as of September 9

County completed vaccination rates as of September 9 compared to the national rate (adjusted*) of 49.7% of the population. **Average or Better** is equal to or greater than the national adjusted average of 49.7%. **Low** is up to 30% below national adjusted average. **Very Low** is more than 30% below the national adjusted average.



**Approximately 11 million completed vaccinations have not been assigned to specific counties as of September 9, 2021, and therefore are not part of this county-level analysis. The national adjusted rate used as a reference for this map excludes these vaccinations. The adjusted rate also excludes population from counties for which there is no data. The adjusted national rate for completed vaccinations used as a reference for this map for September 9 is 49.7% of total U.S. population. The actual national rate of completed vaccinations is 53.1%. Vaccination data for Hawaii, Massachusetts, and Texas are from those states' departments of health.*

Map: Daily Yonder/Murphy-Marema • Source: Centers for Disease Control and Prevention and selected state departments of health • Get the data • Created with Datawrapper

WHAT HAS CHANGED?

LOSS OF A TRADITIONAL RELATIONSHIP WITH A FAMILY DOCTOR

RETRACTION OF “TRADITIONAL COMMUNITY”

EXPANSION OF “DIGITAL COMMUNITY”

POLARIZATION OF AMERICA AND THE GROWTH OF DISTRUST AND DIVISION

GROWING DISTRUST OF EXPERTISE

SOLUTION: TO DELIVER QUALITY RURAL HEALTH CARE,
WE NEED TO NOT ONLY IMPROVE INFRASTRUCTURE BUT PROVIDERS NEED TO BE SKILLED AND TRAINED IN COMMUNICATION AND PUBLIC RELATIONS:

1. ESTABLISH OR RE-ESTABLISH ROBUST PUBLIC HEALTH CARE SYSTEM INFRASTRUCTURE IN RURAL AMERICA
2. FIND THE RIGHT ALLIES AND UNIQUE MESSENGERS
3. LEARN HOW TO DIALOGUE TO AVOID DEFENSIVE REACTIONS
4. AGGRESSIVELY AND STRATEGICALLY RESPOND TO FALSE AND MISLEADING INFORMATION REGARDLESS OF THE SOURCE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ORGANIZATION


Thank you!

Reminders

- Use the activity code **98FLED** to receive your CME certificate.
  - You will have access to the activity code for 24-hours.
  - If you do not download your CME certificate via the activity code within the allotted time, please email EOCCOmetrics@modahealth.com to receive your certificate.
- EOCCO staff will email a post-event evaluation to all attendees.
- If you have any questions or concerns after the event, please contact us at EOCCOmetrics@modahealth.com.

98FLED

is the Activity Code

Thursday, September 16, 2021 | 9:00 AM - 1:00 PM
EOCCO Annual Summit

Sign-In to Get Attendance

Go to www.eeds.com > Click the 'Sign-In' Button > Enter the Code

- OR -

Scan this QR Code

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