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EASTERN OREGON
COORDINATED CARE
ORGANIZATION
10th Annual EOCCO Summit

Announcements

Follow the below steps to claim your continuing medical education (CME) credits:

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Note: The activity code will expire on Thursday, September 22, 2022 at 9 am

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PowerPoint Slides

Where can I find the PowerPoint slides for today's event?

- Scan the below QR code or visit https://www.eocco.com/news/Current/2022-EOCCO-Clinician-and-Staff-Summit.

Draft PowerPoint slides are uploaded to eocco.com and may not match the content presented today. The final version of the slides will be posted after the event.

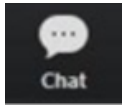
Will today's presentations be recorded?

- Yes. The presentations will be recorded and posted to https://www.eocco.com/news/Current/2022-EOCCO-Clinician-and-Staff-Summit after the event.

In-person Attendees:

- Refer to the FAQ document located in the folder you received at check-in for common questions and concerns.
  - Direct questions or concerns not addressed in the FAQ document to the EOCCO staff members wearing a blue shirt.

Virtual Attendees:

- Direct questions or comments for EOCCO staff or your peers to the chat: 

- Direct questions for the speakers to the Q&A: 

- Contact EOCCOmetrics@modahealth.com for questions or concerns after the event.

Door Prizes!

In-Person Attendees

Attendees joining us in person will be entered into a drawing for a **gift basket**.

- BBQ sauce from Bellinger Produce, savory jam & almonds from The Cheese Fairy, coffee from the Buckin' Bean, and more!

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Welcome & Introductions

Dr. Chuck Hofmann

Tribal Blessing


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CEO Update

Sean Jessup, CEO

Disclosure Statement

- No disclosures

Learning Objectives

- Explain significant EOCCO updates from the first 10 years operating in Eastern Oregon.
- Summarize how the delivery system and community involvement has changed to benefit EOCCO members.


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Incentive Measure Update 2021 – 2022

Kali N. Paine, MPH

Disclosure Statement

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

Learning Objectives

After this session, attendees should be able to:

1. Summarize EOCCO's 2021 quality measure performance
2. Identify one success and one challenge that EOCCO experienced in 2021 related to quality measures
3. Summarize EOCCO's current 2022 quality initiatives

Agenda

- Overview of Statewide CCO Quality Program
- 2021 Incentive Measure Performance
- 2022 Incentive Measure Initiatives
- What's Next for Quality

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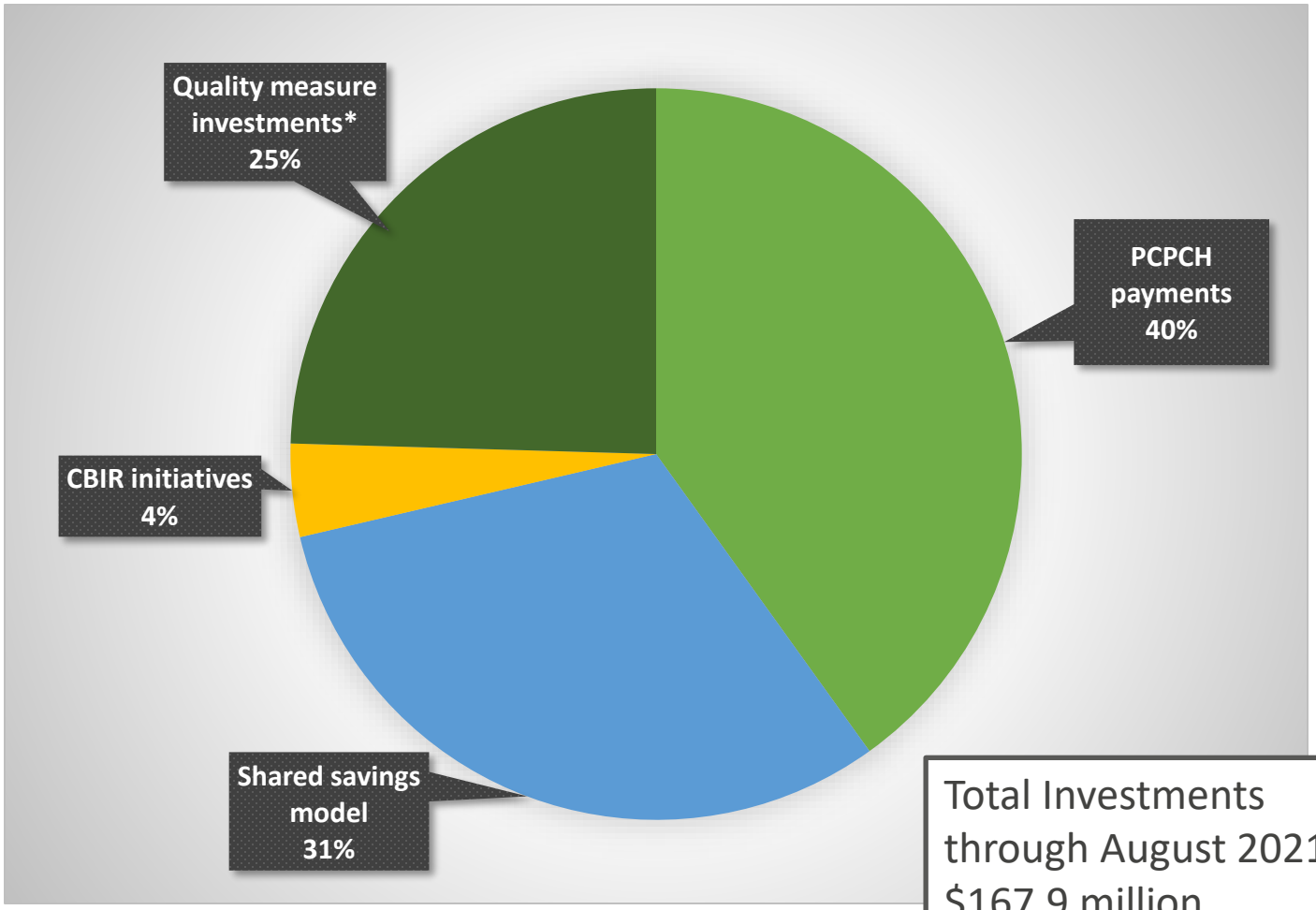
Overview of Statewide CCO Quality Program

Incentive Measure Program Background

- OHA Committee selects measures and targets each year to show how well CCOs:
  - Improve care
  - Make quality care accessible
  - Eliminate health disparities
  - Curb the cost of health care
- CCOs are awarded quality funds based on performance
- EOCCO uses their awarded funds for:
  - Primary care clinic quality bonus payments
  - Enhanced PCPCH payments
  - Dental Care Organization support
  - Community Mental Health Program (CMHP) incentive payments
  - Community Benefit Initiative Reinvestment (CBIR) grants

EOCCO Community Investments



Total Investments through August 2021: $167.9 million

*PCP Quality Bonus Payments, LCHP funding, dental and behavioral health quality bonus payments, additional investments

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EOCCO 2021 Incentive Measure Performance

Final 2021 Performance

2019	2020	Incentive Measure	2021 Final Rate*	2021 Target	Performance
Y	N	Childhood Immunizations	**71.5%**	68.9%	●
N	Y	EDMI	**95.4**	111.2	●
Y	Y	DHS	**91.3%**	87.0%	●
-	N	Immunizations for Adolescents	**39.7%**	29.0%	●
-	N	IET: Initiation	**37.3%**	37.3%	●
-	Y	IET: Engagement	**13.4%**	9.9%	
N	N	Oral Eval for Adults with Diabetes	**22.0%**	17.3%	●
-	N	Preventive Dental Services: 1-5	**45.9%**	33.7%	●
-	N	Preventive Dental Services: 6-14	**58.5%**	43.1%	
-	N	Well Child Visits	**64.2%**	54.6%	●
Y	Y	Postpartum Care	**70.4%**	61.3%	●
-	Y	Language Access	**Met Attestation Requirements**	Report Only/Attestation	●
Y	Y	Depression Screening	**58.1%**	Report Only	●
Y	N	Diabetes HbA1c Poor Control	**31.9%**	33.3%	●
Y	Y	Cigarette Smoking Prevalence	**21.0%**	26.6%	●
-	Y	SBIRT Rate 1	**58.8%**	Report Only	●
-	Y	SBIRT Rate 2	**27.0%**	Report Only	
					14/14
		*Final performance from OHA using data from 1/1/21-12/31/21 with claims runout through 3/31/22			**Must meet: 12/14 = 100%**

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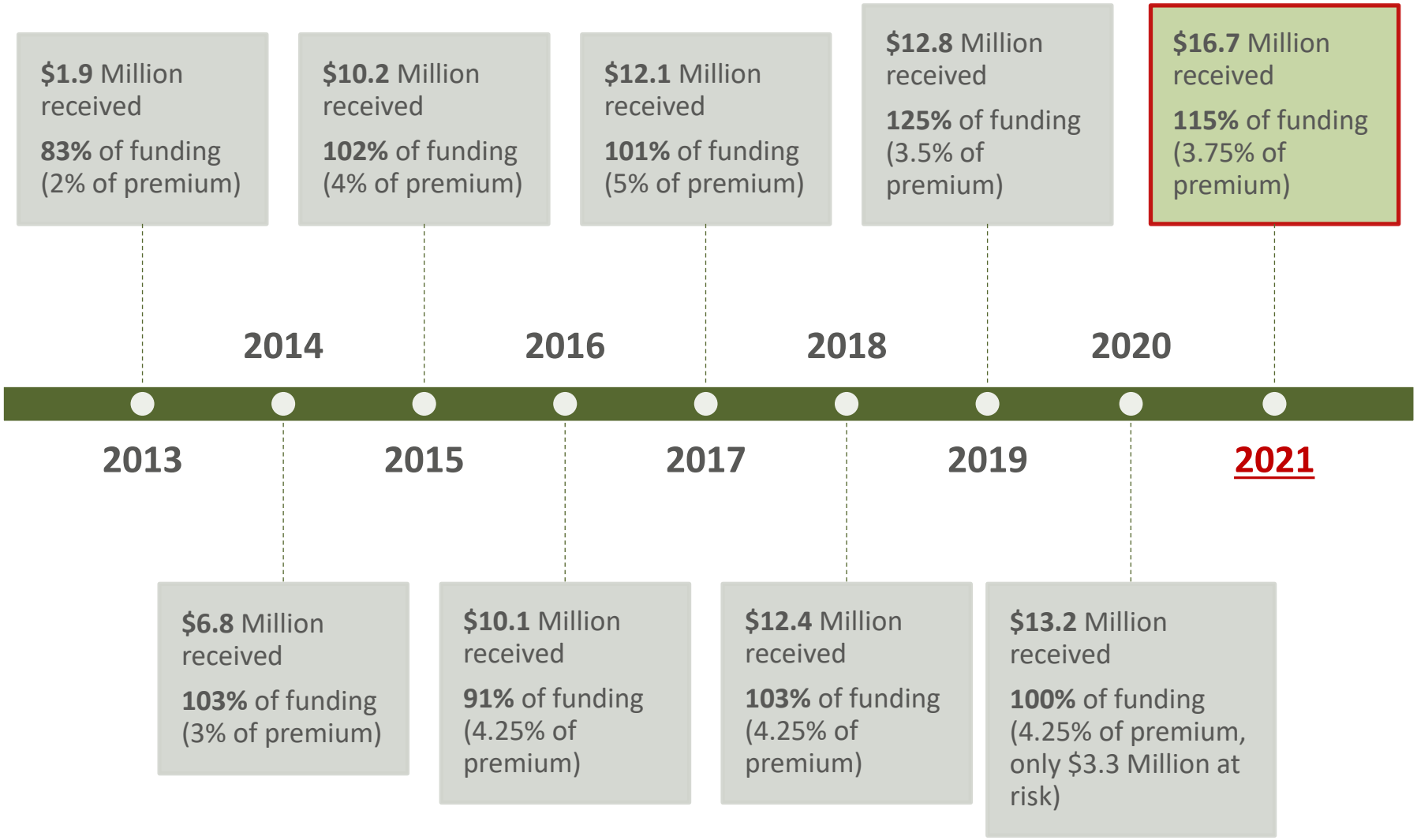
Final 2021 Performance

Emergency Outcome Tracking COVID-19 Vaccine Metric:

2019	2020	Incentive Measure	2021 Final Rate*	2021 Target	Change from 04/2021 Baseline	Performance
-	-	**Emergency Outcome Tracking Measures - COVID-19 Vaccine**				
-	-	Members 16+ (90% weight)	**40.8%**	47.7%	+25.9%	
-	-	Members 12-15 (10% weight)	**29.7%**	42.0%	+29.6%	
						0/2

2013-2021 Quality Measure Funding



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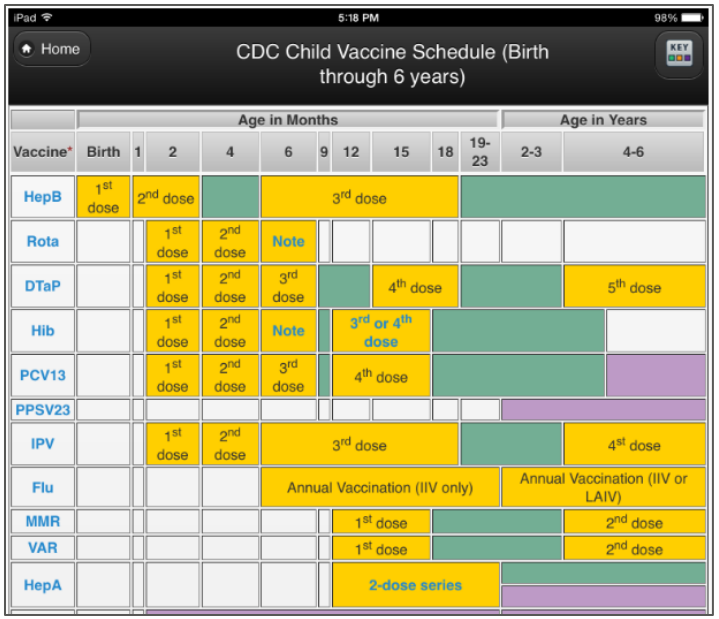
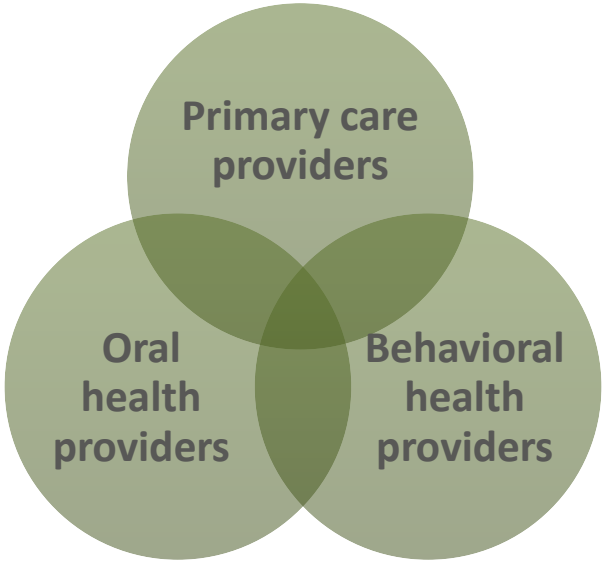
2021 Measure Challenges

- Outreach and follow-up for *Initiation & Engagement of Substance Use Disorder Treatment (IET)* measure
- Post-quarantine immunization catch-up
- Language Access interpreter tracking and reporting
  - Only received information on 24.8% of 2021 encounters



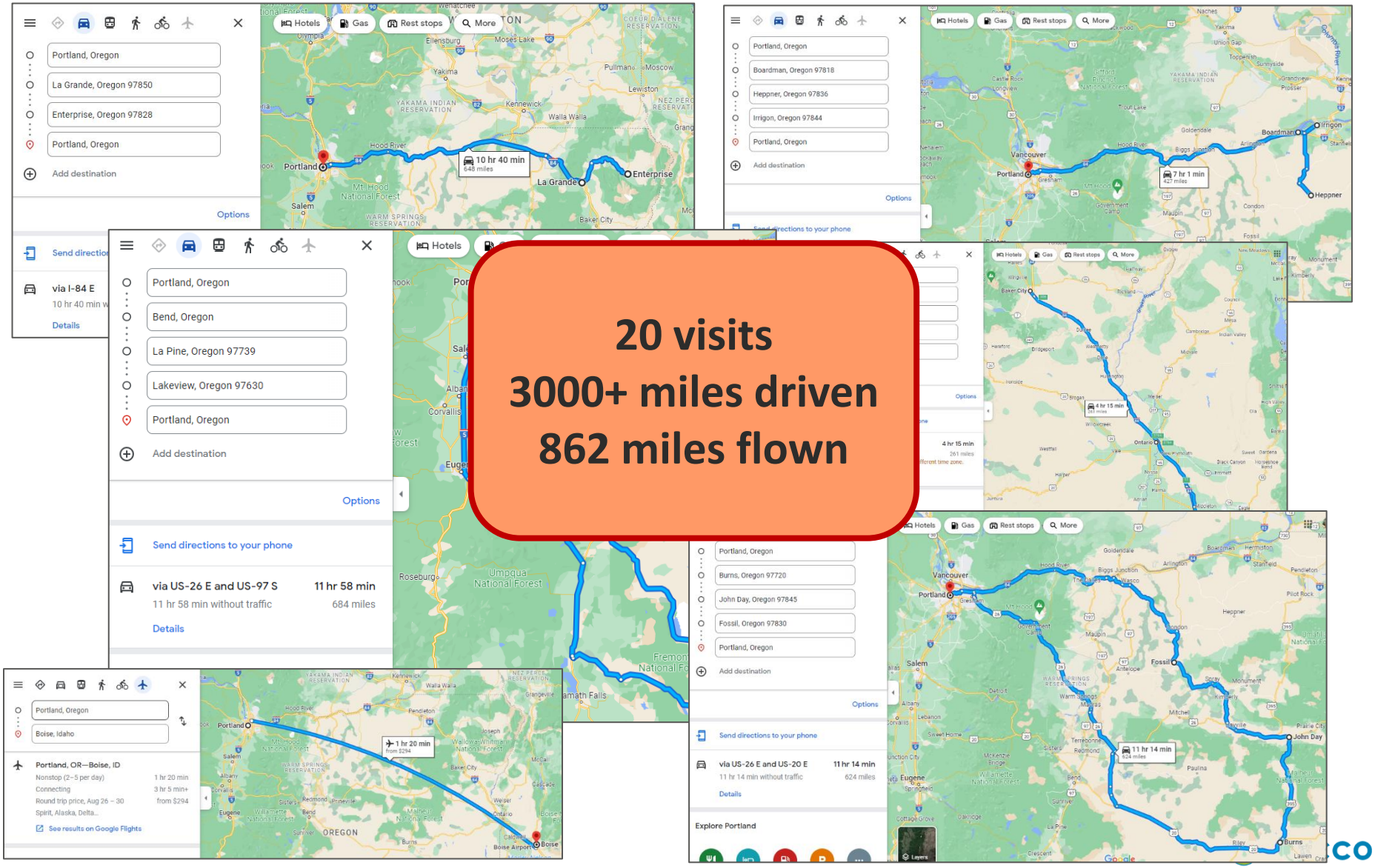
2021 Measure Successes

- Well-Child Visit incentive program
- Incorporating Washington State immunization data into ALERT
- Improved partnerships with behavioral and oral health providers



2022 Incentive Measure Initiatives

Clinic Visits & Travel



Immunization Initiatives

- CCO & State: Continued partnership with WA IIS and Local Public Health Authorities to gather out-of-state immunization records

- CCO: Childhood Immunization incentive program launched in August
  - $50 Amazon gift card
- Members: Phone outreach to parents of members due for vaccines

Well-Child Visit Initiatives

- CCO: Incentive program continued with refined age range (3-6 years) and increased to $50
- Clinics: Well-visit data scrubbing and patient recall pilot project

- Members: Phone outreach to parents of members due for visits

IET Education & Outreach

- CCO: Update weekly outreach reports to more accurately capture new individuals entering measure

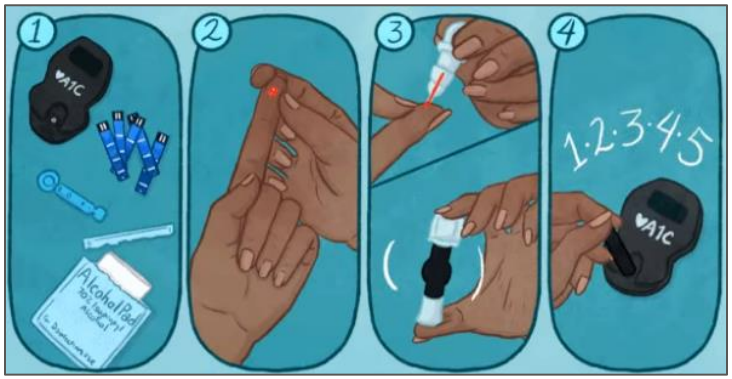
- Clinics: IET Learning Collaborative
  - Education on measure definition, notification process, and outreach recommendations

- CCO & Community: GOBHI Youth SUD Workgroup
  - Behavioral health-focused group aiming to reduce barriers to access for adolescent SUD services
  - Community events and resources

Diabetes Management

- CCO, Clinics, & Members: Livongo Diabetes Self Management (DSM) program
  - Provides health coaching, blood glucose meter, & unlimited test strips and refills
  - 10% of recruitable members enrolled
  - 63% of enrolled members actively participating

- Clinics & Members: HbA1c Direct Mail Kit Program available through CBIR grant



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Language Access Initiatives

- CCO: Hybrid Spanish Health Care Interpreter training offered this fall
- Clinics: Quality team now provides pre-filled claims documents for quarterly reporting
- Clinics & Members: New contract with Linguava for interpreter services

LINGUAVA

Health Equity Through Language Access

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2022 YTD Performance

2020	2021	Incentive Measure	2022 Current Rate*	2022 Target	Performance Prediction
N	Y	**Childhood Immunizations (Combo-2)**	**63.4%**	66.3%	●
Y	Y	**DHS**	**18.6%**	90.0%	●
N	Y	**Immunizations for Adolescents**	**34.1%**	36.9%	●
N	Y	**IET: Initiation**	**36.9%**	43.0%**	●
Y	Y	**IET: Engagement**	**14.9%**	13.9%**	●
N	Y	**Oral Eval for Adults with Diabetes**	**9.9%**	20.4%	●
N	Y	**Preventive Dental Services: 1-5**	**23.7%**	43.1%	●
N	Y	**Preventive Dental Services: 6-14**	**42.3%**	52.0%	●
N	Y	**Well Child Visits**	**24.0%**	64.0%	●
Y	Y	**Postpartum Care**	**Chart Review**	71.5%	●
Y	Y	**Language Access**	**Reporting**	56 points/ hybrid report	●
-	-	**Social Emotional Health**	**Reporting**	Report Only	●
Y	Y	**Depression Screening**	**Clinical Data**	58.8%	●
N	Y	**Diabetes HbA1c Poor Control**	**Clinical Data**	31.5%	●
Y	Y	**Cigarette Smoking Prevalence**	**Clinical Data**	25.0%	●
Y	Y	**SBIRT - Rate 1**	**Clinical Data**	59.7%	●
Y	Y	**SBIRT - Rate 2**	**Clinical Data**	29.7%	●
		*Data from 1/1/22 - 6/30/22			

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What’s Next for Quality

2023 Incentive Measures

Claims Based Measures

1. Child Immunization Status Combo 2
2. Health Assessments for Children in DHS custody
3. Immunizations for Adolescents^^
4. Initiation and Engagement in Drug and Alcohol Treatment
5. Oral Evaluation for Adults with Diabetes
6. Preventive Dental Visits Ages 1-14^^
7. Well-child Visits Ages 3-6^^

Chart Review Measure

8. Timeliness of Postpartum Care^^
9. Meaningful Language Access to Culturally Responsive Health Care Services
10. Health Aspects of Kindergarten Readiness: CCO System-Level Social-Emotion Health
11. Social Determinants of Health: Social Needs Screening & Referral

Clinical Quality Measures

12. Depression Screening and follow-up
13. Diabetes HbA1c Poor Control
14. Cigarette Smoking Prevalence
15. SBIRT

Quality measure in blue is new for 2023

^^Challenge Pool measures

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QUESTIONS?
eoccometrics@modahealth.com


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Connect Oregon

Kathryn Hart
Traditional Health Worker Liaison, EOCCO

Kaleema Murphey
Customer Success Manager, Unite Us

Unite Us Overview

- EOCCO has implemented Unite Us, a Community Information Exchange (CIE) platform
  - A CIE connects health care, human and social services partners to improve the health and well-being of communities and address health disparities and health equity*
- Unite Us uses the Connect Oregon network, a statewide network of healthcare and social service providers
- Eastern Oregon implemented Unite Us in two waves
  - *Wave 1 (4/12)*: Baker, Gilliam, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
  - *Wave 2 (7/19)*: Harney, Grant, Lake, Malheur

**Definition developed by Oregon Health Leadership Council*

Importance to EOCCO

- EOCCO has been working with Unite Us and local organizations over the past two years to assess the need for a Community Information Exchange platform and implement the Connect Oregon Network
  - Unite Us was selected, in part, because it supports current workflows and integrates into existing referral pathways
- EOCCO recognizes the importance of investing in resources to address social needs and increase partnerships with SDoH-E partners
- Eastern Oregon has increased access access to social services across the entire state via Unite Us


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Supporting Health for All through REinvestment (SHARE) Update

Summer Prantl Nudelman

Disclosure statement

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

Learning objective

- Understand the policies of the Oregon Health Authority's SHARE program.

Agenda

- SHARE Initiative background and program requirements
- 2020 SHARE Initiative results
- Looking ahead, 2021 & 2022 SHARE Initiative preview
- Q&A

Share Initiative background and program requirements

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

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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

2020 Share Initiative Results

EOCCO SHARE Designation- CY 2020

In February 2021, the board approved:

- Allocation of $310,000
- Utilize the grant subcommittee to align the SHARE initiative with the annual grant program

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

SHARE Decisions

Review Process:

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

Subcommittee actions

Scope of work of the subcommittee:

- Defined the spending priority, housing
- Timeline created to meet requirements
- Created the RFA and review process to meet OHA requirements
- Reviewed submitted RFAs
- Approval through the Grant Subcommittee
- Executed tentative contracts with SDOH-E partners
- Created and submitted a detailed spending plan to OHA

Grant subcommittee selected projects

- Eastern Oregon Center for Independent Living
- Northeast Oregon Housing Authority
- Mid-Columbia Community Action Council
- Northeast Oregon Network/Housing Matters of Union County
- Martha's House

Looking ahead, 2021 & 2022
SHARE Initiative preview

2021 SHARE Initiative

In February 2022, the board approved:

- Allocation of $1.5 million
- Request for applications went out in early July, applications were due August 31st
- Open to all domains, with a priority in housing
- Award notifications in December

2022 SHARE Initiative

The board will approve 2022 SHARE allocation in 1st quarter 2023.

Request for applications (RFA) will be aligned with the LCHP applications to ensure funding will continue to communities.

Open to all domains, with a priority in housing

Disclosure

- No disclosures

Program Development

- Assessed the need for quality, affordable housing.
- Availability of OHOP slots in the Ryan White Part B Program.
- Average wait time for OHOP slot in Ryan White Program minimum 1 year (except for incarcerated clients or homeless).
- Approached Oregon Health Authority in purchasing units for Ryan White clients.
- Development of proposal to Oregon Health Authority.

Program Overview

Cultivate Housing Program is a comprehensive, intensive trauma-informed approach to providing core treatment and sustainability of services to individuals living with HIV.

Cultivate Housing Program follows the End HIV Oregon initiative, in ending HIV infections through testing, prevention, and treatment.

Designed to assist individuals experiencing supports in behavioral health and addiction.

Cultivate Housing Program aims to increase low barrier supportive housing options for individuals living with HIV.

Program Goals

Goal 1: Supportive Housing clients will achieve and maintain viral suppression.

Goal 2: Supportive Housing clients will achieve and maintain engagement in HIV medical care.

Goal 3: Supportive Housing clients will establish long-term wellness through engagement in program services.

Goal 4: Self-Sufficiency.

Goal 5: Quality, Safe, Affordable Housing.

Goal 6: Flexible Voluntary Services.

Trauma Informed Care Approach

Supportive Housing Navigator

- Housing Navigator provides intensive housing case management.
- Provides all Ryan White Care Coordination Services under the Housing Program.
- Housing Navigator in Pendleton, Ontario, and The Dalles.
- Building relationships and agrements with landlords.
- Alleviate barriers by meeting the clients in their own homes.
- Supporting tenant compliance with lease terms

Behavioral Health Specialist

- Provides all formal behavioral health services to clients under the housing program.
- Assesses the client's behavioral health needs in close coordination with the client and the supportive housing navigator, supportive housing registered nurse.
- Forming and leading psychoeducation groups, support groups, process groups, substance use groups, or other therapeutic groups as demand arises (open to all clients through EOCIL).
- Individualized drug counseling, focusing on harm reduction, reducing or stopping drug use, and addressing related life areas impacted by substance abuse.

Supportive Housing Registered Nurse

Supportive Housing Registered Nurse (RN) provides medical case management services specified in the Ryan White Care Coordination Standards.

Supportive Housing RN may perform nursing services to clients in the home to reduce client barriers to accessing medical barriers.

Medication Management and adherence counseling, including psychiatric medication management and the importance of viral suppression.

Conducting regular health assessments.

Supportive Housing Referral Process

Referral Process (Cont.)

Clients who score 8+ on the VI-SPDAT are indicated as needing the high-level supports offered through the Supportive Housing Program.

If the Supportive Housing Program is not at enrollment capacity. In that case the client should be enrolled in the housing program moving off their assigned Care Coordinator and RN's caseloads with a warm hand-off.

If the Supportive Housing Program is at enrollment capacity, the client will be added to the RW part B service area housing waitlist with a supportive housing designation.

Supportive Housing Eligibility Requirements

HIV positive diagnosis verification must be obtained.

The client must sign the Consent for Services Form before the services commence.

Client is at or below 300% of the Federal Poverty Level (FPL) are eligible.

The client must reside in the EOCIL and Supportive Housing Program service region at the time of referral.

The client must have a housing acuity 3 or 4. The client must also have a mental health life area acuity 3 or 4 or an addiction life area acuity 3 or 4.

Successes

- Since January of 2021 we have enrolled 11 individuals in the Cultivate Housing Program (2 individuals on waitlist for 2022).
- January of 2022 we can additionally 10 more individuals for a total of 20 slots.
- 2 of the eleven enrolled were about to lose housing permanently.
- All enrolled individuals are following program guidelines.

QUESTIONS


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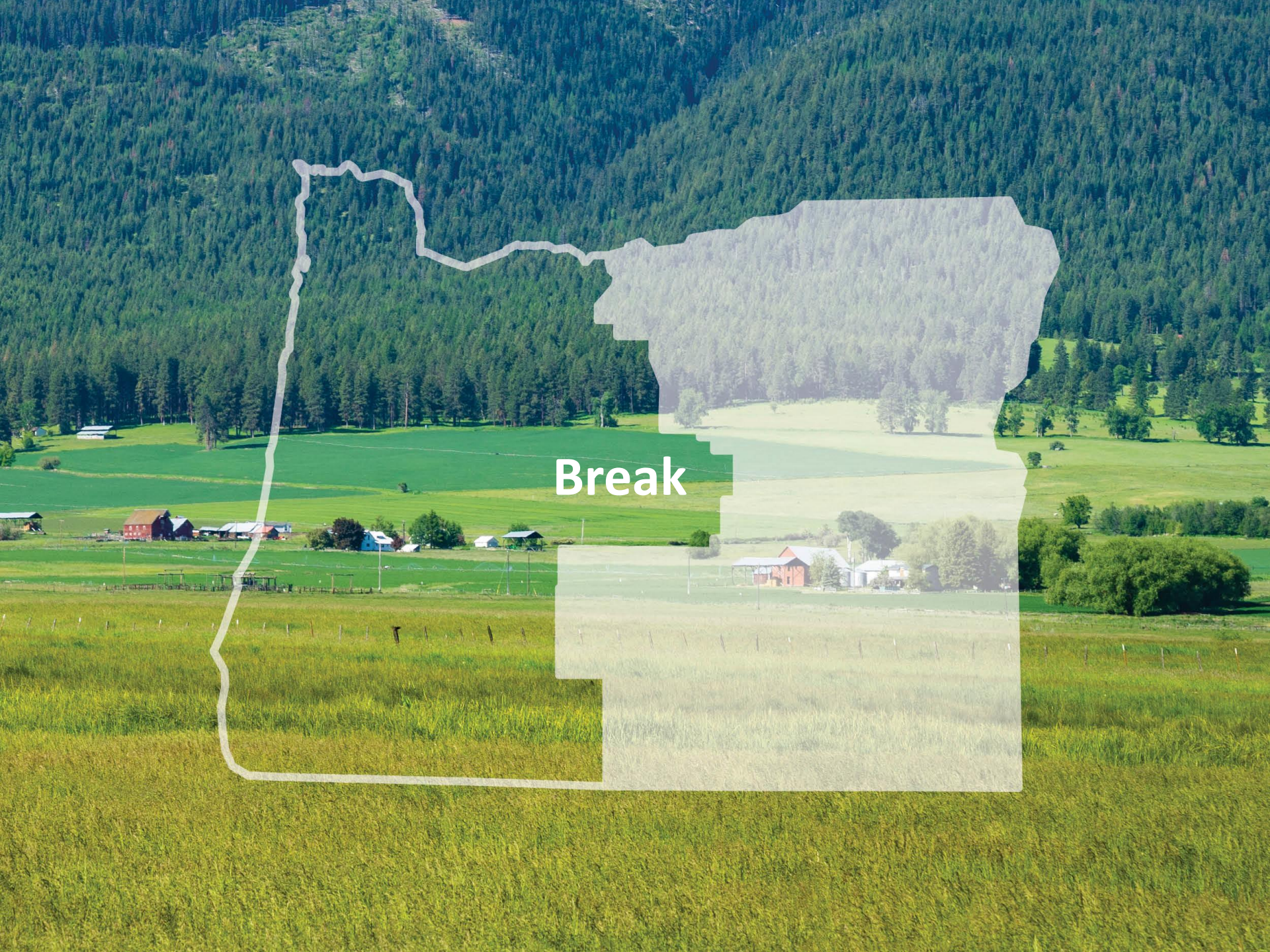
Break

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Bipartisan Policy Center

Making Prevention the Nation's Top Health Policy Priority

Anand Parekh, MD MPH
Chief Medical Advisor

Eastern Oregon Coordinated Care Organization Summit
September 21, 2022

Disclosures

No disclosures

Learning Objective

Apply presented strategies to encourage preventive screenings and interventions amongst your patients.

Bipartisan Policy Center

- Washington, DC-based think tank that actively fosters bipartisanship by combining the best ideas from both parties to promote health, security, and opportunity for all Americans.
- Founded in 2007 by 4 former Senate Majority Leaders: Howard Baker, Bob Dole, Tom Daschle, and George Mitchell
- 501(c3) organization that works with BPC Action (501(c4)) to advocate for bipartisan policy solutions

bipartisanpolicy.org

CCOs – Health Policy Innovation

- Geography matters
- Clinical-community linkages
- Prevention
- Integrated care
- Value-based care

BPC Recommendations: Impact of COVID-19 on the Rural Health Landscape

- Provide immediate stabilization for rural hospitals, rural health clinics (RHCs), and federally qualified health centers (FQHCs)
- Strengthen the Rural Emergency Hospital Model and advance other rural care delivery transformations
- Ensure an adequate rural health care workforce
- Secure access to virtual care in rural communities

BPC Recommendations: Digital Health (forthcoming)

- Ensure Equitable Access to Care
- Ensure Benefit Transparency and Consumer Protections for Telehealth Services
- Strengthen Fraud, Waste and Abuse Protections
- Incentivize Provider Participation in Value-based Care
- Improve Data Quality for Future Policymaking
- Specific recommendations related to
  - Primary Care
  - Specialty Care
  - Behavioral Health

BPC Recommendations: Tackling America's Mental Health and Addiction Crisis Through Primary Care Integration

- Transform Payment and Delivery to Advance Value-Based Integrated Care
  - Establish core behavioral health integration essentials
  - Build upon existing alternative payment platforms to drive large-volume integration
  - Drive integration at the practice level
  - Advance integration through certified Community Behavioral Health Clinics and FQHCs
  - Enforce and expand mental health and addiction parity laws
  - Require agency coordination
- Expand and Train the Integrated Workforce
  - Increase coverage of behavioral health providers in Medicare
  - Expand access to the currently available workforce
  - Improve training, recruitment, and retention
- Promote Technology and Telehealth to Support Integrated Care
  - Optimize health information technology for behavioral health integration
  - Expand telehealth access

End of COVID-19 Public Health Emergency Declaration

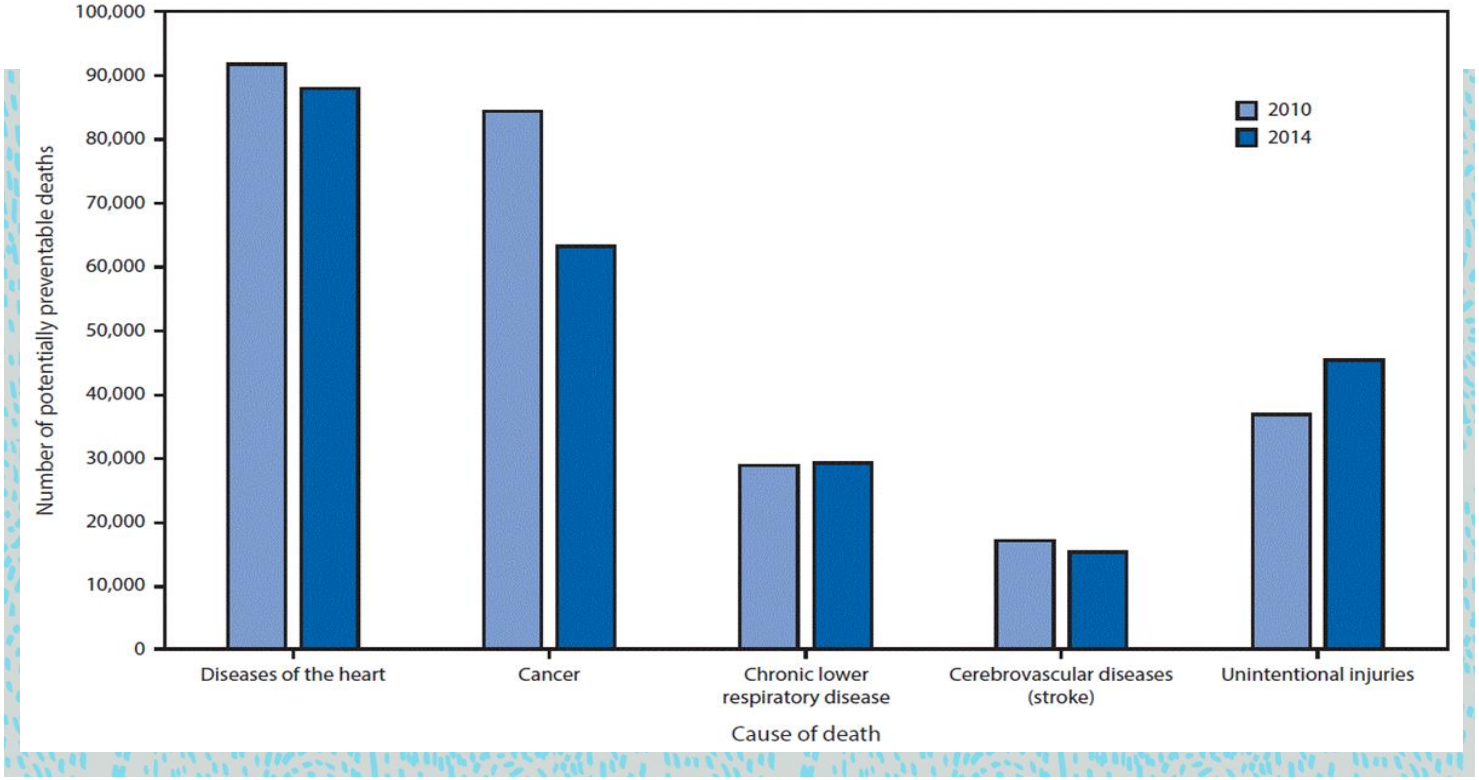
- Coverage, Costs, and Payment for COVID-19 Testing, Treatments, and Vaccines
- Medicaid Coverage and Federal Match Rates
- Telehealth
- Medicaid and CHIP Flexibilities
- Medicare Payment and Coverage Flexibilities
- Private Insurance Coverage Flexibilities
- Access to Medical Countermeasures Through FDA Emergency Use Authorization
- Liability Immunity to Administer Medical Countermeasures

Prevention-First System

Key Themes

- Prevention should be the nation's top health policy priority
- Prevention requires shared responsibility; elected officials and policymakers play a critical role
- Urgency given nation's current health trends
- Federal leadership can catalyze state and local efforts

Potentially Preventable Deaths in US



250,000 potentially preventable deaths annually

CDC/MMWR, 2016, https://www.cdc.gov/mmwr/volumes/65/wr/mm6545a1.htm

Stagnant U.S. Life Expectancy

Key Preventable Factors

- Opioid epidemic & “diseases of despair”
- Obesity crisis
- Plateauing in the decline of mortality rates from cardiovascular disease
- COVID-19 pandemic

Disparities exist by

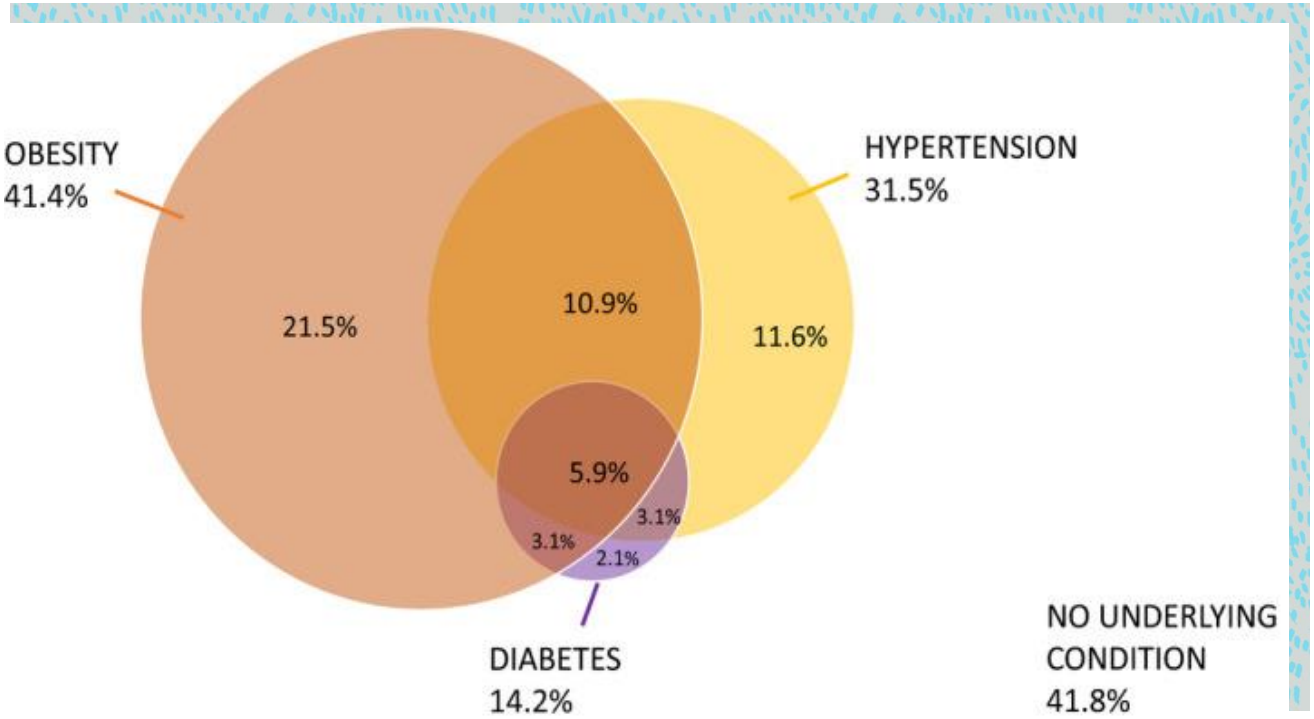
- Income
  - Comparing the richest 1% of Americans versus the poorest 1%
    - 14-year life expectancy difference amongst men
    - 10-year life expectancy difference amongst women
- Race (e.g., infant mortality)
- Geography

Table 1. Life expectancy at birth, by sex: United States, 2010–2018

Year	Total	Male	Female
2010	78.7	76.2	81.0
2011	78.7	76.3	81.1
2012	78.8	76.4	81.2
2013	78.8	76.4	81.2
2014	78.9	76.5	81.3
2015	78.7	76.3	81.1
2016	78.7	76.2	81.1
2017	78.6	76.1	81.1
2018	78.7	76.2	81.2
2019	78.8	76.3	81.4
2020	77.0	74.2	79.9

SOURCE: NCHS, National Vital Statistics System, Mortality.

COVID-19 Hospitalizations Attributable to Preventable Conditions in the U.S.



Prevalence of cardiometabolic conditions in the U.S. adult population

bipartisanpolicy.org

- Nearly 2/3 of COVID-19 hospitalizations attributable to 4 major US cardiometabolic conditions:
  - Obesity, 30.2%
  - Type II DM, 20.5%
  - HTN, 26.2%
  - Heart Failure, 11.7%

Does Prevention Work?

- U.S. Preventive Services Task Force
  - Immunizations
  - Cancer screenings
  - Substance use counseling
- The Community Guide
  - Smoke-free policies
  - Motor vehicle injury prevention
  - Diabetes prevention program

Example

- Flu Vaccine
  - University of Florida researchers modeled a poorly matched vaccine (20% effectiveness with 43% uptake) and compared its impact versus having no vaccine at all.
  - Model demonstrated that such a vaccine would reduce hospitalizations by 129,000 & deaths by 61,000.
- COVID Vaccine
  - Imperial College researchers modeled COVID deaths with or without vaccination over the period from Dec 8, 2020 to Dec 8, 2021.
  - COVID vaccines found to reduce the global death toll during the pandemic by almost two-thirds in their first year, saving an estimated 19.8 million lives.

Does Prevention Save Money?

This should never be the first question…

- In about 20% of cases, yes.
  - Clinical - Childhood immunizations, tobacco screening & counseling, secondary prevention with aspirin, alcohol screening & counseling
  - Community – community fluoridation, use of motorcycle helmets
- Waste in healthcare
  - Approximately 25% of health care costs
  - Recent estimates are that $4 billion to $25 billion could be reduced through prevention activities

Example

- Medicaid Tobacco Cessation
  - 2006 Massachusetts Health Care Reform law contained a provision making all FDA approved tobacco cessation therapies & behavioral counseling available to Medicaid beneficiaries without barriers (e.g., prior authorization, cost-sharing). Along with significant promotion, within 30 months
    - Smoking rates fell from 38% to 28%
    - Hospitalizations for heart attacks and other heart disease fell 46% and 49%, respectively
    - For every $1 in program, there was a $3.12 savings
  - A UCSF 2019 study demonstrated that if states reduced their Medicaid smoking rates by 1%, there would be $2.6 billion in total Medicaid savings in the following year.

Personal Responsibility or Policy, Systems & Environmental Changes?

Healthy Defaults (*libertarian paternalism*)

- Regulatory examples
  - Menu labeling regulations
  - Revised Nutrition Facts Label (including added sugars information)
    - A 2019 study modeled impacts over 20 years
      - Consumer impact: 1 million fewer cases of heart disease and diabetes resulting in $30 billion in healthcare savings
      - Consumer impact + Industry reformulation: 2 million fewer cases of heart disease and diabetes resulting in $60 billion in healthcare savings
  - Voluntary sodium reductions
    - Reducing average daily adult consumption from 3,400 milligrams/day to 3,000 milligrams/day in 2 years & 2,300 milligrams/day in 10 years
      - Over 20 years, modeling suggests that 450,000 cases of cardiovascular disease could be prevented resulting in cost savings of approximately $40 billion.
  - Cigarette package warning labels

Should Healthcare Pay for Social Services?

- Higher social services: healthcare services ratio correlates to better population health outcomes
  - US versus other countries
  - State comparisons
- Twin desirable goals –
  - Increase social services spending (e.g., education, income support)
  - Leverage $4 trillion health expenditures
- Social needs versus social determinants of health
- Humana Bold Goal Initiative
  - Food insecurity and social/emotional support had the strongest link to CDC's Healthy Days Measure
- Low-hanging fruits
  - Nutrition/Food Insecurity (e.g., Geisinger)
  - Housing (e.g., United, Kaiser, Bon Secours)

Why Hasn't Prevention been Prioritized?

- Reactive versus proactive mode
- Patience required (few "quick" wins)
- Wins may be invisible
- Policymaker education necessary
- "Nanny state" arguments
- Elusive mandatory $ & limited discretionary $
  - Prevention – 5%
  - Public Health – 3%
  - Primary care – 6-7% (half of peer countries)
- Not easy to make $ from prevention in a "sick care" system
- Lack of grass roots movement

Federal Opportunities to Support States/Localities

Prevention as HHS #1 Priority

- Department & individual agencies should ensure this is reflected in
  - Annual budgets to the Office of Management and Budget
  - Quadrennial strategic plans
- Limited set of specific metrics should be associated with the department's prevention goals and aligned with Healthy People
- HHS Operating Divisions should likewise elevate prevention in a manner consistent with each division's unique mission

Examples – Prioritizing Prevention

- Clinical Preventive Services
- Some preventive services, such as cancer screening and childhood immunizations, declined during the pandemic
- Kelley vs. Becerra verdict threatens to further undermine access to free preventive care services
- Critical for providers and payers to reach those at highest-risk

- Hospital Community Benefit
- ACA required non-profit hospitals to conduct community health needs assessments & implementation plans
- Limited transparency & unclear impact on community benefit spending or to overall community health improvement

Incentivizing Prevention through Quality Metrics

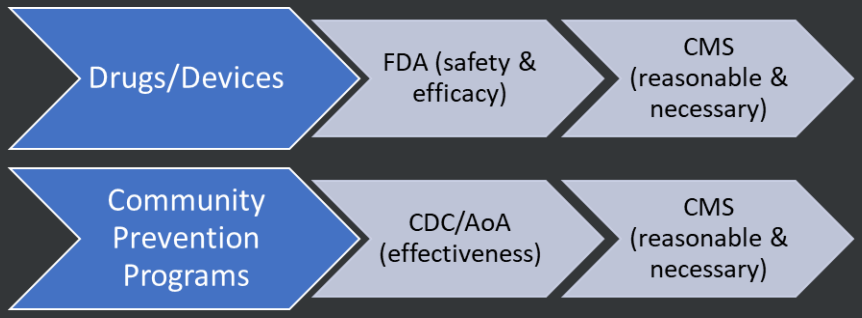
- Quality metrics are the currency of value-based health care transformation
- Introduce health status measures
  - Prevalence of chronic disease risk factors (e.g., tobacco use, obesity)
  - Incidence of chronic diseases (e.g., diabetes, heart disease, COPD)
- Example: Obesity
  - % of patients with an initial BMI >25 who achieved at least a 5% reduction in weight within 9-12 months during the reporting period

Example – My Healthy Weight Pledge

- My Healthy Weight is a collective initiative of private insurance plans, state Medicaid programs, and purchasers offering obesity prevention and treatment for individuals of all ages.
  - Members offer intensive behavioral interventions (consistent w/ every plan year for members with a qualifying diagnosis
  - Members implement and/or cover one or more community-based program(s) for adults and/or children

Scaling Community-Based Prevention Programs

- Evidence-based programs
  - Falls prevention (e.g., A Matter of Balance)
  - Physical activity promotion (e.g., Enhance Fitness)
  - Chronic disease self-management programs (e.g., CDSMP)
- Lessons from the Diabetes Prevention Program (DPP)
- Proposed parallel regulatory pathway for community-based prevention programs



Targeting Public Health Investments

- Public Health Infrastructure
  - $13 per capita gap in funding public health capabilities to assure the conditions for healthy populations
  - Recommendation for a Public Health Infrastructure Fund
- Community Prevention
  - Supporting states & localities in making policy, systems, and environmental changes to make the healthy choice – the easy choice.
  - Example: Recovery Act's Communities Putting Prevention to Work
- Public Health Emergency Preparedness & Response
  - Bridge funding necessary between preparedness & supplemental emergency funds
  - Permanent budget designation for mission critical programs (exempt from caps)

Prevention Research

- Lack of prioritization of prevention in US health research enterprise
  - NIH 2012 estimate of prevention research – 19% of the budget ($6 billion)
  - 2018 estimate of NIH nutrition research – 5% of the budget ($1.8 billion)
  - 2018 estimate of NCI cancer prevention & control activities – 5.7%
- Necessary areas of focus
  - Biology
  - Behavior change
  - Policy implementation
- Critical for Congressional Budget Office (CBO) to score prevention

Thank you!

Questions?
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Traditional Health Worker Updates

Kathryn Hart, CHW
Traditional Health Worker Liaison

Disclosures and Learning Objectives

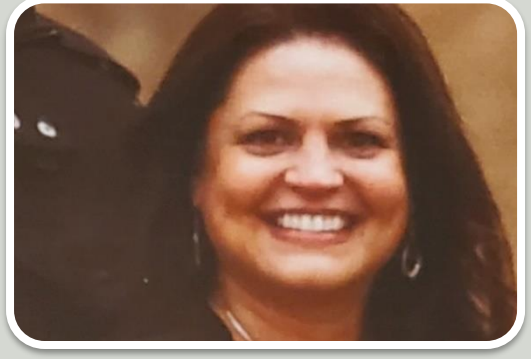
- Disclosure Statement:
  - I do have a relevant financial relationship with commercial interest whose products or services relate to the content of the educational presentation
    - Company: Moda Health, Inc./EOCCO
    - To ensure independence and balance of content, current conflicts of interest were 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
  - Understand how EOCCO is collaborating with community partners to use Traditional Health Workers in innovative ways through CBIR funding

EOCCO THW Team

Kathryn Hart, CHW

- Traditional Health Worker Liaison
- EOCCO



Cheristy Anderson, PSS

- Behavioral Health THW Community Liaison
- GOBHI

Sharyn Smith, FSS

- Youth And Family Peer Support Program Specialist
- GOBHI

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St. Anthony's Physicians Clinic

Doulas Latinas International

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Community Health Worker Training Update

Oregon State University
Center for Health Innovation

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Updates On CHW Training Program

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	Remote	5
Summer 2020	Remote	14
Fall 2020	Remote	14
Winter 2021	Remote	16
Spring 2021	Remote	29
Summer 2021	Remote	23
Fall 2021	Remote	8
Winter 2022	Remote	23
Spring 2022	Remote	22

CHW Training Program CEUs

Table 2. Participation in CHW Continuing Education Courses		
CEU Course	**Launched**	**Total Number Completed**
Management of Chronic Health Conditions	2017	21
Poverty & Related Social Determinants of Health	2017	14
Mental & Behavioral Health	2018	20
Supporting families; Navigating Care Services for Children with Special Health Needs	2022	36

CHW Training Program Future Directions

- OSU is developing additional CEU opportunities, marketing strategies, and partnerships
  - Collaborated with OHA on the HRSA CHW Training Program grant (submitted June 2022)
  - Partnering with other CCO health plans to fund scholarships for CEU courses
  - Oregon Office of Rural Health at OHSU was awarded the HRSA Rural Public Health Workforce Grant; partnering with OSU's program to offer scholarship opportunities for the entry-level training

- OSU developed and launched one additional CHW CEU course in partnership with OHSU Oregon Center for Children and Youth with Special Health Needs
  - "Supporting Families; Navigating Care Services for Children with Special Health Needs"
  - Course has already exceeded other enrollments with 36 total completed since the pilot launch

- OSU developed and launched a THW training as part of the Coast to Forest project.
  - "Substance Use Disorders 101"
  - Pilot launched in Winter 2022, with a total of 32 completions

Health Care Interpreter Training Update

Oregon State University
Center for Health Innovation

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Updates On HCI Training Program

HCI Program Curriculum		
Module 1	Intro to Interpreting	6 hours asynchronous/2 hours live
Module 2	Interpreting in Health Care	6 hours asynchronous/2 hours live
Module 3	Ethics	6 hours asynchronous/2 hours live
Module 4	Interpreting Skills I (focus on consecutive mode)	4 hours asynchronous/4 hours live
Module 5	Interpreting Skills II (focus on simultaneous mode)	4 hours asynchronous/4 hours live
Module 6	Memory for Interpreters	6 hours asynchronous/2 hours live
Module 7	Note-Taking	6 hours asynchronous/2 hours live
Module 8	Working as a Health Care Interpreter	6 hours asynchronous/2 hours live
		44 hours asynchronous/20 hours live

Pilot cohort planned for Fall 2022, with additional cohorts planned for Winter and Spring

HCI Training Program Unique Features

- In addition to meeting OHA standards, this HCI program incorporates the following unique characteristics:
  - **Language-specific:** Addresses issues specific to Spanish-English interpreters and provides terminology resources in Spanish and English.
  - **Rural focus with a hybrid modality:** In-person sessions planned for Eastern Oregon, asynchronous learning can be done from anywhere. Instruction on remote interpreting work, including practice using remote interpreting platforms—especially important for rural interpreters who may not be able to find enough on-site work.
  - **Simultaneous instruction and practice:** Practice in simultaneous mode, using simultaneous interpreting equipment with instructor feedback.
  - **Focus on career readiness:** Course time spent learning about professional credentials, completing OHA application, learning about continuing education and renewal, and comparing contract and employee positions.

HCI Training Program Future Direction

- OSU has developed survey questions to evaluate the program and plans to use the results to continue to refine the program after the initial pilot. Questions focus on:
  - Interpreter knowledge
  - Interpreter skills
  - Career and professional development
  - Barriers to completion

- OSU plans to have future cohorts aligned with terms at Oregon State University, with potential to offer future iterations of the course in different regions of the state depending on needs.

- Long-term goals:
  - Training to work as a health care interpreter is accessible to rural populations
  - Consistent access to interpreters on the OHA registry statewide, including in rural areas
  - Health disparities among language minority patients are reduced
  - Improved performance on language access incentive metrics for rural CCOs

Traditional Health Worker Panel

Saint Alphonsus Medical Center

Doulas Latinas International

Origins Faith Community

Panelists

- **Kathie Pointer & Elizabeth Barber**
  - Saint Alphonsus Medical Center, Baker County
  - Baker City School-Based CHW Expansion Partnership
- **Sandra Hernandes**
  - Doulas Latinas International, Umatilla County
  - MATCH Project
- **Sandy Kendall**
  - Origins Faith Community, Malheur County
  - Accessible Community Health Worker (CHW/PSS) Project

Questions

1. Please introduce yourself and your CBIR project. What are the goals of your THW intervention?
2. Can you share early outcomes of your CBIR project and its impacts on EOCCO members?

References and Resources

- References
  - Community Health Worker Training Program (oregonstate.edu)

- Resources
  - EOCCO's THW Team
    - Kathryn Hart: kathryn.hart@modahealth.com
    - Cheristy Anderson: canderson@gobhi.org
    - Sharyn Smith: ssmith@gobhi.org


Questions?


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Motivational Interviewing

EOCCO Summit 2022

Disclosure Statement

- No disclosures

Learning Objective

- ➔ Understand the spirit and principles of Motivational Interviewing
- ➔ How to apply the OARS when talking to patients about change
- ➔ Identify when change talk is occurring
- ➔ Provide information and giving advice through collaboration

Motivational Interviewing

A collaborative conversation to help strengthen a person's own motivation for change.

- ★ Ambivalence about change is normal
- ★ Change is nonlinear
- ★ Readiness is not static
- ★ Attend to readiness in your work

MI Principles

R- Resist the righting reflex

U- Understand your patients motivation

L- Listen to your patient

E- Empower your patient

MI Principles continued...

Foundational Skills- “Rowing with your OARS”

- Open ended questions
- Affirmations
- Reflective Listening
- Summaries

Eliciting Change Talk-

Central goal of MI is to help patients articulate their reasons for changing and, in doing so, strengthen their intention to change.

Spirit of Motivational Interviewing

Collaboration- refers to the practitioner working in partnership with the patient

Evocation- involves drawing out ideas and solutions from the patient. Our goal is to evoke from patients their reasons and potential methods for change and to offer, as appropriate, ideas for patients consideration.

Autonomy - decision making is left to the patient. The practitioner does not choose the destination but offers information about the paths the patient might choose.

OARS

Open Ended Questions- How or What

What is your primary concern? What do you think you will do now?

Affirmations- "Use "You" statements

"You care deeply for your family and are willing to quit smoking to take better care of your health."

Reflective Listening- Mirror the patient

"It's been a year since I had an HIV test." Reflection "You are scared what your results might be."

Summaries- Pull together the information

"You are here today to find solutions to quitting smoking. We talked about…and that brought up concerns for you. Did I miss anything?"

Eliciting Change Talk

Change talk- patient statements that indicate the person is oriented towards making a positive change in a problem behavior.

1.The desire or ability to change, see the benefits of change, observe the difficulties of their current situation, are committed to change or are taking steps to change.

2. These statements are linked to a specific behavior or set of behaviors. (identified goal)

3. Change talk typically comes from the patient, though it does not have to. (practitioner uses a reflection and client endorses it)

4. Change talk is typically phrased in the present tense.

Change talk

Change talk has 4 elements: Content, recognition, a specific target behavior, and present tense.

⅔ of people who consider a behavior change feel strongly ambivalent about that change- they are uncertain. The practitioner's goal is to help the patient identify and articulate reasons for change (not arguing for change).

Two categories of change talk: preparatory language and mobilizing language.

Preparatory language: Desire, Ability, Reason, and Need (DARN)

Mobilizing language: Commitment and Taking steps (CAT)

Desire- “I wish things were different”

Ability to change (optimism)- “ I can make a change; I just need to commit to it”

Reasons for change- “ My wife would get off my back if I didn’t drink quite so much”

Need to change- “I need to get a handle on things”

Commitment- “ I am going to…..” “I plan to…” “I have already started to…”

Taking steps- “ I went to the gym and worked out twice this week”

Eliciting Change Talk

Evocative Questions- asking the patient directly for change talk.

"In what ways does this concern you?"

"If you decided to make a change, what makes you think you could do it?"

"How would you like things to be different?"

Moving into commitment language-

"So, given all this, what do you think you will do next?"

"What's your next step?"

Elaboration- situations that illustrate change talk.

"Tell me about recent time when you spent money on gambling that you needed for something else?"

"You said things were better then. Tell me about a time when you and he got along better. Specifically, what was happening?"

Information Sharing- Basic concepts

1. Offer information, don't impose
2. Find out if the patient wants the information before you give it. People ask what we think as a lead-in for telling us what they think. Ex. "I am happy to answer that, but first I'm wondering what you think?"
3. Ask permission, especially if patients haven't asked for the information. Ex. "I have some information that might be helpful. Would you be interested in hearing it?" (except in the risk of harm)
4. Provide information in the context of other patients Ex. "In my work with other patients like yourself,...".

Basic concepts cont...

5. Give patients implicit or explicit permission to disagree with you. This increases the chance patients will hear you concern. Ex. “This may or may not be of concern to you…” “You may not agree with me on this…”

6. Use a menu of options. Provide more than one way to solve a problem and ask which way seems to fit best for a particular patients.

7. Use patient statements. By returning their statements, we provide a powerful reminder of how they’ve looked at the situation.

8. Give information that is factually or normatively based, rather that just opinion. (Present data as information for patients to consider).

Basic concepts cont...

9. Invite patients to decide what the information means for them. Ex. “I wonder what you make of the information?”

10. Remember, your patient is a person, not information receptacle. (try not to bury the patient with a barrage of data).

Elicit-Provide-Elicit

Elicit- Start by asking the patient what they know already (or want to know).

Provide- add information to what the patient already knows. (this helps to avoid giving information the patient already knows.)

Elicit- Ask the patient their views on what is offered.

Example:

"What do you know about reducing anxiety?"

"I know it would be good if I could."

"I'm guessing that you've probably tried some things."

"Yeah, like saying "don't worry so much."

"And that didn't work so well."

"Nope."

"I wonder if you would be interested in some techniques that other patients have used?"

Giving Advice - FOCUS

- First ask permission. Make sure the patient is interested in what you are about to offer
- Offer ideas. Don't try to persuade.
- Concise. Don't ramble. Be direct and succinct. If you offer too many concerns, you do not help patients organize and respond effectively to their situations.
- Use a menu. Provide different ways or ideas the patient might use to address the situation.
- Solicit what the patient thinks. Always begin and end with the patient.

Reference

Motivational Interviewing [Flim]. (2013). Change Companies.

Rosengren, D.B. (2018). *Building Motivational Interviewing Skills: A Practitioner Workbook* (2nd ed.). The Guilford Press.


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EASTERN OREGON TEAM ADVANTAGE COMMUNITY CARE DENTAL SERVICES

2022

Advantage Dental
From DentaQuest

Disclosure

- No disclosures

Learning Objectives

- Understand how Advantage Dental as a DCO is collaborating with community partners to expand access to dental services.
- Understand how the Community Care Team assists patients with navigating the dental system and connecting them to their dental home.
- Understand how Community-Based Care reduces health disparities and improves health equity.

Community Based Dental Services

Purpose

The purpose of the Advantage Dental Community Team is to reduce oral health disparities by acting as an extension of the Primary Care Dentist in providing dental services in locations where community members are already receiving other social services, to improve access and improve the oral health of the community.

Goal

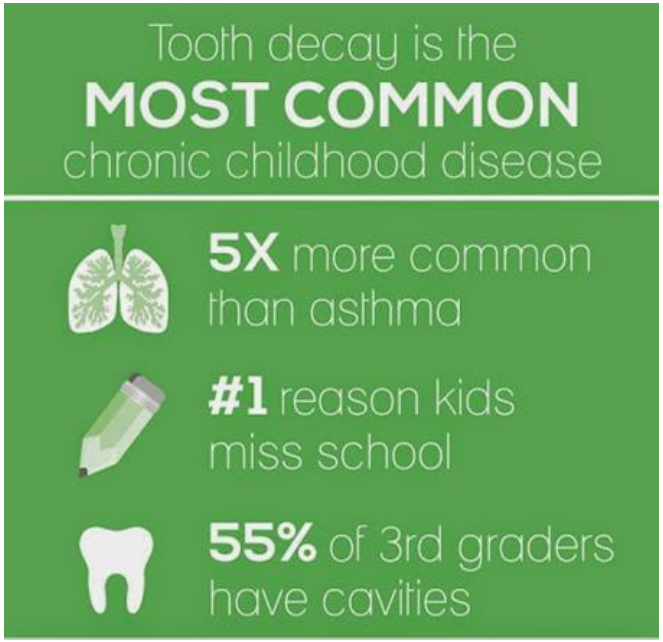
The goal of the program is to improve the oral health of Oregon communities by:

- Engaging the community in actively addressing their oral health needs
- Providing risk-based prevention and disease management dental services
- Case management services to assist in follow through to timely and appropriate care
- Coordination of care with dental home for timely and appropriate treatment

Prevention and Stabilization Dental Services

Services available at no cost to all participants:

- Oral Health Assessment
- Determination of Risk Level
- Fluoride Treatments
  - Silver Diamine Fluoride (SDF)
  - Fluoride Varnish with Betadine
- Dental Sealants
- Oral Hygiene Instructions
- Nutritional Counseling
- Tobacco Counseling
- Anticipatory Guidance
- Toothbrush Kits
- Temporary Restoration w/out Excavation *(removal of tooth structure)*
- Case Management



Eastern Oregon Prevention and Stabilization Sites

Sites by County:

Baker: 4 School Districts, 2 Head Starts, WIC

Gilliam: 2 School Districts, 1 Head Start

Grant: 5 School Districts, 2 Head Starts, WIC

Harney: 8 school Districts

Lake: 5 School Districts, 1 Head Start, WIC

Malheur: 8 School Districts, 5 Head Starts, WIC

Morrow: 2 School Districts, 2 Head Starts, 3 WIC

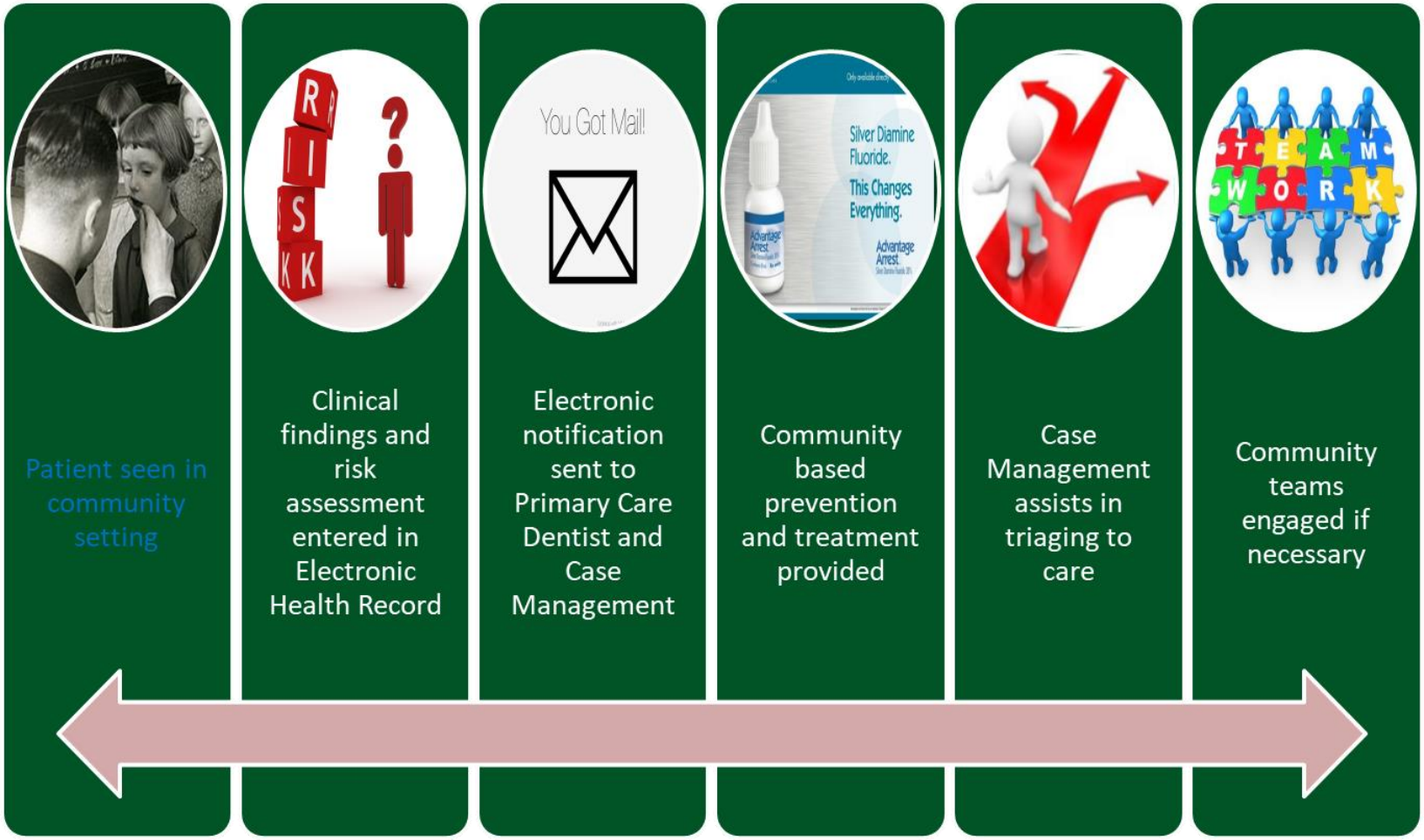
Sherman: 1 School District

Umatilla: 10 School Districts, 3 Head Starts, 2 WIC

Union: 6 School Districts, 2 Head Starts, WIC

Wallowa: 3 School Districts, 1 Head Start

Connecting the Community – Access to Care

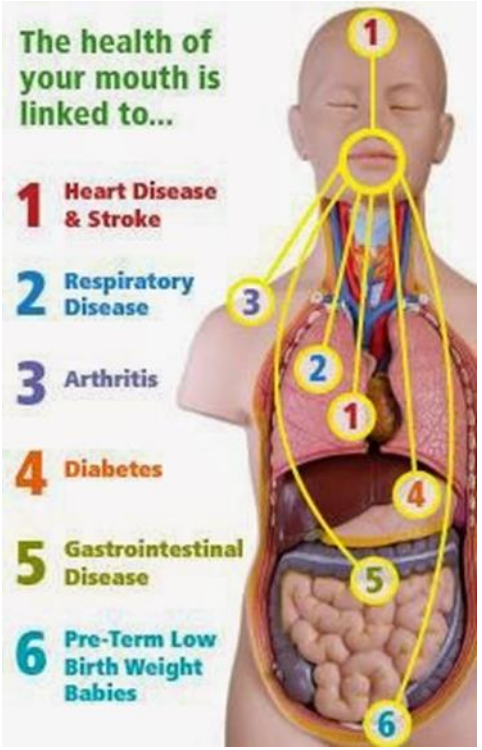


Advantage Dental
From DentaQuest

Physical and/or Behavioral Health Integration

- **Providers Engage with Patients about Oral Health**
  - Are you experiencing any dental pain?
    - Refer to dentist
  - Have you seen your dentist in the last year?
    - Schedule/refer patient to see EPDH

- **Integrated Care**
  - Breaks down barriers
    - Transportation
    - Navigating Care
  - Dental Anxiety
    - Meeting patients where they are comfortable
  - Improve Health Outcomes
  - Increase Access

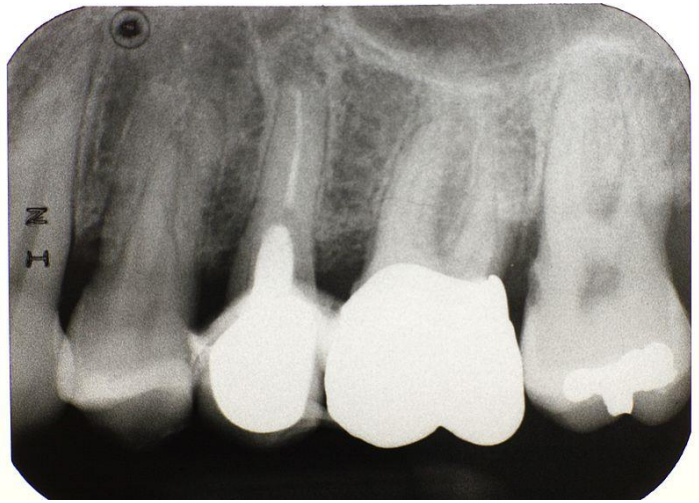


Advantage Dental
From DentaQuest

Asynchronous Teledentistry

Asynchronous *(store and forward)* Teledentistry Services:

- Radiographs
- Intraoral Photos
- Periodontal Probing
- TeleDentist Exam
- Fluoride Treatments
  - Silver Diamine Fluoride (SDF)
  - Fluoride Varnish with Betadine
- Dental Sealants
- Oral Hygiene Instructions
- Nutritional Counseling
- Tobacco Counseling
- Anticipatory Guidance
- Toothbrush Kits
- Dental Cleanings
  - Available in some settings



Advantage Dental
From DentaQuest

Integrated Services within EOCCO

Asynchronous Teledentistry Services:

- Arlington Medical Center
- Sherman County Medical Clinic

Advantage Dental
From DentaQuest

Childhood Caries Prevention Program

Children 0-15 and Pregnant Women

Phone Synchronous Teledentistry Services:

- Oral Health Assessment
- Oral Hygiene Instructions
- Nutritional Counseling
- Tobacco Counseling
- Anticipatory Guidance

First Tooth Trainings

- Reduce early childhood caries rates in Oregon by training pediatric providers to implement preventive oral health services for children.
- Provide the resources for pediatric providers to: assess child oral health, educate parents of their patients, provide preventive fluoride varnish, and make effective referrals to dental care.

- 4 Trainers
- In-person and virtual trainings available

Unite Us / Connect Oregon & Community Care

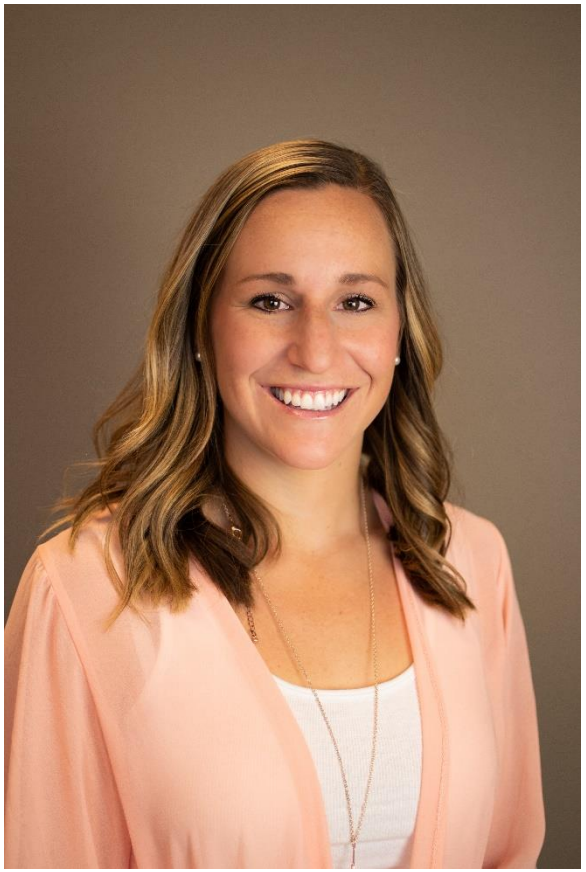
Implementation Plan:

- **Piloted Platform**
  - Central Oregon
  - Lane County
- **Broader Rollout** – Quarter 3 in applicable regions
- **Community Care Dental Team**
  - Screen for Social Determinants of Health
    - Transportation
    - Food Insecurity
    - Housing

Community Care Dental Team

- **Expanded Practice Dental Hygienist (EPDH)**
  - Can practice without a dentist on-site
  - Dental Hygiene Services
    - Prevent Cavities
    - Assist managing patients' oral health care needs
- **Community Care Dental Assistant**
  - Assists EPDH with services
  - Data entry
  - On-site set-up/breakdown of equipment.
- **Community Care Supervisor / EPDH**
  - Oversight of regional team
  - Dental Hygiene Services
- **Program Coordinator**
  - Scheduling
  - Teledentistry Tracker Oversight
  - Administration

Meet Community Care Dental Team



KayLynne Todd, Supervisor East and Expanded Practice Dental Hygienist

Region:

Eastern Oregon, North Central & West Valley

Hobbies:

"I like to spend time with my husband and 2 sons, hiking, and running."

What KayLynne likes about her job:

"I love that every day is different, and that typically I get to help people who really need it and are appreciative of us bringing care to them."

Meet Community Care Dental Team

Jordan Mikel

Expanded Practice Dental Hygienist

Region:

Umatilla, Union & Wallowa

Hobbies:

"I enjoy spending time with my husband and kids' outdoors and reading!"

What Jordan likes about her job:

""I enjoy the diverse types of patients I get to interact with and I also enjoy getting to work in so many different settings. (Schools, WIC office's Health fairs, our dental clinics.)"

Advantage Dental
From DentaQuest

Meet Your Community Care Dental Team

Jodi Bissonette

Program Coordinator East

Region:

Eastern Oregon and The Gorge

Hobbies:

“I enjoy spending time with my family at the lake and at our farm.”

What Jodi likes about her job:

“What I love most about my job is helping those in need and educating people on the importance of oral health.”

Meet Community Care Dental Team

Ashley Danielson

Expanded Practice Dental Hygienist

Region:

Gilliam, Hood River, Sherman & Wasco Counties

Hobbies:

"I enjoy being with my family. We live on a ranch and enjoy riding horses, 4 wheelers, hunting and boating in the summer!

What Ashley likes about her job:

"I love so many aspects of my job, but mainly I enjoy sharing knowledge and tips on how to keep teeth healthy."

Meet Your Community Care Dental Team

Laurie Stewart

Dental Assistant

Region:

Baker, Malheur, Umatilla, Union & Wallowa Counties

Hobbies:

"I love spending time with my family and friends having BBQ's and bon fires, camping, hunting and fishing."

What Laurie likes about her job:

"I realized that I wanted to go in to the dental field after a bad car accident I was in at 18 years old. I have never regretted my decision. Dental is my passion. I love being able to go in to the school setting and teach children about how to take care of their teeth and why it is important. I love seeing "the light bulb" go on when I am talking to them, knowing that they get it!! "

Advantage Dental
From DentaQuest

Meet Community Care Dental Team

Katie Stahl

Expanded Practice Dental Hygienist

Region:

Morrow & Umatilla Counties

Hobbies:

“I enjoy reading or being outside with my kids.”

What Katie likes about her job:

“I love that I am able to reach a population that would otherwise not see a dental hygienist or dentist.”

Advantage Dental
From DentaQuest

Meet Your Community Care Dental Team

Maya Douglas

Dental Assistant

Region:

Gilliam, Hood River, Sherman & Wasco Counties

Hobbies:

"I enjoy riding horses."

What Maya likes about her job:

"I believe in community care and I am proud to be able to provide services."

Advantage Dental
From DentaQuest

Meet Your Community Care Dental Team

Brooke Walker

Dental Assistant

Region:

Morrow and Umatilla Counties

Hobbies:

Hunting, visiting the sand dunes, boating

What Brooke likes about her job:

“Being able to help people of all ages.”

Advantage Dental
From DentaQuest

Meet Community Care Dental Team

Jessica Steele

Expanded Practice Dental Hygienist

Region:

Baker, Harney & Malheur Counties

Hobbies:

“I enjoy being with my husband and daughter. Riding, Roping, and taking my daughter to rodeos. Also working on our ranch. ”

What Jessica likes about her job:

“We are able to reach so many kids and do education to a lot of people. Little information can go a long ways and change a person’s life. Simple as giving them the tools of brushing their teeth twice a day. ”

Meet Community Care Dental Team

Brynna Rust

Expanded Practice Dental Hygienist

Region:

Morrow & Umatilla Counties

Hobbies:

In her spare time she enjoys hiking, moving cows, boating, skiing, working out, spending time with family, reading and listening to a good podcast.

What Brynna likes about her job:

"I love working with my coworkers; we are all so hard working and we all strive to help people. I love helping people and especially when I see the full circle; such as local organizations (transportation, family advocates, etc.) coming together to help get a child in who has an emergency. I enjoy going to various sites because not every site is the same and we have to problem solve what would be the best route of action along with what the site agrees to."

KayLynne Todd, EPDH
Supervisor, Community Care East
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Advantage Dental
From DentaQuest


ODS

2022 EOCCO Summit
Dental Access

ODS Community Dental
September 21, 2022

Nancy Avery
Manager, ODS Operations & Provider Network

Amy Lawrence
Lead OHP Dental Coordinator

ODS

Disclosures

- No disclosures

Learning Objective

- Understand how ODS leverages partnerships with EOCCO, dental providers, and community partners to address dental access.

ODS Community Dental Program

- About ODS Community Dental
- ODS and EOCCO
- Today's challenges
- Our program
- Oral health, overall health
- Navigating dental Medicaid

ODS

ODS Community Dental Program

- Serving dental Medicaid members since 1994
- 287,850 members statewide
- Partnerships with ten community care organizations
  - PacificSource (4)
  - EOCCO
  - Trillium
  - Columbia Pacific CCO
  - Jackson Care Connect
  - Health Share of Oregon
  - InterCommunity Health

ODS

OHP Dental Benefits

- Cleanings
- Fluoride
- Sealants
- X-rays
- Fillings
- Extractions
- Dentures/Partial Dentures
- Root canals
- Crowns
- *There are benefit limitations for some dental services*

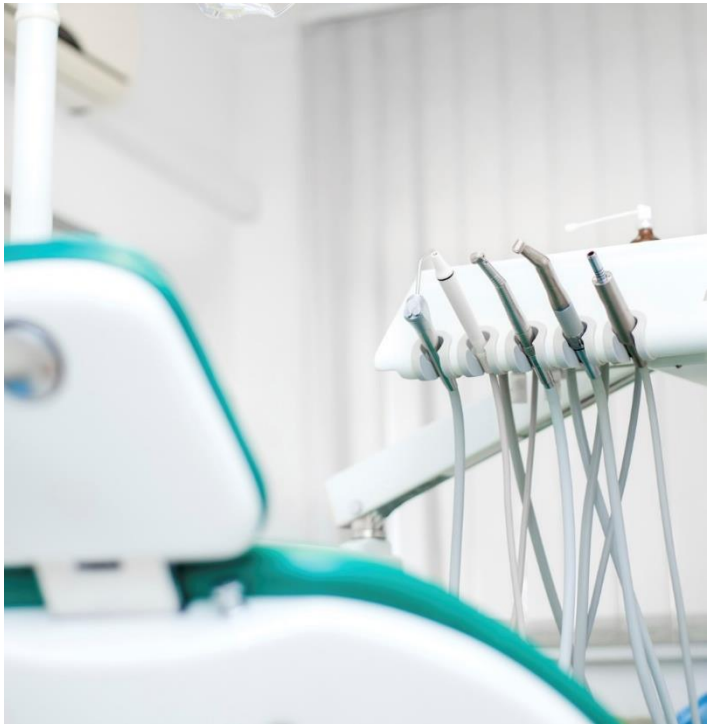
ODS and EOCCO

- Seven counties:
  - Wheeler, Umatilla, Grant, Wallowa, Union, Baker, Malheur

- 21,366 members
- 30 unique locations
- 64 providers (all types)

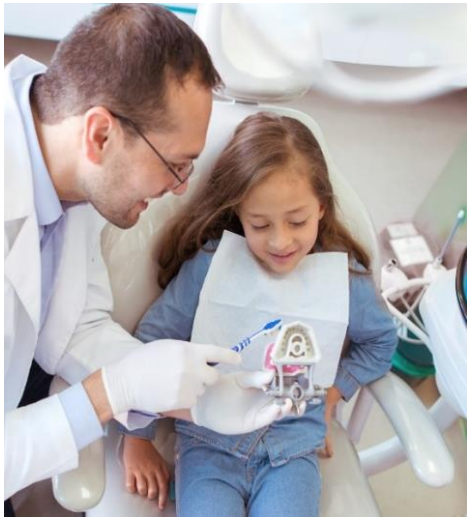
- Assignment
  - Winding Waters. Enterprise and Joseph
  - Elgin Family Dental, Elgin
  - Dr. James Klusmier, John Day
  - Eastern Oregon Dental Group, Baker City

- Overall dental utilization 2022
  - Children under age 19: **48.4%**
  - Adults 19+: **26.4%**



2022 Dental Incentive Measures

Metric	Annual Target	Aug-22	Numerator	Denominator	Needed for goal
Preventive services Ages1-5	43.10%	34.30%	766	2,236	198
Preventive services Ages 6-14	52.00%	53.40%	2,472	4,625	0
Diabetic oral health evaluation-adults	20.40%	19.20%	184	960	12
Utilization Children up to age 14	50.00%	50.80%	3,287	6,470	0
Utilization Adult 14 and older	50.00%	29.90%	4,329	8,942	142



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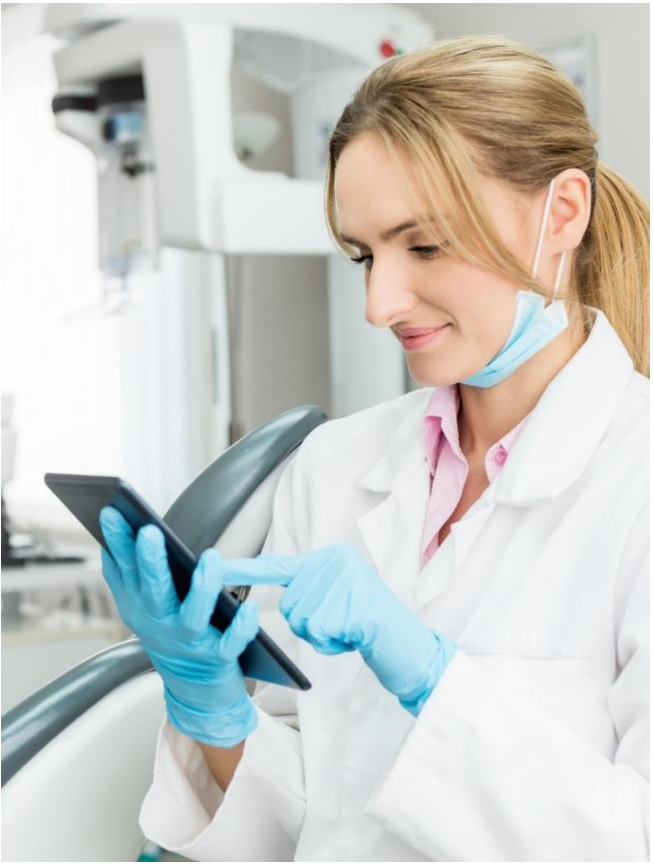


Today's challenges

- **Dental office staffing**
  - Dental assistants, dental hygienists
  - Shortage of back-up clinical staff
  - Single column scheduling
- **Scheduling**
  - Missed and cancelled appointments
- **Behavioral concerns**
  - Potential of putting staff at risk, may have to dismiss
- **Specialty services in rural areas**
  - Oral surgery, hospital dentistry and endodontics
  - Seasonal, winter travel
- **Utilization-Healthcare Community**
  - Encourage members to see their dentist
  - Care coordination teams, help members understand they have a dental benefit

ODS

ODS Member & Provider Services

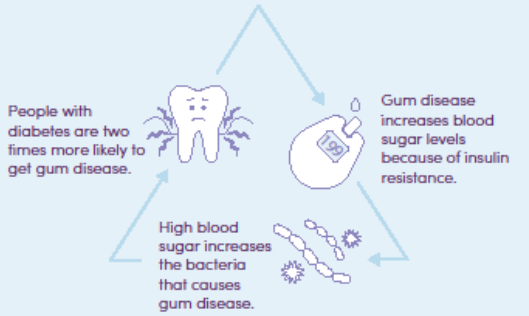
The Dental Medicaid Team

- **Care Coordination**
  - CCO coordination with physical & behavioral health
  - Special needs assistance
  - Specialty referrals
  - Emergency room follow-up
  - HRA follow-ups
  - Facilitate transportation
- **Education**
  - Health through Oral Wellness
  - Perio Program
- **Member Experience**
  - Customer Service & Quality
- **Interpreter Services**
- **Community Programs**
  - Outreach-expanded practice dental hygienist
  - Connect Oregon
  - Arrow Dental Van
- **Provider Recruitment and Retention**

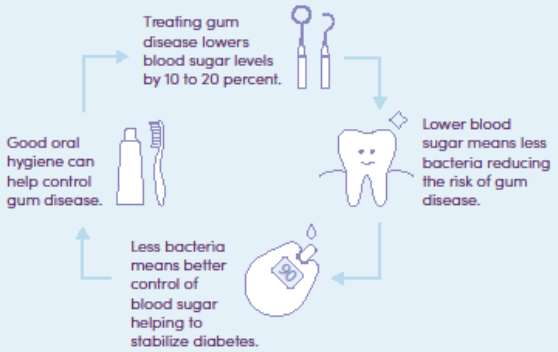
ODS Perio Program

- **Periodontal Disease**
  - Infection and inflammation of the gums, ligaments, and bone that surround your teeth. Advance periodontal disease can lead to bone loss and ultimately loss of teeth.
- **OHP benefit for periodontal services**
  - Benefits are limited
  - Do not include surgery and implants
- **Our goal**
  - Educate members
  - Support providers
  - Assist with care coordination
- **Perio Packet**
  - Letter
  - Educational materials
  - Next steps for member

Gum disease and diabetes have a two-way relationship



The relationship works both ways



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Interpreter Services

- **Service types**
  - Onsite
  - Telephonic
  - Video
- **Two vendors**
  - Passport to Languages
  - Linguava
    - Free download
    - Staff training
- **Internal quality monitoring**
  - Customer service training
    - Best practices when working with telephonic interpreter
  - Phone observation
  - Coaching
    - Vendor
    - Customer service representative

ODS

Serving the community

arrow dental

CONNECT OREGON

ODS

Navigating Dental Medicaid

Unsure of member's dental plan
Call EOCCO customer service
888-788-9821

Member has ODS
Call ODS customer service
800-342-0526

Member has Advantage Dental
Call Advantage Dental customer service
866-268-9631

Reminders
- Diabetic members
- Children
- Edentulous members (no teeth, full dentures)

Thank you!

Questions?

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EASTERN OREGON
COORDINATED CARE
ORGANIZATION

10th Annual EOCCO Summit

OHSU Portland State University | SCHOOL OF PUBLIC HEALTH

READ & SOGI DATA

Alexis Dinno
Associate Professor
OHSU-PSU School of Public Health

SEPTEMBER 21, 2022

Disclosures: None.

A little about me 1

Transgender, transsexual

Social epidemiologist and activist

Collaboratively work for the just and accurate representation of people with sex, sexual orientation, and gender minority experiences (SSGM)

My collaborators on SOGI data include OHA, Oregon AETC's SOGI CoP, and ATHN. My collaborators are people with SSGM experience, BIPOC Oregonians, and PH professionals motivated by justice for SSGM.

Disclosures

- No disclosures.

Learning objectives

- Summarize the primary values driving REALD and SOGI data collection.
- Understand REALD and SOGI concepts to apply in your own programs and organizations.
- Take part in addressing your challenges and successes in REALD and SOGI implementation.

Where we are now 2

Historical moment in Oregon: REALD and SOGI codified into law, and increasingly institutionalized.

Why this matters:

1. Accurately represent Oregon's diversity
2. Support inclusive practice and welcome in services
3. Striving for a society which does not systematically harm one population in favor of another; eliminate or ameliorate ongoing harms.
4. More effectively identify those who may require group-specific services.

Questions often come in two versions (SOGI)

Many questions come in two versions—free text, and structured responses—and these serve overlapping & different purposes. E.g., some SOGI questions about sexual orientation:

Please describe your sexual orientation or sexual identity in any way you want:

_____

How do you describe your sexual orientation or sexual identity? (Check all that apply)

- ☐ Same-gender loving
- ☐ Same-sex loving
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Pansexual
- ☐ Straight (attracted mainly to or only to other gender(s) or sex(es))
- ☐ Asexual
- ☐ Queer
- ☐ Questioning
- ☐ Don't know
- ☐ Another identity not listed. Please specify: _____
- ☐ I don't know what this question is asking
- ☐ I don't want to answer

Questions often come in two versions (REALD)

E.g., some REALD questions about race, ethnicity, tribal affiliation, country of origin, or ancestry (excerpt):

How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry:

_____

Which of the following describes your racial or ethnic identity? Please check ALL that apply:

American Indian & Alaska Native

- ▫ American Indian
- ▫ Alaska Native
- ▫ Canada Inuit, Metis, or First Nation
- ▫ Indigenous Mexican, Central American, or South American

Asian

- ▫ Asian Indian
- ▫ Chinese
- ▫ Filipino/a
- ▫ Hmong

Black & African American

- ▫ African American
- ▫ African (*Black*)
- ▫ Caribbean (*Black*)
- ▫ Other Black

Hispanic & Latino/a/x

- ▫ Central American
- ▫ Mexican
- ▫ South American
- ▫ Other Hispanic or Latino/a/x

Native Hawaiian & Pacific Islander

- ▫ Chamorro
- ▫ Guamanian
- ▫ Microneasian/Marshallese/
- ▫ Palauan
- ▫ Native Hawaiian
- ▫ Samoan
- ▫ Tongan
- ▫ Other Pacific Islander

Other Categories

The purposes of free text & structured responses

Free text responses

Center patient/client self-language & experience

Support interpersonal connection

Identify group-specific needs

Structured responses

Support demographic representation at organizational and state levels

Facilitate contrasts between group access, outcomes, etc.; identify whether and which groups are being treated differently

Identify group-specific needs

SOGI and *sex*

Our social habit of thinking of sex as binary, and compassing exactly two conditions is a convenient fiction, for sex is both multi-dimensional—e.g., chromosomal, anatomical, physiological (hormone levels, dynamics, and receptors), and legal (and varying by jurisdiction)—and, even at the chromosomal level, sex is *bimodal* not binary.

Practice is not there yet, but a patient's interests would be best met by representing sex using anatomy inventories and physiology inventories, without assuming that any particular answer precludes another.

Of course, the validity of such inventories in *survey form* will be contingent on how much one can actually know about one's body.

Important: A separate question about sex specifically for the purpose of ID matching with the Social Security Administration.

SOGI and *gender identity* 1

Common SOGI gender identities are **girl** or **woman**, and **boy** or **man**.

Agender, Non-gender: those rejecting masculine/feminine roles and identities, or even rejecting any participation in gender.

Non-binary: Some people occupy both masculine and feminine roles and identities, in androgyny (simultaneously masculine and feminine), through **fluid** expressions that are labile with internal or external contexts, and some through situational specificity (e.g., work gender vs. home gender). People with non-binary gender identities may or may not identify as agender.

The structured SOGI gender identity question also welcomes **multiple gender identities**.

SOGI and *gender identity* 2 still to come

The gender categories above are culturally and linguistically situated. For example, **Two-Spirit** is a pan-North American indigenous non-binary or third gender label. (Not all North American indigenous individuals with transgender experience, or non-binary gender identity necessarily identify as Two-Spirit. Some South Pacific cultures have adopted the term Two-Spirit in a similar way.) There is recognition that if someone checks an identity in the American Indian & Alaska Native category on REALD, the Two-Spirit option should be made available for gender identity. There is a desire to not encourage appropriation of Two-Spirit by people outside the American Indian & Alaska Native community.

Community engagement and collaboration should inquire about similar links for other cultural groups. For example, Samoans, Thai, and many cultures have gender categories outside the binary prevalent in the USA.

SOGI and *gender modality*

Gender modality distinguishes **transgender, cisgender**, and **questioning** experiences.

Transgender means one rejected or grew beyond the gender assigned one at birth. Cisgender is its logical complement. People who are agender, non-binary, or multiple genders may or may not be transgender.

Identifying sex at birth and gender identity are not enough to determine whether someone is transgender. Separating transgender from (binary) sex at birth—as the OHA SOGI tool does—makes room to understand why people raised agender, or non-binary, may not identify as transgender, but also recognizes that people can simultaneously have male sex, a masculine gender, and still be transgender—for example when their experience is one of *gender transition* and they are on starting side of that journey.

SOGI and minor children

At which ages to ask which questions

When can we ask parents to answer for their children?

What if parents are in the room but we ask the child, or vice versa?

Can we collapse READLD and SOGI categories?

Yes, but…

Still need to collect the READLD and SOGI data, so collapse in **analysis**.

Be explicit about which categories contribute to a grouping. E.g., if one wanted to make a broad umbrella 'Queer' sexual orientation group, be sure to document or explain exactly which structured items mean one is in or not in that category (for example, does this include individuals identifying as Asexual? What about individuals identifying as 'Straight' but another sexual orientation or identity also?).

Frequency of REALD and SOGI data collection

REALD & SOGI demand time!

They are also an emotional ask. Vulnerability.

There is a question of labor equity in asking for demographic information.

Allow clients to change their demographic data, but do not request updates more than once a year—across the entire provider system (i.e. they should not have to fill out REALD and SOGI at the primary care provider, and then again at the specialists, and then again at the therapists, and then at the pharmacy, etc.)

Do not assume READLD or SOGI responses are static

People change across the life course.

A change in any READLD or SOGI response does not mean there is necessarily an error. A change in race & ethnicity, or gender, or sexual orientation should be be automatically flagged as false.

Most of us who enjoy good health, and minimal disability simply have no lived long enough for that condition to have changed.

Why this matters: Empathy & cultural humility 10

Centering active patient participation and autonomy in the clinic necessitates both empathy for the patient's needs and cultural humility.

Empathy is requisite both for valuing and understanding their immediate and long term health & health care needs, but also in terms of their relationship with a provider in a clinical context. (Researchers also!)

At the same time the provider's cultural humility in recognizing the limits of their own knowledge of the patient's experiences is a necessary part of a good-faith invitation to share in decision making.

Because our sexual biology is so socially laden with meaning, and because our gender experiences are for so many central to our immediate conceptions of self, we must strive for inclusion with SSGM, who historically have been systematically excluded from representation.

Why this matters: Equity & sanctioned ignorance

We expect inequities in SSGM health relative to cisgender-binary health, because:

> We have to educate our providers about our bodies and our genders, while in clinical settings,
> We have to navigate health systems which often assume that it is fine to operate ignore our experiences and use the sex/gender binary,
> We have more economic barriers to access, and often geographies of violence to navigate to access care and in the day to day.

"If you don't know, you can't act."—epidemiologist Nancy Krieger

Can you help us see those inequities? Can you ask these questions? Can you act?

Changing our culture

Implementing these questions will invite push back. Some cisgender and binary gender persons will not see the point, or may respond with **Can't you tell?** Some GSM people will prefer to remain anonymous. Some people will become exercised at asking or being asked.

It will help to develop **response matrices** of scripted answers guiding people having these kinds of reactions back to the points: we try to make space for everyone; people of different sexes, genders, or gender modalities are treated differently (when they should not be), and this helps us be accountable; different people have different needs.

It was once verboten to ask a patient whether one had female sexual partners *and* whether one had male sexual partners, yet resistance to such questions has diminished, and such questions are now more commonplace in clinics.

Why this matters: Pathologization of difference

Researchers and clinicians have enacted harm of SSGM persons by treating gender diversity as pathological.

This orientation is perhaps captured by the question **Why do gender (or sex) minorities have worse health than gender majorities?** and also by the statement **Being a gender minority is a risk factor for disease**.

The pathologization of difference can lead to a malefic stance that demands that the SSGM patient cease existing—as with the literal erasures implied by so-called conversion therapy.

Why this matters: SSGM as health-relevant condition

Gender diversity and sex diversity may instead be recognized as simply health-relevant conditions (as the ICD and DSM both now do).

Consider how the questions **What causes people with gender minority experience or with sex minority experience to have the highest levels of health?** and **What reduces health inequities between gender and sex minorities and majorities?** present a very different stance towards patient well-being compared with the pathologization of difference.

Q&A

Resources and links

READ
SOGI Draft
40 Falsehoods programmers believe about names
Trans is my gender modality
AETC SOGI Community of Practice Draft Glossary
AETC SOGI Community of Practice inquiries
Preliminary (Year 1) Report to OHA on Pediatric SOGI
Personal invitation


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ORGANIZATION

Reminders

- Use the activity code **70CHEF** to receive your CME certificate.
  - You will have access to the activity code for 24-hours.
  - Email EOCCOmetrics@modahealth.com if you did not download your CME certificate within the allotted time.
- Contact EOCCOmetrics@modahealth.com for questions or concerns after the event.

Follow the below steps to claim your continuing medical education (CME) credits:

1. Visit www.eeds.com or scan the below QR code

2. Enter the activity code: **70CHEF**
3. Click 'sign-in'
4. Enter your St. Charles email or create your free account
5. Complete the evaluation survey (required for credit)
6. View or download your certificate from the home page

Note: The activity code will expire on Thursday, September 22, 2022 at 9 am

eocco

Door prizes!


Thank you!