



EOCCO Regional Community Advisory Council

Annual Report

To the

Eastern Oregon Coordinated Care Organization

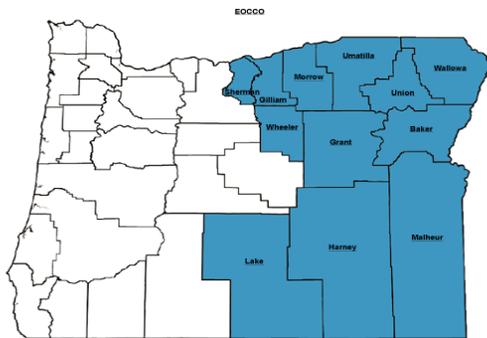
July 1, 2018 to June 30, 2019

2019 Annual Report

The Eastern Oregon Coordinated Care Organization (EOCCO) is one of fifteen CCOs in Oregon and covers all Oregon Health Plan Members (OHP) in twelve Eastern Oregon Counties (Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler). EOCCO is a Limited Liability Corporation sponsored by Greater Oregon Behavioral Health, Inc. (GOBHI), Moda Health, Good Shepherd Hospital, St. Anthony Hospital, Grand Ronde Hospital, St. Alphonsus Hospital System, Eastern Oregon Independent Physicians Association, and Yakima Valley Farm Workers Clinic.

Local Community Advisory Councils (LCACs) are a principal component of Oregon's Health Integration Model. They were established to help CCOs understand the health needs of local populations and make recommendations that help CCOs reach the triple aim. LCACs are the critical link between CCOs and community-based providers and partners. The

EOCCO has established a LCAC in each county and a Regional Community Advisory Council (RCAC). The EOCCO Board of Directors appointed the RCAC with representation from each of the twelve LCACs. One of the main goals of the RCAC is to oversee and coordinate LCAC activities such as the Community Health Assessments, Community Health Plans and preventative health care activities.



The work of the LCACs is typically described as having the purpose of helping the EOCCO in meeting the needs of OHP enrollees, identifying and advocating for preventive care services, overseeing a Community Health Needs Assessment and Community Health Plan at the county level, evaluating EOCCO services, helping EOCCO communicate with OHP enrollees and implementing activities to improve community health.

The RCAC is pleased to submit this annual report to the Eastern Oregon Coordinated Care Organization's Board of Directors as required by ORS 414.627. The purpose of this report is to provide the Board with a status update on the extent to which the LCAC's are experiencing successes and barriers.

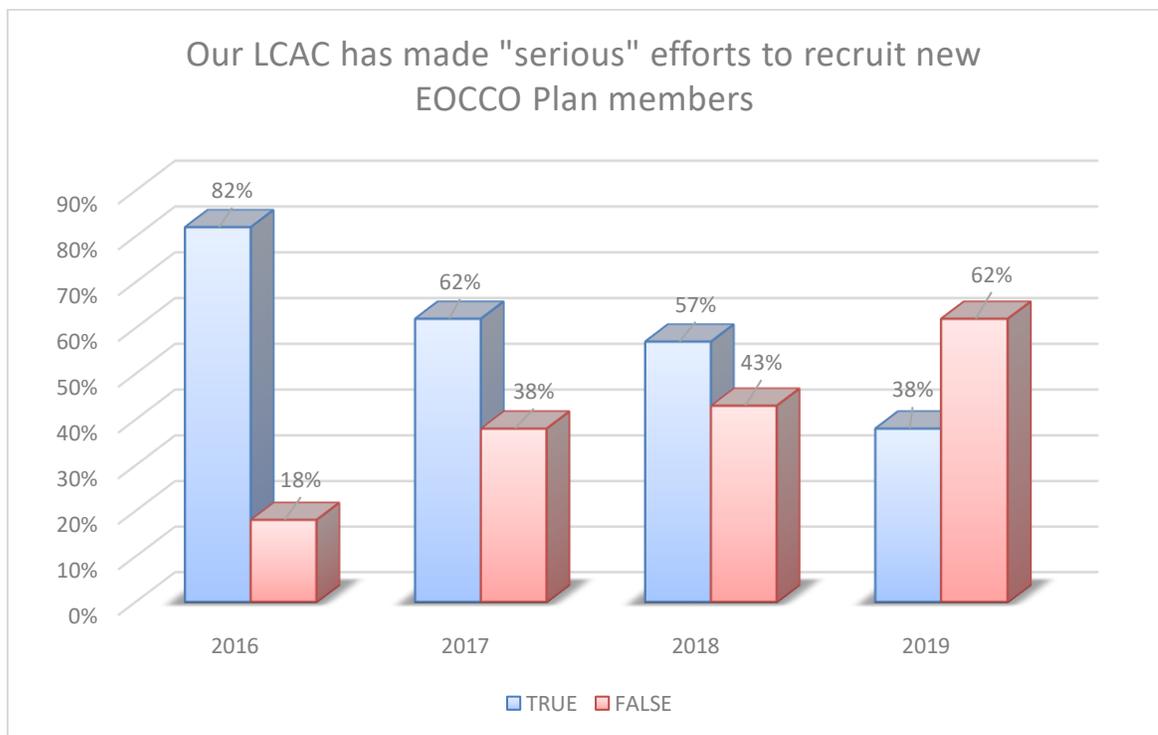
Summary of Findings

Most significantly, all twelve LCACs maintain regularly scheduled meetings. Community Health Assessments and Community Health Plans were conducted and

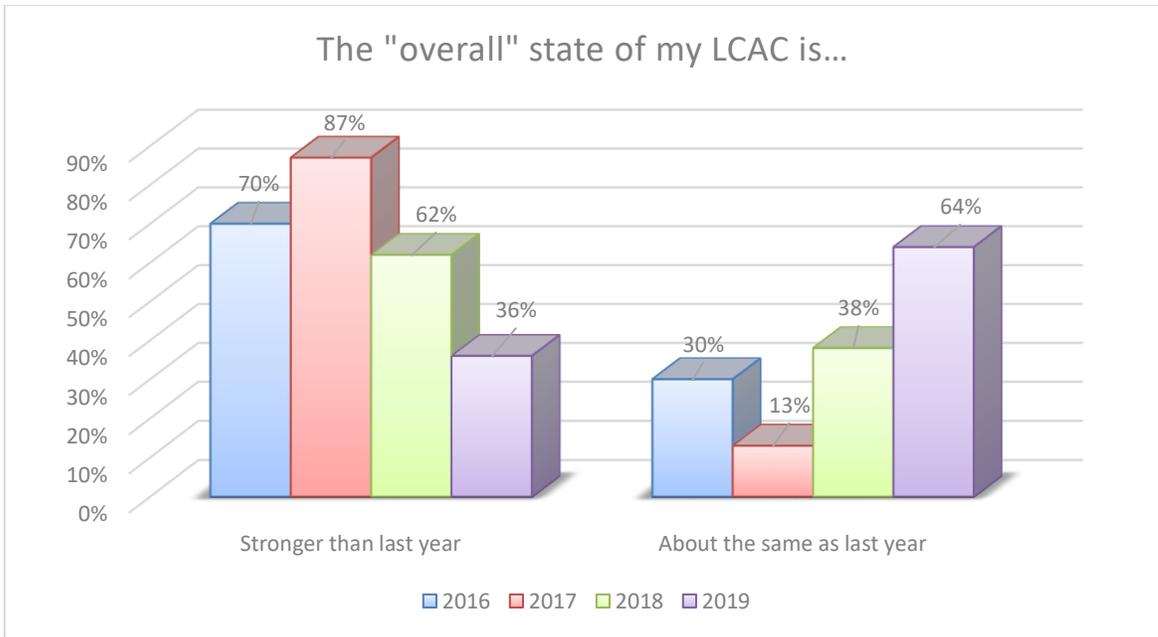
completed during the late Spring of 2019. These assessments and plans will be shared with the Oregon Health Authority as required and be posted on the EOCCO website.

At the March 26, 2019 Regional CAC meeting members were asked to assess the performance of their LCACs using audience participation tools (through the software Turning Point) and also through verbal reports. The questions asked were intended to measure the attitudes and beliefs regarding the overarching purpose and activities of the LCACs. Several of the questions have been asked annually since 2016 and we share the results and comment on trends if possible.

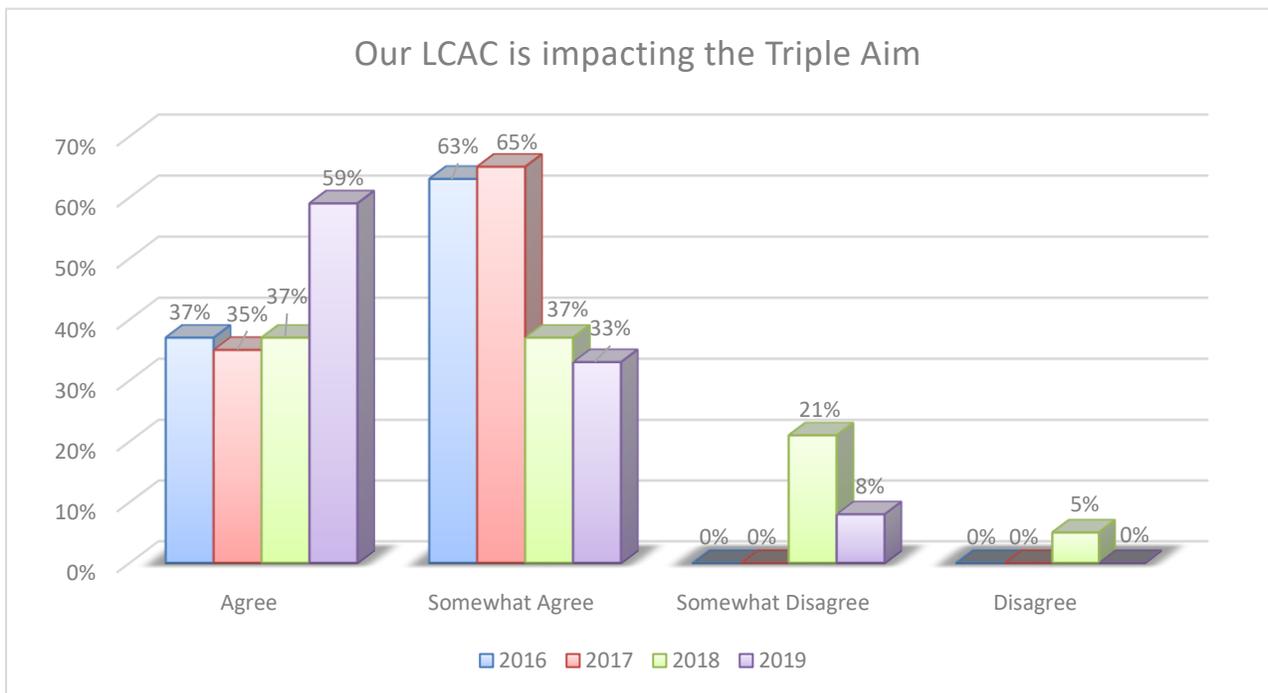
The LCACs have continued to expand their representation of OHP members and have outlined methods to increase that participation. OHP members serve in leadership roles. It should be noted that OHP consumer representation has been improved but many LCACs do not have 51% consumer representation. This is the first year since the poll has been conducted that more people said they did not make “serious” efforts to recruit new EOCCO plan members. This reflects, that despite many efforts including participation in the Transformation Center’s CAC Recruitment and Engagement workgroup, the LCACs are devoting less energy because of a lack of success.



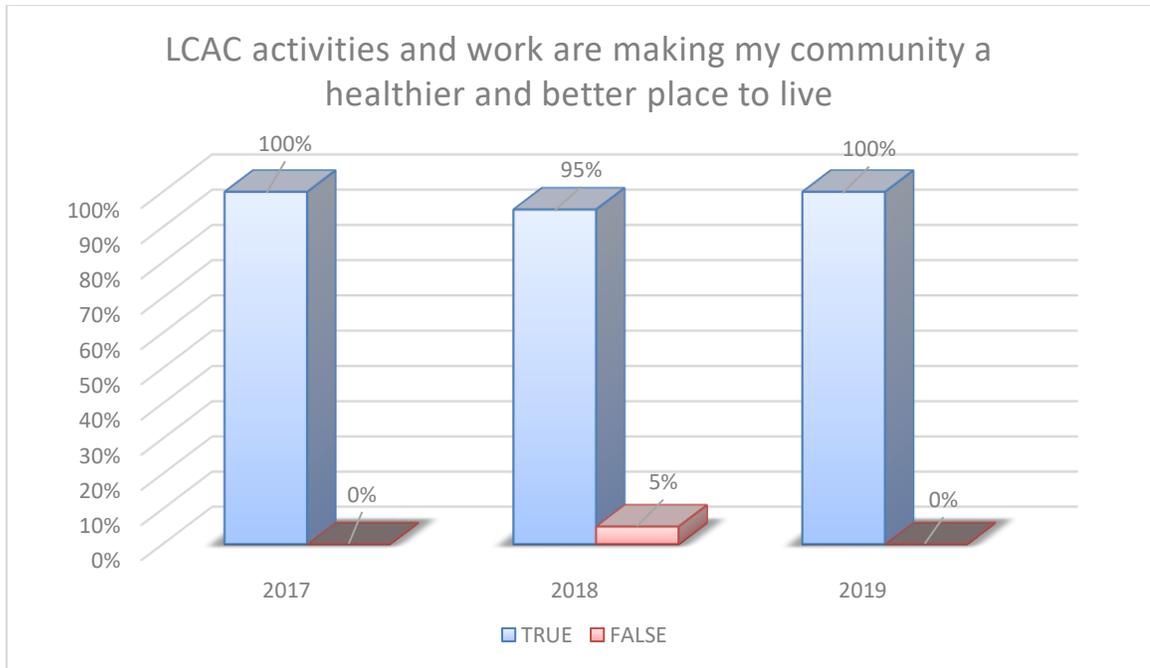
64% of participants felt that the overall state or condition of their LCAC was about the same as last year. 36% said it was stronger than last year. None cited conditions being worse than last year. This was almost an identical “flip” from last year.



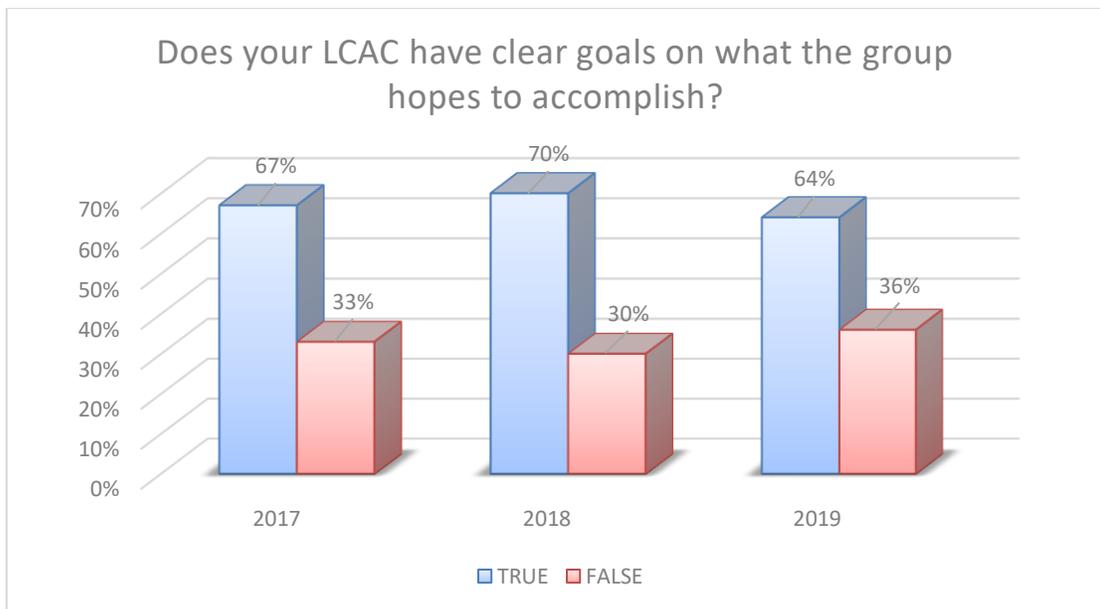
When asked to assess if the LCAC is impacting the Triple Aim, 59% fully agreed with the statement 33% said they somewhat agree, 8% somewhat disagree and none disagree. This increase may reflect the better understanding of the meaning of the Triple Aim.



100% of the participants agreed with the statement, LCAC activities and work are making their communities healthier and a better place to live.

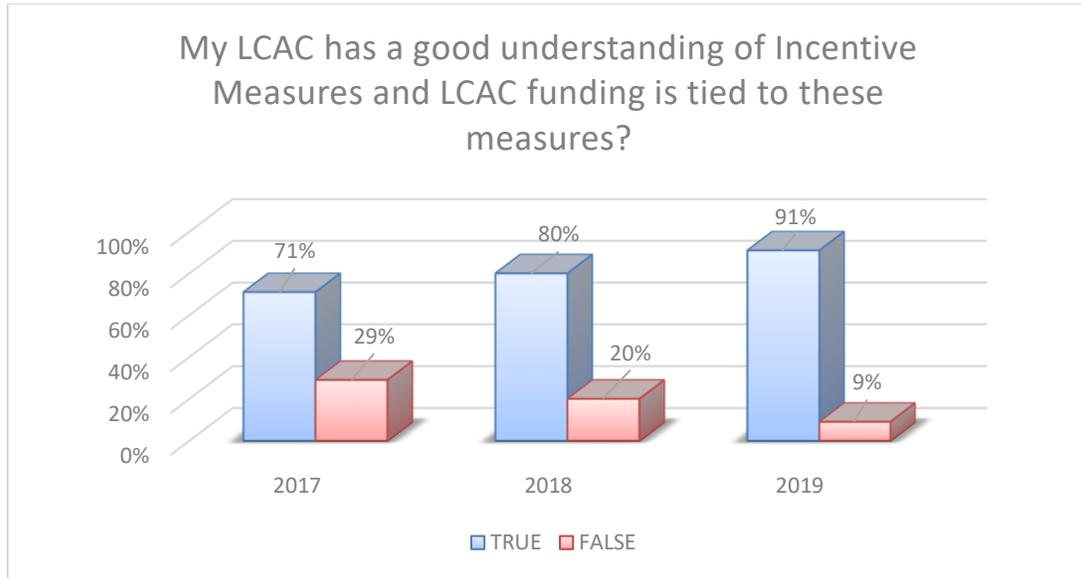


Reflecting the mix of performance among the 12 LCACs, 64% felt their LCAC had clear goals on what the group hopes to accomplish. 36% disagreed. Discussion reflected the fluidity of the health care environment and the difficulty of continuing to address changes at a rapid pace.

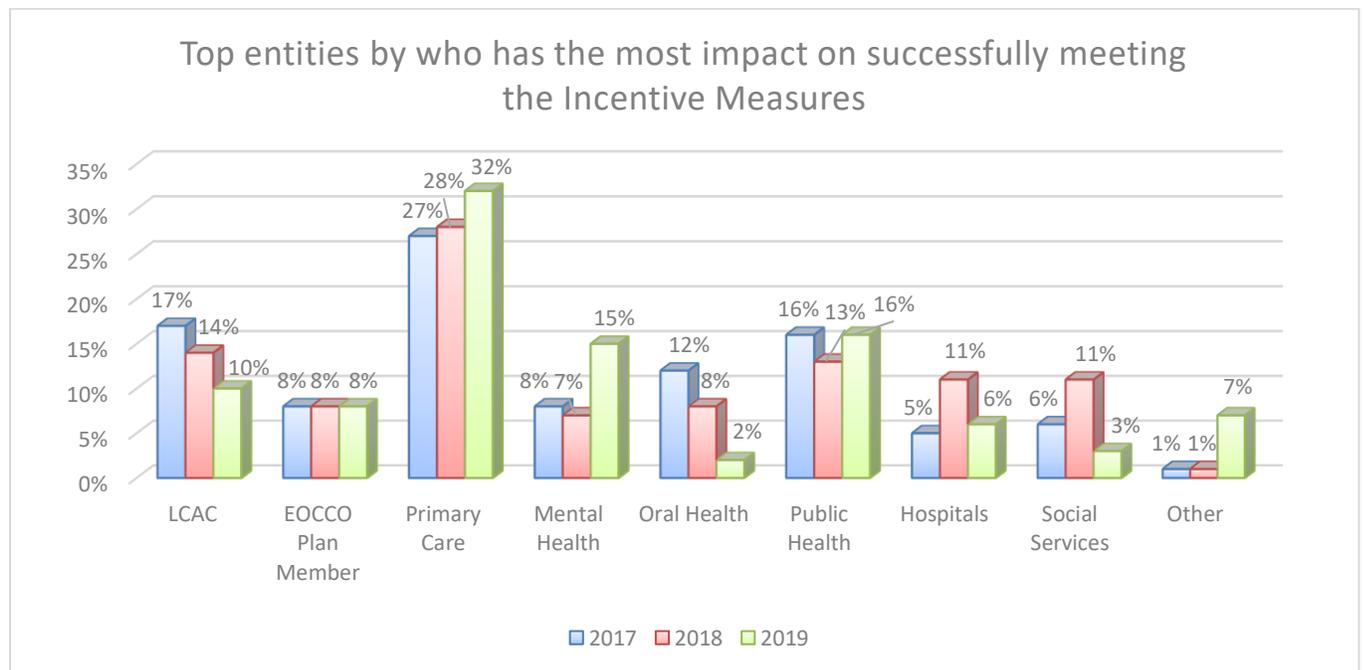


During the past several years, EOCCO support staff have made extensive efforts to raise the LCACs knowledge and understanding of the Incentive Measures. 91% agreed that their LCAC had a good understanding of the Incentive Measures and how LCAC funding is tied to the outcome of Incentive Measures, 9% disagreed. This indicates we are making progress, but continuing education and making available tools so that measures can be met

are still needed. This question was not asked in 2016. There was continual improvement from 2017.



In 2017 and 2018 we asked the RCAC members and guests to rank the top four entities that felt were most responsible for meeting the Incentive Measures. In priority order for the top five, they were Primary Care, Public Health, Mental Health, LCACs, and EOCCO Plan Members.



As the EOCCO continues to move from theory to practice, there lies within the evolutionary process a continuum for success and challenges.

During the past five Annual Reports, the EOCCO Board has made significant efforts to accommodate several recommendations. Data flow on Incentive Measures continues to

improve. EOCCO Staff have been diligent in producing monthly Incentive Measure Progress Reports for the LCACs. The new column showing where the county was at the same point in time last year enhanced the effort. We will continue to seek methods of improvement based on input from the community.

Formatting changes to the annual Cost and Utilization Report, by county, have led to better understanding of bending the cost curve at the local level. We will continue to seek methods of improvement based on input from the community.

The balance between directing activities and energy among “community health” and the health of EOCCO plan members remains a challenge. This is not an EOCCO specific issue, but rather a state-wide effect of the CCO’s population focus. Oregon’s health reform is based on serving the OHP population. Local planning, however, is concerned with health for all community members. The LCACs simply wish to acknowledge this as a continuing issue.

While progress has been made, some issues continue to be of concern. The following are past recommendations or iterations.

Incentive Measure Funds and other Community Benefit Reinvestments

The LCACs recognize that without Incentive Measure dollars being redistributed and Community Benefit Reinvestments through the Opt-In awards and continuation transformation grants, there would be few if any resources to conduct local activities. The LCACs are grateful for the opportunity to apply for the use of these funds.

At the March 26, 2019 Regional CAC meeting, the group endorsed the recommendations from the Morrow LCAC’s regarding use of Community Benefit Reinvestments. Their suggestions are here with edits (and addition of item 5) to expand beyond one county and be inclusive of all:

1. Continue to simplify the grant application process. With each passing year, applying for EOCCO grant funding (for the 6-8 least populated counties) has become more onerous. Continue to hold grantees accountable, but with reasonable eligibility and program requirements.
2. Continue to seek understanding of county issues and provide assistance with system improvement. The Community Health Plan’s outline the strategies employed and also incorporates EOCCO incentive measure goals and strategies. CBRI funding opportunities are becoming so prescriptive and strictly tied to the EOCCO population that it impedes our systems ability to improve health of the entire community.

It is becoming increasingly difficult for LCACs and partners to be eligible for funding that is compatible with and supportive of local comprehensive planning goals. Local communities do not have the luxury of developing “partitioned” programs or resources

serving only the EOCCO population. The local system must be preserved by collaboratively planning for all people residing in our county.

3. A considerable number of programs would not be successful without our “community” partners. It seems that community partners are systematically being excluded from requesting EOCCO funding unless they can identify and strictly address an incentive measure, even if a need and strategy had been identified in the local CHP and progress was being made toward that end.

Our concern is that if our community partners aren't justified or rewarded in an attempt to request or receive funding from EOCCO without unreasonable restriction, they will stop partnering with the health care providers and Incentive Measure goals for our region won't be achieved. This will become more and more important as we incorporate strategies to address social determinants of health.

4. It is a significant struggle to recruit and retain a health workforce. Creative flexible options will allow maintenance of high quality services in the areas of greatest need. Funding is critical to the mission, but someone has to complete the work. Limited human capital in the lesser populated counties to implement all new, innovative or pilot programs without some assurance of sustainability of current programs is problematic. An example of this requirement in CBIR application, “Support from CBIR program can be used to establish new roles within a community that are substantially devoted to improve the health of EOCCO members.”
5. With limitations in human capital and workforce availability, community capacity to support the work of the LCACs (who are composed primarily of volunteers) can be a barrier to project execution and completion. As the role of LCACs continues to evolve and expand (acting as an advisory council; management of funding for community-based projects; additional requirements and activities through the Regional Community Health Plan; and the requirements of CCO 2.0) having dedicated staff committed to the function of the LCACs is essential to the success of their work going forward. Support from the EOCCO Board of Directors in utilizing CBIR funds to support staff committed to the work of the LCAC will only enhance the efficacy and allow for continued development of innovative approaches to address gaps in services.

The pilot programs are very useful, but don't discontinue support for those programs that are currently working by expecting local resources to replace EOCCO investments.

Per Member Per Month Patient Centered Primary Care Homes- LCACs recognize that for many of the Incentive Measures they are dependent on local primary care clinicians to be successful. In 2017, when asked to rank the entities MOST responsible for meeting Incentive Measures Primary Care ranked the highest. (2018 & 2019 Results) Many LCACs have good relationships and active participation from clinic staff and some clinicians. Some do not. Primary care in partnership with LCACs can achieve better

integration of Incentive Measures at the community and clinic level. Some LCACs have established clinic manager meetings outside of the LCAC setting to focus on Incentive Measure activities. EOCCO staff have participated in these meetings.

Recommendation: Especially in those clinics that are Patient Centered Primary Care Homes who receive Per Member Per Month payments from the EOCCO, the LCACs request that a condition of those funds be to have someone from the clinic attend LCAC meetings.

Public Health and Incentive Measures- As noted above, the LCAC ranking of entities MOST responsible for meeting Incentive Measures was topped by Primary Care. Public Health was ranked second. Public Health plays a significant role in helping the community meet the measures including: Childhood Immunizations, Effective Contraceptive Use, Weight Assessment, Developmental Screening and Adolescent Well Care Visits.

The RCAC acknowledges and thanks the EOCCO for making a pool of funds available for ONLY Public Health to apply for, but that is not something they can use to support their basic population health functions which benefit the EOCCO and the entire community.

Recommendation: That the contributions of Public Health in meeting Incentive Measures be recognized by the EOCCO Board of Directors through a Per Member Per Month payment.

Traditional Health Workers: LCAC and community health partners have been encouraged to employ Community Health Workers and expected to submit claims for their services to ensure sustainability of the positions. We do not believe the amount of claims will cover the positions and feel it is necessary to measure the impact of Community Health Workers on the total health expenditures of those EOCCO plan members who interact with Community Health Workers.

Recommendation: Support EOCCO Data Analytics to conduct a study to determine the overall cost benefit impact of Community Health Workers in the EOCCO region.

Coordinated Media - Activities of the LCACs at the local level often go unrecognized by general public, leaving excellent stories of progress untold in earned media.

Recommendation: Consider portions of the Incentive Measure reinvestment to pay for media or media strategies that can benefit the entire region.

LCAC Charter Updates Because of anticipated changes due to CCO 2.0 requirements the RCAC held off on requesting Charter changes during this year.

Recommendation: When the outcome of EOCCO's CCO 2.0 application is known, review the Charters to make certain we are meeting expectations and requirements.