

**Oregon's Coordinated Care Model Summit:
Inspiring Health System Innovation
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Eastern Oregon CCO – Modeling Community Input and Involvement

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Sean Jessup, Director of Medicaid Programs, Moda Health
Moderator: Diana Bianco, Principal, Artemis Consulting**

Diana Bianco

We're now going to hear from Eastern Oregon CCO about their process of reaching into and hearing from the community. From the beginning, Eastern Oregon CCO knew that it was serving a vast geography and that each community had unique needs. They set about in a very intentional community engagement and community partnership effort. They don't have one community advisory council. They have twelve, which cover all of the counties that they serve. Now we're going to get to hear from Kevin Campbell from Greater Oregon Behavioral Health. He will share a little bit about the background and context of the formation of the EOCCO CACs. We're going to hear about how the CCO distributed their transformation funds in partnership with the community from Sean Jessup from Moda Health. Finally, we'll hear from Megan Gomez, a CAC member who will talk about her perspective on the work. We're going to start with Kevin.

Kevin Campbell

It's a privilege to be here. Our challenge in Eastern Oregon in creating a CCO is how we would possibly be local enough to be relevant and big enough to be solvent. If we were a county in the state of Oregon, we would be the seventh biggest county in population. If we were a state, we would be the size of the state of New York, with 50,000 square miles and less than 200,000 people total population. We finally achieved one member per square mile thanks to health transformation. We have to build on our strengths and one of the strengths we had was good relationships with counties. We put many, many miles, I don't know, couple hundred thousand miles, in the formation of the CCOs. Listening to communities, understanding communities, and not talking about health care reform. Talking about opportunity. Talking about opportunities for self-determination and local control, which is really what rural Oregon is all about. We didn't talk from an area of lack and needs, we talked from strengths. Relationships are strengths that rural Oregon has and Eastern Oregon has particularly strong.

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I think that the idea to form a community advisory council at every county level was really transformational. No regionalization unless they told us they wanted to regionalize. Certain CACs are now meeting together but they're still independent and meet separately. Every county forming a community health improvement plan of its own. Doing a community health assessment. Forming a regional community advisory council that was self-selecting with the chair of each local CAC. A county commissioner who was a convener or judge who were conveners of and co-appointers of the CACs coming together and forming a single vision for what our community health improvement plan would look like in Eastern Oregon. The proof is in the pudding. When you can come up with twelve independent plans and then have consensus that the plan that everybody agrees upon consists of better coordinate care to kids from zero to five. Breaking down the barriers to behavioral health services and getting rid of the stigma to accessing mental health. Coming up with common determinations of what community health workers are and could do and will do throughout the region. Basically looking at a preventative model for dental care for kids under the age of 10. Integrating public health into the health delivery system in its entirety. All of those things are population-based health efforts that have to impact the entire community, not just the Oregon Health Plan population. We formed, our regional CAC formed the Eastern Oregon Healthy Living Alliance which is a private not-for-profit recruiting dollars from the philanthropic community to support the needs of the entire communities in achieving our community health improvement plan. Not just leaving it out there as a Medicaid only plan. Thank you.

Sean Jessup

Thanks Kevin. I know Kevin talked a lot about our focus and commitment to communities and counties. That same focus and commitment was taken into consideration as we were developing our strategy for how EOCCO would use our 1.6 million dollars in transformation funds. As a result of our geography and our unique needs of each of our counties, we knew that a one-size-fits-all approach for how we're going to use those funds would not work. As a result and with approval by the EOCCO Board, we decided to have our own grant process. We submitted requests for applications out to a number of community partners including hospitals, primary care providers, public health, behavior health providers and even gave an opportunity for the local community advisory councils themselves to apply for grants. Our goals and strategy for this approach were to fund the most innovative grants which were the most relatable to health system transformation. We had a goal of having at least one transformation grant in each of the twelve counties that we serve. In communities where we had similar grants, we required those applicants to work together as a condition of funding. Really we wanted that collaboration to start and that helped free up dollars for other grantees.

In order to have the kind of a fair and impartial review process, MODA on behalf of the EOCCO hired the OHSU Center for Evidence-based Policy to help us administer the grant process. Overall we received 36 grant requests totaling 2.8 million dollars in funds requested. Obviously we couldn't fund all of those grants. We were able to fund twenty-three of those. It is also important to note that we were successful in our goal of getting one grant in each county. We made sure that a hundred percent of that 1.6 million in funds would go to the grantees. We did not take a single dollar and use that for administrative expenses related to the grant.

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There was a wide variety of grants across those twenty-three that were funded. I will give you an example of a couple of those. Gilliam County a very small county, the South Gilliam Health District submitted a request. That request was to build a wellness center. We were able to help fund the building of that Wellness Center. The Wellness Center is going to be attached to the health district which also serves as the primary care provider in the community. Their goal was to focus on reducing obesity, reducing disease burden on the population and to purchase equipment so that physical therapy services can be provided in that community, and that's not a service that's available today. The beauty of this grant is it will serve the entire community not just the Medicaid population. From the hospital standpoint, Good Shepherd Health Care System in collaboration with Umatilla Public Health and other entities, we were able to help fund the development of a workforce of community health workers. They're going to focus on population health management, case management, disease management and coaching other outreach efforts in helping members follow up for treatment. This particular grant's goal is to focus on reducing health disparities for low-income families and minorities.

Our last community advisory council I will give an example of is the Morrow County local community advisory council submitted a grant. We were able to help fund two nurse case managers that are going to focus on prenatal care and well-child exams including behavioral health screens and other routine screens. With this project, they're going to have other state and local services wrap around their program and include folks like Head Start and the school-based health centers that operate in that county. This particular grant will also fund one of the community health improvement projects that the local community advisory council submitted to the CCO. As we look at the next year, we're going to put together learning collaborative to showcase successes with an aim for sustainability of the most successful grants. Hoping that we can implement those across the CCO once our transformation funds are exhausted.

Megan Lee Gomeza

These gentlemen here are architects of a grand plan to bring together twelve counties under a regional set of priorities. I'm honored to represent Malheur County. First of all, I wanted to say that the view from the ground and from our CAC's level was one of community engagement. Not capacity building, because the capacity already existed in our community and they recognized the collaborative efforts of organizations, patients, clients, and community members that were already in existence. We really appreciated that they were not there to offer cookie-cutter solutions but guide us in the creation of own community health assessment and community health improvement plan. I don't know how familiar you are with Malheur County, but if you live in Multnomah County you can know this. If you moved out to our county, each resident would own eight acres of land.

Our county is very rural and we experience a disproportionately socioeconomic concerns that many organizations in our area had already attempted to address through collaboration with Oregon Solutions, through collaboration with one another. We are rural. We are self-reliant and resourceful. We're used to doing more with less. Our CAC and our CHP really focused on not duplicating any prior efforts but

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binding together all of the concerns of the member organizations and the patients that were present and participating. We recognize that we are a health professional shortage area. We understood that our community members were suffering from negative social determinants of health at a greater rate. We looked at over fifty health outcomes and social determinants of health in selecting the priorities for our committee.

In the end, after gaining a little bit more familiarity with the profile of our community (not our Medicaid members) but our community. We determined that we wanted to try to deploy a strategy that had worked before with populations which experienced desperate health care health outcomes. We are piloting a community health worker project with a segment of our population. Our adolescents 14-18 that have traditionally under-utilized health services in our community in our local health care neighborhood. It's our hope that providing these adolescents with more guidance about accessing wellness and preventive services will set them up for a lifetime of health care utilization patterns that will avoid chronic condition, which we currently see frequently in our population.

In the next year, I do want to say that the use of traditional health workers will expand in our county. The shortage of professional health care professionals is too great to be overcome by recruitment or workforce development. We are confident that with the support of our CCO, we will continue to grow innovative strategies that will serve our small rural unique county. One of twelve in the EOCCO.

Diana Bianco

Thank you. Thank you so much.

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