2024 Senate Bill 902 Report to the Oregon Legislature

Coordinated Care Organization (CCO) collaboration with providers of services to children & adolescents through Community Health Improvement Plans (CHPs)

December 31, 2024

OREGON HEALTH AUTHORITY

Contents

Acknowledgments

This publication was prepared by Oregon Health Authority Transformation Center staff. For questions about this report, please contact: transformation.center@odhsoha.oregon.gov.

Executive Summary

Senate Bill 902 (SB 902; 2015) requires coordinated care organizations (CCOs) to collaborate with service providers for children and adolescents through their community health improvement plans (CHPs). This bill requires OHA to gather this information and report it to the Oregon Legislature by December 31 of each even numbered year.

CCOs are required to complete a new CHP at least every five years. Some CCOs are on a three-year CHP cycle to align with local hospitals. Because of this, different CCOs submit their new CHPs at various times. On years they are not submitting a new CHP, CCOs are required to submit a CHP Progress Report annually to OHA In 2023, this included a narrative progress report and report questionnaire. All but one of the 16 CCOs submitted a CHP Progress report by 6/30/23. The one CCO, Cascade Health Alliance submitted a new CHP in 2023, and thus were not required to also submit a CHP Progress Report.

From June-July 2023, OHA staff reviewed CHP Progress Report submissions to assess the extent to which they met Oregon Revised Statutes (ORS), Oregon Administrative Rules (OARs) and CCO Contract requirements. The reporting period covered activities from 7/1/22-6/30/23. Through a comprehensive review of the progress reports, the Transformation Center shares the following key findings:

CCOs worked with many of the SB902 partners to implement their CHPs, but not all. Findings showed:

- 100% of CCOs worked with local public health department administrators and other child and adolescent health program administrators to implement their CHP
- All but one CCO worked with hospitals in their region when implementing their CHPs
- Over half of CCOs worked with community mental health providers, oral health providers, community health centers, Healthy Start Family Support services programs, early learning hubs (ELHs) and programs developed by ELHs or the Early Learning Council
- None of the 15 CCOs reported working with the statewide Youth Development Council to implement their CHP

CCOs partnered with ELHs in their regions most frequently supporting the areas of:

- Childcare
- Maternal child health
- Parenting education
- Pre-school
- Kindergarten readiness

Several themes emerged for how CCOs worked with CHP partners to coordinate the effective and efficient delivery of health care to children and adolescents. Focus areas included:

- Access to care
- Behavioral health services
- Prevention
- The social determinants of health

Please refer to the SB902 findings section for detailed results.

Report Methodology

2023 CHP Progress Reports were analyzed for the 2024 SB902 Report, as 2024 CHP Progress Reports were not available by the time this report was written. These submissions provide a one-year snapshot of CCO CHP implementation from July 1, 2022, to June 30, 2023. As referenced in the Executive Summary, 15 of 16 CCOs submitted a 2023 CHP Progress Report. However, it should be noted that several CCOs have shared CHPs with other CCOs. This includes:

- Advanced Health and AllCare CCO (Curry CHP)
- AllCare CCO and Jackson Care Connect (All in for Health CHP)
- Health Share of Oregon & Trillium Community Health Plan Tri-Counties (Together in Health CHP)
- PacificSource Lane & Trillium Community Health Plan Southwest (Live Healthy Lane CHP)

For the purposes of this report, findings are displayed by CCO rather than by CHP.

From June-July 2023, OHA staff undertook a thorough review of these progress report submissions to assess compliance with the established requirements (refer to Appendix A for detailed criteria). Following this initial review, Transformation Center staff provided feedback to each CCO, identifying areas where specific requirements were met, not met or only partially met. If not met or partially met feedback was provided, CCOs were given 30 calendar days to address and correct these deficiencies. Upon receipt of the corrections, OHA staff conducted subsequent reviews to ensure all feedback was properly addressed.

SB902 findings reflected in CHP Progress Reports

SB902 partners involved in CHP implementation

As noted in the table below, CCOs worked with many of the SB902 partners, but not all. CCOs are required to have a shared CHP with local public health and hospitals, and that partnership is reflected in the number of CCOs working with these partners during CHP implementation. Other frequent collaborators across CCOs included child & adolescent health program administrators, early learning hubs, and Healthy Start family support services programs.

In addition, close to half of CCOs worked with local school-based health centers during CHP implementation. In a few cases, CCOs worked with school nurses and/or school mental health providers in schools that did not feature a school-based health center. While all CCO CHP activities included youth development programming, none of the 15 CCOs in this year's report indicated working with the statewide Youth Development Council.

Table 1: Partners required by SB902 that were involved in CHP implementation.

SB902 Partner	# of CCOs	% of CCOs
Local public health department administrators	15	100.0%
Other child and adolescent health program administrators	15	100.0%
Hospitals in the region	14	93.3%
Early learning hubs (ELHs)	13	86.7%
Programs developed by the ELH and/or Early Learning Council	11	73.3%
Healthy start family support services programs	10	66.7%
Community health centers	9	60.0%
Oral health care providers	9	60.0%
Community mental health providers	8	53.3%
School-based health centers	7	46.7%
Cover All Kids & other medical assistance programs	5	33.3%
Relief nurseries	5	33.3%
School nurses	3	20.0%
School mental health providers	1	6.7%
Youth Development Council	0	0.0%

Themes and activities demonstrating how CCOs worked with early learning hubs (ELHs) and the statewide Early Learning Council

Several themes emerged for how CCOs worked specifically with ELHs in their region. During the planning phases of CHP development, ELH staff most frequently provided feedback and guidance on CHP prioritization and strategies. This was done through ELH staff attending CHP meetings, participating in the CCO's Community Advisory Council (CAC), and in at least one case, serving on the CHP steering committee.

Programmatically, the following themes emerged (with selected examples highlighted below):

Childcare

- Baby Promise pilot project aimed at building a supply of quality infant and toddler care

- Participation in a childcare task force or coalition to address the shortage of childcare options in county

Maternal child health & parenting education

- Sponsoring an Early Learning Parent Resource Center
- Hosting Be-Strong Family Cafes for Mothers of Preschoolers
- Improving access to maternal child health services through programs such as Family Connects, WIC, Help Me Grow, and the Healthy Birth Initiative

Pre-school

- Sponsoring Pre-school Promise, a free pre-K program for ages 3-5, aimed at low-income families
- CCO provided funding to support ELHs efforts to connect children to pre-K through family outreach

Kindergarten readiness

- Health Aspects of Kindergarten Readiness: CCO System-Level Social-Emotional Health

Only a few CCOs reported working directly with the statewide Early Learning Council (ELC). In two cases, CCOs shared results from a study of issues surrounding families accessing resources in the region. Other examples included ELC staff reviewing the CHP and providing feedback on CHP prioritization and strategies.

Themes and activities demonstrating how CHP activities improved the coordination of effective and efficient delivery of health care to children and adolescents in the community

Several themes emerged for how CCOs worked with their CHP partners to improve the coordination of effective and efficient delivery of health care to children and adolescents. These included: Access to care, behavioral health services, prevention, and the social determinants of health (selected examples highlighted below).

Access to care

- Increased the availability of behavioral health providers, and improving timely access to specialty behavioral health providers
- Increased access to traditional health workers (including youth-related peers)
- Increased referrals between community-based organizations and health care providers via Connect Oregon
- Improved access to quality and affordable health care services such as well child checks and immunization appointments through mobile mental clinic services at schools

Behavioral health services

- Connected students to additional behavioral health resources through educational partnerships (including school districts)
- Disseminated culturally and linguistically tailored information on substance use prevention to youth
- Reduced substance abuse emergency department visits in marginalized areas

- Developed an intensive in-house behavioral health treatment program (IIBHT) to help children, youth, and young adults through age 20 who required more frequent and intensive behavioral health treatment

Prevention

- Convened a monthly Youth Advisory Council to hear feedback from youth to inform the development and implementation of youth-serving programs
- Sponsored mobile health clinics to increase youth vaccination rates
- Increased two-year youth immunization rates
- Decreased vaping and e-cigarette use among youth

The social determinants of health

- Adverse childhood experiences/trauma:
    - Supported the mitigation of youth trauma (and resilience) by creating affirmation closets in a local high school, and providing supports such as travel and lodging reimbursement for out-of-area travel to access gender affirmation care
    - Implemented programs that allow for police and schools to communicate when a child has experienced a trauma relating to justice involving a family member
- Health information technology:
    - "No wrong door" approach to accessing resources improved through funding Connect Oregon/Unite Us, a closed loop referral system
- Housing:
    - Provided housing and resources to youth in crisis through a youth shelter and community outreach program
    - Provided emergency shelter assistance to youth in rural areas
- Other:
    - Offered supports such as coats, shoes, blankets, snacks, and activity packs for at-risk youth

Appendix: 2023 CCO Community Health Improvement Plan Progress Report Guidance

This guidance helps CCOs address contractual requirements for the community health improvement plan (CHP) progress report deliverable. This deliverable can be found per **Exhibit K, Section 7, Paragraph l** and **Oregon Administrative Rule 410-141-3730(10)**.

A. The CHP progress report is due by June 30, 2023. It must be submitted by email to the CCO deliverables mailbox at CCO.MCODeliverableReports@odhsoha.oregon.gov.

B. Two documents are required to complete your annual progress report:
   1) The progress information noted in item C below; and
   2) The completed CCO CHP Progress Report Questionnaire (starting on page 2 of this guidance document) as an appendix to the progress report. If your CCO has multiple CHPs, you must complete a separate questionnaire for each CHP. If your CCO has multiple service area contracts, you must submit a separate progress report for each contract.

C. The annual progress report should document progress made in implementing the CHP, including:
   1) Changes in community health priorities, goals, strategies, resources or assets;
   2) Strategies used to address the CHP health priorities;
   3) The role of the CCO and responsible partners who have been involved creating and implementing strategies to address CHP health priorities;
   4) Progress and efforts made (including services provided and activities undertaken) to-date toward reaching the metrics or indicators for CHP health priorities; and
   5) Identification of the data used; and the sources and methodology for obtaining that data, to evaluate and validate the progress made toward metrics or indicators identified in the CHP.
      - For CHPs that did not include quantifiable metrics or indicators for each health priority goal, the CCO should include the metric/indicator, data source, baseline data and year, and current year's data for each health priority goal. The CCO may include additional information to provide insight on data collection or context for why a metric/indicator has or has not made progress.
      - For CHPs that did include quantifiable metrics or indicators for each health priority goal, the CCO should include the metric/indicator, data source, baseline data and year, and current year's data for each health priority goal. The CCO may include additional information to provide insight on data collection or context for why a metric/indicator has or has not made progress.

D. The annual progress report evaluation criteria, includes ensuring the progress report:

1	Be published annually by the CCO, and then submitted to OHA. Publishing requires, at a minimum, publicly posting the progress report online to CCO and/or separate CHA/CHP website.
2	Report details changes in community health priorities, goals, strategies, resources or assets. The progress report should note any changes from the previous progress report, if applicable. If there are no changes, the CCO should clarify this as well in the progress report.
3	Include information about agencies and organizations, including the CCO, who created and implemented strategies to address CHP health priorities.
4	Detail progress and efforts to date in addressing CHP health priorities.
5	Detail progress to date towards meeting the CHP metrics and indicators for each CHP health priority.

6	Identifies what data, data sources, and data methodology were used to validate progress made towards meeting the CHP metrics and indicators for each CHP health priority.
7	Includes a completed OHA questionnaire.

CHP Progress Report Questionnaire

Key Players, Health Priorities and Activities in Child and Adolescent Health

1. **Which of the following key players are involved in implementing the CCO's CHP? (select all that apply)**
   - ☐ Early learning hubs
   - ☐ Other early learning programs[1]
     Please list the programs: Click or tap here to enter text.
   - ☐ Youth development programs[2]
     Please list the programs: Click or tap here to enter text.
   - ☐ School health providers in the region
   - ☐ Local public health authority
   - ☐ Hospital(s)

2. **For each of the key players involved in implementing the CCO's CHP, indicate the level of engagement of partnership:**

	No engagement	Partial engagement	Full engagement
	1	**2**	**3**
Early learning hubs	☐	☐	☐
Other early learning programs[1]	☐	☐	☐
Youth development programs[2]	☐	☐	☐
School health providers in the region	☐	☐	☐
Local public health authorities	☐	☐	☐
Hospital(s)	☐	☐	☐

Optional comments: Click here to enter text.

3. **Describe how these key players in the CCO's service area are involved in implementing your CHP.**

4. **If applicable, identify where the gaps are in making connections to the key players listed above.**

5. **For CHP priorities related to children or adolescents (prenatal to age 24), describe how and whether the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.**

[1] This could include programs developed by Oregon's Early Learning Council.
[2] This could include programs developed by Oregon's Youth Development Council.

6. **What activities is the CCO doing for children or adolescents (prenatal to age 24)?**

7. **Identify ways the CCO and/or CAC(s) have worked with school and adolescent providers on prioritized health focus areas.**

Health Disparities

CCO contract: Exhibit K, Part 6 & 7

8. **Describe any new CCO and CHP partner efforts in the past year to address health disparities that were prioritized in the CHP. Include updated metrics or indicators to show progress from the prior year in addressing identified health disparities.**

9. **What new successes or challenges has the CCO had in engaging populations experiencing health disparities in the CHP implementation?**

Alignment with the State Health Improvement Plan (Healthier Together Oregon)

Per contract section Exhibit K, Part 7, CCOs are required to address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

10. **If any changes from the prior progress report, please note which of your CCO's CHP strategies align with the 2020-2024 State Health Improvement Plan strategies.**
    - ✓ The SHIP (healthiertogetheroregon.org/priorities/) priority areas include 1) Institutional Bias, 2) Adversity, Trauma and Toxic Stress, 3) Economic Drivers of Health, 4) Access to Equitable Preventive Health Care, and 5) Behavioral Health.
    - ✓ The SHIP priorities are being implemented with strategies in eight implementation areas, as outlined below. Each implementation area includes a link to a list of the associated strategies. Check the box to indicate where a specific CCO CHP strategy is in alignment with a SHIP strategy and provide a brief narrative describing the alignment.

Equity and Justice

☐ Declare institutional racism as a public health crisis.

☐ Ensure State Health Indicators (SHIs) are reported by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality and geographic location.

☐ Require state agencies to commit to racial equity for black, indigenous & Alaskan Indian/Alaskan Native individuals, and people of color in planning, policy, agency performance metrics and investment.

☐ Reduce legal and system barriers for immigrant and refugee communities, including people without documentation.

☐ Ensure accountability for implementation of anti-racist and anti-oppression policies and cross-system initiatives.

☐ Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.

☐ Build upon and create Black, Indigenous, People of Color – American Indian/Alaskan Native (BIPOC-AI/AN)-led, community solutions for education, criminal justice, housing, social services, public health and health care to address systematic bias and inequities.

☐ Require that all public-facing agencies and contractors implement trauma-informed policies and procedures.

Healthy Communities

☐ Provide safe, accessible and high-quality community gathering places, such as parks and community buildings.

☐ Expand culturally and linguistically responsive community-based mentoring and peer-delivered services.

☐ Develop community awareness of toxic stress, its impact on health and the importance of protective factors.

☐ Enhance community resilience through the promotion of art and cultural events for priority populations.

☐ Invest in workforce development and higher education opportunities for priority populations.

☐ Invest in workforce development and higher education opportunities for priority populations.

☐ Strengthen economic development, employment and small business growth in underserved communities.

☐ Enhance financial literacy and access to financial services and supports among priority populations.

☐ Increase affordable access to high-speed internet in rural Oregon.

☐ Build climate resilience among priority populations.

☐ Center BIPOC-AI/AN communities in decision making about land use planning and zoning in an effort to create safer, more accessible, affordable, and healthy neighborhoods.

☐ Co-locate support services for low-income people and families at or near health clinics.

☐ Expand programs that address loneliness and increase social connection in older adults.

Healthy Families

☐ Ensure access to and resources for affordable, high quality, culturally and linguistically responsive childcare and caregiving.

☐ Expand evidence based and culturally and linguistically responsive early childhood home visiting programs.

☐ Build family resiliency through trainings and other interventions.

☐ Increase patient health literacy.

☐ Expand the reach of preventive services through evidence-based and promising practices.

☐ Support Medicare enrollment for older adults through the expansion of the Senior Health Insurance Benefits Assistance (SHIBA) program

☐ Increase access to pre and postnatal care for low-income and undocumented people.

☐ Improve access to sexual and reproductive health services.

☐ Use healthcare payment reforms to support the social needs of patients.

Healthy Youth

☐ End school related disparities for BIPOC-AI/AN children and youth through teacher training, monitoring of data and follow-up with teachers, administrators and schools.

☐ Increase use of mediation and restorative justice in schools to address conflict, bullying and racial harassment.

☐ Ensure all school districts are implementing K-12 comprehensive health education according to law.

☐ Expand recommended preventive health related screenings and interventions in schools.

☐ Increase access to dental care that is offered in schools, such as dental sealants and fluoride varnish.

☐ Provide culturally and linguistically responsive, trauma informed, multi-tiered behavioral health services and supports to all children and families.

Housing and Food

☐ Increase affordable housing that is co-located with active transportation options.

☐ Increase homeownership among BIPOC-AI/AN through existing and innovative programs.

☐ Require Housing First principles be adopted in all housing programs.

☐ Maximize investments and collaboration for food related interventions.

☐ Build a resilient food system that provides access to healthy, affordable and culturally appropriate food for all communities.

☐ Increase access to affordable, healthy and culturally appropriate foods for people of color and low-income communities.

Behavioral Health

☐ Enable community-based organizations to provide culturally and linguistically responsive information about behavioral health to the people they serve.

☐ Implement public awareness campaigns to reduce the stigma of seeking behavioral health services.

☐ Conduct behavioral health system assessments at state, local and tribal levels.

☐ Create state agency partnerships in education, criminal justice, housing, social services, public health and health care to improve behavioral health outcomes among BIPOC-AI/AN

☐ Improve integration between behavioral health and other types of care.

☐ Incentivize culturally responsive behavioral health treatments that are rooted in evidence-based and promising practices.

☐ Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.

☐ Use healthcare payment reform to ensure comprehensive behavioral health services are reimbursed.

☐ Continue to strengthen enforcement of the Mental Health Parity and Addictions Law.

☐ Increase resources for culturally responsive suicide prevention programs for communities most at risk.

Workforce Development

☐ Expand human resource practices that promote equity.

☐ Implement standards for workforce development that address bias and improve delivery of equitable, trauma informed, and culturally and linguistically responsive services.

☐ Require sexual orientation and gender identity training for all health and social service providers.

☐ Require that all public facing agencies and contractors receive training about trauma and toxic stress.

☐ Support alternative healthcare delivery models in rural areas.

☐ Create a behavioral health workforce that is culturally and linguistically reflective of the communities they serve.

☐ Increase the cultural and linguistic responsiveness of health care through use of traditional health workers and trainings.

Technology and Health

☐ Expand use of telehealth especially in rural areas and for behavioral health.

☐ Improve exchange of electronic health record information and data sharing among providers.

☐ Use electronic health records to promote delivery of preventive services.

☐ Support statewide community information exchange to facilitate referrals between health care and social services.