Agenda

Meeting: Oregon CIE Advisory Group
Date: Tuesday, January 21, 2020 **Time:** 9:00 - Noon
Location: Oregon Medical Association, 11740 SW 68th Parkway Portland, OR 97223

Call-in information: 503-850-8755 No Pin Needed
Uber conference link: https://www.uberconference.com/ohlc20

Topics	Time	Action	Lead
Welcome & Agenda Review	9:00 am	Inform	Liz Whitworth
Kick off Meeting Recap & Communications Update	9:05 am	Inform	Liz Whitworth
HITOC Strategic Plan & Input	9:25am	Inform/Discuss	Susan Otter
Health Equity Alignment and Discussion	9:50 am	Inform/Discuss	Carly Hood-Ronick
BREAK & VOLUNTEER SIGN UP	10:20 am		
Connecting Health Care and Social Service Sectors: ***CBO Spotlights*** • **C.H.A.N.C.E.** • **Impact NW** • **Oregon Food Bank** ***Linking Clinical Care to Social Services*** • **Thrive Local**	10:30 am	Inform/Discuss	Jeff Blackford Andy Nelson Lynn Knox Kristin Kane
Next Steps/Wrap Up	11:50 am	Inform	Michael Pope

HIT COMMONS
Accelerating Health Information Technology

Oregon Community Information Exchange (Oregon CIE)
Advisory Group
January 21, 2020

IN PARTNERSHIP WITH OREGON HEALTH LEADERSHIP COUNCIL | Oregon Health Authority

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Agenda

- Welcome & Agenda Review
- Kick off Meeting Recap/Communications Update
- HITOC Strategic Plan & Input
- Health Equity Alignment and Discussion
- Break
- Connecting Health Care and Social Service Sectors
  - C.H.A.N.C.E.
  - Impact NW
  - Oregon Food Bank
  - Thrive Local
- Wrap up

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Kick off Meeting Recap & Communications Update

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Introductions: If not done in December

- Name
- Organization
- Title
- One sentence on your organization and link to this work
- What do you bring to the table (e.g., specific expertise)
- Your hope for this work in 2020

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Meeting Recap/Themes

- Vendor space becoming crowded
- Vendor proliferation should be limited
- Burden on CBOs needs to be considered
- Now is the time for collaboration
- Now is the time to get this right
- Keeping an equity and patient centric lens is key in the decision making

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Advisory Group "Hopes" For This Work

The Advisory Group hopes to focus on these core ideas as part of the work in 2020:

- Equity/Digital Equity
- Learning from other states
- Standardization/Optimization of best practices across organizations
- Coalition/Cohesion
- Common Utility
- Sustainability for CBOs
- Connecting the dots between CBOs and Providers
- Broad communication/engagement across stakeholder groups
- **What else?**

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Advisory Group Roster & Communications Review

- Current Group Roster is 26 individuals
- Membership selection includes broad representation across CIE topics
- Balancing manageable size to ensure effective conversations/actions and ensuring all voices—a few more additions in process based on your feedback
- Communications materials and strategy will seek to engage a multitude of additional stakeholders:
- Website to be updated w/ core materials ASAP!

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Charter Updates from Discussion in December

- Based on feedback from Advisory Group, our group charter was updated to include language to address the following:
  - Health equity lens
  - Bi-directional interface
  - Addressing “whole person” care
  - A need to limit vendor proliferation
  - Acknowledgement of the burden on CBOs
- As requested, the HIT Crosswalk for decision making linkages is included in the Appendix for reference

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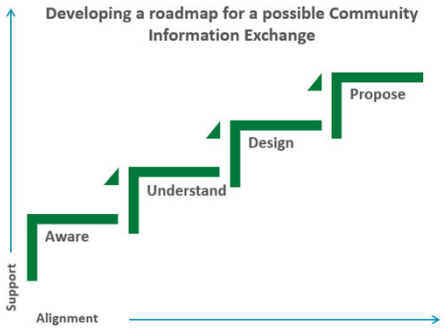
Communications Plan

- HITC in conjunction with the OHC Communications Team have developed a Communications Strategy.
- The plan will be shared with the Advisory Group at the next meeting.



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Communications: Call to Action

- HITC needs the Advisory Group to assist with developing **a list of organizations and contacts who should be informed of Advisory Group progress**.
- We are in the process of posting Charter, Fact Sheet, and other communications materials on Oregon CIE Website for reference and circulation:
- http://www.orhealthleadershipcouncil.org/oregon-community-information-exchange-ocie/

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HITOC Strategic Plan & Input

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Your input: Oregon's health IT strategies

Oregon's Health IT Oversight Council (HITOC) is revising Oregon's strategic plan for health IT for 2021 and beyond.

Where are Oregon's strategies working well? Where do we need to change course? HITOC wants your input!

Oregon Health Authority

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What is Oregon's health IT strategic plan?

- OHA is transforming the health care system; the core of those efforts is the coordinated care model
- The coordinated care model relies on health IT to succeed
- Coordinating health IT efforts at the state level is important because there are so many moving parts
- HITOC is charged with creating a statewide strategic plan for health IT in Oregon

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How does health IT support the coordinated care model?

Health IT helps...	
Consumers/patients, their families, and their caregivers	Get access to their own health information and participate in their care
Providers	Securely gather, store, and share patients' clinical data so the care team can work together to provide care
Providers	Track and report on quality measures, which support efforts to hold the health care system accountable for delivering high-quality care
CCOs, health plans, and providers	Analyze data to identify disparities and identify patients who need more care to allow targeted efforts to improve health

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Health IT Progress: Key Areas

- Providers are using EHRs/EMRs at high rates overall
- Health information exchange options have grown significantly
- Health IT supports value-based payment
- Health IT can help address social determinants of health
- See handout for details about how HITOC's work supports goals

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Health IT goals/areas

Goal/Area	Description
Goal 1: Share Patient Information Across the Care Team	Oregonians have their core health information available where needed so their care team can deliver person-centered, coordinated care.
Goal 2: Use Data for System Improvement	Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, and incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.
Goal 3: Patients Can Access Their Own Health Information and Collaborate in Their Care	Individuals and their families access, use and contribute their clinical information to understand and improve their health and collaborate with their providers
Emerging Area: Health IT supports social determinants of health and health equity	

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Conversation starters for your input

Considering the goals/areas on the previous slide:

- How is this going for you today?
- What would achieving this goal look like?
- Where are you experiencing impacts?
- What has been most helpful?
- Where are the biggest challenges/barriers?
- What are the right roles for state, providers, CCOs/health plans, and others?
- What changes would have the biggest positive impact? Biggest negative impact?

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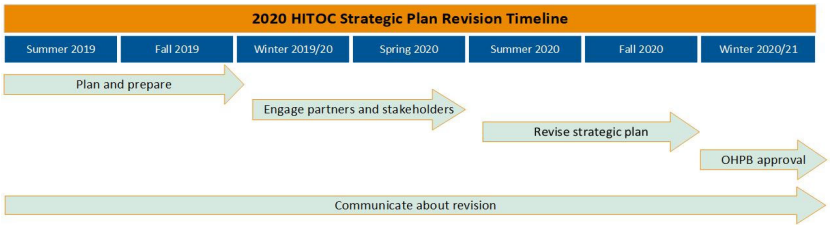
Process and input opportunities



- Join a listening session in person or by phone. Register at go.usa.gov/xpzy2.
- Submit a written comment (Feb. 1 – Apr. 30) at go.usa.gov/xpzVt
- Stay up to date at our website, go.usa.gov/xpeQc

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Key Resources

- 2017-2020 Strategic Plan for Health IT go.usa.gov/xpzEt
- Health IT Oversight Council (HITOC) Overview go.usa.gov/xpzEK
- Office of Health IT Overview go.usa.gov/xpzEz
- Health IT Roles (HITOC, HIT Commons, and more) go.usa.gov/xpzEJ
- 2019 Data Report to HITOC (draft) go.usa.gov/xpzEh

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Health Equity: Alignment & Discussion

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Health Equity Definition

Health Equity Committee (HEC)
Carly Hood-Ronick, HEC
Michael Anderson-Nathe, HEC
Leann Johnson, Director OHA Equity and Inclusion Division

Oregon Health Authority | Office of Equity & Inclusion

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Definition adopted by OHA and OHPB

- In October 2019, the Oregon Health Policy Board and the Oregon Health Authority adopted the heath equity definition developed by the Health Equity Committee.
- HEC Co-Chairs and Equity and Inclusion Division Director planned a series of presentations to OHPB Committees to introduce the definition.
- The Health Equity Committee is currently developing a definition framework aimed to support the operationalization and the development of metrics.

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Current work

- Presentations on health equity definition:
  - Medicaid Advisory Committee (12/2019)
  - HITOC (11/2019)
  - HPQMC (12/2019)
  - Health Care Workforce Committee (1/2020)
  - Metrics and Scoring (01/2020)

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The need for a health equity definition

HEC is tasked with making recommendations to OHPB, OHA, and the broader health systems in Oregon using an equity lens (HEC Charter, 2017)

Development of an equity framework starts from a common working definition of health equity.

Consensus around a definition of health equity helps foster dialogue and bridge divides.

Lack of clarity on the definition can pose a barrier for effective engagement and action

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Health Disparities v/s Health Inequities

Health Disparities

- **Health disparities** mean the same thing as health inequalities. They are numeric differences in outcomes.

(Boston Public Health Commission)

Health Inequities

- **Health inequities** are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.

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For example

- Male babies are generally born at a heavier birth weight than female babies. **This is a health disparity.**
- We expect to see this difference in birth weight because it is rooted in genetics. Because this difference is unavoidable, it is considered a **health disparity**.

- Babies born to Black women are more likely to die in their first year of life than babies born to White women.
- A higher percentage of Black mothers are poor and face hardships associated with poverty that can affect their health.
- However, we find differences in the health of Black and White mothers and babies comparing Blacks and Whites with the same income.
- Research has shown links between the stress from racism experienced by Black women and negative health outcomes. **This is a health inequity** because the difference between the populations is unfair, avoidable and rooted in social injustice.

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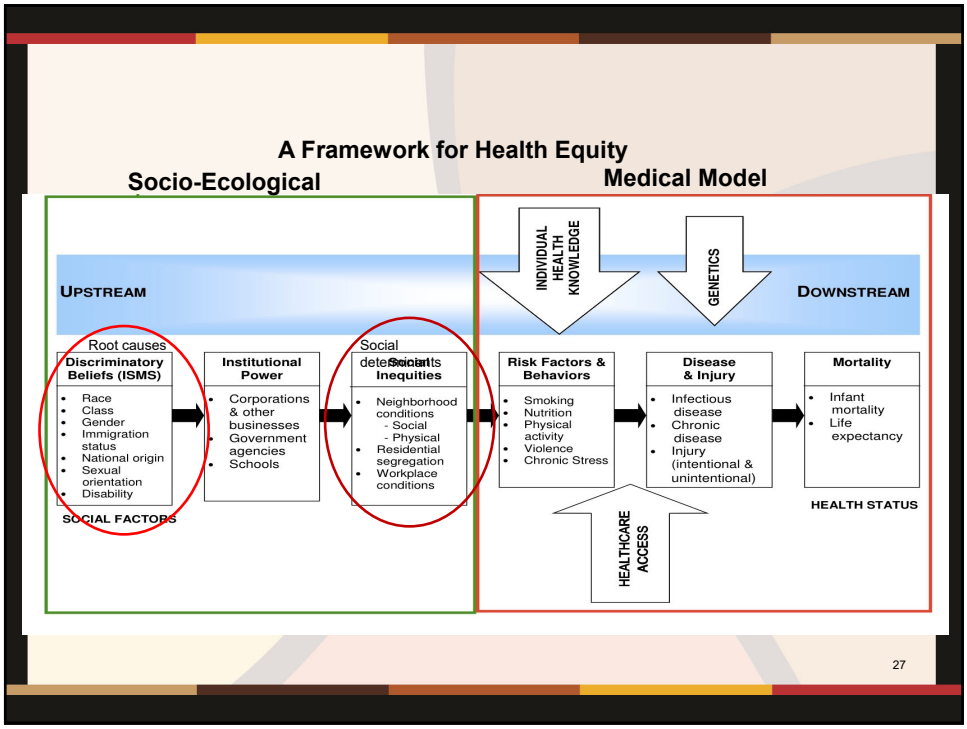

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Definition Vetting and Feedback

- Tribes
- Community Advisory Councils
- Community Based Organizations
- Oregon Health Policy Board (OHPB)
- OHPB Committees
- Coordinated Care Organizations
- Regional Health Equity Coalitions

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Assumptions and Values that informed the definition

Health is broadly defined as a positive state of physical, mental, and social well-being and **not merely the absence of disease**.

Everyone has the right to a standard of living adequate for health, including nutrition, education, housing, medical care, and necessary social services.

Rural racial/ethnic minority populations have substantial health, access to care, and social determinants of health challenges that can be overlooked when considering aggregated population data.

Inequities in population health outcomes are primarily the result of **social and political injustice**, not lifestyles, behaviors, or genes.

Addressing health inequities means addressing differences that are not only unnecessary and avoidable but also, unjust and unfair.

Equity must be intentionally pursued as a strategy; it will not necessarily happen as a byproduct of other development efforts.

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HEALTH EQUITY DEFINITION

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Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The **equitable distribution or redistribution** of resources and power; and
- **Recognizing, reconciling and rectifying** historical and contemporary injustices.

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Comments or Questions

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Break & Volunteer Sign Up

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Thrive Local

Connecting Health Care and Social Service Sectors

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CBO Spotlight – C.H.A.N.C.E.

- Overview of Organization/Key Programs
- Challenges in Connecting to Health Care/Clinical Providers
- Opportunities/Recommendations for Connecting with Health Care/Clinical Providers
- Question and Answer

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CBO Spotlight – IMPACT NW

- Overview of Organization/Key Programs
- Challenges in Connecting to Health Care/Clinical Providers
- Opportunities/Recommendations for Connecting with Health Care/Clinical Providers
- Question and Answer

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CHANCE

Offering recovery support services for friends, family and the people of Linn, Benton and Lincoln Counties.

CHANCE

Mission Statement

Our mission is to assist individuals with our communities who have mental health and / or substance abuse related issues, and who are seeking recovery to effectively implement positive change.

CHANCE provides support, guidance, and the necessary resources to facilitate development of life skills.

CHANCE integrates short term goals with long term goals so individuals have a better chance of becoming productive members of our community. Our goal is to demonstrate our commitment by applying spiritual values.

Vision Statement

C.H.A.N.C.E. offers peer guided wellness services and supports for community members seeking personalized recovery from life crises.

We achieve this through compassion, advocacy and understanding.

Locations

Albany
(Main Headquarters)

Corvallis

Lebanon

Lincoln City
(Regional Headquarters)

Newport

Who we are…

- C.H.A.N.C.E. is a peer ran and led recovery support centers, that uses non-clinical, peer based activities that engages, educates and supports an individual to successfully make the life changes necessary to recover from mental health and or substance abuse disorders.

What we offer…

- CHANCE offers a variety of supports, including case management, employment supports, transportation, rental assistance, birth certificate and ID supports, financial budgeting, GED assistances, access to primary care, transportation to detox and or treatment, smoking cessation, food box 101, Peer Support Trainings, support groups, AA, NA, DDA, and much, much, more.

Some info about CHANCE.

- CHANCE has been around since 2005.
- CHANCE employs 25 people in five location.
- CHANCE serves over 1600 members in the tri county region.
- We have a 24 / 7 emergency hotline. We will meet “curb side” or at the ED or jail with in 30 minutes of a call. (Albany only at this time)
- We will take people to detox, same day if a detox bed is avail and the person is willing, anywhere in the state.
- Has a peer support training program (currently being revised and recredentialed) for both mental health and addiction.

CHANCE Partnerships.

- InterCommunity Health Network CCO (IHN-CCO)
- Samaritan Health Services
- Lincoln County Behavioral Health
- Lincoln County Sheriffs Department
- Benton County Drug Court
- Linn County Mental Health
- Linn County Alcohol and Drug
- SHS Homeless Resources Team
- Albany Police Department
- City of Albany
- Just to name a few……

Some things that CHANCE did in 2019

- Hired 14 more staff to help with the lack of Peer Support. We now have 25 staff and still need another 10 Peer Supports. The staffing has helped with our IHN-CCO metrics.
- Opened CHANCE Corvallis in July 2019
  - Staff 4 peer supports
- Opened CHANCE Lincoln City September 2019 (Merged with Lincoln City Warming Shelter in June 2019)
  - Have 4 staff, need another 4+
  - As of Dec 15, we operate a cold weather emergency shelter in Lincoln City.
- CHANCE made a 10 year goal in 2014 to have a CHANCE location everywhere there is a Samaritan Hospital. We achieved this in goal in 2019. This will allow us to better serve the peer in the local areas.

Some things that CHANCE did in 2019

- City Solutions Team – Partnership with the City of Albany, Albany Police, Albany General ED, Albany Fire, Albany Parks and Rec. CHANCE provides a 24 hours crisis hot line, Police, Fire, ER, etc can call 24 / 7, if the officer, er staff or anyone calling the hotline has someone in crisis with a mental health, addiction, or homelessness related issues / crises, we will meet them "curb side" and offer support. Might be just talking with them, might be offering shelter, might be offering a bus ticket.

City Solutions Team – Cont.

- From April to Dec 1, we have……
  - Responded to over 220 CST (City Solutions Team) Calls
    - 110 Albany Police
    - 7 Albany Fire
    - 103 Albany ER
  - Provided Emergency shelter at a shelter bed paid by CHANCE for 18 people
  - Provided 18 IDs
  - Provided 4 emergency Hotel Stays
  - Provided 18 bus tickets (8 out of state / 10 in state*)
  - Engaged 22 people into treatment for Alcohol and Drug (ie: Linn County A&D)
  - Taken 7 people to DETOX (Same Day) anywhere in Oregon once bed is available
  - Engaged 18 people with Linn County mental health
  - Provide basic needs: 97 (Hygiene kits, bottle water, garbage bag to help clean up homeless camp, clean clothes, new clothes for job interview, relocation support, rental support.

Because of our funding, we were able to create a CHANCE 2nd Chance" assistance grant.

- Since we have started the CHANCE 2nd CHANCE Grant we have
  - Provided support for 453 people
    - Rent support for 102 people
    - Application fees for Apartment searching 197 people
    - Oregon ID 75 People
    - Birth Certificates 21 people
    - Bus Tickets / Gas Vouchers 70 people
    - Oregon Food Handlers Card 24 people
  - **Total Direct Community support provided: Chance 2nd CHANCE $65,914.69**
    - This grant helped keep people from being homeless, got people into homes that were homeless, helped with employment, helped people become self-supportive and non-dependent on other systems.
    - This also gives us opportunity to talk about the other metrics like smoking and pcp. Engaging them one on one.
    - In order to qualify, they must be an IHN member, meet CHANCE eligibility requirements, be engaged in services for two weeks and be willing to meet with CHANCE staff at least twice before we will offer financial assistance.
- *Bus tickets All people requesting bus tickets, people are vetted and must have a support person / relative at destination they are going too.

Some things that CHANCE did in 2019

- Jail Diversion / Pre-Trial House – Lincoln County- in partnership with Lincoln County Sheriffs, we provide case management for the Stepping Up Initiative Pre-Trial house.
- Jail diversion tri county: we are working with local jails and prisons to create a path for people to have a plan when being release. We want to provide recovery supports and housing opportunities to people being release so they have a chance of being successful, instead of the drug dealer being the first person that reaches pout to them. If we can be first contact and get them connected with the resources. They have a fighting chance of being productive members in the community and not being a drain on the criminal justice of the Emergency rooms.
- We are part of the CCCWN tri county Opioid grant to provide education and awareness.
- We purchase NARCAN with some of our funds and distribute to the community free of charge and provide free Naloxone training and kits to recovery houses and other community resources.
  - We have purchased over $65K of NARCAN in 2019 as part of our education platform to educate against opioid and harm reduction.
  - We provide naloxone (Narcan) free of charge to people who identify as opioid users or heroin users. Prevention of overdose.

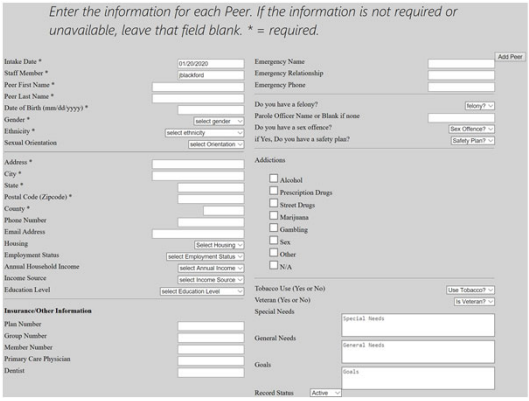
What is to come?

- CHANCE plans to continue to grow in the tri county region.
- Our Regional headquarters will be complete summer of 2020
  - will include office space for 20 staff
  - multipurpose classroom / conference room
  - Clinical room
  - Showers and laundry facilities
  - Teaching Kitchen and curriculum
  - Space for NA / AA / Wellbriety / GA and other 12 step programs

What is to come?

- Future plans……!
- Looking at creating a Peer Ran Mental Health / Addiction respite home (Yellow Line / Mental Health Jail Diversion Program with Linn County Mental health. (At our Lebanon Property)
- Lincoln City- we have started a feasibility study to create / build a permanent homeless shelter in Lincoln City. (there is no homeless shelter or emergency shelter in Lincoln City right now)
  - Will create shelter with men's, women's and family dorms
  - Addiction and mental health services built in
  - A clean and sober environment for people wanting to make a change. While…..
  - A emergency "wet" low barrier shelter with access to detox services would be available to those not ready but can provide resources to encourage recovery supports.
- If the shelter model works, we hope to create model that we can replicate a "Shelter / with addiction and mental health services built in" at each of our locations.

CHANCE Intake Data Collection



*Enter the information for each Peer. If the information is not required or unavailable, leave that field blank. * = required.*

Add Peer

Intake Date * 01/20/2020
Staff Member * jblackford
Peer First Name *
Peer Last Name *
Date of Birth (mm/dd/yyyy) *
Gender * select gender
Ethnicity * select ethnicity
Sexual Orientation select Orientation

Address *
City *
State *
Postal Code (Zipcode) *
County *
Phone Number
Email Address
Housing Select Housing
Employment Status select Employment Status
Annual Household Income select Annual Income
Income Source select Income Source
Education Level select Education Level

Insurance/Other Information

Plan Number
Group Number
Member Number
Primary Care Physician
Dentist

Emergency Name
Emergency Relationship
Emergency Phone

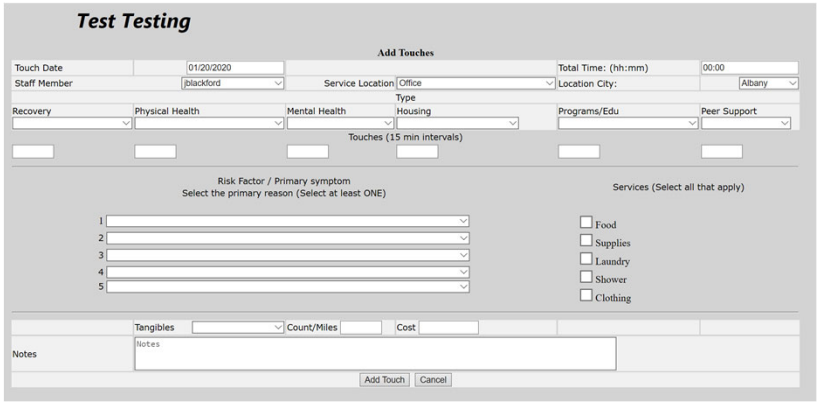
Do you have a felony? felony?
Parole Officer Name or Blank if none
Do you have a sex offence? Sex Offence?
if Yes, Do you have a safety plan? Safety Plan?

Addictions

- Alcohol
- Prescription Drugs
- Street Drugs
- Marijuana
- Gambling
- Sex
- Other
- N/A

Tobacco Use (Yes or No) Use Tobacco?
Veteran (Yes or No) is Veteran?
Special Needs
General Needs
Goals
Record Status Active

CHANCE Touch Tracking



Test Testing

Add Touches

Touch Date 01/20/2020 | Total Time: (hh:mm) 00:00
Staff Member jblackford | Service Location Office | Location City: Albany

Type

Recovery | Physical Health | Mental Health | Housing | Programs/Edu | Peer Support

Touches (15 min intervals)

Risk Factor / Primary symptom
Select the primary reason (Select at least ONE)

1
2
3
4
5

Services (Select all that apply)

- Food
- Supplies
- Laundry
- Shower
- Clothing

Tangibles | Count/Miles | Cost

Notes

Add Touch | Cancel

Questions?

Thank you!

IMPACT NW

PREVENTING HOMELESSNESS

SINCE 1966

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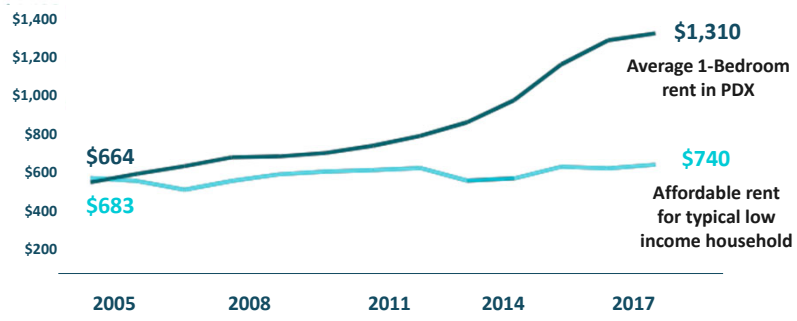
Oregon's housing crisis



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Who is housing unstable?

56,000*

* People you know

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Challenge of our generation

Priorities

% Total high	Metro	ClackCo	MultCo	WashCo
Reducing homelessness	**86**	**83**	**88**	**77**
(Split) Improving public schools	77	77	79	**81**
(Split) Lowering the cost of housing	66	68	70	65
Reducing traffic congestion	66	69	60	66
(Split) Increasing availability of affordable housing	72	57	79	57
(Split) Providing universal Pre-K	41	33	49	27

Across the region, voters prioritize homelessness

GBAO Strategies
Conducted September 5-10, 2019 via cellphone and landline
N=900 likely 2020 general election voters, 300 in each of Clackamas, Multnomah, and Washington Counties

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Our response

Prevent homelessness

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Our response

Emergency rent assistance
Utility bill payment
Master lease holder
Housing for Veteran's
Drug & alcohol recovery
Domestic violence recovery

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Our response

Thrive By 5
After-school programs
STEM at schools
Support for teens
Jobs 101
Pathways to Manufacturing

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Figure 1
Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF

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About Impact

Year founded
1966

People served a year
25,000

Service Area
Clackamas
Clark
Multnomah
Washington

Annual Budget
$11.5 m

Employees
185
40% people of color

Employees
185

ImpactNW.org **@ImpactNW**

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CBO Spotlight – Oregon Food Bank

- Overview of Organization/Key Programs
- Challenges in Connecting to Health Care/Clinical Providers
- Opportunities/Recommendations for Connecting with Health Care/Clinical Providers
- Question and Answer

OREGON FOOD BANK

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Overview of Oregon Food Bank

- ✓ Only statewide food bank system in U.S.
- ✓ Partner agencies in every OR county + Clark county WA
- ✓ 21 Regional Food Bank hubs
- ✓ 1400 pantries and 220 additional food distributions located in churches, schools, vineyards, orchards, public buildings, housing complexes and now many clinics
- ✓ 156/yr. Healthy Cooking, Shopping & Gardening workshops & classes

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OFB Mission: To address hunger and its' root causes.

Food Insecurity in Oregon 2019

- Oregon
- 12.3% of all Oregonians are food insecure
- 552,900 Oregonians (almost as many as the population of Portland)
- 18.9% of all Oregon children are food insecure
- 165,290 children (more than all of Eugene)

OFB staff: 165
Volunteers: 75,000
Increase in produce since 2015 = 60%

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OFB Health Care Partnerships

- Program started in 2014 triggered by the implementation of the ACA
- Initial focus on implementing food insecurity screening & patient connections to local resources
- Training, best practice sharing, list of local resources for every county
- Assisted over 400 clinics, many now have transitioned to broader social needs screening
- Screening often triggers clinic or hospital interest in doing more (100+)

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What More Can We Do?

- Cooking & smart shopping classes
- Gardening classes & assistance
- Diabetes clinic/pantry partnerships
- On-site produce distributions or pantries
- Veggie Rx or CSA Rx programs
- Medically Tailored Meals; Food to prevent ED use & re-admissions
- Continue, expand SNAP match
- Home health or CHW delivery of food

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Challenges Working Together Health Care/Food Banks

- ❑Food Banks have very limited regional staff, sometimes 3 people for several hundred square mile region
- ❑Pantries especially outside of Metro run by volunteers
- ❑Limited hours, days of food distribution due to above limitations, limited home delivery
- ❑Challenges getting culturally appropriate foods, misunderstanding of expiration labels, OFB has nutrition standards for 75% of food we provide but pantries can add unhealthy food if they wish
- ❑Vast differences between FB & health care in funding/available resources
- ❑Health Care staff have limited time and many demands, priority for SDOH improving, but still low
- ❑Clinic staff have often no knowledge/input about potential resources i.e. hospital community benefit, health related services (community benefit or flex funds)

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OFB Client Data Management System: Link2Feed

- Canadian product used by more food banks around the country than any other, but not many have <u>any</u> data management system.
- Implemented to date in only about half of our 1400 pantries not in the other 100+ other types of distributions i.e. clinic distributions, monthly free farmer's markets…
- All info voluntary, used to support continuation of efforts
- Info collected: client name, special food or assistance needs, current zip code if any, household size, language & demographics
- No case-management, some co-location of other agencies, 95% volunteer run
- Any communication needs to be automatic, no labor

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CIE Specific Challenges for OFB

- No case management functions
- Currently only 50% of pantries & none of produce distributions have electronic tracking
- A year ago I asked Unite Us if they could talk to Link2Feed & finally got answer: no & it would be costly to develop capability
- Yet, AHC screening data says food is by far the dominant social need
- Leaves us wondering about value of CIE for OFB

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Questions ?

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Oregon Food Bank
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OREGON FOOD BANK

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Linking Clinical Care to Social Services – Kaiser Permanente's Thrive Local

- Overview of Organization/Key Programs
- Challenges in Connecting Health Care with Social Service Sector
- Opportunities/Recommendations for Connecting Health Care with Social Service Sector
- Question and Answer

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CIE Advisory Group –
Addressing the Social Needs of our Community

January 21, 2020

Kristin Kane
NW Permanente
Practice Director, Social Needs and Community Partnerships

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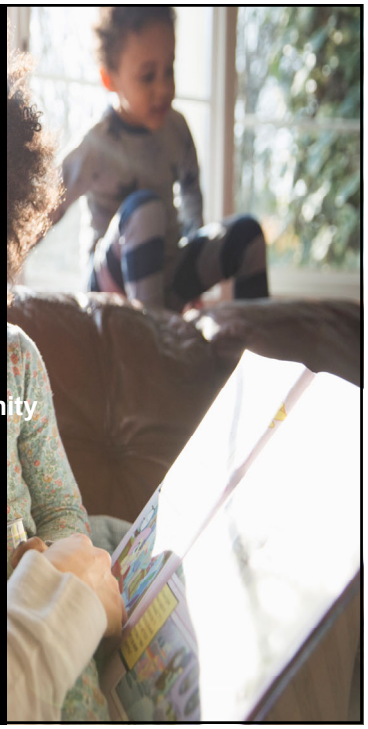

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THRIVE LOCAL BENEFITS

Thrive Local will facilitate comprehensive, coordinated services in our communities

KAISER PERMANENTE® UNITE US

Thrive Local is a partnership between Kaiser Permanente and Unite Us.

Thrive Local will...

Connect health care and social services providers to deliver integrated care

Empower organizations across communities to work together through a **shared technology platform** that connects individuals to an array of services

Be fully implemented in **3 years**

In **3 years** Thrive Local aims to be available to all **12.3 million KP members** and **68 million people** in the communities KP serves

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THRIVE LOCAL VISION & CONTEXT

Thrive Local is at the core of KP's solution to address social health needs

Identification

Social needs identified by KP staff, providers, patients, caregivers, or community partners

Information

Thrive Local provides information on community resources and tracks referrals with community partners

Connection

Using the Thrive Local network, health or social service providers can locate the appropriate community, government, or health care systems resources to meet social needs

Optimization

Information from the Thrive Local network is used by Kaiser Permanente and community partners to better understand social needs, identify community wide social care gaps, and improve community conditions for health

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Thrive Local consists of three components

Resource Directory

Online platform allows users to search and filter for community resources

Resources updated regularly by contracted vendor

Community Networks

Community Based Organizations (CBOs), health care providers, and public agencies outside of KP use vendor platform

KP users send and track referral to Community Network

Technology Platform

Closed loop referrals

Bidirectional exchange of information between KP and Community Network

Integration of KP HealthConnect and kp.org

Together, these components **provide integrated clinical and social care**, supported by **data integration** and **partnerships** with the community

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KP is partnering with Unite Us to implement Thrive Local

Unite Us offers an **outcome-focused software platform** with a community engagement team that **builds coordinated networks** to address **social needs**

Unite Us…

- **Connects health care and social services into one accountable, coordinated ecosystem** – empowering health systems and communities to work together seamlessly to impact every person's health and social needs (e.g. transportation, housing, food, among others)
- Provides a **flexible** and **scalable** platform and helps all network partners track referrals during the patient's total health journey
- Ensures successful implementation by **deploying a team in each community to work directly** with all partners that choose to join the platform

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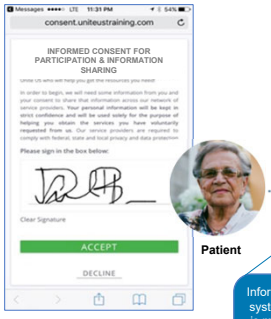
KP ensures Thrive Local's compliance with patient privacy law



Patient

Thrive Local

Informed consent is requested by the system once, before the first referral is made. Patients also authorize the system to share their information in order to receive services from network partners.

Transportation

Compliant with Health Insurance Portability and Accountability Act (HIPAA) & Personally Identifiable Information (PII) standards

Housing Provider

Compliant with Security & Data Storage Standards and Breach & Enforcement Rules

Food

Sensitive information is restricted from view based on users' viewing permissions

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KPNW TIMELINE

KPNW High Level Timeline: Phase 2

Activation of the Community Partner Network

Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020

Community Engagement Strategy

- Over 50 Influencer sessions held generating local excitement and interest
- 8/9 Community Event success with 250 community members represented
- Completed 6 Strategy sessions hosted in each county
- CBOs submitting partner registration forms and signing up for training prior to 12/17

12/17: CPN Launch (Portland Metro/SW Wash)

- Community based organizations will be able to send and track referrals to one another through platform

02/25: KP Joins CPN

- KPHC has been configured and target architecture is implemented in KPHC
- Additional link locations for users to access TL
- Release functionality to AQM/IQM users (240)
- Member demographics will flow into platform and users will be able to create referrals to CBOs

04/28: Mid Valley/Eugene Join CPN

- Mid Valley/ Eugene join network
- KPHC will turn on functional for all care delivery users in NW – Anyone will HC access can access platform and create referral

KPNW February Timeline

- Auto Provisioning
- HIPAA/Consent Authorization

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PERFORMANCE MANAGEMENT & EVALUATION

We will measure Thrive Local's impact and success

Desired outcomes	*Sample indicators*
Closure of social care gaps	• Number of referrals to community-based organizations • Number of social needs met
Improved clinical outcomes	• Reduced HgA1c for food insecure diabetics • Reduced depression, functional impairment for socially isolated seniors • Improved asthma control for people living in poor quality housing
Improved personal health and well-being	• Improved member experience and satisfaction • Improved health-related quality of life • Improved overall well-being
Enhanced system performance	• Reduced inpatient and ED utilization and total cost of care • Reduced duplicative solutions across regions and business units • Improved provider satisfaction and retention, increased joy in work
Improved community health	• Improved neighborhood-level measures of health • Reduction in health inequities • Improved performance, financial health of community-based organizations

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THRIVE LOCAL BENEFITS

Thrive Local benefits communities, patients, and health care systems

For Communities	Community-wide asset created through free access to the Thrive Local platform for community health centers and community-based organizations	Referral volume and proof of impact may lead to increased partnership opportunities	Community-wide analysis to inform policy, investment decisions and community advocacy	Increased organizational capacity through more targeted referrals and connections among community-based organizations
For Patients	Reliable referrals to organizations that can address patients' most pressing needs	Help navigating complex systems	Improved experience of care due to built-in capabilities for referral and feedback	Improved health and well-being
For Health Care Systems	Improved satisfaction among frontline providers	Improved performance on health outcomes and patient well-being	Reduced utilization and total cost of care	Adoption of community-wide social health networks that address patients' needs

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Connecting Health Care and Social Service Sectors—Discussion & Key Takeaways

- Challenges in Connecting Health Care with Social Service Sector?
- Opportunities/Recommendations for Connecting Health Care with Social Service Sector?
- Other:
  - Do we need an CBO environmental scan?

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Next Steps/Wrap Up

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OHA Launching New SDOH Measurement Workgroup

Social Determinants of Health (SDOH) Measurement Workgroup: Screening for Social Needs

A new public SDOH Measurement Workgroup will develop a measure concept to incentivize screening for individual health-related social needs (such as housing, food insecurity, and transportation) to be recommended to the Metrics & Scoring Committee for possible inclusion in the CCO Quality Incentive Program. **The Workgroup will meet on a monthly basis from approximately April to October 2020.**

Applications should be submitted to metrics.questions@dhsoha.state.or.us **by 5pm on January 31, 2020**, and include:

- Completed application form; and
- Resume/biosketch

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2020 Meeting Schedule

- Meetings are generally on 3rd Thursdays with a few exceptions.
- Meetings for 2020:

Date	Time
2/20	1-4pm
3/12 (2nd Thursday)	9-Noon
4/16	1-4pm
5/21	1-4pm
6/18	1-4pm
7/16	1-4pm
8/20	1-4pm
9/17	1-4pm
10/15	1-4pm
11/19	9-Noon
12/10 (2nd Thursday)	9-Noon

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March Meeting: Vendor Demos

- Planning to invite 3 vendors in March for demo/Q&A
  - Aunt Bertha
  - Clara/Vista Logic
  - Unite Us
- Could open a virtual meeting to interested CBOs, others.
- Thoughts?

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Wrap Up

- Next meeting: **February 20, 1-4pm**
- Key Agenda Topics:
  - Social Needs Screening
  - Referral Directories
- Volunteer presenters:
  - Anne King (AHC)
  - Carly Hood-Ronick (PRAPARE)
  - Ann Kirby (EPIC SDOH Wheel)
  - North Carolina SDOH screener
  - Dan Herman (211info)

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Additional Materials

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HIT Role Table (May 2019)

	Oregon Health Policy Board (OHPB)	Oregon Health Authority (OHA)	HITOC (HIT Oversight Council)	HIT Commons
Geographic reach	Statewide	Statewide	Statewide	Statewide
Stakeholders: Payers, providers, systems	All markets and sectors	All markets and sectors – primary on Medicaid	All markets and sectors	All markets and sectors
Health system transformation (HST)	Determine goals, action plan, priorities, provide oversight	Implement plan, priorities – primary on Medicaid, State budget	Support all HIT components (broad accountability for health reform HIT support)	Support selected HIT components (e.g. PreManage)
Stakeholder engagement*	All HST stakeholders	All HST stakeholders – primary on Medicaid	All HST stakeholders that touch HIT	HIT Commons members (current and potential)
Oregon's HIT strategy*	Sets policy priorities Approves HITOC's Strategic Plan	Align efforts with HITOC's Strategic Plan	Sets Oregon's HIT Strategic Plan Engage stakeholders in strategic plan updates	Aligns HIT Commons efforts with HITOC strategic plan Key stakeholder input on HITOC strategic plan updates
HIT policy*	Refer HIT policy issues to HITOC, review HITOC recommendations	Office of HIT analysis of state, federal policy	Monitor and explore policy issues, make policy recommendations to OHPB	Can raise policy issues to OHA/HITOC
HIT programs, services		Operate Oregon HIT Program Co-Sponsor HIT Commons Can recommend HIT projects to HIT Commons	Oversee and provide public transparency (re: Oregon HIT Program, OHA's Partnership with HIT Commons) Can recommend HIT projects to HIT Commons	Select HIT Projects Operate HIT Commons programs, initiatives Accelerate HIT efforts (e.g. Oregon Provider Directory)
Oregon's HIT landscape and HIT progress*	Receive HITOC reports	Assess landscape and report on HIT progress	Review and report to OHPB on landscape and HIT progress	Assess and monitor landscape related to HIT Commons efforts Report on HIT Commons project progress

*Opportunity to coordinate OHA, HITOC and HIT Commons work

Oregon HIT Program: Oregon Provider Directory (OPD), Clinical Quality Metrics Registry, Medicaid EHR Incentive Program, Medicaid PreManage subscription, Oregon Medicaid Meaningful Use Technical Assistance Program (OMMUTAP), HIE Onboarding Program

HIT Commons initiatives: EDie/PreManage, PDMP Integration initiative, Accelerating Oregon Provider Directory (exploratory), Oregon Community Information Exchange (exploratory)

The Oregon Health Authority and Health IT: Strategies for Health IT Goals

Oregon's health IT goals advance health system transformation goals

Health System Transformation Policy Priority	Health IT Goal/Area
Increase access to health care	Goal 1: Share patient information across the care team
Enhance care coordination	Goal 1: Share patient information across the care team
Pay for outcomes and value	Goal 2: Use data for system improvement.
Measure progress	Goal 2: Use data for system improvement.
Improve health equity	Emerging area: Health IT supports social determinants of health and health equity
Shift focus upstream	Emerging area: Health IT supports social determinants of health and health equity

Strategies for Oregon's health IT goals

Goal 1: Share patient information across the care team. Oregonians have their core health information available where needed, so their care team can deliver person-centered, coordinated care.

- Electronic health records (EHR/EMR)
    - Medicaid EHR Incentive Program go.usa.gov/xpzPn
    - *Complete: Oregon Medicaid Meaningful Use Technical Assistance Program* go.usa.gov/xpzPd
- Electronic health information exchange (HIE)
    - EDie/PreManage (Collective platform), including Medicaid Subscription bit.ly/2Quu6NJ
    - Prescription Drug Monitoring Program Integration initiative bit.ly/2FodEbn
    - Oregon Provider Directory and Flat File Directory go.usa.gov/xpzPz
    - HIE Onboarding Program go.usa.gov/xpzPJ
    - Network of networks for statewide HIE go.usa.gov/xpzPS
    - *Planned: Behavioral Health Information Sharing Toolkit (42 CFR Part 2)*
    - *Complete: Expanding Interoperability - ONC Cooperative Agreement*
- Behavioral Health and Health IT Workplan: go.usa.gov/xpzPE
- Shared Governance: HIT Commons public/private partnership bit.ly/37CNJsD
- CCO 2.0 EHR and HIE support requirements go.usa.gov/xpJDR

Goal 2: Use data for system improvement. Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

- Goal 1 work on EHRs and HIE is foundational
- Clinical Quality Metrics Registry go.usa.gov/xpumR
- Health IT Roadmaps for CCOs (ensuring health IT in place for value-based payment arrangements and population health efforts) go.usa.gov/xpJDR

Goal 3: Patients can access their own information and engage in their care. Individuals and their families access, use, and contribute their clinical information to understand and improve their health and collaborate with their providers.

- Goal 1 work on EHRs and HIE is foundational
- CCO 2.0 Year 2 requirement for health equity plans: patient engagement with health IT go.usa.gov/xpJWc (p. 71)
- HITOC exploration of barriers and opportunities from consumer perspectives go.usa.gov/xpJWp (June 2019 HITOC)
- *Complete: State Innovation Model (SIM) grant for OpenNotes*

Emerging area: Health IT supports social determinants of health and health equity.

- HIT Commons: Exploration of Oregon Community Information Exchange (CIE) bit.ly/2QOiaW1
- Potential for EHRs to track demographic data to help identify disparities (ONE system tracks this data for OHP members) go.usa.gov/xpJWp (October 2019 HITOC)
- Clinical Quality Metrics Registry future capacity to track patient-level data go.usa.gov/xpumR
- Oregon Provider Directory captures demographic information go.usa.gov/xpJWp (October 2019 HITOC)
- Exploration of connection between health IT and health equity go.usa.gov/xpJWp (October 2019 HITOC)

The Oregon Health Authority and Health IT: Strategic Plan 2021 Update

What is Oregon's strategic plan for health IT?

OHA is transforming the health care system, and the core of those efforts is the coordinated care model. The coordinated care model relies on health IT to succeed. Coordinating health IT efforts at the state level is important because there are so many moving parts. Therefore, the Oregon legislature charged HITOC with creating a statewide strategic plan for health IT for everyone in Oregon.

Health IT helps…

Consumers/patients, their families, and their caregivers: Access their own health information and participate in their care

Providers: Securely gather, store, and share patients' clinical data so the care team can work together to provide care; track and report on quality measures, which supports efforts to hold the health care system accountable for delivering high-quality care

CCOs, health plans, and providers: Analyze data to identify disparities and find patients who need more care to allow targeted efforts to improve health

Oregon and Health IT: Quick Orientation

Providers are using EHRs/EMRs at high rates overall. Electronic health records or electronic medical records (EHR/EMR) support patient care and patient access to their own information (via patient portals); the data they gather supports care coordination, value-based payment, and population management.

Status: Overall EHR adoption rate is higher than the national average, number of providers using more advanced EHRs is growing, "digital divides" remain

Health information exchange options have grown significantly. HIE securely moves health information between organizations, supporting care coordination, value-based payment, and population management.

Status: EDie/PreManage (Collective platform) have been a standout success, national networks provide access to care summaries, regional HIEs and other efforts support CCOs and communities, no single tool can meet all needs, "digital divides" remain

Health IT supports value-based payment. CCOs and providers need health IT tools and processes to manage value-based payment arrangements.

Status: CCOs have developed Health IT Roadmaps that include plans for health IT and value-based payment which will support major growth in value-based payment arrangements under CCO 2.0; most CCOs, health plans, and providers will need to develop new health IT capacity to manage value-based payment

Health IT can help address social determinants of health. Health IT tools can support social needs assessments, risk scoring, and connect health care with social services.

Status: Providers are exploring using health IT to assess social needs; work is underway to explore options for community information exchange, connecting health care providers with social services; this area raises new challenges with technology, privacy, and care coordination

Gathering your input: health IT goals and question prompts

HITOC wants to hear your input on what strategies are going well and where Oregon needs to change course. **Please look at the health IT goals below and reflect on how things are going.** The optional question prompts below can help you organize your input, but you are not required to use them.

Goal 1: Share patient information across the care team. Oregonians have their core health information available where needed, so their care team can deliver person-centered, coordinated care.

Goal 2: Use data for system improvement. Clinical and administrative data are efficiently collected and used to support quality improvement and population health management, incentivize improved health outcomes. Aggregated data and metrics are also used by policymakers and others to monitor performance and inform policy development.

Goal 3: Patients can access their own information and engage in their care. Individuals and their families access, use, and contribute their clinical information to understand and improve their health and collaborate with their providers.

Emerging area: Health IT supports social determinants of health and health equity.

Optional question prompts (all questions can be applied to all goals)

1. How is this going for you today?
2. What would achieving this goal look like?
3. Where are you experiencing impacts?
4. What has been most helpful?
5. Where are the biggest challenges/barriers?
6. What are the right roles for state, providers, CCOs/health plans, and others?
7. What changes would have the biggest positive impact? Biggest negative impact?

Submitting your input

- Register for a listening session (in person/webinar): go.usa.gov/xpzy2
- Submit written comment (Feb. 1 – Apr. 30). We encourage written comments!: go.usa.gov/xpzVt
- Make a public comment at a HITOC meeting: go.usa.gov/xpJT8

Stay Connected

You can find more information about the strategic plan update at our website: go.usa.gov/xpeQc

Program Contact

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Get involved with Oregon Health IT

Office of Health Information Technology: HealthIT.Oregon.gov

Join the listserv: bit.ly/2VYgoDB