Eastern Oregon Coordinated Care Organization

Annual CAC Demographic Report 2022

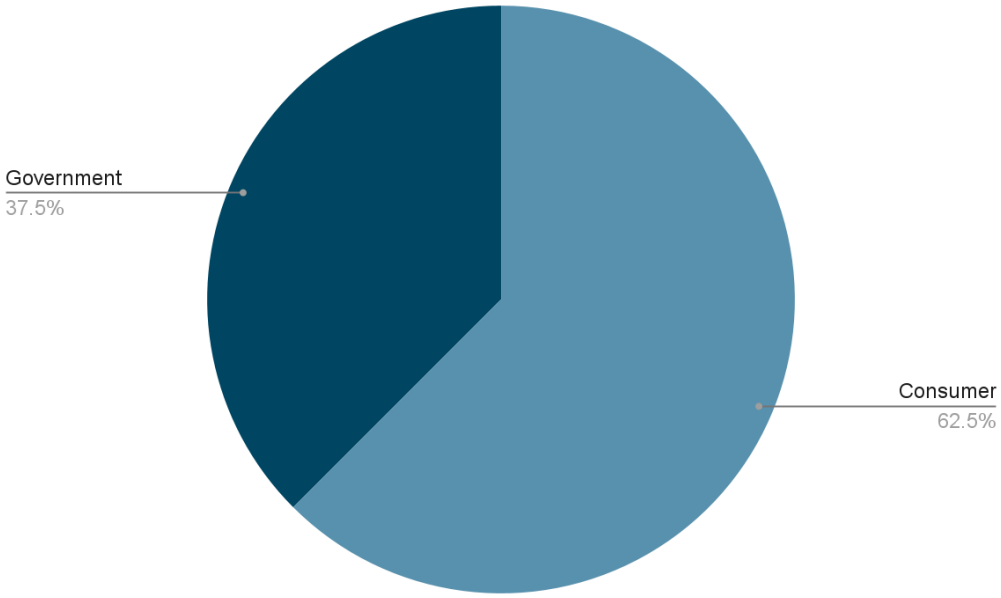
EOCCO CAC Demographic Composition

1. **How many CACs has your CCO established? Please list all CACs, as defined under ORS 414.575.**

   The Eastern Oregon Coordinated Care Organization (EOCCO) has one Community Advisory Council (CAC) that serves Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler, the Umatilla Indian Reservation (CTUIR) and the Burns Paiute Tribe.

2. **What percentage of the total CAC membership on each CAC are consumer representatives[1]? If there are less than 51% consumers on a particular CAC, please explain why and provide a plan with milestones to increase consumer representation.**

   62.5% of the CAC members are consumer representatives.



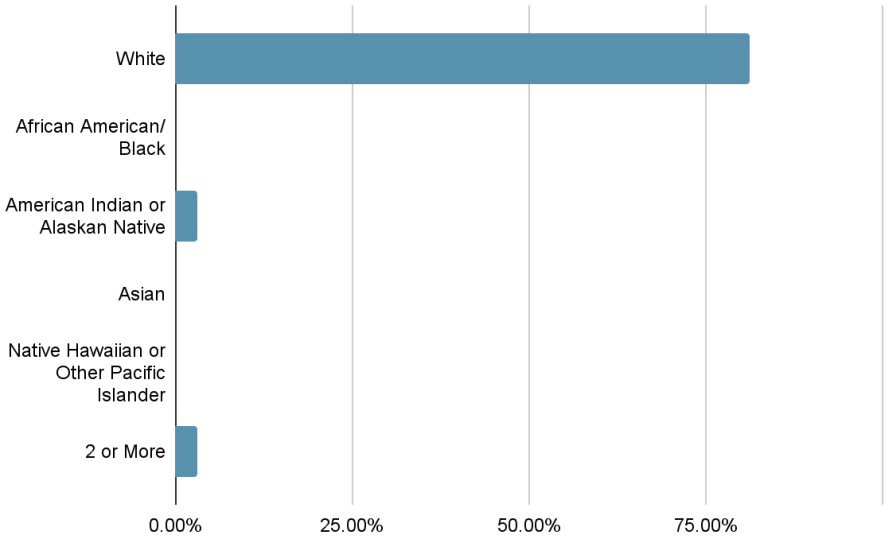
3. **Describe the demographic composition of each CAC. Please include as much demographic information as possible for CAC members, in the aggregate. Please refer to the CAC Demographic Assessment Worksheet for examples of demographic categories that can be collected. However, OHA understands that there may be reasons a CAC member does not wish to share specific demographic information. In these cases, please include that the CAC member declined in your narrative response.**

[1] *Consumer representative* refers to a person serving on a CAC who is, or was within the previous six months, a recipient of medical assistance and is at least 16 years of age; OR a parent, guardian, or primary caregiver of an individual who is, or was within the previous six months, a recipient of medical assistance.

EOCCO CAC Demographic Composition

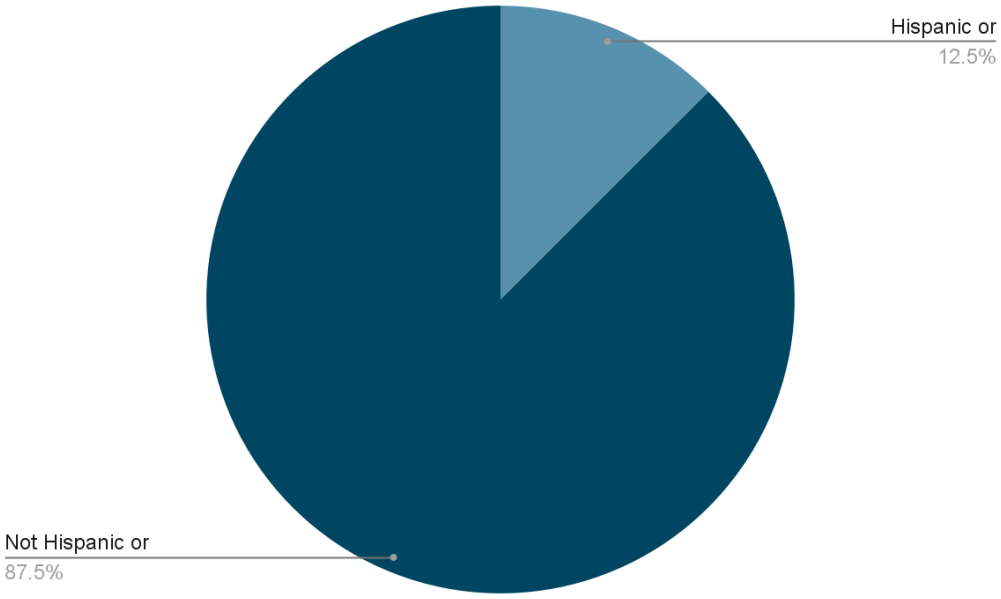
Race

The demographic survey included five major categories recognized by the Office of Budget Management (OBM) and are consistent with Census Bureau standards. This included White, African American/Black, American Indian/Alaskan Native, Asian, and Native Hawaiian or other Pacific Islander. 81.3% of the members self-identified as White, 3.1% self-identified as American Indian or Alaskan Native, and 3.1% self-identified as two or more races.



Ethnicity

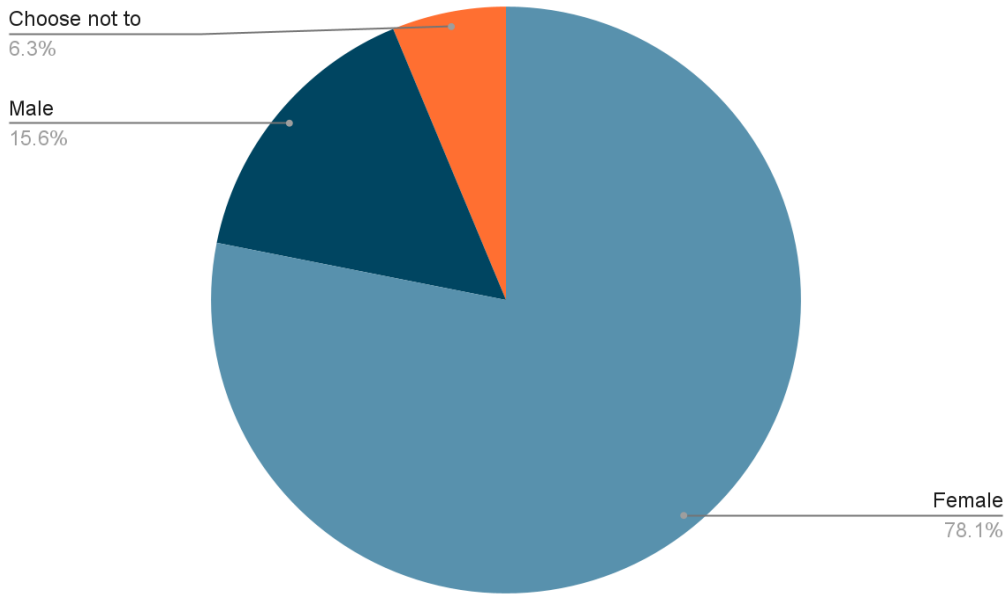
We captured the ethnicity data separate from the race. CAC members could select from two choices: Hispanic/Latino/a/x or Non-Hispanic or Latino/a/x. 12.5% identified as Hispanic or Latino/a/x.



EOCCO CAC Demographic Composition

Gender Identity

78.1% of members identified as female, 15.6% identified as male, and 6.3% of individuals choose not to disclose.

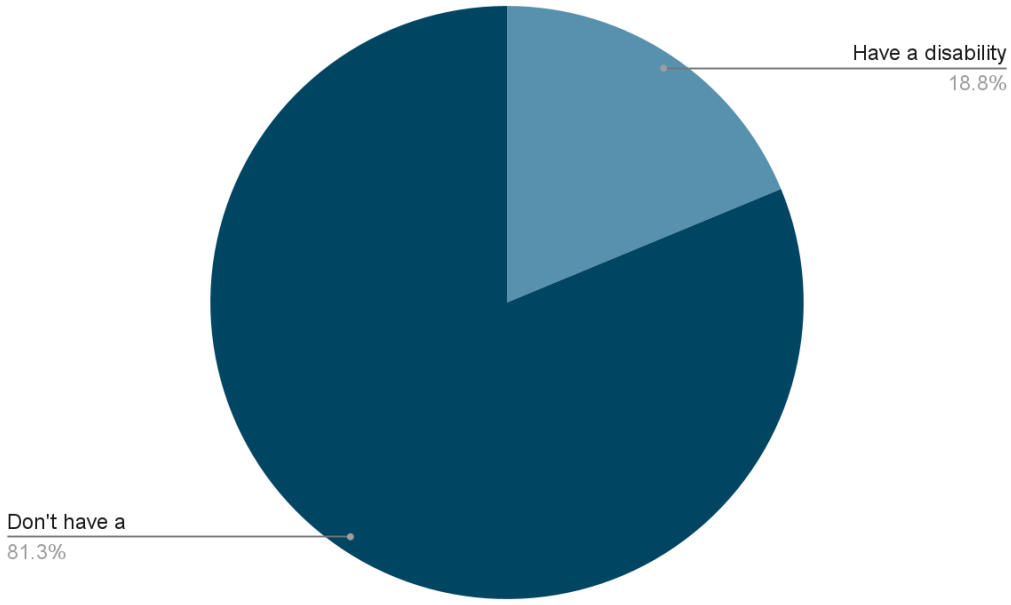


Languages spoken at home

We asked members about the languages spoken in their home. 93.8% of the members use English in their home and 6.3% use Spanish.

Disability

We also collected data on CAC members' self-identifying as having a disability. 18.8% of the CAC members self-identified as having a disability.



EOCCO CAC Demographic Composition

4. Describe your CCO's approach to CAC member recruitment, including strategies to ensure adequate CAC representation.

EOCCO has engaged in robust activities to recruit CAC members and ensure adequate representation from our large geographic area. Those strategies include:

1. Utilize OHA consultation assistance through Collective Health Strategies, Nancy Goff, for best practice for EOCCO CAC Consumer recruitment, including:
    a. Revision of EOCCO CAC membership application; approved by OHA and available to members online and by paper for existing LCHP members and new members outside the LCHP.
    b. Easy to navigate onboarding packet for new CAC members, which includes new membership application (English and Spanish), EOCCO CAC meeting schedule, letter of introduction to the EOCCO CAC (use ProWritingAid software for equity), updated acronym and definitions handout, communication flow, and all orientation materials.
    c. Attending meetings to promote EOCCO CAC efforts with local, external partners such as Community Partner Outreach Collaboratives, Early Learning Hubs, and Head Start.
    d. EOCCO Field Team staff have hosted virtual learning/info sessions throughout the year for individuals interested in CAC membership, including an orientation meeting prior to the second EOCCO CAC meeting to review key processes, meeting goals, and respond to questions to enhance retention.
    e. Developed "Removing Barriers to Participation" documents for EOCCO CAC and LCHPs; documents addressing transportation opportunities within the EOCCO region, virtual participation and assistance with wi-fi/broadband, supportive technology, equipment and teleconference support. Include a virtual technology "cheat sheet" for EOCCO CAC/LCHP meetings. The cheat sheet includes directions on how to join by computer/phone, meeting etiquette (mute/unmute), whom to contact if having an issue prior to/during meetings, how to request assistance with equipment/phone minutes, and other instructions.
2. EOCCO Field Team staff conducted research to analyze and describe the overall population. We used this information as our reference point to ensure we recruited a representative group for the CAC.
    a. Utilized the following data to identify diversity in EOCCO service area: (a) secondary sources of data such as the U.S. Census, and (b) the analyses of our CCO's enrollment data (enrollment data analysis dashboards in Tableau); other sources include *Population Assessment*, *Demographics* sections in *Annual Reports*, *Cultural and Linguistic Analyses*. Our intention is to make this data widely available and "shareable" with directors and program managers across the EOCCO region.

b. Identification of specific health disparities defined by REALD through reports listed in #1 (above) and CHA focus group data collection (https://www.eocco.com/-/media/EOCCO/PDFs/CAC-meetings/reports/2019-Wide-Focus-Group-Report.pdf
c. Use EOCCO CAC application to identify members that reflect the EOCCO population. Review demographic information through EOCCO CAC Selection Committee and make recommendations based on comparisons to community data and targeted outreach to specific community stakeholders for recruitment.

3. Methods/strategies to recruit health disparity populations was a two pronged approach: 1) work within the existing activities concentric to ongoing CAC recruitment efforts and invest resources for extra recruitment efforts that are linguistically and culturally appropriate; 2) invest in partnerships with Community-Based Organizations that specialize in working with ethnic minority populations, specifically the following partners:
    a. Hispanic/LatinX Members - worked with the Oregon Child Development Coalition and Euvalcree to engage Hispanic/LatinX Members with a focus in Morrow, Umatilla, and Malheur Counties and recruit Members to EOCCO CAC.
    b. Established positive collaboration with Euvalcree. GOBHI has drafted a contract with Euvalcree. The scope of work includes outreach and recruitment for the LCHPs and EOCCO CAC. In addition, it includes assisting the EOCCO field team in establishing partnerships within the Latinx communities for ongoing engagement in the CHP, CHA and other community engagement work.
    c. Aging members (dual enrolled) and members experiencing disabilities - recruit EOCCO/OHP Members from the Consumer Advisory Group facilitated by GOBHI. Work with the Older Adult Behavioral Health Team (OABHI) who work with the Area Agencies on Aging (AAA) and Aging and People with Disabilities (APD).
    d. Families and caregivers for children enrolled in EOCCO/OHP - work with Early Learning Hubs, Head Start, Department of Human Services Child Welfare and Self Sufficiency, foster parent and kinship family/caregiver groups.
    e. LGBTQIA2S+ Individuals - work with Eastern Oregon Center for Living, New Directions, Greater Oregon Behavioral Health, Inc. (wi-fi/broadband, supportive technology, equipment and teleconference support)
    f. Individual outreach to existing OHP members of LCHP
    g. Outreach by GOBHI staff to GOBHI Consumer Caucus

5. Describe any barriers or challenges experienced in CAC member recruitment. Please also detail how your CCO plans to or has overcome barriers or challenges in CAC member recruitment.

While the COVID-19 pandemic has perpetuated many challenges in establishing a trusting relationship with CAC members as well as streamlining the communication process, the EOCCO has worked diligently to address and alleviate CAC member participation and recruitment. The EOCCO Field Team has built and maintained strong partnerships with many community-based organizations that have been integral in the successful recruitment and retention of our CAC members, especially

the OHP consumer members. The Field Team has implemented strategies to address additional barriers to participation, including supporting virtual participation assistance with wi-fi/broadband, supportive technology, equipment, and teleconference support. Highlighting the opportunities for CAC members to receive stipends, child care assistance and transportation reimbursement to-from meetings has also been a successful recruitment tool. These strategies and awareness of the needs of OHP consumers in the 12-county region has enabled the EOCCO CAC to maintain the 51% consumer membership to date.

6. **a. If there are federally recognized Tribes in your CCO's service area, please describe the Tribal representation on each of your CACs. If your CCO service area is metropolitan and has no federally recognized Tribe, please describe the Urban Indian Health Program representation on each of your CACs.**

There are two federally recognized tribes in the EOCCO service area: the Confederated Tribes of the Umatilla Indian Reservation (CTUIR) and the Burns Paiute Tribe. We currently have active representation from the CTUIR.

b. If there are federally recognized Tribes in your CCO's service area, please describe your CCO's efforts to reach out to local Tribes to identify tribal CAC member(s).

EOCCO's Tribal Liaison is an active member of OHA's Tribal Advisory Council and works closely with EOCCO CAC to make strides in the engagement of Native Americans with the Local Community Health Partnerships in Umatilla and Harney Counties. A subcommittee was formed to focus on the recruitment, engagement, and retention of members who belong to the Confederated Tribes of Umatilla Indian Reservation (CTUIR) at the Umatilla County LCHP. Recent LCHP outreach efforts also include invitations by Harney County LCHP members, as well as an invitation to the leads to Indigenous People of the Burns Paiute Tribe in attending the EOCCO CAC. Moreover, our EOCCO Tribal Liaison has reached out directly to the OHA Tribal Affairs Director in order to develop strategies for the engagement of Native Americans with the EOCCO CAC.

Outreach and recruitment by the EOCCO Tribal Liaison to tribal communities and CTUIR

1. 12 Tribal Liaison's outreach: 6 outreach efforts to the Confederated Tribes of the Umatilla Indian Reservation (CTUIR), and 6 with the Burns Paiute Tribe. Outreach to both communities included emails with background information, phone calls, and in-person meetings, all from the EOCCO Tribal Liaison.
2. Continue working closely with the EOCCO Tribal Liaison to share EOCCO CAC information (flier, application) with Tribal Partners. Tribal Liaison currently has strong relationships with the Confederated Tribes of the Umatilla Indian Reservation (CTUIR).

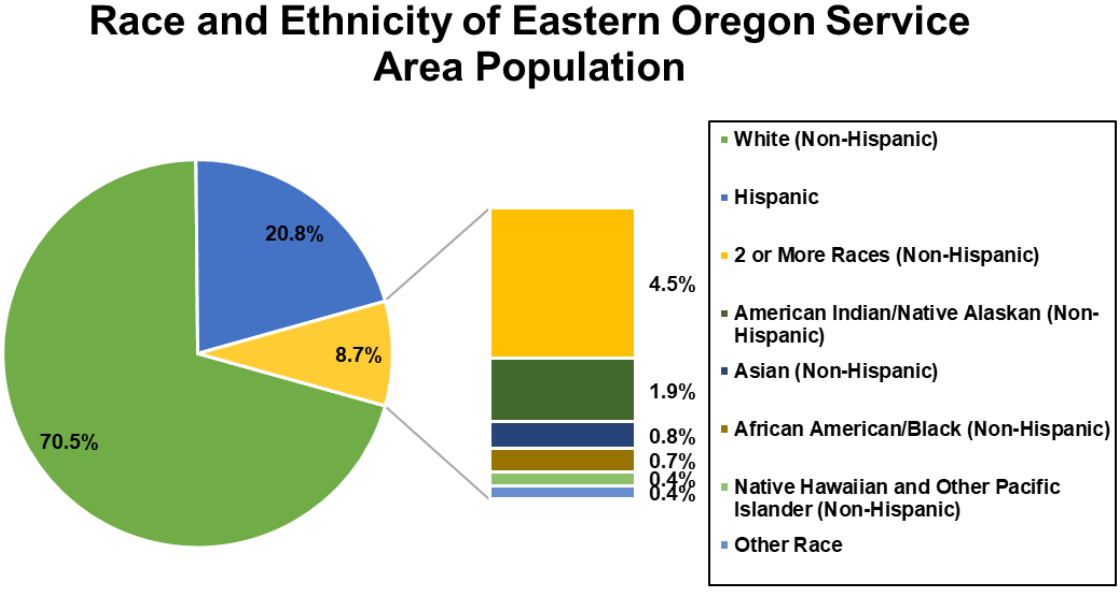
c. Describe any barriers or challenges experienced with Tribal member or Urban Indian Health Program CAC member identification. Please also describe how your CCO plans to overcome these barriers or challenges.

In January 2022, EOCCO's tribal liaison reached out to the Burns Paiute Tribe to invite them to apply for CAC membership. To date, we do not have a member from the Burns Paiute Tribe on the EOCCO CAC, however, efforts to engage will continue.

7. **Describe the demographics and diversity in the communities in your CCO's service area. Please refer to the CAC Demographic Assessment Worksheet for examples of demographic categories. Please also provide a narrative describing the diversity of these demographics.**

One important defining feature of our CCO is its geographic size–approximately 50,000 square miles (roughly the size of the state of New York)–with a population across the 12 counties of over 204,000. The population-to-land ratio renders all of our 12 counties as significantly Rural and 10 as Frontier (having fewer than 6 people per square mile). EOCCO consumer members live in counties that vary widely in total population ranging from approximately only 1,456 to 80,463 individuals.

The 2020 U.S. Census and American Community Survey data of the 12-county EOCCO total population region show the majority report an identity of White, Non-Hispanic background 70.5%; one-fifth (20.8%) report a Hispanic background, 1.9% Native American, and less than 1% identify as African American. Notably, for 17% of individuals, ethnicity was not reported. The chart below describes the demographic distribution by race/ethnicity of the EOCCO region.



There are at least two distinct demographic profiles in our CCO. In 9 of the 12 counties, White Non-Hispanic population ranged from 79.8%% to 89.3% and Hispanic background from 3.5% to 9.8%. In contrast, in three counties (Malheur, Morrow and Umatilla), White Non-Hispanic background ranged from 54.2% - 62.1% and Hispanic background from 28.3% - 40.9%. County-level analyses revealed language preference profiles that paralleled the ethnicity profiles. In 9 of the 12 counties, English is the preferred self-reported language. In contrast, preference for Spanish exceeded the 1-out-5 mark in three counties: Malheur (24.1%), Morrow (32.8%), and Umatilla (21.6%). There are an increasing number of individuals reporting Arabic, Marshallese, and Somali language usage; they currently account below 1%.

A detailed profile of the demographics across the Eastern Oregon service region are described in both the EOCCO CAC Demographic Worksheet 2022 and the 2022 EOCCO CHA Data Elements documents.

EOCCO CAC Demographic Composition

EOCCO produces an array of reports throughout the year to support the ongoing work of the Community Advisory Council and provide an analysis of the health disparities that exist in all 12 of our counties, including contributing factors. Examples of those reports and tools are listed below, with a brief description of what is contained in each document:

2022 CHA Data Elements	Provides and overview of the racial, ethnic, age, language, disability status (REAL-D), sexual orientation, and gender identity (SOGI) profiles of each of the 12 counties in the Eastern Oregon Region. The report also provides data on various health and social determinants of health indicators across the region, including data in the following categories: morbidity and mortality, health behaviors, health status, teen health, maternal and child health, transportation, housing, and socio-economic risk factors.
2019 CHA Data Elements and Sources	Provides an overview of the racial, ethnic, age, language, disability status (REAL-D), sexual orientation, and gender identity (SOGI) profiles of each of the 12 counties in the Eastern Oregon Region with trends since 2013. The report also provides data on various health and social determinants of health indicators across the region, including data in the following categories: morbidity and mortality, health behaviors, health status, teen health, maternal and child health, transportation, housing, and socio-economic risk factors.
EOCCO Comprehensive Behavioral Health Plan	As part of the CCO's Behavioral Health Plan development, EOCCO conducted a behavioral health environmental scan that describes EOCCO members' needs surrounding mental health, substance use disorders, and social wellbeing; the existing systems to serve those needs; and areas where those services could be more effective.
2021 EOCCO Cost and Utilization Dashboard 2021 EOCCO Baker County C+U Dashboard 2021 EOCCO Gilliam County C+U Dashboard 2021 EOCCO Grant County C+U Dashboard 2021 EOCCO Harney County C+U Dashboard 2021 EOCCO North Lake County C+U Dashboard 2021 EOCCO South Lake County C+U Dashboard 2021 EOCCO Malheur County C+U Dashboard 2021 EOCCO Morrow County C+U Dashboard	EOCCO Cost and Utilization Dashboards provide overviews of our CCO member demographics, trends in costs of care, overall utilization of health services across the region, utilization of primary care, utilization of emergency departments, utilization of specialty services, and pharmacy data. Reports provide analysis of regional health disparities and help to identify areas of quality improvement across the CCO.

2021 EOCCO Sherman County C+U Dashboard 2021 EOCCO Umatilla County C+U Dashboard 2021 EOCCO Union County C+U Dashboard 2021 EOCCO Wallowa County C+U Dashboard 2021 EOCCO Wheeler County C+U Dashboard	

8. **Identify the data sources your CCO used to determine the demographics and diversity described in your answer to the prior question. This should include the date each data source was last updated. These can be the same data sources used to describe the community's demographics in your CCO's Community Health Assessment (CHA).**

   Data sources used to determine the demographics and diversity in the communities of the EOCCO service region as part of EOCCO's ongoing Community Health Assessment initiatives are included in the 2022 EOCCO CHA Data Elements document. The EOCCO CAC Demographic Assessment Worksheet and REAL-D and SOGI demographic data assessment described in question 7 come from the following data sources listed below:

Source of Data Used in EOCCO CAC Demographic Assessment Worksheet and analysis	**Year Data Source Updated**
Portland State University Center for Population Research and Census, Annual Population Estimates	2021 data updated in April 2022
American Community Survey 2016-2020 5 Year Estimates	Data Released 2022
2020 Census Data	Data Released 2022
UCLA Williams Institute Adult LGBT Population Survey	Data Released 2021

9. **Describe the extent to which the membership of each CAC is in alignment with Community Health Improvement Plan (CHP) priorities and can help drive the success of your CCO's CHP.**

   Each one of the EOCCO CAC members live and serve as representatives of their community within the 12-county CCO region. Some CAC Members are employed by entities or organizations working to address CHP priorities. This includes Public Health, Justice System, Economic Development, School District, and Tribal Nations. There are also CAC Members with lived experience actively dealing with and/or overcoming challenges that are reflected in CHP priority areas such as poverty, food insecurity, childhood trauma, and SUDs.

   Each of the 12 EOCCO counties completes a Community Health Plan with the Local Community Health Partnerships (LCHP), aligning with the county and CCO Community Health Assessment (CHA). The priority areas from each CHP are reviewed, shared, and compiled together as part of the EOCCO wide CHP. The local voice is imperative and ultimately is what drives the success of the CHP.

EOCCO CAC Demographic Composition

10. OPTIONAL. You are *not* required to answer questions A or B here, as they are *not* part of your CCO contract. We are asking these questions because OHA's Public Health Division would like to use responses to inform metric development for Oregon's State Health Improvement Plan (SHIP), called Healthier Together Oregon (HTO). For this reason, you will *not* see a description of these questions in the evaluation criteria matrix.

A. For each CAC, please note all organizational partners who are voting CAC members.
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B. Below, please check all boxes that represent these partners. Note: A CAC member may represent more than one sector or category.

☐Education (K-12 and/or early childhood; e.g., Early Learning Hub)
☐Human services (e.g., local food bank)
☐Public health
☐Transportation
☐Corrections (e.g., jails, prisons)
☐Law enforcements and/or courts
☐Housing (e.g., non-profit focused on housing)
☐Land use planning
☐Parks and recreation
☐Faith-based
☐Arts and culture
☐Business
☐Other (Please list) Click here to enter text.

Relationship of the CAC to other Parts of the CCO

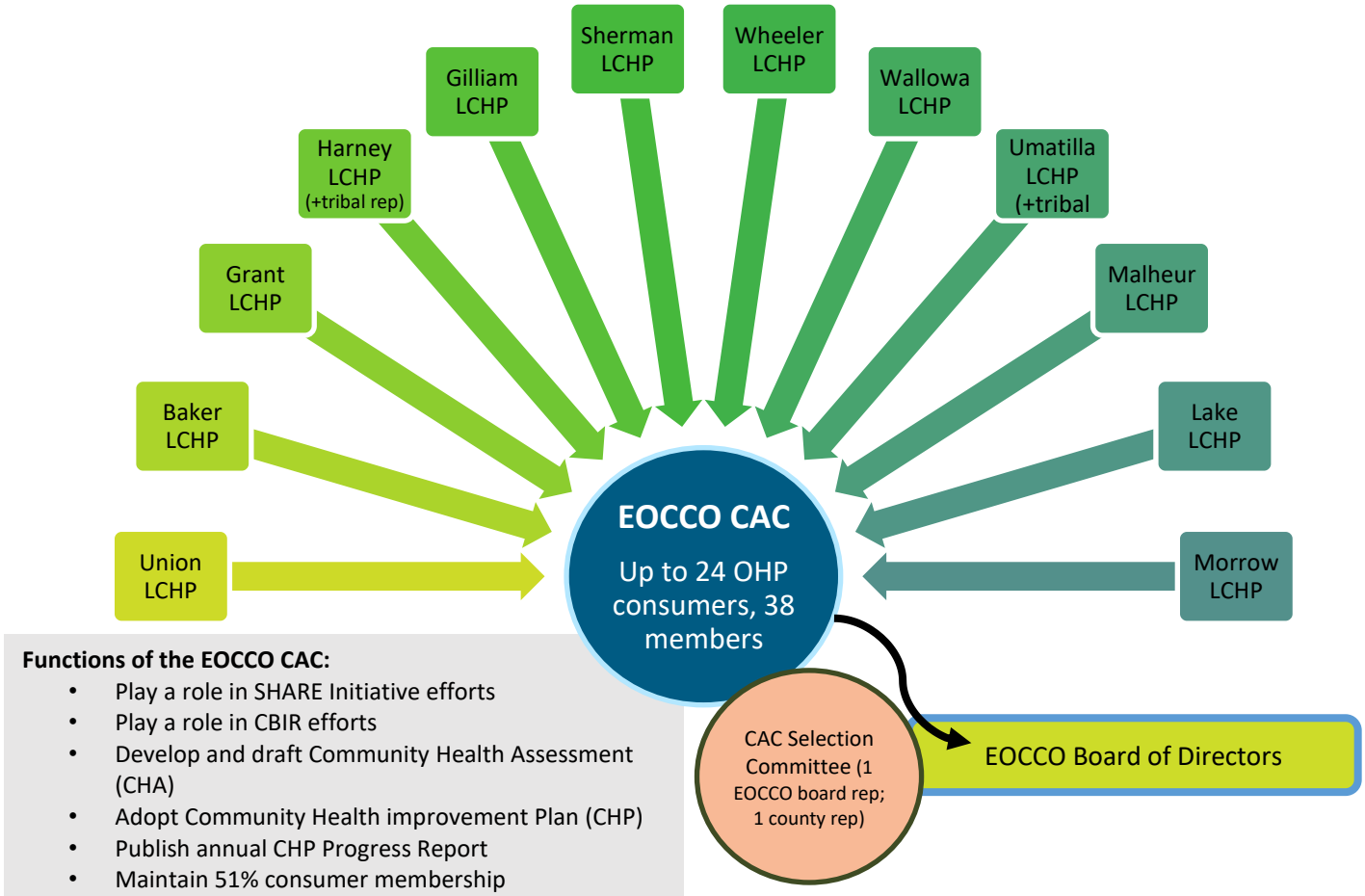
11. a. Describe the feedback loop/communication flow between each CAC and the CCO's leadership (including governing board), and any other CCO committees and/or CCO subcontractors relevant to the CAC's work. Describe how information is communicated between each party. Please also describe how the CAC's involvement in decision-making is considered by CCO leadership.

The EOCCO has 12 county Local Community Health Partnerships (LCHPs) and one EOCCO CAC. Specific duties within the EOCCO CAC model include review/approval of CBIR funds, yearly oversight of the Community Health Plan (CHP) and development/review of the Community Health Assessment (CHA) every five years. Under this CAC model, there is an intentional focus on local efforts. The Regional CHP has evolved into a compilation of all 12 LCHP Community Health Plans (CHP) with evaluation and oversight directed by the EOCCO CAC.

The EOCCO CAC Chair serves on the CCO's governing board and presents information on behalf of the CAC. Based on the information presented and the recommendations of the CAC, the CCO leadership makes thoughtful considerations. The EOCCO CAC also has representatives from the EOCCO Leadership Team in attendance, which allows for an opportunity for CAC members to address concerns, issues, or provide positive feedback on behalf of their county regarding EOCCO services.

The EOCCO Board of Directors also serve as part of the CAC Selection Committee, which also enhances opportunities for connection and more in-depth knowledge of the CAC structure and membership on

an individual scale. Relationship building and trust are key elements in any relationship; by having EOCCO leadership interact directly with OHP members at this level, the opportunity for OHP member consumers to find their voice and be heard directly by those who can impact change is a powerful model that the EOCCO will continue to foster. The image below reflects the structure of the EOCCO CAC.



In addition, EOCCO has been distributing a set amount of funds every year to each of its 12 counties through its community benefit initiative reinvestment (CBIR) program. These funds help support projects within each of our eastern Oregon communities that align with the CHP priority goals and social determinants of health. By reinvesting funds in the communities, EOCCO hopes to help support better health, better health care, and lower cost for EOCCO members and their communities.

b. List the number of CAC members who have been selected to serve on the CCO's governing board, and whether they are consumer or non-consumer CAC members.

Two CAC members have been selected to serve on the CCO's governing board. CAC members serving on the EOCCO Board include a consumer from Malheur County and a consumer from Union County.