2022 SB 902 Report to the Oregon Legislature

CCO Collaboration with Providers of Services to Children & Adolescents through Community Health Improvement Plans

December 31, 2022

Contents

Acknowledgments

This publication was prepared by Oregon Health Authority Transformation Center staff.

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Executive Summary

Senate Bill 902 (SB 902; 2015) requires coordinated care organizations (CCOs) to collaborate with child and adolescent service providers through their community health improvement plans (CHPs). This bill also requires the Oregon Health Authority (OHA) to compile this information and report it biannually 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. Given that some CCOs are on a three-year CHP cycle to align with local hospitals, newly completed CCO CHPs have been submitted to OHA at different periods of time. CCOs are also required to submit a CHP Progress Report annually to OHA in years they do not submit a new CHP to OHA. All 16 CCOs submitted a CHP Progress report to OHA by June 30, 2022.

In fall 2022, OHA staff reviewed the most recent CHP Progress Report submissions from all 16 CCOs to assess how well they met Oregon Revised Statutes (ORS), Oregon Administrative Rules (OARs) and CCO contract requirements. The date range for progress report activities was 7/1/21-6/30/22. A comprehensive review of the progress reports let to the following highlights:

CCOs worked with many of the required SB 902 partners to implement their CHPs, but not all.

- 100% of CCOs worked with Early Learning Hubs (ELHs) to implement their CHP, and 88% of CCOs worked with programs developed by ELHs or Early Learning Councils (ELCs) to implement their CHP
- 100% of CCOs worked with other child and adolescent program administrators, hospitals in the region and local public health departments to implement their CHP
- More than 80% of CCOs involved school health providers in CHP implementation
- 75% of CCOs worked with community mental health providers on CHP-related activities
- Just over 50% of CCOs included school-based health centers (SBHCs) in CHP implementation
- Only 13% of CCOs worked with healthy start family support service programs, while only 6% of CCOs work with the Cover All Kids program and/or other medical assistance programs when implementing their CHP

CCOs worked with early learning hubs, early learning councils, and youth development councils in a number of ways.

- 25% of CCOs supported an ELH program targeted at pre-K children
- 25% of CCOs worked with an ELH program focused on parent/caregiver support and life skills
- 19% of CCOs partnered with ELHs on programming to address trauma and adverse childhood experiences, social-emotional learning & kindergarten readiness, childcare needs and/or maternal child health
- 19% of CCOs worked with YDCs on programs supporting alternative high school education & job training

A few themes emerged for how CCOs worked with partners to coordinate the effective and efficient delivery of health care to children and adolescents.

- Close to 40% of CCOs supported programs aimed at mitigating the effects of youth trauma, and promoting resilience
- Just over 30% of CCOs worked to develop community information exchanges, supporting closed-loop referrals to providers, schools and social service agencies supporting youth and adolescents
- 19% of CCOs supported the implementation of mobile youth medical clinics to increase well-child visits, vaccinations and dental examinations
- 19% of CCOs worked with partners to support implementation of mental health assessments for children in foster care

CCOs worked with schools and adolescent health providers on prioritized health focus areas by implementing a wide range of CHP activities. Examples included:

- Partnerships with school districts to promote trauma-informed practices and coordinate parent educational programing
- School district partnerships focused on youth suicide awareness, and student behavioral and oral health supports
- Partnerships with providers focused on promoting healthy nutrition, physical activity and student literacy

Please refer to the SB902 findings section for detailed results.

In Summary

Over the past year (7/1/21-6/30/22), CCOs worked with a variety of required SB902 partners to implement their CHP. The nature and extent of these partnerships varied depending on a number of factors, including CCO CHP priority areas, strength of community-based relationships, as well as the longer timeline of CHP implementation. One commonality was that a majority of CCOs worked with SB902 partners to address the social determinants of health through their CHP. Across the 16 CCOs, this included projects focused on addressing youth food insecurity, houselessness, job training, trauma & adverse childhood experiences. Early evidence demonstrated by CCOs also shows that these CHP activities are on track to improve the coordination of effective and efficient delivery of health care to children and adolescents. However, it will be important to collect data from future CCO CHP progress reports to fully answer this question.

Report Methodology

2022 CCO CHP Progress Report submissions served as the sole source for this report. These reports covered a one-year snapshot of CCO CHP implementation, from 7/1/21 – 6/30/22. This is in contrast to full CHPs, which typically cover a period of five years in duration.

By June 30, 2022, OHA had received CHP Progress Reports from all 16 CCOs. The progress report submissions included two required documents:

1. A **report narrative** documenting progress made in implementing the CHP; and
2. A completed **progress report questionnaire**, which included a series of questions focused on key players, health priorities and activities in child and adolescent health

In fall 2022, OHA staff reviewed progress report submissions from each CCO to determine the extent to which they met progress report requirements (see Appendix A for reference). Transformation Center staff then provided feedback to each CCO, requesting that corrections be made if specific requirements were found to be either not met or partially met.

SB 902 findings reflected in CHP Progress Reports

Table 1: Key partners required per SB902 that were involved in CHP implementation, by CCO.

	AH Coos	AH Curry	AllCare Curry	AllCare J/J/SD*	CHA	CPCCO	EOCCO	Health Share	IHN CCO	JCC	PSCO	PSCG	PS-Lane	PSMP	Trillium N.	Trillium S.	UHA	YCCO
School-based health centers	Y			Y	Y					Y		Y		Y	Y		Y	Y
School nurses	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	
School mental health providers	Y	Y	Y	Y	Y	Y	Y			Y	Y	Y	Y	Y	Y	Y	Y	
Early learning hubs (ELHs)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Programs developed by the ELH and/or ELC	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	Y
Youth development programs	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y	
Healthy start family support services programs				Y						Y								
Cover All Kids & other medical assistance programs								Y										
Relief nurseries									Y		Y							
Community health centers	Y	Y	Y	Y		Y	Y		Y	Y	Y		Y	Y		Y	Y	
Oral health care providers	Y	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y				Y
Community mental health providers	Y	Y	Y	Y	Y	Y	Y		Y	Y		Y		Y	Y		Y	Y
Local public health department administrators	Y			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hospitals in the region	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Other child and adolescent health program administrators	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*AllCare Jackson, Josephine & the Southern portion of Douglas counties.

Table 2: Key partners required per SB902 that were involved in CHP implementation, across CCOs.

SB 902 Partner	# of CCOs	% of CCOs
Local public health department administrators	16	100%
Hospitals in the region	16	100%
Early learning hubs (ELHs)	16	100%
Other child and adolescent health program administrators	16	100%
Programs developed by the early learning hub and early learning councils	14	88%
School mental health providers	13	81%
School nurses	13	81%
Youth development programs	13	81%
Community mental health providers	12	75%
Community health centers	11	69%
Oral health care providers	11	69%
School-based health centers (SBHCs)	9	56%
Relief nurseries	2	13%
Healthy start family support services programs	2	13%
Cover All Kids program and other medical assistance programs	1	6%

Table 3: Themes and activities demonstrating how CCOs worked with early learning hubs (ELHs), early learning councils (ELCs) and youth development councils (YDCs) in CHP implementation.

	AH Coos	AH Curry	AllCare Curry	AllCare J/J/SD	CHA	CPCCO	EOCCO	Health Share	IHN CCO	JCC	PSCO	PSCG	PS-Lane	PSMP	Trillium N.	Trillium S.	UHA	YCCO
ELH program - pre-K children	Y	Y	Y			Y		Y										
ELH program addresses childcare needs	Y	Y	Y				Y											
ELH program-social-emotional learning & K readiness												Y		Y	Y			
CCO & ELH program supports early childhood educators											Y							
ELH program focused on access to social safety supports						Y												
ELH program focused on maternal child health								Y							Y			Y
CCO partners w/ ELH on programming to address trauma and ACEs				Y						Y								Y
ELH program-parent/caregiver support & life skills				Y						Y			Y			Y		
CCO partnered w/ ELH-decreasing infant mortality					Y													
CCO partners w/ ELH to offer equity-related programing					Y										Y			
CCO & ELH program-home visiting																		Y
CCO & ELH program - dental/vision/hearing + dev. screening w/ K registration																		Y
CCO & ELH Good Behavior Game support																		Y
CCO solicited input from ELH parenting council																		Y
YDC program focused on alternate high school education & job training	Y	Y	Y															
YDC program focused on social-emotional learning	Y																	
CCO partners w/ YD groups on trauma informed care & resilience programming						Y												
CCO partners w/ YD groups to address homelessness									Y									
CCO included YDC in qualitative data process to inform CHP											Y							

Table 4: 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

	AH Coos	AH Curry	AllCare Curry	AllCare J/J/SD	CHA	CPCCO	EOCCO	Health Share	IHN CCO	JCC	PSCO	PSCG	PS-Lane	PSMP	Trillium N.	Trillium S.	UHA	YCCO
Mitigation of trauma in youth - increase resilience	Y	Y	Y			Y		Y						Y			Y	
Youth care coordination						Y		Y										
Youth care integration													Y			Y		
Youth therapy	Y																	
Youth suicide awareness/ed						Y										Y		
Family & parent resilience				Y						Y								
Mobile youth medical clinics	Y											Y					Y	
Clothing items - at-risk youth	Y											Y						
Youth peer supports						Y						Y		Y				
Snack/activity packs to youth during summer		Y	Y															
CIE: closed-loop referrals - providers, schools & agencies		Y	Y	Y		Y				Y								Y
Expansion of SBHCs				Y						Y				Y				
Program to increase # of planned pregnancies											Y							
Program addressing opioid use in pregnant patients					Y													
WIC partnership to increase breastfeeding rates									Y									
Dental care ed program for pregnant patients					Y													
Safe sleep crib program					Y													
Doula program - reduced cesarean sections									Y									
Post-partum program to support high-risk patients								Y							Y			
Infant & toddler safety care																	Y	
Home visiting programs; Kindergarten readiness															Y			Y
Coaching-day care providers					Y													
Prevention projects - children & adolescents							Y											
Foster care support - mental health assessments								Y	Y					Y				
Developmental and BH supports prenatal-five								Y										
Housing & resources-youth in crisis									Y						Y			
Program to increase 3rd grade reading proficiency											Y							
Programs to increase # of youth BH providers											Y	Y		Y				
Program to increase # of youth oral health providers						Y												
Program to improve cultural competency - BH providers														Y				

Table 5: Themes and activities demonstrating ways that CCOs and/or CACs worked with schools and adolescent health providers on prioritized health focus areas

	AH Coos	AH Curry	AllCare Curry	AllCare J/J/SD	CHA	CPCCO	EOCCO	Health Share	IHN CCO	JCC	PSCO	PSCG	PS-Lane	PSMP	Trillium N.	Trillium S.	UHA	YCCO
School district partnership - trauma-informed practices	Y	Y	Y	Y		Y												
ESD partnership - CHWs in schools												Y						
ESD and/or school district partnership-parenting ed	Y	Y	Y													Y		
ESD partnership to increase school BH staffing																	Y	
ESD partnership - school nursing program																	Y	
ESD partnership to coordinate prevention and professional development services - schools																		Y
ESD facilitates social emotional learning and mental health network														Y				
Clinic youth behavioral health support	Y																	
School partnership - programs to student behavioral health needs										Y	Y		Y					
School district partnership-youth suicide awareness		Y	Y					Y					Y					
School and/or provider partnership - healthy nutrition and/or physical activity programming											Y		Y			Y	Y	
Partner w/ schools and/or providers - CIE platform			Y							Y			Y					
Health-related services CBI grants to providers				Y						Y								
Provider, school and/or SBHC partnerships to improve dental health in schools					Y				Y									Y
CAC includes representation from school rep's						Y				Y								
CHWs from pediatric clinics attend CAC meetings							Y											
Clinicians representing SBHCs participate in children's health advisory council								Y										
School & provider partnership-system of care								Y							Y			
School partnership on youth opioid/substance misuse education									Y									
Provider partnership - Reach Out & Read program											Y							
Community resource huddle - providers, CBOs, social service orgs - school health fair												Y						

Appendix A: 2022 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, Part 7.m** and **Oregon Administrative Rule 410-141-3730**.

A. The CHP progress report is due by June 30, 2022. It should be sent to the Oregon Health Authority's Health Systems Division by email to CCO.MCODeliverableReports@dhsoha.state.or.us. .

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 two 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.

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. It must be reviewed by the CAC 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.
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				Full engagement
	1	**2**	**3**	**4**	**5**
Early learning hubs	☐	☐	☐	☐	☐
Other early learning programs[1]	☐	☐	☐	☐	☐
Youth development programs[2]	☐	☐	☐	☐	☐
School health providers in the region	☐	☐	☐	☐	☐
Local public health authority	☐	☐	☐	☐	☐
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.

Examples:

- ✓ *The early learning hub in our region is included in the prioritization and strategies.*
- ✓ *CCO is working with local youth development groups on homelessness.*

Click here to enter text.

4. If applicable, identify where the gaps are in making connections.

Examples:

- ✓ *CCO did not work with school health providers as there is no school-based health center, but the CCO has reached out to the school district.*

Click here to enter text.

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.

Click here to enter text.

6. What activities is the CCO doing for this age population?

Examples:

- ✓ *CCO is collaborating with its local SBHC and WIC program to improve oral health in their populations (0-18).*

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

- ✓ *CCO is working with youth, homeless, child welfare and mental health agencies on suicide prevention.*
- ✓ *CCO is coordinating prenatal services with local providers and public health agencies, including the SBHCs.*
- ✓ *Several CCO staff, CAC members and partner organization staff have attended ACEs trainings.*

Click here to enter text.

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

Examples:

- ✓ *Steering committee formed to identify gaps in school health needs.*
- ✓ *School nurse is an active member of CAC.*
- ✓ *CCO supported grant opportunities to improve mental health access in schools.*
- ✓ *CCO engaged with local early learning hub, and hub has cross membership with CAC.*

Click here to enter text.

Health Disparities

CCO contract: Exhibit K, Part 6 & 7

8. **Describe CCO and CHP partner efforts to address health disparities that were prioritized in the CHP. Include updated metrics or indicators to show progress in addressing the health disparity.**

Enter text here

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

Enter text here

Building Toward CCO 2.0 Requirements

Per contract section Exhibit K, Part 6 and 7) OAR 410-141-3730, CCOs are required to develop shared CHAs and shared CHPs with local public health authorities (LPHAs), hospital systems and other CCOs that share a portion of the service area, and federally recognized Tribes in the service area that have or are developing a CHA and CHP. Please reference OHA's *CCO Guidance: Community Health Assessments and Community Health Improvement Plans* available here.

10. **Is your CCO's CHA and CHP fully shared with LPHAs, hospitals, other CCOs, and Tribes that share a service area?**

☐ **Yes**

Please name the entities that share the CHA and CHP. Enter text here

☐ **Partially**

Please name the entities that share the CHA and CHP. Enter text here

Please name the entities that do not yet share the CHA and CHP. Enter text here.

☐ **No**

Please name the entities that do not yet share the CHA and CHP. Enter text here.

11. **If your CCO CHA/CHP is not yet fully shared with LPHAs, hospitals, other CCOs and Tribes because it was submitted prior to 2020, does your CHP have health priorities and strategies aligned with other community health improvement plan health priorities and strategies?**

Agency, Organization or Tribe	Aligned Health Priority	Aligned Strategy

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.

12. 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 BIPOC-AI/AN 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 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 policy and procedure.

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 promotion of art and cultural events 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 reach of preventive services through evidence based and promising practices.

☐ Support Medicare enrollment for older adults through 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 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.