Regional Community Advisory Council (CAC)
MINUTES

Date: Monday, November 10, 2014
Time: 12:00 p.m. – 3:00 p.m.

Council Representatives:
CAC Chair: Lawrence Eby;
Benton: Joe Zaerr, Melissa Marshall (Liaison), Michael Volpe, Stretch McCain;
Lincoln: Betsy Williams, Ellen Franklin (Liaison), Patricia Neal, Richard Sherlock;
Linn: Frank Moore, Miao Zhao (Liaison), Paul Virtue;
Others on the Agenda: **Kelley Kaiser**, IHN-CCO CEO; **Rebekah Fowler**, CAC Coordinator**; Bill Bouska**, OHA Innovator Agent**; Hilary Harrison**, Benton Chair (& CAC Rep); **Dick Knowles**, Lincoln Chair; **David Bigelow**, Samaritan Pacific Health Services CEO; **Lauren Zimbelman**, Regional Health Assessment Project Coordinator, Benton, Lincoln, & Linn County Health; **Jessica Deas**, Public Health Planner Benton, Lincoln, & Linn County Health

INTRODUCTIONS, ANNOUNCEMENTS, & APPROVAL OF AGENDA & MINUTES

- Larry Eby, CAC Chair, Called the meeting to order at 12:06
- Chair Eby asked everyone to introduce themselves and state one of the major interests that brings them here to do this work. Interests those at the table listed were:
  - **Chair Eby:** Patient-centered Primary Care Home Model
  - **Ellen Franklin:** Originally the billing aspect, but now about transforming healthcare and better serving members.
  - **Miao Zhao:** Access to care, particularly for vulnerable populations
  - **Melissa Marshall** has a couple "kiddos" on IHN advocate for family and for youths.
  - **Paul Virtue:** Integration of mental health and holistic care
  - **Pat Neal** interested in how Health Reform will look
  - **Joe Zaerr:** Patient engagement
  - **Richard Sherlock** is a "consumer" interested in making sure that healthcare improves and in seeing that what we do here will benefit consumers and mental health peers.
  - **Stretch McCain:** Helping the homeless, giving their point of view
  - **Frank Moore** is here to keep Stretch out of trouble.
  - **Mike Volpe:** underserved populations
- **Chair and Representative announcements:** None
- **Coordinator announcements**: The CAC is looking to fill its Vice-chair seat in January. The Vice-Chair was added to the Charter by the CAC with the primary duty being to fill-in for the Chair when the Chair is unable to preside over a CAC, Executive Committee. The Vice-chair will not be appointed to the IHN Board of Directors. The Vice chair may be asked if they would like to attend a meeting on behalf of the Chair, if mutually agreeable. And the Vice-chair may have the opportunity to learn some of the work of the Chair. Liaisons and Local Chairs (who are CAC representatives) may also serve as Vice-chair.
  - **REQUEST:** If you are interested in this position, please send Dr. Fowler a paragraph or two about why you would be in interested in that position. This will be included

in the January packet, so please, if you don't do this as soon as possible, then please do so no later than the end of December.

- **ACTIONS:** Council approved present *Agenda* (1st Moore, 2nd Neal) and *Previous Meeting Minutes* (1st Moore, 2nd McCain) (**Attachment:** previous CAC meeting minutes).

PUBLIC COMMENT

Seven members of the public present. No comments.

REGIONAL COUNCIL AND LOCAL COMMITTEE COLLABORATION

Rebekah Fowler, CAC Coordinator, led a discussion about local committee and regional council work coordination and communication

Dr. Fowler said that the Communication Coordination Committee (CCC), consisting of the CAC Chair, (Vice-chair, when there is one), Liaisons, and Local Chairs) proposes that the Local Chairs sit at the table during CAC meetings. They would not have a vote; they would be there as a resource and so they can best understand what the CAC is requesting of and/or needs from them.

Representative Zaerr asked what function would the Chairs bring to the meeting that the Liaisons do not.

Representative Zhao (Liaison) said that the Chairs know how the work flows and how their meetings should be organized and run. They have their own perspective and know the history of the group.

Representatives Sherlock agrees that it would add to the discussion, but suggested that it may make too many people at the table. It might be hard to get everyone's perspective in.

Representative Moore said that the Chairs serve multiple roles. The Liaison transfers information and represents the CAC, but the Liaison isn't necessarily able to make decisions for the Chair. He said that he (in his capacity of Health Administrator) meets with the Linn Chairs regularly and they have a lot of information that a Liaison might not have since they do not run the meetings.

Representative Marshall (Liaison) said that she transfers information between CAC and Local, but in her Liaison role, isn't familiar with the meeting processes and workflow.

Representative Neal: The Chairs know the strengths of the Local Committee members and the work that each might do.

Representative Volpe said that the Local Chairs do so much work. It makes sense that they are at the table. Also, it's an acknowledgement of the work that they do.

Representative Franklin agreed that there would there be an advantage to having them sitting at the table, but why not just add them as voting members to the CAC?

Dr. Fowler said that a Chair, like Hilary Harrison, can be on the Council, also, but the other Chairs are community members; there are no current seats for them, and that would impact the consumer majority.

Representative Virtue suggested that adding more people to the table might water down consumer voice.

Representative Sherlock said maybe we should just wait 6-8 months and then decide.

Chair Eby said that we all have a concern about watering down the Consumer voice. It's a struggle to keep the seats filled. We've all had a chance to have some good input. Our primary goal is to have good process and good outcomes. He sees this as enhancing the work of the CAC and that with proper attention a good balance can be maintained.

Representative Moore said we need to have an action. The CAC should make a decision on this and move forward.

ACTION: Motion to include a Local Chair from each county to participate as a non-voting member at CAC meeting (1st Marshall, 2nd Moore). The motion passed (8 in favor, 2 opposed).

IHN-CCO UPDATE

Kelley Kaiser, IHN-CCO CEO, provided a CCO and Board of Directors update:

Operations Report
November 2014

IHN-CCO Total Enrollment

56,781 as of October 2014, this is a 2% increase over August

Highlights

Rates for 2015

The rate development process for 2015 is in full swing. We are working closely with OHA to develop our rates.

OHA Directors Message

September 19, 2014 **OHA Director's messages on the web**

To: **All OHA employees**
From: **Suzanne Hoffman, Interim Director**

News everyone should be proud of

"When you put a lot of hard work into one goal and you achieve it, that's a really good feeling." ~ Derek Jeter

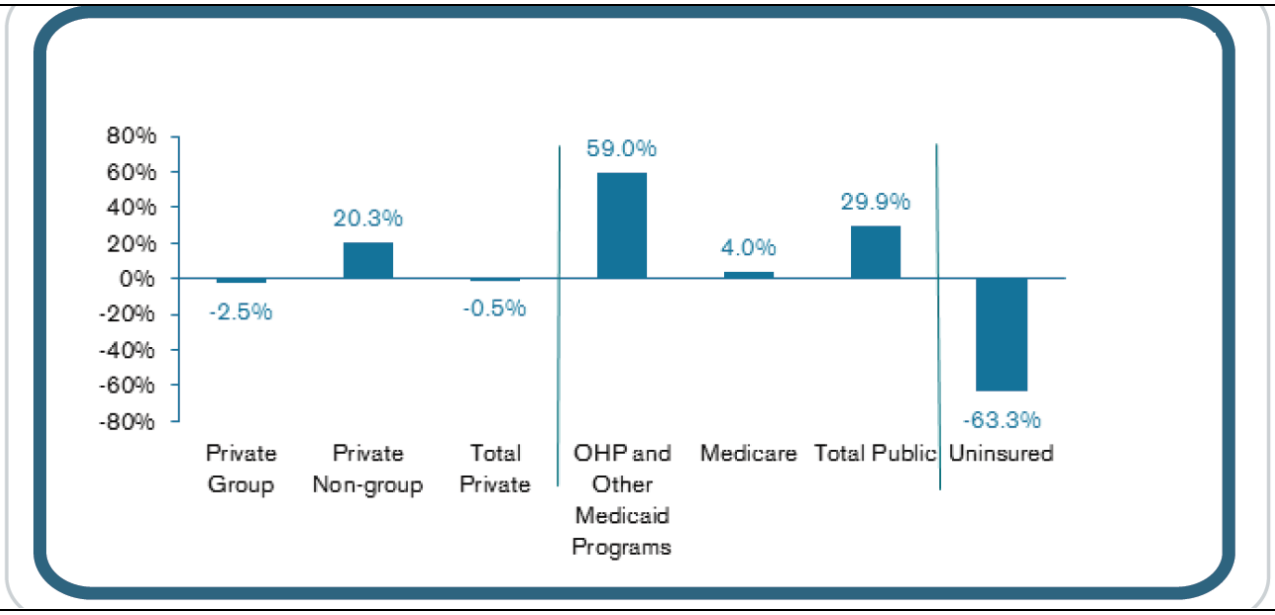
We have been hearing for weeks about the drop in uninsured Oregonians, but the report this week from OHSU tells us definitively: more Oregonians have health insurance today than ever before. Over the past year through an incredible effort by many people, 348,000 people have gained health care coverage and now 95 percent of Oregonians have the security of being insured.

I am deeply proud of everyone at the Oregon Health Authority who worked to make this happen.

We should also be proud that most of the 360,000 new Oregon Health Plan members are entering a new coordinated care health system. Through their local coordinated care organizations, they will have access to team-based and patient-centered care designed to

meet the triple aim of better health and better care at a lower cost. While our work is not yet done, we must take a moment to celebrate this incredible accomplishment. Well done! And thank you again for all you do.

	Number of people			Percent of population	
Type of insurance	June 30, 2013	June 30, 2014	Percent Change	June 30, 2013	June 30, 2014
Private					
Group	1,894,438	1,847,500	-2.5%	48.2%	46.6%
Non-group	180,883	217,563	20.3%	4.6%	5.5%
Total, Private	2,075,321	2,065,063	-0.5%	52.8%	52.1%
Public insurance					
OHP and Other Medicaid Programs	613,782	975,717	59.0%	15.6%	24.6%
Medicare	690,962	718,940	4.0%	17.6%	18.1%
Total, Public	1,304,744	1,694,657	29.9%	33.2%	42.8%
Uninsured					
Uninsured	550,000	201,794	-63.3%	14.0%	5.1%
Total population	3,930,065	3,961,514			



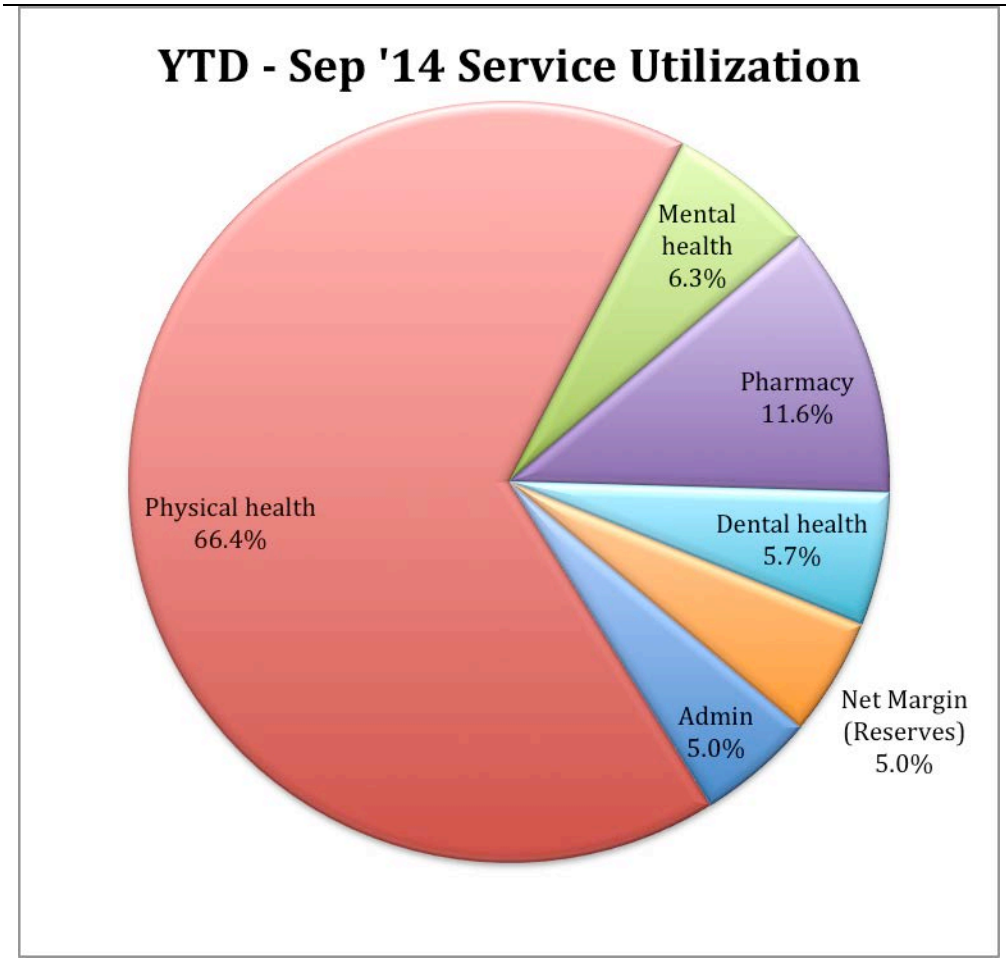
Update on Targeted Case Management
We are working with our Public Health on a July 1st effective data. Below is the timeline of expectations from OHA.

For July 1, 2015 effective date:

- February 1, 2015 OHA prepares new contract amendment language
- March 1, 2015 CCO send non-binding letter of intent
- March 1, 2015 DOJ provides an approved template to OHA (Referred to as legal sufficiency.)
- May 31, 2015 CCO send binding letter of intent
- June 1, 2015 OHA sends executed contract amendment to CMS for post execution review (Required 30 days)
- July 1, 2015 OHA emails executed contract amendment to CCOs (PDF version). (Use Contracts & Compliance primary & secondary distribution list)

High Dollar Cases: IHN-CCO had **4** stop-loss/catastrophic cases as October 2014. Those are people who were so sick and had such a high need for services that the CCO's stop-loss insurance went into effect to pay for those bills.

Utilization Update:



Ms. Kaiser brought back "Dual Eligible," follow up from the last meeting, numbers for Representative Volpe from last meeting. Dual Eligibles are those eligible for both Medicaid and Medicare. Ms. Kaiser reported that there are about 1200 individuals who are dual eligible but who are not covered by both.

Ms. Kaiser said that IHN-CCO lost 4,000 members since the State process of redeterminations has begun taking place. 4,000 members in the CCO region have gone off OHP, mainly because they did not reapply.

Representative Marshall asked how long of a time period are people tending to not be covered by OHP if they fall off enrollment.

Bill Bouska, OHA Innovator Agent said that there is no waiting time from OHP. IHN-CCO prefers that if someone falls off enrollment for a few days, that OHP be effective retroactively. If it's a longer period of time, there could be a month long gap.

Representative Sherlock asked why people are losing benefits.

Ms. Kaiser: All kinds of reasons. They are no longer eligible or they didn't reapply for a variety of reasons such as having moved and didn't get the forms, didn't fill the forms in on time.

Representative Moore, as Linn County Health Administrator, has been working with IHN-CCO to figure out how to reach people. He called up IHN-CCO COO, Kim Whitley, and asked how Linn County could reach people who fell off enrollment. CCOs can't legally "recruit" anyone, but they can let the counties know who is coming up for redetermination and the counties can do the outreach.

Representative Volpe asked if the CCO has noticed problems with access to care due to all the new enrollees.

Ms. Kaiser said that access is still an issue, but it's getting in much better. It has certainly been a problem and is still a challenge, but it seems that all of the projects people have been working on are beginning to relieve the problem and lessen wait times.

Representative Moore said the CCO has been working to make sure that everyone who is eligible is signed up.

Representative Virtue asked if redetermination is just a paper process. Mr. Bouska said that it is. Representative Marshall said she has helped people with their forms and it was literally filling in just a couple bubbles. So, it wasn't a difficult process.

HEALTHCARE CAPACITY UPDATE

David Bigelow, Samaritan Pacific Health Services CEO.

Samaritan Pacific Health Services (SPHS) is a 25 bed, critical care hospital. The building is owned by another entity with its own board. Waldport, Depoe Bay, Newport, Lincoln City, Toledo provide services in Lincoln County.

SPHS Lost 6 physicians to retirement, 4 specialists, and 5 midlevel providers doing middle-level care, all to retirement.

They have been able to hire some people to fill those positions, but not all. Even when a position is filled, temporary absences require considerable time to get them filled. There are wait times for new patients to be seen due to the number of new enrollees.

Hospitals last year, and this year the clinics converted to EPIC (electronic health records). This wasn't without cost. Many Primary Care providers reported a 5-15% reduction in productivity. That is improving, but it also had impact on capacity.

Recently, they have seen record high months in terms of numbers seen at Emergency Departments. The numbers were decreasing at first, but with the new enrollees, it increased. Many of them were self-pay and used to getting their care from the ED and so when they got on OHP, ED is where they went for care.

Rural communities have challenge recruiting new medical staff. Only 1% intends to do primary

care. 44% hospitalists, the rest are going into specialties.

Dr. Bigelow said that this was SPHH's picture of what has been happening; He would argue that it's not likely too different in other communities and clinics. All are working hard to provide access.

Representative Zhao asked if there is a Patient Centered Primary Care Home in Lincoln County. Dr. Bigelow said that Samaritan has one.

Representative Franklin said that the Lincoln FQHC is a PCPCH tier 3(highest tier).

Dr. Eby asked why are there so few PCPCHs here. The PCPCH model could alleviate many of the challenges of Capacity.

Dr. Bigelow said they are working on having more. There will be more. There is a challenge to find a large enough clinic setting.

Representative Sherlock asked if Health Coaches were being hired. Are they looking at Traditional Health Workers, etc. so that everyone can be working at the top of their license? Dr. Bigelow said they are currently trying to fill their usual positions rather than creating new positions such as THWs. It isn't that there isn't a value in that; it's just difficult to start a new model when you're trying to fill vacated positions.

Representative Moore: there are multiple factors influencing increased ED use. Physicians need to shift how they do services. With so many newly enrolled, it's not an optimal time to be asking physicians to do things differently. Many who are new to this benefit are accustomed to using the ED. COMP-NW is training new docs, but they have to graduate. It will happen gradually.

Representative Volpe said his PCP uses Physicians' assistants. Dr. Bigelow said they used to have a 4-1 ratio of physicians to midlevel providers. Then they were 2-6, and now 2-8 doctors to mid-level providers. Are the midlevels acting as PCPs rather than physician extenders? Both, was the answer.

Eby said it's important to support the practitioners during this transition. For the change to happen, they need a lot of "care and feeding."

Dr. Bigelow agrees that the PCPCH model is where they need to go. Representative Franklin pointed out that the FQHC does have a PCPCH model that this group may want to hear from at some point. They are functioning as teams.

LIAISON UPDATES

Three county CAC Liaisons provided updates on Local Advisory Committee activities since the previous CAC meeting.

Representative Marshall of Benton county BLAC discussed the Summit and the CHIP Tracking

Spreadsheet, had a couple potential new members attending the meeting.

Representative Ellen Franklin of Lincoln county: David Bigelow came to talk to the CHAC about the new building and the nutrition education kitchen they're building. She said the building is going to be great for the community.

The CHAC has been working on an Issue Brief on Access they want to tie in with the CHIP.

CHAC has nearly finished a Charter. There is continued discussion about recruitment for local and regional levels.

Representative Miao Zhao of Linn county: Last month the LLAC worked on finalizing local charter with the intention to keep the local flavor of Linn but to mirror the regional charter.

Mr. Knowles, Linn Local Chair: Jessica Hiddleston received a grant from LBHEA for community outreach in East Linn and one in Albany area. Workgroups have met on that. Theresa Conley from the COG gave a presentation. Megan Mackey will be coming to speak about the Healthy Communities Regional Steering Committee.

TRACKING AND REPORTING CHIP PROGRESS UPDATE AND DISCUSSION

Rebekah Fowler, CAC Coordinator, summarized and led a discussion of the recent activities of the Communication Coordination Committee (CCC) and updated the Council on their meetings.

To begin, Dr. Fowler pointed out the various documents in the packet that she'd be referring to during the meeting. They included a partially completed proposed timeline, the CHIP Tracking spreadsheet, and OHA guidelines and checklist.

Since adopting a CHIP, the CAC and its local committees have been looking forward to beginning the next steps in the process of tracking the CHIP.

At the last CAC meeting, the **Communication Committee** (CCC) was tasked with returning today with a proposed plan to track the CHIP so the CAC can provide a spring 2015 progress report.

A) The CCC is:

- Composed of the CAC Chair and Vice-chair, the Local Chairs, and the three county Liaisons.
- Technical advisors/support to the CCC for recent meetings have included the CCO CEO, the CAC Coordinator, one Health Administrator, & the Innovator Agent.

B) The Major responsibilities assigned to all CACs in statute are:

1) Oversee CHA and Adopt a CHIP'
2) Track and report CHIP progress annually
3) Identify & advocate for preventative care practices to be utilized by the CCO

- **Communication Committee** put together this plan to assist the CAC, the local committees,

and the IHN-CCO in tracking CHIP progress.

C) **Tracking Spreadsheet:** Lead CCO staff & community partners are working on filling in the CHIP Tracking Spreadsheet to share this winter & spring with the CAC & Local Advisory Committees.

D) PROPOSED PLAN each Local Advisory Committee to the CAC will take responsibility for two Health Impact Areas of the CHIP and work on:

- Listing how the **Quality Metrics** relate to each specific activity listed for that HIA

- Listing the kinds of **real life health outcomes** and **healthcare transformation** the CAC would ideally like to see impacted by each goal/strategy/and especially activity (e.g. Health Literacy trainings will not just be implemented, but will improve communication and understanding so that CCO members will, where possible, list the kind of data the CAC would like to see these activities measure.

- OHA CHIP Guidelines:

    - Work on familiarizing themselves with the OHA CHIP guidelines and a Checklist and how this relates to the work of the CAC/Local Committees, etc.

    - After receiving a filled in CHIP Tracking Spreadsheet this winter, compare CHIP Activities etc. to the Guidelines and look where the CHIP meets the Guidelines and where the CAC or CCO need to focus attention on gaps in meeting the Guidelines.

The CCC proposed the following HIA focus for each Local Advisory Committee over the next few months:

- **Benton:** Behavioral Health for the region & Access for Benton
- **Lincoln**: Chronic for the region & Access for Lincoln.
- **Linn:** Maternal/Child for the region & Access for Linn

Chair Eby asked the Council if Dr. Fowler's presentation made sense and what questions they might have.

Representative Zhao: Will all the data come in Jan and Mar only? Ms. Kaiser said the information would come in from now until each of those dates. Those dates are the drop-dead dates, but the information will be fed through Dr. Fowler. Some of it will be data, some will be information, some a plan. When IHN said they'd do all this work, that was before the enrollment increased by 20k. That was a priority. This work plan is a good reset for the CCO. Staff are now tuned in to this as a priority with deadlines.

Representative Moore: In looking at the matrix (tracking spreadsheet), there are different kinds of data: yes/no, creating a benchmark, some are hard measures, some they have data for, some they are just now planning for benchmarking. He gave examples of the Mental Health First Aid having

data for how many classes have been taught and how many have completed the course.

Dr. Fowler asked about asking if there might be real life measures from Mental Health First Aide. Bill Bouska said that Mental Health First Aide is an evidence-based practice. There are course evaluations that could deliver measures of change in people's knowledge and perspectives.

Representative Franklin said that some outcomes could be anecdotal. We may not be able measure everything objectively but there are ways to get interesting information.

Representative Virtue says he took both Mental Health First Aid classes, said that before and after survey of information on suicide, said that before taking the class, many said that it was not a good idea to talk about suicide to someone because it might give them the idea to do it. Afterwards, attendees thought it was important to talk about the issue.

Dr. Fowler expressed what a great conversation this is and that it's exactly the kinds of conversations that should take place at the local level where more time can be spent discussing and writing down what people think.

Representative Virtue asked how the CCC came to divide the HIAs the way that they propose doing.

Dr. Fowler said that everyone wanted Access and it was a big enough area that it was decided that each county should do that for its own county. It was also decided that a county shouldn't take on one of the HIAs they didn't originally propose because they're not as prepared to take that on. It made sense that Linn take Maternal and Child because they had championed it and done the most work on it. Then it made sense for Lincoln to take Chronic, and then so Benton took on Behavioral, which was another favorite topic, but a big one.

Except for Access, which each county will do for themselves, the other HIA each county takes on, they need to answer the questions to the best of their ability for all three counties. Information should flow between the local committees throughout. When a county meets and makes progress on their HIA, they should share that progress with the other two counties to get feedback.

Mr. Knowles pointed out that if a county finishes their two HIAs, they could take a look at another one or two of them.

Representative Neal said that there are programmatic differences between the counties, so it will be important for each county to be in the loop as the other counties are filling in their ideas on the spreadsheet.

Dr. Fowler said that, on the spreadsheet, there is a column for deadlines and one for status. The local committees don't need to deal with that. It's something that the CCO may fill in, if it becomes helpful to them.

Representative Zhao asked if data evaluation might be available for the group.

Dr. Fowler asked Mitch Anderson if the CHA alignment project staff might be able to provide such

training. He said yes, that would be possible, and that with Lauren Zimbelman, the Regional CHA Alignment Coordinator--soon to become a member of the BLAC and the CAC—will be available as a resource. Also, an epidemiologist has been hired and will be on board to support the work, also.

Representative Virtue pointed out that data wasn't available to us before. How will we get this data now? Dr. Fowler said that IHN staff is now working on that. The alignment coordinator and the epidemiologist will work on it. We won't be able to get everything. We may have to wait until the future to get some kinds of data, and some data may never become available. It should be better this time and improve over time.

Representative Neal said that it's important that during this work we define what we want to see, the kind of data we want. Then, at least, we'll have a start in what to request and for the data people to work on getting that, if possible.

Mr. Bouska: The CHIP is a strategic plan for getting us from where we were last year when we created the CHIP to where we want to be in 3 or 4 years. It's important in the next months for us to prepare ourselves for understanding the data received so we'll be able to know what questions to ask.

Representative McCain wants the CAC to stop using phrases such as "trying to do this" and "I think we'll do this" and start saying we will do it.

Representative Virtue asked how we'd make requests. Locally, the requests should go through one or two point people to Rebekah and from her to Kelley and then back again.

ACTION: Motion to adopt the CCC work plan as presented by Dr. Fowler. Motion approved.

REGIONAL COMMUNITY HEALTH ASSESSMENT (CHA) ALIGNMENT

Lauren Zimbelman, Regional Health Assessment Project Coordinator & Jessica Deas, Public Health Planner both for Benton, Lincoln, and Linn County Public Health, gave a brief introduction to the work they are doing to coordinate a Regional Health Assessment (RHA).

There are currently a variety of CHA/CHIP and assessment processes that take place within the region, all with their own requirements, populations, and timelines. This includes CHAs for each of the counties, each of the hospitals, the Early Learning Hub, the CAC, and various non-profit organizations. Ms. Zimbelman and Deas were recently hired to strengthen coordination around regional assessment and create a system that provides updated health status data that can be extracted by the various needs of partners (by zip code, age, OHP status, county, etc.). This will include meeting with the various organizations conducting assessment in the region, identifying gaps in data across the region, and constructing a format for future iterations of the Regional Health Assessment. The RHA will focus on data around health status, as opposed to clinical encounters, performance measures, etc.

The Council was supportive of this idea and it will greatly appreciate the resource Ms. Zimbelman and Deas will be for the CAC and its CHIP.

Mitch Anderson said that he and Kelley Kaiser will discuss how to ensure that all three local committees have access to Ms. Zimbelman and Deas' assistance as well as assistance from the epidemiologist.

OREGON HEALTH AUTHORITY UPDATE (OHA)

Bill Bouska, OHA Innovator Agent, provided a state update

There are more than 1200 registrants for the December Coordinated Care Model Summit. Registration is closed for everyone but CAC members, so if you're not registered, do so now.

There was some discussion about whether the CAC should divide up workshops and make sure that all are seen. Approximately a dozen of those present will be attending the summit, so it was generally agreed that people should just go to workshops. They'll mostly get covered.

CAC REPRESENTIVE COMMENTS

CAC Representatives given the opportunity to talk about any service related issues they have encountered or are aware of, thus sharing information between counties and with the CCO.

Representative Marshall said that Head start is seeing people being dropped from OHP because they didn't fill out the forms for a great variety of reasons. So, Head start is working on helping them reapply. Is there a point person for each county that they can work with?

Mr. Bouska: there may be some natural places in communities. Dec 31 will be another date when another group of people will lose their benefits.

Representative Moore agreed to find someone for Linn, Representative Franklin said she'd work on that for Lincoln, and Representative Marshall will work on that for Benton. (Finding an agreed upon list of point persons for helping identify who may fall off OHP and to help them enroll)

Representative McCain needs Summit hard copy. Dr. Fowler said that it hasn't come through to her yet, but she will get that to him.

AGENDA FOR NEXT COUNCIL MEETING REBEKAH FOWLER SOLICITED AGENDA ITEMS FOR THE NEXT CAC MEETING

FQHC and other hospital CEO from each county, like Dr. Bigelow did this time.

Someone to talk about the PCPCH's.

MEETING ADJOURNMENT

Larry Eby adjourned the meeting at 3:06

- Next CAC meeting: January 12, 2:00-5:00, Sunset Building, Corvallis

Acronyms

CAC – Community Advisory Council
CCC – Communication Coordination Committee (subcommittee of the CAC)
CCO – Coordinated Care Organization (Medicaid services)
CHA – Community Health Assessment
CHIP – Community Health Improvement Plan
CMS – Center for Medicaid/Medicare Services (Federal)
DCO – Dental Care Organization
HIA – Health Impact Area (in the CHIP)
IHN-CCO – InterCommunity Health Network CCO
OHA – Oregon Health Authority (State of Oregon)
OHP – Oregon Health Plan (Medicaid)
RHA – Regional Health Assessment

Minutes approved by the CAC January 12, 2015