Community Advisory Council (CAC)
MINUTES

Date: Monday, January 12, 2015
Location: Sunset Building, Sunset Conference Room (ground floor)

Council Representatives and others present at the table:
CAC Chair: Lawrence Eby;
Benton: Joe Zaerr, Lauren Zimbelman, Melissa Marshall (Liaison), Michael Volpe, Stretch McCain, Sr.;
Lincoln: Ellen Franklin (Liaison), Patricia Neal, Richard Sherlock;
Linn: Catherine Skiens, Frank Moore, Miao Zhao (Liaison), Paul Virtue;
Local Chairs: Dick Knowles (Linn), Sam Sappington (Benton)
Presenters: **Kelley Kaiser**, IHN-CCO CEO; **Rebekah Fowler**, CAC Coordinator**; Bill Bouska**, OHA Innovator Agent**; Shiloh Evren**, Primary Care Physician Clinics Director, Samaritan Lebanon Community Hospital; **Mara McManus**, Operations Project Manager, Samaritan Health Physicians; **William Barish**, Samaritan Lebanon Community Hospital Family Physician & Medical Director and Samaritan Park Street Clinic Hospitalist; **Lauren Zimbelman**, Regional Health Assessment Project Coordinator, Benton, Lincoln, & Linn County Health; **Jessica Deas**, Public Health Planner Benton, Lincoln, & Linn County Health; **Mitch Anderson**, Health Administrator, Benton Co. Health Services.
Absent: Hilary Harrison, Betsy Williams,

PUBLIC COMMENT SIGN-UP

Those wishing to speak during the public comment period should sign up at this time

CALL TO ORDER

Larry Eby, CAC Chair, called the meeting to order at 2:00.

INTRODUCTIONS, ANNOUNCEMENTS, & APPROVAL OF AGENDA & MINUTES

Dr. Eby asked those at the table to share one way in which their understanding of the CAC's work has changed since they were appointed.

- Rep. Zimbelman sees that the Council as a bigger part of the dialogue and influence on shaping the discussion of the CCO than she first realized.
- Rep. Skeins said that while the council's CHIP work was done in a hurry to meet deadlines, which was frustrating and fun, she is confident that ten years from now, we'll be proud of what it has accomplished.
- Mr. Knowles said the change he has seen is the amount and availability of information coming out of the three counties.
- Rep. Zaerr originally thought the CAC would be a think-tank, but it hasn't been that way. He said that there is much work ahead if the CAC is ready to take the initiative.
- Rep. Sherlock has always thought of the CAC as a *de facto* guidance committee. He said, "We don't implement. We share our ideas and others implement." He is comfortable with that role.
- Rep. Neal is doing work all over her county and sees the CCO has having a role in bringing that all together. That's what she is interested in.

- Rep. Franklin didn't at first know what the committee's work would be, and has come to see that it involves collaboration of the work between the counties. There are so many initiatives, and IHN is a part of that and has a role to play in that; the CAC influences that.
- Rep. Volpe, when he first came on, he thought the CAC would be the body that came up with the new ideas. Now, he sees the Local Advisory Committees as having the majority of work, which he sees as necessary for the CAC to be successful. He appreciates the work of the local committees.
- Rep. Virtue is a consumer member of IHN. He thought the work would be more about sharing his experiences. Now he sees the OHA and federal influence and how that impacts the health of the community.
- Dr. Sappington echoed the other comments. When he started a year ago, he was just passionate about helping with the efforts of the Affordable Care Act. He thought it was going to be more conflict, but he is glad to see the cooperative effort and he is becoming more knowledgeable about and comfortable with his role.
- Rep. Zhao said that when she first started she was idealistic about the council assisting community members with not falling through cracks in the healthcare system. Now she sees that it's about health system relationship building and collaboration.
- Rep. Moore has seen in the last couple years that council and committee cohesiveness has improved, leading to improved dialogue and better work results. He sees that the group has become more positive in working for positive change and focusing on solutions and less about complaining and pointing fingers. He has gotten to know the CCO a lot better through this process.
- Chair Eby said that everyone said well everything he has been thinking. When we first started, he thought of this group as the "conscience" of the CCO; now he sees us as a cooperative energizer of the CCO.
- Chair & Representative announcements: Representative Franklin: Due to medical reasons, Jackie Stankey resigned as Lincoln Local Advisory Committee Chair (CHAC), effective immediately. The Local group meets Wednesday, Jan 14.

- **Coordinator announcements**
  - **Adrienne Mullock**, Transformation Analyst at the Transformation Center is here. She took over MaiKia Mou's position. Ms. Mullock shared information about the State's CAC steering committee and the opportunity for one member of each CAC to join that committee. The steering committee will no longer operate on a 6-12 month rotating basis. Their primary focus will be to provide input on CAC and CCM Summit planning and on the CAC Learning Collaborative.
    - CAC representatives interested in joining should let Dr. Fowler know.
  - **March 9, CAC** meeting in Linn County. Proposed location is the Tangent Rural Fire District station. 32053 Birdfoot Drive, Tangent, OR 97389. The group said that it was ok to use this location.
  - **March or May Training** proposed: Health Equity and Health Disparities, in partnership with the Office of Equity and Inclusion.

- **ACTIONS:** Council approved present *Agenda* and *Meeting Minutes* from November CAC meeting with the following changes:

- Lincoln hospital is a 25-bed hospital, not 2200 bed.
- During introductions, Representative Zaerr talked about Patient engagement, not single payer healthcare.

PUBLIC COMMENT

16 members of the public present.

Chris Schleiger is interested in joining this Council. He serves on the "ISN" and works with the Salvation Army. He's interested in understanding the CAC because he's confused about CCO benefits. He is an IHN-CCO member. He has personal experience as an OHP member. He wants to know more about the health of the community and would like to apply to be on the CAC.

PATIENT CENTERED PRIMARY CARE HOME (PCPCH)

Bill Barish, Shiloh Evren, and Mara McManus presented about their work in a Patient Centered Primary Care Home (PCPCH), also known as a medical home.

Shiloh Evren, Primary Care Physician Clinics Director, Samaritan Lebanon Community Hospital;
Mara McManus is Operations Project Manager, Samaritan Health Physicians;
William Barish is the Samaritan Lebanon Community Hospital Family Physician & Medical Director and Samaritan Park Street Clinic Hospitalist;

Mr. Evren sees a primary goal and benefit of a PHPCH is a way to improve customer service and communication between providers. The main purpose of the medical home is to insure appropriate care at the appropriate time and place and reduce costs

Ms. McManus: PCPCHs are focused on making the patient the primary partner responsible for their care. Patient engagement is the focus by giving them resources they need and delivering services in a coordinated way.

Mr. Evren: 22 primary care clinics are all recognized at the state level and some at the federal level as PCPCHs in the three County IHN-CCO regions. Each Clinic has Care Coordinators who may be nurses, or have public health background.

- They are currently creating group appointments for education on smoking cessation or diabetes management, etc. Architecture changes.
- Three behaviorists rotate through clinics to focus on behavioral changes to improve health.

Dr. Barish: referral to the behaviorist this may be made by anyone on the team, including the physician, with a warm hand-off to the behaviorist. This has reduced stigma associated with seeing a psychologist because they go directly from primary care to a warm hand off to the behaviorist. PCPCHs are adding social workers to some of the clinics to assist with connecting people with community services.

Mr. McManus: all care coordinators meet once a week to share resources and consult with one

another. They've put a document together as a resource list for providers. They're learning that other things besides medical care impact patient's needs.

There are five patient advisory councils in development. They are recruiting anyone who has a Samaritan primary care provider for that council. They can contact their clinic or go through Dr. Fowler.

Ms. McManus said that the Medical Home academy teaches office staff to understand the model and its requirements. This is for all new staff and those current staff who want a refresher. The Medical Academy is held once per month.

Rep. Virtue: At the December Coordinated Care Model Summit, someone said there is a goal to have all OHP members in a medical home. His family is in a practice that says they will never switch. Their clinic isn't interested in a cost/benefit ratio. They feel it will change/diminish the doctor patient relationship. Rep. Virtue asked how the CCO is working with those people's perceptions.

Ms. Kaiser said this is a quality metric that OHP members are assigned to a medical home. IHN-CCO is focusing on using incentive dollars to assist those practices in becoming a medical home. They'll do what they can to make it easy for them and to understand the benefits and future of this model.

- There are two, or possibly three, Samaritan clinics not accredited but they soon will be.

Rep. Neal: there are problems of space in the clinics for adding new staff and for giving them places to meet.

Ms. McManus: Architectural structure has been changed some as two providers share space so they have more room for new staff. They have worked to have meeting rooms for staff to collaborate. This is an issue. Any new clinics are being built with the medical home model.

Mr. Evren said that with so many clinics, they run the gamut of structures.

Dr. Barish: When he started in medicine in the Marcus Welby era. There was no team. He was the medical home. Now, there is more follow-up and focus on community health or population health. They are working on a new compensation model for getting certain screenings done such as colorectal screenings. This gives providers some skin in the game where they benefit from their patients complying with the doctor's recommendations. It used to be doctors told patients what they thought was best and then the patient either did this or not, but whether the patient followed through or not ha no direct impact on the physician.

Rep. Sherlock: How long does it take for physicians to discuss, recommend, and follow up on a colorectal screening? Could a Health Coach do the work of recommending it? Dr. Barish said usually not, even with training, it's not work that could be handed to a non-clinician.

Rep. Moore: what's in it for Dr. Barish as a physician to make this change, why not retire? Dr. Barish said that for him personally, he does have a handful of patients he has known for 25 years,

otherwise he is an administrator. But, he cares because he sees that population health has an impact on patient care. Also, he sees that more education is occurring and doctors aren't good at that, so a team approach makes sense.

Ms. McManus: the medical home model is being used for all patients, not just IHN, but they report on the quality metrics only for IHN patients. This model is targeted to, and benefiting more than just IHN members.

Mr. Evren: other medical home services include Shared Decision Making, providing literature or DVDs, general education resources.

Chair Eby: What's different now for a physician who practiced 50 years ago who walked in to a clinic now?

Ms. McManus: Primary care is the same, but now they're seeing follow-up about prescriptions and barrier busting for them to get the treatment or medication needed. There are additional services, services that add value.

- Dentists and hygienists are now being made available in the medical home.
- Behaviorists are available for patients to see and for physicians to consult.

Chair Eby asked for guests to list three things that are new with the medical home model:

- Mr. Evren: Behaviorists, patient goal setting so the staff knows how to engage the patients. They customize treatment plans based on what the patient says.
- Dr. Barish: Care coordination is a top new thing.
- McManus: Communication is a priority in medical homes. It's important to not have duplicative services such as multiple follow-up calls for the same thing.

Mr. Knowles is a proponent of education for the physicians, but he wants to see more emphasis on community input on what is needed.

Chair Eby: the team approach is key. He'd like the council to tour a clinic.

Dr. Sappington: is there any thing that the CAC or local committees could do for them? Mr. Evren: Let people know that they are putting together patient advisory councils.

Rep. Neal said there is a general need for education for members, providers, the public.

IHN-CCO UPDATE

Kelley Kaiser provided a CCO and a Board of Directors update

Membership numbers dipped in November, but then returned to the previous level in December.

There was a lot of conversation at the Board about Alternative Payment methodologies.

IHN-CCO has 4 stop loss cases in 2014. She explained how that works. Insurance that the CCO has for stop loss cases pays out at about 200K. Four cases is a good number; they've had years where they had 20. CCOs must carry this insurance to reduce their risk. An example of a very expensive case IHN once had was a pregnant woman who needed a heart transplant who spent 6 months in OHSU before having the transplant. However, most cases involve pre-term babies. About 15 years ago, IHN focused on reducing those numbers and that is likely the cause of the numbers being so low now compared to years past.

Rep. Franklin, when stop-loss insurance is activated, does that ever impact the patient? Ms. Kaiser, not at all. Their care stays the same; it's just paid differently.

Ms. Kaiser reported that the CCO Board talked about the collaboration with the new Early Learning Hub. IHN is a collaborator in that relationship, not a lead.

Quality metrics incentive funds: The incentive money the CCO received was passed to those providers who contributed to meeting the metrics. The CCO used a formula to pay back those providers who helped them reach the goal, and then set aside some of the dollars to help support and encourage other providers to reach that goal.

LIAISON UPDATES

Miao Zhao (Linn): Committee completed Charter. Invited Lincoln and Benton members to attend. Lauren Zimbelman, the Regional Health Assessment project coordinator presented on moving from Goals to Outcomes.

Ellen Franklin (Lincoln): Lincoln met in November. They talked mostly about the CHIP tracking document and what their work is for that. Their next meeting is Wednesday, Jan 14 when Lauren Zimbelman will present on goals to outcomes. The charter is in its third draft. Generally there is excitement about the work.

Joe Zaerr substituted for Melissa Marshall (Benton): Benton had a meeting and accepted three new members. Much of the meeting was spent on the CCM summit. Rep. Zaerr felt that was a good growing process for the group. Mr. Bouska provided an OHA update. Mitch also provided an update on Benton services. Another chunk of the conversation was about the task for working on Behavioral Health for the region and Access to Care for the Benton. Dr. Sappington said that Benton is still actively recruiting new members.

CHIP: MOVING FROM GOALS TO OUTCOMES & AN UPDATE

- Lauren Zimbelman and Jessica Deas provided presentation on a common language and understanding of the CAC's and Local Committees' current task of identifying desired outcomes for the CHIP's goals. (See PowerPoint presentation)
- Kelley Kaiser provided a CHIP activity status update (Handout). The CCO and community partners are working on the CHIP activities and will provide progress updates in March.

OREGON HEALTH AUTHORITY UPDATE (OHA)

Bill Bouska, OHA Innovator Agent, provided a state update
Redeterminations: there will be some who are no longer eligible for OHP. IHN is working with community partners for keeping those on the plan who are still eligible or hooking them up with different insurance. The process for redeterminations will be handled this time so that there will be less gaps in coverage as people reapply.

Dr. Sappington, for those who are no longer eligible or who forget to reapply, are they being contacted for educated on their other options. Mr. Bouska: yes, they are redirected to the insurance exchange or told they can reapply for OHP.

A mid-year performance report of the CCOs' Quality Metrics will be announced Jan 14. That data goes through June 2014.

Quality metrics: two were dropped and two were added. Two additions are sealants for kids and effective contraceptive use for those wanting to avoid pregnancy. The two dropped were reduction of planned delivery before 6 weeks and ADHD follow-up. These were dropped because all CCOs were doing well on those measures.

The state, the CCOs, and the counties are working together to bring targeted case management under the CCOs.

Regarding the state's phone lines for redeterminations: The average wait is 1 hour. Shortest wait times are in the mornings, Saturday, middle of the week, or after 5 p.m. (open 7 a.m. – 6 p.m.). There is a gap between DHS and DMAP in getting coverage for people who are dually eligible processed.

Dr. Sappington said that he is heartened by the information that Kelley is reporting on the tracking sheet. Is there additional information or data that we need to collect? Rep. Zimbelman said that the Regional Health Assessment project is working on being a repository of data for the region.

Mr. Knowles said that the charge of the local committees becomes clearer after Rep. Zimbelman works through an example at the next meeting.

STIPENDS

Dr. Fowler explained the new stipend benefit available for OHP member CAC Representatives. She went over the process for requesting payment (CAC Handouts).

Eligibility: CAC Representatives who are Oregon Health Plan members or guardians of OHP members are eligible for stipends for participation in the following **regional** meetings:

Community Advisory Council	Communication Committee
Executive Committee	Workgroups, CAC Chair appointed

CAC trainings

Amount paid: For meetings that are 4 hours or less, OHP member representatives are eligible to be paid $40. Representatives who need childcare to attend a meeting are responsible for all aspects of that childcare and are eligible to be paid $50.

For meetings that are more than 4 hours, OHP member representatives are eligible to be paid $80. Representatives who need childcare to attend a meeting are responsible for all aspects of that childcare and are eligible to be paid $100.

Annual limit: The total stipend limit per year is $599 (unless a higher limit is approved and the proper tax forms are submitted).

Stipend submission: Stipend requests shall be turned in at the time of the meeting and checks will be processed monthly.

Forms:

1. Stipend Contact Information sheets need only be submitted once or when there is an address or phone number change.
2. Stipend Request forms will be available at eligible meetings and should be submitted at the meeting.

When to expect a stipend check: Due to the timing of checks being printed in batches, stipends checks will be mailed out the first week of the month.

Example: Stipend checks for meetings attended between the 1st Friday of February and the 2nd Monday of March will be mailed out by the 1st Friday of April. It will then take a few days for it to arrive in your mailbox.

Please, **do not ask about a check** until midway through the second week as there is nothing that can be done to hurry the process.

VICE CHAIR ELECTION

Vice-chair duties: According to the CAC's charter, "The Vice-chair is elected by, and may be dismissed by, a vote of the CAC. The duty of the Vice-chair is to support the Chair in his/her role, and preside over CAC meetings in the event the Chair is unable to attend. Vice-chair elections will be held at the October meeting of every odd numbered year."

- The charter also states that the Vice-chair is a member of the Executive Committee and the Communication Coordination Committee.

Statements of Interest: At the last CAC meeting, CAC representatives were asked to submit a paragraph or so stating their interest in serving as the Vice-chair. Two CAC Representatives submitted the following as an indication of their interest: Ellen Franklin and Joe Zaerr.

Action (Ballot vote): Representative Franklin was voted Vice-chair. (Ballots counted by Malinda Moore and Jessica Deas.) Dr. Eby expressed appreciation for Zaerr's participation thus far and for his willingness to serve.

CAC REPRESENTIVE COMMENTS

Rep. Marshall: Called the state two weeks ago to verify that her kiddo's insurance was correct and was kept on hold for 3 hours. Dr. Fowler to pass the information to Bill Bouska.

AGENDA FOR NEXT MEETING

Chair Eby asked if there are proposed agenda items for the next CAC meeting

Rep. Franklin interested in hearing more about the Early Learning Hub at some point.

- Rep. Moore said Jerri Wolfe is going around the region talking about the ELH.
- Dr. Sappington said that this work is being done in collaboration with Linn-Benton Health Equity Alliance.

Rep. Miao would like to hear from the Regional Oral Health Coalition.

MEETING ADJOURNMENT

Larry Eby to adjourned meeting at 5:00.

- Next CAC meeting: March 9, 2:00-5:00, Linn county

MINUTES Approved by CAC March 9, 2015

Acronyms often used during council meetings

CAC – Community Advisory Council
CCC – Communication Coordination Committee (subcommittee of the CAC)
CCO – Coordinated Care Organization (Medicaid coverage)
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)
PCPCH – Patient Centered Primary Care Home/medical home