Community Advisory Council Minutes

August 16, 2016 at Noon
FamilyCare Office
Multnomah County

Members Present: Royal Harris, Sarah Keefe, Celia Higueras, Leticia Sainz, Rowan Everard, Nicholas Ocon, Jessica Coshatt.

Members Absent: Martha Spiers, Christine Lau, Zuri Lopez, Estefany Carcano, Lance Gilbert

Staff Present: Kevin McClean, Sarah Sutton, Sandra Clarke, Annette Dieker, Michelle Luck

Guests/Others: Dustin Zimmermann, Oregon Health Authority (OHA); Rose Sherwood (will take Nicholas' seat)

Welcome/Introductions: Chair Royal Harris welcomed the Council members and guests. Called the meeting to order at 12:10.

Early Learning Hubs: Annette Dieker presented data, information, and the importance around Early Learning Hubs. She explained to the Council that FamilyCare Health has roughly 20,000 children ages 0-5 on our plan. She explained that early health and education can improve health outcomes and prevent chronic disease, making it worth the investment.

Dieker then provided the background on Early Learning Hubs, which were created in Oregon in 2013. Early Learning Hubs are self-organized, community-based, coordinating bodies created to provide a "system approach" to early childhood education that works to improve efficiency and outcomes for our youngest children. She explained that each of the 16 hubs create their own priorities and goals based on their populations.

Dieker explained that FamilyCare Health can support the hubs because of the number of children in need assigned to the plan. She suggested that FamilyCare Health can work with families to identify their unique needs and help connect them to resources, including the hubs.

According to Dieker, FamilyCare Health currently participates with all 3 tri-county hubs, supports the kindergarten registration campaign, gives funding to United Way, has hired a Health and Educations System Coordinator, participates in numerous regional and statewide advisory committees, and develops strategies to support Early Learning and Kindergarten Readiness.

McClean added that the OHA Metrics Committee will include a Kindergarten Readiness metric in 2018.

Asset Mapping: For the sake of time, the Council did not discuss Asset Mapping.

Oral Health: Michelle Luck asked the Council "If we were to invite one of our dental group to talk to the CAC, what would you want to know?" She handed out a flowchart detailing the relationship between FamilyCare Health and Dental Care Organizations (DCOs).

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Rowan stated that he has always wanted to better understand how FamilyCare Health does dental, and that the flow chart was very helpful. He joked to hanging the diagram in his office.

Luck explained that FamilyCare Health receives funding from OMS, then contracts with 8 DCOs (ODS, Care Oregon, Family Dental, Willamette Dental, Access Dental, Advantage Dental, Capitol Dental, and Managed Dental).

Leticia Sainz asked about the process of assigning members to DCO, specifying how FamilyCare Health places members with cultural and/or language needs.

Luck responded by explaining that families are automatically assigned, equally distributed to the dental organizations. This is meant to be a fair system from the DCOs. However, members can call FamilyCare Health if they want to stay with a specific provider. This, she explained, is because FamilyCare Health recognizes the importance of continuity of care. She explained that if an individual changes CCOs, their DCO could change, but if a member falls off of FamilyCare Health and then joins again, they will remain with the same DCO.

Luck stated that FamilyCare Health is in the beginning stages of offering support to dental plans who work with patients with behavioral health issues. Supporting the dental plans with these patients can help prevent dropping the patient. Long term, she suggested, FamilyCare Health is looking into mental health first aid for dental plans and PCP offices.

Luck described the expanded dental benefits which went into effect July 2016. They are:

- Routine care for gum disease every 6 months
- Deep cleaning for gum disease every 2 years
- Full dentures every 10 years and partial dentures every 5 years no matter how long your teeth were removed, even if you were denied dentures in the past.
- Stainless steel crowns for molars

Dustin Zimmerman stated that right now, FamilyCare Health doesn't have a good grasp on how DCOs do outreach, and it would be helpful to look into that.

Luck inquired if it would be valuable to have a DCO/plan speak at a Council meeting. Dustin responded yes, if they focus on how they monitor success.

Sainz suggested members of the Council look into gettrainedtohelp.com

Process Improvement Plans (PIPs): Kevin McClean explained that a Process Improvement Plan (PIP) is a project designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and nonclinical areas that are expected to have a favorable effect on health.

McClean explained the FamilyCare Health, like all CCOs, has to cover 4 PIPs. 1 of these PIPs is selected by the state, and the other 3 are selected by the CCO. McClean stated that we follow the PDSA model.

McClean informed the Council on the current PIPs. The statewide PIP is Opioid Management, which addresses the fourth requirement of integrating primary care and behavioral care.

The Council moved the conversation away from PIPs and to the importance of addressing Opioid Management properly. Keefe asked where members of the Council could learn more about this. McClean suggested Dr. Bennet Garner, Medical Director. He also suggested FamilyCare Health's head of pharmacy.

The second current PIP, McClean explained, is to ensure members with Serious Persistent Mental Illness (SPMI) get metabolic testing (this addresses the third requirement, to deploy primary care teams to improve care and reduce preventable or unnecessarily costly utilization of "super-users"

McClean informed the Council of the two new PIPs that FamilyCare has proposed to the state. The first is Traditional Health Workers, specifically Doulas for Maternity Care Coordination (addressing requirement #6: improving perinatal and maternity care). The second is focused on Tobacco Cessation (#2: addressing population issues by harnessing and coordinating a broad set of community resources).

McClean reviewed FamilyCare's retired PIPs. He clarified that just because a PIP is retired, does not mean FamilyCare is not focusing on it. Retired PIPs are:

- Increase Adolescent Well Care Visits
- Increase Colorectal Cancer Screenings
- Increase number of members assigned to PCPCH-recognized clinics
- Statewide: Ensure A1c and LDL test results of members with SPMI and Diabetes are shared with both the members' physical and behavioral health providers.

Issue Workgroups: Harris told the Council that he has been looking at the strategic initiatives for the next five years. He told the Council that he believes the first 3 initiatives would work well for the Council. The three initiatives are

- Integral relationships with CB orgs that positively impact health of members
- Recognized for innovative leadership addressing one high impact of determinants of health
- Framework has improved health outcomes and distribution of health

Harris explained that this discussion was just an introduction to the initiatives, and that the Council can flesh out the ideas in the next meeting. He encouraged the Council to take time before the next meeting to think about them, and to review Healthy People 2020.

Zimmerman suggested that Mary Zodrow attend a Council meeting and talk about what FamilyCare Health is doing, and how it connects to the goals of the initiatives.

Sainz suggested that the Council clarifies where FamilyCare Health sees the Council being most impactful, and to clarify what and where their role is. Zimmerman responded that the Council should reflect on what their ability and want is, and let FamilyCare Health know.

Sandra Clarke informed the Council that the project Ashely Green (Pop Health, TAY population) is working on will need support from the Council.

Harris reflected that the goal of the Council is to move to a more dynamic role. This means, he explained, that members of the Council will have to do homework and carve out a couple extra hours between each meeting. He told the Council that this will be as incredible as their capacity to add outside time. He also reminded the Council that their position is an advisory role, and the ship still has a captain.

Population Health Department: Sandra Clarke introduced herself to the Council as the new Director of Population Health. She informed the Council that she is a huge supporter of School Based Health Centers (SBHC) and formerly worked at Health Share of Oregon.

Clarke told the Council that the Population Health Department has seven full time employees, including herself. She reflected on the idea of "equity by design" and encouraged the Council to never forget about social determinants of equity while talking about social determinants of health.

Clarke informed the Council that the department has an open position for a project manager who will focus on Addiction and Drug Use. She then reviewed the current positions, which include Maternity Care, Health Equity program coordinator, TAY (includes foster care), and community relationship building.

Community Health Needs Assessment: Clarke introduced the Healthy Columbia Willamette Collaborative Report to the Council. She said the full report is 290 pages. She specifically called attention to the finding that the top 3 conditions among children are asthma, ADHD, and PTSD. The top 3 conditions in adult are hypertension, diabetes and depression.

Clarke explained that even when the data is adjusted for poverty, they still found a huge disparity in communities of color, primarily the African American community.

Clarke called attention to page 2, titled Executive Summary. Clarke explained that the 3 biggest sources of data for the CHNA were

- Population data about health-related behaviors, morbidity, and mortality
- Medicaid data from local CCOs about most frequent conditions for which individuals on Medicaid sought care in the tri-county region in Oregon
- Hospital data for uninsured people who were seen in the emergency department with a condition that should have been managed in primary or ambulatory care.

Clarke informed the Council that one of the number one outcomes from the CHNA was that housing is a priority.

Clarke told the Council that the rest of the report is available online. She then asked the Council how they can break down and explore the data in the CHAN to guide how they move forward and prioritize actions.

Zimmerman updated the Council on the purchasing of One System, which has more capability than other data systems in use at the State. He said that the state is looking at what fields are necessary and how they can expand those. He informed the Council that progress is slow, in part because data upload is manual.

Group Activity: skipped for time.

Agenda Setting: Keefe suggested that Health Happens Here report back on ideas that have been discussed. She also said it would be beneficial to read the PIP and CHIP, as well as receive feedback on equity process interviews.

Rowan Everard asked what the timeline is to change or not change the upcoming CHIP.

Meeting Adjourned at 2:03: Harris thanked Nick for all the work he's done on the CAC.