Community Advisory Council Summit: Communities in Action
May 29-30, 2014
Hilton Eugene, 66 E. 6th Ave., Eugene, OR 97477

Thursday, May 29, 2014

11:00 a.m.	Lobby	**Registration and Lunch**
12:00 p.m.	Williams/O'Neill	**Welcome Address from Leadership** (page 2) **Transformation Updates from Leadership** (page 2)
1:00 p.m.	Williams/O'Neill	**Across the State with CACs** (page 3) CAC representatives share highlights of their work.
2:00 p.m.		**Break**
2:15 p.m.		**Breakout Sessions**
	Wilder	(1) Building & Maintaining a High Performing CAC (page 4)
	Hellman	(2) Working Together for Successful Communication (page 5)
	Williams/O'Neill	(3) Let's Get Engaged: Creating & Sustaining Partnerships for Community Health (page 6)
3:30 p.m.		**Break**
3:45 p.m.	Williams/O'Neill	**Community Health Assessment and Community Health Improvement Plan Sharing** (page 7) CAC representatives share their CHA/CHIP experiences and outcomes.
4:45 p.m.		**Dinner Celebration** (page 8)
6:00 p.m.		**Optional Evening Sessions** (page 8)
	Wilder	(1) Roundtable discussions for CCO CAC Coordinators
	Hellman	(2) Roundtable discussion for CAC Chairs and Co-Chairs
	Williams/O'Neill	(3) Viewing of *Unnatural Causes*

Friday, May 30, 2014

7:30 a.m.	Lobby	**Breakfast**
8:30 a.m.	Williams/O'Neill	**Welcome Back** (page 9)
8:45 a.m.	Williams/O'Neill	**Funding Opportunities** (page 9) Foundation staff share possible funding opportunities to support CAC work.
9:45 a.m.		**Break**
10:00 a.m.		**Breakout Sessions**
	Wilder	(1) Promoting Health Equity (page 10)
	Hellman	(2) Patient-Centered Communication for CCOs: Transformation through Health Literacy (page 11)
	Williams/O'Neill	(3) CHIP Implementation (page 12)
11:15 a.m.		**Pick up lunch boxes**
11:45 a.m.	Williams/O'Neill	**Moving Forward** (page 13) Share plans and hopes for CAC work in the year ahead.
1:00 p.m.		**Closing Remarks** (page 13)

Note: Biographies of presenters begin on page 14.

May 29, 2014

11:00 a.m. **Lobby – Registration and Lunch**

12:00 p.m. **Williams/O'Neill Room**

Welcome Address from Leadership

- Chris DeMars, Director of Systems Innovation, OHA Transformation Center
- Leah Edelman, CAC Steering Committee Chair, Lane County CAC, Trillium Community Health Plan
- Terry Coplin, CEO, Trillium Community Health Plan

Transformation Updates from Leadership

- Chris DeMars, Director of Systems Innovation, OHA Transformation Center
- Lillian Shirley, Director, OHA Public Health Division
- Maria Elena Castro, Rural and Migrant Health Coordinator, OHA Office of Equity and Inclusion
- Nichole June Maher, President, Northwest Health Foundation

Description: Leaders from the Oregon Health Authority and Northwest Health Foundation share updates and thoughts about health system transformation activities in Oregon.

Objectives: By the end of the session, participants will:

- Be up-to-date on the latest developments in health system transformation in Oregon.
- Have a deeper understanding of the connection between public health and the work of the CACs, as well as of the future of public health in general.
- Understand the Northwest Health Foundation's vision for community health.

Notes:

1:00 p.m. Williams/O'Neill Room

Across the State with CACs

Facilitated by Liz Baxter, Executive Director, Oregon Public Health Institute
Panelists:

- George Adams, Jackson Care Connect CAC
- Jolene DeLilys, PrimaryHealth of Josephine County CAC
- Susan Lowe, PacificSource Community Solutions – Columbia Gorge CAC
- Arturo Vargas, Willamette Valley Community Health CAC

Description: CAC representatives share highlights of their work. Hear how their involvement has supported their CCO and changed the way they think about health.

Objectives: By the end of the session, participants will:

- Understand how other CACs have contributed to their CCO and communities to support improvements in health.

Notes:

2:00 BREAK (Breakout sessions start at 2:15 p.m.)

2:15 p.m. Breakout Sessions

(1) Wilder Room
Building & Maintaining a High Performing CAC
Vanessa A. Becker, Principle, V Consulting & Associates Inc.

Description: It takes attention and focus to create a diverse and high functioning group of community members to provide recommendations and advice to CCOs. Learn about creating clear community advisory council roles and expectations, recognizing and celebrating differences in groups, managing meeting times together and creating a community advisory council culture that results in success.

Objectives: By the end of the session, participants will be able to:

- List key characteristics of a high performing community advisory council/committee.
- Discuss good meeting management fundamentals.

Notes:

3:30 p.m. BREAK (meet in Williams/O'Neill at 3:45 p.m.)

2:15 p.m. Breakout Sessions

(2) Hellman Room
Working Together for Successful Communication
Liz Baxter, Executive Director, Oregon Public Health Institute

Description: Learn highlights of successful communication skills. Learn sound communication strategies that are helpful to keep teams and groups functioning, even in times of conflict.

Objectives: By the end of the session, participants will be able to:

- List successful communication strategies.
- Use examples of approaches that can help reduce conflict, and address conflict when it occurs.
- Be aware of how much word choice matters.
- Identify ways to increase engagement among group members.

Notes:

3:30 p.m. BREAK (meet in Williams/O'Neill at 3:45 p.m.)

2:15 p.m. Breakout Sessions

(3) Williams/O'Neill Room

Let's Get Engaged: Creating & Sustaining Partnerships for Community Health

Mary Minniti, Program and Resource Specialist, Institute for Patient- and Family-Centered Care

Description: This highly interactive presentation/workshop will broaden the following:

- Insight and wisdom about inviting, enhancing and sustaining patient and family engagement efforts.
- Understanding of an emerging engagement framework that can be applied to direct care for individuals, community settings, policy and program development settings.
- Key learning from the Patient and Family Engagement Medicaid Brief – soon to be released in summer 2014.
- Knowledge of specific tools and strategies that build strong relationships between people and build sustained partnerships around common goals.

Objectives: By the end of the session, participants will be able to:

- Identify the key components that promote and enhance patient and family engagement.
- Discuss how to use this information to broaden the outreach of community advisory councils in engaging the individuals receiving Medicaid services.
- Use simple tools and approaches that create relationships built on mutual respect and trust, and invite others to participate in new ways of working together.

Notes:

3:30 p.m. BREAK (meet in Williams/O'Neill at 3:45 p.m.)

3:45 p.m. Williams/O'Neill Room

Community Health Assessment and Community Health Improvement Plan Sharing

Facilitated by Katrina Hedberg, MD, OHA Public Health Division
Panelists:

- John Adams, Lake County CAC, Eastern Oregon CCO
- Rebekah Fowler, PhD, Intercommunity Health Network CAC Coordinator with Cascade West Council of Governments
- Richard Kincade, MD, Lane County CAC, Trillium Community Health Plan
- Commissioner Chris Labhart, Regional CAC, Eastern Oregon CCO
- Mike Volpe, Intercommunity Health Network CCO CAC

Description: CAC representatives share their CHA/CHIP experiences and outcomes.

Objectives: By the end of the session, participants will be able to:

- Articulate at least two reasons why community health assessments and plans are critical to health system transformation.
- Articulate at least two strategies that CACs used to develop CHAs and CHIPs.
- Apply at least three new ideas or concepts to their work in local CACs.

Notes:

4:45 p.m. Lobby – Buffet dinner

4:45 p.m. Lobby – Buffet dinner

Dinner Celebration

Chris DeMars, Director of Systems Innovation, OHA Transformation Center
Leah Edelman, CAC Steering Committee Chair, Lane County CAC, Trillium Community Health Plan

6:00 p.m.

Optional evening sessions

(1) Wilder Room
Roundtable discussions for CCO CAC staff

2) Hellman Room
Roundtable discussions for CAC chairs and co-chairs

(3) Williams/O'Neill Room
Viewing of *Unnatural Causes* hosted by Lane County CAC

May 30, 2014

7:30 a.m. **Lobby - Breakfast**

8:30 a.m. **Williams/O'Neill Room**

Welcome Back

Chris DeMars, Director of Systems Innovation, OHA Transformation Center
Leah Edelman, CAC Steering Committee Chair, Lane County CAC, Trillium Community Health Plan

8:45 a.m. **Williams/O'Neill Room**

Funding Opportunities

Facilitated by Chris DeMars, Director of Systems Innovation, OHA Transformation Center
Panelists:

- Melissa Durham Freeman, The Oregon Community Foundation
- Steve Lesky, Cambia Health Foundation
- Jen Matheson, Northwest Health Foundation

Description: Foundation staff share possible funding opportunities to support CAC work.

Objectives: By the end of the session, participants will:

- Understand the three local foundations' priorities, including funding opportunities for community-based health projects.
- Understand the three funders' vision for health in Oregon.

Notes:

9:45 a.m. **BREAK**

10:00 a.m. Breakout Sessions

(1) Wilder Room
Getting on the same page about health equity
Carol Cheney, Equity Manager, OHA Office of Equity and Inclusion
Maria Elena Castro, Rural and Migrant Health Coordinator, OHA Office of Equity and Inclusion

Description: What does health equity mean? What does health equity look like for individuals, communities and systems? Join us as we talk about the basics and have a discussion about how to apply the building blocks of health equity.

Objectives: By the end of the session, participants will be able to:
- Define health equity and health disparities.
- Understand the building blocks of health equity.
- Identify some specific health equity strategies to integrate into CAC and Transformation Plan work.

Notes:

11:15 a.m. BREAK - Pick up lunch boxes in the Lobby
Meet in the Williams/O'Neill Room at 11:45 a.m.

10:00 a.m. Breakout Sessions

(2) Hellman Room
Patient-centered Communication for CCOs: Transformation through Health Literacy
Cliff Coleman, MD, Oregon Health and Science University

Description: Did you know that only 13% of U.S. adults are "proficient" in English? For most patients, low health literacy remains a hidden problem, unrecognized amongst clinicians. This has enormous implications for how health care providers interact with patients and families, both through spoken and written communication, and is a major factor in issues related to quality of care.

This session will increase participants' knowledge about health literacy as a key driver toward or against the quadruple aim of: a) better health, b) better care, c) lower cost and d) reduced disparities. The talk will focus on translating awareness and knowledge about health literacy issues into practical evidence-based patient-centered communication skills at the CCO level – skills which studies show are currently not practiced by most providers. A "universal precautions" approach to health communication will be emphasized. Best practices will be discussed. A discussion period will follow the session.

Objectives: By the end of the session, participants will:

- Understand the widespread impact of low health literacy on health and health care in all Oregon communities.
- Understand how a "universal precautions" approach to health communication can help provide high quality communication to the majority of patients.
- Begin to translate knowledge about health literacy into practical approaches to communicating with patients at the organizational and individual level.

Notes:

11:15 a.m. BREAK - Pick up lunch boxes in the Lobby
Meet in the Williams/O'Neill Room at 11:45 a.m.

10:00 a.m. Breakout Sessions

(3) Williams/O'Neill Room
CHIP Implementation
Facilitated by Cara Biddlecom, OHA Public Health Division
Panelists:

- Tara DaVee, Lane County CAC, Trillium Community Health Plan
- Muriel DeLaVergne-Brown, Crook County Health Department
- Ellen Larsen, Hood River County Health Department
- Jeff Luck, PhD, Oregon State University

Description: CACs are working to help CCOs submit their community health improvement plans (CHIPs) in just a few weeks. This session will help CAC members take a look at the next step in the process – working to implement their CHIP. A panel of local experts will share their experience with using a community process to implement a CHIP that addresses the community's leading health priorities. Participants will also discuss how they can incorporate what they've learned in their own CAC's CHIP effort.

Objectives: By the end of the session, participants will be able to:

- Articulate at least one reason why evidence-based practices should be used to address community health needs;
- Define process evaluation and how it can be applied to CHIP implementation.
- Articulate at least two strategies that local public health authorities are using to implement their CHIPs.
- Apply at least three new ideas or concepts to their work in local CACs.

Notes:

11:15 a.m. BREAK - Pick up lunch boxes in the Lobby
Meet in the Williams/O'Neill Room at 11:45 a.m.

11:45 a.m. Williams/O'Neill Room

Moving Forward

Facilitated activity: Liz Baxter, Executive Director, Oregon Public Health Institute

Description: Share plans and hopes for CAC work in the year ahead through roundtable conversations. Share ideas for further developing leadership skills, use of strategies in doing CAC work and discuss areas for focused support.

Objectives: By the end of the session, participants will be able to:

- List challenges and success of CAC work.
- Prioritize CAC representatives' leadership needs and list areas for focused support and technical assistance.

Notes:

1:00 p.m. Williams/O'Neill Room

Closing Remarks

Tom Cogswell, OHA Transformation Center
MaiKia Moua, OHA Transformation Center

Biographies of presenters

George Adams
George Adams has been a member of the Jackson Care Connect CAC since its beginning in 2012, and has been the co-chair and a Jackson Care Connect board member since 2013. George is also on five other local boards: Aging and Disability Resource Connection of Oregon (ADRC), vice chair of the Department of Human Service's Disability Services Advisory Council (DSAC), vice chair of Rogue Valley Transit District's Special Transportation Advisory Committee (STAC), and the Translink board. George represents people with disabilities and is a champion for health systems transformation. George decided to commit to help others after a life-changing auto accident in 1997. In George's spare time he is a die-hard Seattle Seahawks fan.

John Adams
John Adams, MA, is the CHIP Program Manager at Lake Health District. He received his Bachelor of Arts from the University of Oregon in Political Science and Master of Arts from JFK University in Consciousness and Transformative Studies. John's experience with political and community organizations spans over 15 years, including five years leading and directing nonprofit social justice community organizations in the San Francisco Bay Area. After contributing to and leading campaigns on multiple issues, including housing and foreclosures, education, health and wellness, crime and safety, and the environment, John and his family moved permanently to Oregon to get closer to their roots and to enjoy the outdoors.

Liz Baxter
Liz Baxter, MPH, is currently Executive Director of the Oregon Public Health Institute, a nonprofit that works with local, regional and national partners to address the most pressing issues impacting health today. Prior to her work at OPHI, Liz spent seven years leading We Can Do Better, founded in late 2005 as the Archimedes Movement, an organization that believes small groups of people can have great impact, and that even a small state like Oregon can influence the national debate on health and health care. Liz has spent her career building bridges between complex policy discussions and the public's ability to understand these issues. Even in something as complex as chairing the board of Oregon's health insurance exchange, Liz continues to act as a "translator" of technical knowledge with those who don't live inside the policy world that we do, and vice versa – between community members and decision makers.

Vanessa A. Becker
Vanessa Becker offers 20 years of executive leadership experience in the nonprofit and government sectors, including 12 years as a CEO of a nonprofit organization and multiple government administrative appointments. Her consulting firm, V Consulting & Associates, provides research, strategic planning and community-based assessment planning services specific to health and human service organizations across the United States.

Cara Biddlecom
Cara Biddlecom, MPH is the Health System Transformation Lead at the Oregon Health Authority's Public Health Division. In her position, Cara serves as the liaison between Public Health Division programs and other Oregon Health Authority agencies, focused on the role of public health in health system transformation. Cara moved to Oregon from Washington DC, where she worked as a Senior Analyst at the National Association of County and City Health Officials and as the HIV Services Coordinator at Our Place, DC. Cara holds a Master of Public Health degree from the University of North Carolina at Chapel Hill.

Maria Elena Castro
Maria Elena Castro, M.Ed., has 15 years of experience working in health care, communication and education in the not-for-profit sector. For several years, she served on the Board of the Migrant Health Clinic in Hood River, and is currently a Board of Director for the Oregon Public Health Association, the Northeast Oregon Area Health Education Center and the Hood River County Prevention and Health Promotion Commission. She is a journalist, with a master's degree in education. Maria Elena is certified in project management and is a LEAN Health Care green belt practitioner. As an Education Consultant with OCHIN, she was part of a team responsible for developing and delivering training to clinicians and clinic staff. Maria Elena was also a Community Outreach Manager for Providence Health Systems in Hood River, where she was responsible for creating new services and projects to support patient-centered approaches and developing and managing their Interpreter Services Department and their Diversity and Inclusion Program.

Carol Cheney
Carol Cheney has served as the Equity Manager for the Oregon Health Authority Office of Equity and Inclusion since 2010. Her team develops, implements and reviews policies and practices related to meaningful community engagement, "traditional" health workers, language access, cultural competence and diversification of the health care workforce, and health equity training, planning and strategy implementation. A graduate of the University of Oregon, Carol's field of study focused on women and people of color and her commitment to gender, racial and LGBTQ justice. She has worked for the last 22 years in organizations promoting social change as a case manager for survivors of domestic violence, health educator, fundraiser and nonprofit organizational development consultant and trainer. Her public health experience includes administering grants to increase cancer screening rates for women of color and managing sexual health education programs.

Tom Cogswell
Tom Cogswell is the Learning Collaboratives Coordinator at the Oregon Health Authority Transformation Center. Tom has a background in program coordination, training, and event planning; and has worked in the public sector for the past 10 years. He holds a Bachelor in Sociology from Central Michigan University, and most recently received a graduate certificate in nonprofit and public management from Portland State University.

Cliff Coleman
Cliff Coleman, MD, MPH, is a national expert in the field of health literacy. His teaching and research activities focus on workforce training to improve the clinical and public health response to low health literacy. Dr. Coleman received his medical degree from Stanford University in 2000, and completed a combined residency in Family Medicine and Public Health & General Preventive Medicine at Oregon Health & Science University (OHSU), with a Master of Public Health from Portland State University in 2004. He joined the faculty in the Department of Family Medicine at OHSU in 2004. He practices at OHSU's Richmond Clinic, a Federally Qualified Health Center, where his clinical interests include care delivery for medically complex underserved patients.

Terry Coplin
Terry Coplin Chief Executive Officer and Board member of Trillium Community Health Plan in Lane County Oregon. Over the past 25 years, he has managed a Health Insurance Company, IPA and Medical Group Practices. Most recently,Terry led the creation of Lane County's Coordinated Care Organization (CCO), bridging the relationships between the health plan, County government, hospitals, social service agencies and other key community stakeholders. Trillium, as Lane County's only CCO, covers more than 85,000 Medicaid and Medicare lives, as well as offering commercial insurance products through Oregon's insurance exchange. Terry holds degrees in Mathematics and Medical Technology from the University of Alabama and an MBA from Gonzaga University. He has served on numerous community committees and boards and community meetings including United

Way of Lane County and Oregon's Research Institute. He is an avid fly fisherman and enjoys Oregon's great outdoors. He and his wife live in Eugene and have four grown children.

Tara DaVee
Tara DaVee is a native Oregonian and a mother of two teenage children; a cat and dog complete their family. Tara's work experience is mainly in health care and she formerly worked as a Nursing Assistant. Tara currently volunteers with the Citizen Review Board (CRB). The CRB is part of the court system and provides advocacy support for children and youth in the foster care system. Tara also represents the CAC on the Trillium CCO Board of Directors. Tara is a part of the core team that has helped design the CHIP in Lane County. In her free time, Tara enjoys gaming, music and reading.

Muriel DeLaVergne-Brown
Muriel DeLaVerge-Brown, MPH, RN is the Public Health Director for the Crook County Health Department. As Director, she oversees the public health of Crook County's 21,000 residents by leading a team of 15 employees. In her role as Public Health Director, Muriel has also been involved in the development of the Central Oregon Health Council. Prior to her position in Crook County, Muriel served in leadership positions in Deschutes County Health Services in Bend and Douglas County Health Department in Roseburg. Muriel is a Registered Nurse with a Bachelor of Science in Health Education from the University of Oregon, and a Master of Public Health from Oregon Health and Science University. Muriel currently serves as the Chair of the Conference of Local Health Officials.

Jolene DeLilys
Jolene DeLilys is a poet, writer, artist, and caregiver. Jolene was born and raised in upstate New York and lived there until she was 30 and then lived in Tennessee for 17 years. Jolene has lived in Grants Pass since 2007. She is a single mother of a 17-year-old boy. She has an informal background in art and writing. Jolene has worked a variety of jobs from restaurant and factory to retail and grocery. She also worked as a caregiver in the home and in a facility. She is well versed in the professional graphic design programs. She received an A.A.S. in Visual Communications. Jolene is currently unemployed with three irons in the fire; one is for a micro business dealing in food, another selling jewelry she makes online, and lastly, selling a memoir/poetry book she has written about her early experiences with a mental illness.

Chris DeMars
Chris DeMars is the Director of Systems Innovation at the Oregon Health Authority Transformation Center. Chris recently spent over eight years as a Senior Program Officer at the Northwest Health Foundation, where she managed the foundation's health care reform work, including support for Oregon's delivery system reform and health reform advocacy organizations. Prior to joining the foundation, Chris was a Senior Health Policy Analyst for the U.S. Government Accountability Office (GAO), where she authored numerous reports for Congress on Medicaid, Medicare and private health insurance payment policy. Chris has held positions at various health policy consulting firms in the areas of public health, managed care and reimbursement systems, and she began her career as a Policy Analyst at Indiana's Office of Medicaid Policy and Planning. She holds a Master of Public Health degree from the University of Michigan School of Public Health and a bachelor's degree in English Literature from the University of Michigan.

Leah Edelman
Leah Edelman is a Public Health Prevention Specialist funded by Trillium Community Health Plan to support the Community Advisory Council and the Rural Advisory Council. She is located in Lane County Public Health and is also responsible for supporting the Lane County CHIP efforts.

Melissa Durham Freeman
Melissa Durham Freeman, MPH, currently serves as the Director of Strategic Projects for the Oregon Community Foundation (OCF). She is leading the board's effort to implement two initiatives: the OCF Children's Dental Health Initiative and the Jobs and Economy Initiative. She also manages the Oral Health Funders Collaborative. Prior to working for OCF, she directed a national health promotion program for high school athletes at Oregon Health and Science University. Melissa earned her Master of Public Health degree at Portland State University and is proud to be a native Oregonian.

Rebekah Fowler
Rebekah Fowler, PhD, coordinates the Intercommunity Health Network (IHN) CCO CAC and its Local Advisory Committees. She wrote the IHN-CCO CHIP. Prior to her work with the CAC, Dr. Fowler coordinated Oregon Health Plan member advisory councils for the Accountable Behavioral Health Alliance. She also worked to develop Traditional Health Worker programs within that agency's five-county region. She holds a doctorate in social psychology and a Master of Science in experimental psychology.

Katrina Hedberg
Katrina Hedberg, MD, MPH, is the State Epidemiologist and State Health Officer at the Oregon Health Authority, Public Health Division. Dr. Hedberg received her undergraduate degree from Yale University and her medical degree from Oregon Health Sciences University. Dr. Hedberg earned her Master of Public Health degree from the University of Washington in 1990, and she is board certified in Public Health and Preventive Medicine. Dr. Hedberg has been with the Oregon Health Authority for the past 20 years, and has worked in a variety of public health programs. Dr. Hedberg is an Affiliate Associate Professor in the Department of Public Health and Preventive Medicine at Oregon Health and Science University.

Suzanne Hoffman
Suzanne Hoffman, MPH, began her career in public service in the Oregon Department of Justice and then joined the Oregon Department of Human Services where she served in a variety of roles including health services deputy director, human resources director and chief administrative officer. In 2007, Suzanne also served as the interim director of the Oregon State Board of Nursing at the request of the Governor during a time of transition. As chief of staff in 2009, her major focus was implementing the internal changes necessary to create the newly established Oregon Health Authority (OHA), including the establishment of shared services functions with the Department of Human Services. She was appointed OHA's Chief Operating Officer in 2011. Suzanne is a graduate of Portland State University with an undergraduate degree in social sciences and a Master of Public Health degree.

Rick Kincade
Rick Kincade, MD, is a practicing Family Physician in Eugene, Oregon. He serves as the Vice President of Medical Affairs – Community Based Services for the PeaceHealth Oregon West Network. He is a member of the Lane CCO Board of Directors, Lane CCO Clinical Advisory Panel, Lane CCO Community Advisory Council, and the Primary Care Medical Home Clinical Council. In the Fall of 2011, Dr. Kincade completed a three-year role as the Interim Senior Vice President of Medical Group Development for PeaceHealth. Dr. Kincade has been a leader in PeaceHealth Medical Group's largest region for over 10 years and, prior to that, served in multiple capacities for the Oregon Medical Association, including as its President. He has practiced in both rural and urban settings over 25 years and has been a long-time advocate for patient-centered care. He was the 1996 recipient of the Oregon Medical Association's Oregon Doctor-Citizen of the Year Award.

Commissioner Chris Labhart
Chris Labhart currently serves as Grant County Commissioner. He also serves on the board of

Eastern Oregon CCO and chairs the regional Eastern Oregon CCO CAC. Previously, Commissioner Labhart served as Mayor and on the City Council in both John Day and Canyon City. He is a retired teacher who spent 33 years in the classroom, and he has experience as a small business owner and as the director of Blue Mountain Hospital.

Ellen Larsen
Ellen Larsen, RN, is a registered nurse and has worked in public health since 1987. Ellen has served as director of Hood River County Health Department since 1999. Ellen has served on the executive committee of the Conference of Local Health Officials (CLHO) as the representative of counties with less than 50,000 residents. She serves as the chair of the PacificSource Community Solutions Columbia Gorge CCO Community Advisory Council and the CLHO Information Management subcommittee.

Steve Lesky
Steve Lesky has a diverse background in the philanthropy, nonprofit and local government fields. In his role at the Cambia Health Foundation, he directs strategy and implements plans to help transform population health through a lens of innovation and equity. Steve manages funding initiatives that support nonprofits, emphasizing collaboration and mission-related investing to help create an economically sustainable health system focused on positive outcomes. Prior to his 10 years of work in philanthropy, Steve held various positions in child welfare services. He continues to be committed to this work through volunteer activities in the community. Steve holds Master of Public Policy and Master of Public Administration degrees and a Bachelor of Science in Human Resource Management. He considers his community-based work both a privilege and a valuable ongoing learning opportunity.

Susan Lowe
Susan Lowe is a member of the PacificSource Community Solutions – Columbia Gorge CAC representing consumers since its inception in 2012. She is on the Clinical Advisory Panel as a CAC liaison. Susan worked for the Area Agency on Aging for 23 years and is now currently working at Meals on Wheels in The Dalles. She helped to propose the Meals on Wheels to the Clinical Advisory Panel to support better health outcomes through good nutrition. In addition, Susan is a strong advocate for addiction services, especially for individuals with dual diagnosis. She has two sons, Douglas, age 29, and Dylan, age 20.

Jeff Luck
Jeff Luck, MBA, PhD, is an Associate Professor of Health Management and Policy at Oregon State University's College of Public Health and Human Sciences. His research focuses on the measurement of health care quality and performance, population health and health care utilization; public health policy and operations; and the application of informatics to those topics. He is co-principal investigator of an evaluation of the impact of Medicaid expansion on the health of Oregon women of reproductive age and their infants. Dr. Luck holds a PhD in Public Policy Analysis from the RAND Pardee Graduate School and an MBA from UCLA. He is a member of the Oregon Metrics and Scoring Committee and the state's Public Health Advisory Board.

Nichole June Maher
Nichole June Maher joined Northwest Health Foundation (NWHF) as president and CEO in August 2012. Nichole is the youngest president of a major foundation in the Northwest and has led the organization through a significant transformation. NWHF has become a champion of advocacy, policy, and supporting vulnerable populations to be the leaders in creating healthy families and communities. Born in Ketchikan, Alaska, Nichole attended school on the Siletz Indian Reservation (OR) and is a member of the Tlingit Tribe of Southeast Alaska. Nichole is widely published, and her

work has been influential in the fields of philanthropy, equity and education. She is a proud mother of three young children.

Jen Matheson
Jen Matheson joined the Northwest Health Foundation as a Community Engagement Officer in February 2014. In her prior role at the Native American Youth and Family Center, Jen developed and implemented a culturally responsive economic development and housing program with Portland's urban Native American community. Prior to that, Jen served as the Outreach Manager at 211info for five years establishing connections with community networks across Oregon and SW Washington. She built partnerships with local, regional and statewide initiatives including: Childcare Resource and Referral, HousingConnections.org, 9th Grade Counts, Project Homeless Connect, Continuum(s) of Care in Clark, Multnomah and Washington counties, summer food programs, Oregon Helps!, Cowlitz Asset Building Coalition, Smoke Free Oregon and many others. Jen moved to Oregon from the upper Midwest over 15 years ago and loves the resilient communities that make up this beautiful state.

Mary Minniti
Mary Minniti is a Certified Professional in Health Care Quality and works as a Program and Resource Specialist for the Institute for Patient- and Family-Centered Care. She is the lead author on a soon-to-be released brief on patient and family engagement best practices. Her passion is creating authentic partnerships with patients and family members for health care transformation because of the positive and powerful impact it creates for all involved. She has been actively involved in Oregon's health care reform work especially related to the primary care transformation. With over 16 years experience with PeaceHealth, managing diverse cross-regional projects focused on improving the patient experience of care, she has systematically involved patients and family in quality improvement, safety and redesign initiatives. As a project director for a collaborative statewide effort in Oregon on patient and family engagement, she provided support to a Medicaid health plan and four primary care clinics in establishing patient and family advisory councils.

MaiKia Moua
MaiKia Moua RN, MPH, is currently a Transformation Analyst at the Oregon Health Authority Transformation Center. She was previously with the OHA Public Health Division as a PHN Nurse Consultant to local health departments. She also worked as an Accreditation Program Coordinator and Trauma Coordinator. MaiKia spent eight years at St. Paul – Ramsey County Health Department working in home visiting and community outreach. She received her Master of Public Health from the University of Minnesota and her nursing degree from Linfield College.

Lillian Shirley
Lillian Shirley, BSN, MPH, MPA, is the Director for the Oregon Health Authority's Public Health Division. Lillian holds a bachelor's degree in Nursing from the University of the State of New York, a Master of Public Health from Boston University and a Master of Public Administration from the Kennedy School of Government at Harvard University. Most recently, Lillian led the Multnomah County Health Department. While at Multnomah County Health Department and on the governing board of Health Share of Oregon, she helped launch one of the first coordinated care organizations in the state. She also served as the vice chair of the Oregon Health Policy Board. Before coming to Oregon, she was the Director of Public Health for the city of Boston and was also the first executive director of the Boston Health Commission.

Arturo Vargas
Arturo Vargas graduated from Oregon State University. He is currently the Community Engagement and Impact Director for the United Way of the Mid-Willamette Valley, working with United Way

grantees, other nonprofit organizations and businesses in collective solutions on the issues of education, health and income equality. Arturo believes each county and each community within the counties have their own ways to work, socialize and resolve problems. Being able to understand, be respectful, and build upon these differences creates trust and brings better outcomes for the betterment of all. Currently, Aurturo serves on a variety of advisory boards: CoActive Connections, the Oregon Youth Authority Latino Advisory Council, Mano a Mano, Aumsville Parks and Recreation Council, the Gervais French Prairie Council, the Marion County Parent Education Hub, the WVCH Community Advisory Council serving Marion and Polk counties, and the Mid-Willamette Valley Latino Leadership Academy.

Mike Volpe

Michael Volpe was born in Lake Forest, IL. He graduated from Lake Forest High School in 1972; after graduating from St. Olaf College in 1976 he went to University of Minnesota and received a Bachelor's Degree in Forestry. Later that year, Michael was diagnosed with Multiple Sclerosis. Michael moved to Oregon in 1985, where he attended Oregon State University and earned a master's degree in teaching English as a second language. After completing his degree, Michael also worked at OSU before his Multiple Sclerosis progressed. After retiring from paid employment, Michael has been doing volunteer advocacy for people with disabilities. He is a member of the Disability Services Advisory Council for Oregon Cascades West, and he serves on the State Independent Living Council and the Oregon Disability Commission.

PRESENTATIONS

Note: All slide presentations will be available in CAC Learning Community Groupsite following the CAC Summit (including those not included here).

Health System Transformation:

Overview & Updates

Chris DeMars
Director of Systems Innovation
Transformation Center
May 29, 2014

Oregon Health Authority

Affordable Care Act: Overview

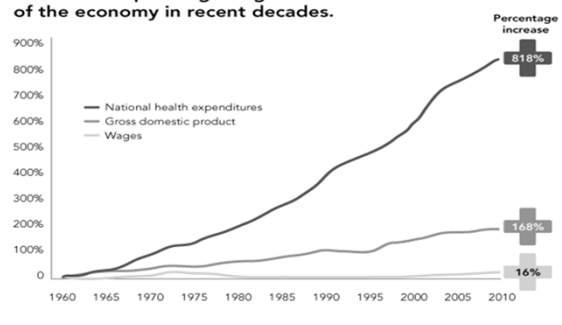
- **Largest changes in health care in 50 years**
- **Coverage and Access**
  - Medicaid Expansion in Oregon
    - Majority are enrolled in coordinated care organizations
  - Health Insurance Exchanges
- **Enrollment**
  - Total Oregon Health Plan enrollment: 950,000 (April 21, 2014)
  - Increase of 300,000 members since December 2013

Health System Transformation Goal

- Oregon's health system transformation efforts seek to achieve the triple aim:
  - ✓better health
  - ✓better care
  - ✓lower costs

OREGON'S COORDINATED CARE MODEL

Health care spending has grown much faster than the rest of the economy in recent decades.



Sources: McKinsey, "Accounting for the Cost of U.S. Health Care" (2011), Center for American Progess

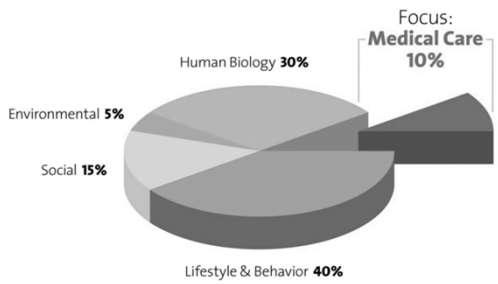
THE HUFFINGTON POST

Traditional Health Care Budget Balancing

- Cut people from care
- Cut provider rates
- Cut services

Transformation Updates from Leadership
Chris DeMars, OHA Transformation Center

Wrong Focus = Wrong Results



The Fourth Path

- Change how health care is delivered to:
  - Reduce waste
  - Improve health
  - Create local accountability
  - Align financial incentives
  - Pay for performance and outcomes
  - Create fiscal sustainability

www.health.oregon.gov

Coordinated Care Model

Coordinated Care Organizations

- 16 CCOs in every part of Oregon serving the majority of OHP members
- Governed by a partnership between health care providers, consumers, partners, and those taking financial risk.
- Consumer advisory councils
- Mental, physical, dental care held to one budget.
- Responsible for health outcomes
- Receive incentives for quality
- Budgets grow at 3.4% per capita per year

CCOs' Early Work…

- Reducing unnecessary Emergency Department visits.
- Working to better integrate mental and physical health care.
- Developing a complex care model for patients with chronic and complex conditions.
- Hiring community health workers to help people manage the most acute and chronic conditions.
- Developing processes that enable families to address all of their child's health needs at a single clinic.

CCOs Provide Better Health and Value Through:

- Innovation
- Focus on chronic disease management
- Focus on comprehensive primary care and prevention
- Coordination: physical, behavioral and dental health
- Alternative payment for quality and outcomes
- More home and community based care, community health workers/traditional health workers
- Electronic health records – information sharing
- Tele-health
- New care teams
- Use of best practices and centers of excellence

Transformation Updates from Leadership
Chris DeMars, OHA Transformation Center

Why a Transformation Center?

- To support Health System Transformation, OHA needs to transform itself, too.
  - Move beyond just regulating CCOs. Be a supportive partner in transformation and the spread of innovation.
  - Transformation Center will operate as OHA's hub for innovation and improvement.
  - Help OHA see where it needs to transform internally.
- Goal: Partner with CCOs to increase the rate and spread of innovation needed to achieve triple aim.
  - Our role is to help good ideas travel faster.
  - Will work collaboratively with partners.
- Spread elements of the coordinated care model to other payers

Meeting the triple aim: what we are seeing so far…

- ✓ Every CCO is living within their global budget.
- ✓ The state is meeting its commitment to reduce Medicaid spending trend on a per person basis by 2 percentage points.
- ✓ State-level progress on measures of quality, utilization, and cost (for the first nine months of 2013) show promising signs of improvements in quality and cost and a shifting of resources to primary care.
- ✓ Progress may not always be linear, but data are encouraging.

Metrics & Transparency

- CCOs accountable for 33 measures of health and performance
- Results are reported regularly and posted on Oregon Health Authority website
- CCO financial data posted quarterly

Coordinated Care Model: Showing Signs of Success

- Recent Health System Transformation Progress Report shows:
  - Decreased emergency department visits and expenditures
  - Increased use of developmental screening in the first 36 months of life
  - Increased primary care visits
  - Decreased hospitalization for congestive heart failure, chronic obstructive pulmonary disease and adult asthma
- Next Progress Report presented at the July1 Oregon Health Policy Board Meeting

To learn more….

www.health.oregon.gov

www.transformationcenter.org

Transformation Updates from Leadership
Maria Elena Castro, OHA Office of Equity and Inclusion

Health Equity in Oregon
Community Advisory Councils
Building the Foundation

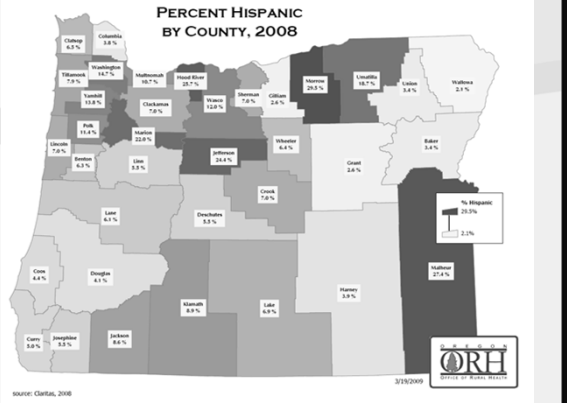
Maria Elena Castro
Office of Equity and Inclusion- OHA
May 29th,2014

Oregon Health Authority | Office of Equity & Inclusion

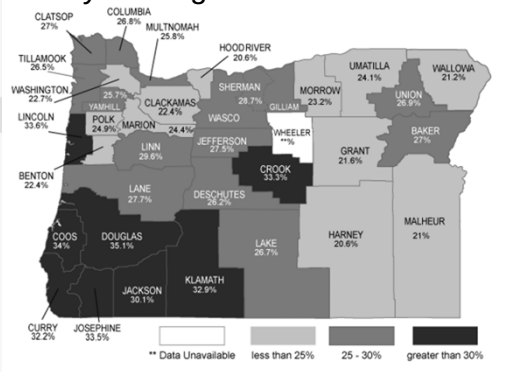
Health Equity in Oregon

- Challenges – what is Equity?
- Opportunities for action

Which are Oregon's most Racially and Ethnically Diverse Counties



Disability in Oregon – 2008-2011 BRFSS

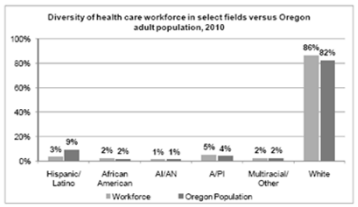


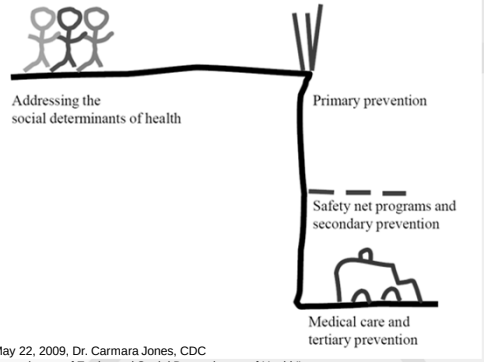
Transformation Updates from Leadership
Maria Elena Castro, OHA Office of Equity and Inclusion

Workforce diversity

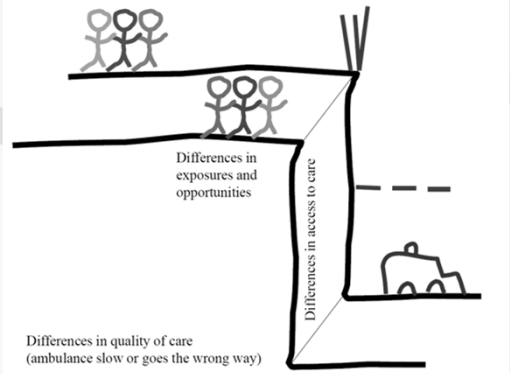
Health Care Workforce Diversity

3. Diversity of health care workforce[34] in select fields compared to the diversity of Oregon population: Latino Oregonians have a lower representation in the health care workforce than in Oregon's adult population. Asian Americans / Pacific Islanders and non-Latino Whites have higher representation in the health care workforce than in Oregon's adult population.





Source: May 22, 2009, Dr. Carmara Jones, CDC
"Social Determinants of Equity and Social Determinants of Health"

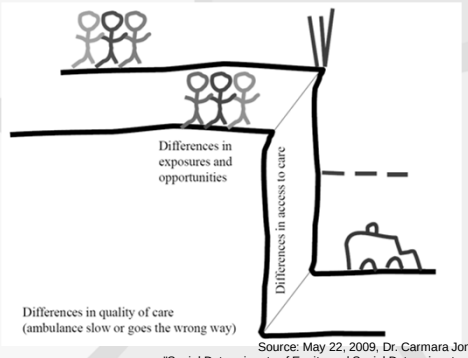


Source: May 22, 2009, Dr. Carmara Jones, CDC
"Social Determinants of Equity and Social Determinants of Health"

Opportunities for Action

- Community engagement
  - CCO Boards/Community Advisory Councils
  - FQHC and Migrant Health Boards
- Social determinants of equity:
  - Dream Act
  - Drivers License
  - CAWEM plus
- Health Care workforce
  - Workforce diversity – leadership, THWs, allied health
  - Certified and Qualified Health Care Interpreters
  - CQI – disaggregate service delivery data
  - Loan repayment/ loan forgiveness
- Systems of care for the uninsured

Opportunities for Action



Source: May 22, 2009, Dr. Carmara Jones, CDC
"Social Determinants of Equity and Social Determinants of Health"

Questions?

Maria Elena Castro
Rural and Migrant Health Coordinator
Office of Equity and Inclusion
Oregon Health Authority
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Maria.castro@state.or.us

http://www.oregon.gov/OHA/oei/

Building & Maintaining a High Performing CAC
Vanessa A. Becker, V Consulting & Associates Inc.

V consulting

CCO Summit Workshop

Building & Maintaining a High Performing CAC

May 29th, 2014

Vanessa A. Becker, Principal, V Consulting & Associates Inc.

High-Impact Model

High-Impact!

1. Great meeting management
2. Has the right CAC mix
3. Clear roles and engaging projects

High-Impact CACs accomplish all the basic responsibilities plus they have these major characteristics

Low/Limited Impact CACs **only** accomplish the basic responsibilities

Medium Impact

Do all below + working toward high-impact characteristics

Low/Limited Impact CACs

1. Meet Oregon Statute
2. Meet Oregon Administrative Rules
3. Meet and perform to CCO policies, procedures and projects

Characteristics of a High-Impact CAC

High Performing CAC Characteristics!

- ✓ Great meetings
- ✓ Great mix of people
- ✓ Clear roles and engaging projects

Recipe for Effective Meetings

1. **Focus**
   - Clear decision making power
   - Guidelines & agreements
2. **Anticipated Outcome or Purpose**
3. **Facilitator & group**
   - Balanced interactions
4. **Time**

Focus: Decision making (Glaser & Associates)

Command Decisions

Leader makes decision

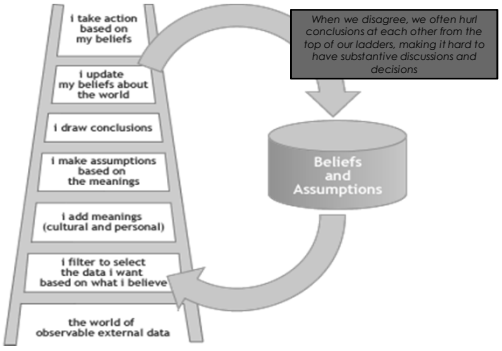
Consultive Decisions

Leader makes decision based on input, ideas, insights from others

Collaborative Decisions

Leaders voice is no stronger than anyone else in group

The Ladder of Inference/Assumption



Tips for a balanced group

- ✓ use inquiry/asking questions to clarify and gain more data
- ✓ remember data is usually void of adjectives
- ✓ understand that different people have different ladders/different realities and different frames of reference and world views
- ✓ remember sometimes the process a group goes through is just as important as the decision
- ✓ ask yourself if your thought/statement/action/behavior is helpful for the group process AND ultimate group decision
- ✓ recognize your own ladder of inference-know when you've climbed the rungs and ask yourself if your actions are based on assumption or data
- ✓ Assume good will and intent

Building & Maintaining a High Performing CAC
Vanessa A. Becker, V Consulting & Associates Inc.

Characteristics of a High-Impact CAC

High Performing CAC Characteristics!
- ✓ Great meetings
- ✓ Great mix of people
- ✓ Clear roles and engaging projects

Group Diversity

1. **Who** we have in our group makes the group successful, helps us meet our roles and responsibilities and makes us high impact!
2. **Recruitment** to your CAC must be intentional & strategic
3. Recognize and **embrace diversity** of board
4. **Use meetings** and time together for decisions & action, not just reports
5. Approach conflict & threats as **growth** opportunity

Characteristics of a High-Impact CAC

High Performing CAC Characteristics!
- ✓ Great meetings
- ✓ Great mix of people
- ✓ Clear roles and engaging projects

Clear Roles & Engaging Projects

1. **Develop** materials with your CCO staff that clarify your roles and responsibilities. Such as:
   - Work plans
   - Charters
2. Use your meeting time for reports and **learning opportunities**
3. Meet outside your meetings to support **fun activities** with the CCO, be an ambassador for your CCO
4. Identify activities within your **CHIP** that you can lead or support
   - More community input
   - CHIP activities/events

Key Points!!

1. Before we can talk about "high-impact", we must succeed at the basics
2. Meeting management is a place to focus your efforts that will make a big difference
3. Who is on the board must be intentional & strategic, do not just fill an opening with a warm body or with the usual suspects, recognize and build diversity
4. Identify fun and rewarding projects to engage your CAC on to build success

Thank you for your time and attention!

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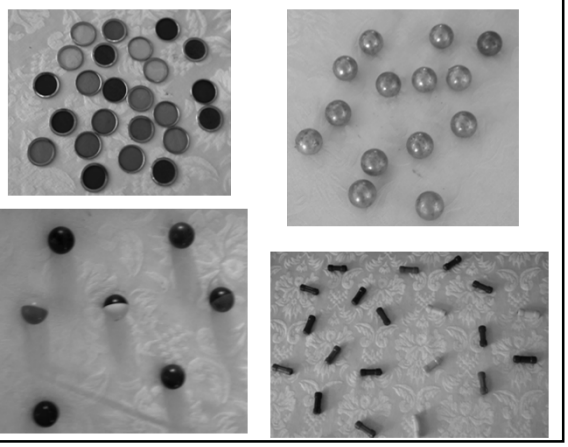
V consulting

INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE
Advancing the understanding and practice of patient- and family-centered care in all settings where individuals and families receive health care

Let's Get Engaged: Creating and Sustaining Partnerships for Community Health

Mary M. Minniti CPHQ
Community Advisory Councils Summit: Communities in Action
May 29 2014



Engagement

What: Active partnership among individuals, families, health care clinicians, staff, and leaders

Why: To improve the health of individuals and communities, and to improve the delivery of health care.

Where:

- **At the clinical encounter**: in direct care, care planning, and health care decision-making.
- **At the practice or organizational level**: in quality improvement and system redesign.
- **At the community level**: in bringing together community resources with health care organizations, individuals, and families.
- **At policy levels:** in setting public policy locally, regionally, and nationally.

Let's Get Engaged: Creating & Sustaining Partnerships for Community Health

Mary Minniti, Institute for Patient- and Family-Centered Care

What I Learned…

- Environment shapes behaviors.
- Empathy and consistency create safety.
- Encounters that provide value sustain long term partnerships.

Document the Takeaways

- Grab a 3x5 card
- List 3 takeaways from this conversation that you can use in your CAC/CCO role.
- Leave your card at the table.

www.ipfcc.org

mminniti@ipfcc.org

For Our Time Together

This highly interactive presentation/workshop will broaden the following:

- The insight & wisdom of the participants about how to invite, enhance and sustain patient and family engagement efforts;
- Understanding of an emerging engagement framework that can be applied to direct care for individuals, community settings, policy and program development settings;
- Key learning from the Patient and Family Engagement Medicaid Brief – soon to be released in Summer 2014.
- Specific tools and strategies that build strong relationships between people and build sustained partnerships around common goals

Upon completion of this session, Individuals attending will be able to:

- Identify the key components that promote and enhance patient and family engagement
- Discuss how to utilize this information to broaden the outreach of Community Advisory Councils in engaging the individuals receiving Medicaid services
- Utilize simple tools and approaches that create relationships built on mutual respect, trust and invite others to participate in new ways of working together.

Improving Population Health Through CHAs and CHIPs

Katrina Hedberg, MD, MPH
Health Officer & State Epidemiologist

Oregon Health Authority

May 29, 2014

Why CHA/CHIPs?

- Identify leading health-related issues in a given community
- Identify and eliminate health disparities
- Mobilize cross-sectoral partnerships to improve community health
- Assist in allocation of limited resources

CHA/CHIPs? – CAC role

- Senate Bill 1580 (2012)
  - CACs must oversee a CHA and adopt a CHIP to serve as a *strategic population health and health care system service plan* for the community served by the CCO

Leveraging partnerships

- Nationally, CHA/CHIPs are also required for:
  - nonprofit hospitals
  - public health accreditation efforts

State Health Profile

- Published in 2012, updated in 2013
- 70+ population health indicators
- Array: social context, diseases, behaviors, healthcare access, disparities

Population health definitions

- Public Health View
  - Defined by time, place, person
  - Indicators at community level
- Health Care Delivery (Clinical View)
  - Panel of patients: eligible, enrolled
  - Patients with specific conditions or utilization

Traditional public health data: population health assessment

- Vital Records: Birth, death, abortion
- Disease Reporting
  - Communicable diseases; Cancer
- Population-based surveys
  - Behavior Risk Factor Surveillance System
  - Oregon Healthy Teens

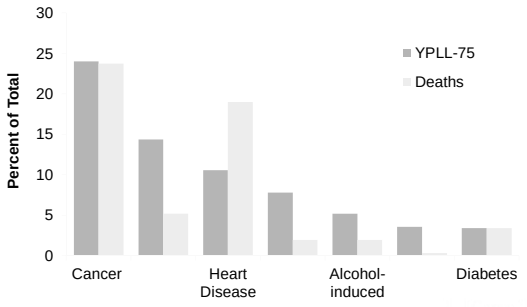
Care coordination/ service delivery

- Service receipt:
  - Vaccines; C-care; HIV care
- Hospital discharge data
- All payer/ all claims data
- Electronic Health Records:
  - health information exchange

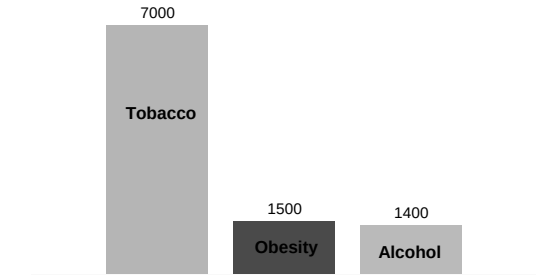
New data source: Medicaid BRFSS

- Telephone survey of CCO members
  - 400 per CCO
  - Augment on race/ethnicity
  - Compare expansion to non-expansion population
- Will assess health status, health behaviors, social determinants of health, chronic conditions, etc.
- Fielding begins June 2014

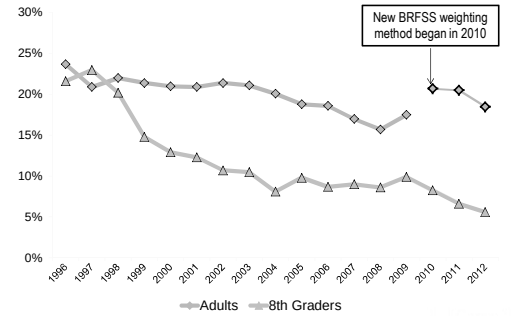
Causes of death & premature death, 2011



Behaviors that kill Oregonians

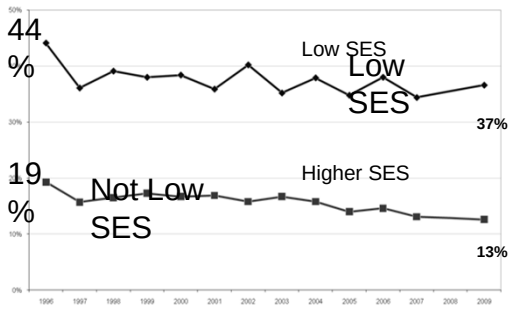


Cigarette smoking prevalence



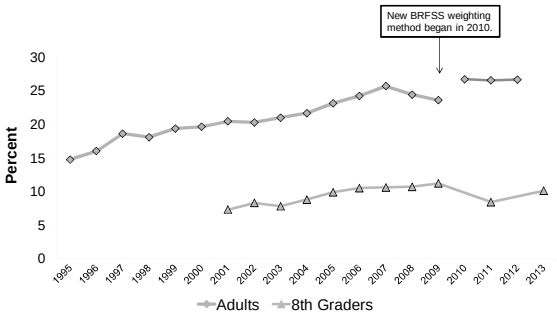
CHA/CHIP Sharing
Katrina Hedberg, Oregon Health Authority Public Health Division

Smoking prevalence by SES



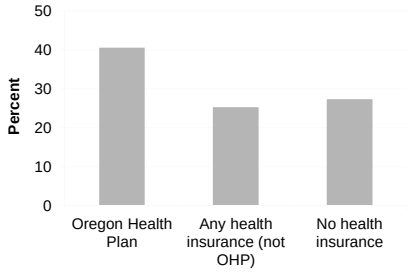
Pub
13
Oregon BRFSS

Obesity in Oregon adults and 8th graders



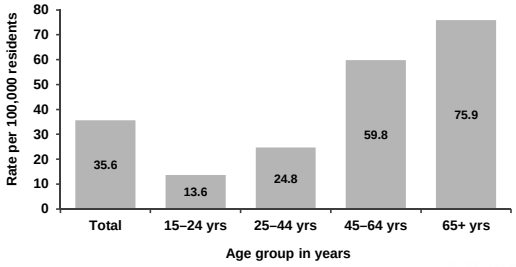
Public Health Division
14
Source: Oregon BRFSS and Oregon Healthy Teens Survey

Percentage of obese adults by health insurance, 2012



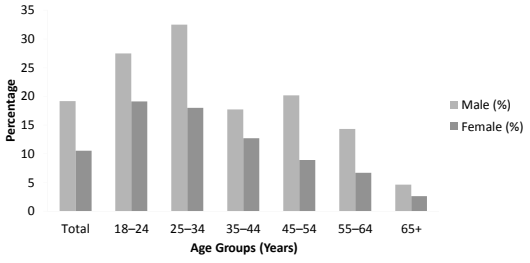
Public Health Division
Source: Oregon Behavioral Risk Factor Surveillance System
15

Alcohol-related deaths, by age group, Oregon, 2011



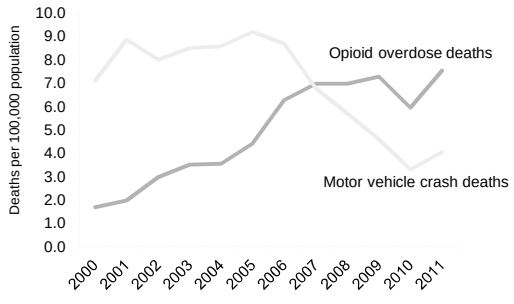
Public Health Division
16

Binge drinking in adults by age; Oregon, 2011



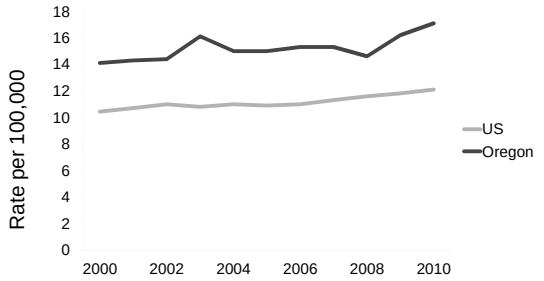
Public Health Division
17

Motor vehicle occupant and opioid overdose deaths

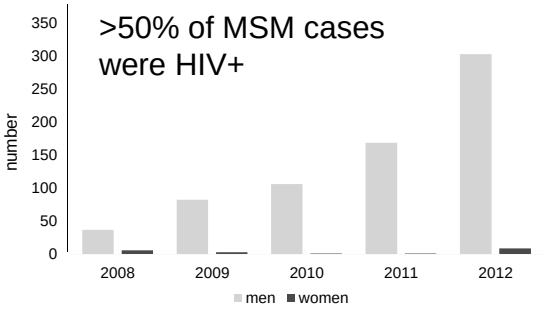


CHA/CHIP Sharing
Katrina Hedberg, Oregon Health Authority Public Health Division

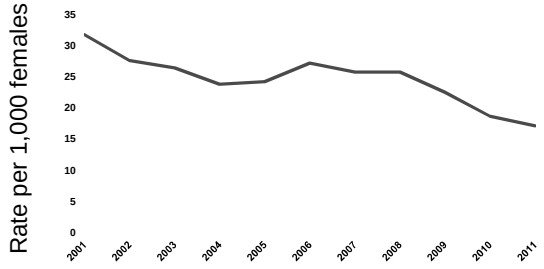
Suicide deaths; Oregon and US



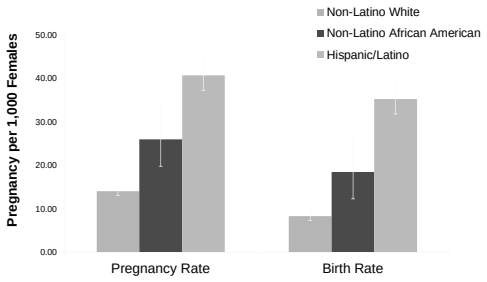
Oregon syphilis cases



Oregon teen pregnancy (15-17 yrs)



Teen pregnancy rates by race/ethnicity, 2010



Collective Impact

- Collaboration needed between: public health; health care system; education; social services; not-for-profit; business; academia; policy-makers; public

Next Steps

- Conducting community forums to get feedback on our SHIP (priority topics)
- Opportunity to learn how local Community Advisory Councils have structured their CHA/CHIP processes
- Identify areas of synergy between the SHIP and the CHIPs


That's the merriest Christmas any smoker can have—
Chesterfield mildness plus no unpleasant after-taste
Ronald Reagon
Chesterfield
CIGARETTES
CHESTERFIELD
Buy the beautiful Christmas-card carton

Questions?

CHA/CHIP Sharing
John Adams, Lake County CAC, Eastern Oregon CCO

Lake County CAC
Coordinator: John V. Adams

Lake Health District

OREGON ORH OFFICE OF RURAL HEALTH

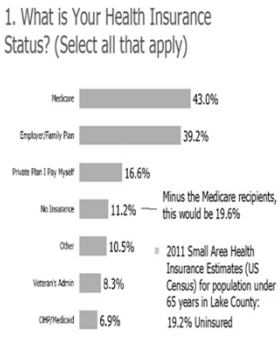
eocco EASTERN OREGON COORDINATED CARE ORGANIZATION

Health Priorities
- Oral Health
- Mental Health
- Physical Activity
- Senior Services

Lake County CAC

Quantitative Community Health Data
- **Demographics** – Statistics of Lake County population
- **Health Status** - Provides information regarding the community's health, disease prevalence and other factors that impact the health of community members
- **Health Utilization** - Gathers inpatient and outpatient utilization data for the local community and identifies where people go to receive care
- **Provider Supply & Demand** - Determines the projected need for health professionals for the service area
- **EOCCO Needs Assessment Checklist** - Addresses CCO specific metrics

Qualitative Community Health Data



Oral Health Strategies
- Administer dental sealant and fluoride varnish programs
- Conduct adult oral health assessment
- Conduct oral heath education, promotion, and outreach

Mental Health Strategies
- Lake County Mental Health to implement the Mental Health First Aid Program
- Lake County Mental Health integrating mental health providers within primary care clinics

Physical Activity Strategies

- Lake County CHIP will conduct physical activity health education, promotion, and outreach
- PA scholarship program
- Establish a parks and rec program and/or nonprofit (long-term)

Senior Services Strategy

- Create a .5FTE outreach and voluneer coordinator position with Lake County Senior Center
- Partner with LHD to establish assisted living facility
- Partner with Outback Retirement Center to expand programs and create senior center facility

CHA/CHIP Sharing
Rick Kincade, Lane County CAC, Trillium Community Health Plan

CHNA/CHIP Lessons Learned

Rick Kincade MD, Trillium CAC

Establish the Community Team

- Identify your key partners with:
  - Common understanding
  - Common measures
  - Common narrative
  - Common objectives
  - Common plan
  - Varying roles

Get your Data

- You never have too much data
- Recognize it just may not all be good data
- Your data will always underestimate the problem
- Expertise in data sources and how to extract data is critical
- Understand your data sources
- Use the review and feedback process to prioritize
- Those who question the data are probably right
- If you need more data, go get it
- Leverage the process of data retrieval and evaluation to get engagement in your community
- Some of the best data is not quantitative, but qualitative

Qualitative Data: Community Engagement

- Outreach to existing community groups
  - Rotary & other service groups
  - Social service organizations
  - Religious groups
- Focus groups: United Way Community Conversations
- Public forums
- Public officials:
  - County commissioners
  - City councils
  - School boards
- Key stakeholder interviews
- Surveys: written and online

Analyze and Share the Data

- Leverage the expertise of the epidemiologists and public health analysts
- Model your analysis around model systems
- Use your core team to develop key themes
- "A picture is worth a thousand words"
- Use the data not just for the scientific argument, but to stimulate an emotional one
- Refine the data, the presentation and the product as you go
- It gets better every time

Establishing your Key Strategies

Best to both "Lump" and "Split"

Example:

1. Improve Access to Care
2. Prevent and Reduce Tobacco Use
3. Prevent and Reduce Obesity
4. Improve Mental Health and Reduce Substance Abuse
5. Reduce Health Disparities

CHA/CHIP Sharing
Rick Kincade, Lane County CAC, Trillium Community Health Plan

Built your CHIP Work Plan by Creating the "Mother of All Spreadsheets"

- Great people are already doing great things, but they are doing it by themselves, and only a very few know about those great things
- Use existing tools to assist in organizing the work
- The more "eyes" to provide input the better
- Look for system issues that go across initiatives
- The answer is not always the need for more resource, but the need for better organization and coordination

PeaceHealth The spirit of healing Trillium Community Health Plan LIVE UNITED United Way

7

Essentials for a Successful CHIP

- Clear Process design, leveraging Collective Impact
- Build close Collaboration with key Community Partners.
- Establish a Strong Organizational infrastructure
  - Leadership
  - Accountability
- Understand and Address Budget Implications
  - Focus existing resources on community health priorities
  - Align community health with other improvement priorities
  - Identify new resources needed
  - Leverage external funding, e.g. grants
- Recognize this is a Long Term Commitment!

PeaceHealth The spirit of healing Trillium Community Health Plan LIVE UNITED United Way

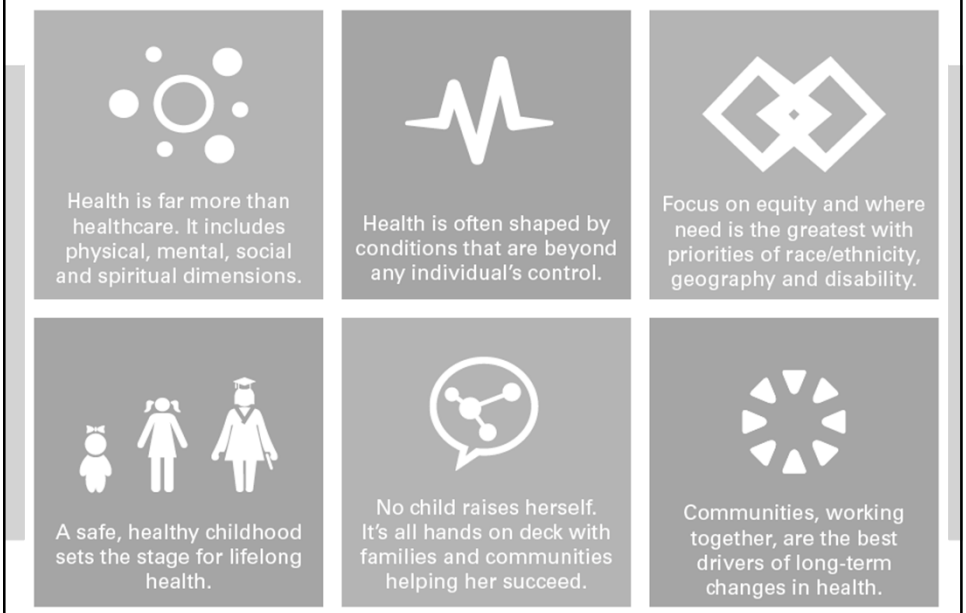
8

Funding Opportunities
Jen Matheson, Northwest Health Foundation

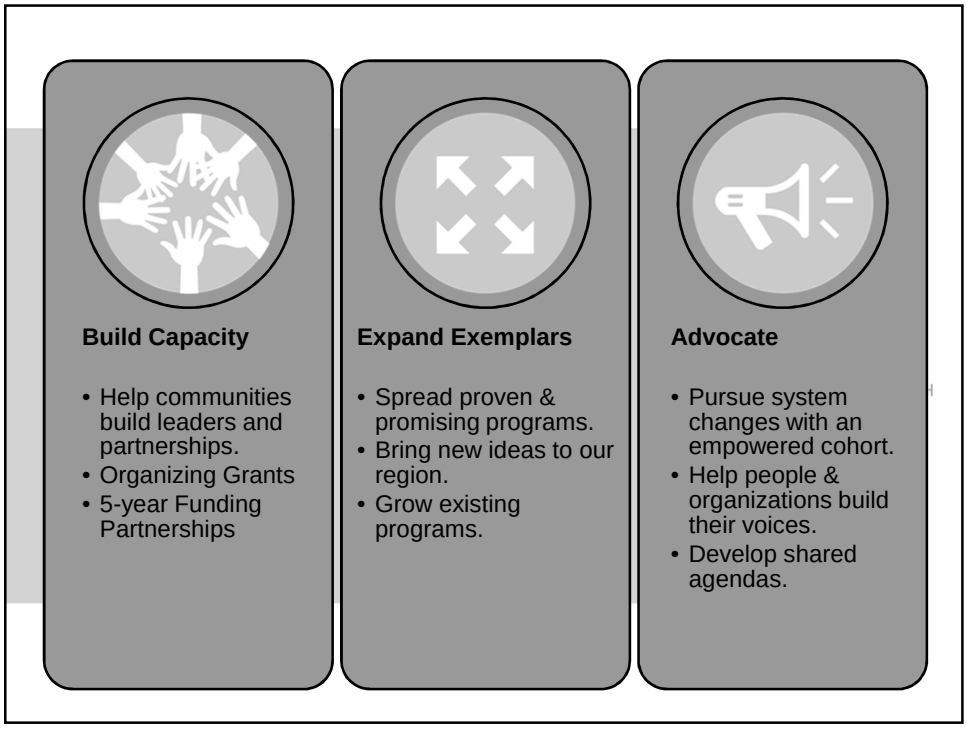
ABOUT US

Health and Funding Initiatives

NORTHWEST HEALTH FOUNDATION



Funding Opportunities
Jen Matheson, Northwest Health Foundation



KAISER PERMANENTE COMMUNITY FUND

- Kaiser Service Area
- 3 Focus Areas
- 2 Funding Cycles remaining

Kaiser Permanente Community Fund
Where health begins

Funding Opportunities
Jen Matheson, Northwest Health Foundation

SPONSORSHIPS

- Up to $3000; $500-$1500 average
- 3-12 months before your event

NORTHWEST HEALTH FOUNDATION

JEN MATHESON
COMMUNITY ENGAGEMENT OFFICER

JEN@NORTHWESTHEALTH.ORG

MICHAEL REYES ANDRILLON
COMMUNITY ENGAGEMENT OFFICER

MICHAEL@NORTHWESTHEALTH.ORG

CONTACT US &
SIGN UP

NORTHWESTHEALTH.ORG/ENEWS

CAMBIA health foundation

BACKGROUND

- Founded in 2007, Cambia Health Foundation is the nonprofit corporate foundation of Cambia Health Solutions.
- A 501(c)(3) grantmaking organization that partners with organizations to create a more person-focused and economically sustainable health care system.
- Make investments in three strategic program areas: Transforming Health Care, Children's Health and Sojourns (palliative care).

www.cambiahealthfoundation.org
Twitter: @CambiaHealthFdn

How Do Communities Define Health?

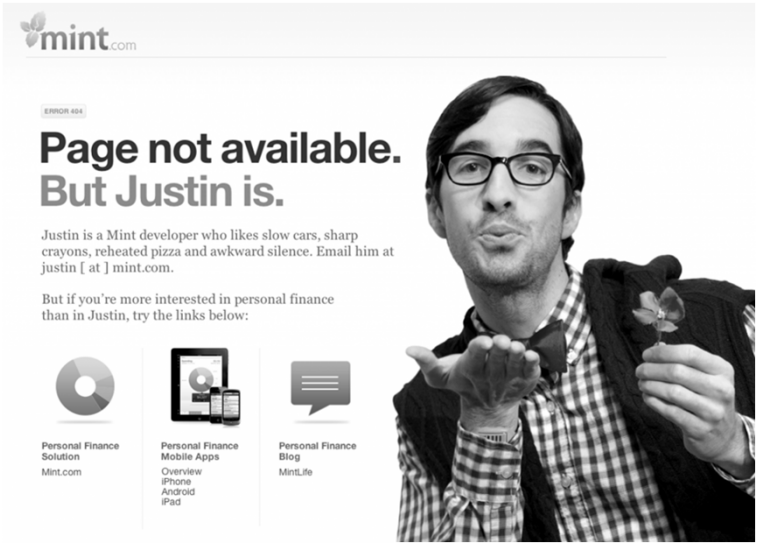
Strategies:

1. Integrating services that are patient-centered
2. Patient engagement & activation
3. Alternative Payment Methodologies (APM)

Are you ready to think about failure in a different light, namely, a person or organization that is willing to develop and implement a new solution or idea that hasn't been tested before?

– Phillip Haid

3



4

Risk: What is it Good For?

- Level of comfort at being uncomfortable?
- Do you have a risk assessment?
- Balance metrics and evidence-based best practices and emerging next best practices.

5

Transforming Health Care

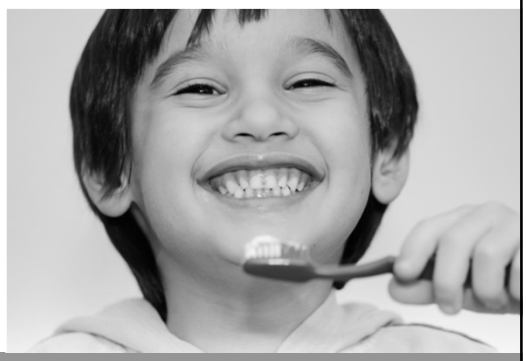
- Committed to supporting the vision and purpose Coordinated Care Organizations
- Importance of engaged and active Community Advisory Councils
- Learning & Development Process

6

A Strategic Priority: Children's Dental Health

Melissa D. Freeman, MPH
Director of Strategic Projects

THE OREGON COMMUNITY FOUNDATION
Here for Oregon. Here for Good.



OCF

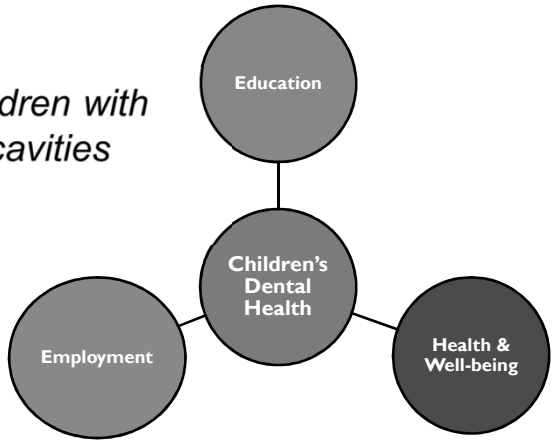
- 1700+ charitable funds
- More than $60 million awarded annually
- 1700 volunteers statewide
- 6 regional offices

- Education and Arts
- Children and Families
- Jobs and Economy

CELEBRATING OCF 40 YEARS
LEGACY • LEADERSHIP • IMPACT

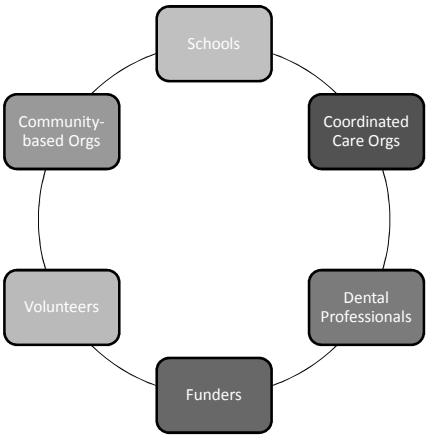
Long-term Impact

17,000 children with 7 or more cavities



Wrap-around Model

PROCESS:
- Convene
- Foster partnerships; set up contracts
- Deliver Services
- Track Progress
- Measure Results
- Continual Communication



SERVICES:
- Coordination
- Parent Education
- Dental Screenings
- Sealants
- Fluoride Varnish
- Oral Hygiene Education
- Referrals
- Transportation
- Access to Dentists

Funding Opportunities
Melissa Durham Freeman, The Oregon Community Foundation

Patient-centered Communication for CCOs:

Transformation through Health Literacy

Cliff Coleman, MD, MPH
Department of Family Medicine
Oregon Health & Science University

Community Advisory Council Summit: Communities in Action
Eugene, Oregon, May 30, 2014

Disclosure statement

I have no financial relationships with a commercial entity producing health care related products and/or services that would present a conflict of interest

Training goal

To provide actionable information about health literacy in order to help Oregon's CCOs meet their goals and satisfy Minimum Standards:

- *"Assuring communications…are tailored to…health literacy…needs."*
- *"CCO proactively provides a plan…to assure communications in formats that reflect the needs of all members."*

Learning objectives

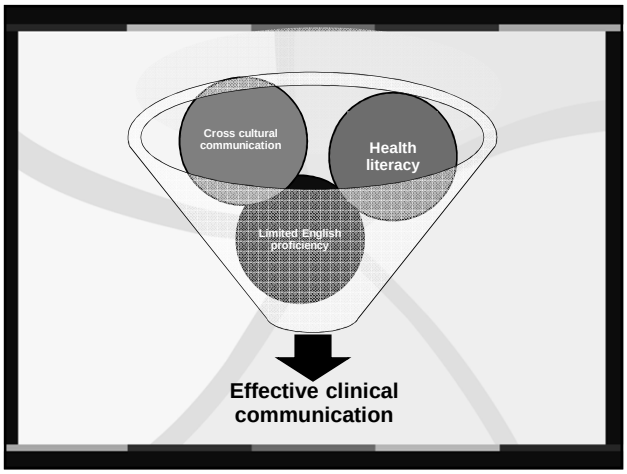
By the end of this training, participants will be able to:

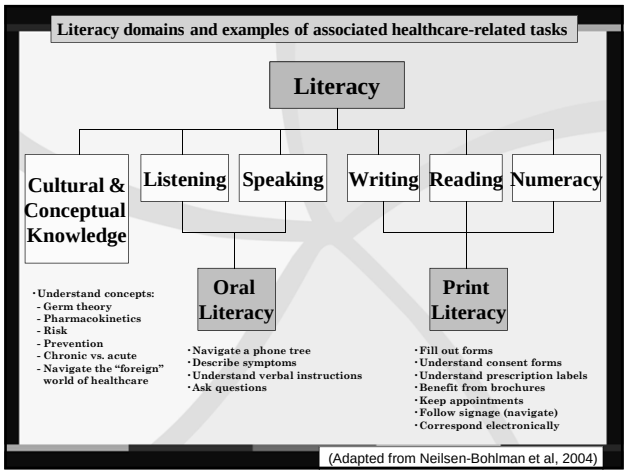
1. Define health literacy
2. Estimate the prevalence of inadequate health literacy
3. Understand communication barriers faced by consumers
4. Recognize health literacy demands placed on patients by the health care system
5. Recognize the general training deficiencies of the current health care workforce with respect to health literacy
6. Make the business case for focusing on health literacy
7. Identify best practices for patient-centered communication
8. Identify tools and resources which CCOs can use to improve communication practices

Overview

- **Background** – health literacy basics
- **The business case** – why health literacy matters to CCOs
- **Attributes of a health literate organization**
  - Best practices
  - Tips and resources for CCOs
- **Supporting materials** (available at www.oregon.gov/oha/oei)
  - Glossary & References

Background





Literacy in America:
National Assessment of Adult Literacy, 2003

43%
of English-speaking US adults
have limited literacy skills

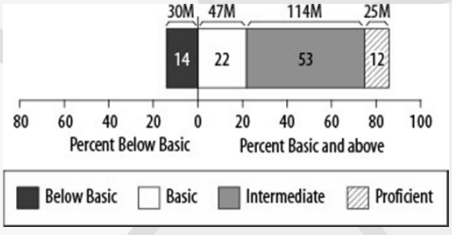
(Kutner et al, 2006)

Health literacy defined

The degree to which individuals have the capacity to obtain, process, communicate and understand basic health information and services needed to make health decisions

(Somers & Mahadevan, 2010)

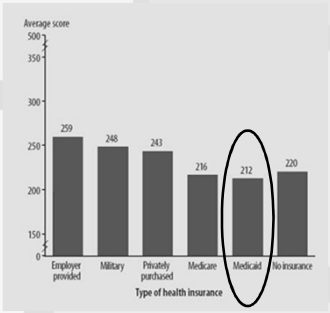
Health literacy of U.S. adults



(Kutner et al, 2006)

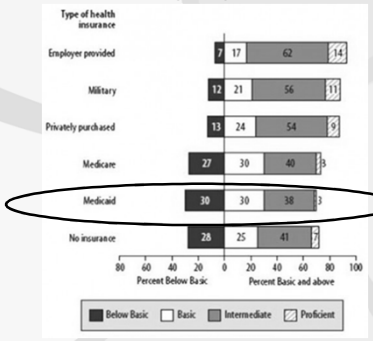
Video

Health literacy by insurance type

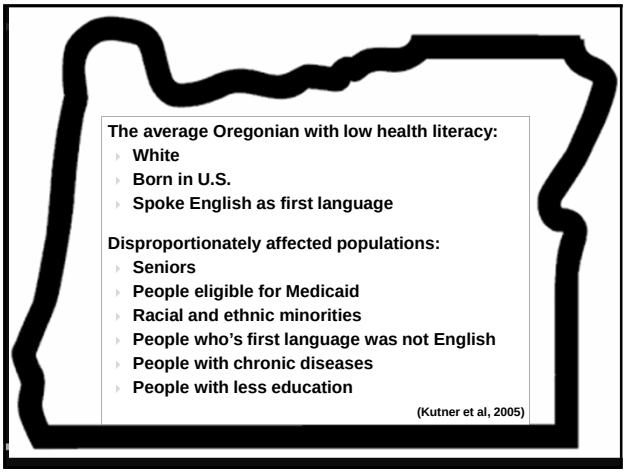


(Kutner et al, 2006)

Health literacy by insurance type



(Kutner et al, 2006)



The average Oregonian with low health literacy:

- **White**
- **Born in U.S.**
- **Spoke English as first language**

Disproportionately affected populations:

- **Seniors**
- **People eligible for Medicaid**
- **Racial and ethnic minorities**
- **People who's first language was not English**
- **People with chronic diseases**
- **People with less education**

(Kutner et al, 2005)

Low health literacy is associated with...

↓ Use of preventive services
↓ Understanding of medication use and prescription label instructions
↓ Overall health status
↑ Use of emergency care
↑ Rates of hospitalization
↑ Mortality rates among seniors
↑ Racial health disparities

(Berkman et al, 2011)

Access and utilization

- Access to health care is not enough
- Utilization requires navigation skills (health literacy)
  - Over-utilization of emergency services
  - Under-utilization of medical homes
  - Under-utilization of preventive services

Current state of preparedness

Providers and systems are not adequately:

- Aware of the prevalence of low health literacy
- Aware of the impacts of low health literacy
- Equipped with knowledge and skills to address low health literacy
- Incentivized to provide solutions (e.g., clear communication)

(Coleman & Appy, 2012; Coleman, 2011)

Universal precautions

Problem:

- Low health literacy is ubiquitous.
- Patients hide their low skills
- Providers can't tell
- Screening tools not appropriate

Solution:

- "Universal precautions" approach to health communication

(DeWalt et al, 2010)

The health literacy business case for Oregon CCOs

The "Quadruple" Aim

1. Better Health

Patients who understand:
- What to do
- How to do it
- Why it's important

2. Better Care

Health professionals who have:
- Advanced communication skills
- Incentives to provide clear communication

Health literate CCOs can deliver…

3. Lower Cost

Health care delivery which is:
- More efficient
- Patient-centered
- Safer

4. Less Disparities

Populations who benefit from:
- Health information equity

Health literacy and CCOs

CCOs can:

- Support and empower partner organizations through education about health literacy
- Use flexibility in their global budget to incentivize clear communication at every level of the system

Additional incentives

- New Joint Commission Standards effective July 1, 2012:
  - The hospital identifies the patient's oral and written communication needs
  - The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient's oral and written communication needs

(The Joint Commission, 2010)

Lower cost

Excess annual costs attributed to low health literacy in the U.S.:

$106 billion - $238 billion

(Vernon et al, 2007)

6 aims for quality care*

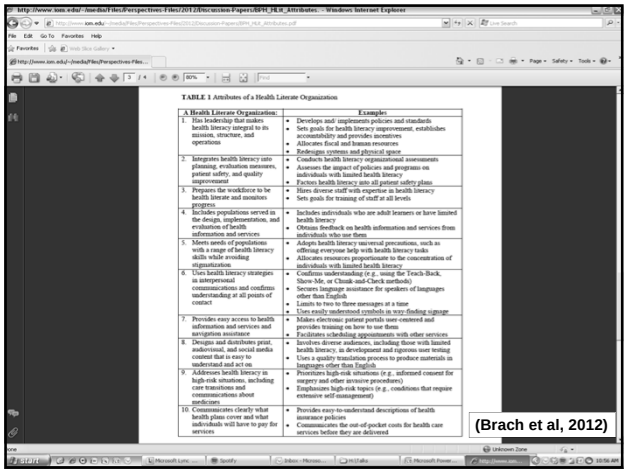
Health Care Should Be…	Health literacy impact
Safe	↓ Patient errors ↓ Iatrogenic harm ↑ Informed consent and informed refusal
Effective	↑ Adherence to treatment ↑ Use of preventive services
Efficient	↓ Use of higher cost services ↓Cost-benefit ratio
Timely	↓ Delays in care seeking and delivery
Equitable	↓ Health care inequalities ↓ Health disparities
Patient-centered	↑Shared decision-making ↑Satisfaction

(*IOM, 2001)

Health literate organizations are

Organizations that make it easier for people to navigate, understand, and use information and services to take care of their health

(Brach et al, 2012)



A Health Literate Organization…

1. Has leadership that makes health literacy an organizational priority

Reflected in the organization's:
- Policies and standards
- Goals
- Accountability structure
- Incentives
- Budgeted resources
- Planning of systems & physical space

Resources:

❑Raise awareness with the 23-minute AMA video, "Help your patients understand": http://www.youtube.com/watch?v=cGtTZ_vxjvA

❑Form a health literacy team: Universal Precautions Toolkit (AHRQ, 2010)

A Health Literate Organization…

2. Integrates health literacy into planning, evaluation measures, patient safety, and quality improvement

"Minimum standard"

Reflected in the organization's:
- Self-assessments
- Assessments of the impact of policies and programs on patients
- Factoring health literacy into all patient safety plans

Resources:

❑Assess Your Practice: Universal Precautions Toolkit (AHRQ, 2010)

❑The Health Literacy Environment of Hospitals and Health Centers (Rudd & Anderson, 2006)

A Health Literate Organization…

3. Prepares the workforce to be health literate and monitors progress

Reflected in the organization's:
- Hiring of staff with expertise in health literacy
- Setting goals for training of staff at *all* levels

Best practice

TIP

❑Hire a training coordinator

❑Develop a training plan for current and future employees

Resources:
❑Health literacy best practices, competencies & training objectives (Coleman et al, 2013)

❑HRSA and CDC online trainings (HRSA, 2012; CDC, 2011)

❑Booklet: Health Literacy and Patient safety: Help Patients Understand (AMA Foundation, 2007)

A Health Literate Organization…

4. Includes populations served in the design, implementation, and evaluation of health information and services

Reflected in the organization's:
- Inclusion of individuals who have limited health literacy
- User-testing of materials and information

Resources:

❑Improving the Health Literacy of Hospitals (Gaard et al, 2010)

❑Get Patient Feedback: Universal Precautions Toolkit (AHRQ, 2010)

A Health Literate Organization…

5. Meets needs of populations with a range of health literacy skills while avoiding stigmatization

Reflected in the organization's:
- Adoption of health literacy universal precautions

Best practice

Resources:

❑Booklet: Health Literacy and Patient safety: Help Patients Understand (AMA Foundation, 2007)

❑Universal Precautions Toolkit (AHRQ, 2010)

TIP

❑Redesign *all* systems and procedures to benefit patients with limited health literacy

A Health Literate Organizatio

Top safety practice

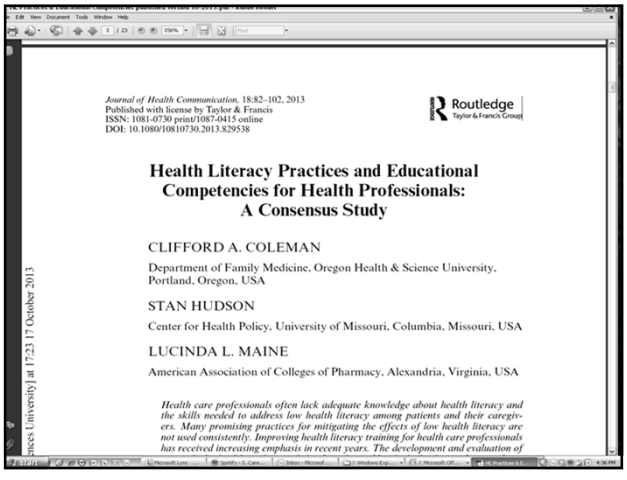
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact

Reflected in the organization's:
- Confirming of understanding
- Use of communication best practices
- Using easily understood symbols in way-finding signage

TIP

The "teach-back" technique requires both training, and incentives

Resources:
❑Tips for Communicating Clearly, & The Teach-Back Method: Universal Precautions Toolkit (AHRQ, 2010)
❑Booklet: Health Literacy and Patient safety: Help Patients Understand (AMA Foundation, 2007)



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DOI: 10.1080/10810730.2013.829538

Routledge
Taylor & Francis Group

Health Literacy Practices and Educational Competencies for Health Professionals: A Consensus Study

CLIFFORD A. COLEMAN
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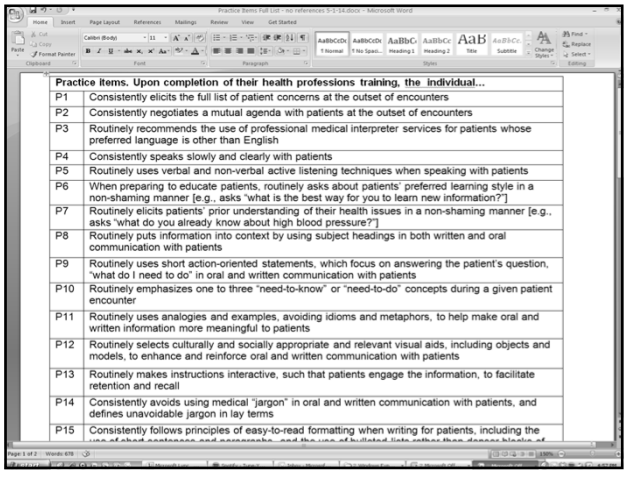
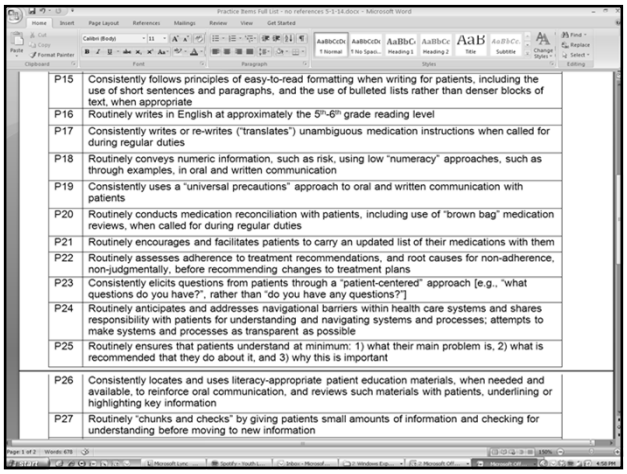
STAN HUDSON
Center for Health Policy, University of Missouri, Columbia, Missouri, USA

LUCINDA L. MAINE
American Association of Colleges of Pharmacy, Alexandria, Virginia, USA

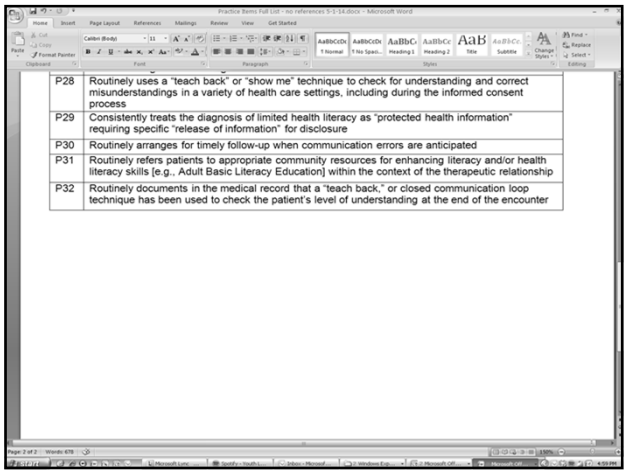
Health care professionals often lack adequate knowledge about health literacy and the skills needed to address low health literacy among patients and their caregivers. Many promising practices for mitigating the effects of low health literacy are not used consistently. Improving health literacy training for health care professionals has received increasing emphasis in recent years. The development and evaluation of



Practice items. Upon completion of their health professions training, the individual…	
P1	Consistently elicits the full list of patient concerns at the outset of encounters
P2	Consistently negotiates a mutual agenda with patients at the outset of encounters
P3	Routinely recommends the use of professional medical interpreter services for patients whose preferred language is other than English
P4	Consistently speaks slowly and clearly with patients
P5	Routinely uses verbal and non-verbal active listening techniques when speaking with patients
P6	When preparing to educate patients, routinely asks about patients' preferred learning style in a non-shaming manner [e.g., asks "what is the best way for you to learn new information?"]
P7	Routinely elicits patients' prior understanding of their health issues in a non-shaming manner [e.g., asks "what do you already know about high blood pressure?"]
P8	Routinely puts information into context by using subject headings in both written and oral communication with patients
P9	Routinely uses short action-oriented statements, which focus on answering the patient's question, "what do I need to do" in oral and written communication with patients
P10	Routinely emphasizes one to three "need-to-know" or "need-to-do" concepts during a given patient encounter
P11	Routinely uses analogies and examples, avoiding idioms and metaphors, to help make oral and written information more meaningful to patients
P12	Routinely selects culturally and socially appropriate and relevant visual aids, including objects and models, to enhance and reinforce oral and written communication with patients
P13	Routinely makes instructions interactive, such that patients engage the information, to facilitate retention and recall
P14	Consistently avoids using medical "jargon" in oral and written communication with patients, and defines unavoidable jargon in lay terms
P15	Consistently follows principles of easy-to-read formatting when writing for patients, including the



P15	Consistently follows principles of easy-to-read formatting when writing for patients, including the use of short sentences and paragraphs, and the use of bulleted lists rather than denser blocks of text, when appropriate
P16	Routinely writes in English at approximately the 5th-6th grade reading level
P17	Consistently writes or re-writes ("translates") unambiguous medication instructions when called for during regular duties
P18	Routinely conveys numeric information, such as risk, using low "numeracy" approaches, such as through examples, in oral and written communication
P19	Consistently uses a "universal precautions" approach to oral and written communication with patients
P20	Routinely conducts medication reconciliation with patients, including use of "brown bag" medication reviews, when called for during regular duties
P21	Routinely encourages and facilitates patients to carry an updated list of their medications with them
P22	Routinely assesses adherence to treatment recommendations, and root causes for non-adherence, non-judgmentally, before recommending changes to treatment plans
P23	Consistently elicits questions from patients through a "patient-centered" approach [e.g., "what questions do you have?", rather than "do you have any questions?"]
P24	Routinely anticipates and addresses navigational barriers within health care systems and shares responsibility with patients for understanding and navigating systems and processes; attempts to make systems and processes as transparent as possible
P25	Routinely ensures that patients understand at minimum: 1) what their main problem is, 2) what is recommended that they do about it, and 3) why this is important
P26	Consistently locates and uses literacy-appropriate patient education materials, when needed and available, to reinforce oral communication, and reviews such materials with patients, underlining or highlighting key information
P27	Routinely "chunks and checks" by giving patients small amounts of information and checking for understanding before moving to new information



P28	Routinely uses a "teach back" or "show me" technique to check for understanding and correct misunderstandings in a variety of health care settings, including during the informed consent process
P29	Consistently treats the diagnosis of limited health literacy as "protected health information" requiring specific "release of information" for disclosure
P30	Routinely arranges for timely follow-up when communication errors are anticipated
P31	Routinely refers patients to appropriate community resources for enhancing literacy and/or health literacy skills [e.g., Adult Basic Literacy Education] within the context of the therapeutic relationship
P32	Routinely documents in the medical record that a "teach back," or closed communication loop technique has been used to check the patient's level of understanding at the end of the encounter

Avoid medical jargon

- Surprise! Clinicians use jargon terms

(Castro et al, 2007)

- Research shows that **all** patients prefer simple health information

(Kripalani & Weiss, 2006)

TIP

❑**If you can't avoid jargon, then define or explain the term, phrase, or concept**

http://www.nchealthliteracy.org/teachingaids.html

A Health Literate Organization…

7. Provides easy access to health information and services, and navigation assistance

Reflected in the organization's:
- Making phone systems and electronic patient portals user-centered, and providing training on how to use them

TIP

❑Make processes transparent

❑Anticipate and lower barriers at every step of the healthcare process

Resources:
❑Website and electronic media design at www.usability.gov

❑Telephone Considerations: Universal Precautions Toolkit (AHRQ, 2010)

A Health Literate Organization…

8. Designs and distributes print, audiovisual, and social media content that is easy to understand and act on

Reflected in the organization's:
- Use of clear communication principles in written materials

Best practice

TIP

The average US adult reads at an 8th grade level.
Writing at the recommended 5th-6th grade level is difficult!

Resources:

❑CMS Toolkit for Making Written Material Clear and Effective (http://www.cms.gov/Outreach-andEducation/Outreach/WrittenMaterialsToolkit/index.html?redirect=/WrittenMaterialsToolkit)

❑Design Easy-To-Read Material: Universal Precautions Toolkit (AHRQ, 2010)

April 16, 2010

Dear _____

Your bloodwork is unremarkable without any signs to suggest parasitic infection, inflammation of blood vessels or other problems. I suspect your symptoms are functional in nature and not due to a specific disease process. I doubt that further testing would be productive. You may want to consider getting a second opinion and I would be happy to assist in arranging one. Please let me know if I can be of help in that regard.

Sincerely,

_____, MD

April 16, 2010

Dear _____

Your bloodwork is unremarkable without any signs to suggest parasitic infection, inflammation of blood vessels or other problems. I suspect your symptoms are functional in nature and not due to a specific disease process. I doubt that further testing would be productive. You may want to consider getting a second opinion and I would be happy to assist in arranging one. Please let me know if I can be of help in that regard.

Sincerely,

_____, MD

Years of formal education Needed to easily understand this text = 10.8

April 16, 2010

Dear _____

Your blood test was normal. I think your symptoms are not due to a specific disease. I do not think that more tests will help. You may want to get a "second opinion" from another doctor. I would be happy to help set that up. Please let me know if I can be of help with that.

Sincerely,

_____, MD

Years of formal education Needed to easily understand this text = 5.9

A Health Literate Organization…

9. Addresses health literacy in high-risk situations

Reflected in the organization's:
- Attention to informed consent
- Management of care transitions
- Focus on medication safety

Resource:

❑Brown Bag Medication Review: Universal Precautions Toolkit (AHRQ, 2010)

Best practice

A Health Literate Organization…

10. Communicates clearly what health plans cover and what individuals will have to pay for services

Reflected in the organization's:
- Provision of easy-to-understand descriptions of health insurance policies
- Communication of the out-of-pocket costs for health care services before they are delivered

Consider:

❑Financial literacy may be lower than health literacy

❑Financial barriers may be at the root of inefficient health care seeking

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Summary

- Focusing on low health literacy is key to achieving the quadruple aim of better health, better care, lower costs, and less disparities within Medicaid populations
- Development of a health literacy culture within the organization can help Oregon's CCOs achieve their goals

Q & A

Supporting materials

Glossary

- **Clear Health Communication:** Written or oral communication which helps patients to understand and act on health care information (Pfizer, 2004)
- **Health Literacy:** The degree to which an individual has the capacity to obtain, communicate, process, and understand health information and services in order to make appropriate health decisions (Somers & Mahadevan, 2010). Health literacy involves reading, writing, speaking, listening, numeracy, and cultural and conceptual knowledge (Neilsen-Bohlman et al, 2004), including navigation of health care systems (Kutner et al, 2006). Health literacy allows the public and personnel working in all health-related contexts to find, understand, evaluate, communicate, and use information (Coleman et al, 2010; Neal, 2007). Health care professionals and organizations can be "health literate" by presenting information in ways that improve understanding and the ability of people to act on that information (Brach et al, 2012 ; Coleman et al, 2010)
- **Health Literacy Competencies:** The knowledge, skills and attitudes which health professionals need in order to address low health literacy among consumers of health care and health information (Coleman, Hudson, & Maine, In review)

Glossary

- **Jargon:** Words, phrases, or concepts, including numerical or mathematical information, which might not be fully understood, or may be misinterpreted by the recipient. (Neilsen-Bohlman et al, 2004)
- **Numeracy:** A working knowledge of numbers (Osborne, 2005). Basic numeracy includes the knowledge and skills necessary to understand and act on numerical information and concepts encountered in routine oral and written communications. The related term, "quantitative literacy", defined as "the knowledge and skills required to apply arithmetic operations, alone or sequentially, using numbers embedded in printed materials" (Kirsch et al, 1993) can be applied to oral communication as well
- **Plain Language:** Sometimes called "everyday language", or "living room language" (AMA Foundation, 2007), plain language is written or oral communication which is clear, concise, organized and jargon-free (Office of Disease Prevention and Health Promotion, 2010). A communication is considered to be in "plain language" if the audience can quickly and easily find what they need, understand what they find, and act appropriately on that understanding (Center for Plain Language, 2010) the first time they read or hear it (US DHHS, 2006a)

Glossary

- **Teach Back:** Teach back, also referred to as an "interactive communication loop", is an iterative technique used to confirm understanding and correct misunderstanding of information by asking patients to explain back or demonstrate ("show back") in their own way what they have understood (DeWalt et al, 2010; Schillinger et al, 2003)
- **Universal Precautions for Safe Communication:** A communication strategy which assumes that all health care encounters are at risk for communication errors (AMA Foundation, 2007), and aims to minimize risk for everyone (DeWalt et al, 2010)
- **Usability:** How well users can learn and use a product to achieve their goals and how satisfied they are with that process (US DHHS, 2012)

About the presenter

Cliff Coleman, MD, MPH is a nationally recognized expert in the field of health literacy. His teaching and research activities focus on workforce training to improve the clinical and public health response to low health literacy. Dr. Coleman received his medical degree from Stanford University in 2000, and completed a combined residency in Family Medicine and Public Health & General Preventive Medicine at Oregon Health & Science University (OHSU), with a Master's of Public Health from Portland State University in 2004. He joined the faculty in the Department of Family Medicine at OHSU in 2004.

Patient-Centered Communications for CCOs: Transformation through Health Literacy
Cliff Coleman, Oregon Health and Science University

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College of Public Health and Human Sciences

Community Health Improvement Plan Implementation

Public Health Policy Institute

Community Advisory Council Summit

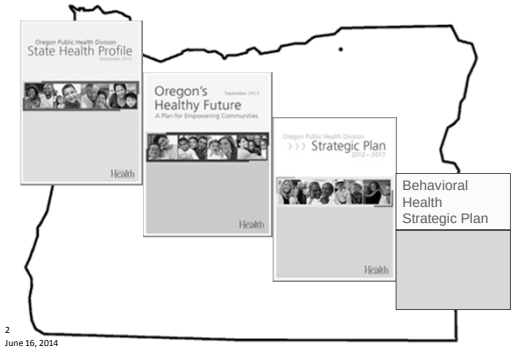
Jeff Luck, MBA, PhD

30 May 2014

CHIP Implementation Issues

- Whole Lotta Plannin' Goin' on…
- Setting priorities for implementation
- Coordinating multiple stakeholders: Benefits & Challenges
  - Collective Impact framework
- Identifying evidence-based solutions
- Evaluating progress over time

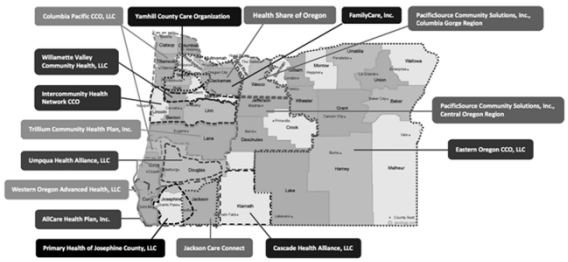
State-level plans frame the overall context



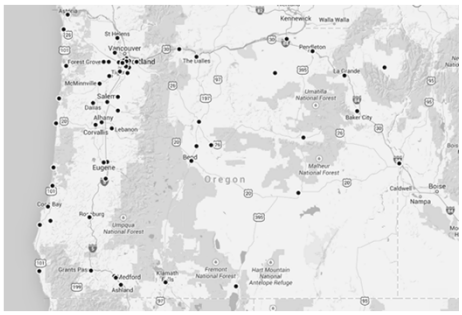
Local Health Department CHIPs aim to improve the health of county residents

Local Mental Health Authority BIPs aim to enhance behavioral health access and treatment

CCO CHIPs focus on improving the health of OHP members



Hospitals' improvement plans focus on the health of residents in their service areas



Early Learning Hubs are making plans to improve school readiness

Current Hubs:

- Early Learning Hub, Inc. (Marion Co.)
- Yamhill Early Learning Hub
- Frontier Oregon Services Hub
- South-Central Oregon Early Learning Hub
- Lane Early Learning Hub
- Early Learning Multnomah

Setting priorities for implementation

- Stay well grounded in CHA
- Explicitly compare your CCO's priorities to other local plans
  - State: SHIP and PHD Strategic Plan
  - Local: Counties, LMHAs, Hospitals, Early Learning Hub
- Engage other local stakeholder organizations
  - CHIP is the start of implementation that will take years
- Focus on just a few goals that have support from multiple stakeholders
  - 1 or 2 to start, 3 at the most

Multi-Stakeholder implementation is powerful but not easy

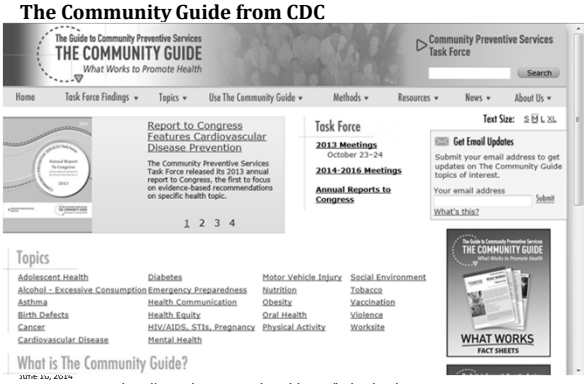
- Benefits
  - Shared tasks—such as CHAs—save resources
  - Shared improvement goals promote mutually reinforcing activities
- Challenges
  - Different populations across stakeholder organizations
  - Diverse content knowledge and interests
  - Logistical complexity of meetings, different planning deadlines, etc.
  - Need to compromise on priorities

There is a continuum of collaboration from full Collective Impact to ordinary communication and coordination

Collective Impact framework offers specific guidelines for success of multi-stakeholder implementation

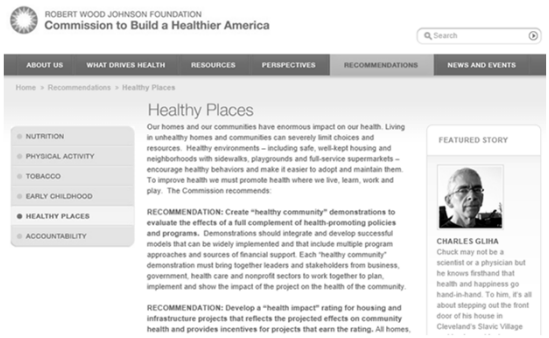
"Collective Impact," J Kania & M Kramer, 2011,
http://www.ssireview.org/articles/entry/collective_impact
Figure: http://hungerintohealth.com/2012/06/13/divided-we-stand...

Start with evidence-based solutions
The Community Guide from CDC



http://www.thecommunityguide.org/index.html

RWJF provides guidelines for underlying drivers of health



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June 16, 2014

http://www.commissiononhealth.org/

Evaluating progress over time

- CHIP is just the beginning of implementation
  - Success still takes years to improve health
- Evaluation should measure both processes and desired outcomes, for example:
  - **Process**: Date when new policy enacted, Number of people trained, number of people accessing services
  - **Outcome**: Reductions in suicide or in obesity rates

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June 16, 2014

CHIP Implementation
Ellen Larsen, Hood River County Health Department

Pacific Source Community Solutions Columbia Gorge Region

Columbia Gorge Regional Community Health Improvement Plan

Collaborating for Optimum Health and Optimized Healthcare

Community Advisory Council Charter

- Strive to be a broad reaching CAC for region
  - Provide tangible member feedback on Columbia Gorge CCO services and programs
  - Be available for organizations beyond the traditional Oregon Health Plan/Medicaid services seeking member input on program and process designs
  - Identify topics of concern from the Community Health Assessment
  - Amplify the impact of agencies and healthcare providers by convening all participants on a specific focus area.
  - Improve community integration by connecting organizations

Community Advisory Council (CAC) extended membership

Healthcare	Social & Economic Conditions	Member Perspectives
• Hood River Fire & EMS • Hood River County Health Department • Klickitat County Health Department • Klickitat Valley Health Hospital • Mid-Columbia Center for Living - behaviroal health services • Mid-Columbia Fire & Rescue • Mid-Columbia Medical Center • North Central Public Health District • One Community Health (Federally Qualified Health Clinic) • Providence Hood River Memorial Hospital • Skyline Hospital	• Aging and People with Disabilities • Area Agency on Aging • DHS - Department of Human Services; child welfare and self-sufficiency • HAVEN - Help Against Violent Encounters Now! • Hood River Commission on Children and Families • Meals on Wheels – The Dalles • Mid-Columbia Children's Council • Mid-Columbia Community Action Council • Mid-Columbia Council of Gov'ts • Oregon Health Authority • Sherman County Court • The Next Door, Nuestra Comunidad Sana • Wasco County YOUTHTHINK (prevention)	• Parent of child with disabilities • Grandparent of child with disabilities • Adult with disabilities • Adult with Dual diagnosis • Latino • Parent of child with behavioral issues • Low-income • English as a second language • Migrant/Seasonal Farmworker liaison

Community Health Improvement Process (CHIP)

- Clarify Focus area
- Itemize Key Questions
- Idenitfy Service Providers

- Report out to CAC
- Clarify gaps

- Letters of Support
- Recommendations
- Endorsement

Identify Focus Areas

- Started with 29 candidate focus areas from CHA
- Selected 10 focus areas with CAC voting + consumer weighting
- Social & Economic are bigger than healthcare; intention is to have strong CAC voice to support local agencies chartered with addressing these issues

Social and Economic Conditions	Direct Healthcare Services	Health and Healthcare Ecosystem
• Housing & Food • Jobs • Transportation	• Dental Access for Adults • Physical and Mental health together • Mental Health access for Children & Youth	• Teamwork across healthcare and social services • Health insurance re-enrollment • Teamwork across the spectrum of healthcare providers (e.g. physical, mental, dental, pharmacy) • Supporting Developmental and Healthy Growth in the Early Years

Integrated Response & Action Items

- For each focus area
  - A focused list of questions based on topic
  - A work team of cross-community participants
  - A CAC liaison
  - Commitment for a presentation to be made to the CAC
- Actions could include:
  - Items needing CAC endorsement for process changes
  - Letters of support for grants tied to identified gaps
  - Recommendations for the Columbia Gorge Health Council Board and PacificSource Community Solutions
  - Support of the agencies and/or other partners needed to implement improvements or to support interventions or innovations to fill gaps or needs

CHIP Implementation
Ellen Larsen, Hood River County Health Department

The CHIP is a Focused Collaborative Process

Category	Focus Area	Integrated Response Team
Social and Economic Conditions	Housing & Food	Mid-Columbia Community Action Council, Mid-Columbia Housing Authority, Homeless shelters, Habitat for Humanity, Regional Solutions, Gorge Ecumenical Ministries, FISH, SNAP, WIC, Gorge Grown Food Network, Bread & Blessings, WGAP (Klickitat Food Bank), Meals on Wheels, School lunch programs, OSU – Food preservation, , OCDC, Registered dietician @ HRCHD
	Transportation	To be developed with Regional Solutions
	Jobs	To be developed with Regional Solutions
Direct Healthcare Services	Dental Access for Adults	Advantage Dental, Capitol Dental, Moda/ODS, Hospital ER contacts, Hospital Community Benefit Funds, Gorge Dental Access Program (GDAC), Dental van, GAP, Private independent dentists
	Physical and Mental health together	Integrated Care Work Team – report out to CAC on progress and assessment
	Mental Health access for Children & Youth	Mid-Columbia Center for Living, Public Schools, Mid-Columbia Children's Council, Early Intervention, OCDC, PCPs, Health Depts, NPS, Children's Advocacy Center, Child care providers, community preschools, private schools, private mental health providers
Health and Healthcare Ecosystem	Teamwork across all healthcare providers	
	Teamwork across healthcare and social services	To be developed as follow-on work from Oregon Solutions work and formation of the Pathways Community Hub in the Columbia Gorge.
	Health insurance re-enrollment	
	Supporting Developmental and Healthy Growth in the Early Years	North Central Public Health District, Hood River County Health Department, OCDC, Head Start, Early Intervention programs, primary care providers, mental health, oral health, DHS – Child Welfare, community preschools programs, child care providers

How to Read the Focus Area Tables

Focus Area: ←*Name of focus area*
CAC Liaison: *Name of CAC member to clarify questions for Integrated Response Team*
Integrated Response Team:

Why:
Summary points on why it is a focus area
Include references from CHA:

- Community Survey results
- ED utilization rates
- Forces of change concerns
- Agency or provider top concerns

Member Stories:
1 or 2 personal stories from OHP members

1. **Key Questions:** We have concerns about overall appointment access for adults for preventive care.
   a. What are your collective plans to address them?
   b. How do you monitor and respond to access issues?
2. How are you adapting services to meet the needs of the under-served populations including those with limited transportation options or limited English proficiency?
3. How are you incorporating member experience into your service delivery?
4. What do you do today or what are your plans to improve integration with the rest of the healthcare community?
5. Over half of survey respondents reported that they were overweight. What are you doing to encourage healthy lifestyles and nutritional eating?
6. What support do you need from the CAC?

Outcome of Integrated Response Does the Integrated Response address the focus area? Do any gaps remain? If so, what actions and/or information are required? Are there any key insights or learnings to be shared?

Actions to Be Taken – to be completed following Integrated Response

Task	Who	By when

CHIP Implementation
Tara DaVee, Lane County CAC, Trillium Community Health Plan

CHIP Implementation

Tara DaVee, Trillium CAC

Our Community Team

- Common understanding
- Common measures
- Common narrative
- Common objectives
- Common plan
- Varying roles

Qualitative Data: Community Engagement

- Outreach to existing community groups
  - Rotary & other service groups
  - Social service organizations
  - Religious groups
- Focus groups: United Way Community Conversations
- Public forums
- Public officials:
  - County commissioners
  - City councils
  - School boards
- Key stakeholder interviews
- Surveys: written and online

Our CHIP Strategic Initiatives

1. Improve Access to Care
2. Prevent and Reduce Tobacco Use
3. Prevent and Reduce Obesity
4. Improve Mental Health and Reduce Substance Abuse
5. Reduce Health Disparities

Tobacco Use During Pregnancy

Tobacco use is the single most preventable cause of poor birth outcomes.
– The National Partnership to help Pregnant Smokers Quit

Prevalence of Tobacco Use	*State*	*Lane County*
Prenatal - Total	12%	15%
Prenatal – Medicaid	22%	*est. 30%+*
Adult – Total	17%	18%
Adult – Medicaid	37%+	34%

- In Lane County, $127 million is spent on tobacco-related illness annually.*
- In Oregon the cost of delivering a baby to a pregnant smoker is $350 more than that of a non-pregnant smoker+.

Intensive Cessation for Pregnant Women

- Screening and Brief Intervention (5As)
- Referral to Oregon Quit Line
- Intensive counseling
- Incentives
- Postpartum relapse prevention

CHIP Implementation
Tara DaVee, Lane County CAC, Trillium Community Health Plan

Intensive Cessation for Pregnant Women

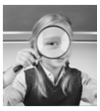
Original Proposal

- Found it difficult to make time to implement the program
- Inconsistent implementation across provider offices
- Not enough women enrolling

CAC Suggestions

- Women will be enrolled through one centralized coordinator, located at Lane County WIC
- Additional training will be delivered to providers
- Incentives offered for joining the program as well as staying quit.

7



What We've Learned

- Building partnerships and buy in is key
- Look for best practices, don't "reinvent the wheel"
- Be bold – advocate for what you want
- Monitor and review
- Don't be afraid to make changes – we want to succeed

8

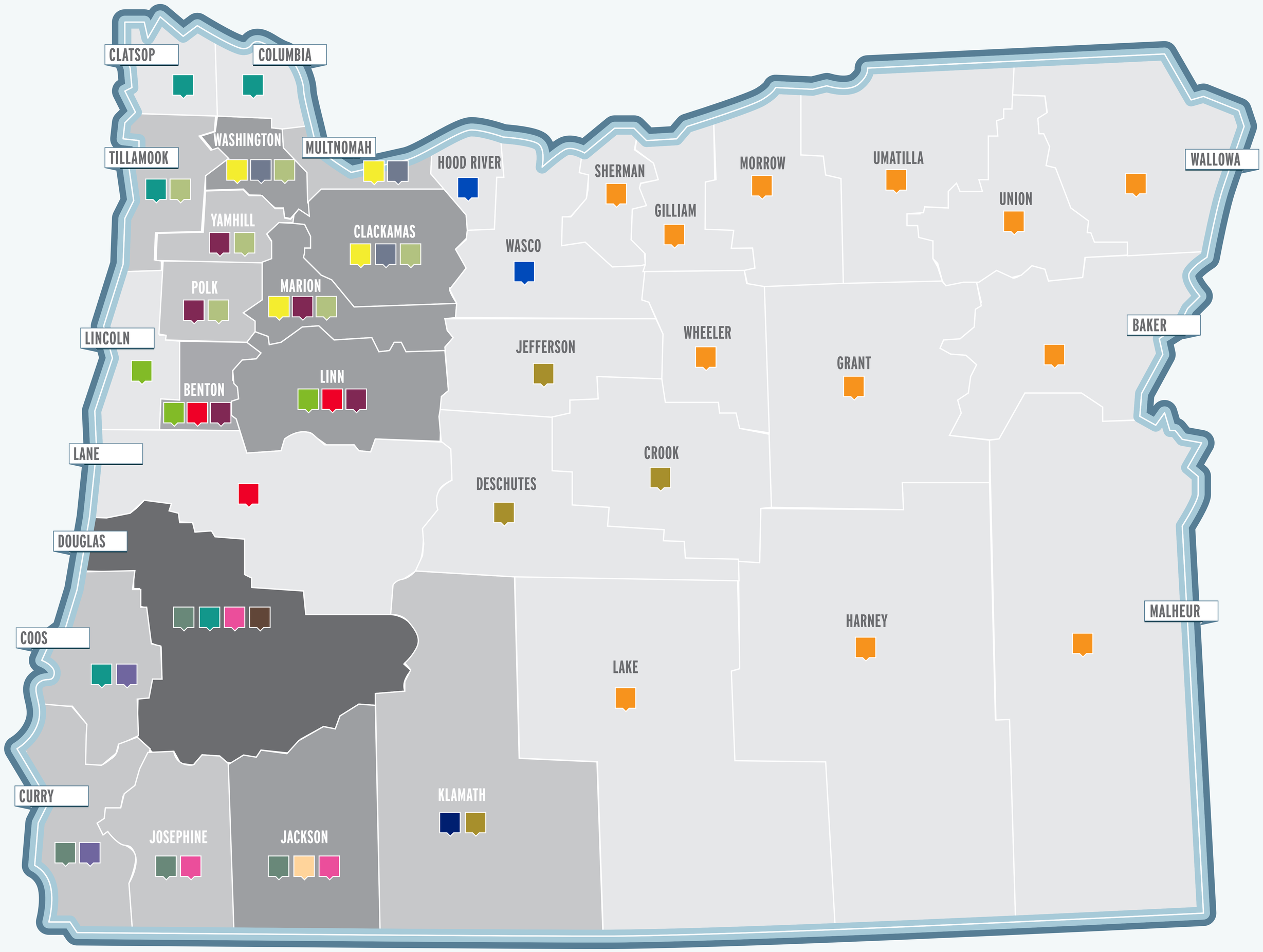
Coordinated Care Organization Service Areas

CCO BY REGION

- **AllCare Health Plan**
  Curry, Douglas, Jackson, Josephine
- **Cascade Health Alliance**
  Klamath
- **Columbia Pacific CCO**
  Clatsop, Columbia, Coos, Douglas, Tillamook
- **Eastern Oregon CCO**
  Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler
- **FamilyCare, Inc.**
  Clackamas, Multnomah, Washington, Marion
- **Health Share of Oregon**
  Clackamas, Multnomah, Washington
- **Intercommunity Health Network CCO**
  Benton, Lincoln, Linn
- **Jackson Care Connect**
  Jackson
- **PacificSource Community Solutions: Central Oregon**
  Crook, Deschutes, Jefferson, Klamath
- **PacificSource Community Solutions: Columbia Gorge**
  Hood River, Wasco
- **PrimaryHealth of Josephine County**
  Douglas, Jackson, Josephine
- **Trillium Community Health Plan**
  Benton, Lane, Linn
- **Umpqua Health Alliance**
  Douglas
- **Western Oregon Advanced Health**
  Coos, Curry
- **Willamette Valley Community Health**
  Benton, Linn, Marion, Polk, Yamhill
- **Yamhill Community Care Organization**
  Clackamas, Marion, Polk, Washington, Yamhill

Number of CCOs per county
Overlapping CCO areas vary by zip code

1 2 3 4



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