Virtual CAC Conference

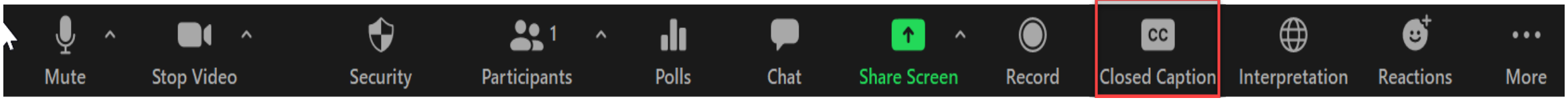
June 8: 8:45 a.m.–12:30 p.m.
June 9: 9 a.m.–1 p.m.

Hosted by the Oregon Health Authority Transformation Center

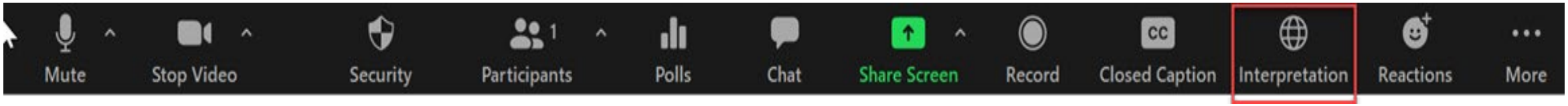
Oregon Health Authority

Conference Logistics

- Contact Laura Kreger (laura.e.kreger@dhsoha.state.or.us, 503-487-7409) or Tom Cogswell (thomas.cogswell@dhsoha.state.or.us) with Zoom issues
- All sessions will be recorded
- **Closed captioning:**



- **Spanish language interpretation will be available throughout the conference. English-speaking participants will need to select the Interpretation button and then the English channel for sound to appear:**



Other Notes

- We like to see you! Please consider leaving your video on as much as you are comfortable
- Take a break if you need to
- Feel free to color, doodle, knit or use fidgets to keep your hands busy
- Let us know if we need to make more time for responses
- Please rename yourself with preferred pronouns (e.g., he/him, they/them, etc.)

Poll:

What is your role?

Conference Learning Objectives

- Discuss how CAC member voices have been elevated through CCO 2.0
- Learn how CACs can address the social determinants of health & equity
- Hear from CAC members about their efforts:
    - Supporting COVID-19 relief in their communities
    - Funding and supporting community health improvement plan projects
    - Participating on CCO governing boards

Agenda – June 8

8:45–9	**Welcome and opening remarks**
9–9:45	**Keynote: The social determinants of health & equity**
9:45–10	Break
10–10:50	**Breakout: CAC 101**
10:50–11:15	Break
11:15–11:30	Optional chair yoga
11:30–12:30	**Breakout: The social determinants of health, health equity and CACs**

Agenda – June 9

9–9:50	**Panel: COVID-19 and CACs**
9:50–10:05	Optional mindfulness activity
10:05–10:30	Break
10:30–11:30	**Panel: CAC sharing of community health improvement plan projects**
11:30–Noon	Break
Noon–1	**Breakout: CAC member governing board experiences**

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Transformation Center CAC supports

- Host peer-to-peer meetings/learning collaboratives:
    - CAC coordinators
    - CAC members
    - CAC governing board members
- Host webinars/learning sessions on topics relevant to CACs
- Host an annual CAC conference
- Develop resources for CAC coordinators to use in supporting CACs
- Community health assessment (CHA)/community health improvement plan (CHP) trainings

Welcome and opening remarks

Chris DeMars, Director,
OHA Transformation Center

Pat Allen, Director, OHA

Health Equity: Anti-Racism, Decolonization and the Social Determinants of Health

Leann Johnson, MS

OHA Equity & Inclusion Division Director

Oregon Health Authority | Office of Equity & Inclusion

Gratitude

This space acknowledges the people who came before, the people in the here and now, and all life sustaining, life affirming forces.

Thank you

We are never alone in strength or accomplishment-

With Love and Gratitude,

Leann

OHA's Strategic Goal

To eliminate health inequities in Oregon by 2030

Health Equity Definition

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- **The equitable distribution or redistribution of resources and power; and**
- **Recognizing, reconciling and rectifying historical and contemporary injustices.**

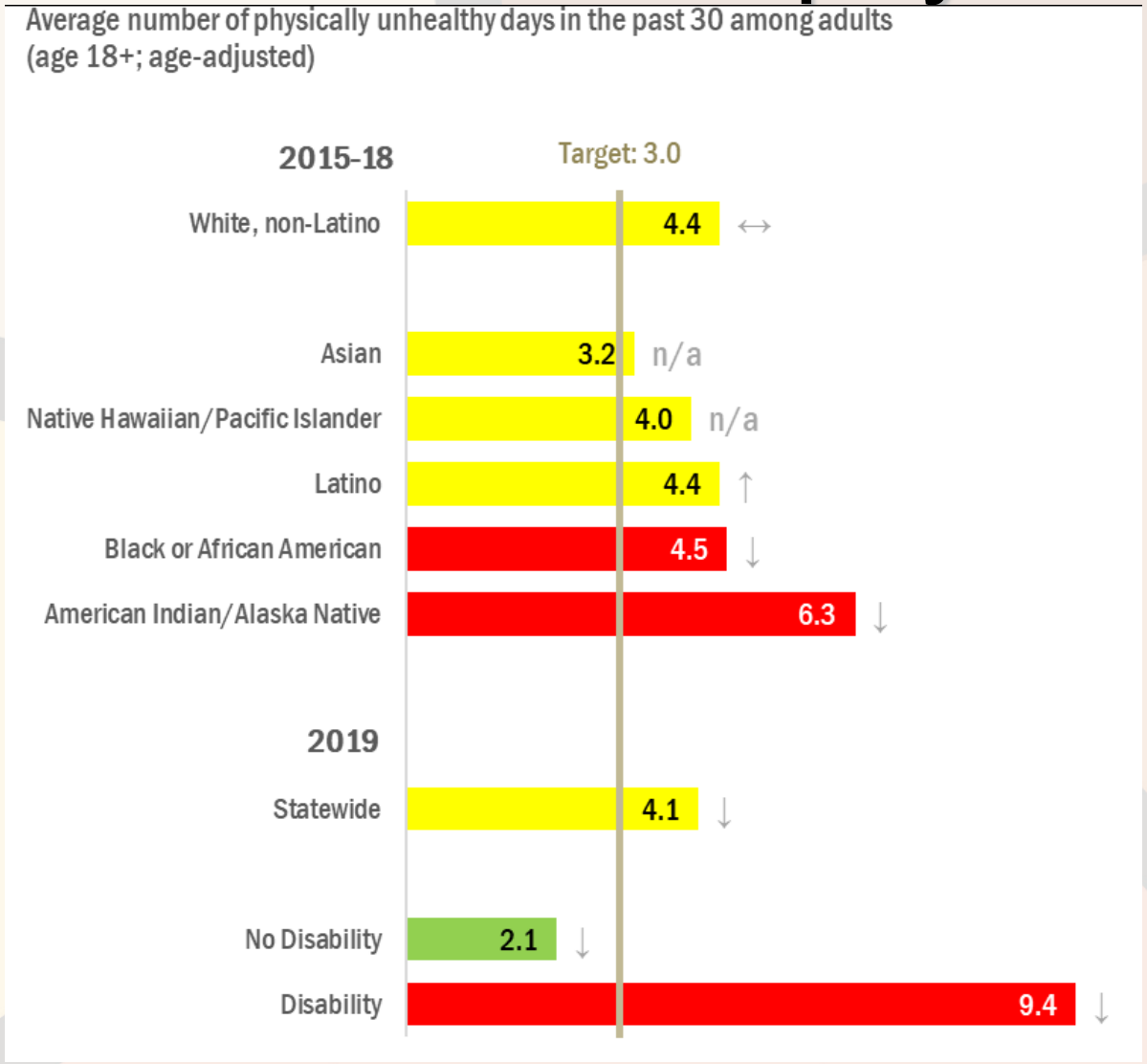
Health Inequities and Racism

- Health inequities are differences in health that are not only unnecessary and avoidable but, in addition, are considered unfair and unjust. Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups.

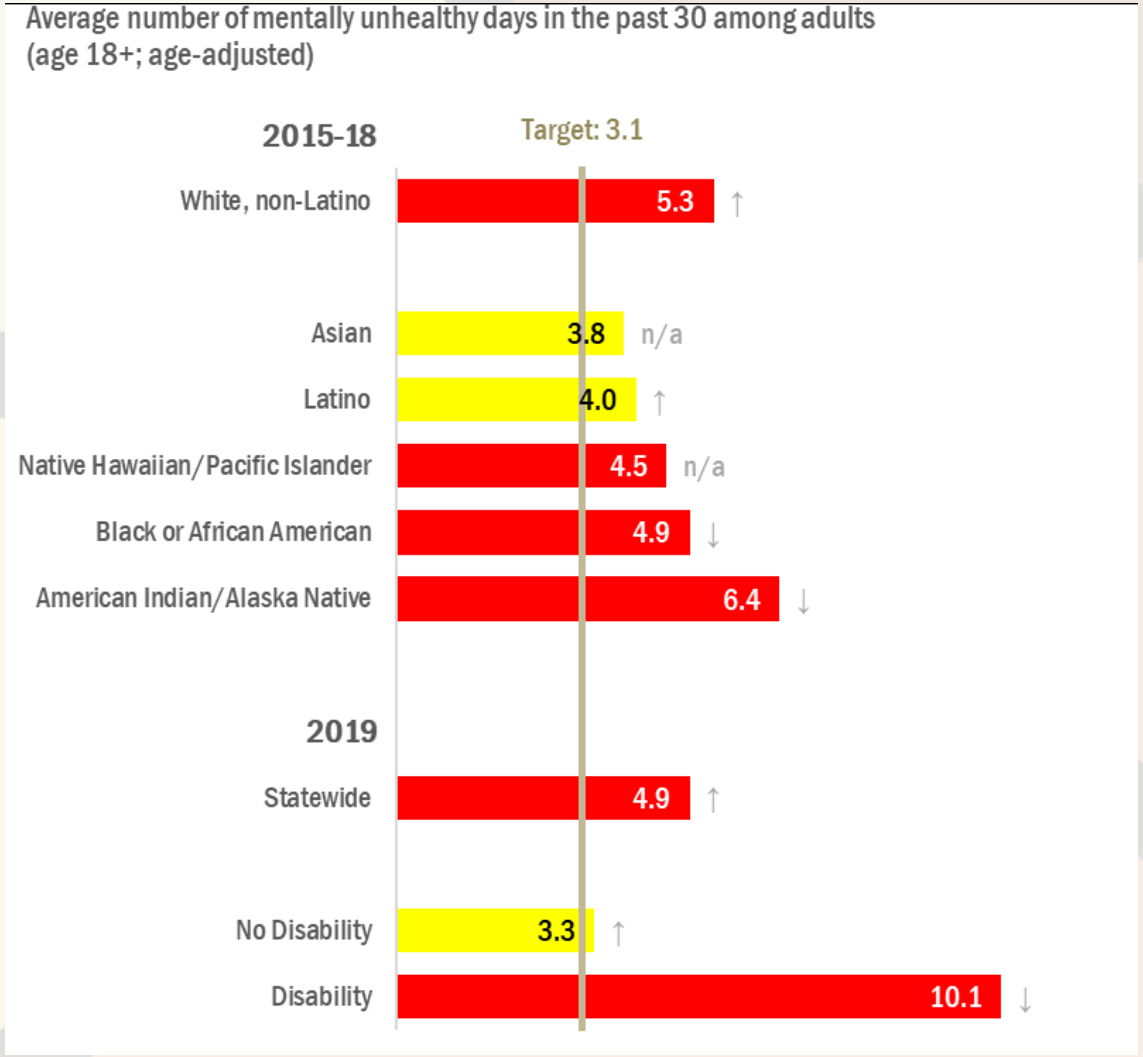
- Babies born to Black women are more likely to die in their first year of life than babies born to White women.
- This remains true even when controlling for income and education
- Research has shown links between the stress from **racism** experienced by Black women and negative health outcomes. **This is a health inequity** because the difference between the populations is unfair, avoidable and rooted in social injustice.

Boston Public Health Commission https://www.bphc.org/whatwedo/health-equity-social-justice/what-is-health-equity/Pages/Health-Disparities-vs.-Health-Inequities.aspx

Inequities in Outcomes-physical health



Inequities in Outcomes-mental health



Intergenerational Trauma and Racism

"Research indicates that AI/AN (American Indian/Alaska Native) populations **have disproportionately higher rates of mental health problems** than the rest of the US population. High rates of **substance use disorders (SUDs), posttraumatic stress disorder (PTSD), suicide, and attachment disorders** in many AI/AN communities have been directly linked to the **intergenerational historical trauma** forced upon them, such as forced removal off their land and government-operated boarding schools which separated AI/AN children from their parents, spiritual practices, and culture."

American Psychiatric Association (2017)

Historical Trauma and Racism

"The Black community suffers from an **increased rate of mental health concerns**, including **anxiety and depression**. The increased incidence of psychological difficulties in the Black community is related to the **lack of access to appropriate and culturally responsive mental health care, prejudice and racism inherent in the daily environment of Black individuals, and historical trauma enacted on the Black community by the medical field**. Moreover, given that the Black community exists at the intersection of racism, classism, and health inequity, their mental health needs are often exacerbated and mostly unfulfilled. Issues related to economic insecurity, and the associated experiences, such as violence and criminal injustice, further serve to compound the **mental health disparities** in the Black population."

Addressing Mental Health in the Black Community, Columbia University (2019)

Toxic Stress and Racism

“Toxic stress can negatively affect a child’s physical, cognitive, and emotional development. When children experience prolonged and continuous stress, referred to as **“toxic stress**,” it can damage connections in the brain, resulting in issues with brain development and **lifelong negative mental** and physical health effects.”

“A growing body of literature finds that the threat of parental detention and deportation is a toxic stress. Children living with the **constant threat of their parents’ deportation may have a constant and heightened state of anxiety that does not allow their body to return to baseline functioning.** The American Academy of Pediatrics recently warned that the stress of living in fear of deportation among immigrant children could disrupt a child’s developmental processes and lead to long-term health concerns.”

“**Over the long term, toxic stress may manifest as poor coping skills and stress management, unhealthy lifestyles, adoption of risky health behaviors, and mental health issues, such as depression.** Toxic stress also is associated with increased rates of physical conditions into adulthood, including chronic obstructive pulmonary disease, obesity, ischemic heart disease, diabetes, asthma, cancer, and **post-traumatic stress disorder**.”

Living in an Immigrant Family in America: How Fear and Toxic Stress are Affecting Daily Life, Well-Being, & Health, Artiga & Ubri (Henry Kaiser Family Foundation, 2017)

What is Anti-Racism?

- Form of action against racial hatred, bias, systemic racism
- Conscious efforts and actions to provide equitable opportunity for all people individually and systemically
- Acknowledge personal privileges
- Confront acts of and systems of racial discrimination
- Reflect and work to change personal racial biases

Why Anti-Racism?

- Historical and structural racism and oppression dating back to colonization and systematic genocide set in motion 529 years ago, to enslavement 400 years ago, to today's continued dehumanization of Black and Brown people are a driving source of today's health inequities.

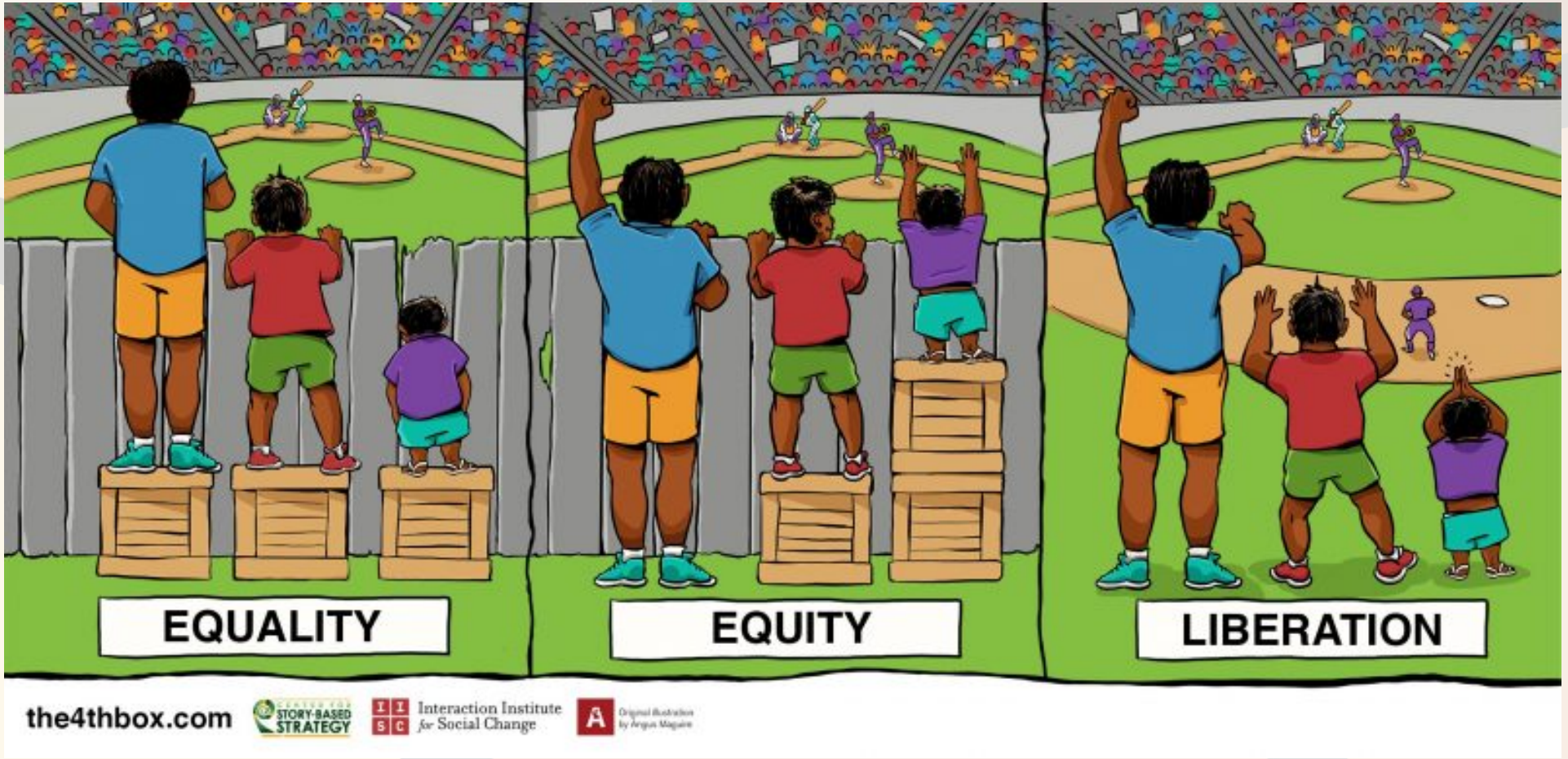
- Racism is addressed through anti-racist strategies, tactics and initiatives
- Anti-racism is a term of art in the Equity and Inclusion discipline
- Anti-racism is not pursued at the exclusion of other equity strategies or communities impacted by health inequities
- Anti-racism is designed to dismantle a root cause problem
- Decolonization and Cultural Humility are necessary in anti-racism work

Colonization

- The act or process of settling among and establishing control over indigenous people of an area.
- Appropriating space, place, domain for one's own use or advantage
- Taking ownership, assuming dominance, superiority, entitlement, saviorism
- We can't talk about racism and anti-racism, without acknowledging/addressing the destructive forces of colonization

Social Determinants of Health

- Income, Education, Transportation, Criminal Justice, Housing, Food, Employment, Environment …
- Racism, Discrimination, Oppression, Colonization
- Anti-racism, Decolonization, Liberation



https://www.storybasedstrategy.org/the4thbox

9:45–10 a.m.

Breakout: CAC 101 – An introduction to community advisory councils

10–10:50 a.m.

Learning Objectives

- Learn about CAC member roles and responsibilities, including changes from CCO 2.0
- Learn about supports available to CAC members from the OHA Transformation Center
- Hear from CAC members about what has helped them to be successful & engaged CAC members

Poll:

How long have you been a CAC member?

- Two teams:
  - Team 1→ Participants with first names starting A-M
  - Team 2→ Participants with first names starting N-Z
- One spokesperson/team
- Team members private chat their spokesperson if they know the answer to a question
- First spokesperson to respond correctly to the question receives points

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Break: 10:50–11:30 a.m.

Optional chair yoga: 11:15–11:30 a.m.

Breakout: The Social determinants of health, health equity & CACs
11:30 a.m.-12:30 p.m.

Breakout: The social determinants of health, health equity and CACs

11:30 a.m.–12:30 p.m.

The Social Determinants of Health, Health Equity, and Community Advisory Councils

Anne King, MBA, CPM

Associate Director

Oregon Rural Practice-based Research Network

Oregon Health & Science University

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Topics

- Overview
- Prevalence of social needs in the U.S. and in Oregon
- How CCOs leverage the Oregon Health Plan (also known as Medicaid) to impact social determinants and social needs through Medicaid
- How CACs can play a role in improving Social Determinants of Health and Health Equity (SDOH-HE) for members and communities

The Social Determinants of Health

- Factors that affect health risks and outcomes, such as:
  - Poverty
  - Pollution, poor environmental conditions
  - Unsafe neighborhoods
  - Insufficient infrastructure, built environment, transportation
  - Inadequate educational systems
  - Discriminatory social structures
  - Inadequate health care systems, access

Social Needs

- Downstream effects of inadequate social determinants of health, including:
  - Homelessness, housing insecurity
  - Lack of healthy food
  - Inadequate heat and light
  - Insufficient transportation
  - Financial strain
  - Unemployment
  - Social isolation
  - Safety needs

Health Equity

Health Equity is where all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling and rectifying historical and contemporary injustices.

Downstream Effects: Health outcomes

- People with social needs:
  - Obtain fewer preventive services
  - Use more emergency services
  - Have increased chronic health conditions
  - Have higher readmission rates
  - Have poorer health outcomes

(McKelvey, 2017; Meddings, 2017)

Addressing Social Needs Improves Outcomes and Reduces Costs

- Housing improvements (heating, ventilation) improve asthma and reduce health care costs.[1]
- Supportive housing for low-income elders reduces ED visits, unplanned hospitalizations and nursing home transfers.[2] It also reduces overall health care expenditures, primarily through lower ED and inpatient care costs.[3]
- Housing for chronically homeless with severe alcohol problems decreased total health care spending 53%.[4]

(1) Barton, 2007; Edwards, 2011; Garland, 2013
(2) Castle, 2014
(3) Wright, 2016; Gusmano, 2018; Counsell, 2008
(4) Larimer, 2009

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Opportunity Costs

- 1 ED Visit = 1 months rent
- 2 hospitalizations = 1 year of child care
- 20 MRIs = 1 social worker per year
- 60 echocardiograms = 1 public school teacher per year

SGIM Presidential Speech, Dr. Moran, 2015

Poll: What do you think are the top 3-4 social needs in your region?

Prevalence of Social Needs- United States

- Social needs are highly prevalent in U.S.
  - 39% of families experience or worry about food insecurity
  - 38% experience stress over social relationship needs
  - 35% experience stress over meeting housing needs
  - 32% experience stress over transportation needs

Top 4 most common U.S. needs

-Kaiser Permanente Research: Social Needs in America, June 4, 2019

Prevalence of Social Needs- United States

- Low income is the root cause of many social needs:
    - 13% of Americans would need to reduce food costs to meet a $500 emergency expense

-Kaiser Permanente Research: Social Needs in America, June 4, 2019

Community Resources- United States

Americans with social needs:

- 39% are not confident that they could identify the best community resource for their needs.
- 42% would turn to medical providers for help on community resources (3rd most common approach after internet search and friends/family)
- 80% of Americans would find it helpful for their medical provider to share information on community resources

-Kaiser Permanente Research: Social Needs in America, June 4, 2019

Social Needs in Oregon

Accountable Health Communities Project- Since 2018

- Screens Medicaid and Medicare beneficiaries to understand social needs: housing, food, utilities, transportation, safety
- Provides patients with information about social service agencies
- Provides referrals to social services through Community Information Exchange (some locations)
- Provides high risk patients help from a patient navigator to access services
- Documents needs in medical record for provider use

Oregon AHC Partners

- First systematic effort in the State of Oregon to document disparities in social needs
    - 9 CCOs
    - Centralized telephone and text screening for 4 CCOs, 13 emergency departments, and numerous clinics
    - In person screening has occurred in about 50 primary care and dental clinics

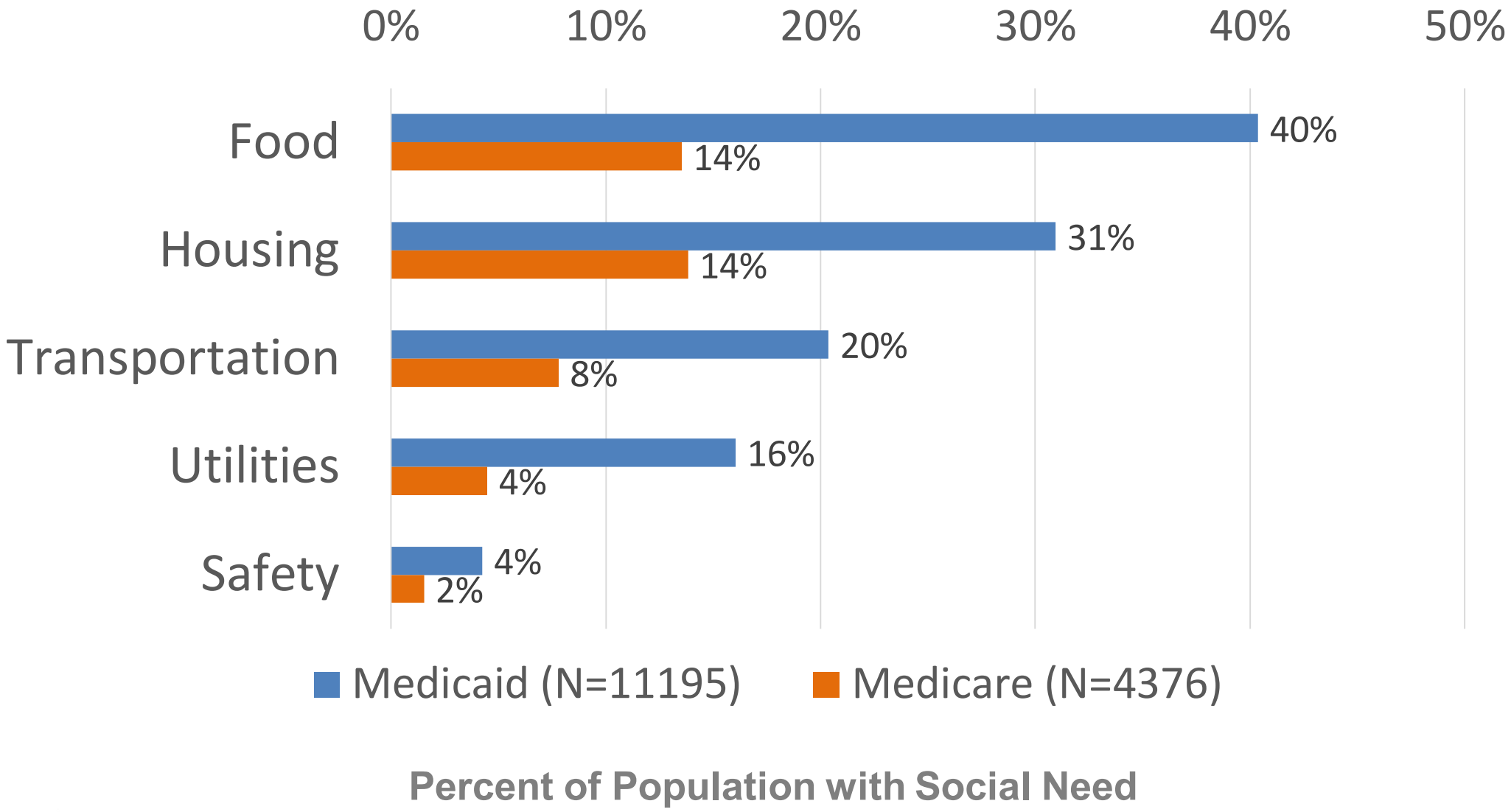
Navigation to Social Services

- All patients with needs get list of social services.
- Patients with more complex needs are offered help from a patient navigator to connect with services.
- Navigators are community health workers, social workers, care coordinators, case workers.

Social Needs in Oregon

- Approx. 20,000 Medicaid and Medicare members screened since 1/1/18
- Analysis of statewide data (through 2/25/21):
  - 55% of Medicaid members report a social need (N=6,204/11,179)
  - 24% of Medicare members report a social need (N=1,076/4,392)

Needs of Populations Screened (as of 2/25/21)



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Changes Since COVID-19

Percent with Social Needs:
Before & after "stay at home" order

	Before		After
Medicaid (N=11,195)	48%	→	63%
Medicare N=(4,376)	22%	→	29%

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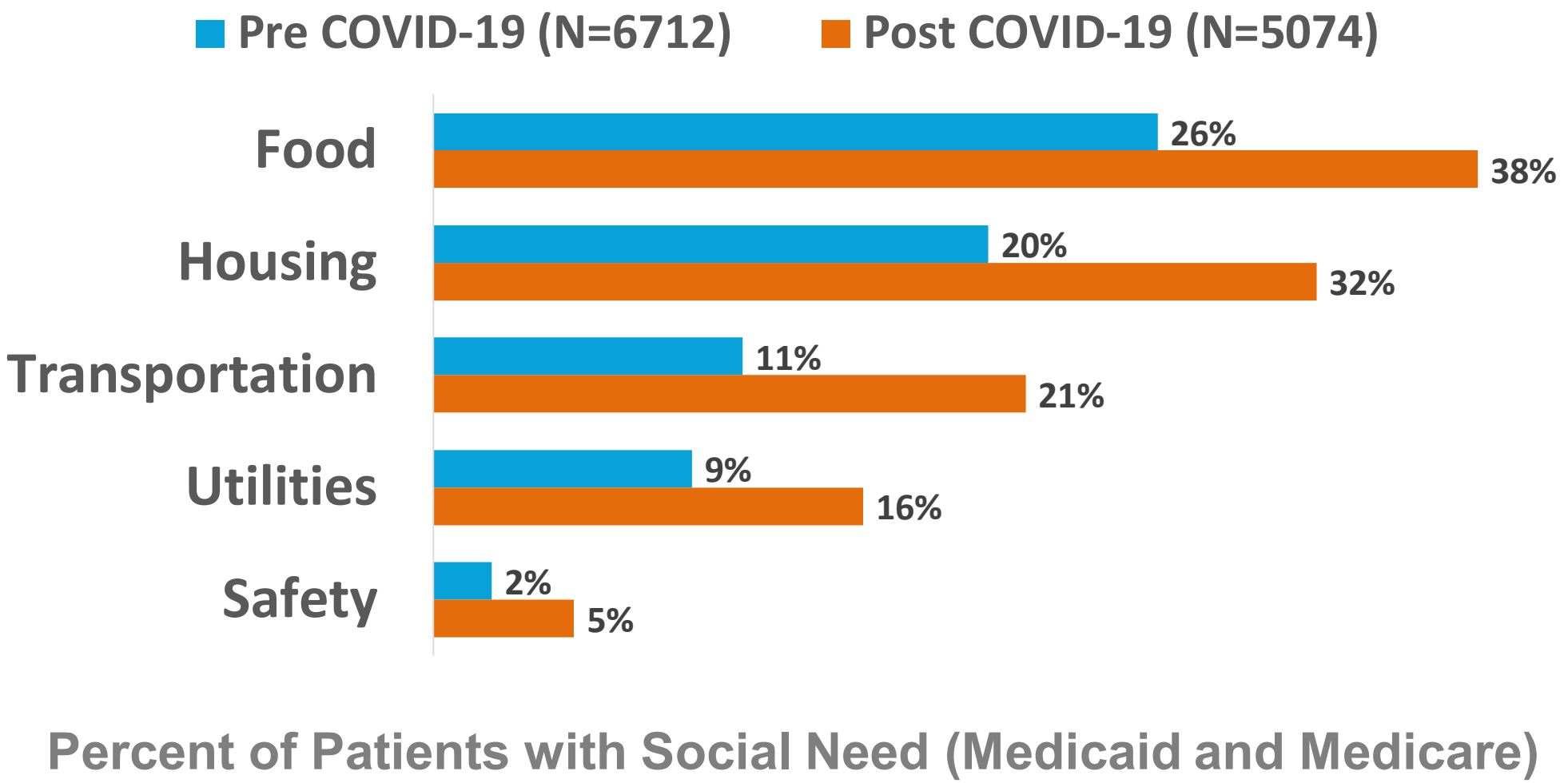
Unmet Needs in Hispanic Population



- March Analysis: Pre-COVID-19 March 22, 2020, Post-COVID-19 March 23, 2020

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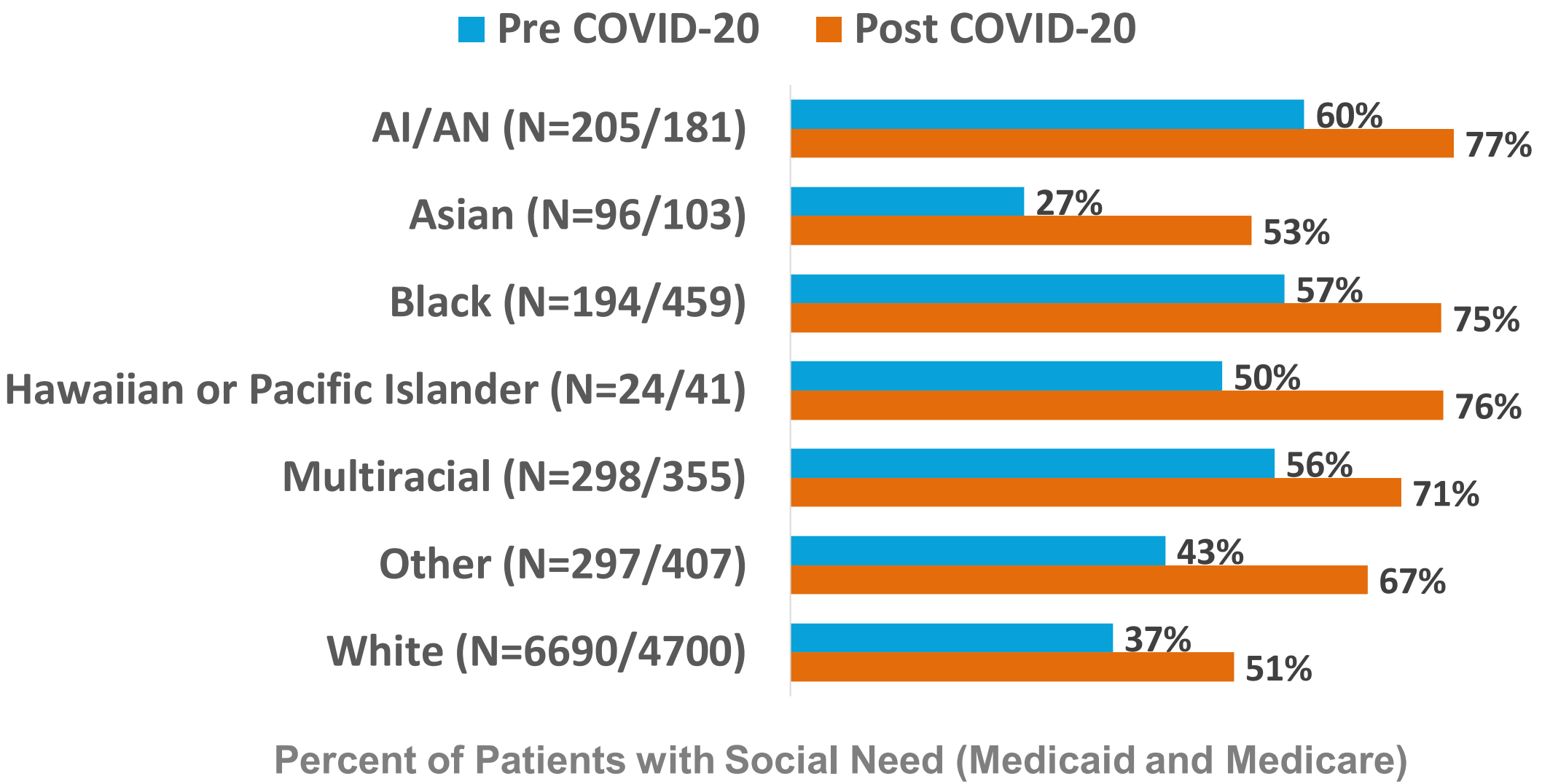
Disparities – Unmet needs by Race



- March Analysis: Pre-COVID-19 March 22, 2020, Post-COVID-19 March 23, 2020

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Breakouts

- In your breakout rooms, share:
  1. Your name and CAC
  2. Which social and health equity needs are prioritized in your Community Health Improvement Plans?
  3. What have you done to address those needs?
     Or, if you are just beginning to work on them, what do you plan to do?

- You will be automatically placed in a breakout room.

What did you learn?

Why are CACs so critical to SDOH-HE work?

Levers to Address SDOH and Social Needs

- Social Needs Screening Metric
- Health-Related Services
- Supporting Health for All through Reinvestment (SHARE) investments

SDOH Screening Metric

SDOH Screening Metric

- Goal to develop an Incentive Measure concept for CCOs that is equitable, and trauma-informed
- Over the past year:
  - Internal OHA metric workgroup
  - Public SDOH Screening Metrics Workgroups

SDOH Screening Metric

- Outcome was a recommended metric:
  - "Rate of social needs screening in the total member population using any qualifying data source"
  - Domains: food insecurity, housing insecurity, transportation needs
  - Goal is for CCOs to identify and coordinate services for members with social needs in these domains
  - Currently being piloted by CCOs

SDOH Screening Metric

Year 1: Structural

- Establish policies, and protocols to avoid unnecessary rescreening
- Identify screening tools
- Enter into agreement with at least one CBO in each of the 3 domains

Year 2: Implementation

- Rate 1: The percentage of CCO members screened for all of the three required domains (from a sample)
- Rate 2: Of the sample population screened, the percent of CCO members with a positive screen

Year 3: Implementation

- Rate 3: Of the CCO members with an identified need, those who received a referral to services (referrals made.)

What's Next

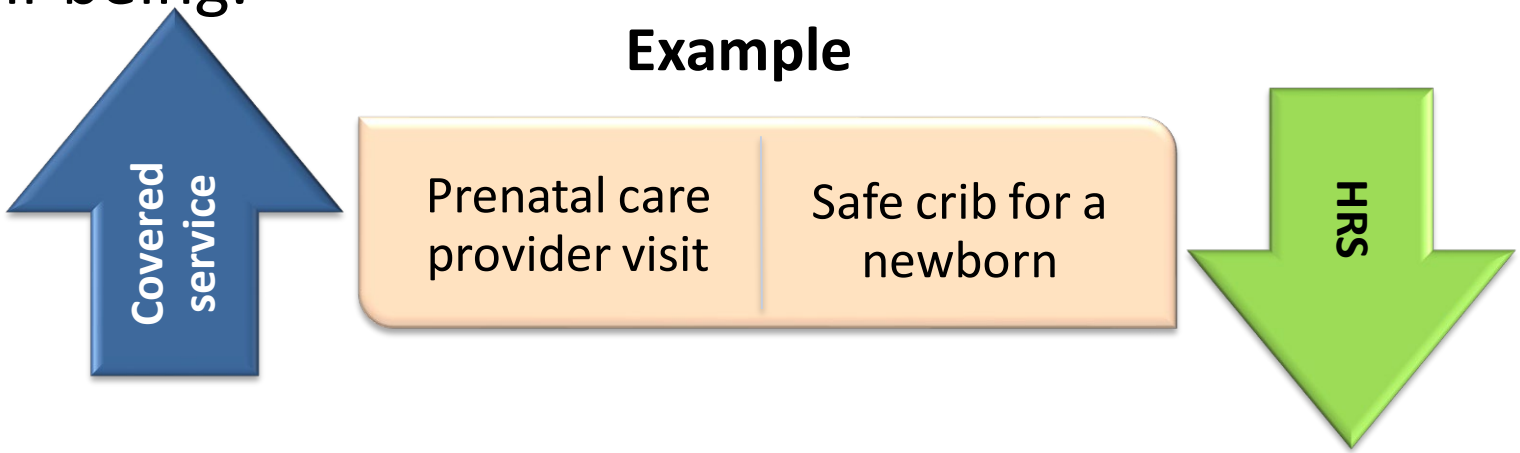
- Results of pilot to Metrics and Scoring Committee in the summer
- Final decision about inclusion as a CCO metric is made by the Health Plan Quality Metrics Committee

- What can CAC members do?
  - Wait and see for now

Health-Related Services (HRS)

Oregon's 1115 Medicaid Waiver

Oregon's 1115 waiver allows CCOs to provide "Health-Related Services (HRS)" which are services beyond members' covered benefits to improve care delivery and support overall member and community health and well-being.



More details in CMS definitions and Oregon Administrative Rules:
45 CFR 158.150 and 45 CFR 158.151 / OAR 410-141-3845

Requirements of Health-Related Services

Must be designed to:

- Improve health quality
- Improve health outcomes
- Focus on enrollees or population beyond at no additional cost
- Be evidence-based

(45 CFR 158.150)

Types of Health-Related Services

Flexible Services

- Member-level interventions
- Focused on improving member health
- Cost effective
- Supplements covered benefits

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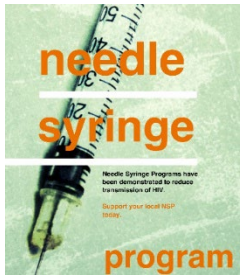
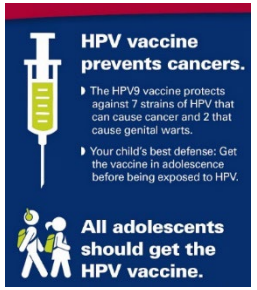
Community Benefit Initiatives

- Community-level interventions
- Focused on improving population and member health
- Includes HIT

NATIONAL SUICIDE PREVENTION LIFELINE™
1-800-273-TALK
www.suicidepreventionlifeline.org





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CCO Use of Health-Related Services

- CCOs can use their global budget to pay for health-related services; there is no other specific funding source for HRS.

- Decisions to use HRS to fund individual requests or to invest in programs is **at the discretion of the CCO.**

- CCOs are responsible for notifying members of refusal of a Flexible Service request (OAR 401-141-3845).

Allowable HRS Costs: SDOH-E

SDOH-E investments in these areas could be included as HRS:

- Access to banking/credit
- Access to healthy food
- Access to outdoors, parks
- Access to non-medical transportation
- Citizenship/immigration status
- Corrections
- Crime and violence
- Diaper security
- Discrimination
- Early childhood education and development
- Employment
- Environmental conditions
- Food security
- High school graduation and higher education enrollment
- Income
- Housing stability (including homelessness)
- Housing quality, availability and affordability
- Language and literacy
- Social integration
- Trauma

For more information see this SDOH and HRS guidance:
www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-SDOH-E-Guide.pdf

Allowable Housing Costs

HRS **can** pay for:

- Temporary housing for members with acute and immediate housing needs
  - For example, homeless, at risk of homelessness, homeless and recovering from illness

- Housing services and supports:
  - Pre-tenancy services to help members get stable housing
  - Tenancy-sustaining services to help members stay in stable housing

HRS **cannot** pay for:

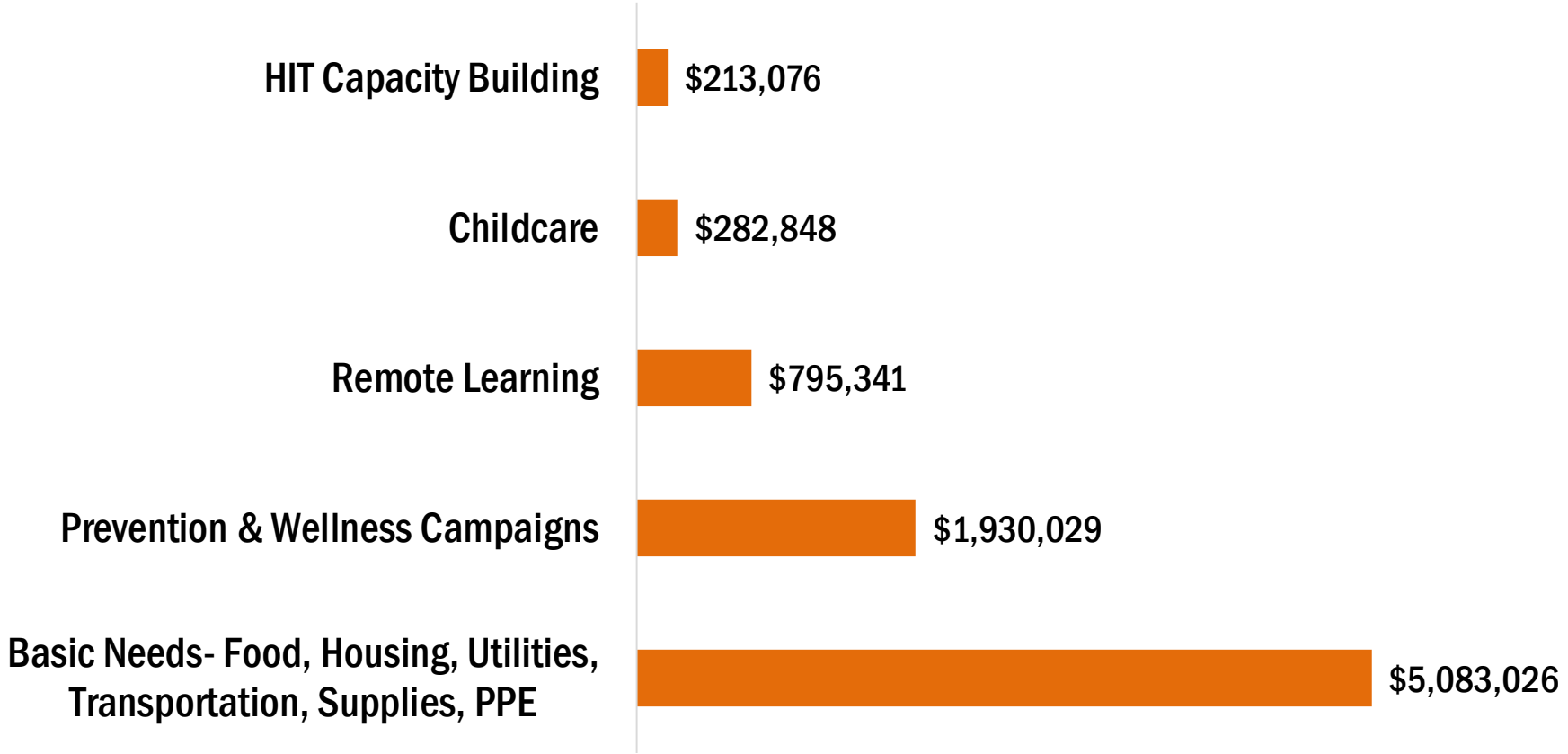
- Bricks and mortar: No new building construction, rooms, or other capital expenses.
- Long-term housing: No ongoing housing costs
- Housing **not** associated with a crisis intervention, stabilization and/or transition for a patient.

For more information see this HRS and housing guidance:
www.oregon.gov/oha/HPA/dsi-tc/Documents/Health-Related-Services-Guide-Housing.pdf

HRS for Resilience and Rebuilding*

$8,304,321 was spent on COVID relief.

61% of COVID support reported was for basic needs, such as food, housing, utilities, transportation, personal supplies.



**Spending has not yet been reviewed by OHA to ensure it meets HRS criteria. Final spending analysis to be available by early fall 2021.*

Role for CACs to Address SDOH-HE in HRS

- Identify community SDOH-HE needs and address them in Community Health Improvement Plans
- Share findings with CCO to support HRS strategy
- Help document positive outcomes of HRS Community Benefit Initiative investments

Supporting Health for All through Reinvestment (SHARE)

About SHARE

- Came about through House Bill 4018 in 2018
- Requires CCOs to spend part of profits in their communities to address health inequities and social determinants of Health and Equity
- 2020 amounts determined by CCOs
  - Determined by September
  - Spent by roughly 9/2023
- CACs have a role in spending decisions- this role is determined by the CCO and may be different from CCO to CCO

SHARE Requirements

- Spending in housing and in four SDOH-E domains:

Domains	Examples
Economic stability	Income, employment, food security, childcare, stable housing
Neighborhood and built environment	Access to healthy food, transportation, housing availability, crime and violence
Education	Early childhood, language and literacy, high school graduation, enrollment in higher education
Social and community health	Civic engagement, discrimination, corrections, trauma

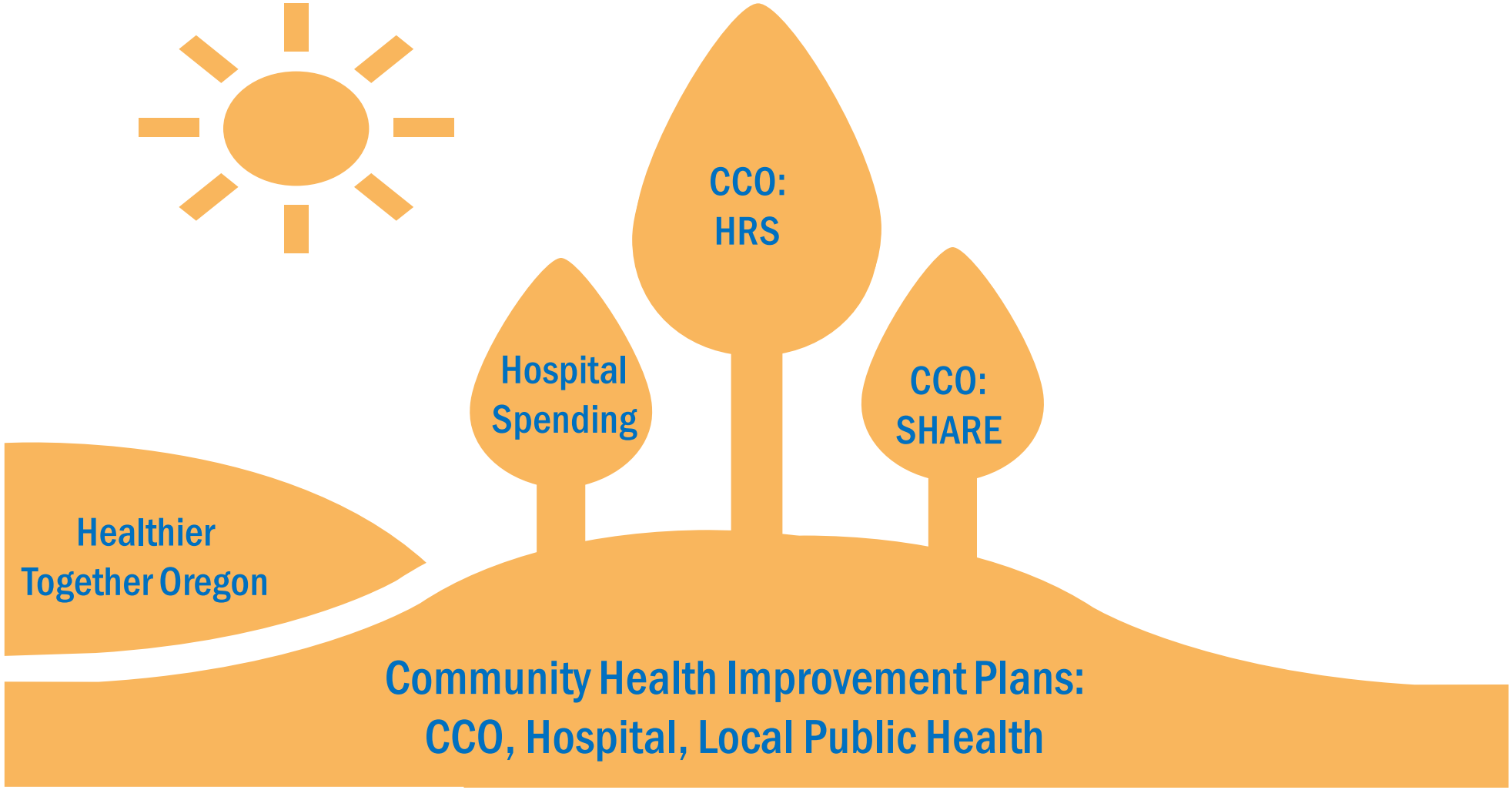
Opportunities

- Fewer restrictions than HRS
- Focus on SDOH-HE
- Opportunities for combining funding from different sources to achieve what cannot be done with HRS alone
  - Example- Partner with a housing agency to transform a motel into housing units for members with SUD and homelessness. Use HRS to provide supportive services to help members sustain their housing.

Role for CACs to Address SDOH-HE through SHARE

- Partner with CCO around SHARE decisions
  - Help to identify community SDOH-HE needs and inform strategy
- Help document outcomes of SHARE investments

Landscape- Role of CACs



Thank you

Anne King
kinga@ohsu.edu

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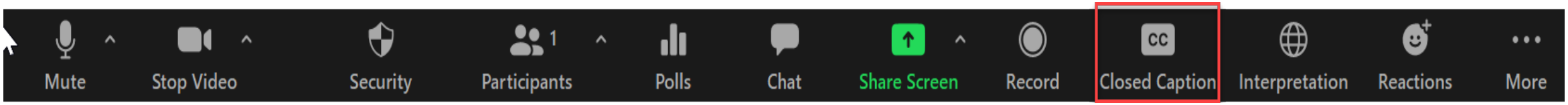

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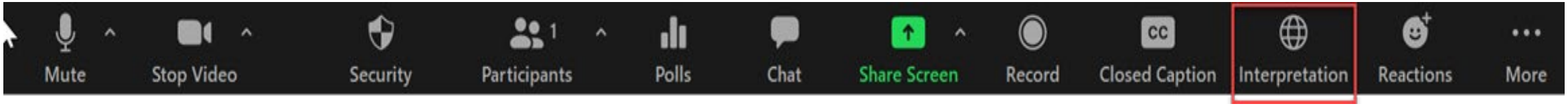

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10:05–10:30	Break
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Noon–1	**Breakout: CAC member governing board experiences**

Oregon Health Authority

Panel: COVID-19 and CACs

9–9:50 a.m.

Learning Objectives

Participants will learn about the different ways CACs have been involved in the COVID-19 response, including opportunities for future action.

Jackson Care Connect

Community Advisory Council

CAC Conference June 9th, 2021

George Adams
Don Bruland
John Curtis

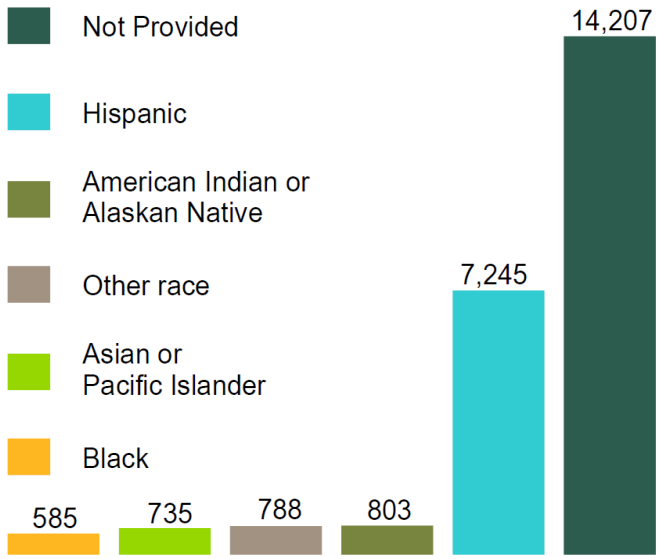
jacksoncareconnect.org
facebook.com/jacksoncareconnect

Jackson Care Connect™

JCC Member Demographics

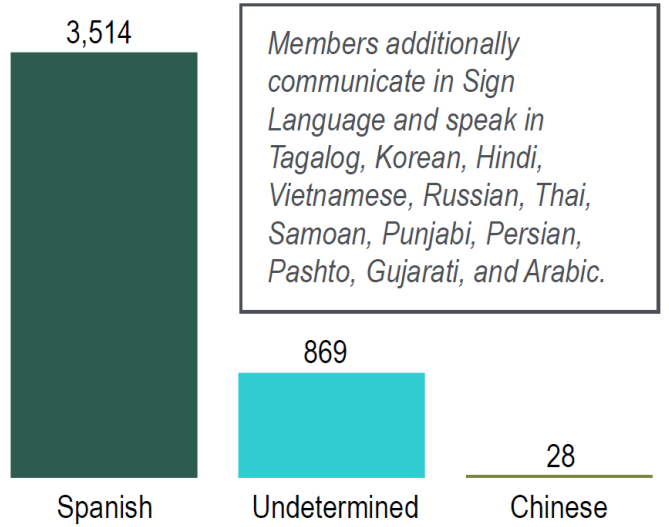
Total Membership: 54,000+

Race/Ethnicity: ***55%*** *of Jackson Care Connect members identify as white. Data below are the other ethnicities that members identify as.*



Racial groups are presented at the highest level of aggregation. However, this can cause racial/ethnic groups to appear homogeneous and obscure variations within the group.

Language: ***92%*** *of members speak English as their primary language. The next most common languages are Spanish and Chinese dialects.*



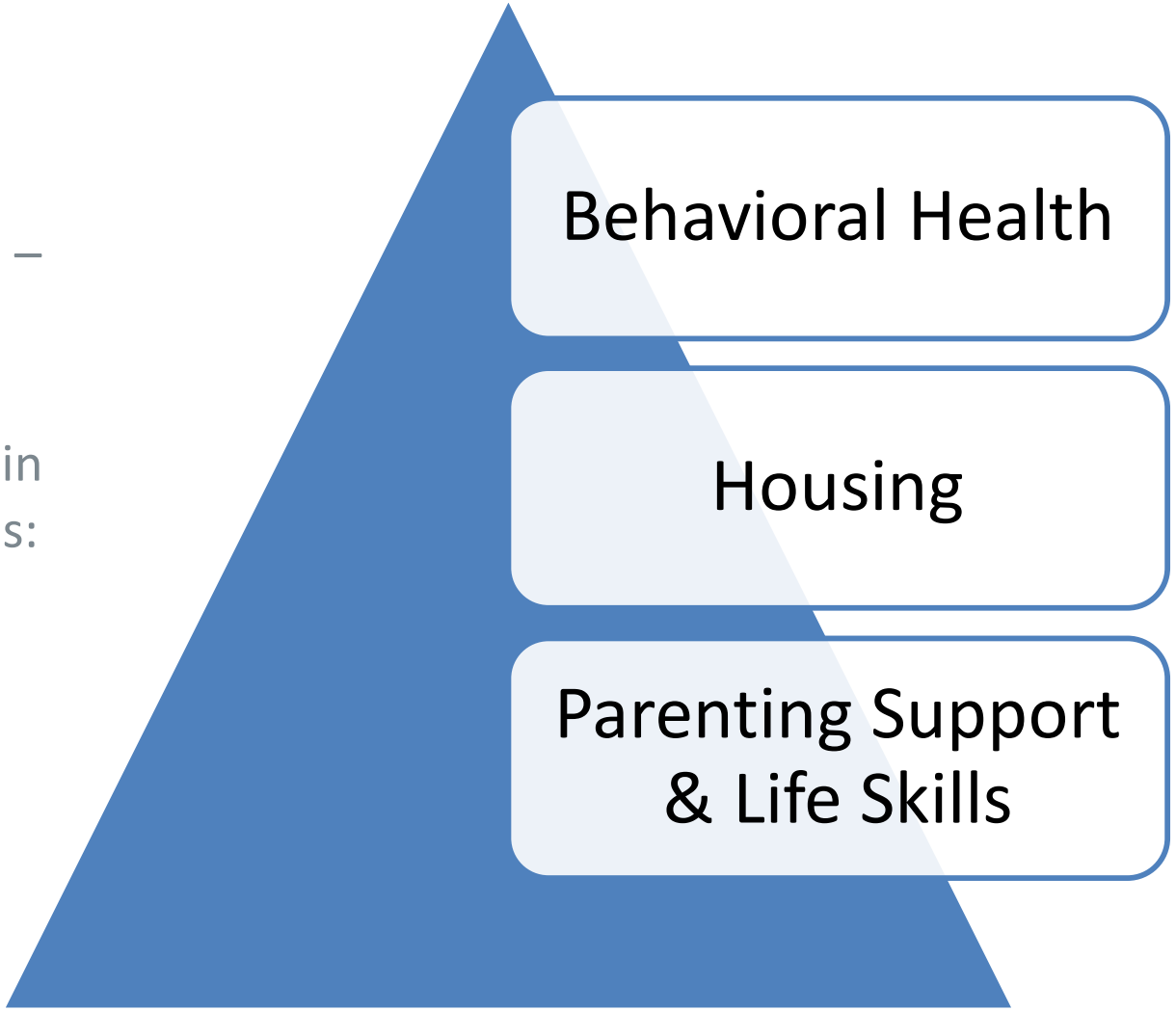
Members additionally communicate in Sign Language and speak in Tagalog, Korean, Hindi, Vietnamese, Russian, Thai, Samoan, Punjabi, Persian, Pashto, Gujarati, and Arabic.

CAC Makeup -12 members

- George Adams
- Rich Rohde
- Lisa Collins
- Jennifer Bethany
- Jackson Baures
- Barrett Gifford
- Don Bruland
- John Curtis
- Diana Alfaro Soto
- Chelsea Reinhart
- Jacquie Jaquette
- Craig Newton

Community Health Improvement Plan

- Participation in Community Health Assessment 2018
- Our CAC was very involved in the development of the CHIP – this has helped guide our funding decisions
- CAC continues to participate in CHIP workgroup priority areas: 2019 - present



Emergency Funding – COVID 19 and Wildfire Relief

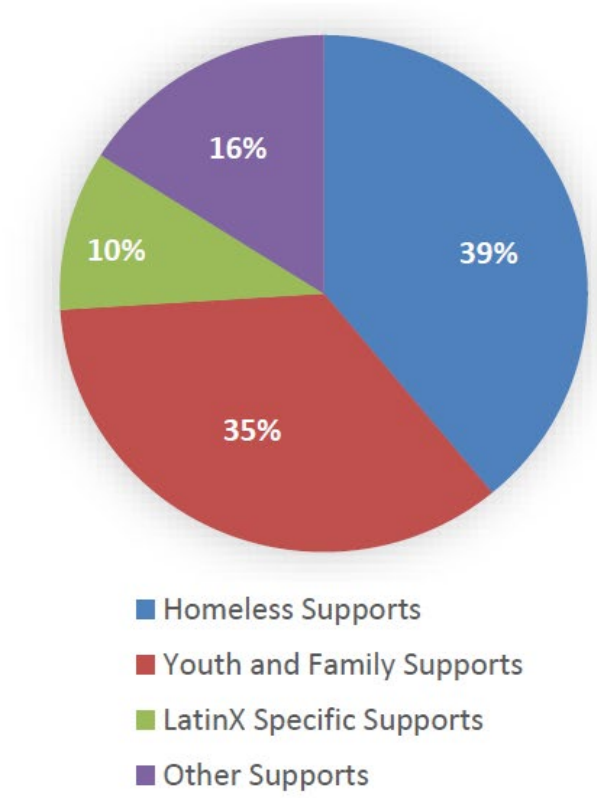
JCC's Community Advisory Council (CAC) played a critical role in reviewing funding applications and directing social determinants of health (SDOH) and health equity investments. Member voice ensured SDOH spending aligned with JCC's mission and vision and the priorities of our Community Health Improvement Plan. The funding process was inclusive and consumer informed, and the CAC guided the decision-making.

- Equity was priority
- Funding direct support for people
  - Food
  - Housing
- Impact on organizations
  - Lost of funding due to COVID 19
  - Supporting agencies that addressed Social Determinants of Heath

COVID 19 Funding Summary

JCC allocated emergency COVID-19 relief funding to the following organizations:

- Ashland Family YMCA
- Butte Falls Community Partnership*
- College Dreams*
- Greenway Project
- Hearts with a Mission*
- Jackson County Mental Health*
- Listo*
- Options for Helping Residents of Ashland*
- Rebuilding Together Rogue Valley*
- Rogue Retreat
- Rogue Valley Family YMCA
- Rogue Valley Mentoring*
- Southern Oregon Consumer Credit Counseling*
- Southern Oregon Health Equity Coalition (SO Health-E)*
- St. Vincent de Paul*
- Unete: Center for Farm Worker Advocacy*
- United Way*



Jackson Care Connect (JCC) allocated more than $378,000 in emergency COVID-19 relief funding to immediately benefit our community amid the coronavirus outbreak.

Disaster Recovery and Resiliency

Wildfire Impact

2549 Homes were lost in the Almeda fire

More than 100 business lost

3,559 members living in Phoenix and Talent

Significant number of providers displaced and many lost homes

Wildfire Relief Funding Summary

- Habitat for Humanity
- Rogue Valley Council of Governments
- Maslow Project
- St. Vincent De Paul
- Consumer Credit Counseling of Southern Oregon
- United Way
- Phoenix Talent School District

- **We have awarded $200,000**

Questions?

Break: 9:50–10:30 a.m.

Optional mindfulness activity:
9:50–10:05 a.m.

Panel: CAC sharing of community health improvement plan projects:
10:30-11:30 a.m.

Panel: CAC sharing of community health improvement plan projects:

10:30–11:30 a.m.

Oregon Health Authority

Learning Objectives

- Learn how CAC members have been involved in Community Health Improvement Plan (CHP) work/projects
- Hear examples of different funded CHP projects across the state
- Learn how CACs are using their CHPs to make an impact in their communities

AllCare's CHIP-Aligned CBI Projects:

Protein Bucks and Mobile Outreach

Sarah Kaplansky, Curry Council Chair &
AllCare Board of Governors

Beth Barker-Hidalgo, Curry Council Vice-Chair

Council voice in HRS spending

- The importance of Community Advisory Council voice in Health-Related Spending

Farmer's Market Protein Bucks

- SNAP Match provides food stamp recipients a financial match up to $10 per market day which increases their purchasing power for accessing fresh and healthy foods.
- With Protein Bucks, people with food stamps can spend the extra Match dollars on either produce or protein.
- Noting the absence of protein in diets, particularly for seniors on food stamps, led to the creation of this program – a pilot in the state.

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Protein Bucks

- The Farmers' Market manager identified the need and brought it to our Council. The Council readily approved the shift in funding to start the pilot project.
- Matching SNAP benefits can give a family up to $80 extra in their food budget. This is calculated by each Food Stamp recipient taking $10 of their SNAP money and having an extra $10 to match using the grant money provided. Several families come in every week during the 8 market days per month to get the extra money. We have seen an increase in new families using the program due to COVID-19.

Mobile Outreach

- This project delivers mobile housing support services to homeless and at-risk individuals in Curry County. The mobile model meets people where they are - literally - and offers a wide array of services directly and through community partnerships. Direct services include: tents, tarps, food, sleeping bags, clothing, laundry, and showers. Partners services include assistor navigation, referrals, STI screening and prevention.

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Mobile Outreach

- Council member Beth Barker-Hidalgo is the ED for Curry County Homeless Coalition. She brought the plan to the Council and abstained from voting.
- The van can support vaccine roll-out to our hard to reach community members, following OHA's vaccine sequencing plan. Mobile Outreach meets people where they are, delivering services with dignity and with trauma informed techniques proven to be more engaging for the target population.
- Over 400 hot meals served to unsheltered and non-congregate shelter community members, supported 9 COVID-19 impacted households with wrap around services, isolation and quarantine client services between 01/01/21 & 03/17/21, and conducted approximately 170 COVID-19 tests throughout Curry County.

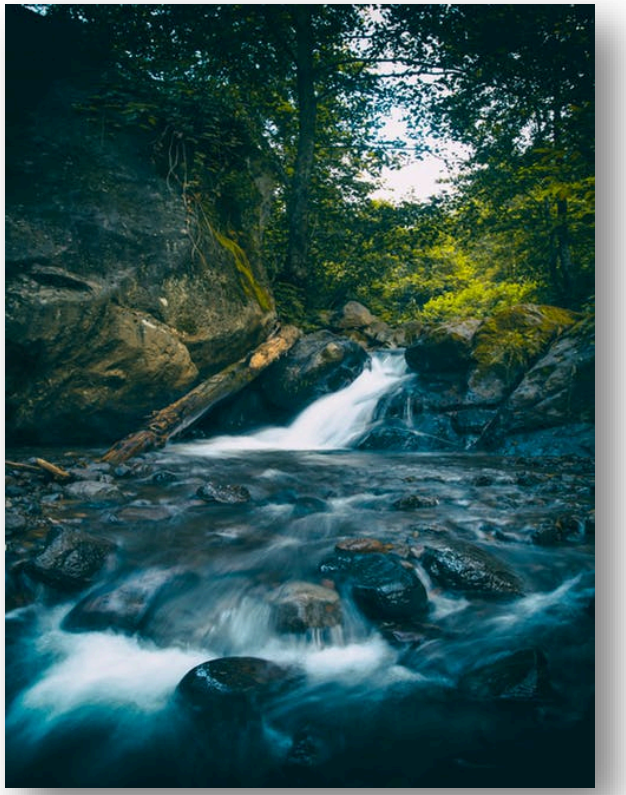

Certified
B

Lane County CAC Prevention Projects

Presented by:
Tara DaVee
Lane Community Advisory Council

Prevention in Lane County

- Prevention model is truly collaborative both in funding and decision-making
- Both Lane County CCOs invest in primary, upstream prevention, steered by the CAC
    - Trillium since 2012
    - Pacific Source since 2020
- Roughly $1.33 per member, per month (PMPM)
    - Funds LC Public Health staff
    - Funds evidence-based programs



Prevention Strategies

- Each strategy is recommended to the CAC by the Prevention Workgroup, a subcommittee of the CAC
    - 6-8 CAC members on Prevention Workgroup
- Prevention strategies target environments/behaviors that lead to most costly and most prevalent health conditions
    - Tobacco use, healthy lifestyle, and mental health promotion
- Strategies are aligned with CHP priorities and strategies
    - Ex: support policies promoting healthy behaviors, ensure access to basic needs across the lifespan

Trillium Community Health Plan

PacificSource Community Solutions

Lane County Oregon PUBLIC HEALTH PREVENT. PROMOTE. PROTECT.

Quit Tobacco in Pregnancy (QTiP)

- Prenatal & postpartum quit coaching and resources
- Clients can build trust, rapport with the dedicated QTiP staff
- "Graduated" incentives (gift cards + baby gifts) for participation and based on quit status
- Measures CO_2 levels
- Partner with Lane County WIC

Mental Health Supports for Families: Triple P (Positive Parenting Program)

- Collaborative approach to implementation
- Universal parenting campaign
- In-person and virtual discussion groups
- Online parenting modules
- Improves parenting skills, decrease stress

Food Security Projects

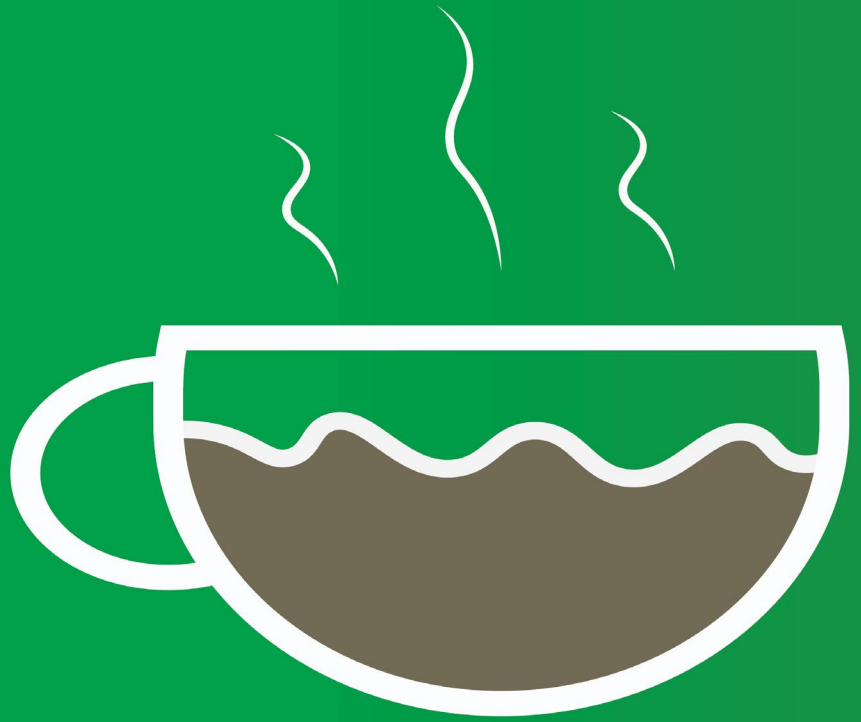
- Prevention funds are used for evidence-based programs, but the CAC is flexible when urgent community needs arise
  - In 2021, CAC Prevention group opted to allocate carry-forward funds to address food security, targeting rural communities, BIPOC, people with disabilities
- Food For Lane County & The Arc: supports small and rural pantries, establishes Hunger Response Network
- Cornerstone Community Housing: pantry and emergency food boxes for residents
- SNAP Match at markets and farm stands; piloting a $20 match

FOOD For Lane County

The Arc Lane County

CORNERSTONE COMMUNITY HOUSING

WILLAMETTE FARM & FOOD



Break Time

11:30 a.m.-noon

CAC Governing Board Member Experiences

Noon-1 p.m.

Nancy Goff, Principal, Nancy Goff & Associates

Debbie Morrow, CAC governing board member, Columbia Pacific CCO

Linda Johnson, CAC governing board member, Central Oregon Health Council

Candy Rosenberg, CAC governing board member, AllCare CCO

Caity Hatteras, CAC governing board member, Trillium Community Health Plan

Oregon Health Authority

Process & Participants

- Gathered perspectives from twelve CAC members that also sit on their CCO governing boards in May 2021
    - Seven interviews & five survey responses
- Included people from at least six different CCOs, representing 50% of all CCOs
- Four participants had recently participated in the related Learning Collaborative hosted by the Transformation Center
- Participants had a range of experience on CCO boards– from brand new to >6 years experience

Responsibilities of CAC members serving on CCO governing boards

- Attend meetings
- Review materials between meetings
- Liaison between CCO board & CAC; share reports at board meetings
- Review grant proposals
- Participate on subcommittees
- Raise awareness about the board in the community, and share contact information

CCO governing boards are very diverse!

- Across CCOs, boards vary greatly in their structure and practices
- Diversity within boards is twofold– when all perspectives are valued it can make a richer experience, but when boards are not intentional or facilitated it can cause issues

Game Show!

What are the characteristics that make CCO governing boards and their CAC members successful?

- Strong relationships within the board
- Strong connection to community
- CCO staff availability for technical assistance
- Board culture of trust and respect
- Dedicated time for important conversations
- Inviting all members perspectives in an authentic/meaningful way
- Ample time for agenda items and decisions

How to improve CCO governing board and CAC member success

- New member orientation and training that includes written CCO board procedures/policies and additional resources
- Form a board subcommittee for recruitment and onboarding
- Clear goals for meetings that connect with larger CCO goal of the Triple Aim
- CCO governing board meeting agendas include a set standing agenda time for CAC updates and public comments, ideally at both the beginning and end of meetings
- Ask for input on decisions in an authentic way– on things that have not already been decided
- The CCO board is accessible to consumers and visible in the community (e.g., contact information on website)
- Make a plan for communicating Board decisions to the community

What are some of the reasons CAC members on CCO governing boards don't engage?

- Unsure of their role
- They have not been invited to speak
- They feel less "professional" than other members
- Fear of retaliation for speaking up
- CAC/CCO Board relationship is confusing
- They are aware of uneven power dynamics
- Decisions have already been made
- They don't fully understand the policy language, system or acronyms
- Worried about misrepresenting consumer views
- Don't know the other people on the board

How to improve Board member engagement

- Clarity on roles & goals, including:
  - More clear roles and expectations for consumer board members, from both CCOs and OHA
  - More clarity on CCO and CAC relationship
- Lengthen term of service, as time served increases Board comfort
- Be intentional about strategies to be inclusive
- Orient new members prior to attending first meeting
- Explain acronyms
- Provide organizational chart and member bios
- Define scope of board work, what they do and don't do
- Allow ample time for people to speak at meetings

What have you enjoyed most about your CCO Board experience?

- Feeling that we are actually helping people and impacting lives
- Getting more connected to the community
- Having input into grant funding spending decisions
- Getting to know board members that are different from me
- Bringing information back to the CAC
- Representing consumer needs that would otherwise be invisible
- Connecting with OHA's larger vision and the broader health system

How to ensure the experience is enjoyable for Board members

- Education could be ongoing– not a one-time thing
- Consider a peer Board "buddy" or mentor
- Have personal zoom meetings for onboarding
- Scheduling meeting at times that people can attend and let them know in advance when the meetings are
- Make agreements/ground rules for participation and reinforce them
- Build relationships & trust over time through consistency in respectful practices
- Create a friendly and welcoming environment
- Make it fun! (e.g., have icebreakers)

Summary of recommendations

1: Provide clarity on roles and goals

2: Integrate consumer voices in a meaningful way

3: Training and onboarding

4: Efficient and effective meetings

From what you've learned today, what are the next steps for you?

Questions?

Additional resources

Slides from this presentation will be available from the Transformation Center

Resources from other CCOs, like onboarding handbooks

CAC Governing Board member Learning Collaborative slides, include:

- Characteristics of high-functioning governing boards
- Summary of OHA requirements
- Tips for crafting effective messages
- Overview of CCO governance structures
- Health equity & elevating consumer voice

Contact information

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Candy Rosenberg netcandy@gmail.com
Caity Hatteras chatteras@icloud.com

Next Steps

- Complete the 2021-2022 **CAC member need's assessment survey**: https://www.surveymonkey.com/r/9P9KZFM
- Provide input on **OHA's 1115 Medicaid Waiver**:
  - View an intro video on the waiver process: https://www.youtube.com/watch?v=YVxbVDntVIs
  - Attend the upcoming OHA Medicaid Advisory Committee Meeting (6/30/21, 9 a.m.-noon) to provide input

thank you!