*Lane Community Health Council is the governing board of PacificSource Community Solutions - Lane

Lane County Coordinated Care Organization Joint (CCO) Community Advisory Council (CAC)
Remote Meeting via Zoom
October 23, 2023
12 p.m. – 2 p.m.

CAC Members: Co-Chair Tannya Devorak (PacificSource OHP representative),Co-Chair Tara DaVee (Trillium OHP representative), Caity Hatteras (Trillium OHP representative), Carla Tazumal (Lane County Developmental Disability Services), Chris Hanson (Trillium Clinical Advisory Panel Liaison), Drake Ewbank (PacificSource OHP representative), Lana Gee-Gott (Lane Community Health Council Clinical Advisory Panel Liaison), Michelle Thurston (Trillium OHP representative), Silver Mogart (Trillium OHP representative), Todd Hamilton (Springfield Public Schools), Val Haynes (Head Start of Lane County), Isis Barone (PacificSource OHP representative), Sheila Wegener (Oregon Department of Human Services), and Mindy Bentley (Advantage Dental).

Attendees: Nena Hayes (Lane County public Health), Jacqueline Moreno (Lane County Public Health), Kayla Watford (Lane County Public Health), Marissa Lovell (Lane County Public Health), Sadie Baratta (Lane County Public Health), Lee Bliven II (Suicide Prevention of Coalition of Lane County), Leilani Brewer (PacificSource Community Solutions), Suzy Kropf (Lane Community Health Council), Debi Farr (Trillium Community Health Plan), Dominique Lopez-Stickney (Trillium Community Health Plan), Ailed Diaz (Trillium Community Health Plan), Dustin Zimmerman (Oregon Health Authority), Kristty Zamora-Polanco (Oregon Health Authority), Jeanne Savage (Trillium Community Health Plan), Kellie DeVore (PacificSource Community Solutions), Megan Romero (PacificSource Community Solutions), Katharine Ryan (PacificSource Community Solutions), Rhonda Busek (Lane Community Health Council), Lauriene Madrigal (Lane Community Health Council), Samantha Duncan (Be Your Best Cottage Grove, Health Hub), Stephanie Griffin (PacificSource), Matt Michel (City of Veneta), Jessica Weber (Trillium Community Health Plan), Genevieve Schaack (Willamette Farm and Food Coalition), David Butler (Lane Community Health Council Board), Lucy Zamarrelli (LaneCare), and Sequoia Kantara (training consultant).

Facilitator: Tannya Devorak, CAC Co-Chair **Support Person:** Nena Hayes

I. WELCOME & INTRODUCTIONS

a. Co-Chair Tannya Devorak opened the meeting at 12:00 p.m.
b. Members introduced themselves and noted their favorite dessert.
c. Devorak welcomed Nena Hayes as meeting support person.
d. **Public Comment**
    - There were no public comments submitted.

II. MEMBER APPROVALS

a. September Minutes
- **MOTION**: Michelle Thurston moved, seconded by Caity Hatteras to approve the September 2023 Joint CCO Community Advisory Council (CAC) meeting minutes.
- Tannya Devorak asked if there were any further discussion.
- *The motion passed unanimously*.

b. CAC Quarterly Summary
- **MOTION:** Michelle Thurston moved, seconded by Lana Gee-Gott to approve the CAC Quarterly Summary to be shared with the CCO Governing Board.
- Tannya Devorak asked if there were any further discussion.
- *The motion passed unanimously*.

c. CAC Charter
- The Co-Chair will hold their position for an agreed upon term between staff and each participating member. The Co-Chair may be nominated for reappointment for an additional term up to, two-consecutive years unless otherwise agreed upon by the CAC.
- **MOTION**: Caity Hatteras moved, seconded by Michelle Thurston to approve the CAC Charter amendments to be shared with the CCO Governing Board.
- Devorak asked if there were any further discussion.
- *The motion passed unanimously*.

d. CAC Co-Chair Term
- **MOTION**: Michelle Thurston moved, seconded by Lana Gee-Got to accept Tannya Devorak's Co-Chair term for six-months, to be redetermined after that six-month period.
- Devorak asked if there were any further discussion.
- *The motion passed unanimously.*

III. CAC PREVENTION WORKGROUP

a. Jacqueline Moreno shared updates on the Quit Tobacco in Pregnancy (QTiP) program, a program of the CAC's Health Promotion and Prevention Plan.
b. The Prevention Plan is overseen by the CAC and Prevention Workgroup. The Plan is developed in alignment with Lane County's Community Health Improvement Plan (CHP).

c. The portfolio of programs is made possible through an ongoing investment in prevention and public health by Lane Community Health Council and Trillium Community Health Plan.

d. QTIP is a graduated incentive program. Program participants must be pregnant and either still be smoking or have quit since learning they were pregnant. Those who enroll and are able to quit tobacco are eligible for gift cards, which increase in value and they receive services and coaching from a dedicated QTiP coordinator. The quit status is verified using a carbon monoxide breath test.

e. Since 2015, 800 clients have come through, with about 30% of those having completed the program. About 92% participants are referred through the Women, infants and Children (WIC) program. Demographic data has only been collected for a few years, of which most of the participants are white and about 3.5% are Native American.

f. Evaluation Goals:
- Increase the percentage of participants who abstain from smoking during pregnancy
- Reduce the number of drop-outs
- Improve pregnancy outcomes - low birth weights
- Reduce disparity in third-trimester tobacco use

g. Next Steps:
- Developing a Mobile Public Health partnership to assist rural communities in the South Lane and Florence areas.
- Expanding coaching services to include vaping and e-cigarette use.
- Re-branding or refreshing the program to be widely recognized by those who vape or use e-cigarettes.

h. Discussion
- Q: Are clients who would otherwise use nicotine encouraged to use other forms such as vaping? A: The message is to reduce the number of cigarettes or better yet, to abstain altogether. Coaches motivate and offer other types of coping mechanisms and pharmacotherapy.
- Would like to see partnerships with Community Benefit Organizations (CBOs) and other culturally specific partners to really make a difference.
- The QTiP coordinator is interested in partnering with Lane County's nursing home visitors that are working out of the family and child health programs.
- Q: Have there been any numbers that show an increase in the use of tobacco since the pandemic? A: Rates have actually been decreasing, but this could also be due to an increase in other products. Although the data on cannabis use in pregnant women is not part of QTiP, it is an ever evolving situation.

IV. BREAK

V. CCO FOLLOW-UP: SOCIAL DETERMINANTS OF HEALTH SOCIAL NEEDS SCREENING & REFERRAL PRACTICES

- **a.** Presented by Katharine Ryan at PacificSource and Ailed Diaz at Trillium Community Health Plan.
- **b.** There is a new metric that OHA created for the CCOs in 2023 related to screening for Social Determinants of Health (SDOH), non-medical needs that influence health outcomes.
- **c.** It is important to have systems in place to address the outcomes of screenings. Goal is to make sure policies are created to support successful screening and referral practices statewide.
- **d.** Phase One - meet with different groups and discuss the screening process and times, referrals to available community resources and sharing member information and data to improve care and services.
- **e.** Phase Two - discuss the screening process and how often, who should be screening, what should be considered in the screen and referral process and to gather feedback, which will help them when forming the policies relating to food, housing and transportation needs.

Members moved into breakout rooms to provide feedback on policy development (see appendix for notes).

The group came back together. Katharine and Ailed summarized next steps:

- **a.** A survey is available to collect any additional feedback (go to survey)
- **b.** Both CCOs will be finalizing policies before the end of the year.
- **c.** The CCOs will return next year to review and collect additional feedback as they work towards making screenings and referrals routine practice.

VI. UPDATES & ANNOUNCEMENTS

- **a.** Kayla Watford welcomed Sequoia Kantara, a training consultant supporting the development of a CAC training plan. They hope to receive feedback and offer the opportunity to help inform the development of a training curriculum.
- **b.** Kayla recapped the CAC's top training interests: trauma informed care, implicit bias, community engagement with priority populations, and advocacy.
- **c.** A three-part series was proposed, which would include:
    - Three, three-hour training sessions in 2024
    - Audience: CAC members, interested sub-committee members and CAC support staff
    - Virtual or hybrid settings available (to be determined by the group)
- **d.** The CAC Co-Chairs will meet with Sequoia on 10/27. Member are encouraged to share feedback and ideas to inform the CAC's training development by phone or email.
- **e.** Discussion

- It was noted that many CAC members have already been through most of these trainings and have been using these practices at the ground levels before they were even adopted within the CCO systems. The CAC includes sitting at the table with the people that could make the changes that those trainings are designed to implement. Interest in seeing the CCOs realize what is missing from their practices and implementation. This would include having outcome measures to see what is working and what is not.
- Staff recognized that this is a shared space with people at various knowledge and experience levels, as well as different audiences – those working in the community on policy change and systems change and those working within big healthcare systems. There is a lot of room to design this training to fit our needs.
- There was agreement about needing to meet the needs of various groups and individuals involved in the CAC. There was interest in finding ways to use the great advocacy and extensive knowledge of CAC members to support this process.
- Sequoia concluded by sharing that they would like to find a way for the trainings to feel meaningful and useful for everyone. They acknowledged the wide range of needs from within the group and expressed that they would love to try and create a way that the different people's needs can be met and also where they can create a collaborative space and those who have more skills, resources and knowledge can be part of the leadership of the group.

VII. BREATHING EXERCISE

CAC members took a moment to participate in a breathing exercise before the meeting was adjourned.

VIII. ADJOURNMENT

Tannya Devorak adjourned the meeting at 2:02 p.m.

Minutes recorded/transcribed by Trenay Ryan, Lane Council of Governments (LCOG).

Appendix

Main Breakout Room: Organizational representatives and guests

- ***What are your thoughts on securely sharing your information and data with members of your care team, or community-based organizations that might be able to provide services to help meet your needs?***
    - Making sure that member/client is aware of how their information will be shared, and have an awareness of the different areas that their information can be shared. Having a document that can be socialized amongst care providers that explains how data is collected and shared. This way questions can be answered if patients/clients have them.
    - Members can opt out of a closed loop referral. Connect Oregon (Unite Us) should be helping with this. Not all organizations are on the Connect Oregon network.
    - In regards to HIPPA, patients sign a HIPPA form, but if this is talking about social needs that affect your health, patients should know if/when they are referred for social services as well.
    - There is a consent form for Connect Oregon, that the providers have to read out to the patient so that the patient can consent in the process of being referred somewhere.
    - Main hesitancy in South Lane- takes time for these systems to be in effect, staff capacity is a concern for using these systems. Need more information about what can and can't be shared, need to have good procedure and policies in place between agencies of what can and can't be shared. Smaller facilities don't have the capacity to uphold.
- ***What things should the CCO think about when looking at REALD to make decisions about SDOH screenings and referrals?***
    - Individual needs may vary depending on how long someone has been in the country.
    - Using it as a data point to help make the decision, but not assuming English is the first language.
    - Cultural understanding/context is important to have when engaging with patients, not just assuming they understand something because it is translated into their language.
    - Materials that are created to explain the process in another language may not be culturally appropriate. Needs to be created by someone who is a native speaker or has cultural background.

- ***What are your thoughts about securely sharing your individual REALD data with other members of your care team, or community-based organizations so that you might be matched with a provider who can meet your SDOH needs?***
    - Vulnerability of citizenship status, there could be a concern of deportation for some families. A family may not want to share too much due to this concern. Some community partners have no earnest of this.

PacificSource Community Solutions Breakout Room, facilitated by Katharine Ryan

- **What are your thoughts on securely sharing your information and data with members of your care team, or CBOs that might be able to provide services to help meet your needs?**
    - Don't want to be treated differently than other patients, marked as 'needy'. Want the focus to be on offering/providing support, 'if you need these services' invites folks to access services if needed in situations where they may not feel comfortable sharing. How does the process support more universal screening for social needs?
    - When information like SSN is requested, make sure it's secure, it's different than information you share with your doctor and know that will stay within the health care system
    - Thinking about innovative service delivery that doesn't require people to go somewhere else to access a service that may or may not work for them
- **What things should the CCO think about when looking at REALD to make decisions about SDOH screenings and referrals?**
    - Differing perspectives on how this data can be used to both tokenize/call out certain groups in a negative way versus recognizing the social and cultural conditions that create inequities.
    - The resources that are available may not be the most helpful, or appropriate for the member
    - Concern about REALD being used to show that services are utilized by certain populations, as a way to focus negatively on this, target those populations for using resources
- **What are your thoughts about securely sharing your specific REALD data with other members of your care team, or community-based organizations so that you might be matched with a provider who can meet your SDOH needs?**
    - Preference for more direct connection to resources/program – like being able to get signed up for a program directly, rather than getting referred to a resource that then you have to go to, find out if you're eligible, sign up, address transportation/location, cultural match of resource, etc

- Culturally appropriate services are really important
- Don't want REALD info to be used in screening/to make a determination about need, want services to be matched to REALD but unclear about whether this information should be used directly in that process
- Ability to decline to include some/all REALD information for consideration
- Members will have different levels of comfort in what they share which would impact the screening outcome – how do we try to account for this?

Trillium Community Health Plan Breakout Room, facilitated by Ailed Diaz

	Item	Discussion
1	**What are your thoughts on securely sharing your information and data with members of your care team, or community-based organizations that might be able to provide services to help meet your needs?**	• This should be individualized by member. • If sharing with provider or CBO we need to gain consent from the member. • Patients receive massive amounts of calls from Medicare, for those members on both Medicare and Medicaid. At what point is it helpful versus an irritant? • Concerned about data leaks. What safety and security protections will be put into place? • Some members wouldn't want to share information about their situation in fear of a negative intervention. (DHS taking children, those who are undocumented, disabled) • We should share with provider, but no one else. • Not a one size fits all question. • Most members don't ask for help when needed even if they are involved in healthcare. They get information about services by word of mouth thru the community. • Can see the apprehension around sharing information due to legal repercussions. • Do what you say, follow up, send information when you say you are going to. This will build trust.
2	**What things should the CCO think about when looking at REALD to make decisions about SDOH screenings and referrals?**	• Know your audience • Those who aren't white might be more hesitant having someone ask about skin color. • It depends on what you are using it for. • Recommend doing breakout groups with other members to ask them. • Knowing the languages. In Somali the word disability doesn't exist.
3	**What are your thoughts about securely sharing your individual REALD data with other members of your care team, or community-based organizations so that you might be matched with a provider who can meet your SDOH needs?**	• Great use in many instances but could also be used to discriminate. Know your audience. • Make sure partners actually have DEI services. • Effecting care in a positive way, if this is what the member wants. • People might be scared of being judges. • Just because they have a disability, specific culture, or speak another language doesn't mean they want/need a special services. • Don't assume where people are from or what they need based solely on data.