Morrow County November 7, 2019 5:30 – 7:30 PM, Sage Center, Boardman	
Number of Attendees	27
List of Invitees	The Morrow County Local Community Advisory distribution list and identified community partners were invited. Additional invites were distributed by LCAC members and community partners upon request by EOCCO.
Summary of Outreach Efforts	EOCCO staff and LCAC partners implemented strategic communications efforts specifically developed to share information and drive community engagement regarding the CCO 2.0 community presentation series. **Regional Meeting:** EOCCO held a preview presentation and discussion regarding the community meeting series at the Region Community Advisory Council meeting in Baker City on September 25, 2019. Attendance at the RCAC was approximately 50 and included not only LCAC representation but also education partners including Early Learning Hubs and Head Start. Informational handouts in English and Spanish were distributed to attendees. **Invites/Flyers:** • Invites and informational materials were sent to LCAC and community partner contacts. EOCCO sent digital copies of informational materials, including an invite flyer, a frequently asked questions document, and a poster. • Flyers were distributed in the community. **Website/Social Media:** • A news article about the meeting — including an event registration link — was posted on www.eocco.com on September 26, 2019. • EOCCO website specialists developed meeting registration webpages for each meeting in the 12-county CCO service

	area. The link to this registration tool was included in outreach materials and was shared with invitees. • An article and registration link were shared in the social media community. **News media:** • EOCCO submitted news releases to outlets throughout the region. Locally, EOCCO submitted press releases to the East Oregonian, Hermiston Herald, Heppner Gazette-Times, and KOHU/KQFM radio. • An article was published in Northeast Oregon Now: https://northeastoregonnow.com/eocco-to-seek-input-from-public-on-future-of-local-health-care/
Summary of Public Input	Presenters: Sheree Smith, Troy Soenen, Mina Zarnegin, Kevin Campbell, Andrea Fletcher. EOCCO representatives opened the floor for input and public discussion. The following questions and comments were covered: **Provide clarity about the slide referring to a behavioral health plan by 2021.** Kevin Campbell, EOCCO, said each CCO not only has to have a Community Health Improvement Plan (CHIP) and Community Health Assessment (CHA); we must produce a discrete document called a behavioral health plan. It's a mandate. My preference is that it be integrated with the CHIP and CHA. It's a way of holding us accountable as CCOs to focus on the behavioral health system and moving outside of silos, moving away from the former "carve-out" system to a "carve-in." Many plans just sit on a shelf. We need to treat the CHIP and CHA, including the behavioral health portion, as a living, breathing document. An earlier slide focused on the ground up in each county moving toward the triple aim.

	A question for Moda focused on the website and available resources. The participant commended a staff member for helping her access documents, but asked whether the website will be improved for accessibility and to eliminate confusion. I found Moda to be extremely helpful for members, but I have a hard time drilling down into the Moda site to find materials for my clients. I consider myself lucky when I find content. I am not a provider and not a client. I am not able to find much, such as the safe sleep kit accessed through Moda. They can be scanned. Mina Zarnegin, EOCCO, explained: As part of the work we are doing for CCO 2.0, we are making the EOCCO website easier to navigate. I am working on keeping the provider and member pages more transparent. In the first quarter of next year, you will start to see changes. It is not an overhaul, but there will be better routing for members. For example, kids for cribs will have better placement. **The tobacco program from the state focuses on changing policy. I was confused and concerned with how Moda has their own method of treating tobacco dependence vs. the Oregon hotline. Will those things be integrated?** Zarnegin noted not being aware of integration. We do have different methods for the time being, based on what resources are available. **A healthcare professional asked EOCCO to summarize the differences between CCO 1.0 vs. CCO 2.0. Are those changes going to be a difference and will they continue to be a challenge?**

	Campbell discussed the administrative differences. It does not really matter to Oregon Health Plan members who the administrators of the plan are; GOBHI, Moda, etc. What matters is they are getting the highest quality of care with little red tape. That's a positive change. We got through 1.0 with the strong identity of Moda and GOBHI and a fairly weak identity for EOCCO. CCO 2.0 said you must be integrated. The website will be integrated. There are more administrative costs wrapped into accountability requirements. We are looking more like insurance companies with the risk-based requirements from the state. In real dollars, you take money statewide and put it in bank accounts in the name of having capital, rather than putting it out the community. Other things in CCO 2.0 include the partnership with public health. They have almost gone full circle in the last 5 years in modernization. In smaller counties, they continued providing services. Nurse home visiting is a godsend to the CCOs. The difference between a baby born premature and a healthy baby is crucial. Much of spending goes to a small portion of the population. LCACs and the energy from the member side are present. We can connect with providers. We can initiate whole person care with the high risk population to save money and reinvest in prevention. I believe the Oregon Health Plan could be doomed if we have to go through an RFP process every five years. Historically, there was not OHP rebidding, but the CCOs are required to rebid. **A local healthcare executive commended EOCCO for its unique achievements in Morrow County.** The community partner stated: I've been associated with EOCCO since its inception. I've always noticed and appreciated about this CCO the ability to listen to their partners. Not all CCOs around the

	state are like this. This is one to invest in the communities through what they take in from premiums because we hit certain targets – (this) is astonishing. You can see what they invested in Irrigon, Heppner, and Boardman. That has helped us as medical partners immensely. Morrow County Health District now has CARE coordinators; that was through the program that allowed us to do that. We can steer patients to the services they need. By the time they leave, with the EMR – they're going to have the directions they need. It's been a tremendous partnership and thank you for listening to us. At the board table, everybody has the same amount of votes. **Will parenting classes be offered beyond the 0-5 age range and what will that look like? Will there be courses for the raising of teenagers? Head Start and similar services stop at age 5.** Campbell said we invest in Triple P (Positive Parenting Program). Parenting classes need to be part of a healthcare curriculum for adolescents. The reality is that we tend to not have an ongoing presence in people's lives. We tend to not take a public health approach to this. We think episodically. So, it is important for kids to be informed what parenting is like and what benefits or resources are available. It must be available to the whole community, not just OHP. School-based health clinics, etc. are investments that need to be supported. This should be brought to the LCAC and clinical advisory panel level. It takes a village to raise a child. There are more difficulties with adolescents. That is an issue to which we need to pay more attention. **CCO 2.0 Committee Structure:**

	On slide 17 about behavioral health integration: The last bullet point that was talked about was the behavioral health plan. Does that tie back to what we have stated on page 14, where we talk about the committee structure? The participant stated: Morrow County has done well at what has been done. Seeing new committees, will those new structures help us meet the requirements of developing a behavioral health plan? I hope we don't undo the progress we've made. Those who have drug and alcohol problems today desperately want for life to change, but it doesn't ever seem to happen. I have ideas; some will respond and some won't. It's interesting to see how that response takes place. The speaker compared this to his experience being scared away from tobacco as prevention. Campbell said: Years ago, there was a behavioral health plan. The difference from what the CCOs and counties did is a different lens and recognizing behavioral health is an equal partner in the health delivery care system, rather than being in a silo. The quality improvement committees – the piece that comes to mind is the diversity, equity, and inclusion committee. There has been stigma attached to accessing behavioral health care. We are ahead of the game. Our CHIP has stated priorities in each of our 12 communities. Behavioral health issue is an identified root cause. The plan is we'll get it done. Will it be a guidebook/recipe book? The main goal is to build on success, not mandate the process; just reward the outcomes. We are blessed in these communities to have strong voices for behavioral health. **Development, trauma:** Campbell stated: When it comes to the brain, we have a lot left to learn. While we're making progress – smoking and nicotine can

	calm someone's anxiety. We need to get back to childhood trauma and understanding how the brain works. In the last 5 years in Eastern Oregon, we've come further than anyone else in conscious discipline and ways to understand brain development. There is not one way to solve the challenge. The best thing we can do if we want to change behaviors and habits by building relationships. **Will this plan help us do that?** Campbell said: It won't hurt. The plan will demonstrate the importance. **Could the patient engagement committee get involved in the tobacco issue?** Campbell said: First, people need to understand their benefit through OHP, upside and downside. The value of health insurance to keep you healthy rather than just a card for when you're sick going to the hospital. The patient engagement committee will have members; listen to them. Reassess what we do to engage members. Our members help us communicate in words they understand and what the goals are: healthy people, economy, etc. We are guilty of acronyms most people wouldn't understand. That is a challenge. We need to get rid of the jargon and get down to simple strategies for the triple aim.
Presentation changes to consider/improve	

Please submit the final meeting agenda with this document.