Tillamook County Health Department
Health Council
Meeting Minutes
November 8, 2016

Present: Harry Coffman, Carol Fitzgerald, Jessica Galicia, Amy Griggs, Tim Josi, Donna Parks, Clayton Rees Carmen Rost, John Sandusky
Excused:
Absent/Unexcused: Rex Parsons
Staff: Irene Fitzgerald, Donna Gigoux, Debra Jacob, Marlene Putman
Guests:

1. Call to Order: Chair Harry Coffman called the meeting to order at 12:19 pm

2. Consumer/Community Needs, Concerns, Issues:

A. **Health Care Issues presented by Council Members**: No report.
   a) **Community/Patient Concerns**: No report.
   b) **Ambassador/Advocate encounters with Community**: No report.
   c) **Community Partners (boards, agencies) Encounters/Projects**: No report.
   d) **Health Center Patient Comments**: No report.

3. Consent Calendar:

A. **Approval of October 19, 2016 Meeting minutes:**
   Action: Donna P. moved to approve the minutes as written; Carmen seconded. Motion carried.

4. Board Development:

A. **Potential New Members –** No update.
B. **Health Council Member Contact & Areas of Expertise –** Donna G. reported that we are now currently contracting with Michelle Hunter to assist us in better alignment of our Quality Measures; therefore, there are only 9 members on the Health Council, the minimum according to bylaws. A quorum of 5 will need to be reached at each meeting.
C. **Common goals – shared resources between agencies:** No update.
D. **Underrepresented & Youth potential members:** No update.
E. **2017 Health Council Meeting Schedule:** Donna P. was not in attendance last month when the schedule was presented and approved. There seems to be a possible error on the meeting schedule for a couple of dates. Donna G. will check the schedule and provide an update at the December meeting.

5. Administrator's Report:

General Update and Report:

A. ***GOAL: Implement Well Planned Actions/Methods to Improve Productivity and Positive Outcomes for our Clients, Our CHC and the Community***

a) Action Planning in Priority Areas -

- **Behavioral Health**: Marlene provided an overview of the grant and indicated that the CCO is offering a grant to provide Behavioral Health Integration in a Primary Care setting. The Health Center would be seeking funding for an additional Behavioral Health provider to provide both clinic based (Mental and Specialty) and community based (schools and social services agancies)services. The grant application is included in the packet for approval of the Council.
- **Dental Health:**
  - **School Based Dental** – The Dental Coordinator job description was sent to HR along with the appropriate pay compensation for the position.HR was scheduled to submit the position to the Union on November 4, 2016. The Union has 14 days to review and approve or negotiate the position from the date of receipt of the position description and salary information. If they want to negotiate, the process will take an additional 90 days; therefore, it is possible we will not get the position filled until the beginning of the new fiscal year, or by July, 2017. Work related to the grant is still being carried forward by our contractor and our dental hygienist. The focus is currently on what services can be provided using the expanded practice hygienist; possibly integrating WIC and children's dental services in the clinic.
  - **Dental Program Manager** – The Dental Manager and other Manager salary and Pay Range changes are scheduled to be on the BOCC agenda November 23rd. Other dental health issues were addressed including new challenges. One of our contracted dentists will not be taking new patients until possibly January, 2017. There is also some issue with the North County dental clinic building, in that the owners are unresponsive to requests for information and commitment to rent the building. An eventual possibility is the need to hire our own dentist and have dental services provided directly by Health Center staff.
- **Patient Access & Support:** No update.
- **Sexual Health and Adolescent Health Services:** Marlene will be meeting with the superintendents of both Tillamook School District #9 and Nestucca Valley School District to discuss School Based Health Centers. More information next month after the initial meetings. Dr. Steffey and Public Health Manager are both very positive about this possibility. Also, Dr. Steffey has both background and experience operating and working in a school-based health center.
- **Maternal and Child Health** – No update.
- **The Early Learning Hub** – No update.
- **Correctional Facility Medical Services:** No update.
- **Medical Director Recruitment –** Dr. Steffey has begun seeing patients and has already begun shadowing, supervising and provider helpful tips on the EHR system.She will be focused on quality metrics over the next 12 month period, as well as, provider productivity and patient access.
- **South County Services –** No update.
- **Tillamook County Year of Wellness (YOW) –** A Strategic Planning meeting is scheduled for December to discuss YOW priorities and direction for 2017 and beyond; moving forward the goals and strategies of Public Health.

- **Staff –**See Above, 5.A.a * Dental Health.
- **Strategic Planning –** No report.
- **HRSA Findings –** See below, Financial Findings (7.A).

B. ***Goal: Increasing Productivity of Providers and Staff to Increase Revenue***

a) See Financial Report – Schedule Dashboard below, (6.D).

C. ***Goal: Improve Financial Practices and Systems in order to Improve Efficiency and Effectiveness***

a) A meeting was held between TCHD's Director, Medical Director and Clinic Operations Managers about workload, projects and prioritization of each. In the discussion of possible projects and priorities, the topic of alternative treatment, specifically, Suboxone prescribing was brought up. Staff was provided additional information about the use of the Suboxone and related substances; see attached "Some basic information about Suboxone" document for some of the provided information,(pg. 8 below). The clinical team indicated that there is only one physician in the clinic that is interested in prescribing Suboxone and that this provider is not interested in having a large number of patients with this prescription and being responsible for the related clinical protocol and practices recommended by the CCO. To this end, the Medical Director, Administrator and Clinic Operations Manager are recommending that the Health Center not begin prescribing this medication for patients at this time. It is possible to work with other clinics that are administering this medication with which TCHD can partner. It may be a possibility in the future, but is not a current priority based on the strategic plan or clinical care metrics. The Health Council discussed the use of Suboxone and Naloxone and were in agreement with staff recommendations. The Administrator will provide updates after more is learned about the clinics that are beginning to prescribe (ie Scappoose). After more learning more about the CCO best practices model and other clinics, staff may have further recommendations for the future.

D. ***Goal: Increasing Revenues for Other Sources in Order to Offset Uncompensated Costs for Public Health Services and/or Operational Changes and Improvements***

a) No report.

E. ***Goal: Implement Policy & Procedure that support our Mission and Improve Quality of Service***

a) Health Resiliency Workers – The CCO has announced that TCHD and all other health care organizations under the CCO will not be getting their own Health Resiliency Workers (HRW). Instead, the CCO can provide a regional Health Resiliency Worker. There were not enough resources to place an HRW in each County. A Regional HRW would manage patients who are struggling to maintain such things as their A1C, blood sugar levels or other chronic, complex conditions. The question is: How many patients could one HRW really serve regionally? A Health Council member asked if TCHD could opt out of using the regional HRW if the cost-benefit of housing the worker was not beneficial compared to the number of TCHD clients they would be able to serve. Marlene believed that TCHD could opt out. A Health Council member thought that the decision ought to ultimately be TCHDs and that not allowing opting-out would be the CCO micromanaging. Another Health Council member stated that on the other hand, what little a regional HRW could provide would still be services being provided. An alternative could be that Rinehart, Tillamook Regional Medical Center and TCHD use the incentive funds from the CCO to fund a County HRW with the offer of sharing the data from the HRW with the CCO. The question would be: Would having one person working with three organizations be the most beneficial use of funds. A Health Council member compared this type of shared arrangement to the "Healthy

Families" approach of service with home visitors. TCHD already provides some home visiting service through in primary care and public health. A HRW, or paraprofessional could be an extension of those services.

b) School Resource Behavioral Health Provider – We will be working with the school district to provide support for students. Marlene will be meeting with Randy to discuss details.

c) Emergency Preparation – No report.

F. ***Goal: Increase Partnerships with Health & Human Service Organizations in Order to Leverage Resources, develop shared resources and strengthen relationships for future collaborations***

a) (See 9.A.a below.)

Action: Donna P. moved to approve the administrative report. Carmen seconded. Motion carried.

6. Finance Report:

A. Total revenue for September (November report) was $805,298.86; total expenditures were $630,966.54, with a month end cash balance of $1,774,914.67. September ended with a net increase in cash of $202,780.90 which, was noted, largely due to receiving two wrap payments in September. Irene reported the following:

- **Revenue:** GL account #4269 and 4290 were donations for the YOW program. GL account # 4371 includes the double wrap payment mentioned earlier.

B. **Expense**: GL #6011 – Computer Supplies includes purchases of Varidesks, an ergonomic desk, and computer monitor privacy screens for multiple employees. $350 posted to GL # 7020, Insurance and Deductibles is a posting error, the expense should go to GL 7022, Public Relations. GL # 7101 – Professional Services has a credit listed which is a credit passed on to TCHD by OCHIN billing services for OCHIN's "HCCN Grant Goal Success". GL # 7450 – R&M Building & Grounds reflects an expense for painting the North County Clinic. It was noted that the orange highlighted rows, GL #s 4800 – Transfer from General Fund , 7110 – Legal, and 8001 - Indirect Cost Allocation, are intended to highlight the increase in indirect costs passed on to TCHD in the current fiscal year.

C. **Encounters** decreased from 1,475 in August to 1,154 for September resulting from a decreased average provider FTE of 2.99; average daily encounters per provider FTE were lower, from 9.5 in August to 9.00. Provider FTE and encounters were affected by several Providers taking leave during the month of September. Monthly Encounters by Provider show Melissa Paulissen continuing to post above 200 encounters with 209 in September, Adrienne Fisher shows a huge drop in numbers, 54 total encounters down from 184, due to her extended leave in the month of September. Christopher Craft had a slight decrease in encounters, 122 from 177 in August, partially attributable to some leave taken from him as well. Erin Oldenkamp's numbers will start showing again with October's financial report in December.

D. **Schedule Dashboard:** Scheduling continues to show improvement with more of the "% Available vs Completed" line appearing in the yellow/green range than previously seen. September's "Average % of Available vs Completed" was up to 60.4 from 54 in August. Melissa Paulissen's schedule shows significant improvement since her FTE adjustment to .8 FTE, her average % of Available vs. Completed for September being 70.2.

E. Total Accounts Receivable was $296,628.72, and shows the majority in the 0-30 bucket at 74.73%. September Payer Mix shows Medicaid/Managed Care still our biggest payer at 57% of total AR.

Action: Amy moved to approve the financial report; Carol seconded. Motion carried.

7. Financial Findings

A. The "HRSA Site Review Financial Findings* - Appendix A" was presented to the Health Council. It was stated that while the previously presented Modified Accrual Financial Statements were approved by HRSA, there is now an additional requirement to have a Financial Management and Control Policy and Procedure stating our processes for financial control and reporting, specifically of Federal funds. What this means is that HRSA is requiring a policy outlining: how we

i. Separately track our Federal funds, (Financial Management and Control Policy & Procedure item 3.1.a-c – Appendix A, pg. 9-10)
ii. Restrict our Federal funds for in-scope activities, (Financial Management and Control Policy & Procedure item 3.1.c.a and 3.1.d-e – Appendix A, pg. 10)
iii. Control our federal expenditures by budget, ((Financial Management and Control Policy & Procedure item 3.1.f – Appendix A, pg. 10)
iv. Report our Financial Statements to who and how often (Financial Management and Control Policy & Procedure item 3.3, Appendix A, pg. 10-11).

No questions were raised over the presented Financial Management and Control Policy and Procedure document.

Health Council members then briefly reviewed the HRSA Fiscal Analyst's recommendation spreadsheet that outlines the above requirements and the discussions that occurred between TCHD staff and the analyst. Irene pointed out that the analyst seemed to be satisfied by the monthly financial packet as is for interim reporting purposes, as long as we are reporting full accrual financial statements, (including asset, depreciation and inventory), at Fiscal Year End and for special reporting purposes. Irene also noted that one addition that will be made to the monthly financial packet presented to the Health Council will be the Budgetary Control spreadsheet that was requested by the analyst for proof of budgetary control. This spreadsheet tracks HRSA funds by program by budget category. The Health Council members had recommendations to make the spreadsheet more reader-friendly, including clearer subtotals/ total line items and changing "revenue" to "income". Mention was made that similar changes restricting federal expenditures to purchasing policies were made in response to the 2 Code of Federal Regulations Part 200 Sub-Part E "Cost Principles" and that TCHD was the only department in the County to be proactive in getting those changes made prior to the FYE16 Audit. One Health Council member was encouraged that the Treasurer's Office has, so far, been okay with the changes in financial requirements.

Action: John moved to approve the "Financial Management and Control" Policy and Procedure and the Budgetary Control Spreadsheet; Clayton seconded. Motion carried.

7. Marketing/Branding: No report.

8. Reports of Committees:

A. Quality Assurance/Quality Improvement Committee: John reported that due to his current schedule, he has not been able to attend the last two QA/QI committee meetings. He has contacted Lola who has contacted the rest of the committee about rescheduling the recurring meeting dates. Carmen reported that there were a couple of Metric parameter issues reported in the month of October. Marlene

extrapolated that Weight assessment parameters had changed, children's weights are now being changed from ages 2-17 to 3-17 although we will need to report on ages 2-17 for one more year. The other issue not being a parameter change but a practice change: the cervical cancer metric reflects a target that is not calculated on current best practices for women's health. TCHD will need to articulate clearly the reason for this incentive metric being at the percentage it is. Providing two flu shots for children by the age of two is another difficult metric that will also need to be articulated well. Dr. Steffey has adult weight management, asthma and cervical cancer on her list of QA/QI priorities to discuss with Michelle Hunter, our QA/QI consultant. Michelle was at the October QA/QI meeting asking questions and taking notes. Dr. Steffey also brought up the issue of exam room charting: The current exam room monitors are too small for the recent OCHIN upgrade which makes charting in the exam rooms much more difficult. Replacement monitors have been ordered for all exam rooms. The hard drives for the computers are fine, only the monitors will be replaced.

Action: Carmen moved to approve the QA/QI report; Donna P. seconded. Motion carried.

9. Old Business:

A. **GRANTS & Resource Development** –

a) OHA Safety Net Capacity Grant – Marlene met with Jorge and Daniel from the Lower Columbia Hispanic Council to discuss contracting and moving forward with the work plan. There is a revised work plan and budget that needs to be sent to OHA. TCHD is in process of recruiting for the outreach position. The next question is: How do we serve the targeted, 200 uninsured children? What services do we provide? What will the costs be? In discussing the targeted population, it was brought out that the attitude towards healthcare is generally that healthcare is only sought for illness. Preventative care is not a priority. With preventative care not being a priority, there are situations where a family may choose to be uninsured and may not qualify for OHP. How do we incentivize these families to seek healthcare services with us? Initial thoughts were to provide services for free through the use of special circumstance forms. However, on further thought, would providing services as "free" or "Nothing out of Pocket" lessen the value of the service and be doing more of a disservice to the population? Experience with behavioral health services is that patient's valued their care more when they were charged a nominal, $5 fee for services. Further, would providing free services be sustainable for TCHD? Marlene presented an idea of an annual packaged service approach where the patient pays a flat fee, maybe $25-$40 annually, for comprehensive services including, well child visits, dental, vision and behavioral health. This would be for children ages 0-17. Providing comprehensive services would also allow TCHD to connect the target population to other community services. Another cost option would be to provide services based on a variation of the sliding fee discount scale or a combo of the flat fee and sliding discount. No matter the fees chosen, payment arrangements will be based on the patient's ability to pay, being very clear that the cost of services should not be a barrier to care. Irene noted that Marlene and her would be consulting with Bob Maxwell at OPCA regarding the implementation of a new fee schedule or special circumstance for this grant. At this point, a health council member asked if they should remind TCHD Care Coordinators that they, with their position at the local Salvation Army, are a community resource that can be utilized. The health council member stated that they have access to funds to help get uninsured or underinsured clients healthcare.

b) OCF Tillamook Education Foundation School Based Dental – discussed in Administrative Report
c) New Building – Tillamook – Donna Gigoux is working on contacting contractors for estimates.
d) Health Resiliency Worker – discussed in Administrative Report
e) PH Emergency Preparedness (PHEP) Coordinator –No report.

10. New Business:

A. Clinical Pharmacist – No report.

B. Policy/Procedure -

a) Credentialing and Privileging – Erin Oldenkamp
b) Credentialing and Privileging – Patricia Dannen

Action: Donna P. moved to approve the Credentialing and Privileging of both Erin Oldenkamp and Patricia Dannen. Amy seconded. Members present, Motion carried.

11. Training (Strategic Plan Goal 2) – Time Permitting – No training this meeting.

12. Unscheduled: Marlene invited the Health Council members to a "Trauma Informed Care" training being held next week, 11/16, at TBCC. This training will inform attendees on a different way of delivering service through a trauma informed lens.

13. Adjourn - The meeting was adjourned at 1:46 PM.

Some basic information about Suboxone…

Suboxone is a prescription medication that combines buprenorphine and naloxone. It's used to treat opioid addiction. (Heroin and narcotic painkillers are common opioid drugs.) Buprenorphine belongs to a class of drugs called opioid partial agonists, which help relieve symptoms of opiate withdrawal.

Buprenorphine is an opioid medication. An opioid is sometimes called a narcotic. Naloxone blocks the effects of opioid medication, including pain relief or feelings of well-being that can lead to opioid abuse. Suboxone is used to treat narcotic (opiate) addiction.

Buprenorphine is a narcotic, a powerful and potentially addicting painkiller that was first approved as a treatment for opioid addiction in the U.S. in 2002. When combined with naloxone to make Suboxone, the two drugs can be used to help wean addicts off opioids such as heroin, Vicodin, OxyContin, and hydrocodone.

Suboxone can help decrease the amount of drug overdoses. Normal opioid overdoses are treated with naloxone, which is included in Suboxone. Because Suboxone has naloxone in it, it can be more difficult to overdose on the substance; however, it is still possible.

Some law enforcement agencies use naloxone to address drug overdoses in the field. To obtain naloxone, many law enforcement agencies implementing law enforcement overdose response programs have collaborated with physicians from the state or local departments of health, local EMS agencies, hospitals, or community organizations.