CLACKAMAS COUNTY COMMUNITY HEALTH COUNCIL
STRATEGIC PLANNING RETREAT 6-16-10

Members Present: Mike Sluss, Graciela Rivera, Paula De Leon, Inez (Dolly) Stillwell, Samuel Saenz, Alma Estrada Lopez
Members Absent: Ada Ruiz (excused)
Guests Present: Lisa Powell, Shari Black, Wayne Beery
Staff Present: Cindy Becker, Janelle McLeod, Bertha Moseson, Karen Slothower, Mike Martin, Liliana Bastres, Karen Erwin, Recorder

Shari Black facilitated the Community Health Council Strategic Planning Retreat on June 16 from 12:30 – 6:30 p.m. following a short business meeting. Shari has a background in nursing and experience as a former FQHC (federally qualified health center) director for Multnomah County. Shari worked with the Multnomah County Community Health Council on board training and orientation.

When participants were asked what they hope to gain from the retreat, responses were:

1) An informative presentation and discussion
2) Identification of core values – get to something concrete
3) Renewed engagement and partnerships as we move forward in a future for the FQHC
4) An exciting opportunity to work together and have common goals for the work of the future.

After introductions of Board members and staff, Shari explained that the first part of her presentation would focus on board orientation and the second part on strategic planning. Goals and expectations for the session will be identified. Board roles and responsibilities will be reviewed. The most recent self evaluation assessment will be used to help generate a work plan for future improvements to become an even better Board. Time will be allotted for staff briefings and overviews. The group will then begin to identify Vision, Mission and Values and work up an analysis of strengths, weaknesses, and external opportunities and threats. Final documents will not be issued immediately. One or two volunteers will be asked to work with staff to review notes and issue a draft to present to the Board at the next meeting.

Cindy Becker clarified that a strategic plan is needed by the end of the calendar year for our grant application. As stated during the audit, there is an expectation that the Board has a strategic plan, and it is not necessary to wait until the new FQHC director is hired.

<u>Member Goals and Expectations for the Session</u>

- Ensure true brainstorming process – avoid analysis
- Keep draft product 'in the room'
- Move along strategic process – consider time; consider new director and grant
- Stay on task

Shari presented handouts and slides on Community Health Boards - how they work and their roles and responsibilities. Resources were noted for technical assistance. This Board is not a non profit, but some of the same principles apply. We are an FQHC established within a government entity. The Bureau of Primary Health Care states that all Community Health Centers with 330 grant funding and program requirements must be governed by a community board with a majority of members who are health center patients. The

goal is for the County and the Board to work together. County Counsel can be utilized to get answers on issues questioned such as responsibilities and liability.

Cindy informed members that there are 70 public entities in the country and that Oregon has more per capita than any other state. We have seven (us, Benton, Multnomah, Tillamook, Lincoln and Lane Counties and OHSU which is a look alike FQHC (doesn't get 330 funding but gets approval to bill for wrap around dollars). We have been an FQHC for 18 years. We are a public FQHC and have a co-applicant agreement with the County. The agreement, generated by County Counsel in 2006 per 330 regulations, needs to be revised. Cindy will bring a draft revision to a future meeting for member input. HRSA (Health Resources and Services Administration), a federal agency, did not originally require the agreements but now does. The County and this Board came together and applied to be an FQHC. Because we are a public entity, some functions can be under the purview of the County, such as personnel and finance. Policies, strategic planning and budget approval fall under the approval of this Board. There is a current country-level effort to encourage HRSA to establish a separate work group for public run entities where more guidance, clarity and consistency would be helpful. We have been more focused on quality services than on governance, but continue to take accountability to correct the problems identified during the audit.

Community Health Council Self Assessment – Future Improvements – (A 'parking lot' list was started to capture items to address at a later time) Reviewing their last self evaluation assessment, Board members identified the following list to help guide them to function more effectively and efficiently:

- Avoid use of abbreviations, technical terms
- Improve accuracy of minutes (ok to record?-check with County Counsel)
- Continue to improve relationship and work more closely with Board of County Commissioners
- Improve our work
- Improve community outreach
- Research best practices from other counties
- Receive meeting materials by Friday prior to meeting (mail English and Spanish docs Wednesday)
- Receive more Board education, especially related to finances
- Discuss further the topic of member ethics
- Share stories about clinic experiences to emphasize mission
- Have more visibility in community
- Form effective committees that know their charge and responsibilities
- Encourage member preparation/reading of materials before meeting
- Understand commitment of Council members - committee attendance and time commitment
- Review idea of utilizing a consent agenda
- Receive timely information, including translated documents (clinical and medical director reports now sent early in packets for review prior to meeting)
- Improve information sharing with Board as staff receives information from other public Community Health Center FQHC's (avoid duplication of efforts)
- Schedule regular staff meetings with Council president before meetings to inform handouts
- Generate Board (Council) reference notebook

Overview
Shari asked staff to give an overview of the Health Center, finances and services. Data maps were posted for a better understanding of the service area and patient concentration.

Health Center - Cindy reviewed the history of the FQHC. Our primary care clinic became an FQHC 18 years ago. Dental was added in 2001 and put under the scope – meaning these services are included in the

grant and that we can bill for the Medicaid wrap rate. Behavioral health services were put under the scope in 2006. In 2005 public health and behavioral health clinics were combined to a single entity called Community Health. Much review and analysis was done and the FQHC was found to be operating at a deficit. An outside consultant was hired, but staff eventually made a recommendation to BCC that we needed to close as the clinics were not financially sustainable. Of the entire department's budget, only 5% comes from the county general fund. At that time, $800,000 to $1M was going to the clinic, and to survive the county was going to have to significantly increase that amount to sustain the clinic.

As that decision was being made, the former director was looking for an entity to take over the patients. Only one entity, Yakima Valley, agreed and even that decision was withdrawn at one point. The conversation was for us to close the Molalla Clinic in June of 2008 and the Sandy Clinic in December of 2008 and transfer $1M of our approximately $2M grant to Yakima Valley to serve individuals in those areas. A letter cosigned by BCC and this Council was sent to the federal government asking them to transfer those funds. Yakima was to serve as many as possible at their existing Salud and Rosewood Clinics. The Beavercreek Clinic was slated for closure in 2012 and the last part of the proposal was for the balance of the grant to be transferred to Yakima to site a clinic in this county. In hindsight, the county probably should not have opened a free standing clinic in Molalla, and Sandy was questionable due to financial problems. When the closure decision was made, information was sent to patients about their choices and the availability of Yakima Valley clinics. We are not sure how many patients Salud Clinic picked up in Woodburn, but Yakima indicated that Rosewood picked up 1,000 to 1,500 patients.

Cindy came on board in 2008 after the closure decisions were already made. Since that time, the wrap rate for Behavioral Health increased and our payor mix has been more balanced; both of which contributed to greater financial stability. During the Behavioral Health redesign process and presentation to the BCC, Cindy recommended that we find a way to stay as an FQHC, which the BCC approved.

In November of 2009 Cindy met with Carlos and told him we were not transferring the entire rest of the 330 grant to Yakima Valley because we wanted to continue as an FQHC. She said we'd try to backfill what we weren't going to give him with some other county general funds going to us if not needed. It was Cindy's assumption that we could stay in the FQHC business and continue getting wrap funds.

Last Fall, the federal government came out with the CIP (Capital Improvement Program) – non competitive stimulus funding that we received. The long term goal was still to get out of the current clinic location and into a more accessible location. As such, we only put a small portion of the funds in the clinic to add a dental chair, remodel the dental service room and replace the carpeting. The money had to be used for capital improvements, so we reached out to partners to see if we could join together to use vacant space in the Gladstone Children's Center location as a satellite primary care clinic. CareOregon came forward with a proposal to staff a clinic to increase access for patients. The clinic, slated to open in September, will have two providers in addition to the six we have at Beavercreek. Bertha is the medical director and the site will operate under our scope and with our sliding fee scale. Shari noted that this Council approved the clinic at the last meeting and that it will be in this Council's governance. CareOregon will do the same arrangement for a site in Milwaukie co-located with Lifeworks, adding three providers placed under our scope. Cindy cautioned, however, that this entire arrangement is still subject to federal approval. We also operate two School Based Health Centers in Oregon City and Canby.

At the Council's request, Cindy invited Carlos Olivares from Yakima Valley to the next Council meeting. Yakima Valley is still committed to a clinic in North Clackamas County – one which they would own and operate. We do want to stay in the FQHC business and continue to negotiate partnerships to best utilize our last $1M in grant funding. The idea would be to have a more accessible clinic to service the Oregon

City/Canby area, the Gladstone and Milwaukie sites and two School Based Health Centers – all operated through our FQHC. The eastern part of the county still has huge access issues. Yakima has a mobile medical van but they are very expensive to operate. Cindy will discuss more with Carlos.

As a point of business, Karen Slothower noted the Council will eventually need to vote to determine if the McLoughlin site will go under scope. Cindy answered members' questions regarding this arrangement which adds additional providers in the county through a no-risk arrangement. It is more expensive to run county clinics because our personnel costs are higher and we have indirects and allocated costs. Even with the grant dollars we have left, we still run in the deficit without the wrap payments we receive. Carlos has indicated to Cindy that he would not have agreed to take Sandy and Molalla patients if he wasn't going to open a clinic in the county. Cindy invited him to the July meeting because of Council concerns voiced. Assuming the Council likes the ideas and partnerships presented, we still need approval from the federal government.

Finance – In addition to the financial overview incorporated into Cindy's report, Karen Slothower noted it was very clear we needed to put behavioral health under scope. At the medical rate, projections were barely going to cover in 2008. In 2009 the rate almost doubled for behavioral health, allowing us to realize more revenue to fund behavioral health and also build a contingency to fill gaps in primary care. Mike Martin added that the rate is based on our cost and how many billable services – it doesn't count grants, county general funds and other sources of income. We can provide more services or establish a reserve for emergencies. Karen stated that funding is different in behavioral health. The state pays us an amount of money for services for indigent populations – not completely different from grant funding from the federal government. The additional funds have been earned in behavioral health – primary care services are running at a deficit. The payor mix is very different in behavioral health with a much greater percentage of Medicaid patients. Mike added that the FQHC scope encompasses about 75% of all the services provided by Community Health.

Services – Janelle McLeod and Bertha Moseson reviewed their handout on services (below):

<u>Clackamas County FQHC: Services</u>

<u>Clinics under the FQHC:</u> Beavercreek, Oregon City HS, Canby HS, Stewart Center, Oregon City Hilltop, and specialty program services at Public Services Building

<u>Staffing**: (Primary Care)</u>
43.74 FTE, including (but not limited to)
1.5 MD, 4 FNP, 4 RNs, 1.4 Dentist
Medical Director*, Dental Director*, Clinical Operations Manager, Nursing Supervisor, Office Manager, Medical Records Supervisor
Quality Improvement Coordinator (Program Planner position)
Front and back office support staff
Interpreter services
*included in clinical FTE; **Behavioral Health Services - licensed clinical staff, psychiatrists, nurse practitioners, case managers, and office support staff

<u>Services provided:</u>
Public Health Services (family planning, birth control, immunizations, sexually transmitted disease treatment, communicable disease treatment, emergency preparedness)
Prenatal care, Dental care

Chronic disease management
Preventative care (women's health, well child, men’s health)
Referrals to specialty care

Revenue from: Medicaid and Medicaid Fully Capitated Health Plans (CareOregon, Family Care, Providence Health Plans), Medicare, self-pay, some private insurance; Multicare Dental

Facility Issues/Challenges:
Old building, retro-fitted as a clinic
HVAC/plumbing; paper chart

Quality Improvement in patient care:
There are a number of quality measures that are a part of the health care plan. Some examples include:
Decreasing diabetic patients' HbA1c
Decreasing patients' blood pressure
Decreasing patients' weight

Initiatives:
Mind over Mountains
Integration - BH in PC, PC in BH
Improved workflow (latest Lean project)
Financial stability (self-pay, payor mix, etc.)
Electronic health record
Increase FNP hours at the SBHC
Increase dental services

Vision/Mission/Values - Shari divided participants into three groups to begin work on Vision/Mission/Values. Group notes were discussed and then posted for additional written comments (notes). Shari asked for one or two volunteers to join Cindy and Janelle to draft language to bring back to the Board for editing. Samuel Saenz volunteered. Their task will be to sit down with typed notes and generate a draft that best represents the consensus of the input below:

Group 1: Graciela, Alma, Bertha, Janelle
Group 2: Samuel, Dolly, Lisa, Mike M., Cindy
Group 3: Mike S., Paula, Karen S.

VISION

1 - A community where . . .

- there are clinics that serve every person, birth to grave (note: clinics *or providers*)
- there are locations accessible to entire county
- we create a culture that promotes health and happiness

2 - Everyone has a medical home where they get affordable, accessible, quality and compassionate health care
(note: Cindy did not see why *compassionate* was needed)

(note: I like this value statement)

3 – Clackamas County will be a community where quality health care is accessible to all

MISSION

1 - Provide quality, cost effective healthcare to those in need

2 - To provide affordable, quality and cost effective healthcare (prevention and treatment) to met the needs of Clackamas County residents (note: I like this mission statement)

3 – Working to assure accessible, quality, cost effective healthcare to Clackamas County residents in need of health services.

VALUES

Ethical	Cooperative (note: Samuel ??)	Fiscally responsible
Dynamic	Cultural awareness (competence)	Accountability
Timely	Culturally sensitive	Stewardship
Holistic	Efficient	Value
Proactive	Flexibility	Reasonable fee
Prevention	Patient centered	Respectful communication
Promote health	Monitoring	Feel respected
Trustworthy	Improved condition	Communication
Quality service	Environmentally responsible	Positive experience
Responsive	Sustainability	Sensitive

SWOT Analysis – Shari asked for an analysis of the system as it exists, to help move the group towards goals and objectives that will maximize strengths and mitigate or minimize weaknesses. She asked for Health Center strengths, weaknesses internal to organization, opportunities in our external environment and threats external to us:

Strengths

- Predictable
- Good building blocks
- Community support
- Board of County Commissioners support
- Dedicated staff
- Competent staff interacting with the Board
- Engaged Board
- Stronger financial position
- Community partnerships
- Common core values for Board
- Long-standing FQHC (federally qualified health center)
- State of the art management information system (MIS)
- Good cooperation with other FQHC's
- Culturally appropriate services
- Constructive, current feedback

Weaknesses:

- ‘Horrible’ building
- No electronic health record (EHR); no show rates
- Limited flexibility within county structure
- Instability with regard to future existence
- Small Board
- County financial system
- Productivity
- Location of services
- Visibility to insured population
- Challenges with hiring due to county personnel
- Co-applicant challenge
- Governance
- Self-pay
- Difficulty providing services (access) to the uninsured
- Difficulty providing services to uninsured individuals due to lack of access to specialty care resources
- Minimal guidance, uncertainty
- Vague federal regulations
- Lack of consumer interest in Board
- Lack of visibility of Board

Opportunities (external):

- Healthcare reform
- More funding
- Electronic health record (EHR)
- Partnering with outside organizations is an opportunity to develop additional health care
- Creative problem solving
- Marketing strategies
- School based health center (SBHC) expansion
- Rural nature
- Closer relationship with County Board
- To increase Board numbers
- FQHC Director (federally qualified health center)
- Board policies
- Potential market of new Medicare patients

Threats (external):

- Provider shortage
- Uncertainty of grant renewal
- Wrap/rate may decrease
- ‘Predatory’ provider (competition)
- Not being able to collect $
- Bureau may not approve changes
- Possible changes to Oregon Health Plan (OHP) due to budget
- Recruit/retain providers
- Access to specialty care

PARKING LOT

1) Co-Application Agreement (Council /Board reference); Draft revision
2) Director's insurance (County Counsel input)
3) Status of audit
4) Review of Council committees
5) Ensure ease of transportation for members
6) Relationships with CareOregon, Yakima
7) Board volunteer(s) to write Vision/Mission/Values draft – Samuel
8) Member transportation issues
9) Bylaws revision to reinstate QI Committee
10) Board vs. Council: Board of County Commissioners is a Board; Community Health Council is a Council

Closing and Next Steps - Cindy asked members to send her any concerns by the end of the month so that she can share with Carlos prior to his visit to ensure that he covers them. Carlos has been actively moving forward in good faith, looking for a building. We are underserved in this county and with healthcare reform numbers will likely increase. He did a needs-assessment to arrive at the need in north county. If the board has major issues they need to be addressed – this cannot wait until the Fall. We do not have capital to build a clinic and the deal on the table was for Yakima Valley to get the grant dollars to locate a clinic in the county. As of November, Cindy has told him of the need to change plans. The Board wants an accounting of what he has paid for with the $1M. It is known that Yakima Valley they generated a lot of information to our patients regarding the availability of Salud and Rosewood Clinics.

It is important to understand that we were closing and Yakima Valley was going to take the dollars and open a clinic in the county. We're now saying we want to open a clinic. The question is should we still give money to Yakima and each of us open a clinic? Concern was voiced about the loss of future opportunities to get grant funding. Lisa Powell asked what other options might be taken off the table by giving them the money? It is thought this would not have an effect as we would still be operating in the area. Samuel Saenz needs to hear something concrete, which he did not see on the first $1M. Cindy noted that we will need to devote a good portion of the agenda to Carlos.