Council Members

- **Brad Porterfield, Chair**
  Consumer Representative,
  Latino Community Association
- **Theresa Nguyen**
  Jefferson County Public Health
- **Mayra Benitez**
  Consumer Representative
- **Conor Carlsen**
  Consumer Representative
- **Miranda Hill**
  Klamath County
  Representative
- **Linda Johnson**
  Community Representative
- **Elaine Knobbs-Seasholtz**
  Mosaic Community Health
- **Jessica Jacks**
  Deschutes County Health
  Services
- **Mandee Seeley**
  Consumer Representative
- **Stacy Shaw**
  Consumer Representative,
- **Christie Rudder**
  Consumer Representative
- **Aimé Maxwell**
  Consumer Representative

CENTRAL OREGON HEALTH COUNCIL

COMMUNITY ADVISORY COUNCIL

February 20, 2025
VIRTUAL
Video Conference Link In Calendar Invite
Conference Line: 1.669.900.6833
Meeting ID: 864 9263 5310#
Passcode: 933436#

12:00-12:20 **Welcome – Brad Porterfield (CAC)**
- **Land Acknowledgement**
- **Meeting Practices**
- **Introductions**
- **Public Comment / Patient Story**
- **Announcements**
- **Approval of Meeting Notes – December**

12:15-12:35 **RHIP Endorsement Discussion & Vote – Gwen Jones (COHC)**

12:35-12:45 **CAC Members Small Group Breakout Session – Bradley Garner (COHC)**

12:45-1:05 **CAC's Role and Forms of Advocacy – MaCayla Arsenault (COHC)**

1:05-1:30 **2025 CAC Planning – Priorities & Strategies – Avery Grace (COHC)**

1:30-1:40 **Emerging Issue Update - Dental Task Force Update – MaCayla Arsenault (COHC)**

1:40-2:00 **VIM Presentation to CAC Dental Pilot Project – Kat Mastrangelo (VIM)**

"The overarching purpose of the CAC is to ensure the COHC remains responsive to consumer and community health needs."—COHC CAC Charter

The Central Oregon Health Council encourages persons with disabilities to participate in all programs and activities. This event/location is accessible to people with disabilities. If you need accommodations to make participation possible please call (541) 306-3523 or email macayla.arsenault@cohealthcouncil.org

Land Acknowledgement

We recognize and acknowledge the indigenous land on which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land where we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: "This land is for you to know and live upon and pass on to the children."

Community Advisory Council (CAC)
Meeting Changes: What to Expect

We want the CAC to be a warm and welcoming place for all. We want to ensure all CAC members feel comfortable to fully participate and contribute. To do this we are making some adjustments to how our CAC meetings are run. These changes are:

- Making the meetings less institutional and formal to create a warmer and more welcoming atmosphere. Examples are using more plain language, having more conversations and less presentations, and simpler voting instead of motioning.

- Renaming each attendee in Zoom with their role; either a CAC Member, Support Staff, or Guest. This will help easily identify who's who in the virtual space especially for guests and those members who are new.

- Asking all supporting staff from COHC, PacificSource, and the OHA to share why they are attending and what their role is in supporting the Community Advisory Council.

- Inviting all CAC members in attendance to share input during discussions and before decisions are made. We want to prioritizing Consumer Representatives and make sure all voices are heard. Guests in attendance are invited to contribute to the conversation when requested by the CAC Chair or Vice Chair.

- Building relationships between CAC members. We will be setting aside time at each meeting for CAC members to go into a virtual break out room, answer icebreaker questions or chat about anything they'd like.

COMMUNITY ADVISORY COUNCIL

December 19, 2024

Held in person and virtually via Zoom
Bend East Library

CAC Members Present
Brad Porterfield, Chair, Consumer Representative
Jessica Jacks, Deschutes County Health Services
Linda Johnson, Community Representative
Stacy Shaw, Consumer Representative
Theresa Nguyen, Jefferson County Public Health
Conor Carlsen, Consumer Representative
Aimé Maxwell, Consumer Representative
Christie Rudder, Consumer Representative
Elaine Knobbs-Seasholtz, Mosaic Community Health

CAC Members Absent
Mayra Tepáyotl-Alvarez, Consumer Representative
Mandee Wyrick, Consumer Representative
Miranda Hill, Klamath County Public Health – could have joined remotely

COHC Staff Present
Gwen Jones, Central Oregon Health Council
Avery Grace, Central Oregon Health Council
Bradley Garner, Central Oregon Health Council
Kelley Adams, Central Oregon Health Council
MaCayla Arsenault, Central Oregon Health Council
Carol Martin, Central Oregon Health Council

Support & Guests Present
Katie Ortgies, PacificSource
Amy Martin, Oregon Health Authority
Dustin Zimmerman, Oregon Health Authority

Introductions

- Brad Porterfield welcomed all attendees. All participants introduced themselves to save time at the meetings.

Land Acknowledgement

- Conor Carlsen read the Land Acknowledgement.

Meeting Practices

- Brad Porterfield reviewed the Meeting Practices and how the CAC meetings are meant to be welcoming for all.

Public Comment/Patient Story

- Brad Porterfield welcomed public comments or patient stories:
    - Stacy Shaw noted that her father has been able to go onto OHP and therefore cut back on work and made improvements in mental and physical health. Worries over costs have been removed. He has had a good experience, and he is happier and healthier.
    - **A**my Martin shared that on November 1st, OHP opened up to DACA and new asylum seekers and there has been a push to get caught up with ongoing care before any new Administration may change the rules. She will send out notes on how to access assistance to CAC members.
    - Aimé Maxwell noted that since being on OHP, she has been able to access alternative practices and very grateful to be able to do this.

Emerging Issues

- Amy briefed on the emerging issue of expedited enrollment and care access for asylum seekers and eligible DACA. Those already on Healthier Oregon can now choose which package they would prefer to be on and ODHS approving access.
- Linda Johnson noted she had a concern regarding the new Administration picking up people while trying to access services either at VIM or the Health Department or when accessing health care.
- Dustin Zimmerman noted from the State's perspective they are always doing what they can to protect health information that gets sent to the federal level e.g. Using State funds rather than Federal matching funds for some programs like Healthy Oregon.
- Amy requested if there could be a conversation about public charge and education on OHA access. Public Charge means for those attempting to gain immigration status if they receive certain state or federal benefits that would disqualify them from claiming an immigration status.

Announcements

- Avery briefed that the RHIP is nearly completed and will be available in electronic form in early 2025. We will want to have CAC endorsement of it in January. The question of how CAC endorsement should be shown was discussed, either by CAC logo with individual names or just the CAC logo as CAC is the entity that is required to endorse it. The CAC voted for endorsement via CAC logo only and to exclude names.

- Potential new membership of Lucia Orozco membership to CAC who lives in Prineville. She had sent apologies for today. The CAC Selection Committee has approved the application unanimously. All attending members approved her membership to the CAC.
- Vice Chair candidates were Mandee Seeley and Stacy Shaw. Avery noted that Mandee was unable to attend. Stacy Shaw added personal comments to her note on the slide. Since Mandee was not present, CAC will be asked to vote via a survey following the meeting.
  Action – send email vote out for Vice Chair
- Solidarity statement – Avery briefed that of those that voted, there was general agreement to exploring a solidarity statement. She proposed for those interested to form a voluntary temporary working group to explore and create a draft statement to bring back to the CAC. For those interested please email Avery.

Approval of November Meeting Notes

- Brad Porterfield asked the CAC members in attendance to vote on approving the notes from November. There were no objections to the meeting notes, so they are approved. There was a mistake in the title of approving the last minutes, where it should read October instead of September. The change will be made to the final notes.

Dental Access Task Force

Brad briefed that MaCayla chaired. Board participants, PCS, Brad, and Linda for CAC were able to attend.

- Upcoming developments include a qualified directed dental payment program due to start on 1.1.25. This is extra money going to providers to provide proscribed services. Increasing access to hygienists and is mainly on preventative dental services.
- Collection of data on how many people see a dentist and whether these new measures will increase visits.
- A review of the dental package also took place.
- The shortage of dental assistants is also a problem.
- Since dentists are only reimbursed 30% of the costs via OHP one of the options discussed would be for private practice dentists to provide OHP services in an OHP environment.
- Cancellations/no-shows from OHP members are high compared to private insurance members
- The new State Dental Director planning on attending the next meeting.
- The suggestion of a salaried periodontist who could work around the region.
- The next Task Force meeting will be on Tuesday 21st January, CAC members are welcome to take part.

CAC Member Surveys (2023-2024) Reflection & Appreciation

- MaCayla Arsenault and Avery Grace to reflect on achievements for this past year. She handed out the planning sheet from the beginning of the year. She asked for additions to this list:
  - Both the Board and CAC had been through some shared equity training, in preparation for the selection process.
  - Increasing consumer engagement has been good, and being able to find a member from Prineville

- The Dental Access Task Force
- Some of the challenges for the CAC were, the capacity to attend all meetings and review all the submissions 40+.

What things would you move forward to next year looking at the list:

- Increasing the CAC visibility – becoming a household name.
- Avery noted that the way COHC will have new funding details for new RHIP, but the CAC remains the direct contact with the public.
- For the next round of applications working in pairs would help and this can be offered.
- Linda noted she would like to see a more measurable response in emerging issues and more partnership between the Board and CAC on the new model. To see more community participation.

Avery briefed on the results of the survey with the learnings and outcomes taken forward for discussion in January for CAC work for the year.

- Regarding the funds to the Tribes, CAC would like to hear feedback from them on the use of the funds.
- Avery one place to build relationships is a monthly meeting called Native Aspirations. About 25% of attendees are tribal members and 75% are local community partners who are doing work or want to build relationships with the tribes. They share what is taking place and the opportunities available.
- Linda noted we should be more intentional about inviting the tribes in consistently when we identify specific issues.
- The CAC refined the English and Spanish language fliers. Members requested if it could be emailed to them. The CAC flyer was never distributed by PCS as has to be in compliance. It has to go through PCS, but the intention was COHC would pay for part of the distribution.

  Action – Staff will follow up on the distribution of the flyer to OHP members and to CAC members

Learnings from the RFP process:

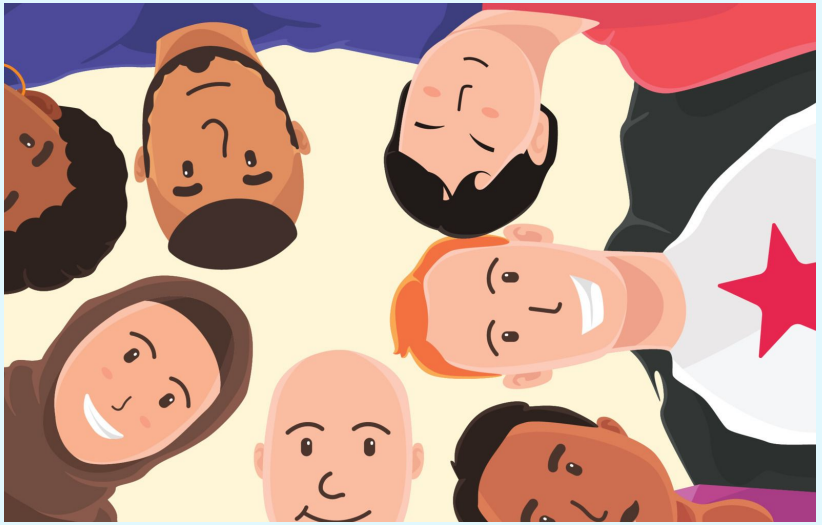
- No points on the score sheet for being a first-time applicant should be included.
- Letters of support – showing some level of engagement/partnership
- More focus on equity than previously
- Evaluating grants was hard, can we strengthen the skills of CAC by strengthening the process to be more consistent with capacity and knowledge?
- The question of trusting the scoring or not came up

February CAC Meeting

02.20.25

CENTRAL OREGON
HEALTH
COUNCIL

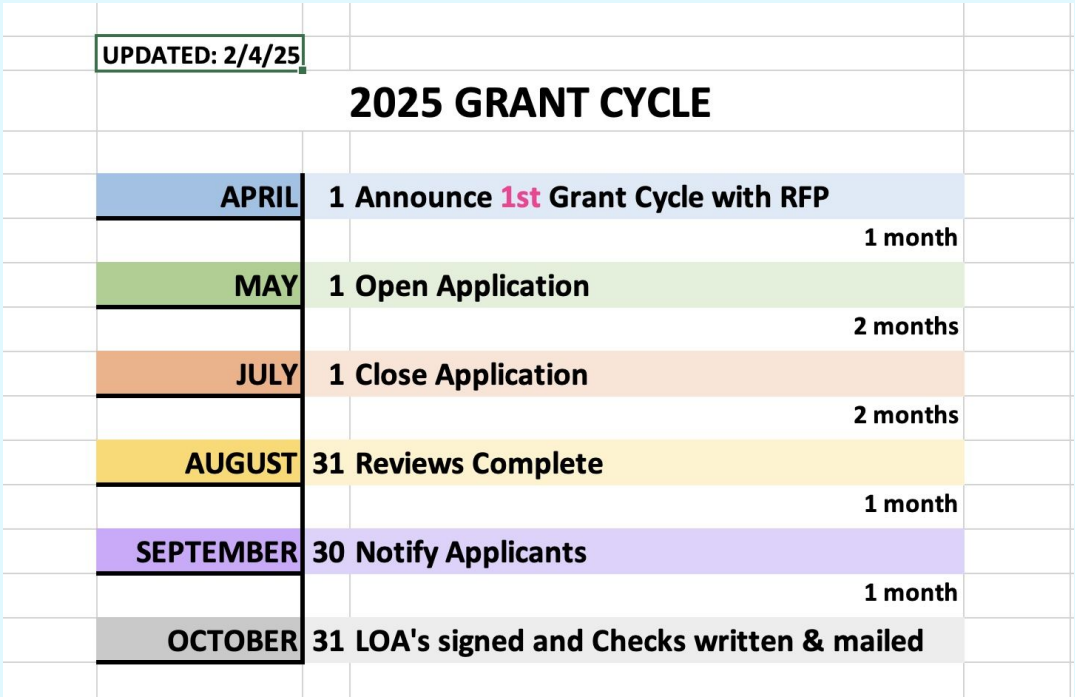
Agenda



- Introductions & welcome
- Announcements
- RHIP Discussion & Endorsement
- CAC's Role and Advocacy Tools
- 2025 CAC Planning
- Dental Access Task Force Update
- Dental Access Pilot Program Presentation - Volunteers in Medicine

COHC Grant Funding Cycle Update

- Recent changes made to how and when COHC does grant-making
- Updates that affect the CAC and its 2025 CHPs:
- New CAC RFP and scorecard by April
- CAC reviews applications July-August (not end of the year as in 2024)
- RFPs based in the RHIP objectives



UPDATED: 2/4/25		
2025 GRANT CYCLE		
APRIL	1	Announce 1st Grant Cycle with RFP
		1 month
MAY	1	Open Application
		2 months
JULY	1	Close Application
		2 months
AUGUST	31	Reviews Complete
		1 month
SEPTEMBER	30	Notify Applicants
		1 month
OCTOBER	31	LOA's signed and Checks written & mailed

2025 CAC Planning!

What goals were set by CAC for 2024? How did CAC do on them?

Goals or priorities CAC wants to keep or continue?

New goals and priorities CAC wants to address?

To know where you're headed, you must remember where you've been…

Review of CAC's 2024 Plans

Consumer engagement/recruitment & increasing consumer voice

- Assess our representation.
- Work on Tribal involvement
- Review community survey data (OHP), grievance and appeals data, customer service data, 2023 flex funds data, any data that could tell us what members are saying and build into meetings 2-3 times per year.
- Recruitment engagement campaign
- Have an orientation event. Come once a quarter and learn. No commitment. Record an orientation and have materials prepped.
- Social media posts

Increase CAC visibility

- Have an event in each of the communities
- Participate in other community events. (have one COHC staff member and one CAC member)
- Flyers
- Provider partner outreach (FAN, Shepherd's House, Family Resource Center, COPA, Mosaic, Summit, Connect Central Oregon etc.)

Make a difference in emerging issues

- Fully address dental access
- More collaboration with the Board
- Gain clarity on what the board looks to the CAC for in terms of advice

Improved feedback/report back loop from grantees

- Planned trips to see the project in action

CAC Member Reflections on 2024

How did we do compared to the goals you set for yourself in 2023, for the year of 2024?

CAC accomplishments that were not part of that first planning list?

Were there things CAC didn't achieve from its original planning?

Other areas for improvement?

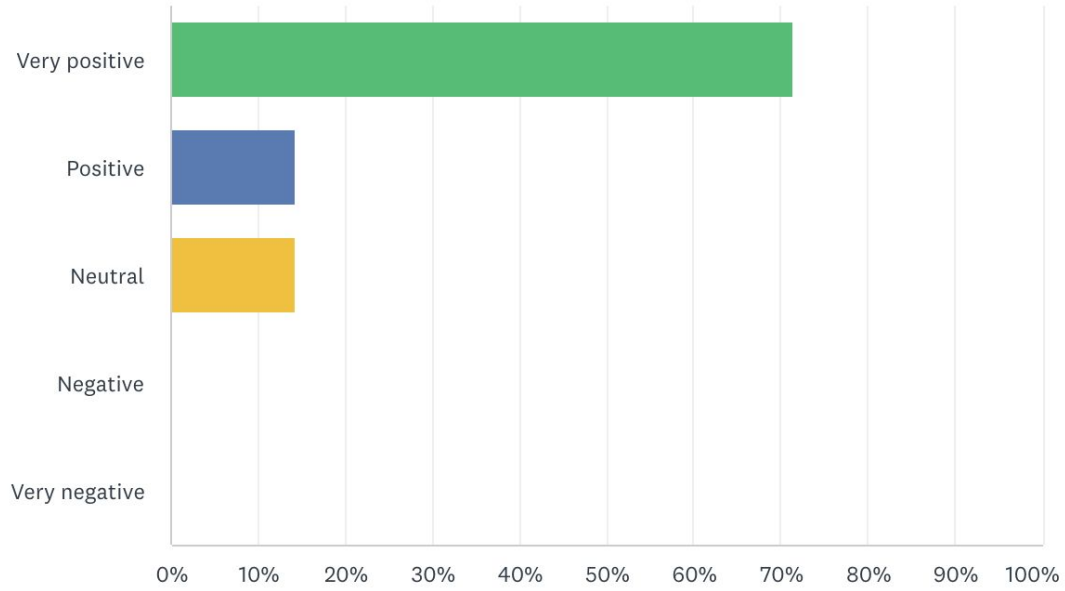
Q1: In your opinion, what has been the greatest accomplishment of the CAC this year?

- "Putting money back into the community and voting on RHIP priorities"
- "Unity! I am amazed at our team who coordinates and opens our whole selves for discussions and decisions"
- "Allocation of resources and OHP member experience advocacy"
- "Movement on the dental access issue in collaboration with the board"
- "BOD and CAC are finding time to meet together and looking forward to ongoing collaboration"
- "Grants Awarded"

What stands out? Learnings?

How do you feel about the CAC's process of setting aside separate community health funds to the Tribes in the CCO service area, and respecting their sovereignty and expertise to use those funds in ways their nations/communities see as best fit to address their needs?

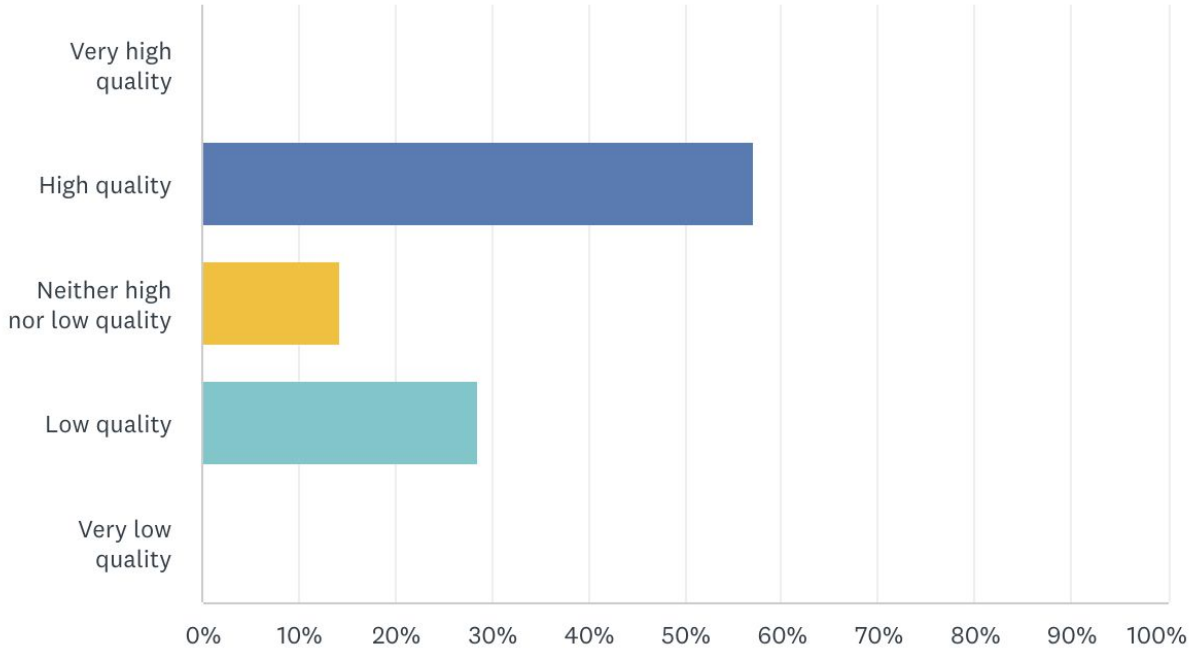
Answered: 7 Skipped: 0



What stands out? Learnings?

How would you rate the CAC's final RFP (Request for Proposals) and scorecard for this year's Community Health Projects (CHPs)?

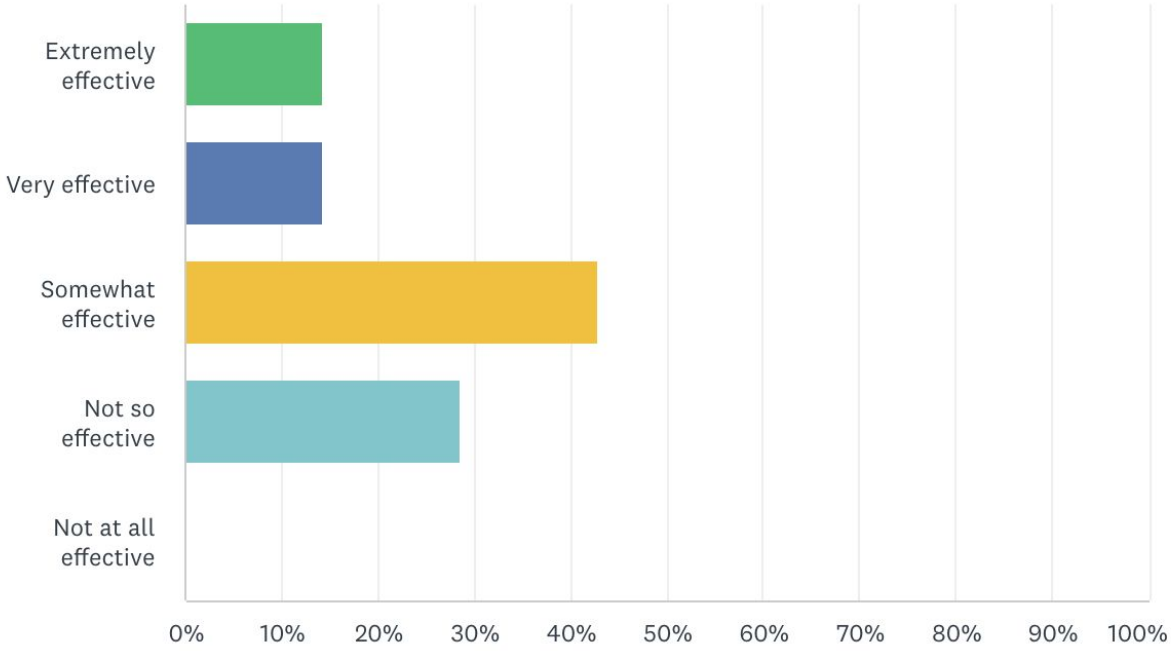
Answered: 7 Skipped: 0



What stands out? Learnings?

How effectively or thoroughly did the CAC review and select the grant awardees of the Community Health Projects across our 4 county areas?

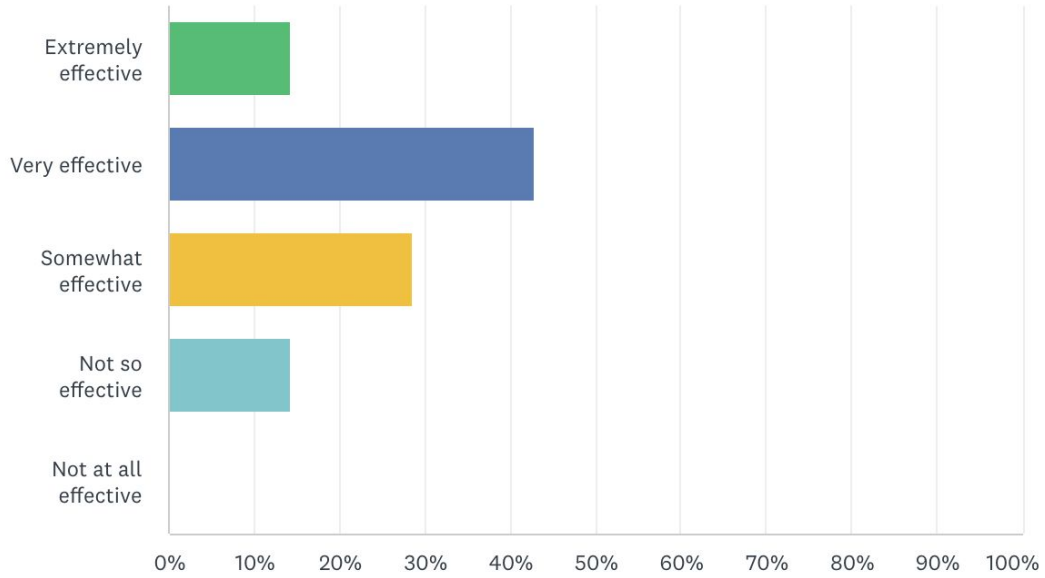
Answered: 7 Skipped: 0



What stands out? Learnings?

How effective was the CAC in bringing forward emerging issues, such as Dental Access?**Not how effective or how quick has the process moved forward after the CAC brought them to the Board of Directors' attention.

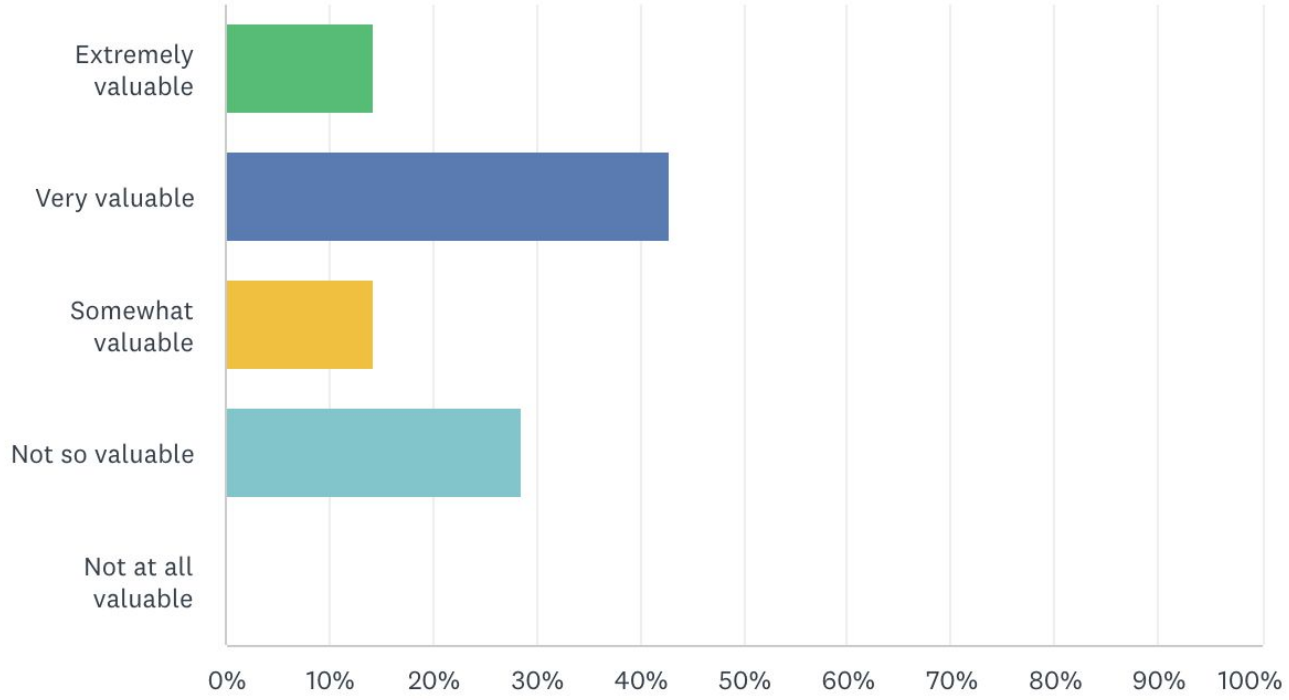
Answered: 7 Skipped: 0



What stands out? Learnings?

How valuable was CAC participation alongside the Board in the Selection process of the final RHIP Health Topics?

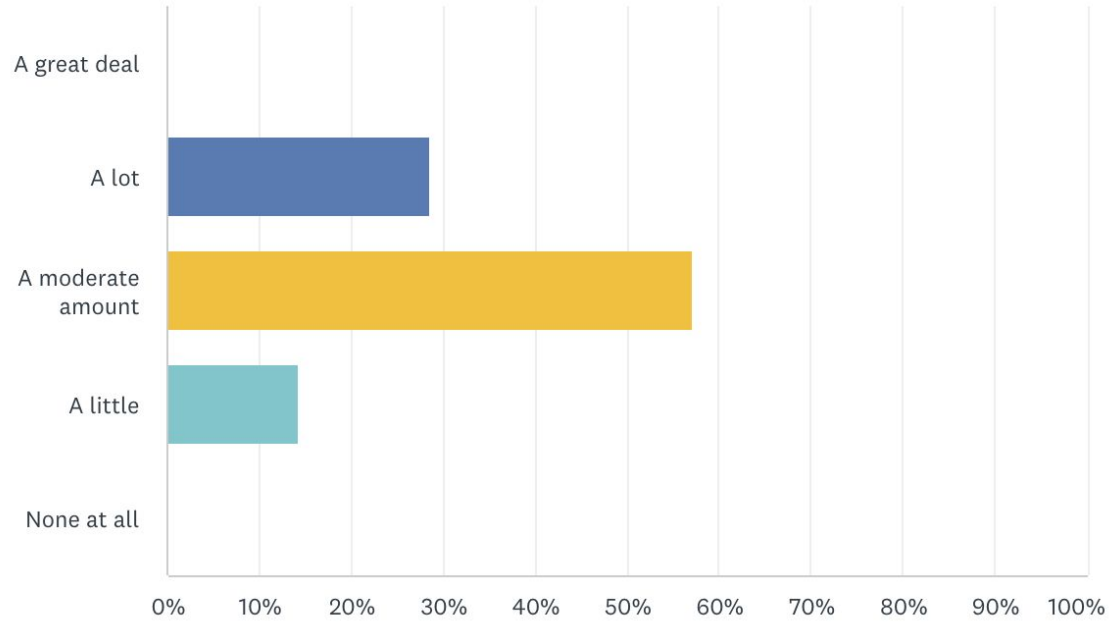
Answered: 7 Skipped: 0



What stands out? Learnings?

How equitable & broadly representative was the CAC's membership of our diverse Central Oregon communities this year?

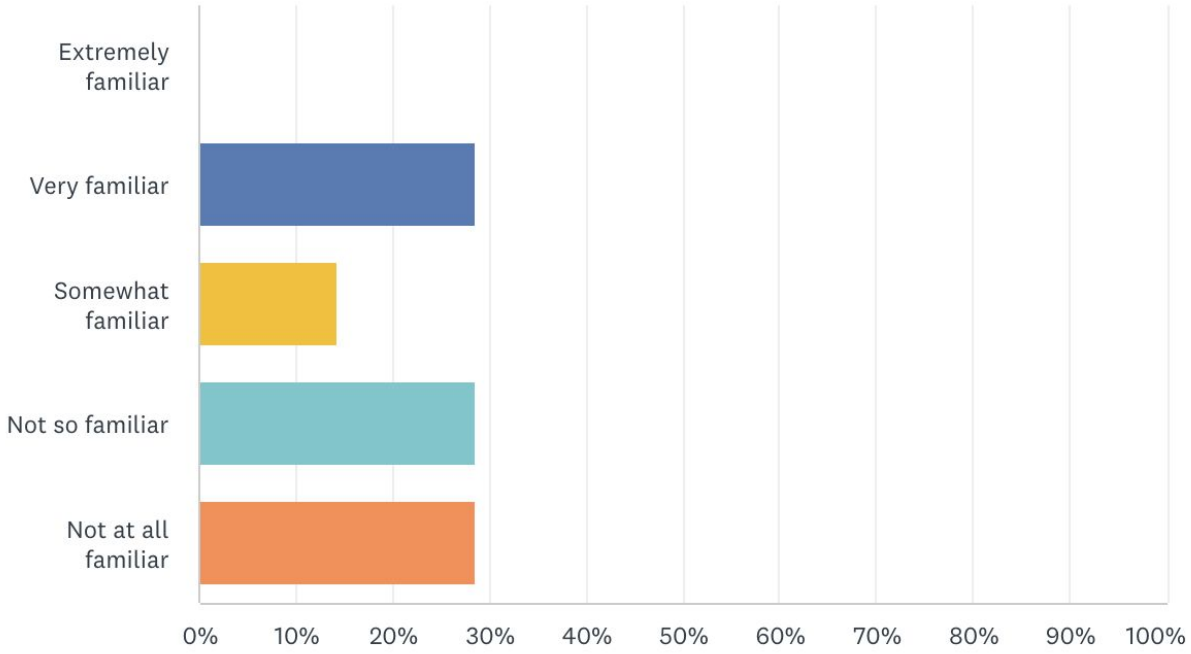
Answered: 7 Skipped: 0



What stands out? Learnings?

How visible or familiar is the CAC overall within our Central Oregon communities and outside the Health Council?

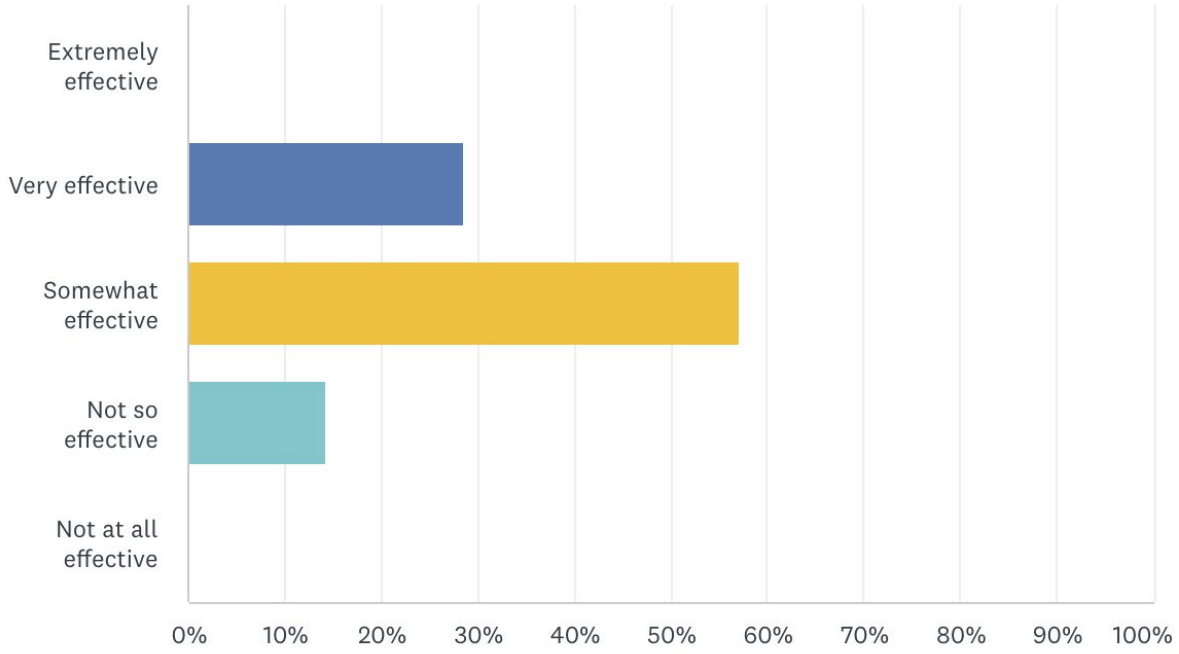
Answered: 7 Skipped: 0



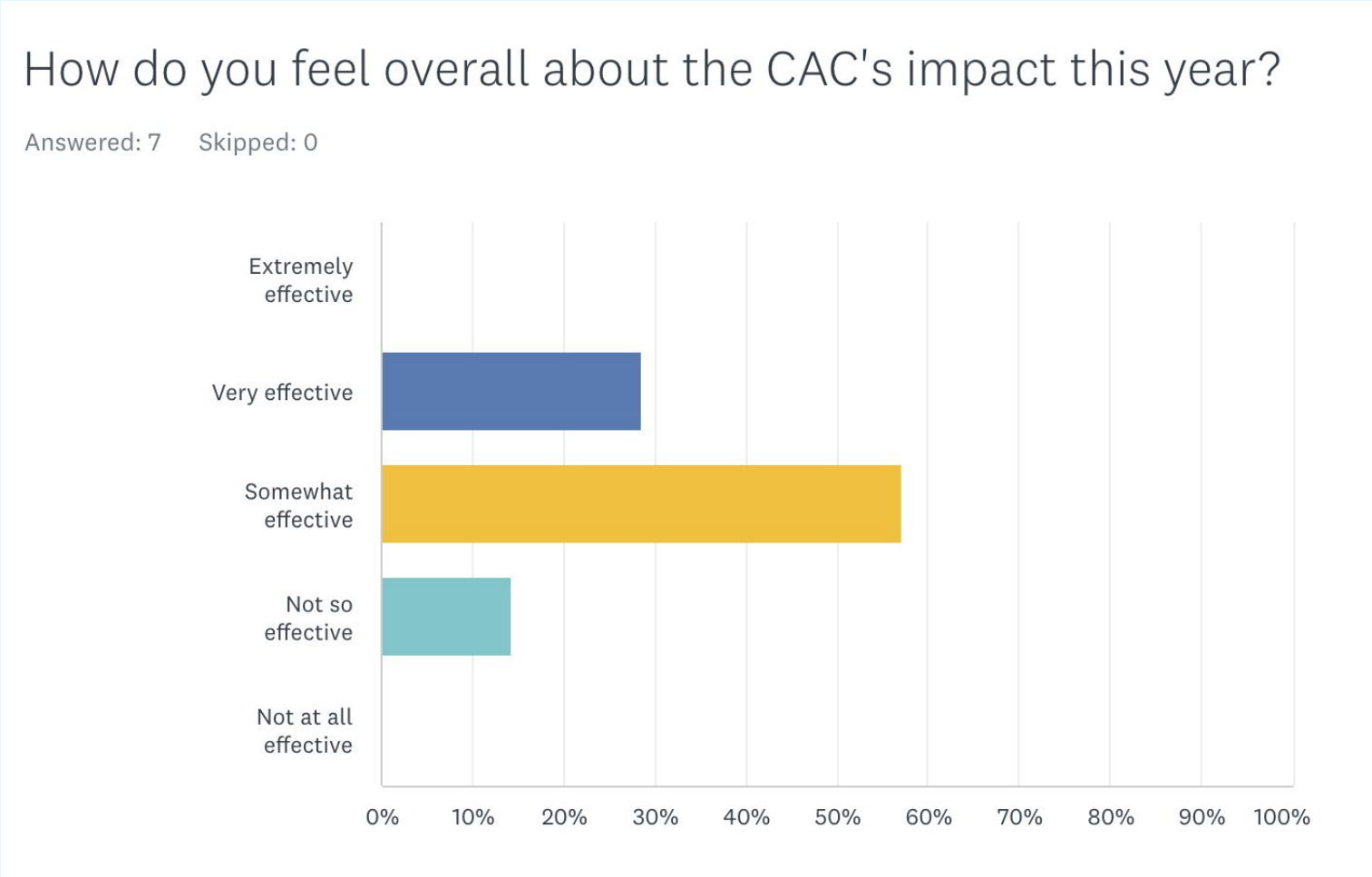
What stands out? Learnings?

How effective was the CAC in new CAC member outreach and recruitment?

Answered: 7 Skipped: 0



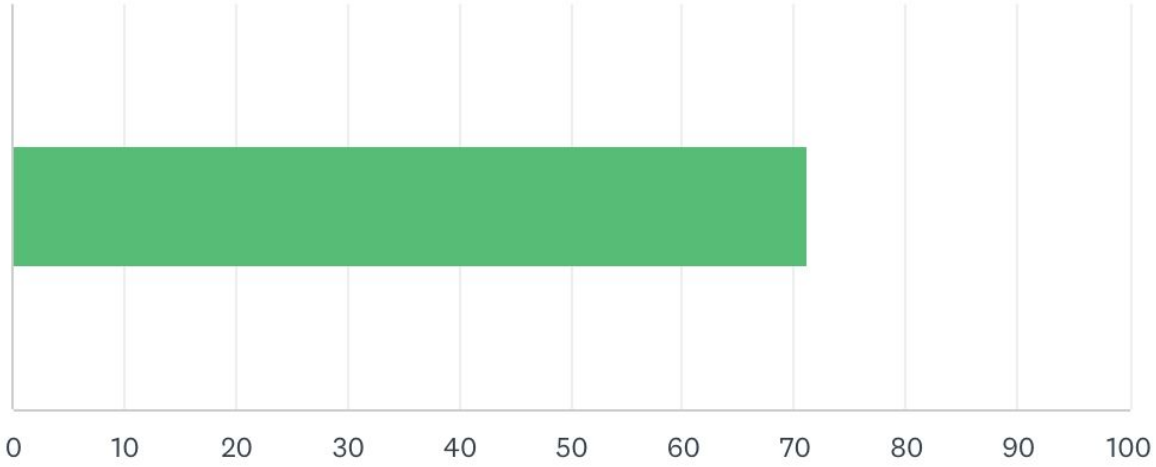
What stands out? Learnings?



How does this compare to your 2024 goals?

How would you rate the CAC's quality and effectiveness overall? (0 = lowest, 100 = highest)

Answered: 7 Skipped: 0



Q4: In your view, what are the CAC's strengths?

- “Being able to advocate and listen to those on OHP”
- “Unity for collaboration of ideas from members of individual diverse backgrounds”
- “OHP member voice”
- “On the ground experience.”
- “Our CAC members' dedication and persistence and our ability to make impartial decisions regarding the community health project funding”
- “Shared goal to improve the health and well-being of our communities.”
- “Committed members and staff”

Q5: What are areas that the CAC could and/or needs to grow in?

- “More member diversity”
- “There are so many people in need of assistance and services. So hard to meet it all. Wish we could focus to meet more. I know it is overwhelming”
- “Overall goals and action plans”
- “Membership from Madras, Prineville, and Warm Springs”
- “I think we need to step back and assess whether or not we are directing our energy toward the tasks that will help us achieve the best outcomes for OHP members”
- “More involvement in the RHA, RHIP planning, implementation, ongoing support for the RHIP; more CAC at the BOD and recruitment of CAC OHP members.”
- “Better alignment with board priorities”

Q18: If the CAC could do or accomplish anything next year that would be of most value to you, your communities, and/or the region as a whole, what would one of those things be?

- “Greater social media presence or attending community outreach events”
- “Accessible affordable housing. We need housing that is inclusive for people with disabilities please!”
- “Actually giving input on board items”
- “I'd like to see greater clarity on why we are distributing money and what impact we want to have”
- “Increase OHP member participation in our processes and/or create more opportunities for CAC members to engage with and hear from OHP members”
- “CAC membership, CAC membership on BOD, process/support reviewing community projects grant proposals”
- “Focus on recruiting members who will speak up on behalf of enrollees”

Congratulations & Wonderful Job!

Thank you for your hard work in helping guide the investment of funds into needed efforts and communities during 2024!

AND, with an explicit intention to help reduce health disparities!

2025 CAC Planning!

What goals were set by CAC for 2024?

How did CAC do on them?

Are there goals or priorities from 2024 that CAC wants to keep or continue?

Are there new goals and priorities CAC wants to address or include?

CENTRAL OREGON HEALTH COUNCIL

PO BOX 6689 | BEND, OREGON 97708 | 541.306.3523 | COHEALTHCOUNCIL.ORG

ORS 414.575 Community advisory councils

(1) A coordinated care organization must have a community advisory council to ensure that the health care needs of the consumers and the community are being addressed. The council must:

(a) Include representatives of the community and of each county government served by the coordinated care organization, but consumer representatives must constitute a majority of the membership; **and**

(b) Have its membership selected by a committee composed of equal numbers of county representatives from each county served by the coordinated care organization and members of the governing body of the coordinated care organization.

(2) The duties of the council include, but are not limited to:

(a) Identifying and advocating for preventive care practices to be utilized by the coordinated care organization;

(b) Overseeing a community health assessment and adopting a community health improvement plan in accordance with ORS 414.577 (Community health assessment and adoption of community health improvement plan); **and**

(c) Annually publishing a report on the progress of the community health improvement plan.

(3) The community health improvement plan adopted by the council should describe the scope of the activities, services and responsibilities that the coordinated care organization will consider upon implementation of the plan. The activities, services and responsibilities defined in the plan shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

(a) Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;

(b) Health policy;

(c) System design;

(d) Outcome and quality improvement;

(e) Integration of service delivery; **and**

(f) Workforce development.

(4) The council shall meet at least once every three months. The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting.

(5) If the regular council meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the council shall hold quarterly meetings:

(a) That are open to the public and attended by the members of the council;

(b) At which the council shall report on the activities of the coordinated care organization and the council;

(c) At which the council shall provide written reports on the activities of the coordinated care organization; **and**

(d) At which the council shall provide the opportunity for the public to provide written or oral comments.

(6) The coordinated care organization shall post to the organization's website contact information for, at a minimum, the chairperson, a member of the community advisory council or a designated staff member of the organization.

(7) Meetings of the council are not subject to ORS 192.610 (Definitions for ORS 192.610 to 192.690) to 192.690 (Exceptions to ORS 192.610 to 192.690). [Formerly 414.627]

Note: 414.575 (Community advisory councils) was enacted into law by the Legislative Assembly but was not added to or made a part of ORS chapter 414 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

Location:
https://oregon.public.law/statutes/ors_414.575

Original Source: Section 414.575 — Community advisory councils, https://www.oregonlegislature.gov/bills_laws/ors/ors414.html (last accessed Aug. 25, 2023).

CCO Community Advisory Councils (CACs): Frequently Asked Questions (FAQs)

This document covers frequently asked questions about CAC requirements. These requirements are detailed in:

- the CCO Contract;
- Oregon Administrative Rules (OARs); and
- Oregon Revised Statute (ORS).

Quick Links

CAC Demographic Report

1. When is the CAC Demographic Report due each year?

The report is due by June 30 each year[1]. CCOs should submit this deliverable through the CCO portal.

2. Is there guidance available to CCOs on completing the report?

Yes. The Transformation Center posts report guidance on the CAC support webpage by March each year.

3. Where can I find prior CAC Demographic Report submissions?

Final reports are available on the Transformation Center's CAC support webpage (scroll down to the CAC Demographic Report's table).

CAC Duties

1. What is a CAC?

A Community Advisory Council is a CCO-convened council that meets regularly to ensure the CCO is addressing the health care needs of consumers and the community[2].

2. What are the primary duties of a CAC?

- Identify and advocate for preventive care practices to be utilized by the CCO[2]
- Oversee a Community Health Assessment (CHA) and adopt a Community Health Improvement Plan (CHP), in accordance with ORS 414.577[2]
- Annually, publish a report on the progress of the community health improvement plan[2]
- Have a role in:
    - Health-related Services (HRS) community benefit initiative (CBI) spending decisions[3]; and
    - Supporting Health for All Through Reinvestment (SHARE) Initiative spending decisions[4]

[1] CCO Contract: Exhibit K, 5.d
[2] ORS 414.575
[3] OAR 410-141-3845
[4] OAR 410-141-3735

3. What are ways CCOs can assist the CAC in promoting preventive care practices?
The following examples were shared from CCOs and CACs:

- The CCO hosts a listening session to give the CAC space to share experiences and observations as consumers within the CCO's plan.
- The CCO hosts a joint CAC and Clinical Advisory Panel meeting to discuss relevant CCO Quality Incentive Metrics.
- The CCO creates a prevention-focused subcommittee of the CAC.
- CAC members are given the opportunity to participate in Community Health Improvement Plan work groups or committees where they can promote preventive care practices.

4. Does OHA require that the CAC officially approve the CHA?
Yes. This could be documented in the CHA directly, in CAC meeting minutes, workgroup meeting minutes or by providing other relevant CHA documentation.

5. What are examples of how a CAC can oversee the CHA process? CACs may:
The following examples were shared by CACs and CCOs:

- Provide feedback to the CCO and CHA partners in developing CHA assessments.
- Advise the CCO and CHA partners on community engagement strategies.
- Participate in the CHA data collection process.
- Review health assessment data and makes recommendations to the CCO and CHA partners about CHP prioritization.
- Participate in a CHA development work group.
- Review drafts of the CHA and provide feedback to the CCO and its CHA partners.

6. Does OHA require approval by the CAC for any revisions made to the CHP?
The CAC is required to adopt the CHP, so any changes made to the document would need to be adopted by the CAC.

7. Is it the responsibility of the CAC to publish the report on the "progress of the community health improvement plan"? And are CCOs required to get approval from their CAC(s) before submitting a CHP Progress Report?
It is the responsibility of the CCO to publish and submit the CHP Progress Report to OHA. In doing so, the CCO should seek approval of the report from their CAC(s).

7. Are there guidelines that CCOs should use when developing a CAC role for Health-Related Services CBI spending decisions?
The CCO determines the CAC's role for these investments, and that should be clearly defined within the CCO's HRS policy and procedure. Many CCOs have involved their CAC(s) in the development of CBI funding opportunities. For example, CACs have been involved in developing a scoring rubric, defining the project award limit and project priority areas, reviewing applications for funding, and selecting projects to fund.

8. Are there guidelines that CCOs should use when developing a CAC role for CCO SHARE Initiative spending decisions?
The CCO defines the CAC role related to CCO SHARE-related spending decisions. Here are a few examples:

- The CAC identifies and/or approves SDOH-E priorities that are in line with community priorities in

the CHP.
- The CAC makes recommendations to the CCO on what types of organizations to fund.
- The CAC develops a rubric to use in scoring SHARE Initiative proposals.
- The CAC reviews SHARE Initiative related proposals and makes recommendations to the CCO leadership or board.
- The CCO designates a portion of funding for the CAC to direct to SHARE Initiative efforts.

8. Can subcommittees of the CAC make decisions on behalf of the regular CAC?
Decisions must made by the main CAC. Decisions cannot be delegated to CAC subcommittees. Subcommittees can make recommendations to the full CAC but cannot make decisions on behalf of the CAC. If required, decisions could be made in between CAC meetings by the regular CAC via email, if permitted in the CAC charter or bylaws. It is recommended that CCOs identify the types of decisions that could be made by the regular CAC via email in the charter or bylaws.

CAC Membership & Selection

1. How many CACs are CCOs required to establish?
One[2].

2. Who is required to participate in the CAC Selection Committee?
The CAC Selection Committee must be comprised of, in equal numbers: 1) individuals who sit on the CCO's governing board, and 2) individuals who are representatives of each county within the CCO's service area[2].

3. What is the alternative if a county in the CCO's service area does not have staffing to serve on the CAC Selection Committee?
The county could delegate its CAC membership rights to another county in the same CCO's service area to vote on its behalf. This would be accomplished through a written agreement between the counties, such as a letter or Memorandum of Understanding, signed by both counties. Since ORS 414.575(1)(b) requires the number of county representatives to be the same as the number of governing body representatives, then the number of governing body representatives would need to be decreased to match the number of county delegates.

4. Can CAC coordinators participate in the CAC Selection Committee?
CAC coordinators can participate in the CAC Selection Committee if they are county employees. If they are not county employees, CAC coordinators are not able to participate on the CAC Selection Committee[5]. It is the expectation that CAC coordinators will engage in CAC recruitment activities and nominate potential CAC members to the CAC Selection Committee to consider.

5. If there is a tie vote on the CAC Selection Committee regarding the decision of whether to appoint a new CAC member, who is responsible for making the tie-breaking vote?
It is up to the CCO to determine who will make the tie-breaking vote.

6. Is the CAC Selection Committee responsible for selecting the two CAC members (one who must be a consumer) to the CCO's governing board?
No, it is up to the CCO to determine how these two CAC members will be selected[6].

7. What seats must be filled on a CAC?

[5] Per ORS 414.575
[6] OAR 410-141-3715

- Consumers must represent a majority (at least 51%) of members on each CAC[2].
- Representatives of each county government in the CCO's service area[2]
- Representatives of the diversity of populations within the CCO's service area, with specific emphasis on individuals who are representative of populations that experience health disparities[7]
- Note: Tribal CAC seats are technically not required seats. Rather, a CCO is required to reach out to tribes to identify if they would like to appoint a tribal member on their CAC(s). CCOs shall afford an opportunity for tribal participation on CACs as follows:
  (a) In CCO service areas where only one federally recognized tribe exists, the CCO shall seek one tribal representative to serve on the CAC;
  (b) In CCO service areas where multiple federally recognized tribes exist, the CCO shall seek one representative from each tribe to serve on the CAC;
  (c) In metropolitan CCO service areas where no federally recognized tribe exists, CCOs shall solicit the Urban Indian Health Program for a representative to serve on the CAC[8].

8. For a CCO that has a very small number of members in an adjacent county, is this county required to be represented on the CAC?
Yes. However, if the adjacent county does not have adequate staffing to identify a county employee to serve on the CAC, the county could delegate its CAC membership rights to another county on the CAC to vote on its behalf. This would be accomplished through a written agreement as described in #3 above.

9. What is the definition of a consumer CAC member?
A person serving on a CAC who is, or was within the previous six months, a recipient of medical assistance (on the Oregon Health Plan) and is at least 16 years of age; OR a parent, guardian or primary caregiver of an individual who is, or was within the previous six months, a recipient of medical assistance[9].

10. Does a CAC need to have consumer representation from each county in its service area?
No.

11. Is there an age limit for considering children as consumer OHP CAC members? For example, if a parent/guardian has a 30-year-old child on OHP, could the parent/guardian be considered a consumer CAC member?
The parent/guardian of the child on OHP would count as a consumer regardless of the child's age. Age is not part of the consumer definition for the parent/guardian. As defined on page one of this document, a consumer representative is a person serving on a CAC who is, or was within the previous six months, a recipient of medical assistance and is at least 16 years of age; OR a parent, guardian or primary caregiver of an individual who is, or was within the previous six months, a recipient of medical assistance.

12. How long do CCOs have to fill an empty CAC seat?
CCOs have 120 days to fill empty CAC seats[10]. If the seat cannot be filled during this timeframe, a one-month extension can be requested by emailing OHA. The request is subject to approval. OHA may ask for information about the CCO's efforts to fill the seat. Note: If a consumer CAC member resigns, and the

[1] ORS 414.575
[7] CCO Contract Exhibit K, 2.a.(2)
[8] OAR 410-141-3500
[9] ORS 414.572
[1] ORS 414.575
[10] CCO Contract Exhibit K, 2.b.

percentage of consumer members on the CAC remains above 51%, CCOs are not required to fill this seat.

13. What are CCOs expected to do if a CAC member requests a leave of absence? Are CCOs required to fill this seat within the required 120-day timeframe?
OHA understands there are a variety of reasons a CAC member may need to take a leave of absence. Recognizing a leave of absence is temporary and not a resignation from the seat, there would not be an expectation to remove and replace someone from a seat during a temporary leave of absence. This individual would continue to count as a CAC member (towards meeting overall CAC membership requirements) during their leave of absence, even though they would be unable to attend CAC meetings.

14. Is there a minimum age requirement for non-consumer CAC members?
No. However, OHA recommends 16 as a good starting age for a non-consumer CAC member.

15. Do tribal CAC members need to be included in the total count of CAC members?
Yes.

16. Can Tribal fee-for-service (FFS)/open card members be considered CAC members? What about non-Tribal FFS/open card members?
Yes. The OHA Lived Experience Advisory Panel is another option for FFS/open card members.

17. How do I determine which local tribes my CCO should reach out to about tribal CAC membership?
Please refer to this document, which is a crosswalk of tribal-CCO service areas.

18. Who should I reach out to at local tribes about tribal CAC member recruitment?
Please reach out to your CCO's tribal liaison and Michael Stickler (OHA Tribal Affairs Policy Analyst) for any questions about engaging tribes.

19. Is there a cap on the number of members per CAC?
OHA does not cap the number of members per CAC. However, CAC membership requirements described in question #7 (What seats must be filled on a CAC?) must be met. It may be helpful to balance the need for a range of members, while also considering the size of the CAC to allow all members to participate in meetings.

20. Can individuals with a personal relationship both serve on a CAC? Examples would be a parent and child, or siblings?
Yes.

CAC Meetings

1. How often do CACs need to meet?
No less than once every three months[2].

2. If the regularly scheduled CAC meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the CCO is required to hold semiannual meetings that provide written reports on the activities of the CCO[2]. What are examples of written reports?
Examples of reports include the Community Health Improvement Plan (CHP), Health Equity Plan, and the Transformation & Quality Strategy (TQS).

3. Are CCOs required to post CAC meeting minutes on their website?
Yes, per ORS 414.575, "The council shall post a report of its meetings and discussions to the website of the coordinated care organization and other websites appropriate to keeping the community informed of the council's activities. The council, the governing body of the coordinated care organization or a designee of the council or governing body has discretion as to whether public comments received at meetings that are open to the public will be included in the reports posted to the website and, if so, which comments are appropriate for posting." It is also up to the CCO to determine how long CAC meeting "reports" should be posted on its website.

Other CAC questions

1. What is OHA's process for reviewing CCO materials that are developed for OHP members (including OHP consumer CAC members)?
Please refer to this FAQ, "Submitting CAC materials for Medicaid compliance review." Note that social media posts do not need to be reviewed. This information is outlined in general material guidance for CCOs.

2. Where do I find a list of all the CAC-related CCO contract deliverables and the associated due dates?
On the Transformation Center's CAC support's webpage. The document is titled, "Guide to CAC-related CCO contract deliverables.

Please contact thomas.cogswell@oha.oregon.gov or transformation.center@odhsoha.oregon.gov with any questions about this document.

COHC DENTAL ACCESS TASK FORCE

January 21, 2025
Held virtually via Zoom

Attendees:
Gary Allen, Advantage Dental
MaCayla Arsenault, COHC
Conor Carlson, CAC Consumer Representative
Avery Grace, COHC
Dr. Ahmed Farag, OHA Dental Health Director
Megan Haase, Mosaic Community Health
Brett Hamilton, Oregon Dental Association
Linda Johnson, Community Representative
Carol Martin, COHC
Brad Porterfield, CAC Chair, Consumer Representative
Ari Powell, COHC
Heather Simmons, PacificSource
Camille Smith, COHC
Stacy Shaw, CAC Consumer Representative

Apologies:
Christian Moller-Anderson, A Smile for Kids - Apols
Manu Chaudhry, Capitol Dental Care
Missy King, ODS Community Dental
Mayra Tepayotl- Alvarez, CAC Consumer Representative

Introductions

Ari Powell welcomed all attendees and called for introductions. She announced that MaCayla Arsenault has been promoted to Director of Quality and a lot of her work will be quality based. She will lead the Dental Task Force in the future.

Background

Ari briefed on the background to the Task Force. The CAC had asked for it to be formed and it had previously met in December. The notes from this meeting as well as some background material had been sent to all attendees on Jan 3rd. The COHC Board created sub-committee to discuss the challenges and several additional attendees were invited. Points discussed were:

- New Dental Direct payments to providers and the services covered;
- Supporting the workforce development pipeline of dental hygienists and assistants;
- Dental Benefit Design
- Rates available to providers
- Suggested ideas to support both patients and providers
- Possible Pilot project ideas on what COHC can assist with

Pilot Project

Ari Powell briefed that the Board had gathered a few providers together and ideas that came out of that meeting:

- What sort of pilot project could be designed
- Who should be the targeted group
- Those on OHP with an A1c of 9 or higher and uncontrolled dental infections were suggested

The Board felt this would be a top pilot project and discussion followed on the feasibility and the targeted population. Although narrowly defined, these patients can be identified easily and one way a start to improvement can be made. It would also benefit the primary care population and point a path to greater health. Access to dental health improvement, would hopefully resolve some diabetic and heart issues caused by diabetes.

Brent Hamilton noted that ODA may have a model that could work and be used as a benchmark. It was a previous study on shared health records between dentures and diabetes with a wrap around with primary care and dentists in liaison.

Ari Powell briefed on suggestions around the scope of the pilot project

- How can we use COHC project to reduce the need of having teeth pulled?
- Payments for project from somewhere other than DCOs
- Payments and care can also be considered within the project
- Although there may not be integrated care within the area, work towards this could be included
- Will include rural access consideration within the project.

Dr. Ahmed Farag noted that there have been previous studies into integrated health on oral health improvement vs diabetes care and has been shown as a relationship that works.
It is a long-standing recommendation to integrate primary care and oral care and some places require good oral health before surgery can take place.

The A1c level is a Quality Improvement Measure (QIM) and therefore measurable. It requires two education point – one on primary care side and one on the oral side.

Heather Simmons reminded people that in 2018, the COHC Oral RHIP Workgroup did some work on the connection between diabetes and oral health. The previous literature may still be available on the COHC website in the archived workgroup area. These could be readily

available to people within the region, although they may need updating. Also in 2018, some pilot work was started by inviting DentaQuest to the area as part of spreading co-location across the country with integration or primary care and oral care.

Dr. Farag noted that part of the Health Evidence Review Committee (HERC) is to review services covered by OHP. The Prioritized list will cease in 2027, but he is encouraged that the levels of services covered will remain the same once the list goes away. Ideally, Federal level funding would be good, but unfortunately that is not on the horizon.

Further discussion on the pilot project confirmed that periodontal work may be considered, although Dr. Allen noted non-surgical periodontal benefit is included within the dental package however surgical intervention for periodontal is not covered. All hygienists are trained in scaling and root planning/cleaning which is non-surgical periodontics. Although there is a limit on the number done, most do the four quadrants over a two-year period and then follow up with maintenance twice a year.

Although prevention and oral health is best, the Board looked to find a group that addresses some of the areas and although on a small-scale, outcomes can be taken to the broader population.

Dr. Farag summed up that there are a lot of other studies like this and he will research some to forward to the group. He questioned the number of patients considered for the project and if they will all be OHP or will some private patients be included as well? He also thanked the Task Force for inviting him to be part of the conversation and involved in the concerns the CAC had brought to the Board.

Ari Powell responded that the Board will work with DCOs and providers to develop the project.

The next Task Force meeting will be set up via a Doodle pole to talk about progress on the pilot project.