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**Engaging Beneficiaries with Medicaid & Medicare and Long-Term Services and Supports (LTSS): Strategic Approaches and Partnerships**

**FALL FORUM PROGRAM AGENDA**

7:30 AM – 8:00 AM Registration and Open Exhibits Forum

**8:00 Conference Welcome**

**—Don Ross, Executive Director, Policy & Programs, Health Systems, Oregon Health Authority**

**8:15 – 9:10 Conference Plenary Keynote:**

**“What we know about patient activation, engagement and health outcomes “ —Judith Hibbard, DrPH, University of Oregon**

**SESSION DESCRIPTION:** Why does true patient activation matter? Our keynote presenter will discuss her international research on patient activation and achieving health outcomes over the short and long-term.

**About Our Keynote Speaker:** *Judith Hibbard, is a Researcher and Professor Emerita at the University of Oregon. Over the last 30 years she has focused her research on consumer choices and behavior in health care. Dr. Hibbard is the lead author of the Patient Activation Measure (PAM). The PAM measures an individual’s knowledge and skill for self-management. The measure is being used around the world by researchers and practitioners. She is the author of over 160 peer-reviewed publications. She holds a masters degree in Public Health from UCLA and her doctoral degree is from the School of Public Health at the University of California at Berkeley. She is recognized as an international expert on consumerism in health care and is frequently invited to speak at national and international health conferences. Dr. Hibbard is listed in Thompson Reuter’s 2014 edition of “The Worlds Most Influential Scientific Minds.” We are grateful that Dr. Hibbard calls Oregon home and is available to share her work with us!*

## **9:10 -10:35 Panel: “Engaging Oregon’s High Need and High Risk Members: Examples of Unique Outreach Approaches “**

**SESSION DESCRIPTION:** Why do specific population engagement strategies matter? What are some important steps to success for specific populations you are working to engage? Presenters will provide key advice on working with specific outreach to engage members.

Panel Presentations:

### **—Holden Leung, MSW, Asian Health & Services Center**

*Holden serves as Director of the Asian Health & Services Center. At AHSC, Mr. Leung has developed an Integrated and Holistic Services Model, which addresses the comprehensive wellness needs of the Asian community in a culturally and linguistically appropriate manner. Holden’s presentation will focus on engaging Asian immigrants and refugee populations. He will discuss health literacy, language and cultural barriers.*

### **—Laurie Lockert, MS, LPC , Health Resilience Program™ Manager, CareOregon**

*Using a trauma informed workforce has been an essential foundation of our high engagement rates, as well as walking in the ‘space’ between Primary Care and the client’s world to bear witness and translate the barriers of our client’s daily living to their Providers. Laurie will speak on CareOregon’s use of trauma-informed approaches to engage high-risk members and improve health outcomes and the importance of using a trauma-informed approach based on data from the ACEs study and CareOregon experience.*

### **—Tamara Sale, MA, Early Assessment and Support Alliance Center for Excellence, Portland State University Regional Research Institute**

*Although most major mental illnesses, and psychosis in particular, commonly begin during adolescence and young adulthood, this is the time period when people are the least likely to be connected to medical care. Psychosis creates a significantly greater risk of hospitalization, suicide, accidental harm, as well as impact on the health and well-being of family members. The Early Assessment and Support Alliance (EASA) was created to ensure that effective interventions are rapidly available when psychosis begins. Four Young Adults in Transition (YAT) “hub” programs have been added to EASA to create a more comprehensive system for youth with serious mental health conditions. To succeed, EASA programs and the young adult “hubs” need strong linkages with local CCOs, including referral systems, financing and linkages to primary care. We will introduce the core elements of what EASA provides, services being developed through the young adult “hubs” and how CCOs can most effectively connect with their local EASA and young adult hub programs.*

## 9:10 -10:35 Morning Panel presentation continued:

—**Connie Bonner, Access Technologies Inc.**

*Connie will share information about the current assistive technology that is available to support older adults and members with disabilities in staying in their homes and communities. She will share how technology can assist in building member engagement and linkages to improved health and access to health care for members.*

—**Joyce Beedle RN, BSN, President, Alzheimer's Consulting Service**

*Joyce will share her experience working with family caregivers for Alzheimer's and dementia patients and tips for engagement of caregivers in care planning and care conferences. She will share her experiences with challenges care coordinators often face while working amidst the conflicts between adult family members when addressing the needs of their parent.*

## 10:35 – 10:50 Break & Exhibits: Please visit our Exhibitors!



For today's meeting, in an effort to limit our use of paper, powerpoint and other handouts, panel and roundtable presenter bios, an exhibitors list, as well as any additional materials are available in electronic format. To access these conference materials, please visit the [OHA Transformation Center Complex Care Collaborative website](http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx) at:

<http://www.oregon.gov/oha/Transformation-Center/Pages/Complex-Care-Collaborative.aspx>

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## **10:50 – 12:00 Innovative & Best Practice Roundtable Sessions: “Building Unique Member Engagement Strategies To Improve Health Outcomes “**

Visit three Roundtable sessions, 20 minutes each, three topics of your choice! Staff will sound a bell to change sessions! If a table is full, please go to another table and try again the next round!

Round One: 10:50 – 11:10am Choose a table!

Round Two : 11:15 – 11:35am Choose a table!

Round Three: 11:40am – 12:00pm Choose a table!

### Morning Roundtable Sessions:

#### **1. Assistive Technology: Technology to support members to gain or maintain independence at home, work, school or in the community —Connie Bonner, Access Technologies Inc.**

*What are the A-Z options to help members who may need technology to assist them with particular needs? How do you help members understand what might be available to them to support their continued independence and what resources exist through partner agencies to help cover the cost of technologies. Learn more about how AccessTechnologies Inc. currently serves our APD LTSS members and assists them in understanding what technology exists, explore their options, test drive equipment, and provides assessments and trainings to help members gain or maintain independence at home, work, school, or in your community.*

#### **2. The Americans with Disabilities Act and the Olmstead Decision: A Life of My Own Choosing —Rick Wilcox, Health Policy & Analytics, Oregon Health Authority**

*This session discusses the historical significance of segregation of people with mental illness and will provide an overview of patients’ civil rights protections. We will highlight the significance of The Americans with Disabilities Act (ADA) and what the 1999 Olmstead decision means to your organization. How do we ensure that barriers to choice are able to be overcome to ensure the Olmstead decision’s goals can be met in our communities? What new thinking must we apply and what tools are available to assist us in getting there? Take home some practical ideas for reviewing your organizational approach to ensuring the individual’s choices are at the heart of your care assessment and planning processes.*

***Session description continued next page***

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**10:50 – 12:00 Additional Morning Roundtable Sessions Continued:**

**3. Foundations for Building Health Resilience By Addressing Trauma in High Need/High Utilizer Member Populations —Laurie Lockert, Health Resilience Program™ Manager/CareOregon**

*Laurie will share key foundational building blocks for building a trauma-informed program to serve your members. She will address how to understand the needs of your high-risk population, steps to building the right workforce to address those needs, & metrics to grow and learn .*

**4. Engagement Approaches for Members with Intellectual and Developmental Disabilities —Jasper Smith, Program Manager, Benton County DD services**

*What are unique aspects to building outreach to members with Intellectual and Developmental Disabilities (I/DD)? How do you learn more about this member populations' specific needs and how to best engage with them and their families? What are included in individualized service plans and how might they inform overall health needs assessments and planning to meet member health needs? Join this session to gain an understanding of issues and challenges I/DD members may face. Jasper will also share strategies to engage I/DD consumers, families and providers in working with health systems, health promotion/prevention activities, developing strategies for success and meeting potential challenges.*

**5. “The Asian Wellness Connection”- Building Engagement and Outreach through the Asian Health and Services Center —Holden Leung, MSW, Asian Health & Services Center**

*“Asian Wellness Connection” is a promising approach of connecting Asian immigrants to navigate the healthcare system and empower them takes active role in chronic disease prevention and self- management. Asian Health and Service Center partnered with FamilyCare Health since 2013 and successfully engaged over 2,000 Asian members. Members who enroll into the program have access to a multilingual and culturally specific program, which enable clients to establish a primary health home, navigating the health care system and receive wraparound services.*

## 10:50 – 12:00 Additional Morning Roundtable Sessions Continued:

### 6. Engaging Family Caregivers in Care Planning: Focusing on the Needs of the Alzheimer's Patient —Joyce Beedle RN, BSN, President, Alzheimer's Consulting Service

*Joyce will share her experience working with family caregivers for Alzheimer's patients and on problem solving to ensure the needs of the patient can be met. Joyce's approach to Alzheimer's care has always been warmly personal and customized to each patient. Joyce believes that it's important to relate to people who have Alzheimer's as unique and valuable human beings. Joyce can answer some of your questions about how your organization can create approaches for members with unique care situations that help maintain a focus on the inclusion of family caregivers and working to meet the needs of the patient.*

### 7. EASA/HUBS: A Great Investment in Oregon's Youth: Going Upstream to Support and Work with Oregon Youth with Emerging Behavioral Health Needs —Tamara Sale, MA, Early Assessment and Support Alliance Center for Excellence, Portland State University Regional Research Institute with Sheyne Benedict, LCSW and Carla Gerber, MS from PeaceHealth

*The Early Assessment and Support Alliance (EASA) provides rapid access to evidence-based care for teenagers and young adults who are experiencing symptoms of psychosis in the early stages of illness. This round table will explore what EASA and related services can offer CCOs and how CCOs and local EASA/youth hub programs can work together most effectively.*

### 8. Project ABLE: A Better Life Experience -- Peer-to-Peer Services and Support —Nancy Snider and Rebecca Eichhorn, Co-Directors, Project ABLE

*Project ABLE began in 2001 as a pilot using peer-led support to offer a recovery-based program to Marion County residents with mental health and co-occurring issues. The overwhelming success of the pilot project led to requests for adding new programs and services to the project and making these services available to individuals in neighboring counties. In 2003 Project ABLE was formed as a 501(c)(3) tax exempt non-profit corporation with the mission to "provide peer-to-peer services and supports for individuals recovering from mental health and/or co-occurring issues. These supports and services embrace human dignity, expand the capacity for individuals to recover, and promote lifelong empowerment. Each year more than 2700 people directly benefit from the services of Project ABLE by participating in a program, using a service, or volunteering as a peer supporter. Visit this session to learn more about Project ABLE's work with healthcare partners and with recovery mentors to impact the health of OHP members!*

## 10:50 – 12:00 Additional Morning Roundtable Sessions Continued:

### 9. Building Cultural Competency: Understanding How To Engage and Support The Deaf and Hard of Hearing Community —Theresa Powell, MA, Operations and Policy Analyst, Oregon DHS Aging and People with Disabilities

*Hearing loss affects about 10% of the U.S. population. The loss may range from mild (difficulty with or inability to hear soft sounds) to profound (difficulty with or inability to hear loud sounds). An individual with significant hearing loss frequently communicates using a combination of strategies that rely on residual auditory ability enhanced by a hearing aid or assistive listening device and often supplemented through lip reading or other visual means. Persons who are deaf in the United States, especially those who are born deaf or lose their hearing at an early age, generally prefer to communicate in American Sign Language. Within a communication dialog with a hearing person, a person who is deaf will use other communication tools like: ASL interpreters, iPod, lip reading, writing, gesturing or other visual communication means. Persons who are deaf and lose their hearing later in life, sometimes referred to as "late deafened", will normally continue to talk, as their first line of communication but rely on lip reading, captioning, or perhaps English based sign language . In order to provide health care and ensure members' needs are being met in our health care system, it is important to understand the deaf and hard of hearing communities and their preferences around engagement.*

**Session description continued next page**



## 10:50 – 12:00 Additional Morning Roundtable Sessions Continued:

### **10. Building Engagement of Seniors in Chronic Disease Self Management, Falls Prevention and other Health Promotion Work Across Cultures —Lavinia Goto, RN, MPH, MBA, DHA. LTSS Innovator Agent, NorthWest Senior and Disability Services, and Sandra Echavarria, Outreach worker, Salud Medical Center**

*Building partnerships with Chronic Disease Self-Management and Prevention programs offered through Oregon ADRCs/AAAs are a great resource to work to engage members in their own health and chronic disease management. Northwest Senior & Disability Services has been working to develop a network of leaders to provide these evidence-based chronic disease self-management workshops throughout Marion, Polk and Yamhill counties. They will share their successes and also specific outreach of the programs for Spanish-speaking members in partnership with Salud Medical Center*

### **11. Addressing the Needs of African American Seniors with Dementia and Alzheimer’s Disease: Keys to Engagement and Partnering to Improve Member Health and Service Delivery —Tiffany Kirkpatrick, Coordinator, African American Dementia & Aging Project, Layton Aging & Alzheimer's Disease Center, OHSU**

*This session will share the work of the OHSU Layton Aging & Alzheimer's Disease Center with African-American seniors with dementia and Alzheimer’s Disease. Our speaker will share her over 20 years experience working with older adults and program delivery. She will highlight her work reaching out to partner with the community and as Co-founder/chair of PreSERVE Coalition; a group of individuals from healthcare, service organizations and the community who collaborate on initiatives that support the health and well-being of older adult African Americans.*



12:00 Lunch Buffet: Please get your lunch and return to the main room for the lunch keynote and plenary session!

**12:20 -1:30 Lunch Keynote & Plenary: “Improving Disability Access and Organizational Disability Competent Care: A Roadmap to Improved Health Outcomes and Quality of Life for Members with Disabilities”**

**—Christopher Duff, Disability Policy Consultant, BA, MA, Massachusetts**

**—June Isaacson Kailes, MSW, Disability Policy Consultant and the Associate Director and Adjunct Associate Professor at Harris Family Center for Disability and Health Policy at Western University of Health Sciences, Pomona, CA**

**SESSION DESCRIPTION:** What is the problem with care today for members with disability? How do we ensure that we meet the policy imperative of the ACA which demands all stakeholders be accountable and responsible for the outcomes of the delivery system? What are the steps health plans and providers must take to ensure we create Disability Competent Care (DCC)? This session will highlight pillars of DCC and important steps to ensuring care and support match members’ needs. It will highlight the importance of ensuring a disability-competent primary care network, integration of behavioral health, and, strategies for stimulating member engagement. Our presenters will share work they have been doing with the Lewin Group, Institute for Healthcare Improvement (IHI) and the CMS Medicare-Medicaid Coordination Office on development of resources and training for Disability Competent Care.

## About Our Keynote Speakers:

**Christopher Duff** has 30+ years experience in the development, delivery and financing of disability competent care services, focusing primarily on care management and long-term services and supports for adults with disabilities. He has been a disability policy and practice consultant, previously serving as the Executive Director of the Disability Practice Institute. He was President/CEO of AXIS Healthcare, the care management component of the Minnesota Disability Health Options (an integrated Medicare and Medicaid demonstration) and other waiver and health plan initiatives. AXIS Healthcare was a leader in the development of team-based disability care coordination, utilizing clinical guidelines and practice standards to ensure persons with disabilities receive timely and appropriate care and support. He was lead author of the **Disability Competent Care Assessment Tool**, and numerous related materials, based on the experiences of pioneering disability competent care organizations. Chris has been working with the Lewin Group, Institute for Healthcare Improvement (IHI) and the CMS Medicare-Medicaid Coordination Office on development of resources and training for Disability Competent Care. He has been active in public policy and advocacy efforts at both the State and Federal levels. He has a Bachelors of Arts in Social Services Administration from the University of Minnesota and a Masters of Divinity from United Theological Seminary.

**June Isaacson Kailes**, ([www.jik.com](http://www.jik.com)) is a Disability Policy Consultant and the Associate Director and Adjunct Associate Professor at Harris Family Center for Disability and Health Policy at Western University of Health Sciences, Pomona, California. Her breadth and depth of experience in disability and access and functional needs issues as a writer, trainer, researcher, policy analyst, subject matter expert, and advocate is widely known and respected. June has been working with the Lewin Group, Institute for Healthcare Improvement (IHI) and the CMS Medicare-Medicaid Coordination Office on providing training for Disability Competent Care and Resources for Integrated Care. June's focuses encompass working as a contractor with a variety of health facilities, managed care plans, government projects and consulting firms. She delivers workshops on developing disability competencies in health care covering the demographics of disability populations (prevalence, causes, function versus diagnosis, employment rates, and health disparities) compliance with the Americans with Disabilities Act (attitudinal, communication, physical, medical equipment and programmatic access), care coordination and long term support services, and stakeholder engagement. June focuses on building actionable disability competencies in the worlds of health care & emergency management to insure people with disabilities & others with access & functional needs are integrated & included in service delivery processes, procedures, protocols, policies & training. She has had the privilege of working in the trenches, as the "fix it" or "change up" crew," with major medical centers around the country, as well as managed care plans and community clinics . 10

1:30 – 1:40 Break & Exhibits

**1:40 – 3:05 Afternoon Panel presentation: “Keys to Care Coordination, Care Planning & Care Transitions for High-Need Populations”**

**Session Description:** These health plan leaders will share important keys to care coordination, care planning and care transitions for Medicaid-Medicare Dual Eligibles. Health plans can make a difference in improving member health and meeting Triple Aim goals by addressing system-wide efforts to impact and support high need beneficiaries.

**—Cynthia Al-Aghbary, RN, MSN, CCM, Executive Director, Clinical Operations Government Programs, Enterprise Health Care Management, Blue Cross and Blue Shield of New Mexico**

*Cynthia will share important keys for creating a care coordination, care planning and care transitions process for dual eligible high needs members, including those who also have LTSS. She will share how Blue Cross Blue Shield utilizes risk stratification and care coordination team metrics and collaboration to improve patient outcomes and reduce hospitalizations, readmissions and avoidable ER visits and post-acute stays. She will also share keys to creating systems processes to ensure members are receiving what they need. She will also briefly talk about work to incorporate CHWs and Paramedics in New Mexico into the care coordination process and how that is working today.*

**—Rebecca S. Ramsay, BSN, MPH , Director – Population Health Partnerships, CareOregon , Portland, OR**

*Rebecca will speak on CareOregon’s use of population health strategies to build organizational approaches for high-risk members to improve health outcomes. CareOregon is nationally recognized for innovative work to integrate care for dual-eligibles and other high-needs members and will share some successes and keys to impacting member health .*



**Session description continued next page**

## 1:40 – 3:05 Afternoon Panel presentation continued:

**—Lucy Zammarelli, M.A., CADC III, Health Equity Officer/Supervisor Trillium Behavioral Health, Trillium Health Plan, Eugene, OR**

*Trillium coordinates behavioral health services across a broad provider system, and Care Coordinators prioritize the integration of behavioral health and aging/disability services, including the use of Lane County’s Older Adult Behavioral Health Specialists. The integration of physical health and behavioral health services for older adults and special needs members is a priority for CCOs to achieve positive health for members*

**—Christopher Duff, Disability Policy Consultant, MA and formerly CEO, AXIS Health Plan, Minnesota [the care management component of the Minnesota Disability Health Options — an integrated Medicare and Medicaid demonstration]**

*Chris will share his experiences working to build a disability competent approach when he was President/CEO of AXIS Healthcare, as well as his involvement with other waiver and health plan initiatives throughout his career. AXIS Healthcare was a leader in the development of team-based disability care coordination, utilizing clinical guidelines and practice standards to ensure persons with disabilities receive timely and appropriate care and support. He was lead author of the Disability Competent Care Assessment Tool, and numerous related materials, based on the experiences of pioneering disability competent care organizations.*

## 3:05—3:15 Break & Exhibits



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### **3:15– 4:25 Innovative & Best Practice Roundtable Sessions: “Impacting Care Coordination, Care Transitions and Member Health & Quality of Life”**

Once again three Roundtable sessions, 20 minutes each, three topics!

Round One: 3:15—3:35 pm Choose a table!

Round Two: 3:40 —4:00pm Choose a table!

Round Three: 4:05 —4:25pm Choose a table!

#### Afternoon Roundtable Sessions:

**1. Innovative Outreach to Beneficiaries with High Need: Use of Community Health Workers & Non-Emergency Medical Transportation — Molly Jespersen, MPH, Director of Care Management, Skylakes Medical Center**

*Last year Sky Lakes Medical Center started a pilot project with Cascade Health Alliance CCO to repurpose the existing non-emergency medical transportation system for high-risk populations. Populations with high health care utilization rates and populations disproportionately affected by chronic disease are paired with community health workers to help address both traditional and non-traditional health care needs. Sky Lakes is currently expanding the program to offer health navigation, disease education and management, and other care coordination services to more community members.*

**2. Medicare vs Medicaid for SBIRT (Screening, Brief Intervention, Referral to Treatment) — Michael Oyster LPC, CADC III, Operations and Policy Analyst for Adult Behavioral Health & SBIRT Initiatives, Oregon Health Authority**

*Why is SBIRT so important for our high-needs dual eligible populations? How can we ensure providers for our senior members and members with disabilities are provided screening during their primary care visits? Need to learn the ins-and-outs on delivering SBIRT, especially who can do it and what Medicare requires for providers compared to Medicaid? This session will share how to code for SBIRT, especially how coding for SBIRT is different for Medicare than for Medicaid and how the metrics works for dual-eligible patients. Stop by to get your questions addressed!*

## **3:15– 4:25 Additional Afternoon Roundtable Sessions Continued:**

### **3. The Coleman Model and Evidenced-Based Care Transitions —Lee Girard, MPA, Community Services Manager, Multnomah County Aging, Disability and Veterans Services**

*The Coleman model is an evidenced-based care transitions model being used in Oregon through Oregon ADRC partners. CCTP is a Partnership for Patients initiative – aim to reduce hospital readmissions by 20% and has targeted Medicare Fee For Service beneficiaries discharging from hospital. This session will cover elements of the Coleman model that impact care transitions for members as well as share more about Multnomah County’s role in this multi-partner pilot funded by Centers for Medicare & Medicaid Innovation. Come learn about how this collaborative was able to reduce readmissions by 52% for program participants. Hear about the successes and lessons learned from this project to take home to your community.*

### **4. The ORPRN Behavioral Health Home Learning Collaborative: Preliminary Lessons —Sonya Howk, MPA:HA, Research Associate, OHSU, Oregon Rural Practice-based Research Network and Rita Moore, PhD., Behavioral Health Home Learning Collaborative (BHH LC) Program Manager and Policy Analyst in the Office of Health Analytics of the Oregon Health Authority**

*Learn more about the Behavioral Health Home Learning Collaborative (BHH LC) that is providing technical assistance to support integrating physical health care into 9 behavioral health settings. We will share how the project has evolved over the last two years and the lessons learned to date.*

### **5. Breaking Down the Silos to Create a Better Model for Care Coordination —Cynthia Al-Aghbary, RN, MSN, CCM, Executive Director, Clinical Operations Government Programs, Enterprise Health Care Management, Blue Cross and Blue Shield of New Mexico**

*Ensuring that processes and systems are in place for care coordination team members to communicate, share patient data, and ensure work flow and processes happen in a consistent manner is an important part of care coordination logistics. How do you work to create systems with hospitals, LTSS, and others to ensure communication and that members are not overwhelmed with too many contacts during critical care transitions? How do you ensure the member is at the helm of their care plan while engaging all of the necessary providers and community resource partners? How do you ensure timely use of metrics and data on patient status to inform patient interactions?*

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### **3:15– 4:25 Additional Afternoon Roundtable Sessions Continued:**

**6. The Nuts & Bolts of a LTSS-CCO Care Coordination Process** —*Kris Boler, LTSS Innovator Agent, APD ; and Pacific Source Community Solutions staff: Dawn Frey, Member Support Specialist, Devona Tafalla, Member Support Specialist, and Cynthia Seger, RN Certified Case Manger.*

*PacificSource Community Solutions has been working closely with their LTSS partners in the Columbia Gorge and Central Oregon to develop a collaborative care coordination process. This session will highlight the development of relationships, processes for communication of all parties, identification of high needs members, and development of a care coordination team to support high-needs members with LTSS. Participants will share their work at beginning to track outcomes of their care coordination work and future targets for collaboration as well.*

**7. Ensuring Accessible Care Environments for Members** —*June Isaacson Kailes, MSW, Disability Policy Consultant, Associate Director, and Adjunct Associate Professor, Harris Family Center for Disability and Health Policy at Western University of Health Sciences, Pomona, CA*

*June Isaacson Kailes has been working with healthcare organizations as a consultant on ensuring accessible care environments for many years. She will share information on what should be addressed when creating an accessible care environment and how compliance with the Americans with Disabilities Act includes attitudinal, communication, physical, medical equipment and programmatic access. She will share her work from the trenches, as the “fix it” or “change up” crew,” with major medical centers around the country, as well as managed care plans and community clinics working to ensure access & functional needs are integrated & included in service delivery processes, procedures, protocols, policies & training.*

**8. The Disability Competent Care Assessment Tool** — *Christopher Duff, MA, Disability Policy Consultant, Massachusetts*

*Learn more about The Disability Competent Care Assessment Tool and how it can help your organization assess action steps to achieving Disability Competent Care. The purpose of the Disability-Competent Care Self-Assessment Tool is to help health plans and health systems and providers evaluate their present ability to meet the needs of adults with functional limitations and to identify strategic opportunities for improvement.*

## 3:15– 4:25 Additional Afternoon Roundtable Sessions Continued:

### 9. Implementing Public Health Approaches within Your CCO to Reduce Tobacco Use Among Multicultural Medicaid Populations — *Scott Montegna and Holly Heiberg, MPP, Oregon Health Authority, Public Health Division*

*Gain an understanding how a variety of evidenced based public health approaches can assist you as you work to reduce tobacco use among multicultural and other high-need Medicaid-Medicare populations. This session is to help you plan ahead for targeted communications and campaigns that can assist you as you work to improve health by reducing tobacco use among your members. Public health will share strategies and approaches that have worked in increasing referrals to the Oregon Tobacco Quit Line, as well as campaign materials your CCO could adopt to support your goals to reduce tobacco use. We will share keys to message development to ensure you are reaching your target population.*

### 10. Care Planning for Members with Intellectual and Developmental Disabilities —*Jasper Smith, Program Manager, Benton County DD services*

*Person-centered planning is a process directed by the member. It may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. This session will focus on the in-depth person centered planning used by I/DD staff to address needs of members, assist members in engagement in decision-making and problem solving, monitoring progress and ensure planning truly meets the goals of the Olmstead Decision/ADA . The PCP approach identifies the person's strengths, goals, preferences, needs (medical and HCBS), and desired outcomes. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires. Current ACA requirements highlight the need for ensuring these requirements are addressed in health care planning.*



**Session description continued next page**

## 3:15– 4:25 Additional Afternoon Roundtable Sessions Continued:

### **11. Addressing Behavioral Health Concerns for Older Adults —Lucy Zammarelli, M.A., CADC III, Health Equity Officer/Supervisor Behavioral Health, Trillium Community Health Plan**

*Oregon’s Older Adult Behavioral Health Specialists are funded by OHA and are located across the state to assist with care coordination, community education, and system integration. Behavioral health is critical for this population, and takes on special significance when a disabled or older adult becomes isolated and/or is challenged with substance abuse or mental health concerns. Lucy will share the work happening to integrate behavioral health for older adults in Trillium’s Coordinated Care Organization and across Lane County, to impact care coordination and care outcomes.*

### **12. The Neighborhood Housing and Care Model — Kim Hutchinson, MSN, ACRN, Our House of Portland, Inc. and Kristin Riley, MSW, Director of Social Work and the Neighborhood Housing and Care Program, Our House of Portland, Inc.**

*Learn more about the Neighborhood Housing and Care Program, developed by Our House of Portland. An established, unique model of care for people with HIV who are living in the community. The program currently serves people who are transitioning from higher levels of care and people who are struggling to maintain independent living. The interdisciplinary care model brings together Nursing, Social Work, Occupational Therapy to support clients who deal with HIV, mental illness, substance use, and other chronic illnesses. This session will focus on how this program uses innovative ways to support their clients, collaborate with providers and health systems--all to achieve stable housing, improved health outcomes, and maintain individualized service provision that is high quality and cost-effective. Drop by to see what might be transferrable from this to other high need member issues!*

## **4:25- 4:30 WRAP-UP/CLOSING/Evaluations**

***We thank you for attending today’s fall forum gathering!***

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