MANY FACES OF COMMUNITY HEALTH

2007 CONFERENCE

October 11-12, 2007

ONSITE GUIDE

DoubleTree Park Place Hotel - St. Louis Park, MN

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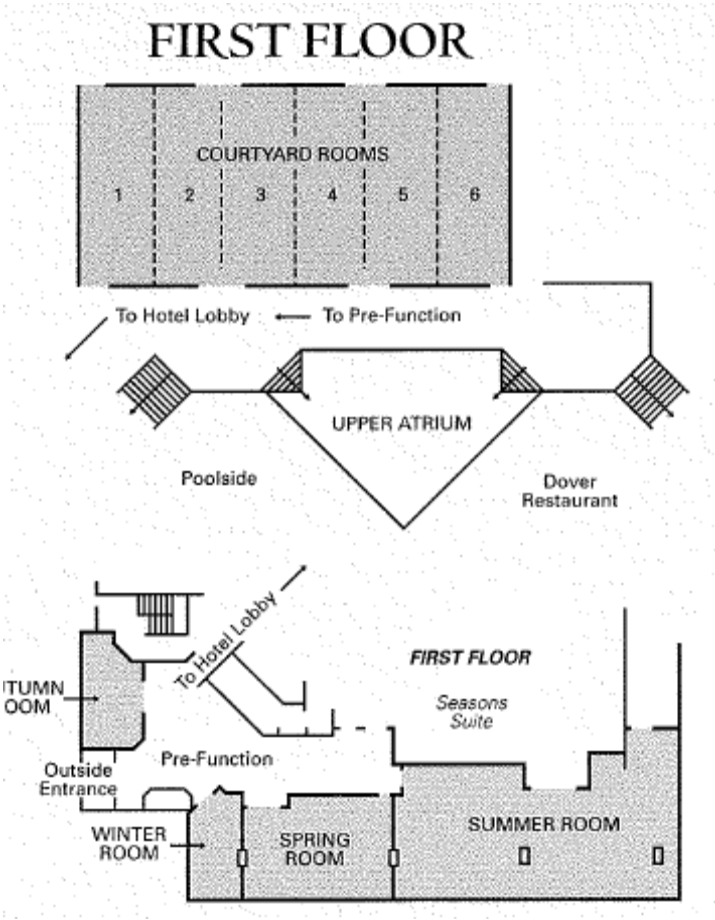
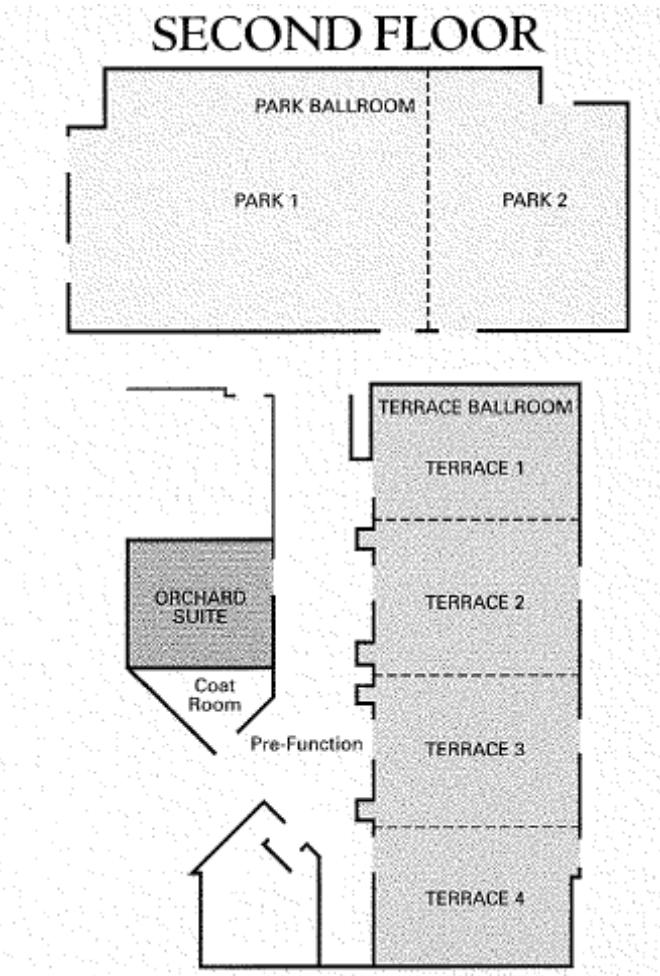
Hotel Floor Plans





Agenda at a Glance

Thursday, October 11, 2007

7:30–8:15am	Registration / Continental Breakfast / Exhibit Set-up	
8:15–10:30am	Welcome & Keynote Address – "Bridges Out of Poverty"	Park 1 Ballroom
9:00am–12:30pm	PECS Training Lab Open	Courtyard 6
10:30–11:00am	Break / Exhibits Open	Terrace Ballroom
11:00am–12:30pm	**CONCURRENT SESSIONS**	
	A. Managing Multiple Diseases: Establishing Goals of Care	Park 1 Ballroom
	B. Federal & State Policy Update	Park 2 Ballroom
	C. Federal Financial Compliance	Orchard Suite
12:30–1:30pm	Lunch	Lower Atrium
1:30–5:00pm	PECS Training Lab Open	Courtyard 6
1:30–3:00pm	Plenary Session: Panel on Poverty & Health Status	Park 1 Ballroom
3:00–3:30pm	Break / Exhibits	Terrace Ballroom
3:30–5:00pm	**CONCURRENT SESSIONS**	
	A. Managing Multiple Diseases: Designing the Clinic Visit	Park 2 Ballroom
	B. New Clinical Measures & Reporting Requirements	Park 1 Ballroom
	C. Pay for Performance & Quality Measurement	Orchard Suite
5:00–5:30pm	Exhibits open	Terrace Ballroom
5:30–7:30pm	Evening Reception	Lower Atrium

Friday, October 12, 2007

7:30–8:00am	Registration /Continental Breakfast / Exhibits	
8:00–8:45am	Welcome & Awards 2007 Bruce Zimmerman Diabetes Award MNACHC 2007 State Legislator Award	Park 1 Ballroom
8:45–10:15am	Health Care Reform Panel: State/National Developments/Trends	Park 1 Ballroom
10:15–10:45am	Break/Exhibits Open	Terrace Ballroom
10:45am–12:15pm	**CONCURRENT SESSIONS**	
	A. Managing Multiple Diseases: Effective Self-Management Support	Park 1 Ballroom
	B. Medicare Advantage Financial Considerations	Park 2 Ballroom
	C. Preparing for OPR Evaluations	Orchard Suite
12:15–2:00pm	Box Lunch and Final Exhibit Viewing	Terrace Ballroom
12:30–2:30 pm	Post-Conference Workshop: Self-Management Support: Helping Homeless Clients Set Goals to Improve Health	Park 1 Ballroom

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VALUE IN PURCHASING

Managing Multiple Chronic Diseases

The clinical focus for this year's *Many Faces of Community Health* conference is how to manage patients with multiple chronic diseases in primary care. This paper summarizes current issues and trends.

The Growing Challenge

Some 57 million Americans have more than one chronic illness. For people aged 65 and older, 88% have one or more chronic illness, and fully **1 in 5 have at least five chronic conditions**.

This situation is having a profoundly negative impact on cost, the quality of care and on quality of life. Patients with multiple chronic diseases have complicated treatment regimens, encounter much higher costs due to the greater number of drugs, devices and office visits, suffer far more disabilities and die sooner than those without multiple conditions. This is because co-existing diseases can alter the effectiveness of therapies and influence the course of each illness.

Patients with comorbid conditions are now the norm.[1] Primary care practices will likely find that the majority of their adult patients already have multiple chronic diseases. And, the problem is growing. The number of patients with multiple comorbidities is expected to reach 81 million people by 2010.[2]

Practice models, reimbursement systems and clinical care guidelines should offer solutions, but in fact these tools have become obstacles.

Limits of Traditional Improvement Tools

Primary care practices have worked long and hard to integrate disease-specific clinical practice guidelines into their care delivery. This has helped to ensure that their care practices are based on the best evidence available. Studies indicate that adherence to guidelines, particularly for drug therapy, helps standardize disease-specific care and reduce adverse outcomes such as hospitalizations and complications. As a key source of quality indicators, guidelines have also provided clinicians with a means for securing financial benefits through pay for performance and other incentives.

However, current disease-specific guidelines ignore the fact that most patients have comorbidities.[3] Likewise, clinical trials, which provide the evidence for drug efficacy and diagnostic and treatment strategies, typically exclude people with comorbidities. Because guidelines do not consider the potential positive or negative interactions among treatments, particularly with drugs, they can be misleading if not dangerous for patients with multiple chronic conditions.[4] For example, treatment with corticosteroids for conditions such as COPD and arthritis can undermine blood sugar control in patients with diabetes; and beta blockers for heart failure could adversely affect asthma or COPD.

Guideline adherence could present additional problems, according to Boyd et al.[5] Because single disease guidelines provide the basis of quality measures and pay for performance practices, following them with complex comorbid cases could create perverse incentives that emphasize over-treatment, diminish the quality of care and subject patients to the risk of adverse drug interactions and poor outcomes.

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[1] Fortin M, Bravo G, Hudon C, Vanasse A, Lapointe L. Prevalence of multimorbidity among adults seen in family practice. *Ann Fam Med* 2005;3:223–228 (http://www.annfammed.org/cgi/content/full/3/3/223) accessed 10/07.
[2] Anderson G, Horvath J. *Chronic conditions: making the case for ongoing care.* Princeton, NJ; Partnership for Solutions; 2002. (http://www.partnershipforsolutions.org) accessed 10/07.
[3] Durso SC. Using clinical guidelines designed for older adults with diabetes mellitus and complex health status. *JAMA* 2006; 295:1935-40.
[4] Tinetti ME, Bogardus ST Jr, Agostini JV. Potential pitfalls of disease-specific guidelines for patients with multiple conditions. *N Engl J Med* 2004; 351: 2870–2874.
[5] Boyd CM, Darer J, Boult C, Fried LP, Boult L, Wu AW. Clinical practice guidelines and quality of care for older patients with multiple comorbid diseases: implications for pay for performance. *JAMA* 2005; 294: 716–724.

While the quality of primary care overall has dramatically improved, the majority of common chronic conditions, when assessed individually, are still being inadequately treated. Regarding the quality of care for patients with multiple diseases, we just don't know. There are few if any evidence-based measures indicating the appropriateness of care for complex, comorbid diseases. The closest would be composite indicators such as Minnesota Community Measurement's "optimal" measure for diabetes and cardiovascular risk (A1c $\geq$7, blood pressure $\geq$ 130/80, LDL > 100, tobacco-free status and aspirin use), where less than 10% of clinics achieved the goals in 2005.[6] Even such composite measures struggle to reflect patient-specific, appropriate care for comorbid diseases.

Promising Practice Models and Trends

Most studies looking at multiple comorbidities note the dearth of research in this area. None-the-less, an emerging body of descriptive work has begun outlining potentially effective strategies for primary care. Theses promising strategies include: multidisciplinary care teams that involve the patient; electronic health records; self-management support and integrated patient education programs; decision support systems that flag drug interactions and other problems; alerts and reminders for both patients and providers; community involvement; and adequate insurance coverage.[7]

Piette and Kerr contributed a helpful framework for understanding ways in which comorbid chronic conditions influence the clinical care, self-management and outcomes for patients with a chronic disease.[8] This model points out system improvements with greater potential benefits and helps explain why other system changes are unlikely to improve the patient's functioning, health status and service use.

The Chronic Care Model has demonstrated that care delivery does not just happen in the clinic. Patients manage most of their own care, with supporting roles for family members, community programs and services and other practice settings.[9] Many clinics have successfully adopted the Model for improving care for individual chronic conditions, but applying the Model to multiple diseases has been elusive. The Stanford School of Medicine Patient Education Research Center has expanded its successful patient self-help training programs beyond the single-disease approach to self-management of differing chronic diseases, even demonstrating effectiveness with internet-delivery.[10]

Also encouraging is that clinical practice guideline developers, including the Institute for Clinical Systems Improvement (ICSI), have begun integrating care recommendations for commonly comorbid conditions, such as hypertension and vascular diseases.

The bottom line is that despite new therapies and years of quality improvement interventions, the quality of care for people with multiple chronic conditions remains inadequate, but some of the chronic care improvement models already in use in primary care settings show promise when applied to managing multiple comorbid diseases.

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[6] MN Community Measurement. *2006 Health Care Quality Report.* 2007: http://www.mnhealthcare.org/Report. Accessed 10/07.
[7] Dorr DA, Wilcox A, Burns L, Brunker CP, Narus SP, Clayton PD. Implementing a multidisease chronic care model in primary care using people and technology. *Dis Manag* 2006; 9:1-15.
[8] Piette JD, Kerr EA. The impact of comorbid chronic conditions on diabetes care. *Diab Care* 2006; 29:725-31.
[9] Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness. *JAMA* 2002; 288:1775-9.
[10] Lorig KR, Bodenheimer T, Holman H, Grumbach K. Patient Self-Management of Chronic Disease in Primary Care. *JAMA*, 288(19):2469-75, 2002.

Detailed Agenda

Overall Conference OBJECTIVES

This conference focuses on the management of multiple chronic diseases, public policy, and financial management issues for community health centers. Content is designed to provide practical and effective tools and strategies for improving community-based primary care practice and reducing health disparities. Sessions on understanding poverty from the perspective of "hidden" rules, behaviors and knowledge that effect peoples' ability to transition out of poverty will help participants apply what they learn effectively with their clients. The conference offers an in-depth look at clinical and management issues, current research, policies and trends that will affect your practice.

Experience a variety of learning techniques and collect useful tools, tips and resources. Enjoy networking and view informative community and industry exhibits. Hear thought-provoking and practical ideas and gain renewed inspiration to meet workplace challenges.

Upon completion of this conference, participants will be able to:

- Describe how generational and situational poverty differ.
- Give examples of challenges that poverty presents to people who are attempting to change to more healthy living.
- Discuss federal and state developments related to maintaining Community Health Centers as health care homes for underserved communities and under/uninsured people.
- Define the impacts that the high cost of health care and increases in the number of uninsured people have on disease management and support services for people with chronic diseases and disabilities.
- Initiate management of patients with multiple chronic diseases by establishing goals for care, improving the effectiveness of clinic visits, and supporting the patients as they become effective self-managers of their multiple chronic diseases.

Thursday, October 11, 2007

7:30–8:15am **Registration / Exhibit Set-up / Continental Breakfast**

8:15–8:30am **Welcome** **Park 1 Ballroom**
Rhonda Degelau, Executive Director, Minnesota Association of Community Health Centers (MNACHC), Minneapolis
Don Bishop, Manager, Center for Health Promotion, Minnesota Department of Health

8:30–10:30am **Keynote Address** **Park 1 Ballroom**
Bridges Out of Poverty: Understanding the Challenges and Strengths of Individuals and Communities

Terie Dreussi Smith, M.A. Ed., OCPS II. Consultant, aha! Process, Inc. Co-author, "Bridges Out of Poverty: Strategies for Professionals and Communities."

Poverty presents major challenges to people attempting to live healthy lives. Understanding poverty can bring insights that will improve health care workers'

abilities to assist those in poverty in achieving and maintaining a healthier lifestyle. This presentation will focus on concepts developed in the books *A Framework for Understanding Poverty* and *Bridges Out of Poverty: Strategies for Professionals and Communities.* These include a basic structure for understanding poverty, a description of the differences between generational and situational poverty, and some hidden social norms that govern behavior & decision-making. Ms. Smith will offer health care providers, educators, and others new insights on differences in economic cultures, how those differences affect opportunities for success, and ideas for improving both services to clients and retaining new hires transitioning from poverty.

OBJECTIVES: Upon completion, participants will be able to:
- Discuss hidden social norms that frequently shape patient behavior and decision-making.
- Describe how differences in economic cultures affect patients' opportunities for success and self-efficacy.

9:00am–12:30pm **PECS Training Lab Open** **Courtyard 6**

10:30–11:00am **Break / Exhibits Open** **Terrace Ballroom**
Refreshments served in Exhibit Hall

11:00am–12:30pm **CONCURRENT BREAKOUT SESSIONS**

A. Management of Multiple Chronic Diseases: Establishing Goals of Care **Park 1 Ballroom**
Most chronically ill patients have comorbid health problems, yet care guidelines traditionally focus on single diseases. Some chronic diseases are managed more for symptom relief, while others are managed to improve physiologic targets. When care guidelines conflict, patients and clinicians have to prioritize treatment goals in the context of limited financial and personal resources. Dr. Piette will review findings from the literature and lay the foundation for a broader discussion about how to provide appropriate and mutually acceptable care to complex patients.
John Piette, PhD, Co-director Ann Arbor Veterans Affairs Medical Center/University of Michigan Program on Quality Improvement for Complex Chronic Conditions

OBJECTIVES: Upon completion, participants will be able to*:*
- Describe potential areas for conflict when multiple chronic diseases are being treated.
- Summarize means for establishing goals of care that meet the needs of patients with a complex set of chronic conditions.

B. Federal & State Policy Update **Park 2 Ballroom**
Hear the latest developments from the 110th Congress including Community Health Center appropriations, reauthorization of the CHC program, and Medicaid and Medicare reforms. Review the recent 2007 Minnesota legislative session and preview the upcoming 2008 legislative session. Learn how your CHCs and citizens can participate in the political process through advocacy.
Daniel Hawkins, Vice President, Division of State, Federal & Public Affairs, National Association of Community Health Centers (NACHC), Washington, DC
Jonathan Watson, Director of Public Policy, Minnesota Association of Community Health Centers (MNACHC), Minneapolis

OBJECTIVES: Upon completion, participants will be able to:

- Explain the latest Community Health Center appropriations and reauthorizations developed by the 110th Congress.
- Review steps your Community Health Center can take to participate in the political process through advocacy.
- Explain policies enacted by the 2007 Minnesota Legislature as they pertain to Community Health Centers and underserved populations.

C. Federal Financial Compliance **Orchard Suite**

Community Health Centers receiving grants under Section 330 of the Public Health Service Act are subject to a host of federal regulations with respect to allowable uses of federal grant funds, procurement of goods and services, audit standards, etc. Review the provisions of 45 CFR Part 74, incorporating OMB Circulars A-110, A-122, and A-133 and related Grants Policy Statements to insure that your health center is operating in compliance with federal grant requirements.
Tim Ritter, CPA, Wipfli CPAs and Consultants, Minneapolis

OBJECTIVES: Upon completion, participants will be able to:
- Identify the funds and grants commonly received by Community Health Clinics by federal numbers and/or names.
- Determine areas of reporting required by federal regulations and grant requirements.

12:30–1:30pm **Lunch Table Discussions** **Lower Atrium**
Join your colleagues for lunch and stimulating conversation!

1:30–5:00pm **PECS Training Lab Open** **Courtyard 6**

1:30–3:00pm **Plenary Session: Panel on Poverty & Health Status** **Park 1 Ballroom**

How can we effectively improve health outcomes for people living in poverty? A panel will discuss the challenges in preventing and managing chronic disease for patients who lack consistent access to nutritious food, exercise, and stable living conditions. Panelists will highlight innovative approaches and best practices for improving health outcomes for low-income and underserved populations, including those who are homeless and migrant farmworkers.
Loretta Heuer, RN, PhD, Migrant Health Services, Inc., Moorhead
Phil Norrgard, MSW, Director of Human Services, Fond du Lac Tribal Health Services, Fond du Lac
Greg Owen, PhD, Research Scientist, Wilder Foundation, St. Paul
Stella Whitney-West, MBA, Interim Executive Director, NorthPoint Health & Wellness, Minneapolis
Moderated by Terie Dreussi Smith, MA, ED, aha! Process, Inc.

OBJECTIVES - Upon completion, participants will be able to:
- Apply innovative and best practices for improving the health outcomes of low-income, homeless and migrant farm-worker populations.
- Summarize the challenges for preventing and managing chronic diseases in patients with little access to healthier foods, activities, etc.

3:00–3:30pm **Break / Exhibits Open** **Terrace Ballroom**
Refreshments served in Exhibit Hall

3:30–5:00pm **CONCURRENT BREAKOUT SESSIONS**

A. Management of Multiple Chronic Diseases:
Designing the Clinic Visit **Park 2 Ballroom**

Your patient has COPD *and* diabetes *and* arthritis. How does a clinic shift from single-disease chronic care to planned care for these complex patients? Examine methods for redesigning the chronic disease office visit as an effective, patient-centered means of managing chronic comorbid diseases

Kellie Prentice, RNC, CDE, Clinical Coordinator, Rice Memorial Hospital Heart Failure Clinic, Willmar
Dan Rehrauer, PharmD, Pharmacist with West Side Community Health Services, St. Paul
Sandy Stover, MD, Physician, Sawtooth Mountain Clinic, Grand Marais
Moderated by Penny Frederickson, RN, Care Improvement Facilitator, Institute for Clinical Systems Improvement, Minneapolis

OBJECTIVES - Upon completion, participants will be able to:
- Identify two components of a planned chronic disease visit.
- Describe ways to adapt the Care Model for treatment of multiple chronic diseases.
- Discuss how to utilize members of a care team to manage a complex patient.

B. New Clinical Measures & Reporting Requirements **Park 1 Ballroom**

Learn about changes to the clinical measures for federally funded Community Health Centers and the reporting changes to the Uniform Data System (UDS) scheduled for calendar year 2008

Dr. Jay Anderson, Chief Dental Officer, HRSA, Rockville, MD

OBJECTIVES - Upon completion, participants will be able to:
- Discuss changes in clinical measures for Federally Funded Community Health Centers coming in 2008.
- Explain reporting changes to the 2008 Uniform Data System (UDS).

C. Pay-for-Performance & Quality Measurement **Orchard Suite**

Hear the latest on strategies to improve quality of care and control costs by recognizing providers who achieve performance benchmarks. We will review national trends in pay-for-performance and quality measurement, discuss efforts in Minnesota to align pay-for-performance across payers, identify how population disparities may be addressed in quality measurement and reporting, and discuss how Minnesota Public Health Programs has participated in these efforts.

Jim Chase, Executive Director, MN Community Measurement, St. Paul
Linda Davis, LCD Consultants, Ltd.., Minneapolis
Vicki Kunerth, Director of Performance Measurement & Quality Improvement, Minnesota Department of Human Services

OBJECTIVES - Upon completion, participants will be able to:
- Identify how pay for performance and quality measures relate to potential financial reimbursement for a clinic.
- Examine how current clinical practice can be improved to qualify for pay for performance reimbursement.

5:00–5:30pm **Break / Exhibits Open** **Terrace Ballroom**

5:30–7:30pm **Evening Reception** **Lower Atrium**
Music with Ecuador Manta, Refreshments, Cash bar

Friday, October 12, 2007

7:30–8:00am **Registration / Continental Breakfast / Exhibits Open**

8:00–8:45am **Welcome and Awards** **Park 1 Ballroom**
Walter Cooney, Executive Director, Neighborhood Health Care Network, St. Paul

2007 Bruce Zimmerman Diabetes Award
Minnesota Diabetes Steering Committee

MNACHC 2007 State Legislator Award
Karen Geegan, Chief Operating Officer, Lake Superior Community Health Center, Duluth

8:45–10:15am **Plenary Session: Health Care Reform:**
State and National Developments and Trends **Park 1 Ballroom**
The pressure of rising health care costs and growing numbers of uninsured has made health system reform a top priority for the public, government, business and health care providers. This session will provide an overview of recent state and national developments and trends that are likely to bring about major changes in how health care is financed, organized and delivered. The panel will explore such areas as universal coverage for the uninsured, provider payment reforms, disease management, and services for people with disabilities.
Tom Huntley, PhD, Representative District 7A, Minnesota House of Representatives
Jeff Schiff, MD, Medical Director, Minnesota Department of Human Services
Jan Malcolm, Executive Director, Courage Center, Minneapolis
Jeanne Ripley, MBA, Halleland Health Consulting, Minneapolis
Moderated by: Michael Scandrett, JD, Halleland Health Consulting, Minneapolis

OBJECTIVES - Upon completion, participants will be able to:
- List four areas of health care that reform efforts are focused upon.
- Interpret how health care delivery may undergo changes as the high cost of health care is explored.
- Predict one change in health care delivery for the uninsured and underinsured you think is likely to occur as a result of health care reform.

10:15–10:45am **Break / Exhibits Open** **Terrace Ballroom**
Refreshments served in Exhibit Hall

10:45am–12:15pm **CONCURRENT BREAKOUT SESSIONS**

A. Management of Multiple Chronic Diseases:
Effective Self-Management Support **Park 1 Ballroom**
Patients struggle to balance disease-management goals, their symptoms, and issues of daily living. Find out about the Stanford Self-Help Training which trains patients in effective chronic disease self-management. Hear about a lifestyle overview tool for assessing barriers to self-care. Learn how motivational interviewing techniques help resolve ambivalence toward change in the goal-weary patient.
Betty Hanna, RN, EdD, Director of Clinical Quality and Disease Management, Neighborhood Health Care Network, St. Paul
Carl Isenhart, PsyD, LP ,MBA, Psychologist, Veterans Affairs Medical Center, Minneapolis

Connie Norman, Health Educator, Native American Community Clinic, Minneapolis

OBJECTIVES - Upon completion, participants will be able to:

- Discuss the Stanford Self-Help Training and its methods of effective disease self-management.
- Apply a lifestyle overview tool to assess barriers for self-care.
- Give examples of how motivational interviewing can help resolve the patient's ambivalence towards making lifestyle changes.

B. Medicare Advantage Financial Considerations **Park 2 Ballroom**

Of particular importance to community health centers is the possibility of receiving Medicare Advantage supplemental payments ("wrap-around payments"). This session will explore the financial considerations of contracting with Medicare Advantage plans and include a discussion of other relevant Medicare reimbursement topics relative to Federally Qualified Health Centers (FQHCs).

Mike Schnake, CPA, BKD, Southern Missouri

OBJECTIVES - Upon completion, participants will be able to:

- List two financial advantages of contracting with Medicare Advantage plans.
- Explain what the term "wrap around payments" means.

C. Preparing for OPR Evaluations **Orchard Suite**

Federally-funded Community Health Centers are subject to federal evaluation through HRSA's Office of Performance Review (OPR). This session will provide a summary of the OPR process by those who have gone through it, as well as tips on how best to prepare for the evaluation.

David Bingaman, Operations Director, HRSA Office of Performance Review, Chicago, IL
Rita Plourde, Executive Director, Sawtooth Mountain Clinic, Grand Marais
Stella Whitney-West, Interim Executive Director, NorthPoint Health & Wellness Center, Minneapolis

OBJECTIVES - Upon completion, participants will be able to:

- Clarify the purpose of the Operational Performance Review as it relates to community health centers.
- Summarize three tips presented in preparation for an OPR evaluation.

12:15–2:00pm **Box Lunch and Final Exhibit Viewing** **Terrace Ballroom**

12:30–2:30pm **Post-Conference Workshop: Self Management Support: Helping Homeless Clients Set Goals to Improve Their Health** **Park 1 Ballroom**

People experiencing homelessness bear a higher burden of illnesses such as diabetes, asthma and heart disease. Managing these chronic conditions while living in a shelter or on the streets can leave clients feeling helpless and overwhelmed. Self-management goal setting is designed to allow clients to take charge of their health, but traditional goals such as walking 20 minutes every day or counting carbohydrates are not realistic within the constraints of homelessness. This training, designed for non-medical and medical personnel alike, will introduce participants to the fundamentals of behavioral change strategies aimed at supporting clients in taking steps to improve their health care. We will learn how to help clients identify self management goals that consider the realities of homelessness and design plans that can support their independence. From designing an action plan to assessing clients' confidence levels for success, this

workshop will walk you through the steps necessary to help your clients better care for themselves.
Sharon Morrison, RN MAT, Diabetic Nurse Educator, Boston Health Care for the Homeless Program

KEYNOTE:

Terie Dreussi Smith, M.A. Ed., OCPS II

aha! Process, Inc.; co-author (with Ruby Payne and Phil DeVol) of *Bridges Out of Poverty: Strategies for Professionals and Communities.*

Author and consultant Terie Dreussi Smith has worked for many years with communities, organizations and individuals to develop policies and services to help people move out of poverty. She has been an author and consultant in this area for the past decade. Prior to this, Ms. Smith served as Supervisor of Prevention Services at a community alcohol/ drug treatment and prevention organization for over nine years, and was instrumental in the organization's redesign of programs and services for prevention and early intervention clients from generational poverty. A long-time educator, she is a former public school teacher with years of experience and has taught at several colleges where her work focused on empowering adult students transitioning out of poverty. Ms. Smith has been a speaker and trainer with *aha! Process, Inc.* since 1997.

OTHER PRESENTERS:

Jay R. Anderson, MDM, MHSA

Health Resources and Services Administration (HRSA), Rockville, Maryland

Dr. Anderson is the Chief Dental Officer in the HRSA Bureau of Primary Health Care (BPHC) Office of Quality and Data (OQD). He has been in this position for 14 years. Dr. Anderson is the lead dentist in the BPHC for primary oral health care services, management and policy, and is on the BPHC Clinical Team. He is the primary consultant for the oral health component of the President's Initiative for community Health Centers Expansion, and is HRSA's oral health representative on the Healthy People 2010 Workgroup. Prior to coming to HRSA, Dr. Anderson was the Dental Director at the Park DuValle Community Health Center in Louisville, Kentucky for 15 years, a position for which he received national recognition.

David B. Bingaman, MSW, MA, LCSW

Health Resources and Services Administration (HRSA), Chicago, Illinois

Mr. Bingaman is a Regional Operations Director for at HRSA's Region V–Chicago Office of Performance Review where he is actively involved numerous work groups, including the national office's Core Values, Balanced Scorecard, State Strategic Partnership Review, eRoom, and Outstanding Outcomes. Previously, he served as the Director of the Northern Operations Division of the HRSA Office of Field Operations. Prior to this, Mr. Bingaman served as the Program Manager and Project Officer for the largest Employee Assistance Program in the world. During his 31-year health care career, Mr. Bingaman has served in a variety of leadership positions including vice president of a community hospital; administrator of a state agency; program director at a private, for-profit hospital and at a community-based, non-profit facility; and founder/team leader for an outpatient behavioral health center.

James Chase, MHA

Minnesota Community Measurement, St. Paul, Minnesota

Jim Chase is Executive Director of MN Community Measurement, an organization founded by the Minnesota Medical Association and Minnesota health plans to publicly report health care quality information. Jim has over twenty years of experience in the health care field and has had a strong commitment to improving the health of the people of Minnesota. Prior to his work at MN Community Measurement, Jim spent nine years as Director of Health Care Purchasing with the Minnesota Department of Human Services. He has also held positions with Health Risk Management, Inc., United Health Care, and Fairview Hospitals. Mr. Chase has been a faculty member with the ISP

Health Administration program at the University of Minnesota since 1989 and served on the State Pharmaceutical Assistance Transition Commission that advised Congress on the impact of the new Medicare drug benefit on state pharmacy assistance programs. He has a Masters in Hospital Administration from the University of Minnesota.

Linda Davis, BSN

LCD Consultants, Ltd., Minneapolis, Minnesota

Linda Davis has a 20+ year career in health care, primarily in product and business development. She currently provides consulting expertise on a pay for performance program to BHCAG, the Buyers Health Care Action Group, a Minnesota based employer coalition, and to Minnesota Community Measurement. She has consulted in PBMs (pharmacy based management), on quality improvement, electronic health information technology and exchange, and value based purchasing. Prior to this, Ms. Davis helped develop HMOs and PPOs for VHA Consulting Services, and products for multiple health plans including Aetna, MedCenters and HealthPartners. Linda received her Bachelor of Science degree in Nursing from the University of Minnesota.

Penny Fredrickson, RN

Institute for Clinical Systems Improvement, Bloomington, Minnesota

Penny Fredrickson works as Care Improvement Facilitator at ICSI, Institute for Clinical Systems Improvement. Her nursing background is in hospital, long-term care and clinic settings. Over the past 20 years, she has held positions in clinic management, health care marketing and development, as well as organizational development. Ms. Fredrickson's experience includes: Training and Development, Operations, Quality Improvement, Utilization Review, Infection Control, Contract Negotiations, and Human Resources. Prior to ICSI she served as Clinical Practice Coordinator in quality for two family practice organizations in the Twin Cities. Ms Fredrickson holds a Certificate in Management from North Hennepin Community College. She is a member of the American Association of Heart Failure Nurses, Minnesota Medical Group Managers Association, and Minnesota Healthcare Quality Professionals.

Betty Hanna, EdD, RN, BSN

Neighborhood HealthCare Network, St. Paul, Minnesota

Betty Hanna has over 30 years of experience in management and clinical capacities. She has been the Director of Clinical Quality at the Neighborhood HealthCare Network since 2005 and in that role develops, coordinates, and supports quality improvement initiatives. She chairs the Community Care Program for NHCN's 14 member clinics. Betty has a BSN, a Masters in Health and Human Services and a doctorate in Educational Leadership. She served for nine years on the Minnesota Board of Nursing and maintains her certification in Operating Room Nursing.

Daniel R. Hawkins, Jr.

Federal, State and Public Affairs, National Association of Community Health Centers, Inc., Bethesda, Maryland

Dan Hawkins has been V-P for Federal, State and Public Affairs at NACHC, the National Association of Community Health Centers for over 25 years and provided federal and state health-related policy development, policy research, analysis, information, advocacy, and technical assistance services to the membership. During this time, federal support for health centers has grown from $350 million to over $1.7 billion annually, and the number of people served by health centers has grown from five to 16 million. Prior to joining NACHC, Dan served as a VISTA volunteer, Executive Director of a migrant and community health center in south Texas, and assistant to HHS Secretary Joseph Califano during the Carter Administration. He has written numerous articles and monographs on health care and health center issues, oversees production of several annual NACHC publications, and has provided testimony before Congressional Committees. Dan has lectured on health policy at Harvard, Johns Hopkins, George Washington, and other universities, and has given many interviews to major news media. He has been named one of America's 1,000 most influential health policy makers.

Loretta Heuer, RN, PhD, FAAN
University of North Dakota College of Nursing, Grand Forks, North Dakota and Migrant Health Service, Inc., Moorhead, Minnesota

Loretta Heuer has worked in nursing for over 30 year, more than half of that with Migrant Health Services. She has developed a program of research and scholarly activities that focuses on the health care needs of the Latino migrant and seasonal population with diabetes. At Migrant Health Service, Inc., she developed and implemented the Diabetes Lay Educator Program to provide a new level of care and service for the Latino migrant and seasonal farm worker population though four major regional and national collaborative. She is alumni of the 2002 Robert Wood Executive Nurse Fellowship. Heuer is a prolific writer and active educator. Currently, she is a participant in the 2006 Leadership for Academic Nursing Program and the 2007-2009 Sigma Theta Tau International Honor Society of Nursing Omada Board Leadership Program.

Tom Huntley, PhD
Minnesota House of Representatives, Duluth and St. Paul, Minnesota

Tom Huntley, Representative District 7A, has served in the Minnesota House of Representatives since 1992, representing Duluth and surrounding communities for over 15 years. He has provided expertise and leadership in the areas of health care and health care finance and serves on the following committees: Finance, Health and Human Services, Health Care and Human Services Finance Division (which he currently chairs), Housing Policy and Finance and Public Health Finance Division, and Ways And Means. He is also on the Legislative Commission on Health Care Access and the Governor's Joint Health Care Task Force. Dr. Huntley is an Associate Professor in the Department of Biochemistry and Molecular Biology at the School of Medicine and in the Department of Chemistry at the College of Science and Engineering at the University of Minnesota, Duluth.

Carl Isenhart, PsyD, LP, MBA
Veterans Health Administration, Minneapolis, Minnesota

Dr. Isenhart is a staff psychologist with the Partial Psychiatric Hospitalization Team at the Minneapolis Veterans Affairs Medical Center. He has been working in the field of mental health for 24 years, involved in training, supervision and consultation. Dr. Isenhart is also an Assistant Professor in the Department of Psychiatry, University of Minnesota College of Medicine; a Clinical Assistant Professor with the Department of Psychology, University of Minnesota College of Liberal Arts, and an Adjunct University Assistant Professor in Counseling and Psychological Services at Saint Mary's University. He received his PsyD in Clinical Psychology from the University of Denver in 1984 and has written extensively on mental health and substance abuse.

Vicki Kunerth, RN, MS
Performance Measurement & Quality Improvement, Minnesota Department of Human Services, St. Paul, Minnesota

Vicki Kunerth is the Director of Performance Measurement & Quality Improvement for MN DHS. The division she heads includes five sections covering Surveillance & Integrity Review, Quality Improvement, Health Care Research & Evaluation, Health Care Programs Member Help Desk/ Managed Care Ombudsman, and Maternal & Child Health, which are responsible for the development and application of health care performance measures and outcome monitoring to address priorities, policies, and program integrity in health care purchasing. The Division is also responsible for oversight of the Federal BBA/EQRO quality requirements in managed care contracts. Ms. Kunerth holds a BS in nursing and a MS in Public Health from the University of Minnesota.

Jan Malcolm
Courage Center, Golden Valley, Minnesota

Jan Malcolm has a history of progressive leadership in health policy in Minnesota. She served as State Commissioner of Health from 1999-2003. During her term at MDH, Minnesota passed major budget initiatives in tobacco prevention and elimination of health disparities and implementation of cutting-edge strategies in those areas. Before that she was VP of Public Affairs at Allina Health

System and a senior VP of Government Programs and Public Policy at HealthPartners. From 2003 – 2005, she was a senior program officer for the Robert Wood Johnson Foundation in Princeton, N.J., where she helped develop funding initiatives to strengthen the nation's public health system. Since 2005 Jan has been CEO of Courage Center, a not-for-profit rehabilitation agency serving people with physical disabilities, speech/vision impairment, and hearing loss. She has also served on numerous foundation and non-profit boards of directors. Malcolm received her B.A. in Philosophy and Psychology, from Dartmouth College.

Sharon Morrison, RN, MAT

National Health Care for the Homeless Council and Boston Health Care for the Homeless Program, Boston, Massachusetts

Ms. Morrison has worked with Boston's Health Care for the Homeless Program for the past ten years. As a diabetic nurse educator, she helps patients understand the complexities of living with diabetes and assist them in identifying self management goals that are realistic within the constraints of homelessness. She brings to her work a perspective that blends both Eastern and Western traditions of care. For the past three years, Sharon has worked with the National Health Care for the Homeless Council, training health care providers to understand the realities of providing care to persons experiencing homelessness. Prior to becoming a nurse, she worked in education as a teacher.

Connie Norman

Native American Community Clinic, Minneapolis, Minnesota

Connie Norman is the Community Health Educator and Master Trainer for the Native American Community Clinic and Minneapolis American Indian Center collaboration on diabetes. She has worked with Minnesota's urban Native American community in the Twin Cities for over 19 years, more than 15 of them on diabetes. In 1995 she helped found the Intertribal Annual American Indian Fair. Connie received the 1999 Minnesota Council on Physical Activity and Sports Award of Excellence for her work in improving health in the Native American community. She is also involved with Full Circle Diabetes Program and Diabetes Community Council which won the 2006 Be Active Minnesota Award of Excellence. Connie graduated from the College of St. Catherine's in St. Paul as a Health and Wellness Counselor and Holistic Health Practitioner.

Phillip H. Norrgard, MSW

Fond du Lac Tribal Health Services, Cloquet, Minnesota

Phil Norrgard has been Director of Human Services for the Fond du Lac Reservation since 1980. In this role, he serves as CEO for a wide array of health care programs including out-patient and in-patient medical, pharmacy, x-ray, lab, dental, maternal child health, public health nursing, in-home health, injury prevention, health transportation, health education, family planning, chronic disease management, medical social services, child protection, home-based counseling, family counseling, self-help groups, individual counseling, chemical dependency counseling and aftercare, chemical dependency prevention/intervention, adolescent residential care, nutrition education and counseling, domestic abuse advocacy, child abuse prevention, victim's of crime assistance, foster care licensing and support, and day care licensing and support. Over the past decade, he has served on national Tribal and Indian Health Committees and received over a dozen awards for his contributions to improving the health of Indigenous Americans.

Greg Owen, PhD

Wilder Research, St. Paul, Minnesota

Dr. Owen has over 30 years experience in applied social research. He is a consulting scientist at Wilder Research, where he has led a wide range of research projects including studies of welfare reform, economic self-sufficiency and homelessness. His work on homelessness dates back to 1984 when he led the first area effort to describe the homeless population in St. Paul. Since that time he has directed six statewide surveys of homeless adults and children and currently provides data to support the statewide plan for ending long-term homelessness. Dr. Owen participated in the 1998 and 2007 national symposium on homelessness research. He does numerous presentations on homelessness

each year, recently speaking at *Homes for All! 2006* convention, the National Association for the Education of Homeless Children and Youth, and the Minnesota Supportive Housing Conference. Greg serves as an adjunct professor in the Health and Human Services graduate program at St. Mary's University.

John Piette, Ph. D.
University of Michigan School of Medicine and Veterans Administration Ann Arbor Health Care System Center for Practice Management & Outcomes Research, Ann Arbor, Michigan

Dr. Piette has conducted research into chronic disease management and health services for 25 years. He received his MS at Harvard School of Public Health and his Doctorate in Epidemiology at Brown University. Currently he is an Associate Professor in the Department of Internal Medicine and a Research Career Scientist with the Center for Practice Management and Outcomes Research in the VA Ann Arbor Health Care System. His research projects have focused on a number of diabetes management issues, including diabetes and comorbid depression, a Spanish Diabetes Self-Management Program, the impact of medication cost on management of low-income patients with diabetes, as well as on other chronic diseases. He serves as reviewer and editorial board member for a variety of medical journals, including *Diabetes Care, Journal of Chronic Illness, American Journal of Managed Care, JAMA, Journal of Diabetes and Its Complications, Journal of General Internal Medicine, Journal of Health Care for the Poor and Underserved, Journal of Research on Aging, Medical Care, Patient Education and Counseling,* and *Quality of Life Research*.

Rita Plourde, MS
Sawtooth Mountain Clinic, Grand Marais, Minnesota

Ms. Plourde has served as CEO of Sawtooth Mountain Clinic for 26 years. The clinic has operated as a Community Health Center since 1976, ensuring health care services to all people in Cook County regardless of ability to pay. Ms. Plourde' s responsibilities focus on recruiting and retaining physicians and support staff, establishing and maintaining public health services, as well as serving as a liaison and/or advisor to health care partners community-wide.

Kellie Prentice, RNC, CDE
Rice Memorial Hospital in Willmar, Minnesota

Ms. Prentice is the clinical coordinator of cardiovascular health and rehabilitation, a position that includes clinical care as well as management of the heart failure clinic and cardiovascular rehabilitation programs. She has been working with an outpatient cardiovascular disease population for 12 years. Rice Memorial saw the need to realign outpatient services to better serve patients with multiple diseases since many heart failure patients were also being seen in the diabetes center and cardiac rehab program. All three programs are now sharing staff, resources and streamlining patient care. The heart failure clinic is also collaborating with clinics, a hospital and a long-term care facility in the Willmar community to better coordinate care.

Dan Rehrauer, Pharm D, BCPS
West Side Community Health Services, St. Paul, Minnesota

Dan Rehrauer, Lead Pharmacist with West Side Community Health Center, graduated in 2000 with a Pharm D degree from the University of Minnesota. During the second year of his two-year Pharmaceutical Care and Leadership Residency, he established pharmacy services at West Side Community Health Services. In 2004 the Minnesota Pharmacists Association recognized the program with its "Innovative Pharmacy Practice" award. Dan has served as a formulary committee member for the Minnesota Department of Human Services AIDS Drug Assistance Program since 2003 and as Prime Vendor Program Community Health Center Advisory Council member since 2005.

Jeanne Ripley, MBA, PAHM
Halleland Health Consulting, Minneapolis, Minnesota

Ms. Ripley is Vice President of Halleland Health Consulting, and an expert in the areas of health care financing and policy, program development, strategic planning, coordinated care systems & insurance

products for seniors. She is a former Executive Director of Seniors Plus, an original Social HMO pilot site which has been nationally recognized for its cutting edge approach to senior care. She has played leadership roles within health plans, integrating delivery systems and community-based providers of senior services. As a consultant, Jeanne has served both care providers and payers for government funded populations and specializes in Medicare and Medicaid dually-eligible populations.

Tim A. Ritter, CPA

Wipfli, Minneapolis, Minnesota

Mr. Ritter is a manager in Wipfli's health care group in Minneapolis and specializes in serving Critical Access Hospitals, Medical Practices, Medicare-Certified Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs). He provides audit and accounting services, non-profit tax returns, and cost report preparations. He is also a member of the Minnesota Society of Certified Public Accountants (MNCPA), the American Institute of Certified Public Accountants (AICPA), and the Healthcare Financial Management Association (HFMA). Tim is a graduate of St. Cloud State University – St. Cloud, Minnesota with majors in accounting, economics, and finance.

Michael Scandrett, JD

Halleland Health Consulting, Minneapolis, Minnesota

Mr. Scandrett is Health Policy Director for Halleland Health Consulting, Special Counsel with the law firm, and co-chair of the firm's health law practice. He has been an advisor and policy analyst for Minnesota's health care leaders and policy makers for 20 years. He was influential in the formation of important health care policies and reforms, from managed care regulations to MinnesotaCare, health care quality measurement, and long-term care reimbursement policies. He has also helped organizations and coalitions launch programs in areas such as community-wide quality measurement, managed care for persons with disabilities, health care for the uninsured and mental health system reform. His past roles include Executive Director of the Minnesota Council of Health Plans and of the Minnesota Health Care Commission as well as legal counsel to the Minnesota Senate.

Jeff Schiff, MD, MBA

Minnesota Health Care Programs (MHCP), Minnesota Department of Human Services, St. Paul, Minnesota

Dr. Schiff has served as medical director for MHCP (Medicaid, General Assistance Medical Care, and Minnesota's SCHIP program, MinnesotaCare) since June 2006. His position was created in the 2005 legislative session. Dr. Schiff's work focuses on the development and implementation of evidence-based benefit policy for the public programs. His specific areas of interest include the development of policy to enhance the role of primary care and the provision of medical homes; the use of collaborative intrastate processes to implement quality improvements across the healthcare system; and the use of claims and clinical data to report and improve health outcomes. Dr. Schiff has recently served as president of the Minnesota Chapter of the American Academy of Pediatrics. He is active on the state leadership team for Minnesota's MCHB President's New Freedom Initiative Integrated Services Grant including the state's pediatric medical home initiative. He practices clinically in pediatric emergency medicine. Dr. Schiff recently completed an MBA in health care administration at the University of St. Thomas.

Michael B. Schnake, CPA, CGFM

BKD Health Care Group, Partner, Springfield, Missouri

Mike Schnake, a partner with BKD Health Care Group, has worked exclusively with health care clients since 1985 and coordinates services for the firm's approximately 150 Community Health Center clients. He helps CHCs improve their financial positions by analyzing the Medicare & Medicaid reimbursement implications of various programs and developing reimbursement strategy. He manages audits and preparation of Medicare & Medicaid cost reports, reviews interim payment rates, analyzes managed care contracting opportunities, and develops strategy. He also consults with clients concerning provider affiliations, mergers and consolidations. Mike routinely consults with state primary care associations as well as the Bureau of Primary Health Care and has developed Medicaid

prospective payment system implementation strategy for several state PCAs. In 1996, he received the Association of Government Accountants CGFM designation (certified government financial manager) which recognizes the expertise of professionals who specialize in government financial management. Mike is a member of the Healthcare Financial Management Association, Medical Group Management Association, American Institute of CPAs and Missouri Society of CPAs.

Sandra Stover, MD, FAAFP

Sawtooth Mountain Clinic, Grand Marais, Minnesota

Dr. Stover has been a Family Physician in Grand Marais for the last 17 years. In 2005 she received a Bush Foundation Medical Fellowship to explore the idea of transitioning patients from chronic care to supportive terminal care. She has also been trained through the Indian Health Services to give lectures on the Education in Palliative and End-of-Life Care curriculum with an emphasis on cultural sensitivity. She completed her residency training with the Duluth Family Medicine Residency program in 1990.

Jonathan Watson

Minnesota Association of Community Health Centers, Minneapolis, Minnesota

Jonathan Watson has served as the Associate Director of the Minnesota Association of Community Health Centers for the past ten years. At the Association, he also serves as the Public Policy Director. Prior to that, he was a Medicaid budget and policy analyst with the State of Wisconsin's Department of Health and Family Services. He holds a BA degree in Economics from Saint Olaf College in Northfield, and a master's degree in international relations from the University of Pittsburgh.

Stella Whitney-West, MBA

NorthPoint Health & Wellness Center, Minneapolis, Minnesota

Stella Whitney-West has been Interim Chief Executive Officer of NorthPoint Health & Wellness Center since spring of 2007. For the prior three years, she served as Chief Operating Officer for NorthPoint's Human Services division. Ms. Whitney-West has over two decades of experience working with governance and policy boards of nonprofit organizations and more than 15 years of senior management experience in the Twin Cities nonprofit community. Prior to joining NorthPoint, Stella was chief program officer for the Minneapolis Urban League and Capacity Building Director for the Greater Twin Cities United Way. Stella has an MBA from the University of St. Thomas. A Bush Leadership Fellow, she currently serves on several community boards of directors.

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Minnesota Association of Community Health Centers (MNACHC)

MNACHC is a nonprofit association of federally qualified health centers (FQHCs) and other safety-net providers located throughout Minnesota that provide comprehensive preventive and primary care services to all individuals, regardless of their ability to pay. Member clinics offer medical, dental, and mental health care to approximately 190,000 patients in urban, rural and tribal areas each year. The majority of patients served by these clinics are low income, uninsured, and medically underserved.
http://www.mnachc.org/

Minnesota Diabetes Program (MDP) – Minnesota Department of Health

The MDP is dedicated to improving the health of all people in Minnesota by reducing the impact of diabetes. To achieve this, the MDP works to attain population-wide impact by collecting and publicizing state diabetes data to guide policy and program design, convening forums and facilitating effective stakeholder partnerships, translating health research into practice, and promoting innovative, effective, and culturally appropriate improvement strategies.
http://www.health.state.mn.us/diabetes/

Neighborhood Health Care Network (NHCN)

NHCN is a management services organization for community clinics in the Twin Cities metropolitan area. NHCN provides centralized business and administrative support to these member clinics. Community clinics provide high quality, accessible, affordable health care to primarily low-income and medically underserved populations. NHCN's mission is to strengthen the community clinics through integrated activities to improve the health of underserved communities.
http://www.nhcn.org/

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