



June 30, 2015

TO: David H. Fisher
FR: Paul B. McGinnis
SB: Transmittal of Community Health Improvement Plan Progress

CC: Estela Gomez (OHA-Innovator Agent), Sean Jessup (Moda Health) and Kevin Campbell (GOBHI)

Attached please find documents which represent the Eastern Oregon Coordinated Care Organization's report on the progress of our Regional Community Health Improvement Plan (CHIP) as well as the progress of each of our 12 individual Local Community Advisory Council CHIPs.

The four attachments represent the following:

- The first attachment uses the OHA's suggested format to report on progress around contractual obligations.
- The second is an updated version and progress on implementation of the EOCCO Regional CHIP.
- The third document is the Annual Report that the Regional CAC submitted to the EOCCO Board of Directors.
- The fourth document is the combined Annual Report summaries from the 12 Local CACs.

This has been an exciting year for the EOCCO and its communities. Portions of these documents overlap but they each have unique properties.

Please let me know if you have any questions or need clarification. I can be reached at paul.mcginnis@gobhi.net or 541-610-2370.

Eocco Community Health Improvement Plan (CHP) Progress Report

(a.1.) To extent practicable the contractor shall include in the CHA and CHP a strategy and plan for working with: *Check any partners that have been included in CHA and CHP work:*

- X Early Learning Council
Youth Development Council
- X Local Mental Health Authority
- X Oral health care providers
- X Local public health authority
- X Community-based organizations
- X Hospital systems
- X School health providers in the service area

Describe actions taken and/or barriers to work:

The 12 individual LCACs are comprised of various organizational representatives depending on the composition and resources in the county. If they are on the LCACs, they were directly involved in the Community Health Assessment.

All 12 LCACs have representation from Early Learning Hubs (ELHs)

All 12 LCACs have representation from Local Mental Health

Advantage Dental has a representative at all LCAC meetings. They are named as members on several LCACs, a dentist is a member of the Baker and Grant LCAC. Sherman County has no oral health services.

All 12 LCACs have representation from local public health

All 12 LCACs have representation from community-based or county-based organizations

Hospitals are represented in 9 of the 12 LCACs. The other three do not have hospital services in their county

Schools are represented in about half of the LCACs

The Regional CHP addresses working with ELHs as a priority through holding a joint meeting between the RCAC and leadership from all five ELHs covering our service area. This occurred in March of 2015. A document was produced that cross referenced items from the Local CHPs and the planning documents provided by the ELHs. Data was collected on OHP members around the two Incentive Metrics which are shared between the CCO and ELHs. These included percentage of 0-36 month old children who has a developmental screen and the percentage of 0-6 year olds assigned to a primary care clinic and if the clinic was a designated Patient Centered Primary Care Home (PCPCH). The data were presented by zip code and broken down by white and non-white populations. The result of this meeting was that each of the Local CAC and ELHs were encouraged to share information and welcome each other at meetings. The Eastern Oregon ELH and the Baker LCAC have held joint meetings to identify and implement shared strategies

for community health. The Local CACs also reached out to ELHs (through 2013 Incentive Measure resources \$3,125 per LCAC) to reach the most isolated families in remote communities (particularly in Malheur County) by supporting Parent Cafes, hosting health fairs, and offering “What to Do” health education classes for pregnant women, teens and parents / care givers. Oral health screenings and education were also offered.

The Regional CHP addresses Mental Health as a priority through Mental Health First Aide (MHFA) Training, reducing community stigma and integration of behavioral health in the primary care setting. Community Mental Health Programs are central to the delivery of MHFA trainings. We identified the certified MHFA trainers in the region. Through Transformation Grants and various “in-kind” resources, MHFA trainings occurred in Lake, Wallowa, Umatilla, Malheur and Grant Counties. We have not made progress on the reducing community stigma objective which involved using clergy and faith-based organizations to deliver messages regarding mental health. The barrier has simply been time and resources. Regarding integration of behavioral health in primary care, Greater Oregon Behavioral Health Inc. (a part owner of the EOCCO) began to offer contracts increasing Per Member Per Month (PMPM) payments by \$2 for Tier 3 PCPCHs which fully integrate mental and behavioral health. A barrier here has been that the attestation documentation collected by the OHA PCPCH program does not clearly differentiate between co-located and integrated services. Still contracts have been signed with two primary care clinics.

Oral health is addressed through the Regional CHP as a priority through the First Tooth Program, increasing oral health screenings in the schools and increasing the number of schools participating in the fluoride supplement program. Advantage Dental has presented the First Tooth program to local public health departments, Head Start, and primary care clinics. Two primary care clinics were trained and 275 people from various organizations listed above have gone through the First Tooth program. School-based screenings have occurred in Harney, Wheeler and Lake Counties. Multiple other screenings have occurred at the outreach health fairs and school registration events. The school-based fluoride supplement program has not had progress. A barrier here has been time and lack of resources to implement.

Integration with Public Health is identified as a priority in the Regional CHP by creating a Public Health Advisory function to the EOCCO, coordinating services to prevent and treat chronic health conditions in children, emphasize the Living Well with Chronic Conditions (LW) program and the National Diabetes Prevention Program (NDPP). In October 2014 we successfully convened all Public Health Directors to begin the conversation about advocacy through the EOCCO. We reviewed websites and created a document to describe which counties had CaCoon, Babies First, and Nurse Family Partnership. A barrier here to implementation was the delay in having Targeted Case Management and Maternity Case Management fully under the CCO funding umbrella. Promulgated rules have not been issued which describe how this is to work. OHA leadership in this area, Don Ross, presented to the EOCCO Board of Directors in October of 2014. Under contract with Community Connection, Inc and through a grant from the Moda Foundation, 17 people were trained in all 12 counties to facilitate the LW classes. 51 people participated in the program. Community Connections, in cooperation with OHSU trained 29 Coaches in 10 EOCCO counties for the NDPP. 7 counties have provided 10 classes with 91 participants. Community Connection will continue to support both projects. Barriers include

patient willingness to participate.

The Regional CHP did not prioritize hospital systems issues.

The Regional CHP did not specifically prioritize school health providers but did include them under the headings of Oral health screenings and fluoride supplements) and Mental health (MHFA training of teachers).

(a.2.) To the extent practicable, the contractor shall include in the CHA and CHP a strategy and plan for coordinating the effective and efficient delivery of health care to children and adolescents in the community: *Check areas of focus for CHP work:*

- X Base the CHP on research, including research into adverse childhood experiences
- X Evaluate the adequacy of the existing school-based health center (SBHC) network to meet specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system
- X Improve integration of all services provided to meet the needs of children, adolescents and families
- X Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in treatment of children and adolescents

Describe actions taken and/or barriers to work:

Not all of the items marked with an “X” above were identified in the Regional Plan as a specific priority. Yet, there has been activity in the EOCCO around these functions.

All strategies for the CHP were delineated with an evidence-based practice created by research. At its Spring Conference in May of 2015, GOBHI sponsored a day-long session lead by Vincent Feletti, MD, the person responsible for the creation of the Adverse Childhood Experiences approach. The meeting was attended by over 200 people. In follow-up to that the many LCAC members and staff attended the Trauma Informed Oregon training in Eastern Oregon in June of 2015.

Two LCACs were directly involved with the creation of new School-based Health Centers. These new clinics will be Ione (Morrow County) and John Day (Grant County). The Regional CAC also invited the interim director of the School-based Health Center to present at its March 2015 meeting. The Malheur LCAC used a Transformation grant to place a Community Health Worker in the Ontario High School.

As noted above one objective of the Regional CHP objectives specifically addresses coordination of services between public health home visiting programs and primary care clinicians for clients jointly served through WIC, CaCoon and Babies First. The inventory is created.

The EOCCO works with Wrap (Around) Coordinators from GOBHI and Community Mental Health Programs to identify and provide care coordination for youth. These activities are associated with the Early Assessment and Support Alliance.

Developmental screens and adolescent well visits have been addressed through resources (\$3,125

to each LCAC) from 2013 Incentive settlement. Four LCACs had efforts to increase developmental screens and 9 LCACs addressed adolescent well visits. Many of these activities are currently on going and we anticipate reporting results in the Fall of 2015. The Umatilla LCAC is working with the community college to create local information and marketing materials to increase community awareness on the importance of adolescent well visits.

(a.3.) To the extent practicable, the contractor shall include in the CHA and CHP a strategy and plan for: Contractor shall add to its CHP: *Check any partners that have been included in the CHA and CHP work:*

School Nurses
School Mental Health providers
 Individuals representing child and adolescent health services

Describe actions taken and/or barriers to work:

As noted above, all LCACs have representatives from the Early Learning Hubs.

Transformation grants in Malheur and Gilliam both placed people in the school settings.

(b.) Contractor, with its CAC, shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities. Resources: OEI Contact – Leann Johnson, Interim OEI Director, leann.r.johnson@state.or.us, 971-673-1287

Describe work with OEI:

Data on race, ethnicity, and language were released by the OHA OEI shortly after the 2014 Regional CHP was approved. The data were shared, but at the top of the document, it said, not for public distribution. We corresponded with OEI and asked if we could release at the county level. With 12 geographically and demographically diverse Local CACs sharing the regional data with individual counties would lack meaning. The OEI contact Carol Cheny recognized that we will need several years' worth of data to annualize the numbers to protect privacy in such small populated counties. The response from Ms. Cheny included links to CCO-wide regional reports, and the following statement. *“That said, these reports are NOT available with demographic breakdowns by county. Because of the low numbers when disaggregating by county AND race/ethnicity and language, we cannot make them available unless we aggregate the numbers up to the CCO Region. It’s possible that in the future, we may be able to take numbers over a series of years, or try another aggregation approach to then divide by county and race, ethnicity and language and have enough numbers to publish.”*

Contractor shall include in the CHA identification and prioritization of health disparities among Contractor’s diverse communities, including those defined by the following. Contractor shall include representatives of populations experiencing health disparities in CHA and CHP prioritization: *Check any that apply*

Race
 Ethnicity
 Language
 Disability

- X Age
- X Gender
- X Sexual orientation
- Other factors in the service area

All of these data elements were collected as part of the CHA process and presented to each of the LCACs.

Describe engagement and representation of diverse communities:

Membership of the LCACs attempt to reflect the socioeconomic and demographics of the populations in the county. We have a specific goal in the Regional CHP to recruit more Oregon Health Plan members to the LCACs. We have used OHA Technical Assistance resources and dedicated a substantial portion of the December 2014 RCAC meeting to work on this issue. The number of OHP plan members who are on each of the LCACs is presented in the Annual Report for each LCAC. The recruitment and engagement of OHP members has been a challenge for all LCACs and despite many efforts only small progress has been made.

The 2015-2017 EOCCO Transformation Plan which was recently accepted/approved by the OHA concludes we need to update the quantitative portions of our CHA in March of 2016 to reflect the new data that is available including the Behavioral Risk Factor Surveillance System (BRFSS) conducted with Medicaid participants. This data better documents the disparities and was just recently released. Further, we now also have a couple year's history of physical, mental and oral health service utilization data of OHP members. With this new data we will have updated CHPs for all the LCACs and the Regional CAC. This data should help us better understand specific needs leading to better opportunities for engagement.

(c.) Contractor shall conduct the CHA and CHP so that they are transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHP comply with Section ORS 414.627.

Describe actions to meet this objective:

All LCAC and Regional CAC meetings are open to the public. Community Health Assessments and CHPs are available on the EOCCO Website. Annual Reports will also be posted there.

(d.) The CHA and CHP adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The CHP may include, as applicable: *Check all that apply*

- X Findings from various community health assessments made available by OHA to Contractor
- X Findings on health needs and health disparities from community partners or previous assessments
- X Findings on health indicators, including the leading causes of chronic disease, injury and death in the service area
- Evaluations of and recommendations for improvement of school based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community
- X Focus on primary care, behavioral health and oral health

- X Analysis and development of public and private resources, capacities and metrics based on ongoing CHA activities and population health priorities
- X Description of how the CHA and CHP support the development, implementation, and evaluation of patient-centered primary care approaches
- X Description of how the objectives of Health Systems Transformation and Contractor's Transformation Plan are addressed in the CHA and CHP
- X System design issues and solutions
- X Outcome and Quality Improvement plans and results
- X Integration of service delivery approaches and outcomes
- X Workforce development approaches and outcomes

Describe actions taken and/or barriers to work:

The EOCCO Regional CHP describes how issues were reviewed and selected as well as progress to date. See additional attachment.

(e.) The CHP shall identify the findings of the CHA and the method for prioritizing health disparities for remedy. Contractor shall provide a copy of the CHP, and annual progress reports to the CHP, to OHA June 30 of each year.

Deliverable: CHP progress report due to David Fischer at DMAP by June 30, 2015.

Reports include:

- Report using suggested Checklist from OHA
- Regional Community Health Improvement Plan and progress to date
- Annual Report from the Regional CAC to the EOCCO Board of Directors
- A document summarizing the Annual activities of each of the 12 Local CACs

(f.) Adopt a comprehensive local plan for the delivery of local mental health services for children, families, adults and other adults that describes the methods by which the LMHA will provide those services.

Describe actions to meet this objective, if applicable, may reference another CCO related report or document

Each mental health program within the EOCCO region submitted a County Implementation Plan for 2013-2015. These documents are referenced here, as suggested, and can be found at <http://www.oregon.gov/oha/amh/Pages/contracts.aspx>

Each of these plans was reviewed and considered as part of the Community Health Assessment process for the EOCCO. There are 12 Local Mental Health Authorities within the EOCCO. Ten of the twelve Counties contract for the provision of mental health services with local not-for-profit organizations. Sherman County is part of an Intergovernmental Agreement with Wasco and Hood River Counties while Lake County delivers mental health services with County employees. All of the Community Mental Health Programs (CMHP's) within the EOCCO are members of GOBHI which is risk bearing owner of the EOCCO. Historically, the vast majority of outpatient mental health services have been delivered through the CMHP in each County on a

sub-capitated payment system. The CMHP's have also born the risk for acute care as well as residential care to children through utilization of risk pools managed by GOBHI. The delivery system is currently being expanded beyond the CMHP's to include Tier III Patient Center Primary Care Homes. Contracts require the coordination of care between these two entities to avoid creation of duplicative systems.

- Program Improvement Plans to increase availability of and access to mental health services for children under the age of 5
- Conduct Mental Health First Aid Trainings throughout the region
- Collaboratively work with law enforcement and the courts to establish trained Crisis Intervention Teams in communities throughout Eastern Oregon
- EOCCO is an early adopter for the transition of the adult mental health residential treatment system

2015

Regional Community Advisory Council Annual Report

Regional Community Advisory Council

Annual Report

To the

Eastern Oregon Coordinated Care Organization

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I. BACKGROUND

In 2010, the Affordable Care Act was signed into law with the goal of making health care more effective and efficient. The law strives to achieve the “Triple Aim” of better health outcomes, a better health care system, and lower costs. As part of the health reform and health care integration, the State of Oregon applied for a Medicaid Waiver to implement its own plan, using Coordinated Care Organizations (CCOs) as the vehicle to achieve the Triple Aim. Oregon’s HB 3650 establishes the Oregon Integrated and Coordinated Health Care Delivery System, in which the key elements are coordination of care, patient-centered primary care homes, and aligned incentives that reward providers and beneficiaries for achieving good outcomes.



In year one, the CCOs saw a 9 percent reduction in emergency department visits among Oregon's Medicaid population.

Coordinated Care Organizations (CCOs) financially integrate and provide coordinated physical health care, behavioral health care (mental health and addictions services), oral health care, and non-emergent medical transportation services for individuals eligible for Medicaid or certain individuals with dual eligibility for both Medicare and Medicaid. CCOs are focused on prevention and helping people manage chronic conditions, like diabetes and heart problems.



The Eastern Oregon Coordinated Care Organization (EOCCO) is one of sixteen CCOs in Oregon and covers all Oregon Health Plan Members (OHP) in twelve Eastern Oregon Counties (Baker, Gilliam, Grant, Harney, Lake, Malheur,

Morrow, Sherman, Umatilla, Union, Wallowa, and Wheeler). EOCCO is a

Limited Liability Corporation sponsored by Greater Oregon Behavioral Health, Inc. (GOBHI), Moda Health, Good Shepherd Hospital, St. Anthony Hospital, Grand Ronde Hospital, St. Alphonsus Hospital System, Pendleton Independent Physicians Association, and Yakima Farm Workers.

Local Community Advisory Councils (LCACs) are a principal component of Oregon’s Health Integration Model. They were established to help CCOs understand the health needs of local populations and make recommendations that help CCOs reach the triple aim. LCACs are the critical link between CCOs and community-based providers and partners. The EOCCO has established a LCAC in each county and a Regional Community Advisory Council (RCAC). The EOCCO Board of Directors appointed a RCAC with representation from each of the twelve LCACs. One of the main goals of the RCAC is to oversee and coordinate LCAC activities such as the Community Health Assessments, Community Health Improvement Plans and preventative health care activities.

The Transformation Center (the center) is an overarching resource for health reform in Oregon. Under the auspices of the Oregon Health Authority, the center is helping CCOs achieve the triple aim by helping spread the coordinated care model to other payers. The center supports CCOs, and the adoption of the coordinated care model throughout the health care system, through technical assistance and learning collaboratives that foster peer-to-peer sharing of best practices. A rudimentary graphic of these aforementioned relationships includes:



II. REPORT PURPOSE

The RCAC is pleased to submit this annual report to the EOCCO Board of Directors as required by ORS 414.627. The purpose of this report is to provide the Board with a status update on the extent to which the LCAC's are achieving their goals. Section III includes "Findings" and provides the following:



- A. LCAC Accomplishments
- B. Challenges
- C. Analysis and Suggestions

Given the variety of activities and work among the diverse twelve counties, information for this report was collected via a content analysis of the following:

- I. LCAC meeting agendas and minutes
- II. LCAC community assessment materials
- III. LCAC and RCAC Community Health Implementation Plan
- IV. RCAC notes and presentation materials
- V. Interviews

III. FINDINGS

LCAC members have spent over 5,700 hours of work to help Eastern Oregon move towards the triple aim.

A. LCAC Accomplishments – 2.7 FTE. This is the estimated number of full time staff equal to volunteer hours LCAC members have spent on evaluation, planning and program / policy development. What has galvanized this type of dedication? As one member said, “We have an opportunity to make real change in health outcomes for our community.” To follow is a summary of activities accomplished through LCAC’s members’ commitment to building a better health care system in rural Eastern Oregon.

✓ Community Health Risk Assessments – \$46,000 - this is a quote from researchers in the educational setting to conduct a single *portion* of the multi-faceted risk assessment data collection and analysis project. Another project consultant gave a bid of \$14,000 to conduct part of this work – for one county – that’s a total of \$168,000 for all of EOCCO. Instead of paying very high consultant prices for *part* of the planning process, GOBHI provided in-kind support with a team of management and research staff to work with each LCAC on completing the full phases of planning. These staff did not direct the process. They built on work already in progress in each community and the LCACs led the planning process. They supplemented existing assessments rather than supplanted them. The community members were the driving force. Staff provided technical expertise and process facilitation. The planning work included a) collaboration with the Oregon Health Authority Office of Equity and Inclusion to develop meaningful baseline data on health needs and disparities; b) collecting quantitative archival data from the Office of Rural Health; c) collecting quantitative archival data from national resources on epidemiological data; and d) collecting community perceptions of health needs through surveys, focus groups, and / or key informant interviews.

These quantitative and qualitative data were then analyzed and triangulated via a meta-evaluation of all findings which were then developed into a) a presentation for each community and b) a single report on health needs

and disparities in each of the twelve counties. The data presentation format focused on describing “themes” among the archival quantitative data along with the qualitative data. This aspect of the analysis was conducted to answer the question,

“To what extent did community perceptions of health issues and needs align with state and national archival data?”

The findings were very significant – community perceptions of need and archival data were extremely congruent in each county. This fact greatly assisted each community with prioritizing their health needs because specific themes rose to the top of the data. The PowerPoint of their health assessment data had over 100 slides for each county. It included charts of specific data and a summary of the comparison between archival national / state data and community perception data. An example of this summary is in the following table:

National / State Studies:	Community Responses:
<p data-bbox="354 1108 781 1140">Higher Death Rates Related To:</p> <ul data-bbox="380 1184 683 1325" style="list-style-type: none"> • Heart disease • Stroke • Smokeless tobacco • Substance Abuse <p data-bbox="331 1371 630 1402">Increase In Rates For:</p> <ul data-bbox="380 1446 834 1549" style="list-style-type: none"> • Motor vehicle death involving alcohol • Suicide 	<p data-bbox="927 1108 1414 1178">Respondents Had Higher Reporting In Areas Of:</p> <ul data-bbox="938 1222 1276 1404" style="list-style-type: none"> • High cholesterol • High blood pressure • Arthritis • Chronic pain • Depression / anxiety <p data-bbox="894 1446 1094 1478">Priority Areas:</p> <ul data-bbox="938 1482 1182 1623" style="list-style-type: none"> • Drug abuse • Alcohol abuse • Obesity • Mental Health

Each LCAC identified their three to five (3 to 5) community health improvement priority areas from findings within their Community Health Assessments. They also held community-wide meetings to help educate the community on the entire planning process and health needs identified from that work. In addition to providing community education, this time was also used to enlist interest in this process and invite participation in future planning processes. Lastly, the LCAC provided feedback to community members on the outcome of their participation in the survey and focus groups.



✓ Community Health Improvement Plans (CHIP) – Each community developed a CHIP based on their identified health needs. The plan includes a problem statement, target population, interventions, projected outcomes, and unfunded budgets. These phases of the local planning process were very strategic because outcomes were determined by strategy, strategy was determined by population, population was determined by need, and need was identified in the extensive assessment process. It followed a “logic model” planning process.

Community Health Planning Logic Model -			
Current Conditions:	Objectives:	Activities:	Outcomes:
<ul style="list-style-type: none"> Positive and negative conditions 	<ul style="list-style-type: none"> Level of improvements 	<ul style="list-style-type: none"> Strategies to effectuate objectives 	<ul style="list-style-type: none"> Measurable impact

✓ Regional Health Priorities – The challenge for the RCAC was to create a CCO-wide CHIP. This group had to find common interest and priorities among the 12 diverse counties. This presented an opportunity to articulate prevalent health issues within the EOCCO but it also had the latent threat to negate individual county’s extensive work if “their issues” were not in the final round of priorities. GOBHI staff endeavored to put together a decision making process that

would respect individual county work while helping to sort out prevalent health issues among the twelve counties. They were successful with that goal and the final regional plan was developed from the work of LCAC representation on the RCAC.

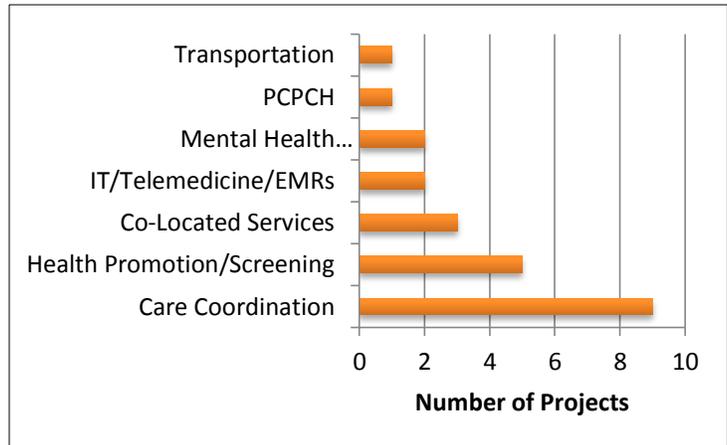
✓ Eastern Oregon Healthcare Transformation Project Grants - EOCCO developed a unique approach among Coordinated Care Organizations to award the full \$1.6 million in funds provided by the State of Oregon Transformation Center to communities throughout Eastern Oregon to support transformative efforts. In an effort to elicit the most pressing and innovative projects from its twelve counties, the EOCCO issued a request for applications and underwent a rigorous peer review process.

The purpose of the EOCCO grant program is to fund projects that support better health, better health care and lower costs for Eastern Oregon's Oregon Health Plan (OHP) members and their communities. Support was designated for projects that are innovative, scalable, transferable and related to overall transformation goals. Overall, the EOCCO reviewed 36 proposals from all 12 counties.

MODA Health contracted with the Center for Evidence-based Policy to conduct a peer review of the submitted proposals. Experts from OHSU in rural health, primary care, Medicaid, technology in rural settings, and a community representative were selected as reviewers.

The sub-committee proposed that the EOCCO Board of Directors fund 23 applications for a total investment in transformation projects of 1.6 million dollars. The portfolio of projects proposed for funding includes at least one grant for each county and represents a wide range of transformation topics and objectives.

The full funding report can be found at, http://www.eocco.com/pdfs/EOCCO_summary_of_grant_wards.pdf. A link is also provided at the end of this report.



It should also be noted that some of the LCACs

submitted their own transformation grant proposals while other community health related organizations also submitted competing applications. In cases where there were competing applications, communities were given the opportunity to merge proposals to demonstrate a more collaborative approach to meeting the identified challenges. The graph above represents the types of projects that were funded. Sustainability of these grants beyond the later part of 2015 and into 2016 will be a struggle for many of the communities.

To follow are examples of the anticipated health outcomes for citizens and health care system impacts as a result of these funding opportunities. This overview for each county may represent more than one funded project:

- Patients with complex medical conditions will receive enhanced care coordination with the goal of reducing ER visits and increasing access to health care and preventative screenings. (Baker)
- Equipment and design support for a wellness facility with the goal of decreasing obesity rates and disease burdens while increasing access to physical therapy. Impact health needs at both ends of the age continuum through school-based counseling and addressing depression in older adults. (Gilliam)
- Expand field-based technology in order to increase health worker : patient care time. Enhance communication among providers through an expanded Electronic Medical Records (EMR) model. Engage high-risk populations in

developing personalized health plans and increasing health awareness and education among at-risk members. (Grant)

- Coordination between behavioral health and the hospital to increase access to behavioral health services and decrease the rate of psychiatric visits to the ER. (Harney)
- Create the county's first Patient Centered Primary Care Home (PCPCH) clinic with the goal of better health and health care through integrated services. Provide evidence-based training on mental health issues in order to increase the knowledge base for community providers and increase referrals to services. Enhance care coordination with the goal of decreasing ER visits and patient engagement in health care. (Lake)
- Provide a school-based adolescent health care program with the goal of developing culturally and linguistically competent service delivery, co-manage referrals to services for school age youth and Hispanic families. Provide navigation services for post-discharge care from ER patients with mental health and addictions issues with the goal of reducing ER readmissions. Develop a community health worker program to coordinate county-wide training and to identify and recruit culturally and linguistically diverse set of "natural helpers" for patients. (Malheur)
- Create an inter-disciplinary community care team of health providers to address unmet health needs for women and children. The goal is to improve access to prenatal care, well-child checkups including behavioral health services, and developmental screening for underserved children and pregnant women. (Morrow)
- Enhance care coordination, health care and access to care through home visits from public health nurses for chronically ill populations with the goal of decreasing ER utilization and hospital readmissions. (Sherman)



- Improve access to behavioral health services for underserved patients with chronic conditions with the goal of improving both health outcomes and patient satisfaction. Conduct community outreach, increase health promotion / coaching / case management / referrals/ and follow-up services in order to reduce health disparities among low-income families, children, the elderly and racial/ethnic minorities. Provide support services for patients in the ER having behavioral health issues with the goal of reducing readmissions and effectively transition patients to outpatient multidisciplinary health services. (Umatilla)
- Facilitate same-day healthcare appointments and pharmacy deliveries to outlying communities living in isolated areas with the goal of reducing the rate of missed appointments and improving health by increased access to prescription medication in communities not served by pharmacies. Increase support associated with healthy birth weight through a targeted media campaign with the goal of increasing healthy birth. (Union)
- Enhance health promotion for children not engaged in activities outside of home on Fridays due to the four-day school week with the goal of increasing the knowledge about nutrition, increasing access to healthy activities and decreasing the percent of overweight children. Adopt healthier lifestyle habits and decrease utilization of healthcare services through a targeted 18 sessions educational program for middle to upper aged populations suffering from one or more chronic diseases. (Wallowa)
- Implement a) a health education, b) an outreach campaign and c) an exercise incentive program to increase access to health promotion activities, health screenings, referrals to treatment and health care services. (Wheeler)



Eastern Oregon Healthy Living Alliance (EOHLA) – The RCAC

recognized that the CHIP had to impact the entire community of Eastern Oregon, regardless of payer source. In that Medicaid funds can only be spent on persons who are Medicaid eligible, a supplemental payer source needed to be developed to fully implement the CHIP plan. It was determined that the formation of a single not for profit corporation would be the best vehicle to develop relationships with philanthropic organizations and generate funds for the entire region.

This organization, the Eastern Oregon Healthy Living Alliance, was incorporated under Oregon law and is currently seeking Internal Revenue Service tax-exempt status as 501c3. Membership of the EOHLA Board of Directors is comprised on one person from each of the 12 EOCCO counties.

The twelve LCACs and RCAC have, with limited funding for support (\$4,635 per year), produced what is difficult for one agency to develop – extensive assessments, planning documents, agreed upon regional focus, etc. In June of 2014, the OHA recognized that the community health assessments and Community Health Improvement Plan met all contractual obligations between them and the EOCCO.

This planning work and service enhancements occurred as OHP enrollment increased by 54.8 percent. In addition, the EOCCO, RCAC and LCACs worked as architects of health reform in their communities and stewards of a new system of care to better serve people with complicated health issues and also to promote wellness in rural Oregon.

Challenges – The extensive and notable aforementioned accomplishments did not occur without uncovering some barriers. As the EOCCO moves from theory to practice, there lies within its evolutionary process a continuum of success and challenges. The RCAC presents these challenges to the EOCCO as they serve as a compass towards process improvements within that evolutionary process.



They include the following themes:

✓ **Incentive Funds** – As briefly described in the background section, there are aligned incentives that reward providers and beneficiaries for achieving good outcomes via incentive measures. In 2014, LCACs were each given \$3,125 (5% of \$750,000 / 12 allocated for distributions to providers and



communities) with the requirement that funds be used to improve performance toward achieving one or more metrics in their community. While the RCAC wants to express gratitude for inclusion in this distribution and recognize its uniqueness among all other CCO's in the State of Oregon, there are two principal concerns regarding the current allocation process. LCACs would like a more meaningful amount of money and have the “requirements” removed. They would like more flexibility with local decision making regarding how they spend the incentive funds to improve community health. There are perceptions of disparity as some providers receive incentive funds without requirements on how these funds should be spent.

Analysis and Suggestions for Consideration – Receiving incentive funding is based on meeting the measures, so it is in everyone's best interest to ensure the most effective system for obtaining these outcomes. This should be of highest priority. There are no data, however, to suggest that providers and communities would work less towards those outcomes without the requirement of how to use these funds. In other words, there are no data, or compelling rationale, to

suggest that if LCACs had discretion on how to spend their incentive funds, that they would not also continue to work towards meeting those measurements because measurement attainment directly effects their funding.

In addition and if not already done so, the EOCCO would benefit from an analysis of which strategies of focus have the most influence towards achieving the incentive measures. Given the population size variance among the twelve communities, a targeted approach towards achieving the incentive measures is to identify the extent to which any area(s) has more of an impact on those measurements. If that does exist, it may be more prudent to develop a model that allocates a higher proportion of all the funds to that area and then target a specific percent of those funds to be spent on measurement activities in that geographic area(s) with the remainder funds as discretionary. Other areas would also experience an increase in funding and would not have requirements on those funds. This approach would a) provide support to meet the measures and b) benefit all the communities through a stronger potential of meeting them. This is, of course, just one model for distribution of funds. It's goal is to develop a more targeted approach to achieving the metric measurements in addition to providing more flexibility for local decision making. It is provided as an example of better alignment between community needs and progress towards the required measures.

We are all working together to improve health care outcomes and reduce costs. There should be more flexibility on how we spend the money generated from our collective success.

✓ Risk Sharing Model – In the EOCCO model, the LCACs are designated to receive 2% of the total savings. LCACs would like a larger percentage and flexibility on how these resources are spent. For example, areas of their local CHIPs could be funded.

Analysis and Suggestions For Consideration – This is similar to the item above in that improved performance drives increased financial benefits. The desire to

have a higher percentage of the funds with more discretion on spending holds constant in both situations.

It may be best to consider a balance between the two ends of the continuum. On the one side is a lower percent of funds and restrictions on how funds are spent. On the other end is a higher percentage and no requirements related to spending. Should the EOCCO decide to increase the percentages and remove restrictions, they may also want to balance the monitoring of those decisions. For example, this process would include on-going and regular monitoring of outcome data. It would be optimal if that occurs in partnership between the EOCCO and LCACs. This co-monitoring has more potential to produce early identification of problem areas and allow these groups to engage in collaborative problem solving with “real time” responses.

✓ Structural Issues – This caption has more than one aspect to it. It basically refers to how the CCO is structured and utilizes LCACs to help with their joint commitment to achieving the triple aim. That general statement has these specific components to it:

- The EOCCO is not a single entity but rather is made up of distinct organizations who have separate staff and operations. While there may be specific governance on how they work together, how they operationalize those protocols within the 12 counties is confusing to community members.
- Staff have been identified as a significant resource to the LCACs and as GOBHI staff, they do not have direct links to resources within Moda Health that support their work with the LCACs. So, when community members ask for specific data, for example, to assist with data-driven decision making, staff are often in the position of saying, “Moda Health has that information.” In and of itself that is not problematic. Barriers arise, however, when staff do not know how to, or are unable to, access needed information. Data access and other information transparency would be a great benefit to this work.
- The lines of communication are unclear. The goal of the LCACs are to make recommendations to the EOCCO. The process for “how and when” that

occurs, or even “who” to specifically contact, are all nebulous rather than defined. There is no formalized process and regular mechanism for LCACs to give feedback to the EOCCO Board of Directors regarding quality improvements nor is there a process to monitor critical benchmarks. This is unfortunate because it creates an environment where problems within the community setting can percolate for some time before coming to the attention of the EOCCO. That creates a “pressure cooker” scenario so when issues are finally articulated, they can seem more raucous than when they first started. It also underutilizes opportunities to identify what is working and build on that success in addition to finding the problematic areas in order to make real time adjustments.

- The other structural issue relates to needing more community members on the LCACs. This is not a product of the EOCCO structure but rather a comment noted in several areas of the report preparation. Particular care is being given to de-bureaucratize CAC meetings by ceasing the use of acronyms, and scheduling meetings at times and places more accessible to CCO Members.

Analysis and Suggestions for Consideration – There is a structure in place for community-based providers, consumers, and other citizens to be involved in local health transformation via the LCACs and a regional group to help synthesize that work in order to represent Eastern Oregon as a whole. The twelve counties and the RCAC have conducted significant work in the early launch of the new CCO structure. As that work has matured, areas have been identified which foster health reform and areas have been identified which hinder it.

Because many of the described obstacles exist within the context of the working relationship among the EOCCO, the RCAC, and LCACs, it seems natural to address these issues within that relationship through a strategic planning session with representatives of these groups. This document highlights the major issues, and there may be others, to include in that strategic planning. At a

minimum, it should produce a common vision, data sharing and monitoring definitions and schedule, communication protocols, formula(s) for funding allocations, regularly reviewed quality assurance measures, and transformative strategy that can be supported by all payers and providers. .

✓ Target Population – This is not a EOCCO specific issue but rather a state-wide affect of the CCO’s population focus. Oregon’s health reform is based on serving the OHP population. Local planning, however, is concerned with health for all community members. Enrollment in the Oregon Health Plan currently constitutes slightly less than 1/3 of the population of Oregon which means that the other 2/3 can also benefit from community-wide wellness measures initiated by one or more CCOs. The challenge is how to get other payers including Medicare to start reimbursing for their portion of these costs. We recognize that 90 percent of costs of healthcare are driven by the social determinants of health and savings will occur throughout the entire population. Hence, it is neither ethical nor legal to expect the CCOs to be the only payer source for these community-based activities. It is hoped that EOHLA can assist on the short-term but there needs to be larger discussions about how to improve access to and payment for population health initiatives.

IV. SUMMARY

Taking an episodic system of health care and transforming it into an integrated system of care and wellness represents one of the most significant changes in our nation’s health care history. Oregon’s CCO blueprint to move that reform from legislation to operations took years in planning, countless hours of effort, and expertise from health care providers and community members. It has also required fiscal resources along with data and other technical support in order to initiate and foster that change.

For Eastern Oregon, these changes came together through the partnership within the EOCCO and the 12 rural counties. The early results of this partnership include a comprehensive assessment of need for each community, a regional

approach to health care prioritization, health improvement plans, the creation of a non-profit entity to assist with CHIP funding and Transformation Grants that support health care coordination, system integration and health care promotion,

The purpose of this ambitious work is to meet the triple aim through the initiation and on-going efforts to build an integrated system of care with coordination of services for high risk members (patients) in addition to building and implementing preventative services which promote health and wellness. If the next steps of implementation are as ambitious and effective as those in which it has been launched, then Eastern Oregon will turn the tide from unmanaged to coordinated and managed chronic illnesses, from high health care costs to efficiencies and cost saving, and from an unbalanced approach to system management with a weighted focus on reactivity to a balanced and efficient continuum of care. The momentum is strong and it needs both the continuation of the EOCCO leadership and an increase in resources in order to evolve into the next level of implement and long-term sustainability.

“How can Eastern Oregon best continue its significant work and document success towards the triple aim?”

By building on the many strengths described in this report and giving thoughtful attention and responses to the obstacles also summarized in it. This approach will foster the health care reform created through Oregon’s statewide movement and effectuated into practice through local determination, expertise, and commitment to healthier communities.

We have made remarkable progress in a very short period of time. We have moved from not identifying ourselves as a single community to becoming trusting partners in achieving the triple aim. Our goal is within reach but we do ask that Community Advisory Councils continue to be viewed as valued partners in the EOCCO’s goal of creating better health, better care, and lower costs in our communities.

Sources of Information – The following resources were used directly or in part in the development of this report.

1. Kliff, Sarah. New Research Shows Medicaid Increases ER Trips. Oregon Has Plan To Stop That. Washington Post. January 3, 2014. (quote on page 2)
2. EOCCO Regional Community Advisory Council Charter
Link – If the link is not functional, use the above title as the search
http://www.gobhi.org/pdfs/fact_sheets/final-rcac-charter-approved061013.pdf
3. Eastern Oregon CCO web page with subsections “Grants” and “Community Advisory Council” Link - If the link is not functional, use “Eastern Oregon CCO” as the search.
<http://eocco.com/cac.shtml>
4. All LCAC meeting agendas and notes
5. RCAC presentation materials to the EOCCO
6. Interviews – Interviews with staff and LCAC members were used to verify or clarify information collected in the variety of documents regarding the LCACs progress. These documents are the major sources of information in this report. These interviews were conducted in confidentiality so names or affiliations are not represented in this report. Interviewees work in one or more of each of the 12 EOCCO counties.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Baker County Community Advisory Council)</i>
Reporting Period:	<i>(July 1, 2014 – June 30, 2015)</i>
Organization Point of Contact:	<i>Charlotte Dudley, CAC Coordinator Phone 541 519 3852 Email charlotte.dudley@gobhi.net</i>
LCAC Officers:	<i>Marji Lind (Chair), Alicia Hills (Vice Chair), no secretary</i>
Official Membership List:	<i>Marji Linda, Alicia Hills, Mary Ann Wren, Mary Jo Carpenter, Cindi Bowman, Aaron Hanson, Melissa Grammon.</i>
Percentage of LCAC Members who are consumers:	The Baker CAC currently has one CAC member who is also an EOCCO plan member and another person in the process of becoming a CAC member.
Number of LCAC meetings held in the reporting period:	<i>7/1/14, 8/5/14, 9/8/14, 10/7/14, 11/4/14, 12/2/14, 1/6/15, 2/3/15, 3/3/15, 4/7/15, 5/5/15, 6/12/15 (joint meeting with Cradle to Career). Meetings are from 12:00-2:00pm.</i>

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	St Alphonsus Medical Center- This project connected the hospital with the St Alphonsus Baker Clinic and New Directions Northwest (Behavioral Health) to coordinate services and link people using the Emergency Room to a medical home, insurance and behavioral health services. A Behavioral Health Specialist is located in Primary Care Centers on a part time basis.	As of 5/2015
Incentive Funds	The Baker CAC hosted a series of health classes. Targeted populations were pregnant women, parents of children (physical and oral health), teens and aging adults. The Northeast Oregon Network served as the fiscal agent, provided the health manuals and taught the classes. Nursing students from EOU completed internship hours assisting with the project. Approximately 40 community members participated in the classes. The Literacy Coalition donated books to give to children and Advantage Dental provided toothbrush kits. Increasing participant’s awareness of supports and services available and increasing confidence in how to handle health situations are the targeted outcomes. Decreasing Emergency room visits was the goal.	As of 5/2015
Local CHIP Implementation	Several strategies from the CHIP have been implemented. Hosting What to do for health classes, increasing the number of children receiving fluoride varnishes and dental screenings and behavioral health integration in the Primary Care Centers and School Based Health Centers is occurring.	As of 5/2015
Other	NEON-Pathways, Community Connection, OWEB/Living Well and Diabetes Prevention, Early Learning Hub- NWHF funding	

2) Local CAC Challenges:

Retaining the membership and involvement of EOCCO plan members is the greatest challenge. Several community members have attended one CAC meeting and decide not to return. The CAC has tried several approaches to help people feel welcome-creating meaningful agendas, discussing issues and developing possible solutions for plan member concerns, avoiding complicated acronyms, providing an orientation for new people coming to the meeting, having lunch at the meetings, and providing a \$35 stipend, mileage and child care reimbursements. Nothing has been overwhelmingly successful.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>Gilliam County Local Community Advisory Council</i>
Reporting Period:	<i>July 1, 2014 – June 30, 2015</i>
Organization Point of Contact:	<i>Teddy Fennern 541-506-2399 Teddy.fennern@co.gilliam.or.us</i>
LCAC Officers:	<i>Chair Vicki Winters Vice Chair Michael Takagi Secretary(filled by Teddy Fennern)</i>
Official Membership List:	<i>Vicki Winters, Lisa Helms, Michael Takagi-(Replaced previous PA), Hollie Winslow, Natalie Wilkins-Reappointed, Marvin Pohl-Reappointed, Steve Shaffer, Rebecca Humphreys, Teri Thalofer-Reappointed, Natalie Wilkens resigned</i>
Percentage of LCAC Members who are consumers:	Currently we have 0% of actual consumer members. We do have partners who are on the LCAC board who serve the consumers and do speak as a voice for the consumer members. Hollie Winslow – South Gilliam Health Center Mike Takagi – South Gilliam Health Center Teri Thalopher – North Central Public Health
Number of LCAC meetings held in the reporting period:	<i>7 meetings total: July 2, 2014, August 28, 2014 Joint Meeting with Wheeler and Sherman LCACs, October 2, 2014, December 11, 2014 Joint Meeting with Wheeler and Sherman LCACs, January 8, 2015, February 5, 2015, April 2, 2015</i>

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>Gilliam County was awarded two Transformation Grants.</p> <p>South Gilliam County Health District – (\$109,928) to build a wellness facility attached to the clinic in Condon. Funds are to supply equipment, consultation on design and use of the equipment for physical therapy services.</p> <p>Status: Most of the equipment has been purchased for the wellness facility. They are currently waiting for the final payment to complete the purchasing of equipment. The construction of the Wellness Center is expected to be completed early July.</p> <p>Gilliam County – (\$87,600) the project has three components: to address negative stigma associated with obtaining mental health services by implementing a local media campaign, to support a school counselor position and to address older adult depression by providing part-time peer mentor.</p> <p>Status: Local Media Campaign: Some Articles have been submitted to the local paper addressing the various resources, services and availability towards addressing the negative stigma associated with mental health services. There will be several more articles going into the newspaper before the end of the 2015 year. In addition, having the school based counselor in the schools has also brought awareness of the services available to the families in our county. The school based counselor will continue to offer services through the summer through various summer activities at both school districts. Our behavioral health agency has had their counselors at the assisted living centers and senior meal sites throughout the year and will continue to do so. They are talking with Seniors and offering someone to talk to without actually accessing the services through a traditional one on one process, as a lot of our seniors only have Medicare and we are currently not able to accept Medicare as a form of payment. If a Senior seems like they</p>	As of June 20, 2015

	need some additional resources they can be referred to have a one-on-one session with a counselor.	
Incentive Funds	Gilliam LCAC targeted their incentive funds at Developmental Screening age 0-36 months; colorectal screening; and adolescent well care visits. The interventions include purchased media, flyers, and fecal blood occult test kits. Status: The Gilliam County LCAC has worked some on the incentive dollars by starting to create the Flyers for the developmental screenings; and adolescent well care visits. Those will soon be going out to all postal patrons in Gilliam county and the Colorectal Screening will start to get going. We are going to work with the local clinic to get the fecal blood occult tests and they are going to help with targeting the certain age group and getting the tests out to community members. We will start having the media campaign start soon as well, and we are going to try to get a person to hire to help with this process or it will just start getting done by team members with a little bit of time to take on a portion of the project.	As of June 30, 2015
Local CHIP Implementation	Portions of the Gilliam CHIP were addressed through the second listed transformation grant above.	As of June 30, 2015
Other		

2) Local CAC Challenges:

No members of the Gilliam LCAC are currently Oregon health Plan members.

Keeping LCAC members interested in working on the projects.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	Grant County Community Advisory Council
Reporting Period:	July 1, 2014 – June 30, 2015
Organization Point of Contact:	<i>Linda Watson Grant CAC Coordinator 541-620-0444 Linda.watson@gobhi.net</i>
LCAC Officers:	Lindsay Maghan, Chair; Sally Bartlett, Vice Chair; Kathy Cancilla, Secretary
Official Membership List:	<i>Teresa Aasness, Families First Director, Frontier Early Learning Hub, Greg Armstrong, Pharmacy owner, Sally Bartlett, Economic Development, CAC Vice Chair, Tracey Blood, CASA Director, Megan Brandsma, Child Care Resource and Referral, Kathy Cancilla, Transformation Grant Project Coordinator, CAC Secretary, Russ Comer, Grant County Safe Communities Coalition, Sheila Comer, Grant County Health Department, Oral Health & Tobacco Prevention Director, Cammi Copenhaver, Community Member, Foster Parent, Janean Dedmore, Community Member, parent, Vickie Harrison, Community Member, Debi Hueckman, Department of Human Services (DHS), Kim Jacobs, Blue, Mountain Hospital Dietician, Chris Labhart, County Commissioner, Thad Labhart, Community Counseling Solutions (CCS), Lindsay Maghan, Grant County Health Department Manager, CAC Chair, Shanna Northway, OSU Extension Director, Erin Osgood, Veteran's Services Officer, Health Department Accreditation Coordinator, Karen Triplett, Grant County Health Department, Nurse Practitioner, Simmie Waddel, Community Member, parent, Robert Waltenburg, Education Service District (ESD) Superintendent, Linda Watson, Greater Oregon Behavioral Health, CAC coordinator, Jessica Winegar, Grant Health Department Manager, Jenni Workman, Grant Health Department, Home Visiting Services Director, Mary Ann Wren, Advantage Dental Regional Manager, Community</i>

	<i>Liaison, Patti Wright, Frontier Early Learning Hub Coordinator</i>
Percentage of LCAC Members who are consumers:	20% of the Grant CAC are consumer members and over 55% of the local CAC members work for agencies that provide services to consumers.
Number of LCAC meetings held in the reporting period:	<p><i>Grant CAC meet on the 4th Wednesday of each month, re-scheduled to another week when necessary. Time: 12:00 PM – 1:30 PM with lunch served.</i></p> <ul style="list-style-type: none"> • Number of meetings held – 11 (no meeting held in Dec.) • Meeting dates; 7/23/14, 8/27/14, 9/24/14, 10/29/14, 11/12/14, 1/28/15, 2/25/15, 3/18/15, 4/22/15, 5/20/15, 6/24/15

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>The Healthy Together grant project received an extension to offer community wellness support through the end of September, 2015.</p> <ul style="list-style-type: none"> • Public events were held for seven consecutive months, bringing medical professionals and consumers together to learn about and discuss prevention and wellness • Monthly activities were offer to consumers and community to promote healthy lifestyle • Monthly media coverage: radio, newspaper, local reader boards, flyers, medical provider referrals • Booths with health promotion information shared at community events • Project is current promoted on the OHA website, feature OHA article <p>Healthy Together Transformation Grant project – Project Coordinator and CAC Coordinator promoted CAC and provided membership opportunity at Healthy</p>	Sept. 2014 – Sept. 2015 (extended project)

	Together public events.		
Incentive Funds	<p>CAC incentive funds have gone towards:</p> <ul style="list-style-type: none"> • Development Screenings - Grant Health Department and Strawberry Wilderness Community Clinic have available parent incentive gift cards and parent education books for parents who have ASQ results reviewed by primary care physicians in their clinics. • Colorectal Screening – paid promotion ads in the local newspaper. • Adolescent Well Care visits – promoted at the Teen Health Fair and the SBHC. Encourage replacing AWC visit with Sports Physical. 	Dec. 2014 – June 2015 and beyond	
Local CHIP Implementation	Children’s Health, Obesity & Overweight, Oral/Dental Health – the three priority areas of the local CHIP have been included in the Healthy Together grant project community outreach events.	Nov. 2014 – June 2015	
Other	CAC members served on the SBHC Community Outreach Committee and helped to promote community awareness around opening a School-Based Health Center in Grant Jr/Sr High School. The SBHC opened the first of May, 2015.	Jan. 2014 – June 2015	

2) Local CAC Challenges:

- **Grant CAC has good member participation but could use increased visibility in the community**
- **Future CAC involvement with the local clinic and hospital**
- **Coordinating projects that responsibly use incentive dollars and reflect the priorities in the LCAC Community Health Improvement Plan (CHIP)**

EOCCO Local Community Advisory Council

Annual Report (due June 23, 2015)

Prepared for Oregon Health Authority

Local CAC County & Name:	<i>Harney County Local Community Advisory Council</i>
Reporting Period:	(July 1, 2014 – June 30, 2015)
Organization Point of Contact:	<i>Evelyn Neasham, LCAC Coordinator eaneasham@msn.com</i>
LCAC Officers:	<i>Chair Dan Brown, MD Vice Chair, Stacie Rothwell Secretary, Evelyn Neasham</i>
Official Membership List:	Stacie Rothwell, Donna Schnitker, Kim Needham, Barbara Rothgeb, Carolyn Bauer, Julie Johnson, Tim Colahan, Gail Buermann, Shauna Hammon, Angie Lamborn, Kathy Rementeria, Pete Runnels, Jen Yekel
Percentage of LCAC Members	0%

who are consumers:	
Number of LCAC meetings held in the reporting period:	<i>LCAC Meet 6 Times</i> August 12, 2014; October 14, 2014; December 9, 2014; February 10, 2015; April 14, 2015 and June 9, 2015

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>This project embedded a part time LCSW from Symmetry Care into the Harney District Hospital Family Care Clinic. Co-location enables care management for behavioral health needs within the primary care clinic and referral to Symmetry Care for services. The goals of the project are to achieve a formal process of integrated care between Harney District Hospital and Symmetry Care, increase enrollment of patients in Symmetry Care for mental health care and reduce the number of psychiatric crisis visits to the Harney District Hospital Emergency Department.</p> <p>Status: The current status of the Transformation Grant is that we have begun MH Integration at the clinic! In April, we started providing Tele-Psychiatry Services to our patients 1 day per week by Dr. Henry Elder, a Psychiatrist based in Canby, OR. This is has provided an opportunity to expand services and an alternative option for patients other than our local Mental Health</p>	As of June 30, 2015

	<p>Agency – some people refuse to go there based on stigma, past experiences, etc. This has been well received by our patients and our providers love having this option.</p> <p>On July 13th, we have a Behaviorist starting full time at our clinic. He is a LMSW, working towards his LCSW. He will work very closely with Dr. Elder and our PCP’s. He will also be somewhat of our “link” to Symmetry Care, locally to ensure patients are following through with their referrals, working closely with their therapists and staff to ensure that our providers are in the loop of what is happening with the patient. He will be available for warm hand off’s in our clinic, motivational interviewing, brief interventions as well as provide assistance to our Care Manager with the patients she manages who are struggling with their health (due to chronic conditions or other issues) that have a behavioral health component that needs addressed.</p> <p>From as data stand point, we have been watching referral patterns for the past year for all Mental Health services – how long is it taking for the patient to get in for mental health services, are they getting the services that our doctors referred them for (Psychiatry, mainly), are patients following through with our referrals? The nice thing about the grant extension to December is that it will give us several months to obtain some comparative data on these same issues now that we have services integrated into our primary care clinic.</p>		
Incentive Funds	The Harney LCAC is using their \$3,125 to increase the number of people being screened for colorectal cancer and increase the number of adolescent	As of June 30, 2015	

	well care visits. Status: The program is being implemented over the summer of 2015.	
Local CHIP Implementation	The integration of behavioral health and physical health was identified in the Harney CHIP and is being implemented using the Transformation Grant described above. No other sections of the plan have been implemented.	As of June 30, 2015
Other	The Harney LCAC also serves as the Community Mental Health Advisory Board and the Community Advisory Board for People with Developmental Disabilities	

2) Local CAC Challenges:

LCAC has not been able successfully to recruit OHP members

**EOCCO Local Community Advisory Council
Annual Report (due June 31, 2015)**

Local CAC County & Name:	<i>(Lake County Community Advisory Council)</i>
Reporting Period:	<i>(July 1, 2014 – June 31, 2015)</i>
Organization Point of Contact:	<i>John Adams, CAC Coordinator Phone: 541-947-4981 E-mail: johnv.adams@lakehealthdistrict.org</i>
LCAC Officers:	<i>Charlie Tviet Chair, Ken Kestner, County Commissioner</i>
Official Membership List:	<i>Tallulah Chiono, Jamie Davis, Deb Diment, Jake Greer, Anne Kasbohm, David Kerr, Ken Kestner, Rachel Klippenstein: Charissa Kucera, Cecilia Montgomery, Mike Newcombe, Dala Pardue, Ben Paz, Ray Simms, Vicky Taylor, Charlie Tveit, Glenna Wade, Pat Widenoja, Mary Wilkie,</i>
Percentage of LCAC Members who are consumers:	<i>Just over 20%</i>
Number of LCAC meetings	<i>August 2014, September 2014, November 2014, December 2014, January 2015, February 2015, March 2015, April 2015, May 2015, June 2015</i>

held in the reporting period:

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	Free dental screenings have been offered to elementary students and will be expanded to 7 th graders next year. Advantage Dental and OIT graduate school students have partnered with the CAC/CHIP to provide fluoride varnish to improve oral health for children in all of Lake County schools.	As of 5/2015
Incentive Funds	<ol style="list-style-type: none"> 1. Oral Health: Improve the oral health of residents, including use of preventative services. 2. Mental Health: Improve the mental health of residents through expanded access to mental health services. 3. Physical Activity: Increase the physical activity of residents through health promotion and expanded opportunities and programming. 4. Senior Health: Increase the health and well-being of senior residents through utilization of services, physical activity and community connection opportunities. 	As of 5/2015
Local CHIP Implementation	<p>GOAL 1: IMPROVE THE ORAL HEALTH OF RESIDENTS IN LAKE COUNTY</p> <p>Objective: Annually, 85% of eligible children will receive a dental assessment</p> <p>Strategy: Provide dental screenings for children in Kindergarten through 8th grades.</p> <p>Case management services will be provided to those students who are identified with an urgent or early dental care needed (based on the ASTTD Basic Screening Survey). This can be done in an “opt out” situation so participation rates are much higher.</p>	As of 5/2015

	<p>Objective: Annually, provide Fluoride Varnish to at least 50% of children in grades K-8th.</p> <p>Strategy: Lake County CHIP will partner with Advantage Dental, OIT, and Lake County schools to administer fluoride varnish to children through Lake County schools.</p> <p>Objective: Annually, starting in 2015, provide Dental Sealants to at least 50% of eligible school aged children in grades K-8th.</p> <p>Strategy: Lake County CHIP will partner with Advantage Dental, OIT, and Lake County schools to administer dental sealants to children through Lake County schools.</p> <p>Objective: Annually starting in 2015, provide Fluoride Varnish to 75% of pre-school aged children in early learning centers and to pre-school aged children through public health and health clinics through “dental days”.</p> <p>Strategy: Lake County Public Health will be the lead organization to administer fluoride varnish to children through clinics, Lake County Public Health, and early learning organizations, including Head Start and day care centers.</p> <p>Objective: Annually, achieve a 50% increase of follow up visits from children with urgent dental care needs who are covered through a DCO and participating in the school-based oral health preventative programs.</p> <p>Strategy: Advantage Dental will identify children with urgent dental care needs and who are covered by a DCO through the school-based dental screenings. Those children identified will receive a follow up phone call to refer them to local dental providers.</p> <p>Objective: By May 15th 2015 conduct a needs assessment of adult oral health needs in Lake County, including access to care and most common risk</p>		
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	<p>behaviors.</p> <p>Strategy: Lake County CHIP will conduct an adult oral health assessment by developing an oral health assessment tool and mailing it to a sampling of the county population in February 2015. The mailing will include an oral health kit, including: a tooth brush, tooth paste, and floss as an incentive to return the survey. This intervention will work to establish baseline data for education and awareness levels of oral health preventative practices of county adults. The goal of the mailing is to receive a strong response rate of at least 30% on the return mailing to allow for statistically meaningful data and a strong assessment of adult oral health needs in Lake County. Final assessment of the results of the data will be conducted in May.</p> <p>Objective: By March 31st 2016, increase the rate of individuals who self-report an increase in their awareness of oral health preventative practices by 15%</p> <p>Strategy: In Lake County, there is a lack of oral health information and outreach on nutrition, hygiene, tobacco, gum disease, meth mouth, programs and services, etc. Lake County CHIP will conduct oral health education, promotion, and outreach through community meetings and events, leafleting, announcements with clubs, associations, and other organizations, and paid advertising.</p> <p>Objective: Annually, improve access to oral health services by increasing the number of individuals who are covered by a DCO and who have received services and provide access to dental services to the uninsured</p> <p>Strategy: Lake County CHIP and LHD will partner with Advantage Dental to organize programs and/or events, such as dental days or mobile dental vans, to improve outreach and access to oral health services. This intervention targets Lake County residents that are uninsured or underinsured and/or those covered by a Dental Care Organization (DCO) but not seeking services.</p>		
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GOAL 2: IMPROVE THE MENTAL HEALTH OF LAKE COUNTY RESIDENTS

Objective: By June 2015, increase support for individuals by training 350 community members and establish a baseline of trainees to referrals.

Strategy: Implement the Mental Health First Aid program. Lake County CHIP will partner with the Lake County Mental Health (LCMH) department who will be the lead organization in administering the Mental Health First Aid Program (MHFA), which is an early intervention public education program that teaches the community how to assist someone experiencing a behavioral health crisis. MHFA teaches targeted community members, including teachers, public employees, health system employees, and social service workers, the skills needed to identify, understand, and respond to individuals who may be experiencing signs of a mental illness or substance use disorder. First Aid is administered to help individuals connect with appropriate care. The goal is to provide training and education to 350 community members.

Objective: By March 31st 2017, increase the number of mental health providers.

Strategy: Lake County will pursue greater access to mental health services. Lake County Mental Health department will be the lead organization to increase access to mental health providers and services by integrating behavioral health/mental health into primary care. This intervention aims to integrate a mental health provider with Lake County Medical Clinic, Warner Mountain Medical Clinic and the North Lake Clinic and work with the primary care physicians and their staff to connect patients with behavioral/mental health related issues.

Strategy: Lake County Mental Health will partner with university graduate programs to connect students/graduates to mental health provider opportunities in Lake County. The university graduate programs that are targeted include OSU Bend/Corvallis, Lewis and Clark, University of Reno, George Fox, Portland State University, and Southern Oregon University.

Strategy: Lake Health District will recruit a Psychiatric Mental Health Nurse Practitioner (PMHNP), using the loan forgiveness program to help attract recruits. The specific goal of the intervention is to increase the HPSA ratio of population to psychiatrist in Lake County from 7,890:0 to 7,890:1.

GOAL 3: INCREASE PHYSICAL ACTIVITY OF LAKE COUNTY RESIDENTS

Objective: By March 31st 2017, establish an activities/recreation nonprofit or parks and recreation program with centralized and coordinated programming and facilities.

Strategy: Lake County CHIP is committed to systems change to foster healthy life styles. Though this is a long term strategy, establishing a work group and creating a county-wide parks and recreation master plan by September 2016 will be the first step in establishing a healthy environment. The goal is to establish a Parks and Rec program by March 2017.

Objective: By March 31st 2016, increase the awareness of the Healthy Outback! Program and create 30 new sign ups at organized physical activity programs.

Strategy: Conduct an inventory of physical activity programs and services and develop a physical activity resource guide by July 2014.

Strategy: Lake County has a lack of year-round low cost physical activity opportunities, which contributes to high risk of heart disease. Lake County CHIP will provide health education, outreach, and health promotion activities, including creating and maintaining a Healthy Outback! website and outreach through social media, creating and disseminating a physical activity handout, providing 10 community presentations, and partnering with local media to provide 4-5 media coverages by March 2015.

Strategy: Lake County CHIP will provide health education, outreach, and health promotion activities, including maintaining a Healthy Outback! Website and outreach through social media, disseminating a physical activity handout, providing 10 community presentations, workshops (Couch to 5K), and partnering with local media to provide 8-10 media coverages by March

	<p>2016.</p> <p>Objective: Promote and enhance existing trails and walking and biking routes in the county by March 2017.</p> <p>Strategy: Lake County CHIP will work with community partners to promote and enhance existing trails and walking and biking routes by March 2017, including developing a Healthy Outback! map of existing trails and walking and biking routes, developing kiosks at popular walking routes, enhancing the Soroptomist Fitness Park, and creating a walking path in N. Lake County around the golf course and/or lake.</p> <p>Objective: By July 2015, and possibly annually, increase physical activity of low-income individuals with risk factors for heart disease, as evidenced by increasing the average Rapid Assessment of Physical Activity (RAPA) score by 30%.</p> <p>Strategy: Lake County CHIP will be the lead to administer the Physical Activity Incentive Program, which helps to cover monthly fees physical activity programs, targeted to low-income individuals with high risk factors for heart disease over an 8 month period. The program will partner with the Lake County clinics and the Lake Health District's Community Health Worker program to provide referrals and coach/motivate scholarship recipients to participate in existing and available community physical activity programs and services. The budget for this intervention is \$14,000.</p> <p>Objective: Create a physical/recreational activity targeting children in grades K-6th in winter months and have 50 youth participate in the program by March 2017.</p> <p>Strategy: Lake County CHIP will work to create physical/recreational activity targeting children in grades K-6th in winter months and have 50 youth participate in the program by March 2017.</p> <p>Objective: Create a physical/recreational education program and/or activity targeting preschool-aged children and their parents and have 50 youth</p>		
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participate in the program by March 2017.
Strategy: Lake County CHIP will work to identify the need and opportunity to provide education programs and physical activity programs in 2015-2016. Also, CHIP will create a parent/child interactive program targeting preschool-aged children and have 50 youth participate in the program by March 2017.

GOAL 4: INCREASE SENIOR HEALTH AND WELL BEING

Objective: By September 2016, Increase the number of seniors who participate in available senior health related programs and services by referring 100 seniors to transportation, nutrition, physical activity, and mental health/social activity programs each by September 2016.

Strategy: The Senior Center will accomplish this by hiring and training staff person who will:

- Refer 100 seniors to transportation services
- Refer 100 seniors to nutrition programs
- Refer 100 seniors to physical activity programs and services
- Refer 100 seniors to mental health/social activity programs and services
- Refer seniors to home care and/or the OPI program

Objective: By March 2016, recruit 15 seniors to participate in cardio physical activity programs targeted toward seniors.

Strategy: The Lake County Senior Center will support/create a cardio related physical activity program targeting seniors.

Objective: By March 31st 2017, grow capacity for senior services by recruiting 15-20 non-senior volunteers who actively support the Lake County Senior Center and the Outback Retirement Center.

Strategy: Lake County Senior Center will work to support/create a “Friends of the Lake County Seniors” organization to help provide volunteer support and fundraising for the Lake County Senior Center and the Outback Retirement Center by March of 2017.

Other			
2) Local CAC Challenges:			
Continuing to keep Members engaged. Working on efforts to recruit OHP Members.			

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Malheur County Community Advisory Council)</i>
Reporting Period:	(July 1, 2014 – June 30, 2015)
Organization Point of Contact:	Megan Gomeza (Chair) Charlotte Dudley, GOBHI/EOCCO Email charlotte.dudley@gobhi.net
LCAC Officers:	Megan Gomeza(Chair), Joni Delgado (Vice Chair), <i>Lindsay Grosvenor (Secretary)</i>
Official Membership List:	<i>The CAC has representation from several community partners who attend on a regular basis and participate in working groups and project development and implementation. Staff from the following agencies attend the CAC meeting- Public Health Dept, Schools, Early learning HUB, DHS, Juvenile Dept., Aging and People with Disabilities, Life ways, Advantage Dental, Primary Care Providers, St Luke’s medical group and St Alphonsus Medical Center, Valley Family Wellness, OCDC</i>
Percentage of LCAC Members who are consumers:	The Malheur CAC currently has two CAC members who are also EOCCO plan members.
Number of LCAC meetings held in the reporting	<i>7/15/14, 8/19/14, 9/16/14, 10/21/14, 11/18/14, 12/22/14, 1/20/15, 2/16/15, 3/17/15, 4/21/15, 5/19/15, 6/16/15 Meetings are held from 12:00-1:30pm</i>

period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>Lifeways- This project provides a school-based adolescent health program at Ontario High School to provide health promotion and services by a full-time community health worker. The objective of the program is to develop culturally and linguistically competent service delivery, co-management and referral services for school age youth and Hispanic families.</p> <p>Saint Alphonsus Medical Center -This project provides post-discharge care for emergency department patients with mental health and substance use disorders and reduces excessive emergency department use by providing customized navigation services to meet medical and behavioral health treatment needs, and reducing social, psychological and financial barriers to care. The goal of the project is to reduce emergency department readmissions among EOCCO members by effectively transitioning patients to outpatient behavioral health services, primary care and community supports.</p> <p>Malheur County Health Department - This project, a collaboration of the Health Department and Lifeways, provided training for community health workers and is developing a system of natural helpers in the community.</p>	
Incentive Funds	The Malheur CAC hosted a series of health fairs in several outlying communities. Fairs were held in Jordan Valley, Vale, Harper, Nyssa and Ontario. The importance of adolescent well visits, developmental screenings, oral health and management of chronic conditions were highlights. The Fairs had great attendance and community participation.	
Local CHIP Implementation	Below are listed a few of the strategies that have been implemented to improve community health and are based on the following identified priorities: Social Determinants of Health, Mental Health, Alcohol and Drugs, Children and Families	

	<ul style="list-style-type: none"> -Coordination of Care at St. Alphonsus Emergency Department between community behavioral health providers, community/social services, and hospital based services. (Project met and exceeded target number served) - Community Health Workers trained for health and behavioral health service navigation in Malheur Co. School-Based Community Health Worker at Ontario High School trained for health and behavioral health service navigation in Malheur Co. (Project met target number and population served. Two additional schools have requested the expansion of this program in to their schools) - Mental Health First Aid trainings for the community. (Trainings are provided on an ongoing basis for anyone working and supporting people in the community) 		
Other	<p>Megan Gomeza, CAC Chair has participated in several statewide conferences and presented information about the CAC on each occasion. She is a very good speaker and represented the EOCCO work with the CACs very well. C Megan Gomeza, CAC Chair has participated in several statewide conferences and presented information about the CAC on each occasion. She is a very good speaker and represented the EOCCO work with the CACs very well.</p> <p>Crystal Clifford, CAC Coordinator and Community Health Worker, has also participated in learning collaborative and at conferences informing others about the great work that is occurring for the communities in Malheur County.</p> <p>Crystal Clifford, CAC Coordinator and Community Health Worker, has also participated in learning collaborative and at conferences informing others about the great work that is occurring for the communities in Malheur County.</p>		

2) Local CAC Challenges:

The engagement and retention of EOCCO plan members for the CACs has been a struggle. The group has been discussing the location and time of the CAC as a possible barrier. Also the number of people attending the CAC is very big and the group is outgrowing the current meeting place location. The CAC is discussing those issues.

The local County elected officials have not participated in any of the CAC or health transformation efforts. The Public Health Department has filled the role of county representation so far. The CAC may need to review and discuss “official” CAC membership and look at the updated CAC Charter to determine how to best create an official membership list.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Morrow County Community Advisory Council)</i>
Reporting Period:	<i>(July 1, 2014 – June 30, 2015)</i>
Organization Point of Contact:	<i>Sheree Smith Phone: 541-676-5421 E-mail: ssmith@comorrow.or.us</i>
LCAC Officers:	<i>Sheree Smith, Chair, Terry Tallman, County Commissioner</i>
Official Membership List:	<i>Sheree Smith, Terry Tallman, Andrea Fletcher, Erin Anderson, Dirk Dirksen, Michelle Misener, Vicki Turrel, Dan Daltoso, Diane Kilkenny, Michael Schaub, George Mendoza, Peggy Doherty, Heidi Zeigler</i>
Percentage of LCAC Members who are consumers:	<i>Currently have 2 consumer Members</i>
Number of LCAC meetings held in the reporting	<i>August 2014, September 2014, October 2014, November 2014, December 2014, January 2015, February 2015, March 2015, April 2015, May 2015, June 2015</i>

period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	To date CARE has received 80 referrals, 53 from schools. CARE has been asked to make a short presentation to the Morrow County School Board. Peggy Doherty will attend and provide Board Members with the data.	As of 5/2015
Incentive Funds	The invoice has been approved by the County Court and has been processed through the accounting office. To date 53 calls had been made in Irrigon and 25 calls have been made in Heppner regarding adolescent well care visits.	As of 5/2015
Local CHIP Implementation	Morrow CAC has a strong collaboration with the school district. CARE team providers have provided needed services and networking to a number of high risk families in the county through referrals from school staff and other agencies. Prenatal Care 0-18 is being provided two days a week by a Nurse Case Manager. Adolescent Well Care Visits were promoted by phone calls and follow-up post cards. Pre-diabetes trainings are on-going. A SBHC will open in lone in the fall, which will provide access to services to a community that does not currently have a medical clinic.	As of 6/2015
Other	<p>Emergency Food and Shelter Program Update</p> <p>Vicki Turrell provided LCAC members with the Emergency Food and Shelter Spending Report for 9/1/2013 through 06/30/2014, Local Board SSA Plan Details, Letters requesting funds from the Neighborhood Center of South Morrow County and Irrigon/Boardman Emergency Assistance Center, and the 2014 Statistics Report for Neighborhood Center. Of the \$4,898.00 allocated to Morrow County for 2013-2014, Heppner received \$1,633.00 and Irrigon/Boardman received \$3,265.00. A decision was made to allocate current funding using the same guidelines (1/3, 2/3). Heppner will receive \$1,253.00 and Irrigon/Boardman will receive the remaining \$2,502.00 for a total of \$3,755.00.</p>	

2) Local CAC Challenges:

LCAC OHP recruiting is a challenge. Engaging OHP Members and keeping them involved.

**EOCCO Local Community Advisory Council
Annual Report
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>Sherman County Local Community Advisory Council</i>
Reporting Period:	<i>July 1, 2014 – June 30, 2015</i>
Organization Point of Contact:	<i>Katie Paul 541-490-2325 Ktj524@gmail.com</i>
LCAC Officers:	<i>Chair Teri Thalopher Vice Chair Secretary</i>
Official Membership List:	<i>Mark Corey, 2016, Amber De Grange, 2017, Teri Thalpher, 2017, Dee Ann Lane (Lieuallen), Tom McCoy, 2017, Mike Smith, 2015, Melody Stafford, Carolyn Mauser, 2016, Bard Seater, 2016, Cliff Jett, Nancy Simpson 2016, Sheri Sharp, 2016, Marvin Pohl, 2015, Shawn Payne, 2015</i>
Percentage of LCAC Members who are consumers:	The Sherman LCAC initially recruited two OHP members but they have not attended and have not been replaced.
Number of LCAC meetings held in the reporting	<i>8 Total Meetings : July 3, 2014, August 28, 2014 Joint Meeting with Gilliam and Wheeler LCACs, October 2, 2014, December 11, 2014 Joint Meeting with Gilliam and Wheeler LCACs, January 8, 2015, February 5, 2015, April 2, 2015 and May 28, 2015</i>

period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	This project provides home visits from a public health nurse to provide services and care coordination. The target population is chronically ill, high utilizers of healthcare services in the Sherman County Medicaid population. Referrals to the program would come from clinicians at the Moro Clinic, the Sherman County Ambulance Service, and eventually the Mid-Columbia Medical Center discharge planning and emergency department staff. The goals of the project are to decrease emergency department utilization and hospital readmission.	As of June 30, 2015
Incentive Funds	The Sherman LCAC is in the process of implementing this project. They are working on creating flyers to increase adolescent well visits, developmental screens for 0-36 months and increase knowledge of colorectal screening. The colorectal screening also includes follow up by the Moro Medical Clinic to provide fecal blood occult test kits.	As of June 30, 2015
Local CHIP Implementation	The LCAC has been coordinating with the Early Learning Hub. The chair of the LCAC also serves on the board of the Early Learning Hub.	As of June 30, 2015
Other		

2) Local CAC Challenges:

The Sherman LCAC initially recruited two OHP members but they have not attended and have not been replaced.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Umatilla County Community Advisory Council)</i>
Reporting Period:	<i>(July 1, 2014 – June 30, 2015)</i>
Organization Point of Contact:	<i>Rod Harwood, Chair Phone: 541-278-3239 E-mail: rodharwood@chiwest.com</i>
LCAC Officers:	<i>Rod Harwood, Chair E-Mail: rodharwood@chiwest.com Jenna Lorenzen, Vice Chair E-Mail: jenna.lorenzen@umatillacounty.net</i>
Official Membership List:	<i>Rod Harwood/SAH/Chair, T. Blair Smith, Robb Corbett, Sue Dagget, Collin Dumont, Mike Gregory, Troy Legore, Genni Lehnert-Berrs, Carolyn Mason, Linda Olson, Mark Royal, Cathy Wamsley, Sarah Williams, Cuck Wood, Meghan Debolt, Jenna Lorenzen</i>
Percentage of LCAC Members who are consumers:	<i>Currently have 1 consumer Member</i>
Number of LCAC meetings held in the reporting	<i>August 2014, September 2014, October 2014, November 2014, December 2014, January 2015, February 2015, March 2015, April 2015, June 2015</i>

period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	Three community health workers and one part time nurse for Good Shepherd were funded with the transformation grant. Community Health Workers to reduce ER high utilizers. A recent assessment indicated a need to address domestic violence and child abuse issues. Additional programs are being implemented to address these findings. Understanding how EDIE works has changed the way the community health workers are able to work cases. They are able to input information into EDIE, and then other agencies can also see that information.	As of 4/2015
Incentive Funds	Incentives are being used to promote Adolescent Well Care Visits. \$3125 was mailed out.	As of 4/2015
Local CHIP Implementation	<p>Preventative Care</p> <ul style="list-style-type: none">• Working on enhancing access to pain clinics for chronic conditions. Plan is to open pain clinics in Hermiston and Pendleton.• 116 new behavioral health assessments, 70 the month before, and 45 the month before last.• Max MD is the vendor for providing information on what was done in the hospital. It involves electronic sharing and transitioning care for continuity.• First tooth training – Free Continuing Education - Designed to help providers implement preventative oral health services for infants and toddlers under the age of 3. • Incredible Years - Infant class - April 15 – May 13. 5:30pm – 7:00pm in Hermiston at the Methodist Church on Gladys Street.	As of 4/2015

	<p>Clearview Mediation received an equipment grant for consumers with “Open Card”. If you have a client on Open card and need equipment, they can get the equipment from Clearview with just a prescription. These are donated and refurbished pieces of equipment.</p> <ul style="list-style-type: none"> • OHA – applications and renewals - Increased phone lines from 400 – 700 and brought the wait down to 10-20 minutes. Hired help with renewal process. A closure line has been added so anyone with a notice for closer, they call the direct line for that. Please wait for renewal notice rather than re-applying before receiving the notice. 		
Other	Without an Urgent Care facility open on Sundays in Hermiston and Pendleton, the only resource is the ER. Working on enhancing access to the pain clinic.	As of 4/2015	

2) Local CAC Challenges:

Incentives to advocate for OHP Member engagement and involvement are being discussed. No acronyms are used at the CAC meetings.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Union County Community Advisory Council)</i>
Reporting Period:	(July 1, 2014 – June 30, 2015)
Organization Point of Contact:	Bob Coulter (Chair) Email: bcoulter@eoni.com Charlotte Dudley, GOBHI/EOCCO Email : charlotte.dudley@gobhi.net
LCAC Officers:	<i>Bob Coulter (Chair), Carrie Brogoitti (Vice Chair), no secretary</i>
Official Membership List:	<i>Bob Coulter, Carrie Brogoitti, Lisa Ladendorff, Margaret Davidson, Dwight Dill, Dr.Kim Monte, Danielle Bechtell, Paul Shorb</i>
Percentage of LCAC Members who are consumers:	The Union CAC currently has one CAC member who is also an EOCCO plan member.
Number of LCAC meetings held in the reporting	<i>7/18/14, 8/15/14, 9/19/14, 10/17/14, 11/21/14, 12/19/14, 1/16/15, 2/20/15, 4/17/15, 6/19/15. Meetings are held every other month (even # months) from 12:00-1:00pm.</i>

period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>Community Connection-This project expands on existing transportation call center to facilitate same-day healthcare appointments and pharmacy deliveries to outlying communities in very rural areas of Union County, Oregon.</p> <p>Center for Human Development-This project is a social marketing campaign targeting primary factors for low weight births in Union County, OR: tobacco use by pregnant women and periodontal disease in pregnancy</p>	
Incentive Funds	The Union CAC plans to hold focus groups that focus on mothers and their pregnancy, deliver and services experiences in Union County. The group has not submitted a request for funds yet.	
Local CHIP Implementation	<p>The two identified health priorities for Union County are transportation and low birth weight babies.</p> <p>Two transformation grants were awarded in Union County to address these issues.</p> <p>-Consumer awareness at point of sale pregnancy kit locations are out in the public. Support to enroll childbearing age patients to insurance programs is available. Fluoride varnish and dental screenings are occurring at the Public Health Dept by Advantage Dental. (The project took some time to develop and implement. The target numbers and the effectiveness of the project have not been measured yet).</p> <p>- Community Connections has been providing coordinated transportation options, call center, community health worker transport with user and network for pharmaceutical delivery to rural county. (The target numbers</p>	

	have been reached and exceeded. Consumer satisfaction surveys are extremely positive and supportive of the efforts. The medical staffs are reporting a great reduction in staff time spent arranging transportation for patients. Medical Clinic hours have been expanded to later evening hours and some weekends, and the project was able to respond to the transportation needs for the community. The project also reaches out to several smaller communities in the county).	
Other	CHD- ASQ/maternal health support-Suzannah Moore	

2) Local CAC Challenges:

The engagement and retention of EOCCO plan members involved in the CAC is a challenge. The group feels an orientation packet may be helpful for new members.

The Transportation project has become a vital service for many community members and a very valuable resource for the medical providers. Directly relating improved health outcomes and population health to transportation is very difficult to do. It is hard to “state the case” for needed continuation of financial support. Additional training and support for CAC members to learn more about developing measurement strategies and using data to evaluate a project would be helpful. (However, the project has done a terrific job soliciting consumer feedback).

The Union CAC has not submitted a request for the \$3125 incentive funds yet. The CAC had discussed having a focus group for women to discuss health and pregnancy. Staff time is likely the biggest barrier to completion of the request for funds and implementation an additional project.

**EOCCO Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>(Wallowa County Community Advisory Council)</i>
Reporting Period:	(July 1, 2014 – June 30, 2015)
Organization Point of Contact:	Bridget Brown (Chair) Email: Bridget.brown@gobhi.net Charlotte Dudley, GOBHI/EOCCO Email charlotte.dudley@gobhi.net
LCAC Officers:	<i>Bridget Brown (Chair and Coordinator), Pepper McColgan (Vice Chair), Chantay Jett (Secretary)</i>
Official Membership List:	<i>Amy Busch, Bridget Brown, Chantay Jett, John Lawrence, Karen Patton, Kathy Norman, Kristen Borgerding, Maria Weer, Pepper McColgan, Steve Rogers, Susan Roberts</i>
Percentage of LCAC Members who are consumers:	There are no EOCCO members currently engaged in the CAC.

Number of LCAC meetings held in the reporting period:

7/18/15, 11/21/15, 3/10/15, 6/18/15. The meetings occur quarterly and are usually from 8:00 -9:00 am

CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>Wallowa Memorial Hospital- This project implemented the Complete Health Improvement Program (CHIP) an 18 session education program developed by the Lifestyle Medicine Institute. (No recent update given to the CAC).</p> <p>Wallowa Valley Center for Wellness-This project provides physical education programming & nutrition education for children who are currently not engaged in activities outside the home on Fridays due to the four-day school week. (Target # has been met)</p>	
Incentive Funds	The CAC decided to utilize the funds to provide children and families with financial support to address barriers to accessibility for physical and behavioral health care services or supports.	
Local CHIP Implementation	<p>Priority health areas that were identified in the CHIP include children and adolescent health and wellbeing, as well as oral health.</p> <p>-A dental education program was presented to all of the school age children at the area elementary schools. Advantage Dental along with Dental Hygienist from the ODS school were able to provide fluoride varnishes and screenings to a great number of children in the county.</p> <p>-The Fit Fridays met the target number of children the project was reaching out to with the efforts to increase children’s physical activity.</p> <p>-Training for Mental Health First Aid was provided for the community and</p>	

	anyone working with youth.		
Other	WVCW-HRSA grant, NEON –Pathways grant		

2) Local CAC Challenges:

The engagement of EOCCO plan members in the CACs has been a challenge. The CAC meets on a quarterly basis with a Wellness group meeting monthly. The Wellness group is a set of medical, behavioral health and other service providers.

Over the past year, the CAC and the Wellness group have combined efforts and meeting times with an emphasis on creating a computer-generated client needs survey to be used by all agency related staff. The goal was to have this survey available to medical providers, teachers, behavioral health staff, law enforcement etc.... The survey could be used to help identify and track needed services available for a community member. The group was unable to resolve issue of information collection, systems flaws, and a universal release of information. Wallowa Valley Center for Wellness had been working with a contracted evaluation firm to develop the program but after a year there were no systems agreements and the group was unable to use the survey.

**Eocco Local Community Advisory Council
Annual Report (due June 23, 2015)
Prepared for Oregon Health Authority**

Local CAC County & Name:	<i>Wheeler County Local Community Advisory Council</i>
Reporting Period:	<i>July 1, 2014 – June 30, 2015</i>
Organization Point of Contact:	<i>Jim Carlson, LCAC Coordinator 541-763-2725 Jcarlson7@asherhealth.net</i>
LCAC Officers:	<i>Chair Candy Humphreys Vice Chair Anne Mitchell Secretary Jim Carlson</i>
Official Membership List:	<i>Dan Allen, Physician Assistant at Asher Community Health Center, Cindy Burlingame, Wheeler County Juvenile Director, Jim Carlson, Quality Assurance & Planning, Asher Community Health Center, Cathy Goldsmith, Fossil based Counselor, Community Counseling Solutions, Candy Humphreys, Chair of the Board, Asher Community Health Center, Anne Mitchell, Wheeler County Clerk, Lynn Morley, Wheeler County Commissioner, Kim Williams, Director / Family Advocate, North Central Education Service District, Brenda Snow, Wheeler County Clerk</i>
Percentage of LCAC Members who are consumers:	12.5%
Number of LCAC meetings held in the	7 Meetings: August 28, 2014 Joint Meeting with Gilliam and Sherman LCACs, September 24, 2014, November 12, 2014, December 11, 2014 Joint Meeting with Gilliam and Sherman LCACs, January 28, 2015, March 25, 2015, May 27, 2015

reporting
period:

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CAC Outcomes:

1) LCAC Accomplishments:

Activity	Describe Progress:	Date
Transformation Grants	<p>The Wheeler LCAC submitted and was awarded a Transformation Grant. The purpose of the project was to reduce Body Mass Index (BMI) in targeted groups by the use of an electronic tablet to track daily exercise and diet. Participants had a monthly check in to measure BMI. There were two groups of participants Group 1- Overweight adults with a BMI between 25 and 29.9 and Group 2 – Obese adults with a BMI of 30 or greater. The measured outcomes are compliance in recording daily diet and exercise and BMI reduction.</p> <p>General Results: 50 participants were recruited to group 1. 37 completed the program. 10 were still using their electronic tablets and recording their diet and exercise. Average weight loss for all participants was 5.1 pounds. Round two is currently on-going.</p> <p>This project was selected to be shared at the Oregon Health Authority Innovation Café.</p>	As of 5/27/2015
Incentive Funds	<p>The Wheeler LCAC targeted Colorectal Screening. The project involved mailing Fecal Blood Occult Tests to 190 community members age 50-75. There were incentives for people to return the kits.</p> <p>General Results:</p>	As of 5/27/2015
Local CHIP Implementation	<p>In reviewing the progress of the CHIP during its May meeting the Wheeler LCAC described the following:</p> <ul style="list-style-type: none">• Increased the % of children fully immunized at age 2• County was a leader in adopting the use of Silver Diamine for arresting tooth decay and killing the bacteria	As of 5/27/2015

	<ul style="list-style-type: none"> • Is increasing school oral health surveillance with Advantage Dental assisting. Currently Asher Clinic looks at school children 1 x per year. • The community maintained the 135 days of Oral Health services this year. • In responding community recreational facility needs, the LCAC provided stipends or scholarships for use of the existing programs at the community gym, step classes and yoga. • Food desert was addressed with local Farmer’s Market in the summer • 2 trained and licensed Living Well with Chronic Illness program staff are available • Publicity campaigns have been conducted around locally available health services • Conducted 3 of 4 mass community mailings focusing on preventive health services. Included refrigerator magnets with phone numbers. • Increased mental health services in the community of Mitchell • Two community mailings focused on mental health • Clinic and Early Learning Hub are coordinating to increase ASQ Developmental Screens 		
Other			

2) Local CAC Challenges:

LCAC continues to seek OHP members to participate but has not retained two who were initial members. With Alternative Payment Model methods such as risk model and holdbacks it is increasingly difficult to do budget projections at the clinic(s)



Community Health Improvement Plan

Introduction

In 2010, the President signed the Affordable Care Act (ACA) into law with the goal of making healthcare more available and better managed. The law strives to achieve the Triple Aim — better health for all, better quality services and lower costs. The State of Oregon applied for a Medicaid Waiver to create its own plan to meet the Triple Aim. This plan uses coordinated care organizations (CCOs) to deliver better care and lower costs.

The Oregon Health Authority (OHA) asked each CCO statewide to conduct a community health assessment (CHA) and create a Community Health Improvement Plan (CHIP). The Eastern Oregon Coordinated Care Organization (EOCCO) CHIP is the outcome of all 12 local community advisory councils (LCACs) and meets the OHA's request. The EOCCO Regional Community Advisory Council (RCAC) developed the CHIP and the EOCCO Board of Directors approved it. RCAC membership includes two people from each of the 12 LCACs appointed by the EOCCO Board of Directors as well as the chairperson of each LCAC and a government official (usually a county commissioner or court member).

Members of the EOCCO RCAC

Officers

Chair: Chris Labhart (Grant County)

Vice chair: Maji Lind (Baker County)

Secretary: Sheree Smith (Morrow County)

Members

Bill Harvey (Baker)

Vicki Winters (Gilliam)

Steve Shaffer (Gilliam)

Lindsay Meghan (Grant)

Dan Brown (Harney)

Pete Runnels (Harney)

Charlie Tviet (Lake)

Ken Kestner (Lake)

Joni Delgado (Malheur)

Terry Tallman (Morrow)

Teri Talhofer (Sherman)

Mike Smith (Sherman)

Rod Harwood (Umatilla)

George Murdock (Umatilla)

Bob Coulter (Union)

Jack Howard (Union)

Bridget Brown (Wallowa)

Susan Roberts (Wallowa)

Candy Humphreys (Wheeler)

Lynn Morley (Wheeler)

Funding

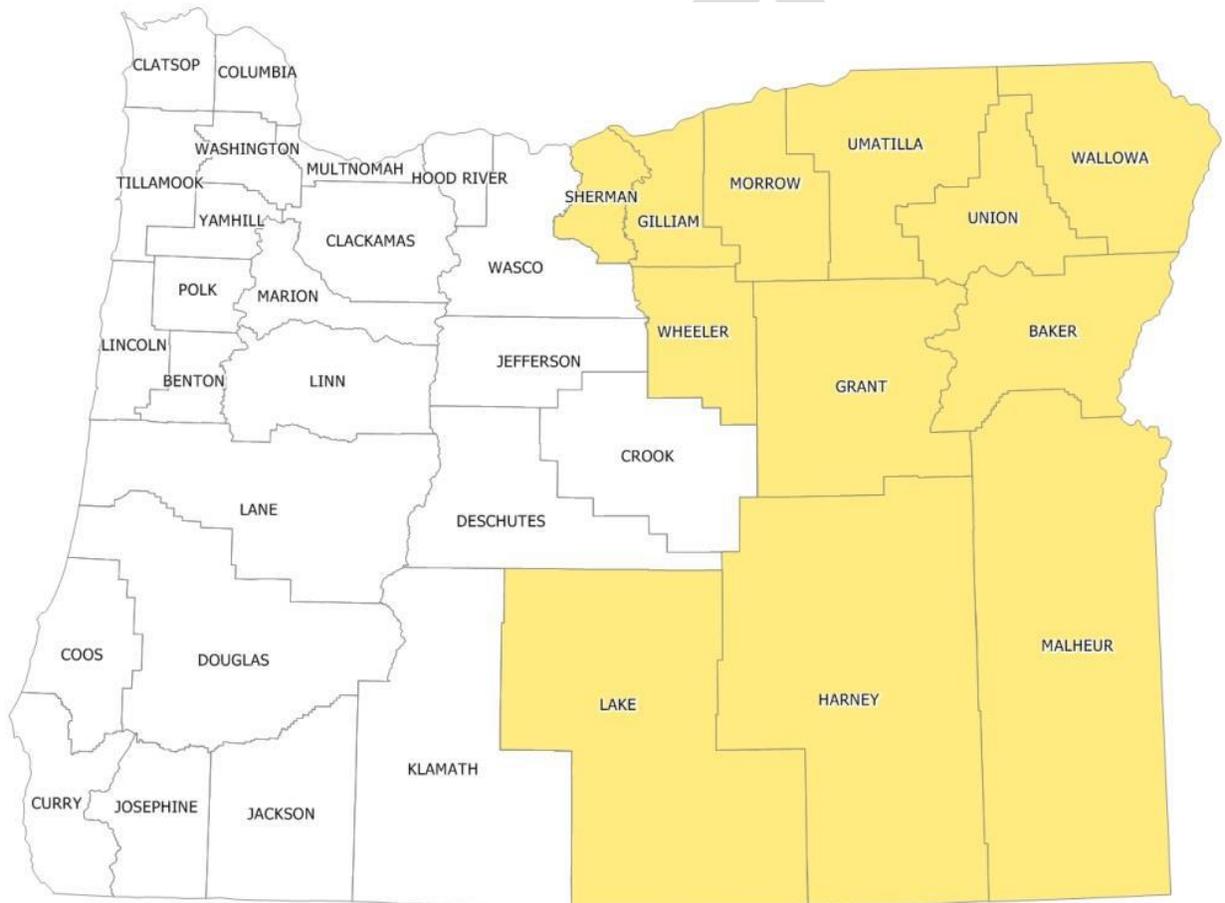
The RCAC understands that a variety of funding sources will be required to support this plan's implementation. These resources include private foundations public funds, EOCCO contributions where possible and donors. The RCAC created the Eastern Oregon Healthy Living Alliance as a public benefit not-for-profit with the focus on raising funds to help make the plan a reality. Activities in this plan will be carried out by using existing staff support, partner organizations and community volunteers.

Updated June 22, 2015 (Pending EOCCO Board Approval August 24, 2015)

EOCCO service area

The EOCCO service area includes 12 counties varying in population from 1,425 to 77,120. It is a large territory covering 49,923 square miles with a total population of 196,990. Ten of the 12 counties are considered “frontier,” which means fewer than six people per square mile live in the area. Each county is unique. Each county formed a local community advisory council and conducted a community health assessment specific to its county. Each LCAC developed its own Community Health Improvement Plan specific to the priorities and needs of that particular county. These 12 local CHIPs are included in Appendix C of this document.

Map of EOCCO service area



EOCCO plan member and diversity involvement

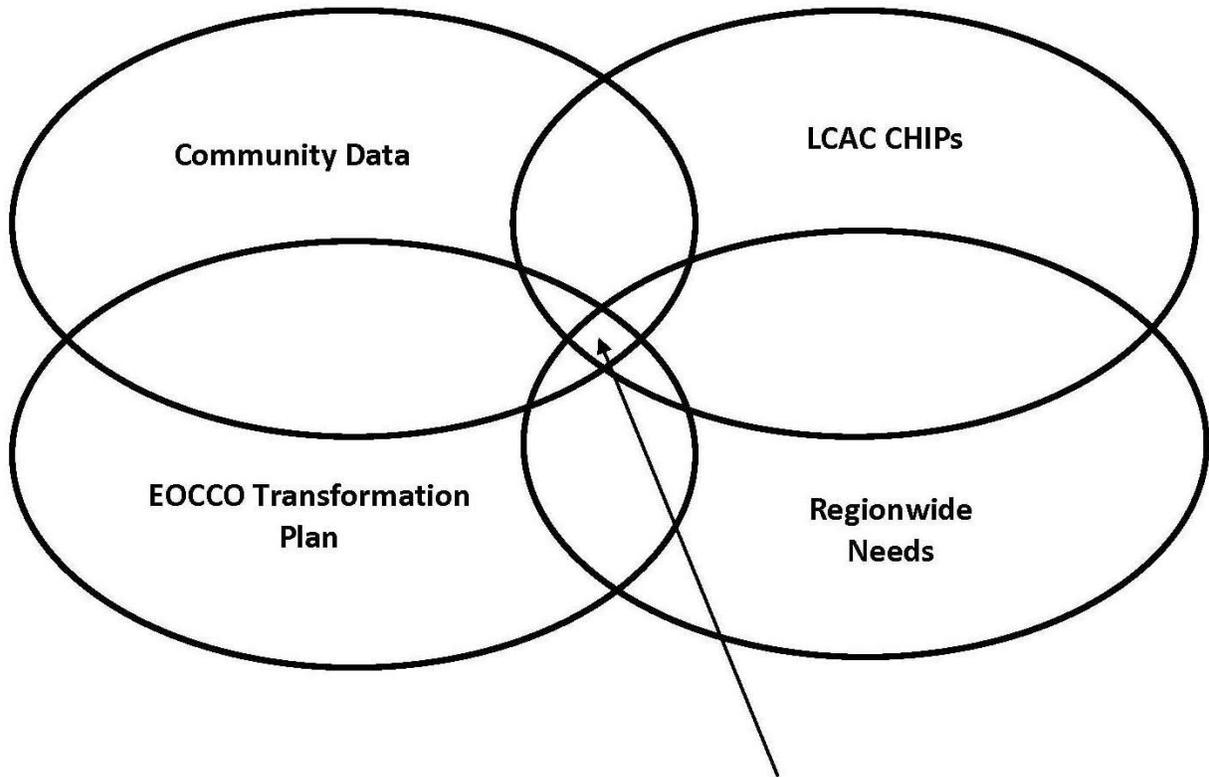
Each LCAC prepared a community health assessment, using various strategies to mix quantitative and qualitative assessments. Specific information about the differences in how the CHAs were created is included in Appendix B. EOCCO plan members helped with the qualitative assessments — including the household survey. During the household survey, 226 people said they use the Oregon Health Plan for insurance. Another 268 people said they have no insurance coverage. Individuals receiving Medicaid were not specifically recorded; however, community members representing all aspects of the population in each county participated in one-on-one interviews, community visioning meetings (using the Nominal Group Technique) and focus groups. Spanish-language focus groups were conducted in Morrow and Malheur County. Morrow County conducted one-on-one interviews with the Hispanic population. Umatilla County conducted a health assessment specific to the needs of the Hispanic population.

EOCCO staff, through Greater Oregon Behavioral Health Inc. (GOBHI), participated in the Oregon Health Authority Office of Equity and Inclusion’s Developing Equity Leadership through Training and Action (DELTA) program and the Institute for Healthcare Improvement (IHI Science in Action project). These activities and projects assist in fulfilling LCAC skill development objectives by fostering health equity awareness.

The LCACs reviewed the community health assessments and used the input from these diverse populations to create their individual county-level CHIPs.

Regional prioritization process

The challenge with creating the EOCCO CHIP is to find areas of common interest and priority among the 12 diverse counties. The following Venn diagram shows how we determined what to include in the EOCCO CHIP. We looked at each of the four areas of the diagram. The circle labeled “Community Data” included demographics, socioeconomics, health status and other information (see Appendix B). That circle also included results from the household survey conducted in nine counties (see Appendix C). The circle labeled “LCAC CHIPs” included all 12 LCAC CHIPs. These CHIPs were sorted according to the issues addressed in each one. This sorting allowed the RCAC to see the number of counties that addressed a particular issue and the strategies purposed. The circle labeled “EOCCO Transformation Plan” included items in each LCAC plan that were related to local activities and that must be part of the EOCCO CHIP. The last circle labeled “Regionwide Needs” represents the attitudes, perceptions and priorities of the RCAC membership.



Components of the EOCCO CHIP

The RCAC considered 12 issues to possibly include in the EOCCO CHIP. Each issue was discussed and ranked by the RCAC. The results are as follows. Note that when issues were looked at by themselves, each one was deemed fairly important.

Oral health (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	63.6%	14
I like it, but we need to talk	13.6%	3
I'll need to be convinced	22.7%	5
Set it aside and forget about it for now	0.0%	0
Totals	100%	22

Mental health (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	90.9%	20
I like it, but we need to talk	4.5%	1
I'll need to be convinced	4.5%	1
Set it aside and forget about it for now	0.0%	0
Totals	100%	22

Obesity/chronic disease management (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	65.2%	15
I like it, but we need to talk	21.7%	5
I'll need to be convinced	8.7%	2
Set it aside and forget about it for now	4.3%	1
Totals	100%	23

Early childhood prevention/promotion (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	63.6%	14
I like it, but we need to talk	27.2%	6
I'll need to be convinced	4.5%	1
Set it aside and forget about it for now	4.5%	1
Totals	100%	22

Patient-centered primary care homes (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	52.1%	12
I like it, but we need to talk	17.3%	4
I'll need to be convinced	13.0%	3
Set it aside and forget about it for now	17.3%	4
Totals	100%	23

LCAC skill training (multiple choice)

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	27.2%	6
I like it, but we need to talk	31.8%	7
I'll need to be convinced	31.8%	7
Set it aside and forget about it for now	9.0%	2
Totals	100%	22

**Community-based participatory research
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	31.8%	7
I like it, but we need to talk	36.3%	8
I'll need to be convinced	18.1%	4
Set it aside and forget about it for now	13.6%	3
Totals	100%	22

**Consumer engagement
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	61.9%	13
I like it, but we need to talk	19.0%	4
I'll need to be convinced	4.7%	1
Set it aside and forget about it for now	14.2%	3
Totals	100%	21

**Public health integration
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	80.9%	17
I like it, but we need to talk	14.2%	3
I'll need to be convinced	0.0%	0
Set it aside and forget about it for now	4.7%	1
Totals	100%	21

**Community health workers
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	61.9%	13
I like it, but we need to talk	23.8%	5
I'll need to be convinced	9.5%	2
Set it aside and forget about it for now	4.7%	1
Totals	100%	21

**Local cost control
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	66.6%	14
I like it, but we need to talk	19.0%	4
I'll need to be convinced	14.2%	3
Set it aside and forget about it for now	0.0%	0
Totals	100%	21

**Incentive measures
(multiple choice)**

	Responses	
	Percent	Count
Should be a part of the EOCCO CHIP	42.8%	9
I like it, but we need to talk	28.5%	6
I'll need to be convinced	23.8%	5
Set it aside and forget about it for now	4.7%	1
Totals	100%	21

After review and discussion of possible activities to address each issue area, RCAC members used Turning Point Audience Participation Software to select which issues were most important across the entire region. The system used a weighted response to help prioritize the issues. Each RCAC member selected their Top 5 issues and the software assigned points. Here are the results:

Prioritize your Top 5 issues for the CHIP (priority ranking)

	Responses	
	Percent	Weighted Count
Oral health	12.6%	91
Mental health	15.9%	115
Obesity/chronic disease management	9.4%	68
Early childhood prevention/promotion	20.0%	144
Patient-centered primary care homes	6.8%	49
Community-based participatory research	2.9%	21
Public health integration	10.5%	76
Community health workers	13.6%	98
Incentive measures	5.0%	36
Local cost control	3.0%	22
Totals	100%	720

Ranking of issues in order

1. Early childhood prevention/promotion
2. Mental health
3. Community health workers
4. Oral health
5. Public health integration (chronic disease management)

EOCCO Community Health Improvement Plan

PRIORITY AREA: Early childhood
GOAL: Improve health outcomes for children ages 0–5 through integrated services

OBJECTIVE No. 1: Coordinate LCAC activities with Early Learning Hubs			
STRATEGY: Establish system of regular communication and strategic planning with each Hub in the EOCCO region			
JUSTIFICATION: EOCCO and Early Learning Hubs are each accountable for similar goals including health and screening			
EVIDENCE BASE: Collective impact			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Create contact list for each Hub and family support manager and Hub Coordinators as they are approved and hired	Frontier Hub Eastern Oregon Hub Blue Mountain Hub South Central Hub Four Rivers Hub	List created	November 2014
Create a plan for coordinated communication and activity between EOCCO, each LCAC and related Hub	Hub Coordinators invited to become LCAC members	Plans developed	January 2015
Identify shared priorities and plan for coordination		Meeting held	April 2015
Conduct RCAC meeting with Early Learning Hub leadership		Meeting held	Spring 2015

PROGRESS as of June 30, 2015:

- The Regional Community Advisory Council (RCAC) hosted a meeting of the leadership of all 5 Early Learning Hubs throughout the EOCCO service area in March 2015
- Created a document that cross references similarities in priority areas between Local Community Advisory Council Community Health Improvement Plans and the Early Learning Hub planning documents
- EOCCO provided a data set by zip code and by race (white and Non-white) for EOCCO plan members regarding Developmental Screens for Children 0-36 months and the numbers of children 0-6 assigned to a primary care provider and if those primary care providers are part of a Patient Centered Primary Care Home

- Using audience participation software the Early Learning Hub leadership and RCAC members ranked ways in which they could share information between the groups. Priority was given to sharing meeting minutes and welcoming attendance at the respective meetings
- EOCCO staff (Linda Watson) serves on the governing Board of the Blue Mountain Hub and attends Early Learning Hub Meetings throughout the region as possible
- The Baker LCAC and the Eastern Oregon Early Learning Hub jointly participated in a Cradle to Career meeting
- All 12 LCACs have representatives from the Early Learning Hubs as members

OBJECTIVE No. 2: Create links between community-based organizations conducting developmental screens and primary care clinics			
STRATEGY: Use OHA Community Prevention Grant (Healthy Eastern Oregon Project)			
JUSTIFICATION: OHA issued a grant to the Center for Human Development to support the EOCCO region's implementation of universal developmental screening. The grant provides for one full-time staff member and resources related to training, curriculum and technology.			
EVIDENCE BASE: Collective impact			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Identify current screening activities across the EOCCO region	Linda Watson, GOBHI Suzannah Moore, CHD	Screening data including, but not limited to, EOCCO coding data	September 2014
Develop mechanism for tracking developmental screening performed by nonmedical and other organizations such as Head Start, Families First, etc.	Oregon Health Authority	TBD	September 2015
Provide training, resources and consultation to medical providers and community programs serving young children	Linda Watson, GOBHI Suzannah Moore, CHD	TBD	September 2016
Develop system for care coordination when developmental concerns are identified	Linda Watson, GOBHI Suzannah Moore, CHD	TBD	Selected sites: January 2016

PROGRESS as of June 30, 2015:

- Note* Suzannah Moore replaced Angie Curtis at the contractor site (Center for Human Development) in April 2015

- Provided Developmental Screening (ASQ) trainings and resources to primary care providers and Early Learning Hub agencies in Grant, Lake, Morrow, Wheeler, Baker, Malheur, Union, Umatilla and Wallowa
- Attended Four Rivers Early Learning Hub meeting to discuss OHA grant project with agency providers in Sherman and Gilliam Counties
- Targeted project outreach to larger clinics located in Umatilla and Union Counties

OBJECTIVE No. 3: Increase prenatal care			
STRATEGY: Strengthen partnership with public health for nurse-based home visiting			
JUSTIFICATION: Nurse-based home visiting increases parental engagement and follow-through on doctors' recommendations for high-risk communities related to prenatal care, case management and care coordination. Programs such as Oregon Maternity Case Management (MCM) reduce the numbers of low birth weight and other results from poor prenatal care by helping expand prenatal services.			
EVIDENCE BASE: Nurse Family Partnership (first-birth population)			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Assess current status and capacity of MCM across EOCCO region	Initial contacts: Carrie Brogotti, Sheree Smith, Joni Delgado, and other public health representatives in the region	Assessment tool created and implemented	January 2015
Develop strategies to expand the capacity of MCM programs and other evidence-based strategies throughout the region	Group above	Plan developed	July 2015

PROGRESS as of June 30, 2015:

- The Nurse Family Partnership program in Umatilla County, made a presentation at an EOCCO Board of Directors meeting.
- Morrow and Umatilla County Public Health Departments entered into a contract with EOCCO for medically and socially high risk pregnancies.

Please note: Objective No. 2 under Public Health Integration specifically targets chronic illness in children.

PRIORITY AREA: Mental health
GOAL: To improve the skill sets of residents of EOCCO to recognize and seek treatment for mental health issues

OBJECTIVE No. 1: Promote and deliver Mental Health First Aid Training (MHFA Youth and Adult modules) to community at-large. MHFA curriculum can be tailored to higher education, military members, veterans and their families, police, first responders, teachers and others.

STRATEGY: Create, develop and implement collaborative partnerships with education systems, public safety, public health, mental health, faith-based organizations/groups and other community entities in providing awareness of Mental Health First Aid.

JUSTIFICATION: MHFA is a public education program that helps the public identify, understand and respond to signs of mental illness and substance abuse disorders.

EVIDENCE BASE: aocmhp.org/mhfa and www.mentalhealthfirstaid.org

Individuals who participated in MHFA have:

- [Greater confidence in providing help to other,](#)
- [Greater likelihood of advising people to seek professional help,](#)
- [Improved concordance with health professionals about treatment,](#)
- [Decreased stigmatizing attitudes, and](#)
- [Experienced improvement in their own mental health](#)

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Partner with county Educational Service Districts to provide training to teachers, coaches, support staff and parents for the Youth Mental Health First Aid program	Armenia Sarabia, GOBHI Erin Rust, GOBHI	Number of community-certified Youth Mental Health First Aid facilitators	June 2015
Create an EOCCO master list of certified Mental Health First Aid trainers; provide local trainer list and MHFA information to local community advisory councils	Armenia Sarabia, GOBHI Erin Rust, GOBHI	List created and local awareness of MHFA trainers and classes promoted	December 2014
Work with local community advisory councils to promote and sponsor MHFA classes	Armenia Sarabia, GOBHI Erin Rust, GOBHI	Total number of MHFA classes being held in communities throughout the EOCCO counties	April 2015

PROGRESS as of June 30, 2015:

- Created list of certified Mental Health First Aide trainers in our region.
- MHFA Trainings held in Lake, Wallowa, Umatilla, Malheur and Grant Counties

- EOCCO Staff (Linda Watson) has been designated to become a Mental Health First Aide Trainer

OBJECTIVE No. 2: Encourage integration of mental health/behavioral health and physical health			
STRATEGY: Increase payment to patient-centered primary care homes (PCPCH) that have a strong focus on behavioral health			
JUSTIFICATION: Additional incentives will encourage more integration.			
EVIDENCE BASE: PCPCH program rules			
ACTION PLAN			
Activity	Lead person/organization(s)	Measurement	Completion date
Work with OHA PCPCH program to acquire attestation documents for PCPCH across the behavioral spectrum	Paul McGinnis, GOBHI	Collected	June 2014 Completed, but data does not differentiate between integrated and co-located services
Verify levels of PCPCH behavioral health integration; establish measures	GOBHI	Summary report	January 2015
Share summary report with each LCAC	GOBHI	Meetings held	June 2015
Create contracts with PCPCHs that meet desired level of integration	GOBHI	Number of contacts	September 2014
Support a Learning Collaborative to share learnings on BH integration work	GOBHI	Collaborative held	TBD
Monitor new PCPCH attestation levels	Paul McGinnis, GOBHI	Monthly OHA Website review	Ongoing

PROGRESS as of June 30, 2015:

- GOBHI has offered a contract with Tier 3 Patient Centered Primary Care Home to pay an additional \$2 per member per month to cover the provision of mental and behavioral health services in the primary care setting
- Currently there are contracts with two clinics (Malheur and Union Counties) and negotiations with 3 others
- EOCCO Staff (Jill Boyd) was hired in April 2015 as Practice Transformation Specialist

OBJECTIVE No. 3: Reduce community stigma
STRATEGY: Work with local faith community leaders to educate the communities they serve about mental health issues and encourage them to seek care when needed

JUSTIFICATION: When community members were asked in the household survey, “Thinking about the past six months, was there a time when you or someone in your household needed treatment for mental health or substance abuse?” only 7 percent responded “yes.” However, 28 percent responded “several days, more than half or every day” to this question: “In the past two weeks, how often have you been bothered by little interest or pleasure in doing things?” Further, 26 percent responded “several days, more than half or every day” to the question: “In the past two weeks, how often have you been bothered by feeling down, depressed or hopeless?”

EVIDENCE BASE: Clinical Gerontologist, 2013;36(3). doi: 10.1080/07317115.2013.767872. **Depression Treatment Among Rural Older Adults: Preferences and Factors Influencing Future Service Use.** Kitchen KA, McKibbin CL, Wykes TL, Lee AA, Carrico CP, McConnell KA.

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Work with Rod Harwood to develop information packet for community faith leaders (talking points, education material, resource sheet)	Paul McGinnis Rod Harwood	Document produced	November 2015
Coordinate with LCACs and faith community associations and fellowships in each county to encourage the use of the Mental Health Information Resource Packet to get their members to seek help if needed	LCAC	Number of meetings	March 2016
Offer Mental Health First Aide to Congregations	LCAC	Number of Trainings	On-Going
Promote faith community events and activities during the National Mental Health Awareness Month (May 2015)	Clergy	Number of events or sermons given	May2016

PROGRESS as of June 30, 2015:

- No progress on this objective during the year.
- Dates changed for completion
- Addition of Mental Health First Aide offering for congregations

PRIORITY AREA: Community health workers

GOAL: To implement a standardized approach to the use of community health workers

OBJECTIVE No. 1: Determine the estimated need for community health workers

STRATEGY: Research demand and caseload for community health workers.

JUSTIFICATION: Need to understand how many will be required by on population under consideration

EVIDENCE BASE:

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Conduct literature review on demand and use of community health workers; differentiate between care coordination, case management, patient navigators and health educators	NEON, GOBHI, OHSU librarian	Literature review	November 2014
Prepare a needs/demand estimate based on literature review for EOCCO service area	NEON, Charlotte Dudley-GOBHI	Report	February 2015
Wide invitation (hospitals, clinics, public health) to webinar on findings for needs of community health workers	Charlotte Dudley-GOBHI, NEON	Webinar held	March 2015
Use RCAC to seek resources for implementation of community health workers throughout region	RCAC subcommittee	Meeting minutes	April 2015

PROGRESS as of June 30, 2015:

- A literature review with OHSU librarian was completed in December of 2014. The review needs to be shared with the RCAC.
- In May of 2015 NEON applied with OHA to become a contracted provider of technical assistance for CCOs. The EOCCO is working with Estela Gomez, OHA Innovator Agent to use available Technical Assistance hours to work with NEON in completing a needs assessment and webinar.

- Completion dates for web training and needs demand estimate needs to be extended and changed to late summer 2015.

OBJECTIVE No. 2: Determine a support system for community health workers			
STRATEGY: Create an infrastructure to support community health workers.			
JUSTIFICATION: Community health workers need organizational and emotional support from which to work.			
EVIDENCE BASE:			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Determine the needed support systems for community health workers	Diane Kilkenny Paul McGinnis	Report	TBD
Determine continuing education needs of community health workers	RCAC subcommittee	Report	TBD
Facilitate use of a learning community network for community health workers or expand use of existing NEON network across the EOCCO region	EOCCO	Creation of network	TBD

PROGRESS as of June 30, 2015:

- A subcommittee has not yet been formed
- The Oregon Community Health Workers Association (OCHWA), NEON, and the Northwest Regional Primary Care Association (NWRPCA) all provide support and learning opportunities for CHWs. NEON has completed 2 CHW training/certifications for Baker, Union, and Wallowa counties, and an additional training/certification in Malheur County.

OBJECTIVE No. 3: Support training of community health workers
STRATEGY: Use exiting training resources, such as NEON and Family Advocates, or create new ones to increase the number of community health workers.
JUSTIFICATION: A level of skill and professionalism is required.
EVIDENCE BASE:

ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Identify community health worker training programs statewide	NEON, Charlotte Dudley-GOBHI, Malheur Public Health	Report	July 2015
Based on demand from Objective 2, determine feasibility of trainings	NEON, Charlotte Dudley- GOBHI, Malheur Public Health	Report	TBD

PROGRESS as of June 30, 2015:

- The identification of statewide CHW trainings is included in the Literature review from December 2015.
- Malheur Public Health Department partnered with NEON to complete a CHW training for Malheur county (Transformation Grant Funds). 20 + new CHW were certified.

PRIORITY AREA: Oral health

GOAL: Improve oral health for children under 10 years old

OBJECTIVE No. 1: Implement First Tooth Project

STRATEGY: Use primary care clinicians to provide preventive oral health services to children ages 0–36 months. Services may also be provided by WIC workers, Head Start staff, etc.

JUSTIFICATION: In 2012 only 15 percent of all children ages 0–23 months received preventive services from dental care organizations in Oregon.

EVIDENCE BASE: Children see primary care providers during well-child visits, and that is the time to deliver oral healthcare,

<http://public.health.oregon.gov/preventionwellness/oralhealth/firsttooth/pages/index.aspx>.

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Create awareness of First Tooth Project trainings	Advantage Dental, ODS, and Capitol Dental	Notices sent	TBD
Recruit primary care providers to participate in First Tooth trainings	LCACs, Advantage Dental, ODS, and Capitol Dental	# of primary care practices trained	TBD
Conduct trainings for providers, including staff members at WIC and Head Start	Advantage Dental, ODS, and Capitol Dental	Number of people trained for First Tooth Project	TBD
Establish method of payment for PCPs from dental care	Advantage Dental, ODS, and Capitol Dental	Payment transfers	TBD

organizations			
Promote First Tooth and oral health preventive practices through marketing, paid advertising, announcements and/or media events	LCACs and DCOs	# of ads and events	On-Going

PROGRESS as of June 30, 2015:

- Presented First Tooth project to local public health departments, Head Start, and rural health centers/primary care
- Number of primary care practices trained: 2
- Number of people trained for First Tooth project: 275
- Advantage Dental provides supplies to support clinics who receive First Tooth training

OBJECTIVE No. 2: Conduct screenings			
STRATEGY: Coordinate local dental screenings in schools for grades 1–3 for kids ages 6–9.			
JUSTIFICATION: The 2012 Smile Survey in Oregon was a representative sampling, and not many schools in the EOCCO service area were selected for the surveillance.			
EVIDENCE BASE: U.S. Preventive Services Task Force			
ACTION PLAN			
Activity	Lead person/organization(s)	Measurement	Completion date
Identify at the LCAC level who is conducting school-based screenings	LCACs	Report summary	February 2015
Coordinate with Advantage Dental practitioners and dental hygienist schools to train students to conduct the screenings	DCOs	Meetings and agreements	February 2015
Identify grade schools that will permit the screening to take place	Linda Watson, GOBHI	Report summary	June 2015
Conduct screenings	Dental students	Surveillance reports	Ongoing

PROGRESS as of June 30, 2015:

- School-based screenings: Lake County (K-6 in 2015/K-8 in 2016), Harney County (K-6 in 2015)

- OHA Sealant program provided screenings and sealants throughout the EOCCO region (Gilliam, Grant, Malheur, Umatilla, Union, Sherman, and Wallowa) Paul, if you want more detail on this you'll need to get it from the State. They do not share data with us.
- Lake County – Lake Health District, Lake County Schools, Advantage Dental, and OIT dental hygiene students collaborated on a school-based oral health screening project on February 25, 2015
- Baker County – Advantage Dental provided screenings at Resource Fair last August for K-6. Providing dental screenings in WIC. OHA state sealant program.

OBJECTIVE No. 3: School-based fluoride supplement program			
STRATEGY: Increase the number of schools using the fluoride supplement program.			
JUSTIFICATION: Not many communities in eastern Oregon have fluoridated water systems.			
EVIDENCE BASE: United States Preventive Services Task Force			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Identify schools interested in or already conducting the supplement program	Linda Watson, GOBHI DCOs	Report summary	TBD
Raise awareness of the resources available through the state program and Dental Care Organizations	Linda Watson, GOBHI DCOs	Information delivered and contacts with schools	TBD
Recruit schools to participate in Dental Screening and Fluoride Varnish programs	LCACs and Linda Watson	# of schools recruited	TBD
Facilitate agreements between state programs and individual schools	Linda Watson, GOBHI DCO's	New schools using the program	TBD
Promote oral health preventative practices including the importance of fluoride varnish programs and dental screenings through marketing, paid advertising, announcements. And/or media events	LCACs and DCOs	# of ads and events	TBD

PROGRESS as of June 30, 2015:

- No progress has been made in this plan area.

PRIORITY AREA: Public health integration (chronic disease management)
GOAL: Better align public health services with primary care for population health management

OBJECTIVE No. 1: Create systems for formal interaction between public health and EOCCO			
STRATEGY: Create Public Health Advisory function for EOCCO			
JUSTIFICATION: Public health and EOCCO serve common high-risk populations, though local coordination among primary care and public health services varies widely throughout the EOCCO region. Many of the EOCCO goals and priorities are consistent with the expertise and existing programming provided through public health.			
EVIDENCE BASE: Collective impact			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Convene public health administrators from EOCCO region around common work areas (i.e., developmental screening, home visiting, etc.)	Diane Kilkenny Suzannah Moore, CHD	Meeting held	August 2014 Completed
Develop action plan for care coordination for specific target populations, TBD (i.e., diabetic patients)	Leadership group developed out of meeting above	Plan developed	December 2014

PROGRESS as of June 30, 2015:

- One regional public health meeting was held in October of 2014
- Targeted Case Management and Maternity Case Management have not come under the CCO's statewide as planned in July 2015. It has been delayed.

OBJECTIVE No. 2: Coordinate services to prevent and treat chronic health conditions in children
STRATEGY: Strengthen relationships between public health home-visiting programs and primary care physicians for clients jointly served through WIC, CaCoon and Babies First to increase care coordination and use of public health programs.
JUSTIFICATION: Public health provides in-home services for children with special healthcare needs that can enhance the primary care treatment plan and health outcomes. WIC staff and home-visiting nurses

provide information on and access to nutritional food choices, decreasing the risks for obesity and diabetes.

EVIDENCE BASE:

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Identify capacity of PH programs throughout EOCCO region	Public health partners	Assessment completed	December 2014
Conduct outreach plan to physicians about the availability, services and effectiveness of partnering with public health programs	EOCCO	Number of enrollees with special healthcare needs enrolled in PH programs	July 2015

PROGRESS as of June 30, 2015:

- This objective aligns with the prior objective and has been delayed

OBJECTIVE No. 3: Emphasize Living Well with Chronic Illness

STRATEGY: Encourage better use of existing Living Well with Chronic Illness education programs — including Tomando Control for Spanish speakers.

JUSTIFICATION: The burden of chronic disease is extensive in the EOCCO area, with high numbers of residents self-reporting that a clinician told them they had one of the following chronic diseases: high blood pressure, high cholesterol, arthritis, diabetes or depression/anxiety.

EVIDENCE BASE:

<http://public.health.oregon.gov/DiseasesConditions/ChronicDisease/LivingWell/Pages/Index.aspx>

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Identify Living Well programs and certified trainers in each county	LCAC Margaret Davidson and Kathy Hayden, Community Connections	Summary report	September 2014 Completed - 20 people representing 8 counties have completed training. An additional training will be held in the fall for additional counties
Remind primary care providers and their care coordinators of the resource and encourage referrals	Paul McGinnis, GOBHI	Information sent	October 2014

Conduct Living Well classes	Living Well coordinators identified in summary report	Number of classes held over a two-year period	June 2016 – First classes begin October 2014
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PROGRESS as of June 30, 2015:

- Community Connection has trained 17 people in 12 of the EOCCO counties to co-facilitate Living Well with Chronic Illness classes. Classes have been held in 6 counties with a total of 51 participants. Primary Care providers and care coordinators have made referrals for the program and many classes are held in the Primary Care setting.

OBJECTIVE No. 4: Implement National Diabetes Prevention Program			
STRATEGY: Piggy back on the efforts that MODA Health has used with non-EOCCO insured			
JUSTIFICATION: This program will take advantage of the roll-out for the entire population.			
EVIDENCE BASE: http://www.cdc.gov/DIABETES/prevention/index.htm			
ACTION PLAN			
Activity	Lead person/organization(s)	Measurement	Completion date
Invite program representatives to speak to LCACs to describe program	Kathy Hayden, Community Connections, Don Kain, OHSU	Number of LCACs made aware	September 2014 Completed Kathy Hayden and Don Kain provided information to all 12 LCACs together or separately
Remind primary care providers and their care coordinators about the resource and encourage referrals	Paul McGinnis, GOBHI	Information sent	October 2014
Conduct National Diabetes Prevention classes	Kathy Hayden-Community Connection Don Kain, OHSU	Number of classes and number of participants	June 2016 27 new people have completed the NDPP training. They represent 10 counties. Classes begin in October of 2014

PROGRESS as of June 30, 2015:

- Community Connection in partnership with OHSU has trained 29 Coaches in 10 of the EOCCO counties for the Diabetes Prevention program. Across the region, 7 counties have provided 10 classes with a total of 91 participants.

PRIORITY AREA: Local community advisory council skill development

GOAL: Improve the skill set of all local community advisory council members

OBJECTIVE No. 1: Develop cultural competency among clinicians and other community health and social service organizations

STRATEGY: Assess and train on cultural competency needs/gaps by using 15 National CLAS (Culturally and Linguistically Appropriate Services) Standards in Health and Health Care

JUSTIFICATION: Requirement of 3 of 8 EOCCO Transformation Plan elements

EOCCO Plan Element #6: Assuring communications, outreach, member engagement and services are tailored to cultural, health literacy, and linguistic needs

EOCCO Plan Element # 7: Assuring provider network and staff ability to meet culturally diverse needs of the community (cultural competence training, provider composition reflects member diversity; nontraditional health care workers composition reflects member diversity)

EOCCO Plan Element #8: Developing a quality improvement plan focused on eliminating racial, ethnic and linguistic disparities in access, quality of care, and outcomes.

EVIDENCE BASE: <http://www.usc.edu/hsc/ebnet/Cc/awareness/ccare.htm>

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Share results of the CLAS Standards Cultural Competency survey conducted as part of EOCCO Transformation Plan with LCACs	Armenia Sarabia, GOBHI	Report and presentations	November 2014
Dissemination of monthly EOCCO county OHP report on Race, Ethnicity and Language (REaL) data	Armenia Sarabia, GOBHI	Reports disseminated	Ongoing
Coordinate and conduct a series of educational webinars with an emphasis in promoting health equity best practices: <ul style="list-style-type: none"> • Client civil rights • Language access services 	OHA Office of Equity and Inclusion staff, by Armenia Sarabia, GOBHI and other State/National webinars	# of health equity webinars, pre post survey assessment, in person presentations and online formats	Ongoing

<ul style="list-style-type: none"> • Cultural competency • Diversifying the health workforce 			
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PROGRESS as of June 30, 2015:

- Data from the OHA Office of Equity and Inclusion is not available by county and so was not shared with individual LCACs
- EOCCO was asked to present on their activities to the 2015 Latino Health Equity Conference.

OBJECTIVE No. 2: Understanding poverty with empathy			
STRATEGY: Build empathy among LCAC members for understanding the struggles faced by people caught in multigenerational poverty.			
JUSTIFICATION: Many of these plan members frequently use health and social services.			
EVIDENCE BASE:			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Identify a competent trainer	Paul McGinnis, GOBHI County extension agents	Contract to deliver webinar	January 2015 Completed :Attended workshop by Donna Beegle PhD
Wide invitation to the webinar		Webinar conducted and number of views	TBD

PROGRESS as of June 30, 2015:

- GOBHI (part owner of EOCCO) sponsored a day long Bridges out of Poverty training attended by about 300 people in 2015
- Grant LCAC conducted its own training; 70 people attended including primary care clinics, public health and Early Learning Hub partners

OBJECTIVE No. 3: Positive Community Norms			
STRATEGY: Introduce LCACs to the Positive Community Norms framework.			
JUSTIFICATION: Positive behaviors can be encouraged across the community by emphasizing strengths rather than needs.			
EVIDENCE BASE: mostofus.org			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Presentation to LCAC	OHA MORE Program	Number of presentations	TBD

PROGRESS as of June 30, 2015:

- Positive Community Norming was written into a Knight Cancer Grant that was not funded

OBJECTIVE No. 4: EOCCO member engagement			
STRATEGY: Increase participation of EOCCO plan members in LCAC activities.			
JUSTIFICATION: Involvement of people who are most affected by the group's activities makes for better programs.			
EVIDENCE BASE: OHA Requirement			
ACTION PLAN			
Activity	Lead person/organization(s)	Measurement	Completion date
Presentation to LCAC regarding the results of OHA's focus groups on engagement	OHA Report	Number of presentations	October 2014
As part of the Health Equity Learning Series, provide sessions focused on: <ul style="list-style-type: none"> • Health equity through member engagement • Best practices for diverse engagement in LCAC 	OHA Office of Equity and Inclusion with Armenia Sarabia, GOBHI	Number of LCACs participating in webinars	Ongoing
Outreach strategy defined by each LCAC	LCAC, Charlotte Dudley, GOBHI	Established plans and number of new participants	March 2015

PROGRESS as of June 30, 2015:

- In December of 2014, the OHA Transformation provided technical assistance allowing Liz Baxter to do a member engagement presentation for the RCAC. RCACs took information back to LCACs.
- All 12 CACs have received the information and forms to provide a stipend and mileage/childcare reimbursement for EOCCO plan members to attend CAC meetings.
- Sample recruitment materials were developed and are available for CACs from the EOCCO and the OHA Transformation Center.

PRIORITY AREA: Fundraising

GOAL: Establish a 501(c)3 nonprofit organization to seek private, corporate and government funding to implement strategies across the EOCCO region

OBJECTIVE No. 1: Bylaws development, articles of incorporation

STRATEGY: Use GOBHI attorney to draft a set of bylaws.

JUSTIFICATION: Need funds to implement regionwide CHIP.

EVIDENCE BASE:

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
Submit Articles of Incorporation to Oregon Secretary of State	Henry O'Keefee, GOBHI	Submission	August 2014 Completed, the official name is Eastern Oregon Healthy Living Alliance
Expand members of the fundraising committee to include a representative from each county	EOHLA	Membership	November 2014
Review draft of bylaws with committee	EOHLA	Bylaws approved	December 2014
Apply for 501c3 status with the IRS, create federal tax ID number and enroll in DUNS	Henry O'Keefee	Documents submitted	June 2015

PROGRESS as of June 30, 2015:

- Eastern Oregon Health Living Alliance (EOHLA) incorporated
- Each LCAC recommended a Board member to EOHLA
- EOHLA Board Members held day long orientation, board roles and responsibilities and planning session
- Created a fiscal sponsorship agreement with the Oregon Rural health Quality Network
- Raised about \$6,000 in unencumbered donations
- Secured resources to recruit for an Executive Director, currently recruiting
- IRS 501 c 3 status applied for in June 2015

OBJECTIVE No. 2: Funders brief

STRATEGY: Invite statewide foundation and funding community to an event that will allow us to describe our needs.

JUSTIFICATION: Without money, the CHIP will not be implemented.

EVIDENCE BASE:

ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Secure date and location for event	Fundraising committee	Venue and date	July 2014 Completed
Invitations to foundations	Fundraising committee	Invitations sent	August 2014 Completed, identified 40 foundations that fit our criteria
Hold event	Fundraising committee	Event held	October 2014 Completed- Event held October 15, 2014 in Sunriver

PROGRESS as of June 30, 2015:

- Event planned and held, attendance by funders was not as strong as hoped for.

PRIORITY AREA: Community-based participatory research

GOAL: Allow LCACs to use their local knowledge to test innovations in science in partnership with university-based researchers

OBJECTIVE No. 1: Define community-based participatory research

STRATEGY: Use video trainings to introduce the concept and develop skills.

JUSTIFICATION: Tools exist and staff is knowledgeable.

EVIDENCE BASE: U.S. Department of Health and Human Services, Clinical and Translational Science Awards Consortium *Principles of Community Engagement (2nd edition)*, June 2011

ACTION PLAN

Activity	Lead person/ organization(s)	Measurement	Completion date
LCAC to view an introductory video on community-based participatory research	LCAC	Number of LCACs presenting	October / November 2014
Ascertain the interest level of LCAC members to participate in community-based participatory research	Paul McGinnis, GOBHI	Number of local research partnerships formed	November 2014

PROGRESS as of June 30, 2015:

- All LCACs with the exception of Wallowa received a presentation on Community Based Participatory Research

OBJECTIVE No. 2: Partner with OHSU for community-based participatory research			
STRATEGY:			
JUSTIFICATION: We need funding for locally generated research studies.			
EVIDENCE BASE:			
ACTION PLAN			
Activity	Lead person/ organization(s)	Measurement	Completion date
Identify LCACs ready to partner with OHSU	Paul McGinnis, GOBHI	Shared information and introduction given to principal investigator	December 2014
Participate in grant development of NIH R01	Melinda Davis, Ph.D.	Grant submitted	TBD
Evaluate opportunity to conduct oral health research for children with OHSU Community Dentistry Program, Oregon Rural Practice-based Research Network and other community partners using NIH Mechanism (UH2/UH3)	Paul McGinnis GOBHI, Nikki Zogg, Advantage Dental	Meetings held	On-going meetings until submission date of December 2014

PROGRESS as of June 30, 2015:

- Each LCAC identified people to serve on an Oral Health Community-based Participatory Research grant as advisors to the program
- Held several meetings with the OHSU School of Community Dentistry
- OHSU determined that the grant would not be submitted