InterCommunity Health Network CCO

Community Health Improvement Plan

Progress Report – May 2015

Stronger, healthier, together.

IHN-CCO CHIP Progress Report

May 11, 2015

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Chapter 1 – Community Advisory Council

The purpose of this chapter is to inform the Oregon Health Authority of the IHN-CCO Community Advisory Council (CAC), and Local Advisory Committees' CHIP related work (since the 2014 transformation report was submitted spring 2014). For a more complete understanding of where this work began, see the IHN-CCO CHIP.[1]

IHN-CCO CAC and Local Advisory Committee Structure

The regional CAC consists of nineteen representatives (six per county, plus the chair) and includes twelve IHN-CCO consumer member representatives, three county staff, and three community members. In partnership with the CAC, each county has a Local Advisory Committee to the CAC. To ensure communication between the regional and local meetings, three representatives serve as elected liaisons, one per county, between their respective local committees and the regional council. Regional CAC representatives are required to participate as members of the local meetings; however, final recommendations are made at the regional council level. For more in-depth information, see the IHN-CCO CHIP.[2]

Community Engagement

The CAC typically averages four vacancies, yet it has always maintained an OHP member majority. The CAC anticipates that the issue of OHP member recruitment and engagement will be a priority area of emphasis for the committees over the coming year and beyond. Some engagement efforts are underway or in the planning stages:

- **CAC public meetings:** All regularly scheduled CAC and Local Advisory Committee meetings are, and always have been, open to the public.

- **Community Conversations:** The Linn Local Advisory Committee hosted two "Community Conversations," with OHP members. The initiative, leadership, and planning for these events was taken up by a Linn Local Advisory Committee member who also serves as a Linn-Benton Health Equity Alliance Coordinator.
    - The purpose of the Community Conversations is to create a forum for Oregon Health Plan members to share their healthcare experiences and perspectives on, "what is and isn't working in the health care system" and to voice what is important to them. The outcome of those meeting was shared with the CAC at their May meeting and will be further discussed at local meetings this summer.

- **Meeting accessibility:** The CAC Coordinator has a meeting scheduled with the Executive Director of the Oregon Council on Developmental Disabilities to explore resources and training opportunities for improving meeting accessibility for CCO and other community members.

- **Issue Briefs:** The CAC and local committees adopted an "Issue Brief" form, which has the potential to allow individual- and committee-level concerns and issues to come forward to the CAC and into the healthcare system.

- **IHN-CCO public meetings:** The CCO hosts three annual public meetings, one per county. At these meetings, three IHN-CCO board members give short presentations before opening the floor for questions. CCO leadership has worked with the Linn-Benton Health Equity Alliance to gather ideas on how to make these meetings more accessible and more encouraging of attendance by IHN-CCO membership. Some of the suggested changes have already been implemented and others may be tried out over time. Those meetings are typically well attended and robust discussions take place between the community and IHN-CCO leadership.

CAC Communication, Collaboration, and Information Sharing

To successfully transform the healthcare system and ensure the CAC's ability to influence this process, communication and the sharing of information are a priority. Here are some ways in which information is shared or made available to the CAC and local committees.

- **Communication Coordination Committee (CCC):** After updating and fine-tuning their charter, the CAC developed a Communication Coordination Committee (CCC) to facilitate communication and collaboration between the counties, the CAC, and the CCO. Formation of this group strengthens the CAC's ability to function and for their work to be influential. CCC membership includes the CAC Chair, the Vice-chair, three Liaisons, and three local committee Chairs. The meetings are staffed by the CCO CEO, one county health administrator, the CAC Coordinator, and the OHA Innovator Agent. After meeting several times last fall, the CCC now meets bi-monthly.

- **Presentations and Trainings:** With such a tremendous amount of transformation effort occurring, the CAC and local committees are committed to keeping informed of the work of the CCO and its community partners. Some trainings and presentations from the past fiscal year include:

    - *CCO Board of Directors & CCO updates* by IHN-CCO CEO at each CAC meeting and as requested at local meetings.
    - *OHA updates* by the Innovator Agent at each CAC and some local advisory meetings
    - *CCO Orientation & Discussion* on the CCO transformation plan, grants, pilots, CCO structure, and on CAC input into the CCO.
    - CAC *Roles, Responsibilities, and Strategic Planning* training led by Liz Baxter (3 hours, twice)
    - *Leadership and Influence* training led by Kevin Boyle (3 hours)
    - Dental care organization (DCO) presentation & discussion with DCO representatives

- Patient Centered Primary Care Home (PCPCH) presentation and discussion with a PCPCH physician and two administrative staff.
- The IHN-CCO CAC and its local advisory committees, on average, send 15 members to participate in all Coordinated Care Model and CAC summits offered by the OHA Transformation Center.
- Local Advisory Committees each meet 1-2 times monthly and have arranged many presentations
- The CAC and Local Advisory Committees all received two presentations on the subject of moving from CHIP goals to outcomes and indicators (see next section of this report) by the Regional Community Health Coordinator and the Benton County Public Health Planner.
- The CAC Coordinator and the OHA Innovator Agent have been in communication with the Oregon Office of Equity and Inclusion and are working to bring a presentation to the CAC on the topic of health disparities and health equity. Identifying health disparities and addressing health equity is a value of the CAC and is included in their charter.
- The CAC chair participates in several IHN-CCO meetings, which informs the work of the CAC, including the Board of Directors, Regional Planning Council, and the Delivery System Transformation Steering Committee.
- As a resource to the CAC, the CAC Coordinator participates in various meetings:
  - **IHN-CCO:** Board of Directors, Regional Planning Council, Delivery System Transformation Committee, Quality Management Committee, Mental Health Advisory Committee, Health Literacy Committee, Regional Planning Council Management Group, Race & Ethnicity subcommittee, Dental Integration workgroup, Privacy Workgroup, Regional Healthy Communities Steering Committee, and Linn-Benton Health Equity Alliance meetings with IHN-CCO staff.
  - **State meetings:** OHA Health Equity Committee**,** OHA CAC Learning Collaborative, OHA CAC Coordinator Learning Collaborative, and OHA CAC Steering Committee

CHIP Outcomes & Indicators

For the CHIP submitted in 2014, the CAC identified four priority focus areas called Health Impact Areas (HIAs). The four HIAs are:

- Access to care
- Behavioral health
- Chronic disease
- Maternal & child health

Related to the HIAs, the CHIP also identified eight goals, with many strategies and activities to meet those goals (these goals, activities, and strategies can be found on pages 21-27 of the IHN-CCO CHIP[3]). Since publication of the CHIP, much CAC and local committee focus has been on answering the question for each goal, "What would success look like?"

To answer that question, they have been working on identifying CHIP outcomes and indicators. For their purposes, these terms are defined as follows:

- **Outcome:** Results or changes that come about from a program—such as changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status.
    - Outcomes are a standard of some level of success. And to that end, in identifying outcomes, the CAC is asking, "What would success look like?"

- **Indicator:** Measurements or data that provide evidence that a certain condition exists, or certain results have or have not been achieved.
    - Indicators measure the level of success or lack of success a program has had in achieving an outcome.

Identification of outcomes and indicators is crucial for the work of the CAC and their ability to evaluate and report on CHIP progress while always keeping in mind the bigger picture of what success will look like. Therefore, the CAC asked each local committee to identify outcomes and indicators for at least the one or two HIAs assigned to them. If they have time, they are also welcome to provide recommendations for any of the other HIAs. At the time of this report, they have identified nearly all the outcomes and are beginning to move on to identify potential indicators, starting with the quality incentive and state metrics. After the local committees have made their outcomes and indicators recommendation, a workgroup with representation from all three counties will be appointed to bring this all together into one cohesive recommendation to the IHN-CCO.

Despite the fact that this is the first time most participants in this process—including those from the CAC, the local committees, the CCO, and the community partners--have undertaken this particular type of task, the work is progressing well. That is not to say that the process has been smooth and frustration-free. There is no clear road map for this process. So, participants are having to create their own. Nevertheless, the work is progressing well; outcome and indicator identification is on track to be finalized for recommendation this year and will serve a crucial role in future evaluation and guidance of CHIP progress. And what is the purpose of all of this CHIP work? The purpose is to transform the system of healthcare, improve wellness and experiences of care, and reduce costs. The current work of the local committees and the regional CAC will serve as a guide for how CHIP success will be measured.

The CHIP's Impact on IHN-CCO Transformation

According to Oregon Senate Bill 1580, the IHN-CCO CHIP adopted by their Community Advisory Council should "serve as a strategic population health and healthcare system service plan for the community served by the IHN-CCO. One of the most demonstrable ways that the CHIP is being used for strategic planning is the fact that IHN-CCO pilot project proposals are not only required to fit under one of the eight elements of the IHN-CCO Transformation Plan, but also under one of the four CHIP Health Impact Areas (HIAs). The CCO and community partners have recognized the importance of the HIAs and are utilizing them in prioritization of their transformation efforts. Also, the CCO created a matrix to highlight the HIAs each pilot project has the potential to improve (See Appendix A). This matrix will be used by the IHN-CCO Delivery System Transformation Steering Committee to identify gaps and to evaluate how each pilot project proposals fits within overall transformation efforts so that gaps can be filled, as possible.

Future CAC Plans

Later this year, after the CAC finalizes its outcomes and indicators recommendations, they will hold a strategic planning meeting to assess where they are and map out a new two-year plan. The identified CHIP outcomes and indicators will be central to the strategic planning of their work and reporting of CHIP progress and evaluation.

Chapter 2: CHIP Progress

The purpose of this chapter is to update members of the CAC and its local committees on the CCO's progress on each of the activities listed in the 2014 IHN-CCO Community Health Improvement Plan (CHIP) and to report that to the Oregon Health Authority. This first progress report will serve as a baseline to compare against future progress. While this document may be shared with any interested persons, it is written, at this point, to update individuals already familiar with the CHIP.[4]

Pilot Projects as Proofs-of-Concept

Some CHIP activities include "pilot projects," often called "pilots." As a reminder of the purpose of these projects, I include the following paragraph from the CHIP:

"While continuing to provide services to its members, IHN-CCO is working diligently to test innovative methods of transforming the healthcare system through a variety of pilot projects. These pilots allow service providers to try out, evaluate, and refine cutting-edge processes for improving healthcare, member satisfaction, and cost efficiency. If a pilot project can be successfully refined, and proves to be a viable concept, these new processes and programs will be replicated and customized throughout the IHN-CCO region[5]."

Format of this report

The report that follows is organized by Health Impact Area. There is a progress update for each activity identified in pages 21-27 of the CHIP.[6]

Access to Healthcare

Access to Healthcare includes the percentage of individuals who thought they received appointments and healthcare when needed.[7] In addition to being able to make appointments on a timely basis, access involves overcoming barriers to care such as having transportation to appointments and receiving information in a manner the member can understand.[8]

Goal 1 - Access to Healthcare: Ensure adequate provider capacity for primary care, dental health, mental health, and substance use for IHN-CCO members

Strategy 1: Ensure that IHN-CCO members are seen by their healthcare provider in a timely manner

Activity A (Access Goal 1, Strategy 1): Plan and implement the Benton County Assignment and Engagement Pilot

ACTIVITY PROGRESS:[9]

Assignment & Engagement Pilot
Phase 1:
"The Assignment & Engagement pilot completed the first phase focusing member assignment to a primary care physician.

- A web portal was created which supports tracking and managing assignment and includes the functionality of requesting primary care physician (PCP) changes by the member at [or by] the PCP [office].
    - The portal is used by the pilot sites and, I believe[10], is in the process of limited expansion to targeted Samaritan clinics.
    - There was an effort to open use of the portal more broadly, but concerns were raised. IHN-CCO is in the process of identifying the best methodology to expand this functionality to all clinic sites; and since this seems to be moving [from the 'transformation' side] into the 'operations' [side] of IHN-CCO, it was decided to end this phase of the pilot. The portal will continue to be used in the interim.

Phase 2
"The engagement portion of the pilot [tested] strategies to bring newly assigned[/enrolled] OHP members into care [by methods] other than a direct physician appointment.

- "RN Care Coordinator visits—to conduct a health history, risk assessment, and screening—was tested on a limited basis.
- "Benton [county] was the only [location] testing the strategy, and we[11] are moving into the Alternative Payment Methodology (APM) pilot, so the question was raised at the [IHN-CCO Transformation Steering Committee (DST)] whether there are other clinics interested in testing strategies.
    - "As yet, I'm not aware of any interest. I do want to point out that engagement (bringing new members into care) will be an important part of the APM pilot so focus will continue in this area.

Access to Healthcare

"So, in summary – the work continues, but it seems to be morphing from pilots to operations or to new pilots [such as Alternative Payment Methodologies]. Once the DST gets our evaluation process in place, we will hopefully have a more defined process for transitions, spreading, or closing pilots."

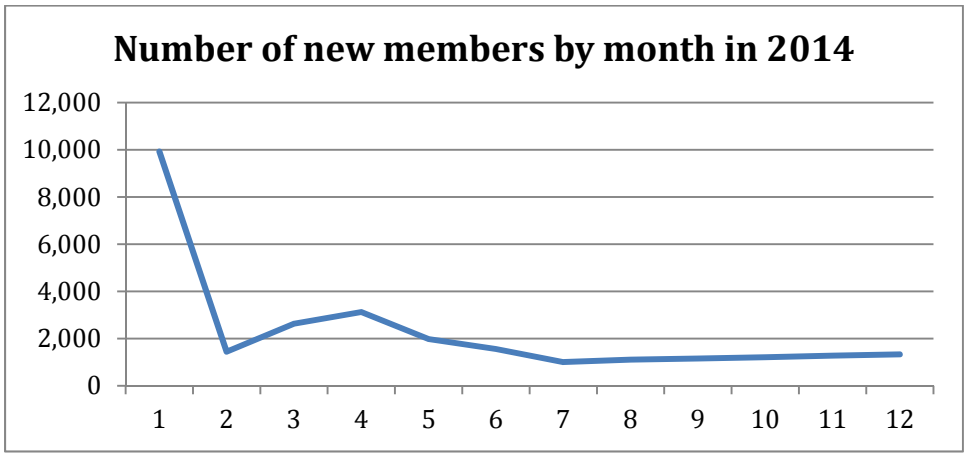
Activity B (Access Goal 1, Strategy 1): Collect baseline data on average length of time from assignment to IHN-CCO to the first visit, type of first visit (e.g. urgent care, ED, PCP), diagnosis, and health risks. Potential data may also include: cost savings (e.g. via reduced Emergency Department visits); reduction in hospitalizations, urgent care visits, etc.; and administrative duplication reduction.

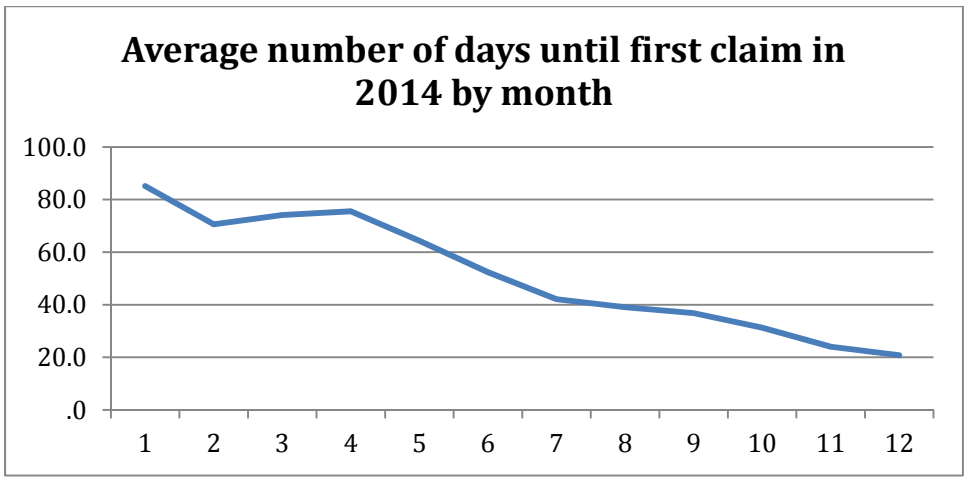
ACTIVITY PROGRESS:[12,13]

IHN-CCO looked at all new members in 2014 and calculated:

- Number of days from IHN-CCO member enrollment to first visit (of any kind).
- Number of days from enrollment to first visit with a Primary Care Provider (PCP).
- IHN is evaluating how data on type of visit, diagnosis, health risks, and other related data might be collected and reported in the long term. It is not currently available.

2014	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of new members	9,924	1,446	2,632	3,128	1,984	1,561	1,008	1,109	1,158	1,209	1,276	1,330
Average number of days until first claim	85.1	70.6	74.1	75.5	64.3	52.4	42.1	39.1	36.8	31.3	24.0	20.8
Average number of days until PCP claim	107.2	91.9	95.6	98.9	82.2	71.0	56.9	51.1	48.1	40.4	34.1	27.1




Average number of days until first claim in 2014 by month
100.0
80.0
60.0
40.0
20.0
.0
1
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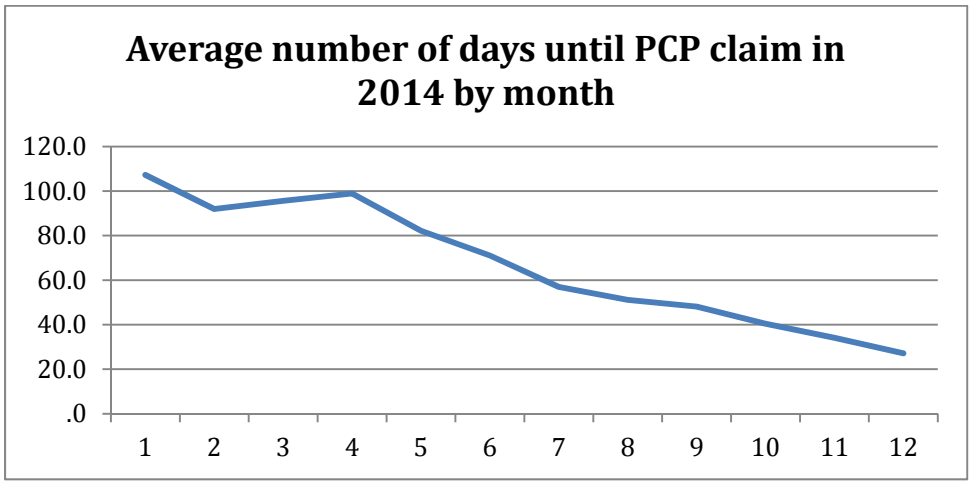
11
12


Average number of days until PCP claim in 2014 by month
120.0
100.0
80.0
60.0
40.0
20.0
.0
1
2
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4
5
6
7
8
9
10
11
12

Average number of days until claims for Newborns and Non-newborns 2014

	Past 12 months	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014
All Members:													
Number of new members	**27,765**	9,924	1,446	2,632	3,128	1,984	1,561	1,008	1,109	1,158	1,209	1,276	1,330
Number with first claim	**19,211**	7,574	1,090	1,857	2,098	1,333	1,065	665	750	729	746	689	615
Average number of days until first claim	**67.5**	85.1	70.6	74.1	75.5	64.3	52.4	42.1	39.1	36.8	31.3	24.0	20.8
Number with PCP Claim	**14,039**	5,822	819	1,339	1,491	970	739	501	533	497	492	445	391
Average number of days until PCP Claim	**87.8**	107.2	91.9	95.6	98.9	82.2	71.0	56.9	51.1	48.1	40.4	34.1	27.1
Only Newborns:													
Number of new members	**876**	69	70	60	79	85	83	82	85	75	66	59	63
Number with first claim	**876**	69	70	60	79	85	83	82	85	75	66	59	63
Average number of days until first claim (birth)	**.0**	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Number with PCP Claim	**805**	63	67	54	76	79	78	74	79	66	61	54	54
Average number of days until PCP Claim	**11.6**	14.4	16.9	7.9	12.3	11.4	11.2	11.1	10.5	9.9	13.1	11.7	8.5
Only non-Newborns:													
Number of new members	**26,889**	9,855	1,376	2,572	3,049	1,899	1,478	926	1,024	1,083	1,143	1,217	1,267
Number with first claim	**18,335**	7,505	1,020	1,797	2,019	1,248	982	583	665	654	680	630	552
Average number of days until first claim	**70.7**	85.9	75.4	76.6	78.5	68.7	56.8	48.0	44.1	41.1	34.3	26.3	23.2
Number with PCP Claim	**13,234**	5,759	752	1,285	1,415	891	661	427	454	431	431	391	337
Average number of days until PCP Claim	**92.4**	108.3	98.6	99.3	103.6	88.5	78.1	64.9	58.2	54.0	44.3	37.2	30.1

Strategy 2: Support, implement, and evaluate new IHN-CCO enrollee engagement strategies

Activity A (Access Goal 1, Strategy 2): Develop and implement an Operations Group consisting of Medical Directors and Samaritan Health Service Provider representatives

ACTIVITY PROGRESS: [14]

IHN-CCO regularly holds successful team meetings with medical directors of the various contracted entities. These groups consist of:

- Federally Qualified Health Centers
- QCA (Quality Care Associates)
- The Corvallis Clinic
- OSU Student Health Centers
- Trillium Family Services
- Samaritan Health Services

Discussions have included Clinical Practice Guidelines, HERC (Health Evidence Review Commission) [15]recommendations, CCO Incentive Metrics. These meetings will continue. They give medical directors and service provider representatives an important opportunity to share best practices for patient care. These meetings also provide an opportunity to share ideas regarding Patient Centered Medical Homes. In 2015, this operations group was named the Physical Health Advisory Council (PHAC).

Activity B (Access Goal 1, Strategy 2): Determine a research strategy for assessing fair and equitable (a balanced distribution of members based on member need and provider expertise) Primary Care Provider assignment of current and new IHN-CCO members

ACTIVITY PROGRESS: [16]
In an effort to provide fair and equitable assignment of IHN-CCO members, IHN-CCO partnered with contracted provider clinics to identify Patient Centered Primary Care Homes (PCPCH). IHN-CCO established a listing of all PCPCHs in the service area and is working with those PCPCHs to establish care for our members. The PCPCHs have expanded and integrated service capability and access within their locations. Based on a medical team approach—a key component of a high functioning PCPCH— they are able to provide expanded and integrated services to the membership.

The goal is 100% membership assignment to, and establishment with, a PCPCH clinic. This rate is currently 81%. IHN-CCO provides education to its providers to increase understanding of the benefits, for both the clinic and the member, of becoming a PCPCH. Internally, IHN-CCO promotes member assignment to a PCPCH for those who request a PCP change.

To increase capacity and move healthcare transformation forward, a Medical Home Readiness pilot[17] is underway. Phase One will assess PCPCH readiness for five solo primary care practices. Phase Two involves coaching two of the practices through the required PCPCH credentialing process. If this pilot is successful, this project will be offered more widely.

Activity C (Access Goal 1, Strategy 2): Create a process to track time of enrollment to time of PCP assignment

Access to Healthcare

ACTIVITY PROGRESS: [18]

IHN-CCO developed and implemented a process to track timeliness of PCP assignment. During the enrollment process, members receive a PCP choice card. This allows the new member to let IHN-CCO know if the member has already has established care with a PCP. If a member has been enrolled for 14 days and has not identified a PCP to IHN-CCO, the member is automatically assigned one at that time.
Data: Moving forward, IHN-CCO will track the percentage of members who are assigned a PCP within 21-days of the enrollment date. This data will regularly be available to governing bodies for IHN-CCO. IHN-CCO will also monitor this on an ongoing basis to ensure timely PCP assignment.

Activity D: (Access Goal 2, Strategy 1): Determine a measurement of PCP's ability to see members in a timely manner

ACTIVITY PROGRESS: See Access Goal 1, Strategy 1, Activity A.

Goal 2 - Access to Healthcare: **Promote the availability of culturally sensitive care, particularly in the areas of language and health literacy**

Strategy 1: Promote educational opportunities for all IHN-CCO providers and staff on trainings that focus on, but are not limited to, health equity, health literacy, cultural competence, cross-cultural communication, and working with non-traditional healthcare

Activity A (Access Goal 2, Strategy 1): Develop a training process by July 1, 2015

Activity B (Access Goal 2, Strategy 1): Ensure that all new employees receive trainings within six months of hire

Activity C (Access Goal 2, Strategy 1): Offer annual trainings for all employees

ACTIVITY PROGRESS A-C: [19,20] The training process is complete and in place for contracted providers. Provider trainings consist of live Continuing Medical Education courses, slide presentations, and provider staff educationals. IHN-CCO staff has also had presentations on health equity, cultural competency, and health literacy. "This training has the potential to engage the members/patients in their care in a much more meaningful way."

Activity D (Access Goal 2, Strategy 1): The IHN-CCO Chief Medical Officer will conduct a Health Literacy Continuing Medical Education course to be attended by a variety of local physicians.

ACTIVITY PROGRESS: [21]
Various Cultural Competency and Health Literacy trainings have occurred:

- The IHN-CCO Chief Medical Officer presented a Continuing Medical Education (CME) cultural competency training to a variety of physicians in April 2014.
- A Health Literacy seminar was presented to attendees of the Oregon Council of Health Care Educators by the IHN-CCO Chief Medical Officer in June 2014.
- A Health Literacy presentation was offered to the community in Newport on September 2014.

Access to Healthcare

- Samaritan provides a quarterly Medical Home Academy for Samaritan Health Service staff. The purpose is to orient them to the Patient Centered Primary Care Home model. Cultural Competency and Health Literacy information sessions are included.
- Cultural Competency on-line learning modules have been developed and disseminated, via the Partners Learning Collaborative, to contracted PCPs.
- IHN-CCO staff received a presentation on Health Literacy during an All Staff Meeting in 2014.
- Monthly Health Literacy Committee meetings within IHN-CCO have led to development of the Samaritan Health Service (SHS) Patient Education Advisory Council. This council will assist in creating health literacy pathways for SHS and for the community.
- Members of the IHN-CCO staff participate in the annual Health Literacy Conference by Legacy Health in Portland.

Activity E (Access Goal 2, Strategy 1): The IHN-CCO Ethnicity and Race Subcommittee will create an inventory of bilingual providers as a baseline.

ACTIVITY PROGRESS:[22,23]

Bilingual Provider Inventory

Within the Primary Care Provider and the Specialties Provider directories located on the Samaritan website.[24] "Other Languages" are listed for any bilingual physician. These directories are updated weekly. In addition to Spanish, there are many other languages listed for the various providers who serve IHN-CCO members.

Quality Improvement Project

In its first year, the IHN-CCO Ethnicity Subcommittee worked to identify and overcome barriers, including difficulties in locating available self-identified member ethnicity and race information in the CCO's database and to getting an actual report completed to pull data from that database. After learning about and overcoming data access barriers, in May 2014, the subcommittee identified IHN-CCO member race/ethnicity demographic data and was able to narrow in on data specific to each particular clinic, particularly for ethnicities of "Hispanic" versus "non-Hispanic." At that time, the group recommended a quality improvement project to assess/identify language barriers to accessing primary care provider services before working to find solutions to overcome those barriers.

The quality improvement project involved creating and fine-tuning a clinic survey to identify ways in which clinics offered service access information in Spanish (for example, signage, phone trees, fliers, member handbooks, promotion of interpretation services, etc.). The group then worked with one clinic to identify gaps in their Spanish language communications.

Beginning April 2015, the work of the Ethnicity Subcommittee is transitioning from IHN-CCO Quality Management leadership to the transformation team; with the leadership and focus transition, it has been renamed the Health Disparities Subcommittee. The group's membership will include

even more community partners (such as additional representation from Linn-Benton Health Equity Alliance and Willamette Neighborhood Housing Services), stakeholders, and IHN-CCO members. Additionally, over the next two years, work will focus on identifying areas of health disparities in vulnerable subpopulations as identified by age, gender, sexual orientation, disabilities, education, and racial and/or ethnic subpopulations—through the use of a variety of data collection tools—identifying root causes, and developing a strategic plan to address health disparities.

Activity F (Access Goal 2, Strategy 1): The Linn County Mental Health Awareness Pilot will promote public understanding of the relationship between physical and behavioral health and the eight dimensions of wellness, which are emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual. [25] The primary goal of this pilot is to increase community awareness of ways they can engage and improve their individual wellness.

ACTIVITY PROGRESS:[26]

An update on the Mental Health Literacy pilot, including results, outcomes, and expansion plans

Mental Health Literacy Pilot for Linn County: *There is no health without mental health*

The American Journal of Health Promotion broadly defines health promotion "as the science and art of helping people change their lifestyle." They state that lifestyle change can be facilitated through a combination of efforts to enhance awareness, change behavior, and create environments that support good health practices.

The aim of Mental Health Literacy Pilot for Linn County was to develop and implement an effective communications campaign to:

- Increase awareness amongst primary care providers, community and faith-based organizations, and local schools in Linn County, and the IHN-CCO organization as a whole, of the ways they can take action to improve the wellness of people with mental health problems.
- Increase awareness amongst community members and IHN-CCO members of the ways that they can improve their individual wellness.

Outcomes and results

<u>Education campaign (English) conducted May – August, 2014</u>

The slogan for this life-health awareness campaign, "Your wellness is more than physical," encouraged local community members to accept a broader meaning of wellness, which incorporates eight aspects of a person's life: emotions, body, mind, environment, finances, community, spirit and work. By emphasizing that wellness is more than one part of a person's life, the campaign strived to normalize mental health as part of overall well-being.

Because of this campaign, the CCO wanted people to stop and think twice about what is going on in their life that may be affecting how they look and feel, and to have compassion for those in their community who may be unwell. The campaign asked, "What affects you?" and urged readers and listeners to visit samhealth.org/TodayIAm, a website with a confidential, self-assessment tool to

help identify areas in their life that may need attention, along with ways that an individual can improve their wellness.

The process to develop and implement the campaign involved conducting community surveys and focus groups about health issues, including attitudes about mental illness. Participants included CCO members, CCO Community Advisory Council representatives, local care providers, and community members at large.

The media campaign included website, billboards, poster, flyers, display materials at community events and within community organizations, newspaper and mall ads, outside banners, online advertising, local magazine articles, interviews with local/regional newspapers, presentations at seminars.

An independent research firm conducted a post-survey of members, stakeholders, and local residents (307 Linn County residents) in August 2014. The results showed that 65% of participants were aware of the life-health awareness campaign, exceeding the project's target of 35%.

Observance of Mental Health Awareness Month, May 2014

Linn County Health Department took the lead in planning and implementing several events and activities for Mental Health Awareness Month, May 2014 in collaboration with Linn County Mental Health Advisory Board and local high school students:

- Hosted community training, Taming the Epidemic of Youthanasia, with Dr. Embry on May 14, 2014 (Attendance 233)
- STAND (Students Taking Action Not Drinking), school-based mental health awareness campaign
    - Included nine Linn County high schools (Albany Options, Central Linn JR/SR High, Harrisburg High, Lebanon High, Santiam Canyon High, Scio High, South Albany High, Sweet Home High and West Albany High schools).
    - Activities included dissemination of posters, video and other promotional incentives bringing awareness to the eight dimensions of wellness
- Campaign posters available in Spanish were distributed and posted
- City Proclamations were made
- Adult and Youth Mental Health First Aid community trainings were provided

Grassroots Outreach, May – August, 2014

In support of education campaigns noted above, campaign staff attended and presented and distributed educational materials at the following community events: (22 event dates and locations deleted for this report. See the CAC Coordinator for details, if interested)

Online Learning and Resource Center for CCO primary care providers launched December, 2014

An online learning and resource center called Partners Learning Collaborative (www.partnerslearningcollaborative.csod.com) was developed to help promote the understanding of the relationship between physical and mental health and the eight dimensions of wellness (emotional, physical, intellectual, environmental, financial, social, spiritual, and occupational).

Access to Healthcare

Initial training modules incorporated focus group feedback. They provided foundational information on mental health issues and guidelines for service upon which future trainings will be built. The successful use of vendor for translating clinical content into training videos will be a model for future training modules.

Coalition of Local Health Educators convened; now part of Regional Healthy Communities Steering Committee - 2014

Linn County Health Department convened a coalition of prevention professionals and health educators to allocate funds for Mental Health Promotion and Prevention projects. Based on data and key informant interviews conducted as part of MHPP Grant, the coalition identified key needs for the Mental Health Literacy project funding, and awarded portion of current-year funds. They prioritized target areas including Girls Circle/Boys Council, LifeSkills Training, STAND (Students Taking Action Not Drinking) and the Seven Project.

This group has served as a model for partner groups in the IHN-CCO region, contributing local data and needs assessments to Regional Healthy Communities Steering Committee, under AMH Mental Health Promotion & Prevention (MHPP) Grant.

Education campaign (Spanish) — Planned for 2015

An education campaign directed to Latino communities in Linn County began development in October 2014 during meetings in Albany and Newport with local Latino advocacy groups and community partners. The advocates and partners worked with an independent marketing research firm to invite local Latino families to participate in focus groups in November 2014 to help the project team identify appropriate messaging and approach for a Latino life-health campaign. It is anticipated that the value of this research will go beyond this campaign and will be used for other educational campaigns directed towards these communities.

It was determined in December 2014 to request additional funds to expand the Linn County efforts to include Benton and Lincoln counties. Funding was granted, by the IHN-CCO Regional Planning Council, in January 2015. Plans are now underway to launch the campaigns in July 2015, coinciding with several local community events planned for Latino outreach and engagement, and ending in October 2015.

As was done for the Linn County English-only campaign, a post-campaign survey conducted by an independent research firm will identify the level of awareness achieved by the campaigns.

Expansion of Educational Campaign to Lincoln and Benton Counties — Planned for 2015

Based on the success of the Linn County pilot, the project team proposed an expansion of the campaign to Benton and Lincoln County. The IHN-CCO Regional Planning Council approved the proposal in January 2015. Plans are now underway to launch the campaigns in May 2015, coinciding with National Mental Health Month, and ending in August 2015.

As was done for the Linn County campaign, a post-campaign survey conducted by an independent research firm will identify the level of awareness achieved by the campaigns. It is expected that the levels will match those of the Linn County campaign, which was 65% awareness of the campaign by those surveyed.

In addition, the project team will develop a template that provides a cost structure for running a media campaign and a roadmap that can be used to guide other messaging campaigns in different topic areas.

Strategy 2: Utilize and expand programs for all types of Traditional Health Workers (THWs), including Health Navigators

Activity A (Access Goal 2, Strategy 2): Produce a comprehensive inventory of current THW services available in the region

ACTIVITY PROGRESS:[27]

The IHN-CCO Traditional Health Worker Subcommittee developed and administered a survey to inventory the region's use of THWs.

In summary of the draft report, 21 of 59 "contacts" responded, in varying degrees of completeness, to the THW survey. Findings include:

- Identification of 15 agencies currently using THW services (Benton 8, Lincoln 5, Linn 2)
- 130 volunteer THW's are utilized by the three counties. Doulas are 100% unpaid volunteers (no numbers listed in draft report)
- Thirty-two THWs are employed by four agencies:
    - Benton: Community Health Workers (21), Doulas (0), Peer Wellness/Support Specialists (8), Personal Health Navigators (8)
    - Lincoln: Peer Wellness/Support Specialists (2), Personal Health Navigators (1)
    - Linn: None responded (see Access Goal 2, Strategy 2, Activity D Linn:):

Activity B (Access Goal 2, Strategy 2): Develop a THW Payment Methodologies Learning Collaborative

ACTIVITY PROGRESS: [28]

IHN-CCO contracted with three Patient Centered Primary Care Homes (PCPCH) to pilot an alternative payment methodology (APM) to their current fee-for-service model. The three clinic sites are Benton Community Health Center, Samaritan Internal Medicine, and Coastal Health Practitioners.

This alternative payment model reimburses each clinic a per-member-per-month capitation payment for each IHN-CCO member assigned to the PCPCH. The level of payment is based on a member's risk score, which is identified by the Oregon Department of Medical Assistance Programs (DMAP).

Two of the three pilot clinics have begun working with Benton County Health Services (BCHS) to integrate THWs into their clinics. The THW Hub Model project is currently a pilot funded through transformation dollars. The THW Hub is run by BCHS, which is responsible for training, recruiting, contracting and assigning resources to PCPCHs in the CCO region. There are currently four THWs

employed at BCHS; Samaritan Internal Medicine has begun the subcontracting phase with BCHS to have a THW assigned to their clinic.

Since the program is being funded by transformation dollars, there is not a payment being made through the alternative payment model. IHN-CCO is collaborating with the pilot sites to understand the services and details; this will allow them to move forward with including these costs into the capitation model and continue to support the implementation of THWs, once pilot funds end.

Activity C (Access Goal 2, Strategy 2): Solicit feedback from counties and community partners on how to best utilize and train current THWs, and implement a THW training support system

ACTIVITY PROGRESS: [29]

The IHN-CCO THW subcommittee is finalizing a report of a survey inventorying current THW services available in the region (*see Access Goal 2, Strategy 2, Activity A*). This work, and the development and implementation of two THW pilot projects (*see Access Goal 1, Strategy 1, Activity E and Access Goal 2, Strategy 2, Activity D for more information*), amongst other work, have been the priority of the TWH subcommittee. Therefore, there has been no progress, to date, on soliciting the feedback listed in this activity.

Activity D (Access Goal 2, Strategy 2): Improve the THW delivery system, allowing THWs to better support and educate members in navigating the healthcare system and ensure appropriate, timely care

ACTIVITY PROGRESS: [30]

- **THW Pilot 1:** The Clinical Community Health Worker Pilot is nearing the end of phase 1. *(See Access Goal 1, Strategy 1, Activity E for updates specific to this pilot.)*
- **THW Pilot 2:** focuses on the use of Community Health Workers/Health Navigators placed in the school setting. Benton County Health Services, using the Hub Model being piloted in Pilot 1.
    - THW Pilot 2 builds on the success of the two grant-funded Community Health Workers placed in Title I schools in the Corvallis School District in Benton County.
        - This pilot will continue those placements and will add an additional school for the 2015-2016 school year.
    - Results from the first year are very promising, with well over 1,300 referrals in the first six months of the project.

County Peer Support Specialists:

- **Benton County Health Services** currently employees a team of eight part-time Peer Support Specialists. The peers work closely with the adult outpatient team, the housing support team, and the ACT team, as well as provide group support.
- **Lincoln County Health and Human Services** currently employs two part-time Peer Support Specialists for the adult population. The Peer Support specialists work closely with the

housing specialist. They also provide individual and group support and positive reinforcement of independent life skills.

- **Linn County Mental Health Services** employs three part-time peers for the adult population. These peers work in the community with the Assertive Community Treatment team, the AMHI team, and soon they will also be working with the Wellness and Recovery team to assist Linn clients in navigating systems such as benefits (food stamps, SSI, insurance), social support resources, physical health, and accessing resources staff may not be aware of. They also facilitate groups such as shopping, exercise and a dual-diagnosis group.
    - Linn is currently recruiting for one full time and two additional part time peers to grow the peer support network.
    - Linn County also contracts with Project ABLE to provide Peer Wellness Teams to the Adult Outpatient Population.

Activity E (Access Goal 2, Strategy 2): Develop and implement a THW pilot project by July 1, 2015

ACTIVITY PROGRESS: [31,32,33]

Benton County Health Services (BCHS) has received project funding for two separate Community Health Worker (CHW) pilots. The first pilot develops the infrastructure for a "Hub" model to hire, train, supervise, and evaluate a "Clinical Community Health Worker" program that will provide care coordination and chronic disease self-management for IHN-CCO members. BCHS hired two Community Health Workers and is in the process of training them to be clinical community health workers/health navigators. These two CHWs will be placed into two primary care agencies in Albany (Geary Street Family Medicine and Mid-Valley Children's Clinic.)

Addressing Health Disparities and Creating Health Equity: Community Health Workers (CHWs) share ethnicity, language, socioeconomic status, and/or life experiences with the residents of the communities they serve. CHWs provide a seamless continuum of culturally and linguistically appropriate outreach, referral, intake, care coordination, self-management, and follow-up services. As members of the primary care team, BCHS' bilingual, bicultural "Clinical CHWs" help clients navigate the health care system, provide chronic disease self-management education and support, and facilitate referrals to social service and community resources.

The second CHW pilot will focus on the use of CHWs / Health Navigators (HNs) placed in the school setting. BCHS, using the Hub Model being piloted in the first pilot, currently has two CHWs placed in Title I schools in the Corvallis School District in Benton County. This pilot will continue those placements and will add an additional school for the 2015-2016 school year. Results from the first year have been very promising, with well over 1,300 referrals in the first six months of the project.

This project addresses the social determinants of health by imbedding bilingual, bicultural school-neighborhood navigators (traditional health workers) into Title I school communities serving the highest number of low income, minority children in Benton County. Known and trusted in the community, they facilitate linkages between families, schools, community resources, and the

health care delivery system to improve community health outcomes (See project model at end of this **Activity E** (Access Goal 2, Strategy 2) update).

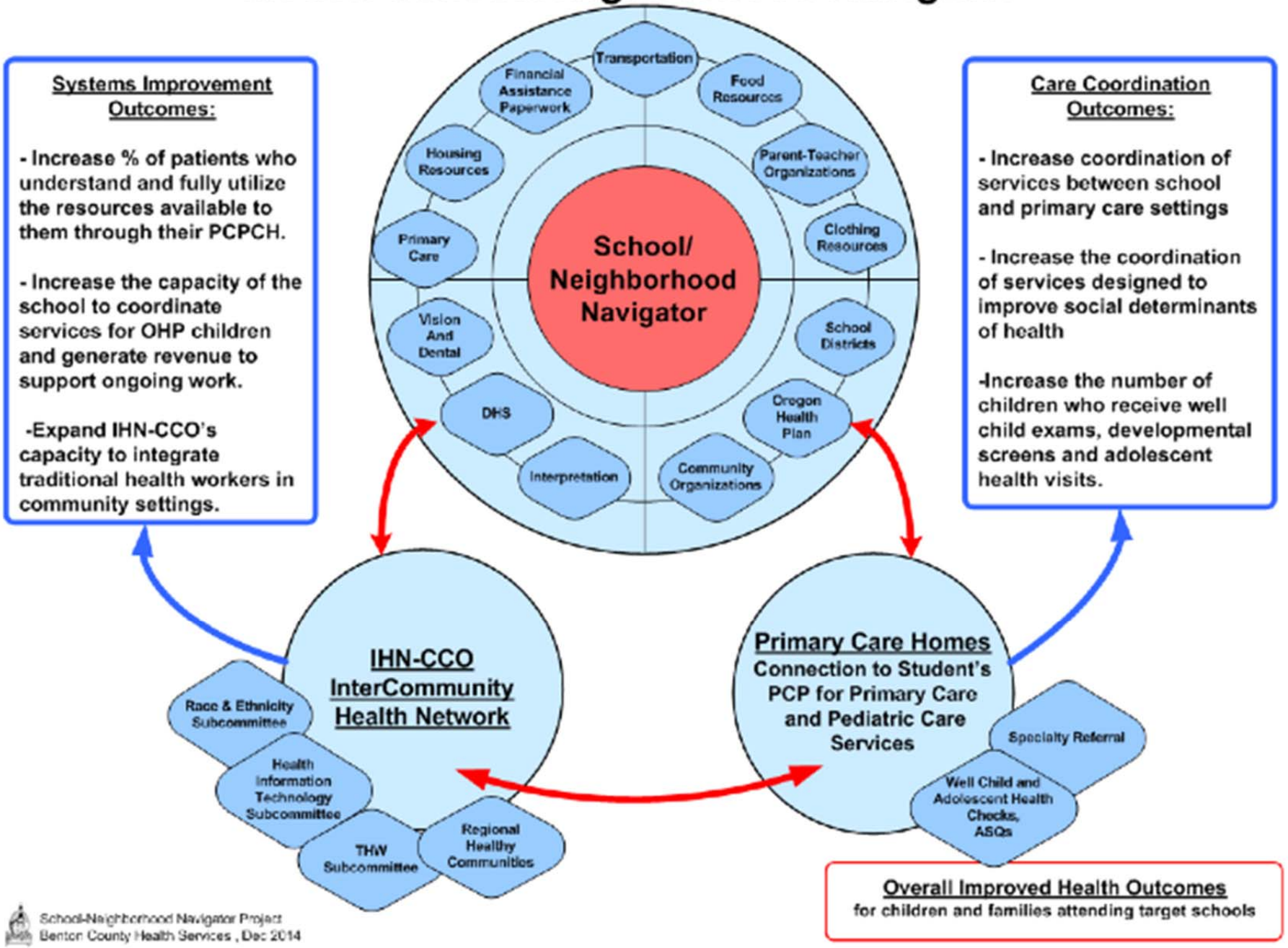
- Promotes health equity by reducing the barriers for Latino/Hispanic and minority and seasonal farmworker children and families in accessing health and social services.
- Supports the coordination and integration of primary

Implementation of the Community Health Worker (CHW) pilot began in October 2014 and is nearing the end of Phase 1 (hiring and training CHWs). Community Health Workers will begin transitioning to placement agencies (Geary Street Family Medicine and Mid-Valley Children's Clinic in Albany) in early April 2015. The project is currently working with placement agencies to prepare staff, developing care model they will use, Electronic Health Record systems for charting and capturing services, and figuring out logistics such as desks and computers.

"This pilot provides qualified Community Health Workers (CHWs) who are part of the IHN-CCO members' care team.

- The pilot provides assistance that is culturally and linguistically appropriate to members who need to access services and participate in processes affecting their care.
- Community Health Workers share ethnicity, language, socioeconomic status, and/or life experiences with the residents of the communities they serve.
- Community Health Workers provide a range of services, including health education and information, health care system navigation, care coordination, limited case management, outreach, provide chronic disease self-management education and support, facilitate referrals to social service and community resources, and work closely with Nurse Care Coordinators.
- This pilot builds on the Health Navigation Program at BCHS, which began in 2008, and further develops the infrastructure to hire, train, supervise, and evaluate a Clinical CHW program that can be integrated within the provider clinics in the IHN-CCO service area.
- Decreases health care costs and health disparities while improving health outcomes and satisfaction."

Model: School/Neighborhood Navigator



Activity F (Access Goal 2, Strategy 2): Deliver a Hub versus Non-Hub Delivery Infrastructure Model presentation to the IHN-CCO Delivery System Transformation Steering Committee provider leadership

ACTIVITY PROGRESS:[34]
The Hub versus Non-Hub THW presentation was delivered to the IHN-CCO Quality Management Committee and to the Delivery System Transformation Steering Committee (DST) in 2014. The Hub Model was selected and the DST approved the Community Health Worker pilot *proposal (See Access Goal 2, Strategy 2, Activity E*). An updated presentation, including progress, will be presented to the DST by June 2015.

Goal 3 – Access to Healthcare: Expand after-hours service availability including normal clinic hours and days for primary and behavioral healthcare.

Strategy 1: All Patient Centered Primary Care Homes (PCPCH) will be open at least four non-traditional business hours.

ACTIVITY PROGRESS:[35]
"IHN-CCO continues to support the development of [PCPCHs] and communicates to all how important extended access is to being a PCPCH. Extended access is not a requirement of becoming a PCPCH based on OHA criteria. PCPCH's with extended hours currently account for 31% of the PCPCH providers contracted with the IHN-CCO. However, IHN-CCO requested all contracted PCPCHs report their services hours, and we are in the process of collecting this data."

Behavioral Health

Behavioral Health spans a continuum of behavioral disorders including, but not limited to, prevention, diagnosis and treatment of mental health disorders, mental illness and addictive disorders. It includes wellness and provides differentiation between lesser behavioral health issues attributed to "mental health" and more intrusive disorders described as severe and persistent mental illness. [36,37]

This definition is also intended to inform resource allocation decisions that range from prevention and early intervention to more intensive supports at the mid- and high-range of intervention up to and including residential resources, acute care resources and under-resourced services such as social and medical detoxification.

Goal 1 – Behavioral Health: **Increase child and youth mental health and wellbeing**

Strategy 1: Build capacity of IHN-CCO to engage youth in substance use and mental health issues affecting our community

Activity A (BH Goal 1, Strategy 1): Focus on adolescent suicide prevention using programs such as Mental Health First Aid[38] and Applied Suicide Intervention Skills Training (ASIST)[39]

Mental Health First Aid – "teaches the public how to recognize signs and symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help. Mental Health First Aid does not teach people to be therapists."[40]

ASIST – is a training "for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over one million caregivers have participated in this two-day, highly interactive, practical, practice-oriented workshop." [41]

ACTIVITY PROGRESS: [42]

Mental Health First Aid (MHFA)

May 2014 - March 2015, Mental Health First Aid trainings, 288 community members were trained (94 people who were with adults, and 194 who work with youths

- May 2014, three individuals trained in MHFA as trainers for MHFA-Adult and MHFA-Youth. As of April 25, 2015, 300+ community members and providers

trained in Linn County at a rate of a minimum of two MHFA trainings monthly for both Youth and Adult versions.

- March 2015, two additional trainers (Linn County mental health staff) trained and two Lincoln County public health staff trained.
- April 2015 two Lincoln County public health staff trained 12 Homeless Education Literacy Program Staff in MHFA.
- Efforts to "regionalize" training infrastructure are currently underway -- including Samaritan; IHN-CCO; Mullins Foundation; and Linn and Benton Counties to expand access to trainings
- Trainings currently underway or provided to this point have been offered free to the public and to providers, funded by Association of Oregon Mental Health Program Directors, Samaritan and Linn/Benton counties
- Linn County presently finalizing submission of Substance Abuse and Mental Health Services "Project Aware" grant to bring at least two additional trainers (one bilingual, Latino) to Linn/Benton to specifically target public school staff
- Planning and discussions are underway to train a retired law enforcement official as a MHFA trainer to work with local law enforcement agencies, using a law enforcement targeted module.

Applied Suicide Intervention Skills Training (ASIST)

- Linn and Benton counties are successful recipients of a Garrett Lee Smith Adolescent Suicide Prevention grant that will bring ASIST, Question, Persuade and Refer or Safe Talk trainings to community members as well as other Evidence Based Practice suicide prevention efforts to providers. Linn/Benton is in second "cohort" that is currently being planned and will begin in fall of 2016.
- **Crisis Intervention Training** a prevention and intervention training for law enforcement agencies
    - Training sponsored by the Linn County Sheriff's Office held March 4-6, Thirty Law Enforcement Agency officials were trained

Activity B (BH Goal 1, Strategy 1): Provide leadership and education opportunities for youth that focus on prevention

ACTIVITY PROGRESS: *See next Activity C update below*

Activity C (BH Goal 1, Strategy 1): Collaborate with the counties to identify and share youth engagement and leadership best practices

ACTIVITY PROGRESS: [43]

Youth M.O.V.E (Motivating Others through Voices of Experience) assigned a Communications and Training Specialist to Benton, Lincoln and Linn counties to work with them on building relationships with local youth.

- Youth M.O.V.E "is a youth led organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare."

IHN-CCO region: Youth M.O.V.E. has begun a regional effort to provide youth focused suicide prevention services. These efforts have begun in Corvallis, where Youth M.O.V.E. has a base, with the intention of spreading them into the other two counties.

- Silent Watch suicide prevention and awareness event, which had about 100 attendees, took place in Corvallis, July 2014. Some youth have reached out since this event and Youth M.O.V.E. gives them continued support.
- Youth M.O.V.E. is working with the Corvallis Boys and Girls Club director to create a plan for doing suicide prevention work in all three Boys and Girls Clubs in the IHN-CCO region. They have a meeting scheduled with the all three Boys and Girls Club directors to plan how Youth M.O.V.E. can support training and coaching of their direct service staff and with creating a permanent Lesbian/Gay/Bisexual/Transgender/Questioning support group presence.
- Youth M.O.V.E. is doing outreach to youths in the region to get input and feedback on their work as they move forward.

Benton County has the following Youth M.O.V.E activities in place:

- Youth M.O.V.E. is in the planning stages for an event at Harding Alternative School.
- Youth M.O.V.E. is working on venues for future youth events. One event they offer is called **Plug N' Play**, dates pending. Plug N' Play is an event that offers high tech games, activities, and food for youth to come and participate.
- Youth M.O.V.E. is working to bring youth to the **System of Care Wraparound Initiative Regional Steering Committee** by forming and building a leadership group. After gaining skills in leadership, they will be invited to sit on the System of Care Wraparound Initiative Regional Steering Committee board.
- Youth M.O.V.E. offers: (1) *Leadership 101*: training for youth who want to participate in youth activities and board involvement, (2) *YPx3 Peer Training*: training for youth to gain skills in peer support.
- Youth M.O.V.E. is developing a youth support group for Gay/Lesbian/Trans-gendered/Bisexual/Questioning (LGBTQ) youths at Philomath High School.
- Youth M.O.V.E. developed an orientation packet to help prepare youth to participate in the Systems of Care Wraparound Initiative Regional Steering Committee.
- The Youth M.O.V.E. representative has connected with the Boys & Girls Club director of Corvallis and is arranging a meeting. Youth M.O.V.E. wants to reach out to youth through the club.
- IHN-CCO's System of Care Wraparound Initiative Site Lead has met with the Benton County family representative. BCHS would welcome Youth M.O.V.E.'s

help with youth in Benton County. Youth M.O.V.E. intends to follow-up with BCHS

On its own, Linn County (outside of Youth M.O.V.E.) has also built relationships with youth in their community. Linn is currently developing a youth group, training program so that youth can obtain the same type of training that their parents have received.

- OFSN trainings include: *Wraparound 101, Journey to Advocacy, Families Experience in Residential Care, Families and Professionals as Policy Partners*.
- Youth M.O.V.E. trainings include: *Helix, Leadership 101, Youth and Professionals as Policy Partners, Peer Delivered Service Workforce Training, and Introduction to Peer Delivered Services.*

Lincoln County is in the beginning stages of working towards a relationship with Youth M.O.V.E..

Activity D (BH Goal 1, Strategy 1): The Wraparound Planning Grant will focus on bringing Wraparound[44] to fidelity to coordinate services and supports for children, youths, and families in all three counties and will identify ways to improve and strengthen youth engagement and leadership.

Wraparound is a planning process that follows a series of steps to help children and youth—particularly those with mental health issues—and their families, with their complex needs. Wraparound does this step-by-step by bringing people together from different parts of the whole family's life. With help from one or more facilitators, people from the family's life work together, coordinate their activities, and blend their perspectives of the family's situation. The Wraparound process also helps make sure children and youth grow up in their homes and communities.[45]

ACTIVITY PROGRESS: [46]

- IHN-CCO hired a System of Care Wraparound Site Lead (12/2014).
- The System of Care Wraparound Initiative Regional Steering Committee, in conjunction with IHN-CCO staff, created and approved the IHN-CCO Wraparound Policy & Admission Criteria.
    - The policy has been submitted. Once approved by the state, the policy will go through the final IHN-CCO policy review and approval process.
- The System of Care Wraparound Initiative Regional steering Committee
    - Created and approved their charter
    - Elected committee co-chairs
    - Formed two new subcommittees:
        - The Training Subcommittee will work to identify and prioritize trainings needed for each county.
        - The Outcomes Subcommittee will work to establish how to measure fidelity for the Wraparound Program.

- Benton, Lincoln, and Linn counties are forming review committees to determine Wraparound services eligibility.
- Oregon Family Support Network (OFSN) and Youth M.O.V.E. have offered trainings to all three counties. OFSN trainings include: *Wrap 101, Journey to Advocacy, Families Experience in Residential Care, Families and Professionals as Policy Partners.* Youth M.O.V.E. trainings include: *Helix, Leadership 101, Youth and Professionals as Policy Partners, Peer Delivered Services Workforce Training, and Introduction to Peer Delivered Services*.
- Portland State University completed a regional assessments needs review and presented this at the System of Care Wraparound Initiative Regional Steering Committee.
- State of Oregon Addictions and Mental Health Division staff presented training on the Wraparound Fidelity Index Short Form survey (WFI-EZ) to the System of Care Wraparound Initiative Regional Steering Committee. This survey will begin in the near future.
- The new Wraparound Site Lead met with county mental health directors and is beginning to attend the Community Care Coordination Committee meetings.

Goal 2 – Behavioral Health: Reduce stigma associated with diagnosis and treatment of behavioral health issues in order to improve access and appropriate utilization of services

Strategy 1: Increase community awareness of the importance of behavioral health issues in our community in order to reduce stigma associated with treatment

Activity A (BH Goal 2, Strategy 1): The Linn County Mental Health Awareness Pilot will promote public understanding of the relationship between physical and mental health and the eight dimensions of wellness. Part of this campaign is to educate people that mental health is an issue for everyone and that there is no health without good mental health.

ACTIVITY PROGRESS: *See Access Goal 2, Strategy 1, Activity F*

Activity B (BH Goal 1, Strategy 1): Provide youth and adult Mental Health First Aid trainings to enhance community awareness, decrease stigma, and increase preventative efforts.

ACTIVITY PROGRESS: [47]

An update on how youth were involved in Mental Health Literacy pilot and outcomes of the Adolescent Wellness Visit mailer was sent out in 2014.

Three versions of an Adolescent well-visit mailer were sent, with age-appropriate messaging, to:

- Parents of IHN-CCO members aged 12-13; 2,064 mailers sent
- IHN-CCO members aged 14-17; 3,483 mailers sent

· IHN-CCO members aged 18-21; 3,110 mailers sent

Linn County Mental Health Literacy Pilot

Linn County Health Department took the lead in planning and implementing several events and activities to involve local youth in the Mental Health Literacy Pilot conducted between May and August, 2014:

- Utilization of local youth groups, prevention coalitions, and other community stakeholders in dissemination of Mental Health Literacy campaign material
    - Local prevention groups incorporated Mental Health Promotion within their focus, and have been successfully mobilized to participate in education campaign.
    - Youth group developed and distributed youth- oriented campaign material consistent with 8 Dimensions of Wellness theme.
- Provided campaign materials at Linn Together middle school registration events (Eight registration dates and locations deleted for this report. See CAC Coordinator for details, if interested)
- Linn Together members completed 650 parent contacts while providing the Mental Health Literacy campaign materials
- STAND (Students Taking Action Not Drinking), school-based mental health awareness campaign included nine Linn County high schools (Albany Options, Central Linn JR/SR High, Harrisburg High, Lebanon High, Santiam Canyon High, Scio High, South
- Albany High, Sweet Home High and West Albany High schools). Activities included dissemination of posters and other promotional incentives.
- Collaborative planning with Linn County Mental Health Advisory Board to develop myth & fact table tents for display as local community events
- CHANCE, Bridges to Recovery, provided Mental Health Literacy campaign materials and other resources to 400 community members

Adolescent Wellness Visits

To encourage youth, aged 12 -21, to engage in preventive healthcare, a postcard reminder campaign was developed and implemented in October 2014. The postcards' messages were tailored for different age groups and focused on the benefits of the free visit covered by IHN-CCO.

<u>Youth aged 12-13</u>

The postcard's message was tailored for the parents. The headline read: "IT TAKES A VILLAGE TO RAISE A CHILD...A DOCTOR CAN HELP!" The body copy outlined the benefits to engaging a doctor in their adolescent child's health:

- Teenagers who access preventive health services are more likely to be healthy, graduate from high school and get a job. Whether your teen needs a sports physical, lacks energy at school, or has basic questions about physical appearance, a visit with his or her doctor can help.

Youth aged 14-17

The postcard's message was directed towards the teen. The headline read: "DOING WELL IN HIGH SCHOOL IS A CHALLENGE A DOCTOR CAN HELP!" The body copy explained how a visit with a doctor can benefit:

- Teenagers who access preventive health services are more likely to be healthy, graduate from high school and get a job. Whether you need a sports physical, are lacking energy, or have basic questions about your physical appearance, a confidential visit with your doctor can help.

Youth aged 18-21

The postcard's message was directed towards the young adult. The headline read: "EVERYONE NEEDS A DOCTOR...HAVE YOU MET YOURS? The body copy focused on why a healthy adult needs to establish with a doctor:

- Getting to know your doctor is an important step to becoming independent and self-sufficient. By accessing preventive health services, you will be healthier and more likely to excel in your passions and career. Make sure you have met with your doctor before a serious medical need arises.

Based on health plan claims received, adolescent well visits increased after this postcard campaign was launched. In 2015, a tracking method will be used to more clearly identify the results of these visit reminders.

Activity C (BH Goal 2, Strategy 1): Screening, Brief Intervention, and Referral to Treatment (SBIRT)[48] will be developed as a standard screening practice at all primary care sites.

SBIRT is "an approach to screening and early intervention for substance use disorders and people at risk for developing substance use disorders. SBIRT emphasizes combined effort of screening and treatment services as part of a cooperative system of early intervention." [49]

ACTIVITY PROGRESS: [50]

The participation of IHN-CCO staff in a State led SBIRT Task Force has allowed the CCO to share SBIRT ideas and best practices with primary care offices. Additionally, collaboration with billing and coding staff was essential to ensuring proper SBIRT coding, thus enabling more accurate data collection and reporting.

IHN-CCO, in partnership with primary care psychologists, is working to identify and remove barriers to SBIRT utilization in the system. The IHN-CCO Mental Health Advisory Council helped create communication path for SBIRT implementation at primary care, county health services, and mental health sites.

SBIRT also occurs with pregnant women at OB/GYN sites. The standardization of screening will be implemented for pregnant women in 2015. The Samaritan Health Services Perinatal Task Force has helped providers adopt SBIRT for pregnant women.

Goal 3 – Behavioral Health: Expand service options for behavioral health treatment for children, adults, and families

Strategy 1: Collaborate with community partners to build upon current resources in our region

Activity A (BH Goal 3, Strategy 1): The IHN-CCO Mental Health Advisory Committee, which includes many partners and stakeholders, will work together to share and build upon mental health resources, including identification and standardization of best practices and standard treatment across the region (e.g. respite/step-down facilities, Peer Support Specialists, co-occurring disorders, etc.)

ACTIVITY PROGRESS: [51]

Behavioral Health Treatment Best Practices for IHN-CCO:

Evidence Based Practice	Benton	Lincoln	Linn
Acceptance and Commitment Therapy	X	X	X
Assertive Community Treatment (ACT)	X	---------	X
Cognitive Behavioral Therapy (CBT)	X	X	X
Collaborative Problem Solving	X	X	X
Dialectical Behavioral Therapy (DBT)	X	X	X
Early Assessment Support Alliance (EASA)	X	---------	X
Illness Management and Recovery	X		X
Motivational Interviewing	X	X	X
Parent Child Interactive Therapy	---------	X	X
Peer Delivered Services	X	X	X
Rental Assistance	X	X	X
Screening, Brief Intervention, Referral to Treatment (SBIRT)	X	---------	X
Seeking Safety Group	X	X	X
Solution-Focused Brief Therapy (SFBT)	X	---------	X
Supported Employment	X	X	X
Supported Housing	X	X	X
Trauma Focused Cognitive Behavioral Therapy	---------	---------	X
Wraparound	X	X	X

Activity B (BH Goal 2, Strategy 1): The Wraparound Planning Grant will focus on bringing Wraparound to fidelity services for children, youth, and families in all three counties.

ACTIVITY PROGRESS: [52]

"State of Oregon Addictions and Mental Health Division staff presented a training on the Wraparound Fidelity Index Short Form survey (WFI-EZ) to the System of Care Wraparound Initiative Regional Steering Committee. This data collection survey will begin in the near future and is a pivotal step in working towards fidelity.

The WFI-EZ is the 'new' tool that the state is planning to use to measure the fidelity of the Wraparound process. The WFI-EZ will be given to families that have been in Wraparound for six months. It is a survey tool that will be administered by IHN-CCO. This is being implemented to give families the opportunity to provide honest feedback about their entire experience and/or process. The WFI-EZ will show the progress of the program and how the families experienced it."

Activity C (BH Goal 3, Strategy 1): The Wraparound Planning Grant recipients will collaborate to improve and strengthen youth engagement and leadership

ACTIVITY PROGRESS: [53] See Behavioral Health Goal 1, Strategy 1, Activity C

Activity D: (BH Goal 3, Strategy 1): Support the further development of Assertive Community Treatment (ACT) teams in all three counties

ACT is an evidence-based model of providing treatment and community support to individuals with serious mental illness, which assists in maintaining them within the community. It is a multidisciplinary team approach.[54]

ACTIVITY PROGRESS: [55]

IHN-CCO hosts a monthly Regional ACT Steering Committee meeting and has a Behavioral Health Care Manager I and a Behavioral Health Care Manager II who work with the county ACT teams.

Benton County:

- Passed their fidelity review; and their ACT Program is fully staffed
- Initiated Integrated Dual Disorder Treatment groups; the Employment Specialist is now meeting with 11 individuals
- Forty-one members are receiving ACT level of care.

Lincoln County:

- Lincoln County hired a Program Manager to develop an ACT program.[56]

- They will post positions for QMHP staff (able to address co-occurring disorders) and Peer Support staff after the ACT Manager position is filled.

Linn County:

- Linn County is working towards meeting fidelity.[57]
- The ACT Team Supervisor and the Substance Abuse Specialist Qualified Mental Health Professional are managing the current caseload. Hiring of an ACT Qualified Mental Health Professional is in process.
- Substance abuse program implementation is occurring with Enhance Illness Management Recovery (EIMR) groups (Oregon Center for Excellence for Assertive Community Treatment recommends this as the model to use for co-occurring disorders treatment; the Linn County team attended the training.)
- Twenty-nine members are receiving ACT level of care.

Strategy 2: Assure adequate and easily accessible community based residential resources with active treatment service supports, particularly with regard to detox and crisis respite care

Activity A (BH Goal 3, Strategy 2): The IHN-CCO Mental Health Advisory Committee, including law enforcement representation, will focus on a regional solution to assess detox and crisis respite care service gaps as the Oregon Health Authority transfers adult mental health residential treatment to IHN-CCO.

ACTIVITY PROGRESS: [58]

"The survey to assess law enforcement needs, in anticipation of the adult mental health residential transition, has been developed." The MHAC believes that more detox and crisis respite services are needed throughout the region.

Activity B (BH Goal 3, Strategy 2): Benton, Lincoln, and Linn County mental health programs will collaboratively assemble a database of residential resources for the region that will include the type of facility; level of care, including specialty services; location; rate; and capability to manage identifiable protected health information.

ACTIVITY PROGRESS: [59]

List of adult mental health facilities by county:

AFH – Adult foster home
RTF – Residential treatment facility[60]
RTH – Residential treatment home[61]

Benton	Facility	Capacity	Type
	Sandra Lyn #1	3	AFH
	Sandra Lyn #2	5	AFH

	Sequoia Creek	5	AFH
	Lewisburg	3	RTH
	Janus House	13	RTH
Lincoln	**Facility**	Capacity	Type
	Bayview	5	AFH
	Benton Place	5	RTH
	Oceanside	4	RTH
Linn	**Facility**	**Capacity**	**Type**
	Golden Wings	1	AFH
	Green Mountain Ranch	1	AFH
	Nancy Towers	1	AFH
	Jamata Happy Home	1	AFH
	Our Home	5	AFH
	Shining Light	1	AFH
	Washington Home	1	AFH
	The Willows	1	AFH
	Casa Rio	5	RTH
	Colorado Lake	3	RTH
	Old Oak	5	RTH
	Sender House	5	RTH
	Springer House	5	RTH

Strategy 3: Achieve functional integration with primary care through a "health home" model or as fits the needs of specific populations of a "behavioral health home."

Activity A (BH Goal 3, Strategy 3): IHN-CCO will create a process for evaluating and auditing PCPCH customer service and member experience through a Consumer Assessment of Healthcare Providers and Systems (CAHPS).

ACTIVITY PROGRESS: [62]

In collaboration with the IHN-CCO Marketing and Customer Service teams, The IHN-CCO Quality Team created a plan to address the customer service and member experience. This plan will use the results of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey of IHN-CCO members. Over the next two years, IHN-CCO will put into place practices to improve customer service and member experience.

Using these survey results, IHN-CCO will improve member benefit guides, the new member welcome program, the member newsletter, targeted member mailings, the provider newsletter, online provider trainings, and the annual report for members. Progress will be measured through IHN-CCO sponsored member and provider surveys and phone interviews.

The current goal of the project is to see 1) at least a 20% increase in IHN-CCO membership awareness of plan benefits and services and 2) at least a 75% increase in its provider panel awareness of plan of IHN-CCO benefits and services.

Activity B (BH Goal 3, Strategy 3): IHN-CCO will create an inventory of Patient Centered Primary Care Home (PCPCH) provider trainings.

ACTIVITY PROGRESS: [63]

- **Annual Education for Health Care Professionals** includes PCPCH related modules.
- **Oregon Health Plan 101:** This educational module is designed to provide health care professionals with information about OHP, IHN-CCO ,and how healthcare is being transformed in our communities.
- **Special Needs Plan (SNP) Model of Care:** This training module describes how SAHP and its contracted providers work together to successfully deliver the SNP model of Care.
- **The Journey to Cultural Competency** training will assist Health Care Professionals in understanding how to improve patient safety and quality of care to diverse patient populations.
- **Cultural Competency Tools:** This module provides tools to enhance Health Care Professionals communication skills to provide quality care to all their patients regardless of ethnicity, religious beliefs, or race. These tools can help providers assess and improve their cultural competency.
- **Advance Health Care Directive and Physician Orders for Life-Sustaining Treatment Paradigm (POLST)**[64] This module provides information about Advance Health Directives and POLST and the importance it has to patient care and to the work of healthcare professionals.

Activity C (BH Goal 3, Strategy 3): IHN-CCO will provide a summary of the Alternative Payment Methodologies (APM) implemented since the inception of the CCO.

ACTIVITY PROGRESS: [65]

IHN-CCO launched a full alternative payment methodology (APM) in three Patient-Centered Primary Care Homes (PCPCH) on 1/1/2015. The clinics are Benton Community Health Center, Coastal Health Practitioners, and Samaritan Internal Medicine.

This APM replaced the fee-for-service model by reimbursing providers a per-member-per-month (PMPM) capitation. The payment rate is based on financial risks, identified by historical costs, for members assigned to them. The three clinics provide services to approximately 20% of the IHN-CCO population. The three clinics are working to build the tools and infrastructure necessary to share risk in the capitation payment beginning 1/1/16.

The APM includes financial, utilization, access, and clinic performance metrics that will be monitored to determine success. Each PCPCH site employs behaviorists (behavioral health professionals working in a primary care setting) and works closely with mental health clinics for referral patterns. The behavioral services are included in the capitation.

The goal for 2015 is for IHN-CCO to work out the details to implementing a successful model across all PCPCH's in the CCO's region.

Activity D (BH Goal 3, Strategy 3): The IHN-CCO Mental Health Advisory Committee will assess the need and feasibility of a behavioral health home. A behavioral health home involves integrating primary care into a behavioral health setting (reverse integration).

ACTIVITY PROGRESS: [66,67]

"Trillium Family Services has hired the provider, who is a psychiatrist and family practice physician, and is located at the Boys and Girls Club in Corvallis. They provide physical, mental, and dental health services to children. The Benton County Federally Qualified Health Center states that their services meet the definition of being a behavioral health home.

Chronic Disease

Chronic Diseases are human health conditions of long duration and generally slow progression.[68] Chronic diseases, such as heart disease, stroke, cancer, diabetes, depression, certain mental health and addictions conditions are among the most prevalent, costly, and preventable of all health problems. Healthy lifestyles (avoiding tobacco, being physically active, and eating well) greatly reduce a person's risk for developing chronic illnesses. Research shows that access to resources that support healthy lifestyles, such as nutritious food, recreational opportunities, and high quality and affordable prevention measures (including screening and appropriate follow-up) saves lives, reduces disability and lowers medical costs.[69, 70]

Goal 1 – Chronic Disease: Implement primary prevention strategies to promote health and reduce prevalence of chronic disease, particularly in areas such as obesity, tobacco use, asthma, and environmental toxins

Strategy 1: Strengthen partnership with Public Health and create a consistent language

Activity A (Chronic Goal 1, Strategy 1)*:* Collaborate on a three county Healthy Food Policy for all hospitals and clinics. This policy will outline recommended healthy foods and beverages.

ACTIVITY PROGRESS: [71]

According to Kaiser Permanente, "Hospitals can improve community food environments by: modeling good nutrition, improving environmental health inside and outside their facilities, and collaborating with community-based programs to support a healthy, regional food system and increased access to healthy food.[72]"

The three county health services of Benton, Lincoln, and Linn; Samaritan Health Services (SHS), and Corvallis City Parks & Recreation have all adopted and implemented healthy nutritional procurement policies. While the details of each policy differ, they apply to all foods and beverages supplied by each agency for events such as meetings, conferences, trainings/classes, events, etc., as well as vending machines, where applicable.

Each policy outlines nutritional standards related to total calories, sugar, types and/or amount of dietary fat, etc. For example, Samaritan Health Services' policy, in summary, states that, "when purchasing foods and/or beverages with SHS funds for approved meetings, food selections should emphasize healthy choices including; vegetables, fruits, whole grains, lean protein, nonfat or low-fat dairy." The standards include,

"limiting sugar, sweets and sweetened beverages, as well as salt, saturated fat, partially hydrogenated oil and trans fats."

Activity B (Chronic Goal 1, Strategy 1)*:* Implement a three county Tobacco Prevention and Education Program.

ACTIVITY PROGRESS: [73]

All three county Tobacco Prevention and Education Program (TPEP) Coordinators continue to educate decision makers about potential tobacco-free policy options and Tobacco Retail Licensure (TRL) options. Some examples include:

- Benton County will present two different TRL options to the City of Corvallis.
- Lincoln County provided recommended edits to Lincoln County School District on their Tobacco-Free Environment policy, including electronic smoking devices in the tobacco definition. The policy restricts tobacco use on district grounds as well as at any school-sponsored activities, on or off district premises.
- All seven of Linn County School Districts have adopted language that includes electronic smoking devices in their school board policies.

The County TPEP programs also continue to facilitate Oregon Tobacco Quit Line presentations to various agencies including Linn County Alcohol & Drug, CARDV, Jackson Street Youth Shelter, My Sister's Place, and the Lincoln County School District's HELP program with the goal to inform agencies about this evidence-based tobacco cessation resource and provide technical assistance around referral pathways.

Activity C (Chronic Goal 1, Strategy 1)*:* Implement and evaluate the process of information sharing to align with the IHN-CCO region Coast to the Cascades Community Wellness Network (CCCWN). [74]

The mission of the CCCWN is to provide leadership to enhance the health of communities through development and support for collaborative regional partnerships in Benton, Lincoln, and Linn Counties. The CCCWN includes the following partnerships: Access to Care, Childhood Obesity, Chronic Care, Mental Health, Oral Health, Pregnancy/Prenatal Care, and Tobacco Prevention.

ACTIVITY PROGRESS: [75]

"Regular attendance at the Coast to Cascades Community Wellness Network (CCWN), by the IHN-CCO CEO and Chief Medical Officer, has enabled information sharing between CCWN and other key community partners. An example is the fostering of the integrated dental team within a primary care setting and the use of an advanced practice dental hygienist in a clinic that serves high numbers of IHN-CCO members."

Activity D (Chronic Goal 1, Strategy 1)*:* IHN-CCO will create a Public Health workgroup whose purpose is to align the three county's services.

ACTIVITY PROGRESS: [76]

A public health workgroup, the Regional Healthy Communities Steering Committee is established and meeting regularly. Leadership and participation in the committee includes: Benton, Lincoln, & Linn Public Health; Linn Benton Health Equity Alliance; IHN-CCO; IHN-CCO CAC (via CHIP & CAC Coordinator), Oregon Cascades West Council of Governments; Samaritan Health Services; United Way; and Willamette Neighborhood Housing Services, etc. Here is a brief summary of some of their work to date.

"Regional Healthy Communities Initiative Goal: 'Improve community health by coordinating health initiatives, seeking efficiencies through blended services and infrastructure, and engaging all stakeholders towards the shared goal of ensuring equal opportunities for health.'

IHN-CCO acts as the fiscal agent and the Regional Healthy Communities Steering Committee is the clearing house for regional grants and for evaluating/applying for other funding opportunities. Although the formal collaboration is less than two years old, the Regional Healthy Communities partnership has already secured over 1.0 million in public and mental health grant funding to improve preventive health services in Linn, Benton, and Lincoln Counties. All projects are strongly informed and guided by both the County and IHN-CCO Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP).

Currently funded collaborative prevention initiatives (annual funding amounts):

- **Mental Health Promotion and Prevention** – improve community mental health to reduce occurrence/severity of mental illness ($200,000)
- **School Based Health Center Innovation Grant** – improve preventive and medical services at these important health centers ($80,000)
- **Community Prevention Program** – reduce tobacco use and tobacco-related illness/death ($390,000)
- **Strategies for Policy and Environmental Change (SPArC)** – reduce tobacco use and tobacco-related illness/death ($226,720)
- **Sustainable Relationships for Community Health (SRCH)** – strengthen referral pathways in clinical systems to improve access to chronic disease self-management resources ($90,000).

The Regional Healthy Communities Steering Committee and its work-groups meet monthly to ensure communication and coordination across diverse projects and stakeholders. Along with in-kind participation and contributions from all stakeholders, the following staff positions support this collaboration:

- A fulltime, co-placed, co-supervised Regional Project Coordinator who facilitates the steering committee, sub-committees, and monitors implementation of joint activities and project plans
- A full-time Grant Liaison provides grants administrative support.
- A full-time (currently being hired) staff position will work with the Regional Project Coordinator to support newly funded collaborative projects in 2015.
- Leveraging of media and marketing resources through Samaritan Health Systems/IHN-CCO Marketing and Public Relations Department.

Regional Community Health Assessment Project
All CCOs, County Public Health departments, Hospitals, Early-Learning Hubs and other stakeholders have requirements to produce Community Health Assessments (CHAs). In addition to the above projects, IHN-CCO is funding a project to enhance and coordinate health data collection and use across the region.

The project also funds a small epidemiological team, housed and supervised within Benton County Health Services, to create a unified Regional Health Assessment through which all stakeholders will be able to meet their mandates, and from which each could extract its unique data set. Benefits envisioned include:

- Elimination of duplication and reduction of costs for all participants
- Enablement of direct comparability and data sharing across jurisdictional and service area boundaries
- Enhancement of health improvement planning through consistent use of standard metrics

Strategy 2: Increase access to screening for chronic diseases, including causative factors, and make follow-up services for treatment available.

Activity A (Chronic Goal 2, Strategy 1): IHN-CCO will categorize members by their chronic disease state, pharmacy utilization, and location of Medical Home. This will enable IHN-CCO to look at clusters of members who have chronic diseases, and grouping of multiple chronic diseases, medication management, and develop a Risk Index.

ACTIVITY PROGRESS: [77]

IHN-CCO developed a database tool to collect data to track IHN-CCO members by:

- Service location
- Medication use
- Costs of care
- Chronic disease state
    - This data collection allows care management and other staff to focus on five main chronic disease states:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure
- Diabetes
- Depression/Mental health

The Samaritan Quality Management Committee, including health provider representatives, have discussed and shared information about guidelines of best practices for care and the Choosing Wisely[78] initiative.

With development of this database, tracking tool, the next steps are to identify clusters of high needs individuals with three or more of the previously mentioned chronic diseases, thus ensuring PCPCH care management is occurring. Medication Therapy Management and Target Case Management will be investigated further for 2015.

Activity B (Chronic Goal 2, Strategy 1)*:* IHN-CCO will determine how to best provide, manage, and coordinate high-risk care and will track costs, disease state, case management, hospitalizations, primary care visits, and prescription adherence. The IHN-CCO Quality Management Committee will assess if there are other appropriate measures available.

ACTIVITY PROGRESS:[79]

The IHN-CCO Population Health department has developed a Chronic Disease registry, starting with Diabetes and moving next to Chronic Obstructive Pulmonary Disease (COPD). They are tracking patients' clinic, costs of their care, and are risk stratifying them so that Care Management can reach out to improve their care coordination.

Maternal and Child Health

Maternal Health begins preconception and continues through postpartum. This is the time before, during, and after pregnancy when supportive services enhance a woman's physical and mental health and wellbeing.[80]

Child Health includes health and wellbeing from birth through 17 years of age.[81]

Goal 1 - Maternal and Child Health: Improve overall Maternal and Child Health and wellbeing, including a focus on preconception needs

Strategy 1: Encourage the adoption of the One Key Question Initiative (Healthcare providers asking women of childbearing age if they intend to become pregnant in the next year and then following a protocol depending on the answer).

Activity A: The IHN-CCO Quality Management Committee (QMC) will evaluate this option and provide a report to the Regional Planning Council to determine next steps**.**

ACTIVITY PROGRESS: [82]
After evaluation by the IHN-CCO Chief Medical Officer, the Samaritan Health Services Perinatal Task Force, and the QMC, the QMC approved the adoption of the One Key Question Initiative. Next steps are being evaluated to ensure that standardization of this concept is implemented.

Strategy 2: Provide and increase access to Maternal Health Navigators and Traditional Health Workers, including doulas.

Activity A: The IHN-CCO Traditional Health Worker Subcommittee will evaluate the need for Maternal Health Navigators. Doulas are covered in the CHIP under Goal 2, Access to Healthcare.

ACTIVITY PROGRESS:[83] The IHN-CCO THW subcommittee is still lacking data/input from Doulas. Current attempts at outreach have been unsuccessful; the subcommittee has lacked the bandwidth to do more widespread outreach while it has been focusing on the THW pilots and an inventory. IHN-CCO fully intends to focus on doulas in the future.[84]

Strategy 3: Focus on early tobacco use, prevention, and tobacco cessation during pregnancy.

Activity A: The Tobacco Master Settlement grant awarded to Benton, Lincoln, and Linn Counties will address tobacco use, prevention, and cessation strategies for pregnant women. The regional team will develop a plan to address smoking rates among pregnant women through a best-practice system, policy, and environmental change in the clinical and community settings. The ultimate goal is to develop and implement a regional tobacco cessation campaign for pregnant women and ensure integration with county Tobacco Prevention and Education Program and Community Prevention Program's (TPEP & CPP) systematic screening and referral strategies.

ACTIVITY PROGRESS: [85]
The Mid-Valley & Coast Tobacco Prevention Initiative Clinical Team (TPC) and the core tobacco team are working towards identifying areas in the region where best practices are already being implemented and areas for improvement. It was determined that in order to have a complete assessment of the region, clinic level data will need to be collected. The core tobacco team, in partnership with the TPC team, will finalize a data collection tool and data collection method in order to complete the assessment.

The core tobacco team will continue to provide technical assistance to clinics moving forward in improving their screening and referral pathways. For example, the core tobacco team is partnering with Dr. Cousins on her Universal Screening Pilot funded through IHN-CCO's Delivery System Transformation Steering Committee and the IHN-CCO's Regional Planning Council that is implementing the 5P's SBIRT screening tool in OB/GYN clinics and the five hospitals across Benton, Lincoln, and Linn counties.

The core team is partnering with Kari-Lyn Sakuma, a professor at Oregon State University, to conduct further assessment of the target population to better understand barriers and opportunities to support pregnant women, and women who may become pregnant, to quit tobacco.

The Lincoln County team has started discussions with their Maternal Child Health (MCH) program managers regarding the ability to assess the barriers to the pregnant and parenting population as well as ways in which screening and referral processes can be improved. There have also been discussions with parish nurses about the possibility of contracting with them to teach tobacco cessation courses specifically to MCH program participants. With the largest MCH staff in the region, Lincoln County has the potential to create a foundation for a future regional campaign.

NOTE:

- See Behavioral Health Goal 1 for a Children's Health goal.
- See Behavioral Health Goal 2, Strategy 1, Activity C for a maternal health SBIRT.
- See Access Goal 1, Strategy 1, Activity B for newborn data.
- See Access Goal 2, Strategy 2, Activity A for a children's THW pilot project

Acronyms

ACT – Assertive Community Treatment
AFH – Adult Foster Home
AMH – Addictions and Mental Health division of OHA
APM – Alternative Payment Methodology
ASIST – Applied Suicide Intervention Skills Training
BCHD/S – Benton County Health Department/Services
CAC – Community Advisory Council
CCO – Coordinated Care Organization
CAHPS – Consumer Assessment of Healthcare Providers and Systems
CCCWN – Coast to the Cascades Wellness Network
CEO – Chief Executive Officer
CHA – Community Health Assessment
CHW– Community Health Worker
CHIP – Community Health Improvement Plan
CME – Continuing Medical Education
COPD – Coronary Obstructive Pulmonary Disorder
CPP – Community Prevention Program
DST – IHN-CCO Delivery System Transformation Steering Committee
ED – Emergency Department
HERC – Health Evaluation Review Commission
HIA – Health Impact Area (of the CHIP)
IHN-CCO – InterCommunity Health Network Coordinated Care Organization
LGBTQ – Lesbian Gay Bi-sexual Transsexual Questioning
MCH – Maternal & Child Health
MHAC – Mental Health Advisory Committee
MHFA – Mental Health First Aid
MHPP – Mental Health Promotion & Prevention
M.O.V.E. – Motivating Others through Voices of Experience (Youth M.O.V.E)
OB/GYN – Obstetrician/Gynecologist
OFSN – Oregon Family Support Network
OHA – Oregon Health Authority
OHP – Oregon Health Plan
PCP – Primary Care Provider
PCPCH – Patient Centered Primary Care Home
PMPM – Per-member-per-month
QMC – Quality Management Committee
QMHP – Qualified Mental Health Professional
RN – Registered Nurse
RTF – Residential Treatment Facility
RTH – Residential Treatment Home

Acronyms

THW – Traditional Health Worker
TPC – The Mid-Valley & Coast Tobacco Prevention Initiative Clinical Team
TPEP – Tobacco Prevention, Education, and Planning
SBIRT – Screening, Brief Intervention, and Referral to Treatment
S.M.A.R.T. – Goals that are specific, measurable, achievable, relevant, and time-bound
SHS – Samaritan Health Services
Youth M.O.V.E. – Youth Motivating Others through Voices of Experience
WHO – World Health Organization
WFI-EZ – The Wraparound Fidelity Index, Short Version

Appendix A – Pilot Project Transformation and HIA Matrix

IHN-CCO Pilots

			Alternative Payments Methodology	Behavioral Health PCPCH (CFM)	Child Abuse Prevention & Early Intervention (FTRN)	Child Psychiatry Capacity	Colorectal Cancer Screening	Community Health Worker	Complex Chronic Care Management	Dental Medical Integration for Diabetics	Hospital to Home (4)	Licensed Clinical Social Worker PCPCH	Medical Home Readiness	Mental Health, Addictions, and Primary Care Integratic	Mental Health Literacy (1)	Pediatric Medical Home	Primary Care Psychiatric Consultation	Public Health Nurse Home Visit	School/Neighborhood Navigator	Tri-County Family Advocacy Training	Youth WrapAround and Emergency Shelter	Universal Prenatal Screening
Transformation Elements	1	Healthcare Integration																				
	2	PCPCH																				
	3	Alternative Payment																				
	4	CHA/CHIP																				
	5	Electronic Health Records																				
	6	Cultural, Literacy, Linguistic Engagement																				
	7	Cultural diversity																				
	8	QIP/Barriers to Access																				
CHIP Areas		Access to Healthcare																				
		Beavioral Health																				
		Chronic Disease Management and Prevention																				
		Maternal and Child Health																				

Footnotes

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