# 2012-2015

# CENTRAL OREGON

# HEALTH IMPROVEMENT PLAN

Central Oregon Health Authority

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# EXECUTIVE SUMMARY

The Central Oregon Health Council and the Central Oregon Health Board see the Triple Aim as the key part of the new vision for a healthy Central Oregon, with the long term goal of making it the healthiest region in the nation. It involves better health care for people, greater satisfaction with care and the reduced cost of care. In order to accomplish this vision, collective effort in the region must occur. The Central Oregon Regional Health Improvement Plan (RHIP) is an effort to collectively look for common directions and common measures that can guide the system and improve the health of the region.

The plan addresses the broad issue of health and the specifics of health care. Health is the state of complete physical, mental and social well-being; reduction in mortality, morbidity, and disability due to detectable disease or disorder; an increase in the perceived level of health and the capacity to adapt to, respond to or control life's challenges and changes. Health care (or healthcare) is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in humans. Health care is delivered by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers. It refers to the work done in providing primary care, secondary care and tertiary care, as well as in public health.

### *Strategic Framework*

The outline or framework for the regional plan was based on the nine strategies established and agreed upon by the three counties and the Central Oregon Health Board for the county-specific strategic plans (which tie into the RHIP). The RHIP strategies emphasize efforts to approach changes in the health care system in a coordinated and collective manner. The approach also recognizes that all health care and social service interests must work collaboratively in order to accomplish the goals of health care reform. The nine strategies are:

1. Improve health equity and access to care and services
2. Improve Health
3. Improve health care and service delivery
4. Reduce cost and increase effectiveness
5. Strengthen health integration and system collaboration
6. Pursue excellence in health care and service delivery
7. Promote regional efforts
8. Strengthen health service organizations
9. Promote sound health policy

Within each of the nine strategies are goals and identified actions that will be taken toward achieving those goals. The plan is a broad picture of the direction health care changes will take in Central Oregon.

## *Ten Focus Areas*

Preparation for the first two strategies in the framework (improve equity and access, better health and well-being) required a thorough review of existing health data. Qualitative and quantitative data was reviewed to determine which issues or areas of concern required attention and which were common to all three counties. The top ten issues were prioritized and recommended as the primary focus areas for the first two sections of the 2012-2015 Regional Health Improvement Plan. The ten prioritized focus areas of need were: disparity/inequity, isolation and access to resources,

food insecurity, early childhood wellness, safety, crime and violence, chronic disease and preventive care, alcohol, drug and tobacco use, behavioral health and suicide, oral health, and healthy environments.

### *Socio-Ecological Model*

In preparing for the work plan development, the Steering Committee decided to use a socio-ecological planning model, which is a comprehensive approach that includes strategies impacting five levels necessary for broad-based change: individual, interpersonal, organizational, community and public policy. This model utilizes a collective impact approach and provides a more comprehensive perspective, even though not every level may be necessary for each of the ten focus areas in the final work plan.

### *Work Plans*

Once the plan is approved, annual work plans will be developed to identify the lead entity responsible for the implementation, the goal and targeted outcomes, the specific strategies and actions to be taken to achieve the identified goals and outcomes, and the source and/or tools that will used to measure and evaluate progress and effectiveness. The work plans will also be used to help monitor and assess where changes are needed when the targeted results or outcomes are not being achieved.

# INTRODUCTION

Senate Bill 204, now Administrative Rule 309-014-0330 through 309-014-0340, established a Regional Health Improvement Plan (RHIP) for Central Oregon creating a four year comprehensive, coordinated plan for the tri-county area that would incorporate and replace all health and human service plans prescribed by the Oregon Health Authority, including but not limited to plans required by the State 430.640, 431.385 and 624.510 and plans required by the State Commission on Children and Families under ORS 417.705-417.801.

The Central Oregon Health Board, in a delegated capacity, will function as the regional public health and behavioral health board for Crook, Jefferson and Deschutes Counties. This will facilitate the public health and behavioral health services being efficiently and effectively coordinate with the new Coordinated Care Organization which will be connected to the Central Oregon Health Council.

The Central Oregon Health Council through the Central Oregon Health Board has been directed to conduct a regional health assessment and to adopt a RHIP to serve as the strategic population health and health care system plan for the region. The plan must define the scope of the activities, services and responsibilities that the Council proposes to assume upon implementation of the plan.

The activities and services under this plan may include, but are not limited to:

A. Analysis of public and private resources
B. Health Policy
C. System Design
D. Outcome and quality improvement
E. Integration of service delivery
F. Workforce Development

## MISSION

The mission is to transform the health of our region's residents, making Central Oregon the healthiest region in the nation. The Central Oregon Health Council creates community alignment in pursuit of better health, better care and lower cost.

## GUIDING PRINCIPLES

1. Creation of efficient organizations
2. Assurance of financial sustainability
3. Reinvestment of shared savings
4. High levels of transparency and accountability
5. Flexibility and responsiveness
6. Use of outcomes-based decision making principles
7. Orientation toward whole person health

In order to create a healthy Central Oregon, we must involve a broad group of stakeholders:

- Chambers of Commerce and business community
- School Districts
- City and County Government
- Community Colleges and Universities
- Insurance companies
- Consumers or customers
- Hospitals and medical providers
- Health and Human Service Organizations

### Triple Aim:

**A POPULATION HEALTH PERFORMANCE SYSTEM**

The Triple Aim is a key part of the vision for a healthy Central Oregon, with the long term goal of making it the healthiest region in the nation. The Aims are:

- Improve health of the population
- Enhance the patient experience of care (including quality, access and reliability); and
- Reduce or at least control the per capita cost of care

To start this process, we completed a regional assessment to identify the critical areas of need to move toward achieving a healthy community.

## ASSESSMENT PROCESS (Full Health Assessment is on COHC Website)

Compiling and using 150 pages of quantitative and qualitative data from a variety of Central Oregon Health and Community sources, the Regional Health Improvement Plan (RHIP) Data and Assessment Work Group met to review the data and to determine the critical issues impacting the tri-county area. The work group initially identified nine priority areas in which to focus and recommended those to the RHIP Steering Committee. The Committee accepted the nine and added a tenth area, healthy environment, to the list. These ten priority focus areas will be the focus of the first 2012-2015 RHIP, and are listed in the blue box below. The following sections also provide a brief tri-county data summary and overview for each of the ten focus areas.

There will be ongoing monitoring and assessment of the RHIP and related work plans to ensure progress is being made, to determine the effectiveness of the strategies used and to make adjustments as needed. Health statistics will also be monitored through the Healthy Community Institute web site that will be fully operational by the summer of 2012. The RHIP Steering Committee, with representation from the tri-county area, will meet on an annual basis to review and evaluate any changes in health statistics, to check on the status of the plan, and to make adjustments and updates when necessary. The RHIP plan is posted on the Central Oregon Health Council (COHC) web site www.cohealthcouncil.org.

### Priority Focus Areas

1. Health Disparity and Inequities
2. Access to Resources and Quality Services
3. Early Childhood Wellness
4. Safety, Crime and Violence
5. Preventive Care and Services
6. Chronic Disease Prevention
7. Alcohol, Drug and Tobacco Use
8. Behavioral Health and Suicide Prevention
9. Oral Health
10. Healthy Environments

### 1. Health Disparity and Inequities

Comparative mortality rates in areas of southern Deschutes County and northern Jefferson County are significantly higher than the state average and are considered a disparity (or difference) in health. Mortality in this case is related to geographic area, but the disparity is also inequitable as it is avoidable and unjust. It is no surprise that our rural areas have high rates of poverty, less access to services, and greater distances to travel for needed care, or that many individuals struggle to meet basic needs. These systematic barriers needlessly impact individuals' health. This is one example of disparity and inequity in our region. Many other disparities exist, warranting investigation to determine if these differences are equitable and just or not.

Improving public health will require work toward health equity—aiming for communities where all individuals have the opportunity to attain their full health potential, and where no one is disadvantaged from achieving this potential due to socially determined circumstance.

Crook and Jefferson counties are consistently among the top 5 Oregon counties with highest food insecurity. Deschutes County has the largest total number of food insecure individuals in Central Oregon. In Crook County, the average cost per meal is nearly $1 higher than the rest of Oregon. It is estimated that more than 37% of children in Jefferson and

Crook Counties may be food insecure. In Deschutes County, of all the food insecure adults and children, 45% are not eligible for SNAP or other federal food programs—a sizeable number of children and adults who may not be able to access much needed assistance.

## 2. Access to Resources and Quality Services

The ability to access resources, services or assistance is impacted by numerous factors, including transportation, travel distance and time, finances, social and cultural barriers, clinic flow, and the systems of care in place. An elderly person living alone and unable to drive may have financial means, but limited access to care. Similarly, a working single mother with no car may have access to public transportation, but can't afford the cost of unpaid leave from work to access resources. More than 41% of Central Oregonians live in unincorporated areas and towns with less than 2,500 people.

## 3. Early Childhood Wellness

A child's growth begins in pregnancy and continues into adulthood. Many factors impact childhood wellness: social, environmental, physical, and cognitive. Children in environments unable to meet these needs are at increased risk for poorer health, safety, development, and the ability to learn. These unmet needs during childhood pose threats to health long into adult and later life. Early childhood wellness is a short-term investment for today and a long-term investment for the business, health, education and social sectors for decades to come, and can result in millions in long term savings to the social services and health system.

## 4. Safety, Crime, and Violence

Central Oregon counties have higher rates of confirmed child abuse and neglect than the rest of Oregon. This may be due to differences in reporting and resources in the system of care or it may be an actual higher rate of abuse/neglect. In 2009, Deschutes and Crook Counties were ranked in the top ten Oregon Counties with highest crude rate of total violent crimes reported. In the same year, Jefferson County was in the bottom ten Oregon counties for number of police per 1,000. Last year, more than 1,450 individuals in Central Oregon called an emergency crisis line about domestic violence alone.

## 5. Preventive Care and Services

"To prevent" literally means "to keep something from happening". The term "prevention" is reserved for those interventions that occur before the initial onset of disorder. The improvements in health status are the result of a health system that influences health status through a variety of intervention strategies and services. Health and illness are dynamic states that are influenced by a wide variety of biologic, environmental, behavioral, social and health service factors acting through an ecological model. Preventive services and health promotion involve activities that alter the interaction of the various health influencing factors in ways that contribute to either averting or altering the likelihood of occurrence of disease or injury. In Central Oregon, prevention activities can play a role in creating a healthier region. Preventive services include immunization rates, teen pregnancy prevention, and screening mammograms along with other interventions.

## 6. Chronic Disease Prevention

In the last 65 years, adult chronic disease has grown to be the main health problem for industrialized nations. Cardiovascular disease, cancers, diabetes and chronic obstructive pulmonary disease account for at least 50% of the global mortality burden. In Central Oregon, chronic diseases, including heart disease and cancer, are the leading causes of death for each county. Crook County's age-adjusted prevalence of adults with high blood pressure is 46.2%, significantly higher than 25.8% of adults for all of Oregon. Exposures, modifiable behaviors, and risk factors all play a role in the development of chronic disease in later life. When exacerbated by a mental health condition, the cost of chronic disease management grows exponentially, often two to five times more than someone without a mental health condition.

## 7. Alcohol, Drug & Tobacco Use

Death, disability and injury due to drug use take a significant toll on the lives of Oregonians each year. In fact, Oregon's death rate from alcohol–induced disease alone is 80% higher than the US rate. A closer look at chronic disease death in Oregon discovers that 50% can be attributed to tobacco use, alcohol abuse and obesity directly.

Central Oregon continues to see increasing rates from Alcohol, Tobacco and Other Drug use/abuse, and in some cases statistics show as significantly higher than State rates (death from alcohol-induced disease, adult 30-day alcohol use, and 8th grade 30-day alcohol use). Of particular concern are high risk drinking (underage, heavy and binge consumption), marijuana use, prescription drug abuse and tobacco use.

The region agrees that in order to improve long term health, prevention efforts should focus on making population-based community change. In order for healthy-decision making to occur, prevention efforts should target alcohol, tobacco and other drug prevention specifically, as well as the issues associated with such use, including but not limited to: suicide, bullying, teen pregnancy, violence, problem gambling, mental health, physical health and nutrition. Communities throughout the region will develop plans with specific prevention strategies and projects that address the unique concerns and needs of each community.

## 8. Behavioral Health and Suicide Prevention

Oregon suicide rates have been higher than national rates for two decades. It is estimated more than 9,000 adults in the tri-county region have serious mental illness. Roughly 1/3 of Central Oregon 11th graders reported having a depressive episode in the last year. High depression scores are associated with poor academic achievement, anxiety, and poor peer and teacher relationships.

The extent of the need for behavioral health services and the capacity to provide services should be included and studied as part of the Access focus area work. Early risk factors and prevention data also needs to be investigated as related to behavioral health.

## 9. Oral Health

Though frequently identified by providers and community members as a problem in Central Oregon, there is little recent data to estimate total burden of poor oral health in the region. Poor oral health can cause pain, discomfort, and disfigurement; it can affect an individual's quality of life, ability to eat and to speak, and can interfere with

opportunities to learn, work, participate, engage and contribute. What's more, oral health is related to chronic disease in later life, and results in increased avoidable emergency department usage, further increasing regional healthcare costs.

## 10. Healthy Environments

There is much to learn about the specific environmental health characteristics of Central Oregon's communities. The ecological surroundings of individuals, families, communities and regions impact the options available to individuals to reach their full potential for health. Environments—on any scale—simultaneously impact and are impacted by those within them. Built and natural environment directly impact human health, and humans directly impact the built and natural environment.

Current and relevant data on all scales of environment is lacking in the Central Oregon region. Locations of stores to purchase affordable fresh fruits and vegetables impact healthy choices. Promoting and encouraging the safe and affordable alternative commute options impacts the behaviors of individuals to choose alternatives to driving, thus impacting the environment. Safe and easily accessible places to play outdoors impacts the ability of children to play outside.

## SOCIO-ECOLOGICAL PLANNING MODEL (Attachment 2)

This model looks at planning in a connected approach. It recognizes there are small units for planning and large units for planning. It is understood that small moves contribute to large moves and large moves, and the large in turn contribute to the small. There is ecological synergy in how we address health issues promoting more holistic, coordinated and population based planning structure.

This model includes the following five areas:

- ***Individual*** – Enhancing skills, knowledge, attitudes and motivation
- ***Interpersonal*** – Increasing support from friends, family and peers
- ***Organizational*** – **C**hanging policies and practices of an organization
- ***Community*** – Collaborating and creating partnership to effect change in the community and increase the efficiency and effectiveness of care
- ***Public Policy*** – Developing, influencing and enforcing local, state and national laws which promote health and create safe and healthy environments

# Improve Equity and Increase Access (Attachment 3 for definitions)

# Improve Health Equity and Population Health

## Indicators and Metrics for Health Inequities (SES)

Social Determinants – a primary approach to achieving health equity (CDC)

Social Status (education, ethnicity, race)

- Kindergarten readiness assessment(TBD)
- Academic progress over time(OAKS
- Absenteeism – specifically fewer than 18 days in 6th grade
- 3rd grade reading and math scores(OAKS)
- 8th grade algebra (and/or other standardized test scores?)
- Credits earned in 9th grade
- High School graduation or completion rates (including GEDs)-(need to decide 4 or 5 year rate)
- College credits earned in high school(per student)
- Work skills, attitudes and/or behavior(needs better definition)
- Life skills and problem solving skills(needs better definition)

Economic Status and Environment

- Number of children in free and reduced lunch program
- Median household income, per capita income, SES, SAIPE
- Poverty rates
- TANF,
- Food Stamps,
- Child Care Subsidies
- Food insecurity
- free and reduced lunch rates
- One day homeless count, school age homelessness(ad hoc data only available)
- Housing conditions(needs better definition)

Work Status (occupations and, jobs per capita)

- Employment opportunities for living wage jobs(needs better definition)

## Data Snapshot

- The number of school districts meeting or exceeding the state benchmarks in reading and math varies by county. All school districts met or exceeded the 3rd grade reading benchmark. Only Bend-La Pine and Sisters school districts met or exceeded 3rd grade math benchmark. Bend-La Pine, Sisters, and Culver met or exceeded the 8th grade math benchmark. Jefferson County SD was well below the Oregon target of 70% for both 3rd and 8th grade math (2010-2011)
- Graduation rates (4 year cohort) for Central Oregon school districts were as follows: Crook County 67%, Jefferson County 57%, Bend – La Pine 68%, Redmond 49%, and Sisters 80% *Redmond School district 4 year graduation rate may be low due to participation in the Advanced Diploma
- The percentage of children living at or below the federal poverty level for Crook, Deschutes, and Jefferson Counties are 29%, 22% and 34%, respectively
- The percentage of children qualifying for free and reduced lunch for Crook, Deschutes, and Jefferson Counties are 61%, 52% and 80%, respectively

- Jefferson County has the highest percentage of children on free or reduced lunches in the state, while having the lowest percent (72%) of 3rd graders meeting the state benchmark (in 2009-2010)
- 2,271 people were reported homeless during the tri-county One Day Homeless count on January 27, 2011 (down from 2,401 in 2010)
- Nearly half of those experiencing homelessness during the 2011 count were under age 18 (significantly higher than 2010)
- The number of homeless pregnant and parenting teens under 18 decreased significantly from 19 to 7 between 2010 and 2011
- 20% of those experiencing homelessness report as disabled, a majority of whom stated that they suffer from a psychiatric disability
- In nearly all categories, Hispanic and Native America populations were over-represented

## Goal 1: Improve Education Success for all Central Oregon Students (with emphasis on those experiencing disparities)

Organizational Strategies

- Provide training to develop a community and education workforce, working together, that is not only more aware of the social determinants of health and what they can do to address inequities

Community Strategies

- Convene and/or support local partnerships among tri-county region public health agencies, community-based organizations, ESDs, and local school districts to support health improvement strategies for students

Public Policy Strategies

- Support educational success as a primary means of reducing child poverty and improving children's health (e.g. through School Based Health Centers, OHP application assistance for qualified uninsured children and Community Schools)

## Goal 2: Address Basic Needs, Living conditions and Environments

Organizational Strategies

- Develop a simple tool that quickly gathers basic needs and living conditions
- Use community health workers or other supports to help patients connect with organizations to meet basic living needs

Community Strategies

- Continue to let the community know about food insecurity needs through media
- Support food banks and other food distribution centers to assist people meeting some of their food needs
- Promote healthy environments for local income housing
- Find ways to support people in housing to reduce homelessness

Public Policy Strategies

- Public and non-public organizational policies must take into consideration the basic needs and healthy environment for the residents

## Goal 3: Increase Number of Living Wage Jobs in the Region

Organizational Strategies

- Organizations should evaluate their salary and benefits to see if it meets the living wage standard

Community Strategies

- Encourage the economic development of living wage jobs
- Economic development organizations and groups must addressing living wages in their establishment and recruitment of new businesses

Public Policy Strategies

- Promote livable wage jobs as a part of economic development plans
- Counties, cities and chamber of commerce's must continue to collaborate and where appropriate consolidate their efforts in pursuing business that provide living wage jobs

# Increase Access

## Indicators and Metrics

Health services, medical care

- Number and percentage of population with medical insurance(ad hoc data only)
- Number and percentage of population with a primary care provider(BRFSS-but old data)
- Under and uninsured(data not available)
- Capacity and availability of care, services and resources(needs better definition)
- Hours of operation, wait time, wait lists
- Challenges for specific populations: adults/seniors, multicultural(needs better definition)
- Well trained work force (including cultural awareness training(needs better definition)
- Outpatient utilization
- Emergency room utilization

Physical environment

- Geographic isolation(distance to health care facility)
- Transportation challenges

## Data Snapshot

- In Crook and Jefferson Counties, an estimated 12.3 to 19.1% of all residents are uninsured. In Deschutes County an estimated 12.2 to 18.6% of all residents are uninsured
- Those individuals (ages 19-64) who make two times the Federal Poverty Limit or less have the highest rates of uninsured
- The percent of uninsured children (18 years and younger) in Crook and Jefferson Counties is estimated to be 9.7%, while percent in Deschutes County is 4.1%

## Goal 1: Increase Access to Quality Health Care (with emphasis on those experiencing disparities)

Individual Strategies

- Address geographical barriers (transportation, bringing services to isolated individuals)
- Promote individual utilization of self-management approaches to health care conditions

Organizational Strategies

- Make services available outside of normal work hours, including weekends

- Implement Patient Centered Medical Homes in Primary Care settings and increase use of Health Engagement Team to support primary care
- Evaluate the need for and access to primary care providers
- Increase use of telehealth to make use of specialty care more efficient and effective and increase access to such care in rural areas
- Use community outreach workers, peer support mentors or community health workers to identify and intervene on barriers to accessing medical and behavioral health Services
- Assure quality, timely access to reproductive health services as a part of implementing healthcare reform

Community Strategies

- Safety Net services engaged in collaborating with health care services.
- Identification of and intervention with barriers to accessing medical and behavioral health services
- Increase community wide development of population self-management programs like the Living Well Program
- Seek funding for uninsured that would help fund a primary care provider position, like at Volunteers in Medicine (VIM)
- For uninsured, recommend providers, hospital and others explore joint fund financial contribution to strengthen ShareCare Program
- Develop a system to assure Oregon Health Plan (OHP) members have access to needed behavioral health services
- For OHP, embed access improvements and incentives with individual Central Oregon Independent Practice Association (COIPA) provider agreements and improvements with other providers such as St. Charles, Bend Memorial Clinic and others
- Promote access and support School Based Health Centers

Public Policy Strategies

- Support maintenance of current funding for access to health care coverage through Oregon Health Plan and School Based Health Centers

# Improve Health

## Early Childhood Wellness (prenatal through age 6)

### Indicators and Metrics (within five domains)

Maternal and Child Health:

Prenatal care by first trimester
smoking during pregnancy,
post-partum depression(PRAMS)
birth weight,
breastfeeding rates
immunization rates,
child abuse

Language and Literacy: Age appropriate vocabulary, key literacy measures(need better definition)

Social/Emotional Development: Quality early childhood care and education settings including child care and preschool, healthy attachment, behavioral indicators for school readiness, cultural identity(need better definition)

Parent and Family Support: Family and parent involvement, realistic parental expectations and interactions, family stability, role and engagement of father figure(need better definition)

Cognitive Development: Problem solving abilities, age appropriate cognitive ability, adaptability(need better definition)

## Data Snapshot

- Over the past ten years, the rates of low and very low birth weights in the tri-counties have usually exceeded the state rate. From 2000-2009, these rates were as follows: Crook County 51.05, Deschutes 57.93, Jefferson County 66.24, per 1,000 live births
- The percent of live births with adequate prenatal care is better than the state rate in Crook and Deschutes Counties. In Jefferson County, the percent of live births with inadequate, late, or no prenatal care is well above the state rate, indicating a problem area
- The percentage of births to unwed mothers in 2009 in Oregon, Crook, Deschutes, and Jefferson Counties were 35%, 34%, 30%, 49%, respectively
- Percent of WIC moms who started out breastfeeding was as follows: Crook County 83%, Jefferson County 90%, and Deschutes County 94% (2010)
- The percent of live births with maternal alcohol, tobacco, or illicit drug use varies by county. In Crook County, maternal tobacco use is problematic, while Jefferson County struggles with maternal alcohol use. Deschutes County numbers are similar or better than the state rates with regard to all three behaviors
- The 2010 rate of teen pregnancy (per 1,000 females ages 10-17) is higher than the state rate (7.3) in Jefferson County (13.4), but lower than the state rate in Deschutes County (6.1). Due to privacy regarding small numbers, Crook County rates are not reported, however health professionals in that area have identified this as a concern
- The prevalence of childhood serious mental illness (< age 18) is 13% in Warm Springs, 12% in Jefferson County, 11% in Crook County, and 10% in Deschutes County (2008)
- The two year old immunization rates were as follows: Crook County 76%, Deschutes County 69%, and Jefferson County 77%. The state rate is 73%. There is a public health concern in Deschutes County due to the growing number of parents who are opting out of some or all immunizations for their children
- The state is in the process of developing assessment tools that will measure language/literacy development, cognitive development, and social emotional health, and family support
- The state is in the process of developing a tiered quality rating and improvement system that will help assess quality in early care and education settings

## Goal 1: Develop and Coordinate Early Childhood System Data Collection and Services

Organizational Strategies

- Develop universal screening and data collection systems for prenatal through six year olds that integrate with regional system(s) including recommendations for a unified and coordinated system for tracking, compiling, analyzing, and summarizing data
- All children 0-5 years of age will be screened in all five domains at pre-determined intervals (tools and intervals defined by the state) through well baby checks

Community Strategies

- Support early childhood programs which implement and evaluate early childhood wellness media campaigns

*"Providing developmental assessments and intervention services for young children experiencing significant adversity before they exhibit problems in their behavior or development will increase their chance for more positive life outcomes."*

***National Scientific Council on the Developing Child***

- Coordinate support for families across Early Learning and Health Care Systems through Family Resource managers and Community Health Workers
- Need a demographic picture, using data, of enrollment in early childhood programs (ECP)
- Need data to address location and accessibility to ECP
- Make sure, based on the data, that the ECP are culturally competent
- Conduct assessment to determine whether evidence based curriculum being used and whether ECPs are effective in preparing children for school

## Goal 2: Improve Coordination and Quality in Early Childhood Care and Education (ECE) Settings

Interpersonal Strategies

- Educate parents about the importance of quality in ECE settings and what standards to look for so they will expect and demand quality

Organizational Strategies

- Implement best practices in ECE settings
- Pursue continuing education or accreditation for ECE providers

> *"High quality care is associated with children's positive development of language and cognitive function, social skills, and emotional well being."*
>
> ***The Economic Impact of Oregon's Child Care Industry, 2010***

Community Strategies

- Increase involvement from the business community in supporting early childhood programs as an economic development strategy
- When available, utilize Kindergarten Readiness data to identify origin of children who arrive "not ready"; offer and/or require remediation (and technical support) for providers with children from their facility that are arriving unprepared or not meeting standards
- When available, utilize the Tiered Quality and Improvement Rating System to monitor and assess quality in ECE settings
- Continue to incorporate integration of WIC services as a part of the health and education transformation framework and planning

Public Policy Strategies

- Promote policies to increase quality standards for providers. Support and monitor development and implementation of improved quality child care standards
- Provide comparative data on facilities
- Fund child care assistance programs adequately such as Employment Related Day Care (ERDC)

# Safety, Crime and Violence Prevention

## Indicators and Metrics

Child (0-18)

- Child abuse rates

- Assault and violent crime rates
- Runaway and homeless youth(ad hoc one night data)
- Bullying incidents
- Pro-social skills and behaviors(needs better definition)
- Life skills and problem-solving skills(needs better definition)
- Juvenile crime rates and indicators, , referrals and/or suspensions for delinquent behavior
- % of youth not entering or moving further into the juvenile justice system at 6 month and 1 year assessments
- % of youth with reduced risk factors as measured by the JCP Risk assessment at 6 mo. and 1 year assessments
- Foster care rates

Adult

- Domestic/interpersonal violence
- Assault
- Elder abuse rates

## Data Snapshot

- The total crimes rate (per 10,000 population) was lower in each county than the state rate of 338, although by county ranking Deschutes ranked 3rd with 337, Jefferson ranked 12th with 268, and Crook ranked 31st with 68 (2010)
- The violent crimes rate (per 10,000 population) was lower for each county than the state rate during 2008-2009. Deschutes County exceeded the state rate in 2010. County ranking indicate Deschutes ranked 4th with 31, Jefferson ranked 24th with 7, and Crook ranked 21st with 10 (2010). The state rate was approximately 23.
- The juvenile arrest rate was higher in all three counties as compared to the state rate between the years 1990-2008. In 2008 and 2009, however, the county rates were the same or better than the state rate. County ranking indicate Deschutes ranked 9th with 203, Jefferson ranked 16th with 155, and Crook ranked 14th with 172. The state rate was 200 (2009)
- 2010 reversed a five year downward trend in child abuse and neglect victim rates in Deschutes County. Crook and Jefferson Counties have also experienced increased rates in the past two years. The rate per 1,000 children was 9.5 in Crook County, 8.1 in Deschutes County, and 13.3 in Jefferson County. The state rate was 12.7 (2010).
- The foster care rate per 1,000 children was 5.0 in Crook County, 3.6 in Deschutes County, and 7.5 in Jefferson County. Deschutes and Jefferson Counties experienced an increase in point in time rates from 2009-2010 while at the same time experiencing an increase child victim rates
- Nearly half of the people identified at last year's Regional One Night Count were under the age of 18. Out of those 1,032 youth, 189 were unaccompanied youth or not living in the physical or financial care of their parent or guardian. In this region there are 49 beds that are youth specific. That is 140-bed discrepancy from the count
- Current 30 day waiting list for only homeless shelter serving youth in the region. A $50,000 federal grant for staffing and basic needs supplies for the Street Outreach Program was not renewed resulting in further decline in capacity to serve runaway and homeless youth at time when need has increased

**Regional Homeless Student Count by School District 2010-2011**

| | | |
|---|---|---|
| Bend La Pine | 726 | 4.6% |
| Crook County | 40 | 1.4% |
| Culver | 47 | 7.4% |
| Jefferson | 94 | 3.4% |
| Redmond | 235 | 3.4% |

| | | |
|---|---|---|
| Sisters | 35 | 2.7% |

- Average age of runaway and unaccompanied youth served at Cascade Youth and Family Center is age 15, 53% are female, 46% male and 1% transgendered
- Top Problems (self reported by youth): parent/ youth conflict, neglect, substance abuse by the adult caregiver and/or poor school attendance and behind in credits to graduate

## Goal 1: Decrease Child Abuse and Neglect

Community Strategies

- In Spring/Summer of 2012, convene Central Oregon child abuse prevention teams and regional partners to review current data trends, issues and barriers related to child abuse in the tri-county area. Develop local and regional plan and strategies to reduce child abuse and neglect in Central Oregon
- Continue to identify resource development opportunities to fund and address identified needs and service providers working to decrease child abuse
- Community and providers in the region engage in child abuse prevention training, such as Darkness to Light Training

Public Policy Strategies

- Enforce policies, such as mandatory reporting and safety protocols, in order to decrease child abuse
- Enforce staff background checks for "recorded" facilities
- Change zoning and / or licensing regulations to meet the needs of providers
- Work with policy makers in the tri-county area to advance the awareness of the lifetime social and economic impact of child maltreatment, to ensure support for programs proven to reduce child maltreatment (i.e. Nurse Family Partnership, Healthy Families)

## Goal 2: Reduce Incidence of Domestic and Interpersonal Violence (including elder abuse)

Community Strategies

- In Spring/Summer of 2012, convene the tri-county domestic and interpersonal violence prevention partners and service providers to review current data trends, issues and barriers related to interpersonal violence in the tri-county area. Develop local and regional plan and strategies to reduce interpersonal violence in Central Oregon
- Continue to identify resource development opportunities to fund and address identified needs and service providers working to decrease interpersonal violence and elder abuse

## Goal 3: Improve Safety for Runaway and Homeless Youth

Individual Strategies

- Provide emergency and transitional shelter
- Promote and make available evidence-based Life Skills training
- Provide needed educational and social services (e.g. drug and alcohol assessment and treatment, tutoring, medical and dental care)

Community Strategies

- Create a drop-in center for homeless, independent youth or youth who are on the verge of becoming homeless
- Continue to promote, support and expand Community School initiatives as a poverty prevention strategy that provides supervision during non-school hours and as a strategy proven to improve academic achievement

## Goal 4: Develop Regional Strategies to Reduce Juvenile Crime

Individual Strategies

- Provide individual group opportunities in skill development for youth 11-17, to include Girls Circle, Boys Council, etc.
- Provide individualized case management to youth 11-17 with three or more risk factors to decrease further involvement in juvenile justice system

Community Strategies

- Provide community service/involvement opportunities for youth 11-17 involved in Juvenile Crime Prevention Programming

Public Policy Strategies

- Development of regional Youth Council structure to provide accountability and advocacy for JCP and Youth Investment funding for region

# Improve Preventive Care and Services

Prevention services are both individual based and population based and must recognize the cultural uniqueness of an individual and community, must be based on data and must engage youth, parents, adults, other community members, providers and other community partners.

## Indicators and Metrics

- 2 year old immunization rates
- Influenza Immunization Rates(APACD)
- Pneumonia Immunization Rates(APACD)
- Teen pregnancy rate
- Chlamydia rates
- HIV rates
- Percentage of reproductive age women using effective contraceptive method(not available)

## Data Snapshot

- The two year old immunization rates were as follows: Crook County 76%, Deschutes County 69%, and Jefferson County 77%. The state rate is 73%. (2010). There is a public health concern in Deschutes County due to the growing number of parents who are opting out of some or all immunizations for their children. Deschutes County's kindergarten religious exemption orate of 9% for the 2010-2011 school year is substantially higher than the state average of 5.6%
- The 2010 rate of teen pregnancy (per 1,000 females ages 10-17) is higher than the state rate (7.3) in Jefferson County (13.4), but lower than the state rate in Deschutes County (6.1). Due to privacy regarding small numbers, Crook County rates are not reported, however health professionals in that area have identified this as a concern
- The aggregated incidence rate (per 10,000 population) for chlamydiosis, 2005-2010, is 21.67 for Crook County, 25.7 for Deschutes County, and 42.81 for Jefferson County
- The aggregated incidence rate (per 10,000 population) for gonorrhea, 2005-2010, is .97 for Crook County, .54 for Deschutes County, and 2.66 for Jefferson County
- The number of cases (per 100,000 population) of persons living with HIV or AIDS in 2010 were as follows: Crook County 0-26.4; Deschutes County 26.5-53.9; Jefferson County 26.5-53.9

## Goal 1: Improve Immunization rates in Central Oregon

Individual Strategies

- Provide education to new parents about the benefits of immunizations (in the hospital through Healthy Start or NFP, at the pediatrician's office, at WIC)
- Provide education and training to clinic staff on quality improvement activities to increase clinic immunization rates

Organizational Strategies

- Require immunizations for enrollment in childcare and preschool settings
- Mitigate refusal rates for immunizations for education setting (K-12)
- Ensure easy and affordable access to immunizations through school based health centers and private clinics
- Promote adult vaccination for flu, pneumonia, and shingles
- Provide education about the benefits of immunizations (in the hospital through Healthy Start or NFP, at the pediatrician's office, at WIC) and through primary care provider
- Leverage electronic medical record (EMR) reporting capabilities to allow for better tracking and outreach within the primary care setting and could EMR be integrated with ALERT system

Community Strategies

- Inform the public, through traditional media, social media, school newsletters, and tabling at children focused events about importance of immunizations
- Maintain a strong immunization coalition that includes representatives from private and public clinics
- Clear provider consensus on communication with patient on recommended immunizations

Public Policy Strategies

- Enforce policies to ensure immunizations
- Partner with Oregon Health Authority to strengthen immunization laws

## Goal 2: Communicable Disease (CD) Prevention – Seven days per week response for CD investigation, community education and intervention

- Maintain practice and standard of a seven day a week response capability for communicable disease investigation, responding and implementing control measures for reportable diseases
- Maintain Tuberculosis case management to provide care and service management and to assure communication with the patient's primary care physician
- Make available, through multiple media sources, information to the public about communicable diseases and their prevention
- Increase testing of Chlamydia
- Increase HIV testing – standard screening

## Goal 3: Strengthen Family Planning Services and Reduce Teen Pregnancy

Organizational Strategies

- Use the public health referral cheat sheet for family planning
- Develop guidelines for prescribers in public health services
- Maintain the family planning services, primarily through public health, for sexually active teens
- Maximize resources for family planning medications to increase access

- Increase outreach for women in need for reproductive health services

Public Policy Strategies

- Evaluate our drug prior authorization policy

# Chronic Disease Prevention

## Indicators and Metrics

- Obesity rates
- Physical activity rates
- Controlling high blood pressure(not available except MRR for Medicare)
- Cholesterol screening percentages
- Asthma rates(DMAP)
- Death rates
- Living Well participants(needs better definition)
- Breast and cervical cancer screening
- Breast cancer rates
- Diabetes rates
- A1C checked annually(not easily available)
- Pulmonologists, or Allergists-Controller/Rescue Ration>=.45% among asthmatic patients
- Number of patients participating in colorectal and mammogram cancer screenings
- Primary Care sensitive hospital admission for chronic conditions (diabetes, asthma, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease)

## Data Snapshot

In the last 65 years, adult chronic disease has grown into the main health problem for industrialized nations. Cardiovascular disease, cancers, diabetes and chronic obstructive pulmonary disease account for at least 50 % of the global mortality burden. In Central Oregon, chronic diseases are the leading causes of death for each county. Crook County's age-adjusted prevalence of adults with high blood pressure is 46.2%, significantly higher than 25.8% of adults for all of Oregon. Exposures, modifiable behaviors, and risk factors all play a role in the development of chronic disease in later life.

## Goal 1: Improve community health and wellness

Individual

- Access information resource Centers Wellness media campaigns through print, radio, or television

Community Strategies

- Public education on mental health, suicide prevention & intervention, and physical health (i.e. workshops, seminars, classes)
- Promote and raise awareness for healthy decision-making (i.e. activities supporting bullying prevention, suicide prevention, problem gambling prevention, obesity prevention, gender specific activities, cultural diversity activities, and health & wellness activities)

Organizational Policy Strategies

- Consider organizational policy strategies that promote health and wellness of employees

Public Policy Strategies

- Assess, promote and improve access to healthy lifestyle choices (i.e. biking to school/work, healthy food options at school/work/community)
- Consider other public policies that will contribute to improving mental health and physical health
- Promote safe fund in the public arena to maintain wellness

## Goal 2: Cardiovascular Disease Prevention

Individual Strategies

- Promote exercise and healthy diet
- Monitor to see that lab screening is done
- Annual physical exams with Primary care Provider for risk management as well as early identification and treatment of hypertension and hyperlipidemia

Organizational Strategies

- Complex Care and Advanced medical management
- Care coordination
- Promote individual prevention or self-management of cardiovascular disease through patient education, like the "Living Well Program", and through engaging patients as active participants in the development of their treatment plan
- Assure that appropriate lab screening is completed and reviewed with the patient

Community Strategies

- Community education and prevention that focus on healthy diets at all ages and the value of exercise
- Accessible, affordable smoking cessation programs
- Community education, with cultural considerations, focusing on nutrition and healthy food choices

Public Policy Strategies

- Promote policies that make walking easier and safer
- Explore the possibilities of other environmental factors that may contribute to cardiovascular disease

## Goal 3: Cancer Prevention

Individual Strategies

- Promote reminders and ease of access to follow up care
- Promote the use of sun screen and other protectors from over sun exposure
- Annual physical exam with Primary Care Provider

Organizational Strategies

- Care coordination and use of community health workers
- Develop and promote good electronic health information exchange that promotes collaboration and coordination of care
- Leverage electronic medical record systems within the primary care setting for tracking and reminder/outreach to patients for timely screening and exams

Community Strategies

- Promote community prevention and early intervention through community education
- Promote mammograms and Pap smears as good preventive screening
- Develop a Task Force to consider focused project(s) to improve colon cancer screening
- Provide known care gaps to PCPs regarding breast cancer

Public Policy Strategies

- Examine policies that may contribute to environmental factors that contribute to cancer
- Coordinate and enhance Media Blast

## Goal 4: Complex Care

Community Strategies

- Develop a comprehensive complex care strategy (CCCS)
- Develop a detailed business and operations plan, as a part of the CCCS, for a freestanding complex care center
- Develop short term opportunities into successes of a comprehensive complex care strategy for Central Oregon
- Self-Management skills is a part of complex care strategy, Living Well is an example a evidence based program

# ALCOHOL, TOBACCO AND OTHER DRUGS

## Indicators and Metrics

- Youth 30-day marijuana, tobacco, alcohol and prescription drug use
- Adult current tobacco use (including prenatal tobacco use)
- Prenatal tobacco use
- Tobacco use in Coordinated Care Organization members
- Use of SBIRT(what contests, frequencies by individual or by visit or by agency)
- Death from alcohol induced disease

## Data Snapshot

- Central Oregon has the highest rate of current alcohol consumption, teen consumption and overall alcohol dependence, as compared to the State
- Rate of death from alcohol induced disease is of particular concern. Jefferson County is statistically significantly higher than the State rate and has been for several years.
- Central Oregon youth have a high rate of "new" users of marijuana smoking
- Amongst youth, prescription drug use trend has had a notable increase

30-day Use by Drug Type. 2010 Oregon Student Wellness Survey

| | Crook | | Deschutes | | Jefferson | |
|---|---|---|---|---|---|---|
| | 8th | 11th | 8th | 11th | 8th | 11th |
| Alcohol | * | 43.4 | 24 | 41.6 | 20.9 | 39.4 |
| Marijuana | * | 21.4 | 13.2 | 25 | 14.3 | 16.1 |
| Prescription Drugs | * | 12.7 | 4.9 | 6 | 2.7 | 9.6 |
| Cigarettes | * | 22.4 | 8.8 | 12.5 | 9.3 | 19.7 |
| Other tobacco | * | 24.3 | 5.2 | 13.3 | 10 | 23.4 |

*sample size too small to

- The chart displays 30-day use rates by drug category for 8th and 11th graders in each respective County. As noted in yellow some rates are statistically significantly higher than the State of Oregon.

## Goal 1: Reduce Alcohol / Tobacco / Other Drug Use

Individual

- Access to information resource centers
- Media Campaigns through print, radio, or television

Community Strategies

- Central Oregon will actively engage and support coalitions through facilitation and technical assistance to implement the Strategic Prevention Framework model and evidenced based strategies as well as support resource development (i.e. enforcement of underage drinking laws such as minor compliance checks)
- Public education and training on substance use/abuse (i.e. workshops, seminars, classes)
- ATOD-Free activities support (i.e. ATOD-free activities, events, Fair, Red Ribbon, after school activities)
- Youth education & involvement (i.e. drug prevention curriculum in schools, youth leadership, youth coalition efforts)

Public Policy Strategies

- Policy leaders will coordinate implementation and enforcement of consequences as outlined in alcohol, tobacco, and other drug (ATOD) protocol
- Develop a regional approach to comprehensive prescription drug drop off sites in every county
- Resource and referral development (i.e. Tip Box, Tip Line, Text Line, CRT)
- Work with regional partners to establish 100% tobacco free policies at all educational centers and government properties (state and local)
- Resource and referral development (i.e. Tip Box, Tip Line, Text Line, etc.)
- Increase policy efforts to reduce exposure to secondhand smoke where community members live by working with all multi-unit housing properties in the tri-county region to voluntarily go smoke free, with a priority on the local housing authority
- Consider other public policies that will reduce ATOD use and related issues

# BEHAVIORAL HEALTH AND SUICIDE PREVENTION

## Indicators and Metrics

- All-age suicide death rate
- Suicide ideation measures (Oregon Student Wellness Survey)-is data available and consistent

## Data Snapshot

- Oregon suicide rates have been higher than national rates for two decades in tri-county region
- Total number of suicides from 1993-2010 have been 69 for Crook, 398 for Deschutes, and 66 for Jefferson counties respectively

## Goal 1: Utilize Evidence Based Strategies to Reduce Suicide Risk Factors

Individual Strategies

- Increase the public's awareness of how to help someone at-risk for suicide by providing suicide prevention presentations

Community Strategies

Develop a regional approach to suicide education using evidenced based strategies in order to prevent and reduce suicide attempts and completions

# Oral Health

## Indicators and Metrics

- Number of children K-5 with untreated tooth decay(need better definition)
- Number of emergency department visits showing dental codes
- Number people treated in hospital operating room for dental diagnosis
- Students graduating from high school with no tooth decay(need better definition)

## Data Snapshot

- 2010 29% of K-5 children in Crook County has untreated decay
- Less than 50% of Oregonians have at least one dental visit a year let alone a preventive visit
- Fee for service dentistry leads to focusing on "sick care" service delivery model
- Upwards of 40% of Oregonians either do not have the ability or the resources to access traditional restorative/replacement dental care
- Access to dental care is challenging due to the limited number of providers who participate in the Medicaid Program

## Goal 1: Improve the Dental Health of Children, Youth, and Adults

Individual Strategies

- Care of teeth through brushing, eating right and regular preventive check ups
- Teeth varnish on 12 month old
- 1st grade and 6th grade students get sealants

Organizational Strategies

- Create dental homes in every community
- Conduct primary care provider (PCP) education so that fluoride varnish could be done in the PCP office
- Improve education and coordination between dentists and medical care providers regarding importance of dental care during

Community Strategies

- Promote values of children getting good care of teeth through preventive strategies including fluoride varnish and distribution of Tooth Tool Kits to K-8.
- Provide community education on the need for pregnant women to care for their teeth which in turn helps their unborn child

Public Policy Strategies

- Promote healthy access to school snacks

# Healthy Environments

## Indicators or metrics

- Number of food borne disease outbreaks(counts and rates)
- Air Quality Index Exceeding 100
- Number of water borne disease outbreaks
- Number of times land use plans and housing developments address health issues in their plans(needs better definition)

## Data Snapshot

- One in six Americans get a food borne sickness
- 3000 Americans die each year from food borne infections
- Food borne infections caused by bacteria, viruses and parasites not toxic substances
- Built environments can include in the design physical activity components that because of the activity will prevent diseases and prolong life
- Physical inactivity and poor diet cause estimated 400,000 deaths annually from chronic diseases in the United States in 2000

### Goal 1: Improve the Quality of Air, Water, and Food

Individual Strategies

- Promote carbon monoxide dictators in all homes to protect and improve health
- Encourage radon testing in all homes where geology indicates there is a threat

Community Strategies

- Protect the quality and quantity of drinking and sub-surface water
- Reduce exposure to food to air, water and hand borne-contaminants
- Built environments, land use planning and housing plans must include the health impact of the plan and include it in the decision making processes for permits
- Maintain public health food inspection programs to aid in safe food for public consumption assuring adequate and trained sanitarians for licensure, inspection and enforcement
- Maintain current practice of investigating complaints and cases of foodborne illness
- Support use and sale of locally grown fruit and vegetables as a means of promoting freshness and quality

# Improve Health Care and Service Delivery

## Indicators or Metrics

- Number and growth of patient centered homes
- Number of Integrated quality councils promoting collaborative quality improvement
- Use of telehealth in chronic care cases
- Rural areas with telehealth care being provided

- Quality and efficiency in service delivery(need better definition)
- Consumers being actively involved in their care(need better definition)
- Customer feedback on satisfaction with service

## Data Snapshot

- Telehealth can improve the care for persons with chronic health conditions living in isolated areas
- Patient centered homes provide coordinated care for the whole person
- Consumer input and involvement in their care will improve care and their attitude about their care
- Joint stakeholder quality groups or councils can be effective in identifying systematic issues that impact deliver of quality care and quality educational services

## Goal 1: Promote and Develop Systems for Consumers or Customers to Express Their View on Their Care Experiences

Individual Strategies

- Collect quarterly feedback on consumer/customer perception of care from across the system with leadership provided by the Coordinated Care Organization (CCO)
- Encourage consumer/customers to submit grievances about the care they have received to the CCO
- Develop electronic reminders to consumers/customers of needed action and appointments to improve engagement in care

## Goal 2: Support and Encourage Family, Friends and Peers to Participate and Support Care Being Given to a Consumer/Customer

Interpersonal Strategies

- Encourage and simplify confidentiality releases that support and encourage family, friends and peers to be present with medical providers and others in the treatment of an individual
- Provide immunization clinics that are convenient for families

Organizational Strategies

- Promote care that is patient and family-centered, meaning that patients and families are active participants in their care
- Use quality councils to continuously improve care

## Goal 3: Promote Best Practices and Safe Practices in the Delivery of Health Care in Community, Public and Private Agencies

Organizational Strategies

- Assure there are quality standards that are available and used to evaluate the delivery of safe practices
- Assure that organizations have internal policies and practices that review best and safe practices
- Utilize system wide quality care councils to review practices throughout the system
- Sustain and continue to report on essential public safety programs and services throughout the region including 24/7 crisis services, Crisis Intervention Training, work with treatment and drug courts, support, where feasible, addiction treatment in jails and correction programs, and civil commitment processes
- Build community resilience through emergency preparedness planning and practice in the region
- Promote the use of Patient Centered Home
- Recognized the value of telehealth in improving care and service delivery for persons with chronic care conditions

- Promote coordination of care throughout the system to assure comprehensive care within the medical care community and between medical care, behavioral health and other safety net providers

### Goal 4: Promote and Develop Quality Review Groups that Utilize Consumers/Customers in the Evaluation of Care

Community Strategies

- Coordinated Care Organization will appoint a consumer/customer advisory committee to help assess and improve care
- Behavioral Health Organization will work with a citizen advisory group including consumers/customers to help assess and improve the delivery of mental health, developmental disability and substance abuse services
- The needs of long term care consumers will be integrated in the comprehensive system of care for Central Oregon
- Create an Integrated Regional Quality Care Council through the Central Oregon Health Board (COHB) to enhance regional quality improvements
- Work to implement electronic health records across the region in all health care providers and other social service or safety net providers as appropriate
- Create an Early Learning Council on a regional basis through the COHB to better integrate early education and improved health of children

### Goal 5: Health Council and Health Board will Monitor Compliance and Manage Risk in Collaboration with the Coordinated Care Organization

Public Policy Strategies

- Council and Board will utilizes professional and clinical advisory committees to assist them in compliance and managing risk

# Reduce Cost and Increase Effectiveness

## Indicators and Metrics

- Decrease in per patient care costs
- Patients return to hospital with 30 days
- Inappropriate use of emergency room
- The development of a new payment model(need better definition)
- Number of preventable hospital stays
- Percentage reduction in inappropriate use of emergency room by persons with a chronic health problem and mental illness
- Reduction in Oregon Health Plan (OHP) per patient cost of care

## Data Snapshot

- Individuals with a chronic health problem and mental illness use the emergency room inappropriately
- The OHP per patient cost in Central Oregon is the highest in the State
- Fee for service payment system is a disincentive to providing whole person health care leading to fragmented care
- Early intervention in cases of early psychosis reduces the long term disability

## Goal 1: Engage Consumers in Manner that Improves Their Satisfaction with Care and in Turn Encourages Them to Follow the Care Plan

Individual Strategies

- Educational efforts through the primary care provider and other educational media will provide guidance to consumer/customer in helping reduce cost and make their primary care more effective

Organizational Strategies

- Organizations will engage their customers in ways that help them reduce their health care costs and promote effective use of the care being provided
- Connect with consumer/customer in a manner that engages the individual in care to reduce inappropriate use of the emergency room

Community Strategies

- When screening tools are developed by the state, work with tri-county providers to develop a system to coordinate and ensure universal screenings of all pregnant women and children 0-5
- Use coordinated care strategies to engage individuals in the emergency room that have a wide range of needs that are not being met and contribute to their inappropriate use of ER
- Develop and strengthen Assertive Community Treatment teams to address the support and structure needs of chronic behavioral health clients in collaboration and coordination with community health workers
- Reduce symptoms of psychosis, mental health crises and hospitalizations by maintaining and expanding the Early Assessment and Support Alliance throughout the region

## Goal 2: Develop New Funding and Payment Structures that Support and Address the Whole Person Thus Increasing Satisfaction, Reducing Cost, and Improving Care

Community Strategies

- Establish a reimbursement model, new payment structure in a manner that supports the Health Engagement Team deployment and allows its partners to realize administrative simplifications

Public Policy Strategies

- Promote the key components of the Triple Aim which are reduce per-capita health costs, improved consumer/customer satisfaction and improved care

# Increase Health Integration and System Collaboration

## Indicators and Metrics

- Oregon Health Plan members are able to access a wide range of services(need better definition)
- Use of social media to communicate health information(need to define source for data)
- Use of technology to communicate with consumers about care issues or reminder appointments(needs to be better defined)
- Advanced Illness Management Task Force activity

- Youth at Risk Task Force developed and meeting
- Communication system between care providers regarding consumer care and treatment is in place and efficient
- Percentage of primary care providers who report no difficulty in obtaining specialty care, including behavioral health, for members

## Data Snapshot

- Care is fragmented and not coordinated
- Consumers not having a primary care provider
- Social Media is becoming a ready source of information for consumers
- Coordination of care hindered by challenges of technology not protecting privacy
- Services to youth at risk and runaway youth need improved coordination and better collaboration
- Long term care is growing but is not coordinated as effectively with the health delivery system and as a part of the Advanced Illness Management process

## Goal 1: Develop Task Groups that Look at Combining Activities, Services and Care by Promoting Coordinated Care and Resource Development

Interpersonal Strategies

- Utilize the social media to improve health integration of treatment and service plans with the consumer/client

Organizational Strategies

- Develop ways of communicating electronically with clients and community providers to improve integration and collaboration in consumer and client care

Community Strategies

- Identify, develop and pursue public and private resources to address needs of runaway and homeless youth
- Reconvene prevention task force to coordinate efforts between social service organizations and public and private providers
- Develop and implement a task group to develop a coordinated, early identification and intervention system for students identified as at-risk and include addressing runaway and homeless youth
- Convene the Child Abuse System Task Force and regional partners to develop strategies to reduce child abuse and neglect in Central Oregon
- Regional participation in the Advanced Illness Management Workgroup in Bend to develop practice and program recommendations around primary, specialty, palliative, hospice and in-home care
- Continue and further collaborative efforts to provide needed food to residents in the region

## Goal 2: Develop Improved Integration and Collaboration Between Behavioral Health and Primary Care

Organizational Strategies

- Timely access to behavioral health and substance abuse treatment/services regardless of payer type or insured status
- Open communication between BH providers and Primary Care Providers to ensure a collaborative approach to patient treatment, appropriate medication management, and continuity of care

- Promote cost-effective treatment through use of generic medications when clinically appropriate
- Collaborate with community partners to develop a maternal mental health system which provides prevention, screening and treatment for women at risk

### Goal 3: Develop Supports that Aid Schools in Addressing, with the Support of the Community and Parents, the Physical, Social and Environmental Barriers that Create Health Disparities

**Public Policy Strategies**

- Support passage of legislation that funds districts and schools to assess and address physical, social and environmental health barriers that impede learning (must include funding)

### Goal 4: Engage the Community in Understanding, Acknowledging, and Collaborating in Promoting Health Equity

Public Policy Strategies

- Better use of a variety of public and social media to not only broadcast health information, but to engage the community in understanding and addressing health issues in a means of community collaboration to improve health equity and improve health outcomes

# Pursue Excellence

## Indicators and Metrics

- Health Assessment process is in place and updated annually
- Health data is available(needs better definition)
- Web based data system for public to use(needs negotiation with HCI)
- Timely Clinical and other social data is readily available to providers(when HIE is operational)
- Local data is used to guide local quality of care(needs better definition)
- Accreditation standards of providers met
- Community standards for managing disease states is established

## Data Snapshot

- Accreditation is a marketing sign of quality
- Accreditation could be tied to funding
- Safety and quality of care are major issues of focus both in hospitals and in community care settings
- Data driven decisions regarding care
- Development of Comprehensive Care Organizations
- Development of Accountable Care Organizations

### Goal 1: Develop Systems that Support, Promote and Monitor the Quality of Healthcare and Service Delivery

Organizational Strategies

- Some funders want some form of accreditation to assure that services are delivered in accordance with standards of care and best practices

- The Joint Commission is a standard for hospital accreditation. Public Health accreditation is moving forward as the measurement of health department's performance against a nationally recognized set of practice standards, evidence-based standards
- National Accreditation: Receive accreditation from Public Health Accreditation Board for all three Central Oregon public health agencies
- Collaboratively, align behavioral health measureable outcomes and clinical and system improvements
- Assure providers have timely accurate data that can draw assessments and lead to conclusions that will improve care and service delivery
- Standards of practice should be a result of evidenced-based medicine or other evidence based practices of care

Community Strategies

- Promote through the COHB an on-going Health Assessment Capacity to guide program decisions and resources allocation
- Create a regional hub for the collection, analysis, interpretation and dissemination of primary and secondary health related data to guide programmatic decisions, resource distribution and gauge outcomes
- Launch a web-based regional and community health data site with shared investment and public health leadership. Develop as an initiative of the Central Oregon Health Board
- Maintain excellence in epidemiological education, surveillance and coordinated intervention

Public Policy Strategies

- Central Oregon Health Council will promote, along with the Central Oregon Health Board the importance of excellence through accreditation and the use of evidence based medicine and evidence based services
- Promote health in all important policies in the region
- Promote the development of community standards for managing disease states

# Promote Regional Efforts

## Indicators and Metrics

- Number of regional programs as determined by the COHB
- Health Information Exchange operational(need to define level of operation)
- Specific MOU between three counties for emergency preparedness
- Behavioral Health Organization for Central Oregon in place and operating
- Regional reduction in inappropriate use of emergency rooms by individuals with a mental illness
- Improved prenatal and early childhood outcomes in the region, including low birth weight and adequate prenatal care
- Regional HUB Administrative structure for Early Childhood System in place and operating
- Regional MOU/Formal Agreements in place with public and private partners for Early Childhood System Administration and Implementation

## Data Snapshot

- Regional programs, where appropriate, create efficiencies and permit sharing of best practices and technology

- Improving collaboration in areas where there is joint planning, joint funding and interagency agreements which value and promote regionalization
- Regional training saves time and creates system consistency
- Some behavioral health services have been regionalized and work efficiently and effectively

## Goal 1: Create Incentives and Systems to expand Care and Services

Organizational Strategies

- Regionally, collaborate with local agencies to reduce the burden of chronic disease by way of policy, systems and environmental change
- Use data to develop and implement health related policies to address priority population health needs and disparities using the HIE and the Health Assessment Capacity Hub
- Inform decision makers and stakeholders about potential health impacts of proposed plans, projects or policies wherein health is not a consideration
- Promote no and low cost community resources that support health related policies
- Collaborate with land use and transportation agencies on projects that impact population health (i.e.; Health Impact Assessments, membership on Regional Transportation Planning steering committee and active transportation initiatives)
- Maintaining a local presence, promote and incentivize regional services that are cost-effective and add to service delivery (including early childhood learning)
- Collaborate regionally with local services, education and health partners to develop a system of early childhood care and education that together addresses health and education outcomes

Community Strategies

- Develop a new Behavioral Health Organization Partnership to coordinate and improve the system and benefits of Behavioral Health (BH) in the region
- Work to provide BH Services to indigent residents in the region
- Develop annual work plans tied to the Regional Health Improvement Plan (RHIP) to improve health care, increase effectiveness of services and increase the efficient delivery of services
- Support and expand the emergency room diversion programs to reduce the inappropriate use of emergency rooms in the region
- Develop a regional complex system of care, in conjunction with other stakeholders that will improve quality of care for patients and reduce the costs of delivering chronic health care
- Coordinate and develop a regional system of home visiting programs that will improve prenatal and early childhood outcomes in the region
- Develop local and regional maternal mental health programs to support the health and wellness of the mother and new born child
- Develop regional early childhood system of supports that ensures “no wrong door” for family access to appropriate services
- Develop and implement regional strategies for quality care of children with public and private child care providers

Public Policy Strategies

- Ensure public private partnerships will promote regional efforts of quality care and service delivery
- Pursue policies (or variances to current policy) to allow sharing of information, better coordination of services and supports, and more effective, cost-efficient service delivery between education and health service delivery systems

# Strengthen Health Service Organizations

## Indicators and Metrics

- Clinical information system is timely and efficient
- Number of collaboratives around special health issues(needs more definition)
- Number of existing workers whose skills have been upgraded(needs more definition)
- Data collection systems are compatible
- Workforce development programs in place
- Number of training programs that are coordinating training with Central Oregon health community

## Data Snapshot

- Addressing social determinants is a critical need in the tri-county area hit hard by the current economic conditions in the region. Addressing social determinants is challenging but necessary to improve personal and population health
- Improving clinical practice comes when data is collected and timely disseminated to providers
- Comprehensive and coordinated care only comes when information is shared quickly among providers
- The new healthcare environment will require current workforce member's skills to be upgraded and training to be developed to meet the new job and skill requirements

### Goal 1: Develop and Coordinate Data Collection Systems and Services

Community Strategies

- Refine mission and guiding principles for a Community Health Information Exchange (HIE)
- Develop an organization, new or existing, to provide governance and operation of a Community HIE
- Develop a selection process for a Community HIE
- Define and develop the financial model necessary to support a Community HIE
- Develop a system for collecting and tracking of screening and assessment data from all participating providers including schools that could be entered into a Community HIE
- Use the data collection to continuously improve the Regional Health Improvement Plan and its corresponding annual work plan

### Goal 2: Provide Training to Develop and Promote Progressive Collaborative Regional Service Delivery via Information Technology

Community Strategies

- Develop a data collection system for the region through the Healthy Communities Imitative
- Pilot and special projects should be collecting and analyzing data on health disparities with focus on diabetes
- Implement coordinate regional media campaigns on areas of prevention with focus on suicide and alcohol abuse prevention
- Develop means of promoting coordination and collaboration using video conferencing
- Create relevant metrics for social determinants of health that would be monitored by subject matter experts; ensure inclusion of social determinants of health in data collection systems; and share, link, integrate data to the greatest extent possible to facilitate analysis

- Develop internal screening and data collection systems that integrate with regional system(s) to compile, track, analyze, and summarize data
- Deploy Clara a VistaLogic software program, which is an integrated, client-centered uniform information management system, throughout the region as appropriate and needed

## Goal 3: Develop Strategies to Increase and Enhance the Health Care Workforce in Central Oregon

Organizational Strategies

- Develop and deploy a comprehensive workforce training and retraining strategy with focus on multidisciplinary teams
- Collaborate with academic partners to provide the needed training and certification for existing workers and recruit from the same programs the additional workers required to support the workforce needs and promotes cultural competency
- Develop an internal Health Engagement Teams (HET) training program
- Contract with a group to train a local practice coaches who will work directly with targeted primary care clinics to optimize the care team and its role in care delivery and assist clinics in patient engagement strategies that will be developed into self-management support that will complement the HET strategies
- Provide training to develop a workforce that is not only more aware of the social determinants of health but what they can do to more effectively address inequities that involves understanding cultures
- Expand the use of community health workers including peer support, peer mentors, and family resource managers
- Promote the development and sharing of specialists throughout the region

## Goal 4: Create and Build a Regional Robust Infrastructure that Supports and Strengthens the Partnering Organizations

Community Strategies

- Coordinate funding to create regional infrastructure for partnering organizations
- Collaborate with local hospitals, through the Central Oregon Health Council, in the development of a regional assessment and regional health improvement plan
- Promote and support health collaboratives on areas of need, for example oral health or diabetes

## Goal 5: Develop Strategies that Integrate Care and Solutions for Families, Youth and Children

Interpersonal Strategies

- Support educational success as a primary means of reducing child poverty and improving children's health
- Promote community dialogue, engagement and accountability in efforts to reduce child poverty and improve children's health

Community Strategies

- Develop and use school based health centers to coordinate, collaborate and integrate urgent care for school age children with primary care providers

- Maintain intensive, collaborative and coordinated community based mental intervention services for youth and adolescents with the goal of keeping them home and in their community

### Goal 6: Align Workforce Development, Housing, Human Service and Education Investments Through Policy Development that Promotes Collaborative Planning, Implementation and Data Sharing

Community Strategies

- Implement policies adopted in Central Oregon 10-year Homelessness Plan

Public Policy Strategies

- Regional county policies will align the efforts of local county departments
- Continue aligning community efforts between the public and private sector

# Promote Sound Health Policy

## Indicators and Metrics

- Number of bike commuters and miles of walking paths
- Communities built with walking, biking, parks and closeness to fresh vegetables
- Workforce with cultural competency skills(needs better definition)
- Cultural competency care policies in place
- Protocols and Policies in place to coordinate work of Family Resource Managers, Community Health Workers and family advocate functions in existing early childhood education and health care programs
- Percent of early childhood education and health care programs that are utilizing best or effective practices
- Policies for and development of parent advisory role and function for early childhood education and health programs

## Data Snapshot

- More consideration being given to integrating health into comprehensive planning
- Transportation planners are considering biking and walking in their transportation plans
- Early education focus and its impact on poverty and health(need better definition)
- Demographic changes requiring cultural competency to deliver quality care

### Goal 1: Engage Community Leaders and Community in Early Childhood Policy Development and Importance for Long Term Health and Productivity

Interpersonal Strategies

- Promote and support parent and service providers' understanding of the value and impact quality early childhood services have on long term health and academic achievement goals
- Promote use of best practices in early childhood health and education services, program implementation and workforce development

Organizational Strategies

- Promote and implement policy that supports universal screening tools and standardized process across all early childhood health and education services and allows for effective, efficient and consistent referral to services
- Develop, promote and implement policy that supports "no wrong door" for child and family access to early childhood health and educational services
- Develop and implement regional protocol and procedures to ensure coordination of services provided by Family Resource Managers (Early Childhood Education System), Community Health Workers (Health Care System) and existing family advocate in early care and education programs

Community Strategies

- Develop and implement policy to support, encourage and allow for parent involvement and input to the development of and maintenance of early childhood health and education services

Public Policy Strategies

- Pursue policies (or variations in current policy) to allow sharing of information and better coordination of supports and services between education and health care systems to improve effectiveness and efficiencies

## Goal 2: Public Policies Will Recognize and Promote Cultural Awareness and Competencies as it Relates to Workforce and Service Delivery

Interpersonal Strategies

- Promote community and service providers' understanding of cultural differences, priorities, traditions and practices that may impact an individual's ability to access health care, succeed in school and/or in the work place

Organizational Strategies

- Organizations will have policies that recognized the need for their workforce to have the cultural competency to service their consumer/client population

Community Strategies

- Communities, through consumer and citizens advisory groups, will insist on the system will develop policies for and assure that organizations and providers will provide culturally competent care

## Goal 3: Create a Safe and Healthy Environment for Children in their Family and in the Community

Community Strategies

- Land use planning and urban planning will integrate built environment policies which encourage walking, and biking
- Land use planning and urban planning will consider safe play areas for children in the development

Public Policy Strategies

- Enforce policies, such as mandatory reporting and safety protocols, in order to decrease child abuse
- Support passage of legislation that funds districts and schools to assess and address physical, social and environmental health barriers that impede learning (must include funding).
- Principles of such legislations should include specific student health measures and routine reporting on these measures (e.g. annual community report card)

- Creating mechanism for training and technical assistance to support school districts in developing and implementing plans
- Ensuring all actions are based on student health data and are connected to measurable outcomes
- Utilize best available evidence including emerging practices