



CHP Progress Report

The Willamette Valley Community Health (WVCH) Community Advisory Council (CAC) has worked diligently to oversee the implementation of the WVCH Community Health Improvement Plan (CHIP). Throughout the process, the group has leveraged its unique composition to ensure that CCO activities adequately identify and prioritize health disparities amongst the diverse communities of Marion and Polk counties. The unique insights and perspectives provided by CAC members has proven to be an invaluable resource to WVCH as the organization continues to examine disparities defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other factors within the community.

The activities outlined in this document represent the initial step towards realizing the goals identified in the WVCH CHIP. The first year of this multi-year process was heavily focused on assessing community resources and developing the cross-organizational relationships necessary to execute transformational activities. WVCH looks forward to continued work in pursuit of the CHIP goals and objectives and establishing a community-wide approach to health improvement.

The CHA-CHIP Development Process

Marion and Polk County Health Departments teamed with WVP Health Authority staff to oversee the design and implementation of the Community Health Assessment. The document was devised using Mobilization for Action through Planning and Partnerships (MAPP) and the Public Health Accreditation Standards Version 1.0 as a framework. A workgroup formed of volunteers from the CAC, both health departments, the mental health system, a state epidemiologist and other community partners provided guidance to the data collection and reporting in preparation for review and analysis by the CAC membership.

The community also provided input to the process via the Community Advisory Council (CAC). The CAC membership is half consumers receiving Oregon Health Plan (OHP) services and half community representatives, including one representative each from the health departments located in Marion and Polk Counties. Members of the CAC reflect the racial, ethnic, gender and geographic diversity of both Oregon Health Plan recipients and the general populations of the two counties. Members reviewed, analyzed and drew conclusions from the data. Part of the data reviewed included input from the general public through surveys or focus groups.

Once the Community Health Assessment was complete, the CAC convened to discuss the findings and select which health indicators would serve as the focus of the CHIP. Ultimately, the group selected the following indicators to be included in the CHIP:

- Access to Early Prenatal Care
- Depression
- Obesity Prevention
- Tobacco Cessation and Prevention

The following pages are intended to provide a brief overview of the progress made towards realizing the goals outlined in the WVCH CHIP.

Depression

WVCH has conducted an assessment of the knowledge, awareness and capacity of primary care providers to screen, treat, and refer appropriately for depression care. The results indicate that there is significant opportunity to engage providers in discussion to devise ways to enhance linkages between mental and physical health as well as consumers. To meet this need, the CCO has partnered with the Patient Centered Primary Care Institute (PCPCI) to host a learning collaborative addressing mental and physical health integration. This initiative will enhance care coordination between mental and physical health providers and help ensure that WVCH members receive adequate screening and treatment for depression. Topics covered will include the creation of a standardized behavioral health referral process for primary care providers, the development of resource guides that promote community services for depression, and education to ensure members have appropriate access.

WVCH is also working to expand colocation of behaviorists in primary care clinics throughout the CCO's service area. The proliferation of embedded licensed psychologists, social-workers and professional counselors will help ensure that member's mental health needs are addressed in a proactive and timely manner. This approach significantly enhances patient safety and provides clear communication on treatment for patients needing to access multiple providers in the delivery system. Behaviorists also work with members who are struggling to manage diabetes, hypertension, chronic pain and chronic medical conditions.

The colocation of behaviorists in primary care settings has proven to be an effective resource for treating members with mental health issues such as depression. WVCH is actively expanding this program and currently has behavioral health professionals embedded in network primary care clinics that serve a collective 77% CCO members. The continued promotion of integrative practices such as this will undoubtedly ensure members suffering from depression receive the care they need.

Tobacco Prevention and Cessation

WVCH has conducted a survey identifying prominent barriers to increased utilization of tobacco cessation services. Findings include:

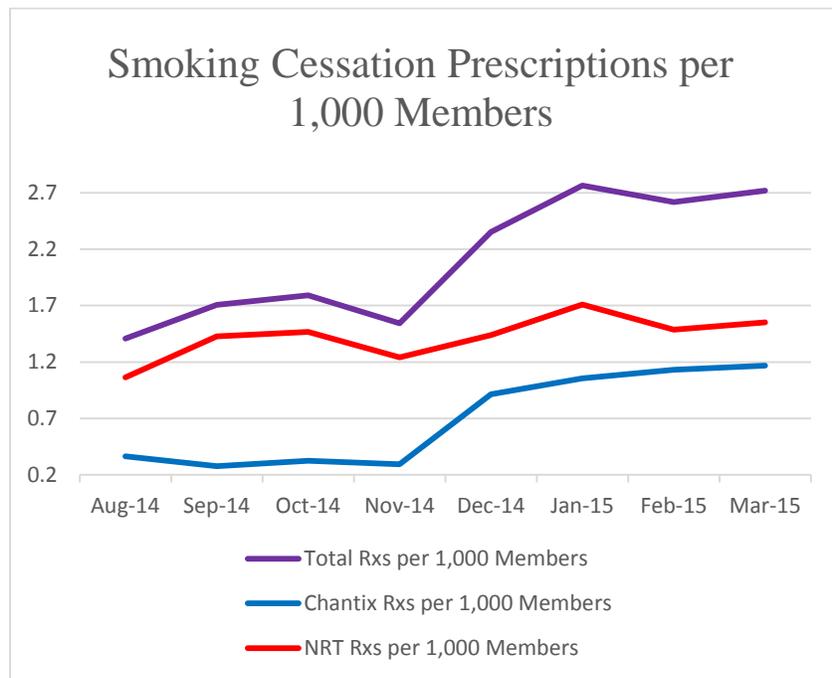
- Providers lacked a comprehensive understanding of the cessation benefits available to members.
- Providers believe reimbursement for tobacco counseling is insufficient motivation to engage members.
- Providers expressed frustration with prior authorization process for pharmacotherapy services and indicated it hindered their ability to prescribe medication when appropriate.

In response to this feedback, WVCH has made strides to address the most prominent barriers to care. Activities include:

- Instituting a 45% increase in reimbursement for tobacco cessation counseling.
- Expanding formulary to include wide range of pharmacotherapy options
- Removing prior authorization criteria for most cessation medications
- Engaging in cross-system conversations between mental, physical and dental providers to promote a uniform and expansive approach to tobacco cessation.
- Development of provider education materials outlining aforementioned changes to reimbursement and formulary process
- Development of member education materials highlighting the benefits of tobacco cessation and outlining services available in the community.

WVCH recognizes that individuals with mental illness and addictions consume tobacco at a higher rate than the general population and has worked to increase the number of members who receive primary care in clinics with collocated behaviorists. Since the CHIPs original publication, WVCH has successfully placed behaviorists in clinics that collectively serve 77% of the CCOs total population.

While the impact of WVCH’s tobacco cessation efforts is still under evaluation, results thus far have been encouraging. The changes made to the WVCH formulary have resulted in a 93% increase in overall use of smoking cessation products.



Access to Early Prenatal Care

WVCH has partnered with the Marion and Polk Public Health departments to conduct an assessment of the prenatal care system in the CCO’s service area. The results provided valuable insights into the delivery system and prompted WVCH to take the following actions:

- Monitor access to care for pregnant women through the WVCH secret shopper process. This process utilizes the WVCH customer service department to call prenatal care providers posing as pregnant WVCH members. The customer service representative then requests an appointment and documents any instances that might hinder the timely provision of prenatal care. Plan representatives then use this information to follow-up directly with clinic staff.
- The WVCH Clinical Advisory Panel (CAP) has endorsed One Key Question as a best practice and is working with the Oregon Foundation for Reproductive Health to devise the necessary workflows for participating clinics. The CCO believes that engaging women in frank discussions about reproductive health will have a significant impact on access to prenatal care.
- WVCH is using the results from the Timeliness to Prenatal Care incentive measure to devise a focus group for OHP members. This activity is intended to provide the CCO with insights into member experience and enable the organization to better identify and address barriers to care.

Obesity Prevention

WVCH has partnered with the Marion and Polk county health departments to begin developing a community-wide health assessment in order to help promote a more unified prioritization of community health needs.

- WVCH has devised a weight management resource guide that identifies weight management support programs available in the community.
- WVCH has identified a guide for members interested in speaking with their healthcare provider about weight and its impact on health. The Your Weight Matters Toolkit is used to help members
 - Understand how weight impacts their health
 - Learn about safe and effective weight-loss options
 - Prepare for having a discussion about weight loss with their provider.
- WVCH vision includes offering members opportunities to participate fully in their own care and advocate for themselves, optimizing prevention and education while incentivizing healthy behavior, and ensuring patients receive the evidence based care they need when they need it. A clinical workgroup with expertise in weight management was established and began meeting in the spring of 2015. It included expertise from community health, weight management, behavioral health, medical management, and bariatric surgery. They reviewed existing services available to members and drafted a model of intervention during the prenatal, early childhood, childhood & adolescence, and adult periods. Methods are anchored in the recommendations outlined by Kushner & Ryan in “Assessment and Lifestyle Management of Patients with Obesity: Clinical Recommendations from Systemic Review,” published in the Journal of the American Medical Association in 2014.

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Reporting period: July 1, 2014 – June 30, 2015

OHA acknowledges CCOs in their dedication, community efforts and partnerships to develop the CHPs. In the review of CHPs submitted June 30, 2014, it was evident that a lot of work has occurred to align a variety of community efforts around the CHP work. As the CHPs evolve, CCOs may change health priorities or further develop them to align with community needs. New strategies may be added to further address health priority areas or engage with new partners, stakeholders or collaborations to support implementation. OHA is interested in hearing about the community level work, challenges and successes as well as how the CCO met its contract requirements.

Per contract, “Contractor shall provide a copy of the CHP, and annual progress reports to the CHP, to OHA June 30 of each year.” The purpose of this document is to guide CCOs in addressing contractual requirements for the CHP progress report submission by June 30, 2015. OHA recognizes that there are many focus areas that CCOs and their partners have identified to work on in their CHP, and those areas are important to the community and certainly can be a part of the identified CHP work. That is, while it is important that CCOs consider the contractual language noted below as part of their ongoing CHP work, the contract requirements do not preclude CCOs from focusing on a broad array of activities.

Contract requirements regarding the original CHP and the annual CHP progress reports are outlined below, followed by guidance and examples. Note that the guidance section provides suggestions for how a CCO may choose to address the contract requirement, and examples are given to illustrate compliance and are not an exhaustive or required list. In addition, a checklist mirroring language and guidance below is provided for **optional use by CCOs**, but is not required. The checklist document is available on the Transformation Center’s Resource page. Select Community Advisory Councils from the dropdown menu:

<http://www.oregon.gov/oha/Transformation-Center/Pages/Resources-Transformation.aspx>. For additional questions, please contact your Innovator Agent or Chris DeMars at chris.demars@state.or.us.

	Language from CCO Contract, Exhibit B #4 (pages 28-30)	Guidance for annual CHP progress report	Examples (not requirements)
a.1.	<p><i>To the extent practicable, the contractor shall include in the CHA and CHP a strategy and plan for:</i></p> <p>Working with the:</p> <ul style="list-style-type: none"> ● Early Learning Council ● Youth Development Council ● Local Mental Health Authority, ● Oral health care providers, ● Local public health authority, ● Community based organizations, ● Hospital systems and School health providers in the Service Area. 	<p>Describe whether and how any of these key players in the CCO's service area, as noted, are involved in CHP work.</p> <p>If applicable, identify where the gaps are in making connections.</p> <p>For example, with which of these entities are you partnering for CHP work?</p>	<p>Hospital systems, the Local Mental Health Authority and Local Public Health Authorities are active participants in the CHA-CHIP development process.</p> <p>We did not work with school health providers as we do not have a school-based health center, but have made an effort to reach out to the school district.</p> <p>Working with local public health on tobacco prevention and prenatal care efforts.</p> <p>Working with local mental health authority and local public health on depression screening</p>

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<p>a.2.</p>	<p><i>To the extent practicable, the contractor shall include in the CHA and CHP a strategy and plan for:</i></p> <p>Coordinating the effective and efficient delivery of health care to children and adolescents in the community.</p> <ul style="list-style-type: none"> a. Base the CHP on research, including research into adverse childhood experiences; b. Evaluate the adequacy of the existing school-based health center (SBHC) network to meet the specific pediatric and adolescent health care needs in the community and make recommendations to improve the SBHC system; c. Improve the integration of all services provided to meet the needs of children, adolescents, and families; and d. Address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents 	<p>For CHP priorities related to children or adolescents (prenatal to age 24), describe how and whether the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.</p> <p>What of these activities are you doing for this age population?</p>	
<p>a.3.</p>	<p><i>To the extent practicable, the contractor shall include in the CHA and CHP a strategy and plan for:</i></p> <p>Contractor shall add to its CHP; school nurses, school mental health providers, and individuals representing child and adolescent health services.</p>	<p>Identify ways CCO and/or CAC have worked with school and adolescent providers on prioritized health focus areas.</p>	<p>WVCH works closely with the Early Learning Hub of Marion & Polk Counties to develop strategies that improve adolescent health. The ELH sits on the WVCH board and is collocated with WVP Health Authority, the Third Party Administrator for WVCH. A school nurse also serves on the WVCH CAC as does the former executive director of The Children’s Guild.</p>

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<p>b.</p>	<p>Contractor, with its CAC, shall collaborate with OHA Office of Equity and Inclusion to develop meaningful baseline data on health disparities.</p> <p>Contractor shall include in the CHA identification and prioritization of health disparities among Contractor’s diverse communities, including those defined by race, ethnicity, language, disability, age, gender, sexual orientation, and other factors in its Service Areas.</p>	<p>For each of the chosen CHP priorities, describe how the CCO and/or CAC(s) worked with OEI to obtain baseline data for different populations within the community including socio- economic demographics, health status and health outcomes.</p> <p>If available, compare local population data to CCO member data, or state data.</p> <p>If data is not available, the CCO may</p>	<p>Our CAC has partnered with OEI representatives to attend meetings and discuss ways the organization could use available data to minimize health disparities. The OEI also collaborated with the CAC to design a network-wide cultural competency event.</p> <p>The CAC has worked to host a poverty simulation for area physicians and community members</p>
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	<p>Contractor shall include representatives of populations experiencing health disparities in CHA and CHP prioritization.</p>	<p>choose to access qualitative data from special populations via focus groups, interviews, etc.</p> <p>What barriers have you experienced in obtaining data?</p> <p>What successes or challenges have you had in engaging populations experiencing health disparities?</p>	<p>The WVCH CHA-CHIP prioritization process included an OHA epidemiologist, public health representatives and numerous community members.</p> <p>Engaged in community’s effort to address poverty through training on poverty in the community and with providers.</p>
<p>c.</p>	<p>Contractor shall conduct the CHA and CHP so that they are transparent and public in process and outcomes. Contractor shall assure that the contents and development of the CHP comply with Section ORS 414.627.</p>	<p>Per ORS 414.627: “If the regular CAC meetings are not open to the public and do not provide an opportunity for members of the public to provide written and oral comments, the CAC shall hold semiannual meetings: that are open to the public and attended by members of the CAC; at which the CAC shall report on the activities of the CCO and the CAC; at which the council shall provide written reports on the activities of the CCO; and at which the CAC shall provide the public to provide written or oral comments.”</p> <p>Per OAR 410-141-3145 “The CCO requirements for conducting a CHA and CHP will be met for purposes of ORS 414.627 if they substantially meet the community health needs assessment requirement of the federal Patient Protection and Affordable Care Act, 2010 Section 9007, and the Public Health Accreditation Board CHA and CHP requirements for local health departments and the AAA and local mental health authority in the</p>	<p>Our CAC is open to the public and public comment time is available each meeting.</p> <p>The CAC has helped WVCH facilitate community forums across the CCO’s service area. These activities enable the community to provide input into the CHA-CHIP development process and stay abreast of WVCH activities.</p>

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		process.”	
d.	<p>The CHA and CHP adopted by the CAC shall describe the full scope of findings, priorities, actions, responsibilities, and results achieved. The CHP may include, as applicable:</p> <ul style="list-style-type: none"> • Findings from the various community health assessments made available by OHA to Contractor; • Findings on health needs and health disparities from community partners or previous assessments; • Findings on health indicators, including the leading causes of chronic disease, injury and death in the Service Area; • Evaluations of and recommendations for improvement of school based health systems in meeting the needs of specific pediatric and adolescent health care needs in the community; • Focus on primary care, behavioral health and oral health; • Analysis and development of public and private resources, capacities and metrics based on ongoing CHA activities and population health priorities; • Description of how the CHA and CHP support the development, implementation, and evaluation of patient-centered primary care approaches; • Description of how the objectives of Health Systems Transformation and Contractor’s Transformation Plan, described in Exhibit K, are addressed in the CHA and CHP; System design issues and solutions; Outcome and Quality Improvement plans and results; • Integration of service delivery approaches and outcomes; and • Workforce development 	<p>As an update, provide information related to new sources of data utilized to identify health needs and disparities, i.e. OEI race/ethnicity data, focus group information, school based data.</p> <p>If applicable, describe how the CHP work aligns with work through the Transformation Plan and/or Quality Improvement plans?</p> <p>If applicable, describe how the CCO has leveraged resources to improve population health.</p> <p>How has the CHP work addressed integration of services?</p> <p>What difficulties has the CCO encountered in accessing health disparities data?</p>	<p>WVCH CAC has analyzed utilization information to identify potential health disparities.</p> <p>WVCH has hosted community forums and collected survey information for targeted data on multiple populations.</p> <p>WVCH is aligning transformation plan work on cultural competency with health equity focus in CHP.</p> <p>WVCH and the Mid-Valley Behavioral Healthcare Network have partnered to advance the application of trauma informed care work.</p> <p>WVCH CAP includes pediatric and dental providers. The broad representation is intended to spur integration across health systems.</p>

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	approaches and outcomes		
e	The CHP shall identify the findings of the CHA and the method for prioritizing health disparities for remedy. Contractor shall provide a copy of the CHP, and annual progress reports to the CHP, to OHA June 30 of each year.	CHP progress report due to David Fischer at DMAP on June 30, 2015. Checklist/reporting form provided by OHA is optional.	<i>n/a</i>
f	Adopt a comprehensive local plan for the delivery of local mental health services for children, families, adults and older adults that describes the methods by which the LMHA will provide those services.	Describe how local mental health services are provided in a comprehensive manner. Note that this may not be in the CHP but may be available via another document.	