InterCommunity Health Network CCO

Community Health Improvement Plan

Addendum – January 2016

Stronger, healthier, together.

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SECTION 1: INTRODUCTION

NOTE: An acronyms list and a glossary of terms are listed on pages 12-14.

Document Purpose

This document serves as a refinement of the InterCommunity Health Network Coordinated Care Organization's (IHN-CCO) 2014 Community Health Improvement Plan (CHIP). It summarizes the work of the Community Advisory Council (CAC), and its local advisory committees, since the CHIP's publication in July 2014. This work focused on clarifying the intentions of the goals identified in the CHIP by identifying priority outcomes and potential indicators.

For the purposes of the CHIP, outcomes and indicators are defined as follows:

> **Outcomes** are results, changes, or improvements that come about from a program, such as changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status. Outcomes are a standard of some level of success.
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> **Indicators** are measurements or data that provide evidence that a certain condition exists, or certain results or progress toward improvements have or have not been achieved. Indicators measure the level of success or lack of success a program has had in achieving an outcome. These indicators serve to further clarify and define their related outcomes.

IHN-CCO Community Health Improvement Plan

The 2014 IHN-CCO CHIP identified the following Health Impact Areas (HIAs): 1) Access to Healthcare, 2) Behavioral Health, 3) Chronic Disease, and 4) Maternal and Child Health. For an in depth understanding of this work, refer to the CHIP[i] and the 2015 CHIP Progress Report[ii]

The CHIP's Impact on Healthcare Transformation
According to Oregon Senate Bill 1580, the CCO CHIPs, adopted by their Community Advisory Councils, should "*serve as a strategic population health and healthcare system service plan for the community served by the CCO*."

Examples of how the IHN-CCO CHIP is used for strategic planning include:

1. **Pilot Project Prioritization:** In the evaluation of pilot project proposals, projects must fit within one of the four CHIP Health Impact Areas (HIAs). Additionally,

the CCO and community partners intend to use the outcomes identified in this document to further prioritize pilot project funding.

2. **Health Equity:** The IHN-CCO Health Disparities Workgroup will use the outcomes as a guide in their effort to identify and address health disparities.

CHIP Outcomes and Indicators Identification

Identification of priority outcomes and indicators is crucial to the CCO's and the CAC's ability to evaluate and report on CHIP progress. Since November 2014, much of the work of the CAC and its local committees has focused on answering the questions, *"What would success look like, and how will we know when we get there?"* To that end, the CAC identified a set of outcomes and indicator concepts for each of the CHIP's Health Impact Areas (HIA).

Local Committees' Recommendations

In November 2014, The CAC asked the three local advisory committees to split up the work of identifying potential CHIP outcomes and indicators. The work was divided as follows:

- **Benton County:** Behavioral Health
- **Lincoln County:** Chronic Disease
- **Linn County:** Access to Healthcare and Maternal & Child Health

Working independently, the committees spent hundreds of hours to complete their task. In September 2015, the CAC received each committee's recommendations. Combined, these recommendations included 32 outcomes and 113 indicators.

Outcomes & Indicators Workgroup

Once the recommendations were received and reviewed by the CAC, the CAC chair appointed three representatives from each county to the Outcomes and Indicators (O&I) Workgroup. The workgroup's task was to use these recommendations to identify three to five outcomes per HIA and a short list of relevant potential indicators.

The nine-member O&I Workgroup met six times for a total of 18 hours. Their work was supported by the CAC Coordinator, an independent meeting facilitator, the Regional Health Assessment epidemiologist, an Oregon Health Authority Innovator Agent, and the IHN-CCO Chief Executive Officer.

Major tasks performed by the workgroup:

1. Established a process and work plan for identifying priority outcomes and indicator concepts
2. Discussed data availability information provided by the epidemiologist (who updated and refined this information throughout the identification process)
3. Agreed to a set of factors or values for consideration when identifying priority outcomes and indicator concepts, which included:
    a. Impact on IHN-CCO members, healthcare system transformation, and prevention/community health

   b. Data availability and reasonableness of data request
   c. Support for innovation
   d. Short term versus long term goals
   e. Opportunity to merge outcomes/remove redundancies
   f. Number of providers/others who could impact outcomes
   g. Honoring the work of the local committees and the CHIP
4. Based on the Linn County recommendation, divided Maternal & Child Health into two separate HIAs: Child Health and Maternal Health and agreed to recommend to the CAC that, moving forward, these be two separate HIAs in the CHIP.
5. Moved all child-related behavioral health goals, and their associated outcomes and indicators, from the CHIP's Behavioral Health HIA to the Child Health HIA
6. Identified 16 priority outcomes
7. Identified indicator concepts for each of the 16 priority outcomes
8. Tasked the CAC Coordinator with writing the CHIP Addendum
9. Met to discuss the CHIP Addendum and prepare for presentation to the CAC

SECTION 2: PRIORITY CHIP OUTCOMES AND INDICATOR CONCEPTS

Introduction to the Outcomes and Indicator Concepts

The CHIP outcomes listed in the table on the following pages, as written, are broadly defined. Broad definitions serve as guidance to allow those who use them the flexibility to do their work innovatively and in a way that fits within the context of their particular work or expertise.

For example, the first Access to Healthcare outcome, *"Increase the percentage of members who receive appropriate care at the appropriate time and place"* is broadly defined. What is appropriate care, an appropriate time, or an appropriate place varies greatly across contexts. Even the term, IHN-CCO *member*, is broadly defined and may, for some improvement efforts, refer to all members, or members who are under age 18, or members of a subpopulation at greater risk of health disparities, etc.

The recommended indicator concepts also serve to more specifically define their related outcome. For example, indicators that include "*length of time from enrollment to first appointment"* or "*trauma-informed care"* are indicators that may measure, and therefore define, progress toward its related outcome. These carefully selected indicators are labeled as "*Indicator Concepts*" in recognition of the fact that they are, or can be, either more or less broadly defined than as worded below. For example, a "rate" may be stated as an indicator, but a "percentage" may be what is available or even preferable; or, general rates of child injuries may be unavailable, while something more specific to recreation or auto collisions may be available.

Future Focus Areas
In working to reform healthcare and achieve the triple aim of better health and better care at lower costs, the state of Oregon and the Coordinated Care Organizations have taken on a momentous task. To make progress toward the triple aim, areas of focus must be identified, innovations explored, changes made, and progress measured. This takes time and patience. Everything cannot be done all at once. For that reason, the CHIP prioritized some areas of focus ahead of others. In the future, the CAC and its local committees will reevaluate their work and list areas for future consideration, particularly in the areas of social determinants of health, health equity, and the integration of healthcare. The following outcomes and indicator concepts are listed in no particular order and are organized by their alphabetically listed Health Impact Area.

Outcomes & Indicator Concepts

Access to Healthcare	
Outcomes	**Indicator Concepts**
A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.	a. Length of time from enrollment to first appointment b. Length of time from appointment request to appointment for behavioral, physical, and oral health services c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Appropriate preventive care for all ages
A2: Increase the percentage of members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.	a. Percentage of members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care b. Percentage of members who access user-friendly, certified language interpreter services
A3: Increase the percentage of members who have safe, affordable housing.	a. Number of homeless persons b. Number of homeless students c. Percentage of members who have stable housing upon discharge from hospital or emergency department visit d. Percentage of residents with high housing costs e. Percentage of members who have safe housing

Outcomes & Indicator Concepts

Behavioral Health	
Outcomes	**Indicator Concepts**
BH1: Increase community awareness that behavioral health issues are normal and widely experienced.	a. Exposure to behavioral health information and self-care skills in health services, schools, and after-school programs b. Availability of programs to train primary care and other health care providers and community members to understand behavioral health c. Efforts made to inform communities about behavioral health through media exposure and other information d. Peer-delivered education about behavioral health
BH2: Increase the expertise of primary care providers who work with people who may have behavioral health needs in order to reduce stigma and improve access and appropriate utilization of services.	a. Number of primary care providers who have exposure to behavioral health education, information, and Continuing Medical Education (CME) b. Co-located primary care and behavioral health providers c. Percentage of members who receive behavioral health services, screenings, and referrals in primary care settings
BH3: Increase behavioral health screenings, services, referrals, and peer and parent support in schools and other community venues.	a. Percentage of members who receive behavioral health services, screenings, and referrals in venues other than traditional medical facilities b. Numbers of certified Peer Support Specialists accessible to members in venues other than traditional medical facilities c. Rate of suicidal ideation, attempts, suicide, and/or self-harming behavior

Outcomes & Indicator Concepts

Child Health	
Outcomes	**Indicator Concepts**
CH1: Increase the percentage of children, and families—particularly those with identified risk factors—who are empowered in their health, who partner with their healthcare provider, and who set their goals and follow through on those goals.	a. Percentage of at-risk children and families who have access to advocacy services such as CASA, LGBTQIA support, OFSN, Youth MOVE, and DHS-Child Welfare. b. Percentage of children ready to learn when they enter school
CH2: Decrease the rate of childhood injuries.	a. Rate of injuries and mortality attributable to inadequate medication safety b. Proper use of child safety equipment such as car seats, seat belts, and safety helmets c. Child abuse and neglect rates d. Child injury rates e. Percentage of members with safe housing
CH3: Increase breastfeeding rates.	a. Percentage of women who receive lactation counseling and support during pregnancy and following childbirth b. Percentage of women breastfeeding at 6 and 12 months c. Percentage of women who can conveniently pump breast milk at work d. Number of certified Baby Friendly Hospitals[iii]

Outcomes & Indicator Concepts

Child Health, Continued	
Outcomes	**Indicator Concepts**
CH4: Increase integration of behavioral health care as part of routine primary pediatric care.	a. Occurrence of care coordination between primary care and behavioral health providers when working with children, youth, and families, including consultations and referrals. b. Number of regular behavioral health screenings occurring for pediatric IHN-CCO members c. Utilization of trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Oregon Psychiatric Access Line about Kids (OPAL-K) utilization

Chronic Disease	
Outcomes	**Indicator Concepts**
CD1: Increase the percentage of members who have their asthma under control.	a. Urgent care and emergency department visits, and hospitalizations for asthma
CD2: Increase the percentage of members who are physically active and/or maintain a healthy diet.	a. Percentage of members who eat the recommended daily amount of fruits and vegetables b. Percentage of members who are obese or overweight c. Percentage of member who have Type II diabetes d. Percentage of members getting the recommended amount of physical activity
CD3: Reduce the percentage of members who use and/or are exposed to tobacco.	a. Tobacco prevalence (2016 Quality Incentive Metric), including tracking prevalence among members who are under age 18, pregnant, or who are a member of another at-risk group b. Use of cessation resources and tools

Outcomes & Indicator Concepts

Maternal Health	
Outcomes	**Indicator Concepts**
MH1: Reduce the rate of unplanned pregnancies.	a. Effective contraceptive use among women at risk of unintended pregnancy (Quality Incentive Metric) b. Effective contraceptive use among men c. Percentage of pregnancies that are unplanned, including data by age, ethnicity, and race d. Use of the One Key Question
MH2: Increase the percentage of women of childbearing age who receive early and adequate pre-conception and prenatal care and who connect with appropriate resources throughout their pregnancy.	a. Timeliness of prenatal care (Quality Incentive Metric), including oral health care (care initiated in first trimester) b. Behavioral health screenings and access to treatment with a behavioral health provider c. Percentage of pregnant members with a healthy weight gain during their pregnancies. d. Percentage of infants with low birth weight or premature birth e. Utilization of traditional health worker services by pregnant women
MH3: Increase the percentage of women, infants, and families—particularly those with identified risk factors—who access postpartum care and support.	a. Percentage of women who attend postpartum follow-up visits b. Percentage of women who receive preventive dental care postpartum c. Percentage of postpartum members who receive a mental health and substance abuse screening and are referred to treatment if necessary. d. Percentage of postpartum members who are contacted by their provider if they do not attend a follow-up visit

SECTION 3: Acknowledgments and Affiliations

Identification of priority outcomes and potential indicators for the IHN-CCO Community Health Improvement Plan was a collaborative effort of the many community members, organizations, and providers with a commitment to improving the health of IHN-CCO members. Listed below are the organizations represented by individuals who worked on the Improvement Plan, either as a Community Advisory Council Representative, as a member of a Local Advisory Committee to the CAC, or within a professional role within the system of healthcare.

Addiction Prevention and Recovery Committee of Lincoln County
Albany InReach Services
Benton County Health Services
Court Appointed Special Advocates of Linn County
Childhood Obesity Coalition, Lincoln County
Children & Families Rural Community Registered Nurse
Children's System of Care Wraparound Initiative Regional Steering Committee, IHN-CCO
Chronic Care Committee, Lincoln County
Coast to Cascade Wellness Coalition
Lincoln County Commissioner Bill Hall
COMP NW - Center for Lifestyle Medicine
COMP NW Medical Education
Corvallis Community Services Consortium
Corvallis School District
Emergency Food & Shelter Program
Faith Community Nursing Coordinator, Lincoln County
Foster parents
Health & Human Services Directors of Benton, Lincoln, and Linn Counties
Health Care for all Oregon
Helping Homeless or near Homeless Veterans & Families
Homeless Enrichment and Rehabilitation Team board member
Hospital District Boards for North Lincoln and Pacific Communities
InterCommunity Health Network CCO
Lincoln Community Health Centers
Lincoln County Health & Human Services
Lincoln County Public Health Advisory Committee
Linn County Department of Health Services & Public Health
Linn County Public Safety Coordinating Council
Linn-Benton Health Equity Alliance
Linn-Benton Housing Authority
Mental Health Advisory Board, Linn County
Mental Health Advisory Committee, Lincoln County
Mental Health, Addictions, & Developmental Disabilities Advisory Committee, Benton Co.
Mid-Valley Health Care Advocates

Mid-Valley National Alliance on Mental Illness
North Senior Connections, Lincoln City
New Roots Housing
Northwest Parish Nurse Ministries
Obesity Prevention Coalition, Linn County
Older Adult Behavioral Health Initiative, OHA
Olalla Center for Children and Families, Lincoln County
Oral Health Coalition, Linn County
Oregon Cascades West Council of Governments, Disability Services Advisory Council
Oregon Cascades West Council of Governments, Senior Services Advisory Council
Oregon Coast Community College
Oregon Department of Human Services, Lincoln County
Oregon Family Support Network
Oregon Health Authority Innovator Agent
Oregon Hospice & Palliative Care Association
Parish Nursing Advisory Board, Lincoln County
Physicians for National Health Program
Progressive Options Independent Living Center
Regional Oral Health Coalition
Samaritan Health Services
Samaritan Health Services, Maternity Care Coordinators
Samaritan Pacific Foundation Board
Signs of Victory Ministries
System of Care Wraparound Initiative Steering Committee, IHN-CCO
Trillium Family Advisory Council
United Way Emergency food and Shelter Program, Linn County
United Way of Benton & Lincoln Counties
Willamette Neighborhood Housing Services

SECTION 4: ACRONYMS

ACE – Adverse Childhood Experiences

CAC – Community Advisory Council

CASA – Court Appointed Special Advocates

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

CCO – Coordinated Care Organization

CME – Continuing Medical Education

DHS – Department of Human Services

HIA – Health Impact Area

IHN-CCO – InterCommunity Health Network Coordinated Care Organization

OFSN – Oregon Family Support Network

OHA – Oregon Health Authority, the state agency responsible for OHP/Medicaid

OHP – Oregon Health Plan (Medicaid)

O&I – Outcomes and Indicators

RHA Team – Regional Health Assessment Team

LGBTQIA – lesbian, gay, bi-sexual, transgendered, questioning, intersex, or asexual

SECTION 5: GLOSSARY OF TERMS

Addendum – Something that is added to the main or original text.

At risk – an individual or group who is more likely, than another individual or group, to experience a problem, such as an illness.

Baby Friendly Hospital – Baby Friendly is a World Health Organization and United Nations Children's Fund initiative to improve breastfeeding support throughout the ward. Baby Friendly is based on The Ten Steps to Successful Breastfeeding (below). A certified Baby Friendly Hospital has successfully met the requirements and been approved by this initiative. [iv]

CASA – Court Appointed Special Advocates—empowered directly by the courts—offer judges the critical information they need to ensure that each child's rights and needs are being attended to while in foster care.[v]

CME – Continuing Medical Education training credits for physicians. One credit equals one hour of education in a certified training. All Oregon physicians must earn 60 CMEs every two years. [vi]

Epidemiologist – is someone who studies patterns, causes, and effects of health and disease conditions in defined populations and is knowledgeable about relevant data.

Health Disparity – A situation where a person or group is more likely (than another person or group) to get sick or have a health related problem because of where they live, or how much education they have, or what race or gender they are, etc.

HIA – Health Impact Area: a priority health focus area identified in the CHIP

Indicator – A measurement or data that provides evidence that a certain condition exists, or certain results have or have not been achieved. Indicators measure the level of success or lack of success a program has had in achieving an outcome

Member – Any individual enrolled in the Oregon Health Plan, whose care is the responsibility of IHN-CCO

OFSN – Oregon Family Support Network is an organization with families and youth working together to promote mental, behavioral, and emotional wellness for other families and youth through education, support, and advocacy[vii]

OHA – Oregon Health Authority, the state agency responsible for OHP/Medicaid

OHA Innovator Agent – Innovator Agents help CCOs and OHA work together to achieve the goals of health system transformation: better care, better health, and lower costs.

One Key Question (Initiative) – An evidence-based practice to prevent unplanned pregnancies or provide preconception preventive care information to those who are planning to become pregnant in the next year.[viii]

Opal-K – Oregon Psychiatric Access Line about Kids provides free, same-day child psychiatric phone consultation to primary care providers in Oregon[ix]

Outcome – Results or changes that come about from a program, such as changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status.

Resiliency – The ability to recover

RHA Team – The Regional Health Assessment Team works to coordinate data collection and reporting across Benton, Lincoln, and Linn counties. They are working to create a standard format (a template) for community partners to provide data to support the repeating cycles of community health assessment across the region.

Social determinants of health – Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect wellbeing.[x]

Youth MOVE – a youth led national organization devoted to improving services and systems that support positive growth and development by uniting the voices of individuals who have lived experience in various systems including mental health, juvenile justice, education, and child welfare.[xi]

SECTION 6: REFERENCES

[i] http://www.samhealth.org/healthplans/SiteCollectionDocuments/IHN-CCO/PDF/IHN-CCO_CHIP_2014Web.pdf, retrieved December 28, 2015
[ii] http://www.oregon.gov/oha/OHPB/CCOCHIP/IHN-%20CHIP%20Progress%20Report%20-%20June%202015.pdf, retrieved December 28, 2015
[iii] https://www.babyfriendlyusa.org/about-us/baby-friendly-hospital-initiative, retrieved December 28, 2015
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[v] http://www.casaforchildren.org/site/c.mtJSJ7MPIsE/b.5301295/k.BE9A/Home.htm, retrieved December 28, 2015
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[viii] http://www.onekeyquestion.org/, retrieved December 30, 2015
[ix] http://www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/index.cfm, retrieved December 28, 2015
[x] http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health, retrieved January 7, 2016
[xi] http://www.youthmovenational.org/Pages/mission-vision-purpose.html, retrieved December 28, 2015