# Bit By Bit

IHN-CCO Pilot PROPOSAL

# Pilot Summary and Goals

- Bit by Bit uses adaptive and therapeutic riding to assist clients through the rhythmic movement of the horse as a way to grow balance, confidence, and assist in other physical and mental growth compassites in our clients.

- Allow for clients to bill insurance and to provide affordable, innovative healthcare options for clients.
- Have to have a licensed occupational, physical or social practiculture conduct our hippotherapy
- Grow the number of sessions that can be provided

# Member and Community Need

- We will serve a multitude of clients, we wish to provide access especially to those in the foster care system.

- With the help from IHN-CCO, we can help serve an additional 30 clients a week and expand our care to include a hippotherapy program
- Volunteers are the backbone of the foundation. Volunteers assist with side walking and general horse care. Once volunteers have been trained and understand horse safety, they are encouraged to help groom the horses.

# System Transformation

How is your proposal transformational?

- Bit by Bit will do the following::
  - Focus on collaboration between entities not previously connected
  - We will establish a strong partnership with Old Mill and their pediatric clinic
  - Work to establish a partnership with Dial a Bus as they wipuld be a great asset to ourselves and our clients
  - Will your proposal reduce costs, positively affect CCO metrics, or improve IHN-CCO member's health?
  - We will improve IHN-CCO members health but most likely reduce costs in all three ways
- Bit by Bit is innovative by:
  - Being a relatively new form of therapy
  - Benefits mental and physical health
  - Totally unique therapy in the tri counties

# Partnerships/Collaboration

- By partnering with State programs and other local community groups, we want to provide to a large percentage of our clients low or no cost care through billing health coverage.
- TriCare, which is the insurance company that works with and for the VA, does institute hippotherapy as a possible healthcare option for clients that suffer certain physical disabilities.
- Collaborating with DHS, Old Mill school and Every Child Linn Benton will help recruit clients.

# Health Equity Plan

- It is Bit by Bit's policy and mission to provide services to all, regardless of race, color, religion, sex, gender orientation, national original, or age.
- Our therapeutic riding program is completely unique to each client as every session is designed by and conducted with our director, Erin.
- Bit by Bit assists clients, including teens and children in the foster system, with many different diagnoses including Down Syndrome, traumatic brain injury with paralysis, autism, hearing impairment, ADHD, general anxiety disorder, and depression.
- Our program has already been successful working with diverse clients, including individuals of Native American and African American descent, hearing impaired, and transgender.
- Bit by Bit currently provide scholarships funded by community partners to welcome clients who are unable to pay.

# Definition of Success

- By the end of this pilot, we will see:
  - Triple the number of available sessions
  - Able to provide a certified hippotherapist
  - Ability to offer reduce costs
- We will use this data to measure success by:
  - Feedback directly from clients and families
  - Clients notes provided from instructors and therapist
  - Information shared by partners
- At the end of your pilot, we will have changed:
  - We will have sustainable Hippotherapy program able to help in a variety of ways
  - Foster children will have access to a positive, life changing therapy they enjoy attending.

# Sustainability Plan

- Bit by Bit is an unique organization in Benton and Linn County. Bit by Bit is open to any individual that needs assistance. By hiring an experienced assistant instructor, we would double our capacity to help people without adding additional horses or equipment.
- Currently 80% of our clients provide their own funding
- Continued successful fundraising programs and partnerships in the community such as-
  - 3rd annual golf tournament fundraiser
  - Re/Max scholarships
  - Private donor scholarships
  - Realtor Joshua Rockholt (contributes 1% of all sales)
  - Kristin Starkey, Town and Country Real Estate donate a portion of her commission sales
  - Rod and Andrea Holmquist donation of equine winter facility lease $8,000.00

# DST Member Questions?

# Coastal Kids Mentoring Program

## Neighbors For Kids – Depoe Bay, OR.

IHN-CCO Pilot PROPOSAL

# Pilot Summary and Goals

- The Coastal Kids Mentoring Program will use a one-on-one matching system to connect adult volunteers and youth, as an innovative approach to address and support the behavioral health of youth.
- Goal 1: Build support systems and make interventions for youth experiencing significant behavioral and mental health challenges
- Goal 2: Promote health equity and eliminate health disparities
- Goal 3: Improve health of underserved populations of youth with specialized social support (mentorship)

# Member and Community Need

Target Population:

- Youth ages 6-18, from underserved populations in rural Lincoln County
- Low income, diverse ethnic backgrounds, LGBTQ+, English Language Learners, foster care, homeless, special needs and disabilities
- IHN-CCO Member Impact: 70% or more will be members. Identified upon enrollment into program
- Community Needs: growing population of youth with behavioral health needs and lack of support services
- Youth identified by parents, school staff, therapists, counselors, juvenile justice system, or health professionals
- Examples at NFK – restraint vests on bus for safety, room clears due to violent outbursts, youth in “fight or flight”

# System Transformation

How is your proposal transformational?

- The power of the human connection
- Supportive, healthy relationships formed
- Youth non-profit partnering with mental health providers
- New approach for behavioral and mental health crisis intervention – circle of support
- Focus on communication, skill-building (assets) and new opportunities to experience
- Innovation: Trained adult mentors, structured program using one-on-one, family and group cohorts
- Addressing needs in aftermath of COVID-19 pandemic

# Partnerships/Collaboration

- Olalla Center For Children & Families – referral source, shared client case management, program integration
- Lincoln County School District - H.E.L.P. (Homeless Education & Literacy Program) – referral source and shared resources. Identification of mentees in need.
- Department of Human Services - Self Sufficiency Program & Child Welfare Program – referral source, social services and foster care system
- Samaritan House, Inc. - referral source and cross-sector services
- Health Care Providers – communication with primary care providers, counselors, therapists – SHS & county

# Health Equity Plan

- Matching mentors with mentees - shared racial, cultural, social and socioeconomic backgrounds
- Looking at social determinants of health and access to resources in a rural area, such as:

  Adequate housing, healthy food, safe transportation, education, recreation, dental, medical and mental health care

NFK will provide all program participants full scholarships:

-year round child care, nutritious meals, transportation, recreation, educational enrichment, field trips

-access to NFK equipment – surfboards, wetsuits, kayaks, row boats, sports equipment, art supplies, books

# Definition of Success

Measures & Outcomes include:

- Participation/Attendance (mentoring, family support, quarterly events, training)
- Pre and Post Surveys (Youth and Parents)
- Search Institute's Developmental Assets Profile (DAP) – a research-based social-emotional assessment

At the end of your pilot, what will have changed?

- New mentoring program will exist in Lincoln County
- Increased supports for youth with mental health and behavioral challenges
- Improved behavioral health, increased emotional and psychological well-being among youth

# Sustainability Plan

- Community Support and Strong Volunteerism
- Community Partnerships
- Diversified Funding Sources (public, foundation grants, individuals, corporate sponsors, fundraising events)
- Year one is critical to sustainability, must prove program is worthy of support – build the foundation
- Strategic Planning – vision and mission-focused

# DST Member Questions?

# Community Based Family Peer Support

## Oregon Family Support Network

IHN-CCO Pilot PROPOSAL

# Pilot Summary and Goals

- Creating a Community Based Family Peer Support and Respite program for all families in Benton and Lincoln County.

- Goal #1Increasing access to Behavioral Health Care
- Goal #2 Improving the Social determinants of health
- Goal #3 Improving Care for members experiencing a mental health crisis.
- Goal #4 Improving Health Equity

# Member and Community Need

- **Talking points:**
  - Who will this program support?
  - Impact
  - Community Needs

# System Transformation

- **Transformation**:
  - Increase partnerships to include student interns from OSU taking on the role of Youth Activity Leaders.
  - Preventive
  - Equity for accessing Family Peer Support and Respite.

# Partnerships/Collaboration

- **Traditional Community Partners**

Safe Families For Children

Health and Human Services

Child welfare and Self-Sufficiency

Parenting Success Network

Early Learning Hub

Developmental Diversity Program

- **OSU**

Intern partnership

- **Community Program Collaboration**

Steppingstone from levels of care

Ability to fill gaps and support waitlist

# Health Equity Plan

- Access for all Families
- Specific supports for the LatinX Community
- Families can self refer rather than be referred by a program or provider.
- Family Peer Support is an evidence based/proven practice among historically marginalized communities and increasing this support in those communities will begin to close the inequities in care, engagement and culturally responsive practices

# Definition of Success

- All Families have access to Family Peer Support and Respite
- Families will know how to navigate the systems that they are connected to.
- Families will know how to find, and access Community Supports
- Families can access Respite Care and therefore reduce stress and fatigue.

# Sustainability Plan

- Leveraging existing partnerships with Benton and Lincoln County as well as the SOC.
- Working with State and Local philanthropic foundations.
- Fee for Services

# DST Member Questions?

# Cultural of Supports

## North End Senior Solutions (NESS)

Jan Molnar-Fitzgerald, Founder and Executive Director

IHN-CCO Pilot PROPOSAL

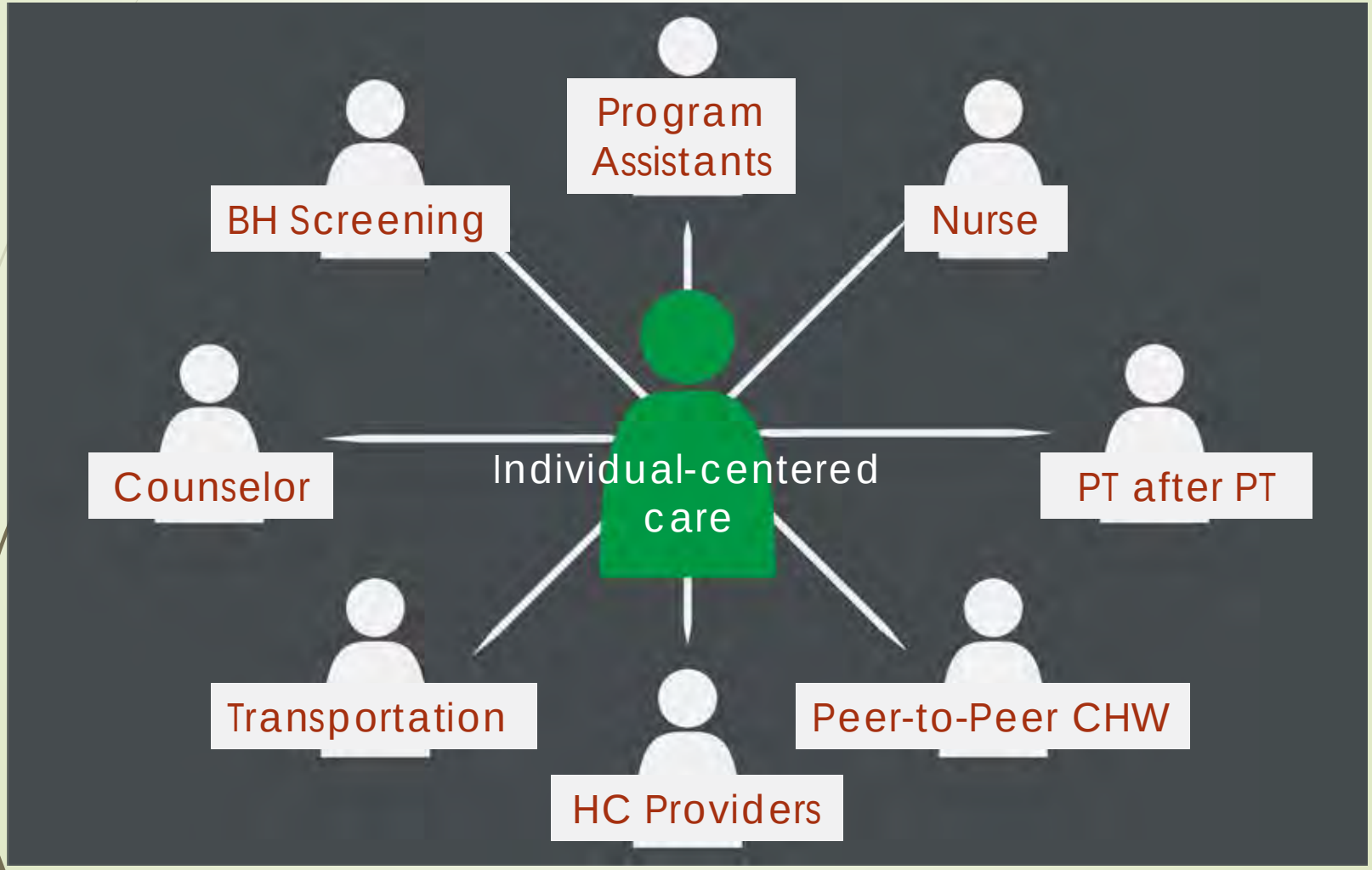
# Pilot Summary and Goals

**Summary**: I stole the title "Culture of Supports" from RFP, because it describes NESS's strategy and long-range plans. We propose to provide services and supports to IHN-CCO members, Health Care Providers (HCPs) and the community.

We propose to Pilot a Culture of Supports that Aims to:

- Goal #1 Improve member satisfaction with Health Care Providers HCP (A1)(A2)
- Goal #2: Provide Community Screening and Support Programs for Behavioral Health (BH1) (BH3) (BH4)
- Goal #3: Contribute to HCPs awareness, knowledge, and new skills for communicating with behaviors (BH2)(BH4)
- Goal #4: Provide more transportation options for members (SD2)
- Goal #5: Eliminate or compensate for disparities causing higher health risks, especially for elders and people living with disabilities. (SD4)

# Cultural of Supports



# Member and Community Need

- Talking points:
  - Target Population :
    - Over 16,000 of IHN-CCO's 55,000 members live in Lincoln County.
    - 41% of LC population are Seniors/people with disabilities
    - 7,266 Lincoln County residents (15.2% of the population) under 65 are living with a disability
  - A place for members: Caring, supportive, nurturing
  - Community Needs: without locally supports you're out of here, you'll have to leave.
  - Culture of Supports is the next step toward building a residential care home and skill-nursing/rehab


We need our own place

# System Transformation

How is your proposal transformational?

- Our proposal will reduce costs: Quoting Marianne Radcliff in response to managing Pace program in midst of Covid-19 Crisis, “when you give people what they need, problems go away….costs go down, even when the budget is used to fulfill the patients desires….the health improves and cost go down.”
- Positively effects CCO metrics: Anthony Biglan says “There is nothing that we can’t measure when it comes to well-being.”
- Improved Health is the object of pilot: Will before and after measures prove people are happier and healthier when we are purposely involved in our own well-being? We will see.
- What makes this pilot innovative?
  - Shifts the responsibility of health and well-being to members
  - Transportation provided, and sometimes by drivers who are involved with person’s well-being. (CHW)
  - Taking care of self and others becomes our community collaborative focus ---fills the gap in caregiver and nursing shortages

# Partnerships/Collaboration

- Marie Laper, Older Adult Behavior, “Preparing for Doctor’s Appointment.
- Gero Care, Stenzel and LCHHS expands BH supports
- Being awarded this pilot will generate providers’ attention and participation; We Need HCP partners
- Continued and expanding partnership with OCWCOG SDS and family caregiver programs, offering supports to IHN members via case managers.
- Private home-care agencies: RNs oversight and shared self-care strategies with member clients.
- NAMI, National Association of Mental Illness

# Health Equity Plan

- How will you address health equity and reduce health disparities?
  - Advocate for seniors and people with disabilities, particularly with screening and interventions
  - Advocate self-care, home- care,
  - Creatively address the lack of transportation options
  - Next steps in: NESS Inclusion, Diversity, and Equity Statement and Plan

# Definition of Success

- Surveys and evaluations show members are:
  - More satisfied w/ health care and providers
  - Taking more responsibility for their own health
  - Members see how mental and dental issues effect health
  - Getting their needs met and desires fulfilled = health
- Community Screening for behaviors and memory
- Safe and nurturing "place" to thrive
- Success is measured on member satisfaction; and HCP
- At the end of your pilot, what will have changed? Oregon no longer #51, at the bottom on AMI scale.

# Sustainability Plan

- Transportation expands as NEMT, increase nonprofit revenue stream
- BH Screening and some counseling billable to Medicare and most insurances
- Increased IHN member enrollment at NESS Club, ADS, and increased private pay enrollment
- Supportive grants for family caregiver program (APD) and other grants, such as Lincoln County.

# DST Member Questions?

# Mental Health Home Clinic

Robert Fallows, PsyD, ABPP
Tim McCarley, MD
Stephanie Dreiling
Heidi May-Stoulil, MHA

IHN-CCO Pilot PROPOSAL

# Pilot Summary and Goals

- The purpose of this pilot is to bring Mental Health services (with community partnership) to a rural service area that has chronic/complex medical and mental health conditions.
- Goal #1 Improve health scores
  - Lower scores in depression, PTSD and anxiety decreased by 25%
  - Lower HgA1c by 10% of original HgA1c
- Goal #2 Appointment completion/no show rates
  - 70% appointment completions (30% cancelled/no show)
- Goal #3 Decreased Emergency Department visits that are for MH/Crisis Services by 50%.
- Goal #4 Patient satisfaction scores of 80% or higher that would recommend the clinicians/facility.

# Member and Community Need

- Talking points:
  - Target Population: severe persistent mental illness and chronic/complex medical patients.
  - IHN-CCO Member Impact: Lebanon and close surrounding area patients with IHN.
  - Community Needs: more access to Mental Health and Behavioral Health resources that concentrates on both the physical and mental health specific needs
  - Team based approach: This clinic would have therapists, group therapy, medication management, case management, crisis intervention, behavioral health consultants and primary care in one location.

# System Transformation

**How is your proposal transformational?**

- We are in a unique position by bringing Linn County Crisis, C.H.A.N.C.E, Samaritan Mental and Behavioral Health specific expertise, from multi-agencies and interdisciplinary teams in one location.
- Increases communication for transition of care between agencies
- Serving the severe persistent mental illness in a comprehensive team approach for both physical and mental health needs.

- **Will your proposal reduce costs, positively affect CCO metrics, or improve IHN-CCO member's health? How is this pilot innovative?**
  - Reduce cost in utilization of Emergency room visits
  - Improve CCO metric such as HgA1C
  - Patients engaging and partner in their care leading to better patient outcomes and satisfaction
  - Patient center and team approach that is focused on Behavioral Health and Mental health needs of the patient while still having the primary care clinician in the same location.

# Partnerships/Collaboration

- Linn County Mental Health would provide the crisis services and case management due to their broader experience with this population, as well as appropriate crisis service as directed by the OAR.
- C.H.A.N.C.E. would provide peer support services and education while striving to increase personal accountability and engagement, which they have a significant degree of experience with.
- SMG Mental Health/Behavioral health would provide the medication management and therapy services, as well program oversite and data gathering/tracking.

# Health Equity Plan

- How will you address health equity and reduce health disparities?
  - Recruit for bilingual clinicians.
  - Have procedures in place for translation services.
  - Have multi-language educational/handouts for patients.
  - This clinic will serve patients of all backgrounds and ethnicities.
  - This clinic will serve those who are low on the socio-economic scale, including the homeless.

# Definition of Success

- Improved HgA1c numbers, lower scores in PTSD, Depression, and Anxiety scales, the number of completed vs no showed/cancelled appointments, clinician retention, the percentage of patients who would refer their family/friends to the facility/clinician.
- Data will be collected and tracked monthly using the electronic medical record to show the changes and decreases in scores and appointment completion. Third party vendor will be used to track patient satisfaction.
- At the end of your pilot, what will have changed? We will have seen significant decrease in ED visits and improvement in physical and mental health of this targeted population

# Sustainability Plan

- Other sources of grant funding will be considered, if necessary
- The measurable goals are quantifiable, and the cost savings will be the primary mechanism for continued support
- Continued IHN payment through billable services, and considering Alternative Payment Methodology
- Private payer mix, if applicable

# DST Member Questions?

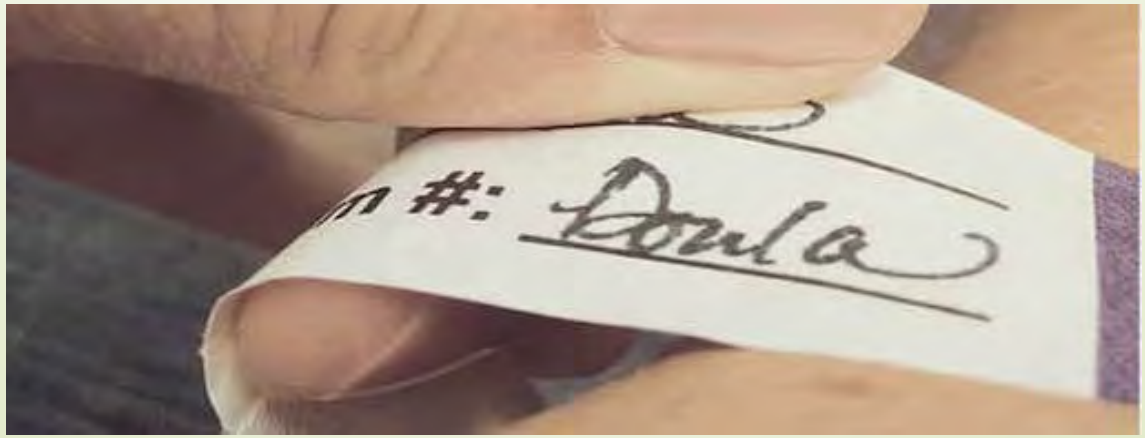
# **Community Doula Program:** Spreading Promising Practices

IHN-CCO Pilot PROPOSAL

Community Doula Program

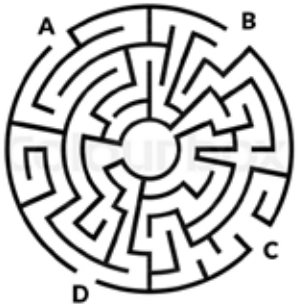
# Pilot Summary and Goals

- Spread promising practices to rural East Linn County
  - CDP doulas improve outcomes, increase satisfaction with care, decrease costs
  - once established, CDP doulas are self-sustaining through reimbursement
  - CDP doulas have attended 0 births at Lebanon hospital
- Spread promising practices to Lincoln County
  - CDP doulas have attended <10 births at Newport, and 0 at Lincoln City hospital
- Increase access to THWs through expanded postpartum services
  - Perinatal mood disorder screening, parenting support, safe sleep, contraception counseling



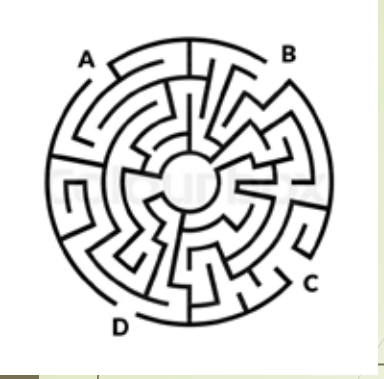
# Member and Community Need

- CDP serves only IHN-CCO members
- CDP results in Albany/Corvallis
  - 15% cesareans (expected 30%)
  - no preterm births (expected 6-9%)
  - >95% initiated breastfeeding (expected 60%)
- Postpartum care and rural maternity care of any kind are lacking (maternity care deserts)
  - expanding doula care in these ways has been shown to improve outcomes




# System Transformation

- Leveraging existing personal relationships to bridge care silos.
- Positive outcomes from CDP programming in Albany and Corvallis have shown positive health metrics, cost reductions, increased member and provider satisfaction
- **CCO 2021 incentive metrics include expanding post partum care, depression screening, and culturally and linguistically responsive care**
- Members accessing CDP doulas report transformative experiences




# System Transformation-2

- **Provide doulas for free to those people who need care the most (not those who can pay)**
- Focus on social and interpersonal interventions, rather than technologies
- Systems integration: CDP doulas are thoroughly integrated into the maternity care workflow at Corvallis & Albany
- Oregon is a leader in providing doula care as an integrated part of the health system and CDP Doulas are currently 1/3 of all THW doulas statewide.

# Partnerships/Collaboration

- Good Samaritan hospitals—Maternity Care Coordinators
- Public health nurses and health departments
- Social service agencies and community based organizations in Lebanon, Sweet Home, Brownsville, Toledo, Lincoln City
- Confederated Tribes of Siletz Indians Tribal Health, Confederated Tribes of Grand Ronde, Oregon Health Authority Tribal Affairs, Legislative Commission on Indian Services—Senate Bill 770 Workgroup
- Ongoing collaboration with Healthy Families, Pollywog, Lincoln Health Center, WIC.
- Oregon State University
- Birthswell, LLC
- OSU Folk Club

# Health Equity Plan

The CDP provides the highest quality services to the most underserved members of our community as a means of building an equitable health care system. We have committed to this by:

- Recruiting and training doulas with lived experience in the communities they serve
- Removing barriers to accessing care (transportation, language, cultural norms)
- Developing programs in rural areas
- Advocating for a living wage for THW Doulas
- Centering members and doulas in program leadership
- Seeking training for CDP leadership on reproductive justice
- Hiring a Black CDP doula to hold the leadership team accountable

# Definition of Success

# Definition of Success

| **Goals 1&2** | **Spread CDP Doula Services to Eastern Linn and Lincoln County** | |
|---|---|---|
| *Measure* | *Methodology* | *Definition of success* |
| Increased referral rate from Lebanon and Lincoln county hospitals | Relationship building and sharing of outcomes | 10% referral rate in year one (Lebanon 25; Lincoln County 30), 10 doulas trained |
| Increased member engagement from rural communities | Track address data and evaluate by RUCA codes | 10% increase in rural services based on RUCA code analysis, 10 doulas trained |
| **Goal 3** | **Expanded Postpartum Services** | |
| *Measure* | *Methodology* | *Definition of Success* |
| Parenting Groups | On-line Zoom meetings with skilled facilitators | Addition of queer parenting group, >50% increase in attendance, client feedback on value |
| Safe Sleep resources | Free distribution of resource packages to all in need as assessed by CDP doulas and collaborating pediatricians | Clients who need safe sleep options receive them (estimated 20-30/year) |
| Contraceptive resources | Integrate checklist education, client Q&A and connection to free and low-cost options during extended postpartum visit delivery schedule | >70% of CDP clients who receive postpartum care receive contraception counseling and assistance to access services as needed |
| Additional postpartum visits | All CDP clients offered 4 postpartum visits | >50% of clients served receive 4 in-home (or zoom) postpartum visits |
| Healthy Families Bridge Program | Joint training with Doulas and Healthy Families to establish warm referral process | 10 joint visit warm hand-offs/year one |
| **ALL CDP SERVICES** | Stakeholder evaluation of project success, interviews and questionnaires | Generally positive feedback, evidence that QI issues are effectively addressed |

# Sustainability Plan

Goals 1 & 2 (spread promising CDP doula practices into east Linn and Lincoln Counties)

- Once established, these are reimbursable services. CDP is currently sustainable in Corvallis and Albany; we anticipate the same will occur in these new service areas

Goal 3 (expanded postpartum services)

- These will be supported in an ongoing manner with community fund grants and donations
- We will also advocate for expanded postpartum reimbursement both at the state level and in contract negotiations with CCOs

# DST Member Questions?