ENLACES

IHN-CCO Pilot PROPOSAL
August 13, 2020

Claudia Torres, MAC, Executive Director
Ricardo Contreras, PhD, President of the Board of Directors

Pilot Summary and Goals

- We are proposing to implement ENLACES, a pilot project to develop a traditional health worker program in Linn County. Through this program we expect to expand the capacity of our organization to serve the most vulnerable Latinos in the county by reaching out to individuals and families at their homes, through a mobile office we will set up in Albany, and by engaging with Latino stores and churches.
- Goals:
  - Goal #1: To identify needs in the Latinx community of Linn County across the social determinants of health
  - Goal #2: To address the felt-needs of Latinos in the area
  - Goal #3: To connect the Latino community with the system of services in the County

Member and Community Need

- Population and CHW Characteristics
  - The ENLACES pilot will work with vulnerable Latinos in Linn County, including low-income families, youth, farmworkers, immigrants, and refugees. In households with a mixed of insured and uninsured people.
  - The ideal community health worker candidate
    - Latino immigrants or first-generation US born
    - Live in the community
    - Bilingual
    - Formal or informal leadership experience in the community

System Transformation

How is your proposal innovative?

- Managed by a local community-based organization led by people of color
- Will require strong cross-collaboration to succeed especially between healthcare organizations and Casa Latinos
- Lack of culturally-specific programs in the area led by Latinx organizations
- Sharing knowledge and findings with our partners to help decrease inequities from the perspective of an organization that relates to the people served
- We will challenge traditional ways of thinking and decision-making that intentionally or unintentionally leave people in disadvantage

Partnerships/Collaboration

- Bi-weekly check-ins with local health department
- Ongoing communications through partner monthly meetings to share information and exchange feedback
- Primary Partners:
  - Benton County Health Department
  - Linn County Department of Health Services
  - Lebanon Community Schools
  - Greater Albany Public Schools
  - Linn-Benton Health Equity Alliance
  - Community Services Consortium
  - Samaritan Health Services
  - City of Albany, Housing Services
  - Farm Worker Housing Development
  - Linn-Benton Food Share
  - Linn-Benton Housing Authority
  - Oregon Health Authority

Health Equity Plan

- How will you address health equity and reduce health disparities?
  - Social Determinants of Health Framework - address the factors that affect a person's well-being
  - The promotoras will educate the system of service providers about the Latino community so that services can be provided in ways that reflect an awareness for the sociocultural characteristics and needs of that community.
  - Promote access to resources and information
  - Our goal as an organizations is to create systemic change - future generations will benefit

Definition of Success

- We will have a model and infrastructure to reach out to the most vulnerable Latinos in Linn County
- Increased level of awareness and knowledge of resources and services available to people
- Providers will have an increase awareness and knowledge of the Latino community, its sociocultural characteristics, felt-needs, and assets.
- We will have a set of collaborations with local partners

Definition of Success

- Measures & Outcomes
  - Goal 1: To identify needs in the Latino community of Linn County across the social determinants of health.
  - Number of homes visited
  - Number of interactions in parks, places of employment, and other locations
  - Number of households assessed
  - Number of people whose needs were identified across the social determinants of health
  - Demographic characteristics of the people whose needs were assessed
  - Types of needs identified
  - Demographics of the families visited
  - Characteristics of the needs identified
  - Strengths that the promotoras identify in individuals and families

Definition of Success

- Measures & Outcomes
  - Goal 2: To address the felt-needs of Latinos in Linn County
    - Number of pieces of information distributed
    - Types of information delivered across the social determinants of health
    - Number of people served through the delivery of information
    - Facilitators and barriers of accessing information from service providers
    - Facilitators and barriers of distributing information in homes and other places
    - Clients' level of satisfaction with the solution provided

Definition of Success

- Measures & Outcomes
  - Goal 3: To connect the Latino community with the system of services in Linn County
    - Number of referrals by agency
    - Number of referrals by social determinants of health
    - Number of people served through referrals
    - Feedback from partner service providers on how ENLACES has contributed to change their level of awareness and knowledge of the Latino community and its needs.
    - Facilitators and barriers of making referrals to service providers

Sustainability Plan

- Specifically address how the pilot activities will be funded or continue on after DST funds are completed.
  - OHA COVID CBO Funds will give us a 6-month head start -> Fund 1 CHW
  - If fully funded by IHN, we will be able to work on the proposed goals by hiring 2 CHW for 1-year
  - Beyond the first year...if successful, we plan to make a commitment to our community to keep it going by reaching out to funders like the Northwest Health Foundation, the Oregon Community Foundation, and The Ford Family Foundation.

DST Member Questions?

IHN-CCO Pilot
PROPOSAL

Partners with Parents and Children

Linda Gray, MA LPC

Pilot Summary and Goals

Lincoln County's Child & Family Behavioral Health program will partner with Maternal Case Management, helping to provide treatment to young families or individual family members that qualify based on scores from the Patient Health Questionnaire-9 (PHQ9) for Adults or ASQ (Ages & Stages Questionnaire) for child/infant.

- Goal #1-Provide Mental Health services to;

a) New Mothers, who have higher rates of maternal depression

b) Children 0-6-year age range as its population is one of the most underserved in our rural area.

- Goal #2- Supporting Families

The primary goal of CPP is to support and strengthen the relationship between a child and his or her caregiver and restoring the child's cognitive, behavioral, and social functioning.

- Goal #3-Parent Group

This would reduce isolation by building a social network with other parents, build and practice parenting/attachment skills, strength-based with solution-led conversation and topics.

Member and Community Need

Community Needs:

Lincoln County is a rural county that has a high population of low-income members. Since the county is also geographically challenged it is difficult for young families to travel back and forth from services. This program would help provide a service to the community where the needs are most prevalent, for example-

- Depressed Mothers who are working with Maternal Case Management and based on a 10 or higher on the PQH9 may qualify for services through Mental Health.
- Inter Community Health Network (IHN-CCO) Member Impact-Research data shows that depression is high among low-income and pregnant women.
- Early Childhood population is majorly underserved.

The benefits of this service would increase and enhance parenting skills and help decrease maladaptive behaviors in the future, which can be cost saving to IHN.

System Transformation

How is your proposal transformational?

Once this collaboration between Maternal Case Management and Mental Health is established our goal is to include:

- DHS Child Welfare
- Women, Infants and Children
- Self-Sufficiency

Overtime, the cost reduction will be a long term effect, by working to decrease depression (which can adversely affect parenting skills and to work with the 0-6 population to involve parents in enhancing their parenting skills), metrics will also show a positive effect by reduction of ED Services, crisis and higher levels of psychiatric treatment.

What makes this pilot innovative?

This pilot is innovative as Mental Health will use two evidenced based treatments-i.e. a CBT curriculum for depression and a Child Parent Psychotherapy Model for parent/child skill building and treatment for the 0-6 age range. Cognitive Behavioral Therapy (CBT) and Child Parent Psychotherapy (CPP) are evidence-based programs that are accepted by the State of Oregon.

Partnerships/Collaboration

- The focus of this treatment would initially be engaged with Maternal Case Management. We would like to expand and include DHS Child Welfare; Women, Infants and Children and Self-Sufficiency.
- The Maternal, Infant, and Early Childhood Home Visiting Program gives pregnant women and families, particularly those considered "at-risk", the necessary resources and skills to support and help raise children who are physically, socially, and emotionally healthy and ready to learn.

"It will be a natural offshoot of our home visiting program to have Mental Health team up and provide services. The women we serve are very trusting of the nurses that see them. Referring them to Mental health Clinician will be much more like a warm handoff. We have a history of providing this service in the past and it was very well received."

Health Equity Plan

How will you address health equity and reduce health disparities?

- Maternal Case Management services are population based. We have a bilingual Child Health Worker CHW that participates in nurse home visiting and our PAT team is bilingual as well.
- Pregnant and new mothers are often left experiencing significant levels of anxiety, depression and/or other mental health challenges, which can have a profound effect on their attachment with their newborn and an impact on the child's emotional, behavioral and developmental growth.

Health Equity Plan

How will you address health equity and reduce health disparities?

- The 0-3-year-old population is one of the most unattended age range in our rural area. With the 0-3 population, there are no programs in this county that work with this age group or focuses on attachment and trauma of both the parent and/or the child. The Impact will be on physical and mental health issues that can actionably change the course of Parenting skills and increase the probability that an infant/child and their family will have the necessary resources to provide growth for all family members. It can provide the necessary tools so that abuse and neglect are minimized and/or eliminated in a family setting.
- Another final but important impact is a that it would enhance the ability to keep the family out of the Emergency Dept. If there is a concern about MH or behavioral issues, they would have the support needed to discuss concerns regarding their or their child's needs.

Definition of Success

- PQH9>10 will generate a referral. An ASQ will be used to determine appropriate developmental stage in the infant/child.
- For treatment in the Child/Infant Program an ASQ-SE and DECA (Devereux Early Childhood Assessment tools).
- PHQ9 will be used monthly to determine continued treatment needs. An ASQ in the normal developmental stage would be positive to determine norms.
- ASQ-SE and DECA for the infant/early childhood and Parent program

What data will you use to measure success?

- It will be measured and reported using the PHQ9, ASQ, ASQ-SE and DECA tool kits. Use of tools through our QA/QI process.

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

- Successful Mental Health treatment with Mom's and family depression and/or using Child Parent Psychotherapy. Sustainability with billing process and referrals from other Agencies such as Child Welfare.

Sustainability Plan

- Specifically address how the pilot activities will be funded or continue after DST funds are completed.
- Outreach and education in the community
- Brochures, posters, radio spots
- Working with Partner Agencies to provide access to a more robust referral process.
- Billing for services that are billable in OHA and IHN billing processes.

DST Member Questions?

Harm Reduction + HCV Treatment in Primary Care

Aimee Snyder, DrPH

IHN-CCO Pilot PROPOSAL

Pilot Summary

Pilot Summary

Integrating Services to Address Inequities in Access to Care in Lincoln County

Partnerships/Collaboration

LC Public Health	LC Primary Care	Siletz Community Health Clinic	Samaritan Infectious Disease

• Health Promotion:
  • Central Coordination and Reporting
  • Harm Reduction
• Communicable Disease investigation and contact tracing
	• Informs the HCV treatment protocol, charting/billing development, and training needs
	• Implements the HCV treatment
		• Central Coordination and Reporting
		• Harm Reduction
		• Informs the HCV treatment protocol, charting/billing development, and training needs
		• Implements the HCV treatment
			• HCV treatment protocol and expert guidance
			• Ensures HCV best practices
			• Provider training
			• On-going E-consult
			• HCV pharmacist

Pilot Goals

Supports

1. To organize the collaborative intervention, implementation, and monitoring processes and supports needed

Model

2. To establish a complete HCV Care Cascade in Lincoln County with support of a medical home and Community Health Worker

Access

3. To increase access to and acceptability of HCV screening and treatment for populations most at risk for HCV infections

Treatment

4. To increase the number of at-risk individuals in treatment for HCV infections

Member and Community Need

- Oregon has high HCV incidence and death burden
- Lincoln County has one of the highest HCV incidence and is listed as a high risk of HCV outbreaks
- People who: use drugs, are unstably housed, been incarcerated, have or are at risk for HIV, LGBTQAI2S+, Native Americans, and people of color
- Majority are IHN-CCO members or eligible
- 5-month pilot in 2019:
  - High interest in HCV testing in the at-risk community
  - 17% reactive for antibodies and barriers to HCV treatment (time and transportation)
    - 32% of people who reported injection drug use were reactive

System Transformation

- Multi-agency collaboration to: 1. Integrate services, and 2. Change the service environment
- Using collaboration to implement evidence-based practices: HCV treatment in primary care[6-13] with specialist e-consult in electronic health records (EHR)[16]
- Establishing a new, sustainable billable service
- Reducing the cost of HCV care through early detection, reduced time to care, and non-specialist care
- Laying the groundwork for HCV micro-elimination[8,14]; Scalable
- Demonstrating a Modernized Public Health system
- Exploring value of Harm Reduction CHW outreach, linkage to care, and navigation services and billability

Health Equity Plan

Inequity influenced by Social Determinants:

Poor HCV outcomes in Lincoln County and marginalized populations caused by barriers to HCV care

Equity Components of Intervention:

1. Targeted no-cost outreach screening and navigation supports provided by Harm Reduction CHWs to most at risk

2. Increased access to and acceptability of HCV care in geographic area through a medical home

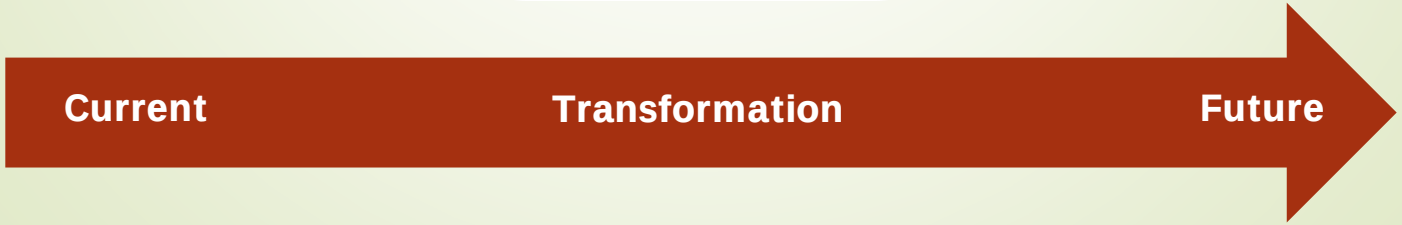
Targeted Outcome:

Higher proportion of at-risk pops receiving HCV care

Less disparities in HCV outcomes

Fewer HCV transmissions

HCV micro-elimination



Definition of Success

- **Goals 1 and 2:** Organization of the supports and the HCV Care Cascade model
- **Goal 3:** Access to Care
  - # of screening events targeting at-risk populations
  - # of clinical sites providing HCV care
  - % of reactives reaching each stage of the Care Cascade
  - Length of time between appointment request and appointment
  - Continued barriers to care identified
- **Goal 4:** Treatment
  - # of at-risk individuals in treatment
  - # of IHN-CCO members in treatment

Sustainability Plan

- Integration and coordination of existing services
- Collaborative systems change capacity and treatment capacity built will remain
- Supports developed (provider training, EHR charting/billing/e-consult structures, partnerships) will continue
- HCV treatment in primary care is billable
- E-consult by specialist is billable
- Harm Reduction funded through 2022: Exploring billability for Harm Reduction outreach screening and navigation/case management service
- Scalable to other IHN-CCO service areas, and beyond
- Foundation of micro-elimination to prevent future transmissions

DST Member Questions?

Partnership for Oral Health

Linda Mann, EPDH, Director of Community Outreach
Capitol Dental Care

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- Our project is designed to improve access to oral health services and provide greater support to members with dental anxiety and mental health issues. We will train traditional health workers (THWs) to increase their awareness of the impact dental health has on overall health, provide in-depth steps they can take to assist members access their dental care network and ways they can assist the member during dental treatment. The project will make an Expanded Practice Dental Hygienist (EPDH) available as a resource for better understanding of dental issues. The EPDH will coordinate and provide clinical care at community locations to reduce access issues such as the ability to get to a dental office and the anxiety of a dental office environment.
- **Goal 1**- Create and champion supplemental oral health education for THWs.
- **Goal 2**- Reduce barriers to dental care access for key populations- pregnant women, patients with diabetes, persons with mental illness or suffering with behavioral health issues, and children in DHS custody.
- **Goal 3**- To improve oral health utilization among IHN clients and positively impact dental related OHA metrics.

Member and Community Need

- The target population is pregnant women, persons with diabetes, persons suffering with mental illness and behavioral health issues, persons in recovery and children in DHS custody.
- IHN-CCO Member Impact-This project includes members assigned to Samaritan Mid Valley Health Center (about **4,800** members assigned), children in DHS custody in East Linn County (roughly **50**), members with diabetes in East Linn County (about 500), and members served at STARS (about **394**).
- Community Needs- **Samaritan Treatment and Recovery Center/STARS**-STARS recognized that many of their clients have not accessed dental services for many years and hoped to bring dental services onsite to bridge the many barriers their clients face receiving dental care including anxiety, transportation, not knowing how to navigate the dental system and other barriers. Having STARS reach out and ask for this partnership was instrumental in us creating this pilot. **Samaritan Mid Valley Health Center** also reached out to partner so that their patients who are not accessing dental services have one more access point so barriers are removed making health more equitable.

System Transformation

- This pilot is ***innovative*** in that it is
  - expanding the reach of a dental hygienist to the locations where the most vulnerable members frequent
  - bringing together community partners and THWs to bridge the gap between oral health, behavioral health, and physical health.
- This pilot will ***positively influence*** dental-related OHA metrics while also reducing disparities and building confidence with behavioral health patients.
- This pilot will ***improve oral health navigation*** for some of the most vulnerable persons in E. Linn county and create a model for the rest of the state to emulate.
- This pilot could ***reduce costs to the healthcare system*** by addressing oral health needs in the community thereby reducing visits to the ER for non-traumatic dental conditions.
- This pilot will ***increase dental utilization*** for previously underserved IHN and community members.

Partnerships/Collaboration

- **Samaritan Lebanon Community Hospital**
- **Department of Human Services, Lebanon Branch**
- **Integrated Foster Child Wellbeing Pilot**-Dr. Carissa Cousins
- **Samaritan Treatment and Recovery Center/STARS**
- **Samaritan Mid Valley Health Center**

- **Traditional Health Workers in Linn county who work with clients/patients in each of these settings**

Health Equity Plan

- ***Increasing access to dental services*** in settings where persons are already accessing other services, we are **decreasing transportation barriers, mobility challenges, time constraints, scheduling difficulties, and minimizing dental anxiety**.
- Our pilot will ***not seek reimbursement for services*** even when the Medicaid member is not assigned to CDC. If reimbursement was sought, this would create inequitable care for all. The locations selected serve populations that have **experienced health disparities**. The project focus at these sites will help **promote care and reduce health disparities**.
- ***Utilizing THWs to educate and help alleviate dental anxiety*** for patients/clients will not only increase the value of the THW in the partner site (for instance, at STAR), but also provide a calming link for clients who have extreme dental fear. Dental providers, the EPDH and community dental partners, will have an opportunity to recognize THWs as valued members of the oral health workforce. **Reducing dental anxiety and phobia reduces barriers of care and furthers the notion of improved oral health through awareness and prevention.**
- Health equity data will be collected by survey for patients/clients who utilized the services of the EPDH in these settings, as well as THWs who complete the oral health training.

Definition of Success

- Creation and utilization of THW training
  - At least 50 % regional THWs trained
- THWs providing assistance to clients/patients with dental needs and concerns
  - THWs provide assistance to XX clients/patients during pilot year (TBD after meeting with THW cohort)
- EPDH providing dental services for patients at partner sites
  - Track encounter data
- Creation of closed loop referral system to be used between partnering sites and Capitol Dental Care
- Increased dental utilization (increase of OHA metrics) in E. Linn county for pregnant women, patients with diabetes, patients with behavioral health or mental illness diagnosis, and children in DHS custody.

Sustainability Plan

- The payouts received by reaching the metrics will be used to offset costs to sustain the model.
- By addressing oral health needs in the community, we may reduce visits to the ER for non-traumatic dental conditions. This would reduce costs to the healthcare system. A portion of those savings could be redirected to continue the project.
- Samaritan Lebanon Community Hospital has already invested in housing the EPDH for the last year. They value the services provided at the hospital and proudly share this role among partners in the community. Partners such as SMVHC, STARs and DHS will also invest time and commitment to ensuring referral protocols are followed, space is provided, and will promote the importance of behavioral and oral health bridges in conjunction with physical health.

DST Member Questions?

The CommCard Program

The Arc of Benton County

Diane Scottaline, Dr. John Gotchall, Cody Gotchall

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- The Arc of Benton County is proposing The CommCard Program, a communication and accommodation program for people with developmental disabilities (DD) and the healthcare professionals who serve them.

- Strengthen self-advocacy skills among adolescents and teens with a communication tool, by making the CommCard part of the Individualized Education Plan (IEP) for every student who qualifies
- Increase DD literacy and skills among healthcare professionals
- Improve communication between patients with DD and their healthcare providers, ensuring adequate care

Member and Community Need

- Talking points:
  - Target Population: Adolescents and Teens with developmental disabilities in Benton, Linn and Lincoln Counties and their healthcare providers
  - IHN-CCO Member Impact: People with DD make up ~20% of the general population and only 20% of them are employed, making most eligible for Medicaid.
  - People with DD use the healthcare system more than their neurotypical counterparts
  - Community Needs: The DD population is growing, schools need more Special Ed teachers, DD education is not yet a prioritized learning objective for healthcare professionals (HCPs)

System Transformation

How is your proposal transformational?

- Linking the Education and Healthcare Systems
  - Students with DD will be taught how to self-advocate in healthcare settings with the CommCard.
  - Breakdown the barrier of poor communication between person with DD and their HCP, improving medical management and health outcomes
  - A simple, tested tool (the CommCard) is brought into the healthcare system. Cardholders role play with uniformed HCPs, and HCPs receive training in DD awareness and accommodations

Partnerships/Collaboration

- The Arc is building relationships with current and former teachers in the tri-county area
- The Arc board member, Dr. John Gotchall, is advocating in GSRMC for DD awareness and accommodations. Further collaborations will follow.

Health Equity Plan

- How will you address health equity and reduce health disparities?
- Studies indicate that the main barriers to access of quality healthcare by people with DD are 1) lack of formal training for healthcare providers and 2) communication deficits between providers and patients[1]
- Communication accommodations afforded under the Americans with Disabilities Act (ADA), when begun at the primary care home and provided at every intercept of healthcare delivery, can reduce the use of more expensive emergency and intervention DD services later.
- The CommCard breaks down communication barriers, providing access to quality care for people with DD.

[1] Ervin, David A, et al. "Healthcare for Persons with Intellectual and Developmental Disability in the Community." *Frontiers in Public Health*, Frontiers Media S.A., 15 July 2014, **www.ncbi.nlm.nih.gov/pmc/articles/PMC4098023/**

Definition of Success

- Measures & Outcomes
- Numbers of students carrying a CommCard; numbers of HCPs receiving DD training; numbers of cardholders using the CommCard with their HCP
- What data will you use to measure success?
- Pre andPost-test results will show the change in comfort levels and awareness before and after training
- Follow-up conversations with CommCard holders will offer anecdotal evidence of the benefits of the card with medical providers
- At the end of your pilot, what will have changed?
- Young people with DD will gain self-advocacy skills to interact with their HCPs; communication will improve between ppl with DD and their HCPs, improving health management and outcomes; sensitivity, awareness and skills serving people with DD will improve among HCPs increasing effectiveness and professional satisfaction

Sustainability Plan

- Specifically address how the pilot activities will be funded or continue on after DST funds are completed.
- The Arc will identify champions within the healthcare settings to sustain DD awareness and include DD training in the facility's training budget; the CommCard program can be franchised to entities in the 3 counties; The Arc will seek continued support for DRT work

DST Member Questions?