# 2015 Q1 Pilot Quarterly Reports
# Executive Summary

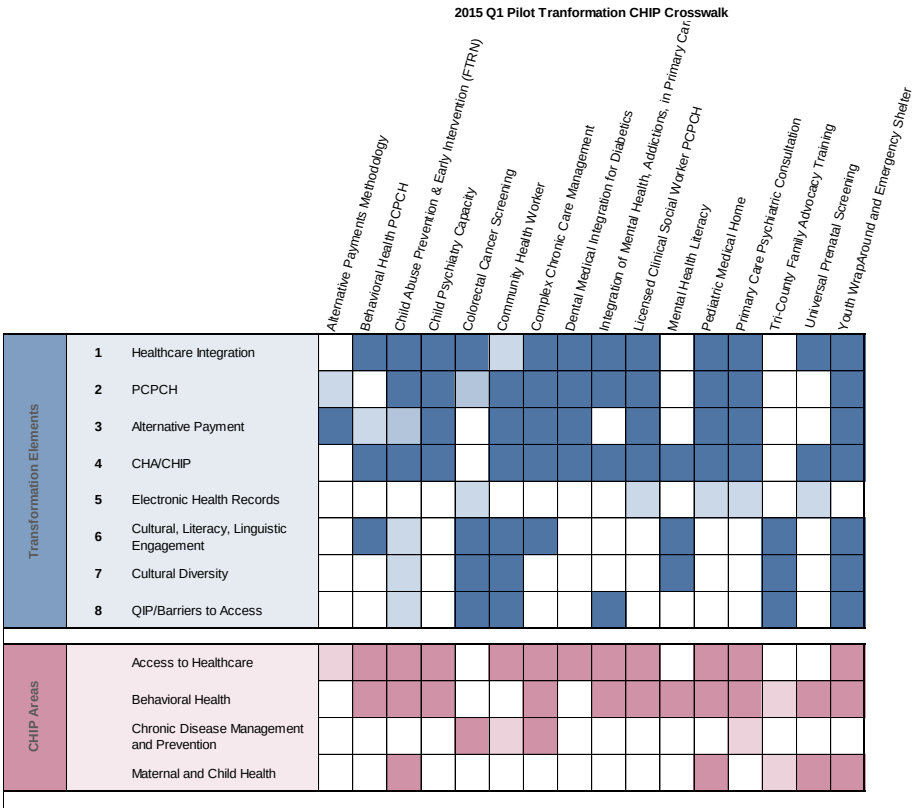
## Objective:

This document provides a summary of progress for the first quarter activities of the 2015 Pilots.

## Summary of Findings:

1. **Reports Captured:**
    - 14 pilots reported, 2 deferred
2. **Pilots Reporting Changes:**
    - Alternative Payment Methods
    - Child Psychiatry Capacity Building
    - Primary Care Psychiatric Consult
    - Pediatric Medical Home
3. **Pilots Unable to Execute:**
    - Integration of Mental Health and Addiction in PC

## Elements of Transformation and CHIP Areas Addressed by Q1 Pilots:




## Approach:

Section 1 provides a summary of reported pilot successes and barriers. Section 2 details Pilot goals, measures and results

## Section 1: 2015 Q1 Pilot Reports Progress Summaries

### ALTERNATIVE PAYMENT METHODS (SIM, Coastal, BCHD)

**Carla Jones, IHN-CCO, (SIM, Coastal, BCHD)**

***Successes:***

1) Been able to reach out and proactively schedule patients we did not know were assigned to SIM for appointments.
2) Partnering with Samaritan pharmacy to do medication reconciliation 1x/wk.

***Challenges:***

1) Risk scoring system shows zero risk 3 and 4 patients likely due to the fact these are largely expansion population. Discussing in APM workgroup.
2) Efficiently reconciling CCO patient assignments. After this had been accomplished, upkeep is simple.

***Change in Pilot:*** Initial intent on capturing SBIRT, PHQ-9s with tablets may need to be rethought based on meetings with EPIC and IT departments..

### BEHAVIORAL HEALTH PCPCH

**Tracy Lenee Bluhm, Corvallis Family Medicine**

***Successes:***

1) Increase in patient referral numbers for MH services.
2) Making progress toward a fiscally viable model which included advertising to IHN-CCO patients.
3) Implementation of SBIRT assessment and interventions.

***Challenges:***

1) Lower than expected referral numbers. Working on advertising services to IHN patients.
2) Challenges in applying for a DMAP and OHP provider number.

### CHILD ABUSE AND EARLY INTERVENTION

**Renee Smith, Family Tree Relief Nursery**

***Successes***:

1) Determined measures that would match elements of transformation.

***Challenges***:

1) Recruiting and hiring bilingual staff.

### CHILD PSYCHIATRY CAPACITY BUILDING

**Dr. Caroline Fisher, Samaritan Mental Health**

***Successes:***

1) Having MH Specialist allows psychiatrist to feel comfortable not seeing patients as frequently for follow-up and has increased capacity.
2) Families like not having to come into the office, but still feel taken care of with phone contacts.

***Challenges:***

1) Moving practice out of OMC to SFC created situation where unable to determine who is on the case load and original patient outcomes measures are not available for comparison. Can determine who is on case load only when patients call in for appt or medication refill.
2) Some families do not want to transfer back to PC.

***Change in Pilot:*** Dr. Fisher will transfer her practice days to Samaritan Family Center 2/1/2015. Old Mill will not provide pilot related services after that date.

### COLORECTAL SCREENING CAMPAIGN

**Megan Mackey-IHN CCO, Rachel Petersen-Lincoln Co, Erin Sedelak-Linn Co.**

***Successes:***

1) Partnering with Oregon Health Authority for this pilot.

***Challenges:***

1) Work plan needs to be more detailed to ensure alignment of all project components.

### COMMUNITY HEALTH WORKER

**Kelly Volkmann, Benton Co. Health Dept.**

***Successes:***

1) Kelly Volkmann is frequently asked to talk about CHW at webinars and conferences at regional and national level.
2) Partnering with the CCO is a new and different idea for most in the nation. The great interest expressed in what we are doing and how we are doing indicate this is important, significant and innovative work.

***Challenges:***

1) Scheduling meetings across three agencies. Getting EPIC and Samaritan HR trainings has be slower than expected.
2) Needing to put the brakes on clinics being very anxious to send CHW into roles for which the HUB wants to be sure CHWs are prepared. Not “ready to go” like MAs or RNs.

## Section 1: 2015 Q1 Pilot Reports Progress Summaries

### COMPLEX CHRONIC CARE MANAGEMENT

**Terry Crowder, The Corvallis Clinic**

***Successes:***

1) Support from clinic management and working with care coordination staff has been very positive.

***Challenges:***

1) Leadership staffing changes have slowed progress and have required reorganization of duties.
2) Developing the 24/7 coverage has required negotiations on a payment model. It is hoped an agreement can be reached by early April.

### DENTAL MEDICAL INTEGRATION

**Eryn Womack, IHN-CCO**

***Success:*** The high level messages of the pilot are being taken seriously:

1) There is a link between diabetes and oral health, and
2) Medical and Dental providers can and should work together to address the oral health of diabetics

***Challenges:***

1) Scope of pilot: As a work group we're exploring how to make clinic implementation with the dental delivery system easier.

### INTEGRATION OF MENTAL HEALTH AND ADDICTION IN PC

Rebecca McBee-Wilson, Lincoln Co

***Successes:***

***Challenges***: Filling key positions and coordinating with Lincoln Co.

***Note:*** Pilot deferred reporting until next quarter since they intended to begin 2/1 but having difficulty filling key position.

### LCSW IN THE PCPCH

**Jana Svoboda, Samaritan Family Medicine and Resident Clinic**

***Successes:***

1) 150 patients served w/500 contacts. Vast majority had never accessed MH services.
2) LCSW has developed low barrier, low cost classes that are underway.
3) LCSW has conducted several trainings to staff in the medical home including MH First Aid, use of screening tools, and promoted values of integrated, low barrier, culturally competent care in the PCH.
4) Pilot champion has relayed three stories to illustrate how early, accessible information and treatment made a substantive difference for patients.

***Challenges:***

1) Lack of student interns until next fall.
2) Newness of PCH model has resulted in slower implementation of integrated care.
3) Lack of time for reflections, coordination meetings and planning due to constantly evolving demands on PCP and clinic staff.
4) Lack of LCSW visibility. Majority of warm hand-offs come from providers physically near LCSW office.

### MENTAL HEALTH LITERACY

**Cristie Lynch, IHN-CCO**

***Successes:***

1) Increased services to rural communities: Partnering with Jackson Street Youth Shelter to provide Girls Circle and/or Boys Council in rural Linn County communities.
2) Increased partnerships/collaboration: Efforts to increase mental health awareness have resulted in new collaborations across Linn County including most recently the table tent project supported by Linn Together and the Mental Health Advisory Board.
3) LifeSkills expansion: Increased funds have supported the expansion of LifeSkills to Sweet Home.

***Challenges:***

1) Continuing need for technical assistance in best strategies for culturally appropriate outreach and education strategies for the Latino community - hired marketing agency with expertise in Latino communications.
2) Securing sufficient outreach assistance via interns or community partners; really lacking connections in Lincoln County - will need to rely on IHN-CCO staff to help with this.

4) Working with marketing agency with deep experience in the Latino market has resulted in: securing unique and effective media placements and campaign messaging that has received the approval of project team.

## PEDIATRIC MEDICAL HOME

**Miranda Miller and Dr. Lon McQuillan, Samaritan Pediatrics**

***Successes:*** Successful partnerships with

***Challenges***: Addressing an exhaustive list of outcomes and difficulties getting data.

***Note:*** Pilot deferred reporting until next quarter while outcomes measures are being revisited.

## PRIMARY CARE PSYCHIATRIC CONSULT

**Dr. Jim Phelps, Samaritan Mental Health**

***Successes:***

1. *Volume of cases seen*: we pushed to increase volume in 3rd quarter of grant, and succeeded. We did so by adding the option of face-to-face evaluations and limited follow-up (see full report for details).

***Challenges:***

1. *Getting PCP's to act on consult recommendations*: Limiting factors of "change fatigue" and overall stress still require caution when pressing PCP's for action.
2. *Getting PHQ and GAD data on all consults:* Now stressing this and in the most recent quarter have achieved very close to 100% acquisition. By the end of the final quarter of the grant we will have some pre-/post- comparison data on these measures.
3. *Working more closely with in-clinic Behavioral Health Professionals*: have had monthly meetings to coordinate efforts, but weekly would be better and working more directly together on entire clinic populations would be better yet (see plans for revising Phase II, below).
4. *Reaching PCP's who are not regular utilizers* of PCPC process:
   a. Chart reviews have revealed the likely basis for Albany clinic's low use (they refer many patients to Linn Co. Mental Health)
   b. We are slowly bringing in more users: one visit to Brownsville catalyzed that clinic's involvement; could repeat in Sweet Home and Main Street but see #5 below
5. *Finding psychiatrists who can do this work after current grant:* no one in sight. We will address this by streamlining the PCPC process to a more minimal program with better odds of continuation in a psychiatrist-starved environment (anticipating this will be the case in July 2016). Have arranged a state-wide meeting of psychiatrists involved in primary care consultation to brainstorm on psychiatrist supply, and what PCPC formats might be sustainable in this and other CCO's.

***Changes in Pilot:***

1. Original goal of getting initial *PHQ-9's and GAD-7s as baselines*, and follow-up as indicators of response to treatment, has been changed to just getting the baselines for every patient. We will go back to getting the follow-up measures in the final quarter of the grant, now underway.

2. Original goal of gathering several *cases demonstrating cost savings* by reduced inpatient and ED/Urgent Care utilization has been changed to getting even a single such case. It has proven difficult to have a crystal-clear case of high utilization, followed by PCPC intervention, and then PCP follow-through on recommendations, to show these changes in a year.

## Section 1: 2015 Q1 Pilot Reports Progress Summaries

3. Original goal of demonstrating the *value of chart-based consultation* (vs. phone curbside vs. face-to-face with patient) has been changed to finding any sustainable mode of consultation given the dearth of psychiatrists. Will be experimenting in remaining quarter, and in PCPC Phase II, with:
   a. Creating a local version of "OPAL-A", the Oregon Psychiatric Assistance Line –Adults. OPAL-K for kids already exists but with only limited utilization outside Portland. OPAL-A would entail phone and chart-based consultation without onsite involvement by a psychiatrist.
   b. Two models for mental health services are now recognized nationally: the PCBH (Primary Care Behavioral Health) model of in-house mental health specialists/ behaviorists; and Collaborative Care, the IMPACT-style model on which the PCPC program was originally based. We hope to demonstrate a means of blending these two approaches.

### TRI-COUNTY FAMILY ADVOCACY TRAINING

**Tammi Paul, Oregon Family Network**

***Successes:***

1) OFSN has also been successful reaching the native Spanish speaking community in Benton County and offer the special education trainings in both English and Spanish.

***Challenges***: Meeting the needs in Linn County has presented a challenge due to the fact that local leaders believe that the training content may be duplicating already existing information for families. The OFSN Executive Director and Training Program Manager have been meeting with Linn County leaders to determine how the pilot goals can enhance or support what is already offered.

### UNIVERSAL PRENATAL SCREENING

**Dr. Carissa Cousins, Tri-County Hospitals**

***Successes***:

1) Great community support.
2) Many nurses and providers were unaware of SBIRT and the effectiveness of providing a brief intervention using motivational interviewing techniques.

***Challenges:*** Difficult to implement changes in timely manner due to required system changes and several committees review/approval of the changes including documentation in EHR, verbal consent process, and patient education materials. Identified many areas of need in our patient population.

### YOUTH WRAPAROUND AND EMERGENCY SHELTER

**Andrea Myhre, Jackson Street Youth Shelter**

***Successes:***

1) Working with DST to understand funding.

***Challenges:***

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| ALTERNATIVE PAYMENT METHODOLOGY | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| Develop financial report, review monthly | Report developed | Met monthly, reviewed capitation amounts. SIM seeing patients/receiving services where education needs to occur. |
| Reconcile patient panels | Provider panel list compared to IHN-CCO panel list match | Reconciled all IHN-CCO patients. Receiving newly enrolled and removed patients weekly ensuring contact is made to newly enrolled. Sending reconciled lists back to IHN-CCO to make PCP changes. |
| Approve plan within the clinic and begin implementation of clinic transformation around care coordination and increasing access. | Progress report by plan compared back to the plan submitted to IHN-CCO | SIM is reaching out to newly assigned IHN-CCO patients to discuss establishing care with SIM, utilizing their PCP for non-emergent care and making initial appointments. Packets are sent out.<br>Partnered with SHS Pharmacy to perform medication management for high risk 3 & 4 IHN-CCO patients and those with high cost medications. Beginning in May 2015, pharmacist will be at SIM 1x/wk.<br>Developing decision aides for preventive services. |

| BEHAVIORAL HEALTH PCPCH | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| Assessment of mental health morbidity using industry standard tools | Use of industry standard MH assessments (written) | A total of 17 patients received DSM-IV-TR diagnoses and ICD-9 codes |
| Expedited access to mental health and coordinated care within a primary care setting<br><br>Transformation Element 1 | Tracking date of referral with date of first contact<br><br>Tracking attendance | Total of 17 patients<br>Mean = 11 patients at a time (goal is 10-15)<br>100% appointment opportunity within 1 week of referral<br>Mean visits per patient = 7<br>Mean cancellations per patient = 1<br>Retention rate = 81% |
| Integration of payment systems within IHN-CCO to ancillary practitioners<br><br>Transformation Element 3 | Provider number with IHN-CCO for billing<br>QMHP status<br>SBIRT billing | Obtained a DMAP provider number<br>Applying for OHP provider number<br>Obtained QMHP status<br>Billed IHN-CCO for MH services with a reimbursement of $0 to test billing process<br>MH provider implemented SBIRT assessments and interventions into practice |
| Establish a fiscally viable model that can be reproduced locally in other primary care settings<br><br>Transformation Element 3 | Provider number with IHN | See above<br>Attempting to collaborate with BCMH to increase referrals and consult about avenues of sustainability |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| CHILD ABUSE AND EARLY INTERVENTION<br>Goals | Measures | Results |
|---|---|---|
| Hire Bilingual Home-based Specialist | | Hired internal candidate English speaking Home-based specialist. Building/enrolling caseload in April. |
| Hire Bi-lingual Program Specialist | | Hired internal candidate Bi-lingual Program Specialist |
| Home Visits, Respite, ASQs and Links to Medical Home | | Begin in April 2015 |

| CHILD PSYCIATRY CAPACITY<br>Goal | Measures | Results |
|---|---|---|
| Create an incentive to do intakes and discharges, to increase turnover | | 1 patient transferred to PCP. |
| Establish funding to pay for a supported discharge to primary care so patients are more successfully maintained in primary care after initial stabilization by MH professional | | 16 Evaluations |
| Establish funding model to pay for a physician extender, nurse or medical assistant to check in frequently with patients by phone to ascertain if they need to come in and when they can postpone a doctor's visit. | | 77-82 Caseload |
| | | Screening tools chosen and used during monthly phone calls or when client comes in for appointment |
| | | Processes are documented |

| COLORECTAL SCREENING CAMPAING<br>Goals | Measures | Results |
|---|---|---|
| By June 2015, adapt and implement OHA's colorectal screening media campaign, reaching 80% of IHN CRS eligible members, in the three-county region. | | • A spokesperson from Linn and Benton counties has been identified to be a part of the social marketing campaign. Lincoln County is working to confirm their spokesperson.<br>• A copy of OHA's media-buy schedule was acquired |
| By December 2015, distribute 3,000 FIT tests in selected Patient-Centered Primary Homes utilizing EMR to identify patients aged 50 to 75 years, with 40% | | • A list of clinics with number of members age 50-75 was created to identify clinics that would be able to reach the largest number of members |

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| (or 1,200 patient member) adherence and return of stool test screenings. | | • Inventoried various channels to communicate to providers/clinic staff<br>• Two different presentations were scheduled to inform clinic managers about the pilot and begin to recruit 10 clinics for FIT test piloting and 30 for distribution of marketing materials |
| By March 2016, utilize traditional health workers/health navigators to reduce barriers related to screening among Latino and Native American populations, reaching 5% IHN CRS eligible members. | | • No progress during this reporting period |
| By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication. | | • The Assessment & Evaluation Subgroup met to discuss what data could be feasibly collected to show project effectiveness<br>• The first draft of a practice based research study was outlined |

| **COMMUNITY HEALTH WORKER** | | |
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| **Goals** | **Measures** | **Results** |
| Develop Hub model that includes target population, site criteria, and evaluation metrics | | Tailoring CHW model for each site. Met with key staff at each target to work out processes for referral, client selection, EHR processes, etc. |
| Hire, train, and supervise 2 CHWS | | Two clinical health navigators are being trained and will be placed into their assigned clinics starting in April. Ongoing training and supervision will continue throughout Phases 2 and 3. |
| Send CHWs through state –approved CHW training and register with OHA. | | One CHW will attend OHA-approved CHW training in late May and upon completion will be eligible to participate in the State CHW registry. Other CHW will attend next available training. |
| Document staff training, roles, policies, and procedures | | Processes for training, role delineation, and agency policy regarding clinical CHWs placed in partner agencies are being developed and documented. |
| Develop an evaluation plan that includes process and health outcome measures. | | There is significant progress on process measures, but work health outcome measures has been slow. Discussions with Dr. Daniel Lopez-Cevallos, our identified evaluator, have begun. Progress on this objective has been hampered by Dr. Lopez-Cevallos' extended sabbatical in Ecuador. This objective should be more "fleshed-out" in the next quarter. |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| COMPLEX CHRONIC CARE MANAGEMENT | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| Convene an interdisciplinary project team | Develop a working relationship with a health-IT company and expert in health service research and evaluation. | • Contract in place with Kannact, Inc. (contact person: Michael May, MD, medical director for Kannact). Contracts with Samaritan and The Corvallis Clinic (TCC) in signed.<br>• Dr. Bovbjerg (research/teaching faculty member, OSU CPHHS) joined us in February and is now an active member of the project team.<br>• Terry Crowder, RPh, MBA, PhD, joined the team as project manager in February. |
| | Determine a staffing plan for the required 24/7 Health Engagement Team (HET) coverage that this pilot project demands | Working with existing TCC existing Care Coordination team and Management to create 24/7 RN coverage. A proposal has been developed and is waiting for approval from the Care Coordination staff and clinic management. |
| Finalize the HET/CCCM protocols | Draft care plans for each of the chronic conditions addressed | Charlene Yager, RN, Clinical Services Director and Dr. Dennis Regan (medical director, TCC, and principal investigator on this project) drafted evidence-based care plans and protocols for each of the chronic conditions. These are based on a green-yellow-red scoring system and will be implemented via Kannact's health-IT system (see below), by the HET. Protocols to be complete 4/3/15. |
| Modify an existing web-based Complex Chronic Care Management interactive system for use in the pilot | Identify a suitable system | Kannact, Inc. developed the system and agreed to provide technical support throughout the project. Further, they will modify the system to suit TCC requirements. |
| | Train the HET on using the system | Kannact, Inc. staff led a 90-minute training session with the care coordinators who comprise the HET |
| | Identify evidence-based, non-commercial patient education resources | Charlene Yager and the HET have identified patient education resources pertinent to each of the chronic conditions under study. |
| Enroll high cost/high utilizing IHN/CCO patients with chronic medical conditions into the HET/CCCM intervention | Identify and select patients | We received from IHN a list of high-cost patients who list TCC as their primary care provider and who have one of the following chronic conditions: diabetes, COPD or asthma, CAD, and CHF. The list was screened according to our inclusion criteria and identified those would be eligible (n=115). |
| | Enroll 60 patients in the HET intervention | Enrollment wills begin in April, 2015. Charlene Yager will make all patient phone calls herself for consistency. Potential list of subjects is 115 patients meeting |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

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| | | criteria. |
| Deliver the HET/CCCM intervention | | |
| Evaluate the HET/CCCM intervention | Develop data collection instruments for non-clinical variables | Conducted a literature review and identified potential instruments that have evidence of reliability and validity<br><br>Selected items from the chosen instruments, assembled into a cohesive self-administered questionnaire, and entered into Qualtrics (a web-based data collection tool with automatic branching capability) |
| Communicate findings | Conduct pre- and post- data collection. Clean and analyze data. | |

| **DENTAL MEDICAL INTEGRATION** | | |
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| **Goals** | **Measures** | **Results** |
| Identification of pilot clinic sites | - | 7 out of 10 of the Top 10 clinics for diabetes have signed on to participate in the pilot. |
| Implementation of pilot in primary care clinics | - | One on one meeting with 7 identified clinics has taken place to discuss pilot implementation. Implementation date for pilot ranges from 4/1/15-5/1/15. |
| Pilot education to dental clinics and providers | - | All 4 dental plans have been tasked with educating their contracted providers on the details of the pilot. Received confirmation from 3 out of 4 dental plans that their contracted providers and clinics have been educated. |
| EHR adoption of oral health screening questions | - | The Samaritan system which accounts for 6 out of the 7 clinics identified above has adopted the screening questions into their EHR. |

| **INTEGRATION OF MENTAL HEALTH ADDICTION IN PRIMARY CARE** | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| ***Note*:** Pilot deferred reporting until next quarter since they intended to begin 2/1 but having difficulty filling key position. | | |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| LCSW IN THE PCPCH | | |
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| **Goals** | **Measures** | **Results** |
| LCSW will select, supervise, and train students to assist with courses | | Late start up meant we could not supervise LCSW students this academic year. |
| Improve patient involvement in managing own health in cost effective ways | Develop health improvement classes for patients that address mental health issues that are aggravating or causing chronic health issues, based on model that vital health protective information and behavioral motivation can be delivered cost-effectively in group format and will result in overall cost savings as consumers manage own health. | • 8 classes developed, several happened as of Jan 17th (Sleep issues, mindfulness skills, stress management, health goals support, habit breakers, understanding depression, happiness research, communication skills). Co-led tobacco cessation group. Engaged additional staff in getting trained to deliver Stanford based "Living Well with Chronic Illness" which starts this month. Care coordinator also began a nutrition course for patients. |
| | Provide accessible and motivating health information and encourage patients to attend classes for support, information and skills. | • Encouraged the provision of evidence based health information for waiting room. It also advertises free classes where patients can learn more about managing stress and meeting health goals.<br>• Provide tip sheets for patients dealing with stress-related illnesses, sleep problems, depression and anxiety. |
| Improve access to MH interventions within PCPCH. | Use Health care goals of IHN patients to develop individual education and intervention plans. | Working with care coordinators and clinic staff to route clients with related health goals to free classes for evidence based skills training to meet health goals. |
| Improve access to MH interventions within PCPCH; educate medical staff about implications of untreated or unaddressed mental health issues on medical health. | | 1) Majority of patients seen have received no previous mental health services but had significant and impairing mental health issues impacting their health. Met patients in the office with provider or was directly referred by provider and ***average wait time was less than a week*** (this is increasing as providers see benefit).<br>2) Provided brief educational presentations at staff meetings and MA trainings<br>3) Average 4-5 warm handoffs a week and 8 referrals a week. Patients are funneled into groups.<br>4) Reduced wait time for behavioral mental health interventions. Behavioral health psychologist at least temporarily saw reduction in wait list. Continue to see patients who are on wait list for specialty mental health (6 months out) to provide immediate skills training to deal with anxiety and mood management.<br>5) Encouraged use of GAD7 and PHQ9 measurements to capture unreported MH issues. Beginning to use ACE scores for patient education around trauma effects on health; provide skills training for mitigating them.<br>6) LCSW completed certification to become a trainer for Mental Health First Aid and has provided one community training, two more are scheduled and more |

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| | | planned.<br>7) LCSW actively promotes staff education regarding impact of MH issues on health to staff in meetings and communications |
| Better outcomes at lower cost. | | GAD and PHQ scores have dropped for patients receiving brief trauma-informed psychotherapy; LCSW will be working with data analyst to evaluate impact on health care costs.<br>Interventions are short term and available cost-free to patients by an on-hand provider.<br>Reducing wait times means fewer crisis ER visits or needless medical interventions for unexplained symptoms. |

| **MENTAL HEALTH LITERACY** | | |
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| **Goals** | **Measures** | **Results** |
| On-line learning & resource center | Provide subject matter expertise, task assignment, and oversight Development of professional training | • Developed Power Point presentation and training video, *Understanding Mental Illness*, as foundation for on-line training targeted at IHN-CCO staff and providers.<br>**January – March 2015 Quarterly Progress**<br>• Identified next steps as developing a public version of the *Understanding Mental Illness* training<br>• For developing additional provider and staff training videos, identified strategy of seeking out existing training videos or webinars for purchase |
| Education Campaign: *Today I Am* | • English language Wellness Campaign, *Today I Am*, completed June 2014 in Linn County.<br>• Marketing firm conducted post-survey of members, stakeholders, and local residents (307 Linn County residents)<br>• *Today I Am* campaign post-survey completed Aug 2014 shows 51% familiarity with IHN-CCO, 65% familiarity with Wellness Campaign (exceeding target of 35%)<br>• Latino Focus Groups completed November 2014<br>• Familiarity with Wellness Campaign in | • Success of *Today I Am* campaign in Linn County has resulted in IHN-CCO plan to expand to rest of CCO region.<br>**January – March 2015 Quarterly Progress**<br>*Spanish Community Education Campaign*<br>• Used Spanish population research to adapt the English campaign to be culturally appropriate.<br>• Developed marketing and public relations plan for Spanish campaign in Benton, Lincoln and Linn counties.<br>• Media plan developed.<br>• Campaign imagery and public event schedule under development.<br>• Campaign messaging proposal reviewed and approved by project team.<br><br>*English Community Education Campaign*<br>• Developed marketing and public relations plan for English campaign in |

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| | Benton and Lincoln counties – target of 35% to be measured in August 2015 | Benton and Lincoln counties.<br>• Photos added to campaign based on feedback from pilot campaign.<br>• Advertising plan developed and ready for execution beginning May 1.<br>• Health literacy review performed on pilot campaign website and handbills. Recommended adjustments are being made for May 1 launch. |
| On-line learning & resource center | Provide subject matter expertise, task assignment, and oversight Development of professional training | • Developed Power Point presentation and training video, *Understanding Mental Illness*, as foundation for on-line training targeted at IHN-CCO staff and providers.<br>**January – March 2015 Quarterly Progress**<br>• Identified next steps as developing a public version of the *Understanding Mental Illness* training<br>• For developing additional provider and staff training videos, identified strategy of seeking out existing training videos or webinars for purchase |
| Educational Campaigns: Partner with local coalition and youth organizations to develop and disseminate prevention messages | • Develop topic or message, identify and engage partners for outreach communication to local schools, community organizations; special attention given to the Linn County Student Wellness Survey data<br>• Mental Illness Awareness Week – Oct 2013 (2014)<br>• Mental Health Month – May 2014 (2015) | • **Students Taking Action Not Drinking (STAND):** Completed countywide mental health awareness campaign during the 2013-2014 academic year.<br>• **Linn Together:** Linn Together and community partners including the local Mental Health Advisory Board and Linn County Mental Health partnered to host a community training, "Taming the Epidemic of Youthanasia," with Dr. Dennis Embry<br>• ***Today I Am* campaign:** Linn County Prevention Program staff participated in project team overseeing development of survey and focus groups providing basis for development of MH Literacy Project *Today I Am* campaign. Prevention staff and Linn County Mental Health Advisory Board members attended several community meetings and events promoting the *Today I Am* campaign<br>• **Linn County Mental Health Advisory Board:** Prevention staff collaborated with MHAB members in working with local communities to promote Mental Health Awareness Month Proclamations in the following cities – Albany, Brownsville, Lebanon, Sweet Home and Mill City.<br>• **Mental Health First Aid Training:** Prevention staff completed training for Mental Health First Aid and, during the reporting period, provided coordination and partnered with another trainer provide (in Linn County.<br>**January – March 2015 Quarterly Progress**<br>• **Students Taking Action Not Drinking (STAND):** Expanded on the 2013-2014 mental health awareness campaign. Disseminated campaign materials to high school students countywide for winter break activity (1000 drawstring bags and 3000 activity cards)<br>• **Linn Together:** Partnered with the Linn County Mental Health Advisory |

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| | | Board to expand the mental health literacy project. Developed informative table tents to increase mental health literacy. Distribution planned for May 2015 as part of Mental Health Awareness Month activities |
| Coalition of Local Health Educators | • Review local data (including the Linn County Student Wellness Survey) to identify local risk and protective factors, prioritize target areas for improvement, assess resources and opportunities for partnership and funding that address identified target areas; develop process for distributing funds to eligible local programs to address the identified target areas.<br>• Award program support. | • The Mental Health Promotion task force met to review and prioritize data.<br>• Target areas were identified and funds awarded<br>**January – March Quarterly Progress**<br>• Funds have been distributed to support the following activities: 1) Girls Circle/Boys Council youth support groups in rural communities, Jackson Street Youth Shelter; LifeSkills Training countywide, Linn County Alcohol & Drug Prevention; and STAND Mental Health Promotion campaign, Linn County Alcohol & Drug Prevention |

| **PEDIATRIC MEDICAL HOME** | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| ***Note*:** Pilot deferred reporting until next quarter as issues around outcomes and data are being addressed. | | |

| **PRIMARY CARE PSYCHIATRIC CONSULT** | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| Perform consults | # seen | Averaging 8 consults per week – right on original estimate |
| Improve care | # seen | Far exceeds psychiatry's new patient intake rate prior to PCPC |
| Improve outcomes | PHQ-9, GAD-7 | Compared to grant Quarters 1 and 2, more scales obtained<br>But not f/u scale data; should have that in fourth grant quarter |
| Reduce hospitalizations | | For both these goals, we will not have the data necessary to demonstrate improvement. Might yet have a clear case or two of reduced utilization. |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| TRI-COUNTY FAMILY ADVOCACY TRAINING | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| 9 Special Education Trainings | 135 participants<br>90 % satisfaction | Benton County- conducted IEP Basics- 20 participants- 100% participants satisfied or very satisfied<br>Lincoln County- conducted IEP Basics- 8 participants- 100% participants satisfied or very satisfied<br>Lincoln County- conducted Behaviors and the IEP- 13 participants- 100% participants satisfied or very satisfied |
| 1 Family Support Group Facilitation Training | 15 participants<br>90% satisfaction | Lincoln County- training anticipated in September 2015 |
| 2 Family Perspectives Training | 30 participants<br>90% satisfaction | Lincoln County- training anticipated in June<br>Benton County- training anticipated in August |
| 2 Collaborative Parenting Series | 20 participants<br>Pre/Post Family Empowerment Scale | Lincoln County- training anticipated in October<br>Benton County- training anticipated in September |

| UNIVERSAL PRENATAL SCREENING | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| Training and employment of 0.075 FTE Program Assistant | Complete/ Hired | Kelly Hower has been employed to assist with this program. Kelly is a nurse with Samaritan currently working in risk management. |
| Establish and formalize referral process | Completed/ Navigators identified. IPV/ DV assistance established,<br>Tobacco referral in EHR/incomplete | Alcohol and Drug and Mental Health Providers from all 3 counties met and developed a process for referrals. This involves using a "Navigator" for each county. For Linn County this is Family Tree Relief Nursery, Benton County it is Community Outreach, Inc. and for Lincoln County it is ReConnections. When a woman is willing to receive assistance for substance use or mental health concerns, this Navigator will help her find the most appropriate services. A warm-handoff will be facilitated whenever possible and, at a minimum, phone contact will be made with the Navigator and the patient. For women wanting assistance with a violent relationship, My Sister's Place (Lincoln County) and CARDV (Linn and Benton Counties) will also provide warm handoffs 24/7.<br>For tobacco referrals in communities without direct tobacco cessation service providers, a fax referral can be completed and faxed, with the patient's consent, |

| | | |
|---|---|---|
| | | to the Oregon Tobacco Quit Line. The Quit Line will then contact the patient. The providers will receive reports of the patient's status. We are working on an electronic version of this referral |
| Plan clinic flow and administration of screening tool | Clinics formalizing process | Every clinic and hospital has different staffing. We have worked with the individual clinics and hospitals to develop the most appropriate work flow based on existing staffing. We will be working with them to establish a written flow chart for each location. |
| Develop and distribute patient literature (English and Spanish) | Literature in offices and OB wards | A booklet on Neonatal Abstinence Syndrome/ Withdrawal and a flyer on substance use and breastfeeding have been developed with the assistance of marketing. This is awaiting approval from the patient education committee. These are to be used in the OB offices to facilitate a discussion with the mothers prior to delivery. A supply of the brochure "10 Reasons not to Drink, Smoke or Use Drugs during Pregnancy" is available in the clinics. An initial supply of these materials will be available in the clinics by the end of April and additional copies will be the responsibility of the clinics. All of these materials are available in English and Spanish. |
| Integrate into Electronic Health Records (Epic) | 5Ps available in EHR | The 5Ps SBIRT tool has been integrated into the EHR with discrete fields for data tracking. Smart phrases have been developed to document consent for drug testing and for billing statements. |
| Develop standardized protocols for all hospital systems and providers | Work Instructions approved | The process for obtaining verbal consent for urine drug testing has been standardized. Labs ordered for urine drug testing had been standardized. The Work Instructions for Universal Prenatal Screening is in the process of obtaining approval. |
| Train providers, residents, clinic nurses, care coordinators, maternity care coordinators, and floor nurses on SBIRT 5Ps and motivational interviewing, documentation and coding | All labor and delivery and OB clinic nurses, MAs trained. All OB providers trained | Over 120 nurses, medical assistants, maternal care coordinators and office staff have received a two hour training on the stated topics by a SBIRT/ MI trainer. Some non-SHS or TCC midwives also attended the training. Additionally over 20 obstetrical providers have received a 1 hour training. All participants received a comprehensive training manual. The training was videotaped for ongoing training of new hires as well as for those unable to attend the training. This will be available on the SHS website. We are scheduling training for midwives and non-SHS providers on the coast who expressed interest in the training. |

## Section 2: 2015 Q1 IHN-CCO Pilot Report Details of Goal, Measures, and Results

| YOUTH WRAPAROUND AND EMERGENCY SHELTER | | |
|---|---|---|
| **Goals** | **Measures** | **Results** |
| 35 youth served in wrap-around case management or shelter services. | Intakes of youth served in shelter, Access database | **15** different youth served in respite and emergency shelter. **3** different youth served in transitional shelter.<br><br>**24** youth engaged in our aftercare services, 15 of which are duplicate youth from the overnight shelter numbers above.<br><br>**16** different youth accessing our outreach case management services, not shelter. |
| Youth served in shelter will achieve stability. | # of youth who exit to safety | **12** safe exits from shelter. *Others remain in shelter and have not exited while one returned to an unstable situation.* |
| Youth in case management will improve well-being and reduce risk factors. | % increasing utilization of community services<br><br>% participating in ISP<br><br>% participating in skill building activities<br><br>% participating in family mediation or counseling<br><br>% who obtain an IHN-CCO PCP and complete an adolescent well-child exam<br><br>% receiving dental services, if needed<br><br>% linked to a QMHP or QMHA, if needed<br><br># of youth who required intensive psychiatric health services through IHN-CCO while in JSYSI care | **100%** of youth served worked with a case manager to increase their awareness and utilization of community services.<br><br>**100%** of youth served in shelter and outreach case management participating in their individualized service plan.<br>**95%** of youth engaged in required skill building activities.<br>**100%** of youth who needed family mediation or counseling received a referral and actively participated.<br><br>**100%** of youth who needed health insurance, obtained it and attended their first appointment.<br>**100%** of youth served received a JSYSI dental screening and **100%** of youth who needed follow up care by a dentist received it.<br><br>**N/A**<br><br>**N/A** |