2015 Q3 Pilot Quarterly Reports
Executive Summary

Objective:

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

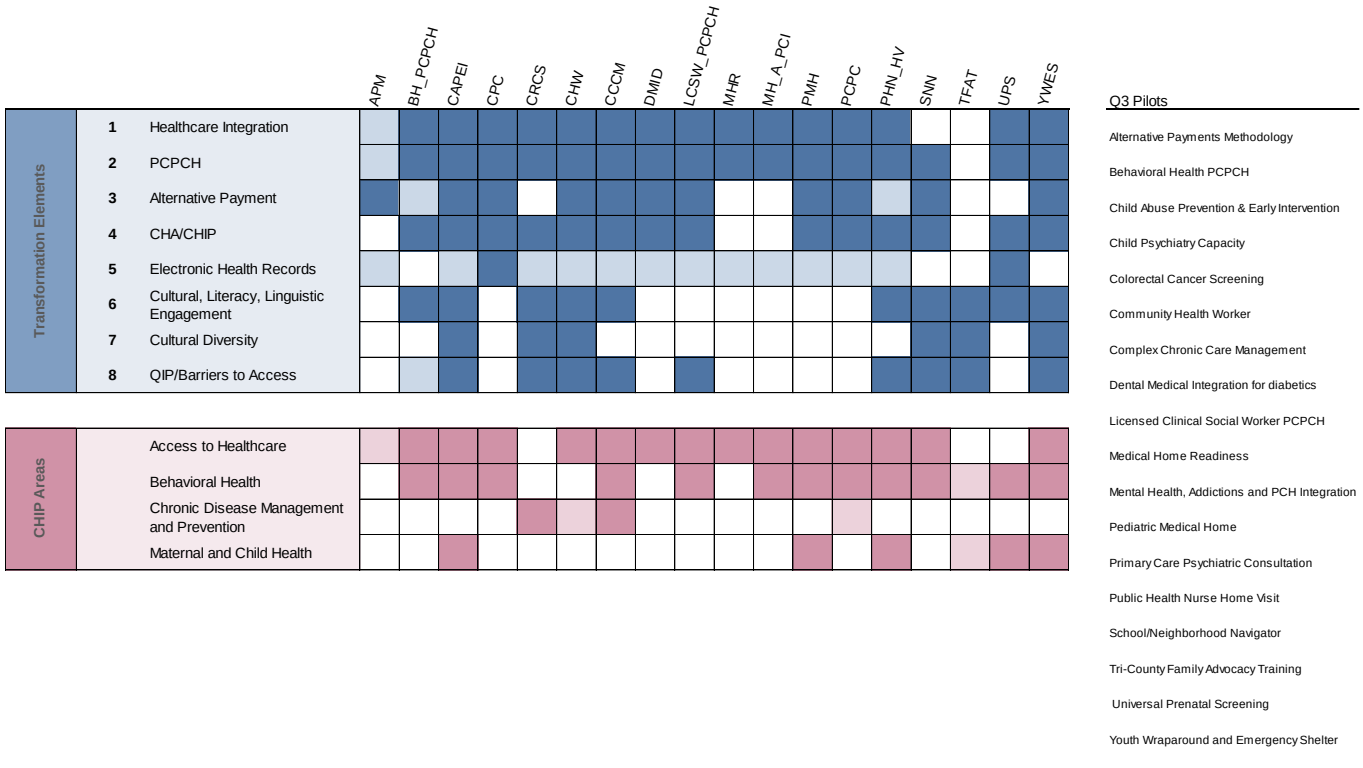
Summary of Findings:

- 21 reports from 18 pilots
- 5 pilots reporting minor changes that resulted in pilot extensions or expansions.
- 1 pilot reports significant limitation from original proposal and will soon close out.
    - **Mental Health, Addiction, and Primary Care Integration** pilot continued to be unable to operate as intended due to inability to hire key position. The contract with IHN-CCO expired 10/31/2015. Pilot has deferred a Q3 report to focus on writing their final close-out report.

Format:

- **Section 1**: Each Pilot successes and challenges are summarized with changes and additional information sections included, when reported. Contact listed is the person who submitted the report. When provided, "*Stories from the Field*" were added under Additional Information section.
- **Section 2**: Details of each pilot Goals, Activities, Measures and Results are presented.

Elements of Transformation and CHIP Areas Addressed by Q3 Pilots:



2015 Q3 Pilot State Metric Cross-Walk

			APM	BH_PCPCH	CAPEI	CPC	CMA_S	CRCS	CHW	CCCM	DMID	HPC	LCSW_PCPCH	MHR	MH_A_PCI	PMH	PCPC	PHN_HV	SNN	TFAT	UPS	YWES
State Metrics (Incentives and Penalties)	1	Adolescent well-care visits (NCQA)	■													■			■			■
	2	Alcohol or other substance misues (SBIRT)		■		■	■						■			■	■	■			■	
	3	Ambulatory Care: Emergency Department Utilization	■							■		■				■						
	4	CAHPS composite: Access to Care		■	■	■	■		■	■		■	■	■		■	■	■	■		■	■
	5	CAHPS composite: Satisfaction with Care		■		■	■		■	■		■	■			■	■	■			■	
	6	Colorectal cancer screening (HEDIS)	■					■														
	7	Controlling high blood pressure (NQF0018)								■												
	8	Dental Sealants on permanent molars for children														■						
	9	Depression screening and follow up plan (NQF 0418)	■	■		■	■						■		■	■	■					■
	10	Developmental screening in the first 36 months of life (NQF 1448)			■		■											■			■	
	11	Diabetes: HbA1c Poor Control (NQF 1448)								■	■	■										
	12	Effective contraceptive use among women at risk of unintended pregnancy	■																			
	13	Electronic health record adoption																				
	14	Follow-up after hospitalization for mental illness (NQF 0576)	■												■							
	15	Mental, physical, and dental health assessments within 60 days in DHS custody														■						
	16	Patient-Centered Primary Care Home Enrollment	■		■									■	■			■	■			■
	17	Prenatal and postpartum care: Timeliness of Prenatal Care (NAF 1517)																■			■	
	2016	Tabacco	■				■						■					■			■	
	2016	Childhood Immunization Status			■											■		■				

Q3 Pilots

Alternative Payments Methodology

Behavioral Health PCPCH

Child Abuse Prevention & Early Intervention

Child Psychiatry Capacity

Colorectal Cancer Screening

Community Health Worker

Complex Chronic Care Management

Dental Medical Integration for diabetics

Licensed Clinical Social Worker PCPCH

Medical Home Readiness

Mental Health, Additions and Primary Care Integratio

Pediatric Medical Home

Primary Care Psychiatric Consultation

Public Health Nurse Home Visit

School/Neighborhood Navigator

Tri-County Family Advocacy Training

Universal Prenatal Screening

Youth Wraparound and Emergency Shelter

Section 1: 2015 Q3 Successes and Challenges

Alternative Payment Methodology: Benton County Health Department	Sherlyn Dahl, Executive Director

Successes:

1. Working to build an internal process library and have published documents available for staff. Next steps will be to publish the processes on an internal webpage.
2. Developed a comprehensive list of clinical quality metrics that are tracked monthly at both the provider level and site level.
3. Care Teams have been relocated so clinical support staff are more available to providers.
4. The Front Desk, Medical Assistant, and Panel Manager positions are all fully staffed and have successfully recruited for a provider at the new clinic in Alsea.
5. The two School-Based Health Centers (SBHC) have been engaged in efforts to complete adolescent well-child and risk assessments and achieved the required SBHC benchmarks.

Challenges:

1. Continue to struggle in recruiting Registered Nurse Care Coordinators and providers. Recent adjustments were made with Human Resources to enhance recruitment efforts.
2. Samaritan turned on Event Notifications so providers now receive multiple Epic inbox messages for patient events (i.e. visit to the emergency department, admission, discharge, radiology, lab) instead of receiving a FAX notice. This will be a good thing in the future but it is challenging to develop new processes to manage this unexpected change in flow.

Additional Information: Working to develop complete "desk manuals" for all roles identified in the internal Roles and Responsibilities document. Developing an internal, secured website where desk manuals as well as other information important to clinic functions like periodic reports, information on projects and accomplishments, information on outstanding issues with our electronic medical record vendor (OCHIN), and standing orders will be held.

Transition to "open access"/more same-day appointments is planned to kick-off on Monday, October 5th.

Alternative Payment Methodology: Samaritan Internal Medicine (SIM)	Miranda Miller, Director of Primary Care Practice

Successes:

1. Medication Management: seen approximately 12 in clinic, started doing these visits in a more structured manner this last month about 30 chart reviews and about 2-5 recommendations per patient
2. Reducing Emergency Room (ER) visits: with three care coordinators in the office, the outreach to patients discharged from the ER has increased. SIM has also created an interdisciplinary care team that meets monthly to discuss frequent ER patients. This has been a very successful meeting (a CCO case manager also attends). SIM has been able to identify barriers and 'out of the box' solutions for these patients. EX: scheduling a standing monthly appointment with the provider or care coordinator.
3. Hiring another care coordinator. This resource allows for additional outreach to the large patient populations that are served.
4. A provider retreat was held at the end of September and spent a considerable amount of time discussing alternative payment methodologies and access and how improvements could be made. Moving forward with scheduling template changes and more same day access.

Challenges:

1. Finding the time to review the data and make it actionable. Scheduling monthly meetings (beyond the one with the CCO) to determine next steps. These meetings include the providers for engagement efforts.

Section 1: 2015 Q3 Success and Challenges

Alternative Payment Methodology: Coastal Health Practitioners	Meg Portwood, Family Nurse Practitioner

Successes:

1. On site mental health care without required preauthorization has been invaluable. Also, there has been some progress in communication from hospitals for patient follow-up and hospital aftercare; notifications are being sent when a patient has been seen in the Emergency Room (ER) or admitted to check in with the patient about their status and needs following hospital encounters.

Challenges:

1. Most of this section is carried over from previous quarters. There continues to be significant challenges surrounding billing for visits and patient assignments. As said in previous reports, patient assignments are going to be an ongoing hassle until it becomes easy to check and change patient provider assignments. Continue to run into challenges with patients seeing more than one primary provider, and with patients who somehow still have no idea that they are assigned to a provider. Unnecessary ER visits continue to be a challenge.

Additional Information: Looking more closely at budgeting for tele med technology to provide this access to care. Allowing office space and fulfilling billing requirements for mental health is now an ongoing concern. Also realizing how much additional work is now expected of the staff for this ongoing total care coordination model.

Behavioral Health PCPCH: Corvallis Family Medicine (CFM)	Tracy Bluhm, Marriage and Family Counselor

Successes:

1. Integration/collaboration was successful: It was found that, especially given the moderate size of our clinic, collaboration between Mental Health (MH) practitioner and Primary Care Physicians (PCPs) was easily forged. There have been frequent and ongoing correspondences regarding the overall well-being and treatment of patients. In addition, on occasion, the therapist has been able to briefly join the PCP for patient visits in order to offer a team approach toward treatment.
2. Treatment of patients was successful according to ongoing verbal and written patient assessments.
3. Billing avenue was successful: By the final quarter, our billing staff successful submitted all IHN-CCO encounters for mental health.
4. Consistent expedited services offered: 9 of 30 patients reported an inability to find immediate mental health support elsewhere in the community. Received approximately five calls from IHN-CCO patients with PCPs in other clinics wishing to start access MH services at CFM. Received an additional 6 calls from patients with referrals from Benton County Mental Health.
5. Increasing health literacy: Much of this was done by exploring individual and family barriers to treatment protocol and offering education. Implementing SBIRT screening and intervention helped 3 patients recognize problem drinking and consequential effects on health.

Challenges:

1. The greatest barrier to success was lower than expected patient referral numbers. Some of this was corrected with increased understanding of the therapist's scope of practice. Increasing patient exposure and understanding of mental health services by use of the lobby screen and a letter to patients helped increase the referral numbers; however, the moderate size of the clinic limits the number of IHN-CCO patient referrals. It is believed that in order to sustain a .75-1.0 FTE position for a therapist, the clinic would need to share therapist's services with another comparable clinic, or be able to accept IHN-CCO patient for mental health services that have a PCP in other clinics.

Change in Pilot: Corvallis Family Medicine obtained a 3 month extension with an additional funding in order to further track sustainability and have more time and structure to complete the goal of creating a financially sustainable and reproducible integrative model of care. Because of the struggle with maintaining high-enough patient numbers for

Section 1: 2015 Q3 Success and Challenges

mental health services. A goal has been added to open up mental health services to non-CFM patients. In addition, CFM wishes to establish clearer measures to track increased health literacy and collaborative care. In order to continue to increase the efficacy of collaboration, will be exploring possible clinical protocols to meet specific goals regarding collaboration. These specific goals have yet to be concretely established and will be established at the launch of the next quarter. Objectives such as "establish a protocol for following up with patients after completion of treatment" or "establish a protocol for integrating medical and mental health treatment plans" will be added. A final added goal will be to work with IHN-CCO and the CFM billing staff to accurately determine the parameters of maintaining the model in a financially sustainable way.

Child Abuse Prevention & Early Intervention: Family Tree Relief Nursery	Renee Smith, Executive Director

Successes:

1. Home visits are being held monthly where staff works with families to identify needs and make necessary referrals. The largest number of referrals is to mental health services and food resources. Additionally, staff works with adults in accessing a Primary Care Physician. Staff is making a good headway in helping parents link their children to the pediatric clinics.
2. Home Visitors are assisting with health needs of both parent and children; with adults working on diabetes information, tobacco cessation, and precontemplation on alcohol and drug issues, nutrition, hypertension, and exercise. With children, focusing on developmental screenings, nutrition, well baby care, well baby appointments, behavior challenges, and mental health concerns. Staff shares educational information on immunizations and well-baby checks and all children are up to date on immunizations.

Challenges:

1. Retaining and training bilingual staff continues to be a challenge. Shortly after sending the bilingual staff person to the Traditional Health Worker training the staff member took another position. It took over 90 days to find a replacement. Spoke with the new Dean of Healthcare Programs at Linn Benton Community College about the possibility of their program creating a training program for this certification. The Dean indicated they had begun discussion around this topic.
2. The other challenge is determining the sustainability after the Transformation funds run out. The members of the Traditional Health Worker Subcommittee are all united in working on this project and are aligning how to track data so that it will be similar and provide a crosswalk with the Alternative Payment Methodologies (APM) Touches report from the Oregon Health Authority. The lack of experience in the medical setting has required a fast and steep learning curve to know what questions to ask and of whom. Continue to work closely with the Transformation Department on these questions and issues.
3. Need to track more closely the Parents/Adults and their connection to a Patient Centered Primary Care Home (PCPCH) and are adding this to the home visit protocols. All the parents are enrolled in OHP, but they are often not linked to a PCPCH. Anticipating this to increase over the next quarter.

Additional Information:

Identified the following metrics/ measures that could be additional goals for the pilot:

- Well Baby checks
- Prenatal support for mom's with substance abuse and mental health issues
- Immunizations
- Tobacco Cessation
- Screenings for A & D issues

Section 1: 2015 Q3 Success and Challenges

- Health Education by A & D Peer Mentors for referral for assessments and treatment support
- Health Education and support around mental health, diabetes, hypertension and substance abuse.

Child Psychiatry Capacity Building: Samaritan Family Center — Caroline Fisher, Psychiatrist

Successes:

1. Increased intakes considerably by using the mental health specialist to collect some of the more rote data ahead of time (and thereby cutting down on the length of time required per evaluation). This has allowed the provider to affirm understanding of the patient's problem and then spend the rest of the scheduled time discussing treatment options with the family, which seems appreciated. The waiting list is cleared and can see urgent intakes within 2 weeks. For comparison, 6 new evaluations in July, 8 in August, and 13 in September. Families continue to appreciate not having to come in, but feel cared for by the regular contact with the mental health specialist.

Challenges:

1. Discharge remains a huge problem. A capable patient is chosen for discharge and at the last minute the discharge falls through when the family is concerned the patient needs more support due to an acute life stressor.
2. Billing is also a problem – the system isn't well set up for client billing, and because patients go on and off IHN-CCO, it's hard to get an accurate count.

Additional Information: The pilot has been so successful that the pilot will approach the DST to roll out this payment model on a long term basis and also to include providers in Adult psychiatry.

Colorectal Screening Campaign: Linn, Benton, and Lincoln Health Departments — Pilot Staff

Successes:

1. Core team meets frequently to update each other on various project components and for feedback in order to move forward

Challenges:

1. The work plan needs to be more detailed to identify next steps and ensure alignment of all project components. The core team is meeting to create a more detailed timeline of the work to be completed.
2. A timeline has been developed as a living document to align all project components and keep each other informed about the pilot timeline

Community Health Worker: Benton County Health Department (BCHD) — Kelly Volkmann, Health Navigator Program Manager

Successes:

1. As the Health Navigators (HN) become more competent in their roles and the agency staff knows how to use them more effectively, the number of touches and referrals is starting to increase. Also starting to see connection points between resources being made for clients that reduce the likelihood that they will "fall through the cracks." For example, the Geary St. HN spends 4 hours a week of her Benton County time providing navigation services at Signs of Victory (SOV), a homeless shelter in Albany. She reports that she has worked with a number of her clients from Geary St. while at SOV, and has been able to build relationships and help them with resources and services that will improve their ability to adhere to their treatment regimen.
2. Another example is that the Mid-Valley Children's Clinic (MVCC) HN has been

Challenges:

1. There are still a few hiccups with the referral system, although it is functioning more smoothly now.

working with another BCHD navigator who is co-placed with Department of Human Services (DHS). Collaborating to provide navigation services for a mutual client family, ensuring that the family meets the requirements of their DHS program, which will increase the likelihood of a positive health outcome for the children.

Change in Pilot: The pilot has been granted an extension and additional funds to the pilot through 12/31/2016.

Stories from the Field :(From the Navigator at MVCC)

'I had a single dad referred to me by his daughter's babysitter whom I had assisted with the SHS Financial Assistance and OHP application. This dad recently gained custody of his daughter and he was having a hard time getting his daughter's OHP and CCO switched and also finding Head Start or daycare programs. He stated he really wanted to establish care at MVCC but was informed that - because the assigned CCO was not one the clinic could bill to - his daughter could not establish care at MVCC unless he paid for services out of pocket.'

'I called OHP and was informed dad needed to reapply for benefits due to the change of address and so that his daughter could be under his case. Dad stated that the biological mom was not being cooperative with him and would not provide him with the child's SSN so that he could apply for benefits to have her switched to IHN-CCO. Dad said he was working with his lawyer to apply for a new SSN card. I submitted the whole OHP application for the Dad and made a follow-up call to OHP to let them know what was going on. The person at the processing center was able to process the application based on the information they had in their system for this child. So now this child is able to establish care at MVCC! I also connected dad with bilingual staff at Kidco Headstart for him to get assistance with applying for the program.'

Complex Chronic Care Management: The Corvallis Clinic — Terry Crowder, Pharmacy and Refill Services Manager

Successes:

1) The patients who use the tablet appear to show benefits. The diabetic patients have the most improvement by being able to continually enter and monitor their blood sugars and having a graph showing chronologic changes. Having the visual seems to provide an immediate connection between daily behaviors and blood sugar results. Asthmatic patients are showing similar improvements. Benefits from this method of contact seem to be beneficial for those who are socially or physically isolated. The connection provides an outreach. One patient referred to this contact as "a gift from God." One patient had a hypoglycemic attack and couldn't reach a phone or other form of communication for help so used the tablet connection. Although this is not the intent, the Complex Chronic Care Management (CCCM) nurse was able to dispatch help. From the nurses survey it was revealed that the nurses like this level of work and that they work very well together delivering the improved care to those enrolled in the study.

Challenges:

1. Patient enrollment continues to be problematic. Once reviewed, the two data lists provided 221 potential study patients. At present there are 40 patients enrolled (total of 48 with 8 dropouts). Many of the other people were contacted on repeated occasions but showed no interest in participating. There have been some software and hardware issues but those all have been quickly addressed and remedied by KANNACT.

Change in Pilot: No changes to goals or measures. One change was made in that originally CPT 4 codes to track the CCCM nurses work. It became apparent that having the nurse's bill through our existing system would not be possible. A solution was developed so that KANNACT would pull the nurse's touches and report those to IHN-CCO.

On 9-24-15, requested a time continuance for the pilot and to also be able to capture any remaining dollars into 2016. No additional funds will be requested.

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Dental Medical Integration for Diabetes: IHN-CCO — Britny Chandler, on behalf of the Dental Plans

Successes:

1. Communication and issue tracking between project coordinator, dental plans, and clinics
2. Review of individual clinic workflow and incorporation of techniques to improve education outreach and proper referral protocol
3. Screening questions by Primary Care Dentist has reached measurement goal

Challenges:

1. High existing budget. Discussed ideas with dental plans on how these funds could benefit the Diabetic population. Reviewed and edited criteria for Sonicare toothbrush to reach more members.
2. Low mailer response rate. Continuing monthly mailers throughout the life of the Pilot. Willamette Dental Group incorporated cold calling and includes it in monthly data sent to the Dental Program Clinical Coordinator.
3. Communication gap between clinic and dental plan after member has seen Primary Care Physician (PCP) and has been referred to Dental Plan. PCP clinics encouraged to use referral sheet to FAX warm hand-offs and referral directly to dental plans. Not all clinics have implemented referral sheet, Dental Program Clinical Coordinator reports to dental plans with a monthly referral log outlining which members were seen by their PCP in the last month and if there was a warm hand off.

Licensed Clinical Social Worker PCPCH: Samaritan Mental Health - Corvallis — Jana Svoboda, LCSW

Successes:

1. Getting the first Masters of Social Work (MSW) student placed at a Samaritan medical home from Portland State University. Oregon Health Science University (OHSU) and Providence hospitals have been benefitting from collaborative student placements for some time. Clinical social workers are being utilized nationally in primary care; interns often return to their placements as professional staff and bring with them training and community/institutional knowledge when they do. MSWs offer culturally competent, strengths based, resource savvy mental health intervention skills and flexible mindsets as clinicians at a lower cost than PhDs or physicians.
2. Increased staff orientation towards mental health needs and disabling conditions and how these impact physical health and overall wellness. Staff are much more likely to consider counseling as a treatment of choice for someone with an anxiety disorder or stress related illness. They are looking at trauma and how it contributes to addiction, disease and lifestyle issues that decrease health and lead to disability. The clinic is also moving forward with plans for multidisciplinary group visits for persons with diabetes and has begun regular team staffing on patients who are high utilizers of the Emergency Department (ED) or have addiction. It appears the clinic as a whole is taking a much more long-term and holistic view of complex patient care.
3. Classes. The StressBusters class is especially helpful in educating consumers in

Challenges:

1. Time and demand. There is a far greater need for mental health and trauma-informed care than can be met by one LCSW, leading to appointments being further out and LCSW not being as available for warm handoffs. The new MSW student may be the key to addressing this, as she can help with some of the administrative tasks, take over some classes, etc.

Section 1: 2015 Q3 Success and Challenges

how stress impacts chronic and acute health conditions and how simple lifestyle changes can reduce risk of illness and disability. The low-stigma, no barrier classes encourage persons from all age groups and walks of life. Other classes offered regularly include education on depression, anxiety and sleep issues. As a result of the start of these classes and support from LCSW, two other classes are now regularly offered in the clinic, free of charge, to IHN-CCO patients: Living Well with Chronic Illnesses, a Stanford evidence-based program for improving lives of persons with an disabling or chronic illness (from diabetes to depression or addiction) and a nutrition class.

4. Warm hand offs. Primary Care Physicians (PCP) ask the LCSW to step into clinical visits to help patients with in the moment crises and to normalize the counseling process for them. Over 90% of persons who were met during their PCP appointments follow up with a 1:1 visit or class.

5. The LCSW has extended the warm-hand off the other direction as well, bringing physicians into counseling sessions to discuss medication options, and to handle emergent medical issues before they result in trips to ED or more invasive care. The physicians have not only tolerated this—they have welcomed it as a chance to improve patient care and health.

Additional Information: Here are some of the other activities of the LCSW in the program:

1. Attending planning and action meetings with PCPs to add mental health perspective and resource ideas for treatment of clinic patients with chronic illness, high utilization, chronic pain and addiction.
2. Presenting a free 8 hour Mental Health First Aid class at least once monthly to the community to reduce stigma, increase understanding and teach first aid skills for helping persons with acute or ongoing mental disorders. In the past three quarters, LCSW has done 7 classes for over 150 persons.
3. Consulting with medical students, interns and residents on mental health issues.
4. Taught the "StressBusters" educational curriculum to the LCSW at Samaritan Internal Medicine (SIM) and last month presented it conjointly to patients from both SIM and Samaritan Family Medicine Resident Clinic.
5. Attended and presented at a conference on transformational care for the State.
6. Collaborated with other clinicians within the Samaritan system on mental health issues, resources and programming.
7. Began a group for persons with disabling mental illnesses; this group now provides not only therapy but peer support to seven women.

Stories from the Field:

"L", a patient in her 30s, was unemployed for five years after a back injury that left her with chronic pain and an opiate addiction. LCSW helped her recognize the disabling aspects of her addiction, got her into a detox program and worked with her doctor to taper off other addictive medications. L found employment, reduced ED visits, has made new friends and rates her overall wellness as an "8" compared to a "2" at beginning of services.

"B", a woman with a life-threatening disease, had fallen into depression and isolation. She had an unrevealed trauma history that made it difficult for her to reach out for needed physical and emotional support. "B" completed classes on stress reduction and is engaged in monthly individual counseling and has been able to establish connections

with an international support community and two local persons with her disease. She is getting out of her house and has found new purpose in a volunteer activity.

"M", a man with diabetes and severe social anxiety, has increased his self-care and exercise and his diabetes and weight are in good control after CBT for his social anxiety. It took several sessions to establish enough comfort and support for him to engage (he has had 9 total); now he is a great self-advocate and is able to ask questions of his PCP as well as greet and talk with staff as he comes in for appointments. He rarely made eye contact before.

"R", a woman with chronic mental illness, severe trauma history who was socially isolated and frequented the ED for anxiety related suicidality, is now coming to a support group with other women and was connected to an in-home parenting mentor to help her with her two young children. She had previously refused counseling services and needed a lot of warmth and support to engage.

Medical Home Readiness (2): Quality Care Associates — Debra Heinz, Executive Director

Successes:

1. Project is proceeding on schedule and on budget. It is anticipated that the clinic will be able to achieve Patient Centered Primary Care Home Tier 3 recognition. The clinic and the consultants have established good rapport and are happy with the progress of the project, as is Quality Care Associates.

Challenges:

1. Neither the clinic nor the consultants have encountered any challenges.

Mental Health, Addictions, and Primary Care Integration — Danielle Hutchinson, PMG Clinic Manager

Successes:

Challenges:

Additional Information: Pilot continued in a limited capacity due to inability to hire key position. Pilot is deferring quarterly reporting to focus on the final report to close out the pilot October 31, 2015.

Pediatric Medical Home: Samaritan Pediatrics — Miranda Miller, Director of Primary Care Practice

Successes:

1. The nutritionist program has been very successful. She has seen 46 patients in Q3. Increased her time at pediatrics to two full clinic days and one administration day and her schedule continues to be full.
2. Sent letters to patients that have not had an adolescent Well Child Check (WCC) and not completed their series of Human Papilloma Virus (HPV). Also sending birthday cards to patients that will be due for their adolescent WCC.
3. Creating newsletters to keep patients informed about services available at Samaritan Pediatrics.
4. Having a mental health specialist 3 days/week and Psychiatrist 1/week to see patients and do chart reviews to assist the pediatricians has proven to be a great resource.
5. Created an Incidental Findings Care team that meets every two weeks to discuss difficult patient cases. Dr. Ilana Dickson has taken the lead on this project and

Challenges:

1. Have had challenges with non-complaint patients who either show up late to appointments or no-show. Addressing this problem by making reminder calls that would not otherwise get done automatically. Also reaching out to these patients if they do not show via telephone or mail to reengage them with the pilot.

2. Challenges with getting another RN from Benton County Health Department (BCHD). The previous RN gave notice and have been without for approximately 4-months. Met with BCHD last week and are looking to hire a public health RN.

engaging pediatricians and other disciplines.

Change in Pilot: The measures changed when the Pilot extension was requested as the metrics proposed exceeded the amount of metrics the clinic could focus on and succeed. The pilot has been granted an extension and additional funds to continue the progress of enhancing our Pediatric Medical Home and meeting revised metrics.

Primary Care Psychiatric Consultation: Samaritan Mental Health - Corvallis — Jim Phelps, Psychiatrist

Successes:

1. Relationships with three of four psychologists in the 7 Phase I clinics have solidified, good team approach without hesitation or conflict.
2. Consults are appropriate.
3. Feedback from PCP's remains very positive. We appear to have solved the implementation problem (recommendations made are acted upon) by alerting the PCP's Medical Assistant each time a consult is completed.

Challenges:

One psychologist continues to underutilize. In that clinic, connection to Linn County Mental Health is more direct. In the long run, for a program like this, there should be a predetermined relationship between psychiatric consultation and longer-term management (primarily county mental health and Samaritan Mental Health). We're working on that, but progress is slow as it involves several large bureaucracies and one relatively entrenched conflict between provider groups.

Change in Pilot: We have yet to hire a Psychiatric Assistant per the plan. It does not appear likely that this person will be an LCSW as originally planned. More likely she/he will have a Bachelor's degree but no more, so cost per year will be lower than budgeted, once hired.

Additional Information: Dr. Phelps has established a network of psychiatrists in Oregon who have experience with primary care psychiatric consultation. That network has created a document summarizing the various approaches to this challenge that have been tried to date in Oregon. With that information, Dr. Phelps and a colleague have joined the Integrated Behavioral Health Association of Oregon (IBHAO), which is the primary group advising the Oregon Health Authority on behavioral health integration in primary care. Our goal in joining IBHAO was to insure that psychiatric consultative services, in some form, were one of the recommended elements for primary clinics attempting to develop a formal program of behavioral health integration. As members of IBHAO's Psychiatric Integration subgroup, we helped with IBHAO's Minimum Standards document. In that document,

1. A specific mention of monitoring *outcomes* as well as services provided was inserted at Dr. Phelps' recommendation. This has the potential to transform the entire primary care behavioral health effort, if clinics are actually measuring whether what they are doing is *working*. We believe that this will be one of the most important drivers of regular psychiatric consultation (thus the connection to PCPC Phase II), when patients are not improving and additional ideas are needed.
2. The following line was added at our instigation: "the integrated team includes psychiatric consultative resources." Prior to this addition, there was no mention of psychiatric services in the primary care behavioral health standards. We believe that psychiatrists and psychiatric nurse practitioners are an important member of the team, rather like – as we suggested during these discussions – a punter on a football team: if things go well, the punter may not even take the field, but one wouldn't start the game without one.

Public-Health Nurse Home Visit: Linn County Health Services — Norma O'Mara, Supervisor for Maternal Child Health

Successes:

1. Still implementing a decrease in the amount of paper work for the Home Visit (HV) Nurse program in order to provide more efficient service to clients. Have seen some really good work done by our HV nurses.

Challenges:

1. Continue to be the lack of access to good reliable data from the state to match what was determined would be the data collection measures. The ability to collect accurate data is difficult, and requires a request to the state for assistance.
2. There has been difficulty providing on-site coordination with Women, Infant, and Children (WIC) appointments for prenatal clients and home visit staff. WIC will be updated regarding availability for prenatal home visits, which will focus more on the newborn rather than prenatal. Working to get the prenatal reimbursement on par with Benton and Lincoln, but have not reached the goal yet.

Section 1: 2015 Q3 Success and Challenges

Additional Information:

1. Added one day of Bilingual support to the home visit program which was not there before. This will provide interpreting service and they will work as a resource person for Hispanic clients. Previously lost staff from this position, but are advertising for a replacement.
2. A BSN nursing student is working with the immunization coordinator in the Sweet Home school district by getting incentives for parents who bring their children in for their immunizations. A brochure is being developed by the student that the home visit nurses will use to discuss the importance of getting your children immunized.

Public-Health Nurse Home Visit: Benton County Health Department — Maikia Moua, Nurse Manager

Successes:

1. Started the Prenatal SBIRT.

Challenges:

2. Nurse staffing continues to be a challenge. Human Resources have worked to reassess the classification and wage scales for nurses in collaboration with the Oregon Nurses Association. Now able to consider a wider range of nurses with varying educational and work experience. Currently considering nurses for multiple positions within the county and best situate candidates to programs.

Public-Health Nurse Home Visit: Lincoln County Health & Human Services — Rebecca Austin, Lincoln County Public Health Division Director

Successes:

1. Continue to focus on collecting correct and complete data. This quarter the pilot was able to collect information about immunizations, obstetrics referrals and number of Women, Infant, and Children appointments.

Challenges:

1) When doing the report for this quarter an error was caught in how the Ages and Stages Questionnaire (ASQ) data is collected and made the change.

Additional Information: Presentation was made to IHN-CCO regarding the DST project and plans to make a poster presentation in October to the Oregon Public Health Association.

School/Neighborhood Navigator: Benton County Health Department — Kelly Volkmann, Health Navigator Program Manager

Successes:

1. Having a School Navigator (SN) at Linus Pauling (LP) has been a good transition for families coming from Garfield and Lincoln. The SNs were strategic in having the LP-SN attend school functions at Garfield and Lincoln schools at the end of last school year and again at the beginning of this year so that families could see her and know that she was part of the navigator program, she was "safe", and she was available to help them. This allowed her to step in easily with a number of families that needed assistance.

Challenges:

1. Creating the "navigator niche" with the staff at the school sites is always a bit of a challenge. It takes time, patience, and persistence on the part of the SN before the staff understands her role and begins to accept her as part of the team there to serve the student and their families. Helping the staff understand that the SN is there to assist with services and connections for the family and the student outside of the school – and not inside the school system - is one example of that.

Stories from the Field:

a. The Lincoln SN was invited to attend Lincoln School's Arabic Night to learn more about the Arabic community and increase her ability to provide navigation services for the Arabic-speaking families at Lincoln. This is a measure of the trust that the Lincoln SN has gained among Lincoln's Arabic families – they feel safe and comfortable inviting her to learn more about them. The Lincoln SN also invited one of the OHP navigators from the health department to join her, increasing the number of people the families have seen and feel comfortable with.

b. Linus Pauling SN is working with an unaccompanied student that lives with relatives. She came from Mexico a few weeks ago. Her father was involved in criminal activity in Mexico and was assassinated. SN was able to help with the OHP application and student is now active on MMIS. SN was able to help establish care at The Corvallis Clinic

with Dr. River. SN referred the student to the McKinney-Vento program, and McKinney –Vento is paying for Tae Kwon Do classes. Student has received the Corvallis Parks and Recreation scholarship. The student was also referred to Trillium Family Services for counseling.

Tri-County Family Advocacy Training: Oregon Family Support Network — Tammi Paul, Statewide Training Program Manager

Successes:

1. OFSN has successfully engaged new and existing family members in Lincoln County with the special education trainings. Are seeing numbers increase over time and contacts with local resources increase as families come together for the training. Also heard from some families that they are empowered to attend Individualized Education Program (IEP) meetings with new knowledge and are slowly forming a network of family members who can attend IEP meetings with each other.

Challenges:

1. Meeting the needs in Linn County as outlined in the pilot 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 continue to meet with Linn County leaders to determine how the pilot goals can enhance or support what is already offered but it is projected to be a long term conversation. However, Linn County families are attending trainings in Benton County.
2. Another challenge that continues to be a barrier to families in Lincoln County particularly is the absence of transportation to attend training. OFSN family partners are providing transportation to families who may not be able to attend otherwise.

Additional Information: All evaluations from participants who attended the two trainings in Lincoln county this quarter indicated that they were 'Very Satisfied' with the trainings which are the highest measure available on the evaluation. Comments included:

"I liked having knowledge and verbiage to make me feel like a better advocate for my child"
"Very informative and educational. The meaningful story examples and crowd management was excellent. This was very well run"
"This information isn't available to parents in small communities and I appreciated this training in my community"
"OFSN should do this more often to help many families"

Universal Prenatal Screening: System wide — Carissa Cousins, Physician

Successes:

1. Established screening in all Samaritan clinics and hospitals as well as The Corvallis Clinic Obstetricians (OB) office. Normalizing the conversation about substance use, violence and mental health in the OB setting. Established a simplified route to connecting women with resources.

Challenges:

1. Challenges with some women upset with the urine drug testing, despite providing verbal consent. Have had several women test positive for opiates and report that they did not use opiates, but did eat poppy seeds. Addressed this issue at the meeting with Department of Human Services (DHS) and have developed a plan of action for these situations. Some insurance plans do not cover the urine drug testing done in the clinic and patients have expressed frustration with receiving these bills.

Change in Pilot: Have asked for an extension of the budget. This is to accommodate the data analysis. Will not have significant, complete data until nine months after the program started. As the Albany OB clinics just recently started (all other started in Late April or early May), complete data will not be available until February or March 2016.

Section 1: 2015 Q3 Success and Challenges

Additional Information: Working with other health systems to share information on project success and struggles. Caring for women with substance use and making sure that their children are raised in a safe and nurturing setting is key to improving community health. Ongoing efforts should be made to support programs that support that goal.

Stories from the field: Below are two quotes from women who were screened and made contact with the navigators:

"I really am interested in treatment but it's so hard to get involved in it when I feel so stressed with everything going on. Thank you for coming in to my appointment and getting me set-up with an appointment for A&D. It was nice to not have to go through all the steps myself".

"I'm just so scared for my baby and I think that going to counseling will help me work through it".

Youth Wraparound & Emergency Shelter, Jackson Street Youth Shelter — Andrea Myhre, Grant Writer

Successes:

1. Working with IHN-CCO staff to understand the goals of transformation and successfully implement our pilot has been a positive process.
2. Helping youth receive dental care and setting up insurance and initial medical appointments has also been successful.

Challenges:

1. Working with Jackson Street case managers to appropriately track measures and better design the database to make reporting simple and more efficient has been a challenge.
2. Attempting to educate and make practitioners aware of our services and how to access them, building relationships to remove barriers and provide better services to youth being served has also been challenging. The process of reaching practitioners could be made easier for community service providers and are looking forward to working with IHN-CCO on improving these relationships.

Stories from the field: We are serving a youth that lost housing due to conflicts at home; her legal guardians are not allowing her home. This youth was staying with a family friend who also kicked her out due to lack of funds to support her. One of Jackson Streets primary goals is to reunite youth with their family, if appropriate. After assessment it was determined there was no abuse taking place so we began steps to engage the guardians During the assessment process, both youth and guardian requested mental health services. Jackson Street Case Management Staff supported several attempts to make a referral to begin services, to connect with the individual's school resources, and to access drop in intake appointments but experienced several barriers to accomplishing this. Due to the barriers encountered the youth lost interest in mental health supports.

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

Alternative Payment Methodology (APM): Benton County Health Department			
Goals	**Activities**	**Measures**	**Results**
Develop a financial report, and review monthly.		Report developed	Benton and IHN-CCO are working together to identify core financial data, identifying and resolving data inconsistencies, and beginning to look at Emergency Department (ED) visits to determine if patient outreach/education may reduce numbers.
Reconcile patient panels	Actively managing terminating patient and new enrollee reports	Provider panel list compared to IHN-CCO panel list match	These lists will not match as Benton does not assign patients to a provider's panel until they have received a service, but our percentage of discrepancy is dropping steadily as Benton staff "work" the IHN-CCO list and provider assignments are clarified.
Approve plan within the clinic, and begin implementation of clinic transformation around care coordination and increase access.	Implementing open access in October 2015	Progress report by plan compared back to the plan submitted to IHN-CCO.	The Chronic Health Care Management team, working as a subgroup of our internal APM Workgroup, is taking steps to implement open access for all providers. This will increase provider capacity and allow for increased patient access. A Client Communication Coordinator pilot has been implemented to identify and implement new ways of engaging patients. Tools are being developed for outreach to new patients; the web-site is being revised to be more client-friendly and the use of social media and text-messaging is also being explored. The Health Center is also expanding access through the addition of a Family Physician at the Benton site and will be opening additional rural clinic sites; one in Benton County and one in Linn County.
Track performance metrics	IHN-CCO developing metric monitoring reports	Monitor progress of metrics related to Patient Access, Quality of Care, and Utilization.	IHN-CCO is developing a Performance Metric Monitoring report and populates more data points each month.
Track "touches" outside of normal billing standards	Submit touches report to IHN-CCO monthly	Data documented and shared with IHN-CCO each month.	The Electronic Health Record (EHR) that Benton uses automatically tracks billable services as well as "touches"; typically non-billable documentation in the patient chart (i.e. letters, phone calls, MyChart encounters, translation).

Alternative Payment Methodology (APM): Samaritan Internal Medicine (SIM)			
Goals	Activities	Measures	Results
Reducing Emergency Room (ER) visits	ICT meeting and additional clinic support	Decrease ER visits	A couple of SIM patients that routinely visit the ER have not done so.
Health Education	Creation of decision aides, new living well with chronic conditions class and a TV in the waiting to promote classes.	Increase preventive services and decrease patients seeking services outside the primary care home (example: ER and Urgent Care (UC)).	SIM has developed decision aides to help patients make decisions on preventive services, such as mammograms, colonoscopy screenings and Public Service Announcements (PSA). Two care coordinators have been trained to provide 'Living Well with Chronic Conditions' with the first class on 10-6-15.

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

Medication Management	The SIM pharmacist and resident are meeting with patients and performing med management	Decrease prescriptions prescribed by the clinic	SIM has partnered with Samaritan Health Services Pharmacy department to have a pharmacist perform medication management for our high risk 3 & 4 CCO patients and those with high cost medications. The pharmacist will begin in May and will be at SIM once per week to start.
Interdisciplinary Care Team (ICT)	Gathered providers at SIM, pharmacist, behavioral health, leadership, care coordinators and a case manager from IHN-CCO to meet monthly.	Decrease patients seeking services outside the primary care home (example: ER and UC).	ICT has brought collaboration and thinking outside the box in order to break down barriers for patients. SIM now has patients being educated on the use of the UC/ER with a couple of success stories of high ED utilizers not utilizing the ED recently and contacting the clinic.
Hired an additional Care Coordinator	Increased patient outreach	Increase preventive services	Now that SIM has three care coordinator, ED and inpatients discharge follow-ups are completed in a more frequent and timely manner. Time can be spent with patients to get to the root of the barriers.

Alternative Payment Methodology: Coastal Health Practitioners (CHP)			
Goals	Activities	Measures	Results
Develop a financial report, and review monthly.	Report reviewed every month		Continuing to determine financial ongoing viability for using the Per Member Per Month (PMPM) methodology in the clinic.
Reconcile patient panels	Provider panel list compared to IHN-CCO panel list match		As patients come in CHP checks Medicaid Management Information Systems (MMIS) for eligibility and the IHN-CCO panel list for provider assignment. Currently tracking and transmitting updated patient assignment lists on an ongoing basis. Staff at CHP is looking forward to being able to access the upcoming patient portal to check eligibility and make changes. Using this list to contact new members as they are assigned to us in order to attempt to satisfy the desire for patients to be seen within 90 days of assignment. This is often not successful as patients have trouble with transportation, family commitments, or would need to take time off work in order to come to the clinic; taking time to do that when there isn't an urgent medical need isn't a priority or possibility for a lot of the assigned patients.
Approve plan within the clinic, and begin implementation of clinic transformation around care coordination and increase access.	Progress report by plan compared back to the plan submitted to IHN-CCO.		Work on this goal simultaneously with similar measures developed for Patient Centered Primary Care Home (PCPCH) requirements. Currently have two mental health professionals holding clinic hours on site. It is the hope that this integrated care will improve outcomes for patients. Establishing access to Tele-med; working to set up technical specifications and requirements for access to care and billing/financial needs to provide access to patients as needed

Track performance metrics	Billing with visits as appropriate		Tracking three measures at CHP and billing and charting these measures as appropriate to provide requested data to IHN-CCO.
Track "touches" outside of normal billing standards	Reports are being submitted; these will now be sent on the 15th of the month following the reporting period		Keeping careful track of substantive contact with patients outside normal visit parameters, including phone, email, and in-person consultations with staff outside provider list.
Risk pool management as small RHC vs. large Federally Qualified Health Center (FQHC)	Discussing monthly with IHN-CCO to determine validity of risk pool		Still discussing options as CHP is a small clinic and one patient ER visit or inpatient stay can have a significant negative impact on the numbers; this isn't currently a valid option moving forward

Behavioral Health PCPCH: Corvallis Family Medicine (CFM)			
Goals	Activities	Measures	Results
Expedited access to mental health and coordinated care within a primary care setting Transformation Element 1	Regular interactions between mental health and medical providers Regular interactions with patients' providers outside CFM	Tracked date of initial contact to date of first visit Tracked number of "pop-in" and warm handoff visits	A total of 30 IHN-CCO patients with up to 15 active at a time. All patients had opportunity for appointment within one week of referral. A total of 8 conjoint visits with Primary Care Physicians (PCPs)
Assessment of mental health morbidity using industry standard tools Transformation Element 1	Every patient given a written and verbal assessment to establish diagnosis, baseline, and progress	Assessments and quarterly reassessments given to measure success Verbal scaling question asked of patients to determine overall success	To date 23 out of 30 patients experienced positive change in mental health status based on assessment
Increase health literacy and overall adherence to treatment Transformation Element 6,7,8	Discuss lifestyle habits that impact overall health with all patients Offered psychoeducation on interplay between mental and physical health Helped patients differentiate between anxiety/panic and heart conditions Discussed barriers to treatment with patients	Track improvements based on re-assessment and scaling questions Track decreased need in psychotropic medication	Ability to manage addictions in 4 patients previously resistant to treatment 8 out of 30 patients reported being able to see some positive change in symptoms due to lifestyle changes 7 of 30 patients reported that preventative measures (i.e. exploration of life style habits and impact on overall health) allowed for overall attainment of treatment goals 76% (22 out of 30) retention rate in patients still in need of services 4 patients (out of 17) decreased or stopped psychotropic medications based on improvements in mental health. Two patients (out of 30) avoided medications based on early mental health interventions

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

Integration of payment systems within IHN-CCO to ancillary practitioners Transformation Element 3		Tracked billed encounters to IHN-CCO	Payment system has been tested and is effective on fee-for-service basis
Establish a fiscally viable model that can be reproduced locally in other primary care settings Transformation Element 3	Increased patient referrals through advertising, PCP education, and patient education Explored possibilities of accepting IHN-CCO with PCP in other clinical setting	Tracked claims submitted on a fee-for-service basis	163 distinct claims made that would have paid $16,135.00 fee-for-service Difficulty in establishing financial sustainability due to lower than expected referral rates

Child Abuse Prevention & Early Intervention: Family Tree Relief Nursery (FTRN)			
Goals	Activities	Measures	Results
Using an array of strategies to implement culturally appropriate and gender specific services for all the families that are served		Certify two staff members as Traditional Health Care Workers (THCW)	Two home-visiting Interventionists attended and completed the Traditional Healthcare training from Multnomah County to become certified through the State of Oregon as THCW
Build case load of IHN-CCO served high risk families with children 0-6.		Numbers of families enrolled with FTRN services Goal: 20 Families; 20 Children	Enrolled in Quarter 3: Families: 28 Adults: 29 Children: 39 Total: 39 Families consisting of 40 adult members and 60 child members
Home Visits		# of home visits	58 Home Visits in Quarter 3 for 58.25 hours Total: 91 Home Visits for 91.25 hours
Respite		# of sessions	Quarter 3: Eleven 2.5 hour sessions Total: 17 sessions 42.5 hours
Respite		# of children attending Goal: 20 Children	Serving 36 unduplicated children in Quarter 3 Total: 45 unduplicated children
Ages and Stages Questionnaires (ASQ's)		# of ASQ & Ages and Stages Questionnaire-Social Emotional (ASQ-SE)	Quarter 3: ASQ & ASQ-SE 22 Total: ASQ-ASQ-SE 29

Link to Medical Home		Link client to Medical Home Goal 100% linked	Quarter 3: Adults-16/29 Children-39/39 Total: Adults 16/40 Children 49/60 ** Improved tracking on this metric in Q4

Child Psychiatry Capacity Building: Samaritan Family Center			
Goals	Activities	Measures	Results
Increase capacity	Number of patients	Number of patients followed	Significantly expanded intakes this quarter.
Improve outcomes	Individual outcome measures	Structured, validated outcome measure by diagnosis	This is going well, with better treatment outcomes or better documentation that parents don't want to treat more aggressively.
Maintain patient/family satisfaction	Outcome calls	Informal survey during patient visit, choice between calls and visits	Families like it and continue to have very few who request not to participate in the calls.
Maintain/improve PCP satisfaction	(none yet)	Survey	Families don't like to leave the program, so discharge has not happened. This will be a focus for the next quarter.

Colorectal Screening Campaign: Linn, Benton, Lincoln Public Health			
Goals	Activities	Measures	Results
By June 2015, adapt and implement OHA's colorectal screening media campaign, reaching 80% of IHN-CCO CRS eligible members, in the three-county region.			Brochures and posters were finalized and printed Progress has been made to post the campaign on County and IHN-CCO websites, purchase bus ads, develop radio ads, and confirm billboard locations Print materials are being dispersed to pilot clinics for distribution to patients
By August 2015, disseminate CRS information beyond the walls of traditional health care settings by partnering with public health and other community organizations, reaching 20% of IHN-CCO CRS eligible clients.			Print materials are being distributed to non-traditional settings in order to further extend the reach of the campaign
By December 2015, distribute 3,000 FIT tests in selected Patient-Centered Primary Care Homes utilizing EMR to identify patients aged 50 to 75 years, with 40% (or			The 10 FIT pilot clinic sites are being finalized. Expectations for participating clinics have been outlined and contracts are drafted. A presentation is scheduled to present the campaign and pilot initiative to the Quality Management Committee in November

1,200 patient member) adherence and return of stool test screenings.			An in-person training for clinic staff is being scheduled for December 2015. An online training has been selected and will be pushed out to primary care providers through the Cornerstone platform
By March 2016, utilize traditional health workers/health navigators to reduce barriers related to screening among Latino and Native American populations, reaching 5% IHN-CCO CRS eligible members.			Completed literature review of barriers for Latino and Native American populations. Findings suggest that provider recommendation was the strongest indicator for screening completion Currently scheduling presentation at the monthly traditional health workers meeting to better understand their role in Colorectal Cancer Screening and to brainstorm opportunities to collaborate in order to improve screening rates in the identified subpopulations
By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.			Determined how baseline and final outcomes for screening rates will be measured. Waiting to confirm all pilot sites before running report. Patient survey is in development to further understand how different components of the pilot influenced screening rates. Provider and clinic staff participation in trainings will be tracked.

Community Health Worker (CHW): Benton County Health Department (BCHD)			
Goals	Activities	Measures	Results
Develop Hub model that includes target population, site criteria, and evaluation metrics			The Hub model continues to develop as Phase 3 of the initial CHW pilot starts. The first introductory meeting with the Registered Nurse Care Coordinators (RNCCs) from Samaritan Family Medicine (SFM) and Samaritan Internal Medicine (SIM), the next two clinics that will be participating in the pilot. To allow the second roll-out of CHWs to the new clinics, the DST has granted an extension of the pilot through 12/31/2016. This will allow time for the new agencies to integrate the CHWs into their care teams and for the new CHWs to fully function in their roles as clinical health navigators. The positions have been posted and expect to start interviews in late October or early November.
Hire, train, and supervise 2 CHWS			Both CHWs are now fully functioning as clinical health navigators. They have completed their self-management training and are settling into their roles. Benton County Health Services continues to send them to trainings when available and appropriate, and the Health Navigation Program Manager provides ongoing supervision.

Send CHWs through state – approved CHW training and register with Oregon Health Authority (OHA)			The Geary St. Health Navigator (HN) will be going through the state-approved CHW training in November.
Document staff training, roles, policies, and procedures			A draft template has been developed as a communication guide for working with new agencies. It will be trialed with SIM and SFM and continue to improve it as the pilot moves forward. A clinic handout was also developed to give to agency staff that explains what HNs can be expected to do with regards to self-management.
Develop an evaluation plan that includes process and health outcome measures			HNs are tracking all patient touches by category. In addition, BCHS Program Manager is working with IHN-CCO and the Traditional Health Worker (THW) Subcommittee of IHN-CCO to develop a way to standardize how patient touches are captured and valued, as well as how to show the value of CHW services.

Complex Chronic Care Management (CCCM): The Corvallis Clinic (TCC)			
Goals	Activities	Measures	Results
Continue enrollment	Contacts	accept / decline	48 total patients; 8 dropouts, 40 remain
Capture nurse billing			KANNACT will pull touches and report
Continue CCCM delivery			As patients are on-boarded.
Conduct nurse interview	By OSU	Midway questions	Complete

Dental Medical Integration for Diabetes: IHN-CCO			
Goals	Activities	Measures	Results
On-going monitoring of clinic pilot activity	• Monthly medical clinic check-in • Monthly dental plan check-in • Medical clinics workflow meeting • Dental plans workflow/budget meeting	NA	100% complete
Budget distribution	Edited Sonicare toothbrush criteria	NA	

Closed communication gap between clinics and dental plans	• Dental Program Clinical Coordinator referral logs to dental plans • Referral sheet from clinic to dental plan	NA	
Collection of monthly data	Budget reporting	NA	Remaining budget: 97.14%
	Medical clinics to Dental Program Clinical Coordinator report	100% of clinics reporting	
	Dental Plan to Dental Program Clinical Coordinator report	100% of dental plans reporting	
	Collecting warm hand-offs from Medical to Dental	75% or greater of all eligible members	158 warm hand-offs/referrals 47% at this time
	Collecting warm hand-offs from Dental to Medical	75% or greater of all eligible members	2 warm hand-offs 1% at this time
	Screening questions by PCP	90% or greater compliance rate from participating medical clinics	281 patients received oral health screening questions by PCP. 83% at this time.
	Screening questions by PCD	90% or greater compliance rate by dental providers	242 patients received medical health screening question by PCD. 87% at this time.
	Mailer response	50% or greater response rate for entire population	63 mailer responses. 2.2% at this time

Licensed Clinical Social Worker (LCSW) PCPCH: Samaritan Mental Health - Corvallis			
Goals	Activities	Measures	Results
Mental health services integration into medical home	Provision of group, individual and family mental health counseling; Psychoeducational	PHQ 9 GAD-7 ORS/SRS	LCSW is seeing patients with complex trauma histories, often with opiate dependency, critical health issues and other compounding factors. Majority show improvement in daily functioning and reductions in clinically elevated scores.

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

	classes	Class evaluations Numbers seen	SRS= session rater scores. Average in high to very high range patient satisfaction with therapist, sessions, goals discussed. 284 direct patient visits in 44 patient-available days last quarter. Average per day 6.45 direct face to face contacts; 110 individuals seen in these visits. 162 patient email messages sent this quarter (case management, follow-up, class information, patient advice). Patient care was also made via telephone—data not available at time of report but estimate 12-15 calls per week.
Increase staff understanding of trauma/mental health needs on Medically Unexplained Symptoms	Consults, staff education via emails, cc'd charts on common patients	Anecdotal Increase in number of warm hand offs and referrals	Referrals continue to rise for individual assistance to patients. Average over 30 clinical contacts a week, 70% in person and remainder in email or telephone. Patients referred increasing present complex mental health issues, including schizoaffective and other psychotic disorders, intractable or disabling anxiety and depression.
Utilize Masters of Social Work (MSW) students to increase access to care, provide training for future Mental Health providers, and offer low-cost, low-barrier case and clinical services	Working with Samaritan Health Services and Portland State University (PSU) to arrange field placement for academic year of 2015/16	Successful student placement and beginning of field work	Met. One student placed for this school term. Additional students could not be placed because of administrative delays. Now that hurdles have been cleared, anticipate PSU could place additional clinical students in future.

Medical Home Readiness (2): Quality Care Associates			
Goals	Activities	Measures	Results
Readiness assessment completed			Completed
Project plan completed			Completed
Site meetings and conference calls			Four site visits and several conference calls have been completed

Medical Neighborhood PCPCH-Behavioral: Lincoln County, Samaritan Lincoln City Medical Center, Samaritan Coastal Clinic			
Goals	Activities	Measures	Results
Deferred reporting to final report			

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

Pediatric Medical Home: Samaritan Pediatrics			
Goals	Activities	Measures	Results
Increase Nutritionist time in the office	Nutritionist days increased to 3 full days in the office. 2 clinic days and 1 admin day.	Access to care and Satisfaction with care	Patients able to access care in a more timely fashion now that Nutritionist is in the office more frequently. Determined that the needs for pediatrics nutritional/diet visits were in great demand. In Q3, our nutritionist saw (46) pediatric patient. The IHN-CCO report is not available yet.
Develop additional schedule for mental health intakes with Psychiatrist Fellow	Warm hand offs and Mental health intakes	Access to care and Satisfaction with care	Psychiatrist Fellow now works with Mental Health Specialist on Monday afternoons.
Reconcile PCP assignment reports	Contacting patients via telephone	Effectiveness of care measures	Able to capture new patients to the clinic or already existing patients who had not been seen in some time, make appointments and engage them in pilot project resources as needed or necessary. Also able to capture patients who still had measures to meet (i.e. adolescent well child check, CRAFFT etc.)
Develop and provide ongoing management of care plans	Warm hand off's	Care plan management Decrease in member costs, overall, by place of service, pharmacy, etc.	As warm hand offs occurring with other disciplines within the office, a care coordinator has been working more as a resource-based liaison. Plan on focusing efforts on care coordination and having the coordinator meet with parents/patients.
Pharmacist	Medication Management		The pharmacist reviewed 161 new patient charts in July, Aug, Sept. In September she also went back over patients that she had made notes on in previous months to look for follow up on issues and reviewed an additional 168 charts. Grand total 329.

Primary Care Psychiatric Consultation: Samaritan Mental Health – Corvallis			
Goals	Activities	Measures	Results
Increase number of clinics served.	Recruiting psychiatric assistant		Two candidates identified; re-writing job descriptions to facilitate their hire
	Clearing the way via Medical Directors		Met with Medical Director for Newport clinics, approved
Deepen routine use of psychiatric consultation in clinics previously served	Regular meetings with clinic psychologists, and social work		Continued flow of consult requests Exploring which personnel might manage follow-up on patients who've had consults done
Determine efficacy of chart-based consultation.	Review prior consults	Qualitative approach so far; looking for quantitative options	Comparing IHN patients with non-IHN there is a trend toward better outcomes in non-IHN patients; need larger sample size

Section 2: 2015 Q3 Goals, Activities, Measures, and Results

Public-Health Nurse Home Visit: Linn County Health Services			
Goals	Activities	Measures	Results
Grid not reported			

Public-Health Nurse Home Visit: Benton County Health Department			
Goals	Activities	Measures	Results
Grid not reported			

Public-Health Nurse Home Visit: Lincoln County Health & Human Services			
Goals	Activities	Measures	Results
Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women.	Provide the SBIRT screen at all initial prenatal appointments.	Percentage of clients who had a SBIRT assessment. This is for women seen in July, Aug and Sept 2015.	54/55 = 98.1% had a SBIRT screen. The denominator is the number of pregnant women seen for an initial needs assessment (INA). The numerator is the number of women seen for a INA that had a SBIRT screen.
Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.	See results to date. Multiple meetings attended to insure that community partners understand Home visiting programs and use referral pathways.	NA	Attended first parent education steering group meeting, Department of Human Services (DHS) meeting to share about home visiting services and making referrals. A Presentation was made to the Public Health Advisory Committee about Home visiting services and a presentation was made to IHN-CC0 on DST project. Work on formalizing MOU for tri-County Health Department nurse home visiting with IHN-CCO. Meetings continue with Lincoln County home visiting programs (Nurse Family Partnership, Maternity Case Management, Babies First, CaCoon, Healthy Families Oregon, and Early Intervention) to start a home visiting parent advisory board. In Sept. a Bilingual newsletter was developed and given to all families that have received home visits, urging them to attend the Parent advisory group.
An Ages & Stages Questionnaire (ASQ) is completed by the age of 6 months, at least 80% of the time	System is in place for pulling accurate data. Work continues thru the Early Learning Hub Health care integration team around the work of ASQ. They have made a recommendation to	% of clients who had an ASQ by age 6 months for time period	23/23 = 100% This represents a baby that had at least one ASQ at 6 months or before. The denominator is the number of clients that were born in Jan 2015, Feb 2015 and March 2015, and had a home visit after 2 months of age - 6 months of age. The numerator is the number of the denominator that had at least one ASQ in that time frame.

	coordinate this process with providers and get everyone trained in ASQ.		
Coordination and referral processes for access to primary care OB care and oral health are established	Monthly triage meetings take place at Samaritan Pacific Communities Hospital, Samaritan North Lincoln Hospital and Peace Health Peace Harbor Hospital in Florence to coordinate with Health Care providers. This is a coordinated care opportunity to make sure no one slips thru the cracks.	Denominator = # of clients seen in time period Numerator = # of referrals made to primary care, oral care and OB.	For primary care - 244 were assessed for Primary Care Physician (PCP) (Unduplicated) Have PCP – 208/244 = 85.2% No PCP – 46/244 = 18.8% Referred to PCP – 75/244 = 30.7% 532 total referrals made for PCP duplicated) For OB 81 assessed for OB provider (Unduplicated count) Have OB provider -58/81 = 71.6% No OB provider 8/81 3.7% Made referral to OB provider 19/81 = 23.4% Total referrals made:149 Duplicated For Dental 175 were assessed for dental provider (Unduplicated count) Have dental provider 94/175 =53.7% No dental provider 93/175 =53.1% Referred to Dental provider 73/175=41.7% Total referrals made:308 Duplicated
75% of children will receive their recommended vaccines before their second birthday	Home visiting staff now has access to ALERT so as to get current immunization status. The standard will be to look up Alert status for each family prior to making the home visit for 2, 4, 6, 8, 12 month olds and then appropriate referrals. Phone calls are also made to clients PCP if the information is not	% of time nurses check with families about immunization status during 2, 4, 6, 8, and 12 month visits? Numbers of immunization referrals were made during time period.	94 clients were assessed for immunizations (Unduplicated) 73/94 =76.5% had their record reviewed 23/94 =24.4% were referred for immunizations A total of 149 referrals were made Duplicated

	complete for verification.		
Coordinate prenatal assessments with Women, Infant, and Children (WIC) appointments for pregnant women. The first report will be available July 2015.	LC Home visiting services begin for prenatal clients with a WIC appointment, usually done by Home-Visiting Nurse.	Number of prenatal clients that had a WIC appointment and a prenatal assessment for time period. N= Prenatal Assessments	45 clients had a WIC appointment and a prenatal Initial needs assessment. Some of the women served live in Douglas County and WIC is not provided through this pilot as they receive services through Douglas County.

School/Neighborhood Navigator: Benton County Health Department			
Goals	Activities	Measures	Results
Improve outreach, coordination and integration of health, social, and community resources through schools for children and their families.			July 2015 School Navigators (SNs) spent the summer school holiday working in the community with the rest of the navigation team, with the focus of their activities in their respective school catchment areas. They continued to provide support for families they had been working with in the spring – in particular, several refugee families from Guatemala who speak Mam. These families have a very difficult time accessing resources in the area, as they have limited Spanish and there are no resource agencies with Mam-speaking personnel. All 3 SNs worked with the families to help them get legal and social services.
			August 2015 SNs participated in all "back-to-school' activities with their respective school staff, including workshops, retreats, and trainings.
			September 2015 School began! Garfield and Lincoln SNs report families and school staff glad to see them back in place. The Linus Pauling SN (this is a new position this year) has spent the first few weeks of school doing outreach to staff and families to let them know who she is, what her role is, and how she can help them.
Improve coordination of the care of IHN-CCO members by improving access and engagement of patients and their families in their primary care medical homes.			

Sept 2015	Garfield	Lincoln	L-P MS
WCC	2	1	0
Primary Care	5	6	8
Vision	2	4	3
Dental	1	3	3
Health Insurance	9	17	9

Counseling	1	1	4
Food	0	7	2
Clothes	4	7	12
Recreational Activities	16	13	14
Interpret Translation	4	0	2
McKinney Vento	5	2	1
Other	16	15	10
Monthly Referral Total	65	76	68

Please see table above for referral numbers for the Garfield and Lincoln school navigators for September. ("WCC" = Well Child Checks; " McKinney Vento" is the program for families experiencing homelessness; "Other" includes transportation, assistance with financial paperwork, immigration forms, and any issue that doesn't fit into the labeled categories. "L-P MS" is Linus Pauling Middle School)
The SNs track referrals on an excel spreadsheet that allows them to chart the status of the referral and if the referral has been closed. SNs attempt to "close the loop" back to the referring party (teacher or counselor) in every case possible.

Tri-County Family Advocacy Training: OFSN			
Goals	Activities	Measures	Results
9 Special Education Trainings	2 trainings	135 participants 90 % satisfaction	Lincoln County- conducted Individualized Education Program (IEP) Basics- 10 participants- 100% participants very satisfied Lincoln County- conducted 504/IEP- 10 participants- 100% participants very satisfied
1 Family Support Group Facilitation Training	Completed	15 participants 90% satisfaction	Benton County- conducted training-6 participants- 100% participants very satisfied
2 Family Perspectives Training	Scheduled	30 participants 90% satisfaction	Lincoln County- training scheduled for November 18th in Newport. Benton County- training scheduled for October 29th in Corvallis.

2 Collaborative Parenting Series	Scheduled	20 participants Pre/Post Family Empowerment Scale	Lincoln County- training scheduled in November. Benton County- training scheduled in November.

Universal Prenatal Screening: Carissa Cousins			
Goals	Activities	Measures	Results
Implement Screening in all SHS and The Corvallis Clinic (TCC) clinics providing Obstetrics (OB) care	Ongoing support and trainings.	# of clinics using the 5Ps screening tool	All Samaritan OB and Family practice clinics and hospitals that provide OB care are now using the 5Ps Screening Tool. The Corvallis Clinic OB is also using the screening tool in their clinic. Currently filming training videos for ongoing training on how to perform a brief intervention. These videos will be available on the intranet.
Implement Screening in all SHS labor and delivery wards	Ongoing support and trainings.	# of Hospitals using the 5Ps screening tool	
Use of Navigators for Mental health and substance use disorders	Connecting the Navigators from Community Outreach, Family Tree Relief Nursery and ReConnections with hospitals and clinics	Number of referrals to the Navigators	The Navigators have visited the OB offices and hospitals and will continue to this as needed to maintain the relationships. As of this report, there have been over 35 contacts with the Navigators from all 3 counties.
Assistance with tobacco cessation	Simplifying the referral to the Tobacco Quit Line in the Electronic Health Record (EHR)	Number of referrals to the Tobacco Cessation Program	There is now a letter in the EHR system that allows providers to fill out information, obtain verbal consent and electronically fax to the Quit Line.
Program Analysis	Data Collection	Measure of the effectiveness of the program	Working with an Epic report writer to extract data for analysis. The results of the screening from Corvallis Clinic will also now be entered into Epic so that data will be included in the analysis as well.
Involve Health Departments and lactation consultants	Train lactation consultants/WIC providers on how to discuss substance use and how to perform a brief intervention using motivational interviewing techniques. Lactation consultants will now be engaging in a dialogue	# of lactation consultants trained on substance use and breastfeeding and how to perform a brief intervention. # of participants who change their practice.	Trainings are scheduled for the beginning of November for the lactation consultants. These trainings are open to other staff that have attended the initial training and would like some additional training.

	with women on the benefits and risks of breastfeeding and substance use.		
Literature for patient education	Provide clinics and hospitals with information for patients on substance use during pregnancy and breastfeeding. Clarifying with patients the risks of marijuana use during pregnancy and when breastfeeding.	Availability of literature	Clinics all have printed literature for patients (10 Reasons not to Drink, Smoke or Do Drugs when you are pregnant). The substance use and breastfeeding flyer is in revision. The statewide literature on marijuana use during pregnancy breastfeeding and when caring for children has had the core messages approved by the Retail Scientific Advisory Committee. It is in development and will go through focus groups prior to publication. An accompanying hand out for providers is also being developed which will provide medical staff with more detailed information.
Protocol for management and testing of newborns	Reviewing the current management and protocol for newborns born to mother who used substances. Revise and update the protocol to reflect improved medical care and social outcomes.	Completion of protocol and implementation of recommendations	A meeting involving Department of Human Services (DHS) supervisors, Samaritan social workers, Pediatrics and nurse managers provided clarification of management of these social situations. The current drug testing of infants has been reviewed and updated. The revised protocol has been written and is currently being reviewed.

Youth WrapAround & Emergency Shelter: Jackson Street Youth Shelter			
Goals	Activities	Measures	Results
35 youth served in wrap-around case management or shelter services.		Intakes of youth served in shelter, ACCESS database	10 different youth served in respite and emergency shelter. 1 different youth served in transitional shelter. 15 youth engaged in our aftercare services, duplicate numbers for reported shelter numbers. 12 different youth accessing our outreach case management services, not shelter. 90 youth to date have been served by this grant funding.
Youth served in shelter will achieve stability and improve well-being and reduce risk factors.		# of youth who exit to safety	8 safe exits from shelter. Others remain in shelter and have not exited.
Youth just participating in case management (not accessing shelter) will; -increase utilization of community services		% increasing utilization of community services % participating in ISP % participating in skill building activities	100% of youth served worked with a case manager to increase their awareness and utilization of community services. 100% of youth served in shelter and outreach case management participated in their individualized service plan. 98% of youth engaged in required skill building activities.

-participate in individualized service plan (ISP) -participate in skill building activities -participate in family mediation or counseling -obtain an IHN-CCO PCP and complete an adolescent well-child exam -receive dental services, if needed -linked to a QMHP or QMHA, if needed		%participating in family mediation or counseling % who obtain an IHN-CCO PCP and complete an adolescent well-child exam % receiving dental services, if needed % linked to a QMHP or QMHA, if needed # of youth who required intensive psychiatric health services	100% of youth who needed family mediation or counseling received a referral and actively participated. 100% of youth who needed health insurance met with a health navigator or Jackson Street case manager to complete paperwork. 100% of youth served received a Jackson Street dental screening and 100% of youth who needed follow up care by a qualified dentist scheduled an appointment. 1 youth received intensive psychiatric health services while in Jackson Street care. 1 other youth was in need of intensive psychiatric health services but it did not get set up before exiting shelter care.