2015 Q4 IHN-CCO Pilot Quarterly Reports
Executive Summary

Objective:

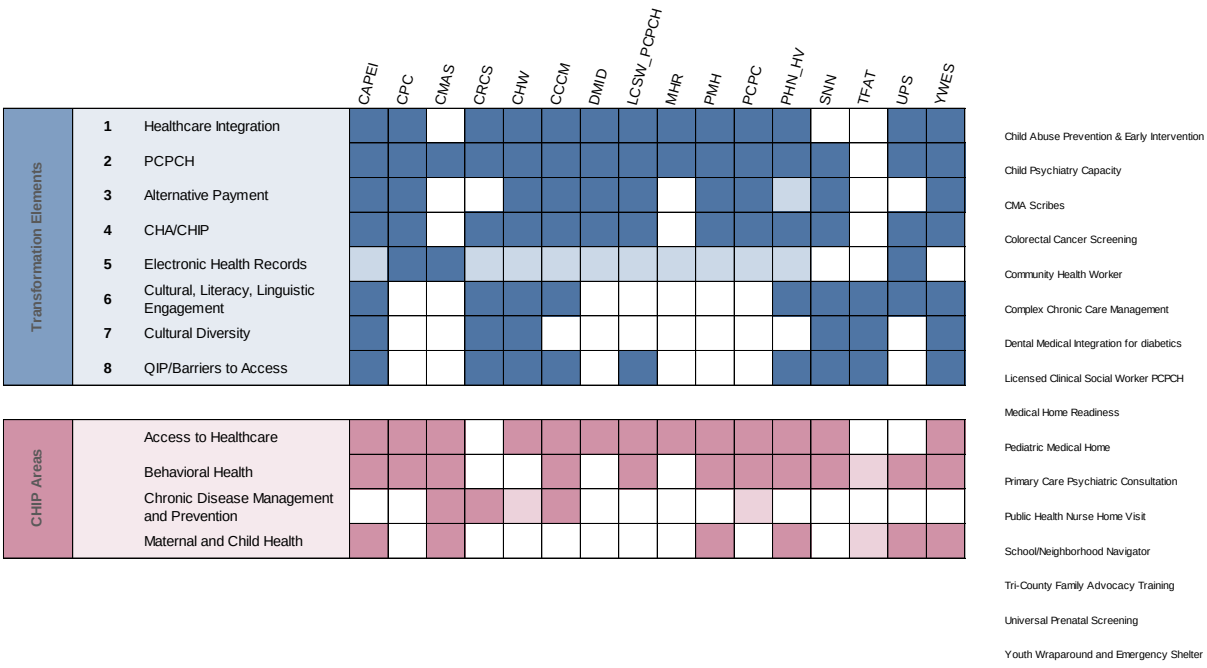
This document provides a summary of progress for the fourth quarter activities of the 2015 Pilots.

Summary of Findings:

1. **Reports Captured:**
    - 16 pilots reported
2. **Pilots Reporting Changes:**
    - 5 Pilots reporting changes that resulted in extensions, budget changes or focus changes (indicated in yellow, otherwise green).

Elements of Transformation and CHIP Areas Addressed by Q4 Pilots:

Q4 Transformation Element CHIP Crosswalk



Q4 State Metric Crosswalk

			CAPEI	CPC	CMA_S	CRCS	CHW	CCCM	DMID	LCSW_PCPCH	MHR	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	■									■		■				

Child Abuse Prevention & Early Intervention
Child Psychiatry Capacity
CMA Scribes
Colorectal Cancer Screening
Community Health Worker
Complex Chronic Care Management
Dental Medical Integration for diabetics
Licensed Clinical Social Worker PCPCH
Medical Home Readiness
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

Approach:

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

Section 1: 2015 Q4 IHN-CCO Pilot Successes and Barriers Summary

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

Successes:

1. We reviewed our success towards meeting our service goals and are over 200% in many, especially numbers of members served. Our numbers of children linked to medical homes is strong and numbers of parents linked to medical homes is increasing. The DST was supportive of our pilot and the services and the linkage to IHN-CCO metrics, transformation elements and the Triple Aim.
2. In our work with the Traditional Health Worker (THW) Subcommittee, we are making strides in collecting similar data across all pilots so that we will have a strong data story to tell. This has been rewarding working with various groups and looking at collaboration around data reporting, training, administration and systems. We have created a common template that we hope to have all pilots with THWs use for "touch" collection.
3. Our services with families remain strong and all of the families we worked with have had children safe and staying out of Foster Care. This is a strong outcome considering we work with families with 5-20 risk factors for abuse and neglect. In the 1st Quarter of 2016 we will have the Adverse Childhood Events scores for all adults and children we are serving.

Challenges:

1. We continue to look at consolidated ways to represent our "touches" data for utilization in an Alternative Payment Methodology. We will continue to work on this in the next four quarters with the other members of the THW Subcommittee. Also with the subcommittee, we are looking at the THW Hub model and how that might work across the three counties. We will be examining any economies of scale that could be done on an administrative level around training, billing, and clinical supervision in the next two quarters.

Additional Information: With the 12 month extension approved, we have identified new metrics that we could have tracked from the beginning. Through our work we have 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
- 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.

Section 1: 2015 Q4 IHN-CCO Pilot Successes and Barriers Summary

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

Successes:

1. Increased intakes by using the mental health specialist to collect the more rote data ahead of time (cutting down on the length of time per evaluation). This has allowed me to affirm my understanding of the patient's problem and spend the rest of the time discussing treatment options with the family. Continue to not have a waitlist and can see urgent intakes within 2 weeks. The new evaluations: 9-October, 7-November, and 3-December. December intakes were down due to holiday, vacation and clinic closures. 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 was set up, thinking we had chosen a very capable patient who requires very little, a supportive family, and an excellent pediatrician, and at the last minute the discharge fell through when the family was concerned he needed more support due to an acute life stressor.
2. Billing – the system is not well set up for client billing, and because patients go on and off Oregon Health Plan, it is hard to get an accurate count.

Additional Information: This has been so successful that we would like to approach the Delivery System Transformation Steering Committee to roll out this payment model on a long term basis and also to include providers in Adult psychiatry.

Community Health Worker — Kelly Volkmann, Health Navigator Program Manager

Successes:

1. Multiple Health Navigators (HNs) in different agencies that are essentially part of the same connected team. There have been multiple stories of navigators at Geary Street and Mid-Valley Children's Clinic connecting with the Benton County navigator stationed at the Department of Human Services to ensure smooth communication and service referral.

Challenges:

1. Culture "rub" between the in-reach culture of the clinic – which values being in the building from the time it is open until the time it is closed – and the outreach culture of health navigation – which values being flexible enough to meet the client outside of the clinic walls and outside of standard clinic times. Goals for the issue are:
    a. Help the care team understand the flexible nature and scheduling of an in-reach/outreach worker, and
    b. Help the HN to be deliberate and careful to document her schedule in all appropriate places (i.e.– EPIC and Outlook) and to communicate to the appropriate team members when she is going to be out of the office.

Stories from the Field:

From the Navigator at Geary Street.: A patient had just started a new job and did not have insurance. She is diabetic and was not able to afford her insulin so decided to 'just go without'. She came the night before she would be at work for the next four days and would be unable to leave as she runs an assisted living house. HN Staff connected with the Elm Street Pharmacy medication assistance program and was able to get a vial of insulin (for free) to get patient by until her insurance started. Patient was over income for Oregon Health Plan but was able to connect her with an agent who helped her pick a plan that works best for her needs. Patient called me a couple weeks later and said that it would be another week until her insurance would cover her medications and she needed another bottle of insulin. Again, I was able to contact the medication assistance program and get her another bottle to last until her insurance began. A few

weeks later she thanked me for being able to help her through that difficult time and connecting her with someone who was able to really explain to her what her insurance plan would cover.

From the Navigator at Mid-Valley Children's Clinic: I am working with a Spanish speaking family of five who recently moved to Albany from California. The youngest child has disabilities. These parents were referred to me by one of the physicians who felt these parents were overwhelmed with the transition and juggling six referrals to six different specialists for this child. This family also needed housing. Together, we made a list of needs and prioritized them. We made sure the child had all the medications needed and worked on finding housing and scheduling appointments with the referred providers. This family is now moving into their new home, we have scheduled appointments to referred providers at Oregon Health Sciences University on the same day for the family's convenience, and this child is also receiving his supplies. Because this is a medically fragile child, I am the first contact for these parents at the clinic and I relay their questions or concerns directly to their physician or to a nurse whom the parents are acquainted. The parents have expressed how grateful they are to have a health navigator coordinate all of this with them and have also reached out to me for assistance with scheduling appointments for their other two children. After they are settled in to their new home, we will look into a school for this child and a medically fragile program as requested by his physical therapist.

CMA Scribes: Family Medicine Residency Clinic

Scott Balzer PMG Operations Manager

Successes:

1. We have been able to identify and gather baseline data regarding quality metrics that the medical assistant/scribe can help satisfy and are important to IHN-CCO and the primary care medical home model. Those metrics are as follows:
    a. Screening, Brief Intervention and Referral to Treatment (SBIRT)
    b. A1C, poor control
    c. Colon Cancer Screenings
    d. High Blood Pressure Control
    e. Tobacco Screening (use & cessation)
    f. Depression Screening Follow up
    g. Breast Cancer Screening
    h. Contraception Management/One Key Question

Challenges:

1. The selected vendor, Essia, is no longer available and the new vendor, Scribe America, will not train medical assistants as they do not believe in the model of training Certified Medical Assistants (CMAs) as scribes. A search for a new vendor and/or a reconsideration of training medical assistants rather than just using scribes needs to be conducted.
2. The shortage of medical assistants also poses a possible problem in regards to availability to train and consistently have two medical assistants per provider. The number of medical assistants may not be sufficient to make this model replicable in other clinics.
3. ScribeAmerica does provide 'Patient Ambassador' positions that still scribe and room patients and conduct the clinic intake for providers. After rooming the patient and going through quality and health metrics, the ambassador would stay in the room and scribe for the provider, which would meet the original intent of the grant. The agreement and use of patient ambassadors through ScribeAmerica is

	currently being reviewed by Samaritan legal and compliance. Tablets are still being analyzed by the Informatics Department to ensure providers are able to run Epic on Surface Pro's with Windows 10.
Pilot Changes: Feedback from Scribe America is that it may be more beneficial to use a patient ambassador and medical assistant per provider model rather than using two medical assistants who are also scribes. This may actually be a more achievable model across other clinics if replicated given the shortage of medical assistants in our community.	
Budget Changes: Given that ScribeAmerica will not uphold the contract agreed upon by Essia, pricing of scribe training is now rather a discussion of cost of then providing patient ambassadors to the clinic. The dollar amount that was previously budgeted would still allot for the hiring of four patient ambassadors, rather than the training of CMAs.	
Additional Information: An analysis will be conducted in Quarter 1 of 2016 to determine if the use of patient ambassadors instead of CMAs will still meet the intent and goals of this project. We still believe that a provider with one patient ambassador and one CMA can increase quality and productivity to offset the cost to make it replicable moving forward. Provider and Medical Assistants' job satisfaction is forecasted to improve as well with this model, still meeting the intent and goals of the pilot.	

Colorectal Screening Campaign: InterCommunity Health Network — Stephanie Jensen on behalf of the Committee

Successes:

1. The core group has been meeting regularly to provide quick turn-around on deliverables and provide feedback as needed.

Challenges:

1. It has taken longer than expected to have all the pilot clinics contracted. Some of the clinics were provided materials and the draft contract before the final contract was executed.
2. Communicating the same campaign/pilot message, documenting, and implementing the project in the same way consistently across the region. We are having regular meetings where process evaluation occurs. Areas of opportunity and solutions are identified and implemented.

Complex Chronic Care Management: The Corvallis Clinic — Terry Crowder, Pharmacist

Successes:

1. Based on the KANNACT / Oregon State University (OSU) mid-study patient interviews, most participants like the program, the connection, and they feel it is helpful. Patients with diabetes report the highest degree of satisfaction. Patients with asthma or Chronic Obstructive Pulmonary Disease are unsure if they are benefitting. Analysis of the diabetic blood glucose records clearly demonstrated worsening for those patients who

Challenges:

1. Some of the patients were having difficulty with study involvement. Four patients were brought in for mid-study care conferences. These care conferences included the patient's Primary Care Provider, The Corvallis Clinic social worker, and members of the nurse care team and KANNACT support. The conferences went well. One patient was having family issues so it was decided to reach out to the Exceptional Needs Care Coordinator

are not engaged. Providers involved in the care conferences are very supportive of the Complex Chronic Care Management (CCCM) nurses and their work on this project.

for IHN-CCO for additional support.
2. Continued engagement from some of the patients has been continually problematic. They are either slow to respond to the nurse's communication or in some cases communication is entirely nonexistent.
3. These patients do seem to continue recording metrics but the recordings are sporadic compared to those patients that are engaged and active participants.
4. The KANNACT software and tablets are still having some issues. The alarm feature to alert the CCCM nurses of a contact continues to be problematic. Graphical uploads for the tablets are very slow; however, the same graphics upload to a desk top quickly. Some difficulty in uploading the biometric information is noted and some difficulty with lost messaging remains. Efforts continue to be made to correct these issues.

Additional Information: November 1, 2015, extended contract period granted for a 24 month period from January 1, 2015, unless terminated sooner pursuant to the terms of Section 5. No changes to planned expenditures.
A meeting is planned for early January 2016 for the project manager to meet with IHN-CCO staff to determine reports needed for the intervention. There are two more care conferences scheduled for patients who can use the extra connection and guidance

Dental Medical Integration for Diabetes: IHN-CCO

Britny Chandler, on behalf of Dental Plans

Successes:

1. Communication and issue tracking between project coordinator, dental plans, and clinics.
2. Pilot evaluation by Coordinators and Dental plans to discuss ways to meet measures and suggestions for budget distribution and possible pilot extension.

Challenges:

1. High existing budget: Discussed and agreed upon pilot extension for more time to boost measure success by utilizing our budget with such suggestions as mailer incentives, edentulous (no teeth) outreach education and oral care, and participation from Lincoln County clinics.
2. Low mailer response rate: Suggestions to boost responses were to add an incentive using funds from our remaining budget.
3. Primary Care Provider to Primary Care Dentist communication: Unable to connect member with their Dental office due to lack of dental plan provider directory available to participating clinics. Providing clinics with IHN-CCO webpage address to locate individual dental plan provider directory.

Additional Information:
Our PCP clinics have called to request how they can continue their care coordination effectively after the pilot has concluded. Requesting the Dental Program Coordinators continue to send population reports and aid in education and outreach to their members.
Clinics continue to see a large population of edentulous (no teeth) members and have concluded there was insufficient education and outreach towards this

population and has requested more materials to aid in education of these members as well as the clinic staff.

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

Successes:

1. Getting the student! We recently met with her Portland State University (PSU) practice supervisor, who expressed appreciation and enthusiasm for the clinical experience and skills the student is gaining here. PSU is very interested in continuing placements; a great future resource for serving IHN-CCO patients at a low-cost. There has not been much of a presence of Licensed Clinical Social Workers (LCSW) within the Samaritan system. When positions have been advertised they have been difficult to fill. Having student interns increases the chance of later hiring competent workers who are already trained and familiar with the system. LCSWs can provide mental health treatment cost-effectively.
2. Social work presence in the clinic: Social workers are trained to provide treatment that is trauma-informed, strength-based, culturally competent, holistic and encompassing. Most social workers are trained to provide services to individuals, families and groups over the lifespan, and to provide education and case management services. Social workers think outside the box to provide interventions that are specific to the person/s served, and know how to change course when things are not improving. The team is assuming a more trauma-informed focus and reinterpreting how to deal with chronic psychophysiological illness in patients.

Challenges:

1. Balancing student supervision demands, patient availability, meetings and paperwork. We are adjusting our own expectations to try to get closer to the paid hours of the pilot (32 hours per week) after averaging closer to 40. As social work student's competencies increase, she can take over more independent work.

Change in Pilot Budget: A one-quarter year extension of the pilot was requested and approved due to the delayed startup did not allow the placement of a student until fall 2015.

Additional Information:

1) Additional activities this quarter: attending IHN-CCO Health Equity and summit conference, attending the National Council for Behavioral Health annual conference, and presenting stress reduction skills to 150+ staff at the Samaritan Health Plans meeting. Participating in an on-line continuing education group for professionals working with "Medically Unexplained Symptoms".
2) Stories of transformation: ***"Everything is held together with stories. That is all that is holding us together, stories and compassion."***
   a) Here are three from this quarter. ***Identifying details altered.***

i) *A retired widower had been to the Emergency Room (ER) four times in a two week period with chest pain and elevated blood pressures, thinking he was having a heart attack. He agreed to return for follow up though insisted his problems were only physical in nature. In session, he revealed the conflict he had been struggling with in the past year: pressure from a son out of state for him to move there and live with family. He had a full life here and did not want to give it up. I worked with him on expressing his feelings to his son via a letter. Immediately after identifying his conflict, his health issues were relieved. The son received the letter and called him and arranged a visit, where they resolved the issue and improved their relationship. The patient had no further ER visits and measurements of depression and anxiety went from critically high to below clinical concern. At his last visit (of four, over four months) he stated "I haven't felt this happy in years!"*

ii) *A 30-something adult still living at home was seen for depression and poor health self-care. She was initially very reluctant to explore emotional concerns. With time (6-8 sessions) she was responding well to interventions designed to improve social communication skills such as eye contact, initiating and maintaining appropriate conversation and personal presentation. She has begun to take care of her hygiene and dress and looks like a completely different person. She has hope for the future. She engaged in and deepened previously superficial friendships and took a trip with friends out of state. She is becoming more independent, is enrolled in college and is beginning to cook and do her own laundry in her parent's home, and working on moving to independent living. She is also taking an active role in managing a chronic disease by exercising and improving her diet and medication compliance.*

iii) *LCSW was called into an exam room where a 40ish woman was in the midst of a full blown panic attack, certain it was a heart attack. She'd been to the ER frequently with similar symptoms. LCSW did de-escalation and regulation work until patient was able to sit up and talk. She revealed multiple acute stressors around financial, job and housing insecurity. She agreed to come in for a full session the next day. After some time, what came out was a life of anxiety driven by illiteracy. The patient had skid through part of high school, managed a General Education Degree but couldn't make it in community college. She was bright but working in a low-skill field because she couldn't take the tests and classes needed for promotion. She avoided situations that might "out" her learning difficulties, which complicated everything from getting a driver's license to finding a more satisfying career. She had shame about it and had not discussed it before. She is now very motivated to learn to read and write. We are gathering resources to help this happen. She has less depression and has gone two weeks without a panic attack-- a recent record. She has begun to take much better care of her hygiene and dress and looks like a completely different person. She has hope for the future.*

iv) *A middle aged man moved in with his disabled mother after losing his job and soon after, his marriage. Within a short time he had isolated himself from former friends and coworkers, and was now having trouble leaving the house at all. He'd become addicted to anxiety and pain medications but was not getting relief from them. With his Primary Care Provider, we began a program of titrating him off these medications while teaching him emotional/anxiety regulation skills. He has had two additional therapy visits. He made connections with a couple old friends to go out and is starting to think about returning to working. His presentation is less angry/defended and his true nature-- quiet, kind, caring-- has emerged. He had never seen a therapist before and didn't think he would have gone had I not been brought right into the room during his doctor's visit.*

v) *A college man with an emerging psychotic illness is learning to differentiate his delusions and hallucinations from reality, and through process work working with the symptoms as metaphor/stories about unresolved trauma and social concerns. He is in beginning stages of accepting and differentiating from his illnesses, and taking responsibility for managing it. His Emergency Department visits are down. He has enrolled in college and developed a mentoring relationship with a professor, enabling him to get needed accommodations to complete his term. He went from total isolation to joining a sports club and is beginning to socialize with peers. He is becoming more compliant on medication.*

vi) *A middle aged woman with multiple autoimmune and stress related medical problems attended StressBusters skills training class. Through information gained there she developed a frame of reference for her symptoms that was acceptable for her and allowed her to take responsibility for managing her health. She'd formally been arguing with doctors for more tests to find out "exactly what was wrong". Now she focuses on getting better through lifestyle changes within her control -- nutrition, meditation and exercise. She identified and processed trauma that had led to unproductive and harmful beliefs, and began to change them. She is excited and hopeful about her future.*

Medical Home Readiness — Debra Heinz, Executive Director

Successes:

1. The project is on time and on budget. Goals and milestones have been achieved as planned. The practice and the contractor have a good working relationship, and the practice is remaining engaged in the project. Mandated survey tools have been developed and Patient Centered Primary Care Home (PCPCH) documentation and Quality Improvement process development are actively in process. It is anticipated that the practice will be able to achieve PCPCH Tier 3 status by the end of the project.

Challenges:

1. It is hard for the physician to find time to work on the project, but even so, she is keeping up with the project schedule.

Primary Care Psychiatric Consulation: Samaritan Mental Health — Jim Phelps, Psychiatrist

Successes:

1. Continued consults for previous seven clinics from Phase I. There are increasing and more regular utilization by a subset of Primary Care Providers. All psychologists are on board. Some clarifications of barriers at Geary St. Clinic. Good agreement to continue after grant.

Challenges:

1. Primary limitations now are the wait for privileges at the coast and the hiring of a Mental Health Specialist, part of our model for Phase II of Primary Care Psychiatric Consult (similar to the model being used on a parallel pilot). Meanwhile, what is limiting utilization of the consult service by the non-participating Primary Care Providers? Working hypothesis: they are still referring out patients instead of keeping them in the Medical Home for management there. If correct, then consultation in coastal clinics should look quite different (as there is no “there” to refer to) by comparison: the county mental health program is swamped, there are no private psychiatrists, and the private psychiatric nurse practitioners are also swamped.

Additional Information:

A Primary Care Provider wrote, after a recent follow-up on earlier consult:
1/6/2016: “Thanks, appreciate the back up! I think I see the big picture here - but nevertheless, you articulated well. I'll hang in there, do what I can. Appreciate much the leg work.”

Compare that to last April, another provider's comment:
4/29/2015: "So I guess I am going to be following this. Patient needs a follow-up appointment. Unless psych is going to follow her but it looks like they were just helping out via chart review."
We're not hearing the latter comments anymore (on the other hand, no consult requests from that provider since, either. Predicting we'll not run into that problem on the coast, where, as noted above, very few alternatives are available).

Public-Health Nurse Home Visit: Benton County Health Department

Maikia Moua, Nurse Manager

Successes:

1. We have initiated a conversation on a Regional Model that would provide equitable services across the region and combining resources. We also conducted a second Tri-County and IHN-CCO Work Session to look at the life course of services using our current programs and establish a continuum of services for families. Our next steps are to assess goals for penetration of services in the community and start looking at case rates.

Challenges:

1. Nurse staffing continues to be a challenge. We have combined our nurse postings in order for applicants to consider for multiple positions within the county. This has drastically improved interests of applicants into public health. This has also shown the additional need for public health orientation and more in-depth public health nursing training is needed. This has forced the Tri-County Nurse Home Visiting programs to consider alternative models to provide maternal, family and child services in our community.

Public-Health Nurse Home Visit: Lincoln County

Rebecca Austin, Lincoln County Public Health Division Director

Successes:

1. Screening, Brief Intervention and Referral to Treatment (SBIRT) is very successful, really helps nurses get a handle on what client needs are.

Challenges:

1. Doing the SBIRT and really understanding our client's situations. Finding appropriate referrals for these women is very challenging.

Additional Information:

- Lincoln County's Home Visiting Nursing program was recognized by the Oregon Health Sciences University (OHSU) Connections Newsletter through their School of Nursing when we brought in an instructor at OHSU to train staff on newborn assessments.
- Despite losing two nurses in program, our numbers are still very high. Goals have not changed

Public-Health Nurse Home Visit: Linn County

Norma O'Mara, Supervisor for Maternal Child Health

Successes:

1. Increasing number of referral sources and overall referral numbers. Making progress with improving charting efficiency so that we can see more clients and spend less time charting. Positive successes coming out of home visits with both parenting and developmental improvements seen in the children.

Challenges:

1. Lack of access to reliable data from the state to match what we determined would be our data collection measures. Continues to be the biggest issue in order to demonstrate the good work that the home visit nurses are doing with their clients. Using small data numbers doesn't represent the body of work done. The state advised us that using smaller numbers alters the overall data.

Section 1: 2015 Q4 IHN-CCO Pilot Successes and Barriers Summary

***Additional Information**:*

- It is difficult to provide on-site coordination with Women Infants and Children (WIC) appointments for our prenatal clients and home visit staff. WIC has been updated regarding our availability for home visits, which will focus more on the newborn rather than prenatal. Although we have been working to get our prenatal reimbursement on par with Benton and Lincoln County, this lack of reimbursement is the reason we elect to do primarily infant home visits. When we get reimbursed at an equal level we will be able to see more prenatal clients. (Ex: 10 prenatal home visits @$42.89 =$ 428.90. But with 10 infant/child home visits @ $355 = $3550.)
- We have added one day of Bilingual support to our home visit program which we have not had before. This will provide interpreting service and work as a resource person for our Hispanic clients. We have new staff starting their training now.
- A brochure was developed by the Oregon Health Sciences University nursing student that the home visit nurses are using to discuss the importance of getting your children immunized. It also discusses some of the common misunderstandings surrounding, why some parents elect to not immunization their children.

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

Successes:

1. The psychiatry team has been very successful with getting patients in for intake appointments and follow-up care. They are always willing to see patients even when they already have a full schedule.
2. After many months of not having a Registered Nurse on staff through the Benton County Health Department (BCHD), we have hired a Registered Nurse who will be a full time employee of Samaritan Pediatrics

Challenges:

1. Patients no showing appointments- we are working together to reach out and make contact with parents to determine what barriers they have to making appointments and how we can help.

Additional Information: Yes, hiring a nurse has changed our Memorandum Of Understanding (MOU) with BCHD. Initially they were going be providing us a part time nurse that was an employee of the county. We now will have a full time nurse who is an employee of Samaritan Pediatrics and Benton County will aid in training. She will fulfill the role of the RN initially set in place in the MOU.

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

Successes:

1. From a quantitative standpoint, the referrals and touches have increased steadily every month. There is a slight reduction in November and December…but there were significant school holidays, especially in December. Please see Attachment A for referral numbers.

Challenges:

1. "Scope creep": Once the school and the community understand the value of a well-trained and skilled school/health navigator, the referrals come in fast and numerous. The program manager is available when needed to assist the navigators in determining if a referral is appropriate for their position or if it should be directed to another staff position.
2. The biggest challenge of all remains sustainability of these positions. Benton County Health Services has been working with the school district on the feasibility of funding the School Navigator (SN) positions through Medicaid Administrative Claim billing, but the school processes are slow

and our time is growing short.

Stories from the field: **Garfield SN**:

a. The Lincoln SN contacted me about a case she was working on. The parent had attempted to make an appointment at the health department, but was told that no appointments were available until a week from the date. The parent had an urgent health concern that needed to be taken care of right away. Lincoln's SN had to attend a meeting; therefore I offered to assist in helping her out with the client. I called the Benton County Health Department (BCHD), they were able to make an appointment for her for that day, but client needed transportation. I arranged transportation and picked her up to take her to the appointment. I then handed the case back to the SN. While Lincoln's HN was out on vacation the parent called to ask for assistance in following up with referral from BCHD to Samaritan Health Services. The client was told that someone from Samaritan Health was going to be calling her, but had not received a call. Since her medical need was urgent I followed up with her provider and the panel manager. I then called Samaritan Health Services, while I had the parent on the other line, and explained the urgency of the parent's medical need. Samaritan was able to make an appointment right away for the client.

b. **Lincoln SN:** Lincoln SN along with a Lincoln parent organized a Cardiopulmonary Resuscitation class session in Spanish. There were 11 participants total, including two Corvallis High School students and one Linus Pauling Middle School student who have parents served by the Lincoln Health Center. It was great to see parents taking a class with their children in which they would both benefit – This was one of Lincoln's great highlights!

c. **Linus Pauling Navigator:** On the first week of December, the Health Navigator at Linus Pauling Middle School (LPMS) was informed that two new students had registered. The parent filled out the Title Programs survey that is part of the registration packet and with this the family was identified as eligible for McKinney Vento (Homeless Assistance). The family is composed of a single parent and three kids, 8th grade, 6th grade and 4th grade. The family moved from Tillamook, Oregon after the mother broke up with an abusing boyfriend. Currently the family is living with family members and is often forced to split up into three different households to spend the night. On top of this, the family has no transportation.
SN contacted parent to arrange a meeting to connect them with community resources. During the first visit the family had access to the hygiene closet at school, the family was given shampoo, laundry detergent, toilet paper, tooth paste and tooth brushes etc. Kids were given school supplies and backpacks. Parent filled out a form for school clothes through the Operation School Bell program. SN also went over housing resources, referring the family to Community Services Consortium, the We Care Scholarship and to Willamette Neighborhood housing.
But most important, the SN was able to assist the family in establishing care at the Samaritan Pediatrics Clinic. The oldest child has severe allergies and is also asthmatic; she was in need of a new prescription for her inhaler. Well Child Checks were scheduled for all three students. Parent was also referred to the Lincoln Elementary SN who could offer additional and more specific resources for the elementary student. The SN at Lincoln provided assistance to register student for the Lion's after school program, provided school supplies and signed up the youngest student for Operation School Bell.
A referral was also sent to the McKinney-Vento Liaison who was able to cover the Boys and Girls club membership fees and the Lion's Club monthly fee. She also provided a gas voucher and was able to arrange school transportation for the students.
It is clear that this family still has many needs to be met but is also true that with the help and support from the Health Navigators and the McKinney Vento Family Liaison their transition to the Corvallis School District was a much more welcoming and comforting one.

Section 1: 2015 Q4 IHN-CCO Pilot Successes and Barriers Summary

Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret Translate	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
	Garfield	0	0	0	0	0	0	0	0	0	0	0	0	17	0	
	Lincoln	0	1	2	1	7	0	2	2	8	0	2	7	20	52	202
Aug 2015	Linus-Pauling	0	0	0	0	4	1	72	0	70	0	0	1	2	150	
Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret Translate	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
	Garfield	2	5	2	1	9	1	0	4	16	4	5	16	47	112	
	Lincoln	1	6	4	3	17	1	7	7	13	0	2	15	70	146	346
Sept 2015	Linus-Pauling	0	8	3	3	9	4	2	12	14	2	1	10	20	88	
Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret Translate	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
	Garfield	2	1	23	30	30	0	5	0	1	54	4	14	42	206	
	Lincoln	0	0	4	9	26	1	41	4	14	12	10	8	125	254	627
Oct 2015	Linus-Pauling	0	1	10	1	29	14	7	7	17	13	4	45	19	167	
Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret Translate	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
	Garfield	2	1	1	5	30	0	64	0	9	11	3	37	31	194	
	Lincoln	0	0	4	9	26	1	41	4	14	12	10	8	84	213	585
Nov 2015	Linus-Pauling	0	3	15	18	30	3	23	0	7	14	0	23	42	178	
Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret Translate	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
	Garfield	0	0	7	21	11	0	43	2	3	27	8	20	41	183	
	Lincoln	0	0	10	43	22	1	3	0	12	6	1	29	45	172	555
Dec 2015	Linus-Pauling	4	8	11	12	22	1	8	7	26	18	14	50	19	200	
Five Months	All Schools	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreation Activities	Interpret translate	McKinney Vento	Other	Family Touches	Total all schools	
All Totals:		11	34	96	156	272	28	318	49	224	173	64	283	624	2315	

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

Successes:

1. Oregon Family Support Network (OFSN) has seen a significant success rate of increasing native Spanish speakers attending advocacy trainings. The Individual Education Plan (IEP)/504 training that was delivered this quarter in Benton County included 18 native Spanish speaking family members from both Benton and Linn Counties.
2. There has been a significant interest in developing the Collaborative Problem Solving (CPS) model in Lincoln County among child and adult serving systems. The recent CPS training that was held this quarter brought together family members as well as representatives from the school district, the Department of Human Services, in home care givers, Court Appointed Special Advocates and others. The training was followed by an evening strategic

Challenges:

1. Meeting the needs in Linn County as outlined in the pilot. Local leaders believe that the training content may be duplicating already existing information for families so OFSN leadership has continued conversations in Linn County to develop training that would enhance existing family advocacy. OFSN anticipates that this will be a long term conversation but are looking forward to delivering some training related to trauma in the Linn county communities with the pilot expansion. It is important to note that even though the trainings in the 2015 pilot project were not delivered in Linn County, we are having Linn county families attend trainings in Benton County.

planning session to discuss further development of the CPS model for Lincoln County which prompted additional interest among community groups. OFSN is excited to build on this interest in the expansion in 2016.

Change in Pilot Budget: OFSN is excited to be able to build on the work of this pilot project through the pilot expansion funding for 2016.

Universal Prenatal Screening: Dr. Carissa Cousins

Successes:

1. The training for the lactation consultants was very successful. We were impressed with the turn-out from this group of care providers. There was great discussion and much interest in helping women who may be using substances when breastfeeding. There is quite a bit of misinformation about marijuana use and pregnancy/ breast feeding and providing lactation consultants with evidence based information is vital so that they can share this with their patients.
2. The Navigators are each receiving an average of five calls per month for women with substance use problems. Having the ability to do a warm handoff is critical to getting these women the help they need.

Challenges:

1. Having data extracted from Epic. There have been issues with Data Governance Counsel and its capacity as it relates to research reporting. This is being worked on. Resource allocation for such data reporting is limited, which may impair further ability to extract data.

Change in Pilot: We have asked for an extension so that we can collect data after a full year of implementation.

Additional Information: As you know, the work on this project has now spun off to another project. We will be working with the Albany Obstetrics offices, Family Tree Relief Nursery and the Benton County Health Department to further integrate health navigators and peer support for women of all risk levels. The evolution of several individual projects, all with similar goals, into a unified project is exciting.

Also in 2016, we plan on gathering organizations and individuals throughout the state for a statewide resource meeting on substance use in pregnancy in conjunction with the Oregon Perinatal Collaborative meeting in Portland. Organizations would be able to share what is working, what is not and help other organizations develop systems to assist pregnant women dealing with substance use issues.

Youth Wraparound and Emergency Shelter Andrea Myhre, Associate Director

Successes:

1. Working with IHN-CCO staff to understand the goals of transformation and successfully implement our pilot has been a positive process. 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 our database to make reporting simple and more efficient has been a challenge. 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. The process of reaching practitioners could be made easier for community service providers such as ours and are looking forward to working with IHN-CCO on improving these relationships.

Stories from the field:

In Linn County we are serving a youth who had been discharged in the recent past from a local residential treatment facility due to insurance coverage, with little to no treatment plan—including stable housing. Before this youth came to our emergency shelter he tried living with his mother who gave up easily and denied access to mental health supports and sent him to another county with his father. After a bit of time with his father, he also gave up and sent him back to his mother.

The mother reached out to shelter, with no idea what to do or how to do it. It took a long time to obtain necessary information for us to be successful working with him. Eventually we received a treatment plan from the residential facility that outlined several therapy interventions and medications that came to a blunt end. The youth had also not been in an educational program since exiting the residential facility.

We have managed to get the youth enrolled and attending an education program however the mental health supports are still non-existent. Because the mother is engaged enough to not make a DHS report we have to work through her to set up mental health supports for this youth. We have been informed that the local county health department can't provide the supports needed and that the youth needs to try accessing services through developmental disabilities.

Section 2: 2015 Q4 IHN-CCO Pilot Goals, Activities, Measures, and Results

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery			
Goals	**Activities**	**Measures**	**Results**
Using an array of strategies to implement culturally appropriate and gender specific services for all the families that we serve		Numbers of families enrolled with Family Tree Relief Nursery services Goal: 20 Families 20 Children	Two Home Visiting Interventionist attended and completed Traditional Healthcare training from Multnomah County. Interventionist completed training and met requirements for certification as THCW Applied for certification through State of Oregon **Goal Completed**
Build case load of Oregon Health Plan served high risk families with children 0-6.		# of home visits	**QTR 4 New enrollment Oct-Dec** Families 10 Adults 18 Children 25 **Total** **49 Families consisting of 58 adult members, 85 child members**
Home Visits		# of sessions	**QTR 4** 142 Home Visits- 146.5 hours **Total** **233 Home Visits – 237.75 hours**
Respite		Numbers of families enrolled Family Tree Relief Nursery services Goal: 20 Families 20 Children	**QTR 4** 22 2.5 hour sessions **Total** **39 sessions 97.5 hours**
Ages and Stages Questionnaires (ASQs)		# of ASQ & ASQ-SE	**QTR 4** ASQ & ASQ-SE 63 **Total** **ASQ-ASQ-SE 92**

Link to Medical Home		Link client to Mental Health Goal 100% linked	**QTR 4** **Adults- 15/18; Children 24/25** **Total** **Adults 31/58, Children 73/85** * Improved tracking on this metric in Q4

Child Psychiatry Capacity Building: Samaritan Mental Health Family Center			
Goals	**Activities**	**Measures**	**Results**
Increase Capacity	Number of patients	Number of patients followed	We have significantly expanded intakes last quarter and have been able to maintain them.
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. We continue to have very few who request not to participate in the calls.
Maintain/improve Primary Care Provider satisfaction	(none yet)	Survey	Families don't like to leave the program, so we have not discharged. This will be a focus for the next quarter.

CMA Scribes: Samaritan Family Medicine and Residency Clinic			
Goals	**Activities**	**Measures**	**Results**
Select Metrics that will be monitored during the project	Chose metrics in which medical assistant can help provider satisfy	Identify metrics most important to capture during clinic office visit	Met. Metrics chosen with baseline data available.
Gather baseline data regarding physician and medical assistant burnout	Providers and medical assistants surveyed	Baseline data gathered	Met. Baseline data was gathered from providers and medical assistants regarding current stress and burnout in their positions.
Tablets to be purchased and tested for feasibility	IS to test capability of tablets with Electronic Medical Record	Tablets utilized by providers to view patient chart	Not Met. Informatics still testing the new Windows capability on tablets along with Electronic Medical Record.
Two medical assistants to successfully complete scribe	Vendor Essia to supply training to medical	Online curriculum passed and on-site	Not Met. Vendor was incorporated by another company which does not support the training of medical assistants as scribes. The new vendor

training	assistants	training completed	however does provide scribes that rooms patients.

Colorectal Screening Campaign: InterCommunity Health Network

Goals	Results
By June 2015, adapt and implement Oregon Health Authority's colorectal screening (CRS) media campaign, reaching 80% of IHN-CCO CRS eligible members, in the three-county region.	**2015 Quarter 4** • Materials are being dispersed to pilot clinics for distribution to patients • All bus ads, radio ads, and billboards have been confirmed and IHN-CCO website banner is currently in development
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.	**2015 Quarter 4** • Print materials are being distributed to non-traditional setting to extend the reach of the campaign
By December 2015, distribute 3,000 Fecal Immunochemical Tests (FIT) in selected Patient-Centered Primary Homes utilizing Electronic Medical Record to identify patients aged 50 to 75 years, with 40% (or 1,200 patient member) adherence and return of stool test screenings.	**2015 Quarter 4** • Eight FIT and Marketing pilot sites are in the contracting process • There are two in-person trainings that will be taking place in February one in Newport and one in Lebanon • Clinics are purchasing FIT tests and a reimbursement process is being developed
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.	**2015 Quarter 4** • Reaching out and providing materials to the Traditional Health Workers that were interested in the campaign
By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.	**2015 Quarter 4** • Two different provider surveys are being developed one for the mid-point of the pilot and another one for the final evaluation • One marketing survey is being developed • Flow chart documentation tool being identified

Community Health Workers

Work Plan Objective	Status of Reportable Milestone Activities
Develop Hub model that includes target population, site criteria, and evaluation metrics	We are well into Phase 3 – "Original hire" Community Health Workers (CHWs) are functioning in their placement agencies, the next two CHWs have been hired and are in process of being trained, and the first planning meeting with the two new placement agencies (Samaritan Internal and Samaritan Family) will take place on January 15, 2016.

Section 2: 2015 Q4 IHN-CCO Pilot Goals, Activities, Measures, and Results

Hire, train, and supervise 2 CHWS	The new CHWs are in process of completing their Oregon Health Plan application assister training and have begun their clinical training. In the upcoming quarter, they will get to be trained in popular education methods, health literacy, public health and prevention principles, and attend the Diabetes Education class at Samaritan Health
Send CHWs through state – approved CHW training and register with Oregon Health Authority	The Geary St. HN was unable to attend the winter training, so will be attending the spring training along with the 2 new CHWs.
Document staff training, roles, policies, and procedures	As our HN Program Manager begins working with new placement agencies, she will be using the documents created and refined during Phase 1 of the pilot. This will provide the opportunity to continue editing and refining the work.
Develop an evaluation plan that includes process and health outcome measures	HNs continue to track all patient touches by category. Please see Attachment A for the table showing clinic touches by category. In addition, BCHS Program Manager continues to work with IHN-CCO and the Traditional Health Worker 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: The Corvallis Clinic

Goals	Activities	Measures	Results
Continue Complex Chronic Care Management delivery			38 patients total, 10 total dropouts.
Conduct mid-study assessment			KANNACT / Oregon State University
Care conference for some of the patient.			Bring in some of the patients having the most difficulty for a care conference.

Dental Medical Integration for Diabetes: IHN-CCO

Goals	Activities	Measures	Results
On-going monitoring of clinic pilot activity	Monthly medical clinic check-in	NA	100% complete
	Monthly dental plan check-in		
	Dental Plan Pilot Evaluation meeting		

Collection of monthly data	Budget reporting	NA	Remaining budget: 97.02%
	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 Medical to Dental warm hand-offs	75% or greater of all eligible members	54% of the measure met
	Collecting Dental to Medical warm hand-offs		1% of the measure met
	Screening questions by Primary Care Provider	90% or greater compliance rate from participating medical clinics	87% of measure met
	Screening questions by Primary Care Dentist	90% or greater compliance rate by dental providers	88% of measure met
	Mailer response	50% or greater response rate for entire population	2% of measure met
Budget distribution	Continual orders of hygiene kits for Primary Care Provider distribution	NA	

Licensed Clinical Social Worker PCPCH: Samaritan Mental Health			
Goals	**Activities**	**Measures**	**Results**

Increase staff understanding of trauma/mental health needs on medically unexplained symptoms.	Consults, staff education via emails, cc'd charts on common points.	Anecdotal Increase in number of warm hand offs and referrals	Regularly consulted with staff individually, via chart in-basket and in team pain management, complex case care and other meetings. Warm Hand offs increased to 41 this quarter (up 30%)
Mental health services integration into medical home	Provision of group, individual and family MH counseling; Psychoeducational classes	PHQ 9, GAD-7 Session Rater Scores (SRS) Class evaluations Numbers seen	Licensed Clinical Social Worker (LCSW) continues to see patients with trauma, pain, depression, anxiety, opiate dependency, critical health issues and other compounding factors. SRS (session rater scores) high to very high range patient satisfaction with therapist, sessions, and goals discussed. Number of visits varies widely—most clients seen four to six (4-6) times, the rest once or twice or more long-term. Majority show improvement in daily functioning and reductions in clinically elevated scores. 323 direct patient visits this quarter (face to face contact). Of these: 76 patients attended a group or class, 41 patients were seen in warm hand-offs as part of their Primary Care Physician visit. 57 MyChart emails sent (not including related follow-ups) from LCSW. Emails content included "homework", additional resources, check ins. Patient care was also made via telephone. Psychoeducational classes in smoking cessation (one series) and stress management (3 series) were offered, as were classes in understanding anxiety, depression and sleep disturbance. "StressBusters" curriculum was taught/shared with Samaritan Internal Medicine's(SIM) LCSW and groups are now co-led monthly with patients from both clinics (group numbers here do not represent any SIM patients). Delivered three (3) full day Mental Health First Aid trainings (two to public, one to substance abuse treatment providers)
Utilize Masters of Social Work 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	Successful student placement and beginning of field work	PSU social work graduate student began her internship this quarter. Provided one hour formal supervision session to her weekly. She observed ~40 sessions and began participating in them. She is now seeing a few selected patients on own with pre and post session debriefs. She is also learning clinical and case management skills,

	placement for academic year of 2015/16		participating in care team meetings and doing assigned learning experiences in clinic.

Medical Home Readiness			
Goals	**Activities**	**Measures**	**Results**
Consultants visit practice on a monthly basis	Site visits on 9/25/2015, 10/30/2015, 11/20/2015		Completed. Reviewed project plan and timeline, initial work on patient experience of care survey
At least one routine phone check-in between visits	Two calls of 20-30 minutes in duration were completed		Completed. Completed survey reviewed and approved. Reviewed workflow in practice, mental health and hospital agreements, and initial work on Patient Centered Primary Care Home documentation binder
Numerous phone calls and emails to clarify instructions and provide assistance	Numerous emails and phone calls to various members of consulting staff.		Completed. Reviewed survey results, reviewed Screening, Brief Intervention, and Referral to Treatment tools, reviewed CCO incentive metrics, Patient Centered Primary Care Home binder reviewed

Primary Care Psychiatric Consulation: Samaritan Mental Health			
Goals	**Activities**	**Measures**	**Results**
Continue same services to existing clinics	Chart-based consultation	Number of consults/time	Roughly same rate of consultation
Analyze patient population for whom consults are requested	Review of 123 charts	Medications used, prior diagnoses	Trauma and bipolarity account for >50% of consults Results submitted for publication.
Examine results of prior consults	Review of all charts Jan-June 2014	Recommendations implemented? Rough sense of outcome?	Chart review complete. Confirmed that Primary Care Providers are implementing recommendations at a high rate now. Very broad utilization range: from a few providers using a lot, many using little, a few using no consults.
Use results to further consideration of psychiatric consultation in other	Member, Integrated Behavioral Health Alliance of Oregon and	Minimal standards document to include psychiatric consultation	Now working on developing a sustainable funding plan for psychiatric consultation. Applied to serve as a Technical Assistant for the Oregon Health Authority in response to their Request For Proposals.

Coordinated Care Organizations	psychiatric integration subgroup		
Extend program to coastal clinics	Meetings with principals	Consults underway?	Met with all the coastal psychologists, after meeting with medical directors: ready to go. Another slow-down: each hospital requires independent privileging, can't do consults without that. That step almost complete.

Public-Health Nurse Home Visit: Benton County Health Department			
Goals	**Activities**	**Measures**	**Results**
1. Collect data on tobacco, alcohol and drug screening for pregnant and postpartum women. 2. Public health nurses to learn about the prenatal Screening, Brief Intervention and Referral to Treatment. (SBIRT) and plan to implement it with pregnant and postpartum women. 3. Develop the process to implement and collect data on SBIRTS completed.	Prenatal SBIRT started in Sept. 2015.	Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women.	Reporting measures: 1. Percent of initial needs assessment completed for pregnant women. 2. Number of Prenatal SBIRTs and SBIRTs completed for women. 3. Describe the Prenatal and Adult SBIRT implementation process for women. Reporting period October - December 2015 1. 90% (19/21) of pregnant or postpartum women are screened for alcohol and substance use. 2. 90% (19/21) of pregnant or postpartum women are screened for tobacco use. There is a slight decrease in completion of screenings. This may be due to the decreased number of referrals, but also possibly screenings being completed at Obstetric offices and primary care offices.
Coordinate with community partners to support a referral system that is easily accessible and loops back to the referral source.	See Results section.	1. Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.	Reporting measures: 1. Describe activities related to and progress of the development of a coordinated home visiting referral process. 2. List collaborative activities with other early learning partners and the outcomes. 3. Identify opportunities for further home visiting and partner collaborations. 4. List support, including Technical Assistance, needed from IHN-

			CCO to support these activities. Reporting period October - December 2015 We continue to struggle with acquiring nurses for home visiting. We have agreement to consider a Health Navigator to expand the care team, but struggle to fund a 1.0 Full Time Equivalent (FTE) position with current funds. We are considering a more global community approach to acquire nursing staff to expand the Home Visiting program where Public Health oversees the training and adherence to Home Visiting and Targeted Case Management practice.
Assess the percentage of children enrolled who receive at least one of Ages and Stages Questionnaire (ASQ) by the age of 6 months. Create a process to inform providers of ASQ results.	Public health nurses complete an ASQ with the family as appropriate, unless it has already been completed elsewhere within the time frame of the ASQ assessment. At present providers are not requesting results of ASQ unless the public health nurse feels it is indicated.	An ASQ is completed by the age of 6 months, at least 80% of the time.	Reporting measures: 1. Percent of ASQs done within the appropriate age. 2. Describe or explore how results are communicated back to primary care physician. Reporting period October - December 2015 Babies First! • 30% (3 of 10) children 6 months of age or younger during this time received at least one ASQ by 6 months of age. • 67% (10 of 15) of children seen during this time had at least one ASQ completed. • 53% (8 of 15) of client seen during this time also received an ASQ. CaCoon • Of the two client seen during this time, none where six months or younger. • No clients seen during this time had an ASQ completed. Fluctuation to these rates may be due to the age clients are opened to services and the duration of services provided.
Connect families to their medical/oral health homes.		1. Coordination and referral processes for access to primary care and	Reporting measures: 1. Percent of clients who have been encouraged or referred to establish a Primary Care Provider (PCP) or dentist. 2. Percent of clients who have been referred to PCP or dentist.

		oral health are established. a. 75% of clients will be encouraged to see their primary care provider and oral provider or referred to a Primary Care Physician (PCP) or dentist at least once.	Reporting period October - December 2015 Babies First! • 20% (3/15) of clients seen during this period were referred to primary care. • 27% (4/15) of clients seen were referred to a dentist. CaCoon • No clients were referred to primary care. • No clients seen were referred to a dentist. (Only 2 visits were made. We had a 0.9 FTE decrease in this program and thus had limited CaCoon case management.) There is improvement in referring clients, reminding clients to see their providers, or making sure clients are still established with their provider.
Childhood immunization rates will improve.		1. 75% of children will receive their recommended vaccines before their second birthday*.	Reporting measures: 1. Percent of 2 year olds* who have completed the 4:3:1:3 vaccine series (4 dose of DTaP, 3 doses of IVP, 1 dose of MMR, 3 doses of Hib (or 2 doses of Merck series). * In ALERT Immunization Information System, 2 year olds*. Includes children 24-35 months. 2. Describe activities to support improvements in vaccines for children. Internal reports show: Only 3 of 41 clients seen in the last year are ages 24-35 months. All three of these clients are up to date (100%). Eight of 41 clients seen in the last year are 18-23 months. 88% (7 of 8) are complete for 4:3:1:3. We looked specifically at clients who had home visits through our electronic medical records and then looked up their immunization rates. In this coming year, the Immunization Coordinator will be training all the nurses in ALERT to check and remind parent of vaccines due.
Coordinate maternal child health services.		1) Coordinate prenatal assessments with Women Infants and Children (WIC)	Reporting measures: 1. Describe the process of coordinating prenatal visits with WIC appointments.

		appointments for pregnant women.	2. Number of prenatal appointments referred through WIC. Reporting period October - December 2015 1. We have a system in place where WIC schedules new mothers for their WIC appointment and their Maternity Case Management (MCM) appointment. 2. 42% (24 of 57) possible WIC clients were referred to MCM. 50% (12 of 24) were seen. 13% (3 of 24) declined an MCM visit 38% (9 of 24) did not show for their appointment.

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 Screening, Brief Intervention and Referral to Treatment. (SBIRT) screen at all initial prenatal appointments.	Percentage of clients who had a SBIRT assessment. This is for women seen in Oct, Nov and Dec. 2015.	44/48 = 91.6% 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	• Joint community advisory board which includes both partners and parents to develop home visiting policy and implementation. Worked on strengthening our referral processes. • Met with community women and Samaritan representatives to develop a baby box for all newborns in Newport. • Work on formalizing Memorandum of Understanding (MOU) for tri-County Health Department nurse home visiting with IHN-CCO. • Met with Lincoln County Communicable Disease nurses to coordinate referrals for families. • Met with local Obstetrician (OB) and Pediatrician providers for review home visiting programs and referral process. • Applied for grant for parent engagement in our County.
An Ages and Stages Questionnaire (ASQ) is completed by the age of 6 months, at least 80% of the	System is in place for pulling accurate data. Work continues thru	% of clients who had an ASQ by age 6 months for time period	23/25 = 92% 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 April 2015,

time	the Early Learning Hub Health care integration team around the work of ASQ. They have made a recommendation to coordinate this process with providers and get everyone trained in ASQ.		May 2015 and June 2015, and had a home visit after 2 months of age - 6 months of age. The numerator is the number that had at least one ASQ in that time frame.
Coordination and referral processes for access to primary care Obstetric 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 = number of clients seen in time period Numerator =number of referrals made to primary care, oral care and obstetrics. We included duplicated numbers to show how many times we actually assess and refer with clients.	**For primary care** - 215 were assessed for Primary Care Physician (PCP) Unduplicated Have PCP – 184/215 = 85.5% No PCP – 34/215 = 15.8% Referred to PCP – 69/215 = 32% Total referrals made for PCP - 426 Duplicated **For OB -** 73 assessed for OB provider Unduplicated Have OB provider – 70/73 = 95.8% No OB provider – 3/73 4.1% Made referral to OB provider 25/73 = 34.2% Total referrals made for OB - 130 Duplicated **For Dental** 124 were assessed for dental provider Unduplicated Have dental provider 57/124 = 45.9% No dental provider 55/124 = 44.3% Referred to Dental provider 60/124 = 48.3% Total referrals made for Dental - 218 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	% of time nurses check with families about immunization status during 2, 4, 6, 8, and 12 month visits?	64 clients were assessed for **immunizations** Unduplicated 60/64 = 93.75% had their record reviewed 19/64 = 29.6% were referred for immunizations

	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 we feel information is not complete for verification.	Number of immunization referrals made during time period.	A total of 111 referrals were made Duplicated
Coordinate prenatal assessments with Women, Infants, and Children (WIC) appointments for pregnant women. The first report will be available July 2015.	Lincoln County 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	37 clients had a WIC appointment and a prenatal Initial needs assessment. Some of the women we serve live in Lane County and we do not provide WIC to them. They receive WIC services thru Lane County.

Public-Health Nurse Home Visit: Linn County			
Goals	**Activities**	**Measures**	**Results**
Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women	Provide the Screening, Brief Intervention and Referral to Treatment. (SBIRT) SBIRT screen at all initial prenatal appointments.	Percentage of clients who had an SBIRT assessment N= number of pregnant women served in October, November and December 2015.	We are working with IHN-CCO to develop an equitable reimbursement between the three counties. The reason we don't do more Maternal Case Management is that the reimbursement is really poor and our focus therefore is on the newborn. Results for prenatal screen: Screened 11 of 11 visits for 100%.
Pathways for home visiting referrals are developed. This includes plans for	We have had 39 new referrals this quarter. We are accumulating	NA	• Monthly meetings with the Regional Maternity Coalition. • Monthly participation with the Community Connections Network for special needs children.

communication and information sharing.	lists of Pediatricians in order to send a brochure discussing our nurse home visit program. Met with the Women Infants and Children (WIC) staff to remind to send referrals for the Home Visit staff.		Ongoing work done on formalizing tri-County Health Department nurse home visiting program with IHN-CCO.
An Ages and Stages Questionnaire (ASQ) is completed by the age of 6 months, at least 80% of the time	We will be relying on the state system ORCHIDS and their data analyst to pull numbers specific for our needs, as the reporting function of ORCHIDS is very difficult for counties to use and seems to be less than accurate at times. We have attempted to pull our own reports with minimal success. The sample size will be low using the criteria of age 6 months during October to December, therefore the reason we included the number of ASQs done	Percentage of clients who had an ASQ at 6 months or before. N= number of clients receiving an ASQ in first 6 months of life D= number of children on the caseload who were born April to June of 2015.	33 % of the clients seen between October – December who was age 6 months received an ASQ. N = 6 D= 18 (75% of all the client visits from Oct to Dec received an ASQ)

	overall during that timeframe. All ASQs are faxed to the provider.		
Coordination and referral processes for access to primary care and oral health are established	Collaboration meeting between Linn and Benton County with Dr. Cousin's regarding a process for referring women from the Obstetrician (OB) to our home visit nurses. Discussion included possibly having a Public Health Nurse in the clinic a specific number or days per week.	Denominator =number of clients seen in this quarter age 0 -2 years. Numerator = number of referrals made to primary care, oral care or OB. *Children are referred for dental care at one year when they have their primary teeth.* We included duplicated numbers to show how many times we actually assess and refer clients to a PCP.	**OB Clients:** 11 were assessed for having an OB provider (unduplicated numbers) 11 of 11 = 100 % Has an OB provider <u>Babies First/CaCoon Clients:</u> **For Dental:** *<u>82</u> were assessed and <u>14</u>* *referred to a dental provider (unduplicated clients)* *14 / 82 = 17 %* **For Primary Care:** <u>100</u> client visits were referred to their primary care provider of the 104 visits made. 100/104 = 96%
75% of children will receive their recommended vaccines before their second birthday	Home visiting staff has access to ALERT so they can check the current immunization status before going to they go on a home visit in order to properly address the need for a referral.	2 year old shot rate for 4:3:1 given as follows: 4 doses <u>DTap:</u> given at 2, 4, 6 and 12 months 3 doses <u>IVP</u>: given at 2, 4, and 6 months 1 dose MMR: Given at 12 months	Baseline data for 4:3:1 in all of Linn County is 61.3%. This quarter 95% of clients seen at home visits were referred for immunizations. 4 completed visits were with older children whose immunizations were completed at 2 years of age as many of our special needs children are.

Coordinate prenatal assessments with WIC appointments for pregnant women. The first report will be available July 2015.	Currently clients are first assessed in the clinic after a positive pregnancy test and referred to both WIC and MCM by the Reproductive Health staff. Current WIC clients with children under 6 months are met at a WIC class where the babies are assessed for home visiting needs; this is usually done by a Home Visiting Nurse. Meeting with the WIC staff to increase referrals and to check to see if a home visit nurse is available to meet with the client at the WIC appointment was on hold due to the new WIC eCard pilot done in Linn and Benton Counties.	Number of prenatal clients that had a WIC appointment and a prenatal assessment for time period. N= Prenatal Assessments	Rebuilding our Maternity Case Management (MCM) program continues to be limited due to the poor reimbursement rate for Linn County for this service. Our focus has been on those after delivery services for the infant/child. Current MCM caseload is 11 with 7 new referrals in this quarter. Current referrals for our small MCM population from WIC are 2 of 7. Current referrals from WIC staff for both prenatal and newborns for this quarter are: 8/39 or 20.5% of referrals come from WIC.

Pediatric Medical Home: Samaritan Pediatrics			
Goals	**Activities**	**Measures**	**Results**
Increase number of patients	• Report created to	Effectiveness of Care	• Nutritionist has seen 40 IHN-CCO members in Quarter 4. We've had a

seen by Nutritionist.	pull in patient list of all IHN-CCO members who have a high Body Mass Index. • Nutritionist has also been communicating with doctors to find patients who could benefit from consult. • Letter created to send to patients who miss their appointments.	Measures	higher number of no- shows this quarter, so we are working hard to increase her numbers so her schedule is sustainable • Have met with the transformation team to edit report of high BMI's. The Nutritionist reviews list and pulls out patient names who she has not seen and communicates w/primary care physician to get referral initiated • Calls being made to patients who no-show to try and get appointment rescheduled. If not reachable via telephone, Nutritionist has created a letter we send to patients.
Increase Well Child Check-ups.	• Pharmacist reviews patient charts and sends epic message to staff notifying of appointment needed. • Staff reaches out to patients via telephone and if not reachable sends letter.	Effectiveness of Care Measures	We have been able to target IHN-CCO members who don't frequently contact office or come across our radar who are due for yearly well child check.
Hire on Registered Nurse to Samaritan Pediatrics staff.	• Warm hand-offs. • Work with patients who have complex needs and coordinate care. • Help facilitate care for patients through	Care plan management and satisfaction with care	We have interviewed and hired a Registered Nurse. We are working with Benton County Health Department for training.

	the Individual Care Team meetings.		
Continue to have open access to mental health providers.	• Warm hand-offs • Mental health intakes • Telephone for follow up care	Access and satisfaction with care	In Quarter 4, the mental health team saw 30 IHN-CCO patients for new intakes, 13 follow-up medical checks and 10 phone follow-up calls have been made.
Receive and maintain primary care physician assignment reports.	Contact patients via telephone.	Effectiveness of care measures.	Continuing to receive monthly reports from IHN-CCO and are reaching out to patients to reconcile the list. We are also able to capture patients who need care and/or who may not have an active Primary Care Physician.

School Neighborhood Navigator: Benton County Health Department	
Goals	**Activities**
Work Plan Objective	**Status of Reportable Milestone Activities**
Improve outreach, coordination and integration of health, social, and community resources through schools for children and their families.	- The School Navigators (SNs) are making a definite impact on the coordination of health and social/community resources for students and their families. They worked closely with the Lions Club and the school nurses to ensure that all students with a positive vision screening were being seen by a vision specialist, and to follow up with any dental referrals as well. - SNs have been working with the Homeless Liaison for the school district, to ensure that children who qualify for the McKinney-Vento program are enrolled and receiving assistance. - SNs continue to connect families to Oregon Health Plan, IHN-CCO, and primary care providers to establish themselves with a primary care home. - The holidays brought increased emphasis on food insecurity and making sure families had enough food. Garfield SN was instrumental in the success of the Garfield Food Pantry in November and December. This is the first year for a navigator at Linus Pauling Middle School (LP) and the LP-SN has been building relationships within the school staff and helping them see the value of being able to directly connect students to health resources. Each month her referrals from school staff have been increasing.
Improve coordination of the care of IHN-CCO members by improving access and engagement of patients and their families in their primary	- Please see chart in section one for referral numbers for the school navigators for the first five (5) months of the school year. (“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” 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

care medical homes	been closed. SNs attempt to "close the loop" back to the referring party (teacher or counselor) in every case possible.

Universal Prenatal Screening: Dr. Carissa Cousins			
Goals	**Activities**	**Measures**	**Results**
Implement 5P Screening in all Samaritan Health Service (SHS) and The Corvallis Clinic (TCC) clinics providing Obstetric care	Training/ Implementation	Number of clinics screening	As of December 31, the Obstetric clinics in Newport, Lincoln City, Lebanon, Albany and Corvallis are using the 5Ps prenatal screening. Sweet Home Family medicine, the Corvallis Clinic Obstetric clinic the Samaritan Family Medicine and Resident Clinic are also using the screening tool.
Implement Screening in all SHS Hospital labor and delivery wards	Training/ Implementation	Number of hospitals screening	All SHS labor and delivery wards are using the verbal screening. Urine drug testing is recommended by all and is done by patient consent.
Use of Navigators for Mental health and substance use disorders	Consulting navigators for assistance	Number of consults	The navigators for Linn County this is Family Tree Relief Nursery (FTRN), Benton County it is Community Outreach, Inc. (COI) and for Lincoln County it is ReConnections. We continue to work with the navigators to track these consults. There has been an average of 5 consults per month for each county.
Program Analysis	Data collection	Effectiveness of screening	We continue working with Epic to build reports to evaluate such information as the number of women screened/clinic, the number of referrals for substance use/mental health, Domestic Violence/Intimate Partner Violence and tobacco cessation. When positive for substance use we will be looking at the results of the woman's screening throughout pregnancy, looking at interventions (referrals) and the outcomes at birth including mother's urine drug test and baby's drug test results, baby's diagnoses. There has been some difficulty in having this information extracted from Epic.
Involve lactation consultants in talking to women about substance use and safe breastfeeding	Training and implementation	Number of lactation consultants trained	In one training in November, we had 50 lactation consultants and lactation nurses attend. This large turnout resulted in not being able to complete the training due to so many questions and discussion. Two additional training are set for February 2016.

Literature for patient education	Development of booklet, drugs and breastfeeding and Marijuana in pregnancy, breastfeeding and childcare	Completion of literature	We have developed a booklet for use by the Obstetricians and Pediatricians on neonatal abstinence syndrome. IHN-CCO has been helpful in the development of this. It is in its final edit and will be translated to Spanish. We have a handout on Drugs and Alcohol during pregnancy and breastfeeding. This has just been finalized with IHN-CCO and will be printed for use. It will also be translated into Spanish. Due to the extremely high use of marijuana in our community and the misperception of its safety, we are working on a handout specifically on marijuana during pregnancy, breastfeeding and the use while caring for children. This is currently being edited. We continue to work with Oregon Health Authority Addictions and Mental Health and the Retail Marijuana Scientific Advisory Committee in developing this as there is an interest in developing a statewide approach to this issue. We have printed the flyers from Oregon Health Authority regarding marijuana and pregnancy and breastfeeding and these have been distributed to the Obstetrics offices.
Protocol for management and testing of newborns Protocol for screening pregnant women	Development of protocol	Completion of protocol	We are working with the pediatric hospitalists to revise the Drug Screening Protocol for newborns. This protocol will reflect the implementation of the 5Ps. We are trying to minimize excess hospitalization time due to high sensitivity testing required of drug testing for infants (usually 2-3 days for confirmation) while also ensuring the safety of the infant. We are working with Department of Human Services and the Samaritan Health Services pediatricians on this. We are looking at implementing umbilical cord testing as we could potentially receive the results more quickly than we do for meconium testing without compromising specificity and sensitivity. In some situations, babies are held for discharge pending these results. The protocol for screening pregnant women has been edited and is awaiting approval.

Billing and coding	Simplify process for entering documentation for billing/ coding of Screening, Brief Intervention and Referral to Treatment (SBIRT) which will help meet IHN-CCO metrics	Ensure that providers are coding for work	We have been working with Epic to make the process of coding easier. As most obstetric care is a package, billing cannot be done specifically for the SBIRT screening, but coding appropriately will help document the SBIRT screening, thus meeting IHN-CCO metrics.

Tri-County Family Advocacy Training: Oregon Family Support Network			
Goals	**Activities**	**Measures**	**Results**
9 Special Education Trainings	2 trainings	135 participants 90 % satisfaction	Benton County- conducted 504/Individual Education Plans 10 participants- 100% participants very satisfied Benton County- conducted 504/ Individual Education Plans - 21 participants- 100% participants satisfied or 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	2 trainings	30 participants 90% satisfaction	Lincoln County- 8 participants- 100% participants satisfied or very satisfied Benton County- 19 participants registered, 9 attended- 100% participants satisfied or very satisfied
2 Collaborative Parenting Series	2 trainings	20 participants Pre/Post Family Empowerment Scale	Lincoln County- 25 participants Benton County- 6 participants

Youth Wraparound and Emergency Shelter		
Goals	**Measures**	**Results**
38 youth served in wrap-around case management or shelter services.	Intakes of youth served in shelter, ACCESS database	**28** different youth served in respite and emergency shelter. **2** different youth served in transitional shelter.

		6 youth engaged in our aftercare services, duplicate numbers for reported shelter numbers. **8** different youth accessing our outreach case management services, not shelter. **128** 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.	Number of youth who exit to safety	**19** safe exits from shelter. *Others remain in shelter and have not exited, ran away, or entered a treatment facility.*
Youth just participating in case management (not accessing shelter) will; -increase utilization of community services -participate in 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	Percent increasing utilization of community services Percent participating in ISP Percent participating in skill building activities Percent participating in family mediation or counseling Percent who obtain an IHN-CCO PCP and complete an adolescent well-child exam Percent receiving dental services, if needed	**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. **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. **0%**

	Percent linked to a QMHP or QMHA, if needed Number of youth who required intensive psychiatric health services through IHN-CCO while in JSYSI care	**0** youth have required intensive psychiatric health services.