2016 Q1 IHN-CCO Pilot Quarterly Reports
Executive Summary

Objective:

This document provides a summary of progress for the first quarter activities of the 2016 Pilots.

Summary of Findings:

1. **Reports Captured:**
    - 24 Pilots reporting
2. **Pilots Reporting Changes: (noted by yellow banner)**
    - 4 reporting notable changes to their pilots, CMA Scribes, Complex Chronic Care Management, Pediatric Medical Home, Prevention, Health Literacy & Immunizations.

Elements of Transformation and CHIP Areas Addressed by Q1 Pilots:

			APM	CAPEI	CPC	CVAIS	CMA_S	CRCS	CHW	CP	CCCM	DMID	HN_HP	HPC	LCSW_PCPCH	MHC	MHR	PM_PCPCH	PMH	PPC	PWI	P_HL_I	PCPC	PHN_HV	SNN	TFAT	UPS	YWES
Transformation Elements	1	Healthcare Integration																										
	2	PCPCH																										
	3	Alternative Payment																										
	4	CHA/CHIP																										
	5	Electronic Health Records																										
	6	Cultural, Literacy, Linguistic Engagement																										
	7	Cultural Diversity																										
	8	QIP/Barriers to Access																										
CHIP Areas		Access to Healthcare	1	2,3	1,2				1,2	1		1	2,3	2	1,2	1,2,3		2	1			1	1,2	1,2	1,2,3			2,3
		Behavioral Health		1,3	2		2			3			3		1,2	1,2,3		1	2		2	1,3	2	3	1,3		2	1,3
		Child Health		1,2,4									2			2,3			4					1,4		1	2	1,4
		Chronic Disease Management and Prevention							2	1			2,3									2,3		3			3	
		Maternal Health		3			1									2,3				1				3			2	

DST Approved Pilots

Alternative Payments Methodology	Community Paramedic	Medical Home Readiness	Public Health Nurse Home Visit
Child Abuse Prevention & Early Intervention	Complex Chronic Care Management	Pain Management in PCPCH	School/Neighborhood Navigator
Child Psychiatry Capacity	Dental Medical Integration for Diabetics	Pediatric Medical Home	Tri-County Family Advocacy Training
Childhood Vaccine Attitudes and Information Sources	Health Navigation and Housing Planning	Pharmacist Prescribing Contraception	Universal Prenatal Screening
CMA Scribes	Home Palliative Care	Physician Wellness Initiative	Youth Wraparound and Emergency Shelter
Colorectal Cancer Screening	Licensed Clinical Social Worker PCPCH	Prevention, Health Literacy and Immunizations	
Community Health Worker	Maternal Health Connections	Primary Care Psychiatric Consultation	

State Metrics Addressed by Q1 Pilots

State Metrics (Incentives and Penalties)			APM	CAPEI	CPC	CVAIS	CMA_S	CRCS	CHW	CP	CCCM	DMID	HN_HP	HPC	LCSW_PCPCH	MHC	MHR	PM_PCPCH	PMH	PPC	PWI	PCPC	PHN_HV	SNN	TFAT	UPS	YWES
	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	Childhood Immunization Status		■		■													■				■				
	7	Cigarette smoking prevalence					■								■								■			■	
	8	Colorectal cancer screening (HEDIS)						■																			
	9	Controlling high blood pressure (NQF0018)								■	■																
	10	Dental Sealants on permanent molars for children																	■								
	11	Depression screening and follow up plan (NQF 0418)			■		■								■				■			■					■
	12	Developmental screening in the first 36 months of life (NQF 1448)		■			■																■			■	
	13	Diabetes: HbA1c Poor Control (NQF 1448)									■	■		■													
	14	Effective contraceptive use among women at risk of unintended pregnancy																		■							
	15	Follow-up after hospitalization for mental illness (NQF 0576)																									
	16	Mental, physical, and dental health assessments w/in 60 days children in DHS																									
	17	Patient-Centered Primary Care Home Enrollment		■								■	■			■	■						■	■			■
	18	Prenatal and postpartum care: Timeliness of Prenatal Care (NAF 1517)																					■			■	

Approach:

Section 1 provides a summary of reported pilot successes and barriers.

Section 2 details Pilot goals, activities, measures and results.

Section 1: 2016 Q1 IHN-CCO Pilot Successes and Barriers Summary

Alternative Payment Methodology (2): InterCommunity Health Plans — Carla Jones, Reimbursement Manager

Successes:

1. InterCommunity Health Network-CCO has received signed amendments from all entities. All entities are on board for moving to an Alternative Payment Methodology. Clinics have begun to implement workflows to support the integration of behaviorist work, care coordination and patient engagement work. They are also ensuring workflows are in place to meet the metrics that are in their contracts. Having the discussion of moving to an Alternative Payment Methodology with Mid Valley Children's Clinic and Geary Street clinic went smoothly, and there was excitement about moving to quality based payment models.

Challenges:

1. Resources to ensure engagement between the data and the clinic are a challenge. InterCommunity Health Network-CCO is hiring a Provider Reimbursement Coordinator to continue implementing Alternative Payment Methodologies.

Additional Information:

1. The provider list that was used to determine employed physician's at each clinic was not accurate. We found out in March that there were several mistakes in our database on who is a Primary Care Provider. The provider team is sending an updated list so that we can reimburse Phase II and Phase III clinics properly.
2. In addition to the Per Member Per Month based capitation model that we are rolling out to most Patient Centered Primary Care Homes, we are also seeking approval from the Regional Planning Council for a policy for distributing the quality pool funds to providers that are contracted with InterCommunity Health Network-CCO through a Pay for Performance agreement. This Alternative Payment Methodology model will help ensure that we meet our goals for converting reimbursements to quality-based models in a more timely and accurate fashion.
3. A grid of performance metrics with participating clinics is being tracked and available with the Transformation Department.

CHANCE — Jeff Blackford, Executive Director

Successes:

1. The sign in kiosk, online peer intake, and the touch tracking all have been successful.

Challenges:

1. The biggest challenge was connecting our Lebanon and Albany offices to share a database and files. There was a need to invest in infrastructure.

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

Successes:

1. Our collaboration with Benton County Health Services through our other pilot has brought new ideas and systems for service delivery. Working with the other pilots in the Traditional Health Workers Subcommittee has moved the work in the region forward aligning the reporting and focus of services.

Challenges:

1. There is a continued struggle in finding a way to electronically share assessments and information regarding patients for review by the physician in the electronic record.

Section 1: 2016 Q1 IHN-CCO Pilot Successes and Barriers Summary

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

Successes:

1. Overall this system continues to work well. Using the mental health specialist for data collection allows for more available time for intakes, more time spend explaining diagnosis and treatment with families, and fewer unnecessary visits. Families feel cared for and in close contact with our office, and problems are noted and addressed earlier than they would be using a conventional model.

Challenges:

1. Discharge remains difficult, although there has been more success this quarter, in part due to closer working relationships with pediatricians, so they feel more confident in accepting discharged, stable patients.
2. Billing is also a problem – the system is not well set up for client billing, and because patients go on and off InterCommunity Health Network-CCO, 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.

Childhood Vaccine Attitude & Information Source: BCHD — Kelly Volkmann, Health Navigator Program Manager

Successes:

1. Completed two institutional review board submissions and received exempt status.
2. A facilitation intern and co-investigator were brought on board with signed contracts and orientation.
3. The budget and funding sources were finalized.
4. Recruitment and focus group guides have been written and are currently being finalized.
5. Key informant interviews have been piloted with an initial set of three interviews. Additional interviews will follow, as well as preliminary analysis of results.

Challenges:

1. The contracted staff (co-investigator and facilitator intern) did not have signed contracts until mid-March; this has delayed recruitment activities a little, but should not be an issue moving forward.

Additional Information: One significant staffing change was made to the budget. The facilitator contract was converted into an internship in order to provide our facilitator with the ability to participate in other stages of the project, in addition to leading focus groups. The cost has not changed significantly, but will allow the intern to do a wider range of activities throughout the project than originally anticipated.

CMA Scribes: Family Medicine Residency Clinic — Scott Balzer PMG Operations Manager

Successes:

1. Quality tracking is available and will be able to be monitored before and during the use of Scribes.

Challenges:

1. Certified Medical Assistants retention has been the biggest challenge for the pilot project. The inability to retain Certified Medical Assistants makes the training, scheduling and implementation unachievable. It has been

	decided to contract these services outside of the organization instead with Scribe America. 2. Tablets have not yet been trialed to see if they will work for providers while the scribes are using the exam room computer. Information Services (IS) department is hoping to have Dell two in one tablets available for trial within the next few weeks. 3. Provider and staff moral improvement will not be able to be tested until after the utilization of Scribes. 4. Productivity increase will not be able to be tested until after the utilization of scribes.

Changes in Pilot: The decision to use contracted Scribes instead of organization Certified Medical Assistants was the most drastic change in the pilot. The Certified Medical Assistant workforce in the primary care clinic does not maintain the retention and/or the staffing level to accommodate training and implementation.

Additional Information:

1. Given the current work force, pool of eligible Scribe candidates and retention issues for primary care, the use of a vendor and contracted services is currently the most appropriate option in order implement this Scribe pilot. With the implementation of Scribes, we still hope to meet goals of the pilot in regards to increasing staff morale, provider morale, quality metrics and productivity.
2. A contract is finalized with Scribe America. We are hopeful that Scribes will be placed in the clinic and practicing in the clinic within 12 weeks.
3. Although the Scribes will change to a contracted organization, the budget is still maintained and allows for the use of four contracted Scribes within the clinic

Colorectal Screening Campaign: InterCommunity Health Network

Savannah Godkin 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. Communicating the same campaign/pilot message, documenting, and implementing the project consistently across the region. This is being addressed with regular meetings where process evaluation occurs. Areas of opportunity and solutions are identified and implemented.

Community Health Worker

Kelly Volkmann, Health Navigator Program Manager

Successes:

1. With the experience and infrastructure of the first phases of the pilot, the dissemination to the two new sites has gone smoothly. The initial meetings were more productive, in part because the Project Manager was more experienced and had better materials with which to present the project, but also because the clinic staff were more “primed” to get started. They have been hearing about the pilot for months, and some have worked with the Community Health Workers in one way or another,

Challenges:

1. One challenge with the initial Community Health Workers is making sure that as they gain experience and confidence, and the clinic gains confidence in them that they remain mindful of their barriers and their roles. To date, there have been no issues, but this is something that the Project Manager is always checking in about with them. It can be a “slippery slope” and it is important to be thinking about where the

or have heard about the good work that has happened with them, and are eager to get started.

boundaries begin and end.

2. A substantial challenge has been getting three of the four Community Health Workers through the state-approved Community Health Worker training. The trainings are held every quarter, but are not always "universal." For example, in the spring, there are two trainings in Portland, one is Spanish only, and the other specifically targeting African-American Community Health Workers. Project Manager has been in conversation with the Traditional Health Worker subcommittee for InterCommunity Health Network CCO to explore possibilities surrounding creating a training center in the mid-Willamette valley.

Stories from the Field:

1. **From the Navigator at MidValley Children's Clinic:** A few weeks ago I was contacted by a dad who was referred to me by the FACT team with the Albany School District. He informed me that his child was dropped off at his home for visitation days, as arranged with mom, and was scheduled to be picked up like usual but mom never showed. Dad said that the mom basically just left the child with him and was unable to continue to care for him at this time so dad was not sure what to do. He stated he lived by himself and was unsure of how to fully take care of his seven-year-old son who was having issues with the situation. He said that he was instructed to contact me to get his son on Oregon Health Plan in order for him to get mental health services covered. I placed an urgent request due to the child needing mental health services and it turned out that dad also qualified for Oregon Health Plan benefits. Dad was so pleased with the information and also seemed to be handling the situation a little better one step at a time with guidance from the FACT team staff. It was so rewarding to be part of the puzzle in getting health care started for this family.
2. An additional story is one from a Registered Nurse here at the clinic. It was another one of my busy weeks and a late day. I was in and out of the office, on and off the phone and one of the nurses peeked into the office at the end of the day and asked, "Do you like your job? You're always really busy." And I said "Yes, I definitely enjoy it a lot. It can be very rewarding and there is also no time to get bored!" The nurse responded very sweetly "Well I'm glad because I love having you here and it's very nice when we are able to make follow-up calls with you and not use the blue phone [for interpretation] it just seems so impersonal." It was a great way to end a long day.

Community Paramedic: Albany Fire Department

Lorri Headrick, Senior Admin. Supervisor

Successes:

1. Reduction of 9-1-1 usage for low acuity patients. There have been several patients incapable of self-care placed in appropriate level of care. Caseworkers have been assigned to facilitate in-home care for multiple patients.

Challenges:

1. Patients that refuse community paramedic services or referrals to other social service agencies and continue to use the 9-1-1 system for care that could be addressed otherwise. This challenge is being addressed by ongoing home visits and patient education.

Story from the field: Our Community Paramedic (CP) responded to a 67 year-old male who was an InterCommunity Health Network-CCO patient and was a frequent user of the 9-1-1 system (two to three times per day) as well as other social services. The Community Paramedic and Senior & Disability Services caseworker responded to the patient's home, finding patient bedbound with the front door open and no food, water, phone service, or medications in the home. In addition, the patient had fired his in-home care provider the previous day with no plan for replacement. The patient had a third degree bed sore and significant urinary tract infection requiring hospitalization. He was refusing all services and was very abrasive, requiring Emergency Medical Services and law enforcement to be requested. In collaboration with all of the agencies and the patient's primary care physician, the patient was transported to a local emergency room for care and treatment, and then placed in an appropriate long-term care facility. This is an

example of the Community Paramedic Program's success. This patient may otherwise not have survived due to being immobile and not having any source for communicating with 9-1-1 or other service.

Complex Chronic Care Management: The Corvallis Clinic

Terry Crowder, Pharmacist

Successes:

1. Many of the patients greatly enjoyed the connection with the Care Coordination nurses. Eight of the patients have asked what will happen after the study – they want to continue the connection. KANNACT decided to end the study encounters as of 3/31/2016 (reported as a business decision). Exit interviews with the patients will begin in April and should be concluded by the end of April so that the information can be analyzed and reported.

Challenges:

1. Making preparations to end the study and working with InterCommunity Health Network CCO to collect the necessary pre and post medical and drug data for analysis and reporting. Once a final agreement is reached regarding the data collection period(s) and the timing of pre and final reporting an amendment to the original agreement will be drafted and signed.

Changes in Budget: The study would have billed $150 per patient per month through the end of August 2016. With the patient encounters ending March 31st, 2016 the monthly billing will end.

Additional Information With KANNACT wanting to discontinue involvement past 3/31/16, some of the patients will not have an entire year of post intervention data. By count, 5 will have 12 months; 17 will have 11 months; 2 will have 10 months; 1 will have 9 months; 10 will have 8 months; and 3 will have 7 months of post intervention data.

Dental Medical Integration for Diabetes

Britny Chandler, on behalf of Dental Plans

Successes:

1. Communication and issue tracking between project coordinator, dental plan, and clinics.
2. Utilization of co-location Expanded Practice Dental Hygienists (EPDH).
3. Implementation of Oral Health Education.
4. Implementation of screenings within clinics.
5. Mid-Pilot Review and Year one analysis meeting. Medical clinics, dental plans, and InterCommunity Health Network CCO dental coordinators all met and discussed barriers from year one and how we wanted to address them in year two to better serve our members and further efforts of the pilot.

Challenges:

1. Reaching Edentulous Patients with dentures, to close this gap there has been Denture Education and Hygiene bags given to patients.
2. Lack of Primary Care Provider education regarding edentulous patients, dental benefits, and emergent needs patients. To address this Clinic staff have been conducting meetings to educate back office staff (Not required for clinic pilot success)
3. No resources for edentulous with no dentures. Possible resource to be implemented July 1st, 2016 by Dental Care Organizations.
4. Lack of patients knowing they have dental benefits. Primary Care Provider education, Clinic posters, member post card education/incentive.
5. Patients do not want to schedule during warm hand off. Create post card education of benefits and incentive
6. Difficulty contacting dental plans. Create pilot contact list
7. Difficulty contacting dental clinics. Update dental appointment schedulers contact list.

8. Lack of successful correspondence between Primary Care Provider and Primary Care Dental clinics. Closing gap of communication with referral logs created by Dental Primary Care Clinic.
9. Mailer Response lower than expected. Edit mailer to include gift card incentive.
10. No participation in Lincoln County. Inviting Lincoln County clinics to participate.
11. Inaccurate population lists. Submit for EPIC report.
12. Inconsistent clinic/plan reporting. Submit for EPIC report/Submit dental claims report.
13. Long wait for members to be seen within dental clinic. Clinics to utilize co-location Expanded Practice Dental Hygienists by referring members for dental screenings located within Sweet Home Family Medicine, Mid Valley Medical Plaza, and Benton County Health Department.

Additional Information:

1. Extension for a second year was approved. To have time to address unforeseen barriers and use pilot funds to further reach our members participating in the pilot.
2. It was unforeseen that the co-location Expanded Practice Dental Hygienists (EPDH) placed into two of our pilot clinics by Samaritan Health Services would benefit our efforts towards medical and dental integration for diabetic patients. Sweet Home Family Medicine and Mid Valley Medical Plaza clinical staff has an efficient referral system with the co-location Expanded Practice Dental Hygienists (EPDH) on site.
3. Capitol has encouraged other pilot clinics to refer their Capitol pilot members to these sites for their patients to receive fast and efficient dental services that the Expanded Practice Dental Hygienists is able to provide such as screenings, adult prophylactic, and periodontal treatments.

Health and Housing Planing Initiative

Brigetta Olson, Deputy Director, WNHS

Successes:

1. Excitement, enthusiasm, and willingness of community partners to further develop cross-sector partnerships on health and housing.
2. Hiring new staff: Deborah Morera who comes with a Community Health Worker certification, and Demetrius Chatfield joins us after a year of Health Navigator service with Council of Governments.
3. Launching Healthy @ Home our Health Navigation Program at all of our properties. This is a wellness coaching program to help Willamette Neighborhood Housing Services residents link up with supportive services, set health goals to become healthier.
4. Gentle Strong Yoga started at Alexander Court, a 24-unit Willamette Neighborhood Housing Services property in South Corvallis. Led by certified and experience Yoga instructor, this program is held once per

Challenges:

1. Data collection and privacy. We are working with partners like Cornerstone and CHANCE to figure out best practices for intake and data collection and tracking. We are also consulting our attorney to ensure we are in compliance with state and federal laws as we develop this new program.

week, on-site at the Center Against Rape and Domestic Violence. Through the course of the first 12 weeks, 13 residents participated in at least one yoga class. The class was so successful it is scheduled to continue through September 2016.

5. Master Chefs, a Linus Pauling Healthy Youth Program reached 10 teen residents at Lancaster Bridge and Seavey Meadows. This program teaches kids about nutrition and develops simple cooking skills. It has become very popular at the property and the second session begins the week of April 4th.
6. Guidance from our peer organization, Cornerstone Community Housing. This organization has provided technical support to develop our Healthy @ Home program and guidance on some Health Navigation services related to onsite program delivery.

Stories From the Field:

1. One of our residents chose to establish care with a new primary care physician and still had a couple of weeks until her appointment. In the meantime she had run out of a very important medication, for a chronic condition, that she reported her old physician would not refill unless she made another appointment. I advised her that her soon-to-be physician should be able to help her and that she may have to be persistent. The next day she called the new physician's office and was able to get her prescription after several phone calls back and forth.
2. Another resident did not realize he had dental benefits under Oregon Health Plan and had lost his Oregon Health Plan card. He is currently in the process of getting a replacement card and reports that he will schedule an appointment with a dentist.
3. A resident was unhappy with her dental care provider and had not been back because she did not know she could request to have her assigned dental provider changed. She is currently going through that process and reported she will make an appointment as soon as she can change providers.
4. Through our Healthy @ Home program that encourages participants to assess the eight areas of wellness as it applies to them, one resident has written goals that include receiving mental health services, finding ways to better control her chronic conditions, start hiking more, and taking a money management class.

Additional Information:

1. Several residents have received the information to register on https://mychart.samhealth.org so that they have access to their healthcare information, engaging them more in their own care. Two individuals have reported success creating an account.
2. Willamette Neighborhood Housing Services residents are excited about the new healthy program opportunities delivered onsite where they live.

Home Palliative Care: Benton Hospice Services

Kelly Beard, Executive Director

Successes:

1. There were a number of planning meetings held between Benton Hospice Service and Corvallis Clinic. We have successfully developed the program and processes needed to complete phase one of the pilot and are prepared to launch phase two of the pilot in Quarter Two including:
    a. Hiring and training direct patient care staff at Benton Hospice

Challenges:

1. There was some difficulty in identifying appropriate patients. We have modified the eligibility criteria from emergency room visits or hospital admission in the last three months to emergency room or hospital admissions in the last six months. With expanded criteria more

b. Completed web based End of Life Nursing Education Consortium training which included Cultural Considerations in Palliative Care
c. Purchased required technological tools i.e. lap top, cell phone etc.
d. Developed palliative care policies
e. Developed and printed a brochure for palliative care
f. Developed a patient information/admission binder for palliative care patients
g. Developed initial, Thirty day, and Ninety day satisfaction surveys
h. Developed palliative care admitting orders
i. Modified Electronic Medical Record note templates and care plan for palliative care
j. Modified electronic referrals process specifically for palliative care
k. Developed referral diagram
l. Scheduled bi-weekly patient coordination meetings between Benton Hospice and Corvallis Clinic to begin two weeks after first patient is admitted
m. Met with intensive care unit section at Good Samaritan Regional Medical Center to introduce the palliative program
n. Reached out to Samaritan social workers and discharge planners to education about the palliative care program. Meeting date is pending.
o. Highly specialized palliative care physician identified as medical director
p. Information about Palliative Care pilot shared with all Corvallis Clinic providers
q. Screening and initial contact with patients regarding program specifics and gauging interest in program participation were completed.

appropriate patients were identified and we are on track to admit our first palliative care patients the first week in April. We anticipate that in the first two weeks of April we will admit one to two palliative care patients to ensure smooth processes are in place. We will then admit patients throughout April and May until full capacity of fifteen patients is achieved. Electronic medical record challenges with access constraints led to creative work arounds to ensure those who "needed to know" were given access.

Additional Information:

1. There has been tremendous interest in this program from the medical community in general.
2. An initial baseline satisfaction survey as part of the patient screening process to better gauge impact of the palliative care pilot.

Licensed Clinical Social Worker Patient Centered Primary Care Home: Samaritan Mental Health, Jana Svoboda, LCSW

Successes:

1. Student as provider. The social work student is seeing patients directly,

Challenges:

1. Beginning to wind down the grant. It has been a rich experience. Licensed

assisting in resource development. A lot of Licensed Clinical Social Worker's energy has been directed toward her supervision this quarter. The student has grown professionally, and is doing some fine work with patients.

2. Increased networking and collaboration with other departments. The StressBusters class is now being offered at Samaritan Internal Medicine and it's my hope to have other clinics use the curriculum as well. Samaritan Internal Medicine is also going to do a tobacco cessation and nutrition class co-led with our staff.
3. Decreasing stigma regarding mental health issues with staff and providers. Providers show eagerness to connect patients to Mental Health services and are able to explain stress-related illnesses in ways that reduce excessive medical service seeking and increase patient self-care. Primary Care Physicians have been very open to medication discussions, treatment plan enhancements and these have been successfully improving outcomes for patient health.

Clinical Social Worker clinical services will stop here in three months; working with Mental Health and the Samaritan Family Medicine team to help patients find similar services in the community. There are some institutional barriers for providing Social Work clinical supervision experiences here. Samaritan has not had a clinical social work culture and has requirements that are unusual for the field instructor, such as being in the building at all times student is seeing patients. This limits the supervisor and the supervisee. The need for oversight reduced my own availability for scheduling, and I saw fewer patients as a result.

2. Finding aftercare for patients is difficult. There are not enough providers. The clinic will continue to offer behavioral services after grant ends, but patients will not have in house access to clinical social work, brief psychotherapy, other services Licensed Clinical Social Worker offers.

Additional Information:

1. Pilot was featured in a short video requested and made by the IHN-CCO Marketing department, and the video was shown at an IHN-CCO public meeting.
2. Social Worker attended a field placement seminar at Portland State University to represent Samaritan as potential collaborative agency.
3. While there are no current plans at Samaritan for expanding the use of students in service provision, Licensed Clinical Social Worker notes there are several open Social Work positions at the agency and has hopes of future programs here. Providing field experience is a great way to train future clinical social workers, behaviorists and medical social workers and such students can become pre-trained long-term employees.
4. Licensed Clinical Social Worker attended community and virtual meetings about health care integration and mental health education and brought back information to the team.
5. When we don't have all that we need, we need all that we have**.** The mission of this pilot has been to support the triple-aim of integrative health care by introducing the elements of social work practice into the medical home. These elements are uniquely supportive of the highest aims of health care reform.
6. From the preamble of the Social Work Code of Ethics: *The primary mission of the social work profession is to enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty. A historic and defining feature of social work is the profession's focus on individual well-being in a social context and the well-being of society. Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living. Social workers promote social justice and social change with and on behalf of clients… Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems. The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective: SERVICE, SOCIAL JUSTICE, DIGNITY AND WORTH OF PEOPLE, IMPORTANCE OF HUMAN RELATIONSHIPS, INTEGRITY AND COMPETENCE. This constellation of core values reflects what is unique to the social work profession.*

7. Licensed Clinical Social Worker has been utilized extensively with patients who have complex trauma, substance issues and emerging or chronic mental health needs. Traditionally such patients had limited support within medical home and limited access to specialized care outside of it. Licensed Clinical Social Worker has accessed specialty care for patients who had lost or never had it. Realistically, there is not adequate accessible outside care to meet patient's complex mental health needs. Such patients historically go un- or undertreated, utilize significant amounts of money in unnecessary Emergency Department visits. Via ongoing education and advocacy with patients and staff, Licensed Clinical Social Worker has facilitated medication management and support for mental health concerns to occur within the medical home. Licensed Clinical Social Worker has encouraged "out of the box" thinking on lowering barriers to adequate treatment, including use of telephone and MyChart support, connecting patients with self-help resources, and focusing on social work values of empowerment and social justice. Patients of Licensed Clinical Social Worker and a Masters of Social Work student receive aftercare directives with homework, community resources, further education for self-care, etc. Both social workers have assisted patients with tasks outside of typical behavioral Cognitive Behavioral Therapy care, filling out social security and housing forms, finding Alcohol Anonymous groups, getting dental care, connecting with mentors for parenting. Social workers go beyond looking at symptoms/behaviors to address causes, whether within or outside of the patient.

Maternal Health Connections: Family Tree Relief Nursery

Dr. Carissa Cousins, Physician

Successes:

1. The clinic managers have been enthusiastic about having these services available. The Community Health Worker has been hired by the Benton County Health Services. One Peer Specialist has been hired and is working to clear background checks.

Challenges:

1. We had some delays in beginning the project due to challenges with the contract as this pilot involves three different organizations. Additionally pool of candidates for an Alcohol & Drug Peer is diverse and large. It has taken time to screen and interview candidates to find the "right fit" for the position. In this situation, you look for the "right person" and not just the "right set of skills"

Medical Home Readiness: Quality Care Associates

Debra Heinz, Executive Director

Successes:

1. The project is on time and on budget. Goals 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 documentation and Quality Improvement process development are actively in process. Patient Centered Primary Care Home application has been submitted to State for approval, and it is anticipated that the practice will be able to achieve Patient Centered Primary Care Home Tier Three status by the end of the project. Hospital agreement was signed. Staff involvement in Quality Improvement activities has increased.

Challenges:

1. Getting the hospital agreement signed took a very long time, and the clinic needed to talk to multiple people, but the agreement has been signed.

Section 1: 2016 Q1 IHN-CCO Pilot Successes and Barriers Summary

Pain Management in the Patient Centered Primary Care Home — Dr. Cuccaro, Physician

Successes:

1. Eleven clinics enrolled to date. Strong participation from Linn County (specifically Lebanon & Sweet Home) and Benton County (Corvallis & Monroe). All Linn-Benton County Health Clinics enrolled. Feedback from Education Sessions (Phase 2/3) performed thus far positive overall. Clinician engagement high.

Challenges:

1. Scheduling & Logistics. Contacting and scheduling clinics more time consuming and difficult than anticipated. Reaching clinicians in eligible clinics directly rather than through administrative intermediary especially challenging. Initial list of Patient Centered Primary Care Homes revised (Initial list had 42 eligible clinics, but there appears to be only 37 eligible clinics at this time.).
2. No clinics in Albany currently enrolled and only two clinics enrolled in Lincoln County. However, only one eligible slot remaining. Ideally, last eligible slot to be distributed to location with greatest need.
3. Not a measured goal but identifying available resources that are
    a. Congruent with pilot goals and
    b. Available for participating clinics has been challenging.
4. Maintaining consistent evidence-based messaging to patients from both participating clinics and clinicians not in pilot program has created unforeseen difficulties (see additional information below).
5. After pilot began, a need was identified that was not addressed in Pilot. Clinicians and clinic administrators have, nearly universally, asked for similar training for their ancillary staff (medical assistants, front office staff, etc.). More explained below.

Additional Information: After initiating Phase 2/3, realized Phase 4 Maintenance Sessions could be optimized to facilitate learning by using "themed case reviews (i.e. Back pain case review, Fibromyalgia case review, etc.). This change allows deeper education into evidence-based and guideline adherent treatment for common pain conditions using problem-based learning. As such, pilot measurements (Post Surveys & claims data for clinicians) should be performed after Phase 4. This is a change from original plan of performing post-surveys after completion of Phase 2/3 education sessions. Other than the timeline, goals and measurements remain the same.

Pediatric Medical Home: Samaritan Pediatrics — Megan Van Vleet, Clinic Ops Manager

Successes:

1. Increased collaboration and utilization with our Pharmacist and her resources provided to the clinic, and our patients.
2. Development and collaboration with Care Coordinators and our Nutritionist to create the Health Kids program.

Challenges:

1. Patients no showing for appointments- reaching out and making contact with parents to determine what barriers they have to making appointments and how we can help.

Section 1: 2016 Q1 IHN-CCO Pilot Successes and Barriers Summary

Changes in Pilot: There was a meeting with Mental Health Admin late in Quarter One to discuss moving away from hiring a Registered Nurse, and focus efforts on hiring a Licensed Clinical Social Worker with a mental health focus, in conjunction with increasing the hours of the current mental health specialists. This will still require better coordination with the utilization of community resources in another way. There are meetings in place to do this early Quarter two.

Physicians Wellness Intiative: IHN-CCO — Dr. Ewanchyna, CMO IHN-CCO

Successes:

1. Pilot is working with Dr. Chinweike from OSU to contract work for a LEAN approach to look at the physician environment from the perspective of identifying and reducing factors that lead to burnout. Contracting details including a Scope of Work and study design requirements are being negotiated.
2. The Physician Wellness Coordinator position has been posted on the SHS website.

Challenges:

1. Pilot progress is moving slower than anticipated.

Prevention, Health Literacy & Immunizations: Boys & Girls Club — Emily Barton, Grant Writer Corvallis BGC

Successes:

1. There has been a lot of success in getting partners to work with us. Everyone seems excited about the pilot and very supportive.

Challenges:

1. The biggest challenge has been because of the alternative payment efforts underway. The move is toward performing primary medical services at the medical home, which challenges our primary pilot goal of delivering services where the kids are. What we are doing going forward is to focus on proving screenings and referrals at our Clubs, not medical clinics. Hope to work through this issue over the course of this year.

Changes in Pilot: There will not be Wellness Clinics at the Clubs for the reasons mentioned in Challenges above.

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

Successes:

1. Lack of communication, or problematic communication, between teams working toward the same goals, has been common and has limited the rate of progress. But some gains have been made through continued meetings of some of the parties involved. We have yet to get the principals into a direct conversation to work out agreements around scope

Challenges:

None

of practice for different practitioners, but this reflects a national-level lack of agreement, not just a local one.
2. What is limiting utilization of the consult service by the non-participating Primary Care Physicians? In-house presence of some sort still appears to be key. There has been progress on getting a telemedical connection to the rural clinics targeted in this grant; at the current rate, regular telepsychiatric presence in rural clinics should be in place by July 2016 when the grant ends.

Changes in budget: Finally using the money allocated for a Mental Health Specialist, and will do so until July to help that position establish itself in a number of Lincoln clinics, as a model for all the coast clinics to come.

Additional Information:

1. Here is an example that illustrates what we've accomplished – with one physician at least, but she's representative of the skill level of about half the Primary Care Providers we have worked with. She writes in a consult request:
   a) Forty Five year old female, not doing well with her depression. Currently on fluoxetine 60 mg daily and also on olanzapine 10 mg daily. Deals with both anxiety and depression, has family history of bipolar disorder. She has been on Celexa, Wellbutrin and Zoloft in the past without improvement of depression. She does admit to suicidal thoughts. Provider was thinking of starting her on lithium but was not sure on how to wean off of and switch from the other two medications.
      i) Note she has no hesitation to start lithium. She is asking for help here with how to taper from one regimen to another. Compared to pre-grant levels of comfort with psychotropics, the paragraph above demonstrates a substantial improvement. Thus fewer patients will require consultation, as these skills continue to improve; and more importantly for our health care system, fewer patients will require transfer to the already-overloaded specialty mental health programs like County Mental Health and Samaritan Mental Health. If they are not as overloaded, they can more quickly step in to help with patients who really need specialty-level services.

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

Successes:

1. Having School Navigators at the three schools (Lincoln Elementary, Garfield Elementary, and Linus Pauling Middle Schools) has provided continuity of care for families with students transitioning from one school to the next. All three School Navigators work closely together to address the multiple and complex needs of many of the families at these schools.
2. The school staff at Linus Pauling (LP) have started to trust the School Navigators there (this is the first year for the program at Linus Pauling) and referrals coming directly from the staff to the School Navigators are increasing.
3. School staff has voiced many times how vital they consider the School

Challenges:

1. Now that the School Navigators are well-established and the school staff sees them as vital, it is important to help the School Navigators keep their boundaries strong and well-established. It is easy for Community Health Workers to feel overwhelmed by the breadth and depth of need they encounter among the students and their families. Self-care and mutual support are important components that we discuss on a regular basis.
2. Sustainable funding as we go forward is the single biggest challenge facing this pilot. We are working with other Traditional Health Worker pilots to find the best way to quantify Traditional Health Worker touches and

Navigators program to be. The School District Superintendent has expressed her support of the program and is advocating for a multi-funded approach as a potential transition step in the sustainability process.	services, but it can be difficult to measure health outcomes, especially in the short term. Project director is working with the school district to develop a multi-funded approach between Benton County Health Services, Corvallis School District, and InterCommunity Health Network CCO that will be presented to the Delivery System Transformation Steering Committee.

Stories from the field:

1. **Linus Pauling Middle School: Helping students find housing**

A Linus Pauling family was facing an eviction notice. They needed to find a new home by February 15th. It was extremely hard for this single mom of four children to afford the moving cost in such short notice. School Navigator (SN) assisted parent in the search for a new apartment. Together parent and navigator visited several rental agencies in Corvallis, including the Willamette Neighborhood housing, submitted an application for housing assistance at Oregon Housing Authority, and applied for the emergency housing program at Community Services Consortium (CSC). The family was able to find a home in south Corvallis. The Community Services Consortium assisted the family with $1,200 for the deposit and the We Care program granted the family $400 dollars for the first month's rent. An application was submitted for a 3 bedroom apartment at Lancaster Bridge Apartments. The family is now in a two year waiting list for housing assistance at the Oregon Housing Authority. School Navigator also helped the family activate water and garbage service and submitted a referral for a bed and two dressers at Linn Benton Furniture Share.

2. **Garfield Elementary School**

First Story: School Navigator (SN) assisted a parent in calling her child's provider office because she had a health concern and also wanted to go over testing that had been done, but had not talked to provider about. Teachers were having some concerns regarding his health and how this was affecting academics. Teachers referred parent to School Navigators to assist with insurance and connecting parent to child's provider. School Navigators also assisted mom in making a Well Child Check for a future date. After appointment, mom came back with a diagnosis and medication for the child. This will help child focus in school and get further assistance with academics if needed in order to be successful.

Second Story: Garfield Navigator assisted Lincoln Navigator in expediting an application for a child that needed medical care urgently. School Navigators contacted Oregon Health Plan customer service line and after almost an hour on hold and with the customer service representative the application was found. Then School Navigators was transferred to their processing department and again it not only took a while to get through, but the School Navigators was told that application could not be found and in order for child to have benefits right away, guardian was going to have to call and provide household information on the phone. The School Navigator advocated for the application and explained the hardship that this would be to the family, because it is not a short phone call and the child's guardian was working. The School Navigator emphasized the urgent medical need, the application was found and the School Navigator was told it would get processed that day. Later that day, The School Navigator again assisted the Oregon Health Plan client service representative with the application, and within an hour, the child was showing up on Medicaid Management Information System (MMIS). This is the kind of dogged persistence that it can take to get an application through the Oregon Health Plan process, and exactly the work that the School Navigators do for students and their families.

3. **Lincoln Elementary School**

School counselor referred student to Trillium at school for counseling services. Dad had just received custody of child, and Trillium informed Dad that they could not see the child due to having a different CCO than InterCommunity Health Network-CCO. Counselor referred student to School Navigators to see if School Navigators could assist with changing CCO to InterCommunity Health Network-CCO. In speaking with dad, child's mom was not cooperating with allowing the change of CCO. Oregon Health Authority (OHA) did not allow dad to make any changes because he was not on the application. School Navigators completed a whole new application for parent and child due to custody papers filed. School Navigators sent in custody forms as well. Since it was urgent for the child to seek counseling services School Navigator called next day and went through the Oregon Health Authority processing center to get the application processed. After about two hours the application was processed and child would be on open card, until assigned to InterCommunity Health Network-CCO. In addition, the OHA representative determined dad did not have coverage and began the application process with him.

After a week, the Counselor was notified that the child had been re-assigned to the original CCO and not InterCommunity Health Network-CCO. The School Navigator called Oregon Health Authority and was transferred to the Customer Service Center where they did not allow the School Navigator as a community partner to correct the error as they needed the parent to give permission. Counselor was able to get dad to come in; after a one hour phone hold, dad spoke to a representative and gave permission. Representative then provided School Navigator with the necessary information. Representative said that it was a "system error" and somehow it had picked up the child's old address and assigned child to the corresponding CCO based on old address. Representative was able to move child to open card. Child has now been assigned to InterCommunity Health Services-CCO and is receiving full Trillium services.

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

Successes:

1. One of the most successful elements of this project to date is the response that we have had to the trauma trainings offered. The training filled to capacity and we are scheduling additional trainings at the request of several agencies that did not get to attend the initial training. A second success is the variety of providers who were interested in the Collaborative Problem Solving model after delivering the Introductory training in Lincoln County. Participants included representatives from Intensive Family Services in Linn County, Foster Parents, a Behavioral Health Clinician, the Director of the Early Learning Center in Lincoln City, Treatment Foster Parent Certifiers, and Catholic Community Services staff.

Challenges:

1. None

Additional Information: We have established partnerships with DHS- Self Sufficiency in Lebanon and Mighty Oaks in Albany who are both interested in hosting training on trauma and its impact which will increase opportunities to bring trainings to Linn County.

Universal Prenatal Screening: Obstetric Clinics and Hospitals Carissa Cousins, Physicians

Successes:

1. All Obstetric Clinics and some health departments are now using this tool.
2. Implementing this screening is a system wide change in both process and approach.
3. Pilot was able to screen 87% of the women who delivered during the data collection period.

Challenges:

1. Initially there was some resistance from some OB providers due to their concerns that this would take too much time, it would alienate patients, and there was a lack of referral resources.
2. Many women do not consider marijuana a “substance” as it is now legal.

Additional Information: Pilot is closing out at the end of this quarter.

Youth Wraparound and Emergency Shelter Andrea Myhre, Associate Director

Successes:

1. Working with InterCommunity Health Network-CCO staff to understand

Challenges:

1. Again, attempting to educate and make practitioners aware of our

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. We launched our internal Mental Health Therapist position, obtaining external clinical supervision, setting up processes/referral systems, and are serving youth in this capacity. We have also started the conversation with Old Mill about sharing billing systems with them until we can get our own billing system established. We anticipate starting this by summer 2016.	services and how to access them, building relationships to remove barriers and provide better services to youth being served has also been challenging. We feel like the process of reaching practitioners could be made easier for community service providers such as ours and are looking forward to working with InterCommunity Health Network -CCO on improving these relationships. We have limited time and resources to dedicate to reaching out to individual practitioners. This quarter, as we have established protocol for our counseling program, we have struggled with obtaining peer support from other Runaway and Homeless Youth organizations to provide guidance in how to establish internal policies and procedures.
Additional Information: We are finding it extremely difficult to follow through with consistency of care when a youth has to transition from one county to another due to living situation. There is about a 30 day (sometimes longer) gap in services due to insurance complications in transferring counties. This has happened to at least 6 of the youth we served this past quarter.	

<table>
<tr><th colspan="4">Alternative Payment Methodology (2): InterCommunity Health Plans</th></tr>
<tr><th>Goals</th><th>Activities</th><th>Measures</th><th>Results</th></tr>
<tr>
<td>Overall, the goal and metric for success of this proposal is to have greater than 80% of members assigned to Patient Centered Primary Care Home's receiving an Alternative Payment Methodology reimbursement payment by December 31st, 2016. This incentive provided to the Patient Centered Primary Care Home's will allow for Patient Centered Primary Care Home's to put workflows in place to meet performance metrics and patient engagement requirements of a Patient Centered Primary Care Home.</td>
<td>Distributed funds by March 31st, 2016 to the following provider clinics:

SAMARITAN INTERNAL MEDICINE CORVALLIS
BENTON COUNTY HEALTH DEPARTMENT
COASTAL HEALTH PRACTITIONERS
MID VALLEY CHILDRENS CLINIC
SAMARITAN FAMILY MEDICINE AT GEARY STREET
SAMARITAN INTERNAL MEDICINE ALBANY
SAMARITAN FAMILY MEDICINE RESIDENT CLINIC
SAMARITAN PEDIATRICS</td>
<td></td>
<td>These Patient Centered Primary Care Home clinics attribute to approximately 40% of InterCommunity Health Network -CCO members paneled at these Patient Centered Primary Care Home's. We have received signed contract amendments from all of these providers agreeing to take transformational infrastructural steps in using the funds to grow Patient Centered Primary Care Home's in preparedness for an Alternative Payment Methodology.</td>
</tr>
<tr>
<td>Each clinic that moves to an Alternative Payment Methodology, outcomes will be established similar to the outcomes in the three clinics that have already adapted an Alternative Payment Methodology. At this time, clinics choose their own metrics for improvement under the Quality of Care Goal.</td>
<td>Samaritan Internal Medicine – Corvallis, Benton County, and Coastal Health Practitioners have all established metrics, and have processes in place to monitor metric performance. InterCommunity Health Network -CCO has developed reports to share on a quarterly basis on counts to date.

Mid Valley Children's Clinic, and Samaritan Family Medicine at Geary Street are in the final stages of negotiating the metrics that they agree to be monitored. The plan is to make the contract effective date to begin April 1st, 2016. These clinics have also started putting care coordination touches processes into</td>
<td></td>
<td>It is too soon to report on results of the metrics other than the activities to address. We only have less than one quarter of data. We will share results on metric performance Quarter Two.</td>
</tr>
</table>

	place. Samaritan Internal Medicine – Albany and Samaritan Family Medicine Resident Clinic have not started any discussions. Samaritan Pediatrics is in the final stages of negotiating and Alternative Payment Methodology with quality metrics including Pay for Performance incentives. Reports to monitor metrics for additional clinics have been submitted for updates.		

CHANCE			
Goals	**Activities**	**Measures**	**Results**
Peer Support Training			Submitting curriculum for approval by state
Tech Support		Data Tracking	Created a peer based / touch tracking system. Implemented Feb 2016
Positive Behaviors	OHP Applications	InterCommunity Health Network -CCO Enrollment	Switched from twice monthly to weekly Oregon Health Plan Application Assistance.
Positive Behaviors	Smoking Cessation		Working with Linn County to create a Tobacco Free Policy
Positive Behaviors	Social Voices		Weekly Support group for those who hear voices.
Positive Behaviors	Anger Management		Weekly classes
Positive Behaviors	Recovering Couples Anonymous, Dual Diagnosis Anonymous, Alcohol Anonymous/ Narcotics Anonymous / Heroin Anonymous		Weekly support group for Albany and Lebanon
Positive Behaviors	Peerpocalypse		Sent two peers to a four day Peer to Peer / Mental Health retreat in Seaside Oregon.
Positive Behaviors	Arts and Crafts		Twice weekly arts and crafts
Positive Behaviors	Peer Support	Individual	Peer to Peer support / homework / active listening / paperwork / etc.
Tracking Data	Implemented Touches Tracking using OHA	Touches	Allowed us to see we were under estimating what we did and the number of people we serve.

	touches report.		
Tracking Data		Peer Intake Form	Added several fields including, Gender Identity / Sexual Orientation, Tobacco Use, etc.
Tracking Data / Positive Behaviors		Peer Improvement Survey	Redoing the peer survey to better serve our peers / clients.

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery			
Goals	**Activities**	**Measures**	**Results**
Adverse Childhood Experiences (ACE's) scoring for each participating Member	Complete Adverse Childhood Experiences screening	95% families surveyed	Staff reviewed and trained on screening tool, screening beginning April 1st, 2016
Four staff complete Community Health Worker or Peer Support training	Completion of training program	Four Staff trained	Researched training opportunities Identified training for Latino Peers Registered one staff person for Peer Training
Referral process with Community Health Worker in Mid-Valley Children's Clinic	Create referral pathway	Completion	Creation of Family Tree Referral form
Referral process with Community Health Worker in Mid-Valley Pediatrics	Create referral pathway	Completion	Creation of Family Tree Referral form
Establish Electronic Record and note sharing with Pediatric Practices	Work with Community Health Worker Program Manager at BCHS creating process	Completion	No action~ In Quarter Two set up meeting with Regional Electronic project to see when social services info can be added
Establish Electronic Record and note sharing with Family Practices	Work with Community Health Worker Program Manager at Benton County Health Services creating process	Completion	No action~ In Quarter Two set up meeting with Regional Electronic project to see when social services info can be added

Establish and Implement common APM touches report for Traditional Health Worker pilots through Traditional Health Worker Subcommittee	Create Touches report Utilize touches reporting book for monthly tracking	Completion of Workbook	Workbook created and implemented in February 2016 Staff reporting touches for February and March This data compiled and submitted to InterCommunity Health Network - CCO
Identify and implement required organizational structure for supervision of Community Health Worker	Research	Supervision in place	Review requirements for Alcohol &Drug Peer Support supervision

Child Psychiatry Capacity Building: Samaritan Mental Health Family Center			
Goals	**Activities**	**Measures**	**Results**
Increase Capacity	Number of patients	Number of patients followed	This continues to do well, with 126 patients on the ongoing treatment list and 13 new evaluations this quarter, an expansion of almost 50% over treatment as usual.
Improve outcomes	Individual outcome measures	Structured, validated outcome measure by diagnosis	This continues to go well, with better treatment outcomes or better documentation that parents do not 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. (just one, in fact)
Maintain/improve Primary Care Provider satisfaction	(none yet)	Survey	Overall Primary Care Provider relations are good, with more confidence in taking stable patients.

Childhood Vaccine Attitude & Information Source: BCHD			
Goals	**Activities**	**Measures**	**Results**
Recruitment of 40 focus group participants	Create recruitment guide and materials Distribute recruitment materials Follow up with recruited individuals	Number of unique participants who agree to sit in on a focus group session	Participant recruitment guide has been drafted, currently going through final review Recruitment flyers have been drafted, currently going through final review

Conduct eight focus group sessions	Complete focus group guide Schedule focus group locations and dates Conduct focus groups	Number of focus group sessions conducted	Focus group guide has been drafted, currently going through review
10 Key informant interviews	Complete interview guide Schedule interviews Conduct interviews	Number of key informant interviews conducted	Key informant interview guide has been drafted, currently going through final review Three key informant interviews piloted
Compilation and distribution of a qualitative report of findings	Transcribe results Analyze results Create report of findings Distribute findings	Report created number of modes distribution and recipients of report	None currently
Recommendations for provider / practice / public health actions to decrease vaccine exemption rates	Use findings to create provider recommendations Distribute recommendations	Recommendation list created number and locations of providers who receive recommendations	None currently

CMA Scribes: Samaritan Family Medicine and Residency Clinic

Goals	Activities	Measures	Results
Select training vendor			Unable to achieve due to lack of Certified Medical Assistant participants
Identify those to be trained			Unable to achieve due to lack of staff retention
Purchase/trial tablets	Providers to successfully trial tablets		Unable to achieve due to change in tablet models, prolonging date of initial trial
Hire Scribes directly			Unable to achieve due to lack of qualified candidates within the community being able to work fulltime.

Colorectal Screening Campaign: InterCommunity Health Network

Goals	Activities	Measures	Results
By June 2015, adapt and implement Oregon Health			Materials have been dispersed to pilot clinics for distribution to patients All bus ads, radio ads, and billboards have been disseminated and

Authority's colorectal screening media campaign, reaching 80% of InterCommunity Health Network-CCO Colorectal Screening eligible members, in the three-county region.			InterCommunity Health Network CCO website banner has been displayed.
By August 2015, disseminate Colorectal Screening information beyond the walls of traditional health care settings by partnering with public health and other community organizations, reaching 20% of InterCommunity Health Network-CCO Colorectal Screening eligible clients.			Print materials have been distributed to non-traditional setting to extend the reach of the campaign
By December 2015, distribute 3,000 FIT tests in selected Patient-Centered Primary Homes utilizing Electronic Medical Record to identify patients aged 50-75 years, with 40% (or twelve hundred [1,200] patient member) adherence and return of stool test screenings.			Eight FIT and 17 Marketing pilot sites have completed the contracting process There were two in-person trainings held in February, one in Newport and one in Lebanon. There will be an additional training held in Sweet Home in May. Clinics are purchasing FIT tests and a reimbursement process is developed The FIT Pilot and marketing campaign ended March 31st, 2016.
By March 2016, utilize traditional health workers/health navigators to reduce barriers related to screening among Latino and Native American populations, reaching 5% InterCommunity			Materials have been provided to the Traditional Health Workers that indicated interested in the campaign during clinic staff meetings.

Health Network-CCO Colorectal Screening eligible members.			
By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.			Mid-Point Check-ins have been completed. Provider surveys for the final evaluation are being developed. A marketing survey is being developed for the clinics who are only distributing marketing materials Flow chart documentation tool being identified A Data Analysis plan is being developed that will measure participating clinics rates and non-participating clinics to allow for comparison in order to measure the effectiveness of the campaign.

Community Health Workers: Benton County Health Department	
Work Plan Objective	**Status of Reportable Milestone Activities**
Develop Hub model that includes target population, site criteria, and evaluation metrics	The Hub model continues to develop. There are process documents in place, along with flow charts and guidelines. The work of the next eight months is to continue working on the sustainability of the model.
Hire, train, and supervise two Community Health Workers; Hire and train two additional Community Health Workers as the next phase of the pilot	The original hire Community Health Workers have now been at their agency sites for one year. We had our quarterly check-in this morning, and both sites reported that referrals are running smoothly from provider to Licensed Clinical Social Worker (LCSW) to Community Health Worker; trust has been built between the care team members; all parties expressed satisfaction at the progress of the pilot to date. The new hire Community Health Workers will be starting at their new site locations this week. They are Oregon Health Plan application assisters, and have completed their resource and navigation training. They will continue their self-management training at Benton County Health Services for the next four to six weeks, with increasing time spent at their agency sites.
Send Community Health Workers through state – approved Community Health Worker training and register with Oregon Health Authority	There have been time and travel barriers to sending all of the Community Health Workers through the state-approved Community Health Worker training. Benton County Health Services continues to look for opportunities to complete this goal, including exploring the possibility of what it would take to have a training site in Benton and Linn counties that would serve the mid-Willamette valley.
Document staff training, roles, policies, and procedures	With the roll-out to the new agency sites, the documentation developed during Phases One and Two are being used and refined. New referral pathways and level-of-care matrices are also being developed to reflect clinic need and style.
Develop an evaluation plan that includes process and health outcome measures	Benton County Health Services Program Manager continues to work with InterCommunity Health Network CCO and the Traditional Health Worker Subcommittee of InterCommunity Health Network CCO to develop a way to standardize how patient touches are captured and valued, as well as how to show the value of Community Health Worker services. As part of

	this effort, the pilots using Traditional Health Workers are working together to standardize the way they capture and track touches, and how they capture the time spent on touches. Table showing clinic touches by category is on file at InterCommunity Health Network CCO, and note the new columns showing time spent. This is an effort to show that one touch may take 15 minutes or it could take one and a half hours. Benton County Health Services is also working with Dr. Daniel Lopez-Cevallos from Oregon State University to develop qualitative patient and agency staff surveys and key informant interviews to determine patient, staff and provider experience and satisfaction with working with Community Health Worker.

Community Paramedic: Albany Fire Department			
Goals	**Activities**	**Measures**	**Results**
Acquire and equip a vehicle.	Ford Explorer has been acquired on short term lease	To be acquired within the first quarter.	Completed
Hire and train Community Paramedic.	Position filled internally	To be completed within the first quarter.	Completed
Establish written protocols approved by Physician Adviser.	Written protocols have been completed and submitted to Physician Advisor for approval	To be completed within the first quarter.	Pending Physician Advisor approval
Establish forms for data collection in the field.	Forms have been drafted	To be completed within the first quarter.	Activities of Daily Living, Authorization, Community Paramedic Program Referral, Community Paramedic Program Intake, Environmental Assessment, and Patient Assessment forms have been created
Establish computer software program for data collection and reporting.	Evaluating adding Community Paramedic Program module to current electronic Patient Care Reporting system	To be completed within the first quarter.	Established software program for data collection; reporting capabilities to be completed next quarter
Promote program within public and private healthcare systems and social service programs.	Established partnerships with Senior & Disability Services, Volunteer Caregivers, Linn County Mental Health, Mobile	Provide the number of presentations and participations within the healthcare and social service provider networks.	Initial contact to promote program has been made with 15 agencies, involving 130 participants

Section 2: 2016 Q1 IHN-CCO Pilot Goals, Activities, Measures, and Results

	Crisis Responder		
Establish protocol with healthcare providers and Emergency Medical Services providers to target InterCommunity Health Network-CCO members for referral to Community Paramedic Program.	Established protocol with EMS providers; focusing on healthcare providers in the next quarter	Count number of referrals, specifically identifying InterCommunity Health Network-CCO members.	11 of 53 referrals were InterCommunity Health Network-CCO patients
Reduce medical transports to InterCommunity Health Network-CCO members.	Data collection initiated	Count of medical transports of InterCommunity Health Network-CCO members compared to total transports.	Reporting capabilities to be completed next quarter
Reduce number of ambulance transports to the emergency department of InterCommunity Health Network-CCO members by focusing on appropriate, alternative care.	Data collection initiated	Count number of referrals to alternate care that otherwise would have been ambulance transports of InterCommunity Health Network-CCO members to an ED. Referrals will be considered avoidance of ambulance transport to an Emergency Department.	Reporting capabilities to be completed next quarter
Reduce number of InterCommunity Health Network-CCO members using 9-1-1 system for overdose and seizures.	N/A	InterCommunity Health Network-CCO members currently comprise a higher percentage of overdose and seizure calls into Albany Fire Departments response	Inadequate data at this time

		area compared to the general population of non- InterCommunity Health Network-CCO members.	
Reduce ambulance transports of InterCommunity Health Network-CCO mental health patients to Emergency Department by referring these patients to mental health providers.	Data collection initiated	Track referrals of InterCommunity Health Network-CCO members to mental health professionals.	Reporting capabilities to be completed next quarter
Provide in-home evaluation and services to reduce patient entrance into the healthcare system.	Data collection initiated	Track services provided to InterCommunity Health Network-CCO members by community paramedic. Services, i.e. EKG, blood sugar levels, fall prevention, home safety evaluations, medication reconciliation, etc.	Reporting capabilities to be completed next quarter

Complex Chronic Care Management: The Corvallis Clinic			
Goals	**Activities**	**Measures**	**Results**
Finish patient engagement			Will complete study patient encounters 3/31/2016
Final amendment			Working with InterCommunity Health Network-CCO / The Corvallis Clinic administration
Determine final reporting			Working with InterCommunity Health Network-CCO / The Corvallis Clinic administration
Patient exit interviews			Final patient exit interviews will be conducted through April.

Section 2: 2016 Q1 IHN-CCO Pilot Goals, Activities, Measures, and Results

Dental Medical Integration for Diabetes			
Goals	**Activities**	**Measures**	**Results**
Ongoing monitoring of clinic pilot activity	Monthly medical clinic check ins	NA	On-going, 100% complete
	Monthly dental plan check in		On-going, 100% complete
	Year one Pilot Review		100% complete
	Lunch and Learns		100% complete with 7 participating clinics. Waiting on response from Lincoln County Health Department.
	Staff meeting education		Available upon request. Not required for pilot success. Medical clinics participating: Samaritan Family Medicine Geary Street, Samaritan Family Medicine Resident's Clinic, and Main Street Family Medicine
Collection of monthly data	Budget reporting	NA	Remaining budget: 96.47%
	Medical clinics to Dental Program Clinical Coordinator(DPCC) 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/referrals	75% or greater of all eligible members	52% of measure met
	Collecting Dental to Medical warm hand-offs/referrals		0% of measure met
	Screening questions by Primary Care Provider	90% or greater compliance rate from participating medical clinics	92% compliance rate met
	Screening questions by Primary Care Dentist	90% or greater compliance rate by dental providers	95% compliance rate met
	Mailer Response	50% or greater response rate for	2% of measure met

		entire population	
Distribution of monthly reporting	Population Reporting	NA	Implementation 100% complete. Distribution on-going.
	Medical Referral log		Implementation 100% complete. Distribution on-going.
	Dental Referral log		Implementation 100% complete. Distribution on-going.
Budget Distribution	Hygiene baggies to Primary Care Provider	NA	Advantage ordered.
	Denture hygiene baggies to Primary Care Provider		Implementation 100% complete.
	Diabetes Education brochures to Primary Care Provider		Capitol ordered.
	Denture care education brochures to Primary Care Provider		Capitol ordered.
	Clinic posters to Primary Care Provider		Submit to marketing for design. Waiting on rough draft.
	Dental Appointment Incentive Gift Cards		Walmart and Fred Meyers $10 dollar gift card incentives for InterCommunity Health Network-CCO to distribute
	Mailer Edits		Edit submit to design. Waiting on rough draft.
	Incentive postcards		Submit to marketing for design. Waiting on rough draft.

Health & Housing Planning Initiative			
Goals	**Activities**	**Measures**	**Results**
Increased access to health care for target populations	Recruited and hired two full-time Health Navigators Launched and Promoted Healthy @ Home, the Health Navigation program at all of our properties Established Meet and Greets and office hours	Number of new enrolls into InterCommunity Health Network -CCO Number of referrals to health care providers	42 residents have attended the Meet and Greets to learn about the Healthy @ Home WNHS Health Navigation Program. 15 meetings were held at the Hotel Julian to reach residents and enroll them into the Healthy @ Home Program. Health Navigators have worked with 13 residents about health issues. 3 residents have been referred to establish care.

	on-site at properties. Health Navigators in process to be Oregon Health Plan application assisters.		
Increased utilization of preventative health appointments and screenings	Made colorectal screening information available at our senior properties with residents over 50.	Establish baseline in partnership with InterCommunity Health Network-COO. Number utilizing preventative health screenings	
Decreased hospital and Emergency Department admission	Assisted resident in getting a prescription refill of a medication that treats her chronic condition.	Establish baseline in partnership with InterCommunity Health Network-COO Number of Emergency Department visits by residents & survey of residents regarding Emergency Department usage	Resident prescription was filled, no ED visit.
Increase communication with Patient Centered Primary Care Home	Met with CHANCE to review their online intake database.	Entries into RHIC	
Enter into Memorandum of Understanding (MOU) with health care provider to deliver two onsite services	Reached out to Breast and Cervical Screening and Living Well with Chronic Conditions.	Memorandum of Understanding in place by April 2016	
Develop "Health and Housing Plans" for existing and future housing developments that	Conduct literature review of health and housing research and	Research successful models to help define measurements and	Currently researching best practices on health and housing Working with Housing Opportunity Action Council (HOAC) to bridge

integrate health care services, intervention, and prevention into affordable housing.	best practices Convene regional housing, social service, and health providers to identify system needs and plan	metrics and capture data Gather baseline data and indicators from CHIP and InterCommunity Health Network CCO Transformation Plan	regional homelessness and housing activities Helped to convene 150 regional stakeholders for health and housing summit (January 25, 2016), compiled results, and are in the process of pursuing next steps for cross-sector partnerships and regional work on this topic

Home Palliative Care: Benton County Hospice			
Goals	**Activities**	**Measures**	**Results**
			Metrics are anticipated starting in Quarter Two

Licensed Clinical Social Worker Patient Centered Primary Care Home: Samaritan Mental Health			
Goals	**Activities**	**Measures**	**Results**
Mental health services integration into medical home	Provision of group, individual and family Mental Health counseling;	PHQ 9, GAD-7 ORS/SRS Class evaluations Numbers seen	Licensed Clinical Social Worker and student see patients with trauma, pain, depression, anxiety, opiate dependency, critical health issues and other compounding factors. Patient satisfaction as measured by SRS is high. End of grant satisfaction surveys start soon. Majority show improvement in daily functioning and reductions in clinically elevated scores. Patients often show higher scores after early visits; this appears related to more trust and openness. Emergency Department visits and medical usage visits for some targeted patients are down and measures will be available at grant end. 238 direct patient visits this quarter (face to face contact). 25 patients

	Psychoeducational classes		were seen in warm hand-offs as part of their Primary Care Provider visit; others received referrals from Primary Care Provider. 32 intakes (new individual patients). Therapist encouraged enrollment with MyChart and many patients used it for non-urgent information. Emails content included "homework", additional resources, check ins. Patient care was also made via telephone, including "virtual" visits for three patients who were housebound. Psychoeducational classes: smoking cessation (one series); stress management (three series); classes in understanding anxiety, depression and sleep disturbance. "StressBusters" curriculum was taught/shared with Samaritan Internal Medicine's Licensed Clinical Social Worker and groups are now co-led monthly with patients from both clinics (group numbers here do not represent any SIM patients). Delivered three full day Mental Health First Aid trainings.
Increase staff understanding of trauma/Mental Health needs on Medically Unexplained symptoms	Staff consults and shared knowledge; emails, cc'd charts on common patients	Anecdotal Number of warm hand offs and referrals	Licensed Clinical Social Worker and Primary Care Provider have collaborated closely on patient care in person and via MyChart. Medication needs have been identified early and psychiatric oversight via chart review has increased. Many patients made less frequent Primary Care Provider visits/requested unnecessary medical testing as anxiety levels and depression were relieved. More Primary Care Providers made direct referrals and warm handoffs were down this quarter, to 25. Licensed Clinical Social Worker did note slight drop off in follow-through when WHO did not occur and made calls or MyChart messages in some cases, which increased likelihood patients would appear.
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	Portland State University social work graduate student continues internship this quarter.	Patients seen, GADs, PHQs.	Student led 41 sessions with 15 clients, watched an additional 30 more. Licensed Clinical Social Worker provided formal supervision hour sessions weekly and ongoing informal trainings. She observed and participated in clinical work conjointly with Licensed Clinical Social Worker; began independent sessions with patients on own. She

			increased clinical, professional and case management skills. Student will continue in a behavioral placement next year as a result of skills learned this year.

Maternal Health Connections: Family Tree Relief Nursery			
Goals	**Activities**	**Measures**	**Results**
Advertise/ hire Community Health Worker for clinics	Job advertisement/ interviews/ hiring process	Hired employee	The Community Health Worker has been hired by the Benton County Health Department. She has begun training and orientation.
Advertise/ hire Peer Support Specialist based at Family Tree Relief Nursery	Job advertisement/ interviews/ hiring process	Hired employee	The recruitment process is underway. One Alcohol & Drug Peer has been hired and is submitting background check information. This process can take up to several weeks given the Peer's past life experience. The second Peer position is in interview stage. We offered position to a candidate and they did not accept the position. We are continuing to interview additional candidates and hope to have second Peer hired by end of April.
Identify needs of Clinics through initial discussions	Group meetings, email conversations	Needs assessment process started	We have begun meetings with the clinic managers to identify needs, workflow, scheduling, co-supervision and other logistics.
Identify training requirements/ needs for Community Health Worker	Meet with clinic supervisors	Requirements and needs identified	The core educational requirements (curriculum) for the Community Health Worker have been identified. We will further identify needs according to requests from the clinic managers.
Identify training requirements for Peer Support Specialist	Meet with clinic supervisors	Requirements and needs identified	The core education requirements (curriculum) for the Peer Support Specialist have been identified.

Medical Home Readiness: Quality Care Associates			
Goals	**Activities**	**Measures**	**Results**
Consultants visit practice on a monthly basis	Site visits on 1/29, 2/26, 3/18		Completed. Discussed documentation for Patient Centered Primary Care Home attestation, Quality Improvement templates, Screening, Brief Intervention, Referral to Treatment (SBIRT) screening, and care coordination

At least one routine phone check-in between visits	Two calls of 20 – 30 minutes in duration were completed		Completed. Quality Improvement strategy and quality measures were discussed.
Numerous phone calls and emails to clarify instructions and provide assistance	Numerous emails and phone calls to various members of consulting staff		Completed. Quality Improvement templates, Screening, Brief Intervention, Referral to Treatment (SBIRT), care coordination, immunization programs, and education and self-management materials were discussed.

Pain Management in the Patient Centered Primary Care Home			
Goals	**Activities**	**Measures**	**Results**
Improve primary care healthcare providers' understanding of the biopsychosocial model of pain.	Provider Survey	Pain Attitudes & Beliefs Scale (PABS)	Baseline Surveys obtained from clinicians in eight clinics.
Decrease primary care healthcare providers' Fear Avoidance Beliefs.	Provider Survey	Fear Avoidance Beliefs Questionnaire	Baseline surveys obtained from clinicians in eight clinics.
Improve primary care healthcare providers' confidence of the diagnosis, treatment and management of chronic pain patients in a primary care setting	Provider Survey	Providers' Report of Self-Efficacy and Outcome Expectations for Chronic Pain	Baseline survey obtained from clinicians in eight clinics.
Improve primary care healthcare providers' adherence to evidence-based chronic non-specific back pain treatment guidelines for imaging.	Clinic InterCommunity Health Network CCO Claims. Population will be defined by specific diagnosis and procedure codes. Rates of provider CT/MRI use will be compared among clinics/providers that receive training vs. those that do not.	Use of CT/MRI or plain radiography for non-specific low back pain.	Diagnosis and procedure codes provided to InterCommunity Health Network CCO. (List of all participating clinicians pending)

Improve primary care healthcare providers' adherence to evidence-based chronic non-specific back pain treatment guidelines for medications.	Population will be defined by specific diagnosis and procedure codes. Rates NSAID/APAP and opioid use will be compared among clinics/providers that receive training vs. those that do not.	Use of NSAIDS/APAP or opioid Clinic IHN Claims data.	Diagnosis and procedure codes provided to InterCommunity Health Network CCO. (List of all participating clinicians pending)
Twelve Tri-county Patient Centered Primary Care Home Participating	List of participating clinics collected	Number of participating clinics & location	Eleven clinics enrolled to date. Of these: ○ 8 clinics completed Phase One ○ 3 clinics in Phase One ○ 2 clinics starting Phase Four ○ 2 clinics nearing completion Phase Two/Three ○ 6 clinics starting Phase Two/Three ○ 1 clinic pending dates for Phase Two/Three

Pediatric Medical Home: Samaritan Pediatrics			
Goals	**Activities**	**Measures**	**Results**
Increase number of patients seen by Nutritionist	Report created to pull in patient list of all InterCommunity Health Network CCO members who have a high BMI Nutritionist has also been communicating with Medical Doctor's to find patients who could benefit from consult Letter created to send to patients who miss their appointments	Effectiveness of Care Measures	Nutritionist has seen 36 InterCommunity Health Network CCO members in Quarter One. We are working hard to increase her numbers so her schedule is sustainable Created two plans for patients who fall into selected categories based on our pilot goals 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 Working with Care Coordinators to develop a Healthy

			Kids Care Plan (system-wide effort)
Increase Well Child Checks	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 InterCommunity Health Network CCO members who do not frequently contact office or come across our radar who are due for yearly well child check If patients no show, we are reaching out same day to reschedule
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 One the mental health specialist has seen 19 new patients for intakes, had three warm hand-offs and completed 15 phone follow up calls The Psychiatrists have seen 12 new patients for an initial evaluation, had 25 follow up appointments and eight medication check appointments Working with Mental Health Admin to increase Specialists' time in clinic for better access.
Percentage of Developmental Screenings performed in the first 36 months of life	Tracking patients who fall into this category of measurement	Effectiveness of care measures	For Quarter One we are currently at 77%

Physicians Wellness Intiative: IHN-CCO			
Goals	**Activities**	**Measures**	**Results**
Development of communication pathways with Physicians.		Convene a Physician Wellness Advisory Committee (PWAC)	Pilot is working with Samaritan Health Services Leadership to develop a common vision and goals.
		Develop survey with input from the Advisory to gather information on factors that contribute to burnout and the degree of burnout perceived by IHN-CCO	The Maslach Burnout Inventory paired with the Area Work Survey offered through MindGarden has been selected as the instrument that will be used.

		physicians.	
Assessment of Burnout		Assessment survey administered to IHN-CCO Physicians	Pilot is working with Samaritan Health Services Leadership to develop a common vision and goals for how survey will be administered, analyzed and shared.
		Report on the state of burnout in IHN-CCO physicians.	Nothing to report to date
Development of ongoing wellness monitoring plan		Identification of quality measures for ongoing assessment of burnout.	Nothing to report to date
		Establish annual review process that incorporates assessment of burnout/resiliency in physicians.	Nothing to report to date
Development of direct and indirect interventions to reduce burnout and develop resiliency in physicians.		Develop resources (information brochures, classes, counseling) for physicians	Nothing to report to date
Evaluation of the effectiveness of the interventions.		Evaluation plan that describes the tools and techniques (survey, rubrics, tracking sheets, etc.) appropriate for each resource and process identified/developed.	Nothing to report to date
		Physician Wellness Program Effectiveness Review (report)	Nothing to report to date
		Develop evaluation tool to measure physician turnover	Nothing to report to date

		within InterCommunity Health Network CCO	
		Design an experiment or survey to assess the relationship between reimbursement model and physician stress.	Nothing to report to date

Prevention, Health Literacy, and Immunizations: Boys and Girls Club of Benton and Linn Counties			
Goals	**Activities**	**Measures**	**Results**
Increasing access by building and strengthening Patient Centered Primary Care Home Neighborhood supports for 8,500 youth in Benton and Linn counties.	Identification of partners that will provide Health Navigation, and offer other services such as well-child visits, Screening, Brief Intervention, Referral to Treatment (SBIRT) screenings, and depression screening.	Memorandum of Understanding (MOU) with listed partners and new partnerships to connect with Patient Centered Primary Care Home's, Health Navigation, and Resilience partners. Schedules for services partners will deliver in our Clubs.	Agreements have been made with: Benton County Health, Linn County Health, Trillium Family Services, & Oregon State University School of Pharmacy to deliver health fair with simple screenings, referrals, & health navigators to assist in Oregon Health Plan navigation. These activities will be completed in spring and fall of 2016. Benton County Health & Linn County Health to deliver Health Navigators to assist in Oregon Health Plan navigation. These activities will be completed quarterly beginning in the fall of 2016.
Increasing access by building and strengthening Patient Centered Primary Care Home Neighborhood supports for 8,500 youth in Benton and Linn counties.	Identification of partners that will provide enhanced resilience	Memorandum of Understanding with listed partners and new partnerships to connect with Patient Centered Primary Care Home's, Health Navigation, and Resilience partners. Schedules for services partners will deliver in our Clubs.	Resilience curriculum has been developed by the Boys & Girls Clubs targeting kids in K-12th grade. Programs will be delivered starting in April 2016, and continue through December 2016.
Enhanced Health Literacy	Identification of	Connections with	Agreements have been made with:

curriculum for 640 youth to empower them to make informed healthcare decisions	partners that will provide Health Literacy and curriculum for 1 year of programming	providers and enhanced curriculum.	Western University of Health Sciences to deliver workshops on diabetes in the fall of 2016 Oregon State University School of Pharmacy to deliver workshops on asthma in the fall of 2016 Oregon State University School of Pharmacy to deliver health fairs and workshops on prescription drug education starting in the spring of 2016 and continuing in the fall 2016.
Increase immunizations by providing access to immunization clinics in four Patient Centered Primary Care Neighborhood Clubs.	Identification of partners that will provide immunization clinics and Oregon Health Plan enrollment assistance	Memorandum of Understandings with immunization partners. Identify target number of youth to be provided immunizations	Agreements have been made with: Benton County Health & Linn County Health to deliver immunizations clinics in the summer of 2016, along with assistance in signing families up for Oregon Health Plan.

Primary Care Psychiatric Consulation: Samaritan Mental Health			
Goals	**Activities**	**Measures**	**Results**
Continue same services to existing clinics	Chart-based consultation	number of consults/time	Maintaining consult rate, roughly five per week. Teaching in Samaritan Internal Medicine, not an original target clinic.
Determine barriers to effective collaboration between psychologists and psychiatric consolation.	Meetings with psychologists in existing and proposed clinics; train Mental Health specialists accordingly	Long run: working collaboration. Short run: relationship development.	Multiple successful meetings, continuing to grow relationships; three additional Mental Health Specialists trained, two more hires approved, candidates in interview phase now.
Use results to further consideration of psychiatric consultation in other CCO's	Member, Integrated Behavioral Health Alliance of Oregon and psychiatric integration subgroup	Reference: The Substance Abuse and Mental Health Services Administration Guide to Behavioral Health Integration, page 5	Contracted to serve as a Technical Assistant for the Oregon Health Authority in response to their Request For Proposals. Conducted two webinars via Oregon Health Authority describing need for psychiatric consultation, and support available.
Extend program to coastal clinics	Meetings with principals, administrative steps	Consults underway?	Privileges obtained at both coastal hospitals (required to work in their associated clinics). Mental Health Specialist hired for Lincoln City, interviewing for Newport-related clinics. Began chart-based consultation

			service April 1st, 2016. Two meetings on telemedical connections; should have in place end of grant.

School Neighborhood Navigator: Benton County Health Department	
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) continue to coordinate health and social/community resources for students and their families. They work closely with Chris Hawkins, the Homeless Liaison for the school district, as well as connecting families to Oregon Health Plan, InterCommunity Health Network-CCO, and primary care providers to establish themselves with a primary care home. In this quarter, there were a number of events focused on Latino parents and families that the SNs helped arrange and assist with. There was a CPR class in Spanish at Lincoln School and an event titled "Conozca sus Derechos" (Know Your Rights) at Linus Pauling designed to help parents understand their rights with regards to immigration. There were over 200 attendants, including the city Mayor and the School District Superintendent.
Improve coordination of the care of InterCommunity Health Network -CCO members by improving access and engagement of patients and their families in their primary care medical homes.	Please see below for referral numbers for the school navigators for the first eight 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 School Navigators track referrals on an excel spreadsheet that allows them to chart the status of the referral and if the referral has been closed. School Navigators attempt to "close the loop" back to the referring party (teacher or counselor) in every case possible. We are working with other Traditional Health Worker pilots to standardize how "touches" are captured and accounted for. School Navigators have begun using a time marker to track time spent, with "one" designating fifteen minutes spent.

Section 2: 2016 Q1 IHN-CCO Pilot Goals, Activities, Measures, and Results

Benton County Health Services: School Navigator Touches, 8/2015-3/2016

Month	School	WCC	Primary Care	Vision	Dental	Health Insurance	Counseling	Food	Clothes	Recreational Activities	Interpreting Translating	McKinney Vento	Other	Family Touches	Monthly referral Total	Total all schools
Aug 2015	Garfield	0	0	0	0	0	0	0	0	0	0	0	0	17	0	202
	Lincoln	0	1	2	1	7	0	2	2	8	0	2	7	20	52	
	Linus-Pauling	0	0	0	0	4	1	72	0	70	0	0	1	2	150	
Sept 2015	Garfield	2	5	2	1	9	1	0	4	16	4	5	16	47	112	346
	Lincoln	1	6	4	3	17	1	7	7	13	0	2	15	70	146	
	Linus-Pauling	0	8	3	3	9	4	2	12	14	2	1	10	20	88	
Oct 2015	Garfield	2	1	23	30	30	0	5	0	1	54	4	14	42	206	627
	Lincoln	0	0	4	9	26	1	41	4	14	12	10	8	125	254	
	Linus-Pauling	0	1	10	1	29	14	7	7	17	13	4	45	19	167	
Nov 2015	Garfield	2	1	1	5	30	0	64	0	9	11	3	37	31	194	585
	Lincoln	0	0	4	9	26	1	41	4	14	12	10	8	84	213	
	Linus-Pauling	0	3	15	18	30	3	23	0	7	14	0	23	42	178	
Dec 2015	Garfield	0	0	7	21	11	0	43	2	3	27	8	20	41	183	557
	Lincoln	0	0	10	43	22	1	3	0	12	6	1	29	45	172	
	Linus-Pauling	4	8	11	12	22	1	8	7	26	18	14	50	21	202	
Jan 2016	Garfield	0	1	4	6	9	0	26	3	8	9	7	27	56	156	496
	Lincoln	2	2	7	27	13	1	4	2	6	14	1	11	62	152	
	Linus-Pauling	0	15	2	7	10	4	1	0	13	15	29	37	55	188	
Feb 2016	Garfield	2	0	3	3	11	6	0	0	6	3	0	17	50	101	384
	Lincoln	1	7	7	7	20	4	3	0	5	21	0	13	85	173	
	Linus-Pauling	2	2	3	3	12	2	23	3	2	9	0	19	30	110	
Mar 2016	Garfield	0	2	7	2	14	2	38	0	68	9	0	90	23	255	449
	Lincoln	0	1	4	2	12	0	1	1	3	13	0	5	51	93	
	Linus-Pauling	0	3	4	0	19	2	1	1	9	2	0	16	44	101	

Four	All Schools	WCC	Care	Vision	Dental	Insurance	Counseling	Food	Clothes	Activities	Translating	Vento	Other	Family Touches	Total all schools
All Totals:		18	67	137	213	392	49	415	59	344	268	101	518	1082	3646

Tri-County Family Advocacy Training: Oregon Family Support Network

Goals	Activities	Measures	Results
Engage native Spanish speaking family members in increasing their advocacy skills	4 Special Education trainings	Attendance at training offered Participant satisfaction	Reached out to cultural informants in Benton county and meetings are scheduled to discuss format

	2 Advocacy skill building trainings		Translation of advocacy training materials scheduled to be completed by April 1, 2016.
Provide a spectrum of Collaborative Problem Solving training in Lincoln County	1 Introductory CPS training 1 Tier One CPS Training 12 Parent Mentor groups	Family members engaged in CPS Parent Mentor groups Providers will seek further training and implementation of the CPS model	One Introductory CPS training was delivered in Lincoln County (Newport) on March 2, 2016. 12 participants. 100% of evaluations indicate satisfied or very satisfied participants.
Provide training for families and providers related to the experience of trauma and best practices for reducing re-traumatization	5 trainings on Trauma and the Impact	Attendance at training offered Participant satisfaction	One trauma training delivered in Lincoln County (Newport) on March 27th, 2016. 24 participants plus 7 youth attended. 100% of evaluations indicate satisfied or very satisfied participants.

Universal Prenatal Screening: Benton, Lincoln and Linn Co OB Clinics and Hospitals			
Goals	**Activities**	**Measures**	**Results**
Establish and formalize referral process for A&D, Mental Health, Tobacco and DV/ IPV	Meet with A & D and mental health from all 3 counties Work with Tobacco Prevention Coalition Connect with CARDV and My Sister's Place (DV/IPV)	One Navigator for each county for A &D and mental health Simplify referral process to Quit Line Formalize warm handoffs with DV/ IPV centers # of warm handoffs for A&D and Mental Health.	One Navigator for each county was identified for warm handoffs for A&D referral and mental health connections Quit Line information provided to all OB clinics, template in Epic for electronic fax referral Face to face introduction to clinic staff with representatives from CARDV and My Sister's Place There were approximately 8 warm handoffs each month from all OB offices
Train nurses, MAs, midwives, PAs, ARNPs, MCCs, lactation consultants and Physicians on	Develop a training program and training	Training program	Over 120 nurses, medical assistants, maternal care coordinators and office staff have received a two hour training on the stated topics by a SBIRT/ MI trainer. Some non-SHS or TCC midwives also attended the

topics in the 5Ps screening, SBIRT and brief MI	manual Provide training (1-3 hours) Identify ongoing training needs	Number of staff trained	training. Approximately 20 obstetrical providers have received a 1 hour training. Over 60 nurses/ lactation consultant have been trained in talking to women about substance use and how to facilitate a warm handoff. The 2 hours training was videotaped and is available on the SHS website. The substance use and breastfeeding training was also filmed and will be available online soon. Staff identified several situations in which there are difficulties screening. These scenarios were acted out and filmed and will be used during the additional training that is part of the Maternal Health Connections Pilot project.
Implement standardized, universal screening using the 5Ps at 2 prenatal visits and at time of delivery, integrate into Epic	Integrate the 5Ps into Epic Begin screening of all women regardless of pregnancy stage	Number of women screened at least once	5Ps in Documentation Flowsheet, BPA alert Of the 1700 initial prenatal visits from March 1- Dec 31, 1638 women were screened at least once (96%).
Implement urine drug testing/ screening by consent	Verbal consent protocol for UDS Protocol for testing at first prenatal visit, mid-term and at time of delivery	Number of women with positive screens	We were unable to pull this information from Epic, linked to the results of the verbal screening.
Provide clinics with public health literature on Marijuana Use during pregnancy, breastfeeding and when caring for children; literature on substance use and breastfeeding, and a booklet for mothers on opiates regarding neonatal abstinence	Develop messaging around these topics, Develop literacy level appropriate literature, Translate into Spanish	Marijuana and your baby brochure Safe and Health breastfeeding flyer Drugs, medications and	These three pieces were develop with the help if IHN-CCO marketing. They are available in English and Spanish. An initial stock has been provided to the clinics. Ongoing need for these material will be funded by the clinics.

syndrome		your baby booklet	

Youth Wraparound and Emergency Shelter, Jackson Street Youth Services		
Goals	**Measures**	**Results**
38 youth served in wrap-around case management or shelter services.	Intakes of youth served in shelter, ACCESS database	45 different youth served in respite and emergency shelter. 2 different youth served in transitional shelter. 24 youth engaged in our aftercare services, duplicate numbers for reported shelter numbers. 14 different youth accessing our outreach case management services, not shelter. 173 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	43 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 Individual Support Plan -participate in skill building activities -participate in family mediation or counseling -obtain an InterCommunity Health Network CCO Primary Care Provider and complete an adolescent well-child exam -receive dental services, if needed -be linked to a Qualified Mental Health Assistant, if needed	Number of increasing utilization of community services Number of participating in Individual Support Plan Number of participating in skill building activities Number of participating in family mediation or counseling Number of who obtain an InterCommunity Health Network CCO Primary Care Provider and complete an	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.

	adolescent well-child exam	
	Number receiving dental services, if needed	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.
	Number linked to a Qualified Mental Health Assistant, if needed	Internal Referrals to Mental Health Therapist: 62
	Number of youth who required intensive psychiatric health services through InterCommunity Health Network CCO while in Jackson Street Youth Services care	