2016 Q3 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot
Quarterly Reports
Executive Summary

Objective:

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

Summary of Findings:

1. **Reports Captured:**
   - 23 pilots reported
2. **Pilots Reporting Changes:**
   - 9 Pilots reporting changes

Elements of Transformation and CHIP Areas Addressed by Q3 Pilots:

Q3 Transformation Element CHIP Crosswalk

			APM	CAPEI	CPC	CVAIS	CMA_S	CRCS	CHW	CP	DMID	HN_HP	HPC	LCSW_PCPCH	MHC	PM_PCPCH	PMH	PPC	PWI	P_HL_I	PCPC	SNN	TFAT	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		■				■	■	■		■	■	■	■	■		■	■	■		■	■	■

Numbers refer to Outcomes and Indicator Concepts in the the CHIP Addendum 2016

		APM	CAPEI	CPC	CVAIS	CMA_S	CRCS	CHW	CP	DMID	HN_HP	HPC	LCSW_PCPCH	MHC	PM_PCPCH	PMH	PPC	PWI	P_HL_I	PCPC	SNN	TFAT	YWES
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	1,2,3		2,3
	Behavioral Health		1,3	2		2			3		3		1,2	1,2,3	1	2		2	1,3	2	1,3		1,3
	Child Health		1,2,4								2			2,3		4						1	1,4
	Chronic Disease Management and Prevention							2	1		2,3								2,3				
	Maternal Health		3			1								2,3			1						

Approved Pilots

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

Q3 State Metric Crosswalk

State Metrics (Incentives and Penalties)			APM	CAPEI	CPC	CVAIS	CMA_S	CRCS	CHW	CP	DMID	HN_HP	HPC	LCSW_PCPCH	MHC	PHLI	PM_PCPCH	PMH	PPC	PWI	PCPC	SNN	TFAT	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)																		■				

Approved Pilots

Alternative Payments Methodology

Child Abuse Prevention & Early Intervention

Child Psychiatry Capacity

Childhood Vaccine Attitudes and Information Sources

CMA Scribes

Colorectal Cancer Screening

Community Health Worker

Community Paramedic

Dental Medical Integration for Diabetics

Health Navigation and Housing Planning

Home Palliative Care

Licensed Clinical Social Worker PCPCH

Maternal Health Connections

Pain Management in PCPCH

Pediatric Medical Home

Pharmacist Prescribing Contraception

Physician Wellness Initiative

Prevention, Health Literacy and Immunizations

Primary Care Psychiatric Consultation

School/Neighborhood Navigator

Tri-County Family Advocacy Training

Youth Wraparound and Emergency Shelter

Approach:

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

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

Section 1: 2016 Q3 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Alternative Payment Methodology (2): InterCommunity Health Network-CCO — **Carla Jones, Reimbursement Manager**

Successes:

1. In addition to the activities listed in Goals, Measures, Activities and Results to date table, the following has been successful:
    a. 100% PCPCH signed Agreement to transform to a value-based payment methodology.
    b. All checks were received by clinics June 2016.
        i. As a result of this work, IHN-CCO was able to make corrections to internal Primary Care Physician (PCP) clinic assignmentrecords.
    c. Several meetings and conversations have occurred to discuss the roadmap for Alternative Payment Methodology (APM) transformation.
    d. Reports are developed to evaluate utilization and metric performance.
    e. Hired a Provider Reimbursement Coordinator.
    f. Infrastructure changes and Patient Centered Primary Care Home development/restructure is occurring.

Challenges:

1. Having a 3-Phased schedule of payments meant that the time to make change had to be drawn out further.
2. With the Provider roster being inaccurate in our system, we had to make some changes on the amounts to be paid, and agree on the roster.
3. Making change requires engagement by both parties, IHN-CCO had a bit of a resource constraint to assist providers in how to use the funds, and how to measure fund use.
4. Communicating the availability of the funds, and the amount to the right people was difficult. In some cases, the right people didn't get the information on the funds to make a quicker change.

Sustainability Plan:

- IHN-CCO has developed Fully Integrated APM's that monitor Access, Quality, Safety, Utilization and Population Health.
- APM's scheduled for 1/1/17 effective dates:
    - Samaritan Health Services (PCP's, Specialists, and Hospital services)
    - Samaritan Health Services Mental Health (child mental health services)
    - Dental Care Organziations (DCO) (all dental services from all 4 DCO's)
    - County Mental Health (all mental health services for all three counties)
    - Traditional Health Worker entities
- IHN-CCO has developed a roadmap and plan for operationalizing all models.

Additional Information: Here are a couple of quotes from PCPCH clinics on how they have been transforming their PCPCH sites in preparation for quality driven payment:

- **Quote 1:** These resources have been invaluable in helping us to provide better, more timely patient care. The care coordinators are proactive in ensuring patients are following through on provider instructions, i.e. meds, referrals, etc. The Licensed Clinical Social Workers (LCSWs) and Behavioral Psychologist, take warm hand-offs from the primary care doctors, which increases patient compliance, patient access, and patient satisfaction. The care coordinators, Mental Health providers and Behavioral Psychologist are not only patient satisfiers, they are also provider satisfiers.
- **Quote 2:** We have already seen an improvement in access to mental health services as we continue to meet the mental health needs of our patients. We continue to get almost daily calls from the local Emergency Room (ER) nurse manager so we can follow up on emergency visits; we also try to get our post hospitalization patients in for a quick follow up visit as needed. We now have a Spanish speaking Medical Assistant, and he is doing an

excellent job of outreach to our Spanish speaking community regarding diabetes education and follow up, nutrition, lipid counseling, childhood exams and needs. We have more Spanish handouts to share with these folks. We performed Adolescent Wellness Visits via a more robust sports physicals at the local Middle and High school two times this summer, and clinic staff came along and we interfaced with school staff and coaches, some parents and many students regarding exercise, nutrition, obesity prevention and treatment ideas, safe activities, adolescent growth and development including mental health, talked with a few kids about contraception, immunizations - especially the Human Papillomavirus immunization, safety, tobacco, alcohol and drugs. We are attending an upcoming web-based certification program for our clinic type with the goal of improving care for our patients

- **Quote 3:** We increased staffing and have worked to reduce physician and staff burnout over the past year. The increased staffing has enabled the clinic to increase its phone access to patients and has reduced the turnaround time on facilitating patient requests. The increased staffing has also helped facilitate patient outreach by contacting patients due for office visits and/or preventative screenings. Staff training has been a priority for the clinic over the past year as well. These trainings help reinforce the organization's mission and better empower staff and providers to meet new quality initiatives and workflow changes.

Breastfeeding Support Services — **Cindy Cole, RD, LD**

Successes:

1. Successfully hired a qualified International Board Certified Lactation Consultant (IBCLC) for the position of lactation consultant at Mid Valley Pediatrics. Training in Women Infant and Children (WIC) processes is ongoing.
2. Met with Mid Valley Pediatric office managers and clinical staff to begin planning space, equipment needs, schedules, and referral and communication process.
3. Participated in a legislative work session regarding licensure of IBCLCs
4. Display board regarding this pilot project award was created and shared with WIC staff at Oregon WIC Statewide meeting.

Challenges:

1. We assumed it would be possible to query baseline breastfeeding rates and use of infant formula from EPIC. So far this information does not seem to be available. New contacts for EPIC have been made and further discussion is planned.
2. Office space availability at Mid Valley Pediatrics has changed. We are now re-working our equipment needs and space use.

Significant Changes: We may need to adjust our data collection expectations regarding breastfeeding rates. A meeting with EPIC experts is planned to learn how we can query this data or re-adjust our goals and measures.

Budget Changes:

- Computer, software and printer costs are now higher than originally estimated.
- Change of office location in Mid Valley Pediatric clinic will require unanticipated furniture purchase.

Sustainability Plan:

- Two Linn County WIC IBCLCs participated in a legislative work session at the State Capitol on Sept 15, 2016 attended by a state legislator, insurance representatives, IBCLC champions from WIC and around the state, and licensure experts.
- A bill is being drafted regarding licensure of IBLCLs in Oregon.
- We will be attending future meetings on this topic with State WIC staff and others involved.

Additional Information: The Linn County WIC program is an active member of the Linn Benton Lincoln Breastfeeding Coalition. The coalition has been updated on the status of this pilot project and has offered full support of the project goals.

Section 1: 2016 Q3 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery	Renee Smith, Executive Director
Successes: 1. Number of families served and meeting markers around immunizations, ASQ and ASQ-SE screenings, referral to PCPCH and support groups/parent education. Also, progress on APM and operationalizing of pilot.	***Challenges:*** 1. Electronic record goal may be unreachable until other HIPAA and FERPA issues are resolved. We are aligning with other projects-Pollywog and other Community Health Worker (CHW) pilots to see how it can be done.
Sustainability Plan: • Continues progress to operationalize pilot with APM model. Should be completed by 12/30/2016.	

Childhood Vaccine Attitude & Information Source: BCHD	Jessica Deas, Public Health Planner
Successes: 1. The third quarter of this project was devoted to wrapping up data collection and moving into our final phase: data analysis and gathering results. By the end of July we wrapped up interviews and focus groups, and sent off all audio files for transcription. August was largely devoted to cleaning, coding, and organizing the data into themes. By mid-September, we had completed our code book and theme documents, and currently have rough drafts of our results in both narrative form and presentation slide deck. The final pieces should come together before the end of October: getting our results out to the community and wrapping up this project in its entirety.	***Challenges:*** 1. Due to scheduling difficulties, we were unable to fill all focus group sessions. In order to even out our participant list, we added one-on-one interviews to our methods, focusing on two groups that were previously underrepresented (Lincoln County parents and vaccine hesitant parents). The six one-on-one interviews raised our participation levels from 33 to 39 and evened out the geographic distribution of participation.
Sustainability Plan: We have been accepted to present our work at the Oregon Public Health Association annual Conference in early October. By sharing our results we hope to influence future local communication, interventions, and policy on child vaccination in order to improve health in our region and or IHN-CCO members.	
Additional Information: We look forward to sending our results soon along with our project wrap up report.	

CMA Scribes: Family Medicine Residency Clinic	Scott Balzer, PMG Operations Manager
Successes: 1. The successes of the pilot thus far includes being able to enter into a contract with ScribeAmerica who has been able to find a substantial amount of applicants for the scribe positions and inheriting lessons learned from the tribulations of hiring or training scribes. We are confident that if this pilot is a success, other clinics will follow our example in going with a vendor to supply scribes instead of training or hiring our own. 2. Scribe coverage for 5 of our providers has increased to 100%. Over 125 office visits per week are being conducted now with a scribe present for	***Challenges:*** 1. Now that the scribes have been implemented and efficiency is already being seen, we will need to start incorporating more visits into the provider's day to increase revenue which will offset the cost. Pre-visit planning implantation more fully across the clinic will help plan for opportunities to see more patients during the day.

the provider and Certified Medical Assistant (CMA). Providers are working more efficiently and are spending less time charting between office visits and at the end of the day Scribes have been able to go through a checklist of items with CMA's to ensure that outstanding quality metrics are met before, during and/or after the office visit. The addition of the scribe to the provider/CMA team has help standardize office visits and pre-visit planning, which in return helps efficiency and quality.

Significant Changes: Fall risk, breast cancer screening and care plan implantation measure have dropped. These measures did not align well with the intent of the scribes being implanted and would have very little impact. We substituted the metrics with other metrics that are more in line with IHN-CCO initiatives and ones that scribes can play a more integral role in. Adolescent well-care visits was added as it is a metric the clinic is needing to focus more on and scribes can ensure correct documentation is had when an adolescent patient comes for an office visit. Contraceptive use screening was also added and this metric is below the goal for the clinic and scribes can help catch this during office visits.

Sustainability Plan: Efficiency has been observed and standardization regarding workflows has been improving. Providers are starting to feel more comfortable using scribes and we predict that one office visit per half day will be added to each provider's schedule by the end of next quarter. This will increase access and productivity. The increased productivity should offset the cost.

Additional Information: Many initiatives are happening to improve quality within the clinic. The implantation of scribes has improved provider satisfaction and reduced fatigue. The prediction is that few efforts could affect provider burnout as much as an addition of another medical assistant and/or scribe.

Chrysalis Therapeutic Support Groups: Trillium Services Benton County High Schools — **Lana Shotwell, Vice President**

Successes:

1. We are currently recruiting at the 5 school sites. We have identified school staff to co-facilitate 4 of the groups with our Trillium therapists. AtMonroe High School, we will have 2 Trillium therapists run the group because the only female school counselor is out on leave. All five of the groups have identified the day/time of their Chrysalis groups and have secured confidential space with the schools where the groups will be held.
2. Corvallis High School is currently conducting interviews and has been generating good referrals.
3. Crescent Valley HS has completed most of their interviews and has had 9 girls verbally express intent to participate in group. They are waiting for intake forms to be returned and are doing a few more interviews in order to try and start the year with about 12 participants. They aim to start their first group on the 13th of October.
4. Monroe HS has interviewed 6 students so far, all of whom expressed interest. They are waiting for packets to be returned and are attempting to get more referrals to interview.

Challenges:

1. Challenges have been getting enough referrals to start group at Monroe HS. Ideally group will start with 10 to 12 participants but the school only has a population of 125 students. We met to brainstorm alternative referral sources who may know of any students who would be eligible for group. We have staff reaching out to the identified referral sources to attempt to access any other eligible students. Trillium will continue to attempt to work with the school to build referrals to this group. This is also the school with 2 Trillium therapists which can make identifying students harder. Trillium staff attempted to work with the school counselor on maternity leave, explaining that she could start the group late when she returned to work. However, she declined so we will have 2 Trillium therapists facilitating which is something we have done in the Metro area when needed.

5. West Albany HS is currently conducting interviews.
6. Philomath HS had a list of 20 referrals and are completing interviews as well as waiting for intake packets to be returned. They are hoping to start group on October 5th if they have enough completed packets to start.

Significant Changes: As stated in our proposal, we looked closely at the measures over the summer to determine which would give us the best information and data. We have changed them slightly. We will be doing pre/post tests of PHQ-A, SCARED, BECK Youth Self Concept, and the ACES. We discontinued the use of the ACORN this year in all of our Chrysalis groups, because of on-going difficulties with using the tool in the group setting. The ACORN was designed for individual sessions, and after years of attempting to use it in our prevention groups, we have decided to use other tools. Because the groups have not started yet, we do not have any results to date.

Budget Changes:

- There have been some increased expenses in some of the activities because of services costing more to travel to the schools. For example, we contract with SYNERGO for team building and One with Heart for Self-Defense classes. Both of these services will cost more because they will have to travel from the Portland area to provide services. These agencies are strong Chrysalis partners that are skilled at working with our program and there were no clear alternatives closer to the Corvallis area.
- We have had success in finding local yoga studios for partnership in the Corvallis area.

Sustainability Plan: We are excited by the opportunity to gather data showing improved graduation and attendance rates proving the effectiveness of the program, therefore improving the program's sustainability by potentially offering it to school districts. School district support would improve the program's sustainability by having schools pay for the program beyond the IHN-CCO pilot project time period.

Colorectal Screening Campaign: InterCommunity Health Network-CCO — **Stephanie Jensen, on behalf of the IHN-CCO CRCS Pilot Committee**

Successes:

1. Compiling results for evaluation and drafting evaluation. Working with Madison Avenue Collective, a design firm, to create evaluation materials to have a professional product for dissemination.

Challenges:

1. Challenges: Continued feedback from clinics after the pilot finished.
2. Addressing: Reaching out to clinic managers via email and phone and ensuring we have the best contact for reviewing evaluation materials.

Sustainability Plan: Preparing evaluation in formats for different audiences. Sharing first draft of evaluation with clinics to get feedback. Developing strategies for sharing evaluation results with clinics, local Quality Management Committee, and health systems leaders.

Community Health Worker (CHW) — **Kelly Volkmann, Health Navigator Program Manager**

Successes:

1. The integration of the Health Navigators (HN) into the clinics continues to be successful. We are seeing increasing touch numbers across all clinics, and referrals are flowing smoothly between providers – Registered Nurses (RN) – Licensed Clinical Social Workers (LCSWs)– HNs.
2. Having the HNs trained to do Living Well with Chronic Disease classes and then having them facilitate the class alongside the RN has been a good use of the Health Navigators (HN) skill and a good pairing for the RN/HN.

Challenges:

1. The challenge at this stage is breaking down the time/touch relationship. We are moving into contract discussions and need to be able to see how much time each specific touch takes. The way we have been capturing the touches isn't letting us see that level of detail – we have been recording how long an encounter takes and how many touches were involved within the encounter. Part of the issue is that we are tracking touches on an excel spreadsheet, since there is no way to track them in EPIC at this time. We

are brainstorming as a group and I have confidence we will come up with a better way to measure this.
Sustainability Plan: I am very pleased to report that we have been meeting with the Reimbursement Manager at IHN-CCO to determine how we can move forward with contracting for the HN services at these clinics. As explained in the "Challenges" section, we are working on developing a useful time/touch tracking method.
Stories From The Field: gives client-level stories from each clinic that highlights the work of the CHW/HN. **Geary Street Clinic: (This is a continuation of the Q-2 story)** Patient called and asked if I could go on a walk with him. We have gone walking a number of times for about 20 mins in the morning. Patient expressed on his walk how much better he feels and feels comfortable that he has someone with him. I've gone with him to a couple of doctors' appointments to just sit in the lobby with him until he's called back. He also has a fear of going to the grocery store and usually sends someone to do it for him. Most recently, he has called and asked me to go with him to the store. I made sure to keep him talking and moving through the store and not bring up his anxiety. At the end of our trip I asked him how he felt, he said there were a few times he wanted to turn around and leave, but decided to make a joke and keep the conversation flowing instead and this helped him a lot! **Mid-Valley Children's Clinic:** A Spanish speaking family was referred to me due to two children being overweight. The physician informed me that the mom was motivated and wanted me to keep the momentum going to support lifestyle changes. I scheduled a self-management appointment and it went great! We discussed physical activity and they were thrilled about the flexible spending funds paying for YMCA membership. I told mom that I could help them with the process and if needed accompany them to the grocery store for some shopping. She was so excited - she said they wanted to make lifestyle changes because dad was diagnosed as being pre-diabetic but they had no idea where to start. We met at Fred Meyer the following week. The mom did not really understand labels and the carb to fiber ratio, so I drew it for her on a notepad and she got it! After that we walked around the store and she applied what she had learned to purchase food. Her facial expressions were priceless. Even the children were making good choices for snacks. The mom told me "We have never looked at the nutrition label. All we ever looked at were the pictures but now I understand how to read the labels and that we don't have to stop eating what we like." It was a great experience for me and very rewarding. Two weeks later I informed mom of the approval of the flexible funds and we met at the YMCA to enroll the children. They were so excited to start using the facility when they were given their passes. I informed mom of the scholarship available for mom and dad and we filled out the application then and there. I will be following up with this family in three weeks to see how things are going and maybe schedule a follow-up self-management appt. **Samaritan Family Medicine:** I recently received a thank you card from a patient I was able to help in early August. When I first met her I could tell that she had a feeling of worthlessness; she felt like she was a burden on everyone (her care team). She was referred to me as a warm hand-off from her PCP for help with insurance. She was hesitant to accept my assistance with an Oregon Health Plan (OHP) application because she didn't want to take up my time. She was worried about the cost of health insurance as she had recently lost her job. I explained to her that my role as a member of her care team was to make sure that she had access to the resources she needed. I also explained the basics of the Oregon Health Plan. She was able to leave the clinic with full OHP benefits, a print out with her member ID that she could take to the pharmacy, and my business card in case she had any issues. A few days later she called stating that she was having issues getting her prescriptions filled at the pharmacy; I spoke to the pharmacy, gave them the information they needed, and she was able to leave with her medications. After her last appointment with her PCP she dropped off a thank you card on my desk that said, "Thank you so very much for taking so much time to help me get health insurance, then following up with me. I really appreciate and sincerely value what you do, and how kind you were. Thank you!!". **Samaritan Internal Medicine:** This month I have been working with a patient who was dropped from Home Health Services for not being "accessible" by phone

and not being able to be reached by Home Health. The patient was unaware that her services were going to be dropped for not being home when they had come to renew her services. Patient's phone had been shut off due to non-payment of her bill and she had no way of contacting anyone at the clinic to help her. She has no family in the area, and lives on her own without being checked on regularly. I had dropped by her house one day to see how she was doing as I hadn't heard from her or seen her in the clinic for a month or so. When I got there the patient told me everything that had happened since I last saw her. She hadn't been seen by a provider all month, her medicines weren't delivered, her pill boxes were not filled, and she had just been completely dropped without any explanation. The patient was beyond upset and had no idea how to go about fixing all this.
I contacted Home Health and spoke with her previous Home Health nurse who helped me figure out what to do next. We had to restart the patient process to be able to be seen by Home Health, which included getting the patient to come into the office for an appointment to determine if she was eligible to receive the services again. I was able to get her an appointment immediately with her provider and connected her with dial a bus to bring her so it wouldn't be missed. This was a crucial appointment to get things going again. Once her provider was able to evaluate her and get a note to home health for services, she was able to be seen in the home again.
This patient has felt cheated by the medical system and she was very upset and did not want to be seen by just anyone. Patient and I have worked together on connecting resources and have built a relationship based on honesty and trust, as no one was able to give that to her during this time. The patient now has a phone, which gives her 500 minutes a month to contact family, dial a bus, her doctors, etc., and this has been a huge help. I showed her how to use the phone and programmed it for her to be easy for her to use. She has been connected to the right resources and her trust in the system is slowly being rebuilt.

Community Helping Addicts Negotiate Change	**Jeff Blackford, Executive Director**
Successes: 1. Partnerships and our peer tracking. I hope we can duplicate it for other organizations.	***Challenges:*** 1. Have not had any real challenges lately.
Significant Changes: Working toward an Alternative Payment Method. It is scary, but welcoming for sustainability. We want to expand to Benton and Lincoln Counties.	
Sustainability Plan: We are trying to add additional contracts and go after grants so we can grow our program and sustain the programs. We are also adding programs that will allow us to "bill for service" (Respite Care and Peer Support Specialist training). We are adding other programs that might allow new contracts to form with other agencies.	
Additional Information: Being a part of the Traditional Health Workers (THWs) and the Transformation work group and the Delivery Systems Transformation Committee (DST) has allowed natural connections to happen and create a welcoming support. I am very thankful that IHN-CCO has been a wonderful partner and sees value in what we do. We look forward to growing with IHN-CCO and be the model for Peer delivered services for all of Oregon.	

Community Paramedic: Albany Fire Department	**Lorri Hedrick, Senior Administrative Supervisor**
Successes: 1. We have seen a reduction in the number of IHN-CCO members transported to the emergency room. • Overall patient transports have increased by 8.1%. • Since inception of the program transports of IHN-CCO members decreased from 15.9% to 14.4% of total transports.	***Challenges:*** 1. Lack of Referrals from Healthcare Providers - In the first three quarters 76% of patient referrals were within our organization and the remaining 24% from outside sources (law enforcement, Mental Health, Senior & Disability Services, Volunteer Caregivers, friends/family). Other healthcare provider and physician referrals are essential to accessing the IHN-CCO

- IHN-CCO patient transports decreased by 6.6% over first nine months of pilot program.
- Number of Fire Department emergency responses dropped by 17.5% to the IHN-CCO top ten users of emergency medical services.

patient community in need of Community Paramedic Program services.

2. Toward that end, we are meeting with Samaritan Health System representatives from the Emergency Department, Discharge Coordinators, First Care Physicians, Home Health, Wound Care, and Patient Care Services. We are on the cusp of establishing a referral program with Samaritan and expect to be integrated into their system within the next six months.
3. Limited to one Community Paramedic – With one paramedic we are limited to service 40 hours/week, Monday through Friday. In order for the healthcare provider referral system to be fully effective, the ability to provide this service on weekends is important. We are also evaluating expansion of the program into East Linn County with the Lebanon Fire District to provide a second Community Paramedic for additional coverage in both communities.
4. Alternative Payment Methodology (APM) - Long-term funding is not obtainable through traditional Fire Department.

Significant Changes: The goal to reduce the number of ambulance transports to the emergency department of IHN-CCO members to alternative care was intended to be a new system for ambulance transport to alternative care. It is evident now that this exceeds the scope of this pilot program and should be eliminated as a program goal.

Sustainability Plan: We are having conversations with IHN-CCO and Samaritan Health Services to address APM and a referral system from other healthcare providers. The meetings have included hospital discharge coordinators, physicians, Emergency Department managers, and Home Health. Samaritan has recently expressed interest in also coordinating this program with Palliative Care.

Additional Information:

- The Community Paramedic (CP) has worked with a 56-year old, morbidly obese male who has been a frequent user of 9-1-1 for the past ten years. He has a history of falling, among other medical needs, and his wife is his primary caregiver. An emergency response with this client typically requires a minimum of four people. He was referred to the CP by Albany Fire Department emergency responders in February.
- The CP's in-home evaluation identified the reason for his frequent falls and determined the need for a Hoyer lift and improvements to a ramp that would allow the client to safely exit the home. The CP connected the client with Senior and Disability Services for a re-evaluation to increase hours of service, aided him in obtaining a Hoyer lift through insurance benefits, and coordinated with Volunteer Caregivers to make the needed improvement to the ramp.
- Since the CP's initial contact with this client, the number of emergency calls has been reduced from multiple calls in a week's or even days' time to only two in the past seven months for medically necessary transport.

Dental Medical Integration for Diabetes	**Britny Chandler, Dental Program Clinical Coordinator**
Successes:	***Challenges:***
1. Implementation within Lincoln County Health and Human Services.	1. Inability to send secure email to and from Lincoln County Health and

2. Increased response rate from mailers.	Human Services. We are faxing Personal Health Information appropriately according to HIPAA standards. 2. Low member response to direct mailers. We have offered incentive gift cards to members who have not utilized their dental services. First round of incentive mailers were distributed late August/early September and since we have received a few more responses than usual. 3. Lack of direct communication between the Primary Care Physicians and the Primary Care Dentistal clinics. 4. Infrequency of monthly reporting from pilot participants.

Sustainability Plan:

- The dental workgroup convened and discussed pilot activities sustainability. Topics discussed were defining flexible services in regards to dental education handouts and oral hygiene bag distribution in a medical office setting.
- As dental plan contracts develop, our coordinated efforts to move towards Alternative Payment Methods leads to more opportunities to reimburse for care coordination that has been developed and integrated from the pilot's efforts.

Health and Housing Planing Initiative: Willamette Neighborhood Housing Services (WNHS) — **Brigetta Olson, Deputy Director**

Successes:

1. Eviction prevention and intervention: From January through August health navigators served 53 WNHS households with eviction prevention services and successfully stabilized all residents in their home.
2. Resident referral success: A disabled senior resident has had a complete life turn around after suffering from depression and pain medication withdrawal. She now has a caregiver and is enrolled in the PEARLS program (Program to Encourage Active and Rewarding Lives). Both the caregiver and PEARLS were made available to her after making a referral to Aging and Disability Resource Connection (ADRC). It all started with an evaluation of her physical and mental health needs. The assistance she gets from her caregiver with her "activities of daily living" has made it so that she has the energy and support needed to engage the world. The PEARLS program has helped her identify those things that are meaningful to her and then create action plans around them. This resident is now more energetic, motivated and active than she was before having a caregiver and involvement with the PEARLS program. All this because she received 20 hours of caregiver services a month and a few hours with her PEARLS counselor when needed.
3. Increased capacity and time for building trust: At our most vulnerable

Challenges:

1. Data collection and privacy remain our biggest challenge. As an owner of affordable housing and nonprofit community development agency we are not only a landlord but an agency that is now providing health navigation services to our tenants. We know that health and housing are directly related. At the same time, we are very sensitive to our residents confidentially and are not comfortable sharing private information with their health care provider or IHN-CCO. We continue to work with the Regional Health Initiative Collaborative (RHIC) team for creative solutions for data sharing to increase community health outcomes.
2. Additionally we collect data in two different places, we utilize our excel document to track our "touches" as well as Family Metrics, a social services software to track resident and household demographics, financial information and resident contact. We have been unable to figure out how to merge these tracking programs so that we can collect data in one place.
3. Accessing available dental health benefits is very challenging as there does not appear to be many resources for many residents, especially those who are on Medicare and/or dual eligible.

property, the Hotel Julian, the majority of residents are either seniors or person with disabilities or both. With an additional health navigator we have been able to dedicate at least three hours of staff time on site each week. This has enabled our Health Navigator to build trusting relationships with the most isolated residents. One resident has severe mental health issues and usually hides in her apartment with the doors locked. Because of our increased presence our Health Navigator has gotten to know this client and is working with her to figure out how to work with property management to minimize the distress on such a vulnerable resident. The Property Manager has commented that even reclusive residents have been reaching out to the Health Navigator.

4. Continued programming: Corvallis Family Table, a free nourishing meal program offered two times a month has been an excellent place to connect with residents, distribute health information, and provide blood pressure and blood sugar screenings. Gentle Strong Yoga at Alexander Court continues to be successful, providing weekly low-cost to no-cost yoga with free childcare.

Budget Changes: One of our two health navigators resigned on August 1st and we have received a no-cost extension through September 2017.

Sustainability Plan:

- We have received two grants to sustain this program past this quarter.
- We have received two NeighborWorks America grants to help sustain the Health Navigation Services after the pilot. We will be working with other organizations across the nation to identify best practices linking health and housing services.

Additional Information: WNHS Health Navigators has been a consistent presence at our properties, offering health services and supportive health coaching to residents as needed. Recently, a Health Navigator has been working closely with a senior resident to sort out her medical benefits. This need arose after the health navigator worked with the resident to address dental care needs. This process has been going really slow because the bureaucratic nature of the health service system, but they have been making progress. During the last two months the Health Navigator has been able to develop trust with the resident and the resident disclosed the anxiety she has around old, unpaid medical bills. The Health Navigator is now working with the resident to tackle the debt in a way that will impact her the least. This is a relationship that the Health Navigator is proud of because it has been developed over time and with each visit the resident is more open to work on other existing needs and challenges. The Property Manager recently noted that he thinks she smiles more and has a more positive disposition since we have started working with her.

Home Palliative Care: Benton County Hospice — **Kelly Beard, Executive Director**

Successes:

1. We have been successful in reducing hospitalizations and Emergency Room (ER) visits for the majority of our patients (excluding two high utilization outliers) and also in improving symptom management and

Challenges:

1. We continue to have low participation in the palliative care pilot even though we believe there are patients that would benefit from palliative care. To address this issue we have agreed to partner with Samaritan

overall satisfaction with healthcare per patient report on initial and follow up surveys.	Evergreen's Palliative Care pilot to jointly educate the medical community about the palliative care pilots including the various models, services and goals of the pilots. We will also work with Samaritan to add Palliative Care referral and order sets in EPIC to facilitate ease of referral for Samaritan Providers as requested by multiple SHS providers. Lastly, unless we significantly increase the number of patients served by the pilot in the next quarter, we will request a 6 month extension of the pilot to increase the number of patients served by the pilot. At this time we do not anticipate a request for additional funds, only time. 2. We have experienced difficulty in obtaining timely prior authorizations for medications and medical supplies (paracenteses kits) that has impacted our ability to keep patients from going to the hospital. One particular patient had to go to the hospital multiple times because we were unable to obtain the needed kits from IHN-CCO. This drastically impacted our outcome results this quarter. When this patient is excluded from the statistics, our outcomes significantly improved. We have met with IHN-CCO and are working to define a process that would either expedite or eliminate the need for prior authorization for palliative care patients for medications or supplies such as paracenteses kits, which are not included in the limited supplies provided through the palliative care pilot. 3. One patient on palliative care with a behaviorally complex dementia and delirium, residing in an assisted living facility which was not an appropriate match for her needs, drastically impacted our outcome results and when excluded our outcome results significantly increased. 4. We have developed additional exclusion criteria for the palliative care program as listed below as these factors severely impact our ability to adequately serve these patients. • Primary reason for acute care utilization is unstable psychiatric condition or active substance disorder • Patient does not have a primary care provider or specialist to oversee care plan • Chronic pain without a serious life-threatening illness 5. We have found that patients self-reporting symptom management is difficult to measure overall wellbeing as many of the patients have comorbidities and while some symptoms are now being managed very well others are still causing them concern and are impacting their overall

quality of life.

Significant Changes: We started looking at Emergency Department (ED) visits and hospitalizations that may have been prevented if the Benton hospice staff had appropriate resources to meet patient needs. During this quarter there were 9 emergency department visits and 4 hospitalizations. We feel that several emergency room visits and hospitalizations could have been prevented if the Benton hospice staff had timely access to appropriate resources to assist the patient.

Sustainability Plan: Pilot met with IHN-CCO on September 29th to discuss a path towards sustainability as well as discuss some challenges with the IHN-CCO system in expediting authorizations for medications and obtaining supplies that are needed to keep patients from going to the hospital. We discussed various payment methodologies that could be utilized post pilot, including fee for service, per member per day/month, and per episode of care. We will follow up again as we come closer to the pilot end date.

Additional Information: Comments are quoted from participants in the Palliative Care Program

- "As time goes on, it gets better. Super reassuring to have you around".
- "Benton Hospice Services went above and beyond in the support for the facility staff and the number of visits. After meds were changed the patient did a lot better" (from facility staff where patient resided, patient unable to answer).
- "I wouldn't be here if not for them and all their work. My house of cards fell down around me and I couldn't do this on my own".
- "The team gives me a lot of support. They are very friendly and help with whatever I need".

Improving Pain Outcomes and the Patient Provider & Therapy Referral Care Pathway	**Kevin Cuccaro, DO**
Successes: 1. Intervention started this month and no successes or challenges noticed at this time (too soon to tell).	***Challenges:*** 1. Intervention started this month and no successes or challenges noticed at this time (too soon to tell).

Maternal Health Connections: Family Tree Relief Nursery (FTRN) & Benton County Health Services (BCHS)	**Carissa Cousins, MD**
Successes: 1. FTRN - 2 staff trained and certified; Referrals from Maternity Care Coordinator; Served 27 mothers and 21 children. 2. BCHS – 1 Community Health Worker (CHW) trained; has worked with 38 mothers with Linn County Public Health Maternity Case Management (MCM) and 11 mothers with Albany Obstetrics clinic; placing Community Health Worker (CHW) with Linn County Public Health has been very successful for building relationships with public health staff, programs, and community.	***Challenges:*** 1. FTRN: • Staff turnover – we lost an amazing Community Health Worker (CHW) and had to rehire • Access to the certified CHW training in Portland is limited and expensive – we are waiting for the next cohort to send our CHW. 2. BCHS: • Access to the certified CHW training in Portland is limited and expensive – we are also waiting for the next cohort. • OB clinic staff are very busy and have had limited capacity to engage the project - we worked out a system for the patient to engage directly with the RN at the downtown OB clinic and placed her with Linn County MCM program 2 days/week instead of just 1 3. Prenatal Screenings:

- More providers need training in Motivational Interviewing and Brief Negotiated Interviewing – Will add an additional training

4. Lack of Social Determinants of Health Screening by health care staff – looking at ways to better address this issue.

Sustainability Plan: Both FTRN and BCHS are in separate discussions with IHN-CCO about how to contract for Traditional Health Workers (THWs) services. If this can happen, then this pilot will be sustainable.

Additional Information: We have had our first successful "tri-agency referral" that went from the OB clinic through the CHW (hired by BCHS) to the CHW from FTRN so that the pregnant mom can access appropriate alcohol and drug services. It took a bit of time to get it working, but now that we have had the first one, more will come!

Pain Management in the Patient Centered Primary Care Home — **Kevin Cuccaro, DO**

Successes:

1. 12 clinics enrolled to date (full participation). Strong participation from Linn County (specifically Lebanon & Sweet Home) and Benton County (Corvallis & Monroe). All Linn-Benton County Health Clinics enrolled—extended staff participation (healthcare providers, medical assistants, behavioral health providers). Two participating clinics in Lincoln County (Toledo & Newport)
2. Overall, program feedback received from participants is strongly positive. Participants recommend this pilot intervention for their colleagues (and other specialties such as Emergency Medicine & Urgent Care).

Challenges:

1. Maintaining consistent evidence-based messaging to patients from both participating clinics and clinicians not in pilot program AND inter-clinic communication (i.e. front office staff, medical assistants, and others not receiving education intervention) continues to create unforeseen difficulties.
2. This has been mentioned on all quarterly reports. Difficulty in addressing it is this pilot intervention is focused on clinical providers' education level. To provide specific, level-appropriate education to additional staff is outside the pilot's scope.

Budget Changes: Budgeted amount for clinician reimbursement exceeded actual participation by $13,000. Savings will be used to train an additional clinc.

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

Successes:

1. The collaboration with mental health and our nutritionist has been extremely beneficial for our patients and our providers. Having the constant presence from both those modalities allows for a seamless process for our patients, as well as our care team.

Challenges:

1. We are actively working on the sustainability of these services moving forward. As with any new or additional programs – ensuring that services can continue to be successful, utilized and sustainable can be challenging.

Sustainability Plan: We have been meeting with each pilot service to discuss and review data; brainstorm payment methods in the future and also review the workflow and workloads to make sure we are using these services to the best ability possible.

Pharmacist Prescribing Contraception — **Penny Reher, Chief Pharmacy Officer**

Successes:

1. All of the pharmacists at the Samaritan outpatient pharmacies successfully completed the Pharmacist Prescribing Contraceptives Course.

Challenges:

1. Time and personnel to develop, implement, and execute this project has been one of the biggest challenges.

- This is being addressed by having a PGY1 Pharmacy resident on a six-week management rotation who is heading this project, get the process developed, and implemented so pharmacists can start seeing patients by the end of the rotation. Patients will be seen at two out of four of the SHS pharmacies.

2. The construction at two of the pharmacy sites has not yet been completed. Although there is grant funding in place to pay for construction, SHS capital funding must be used initially for remodels/construction and then backfilled with grant dollars. Initially it took quite some time for this to be defined and understood and to date; those funds have not been approved.
   - Capital funding has been applied for and approval is pending to be able to move forward with construction. On the other hand, the other two pharmacies already have a private consultation room in place and no construction is needed there.
3. Creating a closed-loop process by utilizing Epic, which was our original goal, has been a challenge because there are numerous restrictions on outpatient pharmacists being granted access to documentation in Epic on the ambulatory side. Documentation of a pharmacist encounter with a patient to prescribe contraceptives in Epic is the most ideal and least labor-intensive way to create a closed loop by using the system that all other providers at Samaritan are using. Access to Epic for outpatient pharmacists was sought out and originally seemed feasible in obtaining; meetings and time were spent pursuing this course of charting and patient referral. Unfortunately, the restrictions and necessities of creating such a process are much more complicated than it may seem on the surface mainly due to the connection of the bill to the encounter and the acquisition of such capabilities are not realistic in a reasonable timeframe. The timeline was originally deemed to be much shorter and now it is clear that a plan B is necessary in creating this closed-loop process outside of Epic. Implementation though, can be nearly immediate once the minimal issues left to do are addressed.
   - This is being addressed by the development of a paper process for referrals to be faxed to the providers' office, a phone call to follow up and ensure the referral was received. The providers then make notes and hand the fax off to medical assistants to make an appointment.

When patients are contacted to schedule an appointment, a telephone encounter is created in Epic so that an electronic paper trail is created to ensure follow up. Pharmacist have read-only access in Epic and can see the appointments a patient is scheduled to have, allowing them to follow up and ensure an appointment has been made, if not the pharmacist will follow up with the provider's office. Pharmacists can also see if the patient attended their appointment and can view the documentation done by the provider to ensure the patient was given some form of contraceptive, thus closing the loop. Each of these steps will be charted in the patients paper chart kept in the pharmacy where patient was seen and documented in the excel spread sheet for data collection.

4. Now that the above process is determined to be the method of the closed-loop process, forms to be faxed are being developed, which will then be shown the clinic supervisors to provide education to the rest of the clinic staff.

Significant Changes:

- The pharmacist will not be able to keep detailed notes in the patients' electronic medical records due to the issue of not being able to access Epic. However, the notes generated from the pharmacist during the visit will be faxed to the primary care provider and they will be scanned in the patients' electronic medical record.
- The pilot leader has not yet met with Public Health from each county. Meetings are being scheduled.

Sustainability Plan: Standardized policies and procedures as well as a comprehensive reference notebook for each outpatient pharmacy are being created, this will allow of updated information to be added when necessary.

Physicians Wellness Intiative: InterCommunity Health Network-CCO — **Jana Svoboda, LIscned Clinical Social Worker**

Successes:

1. Identification of need; clear support for project by administration, managers, providers. Meetings with physicians (about 1/3 complete). Research and literature survey. Collaboration between Oregon State University (OSU), Samaritan Health Plans (SHPO), IHN-CCO, and the willingness of identified clinics to work with the pilot. Additional clinics have requested services.

Challenges:

1. Slow start up because of complexity of collaborating with multiple persons, clinics and institutions. Coordinator was not hired until 6 months into the program; assistant for program was only recently hired and will begin Oct. 17, 2016. OSU study is delayed while students there are cleared by administration, a complex process.
2. While providers have been supportive, scheduling with them is difficult as most are paid on productivity. Interviews are essentially volunteer time. Scheduling lunches or dinners has worked for some.

Sustainability Plan: Research on cost factors of burnout presented to administration and initial interest was shown.

Additional Information: Teams who support the providers are also interested in this pilot and some individuals within teams have been excited to read research

from AMA on LEAN principles staff can adopt to improve the "Fourth Aim" of provider satisfaction.

Pre-Diabetes Bootcamp: Lincoln County	Ruth Morland, RN, OCN and Susan Richwine, RN, OCN
Successes: 1. There has been great support for this program from the healthcare community.	***Challenges:*** 1. One of the challenges has been communication with providers. They are all behind this program and support the concept of pre-diabetes education, but they are so busy and pulled in many different directions that it has been a challenge to get them to participate. We are exploring alternate referral pathways and other ways to promote provider participation, such as through the medical home care coordinators. 2. Staying focused on the goals and measures. As we proceed, additional opprotunties present themselves and discipline is needed to pull ourselves back to the core focus of the pilot.
Sustainability Plan: At every opportunity to discuss and share this program with others, we include the perspective that it is just the start of on-going pre-diabetes education programs, which will be supported by the state and federal government as well as many healthcare organizations and insurance companies.	
Additional Information: The structure has encouraged focus and discipline to enable us to take a concept and move it forward to impact our community. Of course, the money provided for the project is important and necessary, but actually more important to promoting the program is the credibility that IHN-CCO support provides.	

Prevention, Health Literacy & Immunizations: Boys & Girls Club	Emily Barton, Grant Writer Corvallis BGC
Successes: 1. Partnerships with Linn County Health, Benton County Health (BCH), Trillium, and Oregon State University (OSU) School of Pharmacy. Each has been very supportive in planning and participating in various activities. 2. Connecting families to the Oregon Health Plan has been very successful. Many outside organizations have made referrals to Boys & Girls Club of Greater Santiam Application Assister.	***Challenges:*** 1. Boys & Girls Club of Albany immunization Clinic was definitely a challenge. Not having any families show up was disappointing. After talking with the Linn County employees that we worked with, they helped us come up with a plan for gaining interest from families. Sadly, Linn County has been a part of many events such as this where no one attended. We are hoping to hold another immunization clinic closer to the exclusion date, where families are required to fulfill their immunizations for their children to remain in school. 2. Western Medical School – the timing of working with this organization is a challenge because they don't do any new planning until the start of their school year. Therefore we weren't able to get plans in place last school year (like we did with OSU) and now have to wait until October. We still believe that they will be able to train our youth in Diabetes. 3. The success above of having the Boys & Girls Club of Greater Santiam Oregon Health Plan Application Assister is also a challenge. She has had to

request that other Health Navigators stop making referrals of single adult males so that she could focus on assisting families with children.
4. Capacity planning with some partners has been a challenge. We were unable to offer the immunization clinic in Corvallis due to unforeseen capacity challenges with BCH. We have rescheduled to offer a clinic closer to the exclusion date, where families are required to fulfill their immunizations for their children to remain in school.

Significant Changes: The only real change is a reality check on the number of immunizations that we can reasonably expect to administer at the Clubs. We have gotten a lot of families exposed to Health Navigators and Oregon Health Plan, but that has been though family events and not immunization clinics.

Sustainability Plan: All resiliency programs that were developed through Pilot funds are now being incorporated into planned regular year activities.

Additional Information:

- Boys & Girls Club of Greater Santiam Application Assister has been able to make very valuable connections with the schools and has been receiving referrals from counselors. The Boys & Girls Clubs has been such a convenient and non-threatening location for families to come and seek help.
    - There was a family that was referred to our Application Assister from Lebanon High School. The mother had a younger son, and a high school aged daughter with urgent mental health needs. They had just recently moved from Washington and were having difficulties with the Oregon Health Plan application. The son was able to join the other kids in the Club while the mother and the application assister filled out the application. While the mother originally came in solely for application assistance, she found the Boys & Girls Club had several other resources that her family could benefit from. The mother proceeded to sign her son up for the after school program.
- As was mentioned at our last DST review – we believe that the pilot has been beneficial in the following ways:
    1. Reinforces access to kids… "Building sidewalks to where kids are"
        - We believe we are proving that bringing services to where the kids are is a very good model.
    2. Foundation of education being built with kids
        - Our resilience training – while a long-term process - is establishing a strong foundation for our kids
    3. Families will seek information and connection to providers if the services are where the families are
        - We have had overwhelming success connecting families to health navigators and providing information about Oregon Health Plan through family events held at the various Clubs. Families come to the Boys and Girls Clubss and if the right information is there, they will get it.
    4. Providers are gaining information about family needs and behaviors
        - Our partners are gaining information from families and kids that they have not had before and are gaining access to families to be able to ask additional questions. As we shared before, BCH is being connected to a teen focus group to gain more information on how/when/why to run a HPV clinic. This access wouldn't happen without the close partnerships developed as part of this pilot.

School/Neighborhood Navigator: Benton County Health Department	**Kelly Volkman, Health Navigator Program Manager**
Successes:	***Challenges:***
1. This school year has gotten off to a roaring start. The School Navigators (SNs) had 596 touches in September alone. Factors contributing to this are the relationships built last year are continuing and building this year –	1. The challenge this year is going to be keeping the work load at a manageable level and still maintaining the trust and confidence of the community…and the sanity and mental health of the SNs themselves. They

parents already know the SNs and feel comfortable accessing them immediately – and the school staff know what the SNs can do and how they can be used appropriately.	are coming face-to-face with difficult family situations every day and it can be a challenge to maintain the distance needed to be professional while keeping the familiarity that makes up the Community Health Worker. This is always the challenge in this work, and one reason that it is so important to have a cohort of other Health Navigators to belong to – the peer support and mentoring is invaluable.

Sustainability Plan: We have begun to track time spent on all touches, in the same manner that we are doing for our clinical pilot. This will help us align the work to see if there are reimbursable options for Community Health Worker (CHW) work in the school setting.

Navigator Stories from the Field:

Garfield Elementary School: School Navigator (SN) assisted a new student who recently lost a parent and a sibling in a car accident. She came from out of state to live with her aunt. Aunt had no custody paperwork and had health concerns for the child since she was involved in the car accident as well. SN assisted family with OHP application, informed aunt about SNAP, started guardianship paperwork for her, referred her to CASA Latinos Unidos and enrolled them in the McKinney Vento Program. Child was also assisted with Operation School Bell, school supplies and backpack. Since the child needed to be seen by a doctor as soon as possible, SN contacted Benton County. Due to child's situation of not having a father on her birth certificate and mom being deceased with documentation stating this, the child was able to be seen. HN accompanied Aunt to turn in registration packet and to explain the situation. HN will continue to work with Aunt to get counseling services for child and access to other resources.

Lincoln Elementary School: During this summer three girls were enrolled at OSU Bates from two different families. All three were eligible for the program; however transportation was a barrier for these families who live in South Corvallis. These three girls all have older siblings attending Lincoln school. Some of the older students never attended pre-school. In some of these households writing and reading is very minimal. In casual conversation I mentioned this to the family advocate for the school district, and she was determined to find some type of assistance for the families. At the beginning of the new school year 2016-2017, she mentioned how she had connected with South Side Youth Outreach (SSYO). SSYO provides summer school for kids. Two volunteer drivers were willing to make themselves available to transport and they would be using the buses they have available. Today, September 20, was their first day to go see what Headstart is all about and the families were invited to go on the bus with the girls. This could not have happened without ALL of the collaboration between the families, OSU Bates, SSYO, School Family Advocate, and School Navigator. We are excited to have the girls start their first full week of Headstart next week. One of the little girls today did not want to leave school - she wanted to keep playing with her classmates.

Linus Pauling Middle School: SN assisted a new student to establish medical care. The family has recently moved to Oregon from Australia. Their son is diabetic and was not allowed to start school until he had established care with a provider in Oregon that could write a medical protocol for the student. The family did not know where to start. After meeting with the family the SN assisted with the Oregon Health Plan and scheduled a medical appointment at Samaritan Pediatrics. The SN explained the urgency of the situation to the Customer Service Representative at Samaritan Pediatrics, explaining that the student had already missed 3 days of school. They scheduled the student to see the doctor the same day. The student was able to start school the next week. The SN also assisted with the free and reduced lunch application, school bus registration and a Parks and Rec's scholarship application.

Section 1: 2016 Q3 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Sexual Assault Nurse Examiner	Dan Keteri, VP Patient CareServices

Successes:

1. Patient counts (both adult and children) have been higher than expected since Sarah's Place opened.
2. Sarah's Place began receiving clinic referrals in the first month.
3. The community has shown a great deal of interest. Salem would like to start sending pediatric patients to Sarah's Place, and Eugene is talking with Sarah's Place leadership about processes and if/how something can be duplicated in the Eugene area.
4. Sarah's Place is nearly fully staffed; only one open position remains.

Challenges:

1. Access to medication has been an ongoing challenge for Sarah's Place nurses. Initially, Sarah's Place nurses relied on Emergency Department (ED) nurses to pull medications for them; however, ED nurses were hesitant to do so because of liability concerns. This was partially remedied by giving Sarah's Place nurses access to the ED Omnicell; however, this process relies on an ED nurse to either pull medications or sit with the patient in Sarah's Place while the SANE nurse goes to the ED to pull medications. This process adds about 30 minutes to a patient's visit. We are currently remedying this by purchasing an Omnicell for Sarah's Place. We expect the Omnicell to be installed by January 2017.
2. Patient coordination has been a challenge during on-call hours, and has resulted in increased on-call pay costs for the department. Originally when a patient reported to an ED other than Samaritan Albany General Hospital (SAGH), a call was placed to the on-call Sarah's Place nurse and that nurse would arrive at SAGH within 30 minutes to see the patient. However, there were several instances where the patient did not drive directly to Sarah's Place; this meant that the SANE nurse was sitting at Sarah's Place waiting for the patient (for several hours in some instances). A process change has been instituted so that the Sarah's Place nurse now talks directly with the patient to confirm their arrival time. The patient is informed that a SANE nurse and advocate will be waiting for them.

Significant Changes: Yes, for goal 3 we decided against using patient experience surveys to measure success. We feel that calling patients to gauge their satisfaction level can be perceived as insensitive and may unnecessarily cause additional trauma to the patient. We have instead decided to look at wait times (Goal 2) combined with the care provider (trained SANE nurse vs. ED physician). It is expected that if the wait time is low and care is provided by a specially trained SANE nurse, then the patient received proper care to mitigate any additional trauma.

Sustainability Plan:

- Sarah's Place will be supported by SAGH and included in budget planning processes.
- Sarah's Place has been added to the Samaritan Employee Caring Campaign so that employees can make monetary donations to the department during the month of October.
- Sarah's Place has been added to the Samaritan Foundation for additional fundraising efforts in the coming years.

Additional Information: We are currently unable to extract the percentage of Sarah's Place patients that are IHN-CCO members. Since services are not billed to insurance that information is not collected as part of the registration process for Sarah's Place. We are working with our billing department to create a report that will allow us to collect that information as needed in the future.

Section 1: 2016 Q3 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Tri-County Family Advocacy Training: Oregon Family Support Network	Tammi Paul, Statewide Training Program Manager
Successes: 1. This quarter one of the most successful projects was the Trauma training that was provided in all three counties. All four trainings filled to capacity and received very high praise from participants. It was also a welcome opportunity to serve the Linn county communities. The final Trauma training is scheduled for November in Sweet Home.	***Challenges:*** 1. The biggest challenge that we face currently is the overwhelming requests that we are getting to deliver the trauma training for agencies and providers in the three-county area.
Sustainability Plan: Due to the work of the advocacy trainings for Spanish and Arabic speaking families, there is a growing number of family members who are moving towards the development of an ongoing 'parent peer support' program for other non-English speaking families. This is being supported through the Corvallis School District. The increase in Trauma training in both Linn and Lincoln counties has increased the conversations being held across systems who are interested in increasing their trauma informed practices. These trainings are accessible for parents therefore allowing parents to continue their awareness and knowledge base along with providers.	

Youth Wraparound and Emergency Shelter: Jackson Street Youth Shelter	Andrea Myhre, Associate Director
Successes: 1. Our pilot continues to be a positive process and a learning experience for us. As we reported last quarter, 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 continue to hear good reports from youth and their families who have accessed counseling who are grateful to get immediate care (see our success stories) and internal referrals continue to grow as staff gain a better understanding of the benefits of the service. Our therapist has also recently completed Dialectical Behavior Therapy training and received certification and is investigating how to integrate play therapy for teens into the program. To avoid replication of services, if youth are being served by other mental health services or would be better served through a referral, we make sure youth are connected with that service. 2. We are continuing conversations with Old Mill Center about sharing supervision and billing systems with them until we can get our own system established (if that is an option that makes sense) and are at the point of training our mental health therapist in their billing system. We are in the process of collaborating on a larger proposal with Linn County Mental Health and Alcohol and Drug (A&D) to provide a continuum of services in the community. Helping youth receive dental care and setting up insurance and initial medical appointments continues to be very	***Challenges:*** 1. New programs take time to develop. Internal referrals have been slow, but momentum is growing and the program has had a positive impact on youth and staff. As has been reported in the past attempting to educate and make practitioners aware of our services and how to access them, building relationships to remove barriers and provide better services to youth being served has also been challenging. We would also appreciate more technical assistance in help with understanding and getting linked in with billing systems or alternative payment methodologies and partnering with organizations who have the clinical supervision structure needed for billing. Collaboration is also challenging and it takes a lot of staff time to work with other staff to design systems of working together that are effective and efficient. We are working on alternatives in case our partnership with Old Mill is not viable such as a partnership with Linn County Mental Health to provide services in partnership with their staff.

successful.

Sustainability Plan: We have met with potential partners who would provide billing support and have worked through a process of how this would work. See description of the status of this relationship in Successes section.

Additional Information:

Success stories:

ZB had been living in an adult homeless shelter after staying with extended family was no longer a safe option for her. Recognizing that ZB needed support for her transition that was not available to her at the adult shelter, she was referred to Jackson Street by a community partner. In Next Steps, ZB has successfully completed her high school diploma and accessed resources for employment training at Community Services Consortium. She is also participating in Jackson Street's mental health therapy program and meeting with a therapist regularly. This had been a personal barrier for ZB to access, since she recalls more difficult experiences in therapy in her past. ZB is also taking on her own physical health care, tacking an oftentimes daunting health care system to advocate for medical interventions and medications that are necessary for her individual stability and success. Next Steps Coordinator

NJ is a 14 year old female who was referred to Outreach Case Management through Jackson Street. NJ had been putting herself into unsafe situations by wandering the streets with adult male transients into late hours of the night. Due to the unsafe nature of NJ's skill set, she ended up enduring a traumatic experience. NJ's teachers and parents sought help from Jackson Street to build skills with NJ that would keep her safe and prevent her from any further trauma. Jackson Street has helped NJ enter into counseling through Linn County Mental Health, receive help through Developmental Disabilities Services, be connected with a Mentor through Jackson Street's Mentor Program, and supported her through her court case to ensure her and other's safety. Now Jackson Street continues to support NJ as she enters into High School to help her in her success! Case Manager

Section 2: 2016 Q3 Goals, Activities, Measures, and Results

Alternative Payment Methodology (2): InterCommunity Health Plans Goals	Measures	Activities	Results to date
Access	Total combined count of Patient Centered Primary Care Home (PCPCH) office visits and "touches" made by the clinic.	All PCPCH's have invested in resources to create more access, and document touches. Examples include RN Care Coordinators and Non-Clinical Care Coordinators (Spanish speaking), and Health Navigators to create robust Care Teams focusing on holistic care, and focus areas such as pharmacy, nutrition, and screening for suicidality Clinics are reconfiguring clinical sites to create better processes and workflows, and other modalities to improve efficiencies for patients and staff, thereby improving access.	Data will not be available for measurement until Q2 2017.
Quality of Care	Count of Care Coordination "touches" captures in Electronic Medical Record (EMR) and normalized by distinct number of IHN-CCO patients assigned.	Clinics are investing in IT/EMR's to support documentation pathways and quality/performance metric monitoring and reporting, and equipment. Clinics are reconfiguring clinical sites to create better processes and workflows, and other modalities to improve continuity of care, Care Coordination, Chronic Disease Management programs, and thereby improving access improving care coordination.	
	% of Eligible Providers (EP) who have achieved Stage 1 or 2 Meaningful Use certification as appropriate.	Clinics are developing electronic health records, IT support for population health, and quality performance reporting, and meaningful use.	
	Performance in the following IHN-CCO metrics: 1. Determined by Clinic	Clinics are developing IT infrastructures that capture the data necessary for improving metrics,	

		including but not limited to the CCO Metrics, and MACRA/MIPS metrics.	
Utilization	Count of Emergency Room (ER) visits.	Clinics are collaborating with ER and Hospital departments as well as creating ICT meetings for high ER utilizers.	
	Count of assigned IHN-CCO patients seeking outside PCP services ("leakage").	Major PCP roster cleanup has been accomplished as well as processes for communicating ongoing changes. Clinics have assigned designated resources for PCP assignment management, and outreach.	
	Count of Mental Health/Behaviorist visits.	Clinics are investing in Psychiatric Mental Health Nurse Practitioners, Licenced Clinicl Social Workers, and Behavioral Psychologist's to grow integrated mental health and behavioral health access.	
	Count of Preventive services.	In addition to creating better access, some clinics are providing community education, and prevention in the schools.	
Overall, the goal and metric for success of this proposal is to have greater than 80% of members assigned to PCPCH's receiving an APM reimbursement payment by 12/31/2016. This incentive provided to the PCPCH's will allow for PCPCH's to put workflows in place to meet performance metrics and patient engagement requirements of a PCPCH.	Distributed funds by June 2016 in three phases to the following provider clinics: All funds were received are being put to use.		IHN-CCO is negotiating contracts that are fully integrated quality based contracts for a 1/1/17 effective date. Once negotiations are complete over 80% of members assigned to PCPCH's will be assigned to a PCPCH that is paid on a quality based APM.
Each clinic that moves to an APM, outcomes will be established similar to the outcomes in the three clinics that have already adapted an APM.			

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Breastfeeding Support Servics Goals	Measures	Activities	Results to date
Maintain exclusive breastfeeding.	Use of infant formula in first 1-6 days of life.	In discussion with EPIC users regarding availability of this data in the Electronic Health Record (EHR).	
Maintain exclusive breastfeeding.	Use of infant formula at 2 months of age.	In discussion with EPIC users regarding availability of this data in the EHR.	
Increase number of breastfeeding women seen by an International Board Certified Lactation Consultant (IBCLC) for lactation counseling.	Number of referrals made to IBCLC by PCP.	In discussion with EPIC users regarding availability of this data in the EHR.	
Increase number of IHN-CCO members receiving lactation support services in Samaritan Mid Valley Pediatrics clinic.	Number of IHN-CCO members receiving lactation support services in Samaritan Mid Valley Pediatrics clinic.	In discussion with EPIC users regarding availability of this data in the EHR.	
Achieve Primary Care Provider satisfaction with lactation support services in Samaritan Mid Valley Pediatrics clinic.	PCP feedback on lactation support services.	Had initial meeting with two of the PCPs at the Samaritan Mid Valley Pediatric Clinic.	PCPs agree to a follow up meeting.
Participate in the progress toward IBCLC licensure and insurance reimbursement for lactation services.	Contacts with IHN-CCO and Oregon Health Authority (OHA) leadership regarding lactation support as a covered benefit.	Linn County Women, Infant, and Childtren (WIC) IBCLCs participated in a legislative work session at the State Capitol on Sept 15, 2016 attended by a state legislator, insurance representatives, and IBCLC champions from WIC and around the state, and licensure experts.	A bill is being drafted regarding licensure of IBLCLs in Oregon. We will be attending future meetings on this topic with State WIC staff and others involved.

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery Goals	Measures	Activities	Results to date
ACE's scoring for each participating Member.	Complete ACE's screening.	95% families surveyed	12 families screened with ACES
4 Staff complete Community Health	Completion of training program.	4 Staff trained	Measure completed- have some staff

Worker (CHW) or Peer Support training.			turnover so will look for additional training opportunities in Fall or early 2017.
Referral process with CHW in Mid-Valley Children's Clinic.	Create referral pathway.	Completion	No progress this quarter
Referral process with CHW in Mid-Valley Pediatrics.	Create referral pathway.	Completion	No progress this quarter, staff turnover required more training
Establish Electronic Record and note sharing with Pediatric Practices.	Work with CHW PM at BCHS creating process.	Completion	Review agency HIPAA privacy notices insuring that we have proper releases. Adding additional releases to make information transfer.
Establish Electronic Record and note sharing with Family Practices.	Work with CHW PM at BCHS creating process.	Completion	No progress this quarter. Looking at other projects that are working on this and seeing if there is a way to collaborate for access.
Establish and Implement common APM touches report for Traditional Health Workers (THWs) pilots through THW Subcommittee.	Create Touches report. Utilize touches reporting book for monthly tracking.	Completion of Workbook.	Staff using touches report to record work with families. Touches report being used to build sustainability plan with IHN-CCO for after pilot completion.
Identify and implement required organizational structure for supervision of CHW.	Research	Supervision in place.	Continuing meeting with IHN-CCO operations to move pilot to APM model in 2017.

Chrysalis Therapeutic Support Groups: Trillium Services Benton County High Schools			
Goals	**Measures**	**Activities**	**Results to date**
Attendance	Days absent from school.	Will complete upon start of groups.	n/a
Less depressed & anxiety symptoms.	PHQ-A & SCARED	Will complete upon start of groups.	n/a
Increased self-esteem.	Beck Youth Self Concept.	Will complete upon start of groups.	n/a
Graduation	Potentially free/reduced meals eligible and modified graduation.	Will track with schools.	n/a

Childhood Vaccine Attitude & Information Source: BCHD			
Goals	**Measures**	**Activities**	**Results to date**
Recruitment of 40 focus group participants.	# of unique participants who agree to sit in on a focus group session.	• 87 potential participants screened • 33 participants have participated	• 39 parents participated, of 42 who were scheduled to attend

		in focus group sessions • 6 additional one-on-one interviews were scheduled	
Conduct 8 focus group sessions.	# of focus group sessions conducted.	• 8 focus groups were conducted, with an additional 6 one-on-one interviews	• 8 focus groups were conducted, with an additional 6 one-on-one interviews
10 Key informant interviews.	# of key informant interviews conducted.	• 9 interviews were conducted, with an additional 2 unable to be scheduled in time	• 9 interviews conducted
Compilation and distribution of a qualitative report of findings.	Report created. # of modes distribution and recipients of report.	• Results transcribed and cleaned • Codebook and theme documents created • Analyzing results • Creating a report of findings • Distributing those findings	• Results transcribed • Qualitative analysis underway • Report pending final edits • OPHA presentation scheduled – 10/10
Recommendations for provider / practice / public health actions to decrease vaccine exemption rates.	Recommendation list created # and locations of providers who receive recommendations.	• Use findings to create provider recommendations • Distribute recommendations	• Provider characteristics narrative with access addendum • Distribution plan pending.

CMA Scribes: Samaritan Family Medicine and Residency Clinic **Goals**	**Measures**	**Activities**	**Results to date**
Improve key documentation compliance and "scores".	• SBIRT rate • Developmental Screening rate • Decision Aid Utilization • **Contraceptive Use** • ~~Fall risk prevention documentation~~ • Colon ~~and breast~~ cancer screening rates • **Adolescent Well-Care Visits** • ~~Care plan implementation~~ • Tobacco use screening and prevention	30% scribe coverage to 100% scribe coverage for 5 providers. Two metric scores changed to better match grant initiative, scribe capability and IHN-CCO metrics.	Metric scores presented on Attachment A and available upon request.
Improve patient access.	• Number of patient contacts per clinic ½ day • NRC patient satisfaction for access	Adjustments to provider schedules pending provider ability to increase conducted office visits while using a	No Progress on increasing provider schedules – still in planning.

		scribe.	NRC scores –available upon request.
Improve provider and staff satisfaction (decrease burnout).	Maslach Human Services survey.		Attachment B -- available upon request.
Improve patient satisfaction.	Currently in place NRC survey Q's.		Attachment A-- and available upon request.
Document best practices.	Development of a "lessons learned" document by the end of the pilot period.	Pending further results of scribe utilization.	

Colorectal Screening Campaign: InterCommunity Health Network			
Goals	**Measures**	**Activities**	**Results to date**
Change community norms and expectations related to colorectal screening, reducing barriers, related to colorectal screening.	To have 47% of IHN-CCO patients receive appropriate colorectal cancer screenings within the 18-month period of this project.	Communicated project extension to clinics offering additional support to implement referral process, educational materials, and staff education.	
	Reach the 2014 Incentive Measure Benchmark.		Reached 2014 and 2015 Incentive Measure Benchmarks.
By August 2015, disseminate Colorectal Cancer 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 Cancer Screening eligible clients.		Continued distribution of educational materials in nontraditional settings.	Lincoln County has distributed 3,000 brochures in clinical and non-clinical settings. Linn and Benton County has distributed over 5,000 brochures in clinical and non-clinical settings.
By December 2015, distribute 3,000 fecal immunochemical test (FIT) in selected Patient-Centered Primary Homes utilizing Electronic Medical Record to identify patients aged 50 to 75 years, with 40% (or 1,200 patient member) adherence and return of stool test screenings.		Identifying barriers to distribution of fecal immunochemical test (FIT) through review of clinic surveys and have reached out to clinic leadership to identify solutions.	
By March 2016, utilize traditional		Benton County Health Department	

health workers/health navigators to reduce barriers related to screening among Latino and Native American populations, reaching 5% InterCommunity Health Network-CCO Colorectal Cancer Screening eligible members.		Health Navigators reviewed OHA revised Spanish version brochure for potential use.	
By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.		Drafted one-page informational sheet that compiles lessons learned from clinics throughout the process and gives highlights of important information from the training given to clinics last winter. In the process of drafting final evaluation report and executive summary. Working with Madison Avenue Collective (MAC) to create evaluation materials.	

Community Health Workers (CHW): Benton County Health Department and Various Clinic Sites			
Goals	**Measures**	**Activities**	**Results to date**
Benton County Health Department will work with an evaluation consultant to develop an evaluation plan that includes process and health outcome measures.	Touch data Qualitative evaluation: • Patient Satisfaction • Provider and agency staff satisfaction • Navigator evaluation	Monthly Touch Reports • Navigators are putting together the final touches for their patient focus groups • Key informant and provider surveys are in process	• Monthly touch reports continue to show increasing touches • The time tracker has been useful to show average time/touches • We are now looking at how to show time/touch more specifically so that we can begin the process of creating a fee schedule • Touches Report available upon request from IHN-CCO.
By the end of Phase I, Nurse Care Coordinators/identified Patient Centered Primary Care Home	As evidenced by • Meeting agendas showing agency training documents shared	• Monthly or bi-monthly meetings • Hiring and training of CHWs	This phase completed as of March 2015.

agencies and their staff will be trained and ready to work with Clinical Community Health Workers.	• Referral pathways developed • New Community Health Workers hired, trained and ready to begin work in agencies		
By the end of Phase II, project will demonstrate procedures and protocols for implementation and dissemination.	Number and variety of training procedures and protocols, competency documents, agency process docs developed	Development of: • Agency to do checklist • CHW-Agency Site Expectations • CHW-Co-Supervision Guidelines • Clinical Health Navigator Competency checklist • Navigator Training Tracker • Self-Management Education – Navigator Expectations • CHW-Reigstered Nurse Care Coordinator/LCSW Level of Care Matrix • Resource Scavenger Hunts • Navigator Roles and Tasks	This phase completed as of Sept 2015.
By the end of Phase III, project will demonstrate improved patient outcomes.	We are still working on these measures with each of the clinics. We have touch data and will have qualitative data, but health outcome data is difficult to measure.	Working with each agency to determine what client level health data they feel they can gather that Health Navigators (HN) has impacted.	In progress at this time.
Provide other CCO's a roadmap for implementing this program elsewhere (anticipating variations they might expect in their regions).	All processes will be documented to date and throughout the pilot.	Presentations about CHW pilot to other CCOs, agencies, and Universities.	Abstract submitted to the Western Forum on Migrant and Community Health, February 2017.

Community Helping Addicts Negotiate Change			
Goals	**Measures**	**Activities**	**Results to date**
CHANCE clients will develop positive health behaviors.	Update Peer-Improvement Survey.		Peer Survey results submitted in July.
	Completion and analysis of Peer-Improvement Survey.	Gave Peer Wellness survey to member during the month of July 2016.	52 participants took the survey and we submitted final results July 15, 2016.
	Eligible CHANCE clients enrolling in IHN-CCO within 6 months.	Have weekly OHP Application Assistance from Benton County	July: 20 applications August: 12 applications

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		Health.	September: 19 applications
	Enrolled CHANCE clients will seek out preventative care.	Have been using web and hard copies of the Primary.	Made several one-on-one calls with clients to assist in getting a primary care doctor. CHANCE Lebanon is now a tobacco free place campus! Working on making Albany Campus the same.
	Partner with local providers to offer one Outreach clinic held at CHANCE.	Helping to assist with primary care and preventive care.	Working with multiple agencies to provide outreach. Including Benton County Health to provide OHP Application assistance/ and HIV / Hep C testing monthly and weekly. Including, a hope to offer a flu clinic soon. Offering Peer Support, anger management, Dual Diagnosis, Support Groups.
CHANCE will accurately track and report health related data.	Completion of a template for tracking touches.	Created a secure web based platform for touch tracking.	Have been using the peer tracking system since February 2016.
	Begin using the tracker to report touches information.		Have been since Feb 2016.
	Update intake form to include insurance and health information.		Completed January 2016.
	Collection of insurance and health information during intake.	Added Insurance fields to the form.	Completed January 2016.
	Purchase technology to assist in reporting based on need assessment.	Purchased tablets and kiosk system. Created touch tracking system.	Completed December 2015.
	Electronically track health, survey, and touches information.	Daily one on one tracking and data input. Survey was given during the month of June.	Monthly submission of reports and data / IHN-CCO has own log in.
Offer Peer-Support Specialist trainings in our area.	Peer-Support Specialist training session.	Created a Peer Support Specialist Training curriculum.	State approved our training curriculum. Starting classes Nov 2016.

Community Paramedic: Albany Fire Department			
Goals	**Measures**	**Activities**	**Results to date**
Acquire and equip a vehicle.	To be acquired within the first quarter.		Completed
Hire and train Community	To be completed within the first		Completed

Paramedic.	quarter.		
Establish written protocols approved by Physician Adviser.	To be completed within the first quarter.	Received approval from Physician Advisor.	Completed
Establish forms for data collection in the field.	To be completed within the first quarter.		Completed
Establish computer software program for data collection and reporting.	To be completed within the first quarter.		Ongoing evaluation of current software program capabilities and needs of the program.
Promote program within public and private healthcare systems and social service programs.	Provide the number of presentations and participants within the healthcare and social service provider networks.	Met with Samaritan Home Health, Samaritan Primary Care Medical Director, and Samaritan Health Services representing multiple departments.	Samaritan Primary Care Medical Director to establish process and identify a group of First Care Physicians to start directing patient referrals to Community Paramedic Program.
Establish protocol with healthcare providers and EMS providers to target IHN-CCO members for referral to Community Paramedic .	Count number of referrals, specifically identifying IHN-CCO members.	Met with Samaritan Home Health, Samaritan Primary Care Medical Director, and Samaritan Health Services representing multiple departments.	35% of all referrals were to IHN-CCO patients (12 IHN-CCO members); year-to-date is 28%.
Identify and determine IHN-CCO patients with which to follow up.	Number of patients identified. Number of patients followed up with.		100%
Determine savings for IHN-CCO members.	IHN-CCO member's utilization rates of Emergency Department (ED) vs. primary care services.		Need to coordinate data with IHN-CCO.
Reduce medical transports to IHN-CCO members.	Count of medical transports of IHN-CCO members compared to total transports.		At time of application 15.9% of transports were IHN-CCO members; 14.5% in the third quarter; and 14.4% year-to-date.
Reduce number of ambulance transports to the emergency department of IHN-CCO members by focusing on appropriate alternative care.	Count number of referrals to alternate care that otherwise would have been ambulance transports of IHN-CCO members to an ED. Referrals will be considered avoidance		Intended to develop a system for ambulance transport to alternative care, which we are unable to address during the pilot program period, and have determined is outside the scope of this program.

	of ambulance transport to an ED.		
Reduce number of IHN-CCO members using 9-1-1 system for overdose and seizures.	IHN-CCO members currently comprise a higher percentage of overdose and seizure calls into Albany Fire Departments (AFDs) response area compared to the general population of non-IHN-CCO members.		Overall transports of IHN-CCO members related to overdose decreased from 6.3% to 2.8%. Overall transports of IHN-CCO members related to seizures decreased from 9.5% to 5.3%.
Reduce ambulance transports of IHN-CCO mental health patients to ED by referring these patients to mental health providers.	Track referrals of IHN-CCO members to mental health professionals.		One IHN-CCO patient referral.
Provide in-home evaluation and services to reduce patient entrance into the health care system.	Track services provided to IHN-CCO members by Community Paramedic Services, i.e. EKG, blood sugar levels, fall prevention, home safety evaluations, medication reconciliation, etc.		One IHN-CCO patient.

Dental Medical Integration for Diabetes: Dental Plans for InterCommunity Health Network-CCO			
Goals	**Measures**	**Activities**	**Results to date**
Member Communication Delivery System integration.	Mailer response rate.	Mailer distribution to eligible pilot members.	**2.2% of measure met** Success defined as 50%
		Monthly distribution to newly eligible pilot members.	
	Medical to dental warm handoffs.	Referrals from Primary Care Providers and staff to Primary Care Dentist.	**94% of measure met** Success defined as 75%
Lower healthcare cost for IHN-CCO members by.	Oral health screening questions asked.	Screenings done by Primary Care Provider and staff.	**99% of measure met** Success defined as 90%
	Dental to medical warm handoffs.	Referrals from Primary Care Dentist and staff to Primary Care Provider.	**100% of measure met** Success defined as 75%
	Medical screening questions asked.	Screenings done by Primary Care Dentist and staff.	**98% of measure met** Success defined as 90%
Dental Utilization.	Patients seen by Primary Care Dentist.	Post-pilot chart review.	-
	Missed Primary Care Dentist appointments after medical warm handoff.	Post-pilot chart review.	-

	Number of prophylaxis administered.	Post-pilot chart review.	-
	Number of periodontal treatments administered.	Post-pilot chart review.	-
Medical utilization.	Patients seen by Primary Care provider.	Post-pilot chart review.	-
	Missed Primary Care Provider appointments after Primary Care Dentist warm handoff.	Post-pilot chart review.	-
Clinical Outcomes.	A1C levels	Post-pilot chart review.	-
	Probing Depths	Post-pilot chart review.	-

Health & Housing Planning Initiative: Williamette Nieghborhood Housing Services			
Goals	**Measures**	**Activities**	**Results to date**
Increased access to health care for target populations.	Number of new enrolls into IHN-CCO. Number of referrals to health care providers.	On September 30th, CHW started the 10 week Community Health Worker certification course with Oregon State University. Distributed Newsletters in July and August to all residents, focusing on health insurance education, healthy activities, dental health and smoking cessation. Health Navigation office hours at Sweet Home properties and the Hotel Julian and resident meetings scheduled by request.	• 5 referrals made to health care providers. • In July, Health Navigators made 594 touches, 196 (15 minute) increments, totaling 2925 minutes of time. • In August, Health Navigators made 125 touches, 117 (15 minute) increments, and totaling 1755 minutes of time. • September touches are still being processed and will be included in Q4 report. • Made contact with 63% of WNHS residents.
Increased utilization of preventative health appointments and screenings.	Establish baseline in partnership with InterCommunity Health Network-COO. Number utilizing preventative health screenings.	Offered blood pressure and blood sugar screenings at Corvallis Family Table, a free meal program serving South Corvallis, once per month. WNHS owns 77 units of affordable housing in neighborhood and help organize the family table. Dental screenings administered at	• 18 WNHS residents received blood pressure and blood sugar screenings. • 12 WNHS residents received a dental screening at Corvallis Family Table. • 8 WNHS residents received a dental screening at the Hotel

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		Hotel Corvallis Family Table in July and the Julian in September.	Julian.
Decreased hospital and ED admission.	Establish baseline in partnership with IHN-COO. Number of Emergency Department visits by residents & survey of residents regarding Emergency Department usage.	Nothing to report this quarter.	Nothing to report this quarter.
Increase communication with Patient Centered Primary Care Home.	Entries into RHIC.	Meetings with Administrators for the Regional Health Initiative Collaborative (RHIC) to continue discussion about partnership as pipeline service organization.	Nothing to report.
Enter into Memorandum of Understanding with health care provider to deliver two onsite services.	Memorandum of Understanding in place by April 2016.	*2 Dental screenings delivered on-site. Met with Samaritan Pediatrics to coordinate delivery of wellness programs on-site at WNHS properties.	Nothing to report.
Develop "Health and Housing Plans" for existing and future housing developments that integrate health care services, intervention, and prevention into affordable housing.	Research successful models to help define measurements and metrics and capture data. Gather baseline data and indicators from CHIP and CCO Transformation Plan.		Forming a committee to discuss opportunities for senior housing. Recruiting new health and housing contractor/staff to assist with plan.

Home Palliative Care: Benton County Hospice			
Goals	**Measures**	**Activities**	**Results to date**
Reduce Emergency Room (ER) Visits by 10%.	Number of ER visits pre-palliative care / number of ER visit after palliative care.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	• 36% Increase w/outliers • 34% Reduction w/o outliers See narrative
Reduce Overall Hospitalizations by 10%.	Number of hospitalizations pre-palliative care / number of visits after palliative care.	Provided Home based palliative care to IHN-CCO patients admitted to the	• 92% Increase w/outliers • 100% Reduction w/o outliers See narrative

		program.	
Reduce hospital re-admissions within 30 days of hospital discharge by 10%.	Re-admission rate pre-palliative care / re-admission rate post-palliative care.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	NA – No admissions to palliative care within 30 days of a hospitalization.
Improved symptom management.	Patient/caregiver report of improved symptom management.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	85.7% reported that at least one physical symptom had improved since admission to palliative care.
Improved quality of life.	Patient/caregiver report quality of life has improved with palliative care services.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	60% reported that their quality of life had improved since admission to palliative care.
Improved understanding of disease process how to manage distressing symptoms.	Patient/caregiver report of improved understanding of disease process and how to manage distressing symptoms.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	83.3% reported that they better understood how to manage distressing symptoms.
Improved overall patient satisfaction.	90% of Patients and/or caregivers will report overall being satisfied or very satisfied with care.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	100% reported improved overall satisfaction with their healthcare since admission to palliative care.
Prevent unnecessary hospital ER visits and Admissions.	Number of after hour calls/visits that could have resulted in an ER visit or hospital admission.	Provided Home based palliative care to IHN-CCO patients admitted to the program.	12 after-hour calls/visits that could have resulted in an ER visit or hospital admission.

Improving Pain Outcomes and the Patient Provider & Therapy Referral Care Pathway			
Goals	**Measures**	**Activities**	**Results to date**
Improve therapist understanding of the biopsychosocial model of pain.	Pain Attitudes & Beliefs Scale for Physiotherapists (PABS-PT).	Provider pre-survey.	Pre-survey collected from 4 clinical groups.
Decrease therapist fear avoidance beliefs.	Fear Avoidance Beliefs questionnaire.	Provider pre-survey.	Pre-survey collected from 4 clinical groups.
Improve therapist understanding of pain neurophysiology.	Neurophysiology of Pain questionnaire.	Provider pre-survey.	Pre-survey collected from 4 clinical groups.

Tri-county PCPCH clinic participation.	Number of participating clinics & location.	Clinical group recruitment.	5 groups recruited.
Improve therapist understanding of the biopsychosocial model of pain.	Pain Attitudes & Beliefs Scale for Physiotherapists (PABS-PT).	Provider pre-survey.	Pre-survey collected from 4 clinical groups.

Maternal Health Connections: Family Tree Relief Nursery (FTRN) & Benton County Health Services (BCHS)			
Goals	**Measures**	**Activities**	**Results to date**
Using Traditional Health Workers (THWs) to provide care coordination and case management services will increase engagement by referred and/or screened members BCHS Community Health Worker (CHW) Serve 85 Mothers/Members. FTRN Peer Support Specialist (PSS) Serve 50 Mothers/Members.	Referral forms. Patient engagement touches data.	FTRN • Referral to community resources • Recovery support • Post-Partum Depression • Connect with Peds once baby is born • Strong referral pathway for Maternity Care Coordination • Evolving referral pathway at OB Clinics BCHS • CHW establishing relationship with RNs in OB clinic to gain understanding of how they can use CHW for resource support	FTRN • PSS/CHW engaging with 27 mothers to date with 21 children BCHS • CHW has engaged with 11 mothers working with Albany OB clinic
Develop referral tracking system to track referrals between THWs from OB, FRTN and MVCC to demonstrate coordinated services to mutual members.	Referral tracking system.	FTRN • Meet with Maternity Care Coordinators • Meeting with OB Clinics	FTRN • Developed with Maternity Care Coordinator • Developing with OB Clinic
Establish electric information sharing pathway with Adult Primary Care Provider & Peer Support Specialist.	Patient engagement touches data. Report to PCPCH of progress on screenings, assessments, community services accessed.	FTRN • Peer/CHW using touches report	FTRN • No electronic pathway seen to date as barrier to staff accessing EPIC and electronic records
Complete ACES screening on 95% of children and adults enrolled in services by FTRN PSS.	Completion of ACES survey.	FTRN • Competed ACES screenings with referrals between 45 and 60 days of service	FTRN • 10 ACES completed • Analysis to determine average and distribution of scores.

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Using CHWs will decrease provider stress and increase provider satisfaction.	Provider survey.	No activities to date – progress slow due to slower implementation of CHW services in OB clinics than expected.	No progress to date – too soon to tell.
Using THWs to provide care coordination and case management services will increase engagement by referred and/or screened members.	Referral forms. Patient engagement touches data.	FTRN • Services to families with feedback loop to clinic • Patient touches tracked BCHS • Referrals beginning to pick up from OB clinic	FTRN and BCHS • Information pathway back to clinic under development • Transmitting touches to IHN-CCO end of October
Use CHW to connect and engage referred members to Maternity Case Management services offered by Linn County Public Health.	Patient engagement touches data.	BCHS • Establishing connection with Linn County MCM program • CHW accompanying RNs on home visits	BCHS • CHW has engaged with 38 mothers working with Linn County Maternity Case Management • Helping with OHP, resource connection, social support
Develop referral tracking system to track referrals between THWs from OB, FRTN and MVCC to demonstrate coordinated services to mutual members.	Referral tracking system.	No activities to date – progress slow due to slower implementation of CHW services in OB clinics than expected.	No progress to date.
Provide additional training on 5Ps universal prenatal screening.	Improved workflow and comfort for prenatal screening from clinic and hospital feedback.	Provide training to clinic and hospital "champions" form each site. Provide one-on-one assistance in clinic/ hospital workflow.	Two training for champions completed (MI/ Brief negotiated interview and workflow), additional training scheduled.

Pain Management in the Patient Centered Primary Care Home: Multiple Primary Care Clinics			
Goals	**Measures**	**Activities**	**Results to date**
Improve primary care healthcare providers' understanding of the biopsychosocial model of pain.	Pain Attitudes & Beliefs Scale (PABS).	Provider Survey	Baseline Surveys obtained from clinicians in twelve clinics. Post-Surveys received from four clinics (awaiting surveys from six clinics).
Decrease primary healthcare	Fear Avoidance Beliefs questionnaire.	Provider Survey	Baseline Surveys obtained from

providers' Fear Avoidance Beliefs.			clinicians in twelve clinics. Post-Surveys received from four clinics (awaiting surveys from six clinics).
Improve primary care healthcare providers' confidence of the diagnosis, treatment, and management of chronic-pain patients in a primary care setting.	Providers' report of self-efficacy and outcome expectations for chronic pain.	Provider Survey	Baseline Surveys obtained from clinicians in twelve clinics. Post-Surveys received from four clinics (awaiting surveys from six clinics).
Improve primary care healthcare providers' adherence to evidence-based chronic non-specific back pain treatment guidelines for imaging.	Use of CT/MRI or plain radiography for nonspecific low back pain.	Clinic IHN-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.	Diagnosis and procedure codes provided to IHN-CCO. List of all participating clinicians provided. Claims data being collected.
Improve primary care healthcare providers' adherence to evidence-based chronic non-specific back pain treatment guidelines for medications.	Use of NSAIDS/APSP or opioid.	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.	Diagnosis and procedure codes provided to IHN-CCO. List of all participating clinicians provided. Claims data being collected.
Tri-county PCPCH clinic participation.	Number of participating clinics and location.	List of participating clinics collected.	12 clinics enrolled to date. Of these: • 11 clinics completed Phase 1 • 1 clinic in Phase 2/3 • 3 clinics in Phase 4 • 8 clinics in post-intervention assessment

Pediatric Medical Home: Samaritan Pediatrics			
Goals	**Measures**	**Activities**	**Results to date**
Care Plan Engagement.	Monitor the activity and participation	We implemented the Healthy Kids	We saw an increase in specific

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	in the care plan. Continue work with care plans for riskiest populations.	Care Plan with children who were enrolled in the Healthy Heroes class. These children were identified at risk by our Nutritionist in conjunction with the primary care physicians.	measurements, such as, water intake and vegetable consumption. The children were also able to set goals and identify barriers and benefits to their goal.
Obtain 3-Star PCPCH designation for Samaritan Pediatrics Medical Home.	Meet 11 or more of the 13 standards listed in agreement.	We continue to focus on our activities from last quarter – and are currently developing a summary of each standard/measure we are going to attest to review with clinic staff.	On-going.
Increase number of patients seen by Nutritionist.	Effectiveness of Care Measures.	Current activities include reviewing our No-Show list to re-engage patients and doing follow ups from our summer program.	Total patient visits for 2016 = 157.
Increase Well Child Checks	Effectiveness of Care Measures.	We have been utilizing the Population Health tool to pull reports for those patients who have not yet been in for WCC. We are doing outreach via phone and letters to engage with those patients to get them in.	Rate is at 43% for this measure currently.
Continue to have open access to mental health providers.	Access and satisfaction with care.	No changes in our activities. We have added a Licensed Practical Councilor now in office 1 day a week, which began Sept. 7.	YTD Mental Health Numbers: **Psychiatrist #1** Intake: 8, Med Check: 32 **Psychiatrist #2** Intake: 22, Med Check: 45 **MH Specialist** Intake: 34, Phone F/U: 72, Warm Hand Off: 15 **Psychiatrist #3** Intake: 2, Med Check: 6
% of Developmental Screenings performed in the first 36 months of life.	Effectiveness of care measures.	Continued tracking of patients who fall into this category of measurement.	Year-to-date we are at just shy of 89% for this measure.

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Pharmacist Prescribing Contraception Goals	Measures	Activities	Results to date
Improve women's access to hormonal contraceptives.	Number of prescriptions Monthly pharmacists.	All outpatient pharmacists have completed the training to prescribe birth control.	No progress to report.
Decrease barriers to contraception.	Provide this service at each SHS outpatient pharmacy.	Standard policies and procedures are being developed to provide consistent service at all SHS outpatient pharmacies.	No progress to report.
Reduction in Increase in unintended pregnancies in the SHS service area.	Increase in effective contraceptive use (CCO incentive metric).	No progress to report.	No progress to report.
Decrease healthcare costs by providing a more convenient less expensive alternative to a doctor's visit.	Measure the difference in cost of a PCP visit versus the cost of a pharmacist.	No progress to report.	No progress to report.
Develop Action and Communication plan for a closed-loop referral process with OB-GYN or Primary Care Provider offices.	Action and Communication plan completed that describes how clinic staff will be engaged and the workflow established for the closed-loop referral process with Primary Care Providers/OB-GYNs.	A process for a closed-loop referral has been created with the help of medical assistants' knowledge of the current process. Clinic supervisors will be informed of the finalized workflow to educate other clinic staff.	No progress to report.
	Number of closed loop referrals that provide information back to Primary Care Providers/OB-GYN clinics.	No progress to report.	No progress to report.
Create tracking system for IHN-CCO members to determine utilization of the pharmacy contraceptive services.	Number of IHN-CCO members to receive pharmacy contraceptive services.	A system to track IHN-CCO members has been developed.	No progress to report.

Physicians Wellness Intiative: INTERCOMMUNITY HEALTH NETWORK-CCO Goals	Measures	Activities	Results to date
Development of communication pathways with Physicians.	Convene a Physician Wellness Advisory Committee (PWAC).	Identify members, identify role of committee, set up regular meetings, and meet.	PWAC members include two physicians who have administrative roles, IHN-CCO and SHPO leadership, and the project coordinator. Committee has met three times and identified targeted clinics, discussed

			roles and expectations for PWAC, coordinator and clinics.
	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 physicians. Individual and group meetings with providers to discuss work satisfaction, burnout information.	Identify survey and obtain support for its use. Coordinator will meet with individuals and small groups.	Survey approved by PWAC, shared with stakeholders. The Mini-Z was selected, a short form validated survey on satisfaction, engagement and burnout. Met with all teams with their management to introduce pilot. Met individually with six providers at SFMRC, and in groups once each with six residents, four providers. Individual interviews set up with seven providers in Lincoln City in last half of Oct. No individual meetings yet with Lebanon but plans are in progress.
Assessment of Burnout.	Assessment survey administered to IHN-CCO physicians.	Deliver survey to selected clinics.	Survey put on line and delivered to providers at three selected clinics.
	Report on the state of burnout in IHN-CCO physicians.	Collect and analyze survey when results are in.	In progress.
Development of ongoing wellness monitoring plan.	Identification of quality measures for ongoing assessment of burnout.	Mini Z	Survey is out, will be repeated at conclusion of pilot.
	Establish annual review process that incorporates assessment of burnout/resiliency in physicians.	To be discussed at next Physician Wellness Program update.	Nothing to report.
Development of direct and indirect interventions to reduce burnout and develop resiliency in physicians.	Develop resources (information, brochures, classes, counseling) for physicians.	Survey of the literature and research, investigation of existing wellness programs.	Reading books, articles; investigating programs here and at other facilities. Attended International Physician Wellness Conference in Boston about best practices. Met with SHS CEO to discuss need factors. Met with VP Primary/Specialty Services to discuss what's been tried/in progress. Report in progress.

Evaluation of the effectiveness of the intervention.	Evaluation plan that describes the tools and techniques (survey, rubrics, tracking sheets, etc.) appropriate for each resource and process identified/developed.	PWAC meetings Meetings with management (above).	Mini Z out, brief on-line surveys being developed. Report in progress.
	Physician Wellness Program Effectiveness Review (report).	Nothing to report.	Nothing to report.
	Develop evaluation tool to measure physician turnover within the IHN-CCO.	Contacted HR and physician recruiting; no data received.	Nothing to report.
	Design an experiment or survey to assess the relationship between reimbursement model and physician stress.	Review of literature.	In process (literature review; no survey developed).

Pre-Diabetes Bootcamp: Lincoln County			
Goals	**Measures**	**Activities**	**Results to date**
Establish a workflow for identifying IHN-CCO members with pre-diabetes.	Number of IHN-CCO members meeting pre-diabetes criteria accurately flagged.	Working with medical home care coordinators to identify IHN-CCO members with pre-diabetes. Completing database of eligible IHN-CCO members in the Lincoln City area.	EPIC report identifying IHN-CCO members with pre-diabetes is in place. Database developed to track IHN-CCO member progress. At this time, 97 eligible members have been identified.
Establish a work flow for referring IHN-CCO members to the Pre-Diabetes Boot Camp.	Number of IHN-CCO members with pre-diabetes are referred.	Referral form complete and vetted.	Referral form is currently being polished by marketing staff.
Develop pre-diabetes program materials.	Pre-diabetes program materials are tangible, useable product.	Developing pre-diabetes program materials: class notebook, participant tracking tools, marketing materials.	Program materials are in final draft form. Marketing materials currently being polished by marketing staff.
Increase the self-efficacy of IHN-CCO members to impact their health.	Generalized Self-Efficacy Scale.	Researching Generalized Self-Efficacy Scale forms and data collection options.	Generalized Self-Efficacy Scale form in first draft. Not yet vetted or used.
Decrease the weight, A1C, and/or fasting glucose of IHN-CCO members	Pre and post weight, A1C, and/or fasting glucose levels.	Baseline results on eligible IHN-CCO members being collected in database.	Baseline data on Pre-weight, A1C and/or fasting glucose is complete on

in the Lincoln City area with pre-diabetes.			97 currently identified eligible members.
Use IHN-CCO member input and feedback about the effectiveness of the prediabetes program for future planning and sustainability.	Participant survey.	No progress to report.	No progress to report.
Explore reimbursement options for pre-diabetes screening and educational program.	Delineation of current and potential future options for billing pre-diabetes screening and pre-diabetes education.	Researching and compiling current and future reimbursement options.	Reimbursement options in draft.

Prevention, Health Literacy, and Immunizations: Boys and Girls Clubs of Linn and Benton Counties			
Goals	**Measures**	**Activities**	**Results to date**
Increasing access by building and strengthening Patient Centered Primary Care Home Neighborhood supports for 8,500 youth in Benton and Linn counties.	Number of youth and families served.		95 families gained access to Health Navigators, PCPCH providers, and Oregon Health Plan. 2,500 youth have received resiliency training.
		Boys & Girls Club of Corvallis 2016 Quarter 3 resiliency training.	160 Middle School & High School youth completed 10 activities over 10 weeks. 277 1st through 5th graders completed 12 activities over 10 weeks.
		Boys & Girls Club of Corvallis September Back to School Family night & Health Fair.	130 youth and 55 families gained access to Health Navigators, PCPCH providers, and Oregon Health Plan.
		Boys & Girls Club of Albany July Family	150 families gained access to Health Navigators, PCPCH providers, and

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		BBQ night.	Oregon Health Plan.
		Boys & Girls Club of Albany Q3 resiliency training.	480 K-5th graders completed training over 10 weeks. 913 teen completed training over 10 weeks.
		Boys & Girls Club of Greater Santiam – 2016 Quarter 3 resiliency training.	400 members completed training over 10 weeks.
		Boys & Girls Club of Greater Santiam – family Oregon Health Plan connections.	20 families have been connected to Oregon Health Plan.
Enhanced Health Literacy curriculum for 640 youth to empower them to make informed healthcare decisions.	Youth will complete surveys that will test their ability to make decisions about drug dosage, nutrition, communicating with care providers, accessing care, and chronic conditions diabetes & asthma.	Classes will start first week of October across all 4 Boys & Girls Club sites. Pilot asthma class run at Boys & Girls Club of Corvallis 9/19/2016.	29 3rd through 5th graders received training on asthma from OSU school of Pharmacy. Pre & Post survey results show an average of 40% increase in knowledge and ability to make better decisions.
Increase immunizations by providing access to immunization clinics in 4 PCPCH Neighborhood Clubs.	At 4 immunization clinics that will be offered in Benton and Linn county Club locations with credentialed partners, youth will receive immunizations and disconnected	Boys & Girls Club of Albany clinic – August.	0 immunizations 9 immunizations

	families will be signed up for Oregon Health Plan and IHN-CCO.	Boys & Girls Club of Greater Santiam clinic – August 2016. Families connected to Oregon Health Plan.	5 Sweet Home 4 Lebanon YTD 320 families across two counties have been connected to Oregon Health Plan information through family events.

School Neighborhood Navigator: Benton County Health Department			
Goals	**Measures**	**Activities**	**Results to date**
Increase the number/ percent of children who receive well-child checks after SN referral to at least 50% (OR by pre-referral data if available).	Number and percent of children with touch/referral and with post-touch/referral claim data.	• Had an in-service from one of our RNs about the WCC, why it is important, and what are the "talking points" the SN should be using when they talk with parents • We changed our tracking form to capture the education/informing of parents about the WCC and the scheduling of the WCC by the SN • The SNs have been talking with parents about the importance of a WCC for their children – even their adolescent children – and how it is different that a regular "check-up" visit or an acute care visit to their PCP	• Touch data from the 2015-2016 school year show only 3 touches for WCCs in Sept 2015, and only 30 WCC touches for the entire school year. We are considering this to be our baseline • Touch data from Sept 2016 shows **15 informational touches** (where the SN talked to the parent about the WCC) and **16 scheduling touches** (where the SN actually helped the parent schedule the appointment) • IHN-CCO staff will need to pull claims data report to find out if WCC touch is resulting in appointments scheduled and kept
Increase the number/ percent of children who receive vision appointment after SNN referral to at least 50% (OR by pre-referral data if available).	Number and percent of children with touch/referral and with post-touch/referral claim data.	• SNs are working with parents to refer or schedule with vision providers as needed • This will increase after school	• Touch data for the 2015-2016 school year show 9 vision touches in Sept 2015 • Touch data from Sept 2016 shows

		vision screenings, which begin in October	16 vision touches • IHN-CCO staff will need to pull claims data report to find out if vision touch is resulting in appointments scheduled and kept
Increase the number/ percent of children who saw their PCP after SNN referral to at least 50% (OR by pre-referral data if available).	Number and percent of children with touch/referral and with post-touch/referral claim data.	SNs are talking with parents about the importance of establishing care, seeing a PCP, and keeping preventive care appointments for their children.	• Touch data for the 2015-2016 school year show 19 PCP touches for Sept 2015 • Touch data from Sept 2016 shows 22 PCP touches • IHN-CCO staff will need to pull claims data report to find out if PCP touch is resulting in appointments scheduled and kept

Sexual Assult Nurse Examiner Goals	**Measures**	**Activities**	**Results to date**
Develop pathways within the Samaritan systems, through in-person education of Samaritan clinic and Emergency Department (ED) staff and physicians.	Knowledge surveys.	Presentations at SHS Joint Managers, SHS Medical Executive Committees, SHS General Membership meetings, SHS Primary Care/Specialty Managers meeting, SHS Clinic Care Coordinators meeting, SHS Cancer Resource Center, GSR and SLCH ED staff meetings, SHS medical directors, Clinical Operations, SAGH management team and board, Samaritan billing department, Samaritan Foundation	Provider survey results for Q1: • 29 responses received • 55% were at least somewhat familiar with the services offered at Sarah's Place • 17% were at least somewhat familiar with the referral process • 66% provided contact information and requested additional education Sarah's Place staff will provide additional education to those clinics/departments that requested it.
Reduce wait times for sexual assault Patients.	SANE patient turnaround time.	Sarah's Place nurses have been seeing patients within 30 minutes of notification during call hours;	Average wait time for a SANE prior to Sarah's Place (Jan through July 2016): • 1.7 hours

		immediately upon arrival at SAGH for non-call hours.	Wait time for a SANE at Sarah's Place (Aug and Sep 2016): • During staffed hours: seen immediately upon arrival at SAGH • During call hours: maximum of 30 minutes
Mitigate additional patient trauma due to lengthy wait times and/or are provided by untrained staff.	Patient experience surveys.	No surveys are being conducted with patients due to the sensitive nature of their visits. However, Sarah's Place nurses and advocates are following up with 100% of patients.	Advocate agencies have reported that patients are happier with the process since Sarah's Place opened. Patients seen in Sarah's Place have a wait time of 30 minutes or less, and are examined by a trained SANE nurse 100% of the time.
Increase the percentage of sexual assault patients that seek/receive follow-up care.	The number of assault patients scheduled for follow-up visits in the SANE department.	No activities have been performed to date. We are working with Samaritan's Informatics department to build the functionality to schedule appointments in Epic.	Baseline = 0 patients seen for follow-up care prior to Sarah's Place No results to share for Q1.
Improve throughput in Samaritan's EDs by sending sexual assault patients to the SANE department and freeing up ED beds.	Length of stay for assault patients in the ED.	Patients automatically referred to Sarah's Place if they do not require medical care. Those that do require medical care continue to be see in the ED.	Prior to Sarah's Place (Jan-July 2016) the average time in an ED bed for a sexual assault patient was 4.6 hours. Since Sarah's Place opened (Aug-Sep 2016) 18 patients have been referred to Sarah's Place from a Samaritan ED. This means that the patient spent 0 hours in an ED bed.

Tri-County Family Advocacy Training: Oregon Family Support Network			
Goals	**Measures**	**Activities**	**Results to date**
Survey indicating at least 90% satisfaction with each training.	135 participants will complete a Special Education training.	• 9 Special Education Trainings	IEP Basics training delivered in Lincoln County (2) and Benton County (1). Behaviors and the IEP training

			delivered in Lincoln County (1) and Benton County (1). 504/IEP training delivered in Lincoln County (1) and Benton County (3). A total of 130 participants indicated satisfied or very satisfied with the trainings.
Survey indicating at least 90% satisfaction with each training.	15 participants will complete the Family Support Group Facilitation training.	• 1 Family Support Group Facilitation Training	One Support Group Facilitation training was delivered in Benton County. A total of 6 family members completed the training and 100% indicated satisfied or very satisfied.
Increase provider understanding of the family experience.	30 participants will complete the Family Perspectives on Mental Health training.	• 2 Family Perspectives Training	One Family Perspectives training was delivered in Lincoln County and one in Benton County. A total of 27 providers registered and 17 completed and 100% of evaluations indicate satisfied or very satisfied.
All processes will be documented to date and trough the pilot with a goal of providing other CCO's a roadmap for implementing this program elsewhere. Pre/Post training evaluation utilizing Family Empowerment Scale.	20 family members will participate in the Collaborative Parenting Series.	• 2 Collaborative Parenting Series	One CPS series was delivered in Benton County and one in Lincoln County. A total of 31 family members participated and 100% of evaluations indicate satisfied or very satisfied.
Engage native Spanish speaking family members in increasing their advocacy skills.	Attendance at training offered. Participant satisfaction.	• 4 Special Education trainings • 2 Advocacy skill building trainings	Two advocacy skill building trainings were delivered in Corvallis (May 19 and 26, 2016) in partnership with Corvallis School District. A total of 14 family members attended each training (8 Spanish speaking and 6 Arabic speaking) and 100% of evaluations indicate satisfied or very satisfied participants. Four special education trainings will be held in

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			November.
Provide a spectrum of Collaborative Problem Solving training in Lincoln County.	Family members engaged in CPS Parent Mentor groups. Providers will seek further training and implementation of the CPS model.	• 1 Introductory CPS training • 1 Tier 1 CPS Training • 12 Parent Mentor groups	• 8 Parent Mentor CPS groups were completed in Lincoln County (May 7, 14, 21, 28, 2016, August 4, 11, 18, 26, 2016) and 4 additional groups are scheduled for October 21, 28, November 4, and 11 2016). Eleven family members participated in the first session, 10 family members participated in the second session and currently 10 families are registered for the last 4 sessions • 1 CPS Tier 1 training was held in Lincoln County (June 28-30, 2016). 41 community members from agencies and families attended the training • 1 Introductory CPS training was delivered March 2, 2016
Provide training for families and providers related to the experience of trauma and best practices for reducing re-traumatization.	Attendance at training offered Participant satisfaction.	• 5 trainings on Trauma and the Impact	• 1 trauma training delivered in Lebanon on July 8, 2016 and 12 participants indicated satisfied • 1 trauma training delivered in Albany on July 6, 2016 and 21 participants indicated satisfied • 1 trauma training delivered in Newport on September 1, 2016 and 22 participants indicated very satisfied • 1 trauma training delivered in Corvallis on September 2, 2016 and 19 participants indicated satisfied or very satisfied • 1 additional training to be scheduled

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Youth Wraparound and Emergency Shelter: Jackson Street Youth Shelter			
Goals	**Measures**	**Activities**	**Results to date**
Youth achieving stability, youth improve well-being and reduce their risk factors.	35 youth will be served in Wrap-around Case Management and/or Shelter Services.		• 31 different youth served in respite and emergency shelter • 15 youth remained in shelter past 21 nights, transitional shelter • 13 youth engaged in our aftercare services, duplicate numbers for reported shelter numbers • 11 different youth accessing our outreach case management services, not shelter • 269 youth to date have been served by this grant funding
	Number of youth who exit to safety.		• 23 safe exits from shelter • Others remain in shelter and have not exited, ran away, or entered a treatment facility
	80% will increase utilization of services available in the community.		• 100% of youth served worked with a case manager to increase their awareness and utilization of community services
	90% will participate actively in development of their strengths/needs assessments, service plans.		• 100% of youth served in shelter and outreach case management participated in their individualized service plan
	80% will participate in group activities that incorporate topics such as skill building and mastery, developing positive social norms and values.		• 91% of youth engaged in required skill building activities
	75% of families will participate in family mediation and counseling.		• 100% of youth who needed family mediation or counseling received a referral and actively participated
	100% will be linked to an IHN-CCO PCPCH and will undergo an adolescent		• 100% of youth who needed health insurance met with a health

	well-child exam.		navigator or Jackson Street case manager to complete paperwork
	100% will receive dental (Benton County only).		• 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 (Benton County only)
	100% of youth who need it, will be linked to QMHP or QMHA.		• Internal Referrals to Mental Health Therapist: 4
	Will track the number of youth who required intensive psychiatric health services though IHN-CCO while in the care of JSYSI.		• 2 – Were referred to higher levels of care/ residential treatment (Children's Farm Home, St Mary School for Boys, and PADTC)