2016 Q4 IHN-CCO Pilot Quarterly Reports
Executive Summary

Objective:

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

Summary of Findings:

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

Elements of Transformation and CHIP Areas Addressed by Q4 Pilots:

			APM	BSS	CAPEI	CTSG	CVAIS	CMA_S	CRCS	CHW	CHWL	COMPAR	DMID	EDCT	EHCC	HN_HP	HPC	IPRP	MHC	PM_PCPCH	PMH	PPC	PWI	PDBC	P_HL_I	SANE	SPC	SNN	TFAT	YCRC	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																															
CHIP Areas		Access to Healthcare	1	1,2	2,3					1,2	1	1	1		1	2,3	2		1,2,3	2	1				1			1,2,3			2,3
		Behavioral Health			1,3			2				3		2		3			1,2,3	1	2		2		1,3			1,3			1,3
		Child Health		3	1,2,4											2			2,3		4								1		1,4
		Chronic Disease Management and Prevention								2		1		2		2,3								2	2,3						
		Maternal Health		3	3			1			2				1				2,3			1									

Q4 DST Pilots

Alternative Payments Methodology	Community Health Worker Lincoln County	Maternal Health Connections	SHS Palliative Care
Breastfeeding Support Services	Community Paramedic	Pain Management in PCPCH	School/Neighborhood Navigator
Child Abuse Prevention & Early Intervention	Dental Medical Integration for Diabetics	Pediatric Medical Home	Tri-County Family Advocacy Training
Chrysalis Therapeutic Support Groups	Eating Disorders Care Teams	Pharmacist Prescribing Contraception	Youth and Child Respite Care
Childhood Vaccine Attitudes and Information Sources	Expanded Health Care Coordination	Physician Wellness Initiative	Youth Wraparound and Emergency Shelter
CMA Scribes	Health Navigation and Housing Planning	Pre-Diabetes Boot Camp	
Colorectal Cancer Screening	Home Palliative Care	Prevention, Health Literacy and Immunizations	
Community Health Worker	Improving the Pain Referal Pathways	Sexual Assault Nurse Examiner	

State Metrics Addressed by Q4 Pilots

			APM	BSS	CAPEI	CTSG	CVAIS	CMA_S	CRCS	CHW	CHWL	COMPAR	DMID	EDCT	EHCC	HN_HP	HPC	IPRP	MHC	PHLI	PMH	PM_PCPCH	PPC	PWI	PDBC	PHLI	SANE	SNN	TFAT	YCRC	YWES
State Metrics (Incentives and Penalties)	1	Adolescent well-care visits (NCQA)																			■							■			■
	2	Alcohol or other substance misues (SBIRT)						■													■			■		■					
	3	Ambulatory Care: Emergency Department Utilization										■				■	■				■	■									■
	4	CAHPS composite: Access to Care			■			■		■	■	■			■	■	■		■		■		■			■		■			■
	5	CAHPS composite: Satisfaction with Care						■		■	■				■		■				■			■		■					
	6	Childhood Immunization Status			■		■													■	■			■							
	7	Cigarette smoking prevalence						■																■							
	8	Colorectal cancer screening (HEDIS)							■						■									■							
	9	Controlling high blood pressure (NQF0018)										■			■									■							
	10	Dental Sealants on permanent molars for children																			■			■							
	11	Depression screening and follow up plan (NQF 0418)						■													■			■		■					■
	12	Developmental screening in the first 36 months of life (NQF 1448)			■			■																■							
	13	Diabetes: HbA1c Poor Control (NQF 1448)											■		■		■	■						■	■						
	14	Effective contraceptive use among women at risk of unintended pregnancy																					■	■							
	15	Follow-up after hospitalization for mental illness (NQF 0576)																						■							
	16	Mental, physical, and dental health assessments w/in 60 days children in DHS																													
	17	Patient-Centered Primary Care Home Enrollment			■								■	■	■	■			■	■								■			■
	18	Prenatal and postpartum care: Timeliness of Prenatal Care (NAF 1517)		■																				■							

Approach:

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

Section 2 details Pilot goals, activities, measures and result

Section 1: 2016 Q4 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Alternative Payment Methodology: InterCommunity Health Network-CCO	Carla Jones, Reimbursement Manager

Successes:

1. The mass majority of provider clinics are on an alternative, quality based payment model.
2. Reports are developed to evaluate utilization and metric performance
3. Infrastructure changes and PCPCH development/restructure is occurring.
    a. Decentralization of Care Coordination to practice sites
    b. Weekly meetings with providers and care teams to perform incremental improvement activities in Access, Quality, Safety, Utilization and Population Health
    c. All sites have been successful in continuing to implement and integrate dental and mental health services.
4. IHN CCO contracted with Traditional Health Workers and Peer Support Specialists to help PCPCH's with resources to holistically care for their paneled patients.
5. Providers are continuing to prepare for fully integrated value-based payment methodologies.
6. Providers have developed internal reports based off of medical records to evaluate utilization and metric performance.
7. New EMR systems have been implemented that are more robust in reporting

Challenges:

1. Benefit management decisions that are barriers for providers, such as prior authorization requirements on medications and physical therapy.
2. A lot of time is being spent in understanding the complexities of data related to metrics, and putting workflows into place to help with reporting outcomes.
3. The delay in the funding inhibited some offices efforts to align resources with the objectives of complementary transformation programs in a short period of time.
4. Making change requires engagement by the payer and the providers and administration, resource constraints are still inhibiting the deployment of resources necessary to facilitate effective engagement, and operationalize current strategies for transformation.
5. Provider roster management has been difficult. Ensuring that providers in our systeme are always current at each clinic.

Sustainability Plan: Care Coordination is either embedded now or is in the process of being embedded in practice sites from a centralized location. Care coordinators at those sites will take on clinical and administrative lead roles within the practice sites, increasing their traditionally recognized value and further integrating the objectives of PCPCH into the transformation process at those sites.

IHN CCO has developed APM's that monitor Access, Quality, Safety, Utilization and Population Health with 1/1/17 effective dates for vast majority of PCPCH clinics (covering 94% of IHN-CCO members), Dental Care Organizations, and several specialty care providers.

Additional Information: *Quotes from Providers*

Quote 1: We have incorporated BH into primary care. Our LCSW has been invaluable in providing community resources for patients needing support in/out of the home. Also, our LCSW is available for same-day appointments. He keeps hours at each clinic location. Additionally, our RN / CMA Care Coordinator staff have increased our communication with patients visiting the ED and admitted to the hospital. This has improved patient access to their PCP and continuity of care. RNs also aid in helping patients navigate their care plans for chronic disease conditions.

Quote 2: We continue to use CCO funds to improve coordination of care. Specifically we have hired a health navigator working on dual elligibles, high risk

medicare and medicaid and establishing a more tightly knit clinical flow of patients back to PCP in their areas of need. We think we are on the back end (finally) of a transition in IT support which was costly on the front end as it related to some hardware and security needs.

We have used dollars for print and web media to make sure our pediatric patients and their respective families know we provide care from birth on up and aim to keep families together when appropriate.
Time has been personally spent by me navigating the COO metrics as it relates to our contract and most of this is unreimbursed time so your dollars indirectly help shoulder the cost of physicians and staff time navigating the performance metrics and adapting to how we "demonstrate them" appropriately.

Quote 3: We continue to collect the "non provider" touches for pcpch calls and interactions, case management. We are very pleased with how the mental health providers have become available to patients = we have 2 therapists and a PMHNP who are in the clinic on average, 2 days/week; all have full schedules we do have some issues with "no shows" and are trying to come up with a plan to limit this issue. We are looking forward to providing more comprehensive care to our chronic pain patients, using a group approach with mental health and physical health providers. We are very pleased about not having to prior authorize physical therapy visits for our folks! we are recently spending an extraordinary amount of time doing medication prior authorizations - this is requiring time for MA's to spend lots of time trying to get prior auth for routine medications including inhalers, BP medications etc

We are looking forward to the Portal being available for staff to use, as way too many of our regular and long standing patients keep being randomly re assigned to "other" providers. We check the FTP list weekly, and do not understand why folks are assigned elsewhere for care. We check with them and they do not understand either.

Quote 4: We have been focusing on patient access to care. We have many patients in the Albany/Lebanon area that would rather go to urgent care or the ER than take the time to drive to Corvallis to see their provider. We are opening a satellite office in Albany and will rotate some of our providers there. We are also working on sending a mailing out to patient's to encourage them to call us first before going to the UC/ER.

- We have been looking at software to help manage CCMs and hiring staff such as a nurse case manager. We have added some acute slots at the end of our day which has caused some overtime hours for our providers and staff but more access for our patients to reduce UC/ER visits.
- We have been sending out post cards to patients reminding them that they are due for the physicals and then focusing on their preventive services.
- We are recruiting additional providers to improve access to patients as well.

Quote 5: We have been focusing on program development; improving workflows and partnerships with other modalities to improve continuity of care and efficiencies for patients and staff.

- Specific areas include nutrition; mental health and pharmacy
- Focus includes in-clinic presence by all three departments; increased access to services; and increased coordination of care for patient.

Quote 6: We have 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.

We have worked on the standardization of training for medical assistants and pre-visit planning, and have started to address an improved screening for suicidality. Scheduling templates are being revamped, creating more access with additional efficiencies and hosting a monthly interdisciplinary care team to review high ED utilizers and readmissions.

Breastfeeding Support Services: Linn County Public Health WIC Program	**Cindy Cole, RD, LD**
Successes: 1. Obtained EPIC computer access. 2. Plan for data collection is in place. 3. Successful consultations with breastfeeding moms and babies.	***Challenges:*** 1. No direct data reports regarding breastfeeding rates and formula use is available in EPIC. Information must be gleaned from chart reviews. Logistics for collection of metrics are on-going.
Sustainability Plan: Path to International Board Certified Lactation Consultant (IBCLC) licensure and hopeful insurance coverage is in on-going discussion by breastfeeding advocates across the state.	

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery	**Renee Smith, Executive Director**
Successes: 1. Engagement with Traditional Health Worker committee and looking at Community Health Worker and Peer Support systems as a whole across the region. Learning from other programs and streamlining processes aligning for larger impact on health system from a community provider position. 2. Engagement with the Delivery System Transformation (DST) and community leaders vital to this organization's knowledge of how to integrate into the health system and how to leverage resources to meet needs of underserved IHN-CCO members. Our organization is treated as a resource for the community in looking at ways to transform the system for stronger health outcomes for IHN-CCO members.	***Challenges:*** 1. Learning the system and navigating new processes and activities. 2. Electronic record goal was unreachable given the resources of this pilot alone. Hopeful that this goal will be met in 2017.
Sustainability Plan: Family Tree is working with IHN-CCO Operations team to operationalize this pilot into a fee-for-service contract. We have had two meetings with IHN-CCO staff regarding services, possible billing situations, accreditations, credentialing and other issues needed for contracting with IHN-CCO. Family Tree has sought guidance from other community partners that contract with IHN-CCO for credentialing assistance, policies, and facility credentialing. We are in	

negotiations with Samaritan Health for Medical Director Services. Next meeting is set for August to review possible rates and update on facility certification.

Childhood Vaccine Attitude & Information Source: Benton County Health Department	Jessica Deas, Public Health Planner
Successes: 1. We are wrapping up our project on schedule, and have had a successful experience with reaching out to local parents and providers, engaging them in conversation, analyzing qualitative data, and creating a narrative and presentation. We were able to gather a strong team with diverse talents and to create a positive experience for participants while maintaining a lean budget.	***Challenges:*** 1. We were limited in our outreach abilities by a human subject's research protocol that requires participants to opt-in individually before we could work to screen and schedule them. This meant that certain parts of our region and certain vaccine stances were more difficult to represent in our sample. We were able to address barriers to focus group participation by committing to additional one-on-one interviews, traveling to five different public libraries to account for the geographical distribution and busy schedules of interested participants. We do understand that we did not speak to a representative sample of the population, and that our results do not encompass the complete diversity of opinion in the region. However, we feel that we can show with our demographic data that we reached a variety of income levels, races/ethnicities, and vaccine stances/practices.
Sustainability Plan: Our final report is the most important outcome of this pilot. We have compiled our literature review, methods, and results in order to provide local health and vaccine perception information to our community, local partners, and the larger public health research/practice community.	
Additional Information: Listening to people without attempting to challenge their beliefs was seen as a truly transformational activity for a healthcare system that can seem inflexible and inscrutable to users. We were able to offer local parents an opportunity to share their thoughts in an open and safe space, and our evaluations reflect a positive experience across the board. We hope that providers will be able to use our findings to better communicate with the families they serve, and that future interventions/communications/policies can be presented in a culturally appropriate manner. Additionally, issues of access came up organically in our discussion, and we have included these results in our findings.	

Chrysalis Therapeutic Support Groups: Trillium Services Benton County High Schools	Lana Shotwell, Vice President
Successes: 1. We have our program up and running and were able to successfully start 4 groups. The Corvallis High School group currently has 12 girls enrolled in the group; they had started the year with 13. The Crescent Valley High School group has 7 members currently, and that has remained stable. The Philomath group is currently at 9 girls and they had started the year with 12. Lastly the West Albany group currently has 7 group members and they	***Challenges:*** 1. Our only major challenge was that we were not able to recruit enough students to run a group at Monroe High School. We knew that Monroe is a very small school and the team worked diligently to gather and interview possible referrals. There was a small pool that was identified but, anecdotally, appeared to be more resistant to joining group at this school. Trillium informed the Transformation team of this and the budget was

had started the year with 8.
2. All of the groups have successfully managed to build rapport with one another and with their various facilitators. All of the groups have completed their first field trips as well. Three of the groups used our existing provider to complete the first field trip and the 4th used the local resource at Oregon State University (OSU) to do the challenge course there. The groups are all busy working the curriculum to learn about trauma, learn about how they have been impacted, and explore coping skills while finding connection and safety within their respective groups.
3. Trillium facilitators all attended additional 5-hour training with Erica Weber, LCSW, Chrysalis Program Manager, over the school's winter break to continue to learn the Chrysalis curriculum and strengthen clinical group skills held at the Children's Farm Home. Facilitators also continue to meet with Erica Weber, LCSW almost every week in addition to their regularly scheduled clinical and administrative supervision.

changed accordingly.
2. Other minor challenges included a few snow days which impacted a few of the groups, depending on which days groups are held at each of the schools. Some facilitators who had groups that were impacted by the weather problem solved with Erica Weber, Licensed Clinical Social Worker (LCSW), at the winter clinical training around how to stay on track with the curriculum.
3. Facilitators are problem solving at schools around transportation issues for field trips, but have positive leads for getting this in place.

Sustainability Plan: In the next month or two, Trillium will approach the schools about funding Chrysalis through their budgets because schools will begin to budget themselves. However, given that we do not have any outcomes at this point, we will likely have to approach them again in the spring.

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 Scribe America 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 maintained 100% coverage. Over 125 office visits per week are being conducted now with a scribe present for 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

Challenges:
1. The previous challenge of adding more patients to the provider's schedule has been overcome. All providers have felt comfortable seeing more patients with the help their scribe. No major challenges are present at this time of the pilot. Providers, patients and staff have all given positive feedback.

the scribe to the provider/CMA team has helped standardize office visits and pre-visit planning, which in return helps efficiency and quality.

3. In initial concern amongst CMA's was that the scribes would take away or change their job duties. This has proven not to be the case and in fact CMA's are now very happy to have scribes as part of the team. We are working to increase the responsibilities of the scribes, to include helping constructively with CMA's with their workload per their request.

Sustainability Plan: Efficiency has been observed and standardization regarding workflows has been improving. The goal of adding an additional patient to each provider's clinic half day was achieved. With the increase in productivity, we hope to prove that this project is sustainable in the future, if not an increase in net revenue.

Additional Information: Many initiatives are happening to improve quality within the clinic. The implementation of scribes has proved effective in provider satisfaction and reduction in fatigue. The prediction would be that few efforts can affect provider burnout as much as an addition of another medical assistant and/or scribe as the initiative of quality continues. Surveys incidate that patients were satisfied and found benefit from the Scribes.

Attachment A

Metrics pertaining to the grant

	2015	2016 - Qtr 3	2016 - Qtr 4
Adolescent Well-Care Visits	32%	14%	36%
SBIRT	21%	29%	36%
Colorectal Cancer Screening	29%	38%	39%
Developmental Screening	22%	29%	40%
Effective Contraceptive Use	32%	21%	29%
Tobacco Screening and Cess.	85%	89%	88%
Decision Aids	25	19	24

Section 1: 2016 Q4 INTERCOMMUNITY HEALTH NETWORK-CCO Pilot Successes and Barriers Summary

Colorectal Screening Campaign (CRCS): InterCommunity Health Network-CCO	Stephanie Jensen, on behalf of the IHN-CCO CRCS Pilot Committee
Successes: 1. The program with the Health Navigators in Benton County is up and running. 2. We have received positive feedback from individuals who we have shared our draft evaluation with.	***Challenges***: 1. There are so many different efforts around colorectal cancer screening happening around the state right now that it has been a challenge to get the larger health system to implement a standard clinical process. We have been able to use connections to hold meetings with staff at Samaritan Health Services to discuss our project and how we could help them implement standardized workflow processes.
Budget Changes: Money was reallocated for 6-month extension. Money was moved to cover staff time from county coordinators and the Health Navigator program in Benton County.	
Sustainability Plan: Creating and disseminating draft evaluation results. Discussions with clinics about how to improve the clinical workflows and processes they developed during the pilot. Scheduled meeting with the Samaritan Cancer Program Community Outreach Coordinator.	

Community Health Worker (CHW) : Benton County Health Department (BCHD)	Kelly Volkmann, Health Navigator Program Manager
Successes: 1. Seeing the second cohort of clinics working smoothly so quickly. It took less than half as long for the care teams to really integrate the CHWs into the practice and to start using them effectively.	***Challenges:*** 1. The challenges of the last quarter revolved around trying to establish a payment methodology with IHN-CCO, and the challenge there is just that it hasn't been done before. Everything we do is new.
Sustainability Plan: BCHD has been meeting monthly with IHN-CCO to work out a payment methodology. This is going slowly, but well.	

Community Health Worker (CHW) : North Lincoln	Lesley Ogden, CEO
Successes: 1. A lot has been very successful. It's just taking a little longer to get approved job descriptions with pay scales. We have interest already for when the positions are posted.	***Challenges:*** 1 Being ready to hire has been a major hurdle; we are very close to having a posted job within the Samaritan Health System where Community Health Workers did not exist yet.
Sustainability Plan: We were able to hire a panel coordinator that will be a huge help within this structure and he is currently training along with assisting in the patients' health scores.	

Community Helping Addicts Negotiate Change: CHANCE	Jeff Blackford, Executive Director
Successes: 1. Partnerships with other organization and with IHN-CCO. 2. Peer tracking. 3. Working with other organizations as we grow into other communities.	***Challenges:*** 1. Trouble shooting what a peer delivered service looks like. 2. Determining who in our population is an IHN-CCO member as we move toward an Alternative Payment Methodology.

Sustainability Plan:

- We are moving toward a per member/per month (PMPM) and APMs that could hopefully help us become sustainable.
- We are adding additional contracts with other agencies to offer more services.
- Applying for pilots, grants and other funding streams.
- Added rentals as an income source for transitional housing.

Additional Information:

- Being part of the Delivery System Transformation (DST) has been one of the best experiences. Have a lot of connections and lots of support.
- Being part of Traditional Health Worker (THW) and the Health Disparity (HD) Work Groups has given a new perspective of the needs of our community. We are very thankful for the workgroups IHN-CCO has, that we can be part of. Great resources!
- The pilot proposal we did for Fall 2016 will help us reach new people and will allow us to help people who have several barriers of becoming self-sufficient and have rewarding lives. IHN-CCO is allowing us to be transformative and innovative. IHN-CCO has helped us think outside the box and has taught us, it is not black and white in a corporate world. While we are small, we can be mighty. Thank you!

Community Paramedic: Albany Fire Department — **Lorri Hedrick, Senior Administrative Supervisor**

Successes:

1. Professional relationships between Community Paramedic Program and social service resource agencies have been established and allow for smooth referrals and continuity.
2. Reduction in the recurring requests from the same users of 9-1-1 services.
3. Community Paramedic Program results are impacting how other agencies, e.g. law enforcement, are evaluating their frequent system users and how to approach solutions differently.

Challenges:

1. Lack of referrals from Healthcare Providers – 37% of patient referrals were within our organization, and the remaining 63% were from outside sources (law enforcement, Mental Health, Senior & Disability Services, Volunteer Caregivers, friends/family). This shows an increase over the first three quarters and shows a positive trend, but we need to continue that trend to an even greater percentage of referrals coming from healthcare providers.
2. Communications with Samaritan Health System representatives has been minimal this quarter, due to the number of holidays and weather-related issues. The program is a priority to us and we hope to receive a high priority from other healthcare provider systems in order for it to succeed long-term.
3. Alternative Payment Methodology (APM) - Long-term funding is not obtainable through traditional Fire Department revenue sources. We have reached out to IHN-CCO and Samaritan Health Services to help establish APMs.

Sustainability Plan: It was our intent to apply for a second year of IHN-CCO funding through this program in order to allow the time needed to establish APM and expand the program into Lebanon to touch a greater IHN-CCO population.

Additional Information: The Community Paramedic has been working with a 73-year-old female over the past few months. This client was brought to our attention by a concerned neighbor that had noticed an extreme change in the client's behavior. A week prior to meeting with this client, she had fallen in her home, hit her head, and concussed herself. She has an extensive past medical history of bi-polar and mental illness. My first encounter with this client was that of building trust. The neighbor who was concerned was present for the first meeting to help comfort her and to help her build trust with me. This particular client was very closed off and did not want anyone in her home. She presented very paranoid and anxious. She was having memory problems and was confused. Her vitals were stable. When asked about her medications and if she has been taking them, she was unsure. I looked over her medications and noted that she was off on her medications. She would either take too much or she would forget to take them all together.

When asked when she last saw her primary care doctor, she indicated that she had canceled her last few appointments because she was afraid to leave her house. We proceeded to call her doctor and schedule an appointment for the following day. I drove her to the appointment and sat in during the appointment to take notes and help her describe what had been happening. The patient broke down and was transported to GSC for mental health evaluation.

My next encounter with this client was a few days later. When she answered the door she was shaking so violently that she was unable to stand on her own. She was sweating profusely and was anxious and confused. I drove her to the ER for evaluation. Shortly thereafter I partnered with her primary care physician and home health to place her medications in a locked, automated pill minder. Home health and the primary care physician evaluated her medications and as a result took her off of some medications that she didn't need.
After a few days this client improved dramatically. She was clear-minded and starting to take care of herself. I would get her out of the house for short walks to build her confidence of leaving the house. Each walk would get a little longer and her confidence and strength began to build. She wanted to get better for herself. She is now regularly on her medications, seeing a mental health professional, and becoming independent.

Dental Medical Integration for Diabetes: Dental Plans for InterCommunity Health Network-CCO — **Britny Chandler, Dental Program Clinical Coordinator**

Successes:

1. Increased mailer response rate; response rate surpassed the national average by 3% at this time.
2. Medical clinics expressed interest to continue/expand pilot activities post pilot.

Challenges:

1. Direct contact between Primary Care Provider (PCP) and Primary Care Dentist (PCD). We hope that the implementation and participation with Regional Health Information Collaborative (RHIC) will help break down this barrier. We have learned that it is beneficial for medical clinics to know patient's most recent dental appointment, Dentist, referral contact. We have learned that it is beneficial for dental plans to know patients who have been referred by their medical provider and the best contact phone number to reach them. We hope that by learning from our pilot's communication barriers we can help tailor RHIC to better fit our region's needs.

Sustainability Plan:

- Use of pilot funds to order bulk hygiene kits, denture kits, and oral health education as a sustainable supply for medical clinics.

- Discussion around flexible spending to cover future dental hygiene/education purchases for medical clinics.
- Discussion of future Diabetic Screening reimbursement and measurement included within Dental APM contracts.

Eating Disorder Care Teams: Willamette Nutrition Services	Therese Waterhous, PhD, RDN, CEDRD
Successes: 1. Recruitment has been extremely successful with goals exceeded by almost 50%. Procurement of trainers and advisory board members has been very successful. Development of training methods, active learning protocols, and curricula has been very successful.	***Challenges:*** 1. The one major challenge is communication between the Physician and the trainers (the grant started up right before the holiday season so reaching people across the US has not been easy) and working with them to assure training goals are met. This is addressed by persistence.
Sustainability Plan: Development of an online library of training materials that will be available in the future and to the current provider pool over time. Engagement of the provider pool so they can then transmit information about eating disorders to their local community and to other healthcare providers in their region. Also the Physician has explored doing a small capital campaign to sustain the website and library of training materials for two additional years.	
Additional Information: • The provider pool is very excited to begin training. • Members of the board of the International Academy of Eating Disorders are supportive and eager to see results of this grant. • An international Physician, known for his research on treatment modes in the eating disorder field is very interested in the grant's proposed methods of information dissemination. He and others started the Training Institute for Eating Disorders. He has offered advice and counsel. • One change is the decision to not send every practitioner to national level conferences. These reasons include the fact that the provider pool is larger than expected so sending all to a national conference is cost prohibitive. Instead the grant can cover sending providers to local conferences held next year within Oregon, put on by the Willamette Valley International Association of Eating Disorder Professionals and by the Columbia River Eating Disorder Network.	

Expanding Healthcare Coordination (EHCC): Samaritan Health Services (SHS)	Monica DeMasi, MD and Mary Wunderle-M cIntosh, MD
Successes: 1. Population Health Management: • Lebanon - Currently recruiting for MA position. • Albany - Medical Assistant (MA) position hired, currently in training process, will begin population outreach 1/16/2016. 2. MA Training: • Currently recruiting for MA position.	***Challenges:*** 1. Population Health Management: • Albany - Identifying best practice work processes for outreach, MA recruitment and delayed funding for purchasing. 2. MA Training: • Staffing and recruitment.
Sustainability Plan: The MA position is hired and training is in process, funds have been released, equipment requested, scripts beginning to be drafted, base data gathered and reported.	

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

Successes:

1. Eviction prevention and intervention: From January through December health navigators served 62 Willamette Neighborhood Housing Services (WNHS) households with eviction prevention services and successfully stabilized all residents in their home. We have had an increased and consistent presence at our properties for almost a year. The more time we spend at our properties, the more residents we know and the more likely we are able to develop trust. We engage with residents through referrals, social activities; but the most common connection we have with a resident is through an intervention on an eviction notice.
2. One-on-one health coaching: Health Navigation services are made available with health coaching addressing one or more of the eight dimensions of health. Wellness is so dynamic that while we may start to talk to resident about finances, we end up talking about mental and physical health.
3. Continued programming: Corvallis Family Table, a free nourishing meal program offered two times per month has been an excellent place to connect with residents, distribute health information, and provide blood pressure and blood sugar screenings. Gentle Strong Yoga continues to be successful, providing weekly low-cost to no-cost yoga with free childcare.
4. New/returning programming: Linus Pauling's Healthy Youth Program offered a free four week healthy snack program on-site at Alexander Court. It was very successful; we plan to host another program at Seavey Meadows in the spring.
5. On-site health screenings: A resident was able to get the dental work they needed due to the information they received at the Julian Hotel dental screening.

Challenges:

1. We are still challenged by data collection and privacy. We are still connected with the Regional Health Information Collaborative (RHIC) team for creative solutions for data sharing to increase community health outcomes.
2. The need for mental health services is far greater than what is available. When a resident reaches out for mental health services we are only able to refer them back to their mental health worker. We are connecting with mental health case workers regularly to better understand what is available and how we can best support our residents.

Sustainability Plan: Both of our health navigation employees are now certified Community Health Workers.

Additional Information: *Stories from the Field*

- A Health Navigator helped a resident go through their mail because they were too afraid to open it. Over two months the health navigator met regularly for short periods of time, due to the anxiety dealing with all the paperwork caused them. During these sessions they started addressing the issues that resulted from not opening the mail for so long. The resident prioritized issues based on what was most troubling to them. The issues included figuring out how to address past debt that had gone into collection and how that might impact their benefits. The health navigator referred them to the Aging

and Disabled Resource Connection (ADRC) and assisted them in filling out paperwork to see if they were eligible for services and benefits. Additionally they found out they had lost financial assistance to pay for prescriptions. The health navigator helped the resident fill out paperwork to reinstate that benefit. This resident had a lot of self-reported anxiety in dealing with stress around finance management but was able to manage it with one-on-one support. The health navigator was able to provide support in the comfort of her home and build trust over time.

- A resident was having difficulty getting an issue with a grade they had not received for a class at Linn Benton Community College (LBCC) and it was affecting their grades. This was something that they reported was starting to trigger their mental illness. The health navigator referred her to LBCC disability services. The Health Navigator recommended she write a letter to the Dean and helped edit the document. In December she reported that the issue had been resolved and had gotten a grade for the class.
- Our Health Navigators are regularly called upon to help residents keep their Section 8 voucher by ensuring there annual recertification documents are completed on time. One resident who has a mental illness was also challenged by the yearly recertification requirements. Together with the resident and the Housing Authority the health navigator is working on possible solutions to make next year's process run more smoothly and not jeopardize their housing.
- A resident reached out to our Health Navigator because they were experiencing a mental health breakdown. The resident received a lease violation due to a poorly kept porch. The health navigator and resident worked together to identify what needed to be done and broke it down into smaller tasks. The Health Navigator reached out to the Property Manager to let them know that the resident was being proactive in cleaning up the outside of their unit. The property manager was happy to know the resident had recognized they were in violation and that they felt comfortable reaching out for their assistance. As long as the resident continues to work through the plan they created the property manager said they would not issue any notices of violation. This resident was a person our health navigator had intervened on an eviction in the past.

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

Successes:

1. The pilot restricts the numbers of patients served at any given time to 15 patients. In the 4th quarter of 2016 we successfully increased the number of patients served by the pilot. At the end of the 4th quarter the pilot had a current census of 14 active palliative care patients. We submitted ICD-10 codes to IHN-CCO so they could research the pool who would benefit from palliative care. Using these codes, IHN-CCO identified palliative care factors. A letter has been drafted to primary care physicians to notify the providers of who may qualify for our Palliative Care Pilot. The letter will be finalized and sent to the providers in early January.
2. We have been successful in improving symptoms, reducing ER visits, hospitalizations, and re-admission rates. We have found that a number of factors impact the patient's overall quality of life and sense of wellbeing. For example, one patient was extremely upset about the loss of their hair

Challenges:

1. We continue to struggle with how to quickly obtain needed medications, supplies, and Durable Medical Equipment (DME) for palliative care patients within the IHN-CCO system. We have met with IHN-CCO to discuss streamlining the pre-authorization process.

due to treatment and her hair loss has impacted her sense of well-being. However, the palliative care team can't help her with her hair loss, but can provide the patient emotional support.

Significant Changes: No, however

Sustainability Plan: Benton Hospice shared revenue and procedure codes with IHN-CCO that Benton Hospice is using for reimbursement for palliative care with another payer. A meeting is scheduled for February 2017 with IHN-CCO to further explore sustainability of palliative care as an ongoing benefit.

Additional Information:

- We have changed the calculation of Emergency Department and hospitalizations to include the number of hospitalizations/ Emergency Room visits by member months so that we are reporting statistically sound data. Also this report contains year to date data vs. quarterly data.
- There were three hospitalizations in the 4th quarter that were elective procedures unrelated to the patient's serious health conditions that the palliative care team are addressing. These hospitalizations are not included in the calculations.
-

Please see patient and family quotes below.
"Pleased with the palliative care team."
"I wish this program had been available sooner. I don't know what I would have done without them."
"The Registered Nurse and Social Worker have been on top of everything. I don't know how we could do this without them."
"We have had trouble with the hospital bed, but very pleased with the palliative team."
"Very satisfied with the care given."

Improving Pain Outcomes and the Patient Provider & Therapy Referral Care Pathway : Dr. Cuccaro — **Kevin Cuccaro, DO**

Successes:

1. Four clinics completed intervention and all clinics rated the program as being very valuable.

Challenges:

1. Rehab specialists pain knowledge is extremely inconsistent between clinics and, even, individual providers in same clinic. This creates a varied knowledge platform that is challenging to address in an educational based intervention. This is like trying to teach a single class an important subject but that classroom has 1st graders all the way up to 5th graders as students and each grade level has different levels of grade specific knowledge (i.e. 'C' students and 'A' students) . It has been challenging and requires significantly more time than anticipated to design/adjust/modify the curriculum between clinics while maintaining core foundational topics to promote consistent messaging.

Sustainability Plan: As an education based intervention directed to clinicians, theoretically this pilot should be sustainable as long as knowledge provided is

integrated into clinical practice and clinic attrition/turnover is not dramatic.

Additional Information:

This pilot's challenges so far are much different from those in the "Pain Management in the Primary Care Home (PMP)" pilot for the PMP pilot, the greatest challenges have been intra-and extra-clinic messaging consistency (i.e. having all clinic members who interact with patients provide consistent messaging on/about pain along with specialist/primary care consistency in messaging).

Maternal Health Connections: Family Tree Relief Nursery (FTRN) & Benton County Health Services (BCHS) — **Carissa Cousins, MD**

Successes:

BCHS

1. We are starting to see an increase in the number of referrals coming from Elm Street providers. It just takes more time for some clinics to understand the value of Community Health Workers (CHWs) and to know how to use them.
2. Getting CHWs trained to do Oregon Mothers Care work for Linn County Public Health will allow Linn County to receive state "credit" for some of the resource connection work that is already being done as part of the pilot.
3. We are working with IHN-CCO on the Dental Performance Improvement Project (PIP). We feel this has significant potential to engage women in their prenatal dental care and increase oral health for both mom and baby.

FTRN

4. Maternity Care Coordinators at Albany Hospital refer a large percentage of mothers to Peer Support Specialists (PSS) engage well with mothers and many have received services for over four months.
5. Warm hand off after baby is born to other support programs at Family Tree for home visiting by other Peer Support or CHW or Case Management staff.
6. Mothers express satisfaction in services and not feeling alone.
7. We are serving a high percentage of Latino families where this baby is not the first baby so we can offer support and referrals for all children in the family.

Challenges:

BCHS

1. There remain communication challenges between CHWs and the Obstetrics teams, primarily due to the busyness of the teams. We are addressing them proactively, with CHWs making extra effort to meet and engage with team members to establish a relationship with them and to help build their trust in her skills.

FTRN

2. We would echo the same challenges to engage with the OB teams and referring to the Peers.
3. Pollywog project with Linn Benton Community College and Albany Maternity Care Coordinators should assist with even more referrals.

Significant Changes: Due to the slower-than-anticipated adoption of the CHWs services, we have not started the work needed on the referral tracking system. This goal has not been met.

Sustainability Plan: We are currently in discussions with IHN-CCO for an Alternative Payment Methodology that will sustain the service after the pilot period.

Pain Management in the Patient Centered Primary Care Home: Dr. Cuccaro	**Kevin Cuccaro, DO**
Successes: 1. Twelve clinics enrolled and completed intervention (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. Time expansion approved and 13th clinic being recruited.	***Challenges:*** 1. As mentioned on all previous quarterly reports, 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. Additional difficulties mentioned in 'vertical' messaging (i.e. congruency between primary care patient and specialist patient communication). Especially concerning is the lack of consistency between the evidence-based messaging provided by primary care physicians and the messaging (often not evidence-based or consistent with modern pain science) of specialists. This creates confusion for patient, especially patients with complex pain complaints. This also creates a difficult discussion between patients and their Primary Care Physicians who now need to 'correct' what patients have been told by the specialists (i.e. who patients tend to view as more 'expert') . Unfortunately, these discussions require more time in primary care clinics that are already 'time-poor' practice environments.
Sustainability Plan: • In process of contacting clinics for voluntary post-intervention review level of pain knowledge maintained post-intervention. • Turnover/clinician attrition key concern for pilot sustainability. One clinic successfully had high participation/engagement and completed intervention but 80% of clinicians left clinic/health system in ensuing six months after intervention.	
Additional Information: There are efforts to refine pilot metrics***.*** Objective pilot measurements use IHN-CCO claims made data which is limited data set for clinic-wide intervention. To assist, requesting additional information from Samaritan Health Systems to ascertain overall prescription/ordering rates. This would provide better insight into whether this intervention facilitated any clinician behavior change.	

Pediatric Medical Home: Samaritan Pediatrics	**Megan Van Vleet, Clinic Operations Manager**
Successes: 1. Working collaboratively as a clinic team to focus on metrics, engage patients and provide a team care approach with our pilot services.	***Challenges:*** 1. No major challenges in Q4 for our pilot. The most important issues were addressing continued patient engagement towards the end of the year, and communication within the team and between providers.

Sustainability Plan:
We assessed the finances used throughout the pilot to address which services will be sustainable and maintainable, as well as beneficial moving out of the pilot phase.

Additional Information:
We recently had one of our patients identified through our care plan engagement with a Body Mass Index (BMI) over the 85th percentile who attended our Healthy Heroes class come in for their 3-month-class follow up. When measured, their BMI had shown a decrease, which was one of the long-term goals of the class.

Pharmacist Prescribing Contraception: SHS Outpatient Pharmacy — **Penny Reher, Chief Pharmacy Officer**

Successes:

1. All pharmacist staff completion of Contraception Training.
2. All pharmacists have necessary National Provider Identifier (NPIs) for eventual billing process.
3. Pharmacist staff involvement and commitment to the program and patients.
4. Completion of Policies and Procedures with the approval from the Executive Samaritan Health Services Pharmacy & Therapeutic Committee.
5. Working with the EPIC computer system outpatient team for an understanding on what is needed for outpatient retail pharmacy to move forward in the transition of care healthcare environment.
6. Support of SHS physicians as the communication of the program development has been relayed.
7. Increased awareness surrounding capital funding, outpatient pharmacy EPIC charting, scheduling, billing, and the intersection of outpatient departments with the functionality of what has historically been inpatient processes.
8. Marketing in place for community awareness of shift in contraceptive procurement.
9. Education to physician practices.

Challenges:

1. Capital budget for remodeling two sites: getting those funds on the Capital budget to be approved.
2. EPIC charting, scheduling, billing, etc.: numerous meetings with EPIC team to understand outpatient pharmacies needs as we move further into transitions of care – the impact on our patients and clinical need of accessing the Emergency Medical Record.
3. Administrative time of implementation of program - A Post Graduate Year One (PGY1) Resident for one rotation and tenured pharmacist has been valuable but not enough as this is significant and staffing is thin.

Significant Changes: No changes to goals; it's taking longer than expected to get remodeling dollars approved and completed at two outpatient retail sites.

Sustainability Plan: Met with IHN-CCO staff in December 2016 regarding the delay in capital funding and remodeling at two outpatient retail pharmacies to determine if Grant should be extended – it was decided to wait until the coming year prior to making that decision.

Additional Information: The individuals involved have learned a tremendous amount about our organization and IHN-CCO grants and are very appreciative of

the experience and opportunity. The program will be a good thing for our communities and our patients. We are looking forward to the start-up in two sites January 2017 and are still pushing for the remodels at the other two sites.

Physicians Wellness Intiative: InterCommunity Health Network-CCO	**Jana Svoboda, LIscned Clinical Social Worker**
Successes: 1. Provider interest and support of the pilot once they have made themselves available to hear about it. 2. Administration/C-Suite support for pilot and interest in openly addressing the problems. 3. Collaboration between admin, departments. 4. Provider and Administration understanding that this is a national issue, but there are ways individuals and health service corporations can lessen the harm. 5. Focus groups and individual interviews.	***Challenges:*** 1. Scheduling with providers, who have no protected paid time for any extra activities and who are already working unpaid hours on continuing ED, documentation, etc. Addressed by being very flexible with my time (evenings, after or before work, weekends) and by getting even short periods of face time to explain program and get buy-in before trying to schedule longer interviews or meetings. 2. Guardedness on parts of physicians: thinking information might be used against them, not wanting to complain, feeling hopeless, not aware that administration is truly invested in addressing the problem. Addressed via focus groups where they hear peers' stories, via individual conversations where I can reassure them that their burnout is shared by the majority of their peers nationally. 3. Coordination with other groups. SHS is large and there are other efforts being made in wellness; we weren't aware of the other's efforts. Addressed by meeting individually and in group meetings with persons from the Wellness Committee, Resident programs, Graduate Medical Education (GME), Corporate.
Sustainability Plan: Discussions with administration and GME about future planning. There are two meetings scheduled for further discussion.	
Additional Information: • The local findings on physician morale and burnout at or above national levels. There is admin level support to address these issues although the logistics of this is to be determined. It's my hope the committee will agree to begin trial interventions in the remaining two quarters. • Upcoming events: I am presenting on provider wellness at the annual resident physician didactics in later January and looking to meet with providers/administrations at hospitals there to hear how similar health agencies are addressing this problem. • This spring, a physician will do a workshop wellness retreat for interested providers.	

Pre-Diabetes Bootcamp: Lincoln County	**Ruth Morland, RN, OCN and Susan Richwine, RN, OCN**
Successes: 1. During the recruitment phase of the program, IHN-CCO members have	***Challenges:*** 1. It has been challenging to get some providers to agree that their patients

been receptive to hearing about their pre-diabetes and ways to prevent diabetes.	can be recruited for the program. We have addressed this challenge by refining our data and re-approaching providers.
Sustainability Plan: With this pilot we are increasing awareness of pre-diabetes in our community. We are emphasizing that this is the just the start of on-going pre-diabetes awareness and education. We are establishing systems that can be sustained.	
Additional Information: Even those IHN-CCO members who do not want to participate in the full program at this time have been receptive to learning about preventing diabetes and appreciative that their insurance provider wants to improve their health and prevent diabetes.	

Prevention, Health Literacy & Immunizations: Boys and Girls Club	**Emily Barton, Grant Writer Corvallis**
Successes: 1. Oregon Health Plan (OHP) application assisting has been incredibly successful. There is a large need in our community for assisters and our application assister has been able to make connections with school counselors in Lebanon and Sweet Home to help families in the schools get connected to OHP. 2. Partnerships with Linn County Health, Benton County Health, Trillium, and Oregon State University School of Pharmacy. Each has been very supportive in planning and participating in various activities. 3. Having mental health professionals meet with our staff to discuss members monthly has been a huge success. We are able to discuss concerns or situations that come up with our members and are able to then determine whether or not our staff can adjust our approach with the child or if this member should be referred to mental health. 4. The consistency of the same Oregon State Pharmacy students coming to the Club was a great success. There was a point person we discussed everything with and they pulled off every lesson.	***Challenges:*** 1. A challenge for this quarter has been coordinating the Diabetes Prevention Workshop around the holidays and around the schedules of the medical students. The preparation of the workshop itself is coming along nicely; however, the date of the workshop had to be postponed until the week after the New Year. 2. A challenge that we have dealt with is many of our families are already covered by Oregon Health Plan or they shy away from discussing the need to our staff. We have held events where our Assisters were readily available and willing to discuss options, but families weren't engaging.
Sustainability Plan: • Relationships with partner organizations. • OHP Application Assisting. • Health & Wellness Coordinator position continuing after the end of the pilot. • Mental health partnership has progressed and will continue after the pilot. • All resiliency programs that were developed through Pilot funds are now being incorporated into planned regular year activities.	
Additional Information: • Our Health and Wellness Coordinator started doing a Tasting Table every week at the Lebanon and Sweet Home Elementary sites. At this Tasting Table	

she introduces new foods that most of the kids have not tried before, or she makes something that is a healthy alternative to something they most likely have tried before. It's a nutrition education based activity where the kids learn what nutrients are in different foods and the benefits of eating healthier alternatives. We added a measure to encompass this activity because the behavior change that our Health and Wellness Coordinator has seen over the course of 13 weeks has been incredible and something that we wanted to report on.

- We have implemented additional leadership groups in our elementary program allowing our resiliency training education to grow. We have noticed that daily responsibilities and weekly meetings have inspired other members to join in to make our Club even better.

Stories from the Field:

There was a mother that came in that needed assistance filling out the OHP application. During the appointment, our assister was able to connect this woman and her child to OHP. Additionally, she was also able to offer other resources in the Club that have been made possible by the connections with other organizations we've made through this Pilot. For example, the mother mentioned that her child was struggling with their mental health, the assister was able to give her a referral form for Linn County Mental Health and they were able to connect the child to the mental health services he needed. Before the end of her visit she also signed her child up for the afterschool program. She was overwhelmed with emotion and thankful that we were able to connect her to the resources that her and her child needed to be successful.

There have been many stories throughout the year very similar to this. Families are incredibly grateful that we are able to offer health and wellness resources here at the Boys & Girls Clubs and are able to serve them more holistically.

- We had one family connect with us in hopes of gaining mental health assistance for their children. Having the relationship and partnership with mental health has given us the ability to gain that much needed help. We provide the option for our therapist to meet with our members here at our facility, where the children already feel comfortable.
- 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." -Dr. Ewanchyna
  - 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.

School/Neighborhood Navigator: Benton County Health Department	**Kelly Volkman, Health Navigator Program Manager**
Successes:	***Challenges:***
1. The collaboration between the School Navigators, the healthcare system, and school personnel continues to provide successful linkages that support students and their families. The School Navigators have already done 2,267 touches for the first 4 months of the 2016-2017 school year (September – December 2016).	1. The challenges continue to be managing the work load as word spreads about the services provided by the Health Navigators.

Sustainability Plan: We continue to track touches and time, and will be working more closely with IHN-CCO in the coming months to look at trend data from the last 4 months.

Additional Information: Navigator Stories from the field;

Linus Pauling Middle School - SN contacted parent to inform that her daughter had incomplete immunizations. School Navigator explained that they could schedule a Well Child Check (WCC) and receive that immunization at the same appointment. Student was indeed due for a WCC. Parent followed navigator's advised and scheduled WCC for all three of her children.

Lincoln Elementary School - SN has been assisting a parent with arranging meetings with appropriate staff for health protocol. A student had to have surgery and has been out of school for about a month or so and cannot return until the school has a clearance note and a health protocol in place. There are steps that need to be taken before this happens. First a student needs to get the note from the doctor, then meet with the District Nurse, check-in with the teachers, and finally can return to school. School Navigator has been helping with coordinating a meeting with the District nurse to go over student's history and protocol for when the student returns. Upon mothers request SN has also been trying to get a meeting with teachers, and the special-ED teacher to discuss overall academic level for this student. Mother also wants teachers to know what the health protocol for this student will be. With the help of the Operations Assistant and the School Secretary, the SN has been able to help with the communication between the parents, teachers, and District nurse.

Sexual Assault Nurse Examiner: Samaritan Albany General Hospital — **Dan Keteri, VP SAGH**

Successes:

1. Patients tell staff how grateful they are to be able to come to a private, secure setting rather than the emergency department.
2. Referrals from clinics.
3. Lane County Sexual Assault Response Team members requested and received a tour and information of Sarah's Place from staff.
4. Marion County personnel have asked if they could refer patients to Sarah's Place because of positive experiences here.

Challenges:

1. Development process for seeing patients in follow up.
2. Communication among staff which is being address by weekly meetings and more frequent meetings with management.
3. Outlying emergency department wait times remain long; we are working with community partners to transport directly to Sarah's Place.

Sustainability Plan: Samaritan Employee Caring Campaign continues to bring in pledges for help with clothing drives and community resources.

SHS Palliative Care: Samaritan Albany General Hospital — **Stephanie Maxon, SHS**

Successes:

1. Outreach efforts with:
   - Linn County Paramedicine Program
   - SHS Home Health
   - Benton Hospice and Palliative Care Program

Challenges:

1. We have a robust electronic health record (EHR), and we are learning the many challenges of building a tool that is useful for the outpatient and inpatient palliative care providers, as well as other providers, who are part of the patients' care team. We're working closely with our Informatics department, to develop documentation and reporting tools to meet the needs.

	2. We still have a lot of work to do with educating both our internal and external populations. We're working with our corporate marketing professionals to develop materials.
Significant Changes: Probably not categorized as significant, however we have learned through networking with our palliative care colleagues both regionally and nationally, that our goals are too lofty for the first twelve months of this program. We are going to keep the goals, because we believe they are important to track, however we may not be able to make as much progress as we'd like, over a twelve month period.	
Sustainability Plan: Our coding and billing practices have improved. We still have room for improvement, and continue to meet with the business office and coders, however between our providers doing a better job, and the electronic health record working better to support to our services. We have made progress in capturing revenue.	
Additional Information: These number could be slightly higher; we don't have all the data finalized for December. • We completed 182 palliative care consults Q4 2016. • Average daily patients on service for Q4 2016 was 12. • Average of 2.84 consults per day in Q4 2016.	

Tri-County Family Advocacy Training: Oregon Family Support Network	**Tammi Paul, Statewide Training Program Manager**
Successes: 1. The incredible receptivity to both the trauma training and Collaborative Problem Solving has been a success. There is a very high interest in providing additional trauma training in the region as well as the development of a 'next steps' trauma training that dives deeper into strategies to respond to trauma impact both on an individual level as well across organizations.	***Challenges:*** 1. One of the challenges that we encountered this quarter is the trauma training registrations filling quickly and then participants not attending the training which left open seats in several trainings. Each training that was offered filled to capacity and had a wait list but we were unable to fill the training with the waitlist participants because of short notice.
Sustainability Plan: • Due to the high interest and success of the Trauma training in the region, the Linn, Benton, Lincoln Mental Health Promotion and Prevention project group invited Oregon Family Support Network (OFSN) to talk with them about expanding the training across the region. OFSN is now working with Lincoln County Health and Human Services to provide additional trauma training in Lincoln county communities in 2017. • There continues to be growing interest and implementation in Collaborative Problem Solving in Lincoln County and based on the work that was done with this pilot in that county, the Early Learning Hub School Readiness and Family Stability project will be funding Collaborative Problem Solving group for families in all three counties.	
Additional Information: • This is some feedback that we have received from families who participated in the Collaborative Problem Solving groups: …this has changed my life. I am relieved that my child might be able to stay in our home. I learned so much about my kid and I learned about my triggers as well. Our home is so much calmer and I feel like I can breathe.	

- This is some of the feedback that we have received from the Linn, Benton, Lincoln Mental Health Promotion and Prevention project:
  …I received great feedback on the last training OFSN did in Newport. My co-workers really appreciated that it gave a good, solid framework on trauma and its impacts, trauma informed, care, and also touched on ways to implement the principles of trauma informed care.

The Warren Project Nature Therapy: Ollala Center for Children and Families	Ben Williams, Oregon Holistic Counseling

Successes:

1. We have had many successes so far. We have been granted the right to use a private, 27 acre nature conservancy with old growth forest for free. In order to ensure replication is possible, we have decided to use multiple locations including state and local parks, hiking trails and other public lands. Land use agreements have been written and signed by all parties.
2. We have hired and trained some amazing staff members for this program. Our LPC comes to us with many years of experience working in nature therapy programs for adolescents. With his knowledge, we are able to learn from his experience in similar programs. We have also hired a QMHA who is only a few months away from graduating with her Master's degree.
3. Interagency collaboration has been successful with multiple agencies including the Child and Family team at Lincoln County Mental Health, the work crews of Community Services Consortium and the Lincoln County School District, who has agreed to donate indoor space for extreme weather days when we cannot safely keep the clients outdoors.
4. Logistics are completed at this point. The groundwork has been a huge task that has been successfully completed including things like insurance, supplies, land use agreements. Transportation was a challenge but we have solved the problem by purchasing a quality used van.
5. We have created two brochures, one focused on the program for clients and the other focused on attracting mentors.
6. The biggest success that we have had is in building community support. From connecting with partner agencies about referring specific clients to recruiting mentors to promoting the program to motivate volunteers, we have had amazing successes! We currently have so many volunteers to run workshops that we have to channel their energy in other directions or the program will be so big that it will not be replicable. Even the people who initially promised one or two workshops now want to provide more.

Challenges:

1. Talking with Primary Care Providers (PCP's) has been a big challenge. We have reached out through phone calls, emails and leaving brochures with messages to please call. This challenge is surprising as we do have positive relationships with the local PCP's and are able to contact them regarding specific clients on a regular basis. We believe that the PCP's may just be very busy people. In order to break through this barrier, we are going to reach out to one of our board members for advice as she is married to one of the local PCP's. We are proposing taking them all out to lunch but are open to other suggestions and will be gathering her input soon.
2. We have also struggled in the beginning with the basic logistics of scheduling around the holidays, school calendars and weather related closures. We believe we now have a good contingency plan in place.

For example, we will be providing a monthly culturally based workshop on Native traditions.

Sustainability Plan: We have spoken with Lincoln County Young Professionals, the local Chamber of Commerce, radio shows and local Rotary groups in order to obtain mentors and donations to supplement the mentorship program. We believe that the mentorship piece of this program is the most vulnerable to a lack of sustainability yet is one of the most effective pieces and as such, has become the main subject of our focus.

Additional Information: We've been surprised at the large amount of initial community support. For example, we currently have more volunteers then we can use which is a very rare occurrence in Lincoln County. People are excited about this program and want to support in any way they can.

Youth and Child Respite Care Team: Morrison Child and Family Services — **Laura Ruedinger, Program Manager FFCN**

Successes:

1. Finalized Department Human Services (DHS) space agreement.
2. Posted Job Descriptions and in process of scheduling Foster Care Coordinator position interviews the first part of January 2017.
3. Recruitment outreach to Linn/Benton County area churches for recruitment.
4. Recruitment flyer drafts being created for Linn, Benton, and Lincoln Counties.
5. Communications with IHN-CCO regarding obtaining IHN-CCO members' respite authorization process.
6. Hired a Morrison Foster Care Recruiter that started October 2016.

Challenges:

1. Initially, the challenge has been getting connected to local community for recruitment outreach, although the Foster Care Recruiter has meetings scheduled for January 2017 to meet with local contacts and informing about the Respite program and recruitment needs.

Additional Information: In the month of December we had DHS and a Wraparound Facilitator from Linn County Mental Health reach out to Planned and Crisis Respite Care for respite placements in the Portland Metro area for two separate crisis respite placements from Linn County. However, both requests were withdrawn as alternative placements were secured December 2016. One of the crisis respite requests made it to the respite home in Portland, OR with DHS caseworker and therapist, but escalated and did not stay on respite, and heard the youth was taken to the hospital for evaluation/assessment. We are unsure if the youth was admitted.

Youth Wraparound and Emergency Shelter: Jackson Street Youth Shelter — **Andrea Myhre, Associate Director**

Successes:

1. Working with IHN-CCO staff to understand the goals of transformation and successfully implement our pilot has been a positive process. Helping youth receive dental care and setting up insurance and initial medical appointments has also been successful. We launched our internal Mental Health Therapist position, obtaining external clinical supervision, setting up processes/referral

Challenges:

1. Old Mill Center has been great at helping us with the process and keeping things moving along despite staff turnover challenges. We have also been delayed in getting the partnership established as the mental health position was brand-new to our organization and we needed to take time to fully integrate the service successfully into our programs. Again, we appreciate

systems, and are serving youth in this capacity. We already heard good reports from youth and their families who have accessed counseling who are grateful to get immediate care. We have also completed the process of establishing a partnership with Old Mill Center for billing and clinical supervision. We were also able to connect with Linn County Mental Health this past quarter to establish a business agreement and protocols for referrals for counseling once youth are assessed by us.	more technical assistance in help with understanding and getting linked in with billing systems and partnering with organizations who have the clinical supervision structure needed for billing.
Sustainability Plan: See description of the status of this relationship in the challenges area.	
Additional Information: We are finding it extremely difficult to follow through with consistency of care when a youth has to transition from one county to another due to living situation. There is about a 30 day (sometimes longer) gap in services due to insurance complications in transferring counties. This has happened to at least 10 of the youth we served so far. We have been an integral part of developing more consistent wrap around service systems in Benton County, able to provide productive feedback and participate in treatment plans for youth and are beginning to be seen as a mental health partner in some areas.	

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Alternative Payment Methodology : 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.	Provider offices have incorporated care coordinators into their medical homes, and are continuing to work out the details in capturing "touch data".	Seven clinics are able to electronically capture "touches" and report on touches.
Quality of Care	Count of Care Coordination "touches" captures in Electronic Medical Record (EMR) and normalized by distinct number of IHN-CCO patients assigned	Provider offices have incorporated care coordinators into their medical homes, and are continuing to work out the details in capturing "touch data".	Seven clinics are able to electronically capture "touches" and report on touches. We have not yet evaluated the penetration rate.
	% of Eligible Providers (EP) who have achieved Stage 1 or 2 Meaningful Use certification as appropriate	PCPCH's have processes in place to ensure all providers are at the highest level of meaningful use as part of their operations.	85% of providers are at the highest level of meaningful use.
	Performance in the following IHN-CCO metrics determined by Clinic:		
Utilization	Count of Emergency Room (ER) visits.		To be evaluated for Final
	Count of assigned IHN-CCO patients seeking outside PCP services ("leakage")		To be evaluated for Final
	Count of Mental Health/Behaviorist visits.		To be evaluated for Final
	Count of Preventive services.		To be evaluated for Final
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 December 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	Distributed funds by June 2016 in three phases to the following provider clinics: All funds were received are being put to use		As of 1/1/17, 94% of IHN CCO members are assigned to a PCPCH on an alternative payment methodology. - PMPM - FFS+withhold+PFP FFS+PFP

requirements of a PCPCH.			
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.			

Breastfeeding Support Servics: Linn County Public Health WIC Program			
Goals	**Measures**	**Activities**	**Results to date**
Maintain exclusive breastfeeding.	Use of infant formula in first 1-6 days of life.	International Board Certified Lactation Consultant (IBCLC) is providing client consultations.	See Challenges.
Maintain exclusive breastfeeding.	Use of infant formula at 2 months of age.	IBCLC is providing client consultations.	See Challenges.
Increase number of breastfeeding women seen by an International Board Certified Lactation Consultant (IBCLC) for lactation counseling.	Number of referrals made to IBCLC by Primary Care Physician (PCP).	Lactation consultation appointments with the IBCLC began Dec 1, 2016. PCPs are making direct referrals when IBCLC is in the clinic.	See Challenges.
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.		17 lactation consultation sessions occurred in December 2016.
Achieve Primary Care Provider satisfaction with lactation support services in Samaritan Mid Valley Pediatrics clinic.	PCP feedback on lactation support services.	Survey has been created.	
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.	Discussion of path to IBCLC licensure has been on the agenda at the Nov and Dec 2016 Linn Benton Lincoln Breastfeeding Coalition meetings.	

Child Abuse Prevention and Early Intervention: Family Tree Relief Nursery			
Goals	**Measures**	**Activities**	**Results to date**
Adverse Child Experience (ACE's) scoring for each participating	Complete ACE's screening.	95% families surveyed.	30 families screened with ACES- 92% of families served at least 2 months.

member.			
4 Staff complete Community Health Worker (CHW) or Peer Support training.	Completion of training program.	4 Staff trained.	Measure completed in Q3.
Referral process with CHW in Mid-Valley Children's Clinic.	Create referral pathway.	Completion.	Pediatricians held a staff meeting at Family Tree and referral pathway was discussed with contacts and information documented. Clinic CHW will contact our Intake Specialist directly to expedite any referrals.
Referral process with CHW in Mid-Valley Pediatrics.	Create referral pathway.	Completion.	Staff met with receptionist at clinic, shared brochures and business cards for referral process.
Establish Electronic Record and note sharing with Pediatric Practices.	Work with CHW PM at BCHS creating process.	Completion.	Electronic record sharing not viable currently. Project will continue to work with Early Learning Hub to piggy back on projects they are undertaking to build on.
Establish Electronic Record and note sharing with Family Practices.	Work with CHW PM at BCHS creating process.	Completion.	Electronic record sharing not viable currently. Project will continue to work with Early Learning Hub to piggy back on projects they are undertaking to build on.
Establish and Implement common Alternative Payment Methodology touches report for Traditional Health Workers (THWs) pilots through THW Subcommittee.	Create Touches report. Utilize touches reporting book for monthly tracking.	Completion of Workbook.	All Agency staff completing touch reports. Touches submitted to IHN-CCO for review in creating an APM for sustainability of pilot. Contract negotiations currently underway with completion targeted in January 2017.
Identify and implement required organizational structure for supervision of CHW.	Research.	Supervision in place.	Progress in operationalizing pilot with IHN-CCO operations in final negotiations.

Chrysalis Therapeutic Support Groups: Trillium Services Benton County High Schools			
Goals	**Measures**	**Activities**	**Results to date**

Attendance.	Days absent from school.	Unanswered.	Unanswered.
Less depressed & anxiety symptoms.	Patient Health Questionnaire Adolescent (PHQA) and Screen for Child Anxiety Related Emotional Disorders (SCARED).	Measures were given at the start of groups.	The pre-tests are currently being scored.
Increased self-esteem.	Beck Youth Self Concept.	Measures were given at the start of groups.	The pre-tests are currently being scored.
Graduation.	Potentially free/reduced meals eligible and modified graduation.	Unanswered.	Unanswered.

Childhood Vaccine Attitude & Information Source: Benton County Health Department			
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 in focus group sessions. • 6 additional one-on-one interviews were scheduled.	• 39 parents participated, of 42 who were scheduled to attend.
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 completed. • Report narrative. • OPHA presentation 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 report with access addendum distribution plan.

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CMA Scribes: Samaritan Family Medicine and Residency Clinic Goals	Measures	Activities	Results to date
Improve key documentation compliance and scores.	• Screening, Brief Intervention, and Referral to Treatment (SBIRT) rate. • Developmental Screening rate. • Decision Aid Utilization. • Contraceptive Use. • Colon cancer screening rates. • Adolescent Well-Care Visits. • Tobacco use screening and prevention.	Maintained 100% scribe coverage for 5 providers. Scribes assist CMA's and providers identify quality metrics that are due at time of patient office visits.	Metric scores presented on Attachment A.
Improve patient access.	• Number of patient contacts per clinic half day. • NRC patient satisfaction for access.	Adjustments were made to provider schedules to accommodate at least 1 additional patient per clinic half-day.	Increased access for the clinic of approximately 25 additional appointments per week NRC scores – Attachment A.
Improve provider and staff satisfaction (decrease burnout).	Maslach Human Services survey.	Will survey staff and providers again in February.	Attachment B in the Additional Information area. Providers reported less feelings of burnout.
Improve patient satisfaction.	Currently in place NRC survey Questions.	Patient surveys gathered pertaining to their experience with a scribe.	Attachment A in the Additional Information area. Patients reported satisfaction with the addition of scribes and increased face-to-face time with providers.
Document best practices.	Development of a "lessons learned" document by the end of the pilot period.	Pending further results of scribe utilization.	Not Answered.

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.	Continue to offer educational materials to clinics. Offering presentations to clinic staff. Sent drafts of evaluation results to clinic	Completed.

		managers.	
	Reach the 2014 Incentive Measure Benchmark.		Reached 2014 and 2015 Incentive Measure Benchmarks.
By August 2015, disseminate Colorectal Cancer Screening (CRCS) information beyond the walls of traditional healthcare settings by partnering with public health and other community organizations, reaching 20% of InterCommunity Health Network-CCO Colorectal Cancer Screening eligible clients.		Utilizing Oregon Health Authority's The Cancer You Can Prevent campaign. Continued distribution of marketing and educational materials in nontraditional settings including social media.	Lincoln County has distributed 3,000 brochures and posters. Benton and Linn Counties have distributed 5,000 brochures and posters.
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.		Contacted each pilot clinic to determine need for FIT kits. Contacted Samaritan Health Services Pharmacy to understand ordering process for FIT test by Samaritan Health Services clinics	Pilot clinics purchased their FIT kits for the pilot. The eight pilot clinics provided FIT test to patients meeting the criteria for CRCS screening.
By March 2016, utilize traditional 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.		Met with Dr. Ewanchyna and shared results of DELTA project research. Health Navigators conducted a focus group of Spanish-speaking adults to review materials. Compiled current research on Latino educational and outreach methods Reviewed CRCS materials with Health Navigation team. Conducted informant interviews with Health Navigators piloting materials. Health Navigators continue to share CRCS materials at community events attended by Health Navigation team.	Community Health Centers of Benton and Linn County's Health Navigators reviewed linguistically and culturally appropriate CRCS educational materials for use in clinic. Workgroup established with IHN-CCO Medical Director, Health Navigation Program Manager, Health Navigators and Healthy Communities Coordinator to continue Latino Outreach.

By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.		Working with Madison Avenue Collective to finalize evaluation report, executive summary and one-page clinic informational sheet. Working with IHN-CCO data analysts to prepare quantitative analysis.	Draft evaluations completed – One final report, one-page executive summary, and one-page findings and recommendations for clinical staff. Waiting on final quantitative results for final draft.

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	• Qualitative surveys with providers at all four clinic sites • Focus groups with patients from Geary Street (English) and Mid-Valley Childrens Clinic (Spanish).	We have preliminary results (included in final report) and are waiting for the final report.
By the end of Phase I, Nurse Care Coordinators/identified Patient Centered Primary Care Home agencies and their staff will be trained and ready to work with Clinical Community Health Workers	As evidenced by: • Meeting agendas showing agency training documents shared • Referral pathways developed • New Community Health Workers hired, trained and ready to begin work in agencies	This Goal has been completed.	Completed.
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	This goal has been completed.	Completed.
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	We did not develop measurable health outcome data. I believe this is due to the following factors: • The CHWs affect the social determinants of health, which often take longer to manifest in a direct health outcome. • The CHWs work as part of a team, and it is difficult to tease apart	What we CAN measure is: • How many touches and services clinic patients received from their navigator that they most likely would NOT have received. • The value that the provider perceives the CHW brings to both the care team and the patient. • The value the patient perceives

		their contribution as being the factor that made the health outcome improvement.	the CHW has brought to their (the patient's) perception of their care, their self-efficacy, and their overall experience.
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	All processes were documented throughout the pilot.	Processes and documents could be gathered to create a "roadmap" for at least the basic implementation of this program.

Community Health Workers (CHW): North Lincoln			
Goals	**Measures**	**Activities**	**Results to date**
Train 2 Community Health Worker's (CHWs).	Completion of state-approved training program.	We have written a job description and sent it to be approved it's currently in the process of being approved for wages.	Planning on hiring this month, January.
Use checklist and training documents from CHW pilot to train CHW for appropriate clinic duties.	CHW performance on training documents and checklist.	We have created a checklist and training documents in preparation for hiring our CHWs this month.	We will wait and see if they need to be edited as we hire these staff.
Identify and develop Memorandums of Understanding (MOU) documents with key organizations that will be part of the referral pathway.	Signed MOU's.	In progress.	We are continuing to arrange meetings to complete MOU's. The community health workers will continue working on this once hired.
CHW work will unburden providers and other clinic staff.	Providers and clinic staff will report that the CHWs are positively impacting the clinic and appropriately reducing workload.	Waiting to hire.	Waiting to hire.
Develop referral tracking system to track referrals between clinic and agencies.	Documentation of referral tracking system including forms and workflows.	In progress- not completed.	In progress- not completed.
Establish electronic recording system based on the Oregon Health Authorities Touches Report to track CHW touches.	Documentation of the system for recording and tracking CHW touches (who, where, when, how).	In progress- CHWs not hired yet.	In progress-CHWs not hired yet.
Engage patients in their healthcare.	Patient Activation Measure (PAM).	We have reached out to the company	We have reached out to the company

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		and are working with them to purchase new software.	and are working with them to purchase the PAM software.
Determine patient's actual health score.	Chart mine to decrease or increase the patients' health score.	We have been having our care coordinator and a new hired panel coordinator work on this.	In progress still.
Increase providers' productivity.	Increase the number of patients a provider can see a day or week.	We are working on gathering data for all of December and January to assess a baseline.	Ongoing.
Join Traditional Health Workers workgroup.	Ongoing meeting attendance, attendance reported in quarterly report.	Due to weather we have cancelled and/or missed a few meetings. The few attended have been very helpful.	Ongoing progress.
Discuss goals, metrics, and outcomes with previous pilots or current pilots.	Ongoing discussion. Findings reported in quarterly report	Ongoing.	Ongoing.
Work with Benton County Health workgroup specifically to gain any additional barriers they are finding.	Ongoing discussion. Findings reported in quarterly report.	In progress not completed these last few months due to vacations/holidays.	Ongoing.

Community Helping Addicts Negotiate Change			
Goals	**Measures**	**Activities**	**Results to date**
Community Helping Addicts Negotiate Change (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 Oregon Health Plan (OHP) Application Assistance from Benton County Health.	October: 18 Applicants November: 22 Applicants December: 36 Applicants
	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 doc. Use SHS "Find A Doc" on line. CHANCE Lebanon is now a tobacco free place campus.
	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

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			Application assistance/ and HIV / Hep C testing monthly and weekly. Partnering with Linn County Alcohol & Drug, Mental Health, Family Tree Relief Nursery, and Albany Partnership. We are also part of the anger management, dual diagnosis, and 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 December 2016, registered with NPI and Oregon Medicaid for provide information. Will provide more detailed information.
	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 training curriculum, completed first class with 9 graduating students in November.

Community Paramedic (CP) : 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 Paramedic.	To be completed within the first quarter.		Completed.
Establish written protocols approved by Physician Adviser.	To be completed within the first quarter.		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.	Working with internal staff to create data collection/reporting program.	Ongoing. Established communication portal with physicians through EPIC.
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.	Working with Physicians to establish and process and identify a group of First Care Physicians to start directing patient referrals to CP. Attended "Remembering When" Conference with Samaritan Health Physical Therapist (Fire and Fall Safety Program)	Ongoing. Created Spanish program brochure for public distribution.
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 Palliative Care Program Director on how to integrate Community Paramedic Program services. Met with Benton Hospice and Evergreen Hospice regarding referral process and how to integrate Albany Fire emergency services and Community Paramedic Program.	Ongoing.
Identify and determine IHN-CCO patients with which to follow up.	Number of patients identified. Number of patients followed up with.		100% of identified patients have received follow-up.
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 members; 14.7% in the fourth quarter; and 14.6% 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 of ambulance transport to an ED.	Met with Samaritan Home Health Services to coordinate in-home patient care.	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.
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 increased from 2.8% to 8.3%. Overall transports of IHN-CCO members related to seizures increased from 5.3% to 8.3%.
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.		There were no referrals of IHN-CCO members to mental health professional during this quarter.
Provide in-home evaluation and services to reduce patient entrance into the healthcare 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.		There were no in-home visits to IHN-CCO members during this quarter.
Conduct a cost effectiveness analysis	Pilot cost, minus infrastructure cost, divided by unique member.		$1,837.55 per unique member. $749.53 per encounter.

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.	Quarterly mailer distribution to all eligible pilot members.	5% of measure met: success defined as 50%.
		Monthly distribution to newly eligible pilot members.	
Lower healthcare cost for IHN-CCO members by.	Medical to dental warm handoffs.	Referrals from primary care providers and staff to primary care dentist.	95% of measure met: success defined as 75%.
	Oral health screening questions	Screenings done by primary care	98% of measure met: success defined

	asked.	provider and/or staff.	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.	88% 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.	

Eating Disorder Care Teams: Willamette Nutrition Services			
Goals	**Measures**	**Activities**	**Results to date**
Development of Comprehensive School and Community Treatment (CSCT) practitioner pool and advisory board.	Documentation of names and contact information.	All practitioner pool goals have been met and exceeded: 46 total practitioner of various disciplines recruited. Emails, letters and face to face recruitment methods were used and a letter of invitation pus a contact sheet and short questionnaire were employed in recruiting efforts. Advisory board is recruited. All names have been collected and documented. An office assistant was hired to help collect, organize and maintain documentation.	The practitioner pool is recruited and has completed an initial short questionnaire on their perceived level of competence regarding eating disorder treatment. The advisory board has been identified and as of December 31st the advisory board has had two conference calls. Documentation is securely housed and maintained.

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Develop referral pathways and marketing protocol.	Percent increase over time of IHN-CCO members referred to the CSCT.	Referral pathways are being identified and marketing methods are being developed. One marketing tool will be utilizing secondary levels of eating disorder identification and screening such as county health departments, schools and other agencies. Once the provider pool is trained, the fact that they exist will be marketed to health departments, schools and other agencies.	Our physician has contacted key individuals at Benton and Lincoln county health departments and the health departments are interested in doing eating disorder screening. She has spoken to over 30 Corvallis school district counselors who are interested in doing screening. Screening will lead into the referrals pathways. Our physician is actively working with Samaritan Mental Health on referral pathways and screening protocols.
Development of training program and best practices protocol.	Percent of practitioners receiving training and using protocols.	The training curricula are being developed with 15 nationally recognized experts in the eating disorder field agreeing to be part of the training effort for this grant. Legal contracts have been developed being sent to trainers.	Our Physician researched adult active learning methods and consulted with Harvard University, which has done research in this area and developed methods to enhance adult learning in healthcare practitioners. For the grant training a learning platform has been purchased called QStream. This will be customized for this grant. Additionally a web site for delivery of podcasts and short webinars has been developed and it also will host a list serve and forum so providers can discuss concepts and communicate with one another.
A reduction in the number of people diagnosed with eating disorders and being admitted for inpatient treatment will occur	Collect statistics on hospital admits for specific diagnoses	Part of the best practices protocols involves screening for eating disorders in various agencies. As screening is put into place across the Tri-County area, people will be diagnosed earlier and therefore will have a higher chance to avoid becoming severe enough to be admitted to the	Our Physician has not collected statistics from the IHN-CCO to date. Various agencies have been contacted (school districts, county health departments, and school based health clinics) to discuss screening procedures.

		hospital.	

Expanding Healthcare Coordination (EHCC): Samaritan Health Services (SHS)			
Goals	**Measures**	**Activities**	**Results to date**
Engage patients in their healthcare.	Patient Activation Measure (PAM) Score.	IS purchases tickets submitted.	Lebanon: TBD Albany: TBD
Blood Pressure (BP) management.	Blood pressures measured in the office.	Work Instruction completed for Medical Assistants (MAs). Patient high BP lists are being reviewed and outreach is ongoing to schedule Nurse visits or OV for BP checks.	Lebanon: Wunderle 67.3% Fitch 67.3% Albany: 65.38 %
Hemoglobin A1C's at goal.	Hemoglobin A1C.		Lebanon: Wunderle-15.6% Fitch- 10.4% Albany: 14.1%
Hemoglobin A1C's measured.	Frequency of A1C measurements.	Needs clarification.	
Improve access.	Average visit per ½ day clinic.		Reporting in process.
Improve access.	Average time from appointment request to occurrence.		Reporting in process.
Improve patient satisfaction.	Clinic created survey.	Needs to be developed.	N/A
Improve provider satisfaction.	Clinic created survey.	Needs to be developed.	N/A

Health & Housing Planning Initiative: Williamette Nieghborhood Housing Services (WNHS)			
Goals	**Measures**	**Activities**	**Results to date**
Increased access to healthcare for target populations.	Number of new enrolls into IHN-CCO. Number of referrals to healthcare providers.	Helped connect recently hospitalized resident to interim Primary Care Physician (PCP) services, while the resident established care with PCP. Distributed newsletters each month to all residents, focusing on flu vaccinations, establishing care with primary care physician and eviction prevention and housing stabilization resource sharing.	6 referrals made to healthcare providers. In September 2016, Health Navigators (HNs) made 111 touches, 100 (15 minute) increments, totaling 1500 minutes of time. In October 2016, Health Navigators made 161 touches, 119 (15 minute) increments, and totaling 1770 minutes of time.

		Health Navigation office hours at Sweet Home properties and the Hotel Julian and resident meetings scheduled by request.	In November 2016, Health Navigators made 51 touches, 54 (15 minute) increments, and totaling 810 minutes of time. December 2016 touches are still being processed and will be included in Q1 2017 report.
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.	16 WNHS residents received blood pressure and blood sugar screenings.
Decreased hospital and Emergency Department 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 Regional Health Information Collaborative (RHIC).	Nothing to report.	Nothing to report.
Enter into Memorandum of Understanding with healthcare provider to deliver two onsite services.	Memorandum of Understanding in place by April 2016	Two Dental screenings delivered on-site. Meeting with Samaritan Pediatrics to coordinate delivery of wellness programs. Connected with the Linn County Health Department. Organized two health forums to be held on-site at our properties.	Nothing to report.
Develop Health and Housing Plans for existing and future housing developments that integrate healthcare services, intervention,	Research successful models to help define measurements and metrics and capture data. Gather baseline data and indicators	Nothing to report.	Forming a committee to discuss opportunities for senior housing. Recruiting new health and housing contractor/staff to assist with plan.

and prevention into affordable housing.	from Community Health Improvement Plan (CHIP) and IHN-CCO Transformation 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.	8% decrease year to date.
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 program.	64% decrease year to date.
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.	100% decrease year to date.
Improved symptom management.	Patient/caregiver report of improved symptom management.	Provided home based palliative care to IHN-CCO patients admitted to the program.	57% reported improved symptom management in at least one symptom.
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.	43% reported an improved quality of life since being admitted to the palliative care program.
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.	43% reported increased understanding of their disease process and 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 the pilot.

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.	33 calls after business hours that could have resulted in an ER visit or hospital admission.

Improving Pain Outcomes and the Patient Provider & Therapy Referral Care Pathway: Dr. Cuccaro			
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 5 clinical groups. Post-survey collected from 4 groups.
Decrease therapist fear avoidance beliefs.	Fear Avoidance Beliefs questionnaire.	Provider pre-survey.	Pre-survey collected from 5 clinical groups. Post-survey collected from 4 groups.
Improve therapist understanding of pain neurophysiology.	Neurophysiology of Pain questionnaire.	Provider pre-survey.	Pre-survey collected from 5 clinical groups. Post-survey collected from 4 groups.
Tri-county Primary Care Patient Centered Home clinic participation.	Number of participating clinics & location.	Clinical group recruitment.	Eight clinical 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 5 clinical groups. Post-survey collected from 4 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 Benton County Health Services (BCHS) Community Health Worker (CHW) Serve 85 Mothers/Members. Family Tree Relief Nurse (FTRN) Peer	Referral forms. Patient engagement touches data.	BCHS: Clinic sites are starting to use CHW services. Referrals are coming through, especially at the Elm Street site. CHW continues to work with Linn County Public Health as part of their maternal health team.	BCHS Touch Data: • Q-4 client numbers: o Linn County – 21 o Elm Street – 32 o North Albany – 5 • Total clients seen – o Linn County-90 o Elm Street-77 o North Albany- 13 o Total 180

Support Specialist (PSS) Serve 50 Mothers/Members.			FTRN: • Q4 client numbers o Elm Street 2 o MCC-12 o CHW-2 o Linn County-1 o Other 2 o Total-19 • Total clients o Q 2 27 o Q 3 13 o Q 4 19 Total 59
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 continues slow due to slower implementation of CHW services in Obstetric (OB) clinics than expected.	No progress to date. This goal has not been met. FTRN: BCHS CHW and FTRN Peer Support refer clients through phone/meeting referral.
Establish electric information sharing pathway with Adult Primary Care Provider & Peer Support Specialist (PSS).	Patient engagement touches data. Report to PCPCH of progress on screenings, assessments, community services accessed.		Staff tract touches data and sent to IHN-CCO for claims analysis. Unable to develop electric info sharing pathway.
Complete Adverse Childhood Experience Survey (ACES) screening on 95% of children and adults enrolled in services by FTRN PSS.	Completion of Adverse Childhood Experience (ACES) survey.		FTRN: 59 Served- 53 screened at 2 month service. 6 remaining will be screened at 2 month of service that happens after December 2016.
Using CHWs will decrease provider stress and increase provider satisfaction.	Provider survey.	Because of slow adoption of CHW in the clinic setting at the OB sites, it is still too soon to know if having a CHW available is seen by providers as decreasing stress levels.	Unable to assess at this time.
Using THWs to provide care coordination and case management	Referral forms. Patient engagement touches data.	BCHS: CHW is working with IHN-CCO on a dental Performance	BCHS: This is just starting to get off the ground and is still too soon to tell.

services will increase engagement by referred and/or screened members.		Improvement Plan (PIP) to see if having extra "touch" by CHW in the form of a phone call or warm handoff will increase pregnant women follow-through with dental visit.	More time is needed. FTRN: Through touches we can increase screenings and referral for services.
Use CHW to connect and engage referred members to Maternity Case Management services offered by Linn County Public Health.	Patient engagement touches data.	BCHS: CHW will be trained to be an Oregon MothersCare worker as part of her work with Linn County Public Health.	BCHS: CHW has engaged with 58 mothers in Q4 and 180 mothers to date in pilot.
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 continues slowly due to slower implementation of CHW services in OB clinics than expected.	No progress to date. This goal has not been met.
Provide additional training on 5P's (A screening tool for Past, Present, Parents, Partners and Pregnant) universal prenatal screening.	Improved workflow and comfort for prenatal screening from clinic and hospital feedback.	Three additional 3-hour trainings for identified "champions" from each clinic and hospital were conducted. Discussed with individual clinics/ hospitals workflow issues.	Identified and corrected workflow issues. Improved champions comfort with screening using the Universal Prenatal Screening. In addition, we have begun looking at integration of mental health/ behavioral health at the Samaritan OB clinic in Corvallis. We have discussed integrating a Social Determinants of Health into initial prenatal visits.

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 ten clinics (awaiting surveys from two clinics).
Decrease primary healthcare providers' Fear Avoidance Beliefs.	Fear Avoidance Beliefs questionnaire.	Provider Survey.	Baseline Surveys obtained from clinicians in twelve clinics.

			Post-Surveys received from ten clinics (awaiting surveys from two 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 ten clinics (awaiting surveys from two 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 versus those that do not.	Diagnosis and procedure codes provided to IHN-CCO. List of all participating clinicians provided. Claims data being collected. Preliminary data suggest no significant change in IHN-CCO claims rates. January 2016 meeting scheduled with Samaritan Health Systems to discuss clinician imaging ordering rates (i.e. overall rates).
Improve primary care healthcare providers' adherence to evidence-based chronic non-specific back pain treatment guidelines for medications.	Use of Non-Steroidal Anti-Inflammatory Drugs (NSAIDS), Acetyl-Para-Aminophenol (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. Preliminary data suggest no significant change in IHN claims rates. January meeting scheduled with Samaritan Health Systems to discuss clinician prescription rates (i.e. overall rates—not IHN claims data).
Tri-county PCPCH clinic participation.	Number of participating clinics and location.	List of participating clinics collected.	12 clinics enrolled to date. 12 clinics in post-intervention assessment.

Pediatric Medical Home: Samaritan Pediatrics (SP)			
Goals	**Measures**	**Activities**	**Results to date**

Care Plan Engagement.	Monitor the activity and participation in the care plan. Continue work with care plans for riskiest populations.	Continued follow up from our Q3 program Healthy Heroes continued with our in-house dietitian.	Throughout 2016, our nutritionist has a total of 193 visits, 140 of which were IHN-CCO patients.
Obtain 3-Star PCPCH designation for Samaritan Pediatrics Medical Home.	Meet 11 or more of the 13 standards listed in agreement.	SP has continued efforts to develop, track, and improve upon the 11 or more standards needed to meet this requirement – which was changed by the state to a 5-tier designation.	SP will be able to attest to meeting both the 3-star and 5-teir designations for their work throughout the pilot.
Increase number of patients seen by nutritionist.	Effectiveness of Care Measures.	SP has continued outreach and communication, as well as engaging our physicians to increase warm handoffs for patients in need.	Our dietitian more than doubled her visits in 2016 over 2015.
Increase Well Child Checks (WCCs).	Effectiveness of Care Measures.	SP has had an acute focus on this measure and have been working to engage patients via telephone, mailings and in office to increase our compliance.	As of December 2016 SP is at 65% for this measure. The benchmark for 2016 is 33.3%.
Continue to have open access to mental health providers.	Access and satisfaction with care.	SP has been streamlining our mental health services while still providing 40 hours per week of in-clinic service to our patients.	Measurements by our mental health team have proven that 76% of patients that used our mental health services saw a positive outcome. The national standard is under 20%.
Percent of Developmental Screenings performed in the first 36 months of life.	Effectiveness of care measures.	This has been a continued workflow process throughout the year.	To date, SP is meeting this metric at 89.7% - increased from 68.7% in 2015.

Pharmacist Prescribing Contraception: Samaritan Health Services (SHS) Outpatient Pharmacy			
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 to our community patients.	No progress to report although 2 sites will begin consultation and prescribing January 2017: Geary Street Clinic Pharmacy and Lebanon Community Pharmacy. Other 2 sites have remodel barriers relative to capital budget

			issues; current pharmacy locations do not provide for private consultation areas.
Decrease barriers to contraception.	Provide this service at each SHS outpatient pharmacy.	Policies and Procedures are completed to provide consistent and standardized care at all Samaritan Health Services outpatient retail pharmacies.	Stated Policies and Procedures are in place at all sites and will be active at the above go-live January 2017.
Reduction in Increase in unintended pregnancies in the SHS service area.	Increase in effective contraceptive use (CCO incentive metric).	No data to report at this time but targeted to go-live January 2017 at above indicated SHS outpatient retail pharmacies.	No data to report at this time but targeted to go-live January 2017 at above indicated SHS outpatient retail pharmacies.
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 data to report at this time but targeted to go-live January 2017 at above indicated SHS outpatient retail pharmacies.	No data to report at this time but targeted to go-live January 2017 at above indicated SHS outpatient retail pharmacies.
Develop Action and Communication plan for a closed-loop referral process with OB-GYN or (PCP) 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.	Our team is working with SHS EPIC outpatient to have general charting and messaging capabilities using the same platform as other providers in our clinics. The goal is to be also trained to schedule so when consulting with a patient who is determined to need a referral, the appointment can be scheduled at the time of the consultation with a later follow-up by the pharmacy to determine if the patient kept the appointment with the OB-GYN for contraceptives. The data and metrics would be one more indicator for our IHN-CCO partners.	No data to report at this time; meeting scheduled with SHS EPIC team on January 7, 2017. The urgency of this outpatient program is understood.
	Number of closed loop referrals that provide information back to Primary Care Providers/OB-GYN clinics.	No progress to report at this time.	No progress to report at this time.

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.	The tracking of the IHN-CCO member/patients who receive contraception through our SHS outpatient retail pharmacies will be reported through the outpatient retail software and referral will be reported through an excel spreadsheet as they are referred and as appointments are either kept or cancelled/missed.	No data to report at this time but two SHS pharmacy sites are set to go live January 2017 and we are actively working with SHS EPIC on EMR tracking and referral.

Physicians Wellness Intiative: Intercommunity Health Network-Coordinated Care Organization (IHN-CCO)			
Goals	**Measures**	**Activities**	**Results to date**
Development of communication pathways with Physicians.	Convene a Physician Wellness Advisory Committee (PWAC).	Completed.	4 meetings to date with key stakeholders attending. Next meeting this month.
	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.	Completed: MiniZ. In progress.	Completed Focus meetings held in Corvallis and Lincoln city. Additional meetings scheduled for Albany, Newport.
Assessment of Burnout.	Assessment survey administered to IHN-CCO physicians.	Partially complete.	Surveys completed by 31 physicians in 3 catchment areas. Surveys continue to be requested.
	Report on the state of burnout in IHN-CCO physicians.	In progress.	Final report by February identifying personal, departmental, corporate but mostly external changes.
Development of ongoing wellness monitoring plan.	Identification of quality measures for ongoing assessment of burnout.	Mini Z.	
	Establish annual review process that incorporates assessment of burnout/resiliency in physicians.	Not completed.	Need to schedule meeting with Human Resource (HR) directors to discuss putting criteria into annual

			performance manager or supervisory evaluations in ways that cannot be used against employees.
Development of direct and indirect interventions to reduce burnout and develop resiliency in physicians.	Develop resources (information, brochures, classes, counseling) for physicians.	Deferred by PWAC.	Coordinator is requested this goal be opened in upcoming quarter.
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.	Deferred.	
	Physician Wellness Program Effectiveness Review (report).	Deferred.	
	Develop evaluation tool to measure physician turnover within the IHN-CCO.	Deferred.	
	Design an experiment or survey to assess the relationship between reimbursement model and physician stress.	Deferred.	

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.	Setting up a workflow with medical home care coordinators, providers, and community participants to identify IHN-CCO members in the Lincoln City area with pre-diabetes.	The basic workflow is in place to identify IHN-CCO members with pre-diabetes through self-referral, provider referral, and electronic medical record review for provider approval. 165 eligible members have been identified to date.
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 process is established and functioning.	107 members were self-referred or were referred by providers to be recruited.
Develop pre-diabetes program materials.	Pre-diabetes program materials are tangible, useable product.	Pre-diabetes program materials were finalized and approved for	Program materials were published and ready for distribution.

		publication.	
Increase the self-efficacy of IHN-CCO members to impact their health.	Generalized Self-Efficacy Scale.	Self-Efficacy Scale forms finalized and approved for publication.	Generalized Self-Efficacy Scale form published and ready for distribution.
Decrease the weight, A1C, and/or fasting glucose of IHN-CCO members in the Lincoln City area with pre-diabetes.	Pre and post weight, A1C, and/or fasting glucose levels.	Baseline data on eligible IHN-CCO members is being compiled in the database.	Baseline data on pre-weight, A1C and/or fasting glucose is complete on 165 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.	Starting to collect initial data on member response during recruitment phase.	No specifics to report, continuing to collect member response data during the recruitment phase.
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.	BGCC – Q4 resiliency training. BGCC – Mental health connections. BGC-A – Q4 resiliency training. BGC-A – Mental health connections. BGC-A – Family OHP connections. BGC-GS – Q4 resiliency training. BGC-GS – Mental health connections. BGC-GS – Family OHP connections.	• 320 families gained access to Health Navigators, Patient Centered Primary Care Homes (PCPCH) providers, and Oregon Health Plan (OHP). • 4,730 youth have received resiliency training. • 475 1st-5th graders completed 12 activities over 10 weeks. • 104 HS youth completed 7 activities over 10 weeks. • 185 MS youth completed 7 activities over 10 weeks. • 59 members connected to mental health services. • 300 members completed training over 10 weeks.

			• 6 members connected to mental health services. • 1 family re-connected to Oregon Health Plan. • 409 members completed training over 10 weeks. • 14 members connected to mental health services. • 106 individuals 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.	Oregon State University School of Pharmacy: Asthma classes Prescription Drug classes Across all BGC sites: Western University of Health Sciences Diabetes classes BGCC – only: (Other sites are scheduled for January 2017).	• 364 3rd – 5th grade members participated with an average 25.6% improvement in pre/post survey scores. 73% improved greater than 20%. • 95 middle school members participated with an average 25% improvement in pre/post survey scores. 73% improved greater than 20%. • 51 high school members participated with an average 18.1% improvement in pre/post survey scores. 56% improved greater than 20%. • Total participants = 510. • Total average increase in pre/post survey scores = 25%. • 72% improved greater than 20%. • 107 3rd – 5th grade members participated with an average 23.6% improvement in pre/post survey scores. 60% improved greater than 20%.

			• 72 middle school members participated with an average 25.6% improvement in pre/post survey scores. 67% improved greater than 20%. • 17 high school members participated with an average 26.4% improvement in pre/post survey scores. 73% improved greater than 20%.
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 families will be signed up for Oregon Health Plan and IHN-CCO.	Families connected to Oregon Health Plan (OHP).	• 427 families across two counties have been connected to OHP information through family events.

School Neighborhood Navigator (SNN): Benton County Health Department			
Goals	**Measures**	**Activities**	**Results to date**
Increase the number/ percent of children who receive well-child checks after School Neighborhood Navigator (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.	SNNs continue to emphasize the importance of Well Child Check (WCC) visits.	Total Number of Well Child Check (WCC) touches since July 2016: 40 Informational touches. 33 scheduling touches.
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.	All schools have gone through their vision screenings. SNNs have followed up with students who had a referral.	Total number of vision referrals: 31 referrals in Q4. 47 referrals since July 2016. IHN-CCO staff will 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 Primary Care	Number and percent of children with touch/referral and with post-	SNNs are talking with parents about the importance of establishing care,	Total number of PCP referrals: 28 referrals in Q4.

Physician (PCP) after SNN referral to at least 50% or by pre-referral data if available.	touch/referral claim data.	seeing a PCP, and keeping preventive care appointments for their children.	50 referrals since July 2016. IHN-CCO staff will need to pull claims data report to find out if vision touch is resulting in appointments scheduled and kept.

Sexual Assult Nurse Examiner (SANE): Samaritan Albany General Hospital			
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.	Education provided to: • Albany Urgent Care Clinic (UCC), Lebanon UCC. • Samaritan Albany General Hospital (SAGH) Annual Medical Staff Meeting. • ED staff from Good Samaritan Regional Medical Center (GSRMC) & SAGH staff meetings. • ED Staff from Samaritan Pacific Community Hospital (SPCH) & Samaritan North Lincoln Hospital (SNLH). • SAGH Skills Day booth. • GSRMC Physician Continuing Medical Education (CME). • Outreach to physicians who requested additional information from survey sent out in Q3. • Planning educational trainings for the Coast for Sexual Assault Nurse Examiner's (SANEs) and staff. • Monthly meetings with the SANEs to help them with their certification and recertification.	5 referrals and consultations with Samaritan Health Services physicians or clinic staff. • Mock exams were presented to • Coast SANEs to help with their certification process. • Mock trials are scheduled to be done at SPCH in the spring.
Reduce wait times for sexual assault	SANE patient turnaround time.	Continuing to work with community	When patient presents to SAGH the

Patients.		partners including law enforcement and Center Against Rape and Domestic Violence (CARDV) to bring patients directly to SAGH. Educating the community at large to seek help at SAGH to decrease wait times.	wait time is less than 45 minutes if staff is on call, otherwise immediate. When presenting to other SHS facilities the wait times are less than one hour and then transported to SAGH.
Mitigate additional patient trauma due to lengthy wait times and/or are provided by untrained staff.	Patient experience surveys.	Because of past experience with surveys for patients, CARDV is collecting information from patients regarding their stay at Sarah's Place.	CARDV will be giving feedback on 1/11/17 at their staff meeting.
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.	Developing follow up care by working with medical, billing, EPIC, and clinic development personnel.	Still in development phase.
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.	Sexual Assault patients are sent directly to Sarah's Place. Sarah's Place Staff have been providing assistance to the ED, which provides additional staff to decrease stay and wait time. SANEs will be responding to all 5 Samaritan Health Services (SHS) EDs to help with wound documentation and education to recognize victims of abuse.	Since October 1, 2016 we have seen 39 patients in Sarah's Place, thus decreasing hours in the ED by 156 hours for other types of patients. Staff has responded to 3 patients in the ED for documentation.

SHS Palliative Care: Samaritan Albany General Hospital			
Goals	**Measures**	**Activities**	**Results to date**
Increase SHS Palliative Care engagement with patients and families to facilitate their participation in their own healthcare making decisions.	Increase referrals to Palliative Care (PC) Service. Increase patients with Physician Orders for Life-Saving Treatment (POLST) forms for Advanced Directive on file with Samaritan Health Services.	We have increased palliative care provider coverage. System-wide E-POLST project, workflow process has been signed-off and approved.	Fewer days without palliative care coverage. Our census continues to increase; month over month. Due to go-live February 2017.
Reduce pain and systems.	Pain and system control, as reported by patient.	The palliative care, care team, is in process of determining how to best	

		engage patients. Next step: Include patients in the decision making process – how do they want to be engaged.	
Reduce hospital length of stay and cost per day for defined patient populations (cancer, cardiac disease, chronic obstructive pulmonary disease and kidney failure).	Billing revenues, cost per day and length of stay.	We have redefined the patient population to focus resources on, with a defined goal.	Partnered with Population Health and Cardiology, to identify 50 Congestive Heart Failure patients, with the highest readmit rate.
Reduce hospital admissions/readmissions and emergency department (ED) utilization for patients with cancer, cardiac disease, chronic obstructive pulmonary disease and kidney failure.	Visit data for ED and hospital visits	We have done extensive research on this goal/metric, with palliative care colleagues across the country, and we have learned that this goal is too big to achieve during our first year.	What has come out of this research and networking, is a system-wide membership to the Center to Advance Palliative Care. Additionally, our medical director, operations director and senior leadership will be participating in the Center to Advance Palliative Care Leadership Center, which is a nationally recognized program. This affords us access to nation-wide palliative care comparison data, and access to palliative care experts and leaders.
Coordinate with Home Palliative Care Pilot to educate providers and patients on palliative care.	Determined by pilot.	We have partnered with the community paramedicine program in Linn County, and the Samaritan Pacific Communities Palliative Care Program.	

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 Special Education training.	• 9 Special Education Trainings.	• Individual Education Plan (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 trainings 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.	• 1 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.	• 1 Family Perspectives training was delivered in Lincoln County and one in Benton County. • A total of 27 providers registered and 17 completed. • 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 IHN-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.	• 1 CPS series was delivered in Benton County and one in Lincoln County. • A total of 31 family members participated. 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.	• 2 advocacy skill building trainings were delivered in Corvallis (May 2016) in partnership with Corvallis School District. • A total of 14 family members attended each training (8 Spanish speaking and 6 Arabic speaking).

			• 4 special education trainings were scheduled for November 2016. • December 2016 had a total of 42 registered participants. • 100% of evaluations indicate participants were satisfied or very satisfied.
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.	• 12 Parent Mentor CPS groups were completed in Lincoln County in 2016. • 11 family members participated in the first session, 10 family members participated in the second session and twelve families participated in the third session. • 1 CPS Tier 1 training was held in Lincoln County (June 2016). • 41 community members from agencies and families attended the training. • 1 Introductory CPS training was delivered March 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. • 12 participants indicated satisfied. • 1 trauma training delivered in Albany on July 6, 2016. • 21 participants indicated satisfied. • 1 trauma training delivered in Newport on September 1, 2016. • 22 participants indicated very satisfied. • 1 trauma training delivered in

			Corvallis on September 2, 2016. • 19 participants indicated satisfied or very satisfied. • 1 trauma training delivered on December 2016 in Lebanon. • 22 participants indicated very satisfied.

The Warren Project Nature Therapy: Ollala Center for Children and Families			
Goals	**Measures**	**Activities**	**Results to date**
Serve 56 youth in the first year of program.	Number of youth served by Warren Project.	Addressed barriers in the referral system to ensure community partners understand how to access the program.	We received referrals for 8 youth to begin services.
Decrease client safety risk factors.	Child & Adolescent Needs & Strengths Comprehensive (CANS).	Initial CANS assessments were completed at intake to establish a baseline for each client. We will not see any progress or lack of until the next assessment in March 2016.	Initial CANS completed for 7 youth with therapeutic service to begin after the holiday break in January 2016.
Improve client's strengths.	CANS.	Initial CANS assessments were completed at intake to establish a baseline for each client. We will not see any progress or lack of until the next assessment in March 2016.	Initial CANS completed for 7 youth with therapeutic service to begin after the holiday break in January 2016.
Improve client's ability to function well in life domains.	CANS.	Initial CANS assessments were completed at intake to establish a baseline for each client. We will not see any progress or lack of until the next assessment in March 2016.	Initial CANS completed for 7 youth with therapeutic service to begin after the holiday break in January 2016.
Improvement in client's connection with their culture.	CANS.	Initial CANS assessments were completed at intake to establish a baseline for each client. We will not see any progress or lack of until the next assessment in March 2016.	Initial CANS completed for 7 youth with therapeutic service to begin after the holiday break in January.

Decrease in client's emotional/ behavioral needs.	CANS.	Initial CANS assessments were completed at intake to establish a baseline for each client. We will not see any progress or lack of until the next assessment in March 2016.	Initial CANS completed for 7 youth with therapeutic service to begin after the holiday break in January 2016.

Youth and Child Respite Care: Morrison Child and Family Services			
Goals	**Measures**	**Activities**	**Results to date**
Recruit 15 new families to provide respite by December 2017.	The 15 new families will be counted and their information entered into Evolv, our electronic health record.	• Network with local church community. • Marketing through local newspapers, upcoming article. • Collaboration with IHN-CCO and DHS on recruitment of foster parents and brainstorming strategy. • Organizing foster parent training, seek resources such as CPR/First Aid, and Oregon Intervention System. • Recruitment strategy meeting. • Design recruitment ads. • Created excel tracking sheet for potential foster parents, and tracking sheet for work done/items purchases. • Post ad on Craigslist Corvallis/Albany. • Write up Planned and Crisis Respite Care email to send out to churches and organizations, searched churches online, emailed 10 area churches	• Goal/plan for scheduled February 2017 training cohort
Certify 10 new families by December	The 10 new families will be counted,	• Connect via Craigslist response of	• Two foster families invited to

2017.	recorded, and enrolled in certification.	two potential Foster Parents to include in February Cohort for training.	February 2017 training cohort for certification.
Develop authorization and billing system to coordinate referrals with IHN-CCO.	System is established and accepted by all parties; tracked on program spreadsheets.	• Communications with IHN-CCO regarding obtaining IHN-CCO members' respite authorization process.	• In process.
Orientation of respite services to clients and their caregivers.	Each client that has completed intake will receive an orientation to respite services.	• Began managing some initial requests for respite from Linn County. • Created a draft Mid-Valley Placement Sheet • Created a Mid-Valley client folder to hold incoming client referral paperwork • Reviewed Program Guide Sheet for updated needed for Mid-Valley respite program.	• In process.
Respite providers are representatives of population/culturally competent.	Compare demographics data of the geographic area with voluntary identifying information collected during recruitment/certification. Client/respite provider satisfaction surveys.	• Collect demographic data including culturally competence of interested foster parents as part of recruitment.	• In process.
Provide respite services to IHN-CCO members to stabilize families.	Number of respite nights provided and client/caregiver satisfaction.	• Attempted to place crisis respite members (2) in Portland area homes. However, both requests were withdrawn as alternative placements secured December 2016. • Begin intake of an IHN-CCO client referral.	• None at present.
Continue to develop working relationship with Albany Department	Measure number of community partners and resources provided.	• Researching Oregon Intervention System training in Mid-Valley	• Finalized Department Human Services space agreement

of Human Services (DHS) on occupancy and shared resources.	Outcomes will be measured by enhancing resource network.	region, reaching out to Trillium on potential partnership. • Collaboration with IHN-CCO and DHS on recruitment of foster parents and brainstorming strategy • Finalized DHS space agreement November 2016. • Discussed next steps for DHS space agreement October 2016.	November 2016.
Create sustainable, supported satellite office.	Cost, staff satisfaction and ability to complete tasks.	• Receiving/reviewing resumes to schedule interviews early January 2017. • Position posted Foster Family coordinator/certifier. • Developed job description for first position in Albany, foster care coordinator, submitted to Human Resources for approval November 2016. Created draft job description October 2016. • Hired a Morrison Foster Care Recruiter, started October 2016. • Start-up team meetings. • Organized Morrison task force for Planned and Crisis Respite Care Mid-Valley, to begin meeting in November.	• In process.

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	35 youth will be served in Wrap-around Case Management and/or	Youth are served in case management with shelter supervisors, supported by	• 31 different youth served in respite and emergency shelter, 5

risk factors.	Shelter Services.	case workers. Youth provided emergency shelter including basic needs, skills training, and educational support. Youth provided transitional shelter that were unable to return safely to caregivers.	different youth served in transitional shelter. • 39 youth engaged in our aftercare services, duplicate numbers for reported shelter numbers. • 18 different youth accessing our outreach case management services, not shelter. • 227 youth to date have been served by this grant funding.
	Number of youth who exit to safety.	Case management. Family mediation. Mental health services.	• 25 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.	Referrals for services through case management process.	• 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.	Casey Life Skills assessment. Intake process.	• 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.	Positive Youth Development Calendar of Events. In-shelter activities.	• 95% of youth engaged in required skill building activities.
	75% of families will participate in family mediation and counseling.	Mediation and counseling services offered to those who need it.	• 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 well-child exam.	Dental care partnership with Benton County Health Department.	• 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.
	100% will receive dental (Benton County only).	Referrals to Mental Health Therapist.	• Internal Referrals to Mental Health Therapist: 9.
	100% of youth who need it, will be linked to Qualified Mental Health Provider (QMHP) or Qualified Mental Health Associate (QMHA).		
	Will track the number of youth who required intensive psychiatric health services though IHN-CCO while in the care of Jackson Street Youth Shelter.	Case files – tracking.	• 3 were referred to higher levels of care residential treatment (Children's Farm Home, Saint Mary's School for Boys, and Northwest Behavioral Health).