2015 Q2 Pilot Quarterly Reports
Executive Summary

Objective:

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

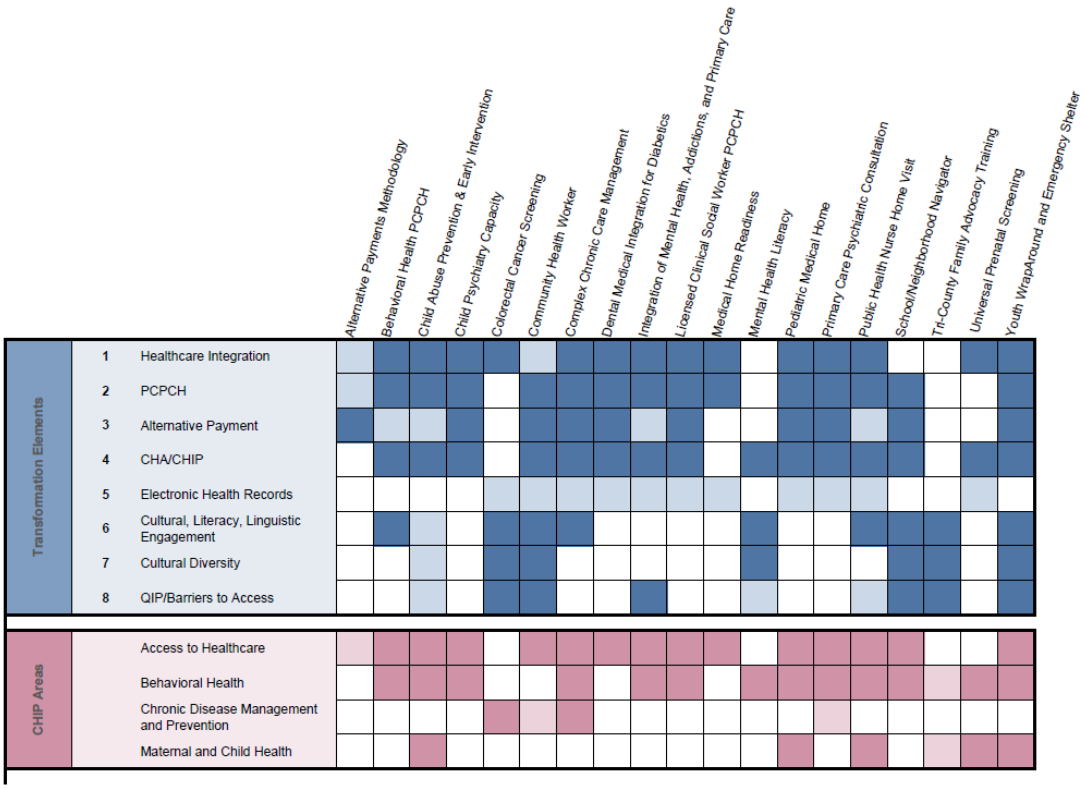
Summary of Findings:

- 22 reports from 18 Pilots with 100% reporting.
- 3 pilots reporting minor changes.
  - **Community Health Worker**: Minor budget change.
  - **Public Health Nurse Home Visit**, Benton County: slight staffing reconfiguration until Public Health Nurse can be hired.
  - **Public Health Nurse Home Visit**, Linn County: slight staffing reconfigurations to address issues and provide bilingual support.
- 1 pilot reports significant limitation from original proposal.
  - **Mental Health, Addictions, and Primary Care Integration** pilot limited by inability to hire key position.

Format:

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

Elements of Transformation and CHIP Areas Addressed:



State Metrics Crosswalk

State Metrics (Incentives and Penalties)			Alternative Payments Methodology	Behavioral Health PCPCH	Child Abuse Prevention & Early Intervention	Child Psychiatry Capacity	Colorectal Cancer Screening	Community Health Worker	Complex Chronic Care Management	Dental Medical Integration for diabetics	Integration of Mental Health, Addictions, and Primary Care	Licensed Clinical Social Worker PCPCH	Medical Home Readiness	Mental Health Literacy	Pediatric Medical Home	Primary Care Psychiatric Consultation	Public Health Nurse Home Visit	School/Neighborhood Navigator	Tri-County Family Advocacy Training	Youth WrapAround and Emergency Shelter	Universal Prenatal Screening
	1	Adolescent well-care visits (NCQA)	■												■					■	
	2	Alcohol or other substance misues (SBIRT)		■		■					■	■			■	■	■				■
	3	Ambulatory Care: Emergency Department Utilization							■						■			■			
	4	CAHPS composite: Access to Care		■	■	■		■	■		■	■	■		■	■	■	■		■	
	5	CAHPS composite: Satisfaction with Care																			
	6	Colorectal cancer screening (HEDIS)	■				■														
	7	Controlling high blood pressure (NQF0018)							■												
	8	Dental Sealants on permanent molars for children												■							
	9	Depression screening and follow up plan (NQF 0418)	■	■		■					■	■			■	■				■	
	10	Developmental screening in the first 36 months of life (NQF 1448)			■												■				■
	11	Diabetes: HbA1c Poor Control (NQF 1448)							■	■											
	12	Effective contraceptive use among women at risk of unintended pregnancy	■																		
	13	Electronic health record adoption											■								
	14	Follow-up after hospitalization for mental illness (NQF 0576)																			
	15	Mental, physical, and dental health assessments within 60 days in DHS custody													■						
	16	Patient-Centered Primary Care Home Enrollment	■		■								■	■	■		■	■		■	
	17	Prenatal and postpartum care: Timeliness of Prenatal Care (NAF 1517)															■				■

Section 1: 2015 Q2 IHN-CCO Pilot Reports Progress Summaries

Alternative Payment Methodology (APM): Benton County Health Department Federal Qualified Health Center	Sherlyn Dahl, Executive Director

Successes:

1) Completed development of a "Roles and Responsibilities" document outlining position responsibility.
2) Developed a plan to share information on the IHN-CCO APM pilot including communication at each quarterly all staff meeting and new documents to capture current projects and accomplishments.
3) The Chronic Health Care Management team is looking at provider schedule templates, patient access to care, and patient communication methods to try and streamline the patient intake process and increase capacity for provider visits.
4) Front Desk, Medical Assistant, and Panel Manager positions are staffed.

Challenges:

1) Struggling to fill openings for Chief Operations Officer, Registered Nurse Care Coordinator, and provider, but working with Human Resources to broaden and change advertising and recruitment for these positions.
2) Provider scheduling moving towards an "open access" approach to increase capacity, but the transition requires new supporting processes to be in place and staff trained before successful rolling out is possible.

Additional Information: "Desk manuals" are being developed for roles identified in the Roles and Responsibilities document that will be housed in an internal, secured website along with other information important to clinic functions (periodic reports, projects and accomplishments, outstanding issues with the Electronic Medical Record vendor, (OCHIN) and standing orders).

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

Successes:

1) No prior authorization required for Physical Therapy services speeds up patient recovery.
2) On site mental health provider now available at specific times for IHN-CCO members.

Challenges:

1) Continued challenges surrounding billing for visits (payment/refund request/rejects/coverage) and patient assignments and will likely persist until the website for checking/changing provider assignments is available.
2) Patients seeing more than one primary provider and not knowing they are assigned a provider even though each patient is called as they are assigned.
3) Unnecessary Emergency Room visits continue to be a challenge.

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

Successes:

1) Education of the staff and practitioners.
   - Pharmacist medication reconciliation has yielded many recommendations to practitioners.
   - Increase in Screenings and Decision Aids being used.
2) Patient engagement prior to seeing a practitioner and creating the Interdisciplinary Care Team (ICT) meeting.

Challenges:

1) Having staff monitor and complete these tasks is time consuming, but the importance of reaching out to all newly assigned IHN-CCO members is understood.
2) Finding time to educate the staff about specific work flows such as screenings, but workgroups have been created to map out the correct workflows as they pertain to EPIC, the clinic, and billing.
3) System of assigning risk to expansion population leads to lower rate for those patients. This needs to be reviewed.

Additional Information: Meetings are happening with EPIC and Information Technology departments regarding technology request. This project is significant and may need to be scaled back. Continued discussion will occur after the EPIC upgrade on 8/11/15. Tablets will be purchased and will use the new EPIC 'Welcome' module.

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Behavioral Health Patient Centered Primary Care Home: Corvallis Family Medicine	Tracy Bluhm, Marriage and Family Counselor
Successes: 1) Increased referral numbers from Primary Care Providers (PCPs). Mental Health (MH) provider has met pilot goals of patient referrals and is near capacity due to increase in education and advertising to patients. 2) Increased patient follow through on therapist referrals as patients enjoy not having to establish a relationship with someone in a separate facility. 3) Corrected difficulties with billing with increased education from IHN billing staff. 4) Integration of care has led to greater adherence to treatment plans and overall positive reports by patients. Patients' are satisfied having the MH provider check-in, assess medication results and side effects with patient, as well as increased communication with providers.	***Challenges:*** 1) Billing process. MH provider and billing staff attended a webinar to clarify some billing questions followed by a meeting with Carla Jones Reimbursement Manager at IHN-CCO to answer remaining billing questions and allowing Corvallis Family Medicine (CFM) to clarify billing confusion and have insight into possible ways to bill for services when pilot is complete. 2) Making project sustainable.
Additional Information: Exploring a request to change the pilot to allow MH patients at CFM be treated with non-CFM PCPs. This is a result of patients contacting MH provider at CFM for services due to referrals from other practitioners, word of mouth, and advertising.	

Child Abuse Prevention & Early Intervention: Family Tree Relief Nursery	Renee Smith, Executive Director
Successes: 1) Staff completed the 6 week Community Healthcare Certification training and submitted certification paperwork to the State of Oregon. 2) Enrollment of 11 new families with extreme risk factors, 5 English speaking and 6 Spanish speaking into caseloads. Staff is working closely with the Traditional Healthcare Workers at Mid-Valley Children's Clinic to assure families are aligned to a medical home and to receive new referrals to the program.	***Challenges:*** 1) Recruiting and hiring a bi-lingual staff person; addressed this by transferring a current bi-lingual/bi-cultural staff person to this position and enrolled families to her caseload. 2) Training in Portland was stressful due to staff needing to travel two days each week for six weeks. Two additional staff will be sent to this training in the fall and looking for closer options.

Child Psychiatry Capacity Building: Samaritan Family Center	Caroline Fisher, Psychiatrist
Successes: 1) Parents and patients really like the system and appreciate not coming in as frequently, but still having the office be responsive to their needs. Psychiatrist is comfortable with the patient calls and feels able to manage them from a distance successfully and safely. Patients are getting better and psychiatrist can monitor that concretely.	***Challenges:*** 1) Getting information out of EPIC. We have been approved to have our compliance person have EPIC reporting privileges but with the latest EPIC rollout, there hasn't been bandwidth to achieve that yet. 2) Billing is difficult. 3) Discharges are difficult in part because of patients not wanting to leave and some are much more brittle than we had expected (fine for 3 months, in crisis for the next few months, okay again for 3 months). Psychiatrist suggests needing a more aggressive approach to collaborating with pediatricians and help them feel more comfortable with the discharges. Currently we only discharge to Samaritan Pediatrics as they have an ongoing pilot and providers know and trust that psychiatrist will continue to consult. 4) Psychiatrist is shorthanded in the department, making it difficult to put as many

	hours in to seeing patients. Actively recruiting for a child psychiatrist and/or a nurse practitioner.

Additional Information: Because pilot is on a per capita basis, total cost to IHN-CCO has gone down with fewer patients on the caseload, however, that is expected to be temporary. Other practitioners are asking if there would be a possibility for them to switch to this method of patient care.

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

Successes:

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

Challenges:

1) A timeline has been developed as a living document to align all project components and keep each other informed about the pilot timeline.

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

Successes:

1) Geary Street and Mid-Valley Children's Clinic (MVCC) staff are willing to work out the initial process "bugs" with program manager and stay optimistic that project will succeed.
2) Placing CHW at MVCC has gone very well and the program manager prepped staff of the addition of the CHW. MVCC had designated space for CHW, utilize EPIC quickly, and referrals to the CHW came quickly.
3) The "iterative process" seems to be successful –creating a process that had the fluidity to fit the need.

Challenges:

1) CHW's placement at Geary had an uneven start with no designated space, difficulty getting started in EPIC, and issues with communication and referrals. Working through the challenges, documenting concerns, and looking for process and system changes to improve navigator integration and rollout at future sites.
2) Communication stream is challenging of who is communicating with who on project details. The Program Manager is creating a Communication Template for Placement Agencies that will identify who needs what level and type of communication. Also, additional people will receive informational emails.
3) Continued impatience about the perceived slow pace of the CHWs and their ability to take on self-management education and coaching. Although I understand the impatience, adequate and thorough training will ensure patient safety.
4) The initial referral process that referrals would come from the provider to the social worker to the CHW – is not working. Reasons for this are:
    a. Providers want the CHW for a "warm hand-off" – Hand-offs needs to be spontaneous and in-the-moment.
    b. Providers are still uncertain about what the CHW can and cannot do.
    c. Providers refer directly to the CHW instead of current protocol. Looking at the referral pathway at both sites to create a better system.

Change in Pilot: The evaluation objective has been delayed. Initial pilot budget had $10,000 set aside for evaluation. The contract with evaluator will be for $5,000 with the extra $5,000 moved to a "supply" category. This allows the purchase of supplies for self-management education CHWs will take with them to their sites.

Additional Information : "Stories from the Field" - a patient story from the navigator at MVCC:
"Last week I received a referral from one of the providers about a mom needing assistance with her child who has a developmental disability. Mom requested information on how to get a new fitted car seat, a stroller, and a step stool. The provider was unsure on how these items could be paid for or if this family was connected to Developmental Disabilities services, but referred the family to me.
I contacted mom and she informed me that she really needs all of these items in order to better care for her child but is unable to pay for any of these items out of pocket. At the time mom was not sure if she was connected with DD services. This family lives in Jefferson and is part of Marion County. Mom confirmed that she was connected with someone in Salem but was not sure if it was DD services. I called her contact and she is connected with DD services.

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The caseworker was so pleased to have me call her. I asked what I could do to better support her and help this family and she told me how much easier it is to assist families when there is someone at the clinic the caseworker can connect with directly. She also stated that she does not know much about Oregon Health Plan and having a health navigator at the clinic was very helpful. The caseworker told me how to get the process started and now we are waiting to hear about approvals. I called mom to inform her of the status of her request and she expressed so much gratitude. She said that she didn't know where she would be at right now in this process if it wasn't for my help and that she is glad that there are people like us who are willing to take the extra time to help families like hers."

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

Successes:

1) Holding the group together in the absence of The Corvallis Clinic (TCC) leadership has been a great success. The care plans, protocols, patient education and nurse education have been completed and are currently being implemented.
2) The original 25 patients who started the study will be brought back in to have the protocols and gap analysis completed.

Challenges:

1) Getting patients to sign up. Continued efforts by the nurses explaining the pilot benefits seem to be dismissed by the majority of potential patients.
2) Nurse compensation was an initial issue but an agreement was developed through negotiation with TCC administration.
3) The tablet software has had glitches and some connection issues all of which have been resolved. The tablet supplier is bringing on a second programmer.
4) CCCM nurses were concerned that patients, who might need emergency services, may try to first contact the nurses for instruction. A wavier and educational material was developed to discuss with the patients during the onboarding session to ensure that those who need help would know what to do.
5) Diabetic patients could not interact well with the touchpad screen so styluses were ordered and seemed to work.

Additional Information: Once the second list of patients has been contacted, TCC will work with IHN-CCO to file for an extension. No additional dollars will be requested but the ability or method to capture dollars from the existing agreement will be asked of IHN-CCO.
The patients who have remained in the pilot report enjoying the contact and interest from nurses. Four of the diabetic patients have shown remarkable improvement. The pilot implementation will likely take a minimum of three to four months of full time work is required to begin and implement a pilot of this complexity.

Dental Medical Integration for Diabetes: Advantage Dental Services, Capital Dental Care, ODS Community Health, Willamette Dental Group — Eryn Womack, on behalf of Pilot Workgroup

Successes:

1) Clinic workflow incorporation has been successful.
2) Project coordinator hired.
3) Communication and issue tracking between project coordinator, dental plans, and clinics.

Challenges:

1) Primary Care Physician (PCP) and Medical Assistant (MA) referrals to dental plan. Recommended review of daily schedule in advance and remind PCP/MA of eligible Pilot patients to be referred.
2) Warm hand-offs from Medical Clinic to Dental Plan. Medical Clinic was referring patients to dental office instead of Dental Plan. Explained the Dental Plan needs referral contact and they will set up patient appointment. Phone number was corrected for a Dental Plan.

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

Successes:

1) ***Increasing patient access to mental health care in a low-barrier, low-stigma***

Challenges:

1) ***Accessing the gathered data.*** There is currently no simple method for pulling out

context. Majority of patients seen had never seen a mental health professional; would not have sought outside care even if referred by physician. Having in-house care, especially when the provider was introduced by the physician while patient was in a regular health appointment. Being able to access care immediately or within days of request.

2) ***Availability of trauma informed, narrative and brief psychotherapy care as alternative to behavioral-only care.*** Most patients with complex medical histories of persistent medically unexplained symptoms (MUS) were found to have trauma in childhood (assessed through interview and/or Adverse Childhood Experience surveys aka ACEs scores). Of these, most reported having never disclosed or if disclosed, discussed these events with a medical or mental health clinician.

   Being able to "Tell the Story" allows patient and clinician to look at and normalize behavioral and emotional reactions to the trauma and examine common mal- or over-adaptive coping skills in a way that is validating, not shaming.

   Patients have expressed relief when able to disclose past abuse, process and begin to change leftover negative effects. At least five patients have been able to take action on long standing drug and alcohol problems as they gained insight into the reasons behind their numbing behaviors. Even in cases where there is no report of childhood trauma, asking the patient to tell their story resulted in more effective treatment.
3) ***Offering a trauma recovery psychotherapy group for survivors.*** Serves individuals with persistent mental and physical illnesses. Members have been great sources of comfort, support to each other; were socially isolated prior to the group.
4) ***Offering free psychoeducational classes to teach mental and physical wellness skills*****.** Habit Busters, StressBusters and Mindfulness Skills provided practice and tools in a low-barrier setting. Patient satisfaction averaged high to very high for these classes. Patients reported they use these skills in daily life. LCSW also facilitated a nurse and a Medical Assistant (MA) getting training in a well-researched curriculum for persons with chronic conditions. The second series of those classes is underway; patient response is positive. Several reluctant patients who would benefit from individual counseling made appointments for it after attending these groups.
5) ***Use of GAD-, PHQ 9, ORS and SRS to track progress.*** Given at the beginning of sessions and groups, these provided ways for clinicians and patients to see progress over time. GAD and PHQ measure self-reported symptoms associated with mental distress. Patients showed progress over time, often in as few as two or three session. Session rating and outcome rating scales allow LCSW to see patient's self-report of general wellbeing, feelings of being heard and understood,

PDQ, GAD and other scores that have been compiled in the electronic record. GAD7 scores cannot be accessed at all unless the LCSW is in an open encounter with patient at the time. The hope is to have data available by 4th quarter and in the charts, the majority of patient scores are dropping below clinical level at 5-6 visits or less. Until recently when a separate tracking category was added for warm handoffs, those notes were contained within Medical Doctor notes and could not be pulled out for separate viewing. Even the number of patients found is inaccurate: Clinic manager found 263 patient visits; by hand counting ONLY closed patient encounters from scheduled visits (doesn't include telephone, email, some warm handoffs) 294 was found for same period. PLAN: Continue hand counting, begin to keep log/spreadsheet of additional contacts, meet with EPIC and data analyst staff to find ways to access "hidden" outcome scores.

2) ***Time*****:** LCSW has consistently worked 20% additional unpaid hours toward grant, in part because of intensity of paper/electronic requirements beyond actual patient contact time, and in part because of time needed for development, group planning, meetings and administration was not carved out from patient availability. PLAN: Have added time for administrative and planning duties held out from patient time. Have added a "planning/reflection/data" day each month.
3) ***Collaboration with behavioral care.*** This grant is a demonstration model of integrated mental health care provided from a clinical social work model; the behavioral program follows a specific treatment protocol and a 30 minute, 4 session model. These can be complementary but there have been misunderstandings and a lack of collaboration in supporting the model from the behaviorist program. The providers on the other hand have been supportive.
4) ***Master of Social Work (MSW) Student Placement*****.** Samaritan Health has not had MSW students and the process of getting this approved and moving forward has required coordination between several departments. The final go-ahead has not been given although we have students who are ready for (fall 2015) placement.

perception of fit of approach and overall satisfaction with process. SRS scores indicated patient's comfort and perception of effectiveness of therapist/sessions was very good to excellent. Numerous studies suggest relationship (trust, feeling of "fit") are more highly correlated with positive outcomes than particular methods of treatment.

6) ***LCSW becoming certified to offer training in Mental Health First Aid (MHFA).*** LCSW completed eight days of intensive training to offer courses for certification in MHFA for Youth and MHFA for Adults, allowing her to offer full day free courses to the general public in MHFA through the Mullins Foundation. Monthly and free of cost, up to 30 participants learn research validated information on recognizing and providing education, support and early intervention to persons with mental illness.
7) ***Provision of clinical social work perspective and services in the Medical Home Model.*** LCSWs are uniquely trained to offer holistic and empowering care. Ethics and core competencies in this field emphasize cultural sensitivity, self-sufficiency, and case management. Being able to connect patients to resources, provide practical tools for self-care, and meet patients where they are at increases patient satisfaction and improves outcome. LCSW provided physicians, medical staff, and patients with information about mental health, wellness tools, local resources, and culturally appropriate care through consultation and informational emails. LCSW's in-house availability led to warm handoffs of patients directly into mental health care.

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

Successes: N/A

Challenges: N/A

Additional Information: Contract was finalized on 6/8/2015 and work began in July therefore no successes or challenges to report at this time.

Mental Health Literacy (2): Linn, Benton , and Lincoln Counties — Cristie Lynch, on behalf of Pilot Workgroup

Successes:

1) Engaging the Latino community: Latino focus groups have been very instrumental in helping with the language of the campaign. The focus groups have also helped build trust among key leaders and Latino based community partners.
2) Increased partnerships/collaboration: Efforts to increase mental health awareness have resulted in new collaborations across Linn County including most recently the table tent project supported by Linn Together and the Mental Health Advisory Board.

Challenges:

1) Finding Spanish translation resources that provide both appropriate education level and dialect. Latino focus groups helped align our message so it was displayed in the most meaningful terms and dialects.
2) Determining the best way to deliver the educational campaign in a culturally appropriate way for Spanish speakers in the service area, which represent several different dialects widely dispersed across large rural areas. Latino focus groups helped to determine messaging and most relevant media for campaign.
3) Securing sufficient outreach assistance via interns or community partners; really lacking connections in Lincoln County - will need to rely on IHN-CCO staff to help with this.

Additional Information: The only changes have been in the media mix and the associated costs. It has not impacted the overall budget. Pilot expansion has been recently

approved at 7/30 DST meeting.

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

Successes:

1) Time for referral from provider to our Behavioral Health Specialist. An increase in the number of IHN-CCO patients that present with Behavioral Health needs.
2) Able to solve billing problems. Most CCO visits were unpaid or denied due to confusion in coding between behavioral and mental health. Worked with the CCO and resolved this issue.

Challenges:

1) Not being able to recruit a LCSW. Attempts are being made to be more creative with recruiting; unfortunately it has not been successful.
2) Continue struggles with obtaining a memorandum of understanding with Lincoln County Mental Health.

Additional Information: Still attempting to hire an LCSW within the next few months. If unable to do so it could significantly change the pilot goals and measures.

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

Successes:

1) The interdisciplinary care team that meets every two weeks has been very successful. This is a time for all of the disciplines to come together and discuss specific cases.

Challenges:

1) Getting ahold of patients that are non-compliant.
2) Receiving no baseline data from IHN-CCO to know whether we are improving.
3) Risk stratification process in EPIC. This process is not always accurate (process is being addressed).

Change in Pilot: Pilot refocus has been recently approved at 7/30 DST meeting.

Additional Information:

Successful example and outcomes of Registered Nurse Care Coordination (RNCC)

- Child Development and Rehabilitation Center (CDRC) referred child to the clinic. Child with developmental needs.
- RNCC setup Mental Health (MH) therapy for the child and family counseling for the family
- Monitored medications.
- CDRC recommended specific equipment to support the child's developmental learning; however the referral was submitted. RNCC called the insurance, but the equipment was not a covered benefit. RNCC followed up with CDRC and identified the referral for equipment was not done to the appropriate place. Once the referral was completed, CDRC was able to supply the equipment.
- RNCC built good rapport with mother. Mother is open to suggestions, but needing lots of coaching and support for follow through. RNCC referred mother to FACT (Family and Community Together) Oregon to provide ongoing support for the development and follow through for the child's Individualized Education Program.
- Mother recently had a mental health crisis. RNCC referred her to MH acute services for further assessment. Upcoming referral for mom includes a Primary Care Physician visit.

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

Successes:

1) Increased the number of referrals provide new staff member a caseload of clients to follow. Existing staff were carrying a relatively high caseload. Working to decrease the amount of paperwork for the Home Visit Nurse program to provide more efficient service to clients.

Challenges:

1) Access to good reliable data from the state to match what we determined would be our data collection measures. Will need to redirect staff to collect data utilizing the ORCHIDS system in a way that gets at more of the specific data measurements.

Change in Pilot: With limited staff often out doing home visits it is difficult to provide on-site coordination with WIC (Women, Infants, and Children) appointments for our prenatal clients. WIC will be asked for referrals for the prenatal program and continue to utilize brief assessments through our Reproductive Health program at the time of the

positive pregnancy test. WIC will be updated regarding availability for prenatal home visits. Added one day of bilingual support to the home visit program which has not happened before. This will provide interpreting service and work as a resource person for our Hispanic clients.

Additional Information: Our bilingual/bicultural Medical Assistant (MA) will be trained in Yamhill County where MAs are utilized for Hispanic clients in home visiting under the guidance of the Registered Nurse. Developing MA duties as learning about the services the MA is qualified to provide to the Hispanic clients and utilize Yamhill's approach and lessons learned. Utilizing nursing students to assist with client education particularly regarding the use of substances while pregnant or nursing and ways to increase immunization rates in Sweet Home.

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

Successes:

1) Regional collaboration in the development of this pilot. Continues to be further strengthened as the needs are communicated to the State Public Health Programs. One example of this is asking a Doctor of Philosophy (PhD) to look at our Ages and Stages Questionnaire measures. No other county in the state is looking at the same data that is being asked for, so staff time is delegated to the requests. This has also provided focused attention on how to better use and get reports from ORCHIDS, the required reporting system.

Challenges:

1) Not being able to obtain the public health nursing services needed to expand the program. Public health nurse wages are not competitive with hospital nursing wages, losing potential prevention nursing services to acute care nursing services. Working with Human Resources to look at opportunities to bring in qualified candidates for population health nursing.
2) Differences in Electronic Medical Records (EMRs) and data collection mean the initial measures may require more work to see the real picture of current services and to project outcomes.

Change in Pilot: At present, being open to alternative staffing possibilities may help address the shortage of public health nursing services. Considering a Health Navigator to enable the current public health nurse workforce to expand their case load.

Public-Health Nurse Home Visit: Lincoln County Health & Human Services — Shelley Paeth, Program Manager and Supervisor

Successes:

1) Focused on learning how to pull data needed for this report, getting data set up and running in the electronic medical record, and reaching out to community partners to help meet the goals. All home visitors are able to access Alert II information for immunization status.

Challenges:

1) Still not exactly sure about pulling the correct data for this report. There is a learning curve and will need to ensure that the region is reporting data that is comparable. Open for suggestions.

Additional Information: This pilot project has moved forward in the ability to set goals and figure out how to measure if they are being met. Reviewing the results shows where to improve and what partners are needed. Bringing the attention of overall metrics to staff will assure consistency. Bringing staff along is important.

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

Successes:

1) Hiring third school navigator is a tremendous bonus for this project and for the families at Linus Pauling School. The navigator comes to the project with a wealth of experience working with a community agency in Albany.
2) Transitioned a navigator from one team to the school navigator team. This navigator also has a wealth of experience.
3) The community partner "meet and greet" was successful. Representation from Jackson Street Youth Shelter, Old Mill Center, Trillium, Juvenile Department, Oregon Family Support Network, and Court Appointed Special Advocate (CASA).

Challenges:

1) There has been significant key school staff changes and requires extra effort to do the outreach and information exchange needed for the sustainability of processes and procedures already in place.
2) One of the most significant staff changes is the principal at Linus Pauling. A meeting was set up with the principal after school ended that gave both sides the information needed to feel confident that the program will be able to start in the fall successfully.

Additional Information: "Stories from the Field" – how School Navigators have helped families connect to the resources they need.

Section 1: 2015 Q2 IHN-CCO Pilot Reports Progress Summaries

1) **Family 1:** The Navigator received a referral for a family that uses the local emergency room as a primary care center. Navigator got in contact with this family and found out that they have private insurance through Oregon State University but that insurance doesn't fully cover everything. The family's primary language was Arabic. Navigator identified that both children in this family were eligible for the Oregon Health Plan and asked the father of the two children if he was interested. The father applied for both his children. Navigator then explained the process of how it all worked and mentioned all the benefits the two children would have. The father mentioned how sons had gotten colds and how he was going to take them to the emergency room because they were sick. Navigator then assisted the father with setting up a primary care doctor for both the children. Navigator provided OHP ID numbers, dental, and vision locations where they could go. Navigator made doctor and dental appointments for both kids. The father now understands how he can use the dual coverage for his children. The father now knows how to use his insurance for his family and has primary care providers for his children.
2) **Family 2:** Navigator made a vision appointment after vision screening done at school for a family. Navigator determined they needed transportation services as mother of this family doesn't drive. Her husband always drives but works until late. Navigator provided transportation to All Family Vision Care for the vision appointment for child. The mom before the appointment was mentioning that she didn't think her child needed glasses and Navigator reassured it was an exam to make sure he had healthy eyes. After exam it was determined child did need glasses as he has farsighted vision. Mom was glad he had gone because she would not have known he needed glasses otherwise. Navigator also determined mom needed access to other services such as Operation School Bell, Supplemental Nutrition Assistance Program and dental appointments. Mom also needed assistance with calling the waste services in town to pick up her trash at home. Ever since she arrived in Corvallis, March 2014, she was unable to set up the service because of her language barrier. She now has trash services.

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

Successes:

1) Developing a relationship with the Spanish speaking student/family advocates in the Corvallis school district has been a great opportunity to deliver the Behaviors and the Individualized Education Program (IEP) and the 504/IEP trainings to both English and native Spanish speakers. There is an increase in the number of Spanish speaking families attending training.

Challenges:

1) Meeting the needs in Linn County due to local leaders believing that the training content may be duplicating already existing information for families. The Executive Director and Training Program Manager have been meeting with Linn County leaders to determine how the pilot goals can enhance or support what is already offered but it is projected to be a long term conversation.
2) Linn county families are attending trainings in Benton County and are requesting additional training in Linn County.

Additional Information: Requested to do an additional Family Support Group Facilitation in Lincoln County and have enough money in the current budget to accommodate this since the training in Benton County had fewer participants than was anticipated.

Universal Prenatal Screening: System wide — Carissa Cousins, Physician

Successes:

1) Assisted over 25 pregnant women with referrals to substance use and mental health treatment in the past three months. Children born into homes where there is substance use and mental health conditions are much more likely to be abused or neglected and suffer from poorer health. It is hoped that referrals have helped provide a healthier start for these babies.
2) Providers are using the same screening tool and it is located in a central, accessible location in the Electronic Health Record (EHR).

Challenges:

1) Some insurance companies are not paying for the midterm urine drug test. It was decided that if insurance will not cover the testing, it can be deferred unless there are other concerns. The utility of the midterm testing will be assessed after the program has been in place for at least 9 months. A representative from Oregon Health Authority (OHA) is working with those insurance companies to see if the coverage for the testing can be obtained.
2) "Growing pains" as we implemented the program universally for women at any and all times during their pregnancy. Some women were screened for the first time at the time of delivery and this appeared as invasive making some of the hospital nurses uncomfortable asking these questions when they had not been

asked in the clinic. As the project matures and more women become familiar with the questions since they are asked in a calmer, familiar setting of the clinic; we anticipate this issue will wane.

3) Women who eat poppy seed products have tested positive for opiates on the urine drug screening at the hospital. If this is the first time they have been tested and are not familiar with the purpose of the test, these positive tests have caused some stress for the patient, the Obstetrics providers, the pediatricians, and the nursing staff. Again, if these women are screened in the clinic, these conversations can be conducted in a calmer, more familiar setting. Unfortunately, due to the "poppy seed issue", some OBs have decided to continue using the verbal screening, but will selectively use urine testing. Will address this again with these providers when we have evidence to support universal urine drug testing throughout the pregnancy.
4) Integrating the verbal screening and urine drug testing done at TCC into EPIC. The labs will more easily be integrated and that is being worked on by the EPIC team. The verbal screening integration is more challenging and we will continue to have discussion with the nurse managers at Good Samaritan Regional Medical Center and the manager at TCC Obstetrics clinic to accomplish this.

Many of these challenges present helpful learning opportunities. Would like to see this program expanded to other areas, our trials and errors will allows further refine the program for them.

Additional Information: No significant changes to the Goals and Measures, but have expanded the program to include the lactation consultants and the health departments. Expanded to working on a state level to develop literature on marijuana use during pregnancy, breastfeeding and while caring for children.

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

Successes:

1) Working with the DST to understand this new stream of funding and successfully implement our pilot.
2) Helping youth obtain insurance and setting up initial medical appointments.

Challenges:

1) Developing a system to track measures to make reporting simpler and more efficient and communicating with those doing direct services on requirements of funding for youth in case management.

Additional Information: In Linn County Rural Outreach Case Management, we are working with a youth, female age 17, who is on private insurance with her guardians who have "dis-owned" her and are threatening to take her off their insurance. We are getting her on her own OHP so that she can continue to get her medication for her thyroid so it can be managed appropriately.

In Linn County Outreach Case Management we have been working with a youth, female age 13, who lives with her single father and older sibling. She struggles with severe mental health issues that are being managed appropriately but her physical health has been overlooked. Our case manager has been working with her and her family for the last 3+ months to set up, attend, and follow up on all necessary medical appointments. Currently working on getting her to the dentist for the last two months; we are helping the family navigate the paperwork and trying to iron out with the dentist what account the youth is under.

In Corvallis Overnight Shelter we just assisted a youth, female age 16, obtain birth control and set up her mental health services. Two needs that had not been met previously.

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

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

Alternative Payment Methodology (APM): Coastal Health Practitioners (CHP)			
Goals	Activities	Measures	Results
Develop a financial report, and review monthly.	Continuing to determine financial ongoing viability for using the Per Member Per Month (PMPM) methodology in the clinic.	Report developed	
Reconcile patient panels.	This is ongoing as patients are seen in the clinic. CHP checks Medicaid Management Information Systems for eligibility and the IHN-CCO panel list for provider assignment when a patient is seen who thinks they have or have had IHN-CCO.	Provider panel list compared to IHN-CCO panel list match	CHP are tracking and transmitting updated patient assignment lists on an ongoing basis.

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

Approve plan within the clinic, begin implementation of clinic transformation around care coordination and increase access.	This is worked on simultaneously with similar measures developed for Patient Centered Primary Care Home requirements.	Progress report by plan compared back to the plan submitted to IHN-CCO.	
Track performance metrics.	IHN-CCO developing metric monitoring reports.	Monitor progress of metrics related to Patient Access, Quality of Care, and Utilization.	Tracking three measures at CHP and billing and charting these measures as appropriate to provide requested data to IHN-CCO.
Track "touches" outside of normal billing standards.	Keeping careful track of substantive contact with patients outside normal visit parameters, including phone, email, and in-person consultations with staff outside provider list.	Data documented and shared with IHN-CCO each month.	

Alternative Payment Methodology: Samaritan Internal Medicine (SIM)			
Goals	Activities	Measures	Results
Advanced Medication Reconciliation	SIM has partnered with Samaritan Health Services Pharmacy department to have a pharmacist perform medication management for high risk 3 & 4 IHN-CCO patients and those with high cost medications. The pharmacist will begin in May (started in June) and will be at SIM once per week to start.	*Utilization:* Cost of prescriptions prescribed by the clinic	Waiting on final numbers from pharmacist I will send as soon as I receive.
Decision Aid creation	Developing decision aides to help patients make decisions on preventive services such as mammograms and colonoscopy screenings.	*Utilization:* Count of preventive services	Decision Aids are developed for: Colorectal Cancer Screenings, Prostate-Specific Antigen (PSA) and Mammogram. These are distributed into each of the physician exam rooms and discussed at weekly care team meetings.
Create Interdisciplinary Care Team (ICT).	SIM created their first ICT. The first meeting was held Friday, 7/17/2015.	*Quality of care and Utilization:* Count of ER visits	Attendees of the ICT meeting were case managers from IHN-CCO, pharmacy department, SIM behavioral Health, SIM Care Coordinator, SIM Managements and SIM practitioners. The ICT team is currently working through the list of *Emergency Room (ER) High Utilizers* that the IHN-CCO provided.
Screening, Brief Intervention, and Referral to Treatment (SBIRT) workflow	Workgroup met from clinics, EPIC and Regional Business Office (RBO)	*Quality of Care:* Screening count	Updated workflow has been created and dispersed. Education regarding the updated SBIRT workflow is occurring.

Depression Screening and Follow-up workflow	Workgroup met from clinics, EPIC and RBO on Friday, 7/17/2015.	*Quality of Care:* Screening count	Workflow for Depression Screening and Follow-up is being created. The work flow is EPIC dependent and need to ensure it is capturing the necessary items. Education for practitioners and staff will be scheduled soon.

Behavioral Health Patient Centered Primary Care Home: Corvallis Family Medicine (CFM)			
Goals	Activities	Measures	Results
Assessment of mental health morbidity using industry standard tools. *Transformation Element 1*		Use of industry standard Mental Health (MH) assessments (written).	A total of 24 patients (from onset of pilot in first quarter) received DSM-IV-TR diagnoses.
Expedited access to mental health and coordinated care within a primary care setting. *Transformation Element 1*		Tracking date of referral with date of first contact. Tracking attendance.	Total of 24 patients. Average of 14 active patients at a time (goal is 10-15). All patients had opportunity for appointment within one week of referral. Average number of visits per patient to date is 13. Average number of cancellations per patient is 2. Retention rate is 71%.
Integration of payment systems within IHN-CCO to ancillary practitioners. *Transformation Element 3*	Obtained a Division of Medical Assistance Programs (DMAP) provider number for MH provider. Billed IHN-CCO for MH services with a reimbursement of $0 to test billing process. CFM billing staff and MH providers have been working with IHN-CCO closely to understand billing procedures.	Provider number with IHN-CCO for billing. Screening, Brief Intervention, and Referral to Treatment (SBIRT) billing.	Exploring possibility of accepting IHN-CCO patients with non-CFM PCPs for MH services.
Establish a fiscally viable model that can be reproduced locally in other primary care settings. *Transformation Element 3*		Provider number with DMAP.	
Increase health literacy of patients in order to increase adherence to overall treatment. *Transformation Element 6,7,8*	Offered psychoeducation regarding medication for patients in high risk category who typically discontinue psychotropic medications. This has resulted in three patients maintaining medication regiment after education	Tracking Emergency Room (ER) visits for IHN-CCO patients. Tracking improvements based on re-assessment and scaling questions.	To date there has been one ER visit with IHN-CCO patients for incident not related to mental health. Reassessments show that all IHN-CCO patients that have attended at least five mental health sessions have had a decrease in some or all mental health

	received. Offering services in community settings when applicable; i.e. assisted living facilities and assessing in school settings when indicated. Collaborate with practitioners/leaders outside clinic when indicated; i.e. teachers, psychiatrists, drug counselors, residential settings, Department of Human Services (DHS), etc.		symptoms/complaints.
Increase referral numbers of IHN-CCO patients. *Transformation Element 1*	MH services at CFM have been advertised through Psychology Today website. Explanation of MH services has been put on website. Bio and photo of MH practitioner has been put onto advertising screen in lobby.	Meet the goal of 10-15 patients.	Increased communication with providers on referral process has increased active patients from 11 (second quarter) to 14 (current).
Integrate SBIRT into practice. *Transformation Element 1*		Billing for SBIRT services.	Therapist has worked with providers and staff to incorporate SBIRT screening and intervention into practice.
Increase collaboration through use of electronic documentation (EClinical Works). *Transformation Element 5*	Therapist has streamlined electronic charting which has led to greater ease of information exchange and collaboration between providers.	EClinical Works license for MH provider.	This has created an easier method for billing for MH services.

Child Abuse Prevention & Early Intervention: Family Tree Relief Nursery (FTRN)			
Goals	Activities	Measures	Results
Using an array of strategies to implement culturally appropriate and gender specific services for all the families that we serve.	Two Home Visiting Interventionist attended and completed Traditional Healthcare training from Multnomah County. Interventionist complete training and meet requirements for certification as Traditional Health Care Workers (THCW). Applying for certification through State of	Certify two staff members as THCW.	

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

	Oregon.		
Build caseload of IHN-CCO served high risk families with children 0-6.	Eleven families are enrolled.	Numbers of families enrolled with FTRN services.	English: Three- Mid-Valley Children's Clinic (MVCC) One-Dr Cardgallant- Lebanon One reports PCP but didn't disclose name Spanish: Six -MVCC
Home Visits.	Thirty three home visits.	# of home visits	English: Five families with three visits each (totaling 15 visits). Spanish: Six families with three visits each (totaling 18 visits).
Respite		# of sessions	Six sessions of three hours per session this quarter.
Respite		# of children attending	Twenty two children attending.
Ages and Stages Questionnaires (ASQ's)	Spanish ASQ totals are seven and Ages and Stages Questionnaire-Social Emotional (ASQ-SE) totals are seven this quarter respectively.	# of ASQ & ASQ-SE	
Link to Medical Home.		Link client to Medical Home.	

Child Psychiatry Capacity Building: Samaritan Family Center			
Goals	Activities	Measures	Results
Increase Capacity.	Number of patients.	Number of patients followed.	Due to work hour limits increasing capacity is moving slower than anticipated, but will try to expand next quarter.
Improve outcomes.	Individual outcome measures.	Structured, validated outcome measure by diagnosis.	This is going well, with better treatment outcomes or better documentation parents do not want to treat more aggressively.
Maintain Patient/family satisfaction.	Outcome calls.	Informal survey during patient visit, choice between calls and visits.	Most families like it (two families reported initially that they do not like it – and one has been won over recently).
Maintain/improve Primary Care Physician (PCP) satisfaction.	(none yet)	Survey.	Not enough discharges to warrant a survey yet.

Colorectal Screening Campaign (CRS): InterCommunity Health Plans (IHN-CCO)			
Goals	Activities	Measures	Results
By June 2015, adapt and implement OHA's colorectal	Decided to find another spokesperson to diversify the campaign.		Finalized design of print materials.

screening media campaign, reaching 80% of IHN-CCO eligible members, age 50-75, in the three-county region.	Developed a timeline for the full media campaign.		
By August 2015, disseminate CRS information beyond the walls of traditional health care settings by partnering with public health and other community organizations, reaching 20% of IHN-CCO CRS eligible clients.	Researched various channels for the media campaign in the local communities to supplement larger campaign buys like billboards and bus ads.		
By December 2015, distribute 3,000 FIT (Fecal Immunochemical Test) tests in selected Patient-Centered Primary Homes utilizing Electronic Medical Record (EMR) to identify patients aged 50 to 75 years, with 40% (or 1,200 patient member) adherence and return of stool test screenings.	PowerPoint was developed for presentations to Lincoln County Federally Qualified Health Centers (July 21), Samaritan Coastal Clinic Managers (July 8), Samaritan Valley Clinic Managers (July 23), and Benton County Federally Qualified Health Centers (TBD). Presentations will give the opportunity to inform clinic managers about the pilot and recruit participants to be involved. Developed a list of the ideal 10 clinics plus alternates to be involved in FIT test distribution based on number of IHN-CCO members served. Collecting information from the Samaritan Health Plan Operations Population Health staff to learn about their FIT test project and glean lessons learned for this pilot.		
By March 2016, utilize traditional health workers/health navigators to reduce barriers related to screening among Latino and Native American populations, reaching 5% IHN-CCO CRS eligible members.	Acquired report with breakdown of members reporting Race or Ethnicity of Hispanic or American Indian/Alaskan Native by assigned PCP clinic. Acquired a list of clinics that utilize traditional healthcare workers. Will use these lists when choosing pilot clinics.		

By June 2016, conduct evaluation of pilot and provide written documentation of evidence for replication.	Continue to develop the practice based research study outline.		

Community Health Worker (CHW): Benton County Health Department			
Goals	Activities	Measures	Results
Develop Hub model that includes target population, site criteria, and evaluation metrics.			This continues to be an ongoing process as the Health Navigators (HNs) settle into their new agencies. We have run into some "bumps" as the care teams at The Geary Street Clinic and Mid-Valley Children's Clinic (MVCC) decide how best to use the new HNs. In particular, the referral process has needed multiple discussions.
Hire, train, and supervise two CHWs.			Two newly trained individuals are becoming competent clinical health navigators. Both are Oregon Health Plan (OHP) application assisters, have gone through popular education and motivational interview training, and can function in the role of care coordinators. Currently in the process of building the HN's self-management education skills and working to finish their training. The hope is to have them start self-management education in their agency sites in August.
Send CHWs through state – approved CHW training and register with Oregon Health Authority (OHA).			One individual has completed her state-approved training and is now a certified CHW! The other will be sent to the next training offered.
Document staff training, roles, policies, and procedures.	Working on developing processes and templates for initial and ongoing communication with agency staff, based on experience to date. Examples are in progress at this time and will be included in the next quarterly report.		
Develop an evaluation plan that includes process and health outcome measures.			Progress on this objective has been stalled, with no substantive progress in the last quarter. This is an area of focus for the upcoming quarter.

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Complex Chronic Care Management (CCCM): The Corvallis Clinic (TCC)			
Goals	Activities	Measures	Results
Enroll high cost/high utilizing IHN-CCO patients with chronic medical conditions into the CCCM intervention.	After the first list of potential candidates was exhausted, IHN-CCO agreed to work with TCC to provide a second list. After cleaning, the second list provided 106 additional prospects. These patients are in the process of being contacted.	Identify and select patients.	The first list provided 115 potential patients, 31 signed up, 41 said they would consider the pilot but never agreed after up to 3 call backs, 33 said no on the first contact, 10 could not be contacted.
		Enroll 60 patients; follow for 12 months.	n=25 patients enrolled to-date – started with 31. One patient changed to private insurance, one withdrawn on his own, two others were withdrawn by physician secondary to a mental health crisis. Two patients are non-response to calls. Twenty five patients are being actively followed. Additional patients are being invited (see above).
Deliver the CCCM intervention.		Determine a staffing plan for nurse case manager coverage of the tablets.	Currently working with four nurse case managers, one pharmacist / project manager, one physician, six weeks of a family nurse practitioner, and an assistant on the pilot.
		Finalize care plans.	Care plans, protocols, and patient education is now complete for diabetes, hypertension, Chronic Obstructive Pulmonary Disease (COPD), asthma, Congestive Heart Failure (CHF) and Coronary Artery Dissection (CAD).
		Deliver care via the CCCM software.	Ongoing – asthma and hypertension have been added as separate disease.
		Address unanticipated difficulties.	The Chief Medical Officer left the organization leaving the pilot without physician oversight. Another physician has agreed to help with the project.
		Set up specific billing procedures with IHN-CCO to capture time spent.	Working with IHN-CCO to capture the touches and various interventions. Utilizing existing TCC billing methods was not possible due to the inability to separate pilot from legitimate billing and the nurse case managers do not have provider status to enable the software (NexGen and Allscripts) to bill independently.
		Hold regular project team meetings.	A weekly standing meeting is held that involves all project personnel on each Tuesday at 10 am.

Evaluate the intervention.		Conduct focus groups with both nurse case managers and patients—what is going well, what is not?	Dr. Bovbjerg will conduct these in late summer/early fall. Findings will be communicated back to the team and incorporated as necessary.
Communicate findings.		Present project findings at local, state, and/or national meetings.	Dr. Bovbjerg presented this project at the Oregon Health Authority's Innovations Café, on June 8.

Dental Medical Integration for Diabetes: IHN-CCO			
Goals	Activities	Measures	Results
Medical Clinic Go-live.	• Distribution of Hygiene Kits. • Distribution of educational materials. • Establish referral system with each clinic. • Onsite Question and Answer. • Clinic workflow walk-through. • Establish data collection mechanism.	100% of clinics implementation of Pilot.	100% complete.
Hiring of Dental Program Clinical Coordinator.	Hire date: June 1st, 2015.	NA	100% complete.
On-going monitoring of clinic pilot activity.	• Monthly medical clinic check-in. • Monthly dental plan check-in.	NA	100% complete.
Collection of monthly data.	Budget reporting	NA	Remaining budget: 97.3%.
	Medical clinics to Dental Plan Care Coordination report.	100% of clinics reporting.	
	Dental Plan to Dental Plan Care Coordination report.	100% of dental plans reporting.	
	Collecting warm handoffs.	75% or greater	14 warm handoffs.
	Screening questions by Primary Care Provider	90% or greater	24 patients received oral health screening questions by Primary Care Provider.
	Screening questions by Primary Care Dentist.	90% or greater	Seven patients received medical health screening questions by Primary Care Dentist.
	Mailer response.	50% or greater	14 mailer responses.

Licensed Clinical Social Worker Patient Centered Primary Care Home: Samaritan Mental Health - Corvallis			
Goals	Activities	Measures	Results
Mental health services integration into medical home.	Provision of group, individual and family Mental Health (MH) counseling; Psychoeducational classes.	PHQ 9 GAD-7 ORS/SRS Class evaluations	Data is not yet compiled. Estimates show most patients drop from critical to subclinical scores over time seen. SRS= session rater scores. Average in high to very high range patient satisfaction with therapist, sessions, and

		Numbers seen	goals discussed. 294 direct patient visits in last quarter; 101 individuals seen in these visits. 486 patient email messages sent since January 1, 2015 (case management, follow-up, class information, and patient advice). Patient care was also made via telephone—data not available at time of report.
Increase staff understanding of trauma/mental health needs on medically unexplained symptoms.	Consults, staff education via emails, cc'd charts on common patients.	Anecdotal, increase in number of warm handoffs and referrals.	Referrals rose dramatically from last quarter, example: one day in which Licensed Clinical Social Worker saw 5 warm handoffs in addition to full schedule of patients. Averaging 10 or more referrals per week most weeks.
Utilize Master of Social Work students to increase access to care, provide training for future MH providers, and offer low-cost, low-barrier case and clinical services.	Working with Samaritan Health Services and Portland State University to arrange field placement for academic year of 2015/16	Successful student placement and beginning of field work.	Not met.

Medical Home Readiness (2): Quality Care Associates			
Goals	Activities	Measures	Results
Phase 1: Conduct a readiness assessment for five solo primary care practices Phase 2: Provide coaching of two practices through all the steps necessary to achieve Patient Centered Primary Care Home status	Project kickoff		Agreements have been signed, kickoff meeting has been held. Clinic and consultants will begin active work on the project in July.

Mental Health Literacy (2): SHS Marketing			
Goals	Activities	Measures	Results
Education Campaign: *Today I Am*	Media campaign included website, billboards, poster, flyers, display materials at community events and within community organizations, newspaper and mall ads, outside banners, online advertising, local magazine articles, interviews with local/regional	Website completed: http://www.samhealth.org/healthplans/community/Today-I-Am/Pages/Landing.aspx Community Events Attended: • 4/14 Lebanon Chamber	Website Analytics will be reported soon. Extend the English Campaign to Benton & Lincoln Counties launched April 1, 2015, completed July 2015. Today I Am campaign post-survey completed Aug 2014 shows 51% familiarity with IHN-CCO, 65% familiarity

	newspapers, presentations at seminars.	Business Expo. • 5/3 5K Run. • 5/14 Heart 2 Heart homeless fair. • 5/26 Monroe Health Fair. • 5/15-5/26 GSMRC	with Wellness Campaign (exceeding target of 35%).
	Regional (Linn-Benton-Lincoln) Latino community education campaign launched June 2015.	Website Completed: http://www.samhealth.org/healthplans/community/hoyestamos/Pages/default.aspx Community Events Attended: • 6/21 Corvallis Fiesta	Used Spanish population research to adapt the English campaign to be culturally appropriate. Developed marketing, public relations and media plan for Spanish campaign in Benton, Lincoln and Linn counties. Media campaign will include website, billboards, poster, flyers, and display materials at community events and within community organizations, social media Facebook campaign, outside banners, online advertising. Presented adapted campaign materials to two Latino focus groups and used feedback to fine tune the messaging. The feedback was largely positive and very helpful in finalizing the campaign imagery and tone. Developed campaign imagery, messaging, and public event schedule in consultation with Latino stakeholders and project team. Events planned: • 7/11 Latino Tour for Farmer's Market-Corvallis • 7/18 Latino Tour for Farmer's Market – Albany • 7/15-7/18 Linn County Fair • 7/29-8/1 Benton County Fair • 8/29 Campeones de Salud • 9/20 Festival Latino

Mental Health, Addictions, and Primary Care Integration: Samaritan Lincoln City Medical Center			
Goals	Activities	Measures	Results
Integration of Behavioral Health in the PCPCH.	Education of staff and primary care providers from Behavioral Health	Number of "warm hand-off" referrals from PCP to Behavioral	We have seen a very successful increase in warm handoffs by PCP providers to behavioral health

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	Providers.	Health Specialist.	specialists.
Decrease the time from when the patient is referred from the primary care behavioral health specialist until seen by current model of care (Lincoln County Mental Health)	Meetings between Samaritan and Lincoln County Mental Health. Attempts in a memorandum of understanding.	Measured by EMR but also word of mouth from Behaviorist, patient, and sometimes County Mental Health	Currently creating best practices and work flow for referring patients that need a longer intake process and medication prescribed to them. Unfortunately this has been a very big challenge for us. Most of the patients we do see have had an 'intake' from us but still require a longer intake process, most of them are at the point of needing medication but after a long process come back to our primary care providers because they saw someone who was unable to prescribe, were unable to be seen at all, etc.
Improve Healthcare Utilization.	Hiring a Care Coordinator in the ED (emergency department) to work with the clinics Care Coordinator. More Education as well.	Measured by EMR, still a newer process and collecting data.	Collecting data for this but preliminary results show that having a care coordinator in the ED to reach out immediately to our care coordinator to get a patient seen within a day has been extremely successful.

Pediatric Medical Home: Samaritan Pediatrics (SPE)			
Goals	Activities	Measures	Results
Target patients with complex care conditions.	Warm handoffs.	Care plan management. Decrease in member costs, overall, by POS, pharmacy, etc… and effectiveness of care measures (major depressive disorder, Well Child Checks (WCC's) (including adolescent) and follow-up care for children prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication	21 patients seen by a Mental Health Specialist on site and 42 patients seen by a Psychiatrist. 46 patients seen by a Registered Nutritionist on site. 225 charts reviewed by Clinical Pharmacist at SPE *of these reviewed 15 children were scheduled for WCC's and 15 children were discussed at the interdisciplinary care team for medicine changes. Pediatric Registered Nurse (RN) Care Coordinator followed five complex patients.
Increase Well Child Checks	Contacting patients that are overdue for WCC's and sending adolescent WCC birthday cards.	Effectiveness of care measures.	During the first month, July, we sent 85 birthday cards.
Educate patients and families.	Created a newsletter.	Access to care and Satisfaction with care	This has been handed out to each parent coming in for an appointment.
Development of the Interdisciplinary Care Team (ICT).	ICT meets every two weeks to discuss complex patient cases.	Care plan management and effectiveness of care measures.	

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

Public-Health Nurse Home Visit: Linn County Health Services			
Goals	Activities	Measures	Results
Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women.	Linn County home visit team all received training on Screening, Brief Intervention, and Referral to Treatment (SBIRT) in May 2015. This was an opportunity to open communications with prospective referral sources in attendance at the training. Prepared SBIRT forms end of June for staff use and implementation in July 2015. Utilizing data from ORCHIDS for screening clients, not specifically SBIRT, at this time.	Percentage of clients who had an SBIRT assessment. N= number of clients seen in Apr, May, June 2015.	Starting the implementation of SBIRT after the May training so the data for this quarter is small as the caseload for prenatal is also small but building. Staff members have been utilizing the 5As to assess smoking until July as that has been the state requirement for the home visit program. This will change through appropriate protocols for future use of the SBIRT. Results for prenatal screen: 100% of nine visits.
Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.	Discussed referrals at SBIRT training with various community partners. Worked on increasing the number of referrals with the Maternity Care Coordinators (MCC) from the three local hospitals. Will send the Hispanic Medical Assistant to local MCC Hispanic coordinators to meet and open up referrals for Hispanic clients in East Linn and Albany. Future plans: connect with Relief Tree Nursery to discuss the program as they are a major referral source in Linn County. Outreach will need to be done methodically while building home visiting staff and also capacity to provide service to all of the referrals that are received from the community. Staff members have access to Care Link but as “read only”, as there is no access EPIC. Unable, at this time, to upload anything into the medical record of the client. Dr. Cousins is working to determine the options.	NA	Getting a lot of home visit referrals from the various local and out of town Level III hospitals and the MCC Coordinators. Referrals have increased each month this quarter; 35 new referrals this quarter. Several referrals are from pediatricians in the community. Preparing a research based presentation on marijuana use and breast feeding to the Linn County Breast Feeding Coalition set for early July. Working with Dr. Cousins to learn how marijuana use is affecting the infants/children of Linn County.

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

An Ages and Stages Questionnaire (ASQ) is completed by the age of 6 months, at least 80% of the time.	Relying on the state system ORCHIDS and their data analyst to pull numbers specific for the project's needs, as the report function of ORCHIDS is very difficult for counties to use.	% of clients who had an ASQ by age 6 months for time period. N= number of clients at least 6 months old.	45% of the clients are receiving an ASQ by 6 months. This data from the state does not include the month of June, when new staff was added.
Coordination and referral processes for access to primary care and oral health are established.	Developing a plan on how best to access the primary care and dental providers. Developing for home visit staff a resource list for providers in order to have an easier referral for clients to those needed services. Plan to meet with Obstetrics provider regarding best way to coordinate with them on Maternity Case Management (MCM) clients and services they would like to explore particularly SBIRT positive screens.	NA	Will be sending all ASQs to primary provider for all babies whether normal or abnormal. ORCHID's data shows a 46% referral to PCP and 33% to dental. Staff members have documented much higher percentages with 82% referred to a primary health care provider and 44% to dental.
75% of children will receive their recommended vaccines before their second birthday.	Linn County home visit staff has access to the Alert system so they can access up to date information on a child's current immunization status prior to a home visit. It is an expected standard that the immunization status is addressed at each visit. An Oregon Health and Science University nursing student working with Public Health has a project, based with Sweet Home residents, to increase their immunization rates. By offering incentives, in the form of gift cards through local merchants, the goal is to have parents immunize their children.	Two year-old shot rate for 4:3:1 given as follows: 4 doses DTap: given at 2, 4, 6 and 12 months. 3 doses IVP: given at 2, 4, and 6 months. 1 dose MMR: given at 12 months.	Baseline data for 4:3:1 in all of Linn County is 61.3%. This quarter 82% of clients seen at home visits were referred for immunizations.
Coordinate prenatal assessments with WIC (Women, Infant, and Children) appointments for pregnant women. The first report will be available July 2015.	Currently clients are first assessed in the clinic after a positive pregnancy test and referred to both WIC and MCM. Current WIC clients with children under 6 months are met at a WIC class where the babies are assessed for home visiting needs, this usually done by a Home Visit Nurse. Plan to work with the WIC Coordinator to have	Number of prenatal clients that had a WIC appointment and a prenatal assessment for time period. N= Prenatal Assessments.	Rebuilding our MCM program which has been limited due to the number of staff Full Time Equivalent (FTE) available and the reimbursement rate for this service. Focus has been on the after delivery services to the infant/child. Current MCM caseload is 45 with nine new referrals in this quarter.

	staff increase referrals and to check to see if a home visit nurse is available to meet with the client at the WIC appointment.		Current referrals for our small MCM population from WIC are one of nine.

Public-Health Nurse Home Visit: Benton County Health Department			
Goals	Activities	Measures	Results
Collect data on tobacco, alcohol and drug screening for pregnant and postpartum women. Public health nurses to learn about the prenatal Screening, Brief Intervention, and Referral to Treatment (SBIRT) and plan to implement it with pregnant and postpartum women. Develop the process to implement and collect data on SBIRTS completed.	Working with OCHIN staff to train nurses to use the 5P flow sheet. Connected with the state to see if ORCHIDS can capture the data needs. Registered Nurse (RN) staff attended Prenatal SBIRT training in February 2015.	Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women.	Reporting measures: • Percent of initial needs assessment completed for pregnant women. • Number of Prenatal SBIRTS and SBIRTS completed for women. • Describe the Prenatal and Adult SBIRT implementation process for women. Reporting period March 1, 2105 – May 31, 2015: • 95% of pregnant and postpartum women are screened for alcohol and substance use. • 98% of pregnant and postpartum women are screened for tobacco use.
Coordinate with community partners to support a referral system that is easily accessible and loops back to the referral source.	Future activities: There is a Benton County Coordinating group pilot members plan to participate in. This will help determine how to better inform the community of nurse home visiting programs and how to better connect to families. Posted RN positions and will add an additional public health nurse as soon as possible. Support from CCO: At present, being open to alternative staffing possibilities may help address the shortage of public health nursing services. Considering a health navigator to enable the current public health nurse workforce to expand their case load.	Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.	Reporting measures: • Describe activities related to and progress of the development of a coordinated home visiting referral process. • List collaborative activities with other early learning partners and the outcomes. • Identify opportunities for further home visiting and partner collaborations. • List support, including Technical Assistance (TA), needed from IHN-CCO to support these activities. Participating in the Early Learning Hub meetings and regional Maternal Case Management meetings to share the referral form. It is a simple form that can be filled and faxed to the health department, where a nurse will take up the referral. Due to historical challenges in staff capacity, we have

			run a cycle of being opened or closed to referrals. This leaves some inconsistency in taking referrals from community agencies. Therefore, before the initiation of a strong outreach campaign to actively recruit children and families, capacity will need to be determined to ensure the nursing staff can accept the influx of referrals. Hiring of RNs has been a challenge for the public sector and currently collaborating with Benton County Human Services to try to alleviate barriers and in the process of conducting a salary review.
Assess the percentage of children enrolled who receive at least one Ages and Stages Questionnaire (ASQ) by the age of 6 months. Create a process to inform providers of ASQ results.	Public health nurses complete an ASQ with the family as appropriate, unless it has already been completed elsewhere within the time frame of the ASQ assessment. At present providers are not requesting results of ASQ unless the public health nurse feels it is indicated.	An ASQ is completed by the age of 6 months, at least 80% of the time.	Reporting measures: • Percent of ASQs done within the appropriate age. • Describe or explore how results are communicated back to primary care physician. Reporting period March 1, 2105 – May 31, 2015: • Of the 26 children enrolled during this period, they received at least one ASQ by the time they reached 6 months or age (38%). • Overall, 58% of the 26 children enrolled received an ASQ. • Currently do not have a way to report if an ASQ was completed elsewhere. • In addition, duration of enrollment may impact our ability to complete an ASQ. More data analysis is being done.

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

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<tr><th></th><th colspan="2">Benton</th></tr>
<tr><th></th><th>Babies First</th><th>CaCoon</th></tr>
<tr><td>Children enrolled in program March-May 2015</td><td>26</td><td>16</td></tr>
<tr><td>Number receiving ASQ</td><td>15</td><td>4</td></tr>
<tr><td>Children receiving ASQ assessment by age six months</td><td>10</td><td>0</td></tr>
<tr><td>Percent receiving ASQ</td><td>58%</td><td>25%</td></tr>
<tr><td>Percent receiving ASQ by six months</td><td>38%</td><td>0%</td></tr>
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<td>Connect families to their medical/oral health homes.</td>
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<td>Coordination and referral processes for access to primary care and oral health are established.

75% of clients will be encouraged to see their primary care provider and oral provider or referred to a Primary Care Physician (PCP) or dentist at least once.</td>
<td>Reporting measures:
• Percent of clients who have been encouraged or referred to establish a PCP or dentist.
• Percent of clients who have been referred to PCP or dentist.

Reporting period March 1, 2105 – May 31, 2015
• 52% of children were referred to primary care.
• 15% of children were referred to dental health.

The chart below separates these rates by program.</td>
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<tr><th colspan="2"></th><th>Benton
Babies First</th><th>Benton
CaCoon</th></tr>
<tr><td rowspan="3">Primary care referrals</td><td>Total clients with visits</td><td>26</td><td>16</td></tr>
<tr><td>Primary care referrals out</td><td>11</td><td>11</td></tr>
<tr><td>Percent referred out, primary care</td><td>42%</td><td>69%</td></tr>
<tr><td rowspan="2">Dental referrals</td><td>Dental care referrals out</td><td>4</td><td>1</td></tr>
<tr><td>Percent referred out, dental care</td><td>15%</td><td>6%</td></tr>
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<td>Childhood immunization rates will improve.</td>
<td>As of June 15, 2015, non-medical vaccine exemption rates from the state have been shared. Will draft a work plan to work with schools and parents on educating and promoting vaccines.</td>
<td>75% of children will receive their recommended vaccines before their second birthday*.</td>
<td>Reporting measures:
• Percent of 2 year olds* who have completed the 4:3:1:3 vaccine series (4 dose of DTaP, 3 doses of IVP, 1 dose of MMR, 3 doses of Hib (or 2 doses of Merck series).

* In ALERT Immunization Information System, 2 year olds*. Includes children 24-35 months.

• Describe activities the local public health department is doing to support improvements in vaccines for children.

Evaluation up to 6-15-2015.
75% (18 of 24) of active children in Alert for Benton County Public Health are up to date with the 4:3:1:3 series.

Benton County is working with the Linn and Benton Community Health Center (CHC) to update our OCHIN charts. ALERT data needs to be manually entered into OCHIN in order for CHC to assess their immunization rates for children and adolescents. The Immunization Coordinator has also made site visits to the four clinics to support vaccine management and reporting and correct documentation of vaccines.</td>
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Section 2: 2015 Goals, Activities, Measures, and Results

Coordinate maternal child health services.		Coordinate prenatal assessments with WIC appointments for pregnant women.	Reporting measures: • Describe the process of coordinating prenatal visits with WIC appointments. • Number of prenatal appointments referred through WIC. Reporting period March 1, 2105 – May 31, 2015: • Has a system in place where WIC schedules new mothers for their WIC appointment and their Maternity Case Management appointment. • Received 71% of MCM referrals from WIC: MCM / Benton Total clients with visits March-May: 41 Referred by WIC: 29 Percent referred by WIC: 71%

Public-Health Nurse Home Visit: Lincoln County Health & Human Services			
Goals	Activities	Measures	Results
Tobacco, alcohol and drug screenings completed for all pregnant and postpartum women	Received training in SBIRT, learned about resources for referrals and set up documentation in client charts so the data can be pulled for this report beginning July 1, 2015.	Percentage of clients who had a Screening, Brief Intervention, and Referral to Treatment (SBIRT) assessment starting July 1, 2015. *For this quarter's report using number of assessments completed for drug alcohol and tobacco with different tool.	51/51 = 100% had SBIRT-like screens. The denominator is the number of new pregnant women we saw and the numerator is the number that had SBIRTS-like assessments. *Next quarter report will measure SBIRT screens.
Pathways for home visiting referrals are developed. This includes plans for communication and information sharing.	Discussed referrals from SBIRT with community partners. Worked on referral process with Obstetrics (OB) department at local hospitals. Held a meet and greet with Centro de Ayuda, Lincoln County School District, Healthy Families and Nurse Home Visiting programs. Outreach to local Pediatric offices.	NA	Hospital OB departments Centro de Ayuda – community based organization Lincoln County School District Pediatric office Training with partners on DHS differential response, creating better communication with agency. Media outreach on home visiting programs and WIC.

	Differential Response Training with Department of Human Services (DHS), building relationships. Radio talk show about home visiting programs and Women, Infant, and Children (WIC). Met with community partners to evaluate status of Babies Learn Together, parenting and child development service created to fill a gap for new families. Changed Electronic Health Record (EHR) system to highlight all the outcome measures for the Home Visiting Grant from IHN-CCO. Healthy Beginnings Healthy Communities (HB + HC) Grant focus groups were conducted to get parent input about Early Learning and how to help get kids ready for kindergarten. Building the system for home visiting across three County regions. Starting to collaborate with other agencies to form an Advisory Board for all home visiting programs in County.		Presented about home visiting programs to local National Organization for Women (NOW) chapter and Early Learning Hub Governance Board.
An Ages and Stages Questionnaire (ASQ) is completed by the age of 6 months, at least 80% of the time.	Experimenting on ways to pull this data in home visiting EHR system. Early Learning Hub met for a full day in Lincoln County. The Health Care Integration work group discussed the survey for providers about their use of the ASQ.	% of clients who had an ASQ by age 6 months for time period. *This is still in process; need to coordinate with Linn and Benton.	25/26 = 96% This represents a baby that had at least one ASQ at 6 months or before. The denominator is the number of clients that were born in Nov 2014, Dec 2014 and Jan 2015, and had a home visit after 2 months of age - 6 months of age. The numerator is the number of the denominator that had at least one ASQ in that time frame.

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

Coordination and referral processes for access to primary care and oral health are established.	Met with partners in Mental Health related to their Parent/Child Interaction Therapy (PCIT) and referral pathways. Meet monthly with Early Learning Hub to coordinate with Health Care providers.	Denominator = # of clients in time period. Numerator = # of referrals made to primary care and oral care.	**For primary care** - 70 assessed for PCP Have PCP - 66/70 = 94.2% No PCP - 4/70 = 5.7% Referred to PCP - 21/70 = 30% **For OB** 25 assessed for OB provider Have OB provider -22/25 = 88% Made referral to OB provider - 3/25 = 12% **For Dental** 44 were assessed for dental provider Have dental provider - 25/44 = 57% No dental provider - 19/44 = 43% Made referral to dental provider - 16/19 = 84.2%
75% of children will receive their recommended vaccines before their second birthday.	Lincoln County (LC) Immunization Coordinator is setting all home visiting staff up with access to Alert II. The standard will be to look up Alert status for each family prior to making the home visit for 2, 4, 6, 8, 12 month olds and then appropriate referrals. Recently put this practice into action, so data only shows the last two weeks in June.	% of time nurses check with families about immunization status during 2, 4, 6, 8, and 12 month visits? Several immunization referrals were made during time period.	19 Immunization records were reviewed. Referred for immunizations - 6/19 = 31.5% Up-to-date on immunizations - 13/19 = 68%
Coordinate prenatal assessments with WIC appointments for pregnant women. The first report will be available July 2015.	LC Home visiting services begin for prenatal clients with a WIC appointment, usually done by Home Visit Nurse.	Number of prenatal clients that had a WIC appointment and a prenatal assessment for time period. N= Prenatal Assessments	51 clients had an Initial Needs Assessment. Had WIC appointment at same time – 42/51 = 82%

School/Neighborhood Navigator: Benton County Health Department			
Goals	Activities	Measures	Results
Improve outreach, coordination and integration of health, social, and community resources through schools for children and their families.	April 2015: Hired and began training new school navigator. School Navigator (SN) began shadowing current school navigators, to learn		April 2015: - Met with school district personnel to review school data and identify third school for navigator placement.

	processes, become familiar with school staff and families. May 2015: New School Navigator (SN) completed her Oregon Health Plan (OHP) training and is now able to assist individuals/families with OHP enrollment. New SN completed her community resource training and is able to assist parents/families connect to community and social service resources in Benton County. New SN is working on her "resource scavenger hunt" in which she visits a list of community agencies to introduce herself, meet their staff, get program information, and let the agency know about the school navigator program. This activity will take a few months and includes agencies such as Old Mill Center, Farm Home, Community Outreach, and Center for Rape and Domestic Violence (CARDV). New SN spent three weeks shadowing current SNs from Garfield and Lincoln Schools to learn how the role functions in each school, and to become familiar with the students and their families. The school navigator planning team met with school district officials to plan the new SN integration into Linus Pauling Middle School, and introduction to Garfield School. June 2015: The new school navigator (SN) for Garfield		

	Elementary School began shadowing current SN to learn her new role and to begin meeting the Garfield students and families. She has been a health navigator for two years and is moving into the school navigator role as current SN moves into a different position. The School Navigator team was busy as school activities began to transition to summer activities. The plan is to spend July and August working at community events, getting firmly established in the community, and continue to build relationships with families in the area. The SN team met with community partner agencies that provide mental health, substance abuse, transitional housing, and correctional services. This was a "meet and greet" where all agencies came together to share information and start forming relationships.		

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Improve coordination of the care of IHN-CCO members by improving access and engagement of patients and their families in their primary care medical homes.	SNs began tracking the IHN-CCO clients they "touch" in January 2015 as part of the School Based Health Center grant and will be reporting this data monthly beginning in September 2015 as part of this pilot. Please see table in the 'Results' column for referral numbers for Garfield and Lincoln school navigators in April, May, and the first two weeks in June. ("WCC" = Well Child Checks; "McKinney Vento" is the program for families experiencing homelessness; "Other" includes transportation, assistance with financial paperwork, immigration forms, and additional items not in labeled categories). The SNs track the status of referrals on an excel spreadsheet and if the referral is open or closed. SNs attempt to "close the loop" back to the referring party (teacher or counselor) in every case possible.		

Q-2 (Apr-June)	Garfield	Lincoln	Totals:
IHN members	60	111	**171**
WCC	5	0	**5**
Primary Care	6	11	**17**
Vision	14	6	**20**
Dental	12	20	**32**
Health Insurance	15	25	**40**
Counsel	9	8	**17**
Food	0	9	**9**
Clothes	0	1	**1**
Recreation Activities	77	48	**125**
Interpret Translate	12	21	**33**
McKinney Vento	4	5	**9**
Other	25	30	**55**
Totals	179	184	**363**

Tri-County Family Advocacy Training: OFSN			
Goals	Activities	Measures	Results
Nine Special Education Trainings.	Two trainings.	135 participants 90 % satisfaction	Benton County conducted Behaviors and the Individualized Education Program (IEP). Spanish and English- 14 participants- 100% participants satisfied or very satisfied. Benton County conducted 504/IEP English and Spanish- 14 participants- 100% participants satisfied or very satisfied.

One Family Support Group. Facilitation Training.	One training.	15 participants 90% satisfaction	Benton County conducted training-6 participants-100% participants were very satisfied. Lincoln County training anticipated in October 2015
Two Family Perspectives Training.		30 participants 90% satisfaction	Benton and Lincoln County training anticipated in September 2015.
Two Collaborative Parenting Series.		20 participants Pre/Post Family Empowerment Scale.	Lincoln County training anticipated in October 2015 and Benton County training anticipated in September 2015.

Universal Prenatal Screening: Carissa Cousins			
Goals	Activities	Measures	Results
Implement Screening in all Samaritan Health Services (SHS) and The Corvallis Clinic (TCC) clinics providing Obstetric (OB) care.	Training/ Implementation	Number of clinics screening.	As of July 2015, the OB clinics in Newport, Lincoln City, Lebanon and Corvallis are using the 5Ps prenatal screening. Sweet Home Family medicine, the Corvallis Clinic OB clinic and Dr. Boyle's resident clinic are also using the screening tool. The Albany clinic and Dr. Daskalos' clinic are in the process of implementation.
Implement Screening in all SHS labor and delivery wards.	Training/ Implementation	Number of hospitals screening.	All SHS labor and delivery wards are using the verbal screening. Urine drug testing is recommended by all and is done by consent.
Use of Navigators for mental health and substance use disorders.	Consulting navigators for assistance.	Number of consults.	The navigators for Linn County uses Family Tree Relief Nursery (FTRN), Benton County uses Community Outreach, Inc. (COI), and for Lincoln County uses ReConnections. Currently do not have the numbers of referrals for each facility. ReConnections reports an estimate of more than ten (including women referred from well woman exams). COI estimates approximately ten and FTRN has had approximately eight referrals (all from the hospital screening). Often these contacts involved warm handoffs or immediate follow up by the Navigator. FTRN is expanding the role of their navigator from a

			part-time position to a fulltime position. Working with the Navigators to track and report referrals.
Assistance with tobacco cessation.	Referrals to the tobacco quit line.	Number of referrals.	At this time unable to report the number of referrals. Feedback has stated that many women do not want the referral to the quit line. The process of doing the referral in a paper and fax form is cumbersome. Working on simplifying this in EPIC. Exploring other options for tobacco cessation in this population. Connected with an Oregon State University Public Health professor who will be doing research on tobacco perceptions and effective means of tobacco cessation in pregnant women. The hope is that through her efforts, there will be the ability to provide more effective methods of tobacco cessation. Involved in the Mid-Valley & Coast Tobacco Prevention Initiative.
Program Analysis.	Data collection.	Effectiveness of screening.	We are working with EPIC to build reports to evaluate such information as the number of women screened/ clinic, the number of referrals for substance use/mental health, Domestic Violence/Intimate Partner Violence (DV/IPV) and tobacco cessation. When positive for substance use will look at the results of the woman's screening throughout pregnancy, looking at interventions (referrals) and the outcomes at birth including mother's urine drug test results, baby's drug test results, and baby's diagnoses.
Involve Health Departments and lactation consultants.	Training and implementation.	Number of screening done by nurses at various health departments.	The home visiting nurses from the health departments in Lincoln, Linn, and Benton counties are participating in the program. They have all attended the training and are beginning to use the verbal questionnaire in the pre-pregnancy and post-natal visits. In discussion to involve the lactation nurse and lactation consultants to include substance use in their discussion on safe breastfeeding. They will then be trained in doing a brief intervention and be made aware of the referral resources including the use of the navigators. This allows another opportunity to connect with and possibly help women with substance use issues.

Literature for patient education.	Development of neonatal abstinence syndrome (NAS) booklet, drugs and breastfeeding and Marijuana I pregnancy, breastfeeding and childcare.	Completion of literature.	Developed a booklet for use by the OB and Pediatricians on neonatal abstinence syndrome. Continue to make changes based of patient and provider feedback. Provide a handout on Drugs and Alcohol during pregnancy and breastfeeding. This also is being revised based on provider and patient feedback. Due to the extremely high use of marijuana in our community and the misperception of its safety, working on a handout specifically on marijuana during pregnancy, breastfeeding and the use while caring for children. Working with Oregon Health Authority Addictions and Mental Health and the Retail Marijuana Scientific Advisory Committee in developing this as there is an interest in developing a statewide approach to this issue.
Protocol for management and testing of newborns.	Develop protocol.	Completion of protocol.	Working with the pediatric hospitalists to revise the Drug Screening Protocol for newborns. This protocol will reflect the implementation of the 5Ps. Trying to minimize excess hospitalization time due to high sensitivity testing required of drug testing for infants (usually 2-3 days for confirmation) while also ensuring the safety of the infant. Working with Department of Human Services (DHS) and the Samaritan Health Services (SHS) pediatricians on this. This would be a system wide protocol.

Youth WrapAround & Emergency Shelter: Jackson Street Youth Shelter Inc. (JSYSI)			
Goals	Activities	Measures	Results
Thirty-five youth served in wrap-around case management or shelter services.	Case Management and Overnight Shelter.	Intakes of youth served in shelter, Access database.	15 different youth served in respite and emergency shelter. Three of these youth moved into transitional shelter during their stays. 15 youth engaged in aftercare services, seven of which are duplicate youth from the overnight shelter numbers above. 18 different youth accessing our outreach case

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			management services, not shelter. Total of 48 youth served to date.
Youth served in shelter will achieve stability.	Has a bed, access to showers and laundry, support with hygiene and connecting to medical needs, consistent adult role models, access to positive activities, and education support.	# of youth who exit to safety	Nine safe exits from shelter. *Three remain in shelter, one was returned home to unsafe situation, one went to treatment, and one was removed by police.*
Youth in case management will improve wellbeing and reduce risk factors.	Weekly check-ins with adult role models, individualized service plans, medical/educational/skill-building support, food boxes, and hygiene boxes.	% increasing utilization of community services. % participating in individualized service plan (ISP). % participating in skill-building activities. % participating in family mediation or counseling. % who obtain an IHN-CCO PCP and complete an adolescent well-child exam. % receiving dental services, if needed. % linked to a Qualified Mental Health Professional QMHP or Qualified Mental Health Associate QMHA, if needed. # of youth who required intensive psychiatric health services through IHN-CCO while in JSYSI care.	100% of youth served worked with a case manager to increase their awareness and utilization of community services. 98% of youth served in shelter and outreach case management participating in their ISP. 100% of youth engaged in required skill-building activities. 100% of youth who needed family mediation or counseling received a referral and actively participated. 100% of youth who needed health insurance, obtained it and attended their first appointment. 100% of youth served received a JSYSI dental screening and 100% of youth who needed follow up care by a dentist received it. N/A N/A