

InterCommunity Health Network CCO

Community Health Improvement Plan
2014

LINCOLN

BENTON

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Stronger, healthier, together.

Project Team

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Community Health Improvement Plan 2014

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Chapter 1

Introduction and Overview

Section 1: Intercommunity Health Network CCO

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) is working with community partners to plan and transform the future of healthcare in Benton, Lincoln, and Linn counties. Oregon’s Health Transformation Bill, passed in June 2011, created the opportunity for local entities to integrate care for Oregon Health Plan (OHP) members under one regional Coordinated Care Organization.



IHN-CCO Mission

IHN-CCO was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) members in Benton, Lincoln, and Linn Counties. As IHN-CCO, we are committed to improving the health of our communities while lowering or containing the cost of care. We will accomplish this by coordinating health initiatives, seeking efficiencies through blending of services and infrastructure, and engaging all stakeholders to increase the quality, reliability, and availability of care. IHN-CCO takes the “whole person” approach for the health of its members and supports a continuum of care that integrates mental health, addictions, oral health, and physical health.

IHN-CCO Values

- Stakeholder participation in design and delivery of healthcare
- Prevention, early intervention, and self-care
- Promotion of family health as a means of improving readiness to learn and adoption of lifelong, healthy lifestyles
- Maximizing the appropriate utilization of existing health resources within established protocols
- Achieving positive health outcomes through evidence-based health programs
- Delivering service that is culturally sensitive

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- Coordinating care using the patient-centered, primary care, medical-home model, supported by information for medical need and overall health improvement
- Maintaining continuity of care for IHN-CCO members through integration of services within and across providers and patient-support organizations
- Utilizing performance and outcome data to guide design and development of our healthcare delivery systems
- Strengthening community infrastructure to promote healthy neighborhoods

The IHN-CCO Partnership

As of May 2014, the IHN-CCO partnership serves more than 53,000 Oregon Health Plan members and consists of:

- Advantage Dental, Capitol Dental Care, ODS, and Willamette Dental
- Benton, Lincoln, and Linn County governments
- Local healthcare providers
- Federally Qualified Health Centers
- InterCommunity Health Network CCO
- The Corvallis Clinic
- Mid-Valley Behavioral Care Network
- Oregon Cascades West Council of Governments
- Quality Care Associates
- Samaritan Health Plans
- Samaritan Health Services
- Samaritan Mental Health

IHN-CCO Service Area

- IHN-CCO spans the area of Benton, Lincoln, and Linn counties.
- Our membership includes all Oregon Health Plan (OHP) members in the coverage area.
- Our provider partnership consists of large multi-region health systems to a number of independent providers, clinics, and non-traditional providers.

Section 2: The CHIP, the Community Advisory Council, and the Local Advisory Committees

Community Health Improvement Plan

Oregon Senate Bill 1580 requires that all CCOs “must have a community advisory council” (CAC). The primary tasks of the CAC are “overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and healthcare system service plan for the community served by the coordinated care organization; and annually publishing a report on the progress of the community health improvement plan.”

The first report must be published by July 1, 2014 with annual reports due each July 1 afterwards. The IHN-CCO CAC held its first meeting in November 2012. It consists of one regional council and three local (county) advisory committees.

Community Advisory Council Structure

The regional CAC consists of nineteen representatives (six per county, plus the Chair) and includes twelve IHN-CCO consumer members, three county staff, and three community members. In partnership with the CAC, each county has a Local Advisory Committee to the CAC. Regional CAC representatives are required to participate as members of the local meetings; however, final recommendations are made at the regional Council level. By having one regional council and three local committees to the council, the IHN-CCO increased its:

- **Breadth Community of Input:** The CAC and IHN-CCO have a strong commitment to ensuring that each county community has a distinct voice and ability to influence the process and the strategic planning of the CCO’s healthcare system.
- **Depth of Community Input:** Consisting of nineteen member representatives, the CAC is relatively large. Nineteen is the maximum number to realistically include on a council and remain productive. Yet, more input from a greater number of community members is desirable and beneficial to the process. By participating in local advisory committee meetings, the regional CAC representatives and a variety of community partners work together in the process and create recommendations which are sent up to the IHN-CCO via the CAC.

Guiding Principles of the CHIP

The CAC recognizes the following values as guiding principles of this CHIP

1. **Pursuing optimal health for IHN-CCO members of all ages by:**
 - Meeting people where they are
 - Developing trust by transparency of purpose
 - Ensuring ease of access to healthcare for all

2. **Sharing ownership of individual, familial, and population health through a:**
 - Holistic collaboration between our healthcare providers
 - Active individual participation
 - Accountability for our own health and that of our families
3. **Creating healthier communities through effective stewardship of resources by ensuring active community engagement in all aspects of our healthcare delivery system.**
4. **These values are guided by the principles of:**
 - Effective communication
 - Health literacy
 - Health equity
 - Cultural and linguistic competence
 - Ready access to highest quality of care
 - Cost efficiency

CHIP Purpose and Objectives

The CHIP:

- Is based on the foundational work of the three County Community Health Assessments of Benton¹, Lincoln², and Linn³ counties. This CHIP, with their generous permission, borrows from, and builds upon, those documents.
- Determines a beginning place for planning for the improvement of IHN-CCO members' health and quality of care while effectively managing costs.
- Sets initial areas of focus for health improvement, while building upon ongoing community knowledge and efforts.
- Begins to identify organizational and community assets that can be mobilized to improve services, care, and health.
- Is a collaborative process that incorporates a broad range of community voices.

The CHIP informs:

- IHN-CCO and County decision-making and strategic planning
- Prioritization of health issues and solutions

Major Steps in the CHIP Process

The Community Advisory Council and its Local Advisory Committees:

1. Identified and recommended Health Impact Areas and associated improvement goals
2. Prioritized a narrowed list of goals for the first round of the CHIP

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3. Provided feedback to IHN-CCO and its county partners on the strategies identified to achieve the recommended goals
4. Provided feedback on the writing of the CHIP
5. Adopted the CHIP

Identifying Health Impact Areas

Local committees and their process

Between the months of May and August 2013, each of the CAC's local committees independently met two to three times per month to work on the task of identifying Health Impact Areas to recommend to the CAC. Through this process, the committees:

- Familiarized themselves with their county's Community Health Assessment (CHA) and CHIP
- Learned about the work of IHN-CCO
- Identified prioritization criteria, which were:
 - Prevalence
 - Population
 - Ability to impact,
 - Levels of focus already occurring
 - Cost
- Brainstormed and discussed
- Prioritized Health Impact Area recommendations using a nominal voting process
- Sought input on defining Health Impact Areas (HIAs)
- Sought data specific to IHN-CCO members
- Identified goal recommendations for each HIA
- Workgroups wrote HIA recommendations reports using the criteria as a template, and referred to this in their final selection to submit to the CAC CHIP workgroup.

It is important to note that, while the local committees worked independently, they all recommended the same three or four HIAs.

CAC Health Impact Area Workgroup

The Health Impact Area (HIA) Workgroup consisted of two CAC Representatives from each county and was staffed by the CAC Coordinator. After each local committee independently selected three to four HIAs to recommend to the HIA Workgroup, the workgroup studied them and decided to:

- Recommend all four HIAs to the regional CAC
- Organize all 45 goal recommendations into a cohesive list that honored each county's specific areas of focus

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- Append each of the original nine local recommendations to the final document so that anyone who wants to dig deeper into understanding how the recommendations were made will have the ability to do so.

Health Impact Areas

For its first CHIP, the IHN-CCO CAC recommended, and the CCO accepted, the following Health Impact Areas (HIAs) as priority areas for an improvement plan.

- Access to Healthcare
- Behavioral Health
- Chronic Disease
- Maternal & Child Health

NOTE: See Appendix A for the original 2013 HIA Recommendation Document

Goal Prioritization Process

After identifying the four major Health Impact Areas and 45 goal recommendations, the next step was to narrow to a smaller set of goals to include in the first CHIP.

To prioritize 4-16 goals for IHN-CCO's 2014 CHIP, a CHIP Workgroup was appointed by the CAC Chair. The workgroup was composed of members from each of the three counties; it included IHN-CCO member, local government, and community representation. In the months of January and February 2014, the workgroup met seven times and was staffed by the CAC Coordinator, the IHN-CCO CEO, and an Oregon Health Authority Innovator Agent.

To facilitate discussion, the 45 goal recommendations were grouped by common theme to form 25 focus areas. These were then narrowed to 13 focus areas through a combined numerical ranking system. In preparation for identifying strategies to meet the goals of the CHIP, IHN-CCO created a grid of current and proposed programs corresponding to the selected focus areas.

The remaining goals were prioritized via a nominal voting process. Each member voted for their choice of two goal priorities in each of the four HIAs. This narrowed the recommendations to 13 goals (some of these would later become "strategies" or "activities" within the CHIP, as appropriate). The workgroup then returned to the HIA Recommendation document and combed through the original 45 goals to make certain that no high priority goals had been missed for inclusion in the first CHIP. Through this process, the group made a few minor changes to the original goals to clarify them and bring them into alignment with some of the goals that were not prioritized for this first CHIP. Also, one additional goal was picked up, bringing the total to 14.

In anticipation of including youth related improvement plans in future CHIPS, the group changed the name of the Maternal and Perinatal Health HIA to Maternal and Child Health.

NOTE: See Appendix B for the original 2014 CAC Goal Recommendation Document

Next Steps⁴

The IHN-CCO CHIP is intended as a “living document” that will help sustain, enhance, and expand regional partnerships; provide the foundation for ongoing health system planning, evaluation, and transformation; help monitor progress toward identified objectives; and establish new goals and priorities as needs and resources change.

The CAC and its local committees will provide ongoing input and monitoring of progress toward addressing identified CHIP goals. The CAC Coordinator, IHN-CCO, and the County Health Departments will serve a facilitative role to inform this process by providing data and regular updates.

As part of IHN-CCO’s vision of working with community partners to have a collective impact on IHN-CCO member health, the CHIP will undergo annual review with data being updated as available and progress toward goals documented. IHN-CCO will note progress toward improvement goals, changes in priorities, opportunities, and barriers in updates to the CHIP.

These processes will remain open and transparent, and the CAC will reach out to new partners, such as the Early Learning Hub and stakeholders, and incorporate them into ongoing planning efforts.

IHN-CCO anticipates that, over time, our CHIP will intentionally align with local public health assessments and planning of health improvement efforts occurring throughout the region, thus improving coordination and leveraging of resources and increasing health equity.

Note: See Appendix C for Benton, Lincoln, Linn, and IHN-CCO CHIP Alignment document

Future Needs

Due to legislatively set deadlines, the CAC and Local Committees worked quickly and persistently for many months, in partnership with IHN-CCO and the Counties, to form their council and committees, identify Health Impact Areas, and prioritize goals, strategies, and activities. Availability of county specific, IHN-CCO member data was very limited. This first CHIP is the beginning of a strategic plan that will be enriched over time.

For future IHN-CCO Community Health Assessments, and to further develop the CHIP, the CAC and Local Advisory Committees need increased:

- County specific, IHN-CCO member data
- Community engagement
- Continuing education and networking opportunities
- Funding for new projects and planning, as opportunities arise
- Alignment of regional CHA and CHIP processes (e.g. CHAs and CHIPs for the CCO, the three counties, and the future Early Learning Hub).

Framework for Assessing Health - Health Impact Pyramid

Many factors and conditions affect health and wellbeing. Nationally and internationally, a growing body of research reveals how conditions and social economic opportunity determine health outcomes.⁵

The Health Impact Pyramid⁶ serves as a framework for the InterCommunity Health Network Coordinated Care Organization's Community Health Improvement Plan. This model guides a comprehensive public health approach to community assessment and program development across many areas influenced by behavior.

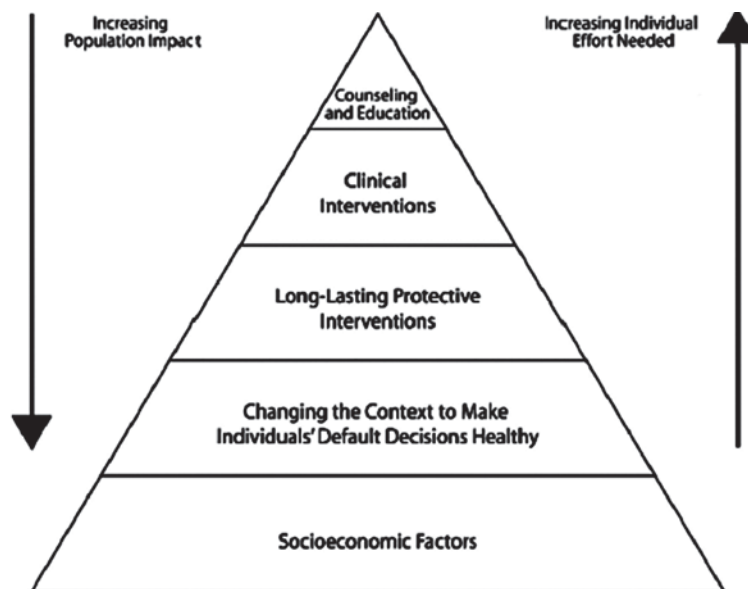


Figure 1.1 Health Impact Pyramid

The Five Tiers of the Health Impact Pyramid

In this pyramid, there are five tiers, beginning at the base level where interventions have the greatest population impact and moving toward the top where interventions involve increasing individual effort:

Base tier: Socioeconomic determinants of health

Second tier: Public health interventions that change the context for health (e.g., smoke-free laws, safe parks, bike lanes)

Third tier: Protective interventions with long-term benefits (e.g., smoking cessation)

Fourth tier: Direct clinical care (e.g. doctor visit, dental hygiene visit, etc.)

Fifth/top tier: Counseling and education

In general, public action and interventions represented by the base of the pyramid require less individual effort and have the greatest population impact overall, particularly for populations prone to increased health disparities.⁷ A similar model, called the Ecological or Social Ecology Model, is used in a variety of disciplines in order to better understand the larger forces that impact individuals.⁸

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The movement from an understanding of health focusing on the individual to one focused on communities and systems is also evident in the development of *Healthy People*,⁹ the national 10-year agenda for improving health of all Americans developed by the U.S. Department of Health and Human Services.

The Health Impact Pyramid aligns with the factors that the U.S. Department of Health and Human Services cite as influencing the development of healthy communities:

“A healthy community is one that continuously creates and improves both its physical and social environments, helping people to support one another in aspects of daily life and to develop to their fullest potential. Healthy places are those designed and built to improve the quality of life for all people who live, work, worship, and play within their borders- where every person is free to make choices amid a variety of healthy, available, accessible, and affordable options.”¹⁰

Healthy People 2020 Overarching Goals

- Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death
- Achieve health equity, eliminate disparities, and improve the health of all groups
- Create social and physical environments that promote good health for all
- Promote quality of life, healthy development, and healthy behaviors across all life stages

Source: U.S. Department of Health and Human Services, Healthy People 2020 Framework

The factors described above informed the selection of strategies and activities to achieve the goals of this CHIP (see CHAPTER 3).

Chapter 2

IHN-CCO: People and Place

Section 1: Population Overview:

IHN-CCO serves Oregon Health Plan (OHP) members in the Oregon counties of Benton, Lincoln, and Linn. This three county region is approximately 4,183 square miles of land stretching from the Pacific Coast through the Willamette Valley and Cascade Mountain Range. It is home to more than 249,804 individuals¹¹.

Age

Overall, the region's age distribution is weighted toward the young adult age groups from 15 to 24 years old. These groups made up 16.6 percent of the 2012 population in Benton, Lincoln, and Linn counties, compared with 13.1 percent statewide. The influence of Oregon State University plays a role in explaining this distribution.



The region has a slightly larger fraction of its population in all age groups over 60 compared with the state. It also has a smaller fraction in age groups 25 to 44, which are generally considered part of the prime working years and include childbearing years. This may help explain the region's lower-than-average percentage of children less than 15 years of age (16.9% in region versus 18.5% statewide).

The regional totals mask considerable differences between the counties within the region:

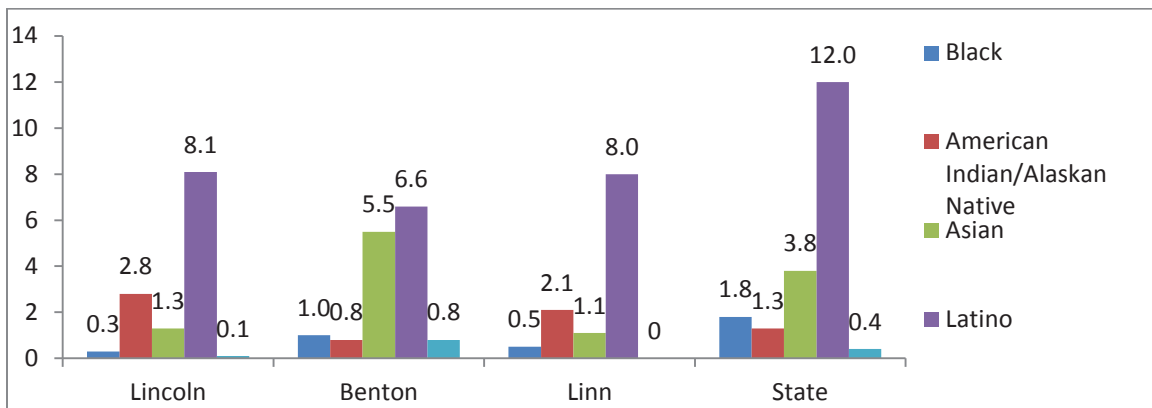
- In **Benton County**, a large percentage of residents are in the young adult age classes from ages 15-to-24 (26.4%).
- However, **Lincoln County** has a relatively large percentage of older residents, since many retirees spend their post-work years on the Oregon coast. More than 22 percent of Lincoln County's population is over 65, compared with about 14 percent statewide. Within the region, Linn County's population most closely reflects the statewide age distribution.
- **Linn County's** largest age classes, the 45-to-54 age group and the 25-to-34 age group, are the same as the largest statewide groups. The county does have a higher percentage of children under age 15 (20%) than the State as a whole.

Race and Ethnicity

The most recent U.S. Census data show that Benton, Lincoln, and Linn Counties have a smaller percentage of minority residents compared with the State. Although the racial mix varies within the region, most residents in each county are white and are not of Latino ethnicity. In Oregon, about 85 percent of the population is white versus about 90 percent for the Benton, Lincoln, and Linn region as a whole. Statewide about 12 percent of the population is Latino versus about 8 percent for the IHN-CCO region as a whole.

Asians are the largest non-Latino minority population in Benton County, accounting for about five percent of the population. Native Americans are the largest non-Latino minority population in Lincoln County, accounting for about 3 percent of its population. In Linn County, Native Americans also account for 2 percent of the population.

Graph 2.1. Percent of non-White population by County compared to the State



Source: U.S. Census, 2012, 2010-2012 three-year estimate

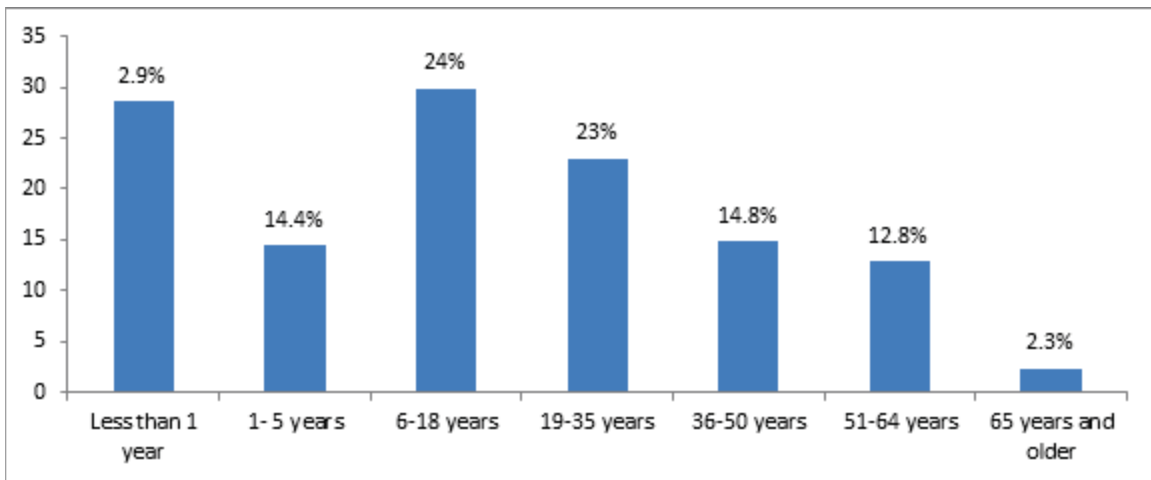
Section 2: Oregon Health Plan Members

As of May 2013, over 34,000 Oregon Health Plan eligible individuals were served by the IHN-CCO. With federal changes in eligibility requirements and a state- and nation-wide push for all Americans to sign up for health insurance, there has been a tremendous increase in IHN-CCO membership. That is, during January through mid-April 2014, the IHN-CCO received over 17,000 new members. These numbers continue to increase daily.

Age of OHP members

In 2011 and 2012, over 53,000 residents of Benton, Linn, and Lincoln Counties were enrolled and/or eligible for health insurance coverage, at various times, by the IHN-CCO. Approximately 41.3 percent of IHN-CCO members were age 18 years and younger, 37.8 percent were age 19-50, and 15.1 percent were 51 years old or older.

Graph 2.2 Unduplicated count of OHP eligible/enrolled, by age group, 2011-2012

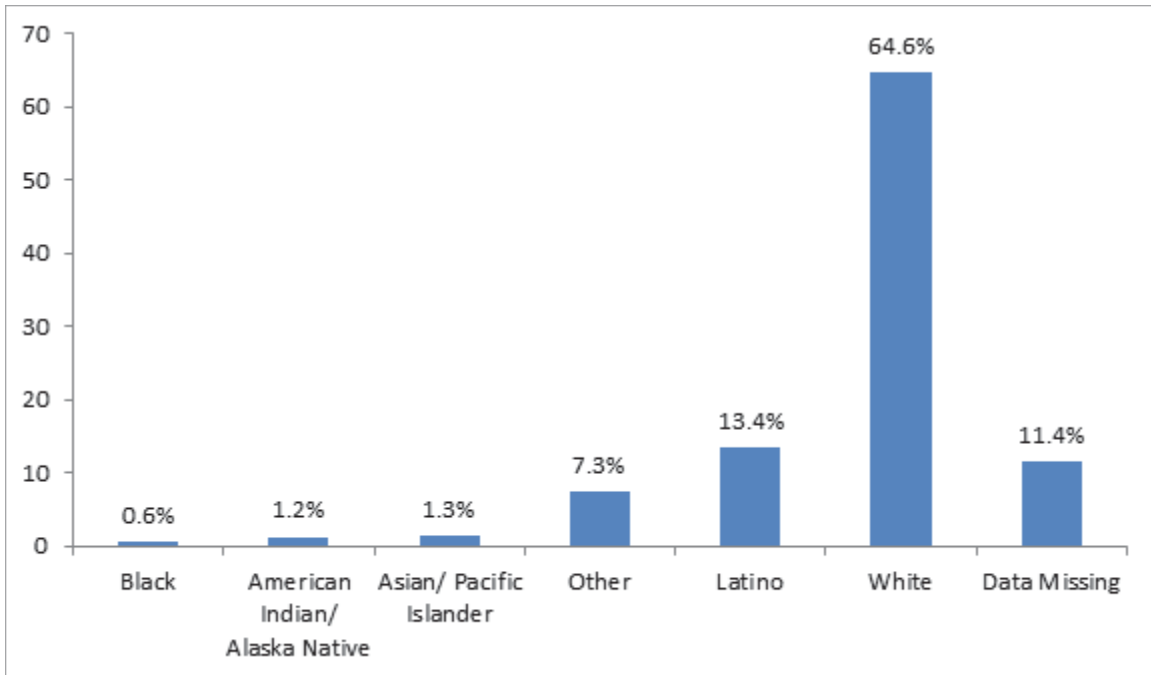


Source: Oregon Health Authority, Office of Health Analytics, DSSURS, 5/10/2013

Race & Ethnicity of OHP members

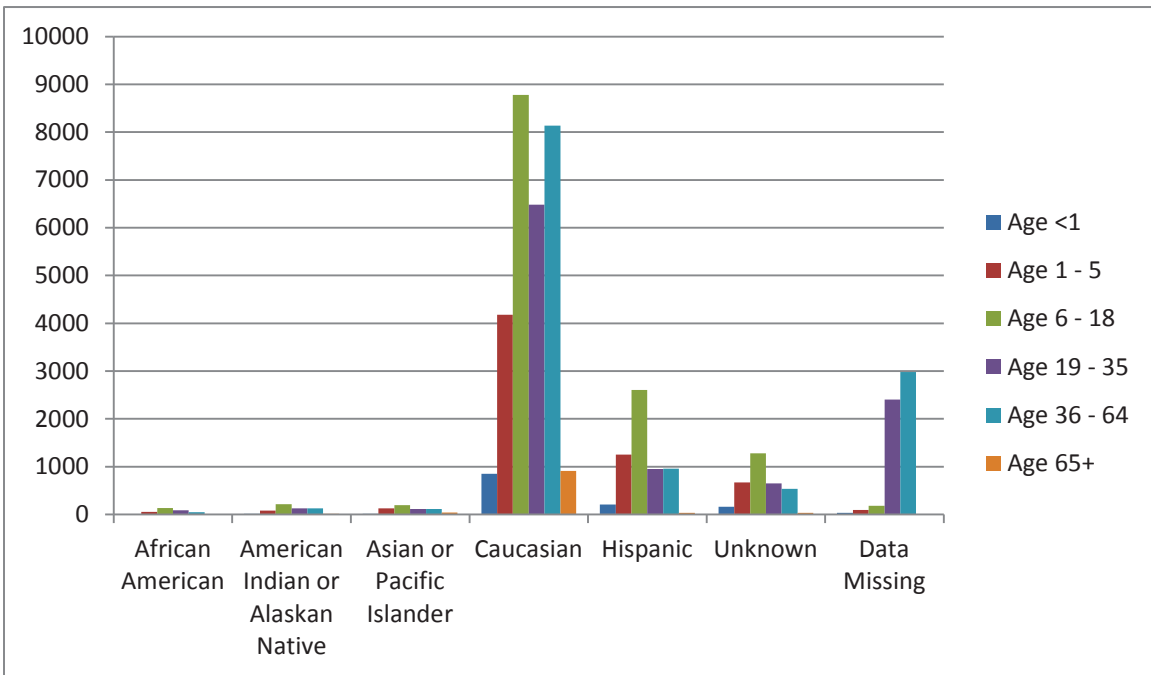
The largest racial minority group served by the IHN-CCO is Asian/Pacific Islander (1.3 percent), while the largest ethnic population served by the IHN-CCO is Latino (13.4 percent) with Whites making up nearly two thirds of the population (64.7 percent).

Graph 2.3 Unduplicated count of OHP eligible/enrolled, by race/ethnicity, 2011-2012



Source: Oregon Health Authority, Office of Health Analytics, DSSURS, 5/10/2013

Graph 2.4: IHN-CCO members by Ethnicity and Age Group for March 2014



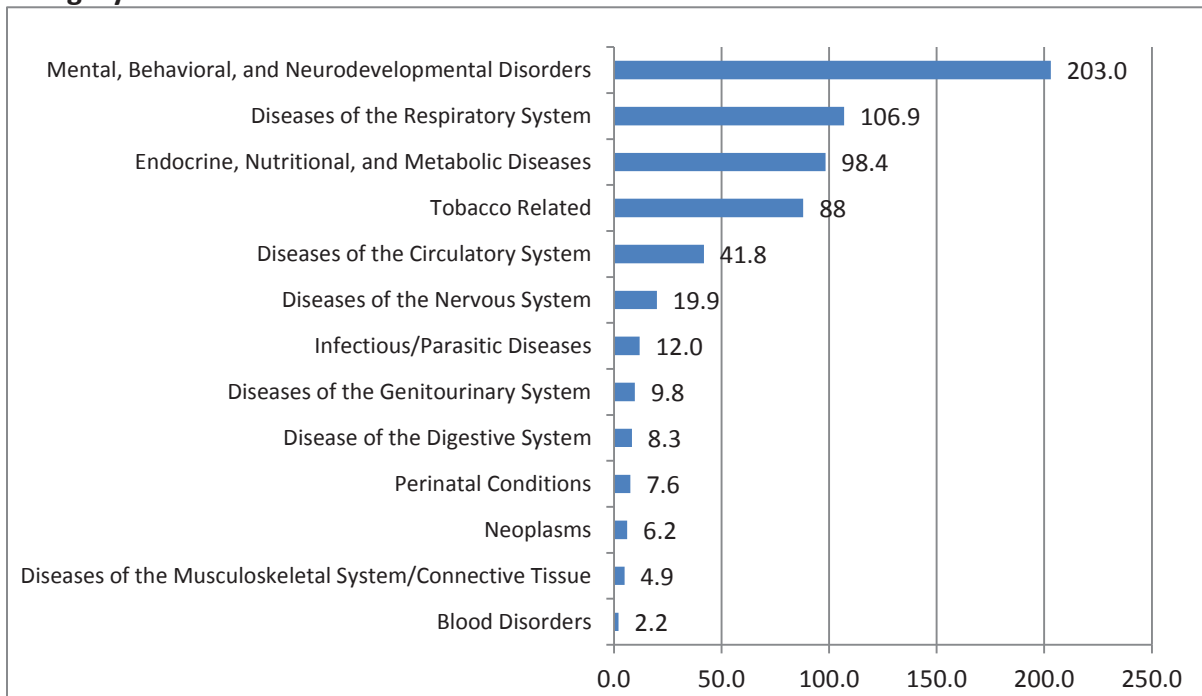
Source: Oregon Health Authority, Office of Health Analytics, DSSURS, 2014

The population forecast for Oregon by the Oregon Department of Human Services and Oregon Health Authority shows significant increase in Medicaid eligibility due to the expansion of coverage through the Affordable Care Act (ACA) of 2010.¹² As a result of this expansion, it is estimated that 241,000 new Oregon residents will be eligible for Medicaid by 2016.

Chronic Disease Diagnosis Rate Among IHN-CCO Members

The rate of chronic disease diagnosis among IHN-CCO members is 309.94 per 1,000 members (nearly 1 in 3). Among IHN-CCO members, mental, behavioral, and neurodevelopmental disorders is the most frequent chronic disease diagnosis among IHN-CCO members at a rate of 203 per 1,000 members (1 in 5). Furthermore, Diseases of the Respiratory System (106.94 per 1,000) and Endocrine, Nutritional, & Metabolic Disease (98.36 per 1,000) are also among the most frequent chronic disease diagnoses.

Graph 2.5 Chronic Disease Rates of IHN-CCO Members per 1,000 by Diagnostic Category



Source: OHP Claims Data, Summer 2013

Rural Populations

People living in rural areas often have added challenges in terms of access to healthcare. Compared to those living in cities and suburbs, rural residents experience higher rates of chronic diseases and disability and death from injuries.¹³

Lincoln and Linn County residents live in rural areas at a higher rate than residents of Oregon as a whole. That is, while 20.7 percent of Oregonians live in a rural setting, 36.2% of Lincoln residents and 31.4% of Linn County residents (18.7 percent of Benton residents live in a rural setting). That's a 15.5 and 10.7 percent difference, respectively, from the state percentage.¹⁴

Section 3: Health Disparities versus Health Inequities

Health Disparities

Health disparities can be described as “differences in the burden of disease, injury, violence, or opportunities to achieve optimal health” that exist among different populations. These populations can be defined by factors such as education, ethnicity, gender, geographic location, income, or sexual orientation.¹⁵

Health Inequities

Health inequities, on the other hand, not only emphasize that differences exist between populations, but also consider the relationship of these disparities to patterns of social inequities. Health inequities take into account the strong connection between a health disparity and the “unequal distribution of social, political, economic, and environmental resources.”¹⁶

Understanding the social, economic, and educational background of IHN-CCO members is an essential first step in addressing health disparities. It is important that services and outreach to IHN-CCO members be provided in culturally and linguistically appropriate ways so that all members have access to prevention services and high quality care.

Chapter 3

The Plan: Goals, Strategies, and Activities

Section 1: Introduction – Planning for Systemic Change

Health System Transformation

Through the coordinated care model,¹⁷ IHN-CCO is developing and testing health system changes to deliver improved, more integrated care to our members. With a focus on primary care and prevention, and using the coordinated care model, IHN-CCO providers of health services are better able to manage chronic conditions and keep people healthy.

Key elements of the coordinated care model include:

- Utilizing best practices to manage and coordinate care
- Sharing responsibility for health
- Measuring and evaluating performance
- Paying for outcomes and health
- Transparency and clear information

Coordinated Care Organizations

A coordinated care organization, or CCO, is a network of all types of healthcare providers (physical, behavioral health, and dental) who have agreed to work together in their local communities to serve people who receive healthcare coverage through the Oregon Health Plan (Medicaid). CCOs are focused on prevention and helping people manage chronic conditions such as diabetes. This helps reduce unnecessary treatments and services and gives people support to be healthy.

Under CCOs, the Oregon Health Plan's medical benefits have not changed. Before CCOs, there were separate administrative structures for physical, behavioral, and dental health. That made things more complicated for OHP members and providers and more expensive for everyone.

CCOs have the flexibility to support new models of care that are person-centered and team-focused and which will reduce health disparities. CCOs are able to better coordinate services and also focus on prevention, early identification, chronic illness management, and person-centered care. They have flexibility within their budgets to provide services alongside today's OHP healthcare benefits with the goal of meeting the Triple Aim of better health, better care and lower costs for those we serve. Additionally, the CCOs have an opportunity to coordinate and integrate services and supports throughout their coverage areas. Through a partnership with other key partners and stakeholders, communities are able to focus on social determinants of health and maximize available resources and supports.

Transformation Plan

The IHN-CCO Transformation Plan establishes the foundation for our partnership with OHA to achieve Oregon’s health system goals. The Plan encourages continuous quality improvement while recognizing that transformation is a continuous process that will and should evolve over time. The IHN-CCO Transformation Plan is geared specifically to the needs of the community we serve. The Plan demonstrates how IHN-CCO is working to improve health outcomes, increase member satisfaction, and reduce overall costs.

Elements of the Transformation Plan

1. **Healthcare Integration:** IHN-CCO is developing and implementing a healthcare delivery model that integrates physical, behavioral, and dental healthcare. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness.
2. **Patient-Centered Primary Care Home (PCPCH¹⁸)** IHN-CCO continues to develop and implement PCPCHs.
3. **Alternative Payment Methodology:** IHN-CCO is developing and implementing consistent alternative payment methodologies that align payment with health outcomes.
4. **Community Health Improvement Plan:** This CHIP will serve as a strategic plan for IHN-CCO and its partners.
5. **Health Information Technologies:** IHN-CCO is developing a plan for encouraging adoption of Electronic Health Records, health information exchange, and meaningful use.
6. **Communication, Outreach, & Engagement:** IHN-CCO is working to assure that communications, outreach, member engagement, and services are tailored to fulfill cultural, health literacy, and linguistic needs.
7. **Traditional Health Worker (THW):** IHN-CCO is working to assess, develop, grow, and implement THW services.
8. **Race and Ethnicity:** IHN-CCO is developing a quality improvement plan focused on eliminating racial, ethnic, and linguistic disparities in access to care.

Pilot Projects as Proofs-of-Concept

While continuing to provide services to its members, IHN-CCO is working diligently to test innovative methods of transforming the healthcare system through a variety of pilot projects. These pilot projects allow service providers to try out, evaluate, and refine cutting-edge processes for improving healthcare, member satisfaction, and cost efficiency. If a pilot project can be successfully refined and proves to be a viable concept, these new processes and programs will be replicated and customized throughout the IHN-CCO region.

Funding for the pilots came about because IHN-CCO service providers collaborated and agreed to take a small reimbursement decrease to create a funding pool for pilot project grants.

Pilot requirements:

1. Ability to replicate with a defined population of IHN-CCO members, a defined demographic, and location.
2. Demonstrates and defines coordination among team members, providers, and multiple organizations.
3. Potential for cost savings, defined by timeframe and duration.
4. Ability to measure and report outcomes using S.M.A.R.T. goals (specific, measurable, achievable, relevant, and time-bound) with pre-established criteria.
5. Clearly identify resources necessary to move the project forward including budget.
6. Models and strives to achieve transformation as described in IHN-CCO contract.

Pilot Project Descriptions:

- **Hospital to Home, Linn County** – This pilot began at Albany General Hospital and expanded to Good Samaritan Regional Medical Center. Its focus is on contacting patients at the Albany and Corvallis hospitals before discharge and setting up a home visit as well as follow-up phone calls. Linn County Mental Health and Addictions staff provides assessments of patient needs for this project. The primary goal of this pilot is to ensure that IHN-CCO members get the care they need so they are less likely to require hospital readmission within 30 days of discharge.
- **Mental Health Wellness Literacy Campaign Pilot, Linn County** – This Pilot is focused on developing an effective communications campaign to increase awareness among primary care providers, community- and faith-based organizations, and local schools— in Linn County and within IHN-CCO—of the ways they can take action to improve their wellness along the Eight Dimensions of Wellness. These eight dimensions are emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual.¹⁹ Through this information, the campaign also seeks to reduce stigma around mental health issues, as mental health is important to each of us.
- **Patient-Centered Primary Care Home (PCPCH), Lincoln County** – This pilot is focused on coordinating IHN-CCO members’ physical and behavioral healthcare and on engaging them in their own wellbeing.
- **Patient Assignment and Engagement, Benton County** – This pilot is looking at which members IHN-CCO shows as assigned to a Primary Care Provider (PCP) at Benton County Health Services, Samaritan Family Medicine, and The Corvallis Clinic-Philomath to see whether the clinic shows the same information—that the member is assigned to them for care.

It is important that the information matches so that when an IHN-CCO member has not been seen in a long time, or after the member receives care at an Emergency Department, that the correct PCP is notified and can check in with the member on their health. Phase two of the pilot involves Registered Nurses contacting newly assigned members and encouraging

them to make an RN appointment for an assessment and to inform them of when to contact their PCP, when to go to urgent care, and when to go to an Emergency Department.

Measures of Success

By their very nature, pilot projects are meant to test ideas and allow healthcare providers to attempt to transform and improve the system of care. Some aspects of a pilot may not provide the predicted outcomes and may need to be refined, or it may be that the outcome of a pilot project is that a particular process does not work as well as hoped. For the healthcare system to be transformed, it is important that, with careful planning, providers be able to innovate by trying new ideas.

Section 2: Access to Healthcare

Access to Healthcare includes the percentage of individuals who thought they received appointments and healthcare when needed.²⁰ In addition to being able to make appointments on a timely basis, access involves overcoming barriers to care such as having transportation to appointments and receiving information in a manner that the member can understand.

Goal 1 – Access to Healthcare:

Ensure adequate provider capacity for primary care, dental health, mental health, and substance use for IHN-CCO members

Strategy 1: Ensure that IHN-CCO members are seen by their healthcare provider in a timely manner

Activity A: Plan and implement the Benton County Assignment and Engagement Pilot

Activity B: Collect baseline data on average length of time from assignment to IHN-CCO to the first visit, type of first visit (e.g. urgent care, ED, PCP), diagnosis, and health risks. Potential data may also include: cost savings (e.g. via reduced Emergency Department visits); reduction in hospitalizations, urgent care visits, etc.; and administrative duplication reduction.

Strategy 2: Support, implement, and evaluate new IHN-CCO enrollee engagement strategies

Activity A: Develop and implement an Operations Group consisting of Medical Directors and Samaritan Health Service Provider representatives

Activity B: Determine a research strategy for assessing fair and equitable (a balanced distribution of members based on member need and provider expertise) Primary Care Provider assignment of current and new IHN-CCO members

Activity C: Create a process to track time of enrollment to time of PCP assignment

Activity D: Determine a measurement of PCP's ability to see members in a timely manner

Goal 2 – Access to Healthcare:

Promote the availability of culturally sensitive care, particularly in the areas of language and health literacy

Strategy 1: Promote educational opportunities for all IHN-CCO providers and staff on trainings that focus on, but are not limited to, health equity, health literacy, cultural competence, cross-cultural communication, and working with non-traditional healthcare

Activity A: Develop a training process by July 1, 2015

Chapter 3, Section 2: Access to Healthcare

Activity B: Ensure that all new employees receive trainings within six months of hire

Activity C: Offer annual trainings for all employees

Activity D: The IHN-CCO Chief Medical Officer will conduct a Health Literacy Continuing Medical Education course to be attended by a variety of local physicians.

Activity E: The IHN-CCO Ethnicity and Race Subcommittee will create an inventory of bilingual providers as a baseline.

Activity F: The Linn County Mental Health Awareness Pilot will promote public understanding of the relationship between physical and behavioral health and the eight dimensions of wellness, which are emotional, environmental, financial, intellectual, occupational, physical, social, and spiritual.²¹ The primary goal of this pilot is to increase community awareness of ways they can engage and improve their individual wellness.

Strategy 2: Utilize and expand programs for all types of Traditional Health Workers (THW), including Health Navigators

Activity A: Produce a comprehensive inventory of current THW services available in the region

Activity B: Develop a THW Payment Methodologies Learning Collaborative

Activity C: Solicit feedback from counties and community partners on how to best utilize and train current THWs, and implement a THW training support system

Activity D: Improve the THW delivery system, allowing THWs to better support and educate members in navigating the healthcare system and ensure appropriate, timely care

Activity E: Develop and implement a THW pilot project by July 1, 2015

Activity F: Deliver a Hub versus Non-Hub Delivery Infrastructure Model presentation to the IHN-CCO Delivery System Transformation Steering Committee provider leadership

Goal 3 – Access to Healthcare:

Expand after-hours service availability including normal clinic hours and days for primary and behavioral healthcare.

Strategy 1: All Patient Centered Primary Care Homes (PCPCH) will be open at least four non-traditional business hours.

Section 3: Behavioral Health

Behavioral Health spans a continuum of behavioral disorders including, but not limited to, prevention, diagnosis and treatment of mental health disorders, mental illness and addictive disorders. It includes wellness and provides differentiation between lesser behavioral health issues attributed to “mental health” and more intrusive disorders described as severe and persistent mental illness.²²

This definition is also intended to inform resource allocation decisions that range from prevention and early intervention to more intensive supports at the mid- and high-range of intervention up to and including residential resources, acute care resources and under-resourced services such as social and medical detoxification.

Goal 1 – Behavioral Health:

Increase child and youth mental health and wellbeing.

Strategy 1: Build capacity of IHN-CCO to engage youth in substance use and mental health issues affecting our community.

Activity A: Focus on adolescent suicide prevention using programs such as Mental Health First Aid²³ and Applied Suicide Intervention Skills Training (ASIST).²⁴

Mental Health First Aid – “teaches the public how to recognize signs and symptoms of mental health problems, how to offer and provide initial help, and how to guide a person toward appropriate treatments and other supportive help. Mental Health First Aid does not teach people to be therapists.”²⁵

ASIST – is a training “for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over one million caregivers have participated in this two-day, highly interactive, practical, practice-oriented workshop.”²⁶

Activity B: Provide leadership and education opportunities for youth that focus on prevention

Activity C: Collaborate with the counties to identify and share youth engagement and leadership best practices

Activity D: The Wraparound Planning Grant will focus on bringing Wraparound to fidelity to coordinate services and supports for children, youths, and families in all three counties and will identify ways to improve and strengthen youth engagement and leadership.

Wraparound is a planning process that follows a series of steps to help children and youth, particularly those with mental health issues, and their families with their complex needs. Wraparound does this step by step by bringing people together from different parts of the whole family’s life. With help from one or more facilitators, people from

the family's life work together, coordinate their activities, and blend their perspectives of the family's situation. The Wraparound process also helps make sure children and youth grow up in their homes and communities.²⁷

Goal 2 – Behavioral Health:

Reduce stigma associated with diagnosis and treatment of behavioral health issues in order to improve access and appropriate utilization of services.

Strategy 1: Increase community awareness of the importance of behavioral health issues in our community in order to reduce stigma associated with treatment.

Activity A: The Linn County Mental Health Awareness Pilot will promote public understanding of the relationship between physical and mental health and the eight dimensions of wellness. Part of this campaign is to educate people that mental health is an issue for everyone and that there is no health without good mental health.

Activity B: Provide youth and adult Mental Health First Aid trainings to enhance community awareness, decrease stigma, and increase preventative efforts.

Activity C: Screening, Brief Intervention, and Referral to Treatment (SBIRT)²⁸ will be developed as a standard screening practice at all primary care sites.

SBIRT is “an approach to screening and early intervention for substance use disorders and people at risk for developing substance use disorders. SBIRT emphasizes combined effort of screening and treatment services as part of a cooperative system of early intervention.”²⁹

Goal 3 – Behavioral Health:

Expand service options for behavioral health treatment for children, adults, and families

Strategy 1: Collaborate with community partners to build upon current resources in our region.

Activity A: The IHN-CCO Mental Health Advisory Committee, which includes many partners and stakeholders, will work together to share and build upon mental health resources, including identification and standardization of best practices and standard treatment across the region (e.g. respite/step-down facilities, Peer Support Specialists, co-occurring disorders, etc.)

Activity B: The Wraparound Planning Grant will focus on bringing Wraparound to fidelity services for children, youths, and families in all three counties.

Activity C: The Wraparound Planning Grant recipients will collaborate to improve and strengthen youth engagement and leadership.

Activity D: Support the further development of Assertive Community Treatment (ACT) teams in all three counties.

Chapter 3, Section 3: Behavioral Health

ACT is an evidence-based model of providing treatment and community support to individuals with serious mental illness, which assists in maintaining them within the community. It is a multidisciplinary team approach.³⁰

Strategy 2: Assure adequate and easily accessible community based residential resources with active treatment service supports, particularly with regard to detox and crisis respite care.

Activity A: The IHN-CCO Mental Health Advisory Committee, including law enforcement representation, will focus on a regional solution to assess detox and crisis respite care service gaps as the Oregon Health Authority transfers adult mental health residential treatment to IHN-CCO.

Activity B: Benton, Lincoln, and Linn County mental health programs will collaboratively assemble a database of residential resources for the region that will include the type of facility; level of care, including specialty services; location; rate; and capability to manage identifiable protected health information.

Strategy 3: Achieve functional integration with primary care through a “health home” model or as fits the needs of specific populations of a “behavioral health home.”

Activity A: IHN-CCO will create a process for evaluating and auditing PCPCH Customer service and member experience through a Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Activity B: IHN-CCO will create an inventory of PCPCH provider trainings.

Activity C: IHN-CCO will provide a summary of the Alternative Payment Methodologies implemented since the inception of the CCO.

Activity D: The IHN-CCO MHAC will assess the need and feasibility of a Behavioral Health Home. A behavioral health home involves integrating primary care into a behavioral health setting (reverse integration).

Section 4: Chronic Disease

Chronic Diseases are human health conditions of long duration and generally slow progression.³¹ Chronic diseases, such as heart disease, stroke, cancer, diabetes, depression, certain mental health and addictions conditions are among the most prevalent, costly, and preventable of all health problems. Healthy lifestyles (avoiding tobacco, being physically active, and eating well) greatly reduce a person's risk for developing chronic illnesses. Research shows that access to resources that support healthy lifestyles, such as nutritious food, recreational opportunities, and high quality and affordable prevention measures (including screening and appropriate follow-up) saves lives, reduces disability and lowers medical costs.³²

Goal 1 – Chronic Disease:

Implement primary prevention strategies to promote health and reduce prevalence of chronic disease, particularly in areas such as obesity, tobacco use, asthma, and environmental toxins.

Strategy 1: Strengthen partnership with Public Health and create a consistent language.

Activity A: Collaborate on a three county Healthy Food Policy for all hospitals and clinics. This policy will outline recommended healthy foods and beverages.

Activity B: Implement a three county Tobacco Prevention and Education Program.

Activity C: Implement and evaluate the process of information sharing to align with the IHN-CCO region Coast to the Cascades Community Wellness Network (CCCWN).³³

The mission of the CCCWN is to provide leadership to enhance the health of communities through development and support for collaborative regional partnerships in Benton, Lincoln, and Linn Counties. The CCCWN includes the following partnerships: Access to Care, Childhood Obesity, Chronic Care, Mental Health, Oral Health, Pregnancy/Prenatal Care, and Tobacco Prevention.

Activity D: IHN-CCO will create a Public Health workgroup whose purpose is to align the three county's services.

Strategy 2: Increase access to screening for chronic diseases, including causative factors, and make follow-up services for treatment available.

Activity A: IHN-CCO will categorize members by their chronic disease state, pharmacy utilization, and location of Medical Home. This will enable IHN-CCO to look at clusters of members who have chronic diseases, and grouping of multiple chronic diseases, medication management, and develop a Risk Index.

Activity B: IHN-CCO will determine how to best provide, manage, and coordinate high-risk care and will track costs, disease state, case management, hospitalizations, primary care visits, and prescription adherence. The IHN-CCO Quality Management Committee will assess if there are other appropriate measures available.

Section 5: Maternal and Child Health

Maternal Health begins preconception and continues through postpartum. This is the time before, during, and after pregnancy when supportive services enhance a woman's physical and mental health and wellbeing.

Child Health includes health and wellbeing from birth through 17 years of age.

Goal 1 - Maternal and Child Health:

Improve overall Maternal and Child Health and wellbeing, including a focus on preconception needs.

Strategy 1: Encourage the adoption of the One Key Question Initiative (Healthcare providers asking women of childbearing age if they intend to become pregnant in the next year and then following a protocol depending on the answer).

Activity A: The IHN-CCO Quality Management Committee will evaluate this option and provide a report to the Regional Planning Council to determine next steps.

Strategy 2: Provide and increase access to Maternal Health Navigators and Traditional Health Workers, including doulas.

Activity A: The IHN-CCO Traditional Health Worker Subcommittee will evaluate the need for Maternal Health Navigators. Doulas are covered in the CHIP under Goal 2, Access to Healthcare.

Strategy 3: Focus on early tobacco use, prevention, and tobacco cessation during pregnancy.

Activity A: The Tobacco Master Settlement grant awarded to Benton, Lincoln, and Linn Counties will address tobacco use, prevention, and cessation strategies for pregnant women. The regional team will develop a plan to address smoking rates among pregnant women through a best-practice system, policy, and environmental change in the clinical and community settings. The ultimate goal is to develop and implement a regional tobacco cessation campaign for pregnant women and ensure integration with county Tobacco Prevention and Education Program and Community Prevention Program's (TPEP & CPP) systematic screening and referral strategies.

NOTE: See Goal 1 in the Behavioral Health Section of this Chapter for a Children's Health goal. Also, at the time of writing the CHIP, the Benton, Lincoln, Linn Early Learning Hub is forming. IHN-CCO anticipates collaboration between the CAC, IHN-CCO, and the Early Learning Hub to identify more goals related to children and families.

Affiliations and Acknowledgments

The 2014 IHN-CCO Community Health Improvement Plan is a collaborative effort of the many community members, organizations, and providers with a commitment to improving the health of IHN-CCO members. Listed below are the organizations represented by individuals who worked on the Improvement Plan, either as a Community Advisory Council Representative, or as a member of a Local Community Advisory Committee to the CAC, or within a professional role within the system of healthcare.

Addiction, Prevention, & Recovery Committee - Lincoln County
Addictions & Mental Health Planning Advisory Council, Oregon Health Authority
Albany InReach Services
Albany Oral Health Council
Benton County Health Services
Benton County Public Health Planning Advisory Council
Childhood Obesity Coalition, Lincoln County
Childhood Obesity Coalition, Lincoln County
Children & Families Rural Community Registered Nurse
Chronic Care Committee, Lincoln County
Coast to Cascade Wellness Coalition
COMP NW - Center for Lifestyle Medicine
COMP NW Medical Education
Corvallis Community Services Consortium
Disability Services Advisory Council, Oregon Cascades West Council of Governments
Emergency Food & Shelter Program
Faith Community Nursing Coordinator, Lincoln County
Federally Qualified Health Center Council, Lincoln County
Foster Parents
Health & Human Services Directors of Benton, Lincoln, and Linn Counties
Health Care for all Oregon
Helping Homeless or near Homeless Veterans & Families
Homeless Enrichment and Rehabilitation Team board member
InterCommunity Health Network CCO
Lincoln County Health & Human Services
Lincoln County Public Health Advisory Committee
Linn County Department of Health Services & Public Health
Linn County Public Safety Coordinating Council
Linn Housing Authority
Linn-Benton Health Equity Alliance
Mental Health Advisory Board, Linn County
Mental Health Advisory Committee, Lincoln County

Affiliations and Acknowledgments

Mental Health, Addictions, & Developmental Disabilities Advisory Committee, Benton Co.
Mid-Valley Health Care Advocates
Mid-Valley National Alliance on Mental Illness
North Lincoln Hospital Foundation Board
North Senior Connections, Lincoln City
Northwest Parish Nurse Ministries
Obesity Prevention Coalition, Linn County
Oral Health Coalition, Linn County
Oregon Department of Human Services, Lincoln County
Oregon Family Support Network
Oregon Health Authority Innovator Agent
Oregon Hospice & Palliative Care Association
Parish Nursing Advisory Board, Lincoln County
Physicians for National Health Care Plan
Progressive Options Independent Living Center
Regional Oral Health Coalition
Samaritan Health Services
Samaritan Pacific Foundation Board
Senior Services Advisory Committee, Oregon Cascade West Council of Governments
United Way Emergency food and Shelter Program, Linn County

Glossary

Assertive Community Treatment (ACT) – is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illness such as schizophrenia.³⁴

Applied Suicide Intervention Skills Training (ASIST) – is a training “for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide. Over one million caregivers have participated in this two-day, highly interactive, practical, practice-oriented workshop.”³⁵

Cultural and linguistic competence – is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

- **'Culture'** refers to language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- **'Competence'** is being able to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.³⁶

Eight Dimensions of Wellness³⁷

- Emotional—Coping effectively with life and creating satisfying relationships
- Environmental—Good health by occupying pleasant, stimulating environments that support well-being
- Financial—Satisfaction with current and future financial situations
- Intellectual—Recognizing creative abilities and finding ways to expand knowledge and skills
- Occupational—Personal satisfaction and enrichment from one’s work
- Physical—Recognizing the need for physical activity, healthy foods and sleep
- Social—Developing a sense of connection, belonging, and a well-developed support systems
- Spiritual—Expanding our sense of purpose and meaning in life

Health equity – a recognition that people’s race and ethnicity, sex, gender identity, age, disability, socioeconomic status, and geographic location all contribute to an individual’s ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations.³⁸

Health literacy – the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions. Aside from the addition of “communicate,” this definition is almost identical to Healthy People 2020.³⁹

Mental Health First Aid – is a training that teaches lay-people help persons who are developing a mental illness or are in crisis.⁴⁰

Glossary (continued)

Patient Centered Primary Care Home (PCPCH) – is a healthcare clinic recognized for its commitment to patient-centered care. In a Patient-Centered Primary Care Home, patients are the most important part of their care. In this team approach, a variety of care providers collaborate and communicate so that patients’ care and services are integrated.⁴¹

Screening, Brief Intervention, Referral to Treatment (SBIRT) – “is an approach to screening and early intervention for substance use disorders and people at risk for developing substance use disorders. SBIRT emphasizes combined effort of screening and treatment services as part of a cooperative system of early intervention.”

S.M.A.R.T. goals – Goals which are specific, measurable, achievable, relevant, and time-bound.

Socioeconomic status – the social standing or class of an individual or group. It is often measured as a combination of education, income and occupation. Examinations of socioeconomic status often reveal inequities in access to resources, plus issues related to privilege, power, and control.⁴²

Traditional Health Workers (THW) – includes Community Health Workers, Peer Support and Peer Wellness Specialists, Personal Health Navigators, and Doulas. Midwives are Alternative Care Providers, not THWs.⁴³

Genitourinary system – the organs concerned with reproduction and urinary excretion.⁴⁴

Wraparound – a planning process that follows a series of steps to help children, particularly those with mental health issues, and their families with their complex needs. Wraparound does this step by step by bringing people together from different parts of the whole family’s life. With help from one or more facilitators, people from the family’s life work together, coordinate their activities, and blend their perspectives of the family’s situation. The wraparound process also helps make sure children and youth grow up in their homes and communities.⁴⁵

Acronyms

ACT – Assertive Community Treatment

ASIST – Applied Suicide Intervention Skills Training

CAC – Community Advisory Council

CAHPS – Consumer Assessment of Healthcare Providers and Systems

CCCWN – Coast to the Cascades Wellness Network

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

CPP – Community Prevention Program

HIA – Health Impact Area

IHN-CCO – InterCommunity Health Network Coordinated Care Organization

OHA – Oregon Health Authority

OHP – Oregon Health Plan

PCP – Primary Care Provider

PCPCH – Patient Centered Primary Care Home

RN – Registered Nurse

TPEP – Tobacco Prevention, Education, and Planning

SBIRT – Screening, Brief Intervention, and Referral to Treatment

S.M.A.R.T. – Goals which are specific, measurable, achievable, relevant, and time-bound

WHO – World Health Organization

**Appendix A – Health Impact Area
Recommendation Document**

Health Impact Area Recommendations

Poor access to healthcare can result in higher economic costs. These may be a result of increased ER visits and higher medical costs due to treating complicated problems rather than catching them early. The overall health of the population not receiving adequate healthcare declines over time and is one of the cost drivers of high cost to IHN.

IHN-CCO is in a position to have an influence on many of these areas. By improving patient's access to healthcare; patient knowledge of resources will increase, use of preventative services will increase and lifetime medical expenses will decrease.

LEVELS of FOCUS ALREADY OCCURRING

- 1) Cover Oregon: to help people become enrolled in OHP
- 2) Traditional Health Workers (formally known as Non-traditional healthcare workers): community health workers, peer wellness specialists and patient navigators
- 3) Willamette Valley Community Health CCO: Emergency Dept. Intervention Team.

RECOMMENDATIONS

- 1) **Increase access to primary care:** this is the gateway to all forms of medical care.
 - A. Offer incentives for physicians who accept new Medicaid patients
- 2) **Increase access to dental care**
 - A. Monitor and decrease wait time between first call to first appointment (identification of patient issues)
 - B. Survey IHN-CCO client experiences with dental care, forming a baseline to identify other access and quality issues to be addressed
 - C. Add capacity to system, if identified as the best solution to improve access, timeliness and quality of dental care.
- 3) **Decrease Emergency Room (ER) use by non-emergent patients:**
 - A. Assign healthcare worker to frequent ER users to help identify other forms of care that may be utilized in non-emergent cases.
 - B. Co-locate ER and Urgent care so patients seeking medical attention have more options
- 4) **Decrease barriers caused by transportation issues or limited access to internet**
- 5) **Increase utilization of resources by improving awareness of resources available**
- 6) **Increase cultural awareness**

SOURCES

Appendix A: HIA Recommendation Document

IHN-CCO CAC

Health Impact Area Recommendations

- 1) Bindman, A., Grumbach, K., Osmond, D., Komaromy, M., Vranizan, K., Lurie, N., & Billings, J. (1995). Preventable hospitalizations and access to health care. *Journal of the American Medical Association*, 274(4), 305-311.
- 2) Strickland, J., & Strickland, D. L. (1996). Barriers to Preventive Health Services for Minority Households in the Rural South. *The Journal of Rural Health*, 12(3), 206-217.

Prepared by: Tara Gaitaud, Hilary Harrison, Karen Stephenson, Michael Volpe

Benton local recommendation Appendix

Barriers to Access to Healthcare

- 1) Geographic barriers
 - Travel distance
 - Rural health professional shortage
- 2) Cultural barriers
 - Language
 - Health beliefs and behaviors
 - stigma
- 3) Socioeconomic barriers
 - Literacy
 - Lack of childcare
 - Full time employment
 - Lack of transportation
 - Financial barriers
 - Social isolation
 - Lack of internet access
 - numeracy
- 4) Organizational barriers
 - Long appointments and wait times
 - Accessibility ADA
 - Benchmark-Centered Care rather than Patient-Centered Care
 - Limited appointment availability: quantity and times
 - High Physician/Dentist to Patient Ratio
 - Reimbursement issues
 - New patient accessibility
 - Practitioner beliefs and behaviors
 - ER Use
 - Inadequate advertisement of services

Appendix A: HIA Recommendation Document
IHN-CCO CAC
Health Impact Area Recommendations

APPENDIX A2

Access to Care and Care Coordination - Local HIA Recommendation
Linn County 2013

HEALTH IMPACT AREA: Access to Care and Care Coordination

Access to Care is defined by the OHA as the percentage of individuals (adults and children) who thought they received appointments and care when needed

Care Coordination is facilitating the appropriate delivery of healthcare and related services that address overall wellness by reaching out to connect members with the right services at the right time with the right provider. This includes medical, mental health, dental and preventative wellness services.

PREVALENCE and POPULATION AFFECTED

Access to Care and Care Coordination have a direct impact on all other Health Impact Areas. Measuring access to care is also an important part of identifying disparities in healthcare and barriers to quality healthcare, including a shortage of providers, lack of transportation or long waits to get an appointment.

Linn County's Quality of Life Survey (QLS) shows that 25% of respondents needed healthcare in the past year and 21% did not have a primary care physician. Only 55% of Hispanic/Latino respondents reported having health insurance and, among those Hispanic/Latino's who do have insurance, 23% are insured through Medicaid or Medicare, 26 % through work plans and the remaining are self-insured or insured through a family member while 45% of non-Hispanic/Latino have insurance coverage provided by work, nearly twice the rate as Hispanics/Latinos. Also, 77% of the residents responding had a regular physician (with a rate as high as 82% in higher income areas). Over 25% of the residents have been unable to get needed healthcare at least once; again, some areas being as high as 44.4% up to 100%, depending on income and education level. They also perceived mental health needs as being higher if a resident knows of a place to go for professional help during times of sadness or depression. Unfortunately, the majority of residents (85.8%) do not know where to go to get help with sadness or depression.

Transportation and childcare are also barriers to access to care. Individuals may actually live closer to population centers (in other communities/counties) than the "required" local healthcare provider yet cannot access those providers. Knowing what healthcare services area are available (e.g., using 2-1-1) does not provide that access; transportation is still be a barrier.

Appendix A: HIA Recommendation Document
IHN-CCO CAC
Health Impact Area Recommendations

COST

The cost of the HIA is unclear at this time. The other HIA's that inter-connect with Access to Care or Care Coordination have differing financial impacts. Better Access to Care and Care Coordination results in decreased, inappropriate use of Emergency Departments and, hence, a cost savings to IHN-CCO. A decrease in no-show rates is anticipated among IHN-CCO members when care is being coordinated according to clients' needs.

ABILITY to IMPACT

Access to comprehensive, quality healthcare services is important for the achievement of health equity and for increasing quality of a healthy life for everyone. Furthermore, Care Coordination empowers all parties involved and reduces unnecessary delay and redundancy that results in inefficiency and frustration. A better understanding of available transit needs, services and gaps in Linn Co. is required and contractual agreements with transportation programs can be installed and/or expanded.

Strong partnerships need to be continued with COMP-Northwest and the various "needs" of the community can be included in the curricula of COMP-Northwest. The development and distribution of reference guides related to Access to Care can be very influential in addressing the need for information regarding available services. Increased use of the community's media outlets to advertise available programs can be helpful.

LEVELS of FOCUS ALREADY OCCURRING

Media outlets are being used for information sharing regarding available programs and individual successes and the current 2-1-1 telephone service has been helpful with behavioral issues. Community Engagement and Service Learning Education at Western University of Health Sciences in Lebanon is striving to service the community through medical student leadership and professionalism. Care coordinators are being implemented at Samaritan Health Services. A Mental Health literacy campaign is being launched in Linn County. The Linn County Public Health and Linn County Mental Health Department are strengthening partnerships throughout the community.

ADDITIONAL INFORMATION NEEDED

More useful and well organized data is needed. There doesn't seem to be data available to show that there is a significant (if any) difference in usage of healthcare services between IHN members and Samaritan Health insured members, particularly regarding their use of the Emergency Departments. The number of Emergency Department

Appendix A: HIA Recommendation Document

IHN-CCO CAC

Health Impact Area Recommendations

utilizations for non-urgent concerns is lacking as is the number of “no-shows” in the health system, in general. Access to care is a particular problem for the elderly and more information is needed about their needs--especially those not currently receiving Medicare (hoping to eventually include Medicare covered individuals). This data would be helpful if it were separated aged (50-64), elderly (65-85) and aged elderly (86+), since their needs requirements differ.

RECOMMENDATIONS

- 1) **Measurable deliverables:** A clear model is needed with measurable deliverables addressing barriers to receiving quality healthcare (e.g., health literacy and language, service availability, after-hour care, non-emergency transportation, childcare).
- 2) **An updated database of community providers** and services with consistent language and format that is user-friendly (to both members and professional staff) allowing for a clear and open pathway for information sharing and referrals is needed.
- 3) **Provider information sharing:** A clearer pathway for information sharing between professionals is also needed.
- 4) **Provider capacity:** We also need to be able to actually provide the services that we are requiring/asking for; there will be limits to the abilities of the various current providers of healthcare services.
- 5) **Incentives for Primary Care providers** (including Nurse Practitioners and Physician Assistants) based on patients health outcome and not fee-for-services.
- 6) Encourage all providers (including Traditional Health Workers) to **practice at the top of their license.**
- 7) **Traditional Health Workers:** Utilization and support of health navigators and case managers.

SOURCES

- 1) Oregon Health Authority; Oregon’s Health System Transformation Quarterly Progress Report by Oregon Health Authority (10/2012 - 12/31/2012 & 1/2013 - 3/31/2013).
- 2) Community Health Assessment 2012 by Linn County Health Services, Linn County, Oregon.
- 3) Linn County Community Health Improvement Plan 2012
- 4) Linn County (Oregon) Mobilization Action through Planning and Partnerships Committee; the Centers for Disease Control and Prevention.

Prepared by: The Care Coordination/Access to Care workgroup: Miao Zhao, Jessica Hiddleston, Denise Diller, Frank Moore, Dick Knowles

Appendix A: HIA Recommendation Document
IHN-CCO CAC
Health Impact Area Recommendations

APPENDIX B1

Behavioral Health – Local HIA Recommendation
Benton County 2013

HEALTH IMPACT AREA

Behavioral Health – Mental Health & Definition: Substance abuse and mental health/wellness for children and adults.

PREVALENCE and POPULATION AFFECTED

Behavioral health disorders are common in the United States.

- 1) Approximately 20% of adults and 13% of adolescents suffer from mental disorders each year.^{1,2}
- 2) Approximately 8.7% of Americans aged 12 and older experience substance dependence or abuse each year.^{1,2}
- 3) Mental health and substance abuse issues co-occur in 40-60% of cases
- 4) Rates of mental health problems are significantly higher for patients with chronic conditions such as: diabetes, asthma, and heart conditions and failure to treat both physical and mental health conditions results in poorer health outcomes and higher health care costs³.

Yet despite the high personal and societal burden of these disorders, fewer than half of adults and only one-third of children with mental disorders and only 11% of individuals with substance use disorders receive treatment.^{1,2}

COST

Mental health comprised 12% of IHN-CCO's current expenditure of OHP funds from the state.⁴ The real cost of mental and behavioral illness is far higher, since many other costly conditions such as obesity, tobacco related disease, heart conditions and others are directly linked to poor mental wellness.

ABILITY to IMPACT

Community interest and mobilization is happening. There are best practices available, including health promotion and prevention strategies.

LEVELS of FOCUS ALREADY OCCURRING

- 1) IHN-CCO transformation plan projects:

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- Screening, Brief Intervention, and Referral to Treatment (SBIRT) and
 - Mental health peer program for Samaritan Wellness Center for “warm handoffs” to all counties
- 2) Benton County Health Department:
 - Mental/ Behavioral health is a priority health issue identified in Benton County’s Community Health Improvement Plan 2013-2018.
 - 3) Benton County: Youth Mental Health Coalition
 - 4) Benton County Health Promotion: drug free community grant – Strategic Prevention Framework grant – Tobacco cessation grant.
 - 5) ASIST Suicide Prevention – grant now ended
 - 6) EASA program operational in Linn County

RECOMMENDATIONS

Mental health is a small proportion of the IHN-CCO budget but actions have a large impact on the total wellness of the OHP population. The focus of effort on children, early intervention and prevention gives the most immediate and future benefit. Children’s mental health funding should be protected by including a protective percentage within the CCO budget process.

Priorities:

- 1) Children’s mental health- Prevention and early intervention
- 2) Mental health and wellness promotion and stigma reduction for all ages
- 3) Ensuring early access to care and navigation services that promote a variety of supports
- 4) Substance abuse – Prevention and Emergency Department diversion/ detox beds and follow up
- 5) Use of lowest cost options for treatment, such as groups (CBT, psychiatry and others), peers and community workers

SOURCES

- 1) 2010-2011 National Survey on Drug Use and Health:
<http://www.samhsa.gov/data/nsduh/2k10nsduh/2k10results.htm>
- 2) Results from the 2010 NSDUH: Mental Health Findings: http://www.samhsa.gov/data/nsduh/2k10MH_Findings/2k10MHResults.htm
- 3) <http://www.cdc.gov/Features/MentalHealthSurveillance/>
- 4) *InterCommunity Health Network CCO Regional Community Advisory Council (CAC) Minutes*. 10 June 2013. Western Title Building, Newport, OR.

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Health Impact Area Recommendations

Prepared by: Hilary Harrison, Michael Volpe, Tara Gaitaud, Amy Roy, Karen Stephenson

APPENDIX B2

Behavioral Health – Local HIA recommendation
Lincoln County 2013

HEALTH IMPACT AREA

Behavioral Health: Prevention, diagnosis, and treatment of mental health and substance use.

PREVALENCE and POPULATION AFFECTED

A 2005-2007 American Community Survey (ACS) estimated there were approximately 1,907 adults in Lincoln Co. with mental disabilities. This was about 6.5% of the county population. During the same period (2007), nearly 4,000 Lincoln County residents, including more than 400 teenagers, were in need of treatment for substance use disorders. (3) During 2011, nearly 22 million Americans (8.4 percent of the population age 12 or over) were classified as needing treatment for substance use disorders; only 10.8 percent had received treatment during the past year; 89 percent (more than 19 million) of those identified as needing treatment had *not* received it. Of persons needing treatment for mental health disorders, 14 million did *not* receive treatment.(1)

Children and youth under 19 make up nearly half the OHP population. The child victim rate in this county is 19.9 per 1,000 children vs. a state wide rate of 12.7 / 1,000. Child abuse/neglect include mental injury, physical and mental neglect, physical abuse, sexual abuse, sexual exploitation or threat of harm. Family stress is a major underlying factor; major sources of stress include untreated mental health and substance use (as well as physical health) disorders. The Statewide Children’s Wraparound Initiative can be included in CCO activities where children and families are concerned.

COST

More people have substance disorders than have cancer and heart disease combined. (1) Nearly 70% of Lincoln County residents are affected, directly or indirectly, by substance abuse. (3) The Governor’s Council on Alcohol & Drug Abuse Programs reported in 2007 that untreated substance use disorder costs Oregon \$5.93 billion each year: \$813 million for healthcare, \$4.15 billion in lost earnings, and \$967 million for costs such as law enforcement, criminal justice, and social welfare.” (6) According to DHS, “every dollar spent on drug treatment in the community returns about \$18.50 in benefits” in reduced costs to taxpayers. (7) Data from the Oregon Health Authority (2012) for Linn, Benton, Lincoln counties show the highest expenditure by diagnosis

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category was \$43,176,356 for Mental Health Disorders (21% of OHP billing in the top ten categories).

ABILITY to IMPACT

“Up to 81 percent of patients in treatment for alcohol dependence are successful, cocaine treatment is successful for 61 percent, and opiate treatment is successful for up to 92 percent of those in treatment.” (10) “Between 70% and 90% of individuals with mental illness will experience significant reduction in symptoms and improved quality of life with treatments and supports.” (10)

LEVELS of FOCUS ALREADY OCCURRING

See IHN-CCO Transformation Deliverables and Benchmarks. Multidisciplinary approaches are necessary when addressing behavioral health needs. Examples of local non- COO / Health Department agencies include My Sisters Place, Children’s Advocacy Center, Olalla Center, and Seashore Family Literacy Center . Benchmarks at these agencies should be closely monitored.

ADDITIONAL INFORMATION NEEDED

Lincoln County billed \$5,242,776 for OHP Mental Health Disorders in 2012. This amount represents approximately 10.5% of the dollars spent on the top ten diagnostic categories in Lincoln County. Past year billings for substance use disorders do not reflect changes in coverage and covered population that will occur as more OHP consumers become eligible for addiction treatment. Careful future tracking of new treatment admissions and separation of mental health and addiction data from physical health data will be necessary to provide measures of the success of efforts to identify and refer more individuals into appropriate treatment and remove barriers posed by stigma and public misinformation.

RECOMMENDATIONS

Specific areas of focus are:

- 1) Child and youth wellbeing regarding substance use and mental health.
- 2) Mental Health and Addiction diagnosis, treatment and recovery
- 3) Specific identified areas of primary need in Lincoln County are:
 - Mental health and addiction screening and early referral to treatment.
 - Prevention education and public outreach to combat stigma and increase awareness and understanding.

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- Maintenance of locally based outpatient mental health and addiction treatment resources and urgent care for children and adults, accessible residential treatment.

Specific recommendations in areas of primary concern in Lincoln County are:

- 1) Increased mental health and addiction screening and early evaluation** of both children and adults to identify both mental health and substance use disorders and make appropriate treatment referrals.(e.g. evidence based screening in doctors' offices, hospital emergency rooms, and school health clinics.) (8, 9, 11, 12)
- 2) Increased prevention education and public outreach** to combat stigma and increase awareness and understanding of mental health and substance use not just in classrooms, but among parents and the general community. (Example: The Olalla Center's workshops to teach parents and others how to identify and deal with signs or symptoms.) (8, 9,11, 12)
- 3) Support and development of locally based outpatient mental health and addiction treatment resources and urgent care facilities for children and adults.** (Specifically: Community based detoxification and mental health respite in each county and regional treatment that is accessible to residents in any part of the coverage area.) (8, 9, 11)
 - Since more than half of OHP recipients are under the age of 19, this is a group of particular area of concern.

SOURCES

- 1) Lincoln Co. CHA – pg. 94 Mental Health Conditions
- 2) Lincoln Co. CHA – pg. 60 Child Abuse / Neglect
- 3) Lincoln Co. CHA – pg. 64 Students /w Symptoms of Depression / Suicide Thoughts
- 4) Lincoln Co. CHA – Slide Presentation #17
- 5) American Community Survey (ACS) 2005-7
- 6) Oregon Health Authority, Billing Data 2012
- 7) IHN-CCO, Transformation Deliverables and Benchmarks, July 1 ,2013
- 8) National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services, 2006 -- 2011. (NSDUH)
- 9) Substance Abuse: The Nation's Number One Health Problem. The Schneider Institute for Health Policy, Brandeis University and the Robert Wood Johnson Foundation, February 2001.
- 10) Alcohol, Illicit Drug & Tobacco Consumption and Consequences in Lincoln County, Oregon 2000-2007 (Updated May 2008)

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- 11)** Domino Effect II 2009-2011, report to the Governor from The Governor's Council on Alcohol & Drug Abuse Programs
- 12)** Article by Karen Wheeler, Addictions Policy and Development Administrator, Addictions and Mental Health Division, Oregon Department of Human Services, released for distribution September 15, 2008.)
- 13)** Formal recommendations of the Lincoln County Mental Health Advisory Committee. August 2013
- 14)** Formal recommendations of the Lincoln County Addiction Prevention and Recovery [Advisory] Committee. August 2013
- 15)** Mental and Substance Use Disorders: Fast Facts, Substance Abuse and Mental Health Services Administration, U. S. Department of Health and Human Services (SAMHSA), 2013.
- 16)** Recommendations on child/youth behavioral health from Olalla Center Director Ray Burleigh, Sept. 2013
- 17)** Proclamation of the Board of Commissioners of Lincoln County, September 11, 2013: The proclamation – prepared and presented by the Lincoln County District Attorney – declared September to be National Recovery and Wellbriety Month in Lincoln County and affirmed that “substance abuse prevention works, treatment is effective, and people can and do recover from substance abuse and mental disorders...it is critical to continue to educate our community that substance abuse and mental disorders are treatable, and people should seek assistance for these conditions with the same urgency as they would any other health problems.”

Prepared by: Chandler Davis & Gary Lahman, September 6, 2013

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APPENDIX B3

Behavioral Health – Local HIA recommendation
Linn County 2013

HEALTH IMPACT AREA

Behavioral Health includes mental health, mental illness, and addictive behaviors.

PREVALENCE and POPULATION AFFECTED

The IHN-CCO Benchmark 1 is aimed at developing and implementing a healthcare delivery model that integrates mental health and physical healthcare and addictions and dental health. This area of transformation must specifically address the needs of individuals with severe and persistent mental illness. On a national level, access to mental healthcare is significantly less than other types of medical services. 89.3% million Americans live in a federally-designated Mental Health Professional Shortage Area (MHPSA), compared to 55.3% million Americans living in similarly designated primary-care shortage areas and 44.6 % million in dental health shortage areas. The 2011 baseline data prior to CCO formations determined that after hospitalization for mental health was 69.3% for IHN-CCO using billing claims numbers; the state baseline was 57.6%.

Per the Linn County Community Health Assessment 2012 (CHA), the “one or two top health problems in your community” were Obesity, Mental Health, Access to Care and then Drug Abuse. Mental health problems were listed as access to treatment, affordability of prescriptions or housing of individuals with mental health issues. Drug Abuse was listed as number 4 but was translated into “Substance Abuse” which was any response, not including tobacco, involving abuse of illegal drugs or abuse of prescriptions. Residents who had someone to talk to during times of sadness or depression were reportedly less likely to report low levels of mental health. Seniors were also noted to have behavioral health issues and untreated mental health issues that compound chronic disease problems they may have. It is common to mistake behavior issues with normal and common aging ; forgetfulness and irritability are frequent indicators of larger mental health issues.

Respondents to the Quality of Life Survey (QLS) listed substance abuse as a top health concern 70 % of the time; noting drug abuse, alcohol abuse and related behaviors as issues in their community. Of note, Linn County has the most supportive housing in the State although no differentiation was made between mental health and substance abuse. Information from the Student Wellness Survey continually shows that teens access alcohol through parents, with or without parental knowledge, as well as through older siblings and friends of legal age. Also of note, Oregon’s Health System Transformation (2013 first quarter) Quarterly Progress Report lists NO appropriate

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screening and intervention for alcohol or other substance abuse. This same document also lists the IHN-CCO at 69.7% in follow-up after hospitalization for mental illness (the State Benchmark is 68%; baseline is 65.2%). Abuse of prescription narcotics is a major problem in the U.S., responsible for 1.2 million emergency room (ER) visits in 2009 alone. An estimated 9,000 Americans begin abusing prescription narcotics each day and as of 2007, 35 million people – 14% of the population – reported having abused these medications at some point in their lives. Narcotics have a potential for dependency through what are called reinforcing effects: reduced anxiety, boredom and aggression, and increased feeling of pleasure. According to the Centers for Disease Control, narcotic prescription overdoses accounted for nearly 15,000 deaths in 2008, a four-fold increase since 1999.

COST

Current costs are unclear at this time making potential cost savings of the Health Impact Area impossible to predict. According to national data, The US spends \$113 billion on mental health treatment (approximately 5.6% of the national health-care spending) with most of that money going towards prescription drugs and outpatient treatment. 45% of the untreated mentally ill cite cost as a barrier yet Americans paid 13% of the costs for health-care services (2005 data) compared to 11% of behavioral health spending, which includes both mental health and substance abuse treatment.

The various areas that impact Behavioral Health (including Developmental Disabilities) will have different financial impacts; a clearer identification of those areas (or, at least, those areas that we will focus on) is needed. Obviously, increasing the use of the more appropriate, outpatient services available in the community for treatment of mental illnesses rather than depending on the much more expensive inpatient services will save money; how much will be more accurately determined with increased (expected) data.

Substance abuse also has a high financial cost. Those who abuse narcotics are 2.3 times more likely to visit an ER than non-abusers. Pharmacy costs for abusers are 5 to 7 times greater than those for non-abusers.

ABILITY to IMPACT

Education campaigns should begin to increase the knowledge base of residents. Appropriate referrals can be made through personal physicians or individual contacts but the availability of these services needs to be made known to both. Partnership with COMP-Northwest with an eye to workforce development needs to be broadened to include education about available resources and need for increased professional services.

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LEVELS of FOCUS ALREADY OCCURRING

The Linn County Alcohol and Drug Abuse Prevention Program is active in prevention and treatment efforts. They provide education to teens through the Life Skills curriculum, an evidence based prevention/education program that serves approximately 1500 students each year. The A and D Program also supports the Linn County Youth Council Students Taking Action Not Drinking (STANDS)--a peer-led group active in developing teen-oriented marketing messages to the community to prevent or reduce teen substance abuse. Early use of alcohol is strongly correlated to future drug use. A focus in Linn Co social media messaging is prevention of early alcohol access and involving parents in having a stronger role in monitoring teenage activities. Linn Together is an area partnership of local schools, law enforcement, parents, faith leaders, youth services, local government, students, healthcare professionals, and business owners. The purpose of the group is to launch evidence-based substance abuse prevention strategies. The Linn County Mental Health Advisory Board has also utilized the media to promote mental health education and awareness activities as attitudes and misconceptions of mental illness are significant impediments to access of individuals seeking care.

ADDITIONAL INFORMATION NEEDED

The data for drug and alcohol use/abuse and mental health concerns in the senior population is noticeably missing from the CHIP/CHA data (how many Medicaid/OHP folks are in the “senior” population?) Some of the age limits are inconsistent in data sources for this population. Abuse of prescription medications appears to be a significant healthcare risk in the senior population--though data seems inadequate. Gathering more data for this population is recommended; perhaps separate into aged (50-64), elderly (65-85) and aged elderly (86+). ***There is also a noticeable lack of information for children of all age groups with emotional disorders and/or Serious and Persistent Mental Illnesses; perhaps emphasizing healthcare needs of autistic, Asperger’s and developmental issues would be useful. Clearer definitions of “abuse” are needed (tobacco, alcohol, illegal drugs, prescription drugs, etc.) along with clarification of their differing impacts on health in the community.

RECOMMENDATIONS

- 1) Federal legislation requires more expansive insurance coverage for mental health services; the IHN-CCO structure should reflect a more aggressive pursuit of coverage for these services. Expansion of current programming by Linn County Mental Health and Addiction Services and an expanded panel of Behavioral Health should be focused on increasing assessment, intervention and treatment of behavioral health

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disorders, prevention and integration of Behavioral Health services with primary care.

- 2) Prioritize Behavioral Health services to seniors.
- 3) Enhance mental health services to children and families; integrate planning and service delivery system design/development with the Early Learning Council Hub and Youth Development Council.
- 4) Continue to enhance the integration of services to consumers with co-occurring disorders.
- 5) Specifically address the needs of individuals with severe and persistent mental illness.

SOURCES

- 1) Coordinated Care Organization-Transformation Amendment-July 1, 2013; WA Post, 12/17/12
- 2) Seven facts about America's mental health system: S. Kliff.
- 3) Oregon's Health System Transformation Quarterly Progress Report by Oregon Health Authority (10/2012-12/31/2012 and 1/2013-3/31/2013).
- 4) CHA 2012 by Linn Co. Health Services, Linn Co., Oregon.
- 5) Linn County Community Health Improvement Plan 2012.
- 6) Linn County (Oregon) Mobilization Action through Planning and Partnerships Committee; Express-Scripts website: Healthcare Insights (2013)

Prepared by: Linn Behavioral Health workgroup: Anthony Amaral, Frank Moore, & Dick Knowles

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APPENDIX C1

Chronic Diseases: Asthma & Cardiovascular Disease
Local HIA recommendation
Lincoln County 2013

HEALTH IMPACT AREA

Chronic Disease: *Chronic:* persisting over a long period of time; *Disease:* any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs... (Dorland’s Medical Dictionary)

Specific Priority Areas:

- 1) **Asthma:** A condition marked by periodic attacks of wheezing and difficulty breathing (The American Medical Association Family Medical Guide).
- 2) **Cardiovascular Disease** (heart disease and stroke)

- **Components of both specific priority areas:**

- Tobacco Cessation
- Obesity
- Physical Fitness
- Nutrition
- Diabetes
- Early diagnosis
- Environmental toxins

PREVALENCE and POPULATION AFFECTED (Lincoln County Health Assessment)

Oregon ranked among the top 10 states with the highest percentage of adults with asthma in the nation. Chronic lower respiratory disease is the third highest cause of death in Lincoln County. Heart Disease is the #2 leading cause of death in Lincoln County. The rate is higher than in Oregon overall.

COST

“The most recent data on the cost of emergency room visits for asthma is estimated to be more than \$546 million annually” (nationwide), American College of Allergy, Asthma, and Immunology (ACAAI)

A 2003 study published in the Journal of Allergy & Clinical Immunology estimated the annual costs for asthma treatment at over \$4900 per person. These include both direct costs—such as medicine and visits to the doctor or hospital—and indirect costs, such as

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time off from work (WebMD). Asthma also results in significant time loss from school. (Lincoln County CHA)

In Lincoln County for 2012 Cardiovascular Disorders was the #2 leading diagnostic code billed for adults: \$5,951,264.20; 15% of billings among the top ten diagnostic code billings by Intercommunity Health Network (as per OHA data). In Lincoln County tobacco smoking leads to \$32.1 million being spent on medical care for tobacco-related illnesses.

ABILITY to IMPACT

Increased access to asthma treatment, medication, and monitoring could significantly increase control of asthma conditions, resulting in less loss of time at work and school, increased energy and improved overall health and quality of life.

Policy, education, screening, early diagnosis and prompt treatment including through smoking cessation, dietary changes and increased physical activity and medication, as necessary, can lower the rates of cardiovascular disease. For example, policy (e.g., cost of a pack of cigarettes; indoor clean air laws), reduces smoking rates and thereby rates of cardiovascular disease.

LEVELS of FOCUS ALREADY OCCURRING

The Lincoln County CHIP offers a series of Living Well with Chronic Diseases workshops to help people manage their chronic condition (including control of risk factors impacting the chronic disease: e.g., asthma, tobacco exposure, obesity) (Oregon Smoke-free Workplace Law & Oregon Tobacco Quit Line 1-800-QUIT-NOW).

ADDITIONAL INFORMATION NEEDED

- 1) Accessibility to medical treatment for, and monitoring of, asthma
- 2) Availability of treatment education and self-management strategies for teens in schools
- 3) Percent of adults and teens with asthma currently being treated and routinely monitored, and rate of improvement seen by physicians among those treated and monitored
- 4) Lincoln County data is needed for rates of heart disease, stroke, asthma and risk factors by age, gender, income, and ethnicity and by city/rural residence.

RECOMMENDATIONS

Facilitate **reduction** in the incidence and prevalence of Chronic Disease by:

Health Impact Area Recommendations

- 1) Removing **barriers** to asthma medication access
- 2) Facilitating **physician monitoring** of patients' medication intake schedule to assure consistent asthma treatment and control
- 3) Increasing **physician referral** to community support services and programs for managing chronic diseases and related risk factors
- 4) Increasing **early screening** for obesity and overweight, blood pressure and cholesterol, diabetes, respiratory diseases
- 5) Encouraging **public schools** to include in their health education curriculum the short and long-term risks of tobacco smoking, physical inactivity, obesity/overweight, diabetes, poor control of lower respiratory diseases
- 6) Increasing **adult access** to screening for chronic diseases and making follow-up **resources for treatment** available
- 7) Encouraging physicians to include **identification of toxic household products** used in the home as part of the initial exam

- 8) **Chronic Lower Respiratory Disease** can cause Asthma, COPD, Lung Cancer and is exacerbated by smoking, obesity, and decreased physical condition due to exercise. The prevalence of certain risk factors (e.g., obesity, tobacco smoking) in Lincoln County is higher than in Oregon overall and there are effective, evidence-based methods to lower the risk factors. Focus on this Impact Area could reduce associated conditions.

- 9) **Cardiovascular disease** should be a top priority because: a. of the high mortality rate (158.5/100k), prevalence (3.9/100k and 3.3/100k, heart disease and stroke respectively) in Lincoln County; b. 91% of adults in Lincoln County have at least one risk factor for cardiovascular disease; the prevalence of certain risk factors (e.g., tobacco smoking) in Lincoln County is higher than in Oregon overall; and c. because there are effective, evidence-based methods to lower the risk factors: tobacco smoking; obesity and overweight; physical inactivity; high blood pressure and cholesterol; and diabetes.

SUPPORTING DATA

1) OHP PATIENTS:

- A. Congestive Heart Failure admission rate for adults >18 yrs. with hospital stay =336.9/100k member years
- B. Adult tobacco users whose doctor discussed or recommended strategies to quit smoking = 22%
- C. Adult patients (>=18 yrs.) with diabetes who had a hospital stay because of a short-term problem from their disease = 192.0/100k member years

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- D. Adult patients (>=18 yrs.) with diabetes who got an LDL-C (cholesterol) test = 67.2%
- E. Adult patients (18-75 yrs.) with diabetes who got at least one Alcohol blood sugar test = 78.5%
- F. Among adults, Lincoln County OHP residents had poor asthma medication ratios compared to the statewide medication ratio
- G. The rate of Asthma per 1000 OHP members is 62.3 and 70.8 per 1000intercommunity health network clients

LINCOLN COUNTY and STATE

1) Mortality

- A. Heart Disease is #2 leading cause of death = 158.5/100,000 (higher than OR; lower than U.S.)
- B. Stroke 47.7/100k (2020 goal = 33.8)
- C. Lung Cancer is the deadliest cancer in Oregon
- D. Chronic Lower Respiratory Disease (Asthma, bronchial disease, etc.) is the 3rd highest cause of death in Lincoln County
- E. Poorly controlled asthma leads to approximately 50-80 deaths in Oregon each year
- F. Asthma costs Oregonians approximately \$125 million a year in direct and indirect costs and significantly affects quality of life
- G. Asthma affects 11.2% of Lincoln County adults and 25.1% of 11th graders, both of which are higher than in Oregon overall
Oregon has one of the highest asthma rates in the nation

2) Risk Factors

Ninety-one percent of adults in Lincoln County have at least one of the following risk factors: currently smoke, overweight or obese, physical inactivity, low fruit and vegetable consumption:

3) Tobacco

- A. The #1 cause of death in OR; 3,320 people suffer from a serious illness caused by tobacco use
- B. 25% of Lincoln County adults smoke cigarettes (OR = 17%; 2020 goal=12.0%)
8,700 regularly
- C. 21.6% of 11th graders smoked in past 30 days
- D. 170 people die from tobacco use
- E. \$32.1 million is spent on medical care for tobacco-related illnesses
- F. \$28.1 million in productivity is lost due to tobacco-related deaths

4) Weight

- A. 37.2% overweight

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- B. 26.2 obese
- C. Since 1990, Oregon’s adult obesity rate has increased 121 %
- D. 12.7% 8th graders overweight; 15.2% obese
- E. 17/1% 11th graders overweight; 11.8% obese

5) Blood Pressure & Cholesterol

- A. Overall, 56 % of adults in Lincoln County meet the CDC guidelines for physical fitness
- B. Adults with less than a high school education, those earning less than \$24,999, and Latinos are less likely to meet CDC physical activity recommendations than their peers.

6) Diet

- A. 25.6% of adults consumed 5 servings of fruits and vegetable per day
- B. 22.4% of 8th grade; 19.2% of 11th grade consume at least 5 servings of fruits and vegetables per day

7) Diabetes

- A. Prevalence among adults Lincoln County = 8.9%
- B. 9.7% in household with incomes at or below the federal poverty level
- C. 13% for African Americans; 12% for Native Americans; 10% for Latinos

SOURCES

- 1) Lincoln County Health and Human Services. August 2013. Community Health Assessment 2013
- 2) Oregon Health Authority. May 2013. Quarterly Report: Oregon Health System Transformation
- 3) Lincoln County, Oregon Asthma Information
- 4) Oregon Asthma Leadership Plan
- 5) “Estimated Prevalence and Incidence of Lung Disease,” (American Lung
- 6) Association)
- 7) Asthma Management and the Allergist (ACAAI)
 - --Asthma Health Center (WebMD)
 - --“Insurance Coverage for Allergy and Asthma Care” (Allergy & Asthma Center, P.C. Physicians)

Prepared by: Linda Fitz-Armstrong, Linda Mollino, Jackie Stankey, Bill Wiist, Karen Wright, Mike Powell, Susan Sturm

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APPENDIX C2

Chronic Disease – Local HIA recommendation
Linn County 2013

HEALTH IMPACT AREA: Chronic Disease

PREVALENCE and POPULATION AFFECTED (See Linn County CHIP pgs. 11-15.)

Almost half of Oregon adults (45%) have at least one chronic disease⁵, and in 2007, chronic diseases caused more than 60 percent of the deaths in Oregon.

Heart disease and **stroke** remain the first and third leading causes of death, accounting for more than 30% of all U.S. deaths. One million Americans are disabled from strokes, and many can no longer perform daily tasks such as walking or bathing without help.

Nearly 26 million Americans **have diabetes**. An estimated 79 million U.S. adults have prediabetes, which places them at increased risk of developing Type 2 diabetes. Diabetes is the leading cause of kidney failure, nontraumatic lower-extremity amputations, and blindness among adults aged 20–74 years.

Cancer claims more than half a million lives each year and remains the nation's second leading cause of death. The total number of Americans living with a previous diagnosis of cancer is currently estimated at 11 million.

One of every 3 U.S. adults and nearly 1 of 5 children aged 6–19 years **are obese**. Obesity has been linked to increased risk for heart disease, high blood pressure, type 2 diabetes, arthritis-related disability, and some cancers.

- An estimated 50 million U.S. adults reported being told by a doctor that they have some form of **arthritis**, such as osteoarthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. Arthritis results in activity limitations for nearly 21 million Americans.
- A SAMHSA report from April 2012 shows that adults (aged 18 and older) who had a mental illness in the past year have higher rates of certain physical illnesses than those not experiencing mental illness. According to the report by the Substance Abuse and Mental Health Services Administration (SAMHSA), adults aged 18 and older who had any mental illness, serious mental illness, or major depressive episodes in the past year had increased rates of high blood pressure, asthma, diabetes, heart disease, and stroke.
(The report entitled, *Physical Health Conditions among Adults with Mental Illnesses* is based on SAMHSA's 2008-2009 National Survey on Drug Use and Health (NSDUH) data. NSDUH is an annual nationally representative survey of the U.S. civilian, non-institutionalized population aged 12 or older.)

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Cost: Nationally, 83 cents and 96 cents of Medicaid and Medicare dollars respectively, are spent treating chronic diseases, and hospitalization costs in Oregon for chronic diseases alone are estimated to exceed \$2.2 billion a year.

ABILITY to IMPACT

- 1) Primary prevention can reduce prevalence of chronic disease in the population.
- 2) Interventions that target those with SPMI with proper supports can reduce costs to the system and increase quality and longevity of people's lives.
- 3) Systematic efforts to support patient engagement, compliance and accountability can prevent and reduce chronic diseases. (See results below)

LEVELS of FOCUS ALREADY OCCURRING:

- 1) IHN pilot project "Hospital to Home"
- 2) A pilot program has been employed by Samaritan Albany General Hospital to care for heart failure patients. Readmission rates have decreased from 23.6% to 2.6%. This is a multi-disciplinary approach already in place with proven results. According to Heart to Heart, a publication of Samaritan Health Services, "Samaritan Hospitals plan to extend this model of care to other health condition in the near future". Shawna Wolfe RN special programs coordinator states "it's about empowering patients with knowledge and tools to best care for themselves."

RECOMMENDATIONS

- 1) **Primary Prevention:** Implement primary prevention strategies to promote health and reduce prevalence of chronic diseases.
- 2) **SPMI:** Integrate health screening practices for people with serious and persistent mental illness (SPMI)
- 3) **Traditional Health Workers:** Adopt and implement the case manager/Health Care Coach model tiered system for intervention described below.
- 4) Recommended model: Expanded role for Case managers / Health Care Coach (**Health Care Navigators**) and Peer Support Specialists.

The **case manager** (preferably Registered Nurse) is responsible for patient assessment, development, implementation and coordination of the patients' plan of care including the medical treatment plan and the evaluation of patient treatment.

The case manager has primary accountability for monitoring patient outcomes. As the team coordinator of the patient care team (including but not limited to: physicians, registered nurses, licensed vocational nurses, technicians, and support and clerical staff), the case manager collaborates, directs, delegates, assigns, guides and serves as a resource to the department and the patient care team for patient care delivery.

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Health Impact Area Recommendations

The case manager promotes a cooperative working relationship with care team members, physicians, other disciplines and the public by facilitating and enhancing communication, displaying honesty and respect, displaying sensitivity to cultural and age differences, and expressing and accepting feedback in a professional manner.

The process would include a tiered level of care:

Level 1 being basic follow up and clarification of the education information given to the patient at time of initial contact. This would include a follow up phone call two to three days after consultation to assure RX was filled and treatment plan is being followed.

Level 2 would be for patients that are at risk of increased complications. In this level the case manager would follow up with contact and referrals if needed to ensure patient has the knowledge of adequate resources and the means to follow the treatment plan. An example of this would be a newly diagnosed diabetic, or an overweight person without chronic symptoms of disease.

Level 3 would include patients with chronic conditions that are symptomatic and that require repeated medical interventions. This would involve a life coach to help the patient with resources that will increase the success of treatment and compliance with the treatment plan. This is the most intensive level; it will require the case manager to meet with the patient and direct patient compliance. A morbidly obese individual may require a multi treatment team that will include the physician, physical therapist, nutritionist, and a mental health specialist and the patient.

SOURCES

CDC website - <http://www.cdc.gov/chronicdisease/states/oregon.htm>

Prepared by: Louise Moscato, Paul Barnes, Kathryn Henderson

Appendix A: HIA Recommendation Document
IHN-CCO CAC
Health Impact Area Recommendations

APPENDIX D1

Maternal Care – Local HIA Recommendation
Benton County 2013

HEALTH IMPACT AREA: Maternal health from preconception through postpartum.

PREVALENCE and POPULATION AFFECTED

In 2009, 43% of babies born in Oregon were born on Medicaid.¹ Forty-nine percent of pregnancies (38% of births) were unintended⁴⁶. Unintended pregnancies present a higher burden to the Medicaid population with 61% of births relating to unintended pregnancy being paid for by Medicaid (2006).⁴⁷

COST

Childbirth and delivery is the second highest expense for the CCO (\$31 million in 2012).⁴

ABILITY to IMPACT

Currently it is common for women to become covered by OHP after getting pregnant and then to cease having coverage six weeks after delivery. With the expansion of Medicaid, there will be more opportunity to focus on maternal care before pregnancy and after delivery as well as during the pregnancy.

LEVELS of FOCUS ALREADY OCCURRING

- 1) Maternal health navigators
- 2) WIC – national program / County health department
- 3) healthy start -- <http://www.parentingsuccessnetwork.org/community-resources/parenting-resource-agencies/healthy-start/>
- 4) Trillium CCO⁴⁸ (Lane County) smoking cessation program --Trillium CCO has started a program involving gift cards as an incentive for pregnant women to quit smoking. It would be worth watching to see how this program goes.

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RECOMMENDATIONS

- 1) Pre-conception: Adopt the One Key Question initiative⁴⁹.**
- 2) Make the question “Would you like to get pregnant within the next year?” a standard question for all women of reproductive age. Follow up with either contraception or preconception care as appropriate.**
- 3) Access to prenatal care including health navigators and traditional health worker**
- 4) Support smoking cessation during pregnancy.**
- 5) Postpartum care:**
 - A. Visit with home health nurse within the first few days after birth for screening, lactation support, and parent education.**
 - B. Screening and treatment for postpartum depression.**

Prepared by: Emily McNulty, Amy Roy, Karen Stephenson

9/13/13

Appendix A: HIA Recommendation Document
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Health Impact Area Recommendations

APPENDIX D2

Maternal & Child Health – Local HIA recommendation
Lincoln County 2013

HEALTH IMPACT AREA

The Lincoln County Coordinated Healthcare Advisory Group whole-heartily urges the IHN-CCO to choose **Maternal / Child Health** as a priority Health Impact Area (HIA). We feel that there are many areas where we could improve birth outcomes immediately, such as reducing the smoking rate among pregnant women, as well as long-term and long-lasting gains such as violence prevention in the home. Improving birth outcomes will require improving the health of childbearing aged women in our community.

The list below highlights areas where coordinating services across the health spectrum in Lincoln County would result in more beneficial outcomes. We feel Lincoln County has a strong home visiting program run by Lincoln County Health and Human Services. In fact, they have recently started a Nurse Family Partnership program for first time parents. Our Early Childhood Coordinating Council started Coastal Families Together to improve parenting skills, start support groups for families and improve violence prevention interventions. These are all services that exist in Lincoln County and need to be strengthened with IHN-CCO involvement.

PREVALENCE and POPULATION AFFECTED

In Lincoln County, one quarter of the OHP population consists of women of child bearing age, and half are children. 23.2% of Lincoln County mothers smoke during pregnancy and there is a spike in youth smoking at the 11th grade. According to the Child Welfare Data book, physical abuse of spouse/fighting and parent/caregiver alcohol or drug use were the top two family stressors in their abuse or neglect reports.

COST

Consider the following in Lincoln County:

- 1) Rates of tobacco use, asthma, COPD, ADD, and obesity are higher than statewide rates.
- 2) \$32.1 million is spent on medical care for tobacco-related illnesses
- 3) \$28.1 million in productivity is lost due to tobacco-related deaths
- 4) Childbirth and Delivery is the highest cost for the CCO in Lincoln County

ABILITY to IMPACT

Use of mandatory screening questions regarding the family environment and exposure to toxins at every clinician visit would improve awareness of the problem while also collecting baseline data for the CCO. Other strategies are currently being used in

Appendix A: HIA Recommendation Document
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Health Impact Area Recommendations

Oregon, for example Lane County has a model in place where they give teen parents incentives to stop smoking. Using this and other innovative interventions would improve maternal and child health in Lincoln County.

LEVELS of FOCUS ALREADY OCCURRING

Current partners include the Health Department and an excellent home visiting program, a parent education program county-wide, the Siletz Tribe, DHS, Lincoln County School District, and clinicians throughout the county.

ADDITIONAL INFORMATION NEEDED

Identify additional information, statistics needed to make decision. Lincoln County has received the Maternal, Infant and Early Childhood Home Visiting (MIECHV) grant to strengthen their home visiting program, family support and early education efforts. We are a rural community with a very high rate (75%) of high risk children, a high school graduation rate of only 63 percent and child abuse is almost double for Lincoln County children compared to Oregon. Twenty-two percent of our children live in poverty and this is disproportionate for children of color.

RECOMMENDATION

Improvements to this HIA will have a wide range of health benefits to the community – from reduction in low birth weights, reduction in early onset of smoking, reduction in cancer rates, and improved productivity, to name a few.

For example, **while tobacco use** is listed as the leading cause of death of Oregonians, our CCO members use tobacco at a rate 40% higher rate than the rest of OHP members. Even so, only 25% of those surveyed in Lincoln County thought tobacco use was a major problem. We believe a priority should be early tobacco prevention – starting with pre-natal interventions.

To improve awareness of the problem, a simple intervention could be to require all direct service providers to ask questions regarding the family environment, access to care, and their exposure to environmental toxicants (insecticide and herbicide use at home, use of scented cleaning products, second hand tobacco smoke, use of scented personal care products, proximity to agricultural and forestry pesticide sprays, proximity to sources of industrial emissions, proximity to high-use roadways and roadside herbicide sprays, exposure to smoke from outdoor burning or wood stoves, workplace exposures to environmental toxics, etc.).

Appendix A: HIA Recommendation Document

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Health Impact Area Recommendations

We could also adopt a standard of care for helping people quit smoking. The use of an evidence-based intervention for children and adults would be helpful. The Tobacco Prevention Education Program is making progress with smoke-free policies around the County and plans are being implemented to address smoking among adolescents.

SOURCES

- 1) Child Welfare Data Book,
- 2) IHN Chronic Condition co-morbidity data
- 3) Diagnosis cost assessment provided by OHA,
- 4) The 2013 Community Health Assessment conducted by Lincoln County HHS.

Prepared by: Rebecca Austen, Tom Kerns, Susan Trachsel

Appendix A: HIA Recommendation Document
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APPENDIX D3

Reproductive and Perinatal Health - HIA
Linn County 2013

HEALTH IMPACT AREA: Reproductive and Perinatal Health

PREVALENCE and POPULATION AFFECTED

Sixty-five percent of female IHN-CCO members are between the ages of 18-44 years old, widely the “childbearing years.” Their health and habits affect the children they bring up. Children make up 56% of IHN-CCO members. In 2009, 43% of babies born in Oregon were born on Medicaid.⁵ (Other sources place this number at 47% or 50%.) 49% of pregnancies (38% of births) were unintended⁵⁰. Unintended pregnancies present a higher burden to the Medicaid population with 61% of births relating to unintended pregnancy being paid for by Medicaid.⁶

COST

Childbirth and delivery is the second highest expense for the CCO costing almost \$31 million in 2012.⁸ Neonatal care costs were over \$17 million and accounted for the most amount of money billed for in the minor population’s coverage.

Furthermore, setting an example and helping to influence the other CCOs can help with the statewide OHP costs. Resources indicate that there were 19,664 births paid for by Medicaid in all of Oregon in 2009.¹

With an average hospital birth, attended by OBGYN care costing close to \$9,000, this adds up to over \$124 Million.

With the cesarean rate being around 30% there were 5,899 surgical births costing on average more than \$13,000 adding up to over \$76 Million.

This totals to over \$200 Million in childbirth expenses paid for by OHP in 2009

These costs do not reflect additional anesthesia used for most births and cesarean births as they are billed separately. This also doesn’t reflect the individual physicians’ costs, or infant care costs.²

We also know that since then, economic impacts have increased the amount of women and children on OHP, so we know that the number has increased.

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ABILITY to IMPACT

The ability to impact this is HUGE. Because of the work that several nonprofit organizations have done, gathering studies and creating Health Improvement tool kits. Corporations and individual physicians can learn ways to reduce the use of costly interventions and create a mother-baby centered model of care that will improve outcomes, reduce the cesarean rate and lead to other health improvement outcomes that will be part of preventative medicine.

LEVELS of FOCUS ALREADY OCCURRING

There are many potential partners in improving the quality of care, creating patient centered models and reducing costs already in place in our communities.

Another way of partnering with professionals is to promote the hiring of **Certified Nurse Midwives** into already existing practices so that the OBGYNs are working with only high risk mothers

Last year, the Legislature passed House Bill 3311, which required the Oregon Health Authority to investigate how **Doulas and other Community Health Workers could improve the birth outcomes of underprivileged and underserved women.**⁴ **Hiring Doulas** as part of hospital staff or assistants to OBGYN and CNMs to attend the labors of women is a way that intervention use could be decreased, with doulas charging in the range of \$300-\$1000 per birth and interventions costing several thousands of dollars, the cost savings could be tremendous. A recent study showed specific results in Medicaid recipients that showed a 40.9% lower risk of cesarean in births in the Medicaid population that were attended by a doula.

Utilizing **WIC and Healthy Start** are other ways to make sure each Mother on OHP is truly getting what is available to them to help their families.

Albany General Hospital is already working on a Pilot program for postpartum depression called **Hope For Mothers** that is a group for new moms to find support for emotional and mental health issues that they often face.

ADDITIONAL INFORMATION NEEDED

Contraception and family planning are easily handled by Nurse practitioners and midwives as well as PCPs. Making it a point at every appointment to ask a woman if she is planning on having a baby or needs contraceptive information is a way to help prevent unwanted pregnancies. However, many of the people who have unwanted

Health Impact Area Recommendations

pregnancies don't see their PCPs regularly so providing outreach services that offer free contraceptive is very important. There is currently no place in Lebanon to get free condoms, whether there are places in other parts of Linn county who do offer them has yet to be determined. Family Planning seminars that are free to the public are also a way to educate and empower consumers.

Catching health habits, like nutrition and exercise, and to some extent for a smaller portion of the population, drugs and smoking, during pregnancy will help mothers and also help their babies. This is something that can be handled with proper prenatal care and maternal health workers.

The current cesarean rate across the country is 35%. The WHO recommends it be no higher than 15% in developed countries. The recommendations provided are a direct attempt at lowering the cesarean birth rate.

Breastfeeding reduces the chances of breast cancer in the mother and reduces the chances of obesity, diabetes, and heart problems in children and also reduces the incidence of behavioral problems and contributes to higher IQs in children.

RECOMMENDATIONS

This should be a top priority for the CHIP because it has the potential to reduce cost by millions of dollars, create better health outcomes, improve the quality of care, increase the potential for preventative care, and impact a large amount of people on OHP in our area.

- 1) **Maternal Health Navigators** who are assigned to each pregnant woman that can help them with education and navigating the professionals that each woman would need to see depending on her treatment plan. This would increase the amount of prenatal and post-partum care a mother receives which might increase their success in moving towards better diet, making sure they are screened for mental health needs, provide avenues for smoking cessation, and provide lactation services in the home of the family to increase the success rate of breastfeeding. Providing postpartum care in the homes of new mothers also allows for a better assessment of mental health conditions and can catch postpartum depression early on. Many mothers who suffer from PPD will often not tell a medical provider out of fear or shame so having someone in the home can help assess the situation differently and may catch some of the more prolonged and severe cases.
- 2) Providing access to **childbirth and parenting classes** through this program can enhance the consumers' personal empowerment by giving them instruction and resources for common issues that might take up time of the doctors and can prevent

Health Impact Area Recommendations

forming habits that could later turn into physical and behavioral/mental health problems down the way.

- 3) Remove the barriers preventing consumers from choosing an out of hospital birth with the licensed provider of their choosing by accepting billing from out of network providers or modeling an existing plan (e.g., the Willamette Valley Health CCO). This provides a safe and cost effective alternative to hospital births for low risk mothers that allow for minimal interventions and privacy which are reasons mothers chose to birth out of hospital, according to women surveyed in 2009.
- 4) **Provide scholarships and loan forgiveness opportunities** to increase the amount of Certified Nurse Midwives in our area so that they can provide primary reproductive care to women freeing up the OBGYNs to work with high risk women. Utilizing the skills of midwives in and out of hospitals will reduce the costs and provide preventative care in the process by lowering the amount of interventions that lead to higher incidences of Cesarean births. Cesarean births are associated with an increased risk of maternal morbidity and mortality with the current and future deliveries, increase risk of NICU stays for infants and lower incidence of breastfeeding.
- 5) Develop a **Doula Program** that will be implemented in Samaritan hospitals to reduce the length of labor, prevent intervention use, and create a more satisfying experience for mothers and families on IHN-CCO.
- 6) As part of prenatal care, mothers should be **receiving dental healthcare** as poor dental hygiene is related to miscarriages, early birth and low birth weight.
- 7) **Condom and other contraception** methods should be available to people for free and anonymously through different programs targeting youth and underprivileged groups. Reducing teen and unwanted pregnancies can cut costs to the CCO and provide better long term outcomes for families.

SOURCES

- 1) <http://kff.org/medicaid/state-indicator/total-medicaid-births/>
- 2) <http://transform.childbirthconnection.org/wp-content/uploads/2012/05/Oregon1.pdf>
- 3) <http://transform.childbirthconnection.org/resources/toolkits/>
- 4) http://www.thelundreport.org/resource/workgroup_recommends_oregon_health_plan_use_doulas
- 5) Katy Backes Kozhimannil, Rachel R. Hardeman, Laura B. Attanasio, Cori Blauer-Peterson, and Michelle O'Brien. Doula Care, Birth Outcomes, and Costs Among

Appendix A: HIA Recommendation Document

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Health Impact Area Recommendations

Medicaid Beneficiaries. American Journal of Public Health: April 2013, Vol. 103, No. 4, pp. e113-e121. doi: 10.2105/AJPH.2012.301201

<http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2012.301201>

- 6) [Boucher D, Bennett C, McFarlin B, Freeze R. J Midwifery Womens Health.](#) 2009 Mar-Apr;54(2):119-26. "Staying home to give birth: why women in the United States choose home birth." doi: 10.1016/j.jmwh.2008.09.006.

Prepared by: Kaire Downin, Emily McNulty, Amy Roy, Karen Stephenson

Appendix A: HIA Recommendation Document
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APPENDIX E

Acronyms from overall recommendation (local recommendation acronyms not included)

CAC – Community Advisory Council

CHA – Community Health Assessment

CHIP – Community Health Improvement Project

HIA – Health Impact Area

OHP – Oregon Health Plan

IHN-CCO Intercommunity Health Network Coordinated Care Organization

Appendix B – CAC Goal Recommendation Document

**IHN-CCO Community Advisory Council
Community Health Improvement Plan 2014
Goal Recommendations
March 3, 2014**

EXECUTIVE SUMMARY

The Intercommunity Health Network Coordinated Care Organization (IHN-CCO) Community Advisory Council (CAC), through a Community Health Assessment (CHA) process, based on their three County CHAs and Community Health Improvement Plans (CHIPs) have prioritized 14 goals for inclusion in the IHN-CCO's 2014 CHIP.

BACKGROUND

Health Impact Area (HIA) Recommendations

The primary task assigned to the IHN-CCO CAC by Oregon Senate Bill 1580 is “overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and health care system service plan for the community served by the coordinated care organization; and annually publishing a report on the progress of the community health improvement plan.” The first report is due July 1, 2014.

After four months of intensive work, in October 2013, the IHN-CCO CAC submitted a Health Impact Area (HIA) Recommendation document to the IHN-CCO. The HIA recommendations serve as the CAC's first Community Health Assessment (CHA), and while they prioritize the needs of IHN-CCO members, they are based on the three more extensive County CHAs.

The Health Impact Areas are:

- 1) Access to Healthcare**
- 2) Behavioral Health**
- 3) Chronic Disease**
- 4) Maternal & Child Health**

Within the four HIAs, the CAC included a total of forty-five goal recommendations. While none have been eliminated for inclusion in future CHIPs, the CAC has prioritized 1 - 5 goals per HIA for a total of 14 priority goals for the 2014 CHIP.

CAC CHIP WORKGROUP PROCESS

Appendix B: CAC Goal Recommendation Document 3/3/2014

To prioritize 4 - 16 goals for IHN-CCO's 2014 CHIP, a workgroup was appointed by the CAC Chair. The CAC CHIP Workgroup is composed of members from each of the three counties and includes both IHN-CCO member and community representation. In the months of January and February 2014, the workgroup met seven times and was staffed by the Oregon Health Authority Innovator Agent, the CAC Coordinator, and the IHN-CCO CEO.

To facilitate discussion, recommendations were grouped by common theme to form 25 focus areas. These were then narrowed to 13 focus areas through a combined numerical ranking system. In preparation for identifying strategies to meet the goals of the CHIP, IHN-CCO created a grid of current and proposed programs corresponding to the selected focus areas.

The remaining goals were prioritized via a nominal voting process. Each member voted for their choice of two goal priorities in each of the four HIAs. This narrowed the workgroup down to 13 goals. The workgroup then returned to the HIA Recommendation document and combed through the original 45 goals to make certain that no high priority goals had been missed for inclusion in the first CHIP. Through this process, the group made a few minor changes to the original goals to further clarify them and bring them into alignment with some of the goals that were not prioritized for this first CHIP. Also, one additional goal was picked up, bringing the total to 14.

In anticipation of including youth related improvement plans in future CHIPS, the group changed the name of the Maternal and Perinatal Health HIA to Maternal and Child Health.

The group then looked at each of the 14 goals and, where needed, further defined them. For example, the first Access to Care goal is adequate provider capacity for primary care, dental health, mental health, and substance abuse. The CAC understands that the CCO is required by the State to meet certain provider capacity standards. The CAC is interested in digging deeper than those requirements and looking to improve how quickly members are seen by their healthcare provider, increasing new enrollee engagement, and making efforts to ensure that IHN-CCO has the capacity to provide culturally sensitive care that meets its members' language and health literacy needs.

CHIP 2014 GOAL RECOMMENDATIONS

1) Health Impact Area: Access to Care

A) Goal 1: Adequate provider capacity for primary care, dental health, mental health, and substance abuse.

i) IHN-CCO Members seen by their healthcare providers in a timely manner.

Appendix B: CAC Goal Recommendation Document 3/3/2014

- ii) New enrollee engagement
 - iii) Availability of culturally sensitive care, particularly in the areas of language and health literacy
- B) Goal 2:** Utilize and expand programs for all types of Traditional Health Workers and Health Navigators.
- C) Goal 3:** After-hours service availability. Expand normal clinic hours/days for Primary Care and Behavioral Healthcare.

2) Health Impact Area: Behavioral Health

- A) Goal 1:** Focus on child and youth wellbeing regarding substance abuse and mental health.
- i) Youth engagement and leadership
 - ii) Education and prevention such as Mental Health First Aid and Linn Together (mentalhealthfirstaid.org and linntogether.org)
- B) Goal 2:** Stigma prevention, education, and outreach to increase general community awareness, understanding, and the reduction—if not elimination of—stigma.
- C) Goal 3:** Build upon the strengths of local mental health and addiction resources, including locally available urgent behavioral healthcare for children, adults, and families.
- D) Goal 4:** Assure adequate and easily accessible community based residential resources with active treatment service supports
- i) Detox
 - ii) Crisis respite care
- E) Goal 5:** Achieve functional integration with primary care through a “health home” model or as fits the needs of specific populations of a “behavioral health home.”
- i) How does the CCO evaluate whether or not care is being integrated?
 - ii) How is the implementation of the Health Home model evaluated?

3) Health Impact Area: Chronic Disease

Appendix B: CAC Goal Recommendation Document 3/3/2014

A) Goal 1: Implement primary prevention strategies to promote health and reduce prevalence of chronic disease.

i) Particularly in areas such as obesity, tobacco use, asthma, environmental toxins.

B) Goal 2: Traditional Health Workers: Adopt and implement case manager/Health Care Coach model tiered system for intervention.

C) Goal 3: Increase access to screening for chronic diseases, including causative factors, and make follow-up services for treatment available.

4) Health Impact Area: Maternal and Child Health

A) Goal 1: Encourage the adoption of the One Key Question Initiative.

B) Goal 2: Provide and increase access to Maternal Health Navigators and Traditional Health Workers, including doulas.

C) Goal 3: Focus on early tobacco use prevention and tobacco cessation during pregnancy.

Acronyms

CAC – Community Advisory Council

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

HIA – Health Impact Area

IHN-CCO – Intercommunity Health Network Coordinated Care Organization

Appendix C
IHN-CCO, Benton, Lincoln, and Linn Counties'
CHIP Alignment Document



Community Health Improvement Plans (CHIP) Benton, Lincoln*, and Linn Counties Alignment Document

This document serves to identify common strands and lists priority health issues for both Linn and Benton counties. This document also includes page numbers throughout the document for referring to a county's Community Health Improvement Plan for further information. (e.g. **pg. 14**)

Common Strands Community Health Improvement Plans Draft May 17, 2014

*The Lincoln CHIP is in development

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
<p>Access to Healthcare</p>	<p>Access to Healthcare pg. 21</p> <ul style="list-style-type: none"> Expand after-hours service availability including normal clinic hours and days for primary and behavioral healthcare. Ensure that IHN-CCO members are seen by their healthcare provider in a timely manner Support new IHN-CCO enrollee engagement strategies Promote the availability of culturally sensitive care, particularly in the areas of language and health literacy Promote educational opportunities for all IHN-CCO providers and staff on trainings that focus on, but are not limited to, health equity, health literacy, cultural competence, cross-cultural communication, and working with Traditional Healthcare Workers Utilize and expand programs for all types of Traditional Health Workers (THW), including Community Health Navigators. <p>Knowledge of Available Services</p> <ul style="list-style-type: none"> Plan and implement the Benton County Assignment and 	<p>Access to Healthcare pg. 19</p> <ul style="list-style-type: none"> Support implementation of Oregon’s primary care medical home model with a focus on integrating mental, physical and oral health services. Promote neighborhood and school-based outreach to improve access to and navigation of health and social service systems. <p>Knowledge of Available Services</p> <ul style="list-style-type: none"> Promote 2-1-1 information line. <p>Transportation pg. 9</p> <ul style="list-style-type: none"> Improve utilization of alternative transportation modes. Develop a neighborhood demonstration project that promotes safe, active, and healthy transportation. 	<p>Access to Healthcare pg. 15</p> <ul style="list-style-type: none"> Maintain and expand Safety Net clinics. Partner with universities and regional medical school to provide basic preventive care. Support grassroots organizations such as Linn-Benton Health Equity Alliance to build advocacy and leadership for health equity and social justice among Linn County communities. <p>Knowledge of Available Services pg. 18</p> <ul style="list-style-type: none"> Promote 2-1-1 information line. Utilize local media to raise awareness of local services. <p>Transportation</p> <ul style="list-style-type: none"> Leverage transportation costs across departments/agencies. Better understand transit needs, services patterns and gaps.

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
	<p>Engagement Pilot, which includes educating IHN-CCO members on when to call their Primary Care Provider, go to urgent care, or go to the Emergency Department.</p>		
Behavioral Health	<p>Behavioral Health pg. 23</p> <p>Youth Behavioral Health</p> <ul style="list-style-type: none"> • Build capacity of IHN-CCO to engage youth in substance use and mental health issues affecting our community. • Focus on adolescent suicide prevention using programs such as Mental Health First Aid and Applied Suicide Intervention Skills Training. • Provide leadership and education opportunities for youth that focus on prevention. • Collaborate with the counties to identify and share youth engagement and leadership best practices. • Focus on bringing Wraparound to fidelity to coordinate services and supports for children, youths, and families in all three counties and identify ways to improve and strengthen youth engagement and leadership. 	<p>Youth Behavioral Health pg. 14</p> <ul style="list-style-type: none"> • Conduct outreach, education, and training on bullying/harassment prevention and reporting. • Coordinate Suicide Prevention programming. <p>Access to Behavioral Health Services pg. 13</p> <ul style="list-style-type: none"> • Improve processes for referral and linkage to high quality mental health services • Promote evidence-based chronic disease self-management among mental health consumers. <p>Adult Behavioral Health pg. 14</p> <ul style="list-style-type: none"> • Promote the use of depression screening in primary care settings. • Expand use of Traditional Health Workers including outreach conducted by mental health peer specialists. 	<p>Youth Behavioral Health</p> <ul style="list-style-type: none"> • Maintain and expand the use of "Life Skills" curriculum in schools. • Develop social marketing and health communication campaigns that address alcohol use among adolescents. • Incorporate messages on parental responsibility and benefits of social host policies in communication strategies. • Continue to convene Linn County Youth Council to foster coalition and policy addressing the needs of youth. <p>Adult Behavioral Health</p> <ul style="list-style-type: none"> • Implement a data-driven mental health improvement plan. • Expand options for drug-free housing during treatment.

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
	<p>Access to Behavioral Health Services</p> <ul style="list-style-type: none"> • Increase community awareness of the importance of behavioral health issues in our community in order to reduce stigma associated with treatment. • Collaborate with community partners to build upon current resources in our region. • Assure adequate and easily accessible community based residential resources with active treatment service supports, particularly with regard to detox and crisis respite care. • Achieve functional integration with primary care through a “health home” model, or as fits the needs of specific populations, a “behavioral health home.” • Increase utilization of Traditional Health Workers, including Mental Health Peer Support Specialists. <p>Promote Integrated Health Awareness</p> <ul style="list-style-type: none"> • The Linn County Mental Health Awareness Pilot will reduce stigma and promote public understanding of the relationship between physical and mental 		

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
	<p>health and the eight dimensions of wellness.</p>		
<p>Chronic Disease Prevention</p>	<p>Chronic Disease pg. 26</p> <p>Tobacco Prevention</p> <ul style="list-style-type: none"> • Implement a three county Tobacco Prevention and Education Program. • Focus on tobacco prevention and cessation during pregnancy <p>Preventative Screening</p> <ul style="list-style-type: none"> • Increase access to screening for chronic diseases, including causative factors, and make follow-up services for treatment available. <p>Other</p> <ul style="list-style-type: none"> • Implement and evaluate the process of information sharing to align with an IHN-CCO region Coast to the Cascades Community Wellness Network. 	<p>Obesity Prevention pg. 5</p> <ul style="list-style-type: none"> • Strategically foster opportunities for collaborative and coordinated planning across diverse sectors and institutions. • Initiate cross-sector collaboration to achieve “Health in All Policies” among key sectors including public health, transportation, agriculture, land use, housing, public safety, and education, among others. • Promote the use of Health Impact Assessments to inform decisions on chronic disease prevention, policy and built environment projects. • Leverage funding among key institutional partners to maximize resources and policy opportunities to advance obesity prevention strategies. 	<p>Obesity Prevention pg. 12</p> <ul style="list-style-type: none"> • Support and expand School Wellness Councils. • Promote Coordinated Approaches to Child Health (CATCH) interventions in rural schools and after school programs. • Implement Peaceful Playgrounds in schools. • Educate community on mental, physical, and environmental health issues. <p>Tobacco Policy pg. 21</p> <ul style="list-style-type: none"> • Adopt policies on smoke free parks and outdoor areas. <p>Preventative Screening</p> <ul style="list-style-type: none"> • Provide free community screening events. • Promote preventative screening in clinical settings. <p>Youth Tobacco Use pg. 19</p> <ul style="list-style-type: none"> • Adopt zoning regulation for tobacco sales that occur near schools. • Promote advertising regulation in proximity to schools. • Strengthen infrastructure for

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
<p>Maternal, Child, Youth, & Family</p>	<p>Maternal Health pg. 27</p> <ul style="list-style-type: none"> • Improve overall Maternal and Child Health and wellbeing, including a focus on preconception needs. • Encourage the adoption of the One Key Question Initiative • Provide and increase access to Maternal Health Navigators and Traditional Health Workers, including doulas. • Focus on early tobacco use, prevention, and tobacco cessation during pregnancy. 	<p>Food Insecurity Among Children and families pg. 1</p> <ul style="list-style-type: none"> • Educate policymakers on food insecurity research and impact on local children and families. • Develop a Community Food and Redistribution Center for local pantries, programs and families. • Conduct outreach to address cultural and linguistic barriers that impede access to food programs (e.g. SNAP, WIC, Federal School food programs, etc.) 	<p>clinical support for tobacco cessation.</p> <ul style="list-style-type: none"> • Strengthen clinical tobacco cessation referral pathways that make it easier for patients to access evidence based cessation services. • Support and provide training in evidence-based tobacco cessation. • Implement tobacco health communication strategies in healthcare venues.

Appendix C

Common Strands	InterCommunity Health Network CCO (IHN-CCO) Priorities & Strategies	Benton County Priorities & Strategies	Linn County Priorities & Strategies
Other		<p>Housing Quality <i>pg. 9</i></p> <ul style="list-style-type: none"> • Conduct a housing needs assessment and inventory of Benton County housing stock. • Develop and enforce housing guidelines and codes in Corvallis. • Implement “Healthy Homes” program to improve indoor environmental quality, advocating for healthy, affordable housing. 	<p>Planning and data sharing with CCO partners</p> <ul style="list-style-type: none"> • Ensure representation of communities experiencing health disparities in healthcare transformation planning in the region. • Establish data sharing pathways between clinical and population health data systems. • Engage academic partners in research and intervention development.

Priority Health Issues and Goals
InterCommunity Health Network CCO (IHN-CCO)

Benton County

Priority Health Issue #1: Food Security

- Goal 1: Improve access to fresh and healthy food in Benton County.
- Goal 2: Improve Utilization of food assistance programs among eligible people in Benton County.

Priority Health Issue # 2: Obesity

- Goal 1: Decrease the prevalence of overweight and obesity across the lifespan.
- Goal 2: Encourage physically active lifestyles in Benton County.
- Goal 3: Reduce the consumption of soda and other sugar-sweetened beverages among youth.

Priority Health Issue # 3: Housing and Transportation

- Goal 1: Improve housing quality for all residents in Benton County.
- Goal 2: Improve home safety for young children and older adults.
- Goal 3: Improve utilization of alternative modes of transportation in Benton County.
- Goal 4: Improve safety for pedestrians and bicyclists on public roads in Benton County.
- Goal 5: Expand trails, bicycle lanes and connections among all communities within Benton County.

Priority Health Issue # 4: Behavioral Health

- Goal 1: Improve mental health and wellbeing among middle school and high school youth in Benton County.
- Goal 2: Improve mental health and wellbeing among adults, ages 18 and older, in Benton County.

Priority Health Issue #5: Healthcare and Community Health

- Goal 1: Promote overall health and wellbeing in Benton County.
- Goal 2: Increase access to health services in Benton County.
- Goal 3: Improve the health and wellbeing of women, infants, children, youth, and families.

Linn County

Priority Health Issue # 1: Chronic Diseases

Goal 1: Reduce the rate of childhood obesity by 5 percent from 27.4 percent to 25 percent by August 2016.

Goal 2: Increase usage, awareness, and advisement of tobacco cessation options.

Goal 3: Improve preventative screening rates for everyone. Increase rate of cholesterol checks (68.1%), mammograms (77.4%), colonoscopies (57.9%), and PAP smears (83.3) at recommended intervals by 10 percent from current baseline by August 2016.

Goal 4: Improve Chronic Disease program use. Increase average attendance and use by 25 percent by August 2016 from current baseline numbers.

Priority Health Issue #3: Tobacco Use

Goal 1: Reduce use and initiation of tobacco among children, adolescents, and young adults. Reduce tobacco use in 11th graders by 5 percent from 23 percent to 21 percent by August 2016.

Goal 2: Increase healthcare provider involvement in tobacco cessation. Increase the number of providers using the quit-line referral process by 25 percent by August 2016.

Goal 3: Increase the number of tobacco-free parks and outdoor areas.

Priority Health Issue #4: Substance Abuse

Goal 1: Continue work to delay initial onset of youth alcohol use. Reduce the number of 11th graders who report drinking at least one drink of alcohol in the past 30 days by 5 percent from 34.6 percent to 32.8 percent by August 2016.

Goal 2: Maintain and enhance, with reduced funds, transportation options for access to treatment services.

Goal 3: Complete a community health improvement plan for substance abuse prevention and treatment by March 2013, in alignment with the county biennial implementation plan for mental health and substance abuse services and InterCommunity Health Network Coordinated Care Organization (IHN-CCO) Community Health Improvement Plan.

Goal 4: Expand options for drug free housing for recovering addicts in treatment.

Appendix C

InterCommunity Health Network CCO

Priority Health Issue # 1: Access to Healthcare

Goal 1: Ensure adequate provider capacity for primary care, dental health, mental health, and substance abuse for IHN-CCO members

Goal 2: Promote the availability of culturally sensitive care, particularly in the areas of language and health literacy

Goal 3: Expand after-hours service availability including normal clinic hours and days for primary and behavioral health

Priority Health Issue # 2: Behavioral Health

Goal 1: Increase child and youth wellbeing

Goal 2: Reduce stigma associated with diagnosis and treatment of behavioral health issues in order to improve access and appropriate utilization of services

Goal 3: Expand service options for behavioral health treatment for children, youth, adults, and families

Priority Health Issue # 3: Chronic Disease

Goal 1: Implement primary prevention strategies to promote health and reduce prevalence of chronic disease, particularly in areas such as obesity, tobacco use, asthma, and environmental toxins

Priority Health Issue # 4: Maternal and Child Health

Goal 1: Improve overall maternal and child health and wellbeing, including a focus on preconception needs

The Lincoln County plan is in development

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