Community Health Improvement Plan Progress Report

June 2018

PacificSource Columbia Gorge Coordinated Care Organization

Community Health Improvement Plan Progress Report

Background - the 2016 Community Health Assessment

The Columbia Gorge Coordinated Care Organization (CCO) is a collaborative effort of PacificSource Community Solutions, which holds the CCO contract with the state, and the Columbia Gorge Health Council, an independent 501(c)3 nonprofit organization which serves as the CCO's governing board through a joint management agreement. The duties related to creating the Community Health Assessment (CHA) and resulting Community Health Improvement Plan (CHP) are delegated through the joint management agreement to the Columbia Gorge Health Council. Responsibility for implementing the CHP is shared by all participants in the CCO and broadly in the community.

In 2016, the Columbia Gorge Health Council led a collaboration of the following community partners, known collectively as "the cohort," who needed to complete Community Health Assessments for their regulatory or legal requirements:

- Columbia Gorge Health Council
- Four Rivers Early Learning Hub
- Hood River County Health Department
- Klickitat Valley Health
- Klickitat Valley Health Department
- Mid-Columbia Center for Living
- Mid-Columbia Medical Center
- North Central Public Health District
- One Community Health
- PacificSource Community Solutions
- Providence Hood River Memorial Hospital
- Skyline Hospital
- United Way of the Columbia Gorge

The Community Advisory Council (CAC) and the cohort share various parts of the decision-making for the Community Health Assessment. In accord with the collaborative agreement, the CHA process meets the most rigorous requirement placed on any member of the cohort. The third iteration of the CHA is current starting, in order to meet the IRS requirement that nonprofit hospitals conduct the process every 3 years.

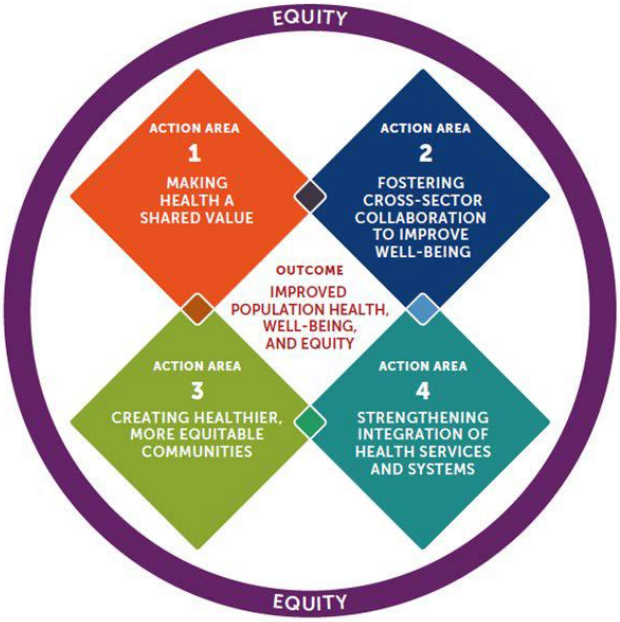
The CAC played an integral role in reviewing, refining, and crafting questions for the community survey as part of the 2016 Community Health Assessment, utilizing a collective impact approach to create effective and aligned community engagement. The CAC includes voting members who are Medicaid consumers and community partner agencies, as well as multiple other attendees who represent community and government agencies. Many of the consumers and community partners helped distribute hand-fielded surveys and assisted in facilitating focus groups reaching targeted populations, contributing to better data for harder to reach populations.

The Community Health Assessment process was recognized in 2016 when the Columbia Gorge Region was awarded the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize. This prestigious recognition further engaged the community in a conversation on what defines health and measurements for monitoring progress towards health.

Adoption of a Health Improvement Framework

Using the 2016 Community Health Assessment, the CAC identified focus areas that represent the highest need areas from the CAC's point of view. The 2017 CHP represents the second iteration of a similar Gorge-wide process. Through creating a community-endorsed CHP, the CAC supports proposals and programs from local organizations to address highlighted areas. As a result, the CHP describes not only the top focus areas but also a method for ongoing collaboration in the region.

During the development of the 2017 CHP, the Gorge region was introduced to and adopted the RWJF Culture of Health Action Framework.



Using the framework, the CAC selected three focus areas (known as Drivers) to become the 2017 Community Health Improvement Plan:

- Sense of Community
- Built Environment/Physical Conditions
- Access

Each Driver in the Culture of Health Framework has a set of measures used to track progress towards improving health. The collaborative process used by the Community Advisory Council included reviewing the Culture of Health Framework standard measures and adapting those definitions to the local community. As noted earlier, collaboration is a fundamental ingredient in how the work is conducted in the Gorge region. Therefore, a 'measure of collaboration' was added as the final measure tied to each Driver.

Overview of Selected Drivers and Measures

Action Area 1: MAKING HEALTH A SHARED VALUE		
DRIVER: SENSE OF COMMUNITY	**MEASURE**	***Sense of community*** - Percentage of population that feel people in their community are willing to help, can be trusted, and that feel safe in their community. ***Social support*** – 1) Percentage of people that think they have someone available to: love them and make them feel wanted, give good advice about a crisis, confide in or talk to about problems, and help if they were confined to a bed. 2) The percentage of caregivers who feel they have adequate support. ***Effective referrals*** - Percentage of cross-organization referrals based on service type and frequency of closed-loop referrals.
Action Area 3: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES		
DRIVER: BUILT ENVIRONMENT/ PHYSICAL CONDITIONS	**MEASURE**	****Housing affordability*** – 1) Percentage of families that are housing burdened or paying more than 50% of their income on housing. 2) Percentage of households feeling at risk of losing housing. ****Access to healthy foods*** – 1) Percentage of population that had to go without food. 2) Percentage of population having 2 or more servings of fruits or vegetables per day. ***Youth safety*** – 1) Percentage of people feeling that Adults watch out for children. 2) Percentage of students not attending school because they do not feel safe. 3) Percentage of teens report being bullied. ***Equity in physical activity opportunities*** - Obesity rates across elementary schools. ****Mobility and transportation*** – 1) Percentage having transportation as a barrier. 2) Percentage going without healthcare due to transportation.
Action Area 4: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS		
DRIVER: ACCESS	**MEASURE**	***Access to comprehensive primary care*** - Percentage of the overall population that state they had a primary care visit and got all the services they needed. ****Access to stable health insurance*** - Percentage of population with stable health insurance for 12 months. ****Access to mental health services*** - Percentage of population who needed mental health services and got all the care the needed. ****Routine dental care*** - Percentage of the overall population that state they had a dental care visit and got all the services they needed. ****Collaboration on information sharing*** – 1) Rate of care coordination for shared patients. 2) Rate of repeated assessments due to lack of information sharing

*Priority also identified in CHP from 2014

CHP Progress

Once the CHP was finalized, the CCO began a Community Grant Award process to support local organizations in addressing the needs from the CHP, the CCO Quality Incentive Metrics, and/ or the CCO Transformation Plan. Awards were announced in February 2018, and activities have only recently commenced. The Community Advisory Council is reviewing the RWJF action areas and adapting definitions and measures (when necessary) to our local community, determining next steps for community driven outcomes on the drivers chosen, and articulating how they relate to the funded activities and other CCO and community work.

DRIVER	MEASURE	ACTIVITIES
ACTION AREA: MAKING HEALTH A SHARED VALUE		
1.2 SENSE OF COMMUNITY	***Sense of community*** - Percentage of population who feel safe in their community and feel people in their community are willing to help and can be trusted.	• CCO contributed funds to the below activities through a Community Grant Award: ✓ The Power of Play improves sense of community and physical activity through an evidence-based, sustainable recess program. ✓ Imagination Yoga addresses childhood inactivity, anxiety, distractibility, and bullying by teaching yoga to second graders and teachers. • One Community Health, a CCO partner organization, launched Gorge Happiness Month and Making Health a Shared Value. • CCO provided administrative support for a grant providing local organizations with trauma informed training.
	Social support – 1) Percentage of people that think they have someone available to love them and make them feel wanted, give good advice about a crisis, confide in or talk to about problems, and help if they were confined to a bed. 2) The percentage of caregivers who feel they have adequate support.	• CCO accepted a Clinical Advisory Panel recommendation to fund a 2-year campaign and community outreach effort that raises awareness regarding the importance having an Advanced Directive in place and having conversations with family members and clinicians regarding ones wishes. • CCO funded Building Resiliency in the Columbia Gorge, which focuses on social-emotional learning to create secure parent attachments as a foundation for health and resiliency.
	Effective referrals - Percentage of cross-organization referrals based on service type and frequency of closed-loop referrals.	• Bridges to Health Pathways, a program operated by the Health Council, is tracking referrals through CLARA. • The CCO, through Reliance Health Information Exchange, has established and fully funded a community-wide referral system.

ACTION AREA: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES		
3.1 BUILT ENVIRONMENT/ PHYSICAL CONDITIONS	***Housing affordability*** – 1) Percentage of families that are housing burdened or paying more than 50% of their income on housing. 2) Percentage of households feeling at risk of losing housing.	• The 'housing challenged' population are served by Community Care Coordinators (CCCs) working at cross sector organizations in Bridges to Health Pathways. Thus far, CCC's have worked with over 150 clients to address issues creating housing insecurity as well as meet other social and medical needs.
	Access to healthy foods – 1) Percentage of population that had to go without food. 2) Percentage of population having 2 or more servings of fruits or vegetables per day.	• CCO contributed funding to the following: ✓ Food Access for All supports the Food Security Coalition which seeks to fill gaps in the food system together. ✓ Blue Zones-The Dalles is designed to make healthy choices easier through permanent changes to the built environment, policy, and social networks.
	Youth safety – 1) Percentage of people feeling that Adults watch out for children. 2) Percentage of students not attending school because they do not feel safe. 3) Percentage of teens report being bullied.	• CCO Community Grant Award funded the following: ✓ Mejor Juntos employs a health promotion coordinator who facilitates accurate and up to date promotion information exchanges between agencies and service providers for youth and their families. ✓ Safer Futures improves access to care and social support for survivors of intimate partner violence.
	Equity in physical activity opportunities - Obesity rates across elementary schools	• The CAP has listed Childhood Obesity as one of its priorities and will financially support an obesity coalition to prioritize and make recommendations to the CCO to fund evidence-based obesity prevention programs.
	Mobility and transportation – 1) Percentage having transportation as a barrier 2) Percentage going without healthcare due to transportation	• Everybody Rides transportation campaign reduces stigma and develops culturally appropriate education materials to promote public transportation.
Action Area: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS		
4.1 ACCESS	***Access to comprehensive primary care*** – Percentage of the overall population that state they had a primary care visit and got all the services they needed	• CCO funded the following: ✓ Safer Futures – supporting people experiencing interpersonal violence to have improved effective contraceptive usage, social support, access to care, safety, and well-being. ✓ Readiness assessment for South Wasco County School Based Health Clinic to determine opportunity for improved health care access for students.

	Access to stable health insurance - Percentage of population with stable health insurance for 12 months.	• 30% of the clients enrolled in Bridges to Health Pathways received a referral to enroll in health insurance because they were uninsured and eligible for coverage. • CCO Practice Coach shares health plan data with PCP offices to facilitate clinic outreach to their patients who are OHP members due for redetermination. • Organizations outside the CCO are supporting Enrollment Assistors to provide outreach to the regional jail and other targeted audiences throughout the region.
	Access to mental health services - Percentage of population who needed mental health services and got all the care the needed.	• Patients with Mental Illness in Local Emergency Departments: Mapping Processes to Improve Outcomes will develop a localized community of practice for this population. • Safer Futures project (see above). • Building Resiliency in the Gorge (see above).
	Routine dental care – Percentage of the overall population that state they had a dental care visit and got all the services they needed.	• CCO partners formed the Gorge Oral Health Coalition whose focus is addressing oral health messaging in primary care and behavioral health.
	Collaboration on information sharing – 1) Rate of care coordination for shared patients. 2) Rate of repeated assessments due to lack of information sharing.	• Maupin Fiber Network received CCO funds towards establishing connectivity for the rural Deschutes Rim Health Clinic and neighboring health facilities to the publicly owned high speed fiber network. • Strengthening Collective Impact used CCO funds to increase partners' capacity to better gather and analyze data. • CCO has invested in Reliance eHealth Collaborative as a platform for health information exchange, and the CCO has actively sought out participation by non-healthcare providers. • CCO has partnered with Reliance eHealth Collaborative and Vistalogic CLARA platform to implement grant funding integrating the two systems across multiple sectors

Community Health Improvement Plan Progress Report: Appendix

Key Players in Child and Adolescent Health

1. Which of the following key players are involved in implementing the CCO's CHP? (select all that apply)

- ☐ Early Learning Hubs
- ☐ Other early learning programs[1]
  Please list the programs: Click or tap here to enter text.
- ☒ Youth development programs[2]
  Please list the programs: CCO partners collaborated on a grant from the Youth Development Council for a youth outreach worker in the schools. CCO also funded grants for youth development: Building Resiliency (YouthThink), Imagination Yoga (CultureSeed), Mejor Juntos (North Central Public Health District), and The Power of Play (Columbia Gorge ESD)
- ☒ School health providers in the region
- ☒ Local public health authority
- ☒ Hospital

2. For each of the key players involved in implementing the CCO's CHP, indicate the level of engagement of partnership:

	No engagement				Full engagement
	1	**2**	**3**	**4**	**5**
Early Learning Hubs	☐	☐	☐	☐	☒
Other early learning programs[1]	☐	☐	☐	☐	☐
Youth development programs[2]	☐	☐	☐	☒	☐
School health providers in the region	☐	☐	☒	☐	☐
Local public health authority	☐	☐	☐	☐	☒
Hospital	☐	☐	☐	☐	☒

3. Describe how these key players in the CCO's service area are involved in implementing your CHP.

The implementation of our regional Community Health Assessment (CHA) and resulting Community Health Improvement Plan (CHP) was performed through a collaborative agreement developed through extensive outreach to leaders in various organizations. Other principles of the collaboration include a commitment to have standard data to track over time, flexibility to adapt to changing knowledge, and a strong role for community members and health care consumers in structuring data collection questions. Thus far, a number of community grant programs, specifically targeted at our CHP topic areas have been funded and begun.

[1] This could include programs developed by Oregon's Early Learning Council.
[2] This could include programs developed by Oregon's Youth Development Council.

The key players listed in question 2 above were all collaborators on our CHA and engaged in the following ways:

- ✓ The Four Rivers Early Learning Hub (4Rivers). There is a significant amount of crossover in membership on 4Rivers and subcommittees of the CCO. The Director of 4Rivers is a member of the Columbia Gorge CCO's Community Advisory Council (CAC) and is currently working on collaboration between Our Kids Network, a resource HUB for all families with young children, and the Bridges to Health Pathways program of the Gorge CCO, a community care coordination program for community members in need. This role has been to advocate for inclusion of childcare workers as health advocates, connectors and educators, and dissemination of information about CCO activities back to childcare settings.
- ✓ School Based Health Center Operators. There is one School Based Health Center in the region, operated by One Community Health (an FQHC) and the Hood River County Health Department. Both organizations are engaged at every level of the CCO (Board, CAC, Clinical Advisory Panel (CAP), the Systems Integration Team, and other sub-committees).
- ✓ The two public health departments in our region, North Central Public Health District and Hood River County Health Department, are also active members at all levels of the CCO and actively involved in the design, implementation and measurement of our CHP. The departments are also collaborators on our CHA and other cross-sector programs that have been implemented through the Community Grant process. The former director of HRCHD was, until recent retirement, our CAC Chair and a CCO Board member.
- ✓ Representatives of the two hospitals in our region, Providence Hood River Memorial Hospital and Mid-Columbia Medical Center, are members of our CCO Board, CAC, and CAP as well as partners in various cross-sector programs supported by the CCO, such as Bridges to Health Pathways and Health Information Exchange.

Other partners who have been funded through the CCO Community Grant Process and other CCO funding to address CHP topics include the following:

- ✓ YouthThink: Building Resiliency in the Columbia Gorge
- ✓ CultureSeed: Imagination Yoga in the Schools
- ✓ North Central Public Health District: Mejor Juntos: Health Promotion in Hood River and Wasco Counties
- ✓ HAVEN: Safer Futures Project
- ✓ Columbia Gorge Education Service District: The Power of Play-Recess Enrichment in 10 Elementary Schools
- ✓ Deschutes Rim Medical Clinic: School based health center assessment
- ✓ The Next Door Inc.: Bridges to Health Pathways in the Schools
- ✓ Public Health Departments: DHS Incidental Supports
- ✓ Blue Zones Project The Dalles

4. If applicable, identify where the gaps are in making connections.

- ✓ Neither Wasco nor Hood River Counties have active Youth Development Councils, although our CAC has highlighted youth as a target population to incorporate into the work of the CAC this year.
- ✓ While 4Rivers staff is very actively engaged in multiple committees of the CCO, direct service child care providers have not been engaged at the committee level.

- ✓ The school districts in our region are collaborative at the local level and cross sector partnerships among numerous programs, but have not yet become deeply engaged with the CCO.
- ✓ Data sharing agreements and shared software continues to be a challenge, but energies are being put towards utilizing systems that can allow for information to be shared and putting agreements in place to do so.
- ✓ Defining and tracking local data that will provide information on successes of our CHP measurements will be challenging.

Health Priorities and Activities in Child and Adolescent Health

5. For CHP priorities related to children or adolescents (prenatal to age 24), describe how and whether the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.

The CCO has improved the coordination of effective and efficient delivery of health care to children and adolescents by supporting the following activities:

CHP Priority: Sense of Community/ Social Support:

- ✓ Building Resiliency in the Columbia Gorge focuses on the social- emotional learning to create secure parent attachments as the future of health and resiliency.
- ✓ The Power of Play improves sense of community and physical activity through an evidence based sustainable recess program.
- ✓ Imagination Yoga addresses childhood inactivity, anxiety, distractibility, and bullying by teaching yoga to second graders and teachers.

CHP Priority: Built Environment/ Physical Conditions:

- ✓ Everybody Rides Transportation Effort reduces the stigma and develop culturally appropriate education materials to promote public transportation.
- ✓ Food Access for All supports the Food Security Coalition which seeks to fill gaps in the food system together.
- ✓ Blue Zones-The Dalles is designed to make healthy choices easier through permanent changes to the built environment, policy, and social networks.

CHP Priority: Access

- ✓ Mejor Juntos employs a health promotion coordinator who facilitates accurate and up- to-date promotion information exchanges between agencies and service providers for youth and their families.
- ✓ Safer Futures improves access to care and social support for survivors of intimate partner violence.
- ✓ Bridges to Health Pathways is a community care coordination program with Columbia Gorge Health Council as the hub, which empowers community members most in need to improve their overall health and wellbeing, improve access to services and resources by addressing disparities and increase collaboration of services in and out of healthcare.
  Bridges to Health Pathways DHS supports is an effort to help meet the DHS QIM and improve overall support for children and foster families entering into DHS custody system.

6. **What activities is the CCO doing for this age population?**

- ✓ The CCO has directly funded all of the activities listed above.
- ✓ The CAP has listed Childhood Obesity as one of its priorities and is supporting an obesity coalition to prioritize and fund evidence-based obesity prevention programs.
- ✓ The Columbia Gorge Health Council acts as the hub for The Bridges to Health Pathways program which provides supports to families, including children and youth in DHS custody, and is also collaborating with the Early Learning Hub program Our Kids Network to provide universal screening and referrals to families with young children.

7. **Identify ways the CCO and/or CAC(s) have worked with school and adolescent providers on prioritized health focus areas.**

- ✓ The CCO participates in the local Early Learning Hub and has cross membership with CAC.
- ✓ The CAP continues to work with healthcare providers on outreach for adolescent well care visits.
- ✓ The CCO has funded the Deschutes Rim Medical Clinic in rural Maupin, OR to perform an assessment on the feasibility of a school-based health clinic.
- ✓ A school district supports a mental health provider who is a school district employee to sit on the CAP.
- ✓ Bridges to Health Pathways will be contracting with The Next Door, Inc. to employ Community Health Workers to provide care coordination in two school districts.

Health Disparities

8. **For each chosen CHP priority, describe how the CCO and/or CAC(s) have worked with OHA's Office of Equity and Inclusion (OEI) to obtain updated data for different populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data.**

- ✓ The CCO facilitated an engagement through OHA with Ignatius Bau to meet with community partners to discuss identifying race and ethnicity data.
- ✓ The CCO sought out targeted underserved population through focus groups and hand fielded surveys in various communities in order to obtain deeper data.
- ✓ The CCO supported a staff person to attend OEI's DELTA training in order to learn skills for using techniques for collecting health data with an equity lens.

9. **Explain whether updated data was obtained by working with other state or local agencies/organization(s) and what data sources were utilized.**

- ✓ The CCO works closely with local health departments to collect data.
- ✓ The CCO has been instrumental in coordinating a regional collaborative effort to implement a joint Community Health Assessment. Providence Health and Services has contributed facilitation and access to their research unit, CORE, as an evaluation partner administering the survey process and analyzing the data.
- ✓ The CCO engaged internal analytics resources to interpret disparities among populations served by the CCO from an extensive review of claims data. This data combined with Behavioral Risk Factor Surveillance System (BRFSS), Public Health information, and demographic data gives a clearer

picture of health disparities.

- ✓ New data sources include data from the Bridges to Health Pathways program that is collected at the local housing authority, local hospitals, primary care, public health, and a local HeadStart agency.

10. Explain CCO attempts to compare local population data to CCO member data or state data. If data is not available, the CCO may choose to access qualitative data from special populations via focus groups, interviews, etc.

- ✓ The data from our CHA is analyzed and integrated in the CHP so that for each data point the outcomes are compared across multiple categories such as race/ethnicity, income level, and insurance type. Thus, we can identify disparities and track them over time through successive CHA processes.
- ✓ The CHA/CHP process sought out underserved populations through facilitated focus groups where qualitative data was collected and included in the CHP.
- ✓ The CCO has a well-attended and engaged Community Advisory Council with strong consumer representation. The CAC raises issues related to health disparities and healthcare access issues.

11. What challenges has the CCO encountered in accessing health disparities data?

- ✓ While improvement has been made in collecting race and ethnicity data across the healthcare system, a challenge still exists collecting data related to sexual orientation, lifestyle choices, and environmental disparities.
- ✓ Community partners hand-fielded surveys and hosted focus groups during the health assessment to help access harder to reach populations. Improvement is always needed particularly in the most rural towns in our region.
- ✓ The multi-racial and multi-ethnic nature of the community makes health disparity data analysis complicated.

12. What successes or challenges has the CCO had in engaging populations experiencing health disparities?

- ✓ The CCO has invested in a cross sector Community Care Coordination program, Bridges to Health Pathways, coordinating and funding Community Health Workers to engage populations most in need.
- ✓ The CCO has a highly engaged and well represented Community Advisory Council which has begun work around engaging populations experiencing health disparities who have not been in attendance.
- ✓ The CAC is also utilizing tools such as popular education to perform its work in an equitable manner.
- ✓ The CCO funded health care interpreter training. More than 30 staff members from local PCPCH clinics participated in the required 60 hour training with the intention of seeking status as state qualified/certified health language interpreters.
- ✓ The CCO is working with the Regional Health Equity Coalition on a Gorge-wide Health Equity Collaborative to provide cross-sector conversations, agreements, trainings, and tools towards equity, diversity and inclusion.
- ✓ CCO staff sit on the Regional Food Coalition, which is working on health equity related to food resources and food sovereignty among the region's Native American populations.

13. **What successes or challenges has the CCO had in recruiting CAC members from populations experiencing health disparities?**

- ✓ The CAC includes multiple consumer representatives from minority populations and members experiencing Serious and Persistent Mental Illness (SPMI).
- ✓ The CAC has not been successful at engaging members of the Native American, Samoan, or youth populations.
- ✓ While the CAC has good representation from both Hood River city and The Dalles, there are no consumer members from the smaller communities, such as Cascade Locks in Hood River county and Maupin, Tygh Valley, and Dufur in South Wasco County.

Alignment, Quality Improvement, Integration

14. **Describe how local mental health services are provided in a comprehensive manner. Note: this may not be in the CHP, but may be available via another local mental health authority (LMHA) plan document. The CCO does not need to submit relevant local mental health plan documents.**

- ✓ The need for a continuum of behavioral health services, encompassing both mental health and substance use disorder treatment, is met through services provided by the Local Mental Health Authority for each county, services provided by other regional providers, and, where necessary, higher-intensity services provided by organizations outside of the region.
- ✓ The Local Mental Health Authority (LMHA) in the Columbia Gorge CCO service area is Mid-Columbia Center for Living (MCCFL), an intergovernmental agency formed by Hood River, Wasco, and Sherman Counties.
- ✓ The start of the continuum of services is behavioral health provided in primary care sites. Over 75% of PacificSource Columbia Gorge CCO members now receive primary care in a clinic with integrated behavioral health services.
- ✓ For low acuity, outpatient, specialty behavioral health services, the CCO contracts with multiple entities, including MCCFL. This supports a diverse range of organizations in order to maximize patient choice and meet needs that include culturally-specific services and treatment for eating disorders.
- ✓ Medication Assisted Treatment for opiate use disorders is provided through coordinated care by physical health providers, often in primary care, and behavioral health professionals. One Community Health, the region's FQHC and largest provider of primary care, provides integrated physical and behavioral health services for substance use disorders including Medication Assisted Treatment.
- ✓ For higher-acuity needs, MCCFL provides an array of behavioral health services, many of which are mobile, community-based, and available outside of usual business hours:
    - Intensive Outpatient treatment of substance use disorders.
    - Mobile Crisis Team.
    - Wraparound System of Care for children and youth.
    - Peer-delivered services for youth and adults.
    - Coordinated services for members with Serious and Persistent Mental Illness, including supported employment.
    - Assertive Community Treatment and Forensic Assertive Community Treatment

- An Enhanced Care Program licensed by the Oregon State Department of Human Services for older adults.

✓ For community members needing high-intensity residential or inpatient services, care is not available from local organizations, and patients need to receive care outside of our region. These services are provided in coordination with the LMHA whenever possible to allow smooth transition back to community treatment settings once the more acute needs have been addressed. For CCO members, facilities under contract with the CCO provide high-intensity substance use disorder treatment and coordinate care closely with PacificSource and local outpatient providers.

The following developments contribute to the quality of services in the region:

✓ MCCFL was one of the sites selected by the OHA to work towards becoming a Certified Community Behavioral Health Center. This initiative has resulted in the addition of nursing staff to better assess medical conditions within the SPMI population and additional tracking of data and outcome measures.

✓ The CCO allows direct access by members to behavioral health providers working outside MCCFL and has actively solicited the participation of additional licensed professionals in this network, increasing access and choice.

✓ MCCFL works to hire and train bilingual staff, and PacificSource has also taken the initiative to contract with other providers who can meet the needs of our diverse member population.

✓ The LMHA has also been a partner in health system planning and leadership in the region, including the following elements:
- The Director of MCCFL is a member of the Community Advisory Council;
- The Deputy Director is a member and co-Chair of the Clinical Advisory Panel.
- MCCFL is a collaborative partner for the CHA and CHP, which means that they have agreed to utilize the CCO led CHP to guide their own strategic planning processes

15. If applicable, describe how the CHP work aligns with work through the Transformation and Quality Strategy (TQS) and/or Performance Improvement Projects (PIPs)?

The Columbia Gorge CCO CHP prioritized three areas from the Robert Wood Johnson Foundation (RWJF) Culture of Health Action Framework: Sense of Community, Built Environment, and Access to Care. The Transformation Quality Strategy (TQS) developed by the CCO focuses on the CHP element Access to Care. Within the TQS there are ten projects, six of which will impact Access to Care.

✓ The RWJF Framework has some specific measures to gauge success in this arena. One of the measures is specific to dental access. The TQS includes a project that targets a specific population with Special Health Care Needs to ensure that they have coordinated access to Dental Care. In addition, one of the Performance Improvement Projects (PIP) also addresses access to Dental Care during pregnancy.

16. OHA recognizes that the unique context of each CCO region means there is a continuum of potential collaboration with local public health authorities (LPHAs) and hospital systems on the CHA and CHP. Please choose the option that best applies to your CCO:

☒ CCO's CHA/CHP is a shared CHA/CHP with LPHAs and/or hospital systems. Note which organizations share the CHA/CHP:

- LPHA(s): Hood River County Health Department, North Central Public Health District, and two others outside of our CCO, Klickitat Public Health Department and Skamania County Public Health.
- Hospital(s): Providence Hood River Memorial Hospital, Mid-Columbia Medical Center, and two outside of our CCO, Skyline Hospital and Klickitat Valley Hospital.

☐ CCO's CHA is a shared CHA with LPHAs and/or hospital systems, but the CCO has a unique CHP. Note which organizations share the CHA:
- LPHA(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ CCO's CHP is a shared CHP with LPHAs and/or hospital systems, but the CCO has a unique CHA. Note which organizations share the CHP:
- LPHA(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ CCO's CHA/CHP is a unique CHA/CHP from LPHAs and/or hospital systems, but the CCO collaborated with LPHAs and/or hospital systems in their development. Note which organizations the CCO collaborated with:
- LPHA(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ Other (please describe): Click or tap here to enter text.

17. If applicable, check which of the State Health Improvement Plan (http://Healthoregon.org/ship) priorities listed below are also addressed in the CHP.

☐ *Tobacco*
☒ *Obesity*
☒ *Oral health*
☒ *Alcohol and substance use*
☐ *Suicide*
☐ *Immunizations*
☐ *Communicable diseases*

18. Describe how the CHP work aligns with Oregon's population health priorities included in the State Health Improvement Plan:

✓ CCO CHP shares three priorities with the SHIP.
✓ Although the CCO doesn't have suicide prevention named as one of its priorities on the CHP, it does have a number of protective factors for suicide such as sense of community, social support, youth safety, and access to mental health services.
✓ CCO partners are implementing a number of SHIP interventions such as: increasing participation in the National Diabetes Prevention Program (CCO hospitals), increasing access to healthy foods in low income communities (Food Coalition and other CCO-funded programs), increasing number of

partners who adopt healthy food standards (Blue Zones), increasing physical activity opportunities (CAP priority), and coverage for chronic disease self-management programs (PacificSource).

19. If applicable, describe how the CCO has leveraged resources to improve population health.

- ✓ The CCO has reinvested funds back into the community through the Community Grant Process and via CAP priorities addressing improved population health.
- ✓ CCO partner Providence Hood River Memorial Hospital responded to this collaborative effort by funding a Collective Health Impact Specialist to serve any organization within their service area. This position is contracted through the regional United Way organization, and provides expertise in resource development and grant writing. Since inception, this strategy has resulted in over $7 million dollars in grant funds coming into the community to address the focus areas outlined in the CHP.

20. How else has the CHP work addressed integration of services?

The work of integrating services in health care settings has been progressing under the leadership of PacificSource staff, including contracting, operations, analytics, and administrative teams, in collaboration with the Clinical Advisory Panel and provider organizations. This work is not an explicit element of the Region's CHP.

CHP Priority: Sense of Community/ Social Support

- ✓ CCO partnered with local organizations to provide funding for trauma informed care work.

CHP Priority: Access

- ✓ CCO partners formed the Gorge Oral Health Coalition whose focus is addressing oral health messaging in primary care and behavioral health.
- ✓ Maupin Fiber Network received CCO funds towards establishing connectivity for the Deschutes Rim Health Clinic and neighboring health facilities to the publicly owned high-speed fiber network.
- ✓ Safer Futures program improved access for survivors of Interpersonal Violence (IPV).
- ✓ CCO has funded an additional staff position at United Way through the Strengthening Collective Impact initiative to increase partners' capacity to gather and analyze data.
- ✓ CCO has fully funded regional organizations' participation in Reliance eHealth Collaborative as a platform for health information exchange, and the CCO has actively sought out participation by non-healthcare organizations.
- ✓ CCO is cooperating with Reliance eHealth Collaborative and Vistalogic CLARA platform to implement grant-funded work integrating the two systems across multiple sectors.