June 2021

Community Health Improvement Plan Progress Report

Benton, Lincoln and Linn Counties

InterCommunity Health Network CCO

Be Healthy. Be Happy.

TABLE OF CONTENTS

NOTE: *An acronyms list and a glossary of terms are listed starting on page 37.*

Introduction

Document Purpose

This document is the 2021 InterCommunity Health Network CCO (IHN-CCO) Community Health Improvement Plan (CHIP) Progress Report from the Community Advisory Council (CAC) to the Oregon Health Authority. It includes all data currently available for the outcomes and indicators identified in the 2019 IHN-CCO CHIP.[1]

2019 Community Health Improvement Plan

According to Oregon Revised Statute (ORS) 414.627(2), the primary tasks of the Community Advisory Council are overseeing a community health assessment, adopting a community health improvement plan (CHIP) to serve as a strategic population health and healthcare system service plan for the community served by the CCO; and annually publishing a report on the progress of the CHIP.

In 2019, the CAC published its second CHIP[2], which includes six areas of focus called Health Impact Areas. These Health Impact Areas are 1) Access to Healthcare, 2) Behavioral Health, 3) Child & Youth Health, 4) Healthy Living, 5) Maternal Health, and 6) Social Determinants of Health and Equity.

OUTCOMES AND INDICATORS

In order to track progress for the CAC's annual CHIP Progress Report, in 2019 the CAC developed a set of 22 *Outcomes* and an associated 32 *Indicator concepts*. For the purposes of the CHIP, outcomes and indicators are defined as follows:

> **Outcomes** are results, changes, or improvements that come about from a program. Outcomes may include changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status. Outcomes are a standard of some level of success.
>
> > The 22 outcomes, as written and adopted by the CAC, were purposely broadly defined. These broad definitions were intended by the CAC to serve as guidance, while allowing those who use them the flexibility to do their work innovatively and in ways that fit within the context of their particular work, setting, or expertise.
>
> **Indicators** are measures that provide evidence that a certain condition exists or that certain results or progress toward improvements have or have not been achieved. Indicators measure the level of success or lack of success a program has had in achieving an outcome. Indicators serve to further clarify and define their related outcomes.

The 32 indicator concepts more specifically define their related outcomes. For example, indicators that include "*length of time from enrollment to first appointment"* or "*trauma-informed care"* are indicators that may measure and, therefore define, progress toward a related outcome.

These carefully selected indicators are labeled in the 2019 CHIP ***Indicator Concepts*** in recognition of the fact that they are, or can be, either more or less broadly defined than as worded. For example, a "rate" may be stated as an indicator, but a "percentage" may be what is available.

AREAS OF OPPORTUNITY

Throughout the CHIP development process, the CAC frequently encountered a lack of available data. For this reason, along with Outcomes and Indicators, the CHIP includes many "Areas of Opportunity."

Areas of Opportunity, similar to Indicators, further clarify and define their related Outcomes. However, Areas of Opportunity do not currently have readily accessible, good quality data for annually tracking improvement or lack thereof. By including Areas of Opportunity, pilot projects and other initiatives may be prioritized to focus on making improvements and potentially establishing measurements in these areas. Also, the CAC and its Local Advisory Committees may invite presentations related to the Areas of Opportunity.

2021 CHIP Progress Report

DOCUMENT ORGANIZATION

The data in this report is organized by the Outcomes and Indicator Concepts identified for each of the six Health Impact Areas.

- Access to Healthcare
- Behavioral Health
- Child & Youth Health
- Healthy Living
- Maternal Health
- Social Determinants of Health and Equity

DATA COLLECTION

Most data reported in this document was collected in collaboration with community partners including IHN-CCO; Benton, Lincoln, and Linn County Health Services; the Regional Health Assessment Team; and the Benton, Lincoln, and Linn Federally Qualified Health Centers. When the CAC developed the CHIP's Outcomes and Indicators, it was understood that some data could be available quickly, other data would take planning and time, some data would not be possible to collect or report, and some data sources only refresh their data every two or more years. These community partners continue to work toward making more data available for future reports.

TRANSFORMATION PILOT PROJECTS

The CHIP is used to prioritize pilot project funding. While providing services to its members, IHN-CCO and its community partners are 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 delivery, member satisfaction, and cost efficiency. If a pilot project can be successfully refined and proves to be a viable concept, its new processes and programs may be adopted throughout the IHN-CCO region.

THE CHIP PRIORITIES AS STRATEGIC PLANNING

As of May 2021, there are 17 active pilot projects being tested (see Appendix III: Pilot Project Brief Summaries). As of April 2021, IHN-CCO had funded more than 80 pilot projects at a cost of more than 22 million dollars. To be considered for funding, a proposal must fit within one of the CHIP's six Health Impact Areas. Since 2019, the pilot project funding has prioritized projects related to the CHIP's Social Determinants of Health and Equity Health Impact Area.

REGIONAL HEALTH ASSESSMENT (RHA)

Development of the CHIP and reporting on its progress is done in collaboration with the Regional Health Assessment (RHA) team, funded by the Regional Health Collaborative (RHC). The RHC is a partnership between organizations dedicated to improving community health in Oregon's Benton, Lincoln, and Linn Counties through collective data utilization. The RHC is working together to develop an integrated system of local and regional data to facilitate collaborative and coordinated cross-sector planning and decision-making efforts that impact health in our region.

Some of the ways in which the Regional Health Assessment team supports regional health assessment and improvement planning efforts is that it:

- Provides baseline data and continual updates to drive policy decisions and health improvement programs
- Engage communities in their own health to address disparities and equip them with the data they need to identify priorities
- Illustrate the impact of social determinants of health
- Use data to bridge the gap between traditional healthcare and other sectors that affect health
- Expanding capacities and the potential for impact at health-related organizations

With inclusion in the regional health assessment and alignment initiative, the IHN-CCO CHIP's focus on Medicaid membership will ensure that the needs of some of our communities' most vulnerable residents, those living in poverty, are assessed and addressed.

Data: Outcomes & Indicator Concepts

Access to Healthcare

Outcome A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.

Indicator A1a: Length of time from IHN-CCO enrollment to first appointment

For IHN-CCO members, the average number of days from enrollment to first appointment with a Primary Care Provider (PCP) dropped 40 days between 2014 and 2017. That is, it dropped from an average of 88 days down to 48 days. In 2018, that number increased three-fold to an average of 150 days. However, two years later, by the end of 2020, the average number of days had decreased again by more than 50%, down to 71 days. See Table 1.

One possible reason for the increase in 2018 is that from 2014-2017, due to changes in eligibility requirements, many new enrollees were first-time members who had been without healthcare for a number of years. By 2018, many newly enrolled members were not actually new members; they were previous members who had briefly lost benefits and been reenrolled. In these cases, they may not have had the same need to see a PCP right away. In 2020, due to job losses during the pandemic, once again there were many new enrollees. IHN-CCO and the CAC will continue to monitor these numbers in future progress reports.

Table 1. Average Number of Days for New IHN-CCO Members to See a Primary Care Provider (PCP) [3]

Year:	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Number of new members	27,765	15,975	14,304	16,739	14,283	14,223	16,624
Number with first claim	19,211	10,872	8,172	9,660	11,885	11,549	10,884
Average number of days until first claim (any provider)	67.5	55.3	41.5	32.9	101.77	76.78	50.39
Average number of days until first PCP claim	87.8	72.3	53.3	47.8	149.9	107.6	70.8

Data for behavioral health and dental providers is unavailable at this time.

Indicator A1b: Length of time from appointment request to appointment for behavioral, physical, and oral health services

Because healthcare providers do not track when appointment requests are made, another way to measure access is by asking members how satisfied they are with how quickly they are able to get care and how easy it is to get needed care. Each year, the Oregon Health Authority (OHA) surveys Oregon Medicaid members on their previous six months healthcare experiences. The survey is called the *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*.

2018 and 2019 CAHPS survey results: For the 2019 survey, 83% of adults responded that they "Always" or "Usually" were able to get care quickly. This is up from 79% in 2018. In 2019, of respondents with children, 86.5% answered "Always" or "Usually" to the same question about their child's experience. This is a 3.5% decrease from 90% in 2018. (2020 data will be available June 2021). See Table 2.

Table 2. 2018 & 2019 IHN-CCO Member CAHPs Survey results[4]

Member experience survey responses of "Always or Usually"

In the last six months, how often…

	Adult		Child	
Year	**2018**	**2019**	**2018**	**2019**
Getting Care Quickly *(Composite*)*	78.69%	82.98%	89.80%	86.54%
Got urgent care as soon as needed	83.04%	85.26%	91.67%	90.91%
Got routine care as soon as needed	74.35%	80.70%	87.93%	82.11%
Getting Needed Care *(composite*)*	79.53%	85.05%	77.33%	83.85%
Easy to get needed care	83.33%	87.64%	88.00%	87.70%
Easy to see specialists	74.35%	82.46%	66.67%	80.00%

Indicator A1c: Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures

IHN-CCO provider groups are looking at workflow and various systems' ability to build ACEs scores into Electronic Health Records.[5]

TRAINING

After a considerable push to get hundreds of Benton, Lincoln, and Linn County providers trained in trauma-informed care by 2016, the work continued in 2017 and 2018 when IHN-CCO providers met locally for one of two all-day Abuse Prevention Summits.

The Abuse Prevention Summits were sponsored by Benton, Lincoln, and Linn County Public Health Departments, Portland State University, and the Oregon Health Authority (OHA) in partnership with IHN-CCO. Participants included community partners and stakeholders from education, healthcare, housing, child welfare, early childhood, judicial, community and mental health services, as well as people with lived experience, and youth and family advocates.[6]

Healthcare providers, staff, and community members participated on a variety of other trauma informed care trainings since 2018, including courses sponsored by the counties and by Samaritan Health Services in Trauma Informed Care(See Table 3); Question, Persuade, and Refer (See Table 4), and Mental Health First Aide (See Table 5 and Bh1a Table 12).

Table 3. Number of attendees at Trauma Informed Care trainings (conducted by counties) by year, by county, and total attendees[7]

	Total Attendees	Benton	Lincoln	Linn	Benton, Lincoln, &/or Linn
2018	155	150	5	0	0
2019	675	140	481	41	13
2020	100	-	-	-	100

Table 4. Number of attendees at Question, Persuade, and Refer suicide prevention training (conducted by counties) by year, by county, and total attendees[8]

	Total Attendees	Benton	Lincoln	Linn	Not classified
2017	*332*	120	54	158	0
2018	*1278*	1135	32	9	102
2019	*642*	563	35	18	26
2020	*1063*	0	504	559	

Table 5: Number of 2019 attendees at Mental Health First Aid (MHFA) trainings & other mental Health presentations[9]

Date	General theme	Area	Attendees
2019	Various mental health topics in 10 classes	Benton	264
	MHFA statewide summit	Statewide	50
	Oregon Health Sciences University (OHSU) Family MHFA	Portland	15

Indicator A1d: Appropriate physical, behavioral, & oral preventive care for all ages

IHN-CCO has improved on all preventative care quality incentive metrics since the last CHIP Progress Report. However, it did not meet all of its 2019 improvement targets. See Table 6.

Table 6. Preventative Health Quality Measures Data from OHA[10]

Preventative Health Quality Measures Data from OHA	**2014**	**2015**	**2016**	**2018**	**2019**	**2019 Improvement Target**
Adolescent Well Care Visits	24.1%	30.1%	36.5%	41.9%	46%	41.9%
Child Immunization Status	58.2%	63.6%	65.0%	66.9%	68.9%	66.9%
Dental Sealants – All Child Age Groups	9.9%	16.8%	20.2%	23.4%	23.8%	24.9%
Developmental Screening	26.9%	36.2%	54.6%	70.4%	75.6%	70.4%
Effective Contraceptive Use – Women ages 18-50	26.9%	35.8%	42.3%	49.5%	51.7%	60.2%

Source: OHA Office of Health Analytics

A1d Area of Opportunity – used for prioritization, not annual reporting

i. Culture of support for healthcare providers

Outcome A2: Increase the percentage of members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.

Indicator A2a: Percentage of members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care

Each year, the Oregon Health Authority (OHA) surveys Oregon Medicaid members on their previous six months healthcare experiences. The survey is called the *Consumer Assessment of Healthcare Providers and Systems (CAHPS)*. Results for questions related to adult and child satisfaction with services for 2018 and 2019 remained high in numbers ranging from about 89% to 99%. These percentages refer to the number of people who answered "Always" or "Usually" to various questions. See Table 7.

Table 7: 2018 & 2019 IHN-CCO Member Experience of Care Survey Data[11]

Member experience survey responses of "Always" or "Usually"

In the last six months, how often…

	Adult		Child	
Year	**2018**	**2019**	**2018**	**2019**
***How well doctors communicate** (Composite*)*	90.48%	93.73%	95.63%	96.38%
Doctor explained things in a way that was easy to understand?	94.58%	95.00%	95.37%	96.15%
Doctor listened carefully to you?	89.16%	95.00%	97.25%	97.12%
Doctor showed respect for what you had to say?	89.63%	95.63%	99.08%	96.15%
Doctor spent enough time with you?	88.55%	89.31%	90.83%	96.08%

Source: OHA Office of Health Analytics

Outcome A3: Improve integration of oral health services with behavioral health and physical health services

A3a: Percentage of members who have a dental visit during pregnancy compared to total percentage of members who have a dental visit

The percentage of members who had a dental visit during pregnancy decreased from 59% in 2018 to 30% in 2020.While that might be expected in the early months of the pandemic, the percentage had already shown a decrease in 2019. See Table 8.

Table 8. Percentage of members who have a dental visit during pregnancy, 2018 – 2020.

	Percent of pregnant members who have had a dental visit	Improvement target (set by IHN-CCO)
2018	59%	48%
2019	36%	46%
2020	30%	46%

Source: Dental Care Organizations contracted with IHN-CCO, April 2021

A3b: Percentage of dental assessments for youths in Department of Human Services (DHS) custody

The percentage of youths in Department of Human Services (DHS) custody who received mental, physical, and dental health assessments in 2019 was 72%; this is an 8% decrease since 2018 when it was 80%.[12]

However, in looking at dental assessments alone for the same population and timeframe, the percentage has increased from 2018 when it was 85% to 90% in 2020. See Table 9.

Table 9. Percentage of child IHN members in DHS custody who completed a dental assessment, 2018 – 2020.

	Percentage of youth IHN-CCO members in DHS custody who completed a dental assessment	Improvement target (set by OHA)
2018	85%	82.5%
2019	82%	87.5%
2020	90%	75%

Source: Dental Care Organizations contracted with IHN-CCO, April 2021

A3c: Percentage of adults with diabetes who access dental care

The percentage of adults diagnosed with diabetes who accessed dental care decreased from 40% in 2018 to 17% in 2020.While that might be expected in the early months of the pandemic, the percentage had already shown a decrease in 2019. See Table 10.

Table 10. Percent of adult IHN-CCO members diagnosed with diabetes who utilized their dental benefit, 2018 – 2020.

	Percent of adult IHN members diagnosed with diabetes who utilized their dental benefit	Improvement target
2018	40%	37% (set by IHN-CCO)
2019	28%	28% (set by OHA)
2020	17%	26.8% (set by OHA)

Source: Dental Care Organizations contracted with IHN-CCO, April 2021

A3d: Percentage of Emergency Department visits with a caries-related diagnosis that are followed up on in a dental care setting

Follow-up in a dental care setting after emergency department visits for caries-related diagnoses improved and so consistently met target levels, the metric was retired in 2020. See Table 11.

Table 11. Percent of IHN members who visited the Emergency Department with a non-traumatic dental condition (NTDC) that received a follow-up from their Dental Care Organization (DCO), 2018-2019

	Percent of IHN-CCO members who visited the Emergency Department with a NTDC that received a follow-up from their DCO	Improvement target (set by IHN-CCO)
2018	77%	48%
2019	77%	65%
2020	Metric retired due to repeated success.	

Source: Dental Care Organizations contracted with IHN-CCO, April 2021

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, substance use, 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.[13]

Outcome BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.

Indicator Bh1a: Number of community members, employers, landlords, teachers, elected officials, and first responders (e.g. law officers, firefighters, Emergency Medical Technicians) trained in Mental Health First Aid

Mental Health First Aid (MHFA)[14] is an 8-hour course that teaches lay-people and non-clinical staff how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The training gives participants the skills necessary to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.[15]

Between 2014 and 2017, the numbers of MHFA courses taught and the number of community members trained increased steadily, leveling off overall in 2018. In 2019, Samaritan Health Services stopped providing MHFA trainings. In 2020, trainings stopped altogether due to social distancing and public health's need to focus on the wildfire crisis, vaccination efforts, and other pandemic related complications. However, statewide and across the country, many programs shifted from in-person to video MHFA classrooms. It is unknown at this time if and when MHFA trainings will resume in our region and who will provide the trainings. See Table 12.

Table 12. Mental Health First Aid: Number of Certified Participants 2014 - 2020 [16]

County	2014	2015	2016	2017	2018	2019	2020
Benton	107	184	319	589	689	543	
Lincoln	15	32	234	354	160	75	
Linn	180	240	508	315	446	403	81
TOTAL	302	456	1,061	1,258	1,295	1,021	81

Sources: IHN-CCO Transformation & the Association of Oregon Community Mental Health Programs

Indicator Bh1b: Peer-delivered behavioral health education and services

What is reported below is only a partial picture of the certified peer support and other traditional health worker services that occurred in the region in 2020.

IHN-CCO contracts with certified Traditional Health Workers (THW) such as doulas, peer support specialists, and community health workers. Many THWs are contracted in more than one county, so the sum of the county numbers may not match the totals. See Table 13.

Table 13. Contracted Traditional Health Workers by county, 2020

	Linn County	Benton County	Lincoln County	Total
Doulas				36
Peer Support Specialists	10	7	19	37
Community Health Workers	9	3	19	35

Source: IHN-CCO Transformation Department, April 2021

Bh1 Areas of Opportunity – used for prioritization, not annual reporting

i. Behavioral health stigma within the community
ii. Community supports to normalize behavioral health issues

Outcome BH2: Increase the behavioral health expertise of healthcare providers and staff to reduce stigma and improve access and appropriate utilization of services.

Indicator Bh2a: Oregon Psychiatric Access Line about Adults (OPAL-A) utilization

OPAL-A provides free, same-day weekday, adult psychiatric phone consultation to primary care providers in Oregon.[17] This service is underutilized in the IHN-CCO region (as well as statewide). See Table 14.

Table 14. OPAL-A Utilization from October 2018 to December 2020

	Number of registered providers	Number of case consultations
Benton County	28	33
Lincoln County	11	7
Linn County	34	11

Source: Oregon Psychiatric Access Line about Adults[18]

Bh2 Areas of Opportunity – used for prioritization, not annual reporting

i. Members receive behavioral health services, screenings, and referrals in primary care settings
ii. Co-located primary care and behavioral health providers
iii. Primary care providers and Emergency Department staff exposed to behavioral health education, information, and Continuing Medical Education

Outcome BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.

Indicator Bh3a: Screening, Brief Intervention, Referral to Treatment (SBIRT) rates

SBIRT is a new Quality Incentive Metric as of 2019. All Oregon CCOs were required to report their SBIRT rates for the first time in 2019.

In 2019, the percentage of members 12 years old and older who received an age-appropriate screening for alcohol and substance use was 50.2%. The percentage of members who screened positive for alcohol or other substance abuse and received a brief intervention and referral to treatment was 85.4%.

In June 2021, the final numbers for 2020 will be available to be reported in the next CHIP progress report.

Indicator Bh3b: Rate of suicidal ideation, attempts, suicide, and/or self-harming behavior

Table 15 outlines the percentage of 8th & 11th grade students in the region and statewide who self-reported that they had experienced depression, thought about suicide, or attempted suicide during 2019. These numbers are alarmingly high and have not significantly changed since previously reported in 2015. See Table 15.

Table 15. Percent of 8th and 11th grade students with self-reported depression, thoughts about suicide, or suicide attempts during the last 12 months, Benton, Lincoln, and Linn Counties, and Oregon, 2019

	Grade	Benton	Lincoln	Linn	Oregon
Felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities	8th	24%	34%	34%	32%
	11th	39%	43%	36%	36%
Seriously considered attempting suicide	8th	19%	23%	18%	20%
	11th	18%	21%	20%	19%
Attempted suicide at least once	8th	8%	14%	7%	10%
	11th	5%	7%	10%	7%

Source: Oregon Healthy Teens Survey, 2019.[19]

Indicator Bh3c: Overdose rates

In Lincoln and Linn Counties, hospitalizations for overdoses decreased between 2015 and 2018. Benton County rates have remained constant over that same time period but are much lower overall. See Table 16.

Table 16. Overdose hospitalizations per 100,000 people, 2015 – 2018

	2015	2016	2017	2018
Benton County	59	67	66	61
Lincoln County	149	98	96	95
Linn County	121	112	116	98
Oregon	113	101	100	97

Source: Oregon Prescription Drug Monitoring Program[20]

Overdose deaths per 100,000 people in Benton County are much lower than in Lincoln and Linn Counties. See Table 17.

Table 17. Overdose deaths per 100,000 people, 2016-2018 (aggregated)

	Overdose deaths per 100,000 people, 2016 - 2018
Benton County	4.4
Lincoln County	16.4
Linn County	10.1
Oregon	7.9

Source: Oregon Prescription Drug Monitoring Program[21]

Bh3 Areas of Opportunity – used for prioritization, not annual reporting

i. Mental health and substance use services, screenings, and referrals in venues other than traditional medical facilities, including schools
ii. Peer delivered education and support
iii. Mental health service wait-times
iv. Lack of mental health services for those not in crisis

Outcome BH4: Improve care for members experiencing mental health crisis.

Bh4: Areas of Opportunity – used for prioritization, not annual reporting

i. Quality of mental health care
ii. Appropriate care at the appropriate time and place for people experiencing a mental health crisis
iii. Time from appointment request to appointment with a mental health care provider
iv. Care Coordination

Outcome BH5: Improve care for members experiencing severe and persistent mental illness.

Bh5: Areas of Opportunity – used for prioritization, not annual reporting

i. Non-mental health care (i.e., physical & oral)
ii. Continuity of care
iii. Ongoing engagement with a behavioral health provider
iv. Health equity for this marginalized population
v. Stigma reduction
vi. Assertive Community Treatment (ACT)

Outcome BH6: Behavioral Health funded and practiced with equal value and priority as physical health.

Indicator Bh6a: Implement and report progress on behavioral health parity plan

According to the National Alliance on Mental Illness (NAMI), "Mental health parity describes the equal treatment of mental health conditions and substance use disorders in insurance plans. When a plan has parity, it means [for example] that if you are provided unlimited doctor visits for a chronic condition like diabetes then they must offer unlimited visits for a mental health condition such as depression or schizophrenia."[22]

In 2018, the Oregon Health Authority (OHA) began a Mental Health Parity Analysis[23] of the Oregon Health Plan's (OHP/Medicaid) full delivery system for all of its Coordinated Care Organizations (CCOs), such as IHN-CCO. This included an inventory of all mental health and substance use disorder benefits offered to IHN-CCO members, as well as the limitations applied to those benefits. The purpose of this analysis was to ensure that mental health and substance use disorder benefits were comparable to, and not more strictly limited than, medical and surgical services. [24]

The key areas of rule parity are for 1) Combined lifetime and annual dollar limits; 2) Financial requirements, such as copays (Medicaid members do not have co-pays); 3) Quantitative treatment limits, such as day and visit limits; and, 4) Non-quantitative treatment limits, such as prior authorization and provider network admission requirements.

In 2020, a follow-up study was conducted across all CCOs and reported in the "InterCommunity Health Network 2020 Mental Health Parity Analysis Report, state of Oregon."[25] The overall summary of that report is that IHN-CCO was found to be in compliance with all aspects of federal mental health and chemical use disorder parity requirements (see page 3-3 of the parity report). The specific areas included in the report that IHN-CCO is in compliance with are for:

- Utilization management limits applied to inpatient services

- Utilization management for prescription drugs
- Enrollment/credentialing decisions

BH6a Areas of Opportunity – used for prioritization, not annual reporting

i. Number of mental health providers
ii. Preventative behavioral healthcare and promotion of general wellbeing

Child & Youth Health

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

Outcome CY1: Increase the percentage of children, youth, and families who are empowered in their health.

CY1 Areas of Opportunity – used for prioritization, not annual reporting

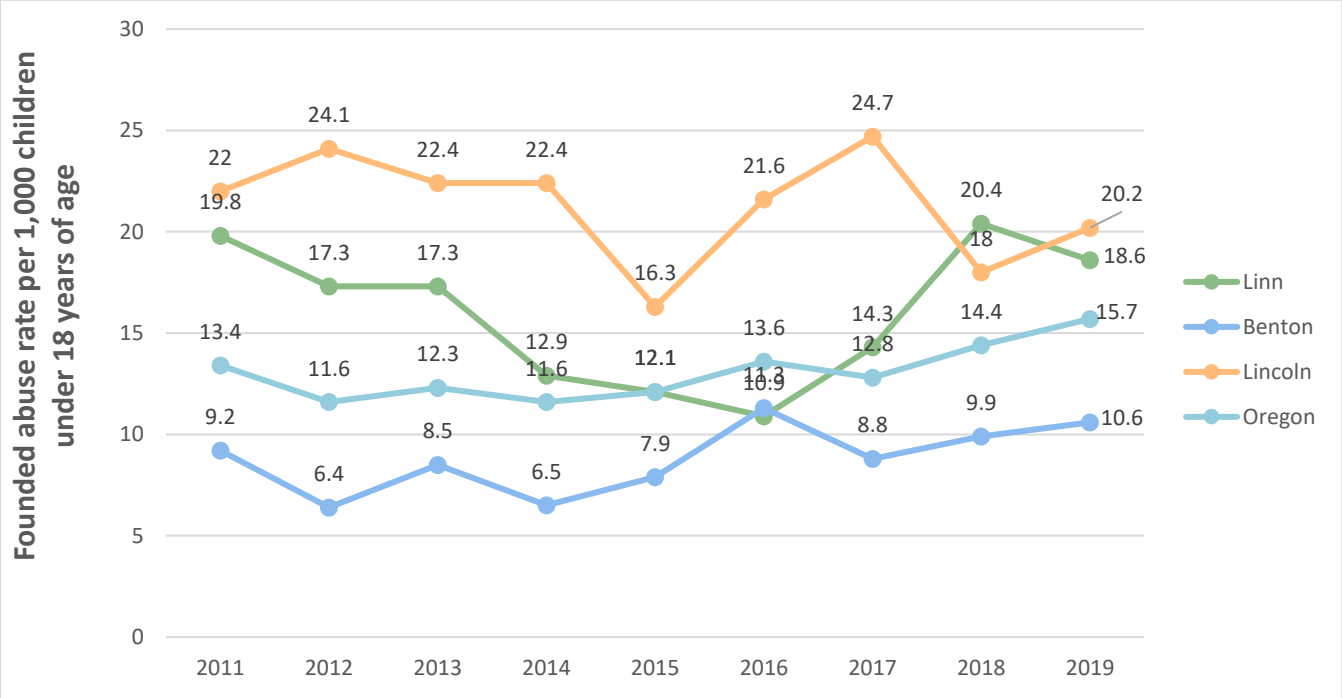
i. Utilization of advocacy services and supports
ii. Children, youth, and families partner with their healthcare providers, set their own goals, and follow through on those goals.

Outcome CY2: Decrease child abuse and neglect rates

Indicator CY2a: Neglect; emotional, physical, and sexual abuse rates

The 2019, founded[26] abuse rates in Benton (10.6 reports per 1,000 children) were lower than the statewide rate (15.7). While Lincoln (20.2) and Linn (18.6) counties' rates were each higher than the statewide average. See Figure 1.

Figure 1. Founded abuse rate per 1,000 for children less than 18 years of age in Linn, Benton, and Lincoln Counties, and Oregon, 2011-2019

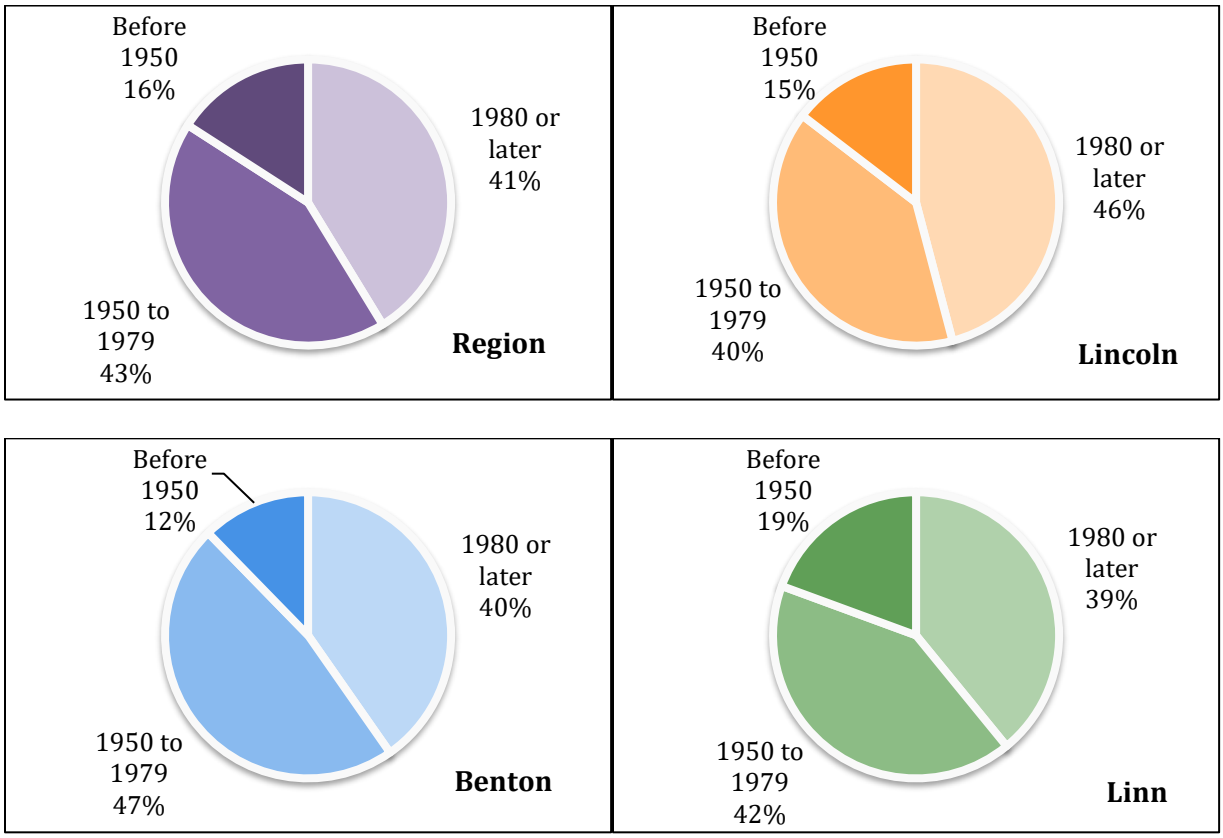


Source: Oregon Department of Human Services, Child Welfare Data Book 2011, 201227, 2013, 2014, & 2015. Rates include neglect, physical abuse, and sexual abuse[28]

Indicator CY2d: Percentage of members with safe housing

Data for this indicator is from the 2015 Regional Health Assessment.[29] Data on the safety of housing is not available. A reasonable proxy for the safety level of a house is its age. Older houses are less likely to have modern safety features, more likely to suffer from mold or other health threats, and more likely to contain lead paint. The following charts show the age of housing in the region. Beginning in 1980, lead paint was outlawed in houses. See Figure 2.

Figure 2. Age of housing stock in Linn, Benton, and Lincoln Counties.



This is the most recent data.

Outcome CY3: Increase breastfeeding initiation and duration rates.

Indicator CY3a: Percentage of women who receive lactation consultation and support during pregnancy and following childbirth

The Women, Infants, and Children (WIC) program provides lactation consultation and support, during pregnancy and following childbirth, to qualifying mothers. Table 18 shows the number of women in each county receiving WIC services for 2019. See Table 18.

Table 18: WIC families receiving services, 2019

	Number of families	Percent of all pregnant women
Benton County	1,821	28%
Lincoln County	1,052	46%
Linn County	4,365	34%

Source: *Source: OHA 2019 WIC Fact Sheets.*[30]

Indicator Cy3b: Breastfeeding rates

Pediatricians recommend that infants are exclusively breastfed from birth until age six months. While WIC mothers in Benton, Lincoln, and Linn counties have high initial success rates in breastfeeding at birth, there is a significant drop off by age 6 months and those rates are dropping slightly each year. See Table 19.

The six-month data is for infants who are still breastfeeding, even if they are not exclusively breastfeeding. Many low-income mothers find it difficult to balance work with breastfeeding and turn to formula to supplement and eventually replace breastfeeding.[31]

Table 19. Percentage of mothers in the Women, Infant, and Children (WIC) program who are breastfeeding at birth and 6 months in Benton, Lincoln, and Linn Counties, 2016, 2017, and 2019

	Percentage of WIC mothers breastfeeding at birth			Percentage of WIC mothers breastfeeding at 6 months		
	2016	2017	2019	2016	2017	2019
Benton County	94%	93%	97%	45%	47%	42%
Lincoln County	94%	95%	97%	36%	40%	36%
Linn County	92%	91%	91%	34%	36%	35%

Source: OHA 2016, 2017, & 2019 WIC Fact Sheets. No data available for 2018. [32]

CY3 Area of Opportunity – used for prioritization, not annual reporting

i. The ability to conveniently pump breastmilk at work

Outcome CY4: Increase integration of behavioral health and oral care as part of routine primary pediatric care.

Indicator CY4a: Number of regular behavioral health screenings occurring for pediatric IHN-CCO members

The 2018 Progress report included 2016 and 2017 data on the number of regular behavioral health screens for pediatric IHN-CCO members. More recent data is not available.

Table 20. Number of regular behavioral health screenings for pediatric IHN-CCO members, 2016 & 2017

	Number of Behavioral Health Screenings	Number of Behavioral Health Treatments
2016	13,966	15,649
2017	9, 553	11,286

Source: IHN-CCO, April 2018.

Indicator CY4b: Oregon Psychiatric Access Line about Kids (OPAL-K) utilization

OPAL-K provides free, same-day weekday, child psychiatric phone consultation to primary care providers in Oregon.[33] This service is underutilized in the IHN-CCO region (as well as statewide). See Table 21.

Table 21. OPAL-K Utilization from June 2014 to December 2020

	Number of registered providers	Number of case consultations
Benton County	36	36
Lincoln County	12	15
Linn County	41	55

Source: Oregon Psychiatric Access Line about Kids[34]

Indicator CY4c: Mental, physical, and dental health assessments for children in DHS custody

The percentage of children in Department of Human Services (DHS) custody who received mental, physical, and dental health assessments in 2019 was 72%, this is an 8% decrease since 2018 when it was 80%.[35]

Indicator Cy4d: Percentage of teens who had a dental check-up, exam, teeth cleaning, or other dental work

The percent of 8th and 11th graders who had "dental check-ups, exams, or teeth cleanings in the past year", for 2019, increased in Benton County, while those same numbers decreased in Lincoln County. For Linn County 8th graders, the percentage increased slightly in 2019 from 2018, but decreased slightly for Linn 11th graders. See Table 22.

Table 22. Percent of 8th graders and 11th graders who had a dental check-up, exam, or teeth cleaning in the past year, 2017 and 2019.

		2017	2019
Benton County	8th grade	88.0%	93.1%
	11th grade	83.7%	86.2%
Lincoln County	8th grade	82.8%	77.9%
	11th grade	80.0%	76.2%
Linn County	8th grade	86.9%	87.6%
	11th grade	81.1%	77.8%

Source: Oregon Healthy Teens Survey, 2017 and 2019.[36]

Cy4c Area of Opportunity – used for prioritization, not annual reporting

i. Occurrence of care coordination between primary care and behavioral health providers when working with children, youth, and families, including consultations and referrals.

Healthy Living

Healthy Living includes disease prevention, management, and recovery through nutrition; physical activity; stress prevention, management, and resiliency; good sleep; and responsible behavior. Healthy living greatly reduces a person's risk for developing chronic illnesses. Healthy Living should not be about "shaming and blaming" but about ensuring that people are empowered to be the healthiest that they can be.

Chronic Diseases are human health conditions of long duration and generally slow progression.[37] 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. 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.[38]

Outcome HL1: Increase the percentage of members who are living a healthful lifestyle

Areas of Opportunity HL1a: – used for prioritization, not annual reporting

i. Disease prevention, management, and recovery
ii. Nutrition
iii. Physical activity
iv. Weight shaming and blaming
v. Stress
vi. Sleep quality
vii. Social supports, such as family, friends, and community

Outcome HL2: Reduce the percentage of members who use and/or are exposed to tobacco or nicotine

Indicator HL2a: Tobacco prevalence, including tracking prevalence among members who are under age 18, pregnant, or who are a member of another at-risk group (Quality Incentive Metric)

For IHN-CCO members, tobacco prevalence reported in both 2018 and 2019 was 26%. That includes tracking prevalence among members who are under age 18, pregnant, or who are a member of another at-risk group. This is a new statewide quality incentive metric. The state will use these baseline numbers to determine overall benchmarks and annual targets for each CCO.

See Indicator HL2a for more data.

SMOKING DURING PREGNANCY

The percentage of members in the IHN-CCO region who smoked during pregnancy in 2016-2017 was 15%, which is 50% higher than the statewide rate of 15% during that same time period. Those numbers decreased slightly in 2016-2018, down to 13% for the region and 9% statewide. It is notable that the younger one is when pregnant, the more likely the individual is to smoke. Data for vaping for this group was not reported for this data set. See Table 23.

Table 23. Smoking rates during pregnancy by age in the region and Oregon, 2014-2016, 2015-2017, and 2016-2018

Population (by age)	Region, 2014-2016	Region, 2015-2017	Region, 2016-2018	Oregon, 2014-2016	Oregon, 2015-2017	Oregon, 2016-2018
15 to 17	26%	23%	22%	13%	12%	11%
18 to 19	26%	24%	22%	17%	16%	15%
20 to 24	24%	21%	18%	17%	15%	14%
25 to 29	13%	13%	13%	11%	11%	10%
30 to 34	9%	10%	10%	7%	7%	6%
35 to 39	9%	9%	9%	5%	5%	5%
40 to 44	9%	8%	10%	5%	5%	5%
Total	**15%**	**14%**	**13%**	**10%**	**10%**	**9%**

Source: OHA, Center for Vital Statistics, 2014-2018.[39]

The high percentage of those who smoke during pregnancy is particularly striking when compared to the low number of youths who report tobacco use in an anonymous survey. See Tables 24-26.

YOUTH TOBACCO CONSUMPTION

Between 2015 and 2017, the percent of Benton, Lincoln, and Linn County teens that reported tobacco use decreased. Vaping, or the use of e-cigarettes (electric cigarette), is more common than smoking cigarettes. Most concerning is the large increase in reported vaping by 2019. For example, in 2019, of 11th graders asked to anonymously report use of e-cigarettes in the past 30 days, the percentage of those who said they had were 20%, 16%, and 37% in Benton, Lincoln, and Linn Counties respectively. See Tables 24-26.

Table 24. Percent of youth who reported tobacco use in the past 30 days in Linn, Benton, Lincoln Counties; the region; and Oregon, 2015

	Grade	Benton	Lincoln	Linn	Region	Oregon
Smoked cigarettes	8th	1%	8%	8%	5%	4%
	11th	7%	7%	11%	9%	9%
Used e-cigarettes/vaped	8th	5%	10%	14%	10%	9%
	11th	12%	10%	21%	16%	17%

Source: Oregon Healthy Teens Survey, 2015.[40]

Table 25. Percent of youth who reported tobacco use in the past 30 days in Linn, Benton, Lincoln Counties; the region; and Oregon, 2017

	Grade	Benton	Lincoln	Linn	Region	Oregon
Smoked cigarettes	8th	0.3%	3%	5%	5%	3%
	11th	4%	6%	5%	9%	8%
Used e-cigarettes/vaped	8th	2%	4%	10%	10%	6%
	11th	12%	7%	13%	16%	13%

Source: Oregon Healthy Teens Survey, 2017.[41]

Table 26. Percent of youth who reported tobacco use in the past 30 days in Linn, Benton, and Lincoln Counties; the region; and Oregon, 2019

	Grade	Benton	Lincoln	Linn	Region	Oregon
Smoked cigarettes	8th	0.5%	3%	0.4%	5%	3%
	11th	4%	9%	10%	9%	5%
Used e-cigarettes/vaped	8th	8%	7%	10%	10%	11%
	11th	20%	16%	37%	16%	21%

Source: Oregon Healthy Teens Survey, 2019.[42]

To learn more about vaping health risks, please visit the heart.org website.[43]

ADULT SMOKING RATES

Smoking rates in Benton, Lincoln, and Linn Counties have decreased slightly over recent years, but remain higher than statewide rates. See Table 19.

Table 27. Age-adjusted percent of adults who currently smoke cigarettes in Linn, Benton, and Lincoln Counties and Oregon, 2010-2013, 2012-2015, and 2014-2017

	Benton	Lincoln	Linn	Oregon
2010-2013	14%	33%	21%	19%
2012-2015	11%	32%	20%	18%
2014-2017	9%	29%	19%	17%

Source: Oregon Behavioral Risk Factor Surveillance System (BRFSS)[44, 45].

Indicator HL2b: Use of tobacco cessation resources and tools

Compared to 2017, the numbers of IHN-CCO members who received diagnoses of tobacco use increased from 16,149 to 19,017. [46] The number who utilized the Alere Wellbeing Tobacco Cessation Counseling program in 2016 was 27[47]; 65 used the service in 2017. No new data is available.

HL2 Area of Opportunity – used for prioritization, not annual reporting

i. Youth introduction to and cessation of tobacco or nicotine products (e.g., vaping, cigarettes, chewing tobacco, etc.)

Outcome HL3: Reduce sexually transmitted infection (STI) rates.

Indicator HL3a: Sexually transmitted infection rates

Between 2014 and 2017, chlamydia infection rates in the IHN-CCO region, as well as statewide, increased. In 2018, the rates were once again similar to, or lower than, the rates four years prior in 2014. See Table 28.

Table 28: Chlamydia infection rates from 2014 to 2018: Number of infections per 100,000 people. Not age adjusted.

	2014	2015	2016	2017	2018
Benton	396	462	470	497	381
Lincoln	235	285	333	316	185
Linn	344	363	372	376	219
Oregon	387	407	426	450	202

Source: Oregon Public Health Assessment Tool; 2014 – 2018. This is the most recent data.

The rate of gonorrhea infections within the region increased between the years of 2014 and 2018 but remain significantly lower than statewide rates. See Table 29.

Table 29: Gonorrhea infection rates from 2014 to 2018: Number of infections per 100,000 people. Not age adjusted.

	2014	2015	2016	2017	2018
Benton	23	32	53	57	54
Lincoln	11	68	50	37	28
Linn	21	33	91	126	81
Oregon	58	81	107	121	121

Source: Oregon Public Health Assessment Tool; 2014 – 2018. This is the most recent data.

Syphilis infection rates within the region have fluctuated slightly between the years of 2014 and 2018 but remain significantly lower than statewide rates. Lincoln County's rates are notably low to non-existent for the most recent data. See Table 30.

Table 30: Syphilis infection rates from 2014 to 2018: Number of infections per 100,000 people. Not age adjusted.

	2014	2015	2016	2017	2018
Benton	7	9	3	7	14
Lincoln	4	21	10	2	0
Linn	6	10	4	8	10
Oregon	11	14	15	14	24

Source: Oregon Public Health Assessment Tool; 2014 – 2018. This is the most recent data.

HL3a Area of Opportunity – used for prioritization, not annual reporting

i. Expedited Partner Therapy utilization

Maternal Health

Outcome MH1: Reduce unplanned pregnancies rates.

Indicator Mh1a: Effective contraceptive use among partners

See A1d for effective contraceptive use data

Mh1 Area of opportunity – used for prioritization, not annual reporting

i. Data availability for effective contraceptive use among all members

Outcome MH2: Increase the percentage of members who receive early and adequate care and support before, during, and after pregnancy

Indicator Mh2a: Behavioral health screenings and access to treatment with a behavioral health provider

See Bh3a for Screening, Brief Intervention, and Referral to Treatment data

Mh2 Areas of opportunity – used for prioritization, not annual reporting

i. Healthy weight gain during pregnancy
ii. Utilization of postpartum care and support
iii. Partner education and involvement

Social Determinants of Health & Equity

Outcome SD1: Increase the percentage of members who have safe,[48] accessible, affordable housing (NOTE: Similar to A3 in previous CHIP)

Indicator SD1a: Number of homeless persons

Each year, local community groups conduct a one-night population count of people experiencing homelessness in their communities. This census is coordinated across the country to avoid double counting. This Point-in-Time count is acknowledged to have significant limitations, primarily stemming from the inability of community groups to canvas every area where a person experiencing homelessness might be. Furthermore, over the course of the year there is fluctuation or change in the number of people experiencing homelessness, so a single night count does not capture the true burden. However, the Point-in-Time count provides consistent and comparable information between geographies and across years.

The number of people experiencing homelessness counted during the Point-in-Time census increased by 18% in the region from 2016 to 2017. See Table 31. As in earlier years, about twice as many men as women experienced homelessness. Beginning in 2020, data from the Point-in-Time count has been organized and presented by the groups that conduct the count in each county. This has led to changes in the structure of the reported data. The data available for 2020 is less descriptive. See Tables 31-33.

Table 31. Historical Point-in-Time count homeless population figures, including students

	2011				2015			
	Benton	**Lincoln**	**Linn**	**Region**	**Benton**	**Lincoln**	**Linn**	**Region**
Total homeless count	107	41	135	283	131	47	246	424
Sheltered count	107	41	125	273	94	25	197	316
Unsheltered count	0	0	10	10	37	22	49	108
Female	36	24 *	51	111 *	43	23	108	174
Male	71	16 *	84	171 *	88	23	123	234
Individuals	81	23	109	75	110	29	186	325
Family members	26	18	26	208	21	18	60	99
Average months spent homeless (female / male)	18 / 43	7 / 20	13 / 22	13 / 30	No data	No data	No data	No data

Source: Oregon Housing and Community Services and Community Services Consortium

Table 32. 2016 and 2017 Point-in-Time homeless population figures, including students

	2016				2017			
	Linn	**Benton**	**Lincoln**	**Region**	**Linn**	**Benton**	**Lincoln**	**Region**
Total homeless count	253	199	102	554	186	287	180	653
Sheltered count	188	141	21	350	26	139	113	278
Unsheltered count	65	58	81	204	160	148	67	375
Female	101*	89	50	240	63	97	81	241
Male	153*	110	52	315	117	189	105	411
Individuals	215	135	77	427	154	196	139	489
Family members	38	64	25	127	5	52	46	103

Source: Oregon Housing and Community Services and Community Services Consortium.

**Counts do not sum to total. This is generally due to miscounting or data entry errors in the data collection process. Discrepancies of 1 or 2 are small for numbers of data of this size. This is the most up to date data.*

Table 33. 2020 Point-in-Time homeless population figures, including students

	2020			
	Linn	**Benton**	**Lincoln**	**Region**
Total homeless count	318	233	400	554
Male	193*	152*	215	315
Female	124*	79*	179	240

*Source: Community Services Consortium, 2020. Data on sheltered status and family status is unavailable. * Counts do not sum to total due to individuals identifying as a gender other than female or male.*[49]

Indicator SD1b: Number of homeless students

Table 34 shows the number of school-age children and youths experiencing homelessness in Linn, Benton, and Lincoln Counties. Nearly than one in seven Lincoln County K-12 students experienced homelessness at some point in the 2019-2020 school year. While percentage rates have remained similar across time, total numbers are increasing. See Table 34.

Table 34. Student point-in-time homeless population figures, 2013-2020

	County	Benton	Lincoln	Linn	Region	Oregon
2013-2014	Homeless Student Numbers Grades K-12	228	519	859	1,606	---
	Percent of students	3%	10%	4%	3%	3%
2015-2016	Homeless Student Numbers Grades K-12	290	768	976	2,034	--
	Percent of students	3%	15%	4%	6%	4%
2016-2017	Homeless Student Numbers Grades K-12	386	644	920	1,950	--
	Percent of students	4%	12%	4%	5%	4%
2017-2018	Homeless Student Numbers Grades K-12	259	824	1,044	2,127	--
	Percent of students	3%	15%	5%	6%	4%
2018-2019	Homeless Student Numbers Grades K-12	328	943	1,182	2,453	--
	Percent of students	4%	17%	5%	7%	4%
2019-2020	Homeless Student Numbers Grades K-12	270	801	1,081	2152	--
	Percent of students	3%	14%	6%	6%	4%

Source: Oregon Department of Education McKinney-Vento Act Homeless Education Program.[50]

SD1 Areas of Opportunity – used for prioritization, not annual reporting

i. Stable housing upon discharge from hospital or emergency room visit
ii. Evictions prevention and reduction
iii. Housing-related, closed-loop referral between clinical and community services
iv. Social of Determinants of Health claims data

Outcome SD2: Increase the percentage of members who have access to affordable transportation

SD2 Areas of Opportunity – used for prioritization, not annual reporting

i. Non-medical transportation access
ii. Distance between members' homes and public transportation
iii. Member utilization of available, covered transportation services
iv. Provider knowledge of, and referral to, available transportation services

Outcome SD3: Increase the percentage of members who have access to healthy food

SD3a: Percentage of members living in a food desert

Data was not available in time for this report.

SD3 Areas of Opportunity – used for prioritization, not annual reporting

i. Food security
ii. Availability of fresh, affordable produce

Outcome SD4: Increase health equity

SD4 Areas of Opportunity – used for prioritization, not annual reporting

i. Health disparities experienced by members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.
ii. Availability of health equity data

Appendix I: Acronyms

ACE – Adverse Childhood Experiences

ACT – Assertive Community Treatment

CAC – Community Advisory Council

CCO – Coordinated Care Organization

CASA – Court Appointed Special Advocates

CDC – Center for Disease Control

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

CCO – Coordinated Care Organization

CME – Continuing Medical Education

DHS – Department of Human Services

EHS – Early Head Start

HIA – Health Impact Area

K-12 – Kindergarten through 12th grade

LGBTQIA – Lesbian, gay, bi-sexual, transgendered, questioning, intersex, or asexual

N/A – Not applicable (does not apply)

IHN-CCO – InterCommunity Health Network Coordinated Care Organization

OFSN – Oregon Family Support Network

OHA – Oregon Health Authority, the state agency responsible for OHP/Medicaid

OHP – Oregon Health Plan (Medicaid)

Opal-A – Oregon Psychiatric Access Line about Adults

Opal-K – Oregon Psychiatric Access Line about Kids

O&I – Outcomes and Indicators

SBIRT – Screening, brief Intervention, and referral to treatment

Appendix II: Glossary of Terms

Areas of Opportunity, similar to Indicators, further clarify and define their related Outcomes. However, Areas of Opportunity do not currently have readily accessible, good quality data for annually tracking improvement or lack thereof. By including Areas of Opportunity, pilot projects and other initiatives may be prioritized to focus on making improvements and potentially establishing measurements in these areas. Also, the CAC and its Local Advisory Committees may invite presentations related to the Areas of Opportunity.

Assertive Community Treatment (ACT) – is a form of community-based mental health care for individuals experiencing serious mental illness that interferes with their ability to live in the community, attend appointments with professionals in clinics and hospitals, and manage mental health symptoms.[51]

Caries – decay and crumbling of tooth or bone.

CASA – Court Appointed Special Advocates—empowered directly by the courts—offer judges the critical information they need to ensure that each child's rights and needs are being attended to while in foster care.[52]

E-cigarette or electric cigarette – a cigarette-shaped device containing a nicotine-based liquid that is vaporized and inhaled, used to simulate the experience of smoking tobacco.

Founded Abuse – There is a reason to believe that abuse occurred (founded is the opposite of unfounded).

Health Impact Area (HIA) – A priority health focus area identified in the CHIP.

Healthy Living includes disease prevention, management, and recovery through nutrition; physical activity; stress prevention, management, and resiliency; good sleep; and responsible behavior. Healthy living greatly reduces a person's risk for developing chronic illnesses. Healthy Living should not be about "shaming and blaming" but about ensuring that people are empowered to be the healthiest that they can be.

Indicator – A measurement or data that provides evidence that a certain condition exists, or certain results have or have not been achieved. Indicators measure the level of success or lack of success a program has had in achieving an outcome.

Non-traumatic dental conditions include a variety of oral health conditions, including dental decay, which were not caused by injury. Examples are a tooth erupting through the gum and periodontal disease (infection in gum tissue).

Member – Any individual enrolled in the Oregon Health Plan whose care is the responsibility of IHN-CCO.

OHA – Oregon Health Authority, the state agency responsible for Oregon Health Plan/Medicaid.

OHA Innovator Agent – Innovator Agents help CCOs and OHA work together to achieve the goals of health system transformation: better care, better health, and lower costs.

Opal-A – Oregon Psychiatric Access Line about Adults provides free, same-day adult psychiatric phone consultation to primary care providers in Oregon[53]

Opal-K – Oregon Psychiatric Access Line about Kids provides free, same-day child psychiatric phone consultation to primary care providers in Oregon[54]

Outcome – Results or changes that come about from a program, such as changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status.

Pilot Project – While providing services to its members, IHN-CCO and its community partners are 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 delivery, member satisfaction, and cost efficiency. If a pilot project can be successfully refined and proves to be a viable concept, its new processes and programs may be adopted throughout the IHN-CCO region.

Resiliency – The ability to recover

Social Determinants of Health – Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect wellbeing.[55]

Traditional Health Workers (THWs)[56] help individuals in their communities, providing physical and behavioral health services. There are five traditional health worker types:

- **Community health workers**: Assist community members in receiving the healthcare they need.
- **Peer support specialists**: Provide support, encouragement and assistance to addictions and mental health consumers.
- **Peer wellness specialists**: Provide support, encouragement and assistance to address physical and mental health needs.
- **Personal health navigators**: Provide care coordination for members from within the health system.
- **Birth doulas**: Provide companionship and personal, nonmedical support to women and families throughout the childbirth and post-partum experience.

Vape – inhale and exhale vapor containing nicotine and flavoring produced by a device designed for this purpose.

Appendix III: Pilot Project Brief Summaries

The Pilot Project Brief Summaries begin on Page 41.

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InterCommunity Health Network CCO

IHN-CCO Transformation

Summary of Current Pilots
for Benton, Lincoln & Linn Counties

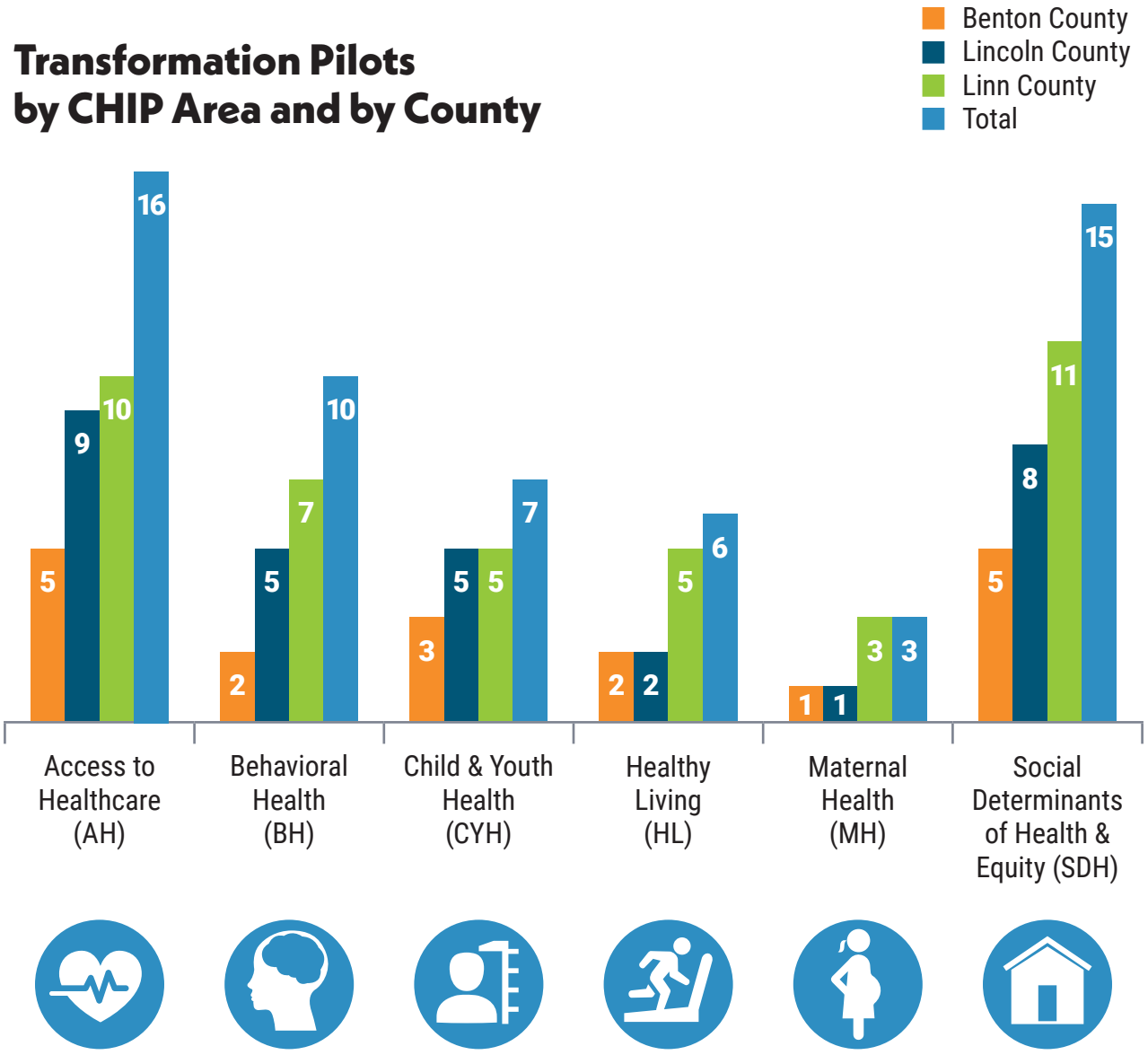
Winter 2021

Be Healthy. Be Happy.

These are the current InterCommunity Health Network Coordinated Care Organization (IHN-CCO) Transformation pilots in Benton, Lincoln and Linn counties. Pilots are selected from a competitive Request for Proposals process. The goal is to achieve better quality healthcare, lower costs and more access to services.

To be considered, pilots must meet at least one Community Health Improvement (CHIP) area. The new pilots in 2021 must address at least one CHIP Outcome and Indicator Concept in the area of Access, Behavioral Health or Social Determinants of Health and Equity. The graph below shows the CHIP areas addressed by each pilot and the icons are carried through the document to represent CHIP areas for each pilot summary.

Transformation Pilots by CHIP Area and by County

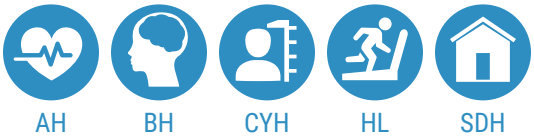


Bravery Center

Date range: January 2020 to June 2021

Location: Lincoln County

Site: Olalla Center



The Bravery Center pilot primary goal is to create an open, accepting center where LGBTQIA2S+ youth can access mental health, educational, vocational, mentorship, and other services such as meals. The Bravery Center pilot will also offer assistance with LGBTQIA2S+ specific needs, such as assisting youth by connecting with LGBTQIA2S+ affirming healthcare providers, navigating the legal processes for name and/or gender changes, and accessing specialist services.

Health Outcomes:

- Provide behavioral health services from affirming providers to LGBTQIA2S+ youth.
- Reduced food insecurity within the LGBTQIA2S+ population.
- Reduced homelessness within the LGBTQIA2S+ population.

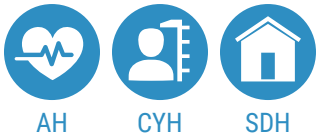
Sustainability: If successful, Olalla will continue support of the Bravery Center pilot with partnerships in the region.

CommCard Program

Date range: January 2021 to December 2021

Location: Benton, Lincoln and Linn counties

Site: The Arc of Benton County



The CommCard Program pilot is a communication and accommodation program for people with developmental disabilities (DD) and the healthcare professionals who serve them. The pilot will be brought to Benton, Lincoln and Linn County middle and high schools to enhance self-advocacy skills among students who experience any degree of communication impairment. The CommCard Program involves a customizable card with important communication accommodation information as well as training for both the cardholders and healthcare professionals who will be viewing their patients' cards.

Health Outcomes:

- Addresses health inequities among people with DD.
- Increased access to healthcare professionals for young people with disabilities.
- Improved satisfaction for healthcare professionals.

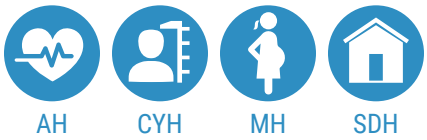
Sustainability: If successful, The Arc of Benton County will continue to support the CommCard Program in all three counties.

Community Doula Program

Date range: January 2021 to December 2021

Location: Benton, Lincoln and Linn counties

Site: Heart of the Valley Birth and Beyond



Birth doulas are Traditional Health Workers that build trusting relationships with pregnant members and provide physical, emotional and informational support during labor and birth. The main goal of the pilot is to expand the original Community Doula pilot into Lebanon, Newport and Lincoln City hospitals.

Health Outcomes:

- Increase number of Spanish speaking doulas in the community, especially to the East Linn and coastal communities.
- Improve birth outcomes such as prematurity, cesarean-section and pain medication use.
- Cross train active multi-lingual doulas to serve as health care interpreters.

Sustainability: If successful, Heart of the Valley Birth and Beyond will continue spreading services into new communities.

Culture of Supports

Date range: January 2021 to December 2021

Location: Lincoln County

Site: North End Senior Solutions

This pilot creates a process of screening for behavioral and memory health with follow-up supports that will result in improved relations between IHN-CCO members and their Health Care Providers. By providing education, peer and mentor supports, adaptive tools, and by addressing social determinants of health, the burden of healing and well-being shifts from health care providers to the individual members. The desired outcome will be an engaged "partnership in health" resulting from a culture of supports within the community.

Health outcomes:

- Improved member satisfaction with Healthcare Providers (HCP).
- Provide Community Screening and Supportive Programs for behavioral and memory health.
- Contribute to HCPs awareness, knowledge and skills for communication with behaviors.
- Provide more transportation options for members.
- Eliminate or compensate for disparities that increase health risk.

Sustainability: If successful, North End Senior Solutions will work to contract with IHN-CCO for traditional health worker services and continue education and training.

Disability Equity Center

Date range: January 2021 to December 2021

Location: Benton, Lincoln and Linn counties

Site: Disability Equity Center

The primary goal of the Disability Equity Center pilot is to create an inclusive cultural and resource center that meets the diverse needs of people living with disabilities across the Willamette Valley, as well as their family and friends. The pilot will address the specific needs of healthcare providers, addressing gaps and augmenting partnerships across formal disability support services as well as educating healthcare workers and support providers about client-driven disability healthcare best practices. We will also teach our local community about ableism and change social misperceptions about people with disabilities.

Health outcomes:

- Increase opportunities for disabled people to be as healthy as possible, in particular through decreased social isolation and increased agential interdependence.
- Increase number of disabled people who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.
- Reduce stigma and increase community awareness that disabilities are part of everyday life and widely experienced.

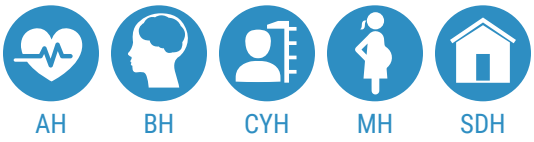
Sustainability: If successful, DEC will work with IHN-CCO to contract for services and also partner around increased opportunities for collaborative, non-traditional healthcare delivery models.

ENLACES

Date range: January 2021 to December 2021

Location: Linn County

Site: Casa Latinos Unidos



The overall objective of the ENLACES pilot project is to enhance the capacity of Casa Latinos Unidos to serve in a culturally sensitive way the most vulnerable members of the Latino community of Linn County and to bridge linguistic and cultural gaps that may exist between this community and the system of services. Through two promotoras(es), the pilot will increase awareness of free and low-cost health care (and other) services available to members of the household.

Health outcomes:

- Increased access to services.
- Improved referral pathways.
- Strengthened the capacity of the system of services in culturally appropriate ways.

Sustainability: If successful, Casa Latinos Unidos will work with IHN-CCO to contract for services.

Healthy Homes Together

Date range: January 2021 to December 2021

Location: Linn County

Site: Albany Partnership for Housing and Community Development and Family Tree Relief Nursery

Healthy Homes Together (HHT) brings community partners together to spread Traditional Health Worker services to new housing communities in Linn County. The pilot's purpose is to improve healthcare access, to positively impact behavioral health, and to improve the social determinants of health for the community and IHN members. HHT will be coordinating with other community partners to provide a support network and educational opportunities for THWs who are embedded in the housing community.

Health outcomes:

- Maintain stable and safe housing.
- Improve access to healthcare.
- Positively impact behavioral health.

Sustainability: If successful, Albany Partnership for Housing and Community Development and Family Tree Relief Nursery will work with IHN-CCO to contract for services.

Hepatitis C Virus Outreach Screening & Treatment

Date range: January 2021 to December 2021

Location: Lincoln County

Site: Lincoln County Community Health Center, Lincoln County Public Health, the Confederated Tribes of Siletz Indians' Community Health Clinic, Samaritan Health System Infectious Disease

Lincoln County Community Health Center, Lincoln County Public Health, the Confederated Tribes of Siletz Indians' Community Health Clinic and Samaritan Health System Infectious Disease are partnering to implement a Hepatitis C Virus (HCV) treatment protocol for primary care providers in community health clinics. This project will be utilizing an innovative approach of combining Harm Reduction outreach testing and navigational peer support with accessible treatment in primary care medical homes.

Health outcomes:

- Increased access to HCV screening and treatment for populations most at risk for HCV infections.
- Increased the number of at-risk individuals in treatment for HCV infections.

Sustainability: If successful, Hepatitis C Virus Outreach Screening & Treatment will continue partnerships and billing for services.

Hub City Village

Date range: January 2020 to December 2021

Location: Linn County

Site: Creating Housing Coalition

Creating Housing Coalition is partnering with several agencies to develop the first tiny home community in Linn County. This is a new and different housing model which meets a need unmet by single family houses and apartments. It also addresses access to resources through onsite health navigation.

Health Outcomes:

- Closed loop referral process based on health needs and income complete.
- Circle of providers established.

Sustainability: If successful, Creating Housing Coalition will work with IHN-CCO to contract for services and expand to other areas.

Integrated Foster Child Wellbeing

Date range: January 2019 to December 2021

Location: Benton, Lincoln and Linn counties

Champion: Dr. Carissa Cousins, Samaritan Health Services

The purpose of this pilot is to develop a model of care to find the best way to coordinate care for high-need foster children. Key activities are coordination of services, intensive care coordination, creating partnerships and establishing a sustainable model.

Health Outcomes:

- Provide timely medical, dental, and mental health care for all foster children.
- Support foster youth and families during transition periods.

Sustainability: If successful, the partnerships will continue, and funding will occur through medical billing and reduced costs.

Linn County Crisis Outreach Response

Date range: January 2021 to December 2021

Location: Linn County

Site: Family Assistance and Resource Center Group

Family Assistance and Resource Center Group's mission is to establish trust and inspire hope by providing access to resources, services, and education to those who are experiencing homelessness and housing instability in Linn County. This pilot will strengthen collaboration and access between related social service agencies, Samaritan Health Services, and Linn County Public Health to provide access to the homeless patients and unstably housed.

Health outcomes:

- Increased access to health services.
- Improved access to housing.
- Improve health equity through innovative crisis intervention and advocacy for the homeless and home at risk.

Sustainability: If successful, Family Assistance and Resource Center Group will continue the project through private and corporate donors, internal fundraising activities, enhanced partnerships and grant opportunities.

Mental Health Home Clinic

Date range: January 2021 to December 2021

Location: Linn County

Site: Samaritan Health Services, Linn County Mental Health, C.H.A.N.C.E.

The Mental Health Home Clinic pilot purpose is to bring together community partners in a place for patients who need more of a focus on their mental health/behavioral health, and crisis needs while still getting their medical needs met. The pilot brings multi-agencies and inter-disciplinary teams in one location, providing all around comprehensive treatment and better care to members through a team-based approach.

Health outcomes:

- Reduced Emergency Department visits for mental health concerns.
- Decreased HgA1c levels.
- Decreased post-traumatic stress disorder, depression and anxiety symptoms scores.
- Improved access through a high number of kept appointments.

Sustainability: If successful, the partnership between Samaritan Health Services, Linn County Mental Health and C.H.A.N.C.E. will continue and support the Mental Health Home Clinic.

Navigation to Permanent Supportive Housing

Date range: January 2020 to December 2021

Location: Lincoln County

Site: Lincoln County Sheriff's Office

Lincoln County Sheriff's Office and many other Lincoln County partners are developing a model of Permanent Supportive Housing targeting gap areas of homelessness. This model would add to existing projects in housing with a referral system hub supported by partners involved.

Health Outcomes:

- Identify and network development of community partners for wrap around services.
- Improved care coordination of housing/social services with the Patient-Centered Primary Care Home (PCPCH).
- Increase permanent housing availability.

Sustainability: If successful, Lincoln County Sheriff's Office will continue to will work with IHN-CCO and other partners.

Partnership for Oral Health

Date range: January 2021 to December 2021

Location: Linn County

Site: Capitol Dental Care

The Partnership for Oral Health project is designed to improve access to oral health services and provide greater support to members with dental anxiety and mental health issues. The pilot will work with traditional health workers to increase oral health awareness and resources. An Expanded Practice Dental Hygienist (EPDH) will be available as a resource for better understanding of dental issues. The EPDH will coordinate and provide clinical care at community locations to reduce access issues such as the ability to get into a dental office and the anxiety of a dental office environment.

Health outcomes:

- Improved dental care access.
- Improved oral health utilization.

Sustainability: If successful, Capitol Dental Care will continue the program by showing reduced costs to the healthcare system and improved partnerships.

Skills and Connections to Support Housing

Date range: January 2020 to December 2021

Location: Benton County

Site: Corvallis Housing First

The Skills and Connections to Support Housing pilot is implementing a program to increase the skills, knowledge, and confidence of residents. The skills and connections to resources will help with employment, education, and more. The end result will be greater stability for residents and less spending on expensive services.

Health Outcomes:

- Increased permanent supportive housing.
- Improved housing stability rates.
- Closed loop referral system and service coordination for residents developed.

Sustainability: If successful, Corvallis Housing First will work with IHN-CCO to contract for services.

Wellness in Neighborhood Stores

Date range: January 2020 to December 2021

Location: Linn County

Champions: Linn County Public Health/Oregon State University

Linn County Public Health (LCPH) and OSU Center for Health Innovation (OSU) are partnering with convenience store owners and managers on environmental and health impact assessments. Convenience stores will be assessed and adjusted to improve healthy eating and food security in areas IHN-CCO members live.

Health Outcomes:

- Increase the percentage of IHN-CCO members who have access to healthy food.
- Improved understanding of IHN-CCO members' health needs with regard to shopping in convenience stores.

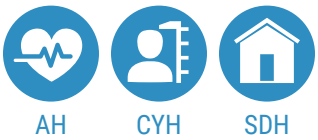
Sustainability: If successful, Linn County Public Health and Oregon State University will develop a toolkit for dissemination throughout the region.

Wellness to Smiles

Date range: January 2020 to December 2021

Location: Lincoln County

Site: Advantage Dental



The Wellness to Smiles pilot program addresses barriers to nutritious affordable food, housing, and oral health by improving the collaboration between oral health care and social services in Lincoln County. The primary goal of the pilot is to coordinate systems among community partners to reduce health disparities and improve oral health and overall health outcomes for IHN-CCO clients.

Health Outcomes:

- Increase oral health usage.
- Screenings for SDoH and referral system developed.
- Improved member satisfaction.

Sustainability: If successful, Advantage Dental will continue to provide services.

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