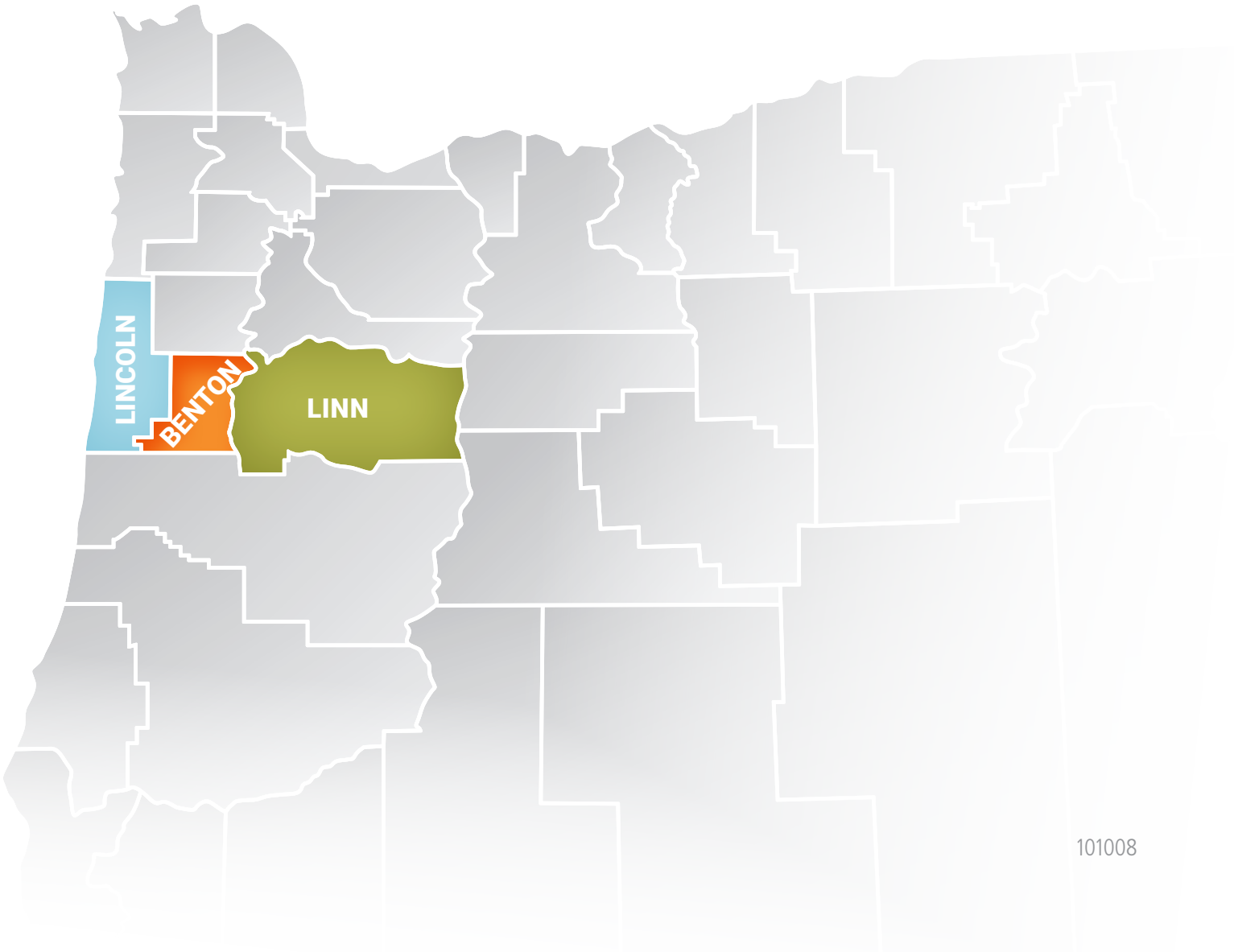
InterCommunity Health Network CCO

IHN-CCO Delivery System Transformation
Pilot Progress Reports

January to June 2020



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Beck Johnson

BRAVERY CENTER

Summary

Bravery Center is an open, accepting environment where youth can access mental health, educational, vocational, mentorship, and other community resources.

Bravery Center promotes health equity and addresses issues regarding social determinants of health among the lesbian, gay, bisexual, transgender, queer, intersex, asexual, two spirit, and the many other facets of the broader queer community (LGBTQIA2S+) youth in Lincoln County.

Bravery Center offers 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 such as hormone replacement therapy or gender confirmation surgery.

- Reporting Period: January 2020 to June 2020
- Budget: $150,075
- Partners: Olalla Center for Children and Families, Samaritan Health Services, Lincoln County Health and Human Services, Parents and Friends of Lesbians and Gays (PFLAG), Central Oregon Coast Trans Community (COCTC)
- Highlights
  - Youth Action Committee, local leadership roles, and gender equity trainings
  - Learning experience: Adapting outreach and services to digital platforms

Successes

Despite the challenges presented by COVID-19, Bravery has started to create waves in Lincoln County

- Member of the Lincoln County PFLAG board of directors
- Member of the Gender Health Community Network
- Member of the Lincoln County Transgender Health Task Force
  - A trans healthcare summit is being planned for 2021
- Partnership with Central Oregon Coast Trans Community for trans support groups and resources
- Established steering committee and youth action committee
- Community outreach meetings
- Regular virtual support groups for LGBTQIA2S+ youth
  - Safe social space, support, connection to resources
- Trainings for local educational institutions, regional organizations and workgroups
- Identified affirming healthcare and mental health providers in Lincoln County
- New partnerships with local and regional activists, organizations, and workgroups

Challenges

COVID-19 has presented unique challenges for Bravery due to the constraints around conducting in-person events, outreach, and services.

- Space has been identified, but Bravery is currently unable to move forward due to concerns over COVID-19
- Difficult to contact youth
- Limitations of virtual platforms
  - Currently unable to provide meals
- Many healthcare providers and service agencies are (understandably) focused on COVID-19

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
EQUITY: Lack of resources for LGBTQ+ youth	Participation numbers, tracking activities, clinical data.	Bravery Center open and providing services to LGBTQ+ youth.	June 2020	Presence on the PFLAG board of directors (Jan 2020) Community Conversations outreach activities (Jan-Feb 2020) Lincoln County School District GSA outreach (Feb-March 2020) Began virtual support groups (April 2020) Established Youth Action Committee (April 2020) Began trans support groups in partnership with COCTC (June 2020) Virtual Pride celebration (June 2020)
EQUITY: Lack of identified LGBTQ+ affirming healthcare providers	Track outreach activities, seminars/workshops, provider surveys.	Identified LGBTQ+ healthcare providers, training/outreach to healthcare providers on LGBTQ+ health equity.	December 2020	Member of the Lincoln County Transgender Health Task Force (Winter 2020) Transgender Health Basics training for IHN-CCO Administrators Gender Health Equity training for the DST (May 2020) Gender Health Equity training for DevNW (June 2020) Lincoln County trans healthcare provider identified (May 2020) Gender Health Equity training for Linn-Benton Health Equity Alliance (June 2020)
SOCIAL DETERMINANTS OF HEALTH: Food insecurity within LGBTQ+ youth population	Youth surveys, tracking number of meals, monitoring food pantry.	Reduced food insecurity within LGBTQ+ youth population.	December 2020	No progress to report.
SOCIAL DETERMINANTS OF HEALTH: Homelessness within LGBTQ+ youth population	Youth surveys, data from CSC housing assistance.	Reduced homelessness within LGBTQ+ population.	December 2020	No progress to report.

Sustainability

- Mental health services will begin summer 2020
    - An affirming mental health provider has been identified to begin to provide individual, group and family services for Bravery youth, as well as LGBTQIA2S+ adults
- Training/speaking fees
- Bravery held its first successful fundraiser in winter 2020
- Grant funds received from the Trinity United Methodist Women's Group and Linn-Benton Health Equity Alliance
- Additional grant funds pending from Pride Foundation, WayOut, Funding Queerly, Hollyfield Foundation, and Coil Foundation
- Donations from individuals and local businesses

Conferences and Presentations

Date	Presentation	Details
2/11/2020	Issues in Queer & Trans Healthcare	Samaritan IHN-CCO Administrative Team - Corvallis, OR Collaborated with COCTC to provide training around queer and trans basics (e.g., language and pronoun usage), as well as specific issues facing queer and trans people in the healthcare system
3/9/2020	Supporting LGBTQIA2S+ Students	Career Tech Charter School - Lincoln City, OR Provided “LGBTQIA2S+ 101” training to academic and administrative staff to broaden understanding on topics such as terminology and pronouns, build queer equity, and help them better serve and support their LGBTQIA2S+ students
5/14/2020	Gender Health Equity Training	IHN-CCO DST - Webinar Collaborated with local and regional members of the trans community to provide training on language, pronouns, transgender identity, and equity issues related to the healthcare system
6/24/2020	Gender Health Equity Training	DevNW - Webinar Collaborated with local and regional members of the trans community to provide training on language, pronouns, transgender identity, and equity issues related to housing and other social services

Stories from the Field

Our community had been hard at work to plan a pride celebration, but it had to be cancelled due to COVID-19. That didn't stop the festivities, however!

Bravery stepped in and held "Together Apart 2020," a virtual pride celebration. The all-ages event was truly something special! It was a relatively small gathering, but the day was filled with wonderful conversation, support, and joy. We even had early afternoon tea with a wonderful drag queen from Eugene, who graced our Zoom screens with her glittering style and warm charm. A member of the community bravely shared poems she had written about her experiences that were both beautiful and heartbreaking.

Though everyone in attendance was different - different ages, backgrounds, identities and experiences - there was a sense of connection and community that lingered long after the party was over.

Questions and Discussion

Presenters

Community Doula

Summary

Facilitates the recruitment, training, and reimbursement of birth doulas to serve pregnant members of IHN-CCO

Birth doulas build trusting relationships with pregnant people and provide physical, emotional, and informational support during labor and birth

The Community Doula Program builds relationships and strengthens connections with providers and key stakeholders, recruits and trains trusted community members, and connects doulas to pregnant people

- Reporting Period: January 2020 to June 2020
- Budget: $74,750
- Partners: Heart of the Valley Birth and Beyond, Oregon State University
- Highlights
  - IHN contract & billing hub
  - Completed aim 1
  - COVID response - parenting group & doulas as team leaders in Trace project
- Learning experiences
  - 12 hour training on diversity, equity, inclusion & reproductive justice

Successes

- IHN contract and billing hub.
- Completing aim 1 – trained 20 new doulas (fluent in 8 languages, including English)
- Launched new website
- Pandemic parenting, strengthened partnerships with Healthy Families, Pollywog, Samaritan Health Services
- Task shifted traditional health workers to participate in Oregon State University's COVID -19 Trace project
- Moved to tele-health visits for Community Doula clients
- Data analysis for phase 1 underway
- Partnership with It's on Us Corvallis – Provides free meals twice a week.
  - Free cupcakes on Mother's Day to CDP clients and doulas

Challenges

- Moving from pilot to a sustainable organization
- Establishing billing hub and being reimbursed for doula services
- COVID-19 resulted in significant decrease in referrals to the doula program
- Doulas unable to provide in-person labor support for 8 weeks
- Telehealth / remote prenatal and postpartum visits. Decrease in postpartum visits
- Trainings cancelled due to Covid: doula training, Pollywog training, Healthy Families Training, Safety in home visiting, CPR, etc.
- Traditional Health Worker application delays from Oregon Health Authority

Goals

Goal	Measure	Methodology	Frequency	Definition of Success	Progress to Date
Double the number of Spanish speaking doulas trained.	Increase from 9 to 18.	Relationship oriented recruitment (e.g. PTA meetings), established CDP training.	1 full round of THW: Doula training conducted	10-20 actively serving Spanish speaking doulas, expanded community contacts.	Completed.
Train 6 multi-lingual doulas as State Qualified or Certified Health Care Interpreters.	Cross train 6 doulas.	Use current State approved translation course, support doulas through credentialing, provide administrative support as they establish their services.	To be evaluated mid program and at conclusion.	4-6 credentialed Health Care Interpreters.	Task shifted due to COVID-19 – Pandemic Parenting.
Community College Curriculum development and partnerships.	Development of standardized and comprehensive course of study for THW: Doula certification.	Convene working group to explore feasibility and coordination with existing curricula, Develop curricula for state approval.	To be evaluated mid-program and at the end of program.	Workgroup formed, curricula developed and approved, plan established for first cohort.	Diverse workgroup formed. Draft curriculum created. Community stakeholder feedback provided. Curriculum being revised.

Sustainability

- New website has donation button
- Submitted letter of intent to delivery service transformation
- Interns
- Responded to request for information from Medicaid and Medicare services about rural healthcare
- Grant writing, ongoing
- Doula training curriculum being developed for community colleges
- Set up Amazon Smile account
- IHN contract for doula services

Conferences, Presentations, Papers, & Outreach

Date	Conference	Details
January 2020 February 2020	Doula training	In-home Visiting Safety HIPAA Trauma Informed Care Interprofessional Collaboration New Doula Training
June 2020 February 2020 April 2020 June 2020	ACNM National Academy American Medical School Conference Questionable ethics about the lack of doula care AMSA Reproductive Scholars Program	Doulas & Birth Settings in America Doulas & Birth Settings in America Doulas & Birth Settings in America Journal of obstetric gynecologic & neonatal nursing, in press Doulas & Birth Settings in America
May – June 2020 May 2020	OSU College of Liberal Arts Synergies magazine	Social Justice Works project that is centering the Community Doula Program as its pilot project Trace Project A Partnership Rooted in Purpose

Stories from the Field

“I worked with a CDP doula today, she was so great with my patient, this young girl with very few resources and no one else to be with her. The doula was so clearly filling the mission of the Community Doula Program. I was grateful that this young girl had her to connect with.

We had another CDP doula helping a patient in another room. How wonderful to have them. I hope that it just becomes more and more.” L&D Nurse

For 8 weeks during the pandemic, doulas were not able to attend births. The first week they were allowed back into the hospital, doulas attended 4 birth in 2 days. Clients, nurses and staff all expressed deep gratitude for their presence.

Questions and Discussion

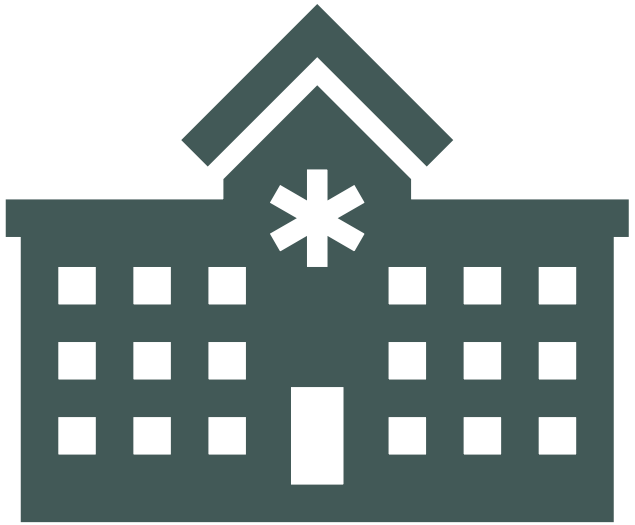
Presenters

Homeless Resource Team

Summary

Creates a Homeless Resource Team including a case manager, Health Navigator, and Homeless and Vulnerable Patient Committee to achieve the following goals:

- Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions
- Increase primary care utilization decrease emergency department utilization among homeless adults with chronic medical conditions
- Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.



- Reporting Period: January 2020 to June 2020
- Budget: $188,075
- Partners: Samaritan; Benton County Health Services; Corvallis Housing First; Community Services Consortium; CHANCE
- Highlights
  - Improved coordination between partners
  - Samaritan hired a Licensed Clinical Social Worker to expand homeless outreach capacity

Successes

- Placed 15 individuals in the COVID-19 RV/Car Camping Program at the Benton County Fairgrounds
- Placed 10 medically vulnerable and/or over 65 years of age individuals in the COVID-19 Hotel Sheltering Program (with CHANCE Recovery)
- Assisted >80 individuals with getting access to their CARES Act stimulus payments
- Addressed emergency shelter needs related to COVID by placing 6 individuals in microshelters and additional individuals in hotels
- Ongoing integration with Good Samaritan Hospital and Emergency Department to provide support and education to staff

Challenges

- COVID-19! Outreach efforts were paused for a while but have now resumed. Unique challenges faced by the homeless population include access/assistance with stimulus checks; ensuring access to transportation, hygiene (including access to masks and keeping reusable masks clean), computers/wifi, etc when community services closed. There has also been an increase in RV/car campers from other jurisdictions.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Document all IHN-CCO members served by the pilot.	IHN-CCO members served by the pilot.	Tracking document with member IDs and dates served.	Quarterly	Submit documentation to IHN-CCO Transformation.	98 IHN-CCO members served since Jan 2019
Actively participate in at least one DST workgroup; DST recommends Social Determinants of Health.	Attend either by phone or in person.	Workgroup sign-in sheet.	Monthly	Active participation in workgroup by pilot representative.	Pilot representative participates in the Social Determinants of Health workgroup
Facilitate placement into permanent supportive housing.	A) Proportion of adults served who are placed into permanent housing. B) Proportion of adults served with one or more barriers to housing resolved.	Tracked by the pilot staff and partners.	Quarterly	A) 25% of adults served will be placed into permanent housing in the project period B) 50% of adults served will resolve one or more barriers to housing.	A) 46% (45/98) of patients were placed in temporary housing; 17% (17/98) were placed in permanent housing. B) 82% (80/98) resolved one or more barriers to housing.
Increase use of primary care services.	A) Number of primary care visits before & after engagement with the pilot (for patients served). B) Trend in number of primary care visits among the homeless population as a whole. C) Trend in number of primary care visits among all Samaritan patients.	A) Number of primary care visits with SHS providers in the 12 months prior to contact and 12 months after contact. B) Number of primary care visits with SHS providers per month for all homeless adults. C) Number of primary care visits with SHS providers per month for all adults.	Quarterly	A) Increase in frequency of primary care visits after contact with the pilot. B/C) Reduce the difference in primary care utilization between homeless patients and SHS's whole patient population.	Final data will be available for pilot closeout presentation

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Decrease emergency department (ED) use.	A) Number of ED visits before & after engagement with pilot (for patients served). B) Trend in number of ED visits among the homeless population as a whole. C) Trend in number of ED visits among all Samaritan patients.	A) Number of SHS ED visits in the 12 months prior to contact and 12 months after contact. B) Number of SHS ED visits per month for all homeless adults. C) Number of SHS ED visits per month for all adults.	Quarterly	A) Decrease in frequency of SHS ED visits after contact with pilot. B/C) Reduce the difference in SHS ED utilization between homeless patients and SHS's whole patient population.	Final data will be available for pilot closeout presentation
Improve primary care providers' knowledge and sensitivity about providing care for homeless adults.	Primary care providers will report more knowledge of the issues related to providing care to homeless adults and available resources for support.	Survey evaluations will be completed after each training (Continued Medical Education events and didactics for primary care residents).	After each training.	Positive evaluations, including reported improvements in knowledge.	Licensed Clinical Social Worker gave a presentation to medical residents about cultural competencies related to the local homeless community
Improve drug adherence rates.	Primary care clinic coordinators, Hospital case manager and hospital Licensed Clinical Social Worker (LCSW) will work directly with the patients, in contact at least once per month and seen once quarterly.	Quarterly Aegis drug testing.	Monthly and Quarterly	Quarterly Aegis drug testing demonstrates positive adherence.	This analysis will take place after the pilot project period
Decrease incarceration rates.	Primary care clinic coordinators, Hospital case manager and hospital LCSW will work directly with the jail nurse to monitor/track rates of patients served and their incarceration.	Number of patients served by the pilot and the rate of those that have been incarcerated in the past and their current rate.	Quarterly	Reduction in incarceration.	Final data will be available for pilot closeout presentation

Sustainability

- We successfully negotiated ongoing support for a permanent Licensed Clinical Social Worker position at Samaritan to be focused on homeless outreach; this position is paid partially by the Samaritan Care Hub and partially by Samaritan Health Plans.
- Regular meetings between Benton County Health Department and Samaritan Health Services related to homeless outreach and care are ongoing
- Homeless and Vulnerable Patients Committee continues to meet monthly with broad participation from community partners

Conferences and Presentations

Date	Conference	Details
7/3/20	Presentation to medical residents at the South Town Food Cooperative	LCSW presented new medical residents with cultural competencies related to the local homeless community.

Stories from the Field

- We were notified from a community physician that a recently relocated lung transplant patient was now homeless as the lodgings he reserved when moving to this area had black mold. His lung transplant team told him that mold and smoking neighbors were both situations that endangered his lungs and they recommended that he evacuate immediately. His primary care provider was very concerned as this patient is low income, couldn't pay for a prolonged hotel stay and needed to hunker down as COVID had just hit our area. We were able to get him into medical respite and then negotiate transitional housing options (as well as new glasses and dentures). We also provided a warm hand off to mental health and maintained caring contacts once a week for three months to help with his anxiety and to combat the obvious loneliness that comes with being waylaid far from family or friends. He describes us as "angels" and his lung transplant team offered the same moniker. J
- We have a gentlemen who is a new diabetic and living in a tent. He has had at least 7 Emergency Department visits in two months. We were alerted to concerns about his welfare from Emergency Department staff. We were able to get him into the Men's Winter Shelter and then provide a diabetes nurse educator to visit twice weekly. We also provided diabetic supplies and arranged for a warm handoff to a new primary care provider who was able to build positive rapport. Since these interventions he has stabilized and has not returned to the Emergency Department.
- We helped a terminally ill and chronically unhoused man negotiate the healthcare system to obtain hospice assistance. We met him in the Emergency Department, requested palliative evaluation, reached to estranged family members and helped him articulate his desire to receive hospice help. He was then placed in the Evergreen Hospice House.

Questions and Discussion

Presenters

HUB CITY VILLAGE

Summary

Hub City Village provides the infrastructure for a tiny home village to address the shortage of affordable housing in Albany

The village will include health navigation services to provide stable, permanent, residence to individuals or families

- Reporting Dates: January 2020 to June 2020
- Partners:
  - Creating Housing Coalition
  - Linn County Mental Health
  - Albany Area Habitat for Humanity
  - CHANCE
  - Square One Villages
  - Pinnacle Architecture
- Budget: $67,499
- Highlights
  - Fund raiser
  - Beautiful website
  - Partnerships
- Learning
  - Choose carefully
  - COVID
  - Momentum

Successes

- Had our first community fundraising event
- 165 attendees
- $20,000 raised
- 7 additional presentations before Covid
- Website up and running
- Partnership Building

Challenges

COVID related Issues:

Lost Program Development Chair

Cancelled presentation to PEO Sisterhood and others

Marked loss of momentum – general mtg attendance

Other challenges:

Change in Web designers

Measures

Specific Measurable Attainable Relevant Time-Bound	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By
	Need to develop policy and procedures.	Consult with lawyers, city planning, partners, etc.	Written policy and procedures to guide CHC in creating stable framework.	In Progress
	Need to choose clients who will reside in village.	Consult with health partners for referral recommendations for village occupancy.	Defined referral process based on health needs and income.	Referral process in progress.
	Need village governing/norm policy.	Consult with partners.	Written policy and increased community confidence in project.	Some information on website. Policy's in progress.
	Expand community partners.	Recruit health and construction partners.	Increase partners from five to 25.	Have 15 partners in place.
	Design print promotional materials.	Design and print promotional materials.	Business cards logo, brochures printed for promotion of CHC.	3/2020
	Design visual and video promotional materials.	Hire videographer Establish on-line presence.	Video produced and on-line presence in place for promotion and procuring donations.	5/1/20 for website Videographer hired and waiting.

Sustainability

We are laying the groundwork for a village community that will sustain itself through the financial and self governance structure created in this process of development.

Individuals are stabile because the rent is proportional to their income. A community land trust (CLT) contracts for the land use as designated. A not-for-profit housing cooperative keeps costs minimal.

House size, solar power and community gardens contribute to the small environmental footprint. Transportation will be minimized due to site location and relation to other services.

Social capital enables residents to reduce their own consumption needs and increase interdependence through cooperative engagement and skill development. Mental and physical well-being increase and a peer trained health navigator provides the bridge to community health resources.

Conferences and Presentations

Date	Conference/Presentation	Details
2/29/20	Doing More Good Nonprofit Conference Corvallis, OR	8 CHC members attended various workshops on fundraising, grant application, board member training, etc.
1/6/20	Helping Hands Shelter Presentation	CHC President presented project and answered questions and (71 attendees)
1/17/20	KGAL radio interview	CHC President and VP interviewed and promoted January 30 Fundraiser in a one hour radio interview
1/28/20	Optimists Presentation	CHC President shared about project, fundraiser and answered questions of group (20 attendees)
1/30/20	Community Fundraiser	CHC President, Program Chair and guest give speeches (165 attendees)
2/14/20	Friend of the Library (Albany)	CHC President and Outreach Chair give presentation and answer questions (65 attendees)
2/17/20	City Development Block Grant (CDBG) follow up (Albany City)	CHC President, Land Development Chair and Habitat Partner responded to questions of board (12 attendees)
2/24/20	Greater Albany Public School Board Mtg	CHC President, Land Development Chair and Habitat Partner presented proposal for school district property (17 attendees)
3/11/20	Emerald Village Tour	CHC President, School Board Member, CHC member tour Emerald Village Eugene, OR (3 attendees)

Stories from the Field

- A surprise at the Helping Hands presentation was how many homeless persons had been in the construction trades and wanted to help make this happen.
- At our Friends of the Library presentation, we had a great turnout with thoughtful questions from the audience that kept us talking for an hour
- Pinnacle Architecture heard about us through our partner Habitat and created a site sketch for us pro bono
- A member of First Christian church jumped on board and connected us to many other partners
- We are looking at our goals in the light of COVID and the likely increased affordable housing need

Questions and Discussion

Carissa Cousins, M.D, MPH

Amy Hamann, B.A.

Michele “Capri” Roberts (Kirkpatrick) R.N.

Integrated Foster Child Wellbeing

Summary

Develop a model of care to achieve the mission of the program of coordinating care for high-need foster children

Key components are coordinating services, intensive care coordination, and establishing sustainability

- Reporting Period: January 2020 to June 2020
- Budget: $223,177
- Partners: Samaritan, IHN-CCO, DHS, Old Mill, Linn County Mental Health, Dental Care Organizations, Every Child
- Highlights
  - Ramping of care coordination services after a year of planning
  - Multiple partners and complex systems make, appreciative of partners' willingness to assist and be flexible as we grow

Successes

- Data collection via tracking.
- Partners have found the weekly summary meetings helpful in determining unmet needs and gaps.
- Community partners coming together with coming goal.
- Care coordinators have notebooks for all children coming into care. Notebooks contain important information for each child and the notebook follows the child on their journey. Quote from foster parent "*I've had a lot of foster kids and I've never had anything like this. It is so helpful in keeping everything organized."*
- Surge in cases in May, went smoothly
- Of the children who qualify for the metric 94% have met the metric (Linn and Benton, since December 2019 when Care Coordination started)

Challenges

This program involves multiple partners each with competing priorities. We continue to work with partners in the most efficient manner.

Solving/resolving gaps: Insurance, notification (OHA)

Establishing program in Lincoln County

COVID pandemic postponing meetings

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Assess needs of foster families and foster children.	Number of families and children participating in the assessments of needs.	Focus groups and surveys to foster families.	To be completed in the first quarter.	Completion of focus groups and surveys.	Focus groups for foster parents held. Due to lack of interest, foster youth group was not held. Summary report generated from the focus groups and available upon request. On-line survey completed in December, summary report available upon request. Results will help guide program development and services.
Assess medical providers, mental health providers, dental and developmental providers needs and capabilities.	Number of providers from each field participating in needs/ capacity assessments.	Planned meetings with medical, mental health, dental and developmental/ educational providers.	To be completed in the first quarter.	Completion of meetings, structed feedback that will guide development of model/s of care.	Pediatricians in the valley prefer to remain the child's PCP with assistance from a child abuse/ foster care expert for children with more complex needs or who do not have an established PCP, preference to have a care coordination team specifically for foster children. Assessment regarding needs at the coast is ongoing. Meetings with multiple clinics to discuss integration of foster child care coordination into their individual clinic system.
Establish tiered level of care system.	Tiered levels of care created.	Examine existing needs in all domains for children in care, determine levels of needs for services.	To be completed in the first/second quarter.	Tiered levels established.	Exploring existing tiering systems, evaluating growing cohort and assessing needs.
Determine medical, mental health, dental needs, developmental assessments and current capacities and alternative strategies.	Number of medical, mental health, dental and developmental assessments that need to be completed on average monthly.	Analysis of existing cases integrated with tiered levels of care.	To be completed in the first/ second quarter.	Number of medical, dental, mental health and developmental assessments needed per month on average established.	Approximately 10 children in each Linn and Benton County come into care per month, average of 5 children per month in Lincoln County, needing initial medical and dental appointments within 30 days and mental health within 60 days. Approximately 450 children (300 in Linn and Benton and 150 in Lincoln) who would benefit from care coordination.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Establish parenting support system (biological and foster).	Formalize parenting support for foster and biological families in all three counties.	Define need and establish formal relationships with Family Tree Relief Nursery, Olalla Center and Old Mill to provide parenting support, work with IHN-CCO and the Department of Human Services (DHS) to establish reimbursement for these services.	To be completed in the second quarter.	Defined relationships, Memorandums of Understanding (MOUs) and/or contracts established.	Development of a SOC Workgroup for Youth and Children in Foster Care that will work on developing a shared vision for youth in foster care based on the Collective Impact Model. Explore existing services and develop partnerships to deliver most effective services (meeting postponed due to COViD pandemic).
Determine most effective billing strategy for medical, mental health, care coordination.	Effective, sustainable billing/ payment strategy established.	Explore various options for reimbursement/ payment for services based on model/s selected.	To be completed in the third quarter.	Billing/ payment strategies established to ensure sustainability of services.	Discussions with IHN-CCO and Samaritan Health Plans regarding payment for services. Contract in draft form.
Determine staffing needs and write job/ role descriptions.	Roles, care team time needed to provide services established, roles and responsibilities established.	Based on information gathered earlier in pilot, the roles and staffing needs will be established.	To be completed in the third quarter.	Defined roles, service hours needed to provide care and care- coordination.	Most programs have a care coordinator to foster child ratio or 1:250. Care coordinators hired, initial training completed, continuing with education . Ongoing assessment of staffing needs, efficiency.
Establish locations for providing services.	Defined location/s for providing services.	Work with existing facilities, including mobile unit, do determine most appropriate, accessible locations for services.	To be completed in the third quarter.	Established location/s for services.	Determined that children should be seen in their medical home if established. If not established, or needing to change, care coordinators are working with families and physicians for optimal placement.
Write clinic protocols, including scheduling, intake, case management, confidentiality, transitions.	Defined intake process, return on investment (ROI) processes, scheduling, requirements for comprehensive case management for children in care and transitioning out of care.	Will using existing resources from other foster care programs to develop protocols, state laws to define ROI and confidentiality protocol, case management for children in care and transitioning out of care.	To be completed in the third quarter and revised as needed.	Established protocols, scheduling management, confidentiality guidelines and case management.	Protocols and templates being developed. Ongoing discussion regarding ROIs, MOUs, BAAs regarding care coordination and privacy concerns.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Determine best methods to obtain medical records (Primary Care Physician [PCP] assignment and visits/oral health assignment and visits/mental health visits) in a timely manner for all IHN-CCO members served by the pilot.	Within 72 hours of notification, the following data is provided to the pilot from IHN-CCO: PCP assignment Last PCP visit Oral health physician and last visit Mental health visits Any other applicable health information.	IHN-CCO claims and membership data.	As needed.	Pilot receives PCP/Oral/Mental Health information from IHN-CCO for 100% of IHN-CCO members within 72 hours.	Partners meeting to discuss the timely notification of placement of children in care. Contacts within DHS established for information sharing. Weekly meetings with care coordinators, DHS, Mental Health, IHN-CCO and DCOs.
Determine most effective case management tool.	Management tool chosen.	Explore existing case management tools and determine the most appropriate for this program.	To be completed in the third quarter.	Case management tool chosen.	On-going discussions with RHIC, IHN-CCO and SHS, Epic team on most effective case management system.
Establish MOUs and contracts with partner agencies	MOUs/ contracts completed with partner agencies.	Involve SHS contracts/ legal department and reimbursement to establish contracts/ MOUs with partner agencies.	To be completed in the third quarter.	MOUs, contracts signed.	Initial discussion with DHS and IHN-CCO regarding communication MOU as well as SHS and DHS MOU regarding communication. Exploring need for Business Associates Agreement (BAA) for information sharing.
Establish metrics that will be measured.	Defined measurements for care team members, foster parent, foster child and partners established, defining satisfaction with services. Define health outcomes to be measured.	Investigate other foster care programs exploring what metrics and outcomes are measured, define measurements for this program, determine how this will be tracked.	To be completed in the third quarter.	Defined metrics of satisfaction of services and health outcomes.	Basic metrics are established. Pre-implementation survey completed with plans to repeat survey 2 years after implementation.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Develop templates in Epic, discrete fields for data tracking.	Defined templates for initial, comprehensive and follow up medical visits established in Epic as well as case management templates.	Work with care team, investigate existing templates used by other programs, define discrete fields for data tracking.	To be completed in third quarter.	Defined templates for medical visits, care coordination.	Working with Epic team on developing templates so that information can be extracted to spreadsheets to be shared with agencies; thereby reducing the need for multiple agencies collecting the same information (currently paused due to COVID efforts).
Trauma informed training for staff, self-care.	All staff trained in trauma informed care (TIC).	Determine most appropriate training for all staff not currently trained in TIC, have staff trained.	To be completed in second and third quarter.	All staff have received training in TIC.	Care Coordinators trained in TIC, on-going training anticipated.
Develop post visit evaluations.	Post- visit survey for foster parents, foster children and biological families defined.	Work with survey developer to most appropriately select information to be collected on post visit surveys.	Survey to be completed in the third quarter.	Defined surveys for appropriate services.	We will be repeating the on-line survey in two years to see if progress has been made regarding care coordination and communication.
Foster children cared for in clinic.	Number of children seen in clinic and participating in the care-coordination program.	Work with DHS in at least one county to have children seen in at least one location, following the implementation, we will review sustainability and perform ongoing Plan Do Study Act (PDSA) cycles.	To be done in fourth quarter.	Number of children cared for by IFCW program.	Care coordinators began providing services at the beginning of December, >100 children and families have been provided care coordination services.

Sustainability

- Working with SHS and IHN-CCO on payment methods
- Exploring billing options for care coordination services

Conferences and Presentations

Details	
Over the past 6 months, the care coordination team has presented the program at almost all primary care clinics that see pediatric patients.	

Stories from the Field

- I love having someone we can reach out for these sort of questions. Much appreciate. (Clinic nurse)
- “Dr. Cousins is great with follow up on high risk children. As a foster parent this was crucial to hear and know they listen to foster parent concerns.”
- The work you are doing is inspiring and such a gift to our communities. It reminds me to keep you in my thoughts as you're battling on the front lines. (Community Partner)

Stories from the Field

- Foster Parent: *Your support is amazing, I see such a difference from the last time I fostered a child. I feel so much more supported with your help and the resource you are giving me with every child. Even the pediatrician and staff have been very helpful this time.*

- *This is such a great service. Thank you!* (DHS worker)

Questions and Discussion

Presenters

Navigation to Permanent Supportive Housing

Summary

Develop Permanent Supportive Housing targeting the gap areas due to federal regulations around homelessness

Enhances existing projects within the housing continuum with a more robust referral system hub supported by the current and expanding cohort of partners involved

- Reporting Period: January 2020 to March 2020
- Budget: $124,516
- Partners:
  - Capri Architecture
  - CHANCE (Communities Helping Addicts Negotiate Change Effectively)
  - Community Services Consortium
  - Confederated Tribe of the Siletz Indians
  - Hispanic Network (HispNet)
  - IHN-CCO
  - Lincoln County
    - Board of Commissioners
    - District Attorney
    - Health & Human Services
    - Housing Authority
    - Parole and Probation
    - Sheriff's Office
    - Veterans' Service Office
  - Northwest Coastal Housing (NWCH)
  - Reconnections Counseling
  - Samaritan House
  - Samaritan Health Services
    - Samaritan Pacific Communities Hospital
    - Samaritan North Lincoln
  - Powerhouse
  - AA/NA
  - Discovery Counseling
  - Crossroads
  - Senior and People with Disabilities Services
  - Lincoln County Courts
    - Mental Health Court
    - Drug Court
  - Grace Winds Day Shelter
  - Oregon Coast Community College
  - Worksource Oregon
  - Phoenix Wellness Center
  - NAMI – National Alliance on Mental Illness
  - COHO – Community Outings Healthy Options
  - Helping Hands
  - Presbyterian Church

- Highlights of the Quarter
  - Community Collaboration
  - Initiation of complementary programs
  - Planning resources are challenging in small communities where people are focused on service delivery.

Successes

- Strong Vision established
- Consultant hired

Challenges

Staff changes in key partner agency

Limited availability from small agencies for planning meetings

COVID-19

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
N/A	Document all IHN-CCO members served by the pilot.	Tracking completed.	12/31/2020	No clients served to date.
N/A	Actively participate in at least one DST Workgroup.	Attendance high.	12/31/2020	No meetings attended to date.
Permanent Supportive Housing Cohort with siloed services	Regular meetings; increased number of community partners for wrap around services.	Identify and network development of community partners for wrap around services.	12/31/2020	Partners identified and network in development.
Existing higher functioning supportive housing	Beta Test of existing supportive housing projects.	Improved care coordination of housing/social services with the PCPCH clinical care.	12/31/2020	Framework in development states.
Community Partners providing independent services	Regular meetings; increased number of community partners for wrap around services.	Formalize Care Coordination Partnerships.	3/31/2020	Meetings and engagement underway with strong participation, slow down due to COVID19 response.
Sheriff's Office convener of Permanent Supportive Housing Cohort	Regular Meetings; Strategic Planning.	Assessment of Needs, Data Sharing Operations, MOU Development.	6/30/2020	In infancy stage, framework in development.
Discussion of aligned referral process	Strategic Plan; MOU development.	Implementation of referral process; Formalize care coordinator contracts.	9/30/2020	Not developed to date.
Identification of strategy, goals and outcomes	Goal evaluation	Assessment of outcomes, process evaluation to develop long term implementation plan.	12/31/2020	No serviced delivered to clients for evaluation to date.

Sustainability

- Partnership MOUs to deliver wrap around services
- Client engagement
- Case management

Conferences and Presentations

Date	Conference	Details

Stories from the Field

- N/A

Questions and Discussion

Presenters

Peer Wellness Specialist Training

Summary

Expands and integrates the existing collaborative partnerships of the Traditional Health Worker (THW) community in the tri-county area by building upon previous pilots and work of the THW Workgroup

Focuses on design, creation, accreditation, and delivery of a certified training course for Peer Support Wellness Specialists

- Reporting Period: January 2020 to June 2020
- Budget: $118,680
- Partners:
- Highlights
  - Curriculum revised and resubmitted for credentialing
  - COVID-19 and group meeting size may impact delivery of training once curriculum credentialed.

Successes

- Curriculum feedback received from Office of Equity and Inclusion
- Curriculum revised as noted in denial notice by Family Tree Peer Support Supervisor and Executive Director
- Revised curriculum documents submitted to the Office of Equity and Inclusion on June 30th

Challenges

- The application process through the Office of Equity and Inclusion includes broad topics required but lacks the specific details the evaluators require which makes it more challenging to know what part of large topics to include.
  - COVID-19 made it more challenging to collaborate on curriculum development when working offsite .
- With community partners focused on COVID-19 in the last 90 days, it has been challenging to move forward planning on when and where to hold training sessions once the curriculum is approved.

Goals

Goals	Measure(s)	Methodology	Frequency	Definition of Success	
THW Subcommittee will engage at least 2 agencies, working with IHN-CCO members in need of PWS services, in developing a plan utilizing PWSs in their communities	Identification and engagement of 2 new agencies working with identified populations that are interested in using PWSs in service delivery.	Analysis of community agency needs assessment; # of contacts with agencies, # of face-to-face meetings, # of verbal and written commitments from agencies, # of new agencies attending THW workgroup.	Analysis of assessment- one time agency contacts- traced monthly, reported quarterly.	2 new agencies working with the THW workgroup to develop a plan for using PWS in service delivery.	• Waiting for credentialing from the Office of Equity and Inclusion to make further plans on delivery. • Spoken with CHANCE and shared opportunity for their Peers once curriculum is credentialed.
Actively participate in at least one DST workgroup; DST recommends Traditional Health Worker workgroup	Attend either by phone or in person.	Workgroup sign-in sheet.	TBD	Active participation in workgroup by pilot representative.	• Executive Director of Family Tree Relief Nursery attending DST meetings. • Community Engagement Specialist with Family tree attending DST Meeting. • Executive Director of Family Tree attends Traditional Health Worker Workgroup meetings.
Create and submit a curriculum for PWS training course for certification	Create curriculum.	Curriculum accreditation application.	At completion.	Completed curriculum.	• Version 2 of curriculum completed.
	Submit curriculum for accreditation.	Oregon Health Authority (OHA) accreditation certification received.	When received.	Certificate of accreditation.	• Version 2 of curriculum submitted for evaluation and accreditation.
Two state-approved PWS workshops will be completed, one in Benton or Linn County and one in Lincoln County	Completed PWS training workshop in Linn-Benton County.	Data from workshop, # of attendees, course evaluations.	Each workshop.	Two workshops completed, one in Benton or Linn County and one in Lincoln County.	• Waiting to schedule once curriculum credentialed. • Analyzing ability to deliver training virtually due to COVID-19.
	Completed training workshops in Lincoln County.	Data from workshop, # of attendees, course evaluations.	Each workshop.		Same as above.
20 attendees will have completed local state-approved PWS workshops and be eligible to apply for enrollment into the state THW registry by OHA	# of certified PWS who have completed a local workshop.	Data from workshops, # of attendees who successfully receive completion certificate.	At end of each workshop.	20 PWSs trained in Benton, Lincoln, Linn Counties.	Not achieved yet.

Sustainability

- Training will be provided by Family Tree Peer Team and direct costs of supplies will be supported through registration fees.
- Family Tree has collaborated with Benton County Health Services and gleaned information and best practices from their experiences in delivering their Community Health Worker training.

Conferences and Presentations

Date	Conference	Details
	None to date	

Stories from the Field

- None at this time

Questions and Discussion

Presenters

Skills and Connections to Support Housing

Summary

Support Housing pilot is implementing a program to increase the skills, knowledge, and confidence of residents to help permanently break the cycle of homelessness and increase their self-sufficiency and well-being

The end result will be greater stability for residents and less incidence of expensive services and offer a template for increasing Permanent Supported Housing for our community

- Reporting Period: January 2020 to June 2020
- Budget: $49,929
- Partners: Samaritan Health Services Homeless Vulnerable Team, Safe Place/Unity Shelter, Benton County Harm Reduction Team
- Highlights
  - The pandemic has totally changed our strategies
  - We are providing case management and skills training one-on-one to people in housing and in micro-shelters, managed camping
  - We are prepping for doing class videos and virtual meetings with residents and will be distributing Chrome Books for this purpose. First videos and consults started in July.
  - We know we will be asking for a 6 month extension

Successes

- CHF has jumped into partnership with Samaritan Homeless Vulnerability Team, Benton County Harm Reduction to provide case management and skills support to people sheltering in place at Benton County Fairgrounds, Safe Place program (micro-shelters).
- Developed a strong curriculum based on other programs and feedback from residents.
- Staff have used social media and filming short videos to help start classes - see https://www.facebook.com/valerie.bostromstewart/videos/10217100343197547

Challenges

- The pandemic has delayed the project by 6 months (we will be asking for an extension)
- It is very tough to provide support and classes to the folks we serve via the internet because of technology skills and equipment gaps. CHF purchased netbooks to help residents participate in the program.

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
Individuals are chronically homelessness	6-month, 12-month housing status updates (CSC)	Individuals stay in housing with support, are permanently housed	12/31/2020	*There have been no evictions since the start of this project
Lack of skills in managing money, healthy communication, caring for themselves, and engaging in the community	Self-reporting survey administered after each round of skills program	Increase in stability, well-being, financial management, and employment/volunteering and engagement in the community	7/31/2020	*No progress to date, started in July
Ineffective, inefficient communication with health care providers, mental health providers, on health care status	Self-reporting survey administered after 6 months, 9 months of program	Timely, efficient, effective communication with health care providers	12/31/2020	*CHF is partnering closely with the project partners because of COVID, will be holding zoom meetings around working relationships in next two months. Have held one meeting to review partnership work.
Nonexistant or chaotic management of health conditions resulting in frequent, costly interventions such as ED visits and hospital stays to manage physical, mental health conditions	Tracking of residents hospital stays and ED visits	More preventative care such as PCP visits, adherance to treatment plans, reduction in intensive interventions such as ED visits, Behavioral Health Unit and hospital stays.	12/31/2020	*Nothing to report at this time. Need IHN-CCO assistance for reporting on hospitalization and ER visits.

Sustainability

- CHF has identified financial support for providing services during the pandemic which may lead to ongoing funding.
- Applied for Permanent Supported Housing funding and training through Oregon Housing and Community Services in partnership with DEVNW. The project were highly ranked but unsuccessful, will apply again in the next 6 months.
- Ran into barriers with partnering with Benton County to bill Medicaid for services, still searching for the right pathway to enable CHF to do this.

Conferences and Presentations

Date	Conference	Details
	N/A	

Stories from the Field

- We hope to have more stories once classes get started in July

Questions and Discussion

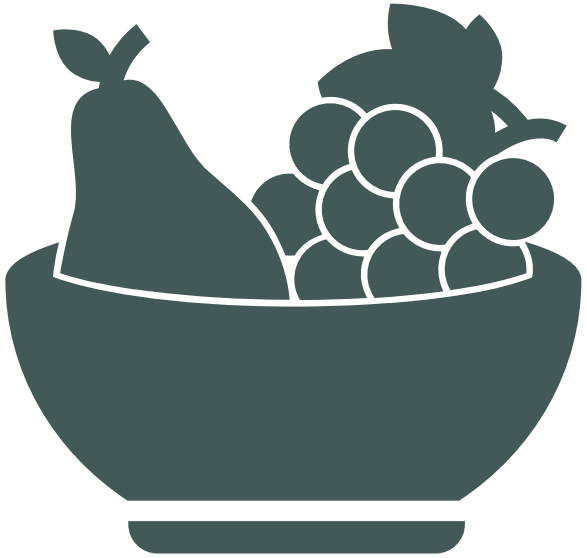
Presenter:

Allison Myers, PhD, MPH

Oregon State University

Center for Health Innovation

Wellness in Neighborhood Stores



Summary

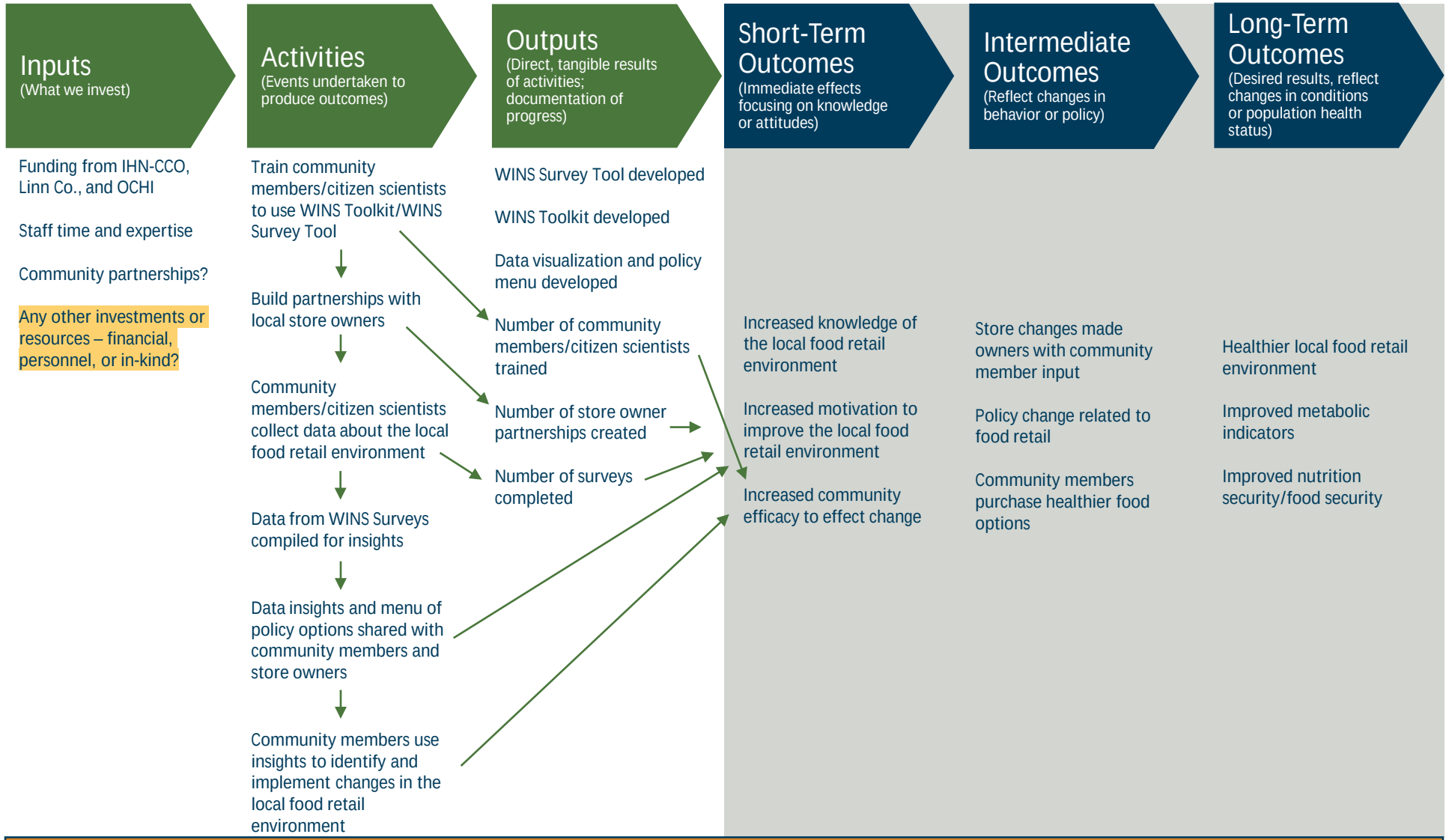
Linn County Public Health (LCPH) and OSU Center for Health Innovation (OSU) are partnering with convenience store owners and managers on tobacco environmental and health impact assessments

Opportunity exists for convenience store owners and managers to grow as partners in the larger health ecosystem to improve healthy eating and food security

- Reporting Period: January 2020 to June 2020
- Budget: $99,485
- Partners: OSU Center for Health Innovation, Linn County Public Health
- Highlights
  - Building the team, shared learning at the intersection of practice and research
  - Navigating program outcomes: food insecurity v. food behaviors v. health behaviors v. health outcomes
  - Characterizing and assessing a store that promotes food security

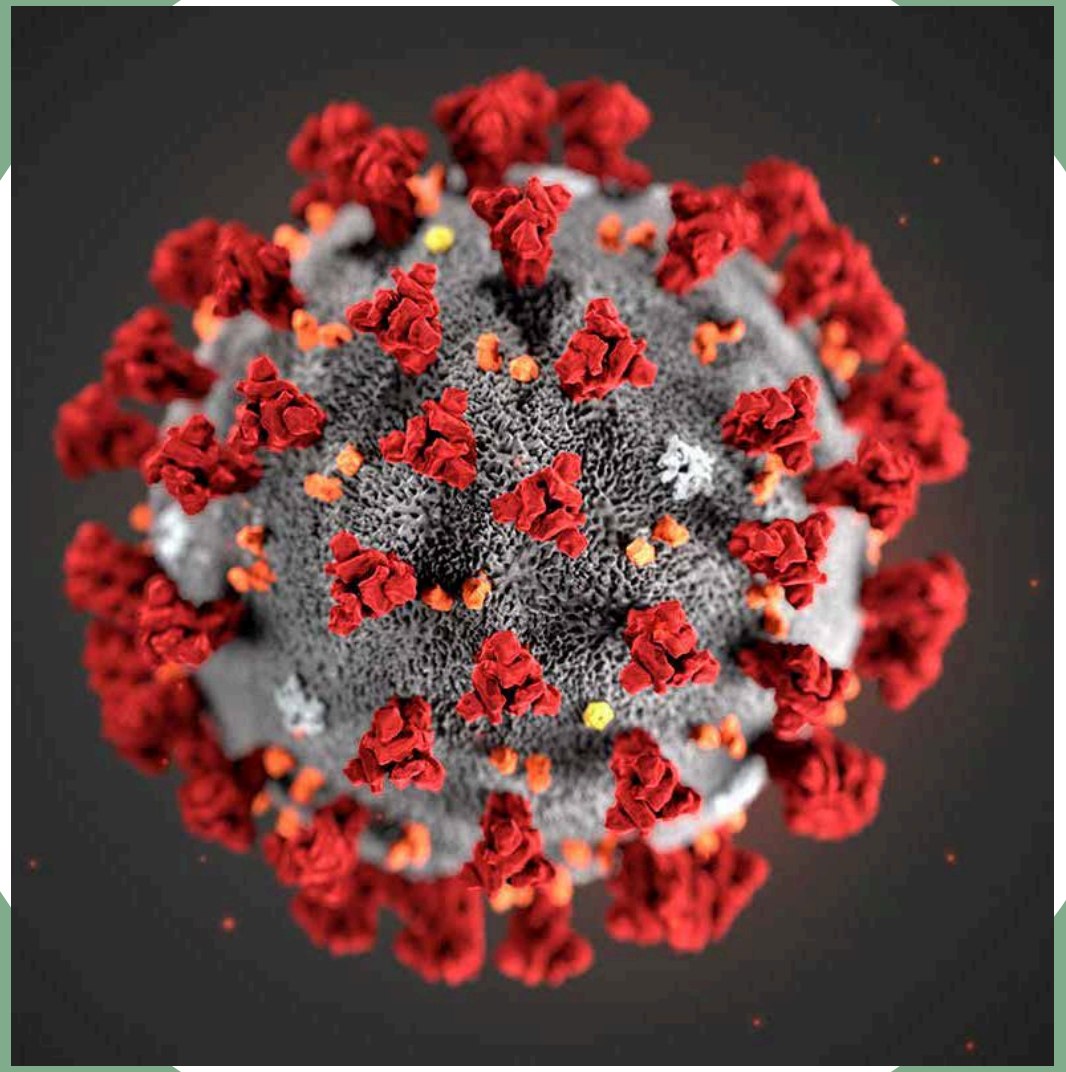
Successes

- We're off to a solid start!
  - Team is strong;
  - All of the necessary pieces and parts of the project are in draft: logic model/theory of change; observational assessment tool (~V12), policy list of store-based changes, store owner/manager and shopper recruitment materials, Human Research Protection Program research protocol.
  - Sustainable place-based changes to affect food security will be more important than ever in the Post-COVID-19-era?


Inputs
(What we invest)
Activities
(Events undertaken to produce outcomes)
Outputs
(Direct, tangible results of activities; documentation of progress)
Short-Term Outcomes
(Immediate effects focusing on knowledge or attitudes)
Intermediate Outcomes
(Reflect changes in behavior or policy)
Long-Term Outcomes
(Desired results, reflect changes in conditions or population health status)
Funding from IHN-CCO, Linn Co., and OCHI
Staff time and expertise
Community partnerships?
Any other investments or resources – financial, personnel, or in-kind?
Train community members/citizen scientists to use WINS Toolkit/WINS Survey Tool
Build partnerships with local store owners
Community members/citizen scientists collect data about the local food retail environment
Data from WINS Surveys compiled for insights
Data insights and menu of policy options shared with community members and store owners
Community members use insights to identify and implement changes in the local food retail environment
WINS Survey Tool developed
WINS Toolkit developed
Data visualization and policy menu developed
Number of community members/citizen scientists trained
Number of store owner partnerships created
Number of surveys completed
Increased knowledge of the local food retail environment
Increased motivation to improve the local food retail environment
Increased community efficacy to effect change
Store changes made owners with community member input
Policy change related to food retail
Community members purchase healthier food options
Healthier local food retail environment
Improved metabolic indicators
Improved nutrition security/food security
ASSUMPTIONS:
Beliefs we have about how the program will work (translate theory/framework from TRL initiatives for example)
Surveys/data insights will work as intended
Changes to the food environment/policy adoptions will cause changes in purchasing behaviors/food choices
EXTERNAL FACTORS:
Socioeconomic, geographical, and food preferences of the target audience will also influence intended outcomes
Local politics will influence enactment of identified food retail policies
Other barriers or factors to identify?

Challenges

- By late March, every member of the team has been detailed to COVID-19 response.
  - Linn and Benton Co. partners on emergency response;
  - OSU partners on TRACE-OSU and responding to LPHA requests.
  - OSU prohibitions on activities.
- Linn Co. and OSU stopped invoicing IHN-CCO with March invoice; have yet to resume.
- Planning to request a no-cost extension through December 31, 2021.



Goals

Goals	Activities	Measures	Met By	Progress to Date
Engage IHN-CCO member shoppers to learn about member needs and behaviors in the retail space	Work with IHN-CCO members to assess shopper needs and behaviors.	# of key informant/focus groups conducted.	12/31/2020	
	Identify convenience stores in Linn County proximate to highest number of IHN-CCO members.	List of top twenty stores that are closest to the largest amount of members.	12/31/2020	Done
	Complete agreements with stores to participate in assessments.	# of completed agreements (5).	12/31/2020	
Collaborate with stores to assess and implement store level changes	Partner with store owners and managers to complete WINS assessments.	# of completed store assessments (5).	12/31/2020	
	Hold bimonthly meetings with store partners to review assessment results and provide technical assistance on policy and environmental changes.	Meeting every other month with store partners (5).	12/31/2020	
	Assist stores in implementing healthy store-based changes.		12/31/2020	
Evaluate and revise toolkit	Conduct process evaluations with participants.	Completed evaluations.	12/31/2020	
	Use evaluations to revise components of toolkit.	Toolkit revisions.	12/31/2020	
	Finalize WINS Toolkit 1.1	Final toolkit.	12/31/2020	
Increase number of WIC/SNAP certified stores in Linn County	Partner with store owners to work towards WIC/SNAP.	At least two stores move towards WIC/SNAP certification.	12/31/2020	

Sustainability

- Well-planned, thoughtful store-based changes that are acceptable and interesting to store owners/managers and shoppers are inherently a sustainable place-based strategy
- Linn Co PH will operationalize store-based change support
- OSU and Linn Co PH hopes to scale this effort once an acceptable pilot program/toolkit is developed

Conferences and Presentations

Date	Meeting	Details
JAN 2020	Meeting of CCOs with Jennifer Chandler, Oregon Health Authority	RP and AEM responded to request for information about Linn WINS at a meeting of CCOs who are working on systems changes to promote food security.
FEB 2020	OSU College of Public Health and Human Sciences Community Advisory Council	AEM presented Linn WINS effort at Dean Javier Nieto's request to members of the CPHHS Community Advisory Council at Portland University Day
MAR 2020	Oregon State University Ignite Sessions	AEM accepted to present Linn WINS "Community science for store-based changes to promote food security" at March 13th university-wide Ignite symposium that was cancelled due to COVID-19
OCT 2021	Oregon Public Health Association; Corvallis, OR	Next year, when we have more to report, we plan to submit an abstract/proposal to the Oregon Public Health Association annual meeting.

Stories from the Field

- Project staff pilot tested V12 of the store assessment tool at two stores in Corvallis, one independent, one chain on March 11th, 2020, days before OSU shut down due to COVID-19.
- Store owners/managers were super excited about the work – had so much enthusiasm, so many questions – and this was a welcome surprise.

Questions and Discussion

Presenters

Wellness to Smiles

Summary

Addresses barriers to nutritious affordable food, housing, and oral health by improving the collaboration between oral health care and social services in Lincoln County

A community-based dental care team including an Expanded Practice Dental Hygienist (EPDH), Dental Assistant/Community Health Worker (CHW) and teledentist will provide oral health services, education and navigation, and also utilize teledentistry

The overarching 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

- Reporting Period: January 2020 to June 2020
- Budget: $100,214
- Partners:
- Highlights
  - choose 1-3 highlights
  - choose 1-3 learning experiences

Successes

- EPDH Retained
- Community Care Assistant Hired
  - Currently in Community Health Worker Course
- Teledentistry equipment purchased

Challenges

COVID-19

Goals

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By	Progress to Date
2019 Data	Increase overall dental utilization by all IHN-CCO clients assigned to the Advantage Dental Clinic in Newport by a 3 percentage point increase from previous measurement year	3 percentage point increase (42.79% 2019)	12/31/2020	19.49%
2019 Data	Increase overall dental utilization by pregnant IHN-CCO clients assigned to the Advantage Dental Clinic in Newport from previous measurement year	TBD (24.44% 2019)	12/31/2020	0.00%
2019 Data	Reduction in ED visits from previous measurement year for nontraumatic dental pain by IHN clients assigned to the Advantage Dental Clinic in Newport, and corresponding cost savings associated with ED visits	TBD (1.50% 2019)	12/31/2020	0.72%
2019 Data	Increase overall dental utilization by adult IHN-CCO clients assigned to the Advantage Dental Clinic in Newport from previous measurement year	TBD (37.38% 2019)	12/31/2020	18.00%
2 sites	Increase access points to oral health care in Lincoln County using teledentistry	5 sites	12/31/2020	Dental Days have been expanded to 5 sites during Q1 of 2020
NA	Ensure that clients who receive a teledentist exam during Dental Days and are identified as “high-risk” with a dental emergency (ie signs of cavitated lesions or existing signs of infection) receive follow up care from their PCD within 24 hours to 6 weeks depending on level of dental urgency	85%	12/31/2020	Teledentistry Services were scheduled to begin in Q2, but due to COVID-19 services weren’t implemented.

Sustainability

- Advantage Dental from DentaQuest has determined the use of teledentistry as an enterprise initiative which provides support from Executive Leadership.

Conferences and Presentations

Date	Conference	Details
April 2020	National Oral Health Conference	RoundTable Presentation (Cancelled Due To COVID-19)
October 2020	Oregon Rural Health Association	Submitted abstract to Present October 2020

Stories from the Field

Participant at Yachats location”

- “She allowed for me to provide her with SDF and Fluoride Varnish as well as education, but had been unwilling to address her broken to the gum line teeth with a dentist. Prior to COVID-19 halting our visits to the sites, I had been able to work with the front desk at the Newport clinic and schedule a consultation with the patient and Dr. Le. Although, she was not ready to have x-rays to determine the best course of treatment for her, she had taken the next step. I firmly believe this is due to establishing a trusting relationship with her. I am hopeful that she will continue to make progress in her willingness to seek treatment in order to improve her overall health.” Rachel, EPDH

Questions and Discussion