Annual Summary Report

Community Health Improvement Plan 2015-2016

Introduction

Yamhill Community Care's Community Health Improvement Plan (CHIP) is a community owned plan that has helped guide community health activities and efforts both for Oregon Health Plan members enrolled, and for individuals residing in Yamhill County. In the past year we have gained much traction on the CHIP, especially with stakeholder support and increased accountability. In the spirt of continuous improvement, we remain focused on highlighting and reinforcing CHIP strategies during organizational committee meetings and the importance of stakeholders' support. We have found persistence to be key in our current CHIP success and work to continue to develop more robust progresses in the coming year and for the life of this plan.

Summary of CHIP Process

Yamhill Community Care has continued the development of systems and processes to implement, track, and evaluate the improvement activities identified in the plan. This work is driven by the Community Advisory Council and internal staff and supported by key community partners and committees to accomplish the work. Responsible partners are identified in the plan and work collaboratively to build upon the organization's culture of collective impact to improve the health of the community.

Key governing bodies that support the work of the CHIP:

Community Advisory Council (CAC) **–** As the primary group that represents member voice among organizational leadership, the CAC is the designated committee for overseeing the CHIP. Historically, the CAC worked closely with the Quality and Clinical Advisory Panel (QCAP) and Yamhill CCO Board of Directors on the development of the CHA and CHIP in 2013. The CAC continues to work together as the CHIP is implemented, and has established a goal of meeting monthly to discuss progress toward the priority goals, objectives, and strategies of the plan. Current milestones for the group include implementing the first Member 101 orientation, and are in discussion around ways to increase committee membership through promoting a recruitment video created by the Oregon Health Authority Transformation Center.

Quality and Clinical Advisory Panel (QCAP) - With a blended focus of clinical transformation and attention to quality assurance and improvement activities this 18 member body represents primary care providers, the hospital systems, behavioral health providers, dental providers, early learning partners, health plan consumers, community peer organizations, Yamhill County Public Health and Health and Human Services.

Internal Planning Workgroups - Team of staff members responsible for planning, implementation, and evaluation activities around CHIP priorities.

Responsible Partners- These are the members in the community that through a collaborative planning process, were identified as key community leaders and champions of the work.

CHIP Infrastructure and Organizational Development

Coordination with the CAC, QCAP, CCO staff support, and the community are key to the development of how the plan is put to action. Yamhill Community Care has developed CHIP implementation strategies to further the work:

- *Designated staff resources*- Community Health Improvement Specialist, Quality Programs Coordinator, Quality Improvement AmeriCorps VISTA, CHIP Implementation team
- *Alignment of the CHIP with organizational plans* - the Transformation Plan, Quality Plan, Organizational Strategic Plan and key internal departments including quality management and business analytics
- *Earmarked financial support*- Build Forward Program to support innovation, staff support, and community granting to fund interventions, Transformation Center CHIP Grant
- *Hosted community forums*-for community education and discussion on key topics including First Tooth trainings, Family Resiliency Conference, Provider CME events, and Pain Summits

Highlights of the Past Year

Priority Goal 1: Promote overall well-being by reducing prevalence of chronic condition

Developed and offered preventative classes to members:
Walk with Ease, Living Well with Chronic Conditions, Diabetes Self-Management, planning for the launch of Diabetes Prevention Program (DPP), Persistent Pain Program, SNACK (Student Nutrition and Activity Clinic for Kids) nutrition education.

• The Wellness Center and Persistent Pain Program created greater access to comprehensive services for chronic pain. Service expansion included pain classes, movement therapy (yoga), massage, risk-based screening tools and self-management education and supports.

- In partnership with the Early Learning Hub and community, family resiliency and Adverse Childhood Experiences (ACEs) were explored through a variety of venues.

Committee work with a consultant to further develop resiliency and the use of an ACE screening tool for children. A community wide conference bringing together educators, early learning, medical providers, and law enforcement allowed for a day long discussion on how to support children and families in our community.

Priority Goal 2: Integrate oral health with physical and behavioral health

- In the spring, providers in three practices received First Tooth training in preparation for an integrated physical, mental and dental screening carnival-like event. The event focused on providing immunizations, oral health screening, education and delivered services to over 115 members in the community.

- The School-based dental sealant program expanded to all Yamhill County elementary schools and included two middle schools. Not only does this community based program screen, educate, and identify students with oral health needs, it also works in conjunction with a CCO state metric to deliver dental sealants to children ages 6-14.

- Yamhill CCO has begun development of an oral health needs assessment in partnership with an MPH candidate and the local Oral Health Coalition. This assessment will identify barriers and dental needs in the community. The previous assessment in 2011 served as a guide for CHA and CHIP development. This updated assessment will help inform community barriers, resource gaps, and inform future CHIP strategies. We anticipate having the oral health needs assessment completed by September 2016.

Priority Goal 3: Leverage existing providers and health care teams' capacities in more innovative and creative ways

- Yamhill Community Care has a one-year contract with the Advisory Board and therefore is offering trainings and web conferences available to CCO staff and

stakeholders on topics including methods to decrease ED utilization, increase patient engagement rates, and care improvement strategies.

- A provider and education calendar was created to deliver trainings for providers and community partners on topics that relate to our CHIP, including patient satisfaction and communication; oral health and patient engagement; trauma, nurturance, and early learning; opioids and self-management; and behavioral health supports.

- Development of member materials: member brochure (draft), image of what Yamhill CCO insurance card looks like, dental brochure, etc. These materials have been used at several events to increase OHP members' understanding of what services they are eligible to receive and increase community understanding of what services the CCO offers OHP patients.

- Internal communications workgroup focused on aligning social media and community engagement activities. This work is ongoing and strives to boost community and member engagement to increase knowledge about the CCO, the services it offers, and the partnerships it maintains in the community to provide quality care for Oregon Health Plan members.

Priority Goal 4: Value the mind-body connection by integrating behavioral and physical health prevention, education, and treatment

- A Yamhill Community Care hosted Family Resiliency Conference brought together multiple community partners and organizations to discuss Adverse Childhood Experience (ACEs), trauma informed care, and how to address these topics when working with community members. This helps provide a foundation for community partners about barriers OHP members may have and to use the knowledge of ACEs to help support individuals and provide effective care.

- Throughout this past year, the development and expansion of Service Integration Teams (SITs) in the region has been a large body of community work. There were initially two SITs (West Valley and Amity), and an additional five SITs have been created. In the future, SITs will continue developing relationships with local community partners in more rural areas and collaborate in the sharing of resources and information for individuals and families of Yamhill County with a particular emphasis on preventative services for underserved and at-risk populations.

- Through collaboration with Early Learning partners, the Wellness to Learn program focused on a school partnership that identified and referred students with health-related issues that were experiencing barriers to learning. Also, a partnership with Oregon Pediatric Improvement Project (OPIP) worked to map referral systems for children identified at-risk by the Ages and Stages Questionnaire (ASQ) screening tool.

Next Steps Continued to leverage CCO and community resources in support of CHIP strategies.

- Stakeholder engagement and support
- Shared accountability
- Bring in more data and analytics to improvement strategies
- Comprehensive communications to highlight CHIP efforts and progress to community partners
- Develop a CAC budget that supports CHIP program work
- Ensuring CHIP work is sustainable and plans are in place to continue existing work

Attachment CHIP Progress Report
CHIP Dashboard

Yamhill Community Care™

Community Health Improvement Plan Progress Report

Key Players

1. **Which of the following key players are involved in implementing your CHP? (select all that apply)**
   - ☒ Early Learning Council;
   - ☒ Early Learning Hubs;
   - ☐ Youth Development Council; and
   - ☒ School health providers in the region.

2. **Describe how these key players in the CCO's service area are involved in implementing your CHP.**
   Examples:
   - ✓ Yamhill Community Care is the Early Learning Hub for our region and is advised by the local Early Learning Council. The Early Learning Hub staff are included in the strategies to address our four goals as responsible partners.
   - ✓ In partnership with McMinnville School District the Wellness to Learn Program was developed to meet the address health and social

3. **If applicable, identify where the gaps are in making connections.**
   Examples:
   - ✓ We did limited work with school health providers through the primary care network but have no formal plan for collaboration.

Health Priorities and Activities

4. **For CHP priorities related to children or adolescents (prenatal to age 24), describe how and whether the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.**
   - ✓ Through work with dental sealants we are able to screen children ages 6-14 to assess oral health needs, so that children can be referred to dentists for treatment
   - ✓ In partnership with referring physicians, the SNACK program has helped lower rates of childhood obesity in the community through nutrition education and working with identified families to promote healthy habits such as physical activity and a balanced diet.

5. **What activities are you doing for this age population?**

Examples:

- ✓ See CHIP Updates Report Summaries

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

   - ✓ The CCO has established the Wellness to Learn program, which is a partnership between elementary schools and our Community Health Worker program to address barriers to health children are facing that affect their ability to function in school
   - ✓ The Early Learning Hub, which is part of the CCO, works with the schools on metrics including well-child checks and immunizations to bridge early learning and child health
   - ✓ The CCO participated in Toothtastic Jab-a-Palooza, an event focused on meeting metrics in children including well-child checks, dental sealants and screenings, and immunizations
   - ✓ The CCO sponsors SWAG Night (Student Wellness and Games), an event that occurs bi-annually to promote physical health screenings among adolescents
   - ✓ The CCO is funding the SNACK program through our Building Forward Grant

Health Disparities

7. **For each chosen CHP priority, describe how the CCO and/or CAC(s) have worked with OHA's Office of Equity and Inclusion (OEI) to obtain updated data for different populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data.**
   Examples:
   - ✓ Received equity consultation and review of all plans, CHIP, Transformation Plan and quality incentive metrics to identify gaps and potential disparities that exist in the data.
   - ✓ In partnership with the Early Learning Hub, the CCO is currently developing a health equity plan, and is using OEI as a resource with the plan development.

8. **Explain whether updated data was obtained by working with other state or local agencies/organization(s) and what data sources were utilized.**
   Examples:
   - ✓ No additional state or local data has been used to this point

9. **Explain CCO attempts to compare local population data to CCO member data or state data. If data is not available, the CCO may choose to access qualitative data from special populations via focus groups, interviews, etc.**
   - ✓ Oral Health Needs Assessment primary data collection: focus groups, individuals, and providers filling out surveys

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

- ✓ Particularly with the homeless count, Yamhill County and the CCO were unable to get an accurate count of the number of homeless individuals. This makes it difficult to target the homeless population in its entirety for health programs.

11. What successes or challenges have you had in engaging populations experiencing health disparities?

Examples:

- ✓ The CCO implemented WellRide, which provides transportation to CCO members who need help getting to healthcare appointments
- ✓ Limited data available to identify disparities, still working on data collection
- ✓

12. What successes or challenges have you had in recruiting CAC members from populations experiencing health disparities?

Examples:

- ✓ Our CAC has struggled with recruitment of individuals from Hispanic and Latino backgrounds. We are now utilizing translators to break down language barriers and boost membership of individuals from this community.
- ✓ CAC membership primarily consists of individuals who work at partner organizations, and it has been a struggle to gain more CCO members to attend the CAC. We have decided to use the Transformation Center's CAC Recruitment video in an effort to reach more individuals and boost membership levels.

Alignment, Quality Improvement, Integration

13. Describe how local mental health services are provided in a comprehensive manner. Note: this may not be in the CHP, but may be available via another document, such as the Local Mental Health Authority's (LMHA) Biennial Improvement Plan (BIP). You do not need to submit the full LMHA BIP.

Examples:

- ✓ The CCO aligns their CHIP with Yamhill County Public Health's CHIP around addressing behavioral health as a priority goal for individuals in the community
- ✓ "YCCO plan to integrate behavioral health with physical and oral health established into Patient Centered Primary Care Homes" (Yamhill County Public Health CHIP)
- ✓ See CHIP Update Report Summaries

14. If applicable, describe how the CHP work aligns with work through the Transformation Plan, Quality Improvement Plans and/or Performance Improvement Projects?

Examples:

- ✓ The CHIP aligns with the Transformation Plan through utilizing the Triple Aim focus of improving health, improving care, and decreasing the cost of physical, behavioral, and

dental care

- ✓ The Transformation Plan addresses health disparities and meeting the culturally diverse needs of members through ensuring health literacy in member materials and offering trainings to staff and providers around cultural competency.
- ✓ Quality Improvement Plans: The CHIP work aligns with the Quality Improvement Plan through a focus on reducing barriers and improving care and outcomes for CCO members.
- ✓ The CHIP aligns with the Performance Improvement Projects through opioid work including efforts to educate providers about reducing rates of opioid prescriptions, in promoting and delivering preventive care for adolescents (AWC) and transforming and integrating care teams (PCPCH).

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

Examples:

- ✓ See CHIP Updates Report
- ✓ Service Integration Teams
- ✓ Sponsoring Build Forward grants for community partners
- ✓ Oral Health Needs Assessment
- ✓ Community Health Hub
- ✓ Wellness Center and Wellness Classes
- ✓ Maternal Medical Homes Model

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

Examples:

- ✓ Service Integration Teams
- ✓ First Tooth Trainings integrating oral health and physical health
- ✓ Early Learning Hub and its collaboration with Early Learning partners

Priority Area: Chronic Conditions

Priority Goal 1: Promote overall well-being by reducing prevalence of chronic conditions

Strategies	Funding Streams	Responsible Partner(s)	Status:	Q2 2015	Q3 2015	Q4 2015	Q1 2016
Objective 1: Reduce rates of obesity from the current rate of 29% to 26% in Yamhill CCO adult members from the current rate of 12.4% to 11.2% in Yamhill CCO child members by June 2019.							
1. Increase access and awareness about resources offering healthy affordable food options	Transform Forward Grants	SNACK Program Coordinator, CAC	**Implementing**	**4/11/2015** The SNACK program held a free screening and panel discussion for the documentary film Fed Up. A total of 51 community members attended the event. During the discussion, panelist and audience members shared where they get healthy and affordable food options in Yamhill County. Some resources that were discussed were gleaning programs, U-Picks, making meals with family, neighbors, and friends, and getting fresh produce from local farmers markets.		**Update:** As of January 2016, SNACK has piloted our program in conjunction with KOB to provide our nutrition education curriculum and activities to 6 elementary school sites. The total number of kids served are 270. Additionally, we piloted 3 health/nutrition education workshops from September -December 2015. Each workshop addressed a nutrition and health education topic to assist our participants in further establishing healthy lifestyle behaviors, specifically regarding nutrition and physical activity. **Data Collected:** 270 KOB participants reached. 17 participants attended the SNACK Pilot workshops. **Challenges/Successes:** Collaborating with KOB's afterschool FitZone allowed the SNACK program to not only expand its services to our desired population of interest, but it also allowed us to remain equitable in our pursuit to reduce childhood obesity rates in Yamhill County. Additionally, the workshops were such a success with our participants that we will continue to offer monthly workshops, year-round to our participants and any community members who are interested in what the SNACK program has to offer. The workshops will also aid our participants through maintaining healthy lifestyle behaviors, once they have completed a full 10 weeks with SNACK program.	Update: Original SNACK Coordinator left role, new coordinator has been hired.
2. Provide education to all providers on how to choose psychiatric medications with a lower side effect risk of developing metabolic syndrome	Yamhill CCO	QCAP	**Delayed**		**9/22/2015** YCCO held their 2nd annual Pain Summit to educate providers on addiction and the importance of not prescribing patients so many opiates.		**3/31/2016** This has not happened community wide. QCAP to partner with YCHHS and enhance communication with YCHHS and identify evidence based practices regardign psychotropic medication selection.
3. Provide resources to assist providers help their members taking psychiatric medications to manage metabolic syndrome	Yamhill CCO Global Budget	QCAP, YCHHS	**Adopted**	**3/15/2015** Currently a statewide PIP focusing on screening for diabetes and members with an SPMI diagnosis. Multiple interventions including hiring a MH nurse, PCP education and mailing, co-location of PC adn MH and robust member and lab test tracking. See separate cover for details. **5/11/2015** Removed CHW Hub from Responsible Partner(s) and added HHS.	**6/30/2015** Final remeasure of statewide PIP. Formal project adopted by HHS. Will continue work on care coordiantion with among providers (PCP/MH)	No update	**3/15/2016** Discussion of hosting a provider meet and greet with PCPs and MH providers to initate further discussion of co-management of patients on psychotropic medications.
4. Provide classes like Walk With Ease, Living Well with Chronic Conditions and Tomando Salud classes in English and Spanish	TMSA Grant	CHW Hub, YCPH TPEP Coordinator	**Implementing**	**02/2015** the CCO began offering ongoing chronic pain classes through the Persistent Pain Program. The class consists of eight sessions, one hour of which is classroom-based where participants learn about pain management and the other hour is movement therapy. The program has held x number of complete sessions and has had x number of total participants. **4/2/2015** A Diabetes Self Management class was held in McMinnville through Northwest Senior and Disability Services. The class recruited 20 participants and ended with four.	**8/12/2015** A weekly Chronic Pain Self-Management class was held at the Yamhill CCO June 18-July 23, 2015. Six people attended at least one class, four graduated by attending four or more classes.	**11/2/2015** Lydia reached out to Natalie Reed to discuss partnering with Walk With Ease. Natalie dropped off fliers and information so YCCO members can register for free.	**4/14/2016:** The Yamhill CCO CHWs have completed the trainings to teach all of the Stanford Living Well classes as well as the Diabetes Prevention Program. They have taught their first Living Well with Diabetes and also partnered with VG to offer Living Well with Chronic Pain. We are still waiting for a local offering of the Tomando Control classes to get them certified soon. Walk with Ease is currently being offered at WVMC free of charge, so we are not pursuing this at this time. **3/17/2016:** Yamhill County's TPEP Coordinator's role in this would not be to provide the classes but can provide technical assistance in figuring out referral processes for PCPs or other providers to refer to the program.
5. Promote SNACK program throughout Yamhill County clinics serving children	Transformation Forward Grants	PMC Western Oregon Center for Pediatric Lifestyle Change (Dr. Koenig)	**Implementing**	**5/11/2015** Changed Responsible Partner(s) from PMC - Dr. Koenig to PMC Western Oregon Center for Pediatric Lifestyle Change (Dr. Koenig).		**Update from Dr. Koenig:** I have promoted SNACK throughout clinics in Yamhill County. We have primarily received referrals from Virginia Garcia Memorial Clinic and PMC **Data Collected:** 80 of our referrals have come from PMC, 31 have come from Virginia Garcia Memorial Clinic	No new data.
6. Develop a comprehensive plan to address child and adult overweight and obese individuals which combines existing community resources into a coordinated referral resource	TMSA Grant	CHW Hub, SNACK Coordinator	**Implementing**	**5/11/2015** Removed YCPH and TMSA Health Educator from Responsible Partner(s) and added SNACK Coordinator. **4/27/2015** The Community Health Hub referral form includes referral to Chronic Disease Self-Management programs, which include a section on nutrition and eating habits.		**12/31/2015 Update:** Through continued collaboration with Virginia Garcia Memorial Clinic, SNACK has coordinated a referral system which allows referred patients of VG to seamless transition into the SNACK program. VG faxes over referrals and notifies me via email of which patients have been referred to the program. All patients referred to the SNACK program (regardless of where the referral came from) are scheduled within 1-2 business days. Additionally, when at outreach events we capture self-referrals through a participant sign-up log and schedule them within the next 1-2 business days. Utilizing existing community resources and partnerships has allowed the SNACK program to expand its reach by approximately 270 children (KOB partnership). Through our pilot workshops, SNACK participants, their families, and interested community members have received in-depth, hands on lifestyle/nutrition education. **Data Collected:** 270 children reached through collaborating with KOB, 17 participants attended the SNACK pilot workshops.	Update: Original SNACK Coordinator left role, new coordinator has been hired.

Objective 2: Develop regularly offered provider education courses to integrate chronic conditions, mental health, and health literacy topics by December 2015.							
1. Provide annual Adverse Childhood Experiences trainings to providers to develop a better understanding of the relationship between childhood trauma and chronic conditions	Yamhill CCO Global Budget	Bonnie Corns, Emily Johnson	**Planning/Researching**	**6/19/2015:** The Yamhill CCO held a provider education lunch event with 75 attendees, who were local clinicians, clinic staff, and social service providers. The event featured Dr. Robert Anda, co-author of the original ACES study, who spoke about the impact of trauma and how communities can build resilience. After his talk, there was a community discussion on how to address trauma locally. **5/11/2015** Removed CAP and Project ABLE from Responsible Partner(s) and added AmeriCorps VISTA. **5/11/2015** Under strategies, changed monthly Adverse Childhood Experiences trainings to annual.		**12/31/2015 Update:** Three follow-ups to last year's ACEs-focused Family Resiliency Conference are in the beginning planning stages: an Early Learning Hub training for home visitors around ACEs, a spring 2016 trauma-informed care forum, and a 2017 conference. **Data Collected:** The past FRC had 280 attendees and was evaluated positively, indicating community interest in this topic. **10/27/2015** Responsible partners changed from AmeriCorps VISTA to Emily Johnson & Bonnie Corns **10/22/2015** The Second annual Family Resiliency Conference was held to educate professionals and indivduals in the community on the importance of ACEs, protective factors, and how ACEs can lead to chronic conditions, etc. Featured speakers included Tony Biglan and Laura Van der Noot Lipsky.	**4/13/2016 Update:** Emily Johnson is taking the lead on researching additional trainings on Trauma Informed Care, ACEs and building resiliency
2. Regularly offer classes to providers on health literacy and the culture of poverty	Potential Grant Funding	Emily Johnson	**Planning/Researching**	**5/11/2015** Removed CAC from Responsible Partner(s) and added AmeriCorps VISTA.		**12/31/2015 Update:** Planning has begun to contract with Figure 8 Consulting to provide a training for WVMC Joint Replacement providers on better communication with Medicaid patients, understanding of implicit bias, and cultural agility. **Data Collected:** Through Office of Equity and Inclusion grant funding, the Figure 8 trainings (~$1800 worth) will be free to the CCO. **10/27/2015 Update:** Changed Responsible Partner from AmeriCorps VISTA to Emily Johnson	Yamhill CCO is still partnering with Figure 8 consulting on trainings around health literacy and cultural agility. The scheduled trainings at WVMC did not occur in Q1, but are planning on being held sometime in Q2.
3. Develop a referral system and training for providers to connect members with significant mental health challenges and chronic conditions to ensure members get the services they need	Yamhill CCO Global Budget	YCHHS	**Implementing**	**5/26/2015** The Community Health Hub referral form includes referral to Chronic Disease Self-Management programs, the Persistant Pain Program, the Multi-Disciplinary Team (which is a committee that discusses coordination of care for high needs patients), Community Health Workers (who work with members to help them better navigate their care), and Project ABLE (which provides individual and team support to those coping with mental health or co-occuring disorders. The CCO Behaviorist and Member Engagement Specialist and Care Oregon Provider Relations has met with providers to promote the referral system, and it has gone out to providers via e-mail. **5/11/2015** Removed CHW Hub from Responsible Partner(s) and added HHS.		**12/31/2015 Update:** Planning has begun to contract with Figure 8 Consulting to provide a training for WVMC Joint Replacement providers on better communication with Medicaid patients, understanding of implicit bias, and cultural agility. **Data Collected:** Through Office of Equity and Inclusion grant funding, the Figure 8 trainings (~$1800 worth) will be free to the CCO.	**4/4/2016 Update:** YCHHS & LCSNW developed a Continuity of Care P&P with a PCP subcommittee through the CAP that was Reviewed at the February 2016 CAP meeting. It was also reviewed at the YCHHS medical staff meeting with our psychiatric licensed medical providers for implementation.
4. Provide information to providers on how to talk with members about the side effects and risks of medications and treatments and how to weigh their options to make informed decisions about their health	Yamhill CCO Global Budget	Emily Johnson, Project ABLE, QCAP	**Implementing**			**10/27/2015** Responsible partners changed from AmeriCorps VISTA to Emily Johnson **10/1/2015** YCCO held their 2nd annual Pain Summit to educate providers on addiction and the importance of not prescribing patients so many opiates.	**4/15/2016 Update:** In this 1st Quarter, Project ABLE held our 6 weeks series, "Peer Paths to Wellness", as well as completing an 8 week WRAP (Wellness Recovery Action Planning) class. **Data Collected:** 14 people attended PPW, and 6 completed the WRAP course. **Challenges/Successes:** The feedback from both classes was overwhelmingly positive with people reporting new motivation to address their own wellness challenges, and also gaining new insights and tools. Several new support relationships were started as a result of the connections made during these discussion based classes.
5. Provide information to providers on how to listen to the physical health needs of patients with high mental health needs	Yamhill CCO Global Budget	QCAP, YCHHS	**Planning/Researching**			**10/27/2015** AmeriCorps VISTA removed from responsible partners, Emily Johnson, CAP, & HHS listed as new responsible partners.	
6. Research options on mechanisms of learning to cater to the busy schedules of providers	Yamhill CCO Global Budget	Emily Johnson, QCAP	**Evaluating**			**10/27/2015** AmeriCorps VISTA removed from responsible partners, Emily Johnson & CAP listed as new responsible partners *This update should be completed, Quality Department is waiting on data from Emily to confirm we have achieved this strategy	2014 Fall Forum: 30/30 respondents either agreed or strongly agreed that the time was convenient – 6:00 – 9:00 on a Tuesday evening. 2015 Pain summit: 21/23 respondents indicated 6:00 – 9:00 on a Tuesday evening at McMinnville Ballroom was convenient. 2015 Fall Forum: 34/35 attendees responded that 6:00 – 9:00 on a Thursday was convenient. 2015 ACES lunch event: 32/33 respondents said the time and location – 12:00 – 1:30 on a Friday was convenient. It should be noted that these results are

Objective 3: Increase the number of patient and community education courses offered about chronic conditions available and course participation rates by December 2015.							
1. Increase early education of healthy behaviors and oral health through pediatrician offices	Yamhill CCO Global Budget	Jenn Richter, Lydia Marshall	**Implementing**			**12/24/2015** Our previous First Tooth training was not attended by providers. We need to poll them and find out why not and what accommodations could be made and/or what other type of oral health training/resources would be beneficial to them.- **Jenn Richter** **12/1/2015** Discussing with Karen Hall & Brittnay Trujillo offering a First Tooth training for providers -**Lydia** **10/27/2015** Responsible partner changed from AmeriCorps VISTA to Jenn Richter & Lydia Marshall	First Tooth trainings were help at Virginia Garcia Memorial Health Clinic- Newberg and Physicians Medical Center/Sheridan Medical Group. All 3 clinics plan to implement systemic changes to the delivery of oral health services including oral health assessments, oral health education, fluoride varnish and referral to a dental home.
2. Offer tobacco, prescription drug, and alcohol and other drug use prevention classes for adolescents	TMSA Grant	Rachel Grant	**Not Started**	**5/11/2015** Removed TMSA Health Educator from Responsible Partner(s). **4/27/2015** Providence Newberg offers an 8-week tobacco cessation course, free to Providence Health Plan members. **4/27/2015** TMSA/TPEP funding does not allow direct client services.		**10/27/2015** Changed responsible partner to Rachel Grant (AmeriCorps VISTA).	
3. Promote the services of community health workers in managing chronic conditions	Yamhill CCO Global Budget	Community Health Hub, All Providers, Partner Agencies	**Planning/Researching**	**5/21/2015** Outreach on the referral process has been provided to clinics by Care Oregon's Provider Relations, Yamhill CCO's Member Engagement Specialist, and Yamhill CCO's Behaviorist. They give presentations to clinic staff and providers to promote the Community Health Hub referral form. Referrals have enabled more members to seek care through chronic disease self-management classes, Project ABLE peer support services, Provoking Hope's Responsible Moms Program and the Community EMS services.		**12/1/2015** Rachel Grant, AmeriCorps VISTA has been promoting the CHWs on social media, Emily & Rachel have promoted the CHWs at VG's Health Fair, etc.	**3/24/2016 Update:** Champion Team provided program materials, explained supports offered & began conversations with CHW's. Discussed ways CHW's can become involved in the broader peer provider community. **Challenges:** Lack of regular communication/networking with CHW's
4. Provide nutrition education information and classes based on cultural dietary habits or cultural diets	Transformation Funds	SNACK Program, Early Learning Hub	**Implementing**	**5/20/2015** In February 2015, the SNACK program relaunched with a new nutrition and physical activity curriculum. The 10-week program serves local children, using interns from Linfield College. Participants are referred to the program by their providers and by self-referral. **5/11/2015** Removed AmeriCorps VISTA from Responsible Partner(s) and added Early Learning Hub.		**12/31/2015 Update:** As an initiative to better serve our participants and provide additional support as they adopt healthier behaviors, SNACK has piloted 3 workshops from Sept-Dec 2015. Like our program curriculum, these workshops have been tailored to be culturally appropriate with regards to our large Hispanic population. All 17 participants in the pilot workshop identified as Hispanic and thus, each workshop (including cooking classes) has been designed with culturally appropriate recipes, nutrition information, and table discussions for participants to discuss challenges they face with healthy lifestyle behaviors in their family. Each workshop has also been facilitated in conjunction with a Spanish speaking translator. Since the pilot workshops were so successful, we will continue to provide monthly workshops to our SNACK participants and their families. **Data Collected:** 17 participants, 100% identified as Hispanic. **Challenges/Successes:** The initial workshop was challenging in that we did not have a Spanish speaking translator on site. From the second workshop on we have made sure to provide a Spanish speaking translator on site for our participants. We will continue to do so for each workshop in the future.	With the previous SNACK coordinator leaving and the transition for the new coordinator I am unsure what work has been done in the past quarter. I am hoping we will have a comprehensive update for Q2.
5. Develop exercise programs for members who can benefit from prescribing less medications and more exercise in managing chronic conditions	Transformation Funds, Yamhill CCO Global Budget	Lydia Marshall, YCCO Wellness Center	**Implementing**	**6/17/2015** A 12-week Tai Chi - Movement for Better Balance class is being held in McMinnville. The class meets twice per week and accepts new participants any time and will go through August 6. **5/11/2015** Removed CHW Hub, Providers, Yamhill CCO Global Budget from Responsible Partner(s) and added AmeriCorps VISTA, Wellness Center.		**12/31/2015 Update:** Persistent Pain Program is an 8-week course, 1-hour of pain school (psychoeducation) and 1-hour of movement therapy (yoga). Currently, Persistent Pain Program has a new orientation every 4-6 weeks. Individuals are referred by primary care clinic, behavioral health provider or community member. In 2015, 249 referred, 118 attended Orientation; 84 started the program, 43 completed the program. **Data Collected:** AUDIT, DAST, Opioid Risk Tool, Pre- and Post-test (Brief Pain Inventory, Oswestry Low Back Pain Disability Questionnaire, PHQ-9, Fear of Movement Scale, Pain Self-Efficacy Questionnaire, DUKE Health Profile), Participant feedback survey. **12/1/2015** Met with Laura Fisk to discuss how we can meet member needs. Potentially offer a weight management class? - LM **10/27/2015** Updated responsible partner to Lydia Marshall (AmeriCorps VISTA)	**3/24/2016 Update:** Champion Team is beginning peer-run workshop called Nutrition & Exercise for Wellness & Recovery (NEW-R) - participants will be rewarded funding toward their wellness upon completion. **Data Collected:** class begins April 2016 **Challenges/Successes:** anticipate positive health outcomes, will measure results based on self-identified surveys

6. Improve community-wide understanding of mental health needs as a way to address societal stigmas towards people with mental illness	Yamhill CCO Global Budget	QCAP, CAC, Project ABLE, Provoking Hope, Champion Team	**Implementing**	**5/11/2015** Removed AmeriCorps VISTA from Responsible Partner(s) and added Project ABLE and Provoking Hope.			**4/15/2016 Update:** Project ABLE participated in the Veterans Stand Down event on 1/27/2016, where we were able to share information and build community awareness related to mental health wellness **Data Collected:** We met and talked with 27 individuals, including local healthcare providers **Challenges/Successes:** This was a great opportunity to reach out to the community and we had several individuals who started participating in our classes as a result. **3/24/2016 Update:** Champion Team is in the planning stages to conduct the 2nd annual peer picnic, a free public event that promotes peer community and education about all peer services in Yamhill Co. **Data Collected:** (2015= 99 participants from community at large) **Challenges/Successes:** Successful event planning/collaboration among peers from: Champion Team, ABLE, Yamhill Co & NAMI. Challenge with peer participation from other organizations

Objective 4: Increase resources available to Yamhill CCO members to manage diabetes and pre-diabetic conditions by December 2016.							
1. Promote hA1c screenings for all patients with diabetes	Yamhill CCO Global Budget	QCAP	**Not Started**				PC3 should also be added to the list of responsible partners, since so many clinical staff are members of the collaborative.
2. Promote regular LDL and hA1c testing status for Severely Mental Ill population by clinic/provider	Yamhill CCO Global Budget	QCAP	**Not Started**				
3. Increase screening of pre-diabetic members	Yamhill CCO Global Budget	QCAP	**Implementing**				Capitol Dental does diabetes screenings and YCCO's Community Health Hub offers a Diabetes Prevention Program to members.
4. Partner with NorthWest Senior and Disability Services to promote Diabetes Self-Management Programs for English and Spanish speaking Yamhill CCO members	Yamhill CCO Global Budget	NorthWest Senior & Disability Services	**Implementing**	**4/2/2015** A Diabetes Self Management class was held in McMinnville through Northwest Senior and Disability Services. The class recruited 20 participants and ended with four.		**12/1/2015** Abraham and the other CHWs have been partnering with Julie from NWSDS on offering a Diabetes program for clients.	Yamhill CCO continues to partner with NWSDS for member services. Due to several classes being postponed or cancelled, only one class had data to report. This is the DSMP class with 10 participants. The other classes started last quarter do not end until next quarter.