InterCommunity Health Network CCO

Community Health Improvement Plan

June 2019

Stronger, healthier, together.

Project Team

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Chapter 1: Introduction & Overview

Document Purpose

This is the 2019 InterCommunity Health Network CCO (IHN-CCO) Community Health Improvement Plan (CHIP). This document describes the CHIP's development and purpose. The document therefore also provides the context and history of IHN-CCO, its Community Advisory Council, the 2014 CHIP, and its 2016 Addendum.

InterCommunity Health Network CCO

IHN-CCO Mission

IHN-CCO was formed in 2012 by local public, private, and non-profit partners to unify health services and systems for Oregon Health Plan (Medicaid) Members in Benton, Lincoln, and Linn counties. In collaboration with its community partners, IHN-CCO works to plan and transform the future of healthcare within its region. IHN-CCO has a demonstrated history of improving the health of our communities while lowering or containing the cost of care. We accomplish this by coordinating health initiatives, seeking efficiencies through blending of services and infrastructure, and engaging all stakeholders to increase the quality, reliability, and availability of care.

IHN-CCO takes the "whole person" approach for the health of its Members and supports a continuum of care that integrates mental health, addictions, oral health, and physical health. The IHN-CCO Community Health Improvement Plan, as developed by its Community Advisory Council and approved by its Board of Directors, is instrumental to IHN-CCO strategic planning.

Community Advisory Council

Oregon Senate Bill 1580 (2014) requires that all CCOs "must have a community advisory council" (CAC). The primary tasks of the CAC are "overseeing a community health assessment and adopting a community health improvement plan to serve as a strategic population health and healthcare system service plan for the community served by the coordinated care organization; and annually publishing a report on the progress of the community health improvement plan."

The regional IHN-CCO CAC consists of nineteen Representatives (six per county, plus the Chair) and includes twelve IHN-CCO consumer Members, three county staff, and three community members. During the development of this CHIP, not all CAC seats were filled. However, a majority of IHN-CCO Member representation was maintained throughout the process, at both the regional and CHIP Workgroup level.

In partnership with the CAC, each county has a Local Advisory Committee to the CAC. Regional CAC Representatives also participate as members of the Local Advisory Committee meetings. Final recommendations are made at the regional Council level. By having one regional council and three local advisory committees to the council, IHN-CCO increased its:

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

IHN-CCO Values

- Stakeholder participation in design and delivery of healthcare
- Prevention, early intervention, and self-care
- Promotion of family health as a means of improving readiness to learn and adoption of lifelong, healthy lifestyles
- Delivering service that is culturally sensitive
- Coordinating care using the patient-centered, primary care, medical-home model, supported by information for medical need and overall health improvement
- Maintaining continuity of care for IHN-CCO Members through integration of services within and across providers and patient-support organizations
- Maximizing appropriate utilization of existing health resources within established protocols
- Achieving positive health outcomes through evidence-based health programs
- Utilizing performance and outcome data to guide the design and development of our healthcare delivery systems
- Strengthening community infrastructure to promote healthy neighborhoods
- Health equity
- Addressing the Social Determinants of Health

IHN-CCO Transformation

IHN-CCO spans the area of Benton, Lincoln, and Linn counties. Our Membership includes all Oregon Health Plan (OHP) Members in the coverage area. The providers in our partnership range from large multi-region health systems to a number of independent providers, clinics, and non-traditional providers.

IHN-CCO and its community partners embrace a collaboration model called Collective Impact. The five conditions to Collective Impact success are:

- *Common Agenda*: Shared vision for change
- *Shared Measurement:* Collecting data and measuring results consistently
- *Mutually Reinforcing Activities*: Differentiated, while still being coordinated
- *Continuous communications*: Consistent and open communication
- *Backbone support*: IHN-CCO is the backbone organization for the entire initiative and coordinates participating organizations

As the backbone organization, IHN-CCO coordinates and supports many councils, committees, and workgroups. These groups include (and are often chaired by) community partners. Those most relevant to healthcare systems transformation are the Regional Planning Council, the Delivery System Transformation Committee, and several workgroups.

Regional Planning Council (RPC)

Public agency and government leaders have come together with private healthcare providers to unify our voice and action in this collaborative endeavor to improve the health of the region. The Regional Planning Council (RPC) is a standing workgroup, charged by the IHN-CCO Board of Directors with planning and coordinating the regional system of health services and supports.

The Regional Planning Council:

- Serves to guide the development of a regional system of healthcare, firmly grounded in a philosophy of equitable, coordinated, person-centered, and locally delivered healthcare
- Develops tools and strategies to transform and integrate the system of care
- Recommends funding needed for transformational activities
- Sponsors an effective, innovative quality improvement process to drive positive system change
- Develops, supports, and maintains active communication and involvement with the Community Advisory Council to provide broad community input on the operations and performance of IHN-CCO
- Recommends and implements measures to ensure the effective continuum of care and care transitions within and between systems
- Provides regular reports to the Board of Directors, including specific requests needing Board approval that support system transformation

Delivery System Transformation Committee (DST)

The Delivery System Transformation Committee (DST) is open to anyone in Benton, Lincoln, and Linn counties who can positively affect the health outcomes of IHN-CCO Members. It includes over 55 partner organizations. The DST meets every two weeks, about 25 times per year.

Through robust collaboration with dozens of partnering organizations, the DST:

- Provides opportunities for learning and collaboration based on best practices, as well as on innovative ideas and efforts
- Supports care teams that work to coordinate care and uses the Patient-Centered Primary Care Home (PCPCH) as the foundation of healthcare
- Utilizes workgroups, comprised of people working toward a common agenda or strategic plan with a focus on cross-sector collaboration between PCPCHs and community efforts and services
- Approves and oversees transformation pilot projects and IHN-CCO health system transformation
- The current DST workgroups are:
    - Health Equity
    - Social Determinants of Health
    - Traditional Health Workers
    - Universal Care Coordination

Transformation Pilot Projects

As of January 2019, IHN-CCO, through the work of the Delivery System Transformation Committee, has supported 65 pilots, awarding over $20 million in transformation pilot project funding to local organizations.

Transformation pilot projects are innovative ideas that implement collaborative strategies with a focus on systems change to meet IHN-CCO Member needs. Pilot projects align with IHN-CCO goals, are prioritized by the CHIP; and, using the Collective Impact Model, pilot projects have described outcomes that focus on the triple aim of better health and better care at reduced cost.

Many pilots focus on creating health equity and addressing the Social Determinants of Health. The priorities in the 2014 CHIP and its 2016 Addendum have consistently been used to prioritize pilot projects. Moving forward, the priorities of this 2019 CHIP will be used for pilot project funding and other strategic planning needs.

Chapter 2: People and Place

Regional Overview[1]

The InterCommunity Health Network CCO (IHN-CCO) annually serves approximately 71,000 Members in the Oregon counties of Benton, Lincoln, and Linn. More than half of IHN-CCO Members live in rural areas (approximately 36,900). The region spans nearly 4,000 square miles: In the east, from the heart of western Oregon at the foothills of the Cascade Mountain range, through a portion of the agriculturally rich Willamette Valley, out to and including sixty miles of Pacific coastline. The diverse region is separated by the Coastal Mountain range, which contributes to some transportation and communication challenges, as 25% of the region's population reside on the Pacific Coast.

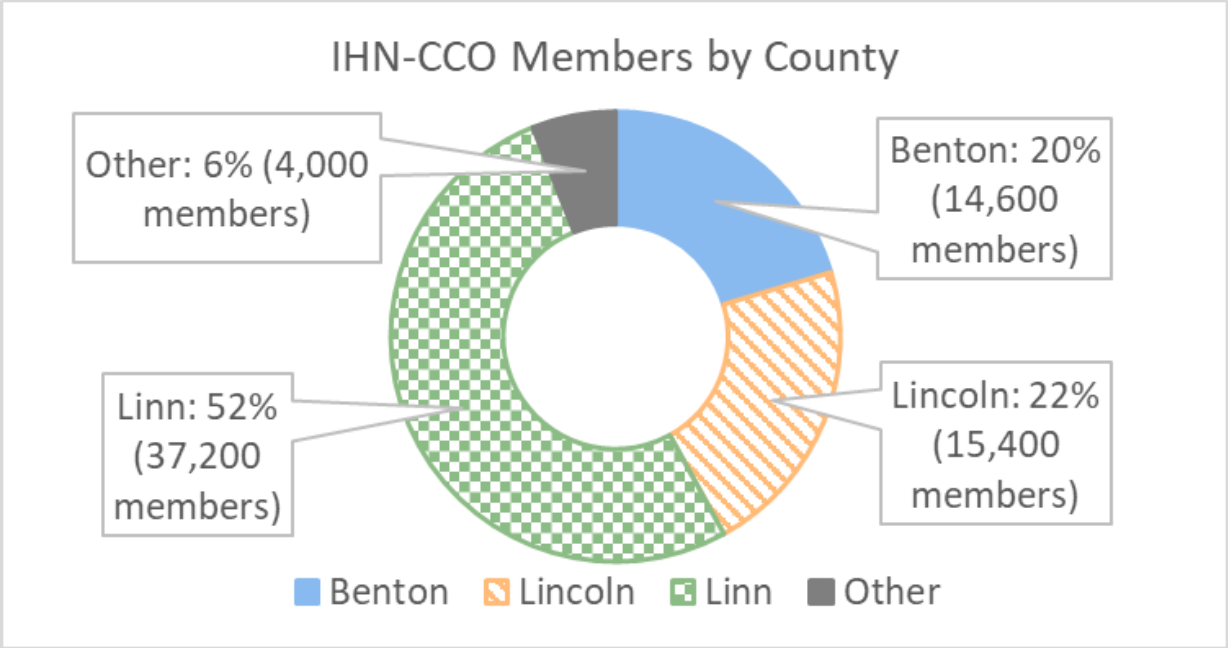
The area is predominantly white; and poverty levels are high, particularly in Lincoln and Linn counties. Latinos represent the largest ethnic minority population in the region (3,490 IHN-CCO Members). The most common language spoken by IHN-CCO Members is English. Ninety-four percent list their preferred language as English, 4.6% list Spanish as their primary language, and 2% list that they prefer to communicate in a language other than English or Spanish.

IHN-CCO Members who are disproportionately impacted by disease and illness include those with mental illness and disabilities. Approximately 36% (25,400) of IHN-CCO Members have been diagnosed with a mental illness, with 16% (11,500) diagnosed with Severe and Persistent Mental Illness (SPMI). Nine percent (6,200) of IHN-CCO Members have at least one disability that limits their ability to work.

IHN-CCO Members by County

Of the approximately 71,000 IHN-CCO Members served by IHN-CCO each year, 14,600 live in Benton County; 15,400 live in Lincoln County; and 37,200 live in Linn County. See Figure 1.

Figure 1: IHN-CCO Members by County

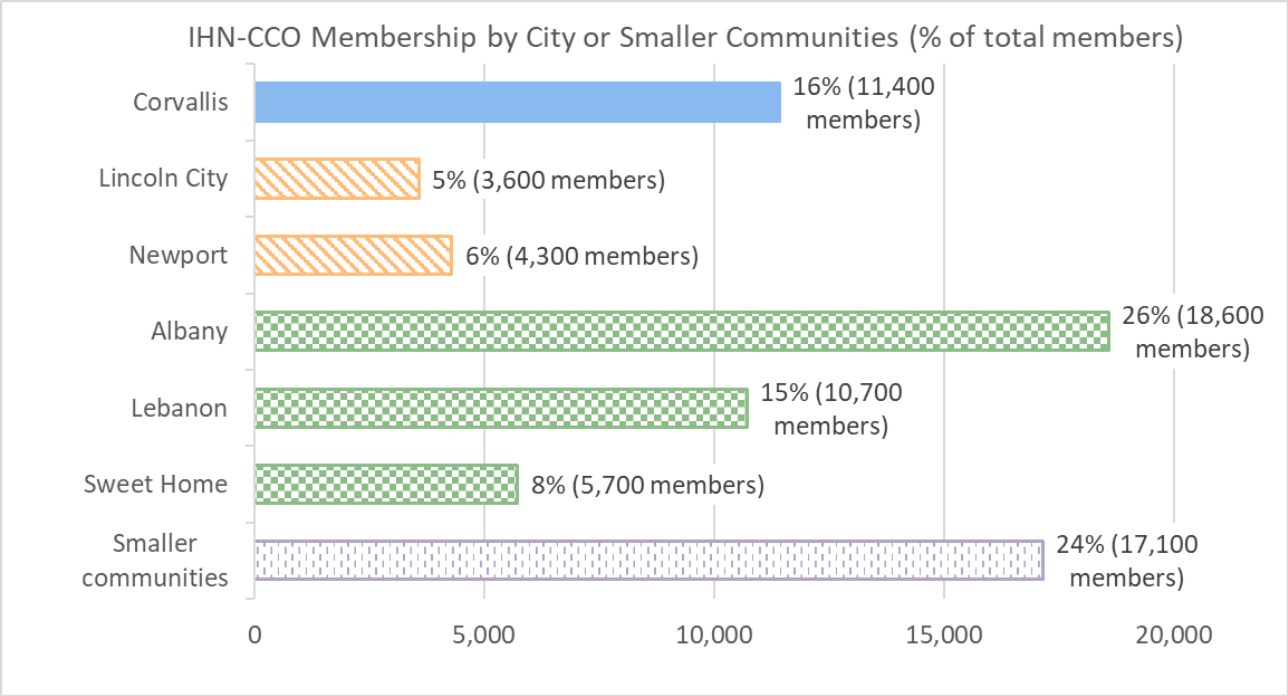


Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017 - June 2018.

IHN-CCO Membership by City

Within Benton, Lincoln, and Linn counties, IHN-CCO Members live in a variety of locations, from urban to rural. The largest proportion of Members live in Albany, followed by the proportions of Members who live in communities smaller than the six largest cities in the region (Albany, Corvallis, Lebanon, Sweet Home, Newport, and Lincoln City). See Figure 2.

Figure 2: IHN-CCO Membership by City or Smaller Communities

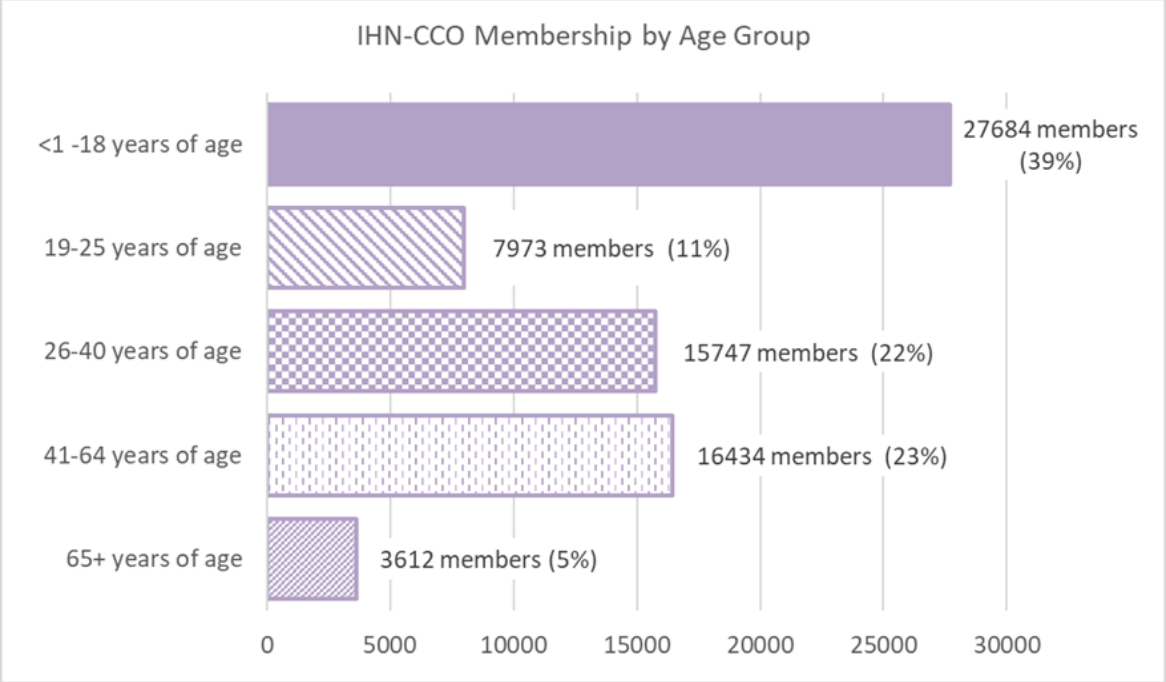


Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017-June 2018.

Members by Age

Most IHN-CCO Members across the region are either ages 26-64 or else less than age 1 to age 18. Another 11% are ages 19-25, while 5% are age 65 and older. See Figure 3a.

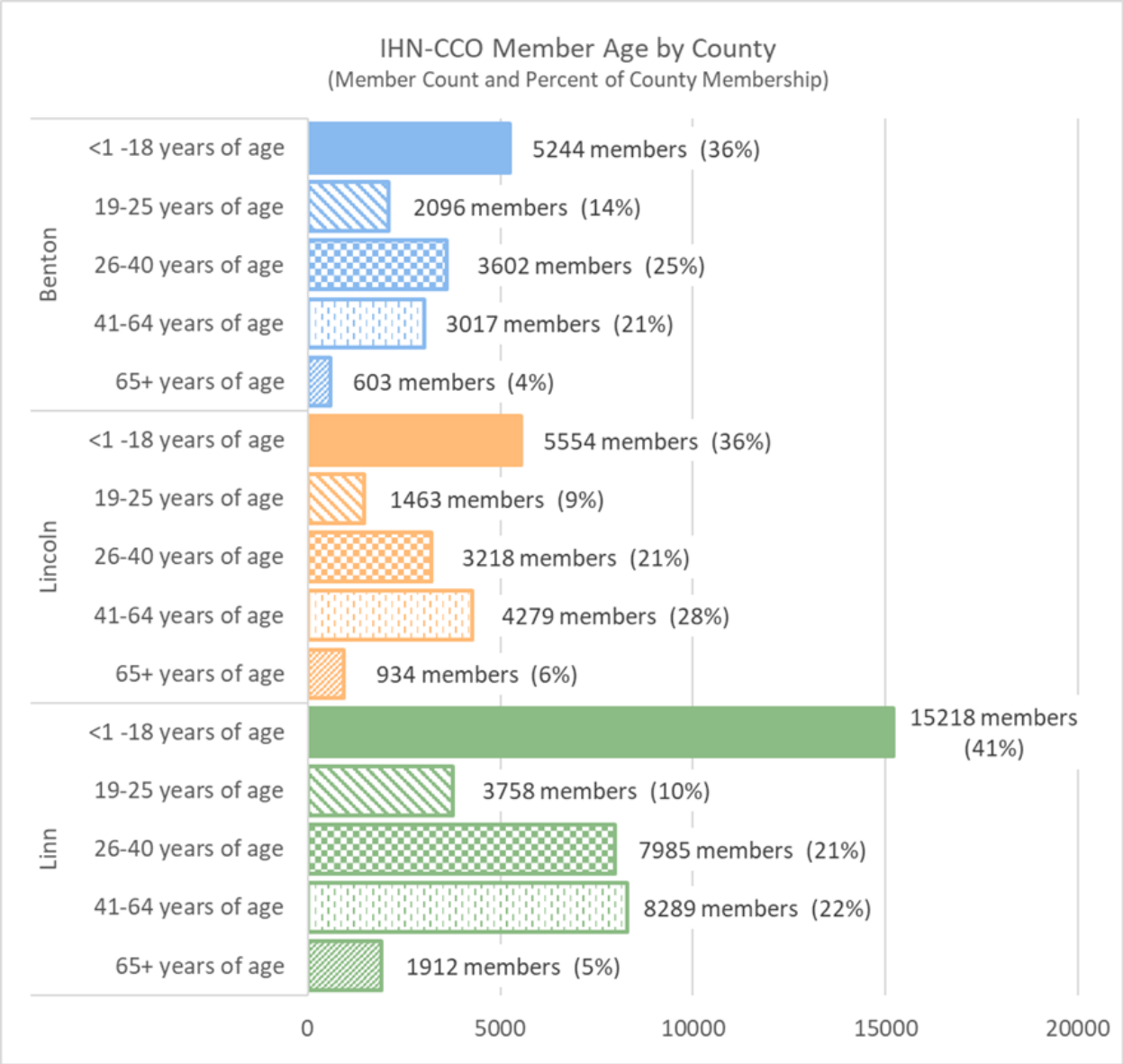
Figure 3a: IHN-CCO Member Age Ranges



Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017 - June 2018

The age distribution of IHN-CCO Members is fairly similar across counties (see Figure 3b). It is notable that— while Lincoln County is often considered to have a higher percentage of retirees overall—for the IHN-CCO Membership, the percent of Members ages 65 and older is very similar across counties at between 4% and 6%. Benton County has a slightly higher percentage of young adults IHN-CCO Members ages 19-24 (14%), while Lincoln and Linn Counties respectively have 9% and 10%. See Figure 3b.

Figure 3b: IHN-CCO Member Age by County

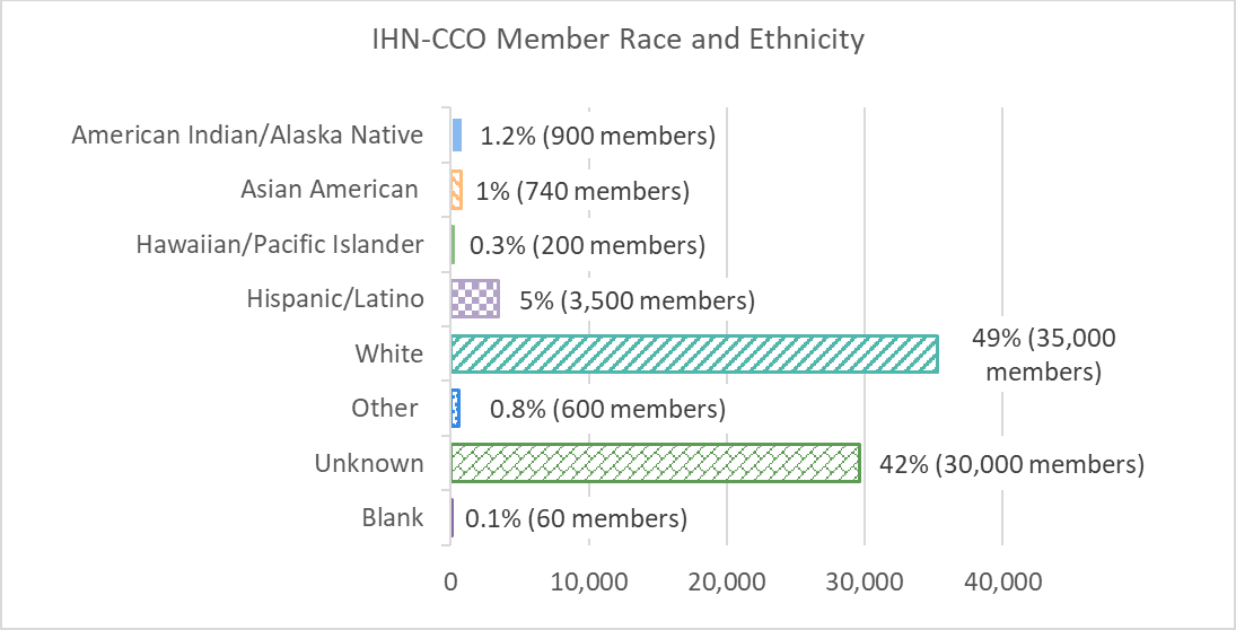


Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017-June 2018

Race, Ethnicity, and Language

Of IHN-CCO Members who reported their race or ethnicity on their application to join the Oregon Health Plan, the three largest reported race/ethnicities were White (49%), Hispanic/Latino (5%), and American Indian/Alaska Native (1.2%). Individuals who belong to a Native American tribe are able to receive care through the Indian Health Service; and they have the option to choose to join a Coordinated Care Organization. Many Members did not report their race or ethnicity (42% of Members). See Figure 4.

Figure 4: IHN-CCO Member Race and Ethnicity

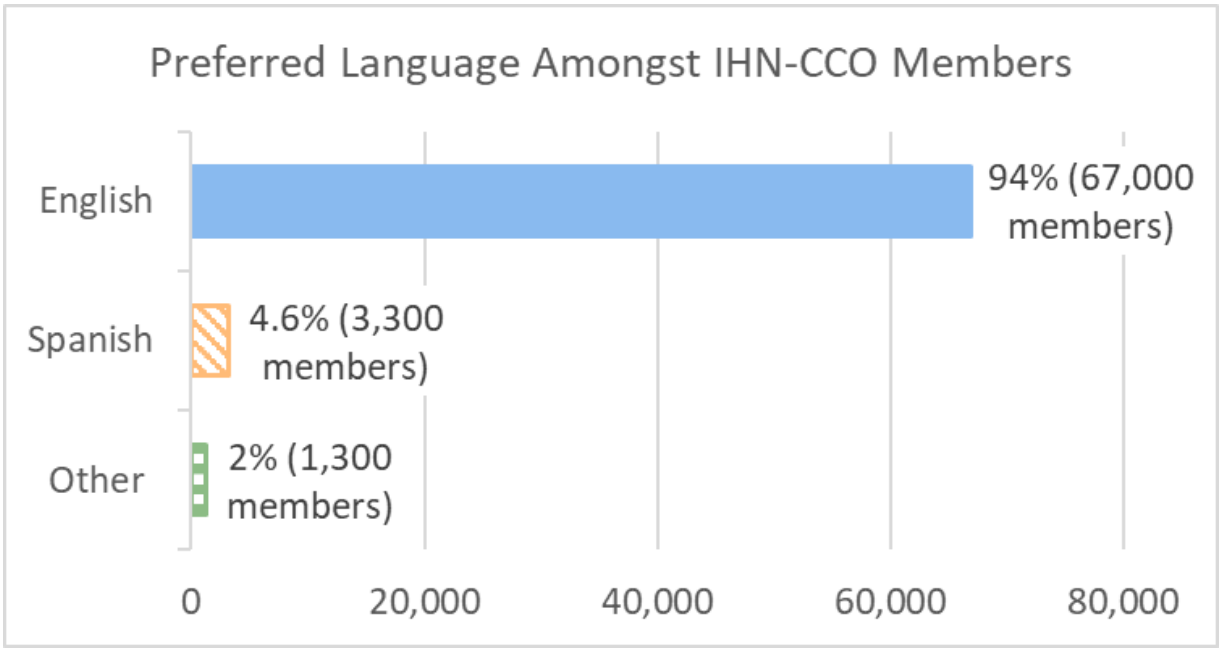


Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017 - June 2018

Preferred Language

Amongst IHN-CCO Members, English is the most common language spoken. That is, 94% indicated their preferred language is English, 4.6% of Members listed Spanish as their primary language, and 2% prefer to be communicated in another language. See Figure 5.

Figure 5: Preferred Language Amongst IHN-CCO Members



Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017-June 2018

Social Determinants of Health (SDoH)

In 2018, a small number of healthcare providers began recording information about the social and economic circumstances in which IHN-CCO Members find themselves. These circumstances, also known as Social Determinants of Health (SDoH), often impact an individual's health and wellbeing. If the negative impacts of people's circumstances are addressed, this can improve their health outcomes.

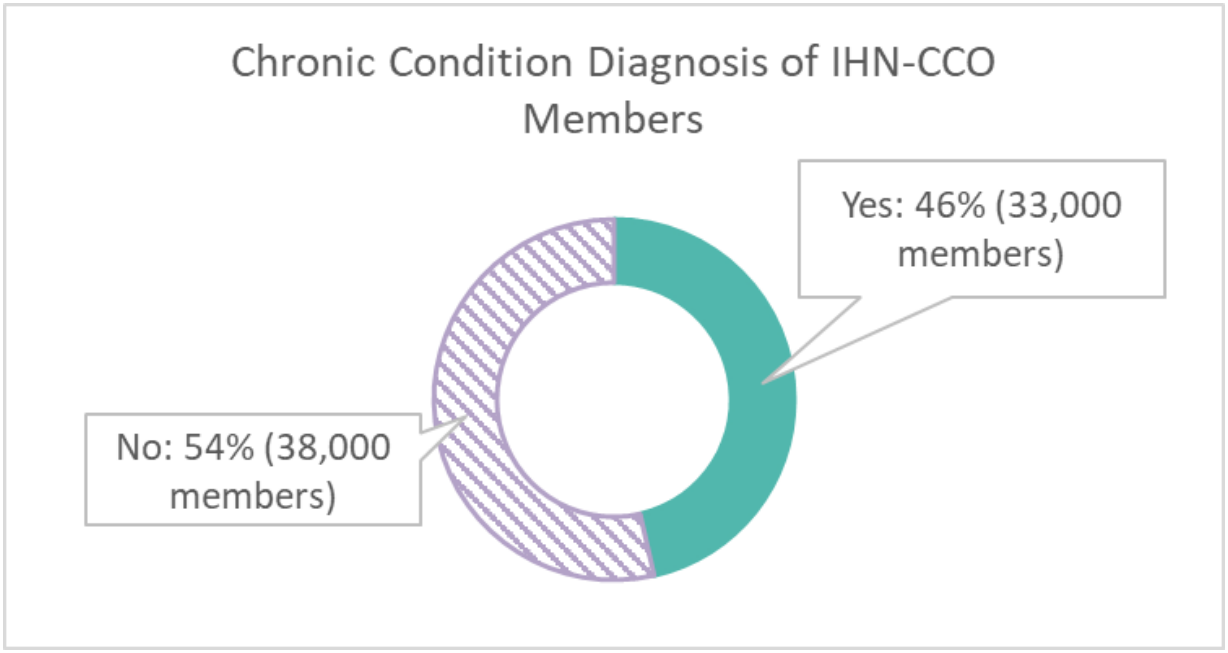
From the data provided, three issues rose to the top as the most commonly experienced issues related to Social Determinants of Health.

- Problems related to housing and economic circumstances, such as homelessness, housing instability, or poverty
- Problems related to an individual's primary support group, including family circumstances
- Problems related to upbringing, such as a history childhood abuse or having been in welfare custody

Health Status

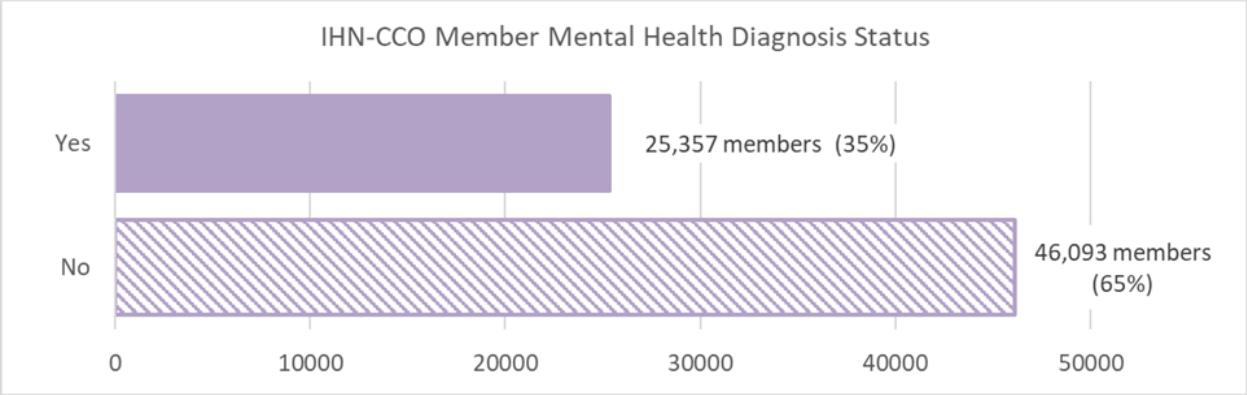
Forty-six percent of IHN-CCO Members have been diagnosed with a chronic health condition. See Figure 6. Thirty-five percent have been diagnosed with a mental health condition. See Figure 7.

Figure 6: Chronic Condition Diagnosis of IHN-CCO Members



Source: 2018 IHN-CCO Member Claims Data

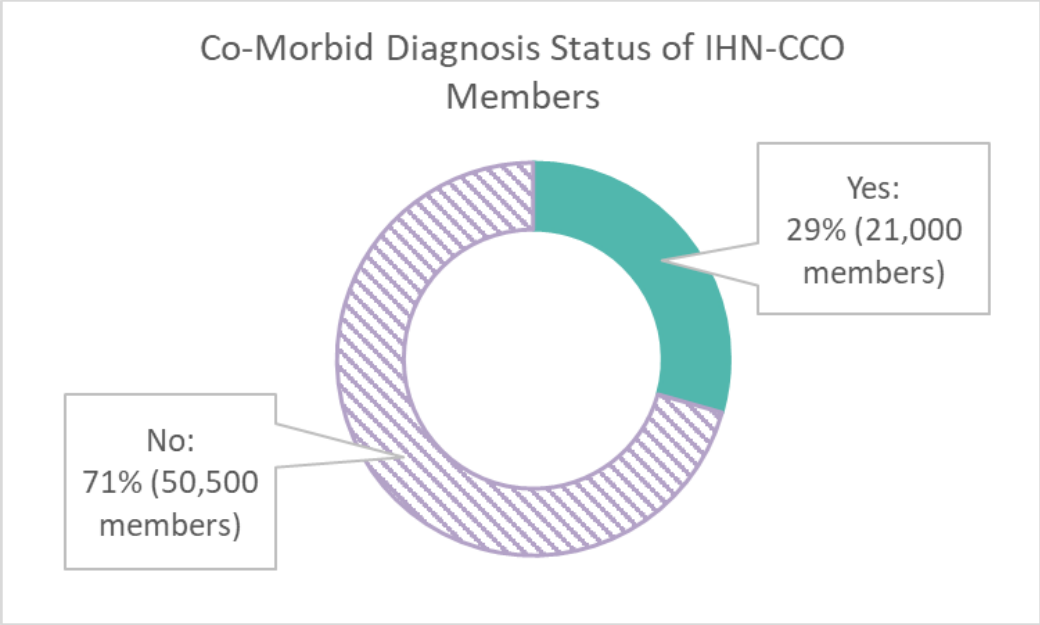
Figure 7: IHN-CCO Member Mental Health Diagnosis Status



Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017 - June 2018

A large percentage of Members with a chronic disease diagnosis are also diagnosed with a mental health condition; this is known as having a co-morbid diagnosis. Nearly a third (29%) of all Members are diagnosed with both a mental health condition and a chronic disease condition. See Figure 8.

Figure 8: IHN-CCO Member Co-Morbid Diagnosis Status



Source: Oregon Health Authority, IHN-CCO Membership Data, July 2017 - June 2018

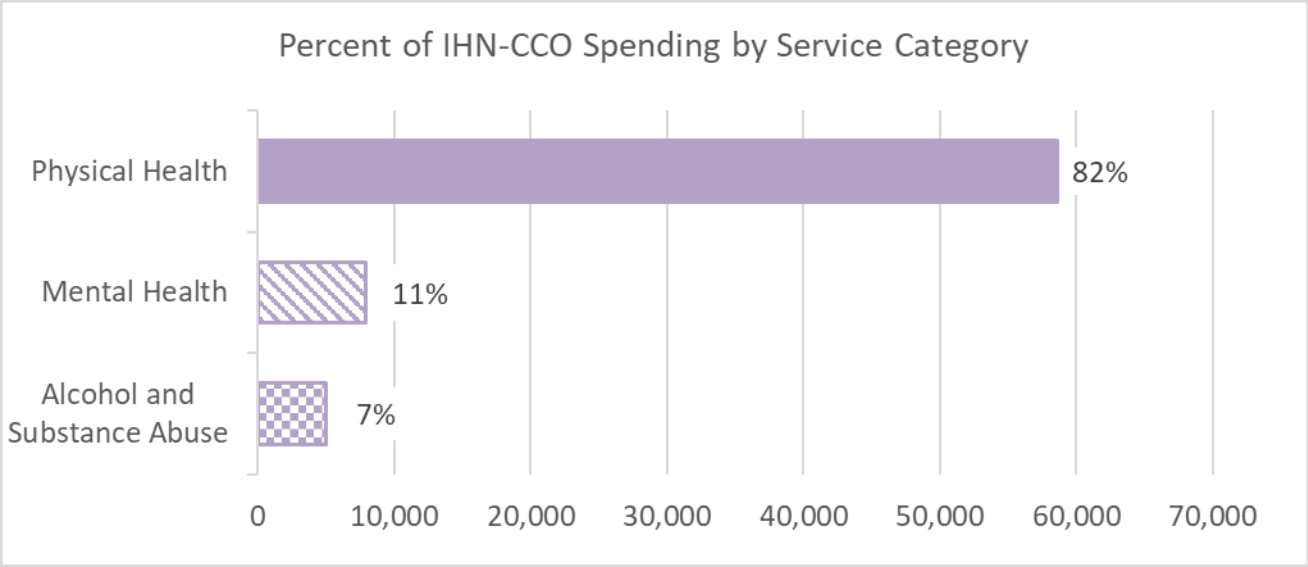
Emergency Department Use

At 22%, substance-related disorders are the condition for which IHN-CCO Members are most often seen in emergency departments within the region.

IHN-CCO Spending by Service Category

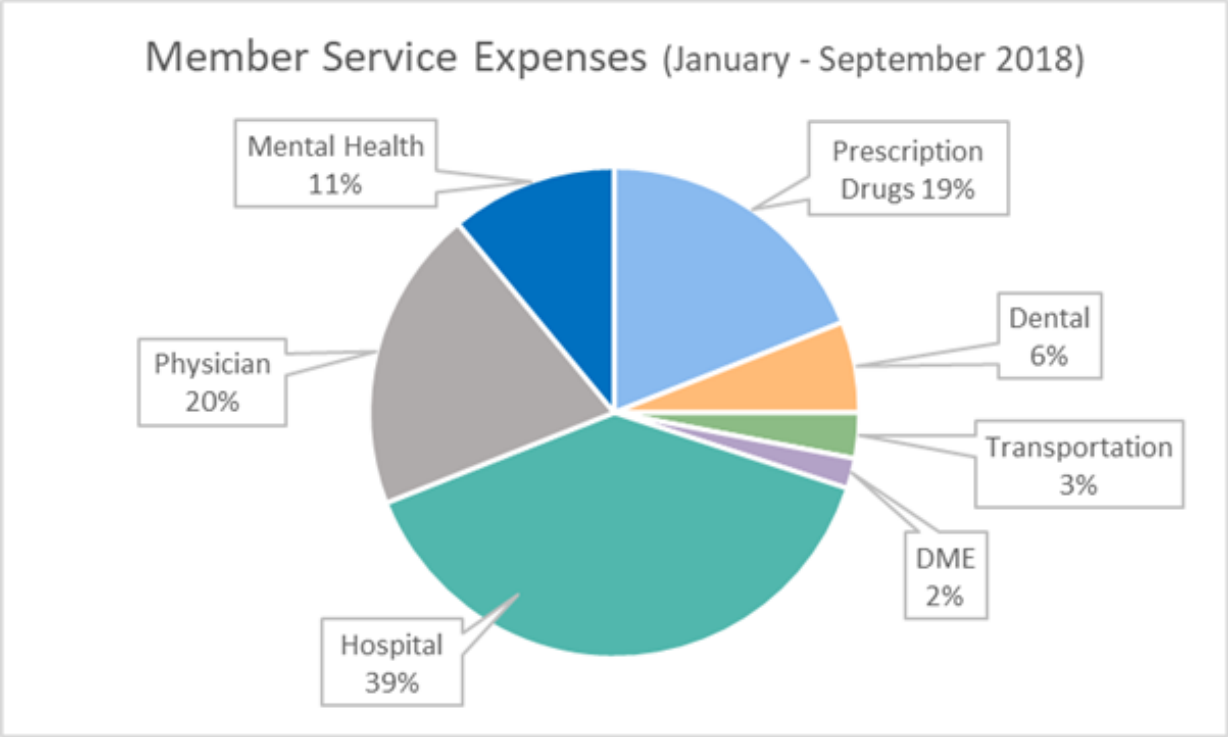
The majority of IHN-CCO spending pays for physical health services. It should be noted that many mental health services take place in the primary care/physical care setting and count toward physical health services spending. See Figures 9 and 10.

Figure 9: Percent of IHN-CCO Spending by Service Category



Source: 2018 IHN-CCO Member Claims Data

Figure 10: Percent of IHN-CCO Member Service Expenses, Jan – Sept 2018



Source: 2018 IHN-CCO Member Claims Data; DME is Durable Medical Equipment.

We can expect to see changes in IHN-CCO spending as provider payments begin to transition to paying for integration and quality via Alternative Payment Methodologies (Value-Based Payments). At the same time, it may become more difficult to determine how many mental health or substance use services are provided in alternative settings.

Chapter 3: Community Health Improvement Plan (CHIP)

The 2019 CHIP's Foundation

The 2019 Community Health Improvement Plan (CHIP) is based on the foundational work of the 2014 IHN-CCO CHIP[2] and its 2016 Addendum[3]. This 2019 CHIP borrows from and builds upon the Regional Health Assessment[4] and the three county Community Health Assessments of Benton[5], Lincoln[6], and Linn[7] counties.

The CHIP:

- Serves as a strategic population health and healthcare system service plan for the community served by the coordinated care organization.
- Sets initial areas of focus for health improvement while building upon ongoing community knowledge and efforts.
- Is a collaborative process that incorporates a broad range of community voices.

Guiding Principles of the CHIP

IHN-CCO recognizes the following values as guiding principles of this Community Health Improvement Plan:

- **Health Equity:**
  - Pursuing optimal health for all IHN-CCO Members:
  - Addressing and preventing potential health disparities due to age, disability, education, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.
  - Meeting people where they are
  - Developing trust by transparency of purpose.
  - Ensuring ease of access to healthcare for all IHN-CCO Members
- **Social Determinants of Health**
  - Recognizing that wellness starts in our homes, schools, workplaces, neighborhoods, and communities
  - A commitment to addressing the social determinants of health such as housing, transportation, and access to healthy food
- **Empowerment**
  - Sharing ownership of individual, familial, and population health through:
  - Holistic coordination between our healthcare providers
  - Active individual participation
  - Accountability for our own health and that of our families
  - Creating healthier communities through effective stewardship of resources by ensuring active community engagement in all aspects of our healthcare delivery system

- **Communication, Collaboration, and Coordination** is of primary importance for achieving the triple aim of better health and care at lower cost.

The CHIP Informs:

- Decision-making and strategic planning
- Prioritization of resources, particularly pilot project funding

CHIP Development Process

Local Advisory Committee Recommendations to the CHIP Workgroup

In January 2018, the CAC asked its Local Advisory Committees to make recommendations to the CHIP Workgroup on issues to consider in updating the 2014 IHN-CCO CHIP.[8] To be best informed in making their recommendations, the Local Advisory Committees were asked to review several documents including the:

- 2014 IHN-CCO CHIP[9]
- 2016 IHN-CCO CHIP Addendum[10]
- 2017 CHIP Progress Report[11]
- 2015 Linn Benton Lincoln Regional Health Assessment[12]
- A draft of their most recent county health assessment[13, 14,15]

The Local Advisory Committees were asked to hold four meetings over two months in order to discuss data and make their recommendations. The Regional Health Assessment Coordinator participated in those meetings, bringing additional data and analysis from the Regional Health Assessment Epidemiologist, as requested and available. The three committees, using slightly different processes, made the following recommendations for the CHIP Workgroup's consideration.

Those recommendations were:

- **Benton Local Advisory Committee recommendations**
  - Social Determinants of Health
  - Adequate nutrition & food security
  - Stress
  - Isolation: elderly and people with disabilities
  - Transportation (rural)
  - Oral Health
  - Sexual health, sexually transmitted infections
  - Substance use
- **Lincoln Coordinated Healthcare Advisory Committee recommendations**
  - Add Health Impact Areas:
    - ◊ Provider supports (including alternative provider)
    - ◊ Social Determinants of Health
  - Combine Maternal and Child Health Impact Areas
  - Add outcomes regarding:

        - ◊ Addictions
        - ◊ Severe and persistent mental illness
    - Review Chronic Disease Indicators (hypertension, coronary obstructive pulmonary disease, cardiac disease, Alzheimer's, dementia, etc.)
- **Linn Local Advisory Committee recommendations**
    - Social Determinants of Health
    - Health equity
    - Opioids/pain management
    - Access across all systems (technology, # of providers, etc.)
    - Severe and persistent mental illness
    - Rural communities
    - Communicable disease
    - Provider supports (burn out, respite training)
    - Respite care (family and other care providers)
    - Communication, connectivity, collaboration between clinical and social services and law enforcement and emergency preparedness, closed-loop referral.

CHIP Workgroup Membership

The CHIP Workgroup consisted of nine CAC Representatives/Local Advisory Committee Members (three from each county); four current IHN-CCO Members and one recent IHN-CCO Member. Nine staff supported the Workgroup, including the CAC Coordinator, the Regional Health Assessment Coordinator, an epidemiologist, a county health administrator, an Oregon Health Authority Innovator Agent, the CAC Chair, and a meeting facilitator. The Workgroup was committed to honoring the work of the 2014 CHIP, the 2016 CHIP Addendum, as well as the Local Advisory Committee recommendations. The CHIP Workgroup did its best to include everything possible, while keeping the scope manageable.

The CHIP Workgroup first met eight times in three months for a total of 24 hours and made decisions via consensus. At that time, the CHIP Workgroup sent a set of proposed priorities back to the Local Advisory Committees, requesting their feedback. Those committees provided written feedback. The CHIP Workgroup then met two more times to integrate the Local Advisory Committee feedback into their proposed priorities; this was then taken to the CAC for their adoption.

Major Tasks Performed by the Workgroup:

1. Established a process and work plan for identifying priority Outcomes and Indicator Concepts
2. Reviewed all Outcomes, Indicator Concepts, and Local Advisory Committee recommendations
3. Discussed data availability information provided by support staff and each other (who updated and refined this information throughout the identification process)

4. Agreed to a set of factors or values for consideration when identifying priority Outcomes and Indicator Concepts, which included:
    a. Impact on CCO Members, healthcare transformation, prevention, and community health
    b. Data availability and/or reasonableness of data request
    c. Support for innovation
    d. Whether there are others working on the issue; value of including in CHIP as Health Impact Area (HIA), Outcome, or Indicator Concept. This factor was also considered in whether to include certain Quality Incentive Metrics
    e. Short-term and long-term goals
    f. Forward looking; this is a five-year plan
    g. Opportunity to merge; reduce redundancies
    h. Number of providers or others who could impact outcome
    i. Cost/savings for IHN-CCO and for Members
5. Along with the agreed upon factors, the group considered the CHIP's ability to impact pilot project prioritization and other strategic planning
6. Agreed that equity, social determinants of health, and care coordination—along with being included throughout the plan—should be included in the 2019 CHIP introduction as guiding principles
7. Agreed on 6 priority Health Impact Areas, 22 Outcomes, 32 Indicator Concepts, and 50 Areas of Opportunity
8. Added Social Determinants of Health and Equity as a priority area, known as a Health Impact Area (HIA)
9. Sent their recommendations to the Local Advisory Committees for feedback
10. Considered and integrated Local Advisory Committee feedback into a final set of recommendations for the CAC
11. Tasked the CAC Coordinator with writing the 2019 IHN-CCO CHIP
12. Provided feedback on a draft of the CHIP
13. Sent the CHIP to the CAC for feedback and adoption

Health Impact Areas, Outcomes, & Indicators

Health Impact Areas

This CHIP identifies six priority areas of focus called Health Impact Areas, which are:

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

For each Health Impact Area, the CHIP identifies several Outcomes and Indicators.

- **Outcomes** are results, changes, or improvements that come about from a program, such as changes in knowledge, awareness, skills, attitudes, opinions, aspirations, motivation, behavior, practice, decision-making, policies, social action, condition, or status. Outcomes are a standard of some level of success.
- **Indicators** are measurements or data that provide evidence that a certain condition exists, or certain results or progress toward improvements have or have not been achieved. Indicators measure the level of success or lack of success a program has had in achieving an outcome. These indicators serve to further clarify and define their related outcomes. They are sometimes referred to as **Indicator Concepts** within this document, recognizing the fact that they are often broadly defined, in order to allow for more flexibility in the types of data to be included in annual CHIP progress reports.

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

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

Access to Healthcare

Outcomes	Indicator Concepts and Areas of Opportunity
A1: Increase the percentage of Members who receive appropriate care at the appropriate time and place.	**Indicator Concepts** a. Length of time from IHN-CCO enrollment to first appointment b. Length of time from appointment request to appointment for behavioral, physical, and oral health services c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Appropriate physical, behavioral, and oral preventive healthcare for all ages
	Area of Opportunity *i. Culture of support for healthcare providers*
A2: Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.	**Indicator Concept** a. Percentage of Members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care
A3: Improve integration of oral health services with behavioral and physical health services.	**Indicator Concepts** a. Percentage of Members who have a dental visit during pregnancy compared to total percentage of Members who have a dental visit b. Percentage of dental assessments for youths in Department of Human Services custody c. Percentage of adults with diabetes who access dental care d. Percentage of Emergency Department visits with a caries-related diagnosis that are followed-up on in a dental care setting

Behavioral Health spans a continuum of behavioral disorders including, but not limited to, prevention, diagnosis and treatment of mental health disorders, mental illness, substance use, and addictive disorders. It includes wellness and provides differentiation between lesser behavioral health issues attributed to mental health and more intrusive disorders described as severe and persistent mental illness.[16]

Behavioral Health	
Outcomes	**Indicator Concepts and Areas of Opportunity**
BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.	**Indicator Concepts** a. Number of community Members, employers, landlords, teachers, elected officials, and service providers (e.g. law officers, firefighters, Emergency Medical Technicians) trained in Mental Health First Aid, or trauma informed care, or other basic mental health awareness training b. Peer-delivered behavioral health education and services
	Areas of Opportunity *i. Behavioral health stigma within the community* *ii. Community supports in the community to normalize behavioral health issues*
BH2: Increase the behavioral health expertise of healthcare providers and staff to reduce stigma and improve access and appropriate utilization of services.	**Indicator Concepts** a. Oregon Psychiatric Access Line about Adults (OPAL-A) utilization
	Areas of Opportunity *i. Members receive behavioral health services, screenings, and referrals in primary care settings* *ii. Co-located primary care and behavioral health providers* *iii. Primary care providers and Emergency Department staff exposed to behavioral health education, information, and Continuing Medical Education*

Behavioral Health (continued)

Outcomes	Indicator Concepts and Areas of Opportunity
BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.	**Indicator Concepts** a. Screening, Brief Intervention, Referral to Treatment (SBIRT) rates b. Rates of suicidal ideation, attempts, suicide, and/or self-harming behaviors c. Overdose rates
	Areas of Opportunity *i. Mental health and substance use services, screenings, and referrals in venues other than traditional medical facilities, including schools* *ii. Peer delivered education and support* *iii. Mental health service wait-times* *iv. Lack of mental health services for those not in crisis*
BH4: Improve care for Members experiencing mental health crisis.	***Areas of Opportunity*** *i. Quality of mental health care* *ii. Appropriate care at the appropriate time and place for people experiencing a mental health crisis* *iii. Time from appointment request to appointment with a mental health care provider* *iv. Care coordination*
BH5: Improve care for Members experiencing severe and persistent mental illness.	***Areas of Opportunity*** *i. Non-mental health care (i.e., physical & oral)* *ii. Continuity of care* *iii. Ongoing engagement with a behavioral health provider* *iv. Health equity for this marginalized population* *v. Stigma reduction* *vi. Assertive Community Treatment (ACT)*
BH6: Behavioral health funded and practiced with equal value and priority as physical health.	**Indicator Concepts** a. Implement and report progress on a behavioral health parity plan
	Areas of Opportunity *i. Number of mental health providers* *ii. Preventative behavioral healthcare and promotion of general wellbeing*

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

Child & Youth Health	
Outcomes	**Indicator Concepts and Areas of Opportunity**
CY1: Increase the percentage of children, youth, and families who are empowered in their health.	***Areas of Opportunity*** *i. Utilization of advocacy services and supports* *ii. Children, youth, and families partner with their healthcare provider, set their own goals, and follow through on those goals*
CY2: Decrease child abuse and neglect rates.	**Indicator Concepts** a. Neglect; emotional, physical, and sexual abuse rates
CY3: Increase breastfeeding initiation and duration rates.	**Indicator Concepts** a. Percentage of women who receive lactation consultation and support during pregnancy and following childbirth b. Breastfeeding rates
	Area of Opportunity *i. The ability to conveniently pump breast milk at work*
CY4: Increase integration of behavioral health and oral care as part of routine primary pediatric care.	**Indicator Concepts** a. Number of regular behavioral health screenings occurring for pediatric IHN-CCO Members b. Oregon Psychiatric Access Line about Kids (OPAL-K) utilization c. Mental, physical, and dental health assessments for children in DHS custody (Quality Incentive Metric) d. Percentage of teens who had a dental check-up, exam, teeth cleaning, or other dental work
	Area of Opportunity *i. Occurrence of care coordination between primary care and behavioral health providers when working with children, youth, and families, including consultations and referrals.*

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

Chronic Diseases are human health conditions of long duration and generally slow progression.[17] Chronic diseases, such as heart disease, stroke, cancer, diabetes, depression, certain mental health and addictions conditions are among the most prevalent, costly, and preventable of all health problems. Research shows that access to resources that support healthy lifestyles, such as nutritious food, recreational opportunities, and high quality and affordable prevention measures—including screening and appropriate follow-up—saves lives, reduces disability, and lowers medical costs.[18]

Healthy Living	
Outcomes	**Indicator Concepts and Areas of Opportunity**
HL1: Increase the percentage of Members who are living a healthful lifestyle.	***Areas of Opportunity*** *i. Disease prevention, management, and recovery* *ii. Nutrition* *iii. Physical activity* *iv. Weight shaming and blaming* *v. Stress* *vi. Sleep quality* *vii. Social supports, such as family, friends, and community*
HL2: Reduce the percentage of Members who use and/or are exposed to tobacco.	**Indicator Concepts** a. Tobacco prevalence (Quality Incentive Metric), including tracking prevalence among Members who are under age 18, pregnant, or who are a Member of another at-risk group b. Use of cessation resources and tools
	Area of Opportunity *i. Youth introduction to tobacco products*
HL3: Reduce sexually transmitted infection (STI) rates.	**Indicator Concepts** a. Sexually transmitted infection rates b. Expedited Partner Therapy utilization rates

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

Maternal Health	
Outcomes	**Indicator Concepts and Areas of Opportunity**
M1: Reduce unplanned pregnancy rates.	**Indicator Concept** a. Effective contraceptive use among partners
	Area of Opportunity *i. Data availability for effective contraceptive use among all Members*
M2: Increase the percentage of Members who receive early and adequate care and support before, during, and after pregnancy.	**Indicator Concept** a. Behavioral health screenings and access to treatment with a behavioral health provider
	Areas of Opportunity *i. Healthy weight gain during pregnancy* *ii. Utilization of postpartum care and support* *iii. Partner education and involvement*

Social Determinants of Health[19] (SDoH) are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.

The Social Determinants of Equity [20] are factors such as ableism, racism, sexism, and others that determine how different groups of people may experience SDoH.

Health Equity means that everyone has a fair and just opportunity to be as healthy as possible, regardless of age, disability, education, gender identity, geographical location, race or ethnicity, etc. This requires removing economic and social obstacles to health such as poverty and discrimination.[21]

Social Determinants of Health and Equity	
Outcomes	**Indicator Concepts and Areas of Opportunity**
SD1: Increase the percentage of Members who have safe, * accessible, affordable housing. *Safe housing: a structurally sound, secure, sanitary, nontoxic residence with basic utilities, timely repairs, and adequate space for residents	**Indicator Concepts** a. Number of homeless persons b. Number of homeless students ***Areas of Opportunity*** *i. Stable housing upon discharge from hospital or emergency room visit* *ii. Evictions prevention and reduction* *iii. Housing-related, closed-loop referral between clinical and community services* *iv. Social Determinants of Health claims data*
SD2: Increase the percentage of Members who have access to affordable transportation.	***Areas of Opportunity*** *i. Non-medical transportation access* *ii. Distance between Members' homes and public transportation* *iii. Member utilization of available, covered transportation services* *iv. Provider knowledge of, and referral to, available transportation services*

Social Determinants of Health and Equity (continued)

Outcomes	Indicator Concepts and Areas of Opportunity
SD3: Increase the percentage of Members who have access to healthy food.	**Indicator Concept** a. Percentage of Members living in a food desert
	Areas of Opportunity *i. Food security* *ii. Availability of fresh, affordable produce*
SD4: Increase health equity.	***Areas of Opportunity*** *i. Health disparities experienced by Members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.* *ii. Availability of health equity data*

Appendix I: Affiliations and Acknowledgements

The 2019 IHN-CCO Community Health Improvement Plan is a collaborative effort of the many community members, organizations, and providers with a commitment to improving the health of IHN-CCO Members. Listed below are the organizations represented by individuals who worked on the CHIP, either as a representative of the Community Advisory Council, a member of a Local Advisory Committee to the CAC, or in a professional role within the system of healthcare and social services.

Addiction, Prevention, and Recovery Committee, Lincoln County
Alcohol and Drug Addiction Council, Lincoln County
Behavioral Health Quality Committee, IHN-CCO
Benton, Lincoln, and Linn Health Administrators
Benton, Lincoln, and Linn Local Advisory Committees to the CAC
College of Osteopathic Medicine Pacific Northwest - COMP NW
Communities Helping Addicts Negotiate Change Effectively
Community Doula Program
Community Health Centers of Benton and Linn Counties
COMP NW - Center for Lifestyle Medicine
COMP NW - Medical Education
Corvallis Community Services Consortium
Court Appointed Special Advocate
Darkness to Light facilitator, Child sexual abuse prevention
Delivery Systems Transformation Committee, IHN-CCO
Dental Program Clinical Coordinator, Samaritan Health Services
Developmental Disabilities Advisory Committee, Lincoln County
Disabilities Services Advisory Committee, Oregon Cascades West Council of Governments
Disability Services Advisory Council, Oregon Cascades West Council of Governments
Eddyville School Board
Foster Parents
Gender & Non-binary advocate
Growing Family Birth Center
Health Care for All, Oregon
Health Equity Workgroup, IHN-CCO
Homeless Resource Team, Benton County
Homeless Vulnerable Patient Panel Member
Homelessness advocate for seniors
InterCommunity Health Network CCO
InterCommunity Health Network CCO Board of Directors
Legal Aid Services of Oregon

Appendix I

Lincoln Community Health Centers
Lincoln County Federally Qualified Health Center Council
Linn-Benton Health Equity Alliance
Linn-Benton Housing Authority
Living Well with Chronic Conditions Facilitator
Meals on Wheels Advisory Committee, Oregon Cascades West Council of Governments
Mental Health Advisory Board, Linn County
Mental Health Advisory Committee, Lincoln County
Mental Health First Aid Instructor
Oregon Aging and Disability Resource Connect Advisory Committee
Oregon Cascades West Council of Governments
Oregon Disabilities Commission
Oregon Health Authority Innovator Agent
Oregon Health Plan Assister
Public Health Advisory Committee, Lincoln County
Quality Management Committee, IHN-CCO
Regional Planning Council, IHN-CCO
Samaritan Health Plans
Samaritan Health Services
School Based Health Centers, Lincoln County
Senior Services Advisory Council, Oregon Cascades West Council of Governments
Sheriff's Community Advisory Group, Lincoln County
Signs of Victory Ministries
Signs of Victory Shelter and Warming Center
Social Determinants of Health Workgroup, IHN-CCO
State Health Assessment Steering Committee
State Health Improvement Plan Steering Committee, Oregon Health Authority
Street Outreach and Response Team, Corvallis
Sweet Home Community Health Committee
Systems of Care Advisory Committee, IHN-CCO
Traditional Health Workers Workgroup, IHN-CCO
Trillium Family Advisory Council
Universal Care Coordination Workgroup, IHN-CCO
Willamette Neighborhood Housing Services

Appendix II: Acronyms

ACEs – Adverse Childhood Experiences

ACT – Assertive Community Treatment

CAC – Community Advisory Council

CHA – Community Health Assessment

CHIP – Community Health Improvement Plan

CCO – Coordinated Care Organization

DHS – Department of Human Services

DME – Durable Medical Equipment

DST – Delivery System Transformation Committee

HIA – Health Impact Area

IHN-CCO – InterCommunity Health Network Coordinated Care Organization

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

OHP – Oregon Health Plan (Medicaid)

Opal-A – Oregon Psychiatric Access Line about Adults

Opal-K – Oregon Psychiatric Access Line about Kids

PCPCH – Patient Centered Primary Care Home

RHA – Regional Health Assessment

RPC – Regional Planning Council

SBIRT – Screening, brief Intervention, and referral to treatment

SDoH – Social Determinants of Health

SPMI – Severe and Persistent Mental Illness

THW – Traditional Health Worker

Appendix III: Glossary of Terms

Ableism – Discrimination against people with disabilities

Adverse Childhood Experiences (ACEs) – Are stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family Members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse[22].

Ageism – Discrimination against people based on their age

Addendum – Something that is added to the main or original text

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

Assertive Community Treatment (ACT) – an evidence-based way of delivering a full range of services to people who have been diagnosed with a serious mental illness. ACT's goal is to give individuals adequate community care and to help them have a life that is not dominated by mental illness[23]

At Risk – An individual or group who is more likely than another individual or group to experience a problem, such as an illness

Durable Medical Equipment – Durable Medical Equipment provides therapeutic benefits to a patient in need because of certain medical conditions and/or illnesses. They are usually prescribed by a physician and are appropriate for use outside of the clinical setting, such as crutches or oxygen tanks

Epidemiologist – Someone who studies patterns, causes, and effects of health and disease conditions in defined populations and is knowledgeable about relevant data.

Food Desert – Food deserts are areas that lack access to affordable fruits, vegetables, whole grains, milk, and other foods that make up a full and healthy diet [24]

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

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

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

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

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

Opal-A – Oregon Psychiatric Access Line about Adults provides free, same-day adult psychiatric phone consultation to primary care providers in Oregon[25]

Opal-K – Oregon Psychiatric Access Line about Kids provides free, same-day child psychiatric phone consultation to primary care providers in Oregon[26]

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

Quality Incentive Metric – Measures that show how well Coordinated Care Organizations (CCOs) are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of health care.

Resiliency – The ability to recover from potentially adverse experiences

Regional Health Assessment Team – The Regional Health Assessment Team works to coordinate data collection and reporting across Benton, Lincoln, and Linn counties. They are working to create a central database for community partners to provide & share data to support the repeating cycles of community health assessment across the region.

Rural – any geographic areas ten or more miles from the geographic city center of a city with a population of 40,000 people or more[27]

Severe and Persistent Mental Illness (SPMI) – Adults with SPMI are defined for individuals, age eighteen or older, based on diagnoses including Schizophrenia and other psychotic disorders, Major depression and Bipolar disorder, Anxiety disorders, and Schizotypal Personality disorder, or Borderline Personality Disorder; or for an individual who has more than one mental illness (excluding substance use and addiction disorders) and a Global Assessment of Functioning score of 40 or less.[28]

Social Determinants of Health – Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, and age that affect health wellbeing.[29]

Traditional Health Workers (THWs)[30] are individuals in their communities, providing physical and behavioral health services. There are five traditional health worker types:

- **Community health workers**: Assist Members in receiving the healthcare they need
- **Peer support specialists**: Provide support, encouragement and assistance to addictions and mental health consumers
- **Peer wellness specialists**: Provide support, encouragement, and assistance to address physical and mental health needs

- **Personal health navigators**: Provide care coordination for Members from within the health system
- **Birth doulas**: Provide companionship and personal, nonmedical support to women and families throughout the childbirth and post-partum experience

Appendix IV: CHIP Crosswalk – Regional & State Alignment

CHIP Alignment Across Benton, Lincoln, and Linn Counties, as well as the Oregon State Health Improvement Plan

		IHN-CCO *(Benton, Lincoln, & Linn Counties)* 2019	Benton County Public Health 2018	Lincoln County Public Health 2019	Linn County Public Health 2018	Samaritan Hospitals *(Benton, Lincoln, & Linn Counties)* 2016	Oregon State Health Improve-ment Plan 2019
Priority Areas for Health Improvement	Access to Healthcare	✓				✓	✓
	Behavioral Health	✓	✓	✓	✓	✓	✓
	Child & Youth Health	✓				✓	
	Community Resiliency & Trauma	✓	✓	✓	✓		✓
	Health Equity	✓	✓	✓	✓		✓
	Food *(Healthy, Affordable, & Secure)*	✓	✓	✓	✓	✓	✓
	Housing	✓	✓		✓	✓	✓
	Maternal & Reproductive Health	✓			✓		
	Physical Activity	✓		✓		✓	
	Sexually Transmitted Infections	✓	✓		✓		
	Tobacco Use	✓		✓		✓	
	Transportation	✓	✓		✓	✓	✓
	Immunizations	✓	✓				

Appendix V: References

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