



**Community Health Improvement Planning for Integrated Care
Guidelines to Meet HB 2675 Requirements**

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Background and Context

In 2017, the Oregon Legislature passed [House Bill 2675](#). This bill amended [ORS 414.627](#) that relates to community health improvement plan (CHP) requirements for coordinated care organizations (CCOs). Specifically, the bill states that the CHP “shall include a plan and a strategy for integrating physical, behavioral and oral health care services.”

The guidelines in this document are intended to help CCOs and their community advisory councils (CACs) implement the requirements and develop integration plans and strategies for their CHPs. The guidelines include concepts, processes, tools, examples and resources to help communities develop meaningful and achievable goals and objectives that increase integration efforts across multiple sectors. A recorded webinar is available for further guidance and provides a walk-through of the process described in these guidelines:

<https://attendee.gotowebinar.com/register/8112498445925907969>

The clinical and social value of integration has been clearly demonstrated in multiple health centers across the country. Bringing multidisciplinary care to clinical environments has been most powerfully documented in the Patient-Centered Primary Care Home (PCPCH) program, which has been a cornerstone of the Oregon Health Authority’s (OHA’s) primary care strategy. The introduction of dental care within the CCO delivery system has been deliberate, with the understanding of the strong link between oral health and overall health outcomes. Integration of oral health services has been challenging in many communities, but it has great potential for improving community health when implemented effectively.

The ultimate goals of integration are improved patient outcomes, improved patient experience, improved provider experience and reduced total cost of care. The financial impact of care integration has been demonstrated with increased efficiency, improved preventive services and more effective collaborative care plans. House Bill 2675 calls for collaborative community-based initiatives to purposefully integrate key services within the delivery system and ultimately within the programs addressing the social determinants of health.

Recommended Approach

These are approaches that could be taken to add integration elements to the CCO CHP:

- 1. Identify potential areas for integration and available resources using the Mobilizing for Action through Planning and Partnerships (MAPP) assessment model as a base and adding a care integration assessment.**
 - The care integration assessment will consist of a planning and preparation phase, a brainstorming phase, and an identification of resources and opportunities phase.
 - Two grids are provided to aid in the assessment process:
 - i. General community grid that identifies areas of existing integration, areas of potential integration, and areas where integration is not possible or desirable.
 - ii. Focused CCO services grid intended for oral health, primary care and behavioral health that identifies areas of integration by level of integration (coordinated, co-located and fully integrated).

- 2. Create plans and strategies for implementing priority areas using 10 domains of integration adapted from an Agency for Healthcare Research and Quality (AHRQ) Behavioral Health Primary Care Integration Model.**

This will help you organize thinking about possible areas for integration initiatives and activities.

 - Two planning grids are provided to assist CHP planning groups take priority areas identified in the assessment and create logical, meaningful and achievable goals and objectives for the plan:
 - i. A domain assessment grid that helps the team assess current efforts in the desired areas of integration by domain, as well as brainstorm possible next step goals.
 - ii. A feasibility assessment grid for each potential goal/objective idea from the brainstorm that assesses for partnerships, readiness and resources for each goal.

- 3. Use toolkits and examples provided in the appendices to operationalize the integration assessment and improvement planning processes.** These resources consist of sample work plans, facilitator guides, sample assessment report and health improvement plan goals, and a reference list of toolkits covering a variety of sectors of integration.

Integration Assessment Process for CCO Community Health Assessments

Supplemental Care Integration Assessment – Overview

The Oregon Health Authority's CCO care integration assessment, based on the MAPP Forces of Change Assessment, allows communities to assess the efforts to provide comprehensive services in the same location, optimally in a team setting, throughout strategic initiatives identified in the community health assessment (CHA) process. Specifically, questions should be addressed such as "How does this initiative bring oral health, mental health and physical health services together to more effectively address the identified problem?" and "What are the barriers and opportunities identified to improve the integration of services across the initiative?" The care integration assessment provides critical information to the planning process to maximize the effectiveness of cross-sector community projects and programs.

Evidence for improved outcomes using integrated care models has been demonstrated across the country and the world.^{1,2} Improving community health requires addressing the social determinants of health and improving the delivery systems designed to address health care needs. The care integration assessment engages participants in brainstorming activities to identify where integration exists in the community delivery systems, where gaps may be, and what resources would be necessary to assure initiatives have oral, physical and mental health, as well as substance use treatment, readily available for community members.

This integration assessment tool is specifically designed to support CCOs in identifying opportunities for integration. It is intended to be led and supported by the CACs with assistance from CCO staff.

How to Conduct the Care Integration Assessment

Step 1: Planning and preparation

During this step a small planning team prepares for one or more brainstorming sessions by identifying key leaders within the community and care providers, dates, locations and facilitation. A communication plan should be developed to support this process. The planning team will oversee the process and collection of information.

Step 2: Convening a brainstorming session to identify integration opportunities

Next, the identified leaders will gather for the brainstorming activity. This will be a facilitated discussion in which participants share ideas and identify integration gaps, required resources or reorganization of care delivery systems to maximize integration opportunities.

Step 3: Identifying opportunities and resources necessary to improve integration as a means of reaching each strategic goal

Once the list of opportunities and barriers are identified, the team will catalog possible community partners and funding streams for potential venues of community interaction. This information will be collated and passed on to the CHA steering committee for consideration as the MAPP process unfolds.

¹ Essential Hospitals Institute. Integrated Health Care: Literature Review. May 2013. <http://essentialhospitals.org/wp-content/uploads/2013/12/Integrated-Health-Care-Literature-Review-Webpost-8-22-13-CB.pdf> Accessed 5/23/18.

² McKinsey&Company. The evidence for integrated care. March 2015. <https://www.mckinsey.com/~media/McKinsey/Industries/Healthcare%20Systems%20and%20Services/Our%20Insights/The%20evidence%20for%20integrated%20care/The%20evidence%20for%20integrated%20care.ashx> Accessed 5/23/18.

Care Integration Brainstorming Worksheet

This worksheet is designed for the care integration assessment committee members to use to prepare for a brainstorming session.

What is care integration?

Care integration is the purposeful presence or coordination of services maximally supporting a person or family at each opportunity for interaction with social and health systems.

Types of integration:

- Coordinated care: provided in separate locations and systems, focuses on communication
- Co-located care: provided in the same location but separate systems, focuses on physical proximity
- Fully integrated care: provided in the same location and system, focuses on practice change

What areas or categories are included?

Consider integration of supporting systems, including the following:

1. Social determinants of health:
 - Social services
 - o Housing supports
 - o Food services
 - o Legal services
 - Education
 - o Primary
 - o Secondary
 - o Workforce planning
 - Income generation
 - o Job skills training
 - o Community development and planning
2. Health care systems:
 - Oral health
 - Physical health
 - Mental health³
 - Substance use treatment
 - Public health

What are the opportunities for integration?

Think about the points of contact with individuals and families that may influence their health outcomes and well-being:

1. What are the points of contact?
2. What gaps in services could have been addressed, if available?
3. What systems of care would need to interact to improve efficiency in care delivery?
4. What are the barriers to more effective integration?
5. Were there areas in the previous CHA/CHP in which integration improved outcomes? Could these be leveraged in the next CHP?
6. What opportunities or resources could be available during the next CHP cycle that could improve the chance of meaningful integration?

³ While the term “behavioral health” is sometimes used to refer to combined mental health and substance use treatment, in other settings it is used to refer to interventions focused on lifestyle behavior change. We have chosen to use the distinct terms of mental health and substance use treatment to be clear about what is constituted by these services, but also because in many communities, these services are not yet provided in an integrated setting.

Care Integration Assessment Exercises

Community Integration Planning Grid

The purpose of this planning grid is to identify the level of integration existing today, or with the potential to become integrated in the three years of the CHP planning cycle. For example, looking at housing environments, as you move across the horizontal axis, consider whether food security services, education services, and income development services are integrated into housing. This tool helps communities to identify opportunities for increasing the level of integration in those environments with targeted initiatives using community collaborative arrangements between service providers.

Use the following symbols to fill out the chart below, indicating the level of integration and value of integration for each of the service area pairs. This will help differentiate areas of opportunity in which less integration exists, but there is moderate or significant value to increasing integration. For an example, see the Community Integration Planning Grid in Appendix E .

- # = Minimal integration occurring today
- ## = Moderate integration occurring today
- ### = Significant integration in place

- \$ = Minimal value in integration
- \$\$ = Moderate value in integration
- \$\$\$ = Significant value in integration

Strategic Area	Housing Services	Food Security	Education	Income	Oral Health	Physical Health	Mental Health	Substance Use Treatment	Public Health
Housing									
Food									
Education									
Income									
Oral Health									
Physical Health									
Mental Health									
Substance Use Treatment									
Public Health									

Focused CCO Services Integration Evaluation Grid

Understanding that CCOs have primary responsibility for coordinating Medicaid services in their communities, this evaluation grid is intended to be used at the plan level, but it could also be applied at the organizational or provider association level to assess the degree of integration of these core services within care environments. Studies have demonstrated increasing value of integration (improved outcomes and lower total cost of care) as an entity moves from being coordinated to being fully integrated. The goal of this assessment is to highlight areas of integration opportunity and develop plans for intentional service integration.

Use the following levels of integration to fill out the chart below:

CC = coordinated care

CLC = co-located care

FIC = fully integrated care

Services	Primary Care	Oral Health	Mental Health	Substance Use Treatment
Primary Care				
Oral Health				
Mental Health				
Substance Use Treatment				

Understanding that different clinics have varying levels of integration, CCOs may wish to quantify the percentage of patients served by primary care providers (PCPs) at each level of integration across the domains of oral health, mental health and substance use treatment. Areas where there are low levels of integration could be addressed by expanding integration with coordinated initiatives, alternative payment models, and grant-based projects.

Integration for Community Health Improvement Planning

**Revised from AHRQ Framework for Measuring Integration of Behavioral Health and Primary Care

Overview

Once a community has conducted a care integration assessment, they will be ready to create integration goals. These goals will vary from community to community and will be based on the current state of integration by sectors, partners at the table, and phases of collaboration among the partners. We recommend two constructs that can be useful in focusing CHP goals and objectives. The first construct applies 10 domains of integration to planning, and is based on the AHRQ Framework for Measuring Integration of Behavioral Health and Primary Care. The second construct is a feasibility assessment related to practical matters such as phase of collaboration, state of existing efforts, and current resources. Taken together these two constructs can guide a community to meaningful and achievable integration projects that will further community health. In all cases, integration projects should be chosen in context of all the other results within the community health assessment.

Integration Continuum

As highlighted in the assessment, communities will have a variety of integration projects in different phases. Some areas will have no integration occurring, others may have coordinated care taking place from different physical locations, and still others will have co-located services or even fully integrated services. Communities are encouraged to think of movement along this continuum as step-wise. While a community with high levels of commitment and resource may decide to move from no integration at all to fully integrated services, most communities will be dealing with a world of limited resources and severe competition for time. In such cases, communities are encouraged to think of taking one step, for example from no integration to coordinated services, or from coordinated services to co-located services, as a way to continue to move integration forward with limited resources and time.

It should also be noted that partners in one geographic or sector area may be fully integrated, while partners in another sector or geographic area may be just beginning the integration journey. This will likely vary by community size. In smaller communities, where there is one Housing Authority and one Department of Human Services branch office, integration will be simpler to design, monitor and track. In larger communities, where there are multiple organizations providing services from a single sector, integration will be more challenging to design and monitor. One suggestion for a simple integration activity is to update the integration grid on a yearly basis, so the community as a whole can track incremental progress on the part of multiple partners. All of the grids noted below can be applied to entire sectors that are integrating, if appropriate, or more simply applied to individual integration projects that may represent integration progress for a community but not complete integration of an entire sector.

Integration Domains Grid

The grid below classifies 10 domains of integration into three categories: service, which refers to the actual provision of integrated services; leadership and business, which refers to system aspects of integration; and measurement, which refers to data collection and use. The grid can help determine where to begin implementation on new integration projects, or can move projects further up the integration continuum by focusing on elements of existing projects that are not yet in place. The grid is designed to take the integration sectors identified as priorities in the assessment, and determine which areas are the most fruitful for meaningful and achievable goal setting.

Integration Domains Grid Instructions:

- 1) Identify the highest priority integration areas from the assessment.
Example: The care integration assessment identified oral health and primary care integration as a top priority.
- 2) Create a CHP subcommittee that has relevant partners and experience to assess the integration efforts in some detail for the identified integration areas.
Example: The subcommittee is composed of two key dentists, three primary care providers, relevant CAC leadership and CCO staff.
- 3) Using the anchors provided, conduct a high level status assessment of existing integration efforts for that priority area.
Example: Provided below in the domain grid.
- 4) Based on the high level assessment, the planning group prioritizes a domain area.
Example: Domain 3 - The integration team has systematic methods to identify and prioritize individuals in need of integrated services.
- 5) For that priority domain area, have the planning group members brainstorm 2–5 goals.
Example:
 - Goal 1: By 3/30/20, all primary care providers in the county will conduct a standardized early childhood oral health screening on all children age 2–5.
 - Goal 2: By 3/30/20, 80% of oral health providers in the county will screen all adult patients for completing a physical in the prior 12 months, and refer 80% of patients who had not completed a physical back to their PCP.

Integration Sectors: Oral health and primary care			
	Functional domains	Anchors	Assessment and goals
Service Domains	1. Staff have knowledge about the population and domains being integrated.	<ul style="list-style-type: none"> • Staff can conduct an individual/family needs assessment in all domains integrated. • Staff can develop a single intervention plan across all domains. • Staff are both cross trained in content, and trained in integration specifically for their areas. 	Status assessment: - The IPA and dental associations have conducted two 1-hour in-services on oral health/primary care for providers. - Some primary care providers are trained in early childhood oral health screening, but many are not. Goal: 70% of PCPCH practices in the community receive training within the three years of the CHP.
	2. The integration team has shared workflows and official protocols to facilitate collaboration.	<ul style="list-style-type: none"> • Shared workflows are consistently implemented rather than informal processes. • Shared workflows increase collaboration towards shared goals. 	Status assessment: - The local FQHC has oral health provided on site and has shared workflows between their providers, but other practitioners do not.

			<p>- Shared workflows and screening tools are used by all oral health providers participating in the local school projects biannually.</p> <p>Goal: Learning collaborative is set up by 1/31/20 to share workflows and best practices for interested community partners</p>
	<p>3. The integration team has systematic methods to identify and prioritize individuals in need of integrated services.</p>	<ul style="list-style-type: none"> • Systematic screening tools are used to identify individuals and families in need of integrated services. 	<p>Status assessment:</p> <ul style="list-style-type: none"> - The FQHC provider and the public health department, maternal child health department conduct early childhood screenings. Others do not. - No routine screenings are being conducted for adults. - Dental health providers routinely screen for vitals, medications and health conditions. <p>Goals:</p> <ul style="list-style-type: none"> - Goal 1: By 3/30/20, all primary care providers in the county will conduct a standardized early childhood oral health screening on all children age 2–5. - Goal 2: By 3/30/20, 80% of oral health providers in the county will screen all adult patients for completing a physical in the prior 12 months, and refer of 80% of patients who had not completed a physical back to their PCP.
	<p>4. The integrated team engages patients and families in shared plans and services.</p>	<ul style="list-style-type: none"> • Integrated service team uses the same methods, philosophy, approach and protocols for individual/family engagement. 	<p>Status assessment:</p> <ul style="list-style-type: none"> - The FQHC utilizes the Patient Activation Model for engagement, as does the hospital clinic. Dental providers typically do not have an adopted model. <p>Goal: 50% of oral health providers receive Patient Activation Model education by 3/20/20.</p>
	<p>5. The integrated services team systematically measures outcomes for all integrated domains over time.</p>	<ul style="list-style-type: none"> • Integrated services team consistently use the same follow-up systems on a regular basis. • The services team can adjust the plan if the individual/family are not reaching the desired outcome. 	<p>Status assessment:</p> <p>The same follow-up system is not being used by any providers.</p> <p>Goal: Establish community data team to understand data sources and options for tracking by 3/20/20.</p>

Leadership and Business Domains	6. Leadership of the sectors to be integrated (or already integrated) are engaged and supportive of administrative alignment.	<ul style="list-style-type: none"> Leaders share values about integration and have a visible commitment to integration. Leadership allocates resources such as money, time and attention to integrated services development. Leadership jointly identifies points of conflict with other organizations and systems and develops practical solutions. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>The FQHC, hospital clinic and dental association have had several meetings to train on and discuss integration concepts and values.</i> <i>The dental association has committed to conducting screening and sealant projects in the school twice a year.</i> <p>Goal: <i>Establish work group including dental care organizations to make recommendations expanding dental sealant program by 3/1/20.</i></p>
	7. Reliable and robust office processes exist to support the integrated services team.	<ul style="list-style-type: none"> Consistently use specific structures, office workflows, processes and standards to support reliable integrated services. Jointly use quality improvement approaches and process improvement methods. 	<p>Status assessment:</p> <p><i>The FQHC has integrated structures and workflows. The hospital clinic staff have been shadowing the FQHC staff to learn their procedures.</i></p> <p>Goal: <i>Learning collaborative is set up by 1/31/20 to share workflows and best practices for interested community partners, FQHC, DCOs, etc.</i></p>
	8. There is a sustainable business model to support the longevity of the integrated services.	<ul style="list-style-type: none"> Develop a comprehensive and realistic sustainability plan. Regularly monitor financial performance of the integrated services, including revenues and expenses. 	<p>Status assessment:</p> <p><i>The FQHC business model is supported by FQHC funding. There is no local modeling for non-FQHC sustainability.</i></p> <p>Goal: <i>CCO explores potential alternative payment method options for integrated services with recommendation to the board by 3/20/20.</i></p>
Measurement Domains	9. The integrated services team collects and uses service level data to improve quality of services.	<ul style="list-style-type: none"> Collect data on key service processes (such as number of individuals with shared intervention plans). Use data to inform quality improvement and decision-making processes. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>The FQHC and dental provider use shared service level data and shared quality improvement processes.</i> <i>The dental association providers participating in the school events use shared screening tools, common data collection, and quality improvements of the events from year to year.</i> <p>Goal: <i>Establish community data team to understand data sources and options for tracking by 3/20/20.</i></p>
	10. Data is collected and used to measure integrated service	<ul style="list-style-type: none"> What is the individual/family's experience of integrated services? What has improved for them? 	<p>Status assessment:</p> <p><i>None of these activities are occurring in any areas.</i></p>

	<p>outcomes from the patient, provider, financial and system perspectives.</p>	<ul style="list-style-type: none"> • What is the provider team experience of integrated care? What has improved for them? • What is the financial outcome of integrated care on cost of services for the provider and for the individual/family? • What are the system administrators' experience of integrated services? 	<p>Goal: <i>Monitor for data collection opportunities during CHP cycle.</i></p>
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Feasibility Grid

Once a list of potential goals and/or objectives has been generated, each will need to be assessed for feasibility, as well as for meaningfulness in the context of the overall CHA and CHP. As noted, the grid above can be focused at a broader community level, or more targeted project levels, depending on which partners are involved. The feasibility assessment may not need to involve all community partners, but rather just those who would be involved in implementation. The meaningfulness assessment should involve all partners where possible. Completion of this grid should raise a few potential goals to the top of the list for inclusion in the CHP.

Feasibility grid instructions:

1. Create a CHP subcommittee that has relevant partners and experiences to assess the brainstormed goals/objectives from the domain grid exercise.
2. Focusing on the domain identified in the domain grid exercise, fill out the grid for each goal/objective brainstormed during that exercise.
Example: Provided below in the feasibility grid.
3. Once the grid has been filled out with each of the 2–5 goals/objectives from the domain exercise, evaluate the goals/objectives for feasibility. Choose the goal/objective with the best feasibility, and/or revise other goals to improve their feasibility.
Example: Goal 2 would be a better choice in terms of feasibility, or a revision of goal 1 to focus instead on the domain of leadership alignment instead.

Domain: #3 – The integration team has systematic methods to identify and prioritize individuals in need of integrated services.					
Goal/Objective	Relates to CHA priority?	Aligned with the rest of the CHP?	Partners identified and committed?	Current integration efforts?	Resources available?
<p>List each potential goal and objective from domain grid.</p>	<p>If no, may be of questionable meaningfulness.</p>	<p>If no, may not be supported by overall community direction.</p>	<p>If yes, who. Are any key players missing? If no, consider starting with leadership domain as a goal area from above grid.</p>	<p>If yes, does goal represent a logical step forward that builds on existing efforts?</p>	<p>Resources of space, staff, expertise, policy, political will and funding.</p>
<p>Goal 1: By 3/30/20, all primary care providers in the county will</p>	<p><i>Yes, children’s oral health identified as a priority need.</i></p>	<p><i>Yes, children’s oral health is also addressed by a CHP goal supporting</i></p>	<p><i>FQHC, health system clinics and public health are on board. Private group and single</i></p>	<p><i>No, since not all practices or IPAs are involved.</i></p>	<p><i>CCO dental provider can provide staff for training and screening</i></p>

CHP Handout #7

<p>conduct a standardized early childhood oral health screening on all children age 2–5.</p>		<p><i>screening and sealants in school age children.</i></p>	<p><i>practitioners have not yet been involved or approached.</i></p>		<p><i>resources, as well as create a billing code for completing the screening.</i></p>
<p>Goal 2: By 3/30/20, 80% of oral health providers in the county will screen all adult patients for completing a physical in the prior 12 months, and refer 80% of patients who had not completed a physical back to their PCP.</p>	<p><i>Yes, oral health in general is identified as a priority need, as is preventive health care.</i></p>	<p><i>Yes, increasing basic screening rates is included as a CHP goal.</i></p>	<p><i>Most oral health providers are involved in the local dental association. When surveyed they noted that many of them already screen for engagement with a PCP.</i></p>	<p><i>Yes, oral health providers already screen for PCP.</i></p>	<p><i>This project will take very little resource to implement beyond agreement of practitioners to add screening and referral to workflow.</i></p>

APPENDIX A: Sample Work Plan

SUPPLEMENTAL CARE INTEGRATION ASSESSMENT AND IMPROVEMENT PLAN WORK PLAN

Phase Objectives

- To determine what is occurring or might occur that would promote improved integration of care services across the delivery system and within the community
- To identify opportunities for integration, particularly of physical, behavioral and oral health for CCOs

Phase Checklist

Activity	Resources Needed	Lead Staff	Due Date	Status/Outcome
<u>Plan the assessment</u> <ul style="list-style-type: none"> • Determine the brainstorming method • Identify a facilitator • Identify a note taker • Find a convenient location • Prepare materials and questions for facilitator <ul style="list-style-type: none"> ○ Brainstorming worksheet ○ Opportunities and resource grid worksheet 	<ul style="list-style-type: none"> • Meeting space 			<ul style="list-style-type: none"> • Planning meetings; agenda finalized; consider use of “snow card”⁴ technique
<u>Invite MAPP committee members and other leaders in the community</u> <p>Participants should be:</p> <ul style="list-style-type: none"> • “Big picture” thinkers, “movers and shakers” • Aware of the important social, economic, and political trends • Aware of integration potential in their service line or area of expertise 	<ul style="list-style-type: none"> • Contact emails for invites 			<ul style="list-style-type: none"> • List of confirmed attendees
<u>Conduct supplemental care integration assessment</u> <ul style="list-style-type: none"> • Snow cards, brainstorming 	<ul style="list-style-type: none"> • Meeting space • Name tags, packets, flip charts, sticky boards 			<ul style="list-style-type: none"> • Data collected from assessment session

⁴ Graber, Anne-Cecile. The Snow Card Technique. 1996. <https://acgraber.com/2013/10/05/the-snow-card-technique/>. Accessed 5/23/18.

Activity	Resources Needed	Lead Staff	Due Date	Status/Outcome
	<ul style="list-style-type: none"> • Sign-in sheet, sticky notes, markers • Refreshments • Facilitator 			
<p><u>Compile and synthesize assessment results</u></p> <ul style="list-style-type: none"> • Opportunities and resources worksheet • Integration grid review • Meet to review assessment • Identify top 2–3 priority areas • Write report • Submit report 	<ul style="list-style-type: none"> • Meeting space 			<ul style="list-style-type: none"> • Completed assessment report
<p><u>Invite sector leaders and CAC members to CHP integration planning event</u></p> <p>Participants should be people with knowledge of the content areas to be integrated, and have a detailed and operational mindset as well as strategic</p> <ul style="list-style-type: none"> • Members of organizations from the sectors to be integrated, including provider and operational representatives • People with expertise in integration • CAC and community members who would benefit from the integration projects/programs 	<ul style="list-style-type: none"> • Contact information for attendees 			<ul style="list-style-type: none"> • Confirmed list of attendees
<p><u>Conduct integration planning session</u></p> <ul style="list-style-type: none"> • Complete domain assessment grid as a group activity • Either as a large group or breaking into small groups depending on size, complete the feasibility assessment grid for each domain area and brainstormed goals/objectives • As a group review the top feasibility goals and select goals and objectives to be included in the plan 	<ul style="list-style-type: none"> • Meeting space • Name tags, packets, flip charts, sticky boards • Sign-in sheet, sticky notes, markers • Refreshments • Facilitator 			<ul style="list-style-type: none"> • Data collected from planning session, including prioritized goals/objectives
<p><u>Compile and synthesize planning results</u></p>	<ul style="list-style-type: none"> • Data collected from planning session 			<ul style="list-style-type: none"> • Completed CHP

Activity	Resources Needed	Lead Staff	Due Date	Status/Outcome
<p>Convene writing committee (writer and integration expert)</p> <ul style="list-style-type: none"> • Utilizing goals and objectives from planning session, collate goals and objectives into a plan • Add operational details to plan, such as outcome measurements, time frame and people/entities responsible • Review plan • Submit plan 				<ul style="list-style-type: none"> • CAC approve final report and recommendations, advancing to CCO board of directors with CHP document

Focused CCO Services Integration Evaluation Grid

Understanding that the CCOs have primary responsibility for coordinating Medicaid services in their communities, this evaluation grid is intended to be used at the plan level, but could also be applied at the organizational or provider association level to assess the degree of integration of these core services within care environments. Studies have demonstrated increasing value of integration (improved outcomes and lower total cost of care) as an entity moves from coordinated to being fully integrated. The goal of this assessment is to highlight areas of integration opportunity and develop plans for intentional service integration.

Use the following levels of integration to fill out the chart below:

CC = coordinated care

CLC = co-located care

FIC = fully integrated care

Services	Primary Care	Oral Health	Mental Health	Substance Use Treatment
Primary Care				
Oral Health				
Mental Health				
Substance Use Treatment				

Integration Domains Grid

Instructions:

- 1) Identify the highest priority integration areas from the assessment.
- 2) Create a CHP subcommittee that has relevant partners and experience to assess the integration efforts in some detail for the identified integration areas.
- 3) Using the anchors provided, conduct a high-level status assessment of existing integration efforts for that priority area.
- 4) Based on the high-level assessment, the planning group prioritizes a domain area.
- 5) For that priority domain area, have the planning group members brainstorm 2–5 goals.

Integration Sectors:			
	Functional Domains	Anchors	
Service Domains	1. Staff have knowledge about the population and domains being integrated.	<ul style="list-style-type: none"> • Staff can conduct an individual/family needs assessment in all domains integrated. • Staff can develop a single intervention plan across all domains. • Staff are both cross-trained in content, and trained in integration specifically for their areas. 	Status assessment: Goal:
	2. The integration team has shared workflows and official protocols to facilitate collaboration.	<ul style="list-style-type: none"> • Shared workflows are consistently implemented rather than informal processes. • Shared workflows increase collaboration towards shared goals. 	Status assessment: Goal:
	3. The integration team has systematic methods to identify and prioritize individuals in need of integrated services.	<ul style="list-style-type: none"> • Systematic screening tools are used to identify individuals and families in need of integrated services. 	Status assessment: Goal:
	4. The integrated team engages patients and families in shared plans and services.	<ul style="list-style-type: none"> • Integrated service team uses the same methods, philosophy, approach and protocols for individual/family engagement. 	Status assessment: Goal:
	5. The integrated services team systematically measures outcomes for all	<ul style="list-style-type: none"> • Integrated services team consistently use the same follow-up systems on a regular basis. • The services team can adjust the plan if the individual/family are 	Status assessment: Goal:

	integrated domains over time.	not reaching the desired outcome.	
Leadership and Business Domains	6. Leadership of the sectors to be integrated (or already integrated) are engaged and supportive of administrative alignment.	<ul style="list-style-type: none"> Leaders share values about integration and have a visible commitment to integration. Leadership allocates resources such as money, time and attention to integrated services development. Leadership jointly identifies points of conflicts with other organizations and systems and develops practical solutions. 	Status assessment: Goal:
	7. Reliable and robust office processes exist to support the integrated services team.	<ul style="list-style-type: none"> Consistently use specific structures, office workflows, processes and standards to support reliable integrated services. Jointly use quality improvement approaches and process improvement methods. 	Status assessment: Goal:
	8. There is a sustainable business model to support the longevity of the integrated services.	<ul style="list-style-type: none"> Develop a comprehensive and realistic sustainability plan. Regularly monitor financial performance of the integrated services, including revenues and expenses. 	Status assessment: Goal:
Measurement Domains	9. The integrated services team collects and uses service level data to improve quality of services.	<ul style="list-style-type: none"> Collect data on key service processes (such as number of individuals with shared intervention plans). Use data to inform quality improvement and decision-making processes. 	Status assessment: Goal:
	10. Data are collected and used to measure integrated services outcome from the patient, provider, financial and system perspectives.	<ul style="list-style-type: none"> What is the individual/family's experience of integrated services? What has improved for them? What is the provider team experience of integrated care? What has improved for them? What is the financial outcome of integrated care on cost of services for the provider and for the individual/family? What are the system administrators' experience of integrated services? 	Status assessment: Goal:

Feasibility Grid

Instructions:

1. Create a CHP subcommittee that has relevant partners and experiences to assess the brainstormed goals/objectives from the domain grid exercise.
2. Focusing on the domain identified in the domain grid exercise, fill out the grid for each goal/objective brainstormed during that exercise.
3. Once the grid has been filled out with each of the 2–5 goals/objectives from the domain exercise, evaluate the goal/objectives for feasibility. Choose the goal/objective with the best feasibility, and/or revise other goals to improve their feasibility.

Domain:					
Goal/objective	Relates to CHA priority?	Aligned with the rest of the CHP?	Partners identified and committed?	Current integration efforts?	Resources available?
List each potential goal and objective from domain grid.	If no, may be of questionable meaningfulness.	If no, may not be supported by overall community direction.	If yes, who. Are any key players missing? If no, consider starting with leadership domain as a goal area from above grid.	If yes, does goal represent a logical step forward that builds on existing efforts?	Resources of space, staff, expertise, policy, political will and funding.

APPENDIX C: Facilitator Guide for Care Integration Assessment

Supplies needed:

- Name tags
- Packets
- Flip charts
- Sticky boards
- Sign-in sheet
- Sticky notes
- Markers

Welcome/review of goals (5 minutes) – *Host, preferably CAC chair*

(Consider holding a 15-minute break at 90 minutes into the assessment session.)

Introductions (10 minutes) – Name, organization, icebreaker item (for example, birth place)

Integration concepts (10 minutes) – *Facilitator*

Importance of integrating care across domains of care

What does care integration look like?

Care integration is the purposeful presence or coordination of services maximally supporting a person or family at each opportunity for interaction with social and health systems.

Types of integration:

- Coordinated
- Co-located
- Fully integrated

Domains of integration:

1. Social determinants of health:

- Social services
 - Housing
 - Food services
 - Legal services
 - Transportation
- Education
 - Primary
 - Secondary
 - Workforce planning
- Income generation
 - Job skills training
 - Community development and planning

2. Health Care Systems:

- Oral health

- Physical health
- Mental health
- Substance use treatment
- Public health

Exercise #1: Brainstorming (20 minutes)

This exercise is intended to get the group thinking about how and where integration is already occurring and to also learn from the other participants, as typically we are not aware of all that is happening in the community.

Participants write down on large sticky notes how and where they have seen the best examples of care integration in our community, OR where they see the greatest opportunity for integration.

The facilitator asks attendees to share their best examples and best opportunities, or reads off some of the cards to start the group thinking about what’s happening and what’s possible.

The facilitator places their examples on the wall or whiteboard (labeling them “best examples” and “best opportunities”).

Exercise #2: Flip-chart activity (60 minutes)

The purpose of this activity is to work in teams to do a deeper dive into the potential integration opportunities in each service area or domain of care.

Divide participants into 11 groups (count off).

Each group starts at a station and answers the following questions related to that service area:

1. In this service area, where are other services well integrated? By whom?
2. In this service area, where are the opportunities for integration?
3. What barriers to integration exist in this area?
4. What resources would be necessary to improve or start integration in this service area?

Rotate to the next station after 5 minutes.

On the 12th rotation, the each group ends up where they started. They review all that has been written, and then score the domain for “integration potential”:

Integration occurring today within the community:

 Some   Moderate    Extensive

Importance to the community:

 Less   Moderate    Very

Report out to fill out integration grid (30 minutes)

1. Scoring team presents for each area of integration.
2. Scores (stars and hearts) are recorded on whiteboard or large flipchart pages.
3. Facilitator asks for agreement around scoring.

Evaluation (10 minutes)

+ /Delta (*Facilitator asks the group what they liked and what they would change about the meeting.*)

Closing remarks/thank you/next steps (5 minutes)

(Facilitator may hand the meeting back to the chair for all or part of the closing)

1. Assessment team review
2. Planning team exercise
3. Report development
4. Communication

APPENDIX D: Facilitator Guide for Integration Planning

(Note that the team assembled for planning needs to be sector specific and have some knowledge of the sectors being evaluated for integration. Therefore, if several sectors are being evaluated, several different teams may need to meet over several different meeting times.)

Supplies needed:

- Name tags
- Packets
- Flip charts
- Sticky boards
- Sign-in sheet
- Sticky notes
- Markers

Welcome/review of goals (5 minutes) – *Host, preferably CAC chair*

Introductions (10 minutes) – *Name, organization, icebreaker item (for example, favorite activity for the time of year)*

Integration concepts for planning (10 minutes) – *Facilitator (if done right after integration assessment do not review first two sections; if separated in time or a different audience review all sections)*

Importance of integrating care across domains of care

What does care integration look like?

Care integration is the purposeful presence or coordination of services maximally supporting a person or family at each opportunity for interaction with social and health systems.

Types of integration:

- Coordinated
- Co-located
- Fully integrated

Domains of integration for planning

Three categories:

- Service domains (1–5)
- Leadership and business domains (6–8)
- Measurement domains (9–10)

Ten domains and their associated anchors:

1. Staff have knowledge about the population and sectors being integrated.
 - Staff can conduct needs assessment in all integrated sectors.
 - Staff can develop a single intervention plan across all sectors.
 - Staff are cross trained in integration fundamentals for their areas, and in content.
2. The integration team has shared workflows and official protocols to facilitate collaboration.

- Shared workflows are consistently implemented rather than informal processes.
 - Shared workflows increase collaboration towards shared goals.
3. The integration team has systematic methods to identify and prioritize individuals in need of integrated services.
 - Systematic screening tools are used to identify individuals and families in need of integrated services.
 4. The integrated team engages patients and families in shared plans and services.
 - Integrated service team uses the same methods, philosophy, approach and protocols for individual/family engagement.
 5. The integrated services team systematically measures outcomes for all integrated sectors over time.
 - Integrated services team consistently uses the same follow-up systems on a regular basis.
 - The services team can adjust the plan if the individual/family are not reaching the desired outcome.
 6. Leadership of the sectors to be integrated (or already integrated) are engaged and supportive of administrative alignment.
 - Leaders share values about integration and have a visible commitment to integration.
 - Leadership allocates resources such as money, time and attention to integrated service development.
 - Leadership jointly identifies points of conflicts with other organizations and systems and develops practical solutions.
 7. Reliable and robust office processes exist to support the integrated services team.
 - Consistently use specific structures, office workflows, processes and standards to support reliable integrated services.
 - Jointly use quality improvement approaches and process improvement methods.
 8. There is a sustainable business model to support the longevity of the integrated services.
 - Develop a comprehensive and realistic sustainability plan.
 - Regularly monitor financial performance of the integrated services, including revenues and expenses.
 9. The integrated services team collects and uses service level data to improve quality of services.
 - Collect data on key service processes (such as number of individuals with shared intervention plans).
 - Use data to inform quality improvement and decision-making processes.
 10. Data is collected and used to measure integrated services outcomes from the patient, provider, financial and system perspectives.
 - What is the individual/family's experience of integrated services? What has improved for them?
 - What is the provider team experience of integrated care? What has improved for them?
 - What is the financial outcome of integrated care on cost of services for the provider and for the individual/family?

- What are the system administrator's experiences of integrated services?

Exercise #1: Integration status assessment (30 minutes)

Using the top sectors for integration prioritized from the care integration assessment, this exercise is attended to assess the state of integration in each of the domain areas. This exercise will be conducted as an entire group led by the facilitator. The room should be prepared with each domain written on a flip chart, with a blank space titled "status assessment" and one titled "goals". These should be posted around the room on the walls.

The facilitator starts by asking participants about each anchor. For example, "Do staff have knowledge about the population and sectors being integrated?" Examples can be provided as needed. Participants write down their (brief) answers on sticky notes. Encourage participants to stay high level and brief.

The facilitator then asks each participant to read what is on their sticky note and put it on the appropriate flip chart under the status assessment title.

Conduct this process for every domain. Explain to participants that in many cases their answers may be that none, or very little, is occurring.

The facilitator instructs participants to review all flip charts, and either the facilitator or a group member provides a brief status of current state of integration.

Exercise #2: Domain prioritization and goal brainstorming (20 minutes)

The purpose of this activity is to prioritize 1–2 domain areas in which to take action that represent the next step in growth based on what is currently happening. Participants will also brainstorm potential goals for the 1–2 priority areas.

Divide number of group members in half and then give that number of dot stickers to participants for voting (for example, if there are eight participants, then give each person four dots for voting). Instruct participants to place their dots by their top four priority domain. The top two scoring domains then become the priority domains for the rest of the planning session.

Each participant is given three sticky notes. Ask them to write down at least one, but no more than three, possible integration goals for the priority domain area. Call them up to read their goals and place them under the suggested goal heading on the appropriate domain flip chart.

As a full group, discuss the goals listed. The facilitator works with the group to combine and revise until each domain area has at least one, and no more than three, possible goals listed.

Exercise #3: Goal feasibility assessment (30 minutes)

The purpose of this exercise is to assess the 2–6 goals (1–3 for each of the top two domain areas) for feasibility on a variety of factors. The facilitator should have a feasibility grid prepared on a flip chart for each of the domain areas, with space to fill in for 1 to 3 goals for each domain.

The facilitator explains that the group will now assess each goal for feasibility based on the following factors: relationship to CHA priorities, alignment with the rest of the CHP priorities, number of committed partners, status of current integration efforts between the sectors, and resources available for implementation.

Divide the participants into two groups, one to work on each prioritized domain. Give the participants a copy of the completed feasibility grid from the guidelines document as an example on how to fill out the grid. Have each group work at rating their 1–3 goals, documenting their assessment on the provided flip chart.

Have each smaller group report back to the larger group with an evaluation of the goals they assessed. The facilitator can provide comments and input for how goals might be adjusted slightly to provide greater feasibility. The group has several options at this point. If this group is the decision-making group, they can prioritize one goal for each domain area using the dot method outlined above. If they are not the decision-making group, then all materials should be passed to the decision-making group for the prioritization and decision-making process. It is recommended that the decision-making group prioritize no more than two goals per domain, and consider limiting goals to two domain areas to improve feasibility of addressing the prioritized goals, without overcommitting limited resources.

Unless this group is the writing team, they should stop here at this point, as the intent is to pass this information to the writing team, who will use it craft the actual goals, objectives and activities for the CHP.

Evaluation (10 minutes)

+ /Delta (*Facilitator asks the group what they liked and what they would change about the meeting.*)

Closing remarks/thank you/next steps (5 minutes)

(Facilitator may hand the meeting back to the chair for all or part of the closing.)

1. CHP writing team
2. Goal review process with the CAC

(Consider holding a 15-minute break at 90 minutes into the assessment session.)

APPENDIX E: Sample Integration CHA and CHP Reports

(From May 2018 pilot conducted in Lane County)



LiveHealthyLane Care Integration Assessment

On May 4, 2018, a large group of diverse community members came together to conduct a care integration assessment. A smaller group of eight people was involved in piloting the planning process. Below is the completed care integration assessment and community integration planning grid.

The care integration assessment was added as a component of the community health needs assessment (CHA) conducted using the Mobilizing for Action through Planning and Partnerships (MAPP) framework, a community-driven strategic planning process for improving community health. The purpose of this care integration assessment is to identify the service areas with integration opportunity likely to influence community health and quality of life of people in Lane County, Oregon.

During the 2017 legislative session, House Bill 2675 was passed. This bill amended ORS 414.627 that relates to community health improvement plan (CHP) requirements that coordinated care organizations must meet. The ultimate goal of integration is improved patient outcomes, improved patient experience, improved provider experience as well as a reduction of total cost of care.

This assessment is designed to inform the CHP, which shall include a plan and a strategy for integrating physical, behavioral and oral health care services and may include, but are not limited to:

- Analysis and development of public and private resources, capacities and metrics based on ongoing community health assessment activities and population health priorities;
- Health policy;
- System design;
- Outcome and quality improvement;
- Integration of service delivery; and
- Workforce development.

The care integration assessment brainstorming session focused on the following questions:

- What are the points of contact?
- What gaps in services could have been addressed if available?
- What systems of care would need to interact to improve efficiency in care delivery?
- What are the barriers to more effective integration?
- In what areas of the previous CHA/CHP did integration improve outcomes? Could these be leveraged in the next CHP?
- What opportunities or resources could be available over the next 3-year CHP cycle that could improve the chance of meaningful integration?

For the purpose of the care integration exercise, integration opportunities can be defined as broad and all-encompassing or narrow and very specific.

- Opportunities: Areas in which integration of services could improve efficiency and improve care quality
- Barriers: Obstacles to moving forward with integration efforts
- Resources: Necessary fiscal or staffing needs to accomplish enhanced integration of services

The findings from the care integration assessment will ensure that the strategic issues identified later in the CHA process are relevant to the changing environment and that the developed action plans are responsive to opportunities identified.

Key Findings

Through the assessment process, the following service areas or domains were evaluated:

- | | | |
|------------------|---------------------|---------------------------|
| • Housing | • Public health | • Oral health |
| • Access to food | • Physical health | • Mental health |
| • Transportation | • Income generation | • Substance use treatment |
| • Legal services | • Education | |

Across the identified service areas or domains, common reoccurring opportunities, barriers and needed resources emerged:

Opportunities:

- A shift of attention to poverty and economic factors overwhelming the systems of education, employment and affordable housing
- Leverage health system changes in PCPCH funding and incentives
- Focusing on shortages of resources
- Increased non-traditional partnerships
- Advocacy for new legislation to increase funding to integration efforts
- Dental organizations have had successful efforts to date and could be replicated easily
- Networking of community partners

Challenges / Resource needs identified:

- Access in rural areas
- Collaboration and innovation will be needed
- Leveraging emerging technology will require funding
- Focus on prevention will require resource shift
- Resources or shifts in the payment system

Methodology

As one component of the 2018 CHA, community leaders from across Lane County convened on May 4, 2018, for the collaborative care integration assessment. The assessment objectives were to determine existing integration and opportunities to integrate services that would affect the health of the community and local health system and to identify the associated barriers and resources.

Facilitated by Rick Kincade, MD, from the Community Health Centers of Lane County, the brainstorming session comprised 29 leaders from diverse sectors including housing, health care, behavioral health, dental services, public health, education and social services. Using a customization of the snow card technique, participants compiled a broad inventory of best practices and opportunities for integration – that are or will be influencing the health and quality of life of the community and the local public health system. Ideas spanned a broad array of local, community-based solutions.

Through the process, all 11 named domains were identified as having some level of existing integration and significant opportunity for enhanced integration. Small groups discussed current and future integration, then recorded the existing barriers and needed resources. This assessment will be incorporated into the CHP planning process using the OHA identified planning tool, which assists in prioritization based on existing activity and overall feasibility. A pilot of the

planning process was carried out by Lisa Ladendorff, LCSW, from the Northeast Oregon Network (NEON) immediately following the assessment. Focusing on a single integration platform, the feasibility and prioritization exercise was modeled, but will need full vetting during the final CHP planning exercises.

Community Integration Planning Grid

Service Location

Strategic Area	Housing Services	Food Security	Education	Income	Oral Health	Physical Health	Mental Health	Substance Use Treatment	Public Health
Housing		#/\$\$	#/\$\$	#/\$\$	#/\$\$	##/\$\$\$	#/\$\$\$	##/\$\$\$	#/\$\$\$
Food	##/\$\$\$		##/\$\$\$	#/\$\$	#/\$\$\$	##/\$\$\$	#/\$\$\$	#/\$\$\$	##/\$\$\$
Education	#/\$\$	#/\$\$		##/\$\$\$	#/\$\$	#/\$\$	#/\$\$\$	#/\$\$\$	#/\$\$
Income	#/\$\$	##/\$\$	##/\$\$\$		N/\$	#/\$\$	#/\$\$\$	#/\$\$\$	#/\$\$
Oral Health	#/\$\$	#/\$\$	##/\$\$	N/\$		#/\$\$\$	#/\$\$\$	#/\$\$\$	#/\$\$\$
Physical Health	##/\$\$\$	#/\$\$	##/\$\$\$	#/\$\$	#/\$\$\$		##/\$\$\$	##/\$\$\$	###/\$\$\$
Mental Health	#/\$\$\$	#/\$\$	##/\$\$\$	#/\$\$	#/\$\$\$	##/\$\$\$		##/\$\$\$	##/\$\$\$
Substance Use Treatment	#/\$\$	N/\$	#/\$\$\$	N/\$\$	N/\$\$\$	##/\$\$\$	#/\$\$\$		#/\$\$\$
Public Health	#/\$\$	#/\$\$	#/\$\$	N/\$	#/\$\$	##/\$\$\$	#/\$\$	#/\$\$	

- # = Minimal integration occurring today
- ## = Moderate integration occurring today
- ### = Significant integration in place
- \$ = Minimal value in integration
- \$\$ = Moderate value in integration
- \$\$\$ = Significant value in integration

Level of Integration within Core CCO Services

- CC = Coordinated care
- CLC = Co-located care
- FIC = Fully integrated care
- NIC = No integrated care

Primary Location of Service

Services	Primary Care	Oral Health	Mental Health	Substance Use Treatment
Primary Care		CC	FIC	CLC
Oral Health	CC		CC	CC
Mental Health	FIC	CC		CLC
Substance Use Treatment	CC	NIC	CLC	

Assessment Results

This report details the comprehensive findings from the May 2018 Lane County care integration assessment. The analysis of the brainstorming process identified opportunities for care integration in all domains of care.

1. Mental Health

Lane County has a strong history of collaboration with community partners becoming increasingly interested in collective impact. In addition, there have been focused integration initiatives within the transformation efforts of Trillium Community Health Plan. Alternative payment models and organized collaborative projects have accelerated the integration of physical health into behavioral health environments with significant reduction in cost of care and improved outcomes. Mental health services have been integrated in primary care environments across the community, as evidenced by over 80% of primary care practices attesting to Tier 3 or higher in OHA's Patient-Centered Primary Care Home (PCPCH) program. Several additional opportunities have been identified for expanded integration.

Best practices cited:

- Federally qualified health center, school-based clinics, certified community behavioral health clinic and Family Resource Centers (Eugene School District)
- Skill building and health education exists in several schools
- Stigma has been reduced in regards to accessing mental health
- Fostering resiliency in communities has been emphasized
- Community health workers and peer support services have been added to support/engage patients
- ElRod Center, Christian-based services (Christians as Family Advocates)

Opportunities and challenges/resource needs identified:

- More education – destigmatize teens, early interventions, school services
- Develop non-traditional partnerships and coalitions with new strategies for managing cross-sector collaboration and leadership
- Collaboration with multicultural organizations, local colleges and universities, and utilizing students as resources for impacts of change
- Tele behavioral health – rural
- Need more systems education
- Privately insured families don't have same access to programming
- Southern Oregon for success model of community-wide vocabulary and conversation/tools for clients
- More hands-on interaction with peers
- Suicide hotline – advertise
- Cultural and linguistic inclusivity
- Wraparound services are working well – expand to all, not just youth
- Supported employment – getting people with mental illness into workforce
- Supporting professional development to help with shortage of prescribers
- Warm hand-offs from primary care to behavioral health
- Trauma – informed care
- Integrated mental health and substance use disorder services, medication-assisted treatment for opiates

2. Food Services

Adequate and easy access to local fresh foods has been a focus with multiple programs in Lane County. Food for Lane County has been the primary vehicle for integrating food availability and nutritional education into housing environments and into primary care clinics. Programs have enhanced SNAP dollars for fruits and vegetables through

collaboration with Willamette Farm and Food Coalition, a particularly effective strategy for increasing healthy food purchases.

Best practices cited:

- Food for Lane County, more accessible gardens, education/food healthy choices
- Local gardening organizations, food boxes (more central list of options), summer lunches, saving food collaborative, SNAP (farm double-up, extra bucks)
- Integration in housing, social services and health care settings
- Produce school program, food in emergency departments/clinics
- Churches (food boxes)
- Healthy food access development within Double Up Food Bucks and Food for Lane County
- Food distribution/expansion near crisis services sites (emergency department, hourglass, etc.)
- Schools students growing food – food sources, career pathways at Bethel/Kalipinya High School
- Veggie pilot

Opportunities and challenges/resource needs identified:

- Improve school lunches
- Homeless camps need access
- Food deserts still exist in many areas of the county
- Maps/lists of where to get food boxes/meal sites
- Funding knowledge – place skills – how to access, budget, make
- Increased collaboration/integration between Double-up Food Bucks and SNAP
- How to distribute food – healthy choices to SNAP families
- Transportation/delivery
- Overcome barrier related to “for profit” organizations reselling food boxes for distribution
- Expand community garden space
- Head Start/school collaborative efforts with students and parents and screen/intervene
- Extra helping
- Produce plans in health care settings
- Promote plant-based diets, cooking classes (options for those with full schedules, off-site participation)

3. Housing

Numerous concerns exist over the trend of decreasing availability of affordable housing. Integration efforts have primarily been centered around developing strong supportive housing entities and leveraging community relationships to bring services directly to residents. The rising cost of housing and relatively flat wage levels has created increasingly vulnerable families in our community. Childcare remains another high cost driver for these families. Integration of services, including job development training and legal services has improved the chances of stability for many families.

Best practices cited:

- Cornerstone utilizes traditional health workers/community health workers and Homes for Good, Saint Vincent de Paul
- Willamette Family Treatment Services – developing all further given housing crisis
- Fair Housing Council of Oregon, Centralized Waitlist for Housing, Saint Vincent de Paul
- Renter’s education
- Better Housing Together collaboration/partnerships
- Neighborhood Economic Development Corporation
- Recovering houses, city housing project, tiny houses, South Lane, Housing First
- Safe camp sites

- Assistance for first time home buyers with Neighborhood Economic Development Corporation and others
- Square One Villages

Opportunities and challenges/resource needs identified:

- Education: budgeting, more ADA housing, community supported shelters
- Strengthen local partnerships and identify local resources
- Culturally and linguistically accessible programs
- Funding more paneled mental health providers Trillium Community Health Plan billing support.
- Certification billing demands/education shortage of mental health providers
- Housing – wait lists long, housing poor quality
- Client centered housing space
- City planners/incentives for contractors/\$ back
- Mental health supportive housing
- Expanding opportunities in rural
- Embedded services at housing sites
- Medical dental social change code rules
- Better use of empty buildings
- Rent prices are very high, consider expanded subsidies
- Providing services/education/training at housing
- MLK – housing 1st project
- Network of private property managers tools to entice property managers to rent
- City and county policy can be a barrier
- Accessory dwelling units
- Youth housing – safe shelters/permanent options
- Social isolation needs to be addressed
- Pro-social housing communities

4. Substance Use Treatment

The integration of substance use disorder (SUD) treatment with more traditional health settings has been limited because of federal regulatory requirements. Creative solutions, including more support in primary care offices, has been helpful to meet the large demand for SUD treatment, particularly problems with opiate use. Extensive efforts to educate the provider community have improved the level of collaboration, opening the door for more integration.

Best practices cited:

- Looking Glass
- Community “211” clearinghouse
- White Bird is working well, and Willamette Family Treatment and Options
- Rapid access program
- Good behavior game as a prevention strategy
- Provider education with the Lane Pain Guidance and Safety Alliance

Opportunities and challenges/resource needs identified:

- Incentives – education and outreach to younger ages
- Homeless folks – outreach/engagement
- More providers doing medication-assisted treatment
- Collaboration and innovation: broadening health care to include more than just medical care
- Economies of scale

- \$2 billion prevention and public health fund will enable reach to upstream issues to advance prevention
- Educating households on tax credits to support affordability and stabilize cost
- CCO incentive metrics
- No opiates in emergency department
- Continuous follow-ups a support after treatment
- Trauma-informed SUD services needed
- Cultural and linguistic inclusivity rural and youth treatment
- Regulatory restrictions regarding sharing of private health information in this category “confidentiality”
- Medicaid Institutions for Mental Diseases Exclusion as a barrier
- Lack of teen treatment, law enforcement – move away from tertiary (or both)
- Residential higher level
- Meaningful integration
- Adjudicated youth have better access to significant treatment programs
- Cannabis – cultural perspective and value vs. harm??
- 42 CFR barriers
- Incentives – not enough beds available, teens need more support care
- Teen/peer education
- Less prescribing meds = more alternative choices
- Primary care could be a more helpful partner! SBIRT
- Community reduction in stigma
- Naloxone at community partners
- SUD waiver will help eliminate some barriers and make integration easier
- Oral health rehab/repair needed – needs partnership

5. Public Health System

The impact of the current care delivery system could be enhanced with a more direct partnership with public health, particularly as strategies for population health are developed. Efforts in prevention have been very successful in Lane County, largely financed by Trillium and led by public health experts. Integration of services could be best supported with a strong data system and a public health construct.

Best practices cited:

- Wellness clinics – more available/support to access
- Continued focus of social determinants (race, racism, etc.)
- Vaccinations = more access, locations, ADA access
- Education/outreach
- Tobacco prevention
- Safe sex kits distribution has been effective
- Cultural and linguistic inclusivity understanding poverty
- Non-traditional locations
- Cultural norm improved regarding value of public health
- Sexually transmitted infections more effectively treated

Opportunities and challenges/resource needs identified:

- HUB program for teens?
- Develop community-wide practice standards and protocols for treatment
- Primary care provider and psychiatry shortages
- Gun control/safety/data
- People need support accessing services, filling out applications and forms

- Know what's available to whom – some services are only for homeless or families, seniors are left out
- People afraid of being shamed – train providers
- Caregivers – training on cultural sensitivity and community services
- Sex education – open and inclusive and without shame
- Exploit social media platforms
- Understanding of public BH and primary care
- ECHO project in Oregon
- Water fluoridation
- Flu shot clinics in neighborhoods
- Stigma of poverty prevents access
- Stigma of public health (feel supported/unpressured)
- Prevention coalition
- Expand into rural communities through telehealth?
- More social connections – reduce isolation
- Better knowledge of what is behavioral health
- Resource navigator – Google, Craigslist, etc.
- Available alternative health modalities (acupuncture, chiropractic, massage)
- Integration of primary care
- Better public awareness of what is available
- Vaping teen use average
- Cannabis use/abuse
- Effective marketing okaying use but not abuse
- Aging and increasingly ill population further stresses the delivery system
- Lack of connection to minority communities both with resources and effective messaging

6. Physical Health

The Affordable Care Act has substantially improved access for almost 50,000 Lane County residents. In addition, Cover All Kids has ensured all children have access to health insurance. Driven by quality expectations and a PCPCH model, care delivery in Lane County has centered around integration with behavioral health services, some with limited oral health integration. Reverse integration, primary care into behavioral health settings, has shown cost reduction primarily in emergency department use and hospitalizations.

Best practices cited:

- Embed dental screenings, varnish, blood pressure and other vitals checks, SD, tobacco interventions
- Food boxes at primary care sites
- Social/community health worker/peer appointment partner
- Group/support visits
- Parenting classes
- PCPCH very effective in expanding integration
- Health education
- Nutrition education (at health clinics and schools)
- Centro Latino
- Legal aid
- Sheltercare center
- Cornerstone centers

Opportunities and challenges/resource needs identified:

- Legal aid/immigration
- Shower facilities
- Laundry facilities
- Pharmacy on-site, accessible to younger generations; efficient way to reach more people
- Partner with organizations who represent and advocate for minority population
- Incorporating active means of transportation into city planning
- Transportation
- Buy-in (patient and provider)
- Record sharing
- Educating what's available
- Space sharing
- Legal protection (for example, slip and fall accidents)
- Barriers can be related to "for profit" organizations, language and culture
- Rural, seniors, homeless
- System is too complicated, patients need navigation assistance
- 24-7 nurse line capacity could be increased
- 42 CFR is a barrier
- Substance use integration!
- Immunizations!
- Lane Independent Living Alliance
- Lane Transit District/taxi
- Lane County public health
- Food and Lane City
- Share model being developed by 15th night alert system
- 211 – needs sign; improvement technically
- Being able to bill for integration (coding system is still in silos)
- Learning collaborative/CMS, making changes
- Willamalane (prioritizing public health) veggie Rx model
- Prescribing physical activity

7. Oral Health

The lack of unified focus on oral health within medicine, inadequate local dental care access (including restorative), lack of coordination in care delivery, and low oral hygiene knowledge and instructions have been major local dental factors affecting the local public health system and community. Recent efforts to improve integration within the dental care organizations has improved overall access and several promising practices exist today that could be replicated.

Best practices cited:

- On-site screenings in affordable housing and schools
- Physical health – control
- Immunization
- Annual wellness
- Health and safety assessment (questionnaire)
- Substance abuse questionnaire
- Food assistance (for example, produce pantry)
- WIC, head start
- Human papillomavirus vaccine/blood pressure and other vitals checks/oral cancer screening
- Free toothbrushes and incentives
- Screening for issues in behavioral health and triage

- White Bird – better developed resource list
- United Way dental kits

Opportunities and challenges/resource needs identified:

- Behavioral health – anxiety initiative (Yamhill County)
- Ongoing anti-fluoride propaganda
- Link with Early Learning Alliance initiatives
- Tele-dentistry to serve rural areas
- Lack of education, intern skills (for example, brush, floss, all ages)
- Partner with existing resources
- Barrier: limited professional resources and space
- The separation of oral, eye, behavioral from physical health is bad
- Not covered by most health insurance providers, separate insurance
- Co-locate hygienists
- A lot of members have Oregon Health Plan
- Barrier: pain associated with treatment, fear, phobia, and intimacy
- Can't get to dental office
- Water fluoridation
- No Medicare coverage for oral health
- Care centers transporting
- Capturing what's out there and up to date
- Shame reduction
- Opiate addiction – fear of being in pain
- Clinics being willing to support/provide care
- Better coverage for adults
- Mobile dental van!
- Dental care in the emergency room (funnel to dental clinic on-site)

8. Income Generation

The health care industry has been a strong employer of residents of Lane County, and training programs continue to supply needed workers. The ability of a resident to earn family-wage income is critical for long term personal and family stability. Integration of workforce development would assist in health stability at multiple levels and should be considered in future integration initiatives.

Best practices cited:

- Goodwill Industries
- Entrepreneurial training
- Now: rain, coastal venture catalyst, small business, career and technical education
- Future: investment funnels, supportive ecosystem
- Micro enterprises
- Incubators – Sprout, Rain, net
- Supported employment
- Financial mentorship
- Standard minimum income
- Job share opportunities
- New requirements might divert energy or focus away from current priorities and traditional services; funds may be insufficient

Opportunities and challenges/resource needs identified:

- Free higher education
- Better public – private partnerships
- Standard minimum income
- Technical skills training
- Older adult re-training
- Community health centers/South Lane/Lane Community College/public health partnership in training
- Needs baseline level of education/degree – including entrepreneurship
- Studies in local curriculum
- Community lack of affordable childcare
- Limited instruction opportunities/resources
- Incarceration to job market, more sponsors including workers program for felons through jail
- Benefits “donut hole”
- More guild or apprenticeship opportunities
- Life cycle changes
- DHS partnership to help welfare recipients get training to re-enter workforce and Lane workforce partnership
- External sources of \$\$?
- Feds, Veterans Center, other?
- Paid “volunteer” programs
- Living wage
- Disabled job programs
- Benefits offered for part time jobs
- Provide professionals in schools
- School loan forgiveness – expand

9. Education

The state funding challenges, current low funding for education, and the privatization of education are significant concerns for the education sector. Optimistically, there is an increased focus, especially locally, on investing in early childhood and the related impact on long-term public health outcomes. A particular example is the well-established Lane Early Learning Alliance. Integration has been done well in school-based clinics, providing both physical health and behavioral health services.

Best practices cited:

- Adult education
- Career and technical education program
- Oral health services (future), behavioral health services (future) problem in schools
- More private sector involvement in health at schools
- Better serving of neighborhoods and families
- Future: training for career and technical education, breakfast after the bell
- Suicide prevention in schools K-12; behavioral health assessing and referral in schools K-12
- Training for staff for crisis intervention has increased
- Mental health providers led skill building groups (intervention)
- Education of the direct link between behavior issues and behavioral health struggles to increase empathy within school systems
- Life-skill curriculum
- Substance use disorder prevention/education in schools
- Social determinants

- Peer-driven/led education
- Social services
- Broaden types of learning styles
- Centro's Mental wellness classes
- Lane workforce partnership
- Food services – Lane Community College

Opportunities and challenges/resource needs identified:

- Future – more services in school based clinics
- Instruments/equip
- Out of class to get care
- Consents
- Disparate records
- Lane Community College doesn't assist professionals
- Alternative payment mythologies
- No access to state school fund for some services (public health/behavioral health, oral health)
- School policy
- Family Education Rights and Privacy Act
- Vision screening
- Gun violence
- \$ for certification
- Education staff to identify social determinants of health – suicide, mental health
- Relief nursery
- Need more family service integration
- More family planning integration
- Family education of adverse childhood experiences/resiliency tools, vocabulary
- Cyber world crisis (impact) for our children
- ADA training and compliance
- Undocumented families – outreach?
- The cost of higher education prohibits people in poverty from accessing it
- Ensure rural schools get services

10. Transportation

The community advisory council (CAC) priorities include transportation as a fundamental barrier to access to care and to other services that could improve health. Discussion focused on opportunities to provider more integrated services using the current transportation platform and vendor.

Best practices cited:

- Ride source – community partners training for clients
- Lane Transit District goes to surrounding areas
- Future – circle shuttles to get to Lane Transit District's Emerald Express bus line, set appointments with providers with consideration to bus schedules
- Willamette Family Treatment Services – provide transportation, food, housing, medical appointments, mental health, etc.
- Equitable options for rural, county residents
- Eugene pediatrics home visits
- White Bird services – for those who can't use other transportation due to behavioral health
- Centro Latino Americano – discounted bus passes

- Blue bikes!

Opportunities and challenges/resource needs identified:

- More rural health care services needed
- Better integration with Lane Transit District
- Future – expansion of transport sites (no transport to school sites), Lane Transit District and school bus integration to access health care, affordable bus passes for students
- Partner with medical facilities for reduced rate passes
- Ride sharing – include Uber and Lyft – allows much more flexible scheduling
- Expansion to rural
- Companies need to pay for cars, safety, insurance
- Ride source only for health appointments
- Coastal community is cut off
- Cost is a barrier for some for Lane Transit District
- Peers on the bus for assistance/coordination
- How to explore removing procedural barriers
- Wait times for outlying areas
- More collaboration between all providers - \$ to increase efficiency
- Better driver training – people skills
- No address, no ride on Lane Transit District/Ride Source

11. Legal Services

Not traditionally considered a service domain influencing health outcomes, this area was identified by the CAC as influencing several aspects of the social determinants of health. Lack of legal services increases evictions and other legal actions that threaten the stability of families. Integration of these services may help provide needed support and improve overall health.

Best practices cited:

- Drug court – MH court – Municipal court
- Many legal profession volunteer on non-profit and social service boards
- Fair housing council

Opportunities and challenges/resource needs identified:

- Sponsors like legal/housing/employment services offered in other settings
- Money for legal barriers (grants/scholarships for expungements, fines, forgiveness programs)
- Future – affordable legal aid (for example, DACA, residency)
- Community court/growth
- Employment
- Housing
- Financial
- Accessing services
- Lack of knowledge of resources
- Removing perceived barriers
- Educate employers on value propositions for giving people a second chance
- Reduce need for legal services – education and paperwork requirements
- Sponsors, legal aid (limited capacity), community court
- Cultural competency training (medical documents like birth certificates)
- Space, employees, resources (for example, community involvement, collaboration with community programs, reduction)
- Free consultations – one hour

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- Immigration law/attorneys/subject matter experts to help with navigation and fear
- Active engagement of legal community at meetings such as this session
- Education in high schools about legal issues, rights
- People, process, ideas, moving, connections



LiveHealthyLane Care Integration Health Improvement Plan

On May 4, 2018, a large group of diverse community members came together to conduct a care integration assessment. A smaller group of eight people was involved in piloting the planning process. The group prioritized focusing on the integration of the behavioral health and school sectors in their communities. Below is the completed domain grid that provides the status of current integration efforts throughout the community in these sectors.

Integration Sectors: Schools and Behavioral Health			
	Functional Domains	Anchors	
Service Domains	1. Staff have knowledge about the population and domains being integrated.	<ul style="list-style-type: none"> • Staff can conduct an individual/family needs assessment in all domains integrated. • Staff can develop a single intervention plan across all domains. • Staff are both cross trained in content, and trained in integration specifically for their areas. 	<p>Status assessment:</p> <ul style="list-style-type: none"> - Four school districts have mental health staff based in the school. - Unsure of ESD status. - Three school districts are actively working on trauma-informed care with mental health providers. - These three districts have just started a system of care staffed by one FTE. - There is no common screening or risk assessment used across schools by the mental health staff. - FERPA and HIPPA are identified barriers to full sharing of information and full integration of care. <p>Goals:</p> <ul style="list-style-type: none"> - Goal 1: Systematically analyze and resolve FERPA and HIPPA barriers by developing processes that satisfy each. - Goal 2: Actively teach and train on these resolutions to all mental health and school staff. - Goal 3: Integrate the fourth school district into the newly created system of care.
	2. The integration team has shared workflows and official protocols to facilitate collaboration.	<ul style="list-style-type: none"> • Shared workflows are consistently implemented rather than informal processes. 	<p>Status assessment:</p> <ul style="list-style-type: none"> - There is some attempt at Springfield schools, but otherwise there is very little use of consistent shared workflows.

		<ul style="list-style-type: none"> Shared workflows increase collaboration towards shared goals. 	<p>Goal:</p>
	<p>3. The integration team has systematic methods to identify and prioritize individuals in need of integrated services.</p>	<ul style="list-style-type: none"> Systematic screening tools are used to identify individuals and families in need of integrated services. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- Each school district has similar tools but they are not the same ones used by mental health.</i> <i>- This has not been systematically reviewed across all schools and mental health.</i> <p>Goal:</p>
	<p>4. The integrated team engages patients and families in shared plans and services.</p>	<ul style="list-style-type: none"> Integrated service team uses the same methods, philosophy, approach and protocols for individual/family engagement. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- Some districts and mental health have adopted and jointly trained on both collaborative problem solving and trauma-informed care systems, but this is not consistent across all districts.</i> <i>- There has been no systematic determination by all parties of what a comprehensive philosophy and approach would be, even though there are some being used in common.</i> <p>Goal:</p>
	<p>5. The integrated services team systematically measures outcomes for all integrated domains over time.</p>	<ul style="list-style-type: none"> Integrated services team consistently use the same follow-up systems on a regular basis. The services team can adjust the plan if the individual/family are not reaching the desired outcome. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- Three districts have started a system of care for high risk kids with mental health systems. This system of care is new, but is developing the same follow-up and service planning processes.</i> <p>Goal:</p>
<p>Leadership and Business Domains</p>	<p>6. Leadership of the sectors to be integrated (or already integrated) are engaged and supportive of administrative alignment.</p>	<ul style="list-style-type: none"> Leaders share values about integration and have a visible commitment to integration. Leadership allocates resources such as money, time and attention, to integrated services development. Leadership jointly identifies points of conflict with other organizations and systems and develops practical solutions. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- The general consensus of the group is that both schools and mental health systems do well in this area, making these sectors ripe for integration services improvement goals.</i> <p>Goal:</p>
	<p>7. Reliable and robust office processes exist to support the integrated services team.</p>	<ul style="list-style-type: none"> Consistently use specific structures, office workflows, processes and standards to 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- There are no integration efforts taking place in this domain.</i>

		<p>support reliable integrated services.</p> <ul style="list-style-type: none"> Jointly use quality improvement approaches and process improvement methods. 	<p>Goal:</p>
	<p>8. There is a sustainable business model to support the longevity of the integrated services.</p>	<ul style="list-style-type: none"> Develop a comprehensive and realistic sustainability plan. Regularly monitor financial performance of the integrated services, including revenues and expenses. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- There is a business model for the metro area but not for the rural area.</i> <i>- There is no joint monitoring of the financial indicators of this model at this point.</i> <p>Goal:</p> <ul style="list-style-type: none"> <i>- Goal 1: Develop and implement a business model that includes the rural school districts.</i> <i>- Goal 2: Create a common set of financial indicators agreed to by all school districts.</i> <i>- Goal 3: Create common confidentiality and data use agreements signed by all school districts and begin sharing financial indicator data.</i>
<p>Measurement Domains</p>	<p>9. The integrated services team collects and uses service level data to improve quality of services.</p>	<ul style="list-style-type: none"> Collect data on key service processes (such as number of individuals with shared intervention plans). Use data to inform quality improvement and decision-making processes. 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- Common data are collected by schools on indicators of root level causes such as poverty and school lunch.</i> <i>- Developmental screening is the only mental health specific indicator data collected.</i> <i>- This data is not commonly shared.</i> <p>Goal:</p>
	<p>10. Data is collected and used to measure integrated services outcome from the patient, provider, financial and system perspectives.</p>	<ul style="list-style-type: none"> What is the individual/family's experience of integrated services? What has improved for them? What is the provider team experience of integrated care? What has improved for them? What is the financial outcome of integrated care on cost of services for the provider and for the individual/family? What are the system administrators' experience of integrated services? 	<p>Status assessment:</p> <ul style="list-style-type: none"> <i>- There are no integration efforts currently taking place in this domain.</i> <p>Goal:</p>

The integration improvement planning group chose the following domains as their priorities:

- #1: Staff have knowledge about the populations and domains being integrated
- #8: There is a sustainable business model to support the longevity of the integrated services.

The group brainstormed the following three goals for Domain #1:

- Systematically analyze and resolve FERPA and HIPPA barriers by developing processes that satisfy each.
- Actively teach and train on these resolutions to all mental health and school staff.
- Integrate the fourth school district into the newly created system of care.

The group brainstormed the following three goals for Domain #8:

- Develop and implement a business model that includes the rural school districts.
- Create a common set of financial indicators agreed to by all school districts.
- Create common confidentiality and data use agreements signed by all school districts and begin sharing financial indicator data.

The group then split into two, and one team analyzed the proposed goals for Domain #1 and the second team analyzed the goals for Domain #8. The results of this analysis are presented below in the feasibility grids.

Domain #1: Staff have knowledge about the population and domains being integrated.					
Goal/objective	Relates to CHA priority?	Aligned with the rest of the CHP?	Partners identified and committed?	Current integration efforts?	Resources available?
List each potential goal and objective from domain grid.	If no, may be of questionable meaningfulness.	If no, may not be supported by overall community direction.	If yes, who. Are any key players missing? If no, consider starting with leadership domain as a goal area from above grid.	If yes, does goal represent a logical step forward that builds on existing efforts?	Resources of space, staff, expertise, policy, political will and funding.
Systematically analyze and resolve FERPA and HIPPA barriers by developing processes that satisfy each.	<i>The improvement of youth mental health and prevention of school violence are key areas in the CHA, and do relate to this integration area, though they are very technical and may not be understood by the larger community.</i>	<i>Yes, as promoting school mental health is a CHP priority. However, this might be seen as "too in the weeds" to be a meaningful goal by those outside the systems.</i>	<i>Yes, school and mental health leadership are aligned. This will require the involvement of compliance and legal officers, who have not yet been involved and may be cautious.</i>	<i>Yes, as all four school districts have mental health staff in the schools and are struggling with how to best share information and create joint plans.</i>	<i>Yes, as leadership is aligned. Not all schools have lawyers or compliance officers, but the larger ones do and have offered to commit their time to this effort, which all can benefit from.</i>
Actively teach and train on these resolutions to all mental health and school staff.	<i>The improvement of youth mental health and prevention of school violence are key areas in the CHA, and do</i>	<i>Yes, as promoting school mental health is a CHP priority, and this guidance would be widely welcomed by</i>	<i>Yes, school and mental health leadership are aligned, and teachers and counselors would see this as a way</i>	<i>Yes, as all four school districts have mental health staff in the schools and are struggling with how to best share</i>	<i>Yes, all school districts have agreed to take time, and have the space, for the training.</i>

	<i>relate to this integration area, though they are very technical and may not be understood by the larger community.</i>	<i>school and mental health staff, as well as parents, as it removes a frustrating barrier for them.</i>	<i>to remove barriers to coordinated care.</i>	<i>information and create joint plans</i>	
Integrate the fourth school district into the newly created system of care.	<i>The improvement of youth mental health and prevention of school violence are key areas in the CHA, and this goal would be widely understood and viewed as getting to a comprehensive system.</i>	<i>Yes, as promoting school mental health is a CHP priority. Because of the lack of communication with rural districts, it is not known what the issues are and how this goal would be seen.</i>	<i>The rural school district has not been in on discussions regarding the system of care, so before any planning could take place, they would need to be engaged at the leadership level to understand needs and barriers.</i>	<i>This does not represent a logical step forward until the rural school district is engaged. A better goal in this area would be to align leadership of all four school districts around goals and needs in this area.</i>	<i>It is unknown what resources will be needed as there is no plan for this. However, it is expected that substantial resources will be needed.</i>

Domain # 8: There is a sustainable business model to support the longevity of the integrated services.					
Goal/objective	Relates to CHA priority?	Aligned with the rest of the CHP?	Partners identified and committed?	Current integration efforts?	Resources available?
List each potential goal and objective from domain grid.	If no, may be of questionable meaningfulness.	If no, may not be supported by overall community direction.	If yes, who. Are any key players missing? If no, consider starting with leadership domain as a goal area from above grid.	If yes, does goal represent a logical step forward that builds on existing efforts?	Resources of space, staff, expertise, policy, political will and funding.
Develop and implement a business model that includes the rural school districts.	<i>While youth mental health and school violence prevention are priorities, the CHA does not mention system of care as a need.</i>	<i>While youth mental health and school violence prevention are priorities, the system of care is not listed as a CHP priority.</i>	<i>The rural school districts are not yet engaged in a joint system of care conversation, so discussing a funding model would be premature.</i>	<i>No, the goal would be premature before the rural school district is engaged in joint plans for a single system of care.</i>	<i>Unknown, as planning has not progressed this far yet. There is leadership staffing time and will to meet and to plan.</i>
Create a common set of financial indicators agreed to by all school districts engaged	<i>Though the system of care is not mentioned specifically, it is a clear pathway to</i>	<i>Though the system of care is not in the CHP specifically, it is a clear pathway to</i>	<i>CFOs of school districts would be the ones to implement the plan, and they do</i>	<i>Given the discomfort of the staff who would have to set the indicators and</i>	<i>While the CFOs are busy, if they are given clear parameters, purpose and time</i>

in the system of care and begin sharing data.	<i>coordinated youth mental health.</i>	<i>coordinated youth mental health response.</i>	<i>not all know one another, and do not feel comfortable with releasing financial information.</i>	<i>share data, and given there is no history for this type of data sharing, it would be premature.</i>	<i>by their principals, the resource is there.</i>
Create common confidentiality and data use agreements signed by all school districts engaged in the system of care.	<i>Though the system of care is not mentioned specifically, it is a clear pathway to coordinated youth mental health.</i>	<i>Though the system of care is not in the CHP specifically, it is a clear pathway to coordinated youth mental health response.</i>	<i>There is relationship between the school district superintendents and principals, but school boards have not yet signed off on approval to share sensitive financial data.</i>	<i>Given that leadership is aligned in purpose to support the single system of care, creating data sharing agreements and gaining approval of school boards does seem like a logical step.</i>	<i>Yes, there is resource with CFOS, principals and superintendents. They may need a small amount of funding for a short-term contract with a school data sharing expert to help them with policies.</i>

Based on the analysis above, the integration planning group chose the following goals as the next best steps:

- Domain 1: Systematically analyze and resolve FERPA and HIPPA barriers by developing information sharing processes that satisfy each.
- Domain 8: Create common confidentiality and data use agreements signed by all school districts engaged in the system of care.

While each of these goals are more “in the weeds,” they do relate directly to supporting the new system of care that is a broad scale initiative to improve youth mental health and provide school violence prevention, which are priorities in the CHA and the rest of the CHP.

The CHP writing team devised the following CHP goals, objectives and activities, which can be overlaid into the already existing CHP in the section relating to youth mental health. While the actual integration activity is very simple, it fits nicely into an existing CHP goal, and can be flagged as an integration goal and activity. In the beginning, it is best to keep these goals and activities small, simple and strategic to avoid CHP planning and implementation fatigue. While small, both of these goals can have a larger impact on future areas of integration when they arrive, as sharing both student/clinical information and sensitive financial information could be barriers in multiple types of integration projects.

Health Priority #1: Improving Youth Mental Health			
<i>Goal: By 5/31/2021, sustain and fully implement a fully functional system of care involving three school districts and the respective mental health centers.</i>			
<i>Improvement Strategy</i>	<i>Performance Measure</i>	<i>Target Date</i>	<i>Responsible Parties</i>
Develop information sharing protocol for school and mental health staff that satisfies both HIPPA and FERPA requirements. <small>**Integration goal</small>	Written protocol and visual workflow documents developed and approved by school district superintendents.	5/31/2019	School district superintendents, mental health compliance officers, either school or mental health lawyer, or contract lawyer specializing in

CHP Handout #7

			HIPPA/FERPA issues. Group should also include parents and youth at key points.
<p>Create common confidentiality and data use agreements signed by all school districts engaged in the system of care.</p> <p>**Integration goal</p>	<p>Data use agreement developed that includes the sharing of financial and de-identified clinical outcome data signed by all school superintendents for districts participating in the system of care.</p>	<p>5/31/2019</p>	<p>School district superintendents, school district CFOs, and contractor specializing in school data sharing protocols.</p>

APPENDIX F: Resource List

Behavioral Health and Primary Care

Advancing Behavioral Health Integration within NCQA Recognized Patient Centered Medical Homes. SAMHSA/Center for Integrated Health Solutions. https://www.integration.samhsa.gov/integrated-care-models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf Published 3/2014.

Dissemination of Integrated Care within Adult Primary Care Settings: The Collaborative Care Model. American Psychiatric Association Academy of Psychosomatic Medicine. <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/APA-APM-Dissemination-Integrated-Care-Report.pdf> Published 2016.

Six Levels of Collaboration/Integration. SAMHSA/Center for Integrated Health Solutions. https://www.integration.samhsa.gov/integrated-care-models/CIHS_Framework_Final_charts.pdf Published 3/2013.

Integrated Care General

Integrated Care Models: An Overview. World Health Organization. http://www.euro.who.int/_data/assets/pdf_file/0005/322475/Integrated-care-models-overview.pdf Published 10/2016.

Oral Health and Primary Care

Integration of Oral Health and Primary Care Practice. Health Resources Services Administration. <https://www.hrsa.gov/sites/default/files/hrsa/oralhealth/integrationoforalhealth.pdf> Published 2/2014.

Oral Health Integration Guideline. Safety Net Medical Home Initiative. <http://www.safetynetmedicalhome.org/sites/default/files/Guide-Oral-Health-Integration.pdf> Published 10/2016.

Oregon Oral Health Integration in Oregon. Oregon Health Authority. <https://digital.osl.state.or.us/islandora/object/osl%3A81347/datastream/OBJ/view> Published 11/2016.

Social Determinants of Health

A Guide to Community Engagement Frameworks for Action on the Social Determinants of Health and Health Equity. National Collaborating Centre for Determinants of Health. <http://nccdh.ca/resources/entry/a-guide-to-community-engagement-frameworks> Published 2013.

A Road Map to Address the Social Determinants of Health through Community Collaboration. American Academy of Pediatrics. <http://pediatrics.aappublications.org/content/early/2015/09/15/peds.2015-0549> Published 9/2015.

Community Tool Box: Chapter 17, Section 5. Addressing Social Determinants of Health and Development. University of Kansas Center for Community Health and Development. <https://ctb.ku.edu/en/table-of-contents/analyze/analyze-community-problems-and-solutions/social-determinants-of-health/main> Last updated 2018.

Measuring Social Determinants of Health among Medicaid Beneficiaries: Early State Lessons. Center for Health Care Strategies, Inc. https://www.chcs.org/media/CHCS-SDOH-Measures-Brief_120716_FINAL.pdf Published 12/2016.

Social Determinants of Health. Healthy People 2020. <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health> Last updated 4/27/18.

Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2016/04/using-social-determinants-of-health-data-to-improve-health-care-.html> Published 5/2/16.

Value Based Payment: Subcommittee Recommendation Report (Social Determinants of Health Section, pg. 43). New York Department of Health. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2016/docs/2016-feb_sub_comm_recommend_rpt_consol.pdf Published 2/2016.

Social Determinants of Health and Primary Care

Integrating Screening for Social Determinants of Health Into Clinical Practice as an Integral part of Quality Improvement. Unity Health Care. <https://www.nhchc.org/wp-content/uploads/2017/06/implementing-sdoh-screening.pdf>

Training Primary Care Residents on Social Determinants of Health. Greater New York Hospital Association. https://www.gnyha.org/wp-content/uploads/2017/09/SocialDeterminants_digital-1.pdf Published 9/5/17.