



# Innovation Café: Strategies for Improving Children's Health

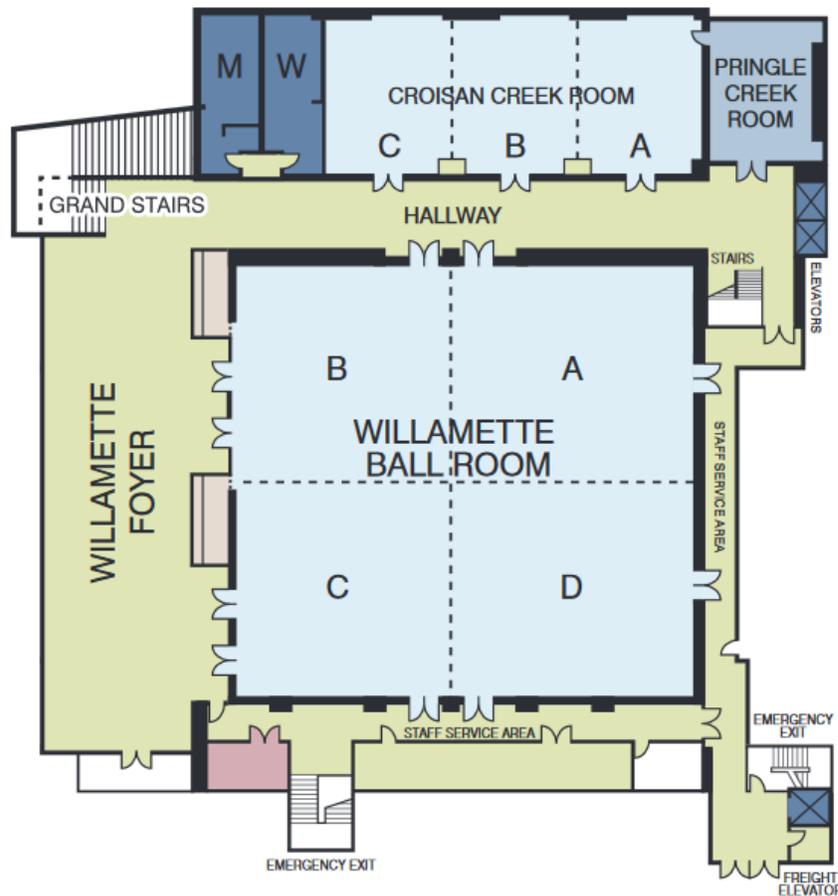
June 12, 2018, Salem Convention Center

## Agenda

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|-------------------------|--|
| 7:30 – 8:30 a.m.        | <b>Registration and breakfast</b>  |
| 8:30 – 8:45 a.m.        | <b>Opening remarks</b><br>Chris DeMars, MPH, Oregon Health Authority & Dana Hargunani, MD, MPH, Oregon Health Authority  |
| 8:45 – 9:45 a.m.        | <b>Plenary – Adverse Childhood Experiences in Children and Families: Understanding Primary Care's Role in Prevention</b><br>R.J. Gillespie, MD, MHPE, 2015–2016 OHA Transformation Center Clinical Innovation Fellow   |
| 9:45 – 10:05 a.m.       | <b>Café instructions/transition time</b>   |
| 10:05 – 11:35 a.m.      | <b>Café session 1 (3 rounds, 27 minutes each)</b>  |
| 11:35 a.m. – 12:00 p.m. | <b>Transition time/lunch buffet</b>  |
| 12:00 – 1:15 p.m.       | <b>Plenary panel – Strategies for Youth Resilience: Strengthening Trajectories from Early Childhood through Young Adulthood</b><br>Maggie Steele, MSW, Peace in Schools; Wes Rivers, MPA, OHA Public Health Division; Susan Fischer, M.Ed., AllCare Health; Safina Koreishi, MD, MPH, Columbia Pacific CCO |
| 1:15 – 1:30 p.m.        | <b>Transition time</b>   |
| 1:30 – 3:00 p.m.        | <b>Café session 2 (3 rounds, 27 minutes each)</b>  |
| 3:00 – 3:45 p.m.        | <b>Networking and refreshments</b>   |

## Event Logistics

- To access Wi-Fi, select the “salemconvention” network. No password is required.
- Restrooms are located on the same floor as the event, to the right of the main ballroom, Willamette C&D.
- If you have a question about the event, or need assistance, you can contact Transformation Center staff, who will have red ribbons on their name badges.
- A lactation room is located on the first floor, within the Salem Convention Center administrative office. Please contact a Transformation Center staff person if you need to use this room.
- Resource tables will be available during the afternoon networking session, 3–3:45 p.m., in the Willamette Foyer. Table topics are listed on the next page of this booklet.
- Join the conversation on Twitter! Use the hashtag #2018OHACafe when tweeting.
- All plenary sessions will be in Willamette C&D, while breakout sessions will be in Croisan Creek, Willamette A, Willamette B and Pringle Creek. Please see below for a 2<sup>nd</sup> floor map of the Salem Convention Center, which shows these room locations:



# Resource Tables

Willamette Foyer

- 211info
- Building Healthy Families
- Capitol Dental Care
- CC0 2.0 (Oregon Health Authority)
- Early Learning Division of the Oregon Department of Education & Vroom Initiative
- Health Aspects of Kindergarten Readiness Technical Workgroup (Children's Institute and Oregon Health Authority)
- Oregon Center for Children and Youth with Special Health Needs
- Oregon Health Authority – Public Health Division
  - Adolescent and School Health
  - Maternal and Child Health
  - Oral Health
  - Supplemental Nutrition Program for Women, Infants and Children (WIC)
- PAX Good Behavior Game (AllCare Health)
- Peace in Schools
- Providence Swindells Resource Center
- Randall Children's Clinic - Emanuel
- Western Oregon Center for Pediatric Therapeutic Lifestyle Change

## 2018 Innovation Café: Strategies for Improving Children’s Health

### Café Session 1 Schedule

Round 1: 10:05–10:32 a.m. / Round 2: 10:35–11:02 a.m. / Round 3: 11:05–11:32 a.m.

#### Croisan Creek

#### Willamette A

#### Willamette B

<p><b>Cross-Sector #1:</b> 211info Community Engagement Model: Strategic Partnerships for Health in Southern Oregon (211info, AllCare Health)</p>	<p><b>Developmental Screening #1:</b> Metrics to Meaning: Using Data to Advance Health Equity across Sectors (Health Share of Oregon, Early Learning Multnomah)</p>	<p><b>Childhood Immunization #1:</b> Prospective Analysis of Immunization Data: Using ALERT Data to Target Outreach for Combo2 (Health Share of Oregon)</p>
<p><b>Cross-Sector #2:</b> Developing Early Literacy Promotion Opportunities: From Primary Care to Home Visiting and Beyond (Reach Out and Read Oregon, Multnomah County Health Department, Multnomah County Library)</p>	<p><b>Developmental Screening #2:</b> Pathways from Developmental Screening to Services: Ensuring Young Children Identified At Risk Receive Follow-up (Northwest Early Learning Hub, Oregon Pediatric Improvement Partnership, Marion-Polk Early Learning Hub)</p>	<p><b>Childhood Immunization #2:</b> Coordinated Student Wellness Events in Yamhill County (Yamhill Community Care, Western Oregon Center for Therapeutic Lifestyle Change, Physician’s Medical Center)</p>
<p><b>Cross-Sector #3:</b> Improving Children’s Whole Health: Community Health Workers and Peer Support Specialists Providing Services in the Home (Family Tree Relief Nursery, InterCommunity Health Network CCO)</p>	<p><b>Cross-Sector #6:</b> A Rural Approach to Bridging Health Care and Social Determinants (Reliance eHealth Collaborative, Columbia Gorge Health Council)</p>	<p><b>Childhood Immunization #3:</b> Improving Childhood Immunization Rates Using Practice-Focused Population Health Strategies (Children’s Health Alliance)</p>
<p><b>Cross-Sector #4:</b> Project Nurture: Integrated Substance Use Treatment and Maternity Care (Health Share of Oregon)</p>	<p><b>Cross-Sector #7:</b> Pollywog – Prenatal and Parental Support (Early Learning Hub of Linn, Benton and Lincoln Counties, Samaritan Health Services)</p>	<p><b>Oral Health Integration #1:</b> Improving Oral Health Outcomes for Young Children and Families with “Everybody Brush” (Advantage Dental)</p>
<p><b>Cross-Sector #5:</b> Social Determinants Screening and Veggie Rx Pilot (Benton County Health Services, Community Health Centers of Benton and Linn Counties, Corvallis Environmental Center)</p>	<p><b>Cross-Sector #8:</b> Breastfeeding Support Services: East Linn County (Linn County Public Health, Samaritan Lebanon Health Center)</p>	<p><b>Oral Health Integration #2:</b> Oral Health Integration Menu. Order Up! (Capitol Dental Care)</p>
<p><b>Pringle Creek Room</b></p>		
<p><b>Prenatal/Postpartum #1:</b> Improving the Health of Mothers and Babies in Central OR (Deschutes County Health Services)</p>		

## 2018 Innovation Café: Strategies for Improving Children’s Health

### Café Session 2 Schedule

Round 1: 1:30–1:57 p.m. / Round 2: 2:00–2:27 p.m. / Round 3: 2:30–2:57 p.m.

#### Croisan Creek Room

#### Willamette Room A

#### Willamette Room B

<p><b>Cross-Sector #9:</b> Starting Strong: A CCO Cross-sector Member Incentive Program (Jackson Care Connect)</p>	<p><b>Developmental Screening #3:</b> Help Me Grow Oregon: Advancing Developmental Promotion, Early Detection and Linkages to Services (Providence, Early Learning Hubs of Clackamas, Multnomah and Washington Counties)</p>	<p><b>Childhood Immunization #4:</b> Improving 2-year-old Immunization Rates in Southwest Oregon (Douglas Public Health Network)</p>
<p><b>Cross-Sector #10:</b> Community UPLIFT (Cascade Health Alliance, Southern Central Early Learning Hub)</p>	<p><b>Cross-Sector #13:</b> Building a Trauma-Informed Community (Yamhill Community Care)</p>	<p><b>Childhood Immunization #5:</b> A Regional Approach to Address Childhood Immunization Rates: AFIX Project (PacificSource Central Oregon, Deschutes County Health Services)</p>
<p><b>Cross-Sector #11:</b> Beyond Silos: Supporting Kids and Families through CCO and Early Learning Partnerships (Trillium Community Health Plan, United Way of Lane County, Lane Early Learning Alliance)</p>	<p><b>Cross-Sector #14:</b> Why You Should Ask: Screening for Childhood Food Insecurity in the Medical Home (Providence Milwaukie Hospital, Providence Family Medicine Residency Program)</p>	<p><b>Oral Health Integration #3:</b> Back to the Basics Prevention (Mercy Foundation)</p>
<p><b>Cross-Sector #12:</b> Improving Health Care and Early Education through Innovation Collaboration (Building Healthy Families, Winding Waters Clinic)</p>	<p><b>DHS Custody #1:</b> Universal Evaluations for Youth Entering Foster Care – the RAPID Program (MindSights, Department of Human Services – Multnomah County, Health Share of Oregon)</p>	<p><b>Oral Health Integration #4:</b> Integrating Oral Health into Well-Child Visits (Care Oregon: Columbia Pacific CCO, Jackson Care Connect)</p>
	<p><b>DHS Custody #2:</b> Using the Pathways Model to Provide Additional Supports to Children Coming into DHS Custody (PacificSource Columbia Gorge, Columbia Gorge Health Council, Hood River Health Department)</p>	<p><b>DHS Custody #3:</b> Medical Home for Children in Foster Care (Randall Children’s Clinic-Legacy Emanuel)</p>
<p style="color: #4F81BD;"><b>Pringle Creek Room</b></p> <p><b>Prenatal/Postpartum #2:</b> Family-Centered Neonatal Opioid Withdrawal Syndrome (NOWS) Care: A Quality Improvement Project (OHSU Doernbecher Children’s Hospital)</p>		

# Plenary Session Descriptions

## Keynote Plenary

### ***Adverse Childhood Experiences in Children and Families: Understanding Primary Care's Role in Prevention***

**R.J. Gillespie, MD, MHPE**

Adverse childhood experiences (ACEs) are known to be associated with myriad health problems. Prior research has suggested that high parental ACE scores are associated with high ACE scores in children; children who experience multiple ACEs experience lower kindergarten assessment scores, indicating early aberrations in developmental trajectories. Understanding parental ACE scores early is the first step in attempting to prevent transmission of ACEs between generations.

Pediatrician and 2015–2016 Oregon Health Authority Transformation Center Clinical Innovation Fellow R.J. Gillespie will discuss his clinical research in screening for parents' ACEs in pediatric settings; impacts of ACEs and social determinants on child health and wellness; and a vision for preventing the lifelong effects of ACEs through partnerships across sectors.

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## Lunch Plenary

### ***Strategies for Youth Resilience: Strengthening Trajectories from Early Childhood through Young Adulthood***

Oregon data demonstrate an overall decline in youth resilience and social emotional well-being, highlighting the need to change children's trajectories during the earliest years of life as well as provide effective supports to youth and families as they move toward adulthood.

This plenary will:

- Include a presentation on Oregon Healthy Teens data trends in positive youth development and indicators of social emotional well-being;
- Describe the evidence base for mindfulness and its impact on physical and behavioral health and other aspects of wellness;
- Highlight Peace in Schools and the PAX Good Behavior Game as strategies that positively enhance youth, family and community resilience; and
- Explore the impact of mindfulness and resilience among clinicians and educators working to support children, youth and families.

Panelists Maggie Steele, Wes Rivers, Susan Fischer and Safina Koreishi will highlight a variety of evidence, perspectives and strategies that connect schools, health systems and other partners to build resilience and mindfulness among Oregon's youth and the professionals who serve them.

#2018OHACafe

## 2018 Innovation Café: Presenter Bios

### ***Plenary speakers***

#### **Chris DeMars, MPH, Director, Oregon Health Authority Transformation Center**

Chris is the director of the Oregon Health Authority Transformation Center. Before joining the Transformation Center in 2013, she spent eight years as a senior program officer at the Northwest Health Foundation. Prior to joining the foundation, Chris spent six years as a senior health policy analyst for the U.S. Government Accountability Office. She holds a Master of Public Health from the University of Michigan School of Public Health and a bachelor's degree in English Literature from the University of Michigan.

#### **Susan Fischer, M.Ed., Health and Education Integration Coordinator, AllCare Health**

Susan joined AllCare Health in 2014, after facilitating the Southern Oregon region's successful application to become contracted as an Early Learning Hub under the Oregon Department of Education's Early Learning Division. Susan's work as an educator at the early childhood, elementary and community college level has provided her with a unique view of the cradle-to-career spectrum. Adding to this systems view, her work as a home visitor and a small business owner allows her to act as a translator between these critical sectors. In creating the role of health and education integration coordinator, AllCare CCO became the first coordinated care organization in the state to dedicate a position to bridging the work of health care transformation with the invaluable talents and services of community partners serving the same children, youth and families. Susan lives in Grants Pass with her partner, Jason, and their two children.

#### **R.J. Gillespie, MD, MHPE, Pediatrician, The Children's Clinic**

R.J. is a pediatrician with The Children's Clinic in Portland. He attended medical school at OHSU, and completed his residency and chief residency at Rush Children's Hospital in Chicago and Master of Health Professions Education from University of Illinois. He also completed a Clinical Innovation Fellowship through the Oregon Health Authority's Transformation Center in 2016. He has worked on a variety of statewide quality improvement initiatives, as the past chair of the Oregon Pediatric Society's QI Committee, the past medical director of QI for the Children's Health Alliance, and medical director of the Oregon Pediatric Improvement Partnership. He has advised the American Academy of Pediatrics through the Medical Home for Children Exposed to Violence Project Advisory Committee, Resilience Project, and the National Screening Initiative and STAR Center for Screening in Practice. His current passion is in studying parental adverse childhood experiences and their effects on early child development, and he recently published his findings in *Journal of Child and Adolescent Trauma* and in *Pediatrics*.

#### **Dana Hargunani, MD, MPH, Chief Medical Officer, Oregon Health Authority**

Dana joined the Oregon Health Authority (OHA) as chief medical officer in January 2018. In this role she provides clinical leadership and integrated thinking to support implementation and spread of the coordinated care model and to transform Oregon's health care delivery system. She serves as the director of OHA's Office of Clinical Services Improvement and provides guidance to initiatives across the agency focused on clinical policy, resources and quality improvement. From 2011–2015 Dana directed children's health policy for OHA in her role as child health director. In the interim she has served as the chief executive officer for the Oregon Public Health Institute and served as an independent health policy consultant focused on child and family

health. In addition to her public health and policy focus, Dana continues to work part-time as a general pediatrician in a small, community-based clinic serving low-income families.

**Safina Koreishi, MD, MPH, Medical Director, Columbia Pacific CCO**

Safina is the medical director of Columbia Pacific CCO. She is also an adjunct associate professor of family medicine at OHSU, and sees patients at OHSU Scappoose clinic. Safina completed the Clinical Innovation Fellowship through the Oregon Health Authority in 2016. She is board certified in both family and preventive medicine, and has spent her career practicing family medicine and providing clinical leadership in safety-net clinics. She has a passion for public health, underserved medicine, serving the community, and improving and transforming the systems of care for patients as well as for those who work within it.

**Wes Rivers, MPA, Policy and Assessment Specialist, Oregon Health Authority Public Health Division**

Wes is a policy and assessment specialist within the Oregon Health Authority's Public Health Division where he analyzes youth health survey data, tracks and crafts policy proposals affecting youth, and promotes evidence-based policy and programming. He has nine years of policy and research experience in health, health care, and local/state tax and public finance. He has a B.A. in Economics from Southwestern University and a Master of Public Affairs from the University of Texas, Austin.

**Maggie Steele, MSW, Training Coordinator and Mindfulness Teacher, Peace in Schools**

Maggie is a licensed school social worker and the training coordinator for Peace in Schools where she creates and facilitates mindfulness-based professional development trainings for educators and youth-serving professionals. She teaches mindful studies at Franklin High School and is a certified provider of Mindfulness-Based Stress Reduction for Teens as well as the Trauma Recovery Empowerment Model. A dedicated mindfulness practitioner since 2003, Maggie has served as the mental health coordinator for Inward Bound Mindfulness Education and believes that scaling depth in mindfulness education is essential for creating trauma-informed and equitable schools.

***Café session presenters***

**Sherri L. Alderman, MD, MPH, IMH-E Policy & Clinical, FAAP, Developmental Behavioral Pediatrician, Oregon Infant Mental Health Association**

Sherri is a developmental behavioral pediatrician, CDC Act Early ambassador to Oregon, Oregon Help Me Grow physician champion, and president of the Oregon Infant Mental Health Association. She has infant mental health mentor endorsement in clinical and policy and a Master of Public Health. Her special interests include early childhood development and systems of care for families with young children. She has made more than 100 presentations in a wide variety of venues. Sherri is affiliate assistant professor in the Department of Pediatrics, Division of Developmental Pediatrics at the Oregon Health & Science University School of Medicine and serves on multiple advisory committees, work groups and boards.

**Jessica Allen, BSDH, EPDH Community Outreach Dental Hygienist, Advantage Dental**

Jessica graduated from Oregon Institute of Technology with a Bachelor of Science in Dental Hygiene. In her current role as a community outreach dental hygienist in Jackson and Josephine Counties she works to engage community partners to expand access to care for community members. She provides dental screenings and services as well as the medical management of caries through the use of silver diamine fluoride. She is a First Tooth and Maternity Teeth for Two trainer. Jessica is passionate about educating and engaging her patients of

all ages to minimize dental fear and improve oral health. She is experienced in both private practice dentistry and managed care.

**LaRisha Baker, Maternal Child Family Health Director, Multnomah County Health Department**

LaRisha is the interim director for Multnomah County Health Department's Maternal Child Family Health program. She holds an MBA and has over sixteen years of service in public health. Her work promotes supporting healthy pregnancy outcomes, early childhood development, and strong family and cultural connections.

**Jessica Barton, MA, IBCLC, Lactation Consultant, Nutrition Educator, Linn County Department of Health Services WIC program**

Jessica is a lactation consultant and Linn County WIC nutrition educator in a pediatric practice in Lebanon, OR under a grant funded by the InterCommunity Health Network Coordinated Care Organization (IHN-CCO). She has been supporting breastfeeding families since 2009 and has been an International Board Certified Lactation Consultant since 2011. She has experience in both clinical and private practice. She is an active member and contributor to the Linn Benton Lincoln Breastfeeding Coalition and she contributes to public access to breastfeeding support and information by making informational breastfeeding support videos, which are freely available on YouTube. She has a Master of Arts in Teaching from Western New Mexico University and a bachelor's degree in physical science and German. Jessica is committed to making a contribution to the health and development of children and communities in both the USA and the developing world.

**Dr. Freda Bax, Psychologist, Co-owner, Mindsights, P.C.**

Freda is a licensed psychologist and co-owner of Mindsights, P.C. MindSights provides psychological evaluation services to children in foster care and those covered by local CCOs, among others. Freda's specialty areas include trauma and traumatic stress; early-childhood loss, attachment disruption, and maltreatment; neurodevelopmental conditions, including autism spectrum disorders and alcohol-related neurodevelopmental disorders; learning disabilities; attention-deficit/hyperactivity disorder; and other complex presentations in which emotional/behavioral challenges are complicated by cognitive issues, learning differences, and/or unique ways of making sense of the world. MindSights' owners are proud to offer the RAPID program to DHS and HealthShare to raise the bar in utility and breadth of mental health assessments of children entering the foster care system.

**Helen Bellanca, MD, MPH, Associate Medical Director, Health Share of Oregon**

Helen is a family physician and associate medical director at Health Share of Oregon. She is the lead for the Project Nurture Collaborative, which is a Center of Excellence model for integrating substance use disorder treatment and maternity care in the Portland Metro region. She also chairs a subcommittee of the Oregon Perinatal Collaborative, which developed the Oregon Family Well-Being Assessment. Helen has a deep commitment to reproductive health, integrating behavioral health and maternity care and early childhood strategies for reforming care delivery for families on Medicaid.

**Leah Brunson, BS, IBCLC, Public Health Lactation Consultant, Breastfeeding Coordinator, Nutrition Educator, Linn County Department of Health Services WIC Program**

Leah is an International Board Certified Lactation Consultant. Leah graduated from Oregon State University with a Bachelor of Science in Nutrition and Food Management. She has worked for the Linn County Public Health Women Infants and Children Nutrition program as the breastfeeding coordinator for over 20 years.

Leah worked together with the state WIC staff to develop curriculum and policies for the Breastfeeding Services Peer Counseling Program, which is aimed at helping improve breastfeeding initiation and breastfeeding duration across Oregon WIC clinics. Leah has been actively involved in advocacy work with revision of the Linn Benton Lincoln Breastfeeding Coalition, the coordination of care through the pediatric clinic and WIC, as well as the licensure process to get billing in place for lactation consultants.

**Bailey Burkhalter, MPH, Epidemiologist, Douglas Public Health Network**

Bailey is an epidemiologist with Douglas Public Health Network and was formerly with Lane County Public Health, communicable disease epidemiology and outbreak investigation.

**Jennifer Clemens, DMD, MPH, Dental Director, Capitol Dental Care**

Jennifer obtained her dental education at Temple University in Philadelphia. She completed her general practice residency with the Veterans Affairs Medical Center in Philadelphia in 2004. In 2017, she completed a Master of Public Health and a Dental Public Health Residency at A.T. Still University. She has worked for SmileKeepers Dental as a general dentist since 2006, focusing on providing care to children and vulnerable populations. Jennifer is the dental director for Capitol Dental Care and works to ensure all members receive quality, compassionate care.

**Kristi Collins, Director, Early Learning Hub of Linn, Benton and Lincoln Counties**

Kristi serves as the director for the Early Learning Hub of Linn, Benton and Lincoln Counties. Her passion for early childhood education began as a young parent volunteer when her own son attended Head Start. She has devoted her career to the field earning a master's degree in early education and child care and a bachelor's degree in multidisciplinary studies from Cambridge College. Kristi's work experience includes work in private preschool programs, federal and state funded programs, and national nonprofits.

**Suzanne Cross, MPH, CHW, Senior Project Manager, Columbia Gorge Health Council**

Suzanne is the senior project manager for the Columbia Gorge Health Council (CGHC), which is a partner with PacificSource Community Solutions in the Columbia Gorge Coordinated Care Organization. Suzanne has had over 20 years of experience working in health care and health promotion. As program manager for the Bridges to Health Pathways Community HUB Program, for which CGHC serves as the HUB, Suzanne has lead the design, development and implementation of the program designed to provide cross sector community care coordination for community members needing assistance. Suzanne has Master of Public Health from the University of Massachusetts.

**Heidi Davis, MSW, Program Manager, Providence Milwaukie Community Teaching Kitchen**

Heidi is the program manager for the Providence Milwaukie Community Teaching Kitchen, and has worked in the social service industry for over 15 years. In 2016, Heidi began working as a patient navigator at the community teaching kitchen where she assisted in the development of a comprehensive program to serve local community members who lack access to healthy foods, suffer from hunger, or need to build healthier eating habits in order to prevail through disease and illness.

**Bess Day, MBA, Director of Education, United Way of Lane County and Director, Lane Early Learning Alliance**

Bess is director of education for United Way and the director of the Lane Early Learning Alliance. Previously Bess had a long tenure working in health care technology research and development. Her experience includes

social science research, mental and emotional health and well-being program development, with a specific focus on resilience, and parent/adolescent relationship strengthening and communication.

**Molly Day, MSW, Early Learning Director, United Way of the Columbia-Willamette, and Co-Director, Early Learning Multnomah**

Molly is the early learning director at United Way of the Columbia-Willamette and co-director of Early Learning Multnomah, the state's early learning hub in Multnomah County. With 33 years of experience in the field, Molly's recent work experience includes three years at Children's Institute setting up the Early Works initiative and eleven years at Morrison Child and Family Services managing parent support programs and therapeutic foster care. Molly is an Equity Leaders Action Network Fellow with the BUILD Initiative.

**Alison Donnelly, RN, Nurse Home Visitor, Hood River County Health Department**

Alison is a public health nurse with Hood River County Health Department providing home visiting services including the Bridges to Health Pathways Community HUB program. She has 17 years of experience in health care, and prior to being a registered nurse, her experience included licensed massage therapy, home health for individuals with disabilities and volunteering as a firefighter/EMT.

**Cate Drinan, Help Me Grow Program Manager, Providence**

Cate is the Help Me Grow program manager at The Swindells Center at Providence Health and Services. Cate previously served as the assistant director of the System of Care Institute at Portland State University, where she helped lead the statewide dissemination of Wraparound and System of Care. She has worked as an early childhood mental health consultant, trainer and parent educator, and her professional work centers on improving the early childhood system of care for families with young children.

**Roxanne Edwinston, PhD, Licensed Psychologist and RAPID Lead Clinician, MindSights, P.C.**

Roxanne is a licensed psychologist and is the lead clinician of the RAPID Program at MindSights, P.C. Her specialty areas include child psychological assessment and working with youth who have experienced trauma and displacement. Her research efforts have included assessing the service needs of youth entering foster care and the cognitive and academic profiles of youth with maltreatment histories. Roxanne has been conducting testing and assessment services with youth involved with the Oregon Department of Human Services since 2013.

**Chandra Elser, MPH, Quality Improvement Analyst, Health Share of Oregon**

Chandra has a Bachelor of Science in Biochemistry and a Master of Public Health. These perspectives have served her well in the analysis of health care data with the aim of population health improvement. She worked in quality management at an FQHC in downtown Portland prior to joining the Health Share team as an analyst overseeing the CCO incentive metric work.

**Debi Farr, Manager, Government Relations, Trillium Community Health Plan**

Debi is the manager of community relations at Trillium Community Health Plan. Debi's experience in community relations and public service spans more than two decades, including State Representative in the Oregon Legislature. She has been a member of both the Lane County Commission on Children and Families and the United Way Success by Six Leadership Team where she served as chair in 2007. Currently Debi represents Trillium on the Governance Consortium of the Lane County Early Learning Alliance, and serves as vice-chair on the Bethel School Board.

**Pamela Ferguson, RN, BSN, MHA, Program Manager, Healthy People and Families, Deschutes County Health Services**

Pamela is the program manager for Healthy People and Families, Deschutes County Health Services, located in Bend, Oregon. She leads five teams to include Clinical Services and Youth Sexual Health, Nurse Family Support Services; Perinatal Care Continuum; Public Health Reception and Vital Records; and Women, Infants and Children. In addition, she is the co-chair of the state level Coalition of Local Health Officials, Access to Clinical Preventive Services Committee. She earned her Bachelor of Nursing at San Diego State University and her Master of Health Administration at Baylor University.

**Elke Geiger Towey, MA, MBA, Practice Coach, Columbia Gorge CCO**

Elke works with primary care provider organizations and community agencies to support them in quality improvement efforts and behavioral health integration. She has significant experience in process improvement, information systems, clinic operations, and program evaluation in both medical clinics and community mental health. She has put together presentations and trainings on best practices in a number of areas. Elke is also on the board of the Columbia Gorge Children's Advocacy Center.

**Holly Hermes, LCSW, Pediatric Social Worker, Randall Children's Clinic at Randall Children's Hospital – Legacy Health Systems**

Holly is a Care Coordinator for Randall Children's Clinic's Medical Home Program for Children in Foster Care. She has worked in the social service and mental health field for over 20 years. For the past 15 years Holly has worked for Legacy Health serving as a Child Abuse Social Worker in the emergency department through CARES Northwest and currently as a pediatric social worker providing comprehensive care coordination for foster children. She has worked in this position for the past 9 years. Prior to working at Legacy, Holly was the clinical supervisor for Albertina Kerr's Early Childhood and Outpatient programs and has worked as a Child and Family Therapist at Albertina Kerr, Lifeworks Northwest and Lutheran Family Services.

**Lisa Harnisch, Executive Director, Marion-Polk Early Learning Hub, Inc.**

Lisa works with and on behalf of Marion and Polk Counties to ensure that children are ready for kindergarten and academic success, with a focus on coordinated and aligned systems and family stability. She convenes and catalyzes action around strategies focused on serving children and families that have limited opportunities. Lisa has over 20 years of experience at the state level, focusing on early childhood, child welfare and organizational development policy initiatives. She was involved in work at the policy and structure level to create the early learning hubs that are now around the state. Working locally in the community where she lives, works and plays provides her great energy and satisfaction.

**Heidi Hill, MHA, Regional Manager/Community Liaison, Advantage Dental Services**

Heidi is regional manager/community liaison with Advantage Dental Services and works with individuals and communities to bring population health strategies focused on oral health into the community setting. Heidi has been involved with the coordinated care organization movement since 2012 as a member of the founding staff team for Jackson Care Connect CCO. In her role as community engagement program manager, she oversaw the development of social determinant work. This framework of community based work has been included in a study done by Dartmouth on accountable care organizations, and her work with Rogue Valley Family YMCA has been recognized by Governor Kate Brown as a primary example of health care transformation. Heidi has a bachelor's degree in public policy/public administration, and a master's degree in healthcare administration from Walden University. She is also a graduate of the Developing Equity and

Leadership through Action (DELTA) program, is knowledgeable in the science surrounding adverse childhood events and trauma-informed care, and is a certified personal trainer with 30 years of coaching and training in the fitness and dance industry.

**Erin Hoar, Regional Perinatal Care Coordinator, Deschutes, Jefferson and Crook County Health Departments**

Erin is the regional perinatal care coordinator for Jefferson, Crook and Deschutes Counties. She has worked for Deschutes County as the point person for the Oregon MothersCare (OMC) program since 2000. In that work she has found ways to evolve OMC and change how we serve pregnant women. This new project has helped expand their capacity and given them new ways to serve more women. Erin earned her bachelor's degree from Pacific Lutheran University and started her work in public health at the Deschutes County Health Department as a Jesuit Volunteer. She then became a health educator, coordinating the Oregon MothersCare program. She also has experience working for the WIC program as a certifier, the Breast and Cervical Cancer Program, and the STARS program, and tobacco prevention.

**Christian Huber, RN, BSN, Manager Randall Children's Ambulatory Services, Randal Children's Hospital – Legacy Health Systems**

Christian is the Manager for Randall Children's Primary Care, Urgent Care and Pulmonology Clinics. He serves as the Program Manager for the Medical Home Program for Children in Foster Care. His work in RCH's medical home program promotes supporting the physical, emotional and developmental health for the foster care population. Christian has 25 years of health care experience with the last 14 years supporting and improving the health care and outcomes for our patients at Randall Children's Hospital.

**Rhonda Janecke, RN, Maternity Case Manager, Cascade Health Alliance**

Rhonda manages high-risk maternity cases for Cascade Health Alliance and the Prenatal Incentive Program for pregnant members age 15-40s; and works with members, providers and community resource partners to address social determinants for pregnant women and their children. She facilitates access to medical, dental and behavioral health care; transportation; housing; food bank; and other community resources.

**Alexa Jett, BSDH, EPDH, Dental Innovations Specialist, CareOregon**

Alexa graduated from OHSU's dental hygiene program with a Bachelor of Science in Dental Hygiene. In her current role as CareOregon's dental innovations specialist, Alexa serves our Medicaid community in two capacities: providing technical assistance and project management as a practice coach for the CareOregon dental provider network, and supporting CareOregon's primary care network in the Metro, Jackson Care Connect and Columbia Pacific CCO regions with oral health integration and as a First Tooth trainer. Alexa holds her expanded practice dental hygiene license and has over twenty years clinical experience in both private practice and FQHC public health settings.

**Jill Johnson, Immunization Program Coordinator, Deschutes County Health Services**

Jill has a Bachelor of Science in Nursing and a Master of Environmental Management. She has nursing experience in a variety of disciplines and currently works in the Immunization and Communicable Disease Programs at Deschutes County Health Services. Her responsibilities as immunization program coordinator include ensuring access to vaccines and activities to support improved immunization rates.

**Carla Jones, Reimbursement Manager, Samaritan Health Plans & InterCommunity Health Network CCO**

Carla Jones, Reimbursement Manager for Samaritan Health Plans, and InterCommunity Health Network (IHN CCO). Carla has over fifteen years of broad-based experience in healthcare administration. Carla's expertise and responsibility entails partnering with traditional and non-traditional service providers to transform the delivery system with value based payment models that incentive quality, integration, PCPCH concepts, holistic care, patient satisfaction and access, and thereby reducing unnecessary healthcare costs. Carla also manages medical and pharmacy risk adjustment programs, fee-for-service payment methodologies, Part D PDE reporting, performance metric reporting, and encounter data reporting and monitoring. To assure success Carla works closely with the State of Oregon, Physician leadership, Community partners, internal department, and others payers across the industry to ensure strategy, vision and goal alignment.

**Peg King, MPHA, MA, Manager, Life Health Initiatives, Health Share of Oregon**

Peg leads Health Share's strategic initiatives on early life health and kindergarten readiness, working closely with the early learning hubs and other community-based organizations. Before that, she worked at the Oregon Pediatric Society managing the statewide START QI initiative, training pediatric clinicians. Peg has also worked in public health, higher education, research, philanthropy and freelance writing, all in pursuit of improving lives of women, children and vulnerable populations. She spent four years overseas, first as a Peace Corps volunteer in Kenya, and later working in Tanzania and Taiwan. Peg has degrees from Duke University, Yale University and Portland State University. She is an avid traveler, reader and crossword puzzler.

**Lisa Kipersztok, MD, MPH, OHSU Family Medicine Resident**

Lisa is a family medicine resident physician at OHSU with clinical interests in addiction medicine for families, women's health, and public health. She went to college at UCF in Orlando, Florida where she worked on sustainability initiatives, spent a year as an AmeriCorps Vista working in public schools in Maryland, and then went to Tufts for an MD/MPH dual program in Boston, Massachusetts. She is interested in gardening, sustainable living, reproductive justice, and spending time with family and friends.

**Annie Lewis, Every Child Initiative Supervisor, Multnomah County Library**

Annie is the Every Child Initiative supervisor for Multnomah County Library where she oversees the library's early childhood services designed to help prepare children to enter kindergarten ready to learn to read. Annie holds a Master of Library and Information Science from the University of Washington and has over ten years of experience serving youth and families through public library services.

**Brian J. Mahoney, MPH, Public Health Modernization Coordinator, Douglas Public Health Network**

Brian is the public health modernization program coordinator with Douglas Public Health Network. Former roles include the public health administrator with Clatsop County and experience with the Oregon Public Health Division, the CDC and WHO working in communicable disease control, immunization, and public health emergency preparedness and response.

**Linda Mann, Director, Community Outreach, Capitol Dental Care**

Linda is an expanded practice dental hygienist and the director of community outreach at Capitol Dental Care. A recent Oregon Fellows award winner for excellence in the health care profession, Linda's current responsibilities include implementing evidence-based practices in outreach programs to provide preventive services in community settings. Her work experience includes 18 years with the Confederated Tribes of Grand Ronde, and the last five years with Capitol Dental. She is passionate about preventing dental disease and bringing services to populations that often experience barriers to care.

**Julie Manning, Vice President of Marketing, Public Relations and Community Health Promotion, Samaritan Health Services**

Julie is vice president for marketing, public relations and community health promotion at Samaritan Health Services, a Corvallis-based regional health system comprising hospitals, physicians and health plans serving Linn, Benton and Lincoln Counties. In addition to her responsibilities at Samaritan Health, Julie completed a four-year term as mayor of Corvallis in December 2014. Julie remains an active community volunteer. She co-chairs the Early Learning Hub of Linn, Benton and Lincoln Counties and is a member of the Oregon State University Board of Trustees. She is also a board member of the Benton Community Foundation, Oregon Humanities and the Greater Oregon chapter of the Public Relations Society of America. She serves on the Oregon Community Foundation's Leadership Council for the Southern Willamette Region.

**Bailie Maxwell, LPN, Pediatric Coordinator, Physicians' Medical Center**

Bailie has been a leader on planning committees for Yamhill County's Student Wellness and Games (SWAG Night) and Toothtastic Vaxapalooza since their inception in 2015 and 2016, respectively. She oversees development and implementation of workflows specific to the medical services provided at these student wellness events, and has contributed to creating a handbook for how to plan these events in other communities.

**Trina McClure-Gwaltney, RN, Healthy Kids Outreach Program Manager, Mercy Foundation**

Trina has served as the program manager for Healthy Kids Outreach Program (HKOP) for Mercy Foundation since 2011 after working as the HKOP resource nurse in Douglas County schools since the program's inception in 2006. She is currently overseeing HKOP prevention programs that include health awareness education, resource nursing, nutrition/physical activity education, and their school-based dental program. Trina has been a registered nurse for 21 years with a certification in psychiatric nursing. Prior to Mercy Foundation, Trina served as a psychiatric nurse for Mercy's behavioral inpatient and outpatient units for nine years.

**Alison McEwing, LPC, Child and Family Therapist, Randall Children's Clinic at Randall Children's Hospital – Legacy Health Systems**

Alison is the Child and Family Therapist at Randall Children's Clinic. Prior to joining the clinic team in 2010, she was a Child and Family Therapist at Easter Seals Children's Therapy Center for three years. Alison has also spent time covering Legacy Emanuel's Inpatient Psychiatry Unit, helping conduct research studies, and supervising graduate level counseling students in outpatient clinic settings. Alison holds a certification in Therapy with Adoptive and Foster Families from PSU, and she co-facilitates a workshop for caregivers to help children who have experienced trauma.

**Jessie Michaelson, Human Resources Officer, Winding Waters Clinic**

Jessie is the human resources officer at Winding Waters Community Health Center in Enterprise, Oregon. Jessie has been facilitating parent education classes in conjunction with Building Healthy Families for the last four years. She has played an integral role in building the cross systems collaboration between providers, educators and home visitors by designing, implementing and coordinating services between the clinic and community partners.

**Christine Mosbaugh, Engagement and Communications Coordinator, Benton County Health Services**

Christine is the engagement and communications coordinator for the Community Health Centers (CHC) of Benton and Linn Counties, a six-clinic patient-centered primary care home with integrated, team-based

services. She supports team needs, particularly around integration of patient voice and engagement; she works with organization leadership to think about innovations in the primary care space; and she builds community partnership and participates in efforts with local organizations to build a space in line with the CHC mission of “healthy people, strong communities”.

**Charlotte Navarre, RN-BC, Faculty Nurse Clinician, Providence Family Medicine-Milwaukie**

Charlotte is a nurse clinician and faculty with the Providence Oregon Family Medicine Residency Program in Milwaukie, Oregon. She is a 1974 graduate of the University of Missouri, Kansas City/Research College of Nursing and is board certified in psychiatric-mental health nursing. She is clinical lead in the two family medicine training clinics for a number of local and national initiatives. Her academic focus is on health equity and the social determinants of health.

**Vanessa Pingleton, Regional Home Visiting Systems Coordinator, South Central Early Learning Hub**

Vanessa works as the regional home visiting systems coordinator with the South Central Early Learning Hub. Her experience includes working for a managed health organization and a coordinated care organization in Southern Oregon. This includes work on a wraparound project with child welfare services and county mental health providers in two rural counties. She believes trusting relationships build collaborative systems.

**Carrie Prechtel, Community Engagement Coordinator for Jackson and Josephine Counties, 211info**

Carrie is the 211info community engagement coordinator for Jackson and Josephine Counties. She brings extensive public speaking, training, outreach and publicity experience to the position, allowing her to raise the level of awareness of 211info in Southern Oregon. Seven years with Jackson County Library Services and four years with the SMART Reading Program, as well as certification in nonprofit management and multiple positions on community leadership teams, have allowed Carrie to build strong, positive connections with the region.

**Cassidy Radloff, Farm to School Manager, Corvallis Environmental Center**

Cassidy is the Farm to School manager at the Corvallis Environmental Center (CEC), a part of the Edible Corvallis Initiative. Prior to coming to the CEC, Cassidy spent four years working in the Corvallis community as a nutrition and garden educator for youth and families while pursuing degrees in public health and sustainability from Oregon State University. Cassidy is passionate about connecting students in the Corvallis School District to healthy, local food, and is working to grow the Farm to School program to reach as many students as possible.

**Bhavesh Rajani, MD, Medical Director, Yamhill Community Care**

Bhavesh joined Yamhill CCO in May 2016 as medical director. He has many years of experience as a family physician and medical director. He has a deep commitment to low-income, underserved and vulnerable populations, and is passionate about population health initiatives. Bhavesh plays an integral role in ongoing community and clinical best practices and helps with program expansions. Bhavesh also has an interest in working on various prevention and wellness efforts and early learning strategies. In his spare time, he enjoys photography, travel, sketching and gardening.

**Daesha Ramachandran, PhD, MPH, Health Equity Strategist, Health Share of Oregon**

Daesha is a health equity strategist at Health Share dedicated to dismantling structural inequality in organizations and health systems. Daesha has spent the past 15+ years examining and upturning how racism,

power and oppression impact the health of individuals and communities. She has partnered with communities in Egypt, Ethiopia, the Navajo Nation, Baltimore, India and Multnomah County to improve maternal and child health, advance gender equity, prevent dating violence, scale and tailor youth sexual health programming and expand access to basic health care services. Daesha is a graduate of the Bloomberg School of Public Health at Johns Hopkins as well as the Edmund A. Walshe School of Foreign Service at Georgetown.

**Colleen Reuland, Director, Oregon Pediatric Improvement Partnership**

Colleen is the director of the Oregon Pediatric Improvement Partnership (OPIP), and an instructor in the Pediatrics Department at Oregon Health & Science University (OHSU). Colleen serves as the lead and principal investigator of OPIP projects focused on improving health outcomes for children. These include quality measurement and improvement projects focused on screening, referral and care coordination for children at risk for developmental, behavioral and social delays, and medical home implementation. She has significant experience working with state Medicaid/CHIP programs and frontline pediatric providers. She has significant experience leading population-based efforts to improve health outcomes for young children that engage partners across health, early learning and education sectors. She ensures these measurement and improvement efforts have a patient-centered focus and methods engage and partner with patients. Colleen is also the measure steward contact for the CHIPRA measure focused on developmental screening, and serves as an expert reviewer for *The Journal of Developmental & Behavioral Pediatrics*, *Pediatrics*, and *Health Services Research*. Colleen has a Master of Science focused on clinical evaluative sciences from Dartmouth College Institute for Health Policy and Clinical Practice. She is married and the proud mother of three children.

**Jenn Richter, Early Learning Program Administrator, Yamhill Community Care**

Jenn is in her fourth year as early learning program administrator for Yamhill CCO's early learning hub. She was previously chair of the CCO's community advisory council, worked in the English as a Learned Language program in Dayton School District, and was the owner of Dot the I Writing Service. In her spare time, she likes to read, write and spend time on the water.

**Riki Rosenthal, Starting Strong Program Specialist, Jackson Care Connect**

Riki is the Starting Strong program specialist for Jackson Care Connect. As a certified lactation counselor, certified community health worker, and peer support specialist, Riki is in a unique position to work with, and offer support to, pregnant members and their families. Riki believes every expecting family deserves access to all available supportive services to optimize opportunities for good health outcomes. This passion fuels her commitment to this work. As a single parent, Riki's experience navigating through local resources has equipped her with both the knowledge and the understanding to support her clients as they work to navigate many of the same services.

**Deborah Rumsey, B.A., Executive Director, Children's Health Alliance & Children's Health Foundation**

Deborah Rumsey, B.A. has served as the Executive Director at the Children's Health Alliance & Children's Health Foundation since 2011. She leads 120-plus pediatricians across Oregon and Washington in the development and implementation of clinical quality improvement, population health management, patient center medical home strategies, and alternative payment models. She also represents children's health care on numerous state and regional health care committees. Deborah has over 20 years of experience in the healthcare industry as a financial executive and consultant, working in all sectors of the healthcare industry. Deborah earned a B.A. degree in economics and public policy from Stanford University.

**Christin Rutledge, MPH, Program Specialist, Douglas Public Health Network**

Christin is a program specialist with Douglas Public Health Network. Prior to this role, Christin was a vaccination program coordinator at a large patient-centered primary care home.

**Renee Smith, Executive Director, Family Tree Relief Nursery**

Renee has been the director of Family Tree Relief Nursery for 11 years and has grown the organization by using various funding models and resources to leverage traditional health care workers within the relief nursery model. These efforts have increased quality of service, increased access for members and increased funding for services.

**Katie Sours, Executive Director, Western Oregon Center for Pediatric Therapeutic Lifestyle Change**

Katie has worked with the Western Oregon Center for Pediatric Therapeutic Lifestyle Change (WOC) since 2016. She directs all WOC programs including SWAG Night, Toothtastic Vaxapalooza, and Student Nutrition and Activity Clinic for Kids (SNACK), which trains students from Linfield College to provide free nutrition education and physical activity opportunities to youth and families in Yamhill County. She oversees promotion, planning and coordination of these student wellness events, and has worked with her co-presenter Bailie Maxwell to create a handbook for how to plan these events in other communities.

**Dorothy Spence, Hub Director, Northwest Early Learning Hub, and Early Learning Education Specialist, Northwest Regional Education Service District.**

Dorothy is the hub director at Northwest Early Learning Hub and early learning education specialist at Northwest Regional Education Service District (NWRESA). For the last three years, Dorothy has worked with cross sector partners in education, health care, human services, and community advocates in Clatsop, Columbia and Tillamook counties to support the children and families in the region to learn and thrive by making resources and supports more available, more accessible and more effective. Prior to coming to NWRESA, Dorothy spent six years working in policy and budget development with state legislators, state agencies, advocates and lobbyists. The last three years of her time in Salem, Dorothy served as the deputy legislative director to speaker of the house, where she focused primarily on education and early childhood policy and budget development.

**Nate Stanley, Social Determinants of Health Navigator, Community Health Centers of Benton and Linn Counties**

Nathaniel is the social determinant of health navigator with the Community Health Centers of Benton and Linn Counties. Nate works with the care team and clinical health navigators to help screen patients, process referrals, follow up on resources shared, and close the loop in supporting patients to meet their health and wellness goals. Nate is thinking creatively about current service connections, gaps and ways to move social determinants of health work forward to best meet health needs and serve the community.

**Ellen Stevenson, Medical Director, Reach Out and Read, and Associate Professor of Pediatrics and Public Health, OHSU**

Ellen is the medical director for Reach Out and Read Oregon, associate professor of pediatrics and public health at Oregon Health and Science University, and a pediatrician at Doernbecher Children's Hospital. Ellen is working to promote early literacy and kindergarten readiness efforts throughout Oregon.

### **Trish Styer, Quality Improvement Analyst, Jackson Care Connect**

Trish is a QI analyst at Jackson Care Connect and oversees quality metrics strategies and evaluation of innovative clinical and community wellness projects. Trish collaborates with several interdisciplinary teams, fulfilling her passion to use data and analytics to directly impact patient care and community health. Trish has supported quality improvement and quality assurance programs in the health care sector for over twenty years. Trish is a graduate of Reed College and the University of Chicago.

### **LeAnne Trask, Database and Media Coordinator, Pollywog Project**

LeAnne has lived in Oregon most of her life. She studied communications, advertising, accounting, and home and family development at Brigham Young University before returning home to the Willamette Valley. LeAnne has been lucky enough to work in a variety of fields—big business, small business, technical, government—and is happy to report that all sectors need advertising and/or accounting! Currently LeAnne is working as the database and media coordinator to help the Pollywog project through its pilot phase and spread out to help new parents throughout Linn, Benton and Lincoln Counties.

### **Scott Tse, Healthcare Data Analyst, Reliance eHealth Collaborative**

Scott Tse is a Healthcare Data Analyst at Reliance eHealth Collaborative where he is dedicated to Reliance Insight, a data analytics platform that strives to help providers, patients and communities improve well-being by integrating and analyzing health information across the entire patient care spectrum. Scott has spent 20 years in the electronics and semiconductor industry with experience in engineering, management, sales and marketing. He holds a BS in Materials Science and Engineering and his dream is to help patients reap some of the incredible benefits that have driven the digital revolution that have resulted in enhanced performance with maintained costs.

### **Maranda Varsik, Transformation Specialist, Columbia Pacific CCO**

Maranda has a background in quality and data driven improvement. After college Maranda began working in quality improvement at an FQHC in Santa Barbara, where she developed a passion for transforming health care and helping underserved populations. After moving to Oregon, Maranda joined another FQHC in the metro area for a few years and held various QI and leadership roles. In her most recent role as a primary care innovations specialist, Maranda coached primary care clinics in Columbia Pacific CCO on practice transformation topics like population health, team based care, integration and access. Working in Columbia Pacific fostered a love of rural health, which lead to expanding her role in the region to become the transformation specialist. Maranda now manages the county-level risk shares, community paramedic program, and Firsts Steps maternity incentive program.

### **Maria Weer, Executive Director, Building Healthy Families**

Maria has nearly 20 years of experience in education and nonprofit management. Her experience has primarily been with high-risk teenagers and their families struggling with the impacts of toxic stress. For the past eight years, Maria has been working in rural Oregon continuing her work with teens and having an increased focus on the first five years of parenting and child development. Cross-systems partnerships between health, education and social services have been a critical component of the successes experienced in Eastern Oregon.

**Paula Weldon, Operations, Reliance eHealth Collaborative**

Paula has over 20 years of experience in health information technology implementation related activities with both payers and providers. She currently oversees operations for Reliance eHealth Collaborative, facilitates and manages implementation of staff communication and outreach strategies in addition to technical interface and data analytic project teams. Paula has a Bachelor of Science in Innovation and Leadership. She currently participates on the Provider Directory SME Committee lead by the Oregon Health Authority.

**Katy Williams, LPN, Bridges to Health Pathways Program HUB Coordinator, Columbia Gorge Health Council**

Katy is HUB coordinator for the Bridges to Health (B2H) Pathways Community HUB Program. B2H Pathways is a program of the Columbia Gorge Health Council, which is a partner with PacificSource Community Solutions in the Columbia Gorge Coordinated Care Organization. Prior to serving in her current role Katy gained more than 13 years of experience in health care as a licensed practical nurse in a wide variety of clinical settings including criminal justice, addiction, developmental disability, home health and community based care.

**Coco Yackley, Operations Manager, Columbia Gorge Health Council**

Coco is the operations manager for the Columbia Gorge Health Council – the governance body of PacificSource Columbia Gorge CCO. Coco mobilizes community partners to implement a regional approach to transformation, community health assessment and the community health improvement plan. A RWJF Culture of Health Prize winner in 2016 exemplifies how the CCO requirements have been an extraordinary opportunity for collaboration to improve the health and wellness of all residents of the Gorge. Prior to health care, Coco worked for Intel for 22 years in leadership roles in product development, marketing, sales, and information technology and technical standards.

**Jessica Young, B.S., Population Health Implementation Manager, Children's Health Alliance**

Jessica Young B.S. is the Population Health Implementation Manager at the Children's Health Alliance. She has a degree in Business Administration, as well as a Pre-Medicine Post- Baccalaureate. She has over fourteen years' experience working in the healthcare industry, including administration, quality improvement, and population health management. Jessica is dedicated to helping practices develop high performing systems where both the business and team members can succeed.

## 2018 Innovation Cafe Participant List

First Name	Last Name	Job Title	Company/Org. Affiliation	Email
Shad	Achek	BSA	InterCommunity Health Network CCO	
Sherri	Alderman	Physician Champion	Help Me Grow	sherri.alderman23@gmail.com
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## Café Session 1: Project Descriptions

Round 1: 10:05-10:32 a.m. / Round 2: 10:35-11:02 a.m. / Round 3: 11:05-11:32 a.m.

### Croisan Creek Room

<b>Cross-Sector #1: 211info Community Engagement Model: Strategic Partnerships for Health in Southern Oregon</b>
Carrie Prechtel, Community Engagement Coordinator for Jackson and Josephine Counties, 211info; Susan Fischer, Health and Education Integration Coordinator, AllCare Health
211info works with local CCOs, the Southern Oregon Early Learning Hub, and The Family Connection to train providers and staff in accessing the 211info referral system, the Oregon Helps social program screening tool, and the EITC calculator, allowing families to actively engage in elevating their own social determinants of health.
<b>Cross-Sector #2: Developing Early Literacy Promotion Opportunities: From Primary Care to Home Visiting and Beyond</b>
Ellen Stevenson, Medical Director, Reach Out and Read Oregon; LaRisha Baker, Maternal Child Family Health Director, Multnomah County Health Department; Annie Lewis, Every Child Initiative Supervisor, Multnomah County Library
To build upon and maximize the impact of the evidence-based Reach Out and Read model, Health Share of Oregon supported a quality assessment of literacy promotion practices in the clinical setting. This project served as a catalyst for renewed and enhanced cross-sector partnerships between the Multnomah County Library, Reach Out and Read and the Multnomah County Health Department to promote language, early literacy, and the social emotional development of children from birth through age five. Presenters will discuss the multiple touch points through which families receive early literacy services including primary care clinics, WIC clinics and home visiting programs; explain program design and implementation; and share resource materials.
<b>Cross-Sector #3: Improving Children's Whole Health: Community Health Workers and Peer Support Specialists Providing Services in the Home</b>
Renee Smith, Executive Director, Family Tree Relief Nursery; Carla Jones, Reimbursement Manager, InterCommunity Health Network CCO
Presenters will discuss the strategic use of certified peer support specialists and community health workers as home visitors trained in the relief nursery service model to support and impact the stability of families far from opportunity and prevent child abuse and neglect with positive metric outcomes for early childhood. An alternative payment model supports this work through contract with IHN CCO.
<b>Cross-Sector #4: Project Nurture: Integrated Substance Use Treatment and Maternity Care</b>
Helen Bellanca, MD, MPH, Associate Medical Director, Health Share of Oregon
Substance use disorders in parents are the primary reason why children are abused, neglected and removed from their parents' custody in Oregon. One of the most important things we can do for children is ensure that pregnant women have the resources they need to be safe and healthy parents. Project Nurture has three sites that provide integrated care to pregnant women with substance use disorders, and we have had huge success in helping families stay together.

**Cross-Sector #5:****Social Determinants Screening and Veggie Rx Pilot**

Christine Mosbaugh, Engagement and Communications Coordinator, Benton County Health Services; Nate Stanley, Social Determinants of Health Navigator, Community Health Centers of Benton and Linn Counties; Cassidy Radloff, CEC Project Manager, Corvallis Environmental Center

The Community Health Centers of Benton and Linn Counties and the Corvallis Environmental Center are working together to assess social determinants of health needs and pilot a Veggie Rx intervention. We have looked at well-child checks as a powerful place to assess patient and family needs. We are making community referrals through health navigation to support better health outcomes for those who are interested in additional supports.

**Pringle Creek Room****Prenatal/Postpartum #1: Improving the Health of Mothers and Babies in Central OR**

Erin Hoar, Health Educator II, Regional Perinatal Care Coordinator, Deschutes County Health Services; Pamela Ferguson, RN, BSN, MHA, Program Manager, Healthy People and Families, Deschutes County Health Services

Regional Perinatal Care Continuum Project Central Oregon home visiting programs from Crook, Deschutes, and Jefferson Counties and their local health departments have implemented a regional approach to an integrated perinatal care continuum model in partnership with key stakeholders. This approach serves as the foundation for a regional referral system that includes: 1) prenatal high-risk nurse home visiting services; 2) linkage to community resources provided by a team of public health care coordinators embedded at local health departments and OB provider clinics throughout the community; and 3) regional coordination and tracking of pregnant women in the tri-county area.

**Willamette Room A****Developmental Screening #1: Metrics to Meaning: Using Data to Advance Health Equity across Sectors**

Molly Day, MSW, Early Learning Director, United Way of the Columbia-Willamette and Co-Director, Early Learning Multnomah; Peg King, MPH, MA, Early Life Health Initiatives Manager, Health Share of Oregon; Daesha Ramachandran, PhD, MHS, Health Equity Strategist, Health Share of Oregon

Health Share is partnering with the metro early learning hubs to make meaning and strategy out of the disparities evident in developmental screening rates. This includes meeting with community organizations such as Immigrant and Refugee Community Organization to identify effective cultural strategies to ensure kids and families understand developmental milestones and are connected to appropriate services.

**Developmental Screening #2: Pathways from Developmental Screening to Services: Ensuring Young Children Identified At Risk Receive Follow-up**

Dorothy Spence, Hub Director, Northwest Early Learning Hub and Early Learning Education Specialist, Northwest Regional Education Service District; Colleen Reuland, Director, Oregon Pediatric Improvement Partnership; Lisa Harnisch, Executive Director, Marion-Polk Early Learning Hub, Inc.

This two-year project aims to improve the receipt of services for young children who are identified at risk for developmental and behavioral delays. The project supports: 1) cross-sector stakeholder engagement and baseline data collection about current processes and where children are lost to follow-up; and 2) the project will work to develop, implement and evaluate improved follow-up processes, including referral to and coordination of processes meant to ensure early receipt of services that help at-risk young children to be ready for kindergarten

## Willamette Room A

### **Cross-Sector #6: A Rural Approach to Bridging Health Care and Social Determinants**

Coco Yackley, Operations Manager, Columbia Gorge Health Council; Scott Tse, Healthcare Data Analyst, Reliance eHealth Collaborative; Paula Weldon, Operations, Reliance eHealth Collaborative

Reliance is a cross-sector organization supporting seamless exchange of health information. Reliance receives data from physical health, oral health and behavioral health organization across the state and processes the information to discern social determinants of health (SDH) concepts that are used to identify children at risk as well as to support population health, quality metric reporting and clinical notifications. In collaboration with Bridges to Health (B2H) in the Gorge, the project has two primary goals: 1) fully integrate SDH and HIE in the Gorge across technology platforms to identify children at risk, assign a care coordinator and get them into appropriate care settings to achieve appropriate early childhood health outcomes; and 2) integrate social service and HIE eReferral applications to support closed loop referrals across health and social service organizations and track progress toward achieving early childhood goals.

### **Cross-Sector #7: Pollywog – Prenatal and Parental Support**

Kristi Collins, Director, Early Learning Hub of Linn, Benton and Lincoln Counties; LeAnne Trask, Database and Media Coordinator, Pollywog Project; Julie Manning, VP of Marketing, Samaritan Health Services

Pollywog was developed to align health care, parenting education and early childhood services for children, prenatal to age five, and their families. Pollywog assists families with signing up for prenatal and parenting education classes, accessing parent support and referrals to appropriate primary health care, child care and early learning opportunities.

### **Cross-Sector #8: Breastfeeding Support Services: East Linn County**

Jessica Barton, MA, IBCLC, Linn County WIC; Leah Brunson, BS, IBCLC, Linn County WIC

The granting of transformation funds to the Linn County Public Health WIC Program has allowed the placement of a Spanish speaking International Board Certified Lactation Consultant (IBCLC) in the Samaritan Mid Valley Pediatric office in Lebanon and the expansion of breastfeeding support services in Linn County WIC clinics. Project goals include: 1) to provide linguistically appropriate access to breastfeeding support services, 2) to provide quality specialty care by an extensively trained lactation professional (IBCLC), 3) care coordination and communication with the primary care provider, 4) decreased use of infant formula as a result of successful breastfeeding, 5) increased percentage of women who receive lactation counseling and support, 6) increased availability of provider time for medical care other than breastfeeding counseling and support, and 7) improved maternal and child health outcomes impacting quality of life and health care costs.

## Willamette Room B

### **Childhood Immunization #1: Prospective Analysis of Immunization Data: Using ALERT Data to Target Outreach for Combo2**

Chandra Elser, MPH, Quality Improvement Analyst, Health Share of Oregon

This project will demonstrate how Health Share has used ALERT data to identify patterns in immunization noncompliance, populations to target for impactful outreach (1-shot catch-up), and children 6-18 months who are behind schedule and are at risk of not meeting Combo2. This prospective approach helped Health Share meet the immunization target for 2017 and identify strategies for more effective appointment scheduling and reminder recall.

## Willamette Room B

### **Childhood Immunization #2: Coordinated Student Wellness Events in Yamhill County**

Katie Sours, MPH, Executive Director, Western Oregon Center for Therapeutic Lifestyle Change; Bailie Maxwell, LPN, Pediatric Coordinator, Physicians' Medical Center

Student Wellness And Games (SWAG) and Toothtastic Vaxapalooza (TT) are unique student wellness events in Yamhill County. SWAG extends clinic hours and provides physicals, vaccinations and behavioral health screenings to teens. TT, held at local middle schools, provides vaccinations and dental sealants to K-8 students. Each model facilitates collaboration between community organizations, schools and clinics. Both feature youth-focused activities, games and giveaways.

### **Childhood Immunization #3: Improving Childhood Immunization Rates Using Practice-Focused Population Health Strategies**

Deborah Rumsey, B.A., Executive Director, Children's Health Alliance & Children's Health Foundation; Jessica Young B.S., Population Health Implementation Manager, Children's Health Alliance

For over a decade, Children's Health Alliance providers and practices in the Portland, Salem and Vancouver areas have collaborated on a quality improvement initiative to improve childhood immunization rates. Currently, the Children's Health Alliance immunization initiative is managed and continually improved using care gap analysis by a population health management tool, Wellcentive™ Outcomes Manager.

### **Oral Health Integration #1: Improving Oral Health Outcomes for Young Children and Families with "Everybody Brush"**

Heidi Hill, MHA, Integration Coordinator, Advantage Dental; Jessica Allen, EPDH, Regional Expanded Practice Dental Hygienist, Advantage Dental

Advantage Dental has been serving Early Head Start in Jackson and Josephine Counties for over two years. Our services include oral health screening, risk assessment, prevention and the medical management of caries with the use of silver diamine fluoride, in addition to education via parenting classes. This presentation will describe the Advantage philosophy of risk-based care and the findings of our risk stratification, as well as techniques employed by the expanded practice dental hygienist for reducing barriers to care due to fear, including non-invasive techniques that build trust between hygienist, patient and Head Start staff.

### **Oral Health Integration #2: Oral Health Integration Menu. Order Up!**

Jennifer Clemens, DMD, MPH, Dental Director, Capitol Dental Care; Linda Mann, EPDH, Director of Community Outreach, Capitol Dental

This presentation will illustrate practical examples of the spectrum of oral health integration activities, ranging from low-effort projects up to the more fully integrated and complex models. The presenters will explain the "how-to"s and resources needed for program design and implementation, and discuss outcome measures.

# 211info Community Engagement Model: Strategic Partnerships for Health in Southern Oregon

## Background

211info connects people to services by:

- Utilizing a contact center that responds to consumers' needs via phone call, text and email
- Locally-based community engagement
- Maintaining an updated resource database
- Compiling and analyzing data that provides reports on services, consumers, and gaps to inform policy makers

## Presenter Information

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## Funding Organizations

- AllCare Health
- Jackson Care Connect
- Primary Health
- Health Care Coalition of Southern Oregon
- Southern Oregon Early Learning Hub
- ACCESS
- UCAN Community Action Networks

## 211info's Community Engagement Model

Embeds staff who are local residents knowledgeable about area service networks to ensure access to resources related to the social determinants of health: housing, food, utilities, child care and more. The model is based on local, shared financial investment. Each project is guided by a stakeholders group that provides feedback on local priorities and desired outcomes. Currently 211info has projects in Jackson & Josephine counties and Linn/Benton/Lincoln counties, with planning underway for a project in Central Oregon. In general, our work includes:

- Attending or convening meetings with key leaders in health care, early learning, social services or underserved populations to support systems integration, identify and resolve barriers, and ensure equitable, quality services across the service ecosystem.
- Facilitating community navigation of the 211info platform(s) by training agency, community or clinical staff or conducting in person navigation sessions at clinics, community centers, libraries, etc.
- Acting as a single point of contact for local service providers to update detailed resource information, freeing staff to focus on direct service and ensuring the most accurate data possible in our database.
- Providing data reports on services requested, demographics of consumers (including health insurance coverage type and zip code) and gaps in services available.

## Jackson & Josephine Project Description

The 211info Community Engagement Coordinator (CEC) works with three local CCOs, the Southern Oregon Early Learning Hub, Health Care Coalition of Southern Oregon and community social services to train staff in accessing the 211info system(s), the Oregon Helps social program screening tool and the Earned Income Tax Credit calculator, supporting families to actively engage in elevating their own social determinants of health.

## Desired Outcomes

Thriving communities addressing the social determinants of health via improved access to resources that improve the conditions where people live, learn, work and play; promoting resilience and self-sufficiency for residents and achieving the triple aim-better health, better healthcare and lower costs.

## Partnerships

It is critical to build relationships with as many local organizations, coalitions, groups and task forces as possible to strengthen and align systems. The Jackson & Josephine County CEC participates in and often takes on leadership roles with organizations including Coalition for Kids, Latino Interagency Committee, Josephine Co. Perinatal Task Force, SO Health-Equity/Diversity/Inclusion Workgroup, Southern Oregon Early Learning Hub, The Family Connection Parenting Hub, Jackson & Josephine County Homeless Task Forces and Rogue Valley Community Organizations Active in Disaster.

## Contact Trends: Jackson & Josephine Counties, 2017



## Overcoming Challenges: Project Funding

Stakeholders across health, early learning and social services systems have generously contributed financial resources for each project. This results in a patchwork funding strategy that requires strong monitoring on an ongoing basis. 211info provides contract administration and ongoing financial development including grant writing and partnership development support. We are moving toward a multi-year funding plan to improve sustainability. We aim to request state support to supplement regional funding.

## Lessons learned

Strong partnerships built on relationships are critical, not only for funding the project, but also for achieving the goals of engagement by identifying and including resources, connections and in-kind support.



*211info's community engagement coordinator co-chaired the 2017 Welcome, Baby! community baby shower in partnership with over 20 service providers and sponsored by the Josephine Co. perinatal task force.*

## Developing early literacy promotion opportunities: from primary care to home visiting and beyond

The Multnomah County Health Department, Multnomah County Library, and Reach Out and Read (ROR) are partnering to integrate early literacy services into the healthcare delivery model. By incorporating the ROR program into primary care visits and extending early literacy promotion to home visiting, WIC, and library programs, we can engage the families of the most at-risk children. Through collaboration, the programs collectively have greater reach and support parent-child interaction, language and literacy development, and school readiness.

### Primary Care:

In all Multnomah County public health clinics, children and their families are served through **Reach Out and Read(ROR)** – the AAP and AAFP recommended, evidenced based program that gives young children a foundation for success by incorporating books into pediatric care and encouraging families to read aloud together.

- Medical providers receive training to make literacy promotion a standard part of their well-child care. Parents and caregivers receive guidance to support early attachment, brain development, and a love of learning.
- Children receive a culturally, developmentally, and linguistically appropriate book to take home at each well check for a total of 10-14 books in the first five years. At the two-week visit, a new parent gift may be provided that includes a library book and information, a rhyme book, and a literacy development guide
- Exam rooms and lobbies are stocked with gently used books that families can use while at the clinic and may take home. Clinics encourage library use and storytime information is posted in the clinic.
- ROR and library staff jointly meet with clinic site champions and medical directors for program support and quality assessment.
- Funding: Reach Out and Read is supported by the Oregon Community Foundation, Kelley Family Foundation and Health Share of Oregon. ROR books are provided through the Multnomah County Library Tax District. New parent welcome gifts are made possible by gifts to The Library Foundation.

Outcomes: Research shows that when health care providers promote literacy readiness according to the Reach Out and Read model, parents read aloud more often at home, children show improved language skills, and children are more likely to arrive at kindergarten with the early literacy and social-emotional skills they need. These effects have been found in ethnically and economically diverse families. The body of published research supporting the efficacy of the Reach Out and Read model is more extensive than for any other psychosocial intervention in general pediatrics. ([www.reachoutandread.org/why-we-work/research-findings](http://www.reachoutandread.org/why-we-work/research-findings))



## Home Visiting Programs:

- Home visiting nurses and community health workers from **Healthy Families, Nurse Family Partnership** and **Healthy Birth Initiative** provide books to families through Multnomah County Library's **Every Child a Reader** program. Families receive a new set of books during each visit, including books in their home languages.
- Multnomah County Library's Early Childhood Specialists host parent nights to support learning about early literacy development, as well as library tours and storytimes.
- Home visitors receive training to support their knowledge and ability to connect families with early literacy information and library services.
- Evaluation results show that after participating in the program, caregivers are more likely to engage in parent child interactions including reading, talking and singing, supporting healthy early literacy and language development.
- Funding: The Library Foundation and Multnomah County Library Tax District.

## Women, Infants and Children (WIC) Clinics:

- Multnomah County Library Early Childhood Specialists provide early literacy classes and storytimes at all county WIC clinics.
- Utilizing the evidenced based **Every Child Ready to Read** curriculum families learn about the importance of reading, talking, singing, playing and writing together including simple strategies for practicing together in the home.
- WIC exam rooms and lobbies are stocked with gently used library books for families to use in the clinic and take home.
- Evaluation results show that after participating in the program, caregivers are more likely to engage in parent child interactions including reading, talking and singing, supporting healthy early literacy and language development.
- Funding: The Library Foundation and Multnomah County Library Tax District.

## For more information visit:

- Multnomah County Library, [multcolib.org/every-child](http://multcolib.org/every-child)
- Reach Out & Read, [reachoutandread.org](http://reachoutandread.org)
- Multnomah County Health Department, [multco.us/health](http://multco.us/health)

## Contacts:

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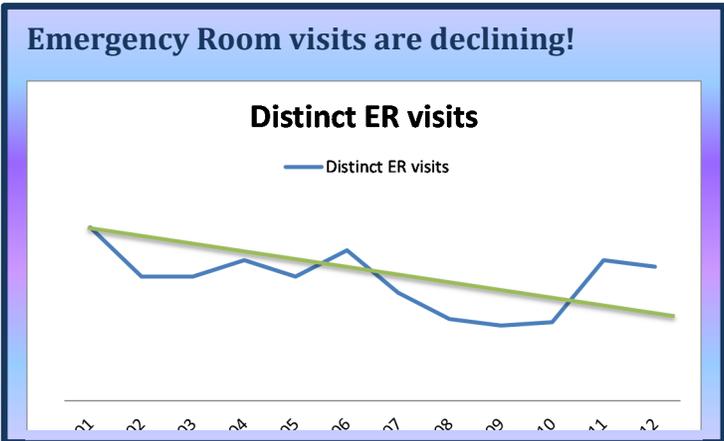
## Improving Children’s Whole Health: Community Health Workers and Peer Support Specialists Providing Services in the Home

**Project Description:** Family Tree Relief Nursery (FTRN), a community based 501(c) non-profit corporation, providing child abuse prevention programs and early intervention services to children and families at no cost in Linn County, Oregon, implemented home-based family services to increase access and support for high risk, OHP served families. FTRN specializes in developing programs that provide services to families that are experiencing high levels of stress as a result of poverty, domestic violence, behavioral concerns, drug and alcohol abuse, food insecurity, criminality and homelessness. FTRN contracted with IHN CCO in January 2017 in a value-based payment (VBP) contract to support the new home-based care program. A blended service delivery model was developed utilizing Family Tree’s Home-based Interventionist position, trained as Community Health Workers and Peer Support Specialists, innovatively, to assist families by creating a bridge between the family and their primary care home as well as linking them to additional health related services, providing parent education, recovery support services, access to food, early childhood education, developmental screenings and other behavioral and social supports. The project has created increased strength and stability of the family resulting in increased outcomes for family health, stability, and attachment.

### The Payment Model

Pay-For-Performance Agreement - Additional incentives available when at least 50% of metrics are met.

Monthly capitation payment for those paneled to FTRN (as determined by monthly capacity reports received by FTRN)



### Prevention and Screening is Happening!

Performance Metrics	Improvement Target	FTRN Performance
Effective contraceptive use among women at risk of unintended pregnancy	38.80%	44.74%
Adolescent Well Child Visits	33.30%	51.02%
Developmental screening in the first 36 months of life	39.20%	60.63%

#### Presenter Contact Information:

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## **Challenges and Lessons Learned:**

### **Family Tree Relief Nursery -**

*Accessing required training for certification as a Community Health Worker or Peer Support Specialist was costly in the early years of the program.*

*Through support from our CCO, a coalition of community organizations was comprised, and developed accredited training programs in our tri-county region. The coalition is continuing to develop more and enhanced training.*

*How does a social service organization outside of the traditional medical model and Primary Care Homes learn how to integrate with that system? There was a steep learning curve around cost models, protocols, electronic medical records, healthcare language, credentialing and contracting. We were supported throughout the whole process by our partners at IHN CCO, staff at Benton County Health Centers and other community partners.*

*Family Tree is now an IHN contracted provider. We're part of the traditional delivery service. What does that mean for us and our culture and for the families we serve. Learning how to conceptualize and operationalize the change is an ongoing learning lesson as we incorporate new standards into our service delivery.*

*Retraining as staff leave is a challenge.*

### **IHN CCO -**

*Determining the value of the services being provided was time intensive for both partners. We are now monitoring and reporting on the value of services being provided on a quarterly basis.*

*Reimbursing FTRN, an essential provider to care for the whole health of our members was important to us, however it is challenging to make that happen with a provider that did not have a standard/traditional EMR nor billing system. It is even more challenging trying to get the services delivered reported to the State of Oregon to support the rate setting process.*

*Getting all of the data necessary to accurately determine outcomes and to find out what else may be a factor, target, etc... in the same place, and from the entire community that serves the members, continues to be challenging. IHN CCO is providing performance metric scorecards and gap in care lists on a monthly basis. IHN CCO continues to enhance the Health Information Exchange (HIE) with a large focus on gaining social determinants of health data.*

## **Key Points – How to successfully implement a quality Community Health Worker and Peer Support Specialist Home Visit Program:**

1. Engage, Align and Value Simplicity
2. Ensure that organizations that employ Community Health Worker and Peer Support Specialists understand the importance of keeping track of service level data, and that it needs to be reportable.
3. Be transparent and provide quality information about the members to be served at least quarterly, including at least financial and utilization reports.
4. The organization must be structured, and integrated into the whole provider community in order for the value-based payment model to be sufficient, and for the services to show value.
5. Seek out quality OHA approved training program for Peer Specialists, Community Health Workers and Peer Wellness Specialists that is affordable and reflects your community.
6. Provide clinical supervision for Peers and CHWs that accounts for high levels of secondary trauma.
7. Create system for Peers/CHWs to compile and track service level data consistently across programs for monthly and quarterly reports.

**For more information on IHN CCO transformational activities please visit our website: [www.ihntogether.org](http://www.ihntogether.org)**

**For more information about Family Tree Relief Nursery please visit our website at: [www.familytreern.org](http://www.familytreern.org)**

# Project Nurture

Integrating maternity care and treatment for substance

## Summary

Project Nurture is a Center of Excellence model for integrating substance use disorder treatment and maternity care. There are 3 sites in the Portland metro area which serve pregnant women with substance use disorders. Core components of the model include integrated Level 1 SUD treatment and maternity care, group visits, intensive care coordination, peer support, facilitated hospital maternity stay and care up to one year postpartum.

**Partner Organizations:** Legacy, Lifeworks NW, OHSU, CODA, Providence, Health Share

[www.projectnurtureoregon.org](http://www.projectnurtureoregon.org)

## Impacts & Outcomes

Compared to pregnant women with SUD in the Portland metro area who were *not* exposed to the Project Nurture model, pregnant women with SUD exposed to Project Nurture had:

- 70% lower odds of preterm birth
- C-section rate of 28% instead of 37% in comparison group
- Higher engagement in prenatal care
- Fewer infants needing higher-level care
- 3x the odds of using MAT during pregnancy

In addition, 93% women who gave birth with Project Nurture have custody of their infants at program exit.

## Challenges & Lessons Learned

### Challenges

- Integration of specialty behavioral health services and physical health services is prohibitively complicated
- Peer recovery mentors and doulas provide an essential bridging function across sectors
- Stigma, shame and judgement cripple the ability of these women to get needed health care. Providing compassionate, respectful care changes their outcomes

### Lessons learned

- Ensure the details of integration are worked out in advance: charting, billing, consents/confidentiality, data collection
- Establish a concrete plan for paying for peer recovery mentors/doulas who work in the program
- Collect data
- The hospital is a critical partner – you can change policies, attitudes and outcomes by communicating well and setting clear expectations

## Funding & Costs

Project Nurture was started by transformation funds from Health Share of Oregon in 2014. It will be sustained by a combination of supplemental payments from health plans and organizational in-kind funding. Costs include paying for peers and doulas, non-billable time for care coordination, reduced productivity of providers, and administrative oversight.



# Social Determinants Screening and Veggie Rx Pilot

The Community Health Centers of Benton and Linn Counties and the Corvallis Environmental Center will implement a Social Determinants of Health (SDOH) screening tool and test a Veggie Rx intervention in a primary care setting.



**This project is a cross-sector partnership between:**



**This work supported by funds from InterCommunity Health Network Coordinated Care Organization.**

## **This project will:**

- Screen patients with a SDOH tool to assess needs outside the clinic walls
- Provide referrals and follow up for SDOH needs through a Health Navigator
- Increase availability of fresh food through a Veggie Rx program at a clinic site

We hope to understand, test, and spread innovations in SDOH work, as well as expand access to nutritious food- creating connections between local food systems and the community at large. ***The timeline for this pilot is July 2017 to December 2018.***

## **At this point we have:**

- Trained a Health Navigator to screen and follow up with clients about SDOH needs
- Introduced screening in 2 rural clinics (Alsea and Monroe)
- Partnered with the Corvallis Farmers' Market to provide tokens which can be redeemed at the clinic farm stand or at the Corvallis Farmers' Market
- Started the Veggie Rx stand at the Benton Health Center in Corvallis 2 days a week
- Networked with other Veggie Rx programs and SDOH screening processes around the state to learn about their work, strategies, and challenges

## Impact and Outcomes- A story from the field about this work

*"A patient was screened for Social Determinants of Health which showed they were in an unstable housing situation. The Health Navigator connected the patient with a housing coordinator who helped them expedite the HUD process. The patient returned in a month's time, stating that they had stable housing now, but sometimes had a hard time filling their fridge and eating healthfully. The Health Navigator then assisted the patient in accessing local food resources. They continue working together to make sure that the patient is never far from fresh and healthful food, with a roof over their head, necessary prerequisites to addressing health needs and staying healthy."*

### Lesson learned, so far...

1. Cross sector partnerships are critical in thinking about system level transformation. Health and social services intersect in many ways. If we are looking to impact community and population level health and wellness, we need to share language, goals, and at times, funding streams to achieve shared outcome in health.
2. Implementing even a well-defined tool or process is not straight forward. Human elements in staff and clients require flexibility, ongoing evaluation, and iterations.
3. Social Determinant screening in health care requires a culture change- some are more willing to adopt and integrate this thinking, others take more time.

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### Resources:

Community Health Centers of Benton and Linn Counties: [\*\*bentonlinnhealthcenters.org\*\*](http://bentonlinnhealthcenters.org)

Corvallis Environmental Center: [\*\*corvallisenvironmentalcenter.org\*\*](http://corvallisenvironmentalcenter.org)

PRAPARE tool: [\*\*nachc.org/research-and-data/prapare/\*\*](http://nachc.org/research-and-data/prapare/)

Veggie Rx work in the state of Oregon: [\*\*ocfsn.net/veggie-rx/\*\*](http://ocfsn.net/veggie-rx/)

Oregon Food Bank: [\*\*oregonfoodbank.org/our-work/partnerships/\*\*](http://oregonfoodbank.org/our-work/partnerships/)

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### For more information contact:

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## The Project: Improving the Health of Mothers and Babies in Central Oregon

Crook, Deschutes, and Jefferson Counties, and the Central Oregon Health Council (COHC) collaborated to develop and implement a regional approach to a perinatal continuum of care model.

This project addresses goals identified in our Regional Health Improvement Plan to increase the percent of women who receive prenatal care in their first trimester and reduce the

percent of low birth weight babies. This approach served as the foundation for a regional referral system that includes: 1) prenatal high-risk nurse home visiting services; 2) linkage to community resources provided by a team of public health care coordinators embedded in specific obstetrics provider clinics throughout the community; and 3) regional coordination and tracking of Oregon Health Plan (OHP) pregnant women in the tri-county area.

**Project Goal:** *“Earlier access to prenatal care and improved birth outcomes.”*

### PROJECT COMPONENTS:

- ⇒ Linkage to community resources provided by a team of public health care coordinators embedded in OB provider clinics throughout the community
- ⇒ Regional coordination and tracking of pregnant women in the tri-county area

### PROJECT OUTCOMES:

- ⇒ Increase the number of women in Central Oregon who receive prenatal care
- ⇒ Reduced prevalence of low birth weight

\* 1,845 women were served by this PCC program from OCT 2016 to MAR 2018

\* This is estimated to be 53% of all births in Central Oregon

## The Partnership

Funding for the project, provided by the COHC\*, went to each of the three participating counties. Deschutes County Health Department housed a regional coordinator for the project who supported the work of public health staff from Crook, Deschutes, and Jefferson Counties.

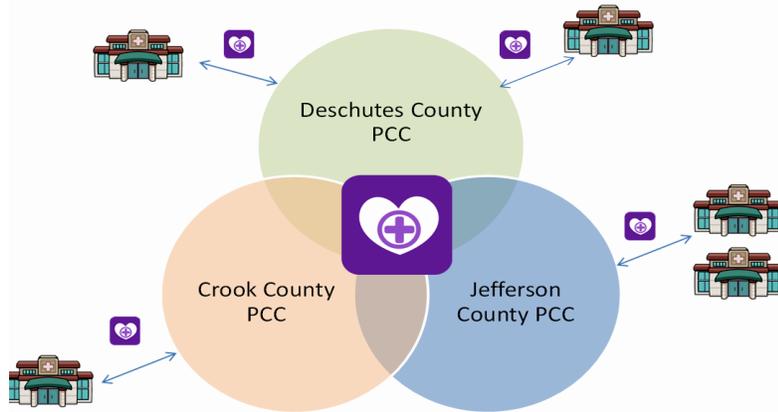
The project staff was trained in the tri-county continuum of care model and resource guide, and worked together to share resources. This coordination was warranted because women in this region often seek services in population centers outside their home county such as the city of Bend.

PacificSource Community Solutions CCO staff was instrumental in convening meetings with the three counties in the early stages of the project and supporting the work.

The Oregon Health Authority, Public Health Division’s Oregon MothersCare (OMC) Program was also a key partner. The tri-county project worked with OMC to add indicators for this project to the existing OMC data system. This allowed project staff to collect and track data on women receiving services through this project.

*\*Note: Central Oregon Health Council (COHC) is the community governing partner of PacificSource Community Solutions CCO. COHC receives funds from PacificSource Community Solutions CCO to fund community projects.*

# PCC Model

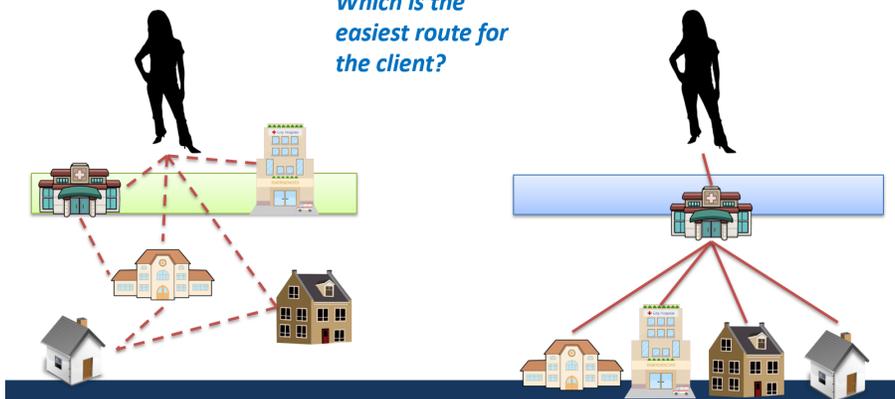


*Tri-County model of perinatal care coordinator embedded support.*

## IDEAL STATE: PCC FIRST POINT OF CONTACT

**Goal:** We want what is best and easiest for the client.

*Which is the easiest route for the client?*



### Model Highlights:

- \* Embedded Public Health staff in OB/primary care provider offices
- \* Regional coordination between partners (Collaboratives and program mapping)
- \* Regional approach to implementation, training and marketing/branding

### Challenges & Lessons Learned:

- \* Sustainability of project funding
- \* Tri-county roll-out of new model at different times
- \* Demonstrating improved outcomes during first-year implementation

### CLIENT FEEDBACK:

"WIC Services"  
 "Insurance help (OHP)"  
 "Education on all of the available programs and benefits."  
 "Public programs that are offered that I did not know about."  
 "Getting information about resources during pregnancy."  
 "Seguimiento de salud para mi y mi bebé"  
 "A wide range of topics were covered which I appreciated."  
 "Her support"

### PARTNER FEEDBACK:

"Continuity of care."  
 "So good to have them here & available with the increasing number of patients w/social disarray."  
 "Helped them to more easily apply "and be informed of programs for pregnant women."  
 "It's been nice for our patients to have the resource here in the office."  
 "I just feel the presence here is so important."  
 "Patients love that they can do OHP and WIC at the same time."  
 "Patients seem to have a greater knowledge of services available to them."



### Project Contact:

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# Metrics to Meaning

Using data to advance health equity across sectors

## Summary

Health Share is committed to health equity across all domains of our work. One of our strategies is to consistently disaggregate our data by race, ethnicity, language, foster care status, geography and other variables in order to better identify and address health disparities in our 320,000 members.

In looking at our **Developmental Screening** rates in 2014, we identified that non-English, non-Spanish speaking children were getting screening at much lower rates than their peers.

We convened community partners to help us make meaning and strategies from our data. The Metro Early Learning Hubs, EI/ECSE, IRCO and others are now meeting to identify effective cultural strategies to ensure kids and families understand developmental milestones and are connected to appropriate services.

**Partner Organizations:** Metro Early Learning Hubs, Metro EI/ECSE, Immigrant and Refugee Community Organization (IRCO), University of Oregon, Health Share of Oregon

## Impacts & Outcomes

Strengthening cross sector relationships and alignment, identifying joint goals and projects, including developing culturally responsive messaging and training

Partnering with Univ. of Oregon ASQ developers to translate and culturally adapt the ASQ and activity sheets into Vietnamese, Chinese, Russian, Somali and Arabic

Creating coordinated, triaged referral pathways working with Help Me Grow and Oregon Community Health Worker Association (ORCHWA)

This and other regional efforts have resulted in increased screening rates across all language groups from 2014 to 2017:

- Burmese: 3% to 52%
- Arabic: 8% to 52%
- Somali: 10% to 50%
- Russian: 19% to 62%
- English: 39% to 62%
- Spanish: 25% to 75%

## Lessons Learned

- Disaggregate data across multiple categories (race, ethnicity, language, zip code) to reveal health disparities
- Use your data as a springboard for health equity
- Question your assumptions
- Convene community partners to make meaning of the data
- Use your data to catalyze conversation and action with unlikely partners
- Have a bias towards action and invest with an equity mindset
- Dedicate people and \$\$ to this work

**READY + RESILIENT** | This work is part of Health Share of Oregon's *Ready + Resilient* strategic investment plan, a long-term roadmap to support the wellbeing of children, families, and communities through prevention, support for recovery, and focused investment in health equity.

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[www.healthshareoregon.org](http://www.healthshareoregon.org)





# Pathways from Developmental Screening to Services: Ensuring Young Children Identified At-risk Receive Follow-Up

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## Project Overview

Led by the Northwest Early Learning Hub (NWEHL) and funded by Columbia Pacific Coordinated Care Organization, this two-year project aims to improve the **receipt of services** for young children who are identified at-risk for developmental and behavioral delays.

The project supports:

1. **Cross-sector stakeholder engagement** and baseline data collection about current processes and where children are lost to follow-up;
2. Second, the project will work to **develop, implement, and evaluate improved follow-up processes**, including referral to and coordination of processes meant to ensure early receipt of services that help at-risk young children to be ready for kindergarten.

The Oregon Pediatric Improvement Partnership (OPIP) is critical partner, supporting the development of stakeholder engagement and evaluation methods and the transformation activities within primary care clinics meant to enhance follow-up and care coordination for children identified at-risk. The project builds off previous efforts OPIP has led in other communities and described on their website: <http://www.oregon-pip.org/focus/FollowUpDS.html>.

## Stakeholder Engagement

Through stakeholder interviews and county-level meetings, we will use a **collective impact model** to engage stakeholders within **health care, Early Intervention (EI), and early learning** focused on developmental screening and/or who provide follow-up services for children identified at-risk for delays on developmental screening tools. Baseline qualitative and quantitative data will be collected in order to:

- 1) **Understand the current pathways** from developmental screening to services in Clatsop, Columbia, and Tillamook, and the community-level assets and resources that exist to support follow-up services; and
- 2) **Understand where and how children are falling out** of these pathways and not receiving services to address the identified risks, including where there is a lack of capacity to serve children identified.

## Asset Mapping & Triage and Referral Map

Informed by presentation of the **baseline data and community-level asset maps** that will be created, the communities will identify the **priority areas for follow-up** and early learning resources where improvements will be focused. To support the improved processes, **community-specific triage and referral processes** will be developed to match the at-risk child

### **NW EL Hub Mission:**

*Work collaboratively to support coordinated systems that are child-centered, family-friendly, culturally and linguistically appropriate, and community-based to meet the needs of the populations and communities of Clatsop, Columbia and Tillamook Counties.*

[www.nwelhub.org](http://www.nwelhub.org)



## **A Northwest Early Learning Hub Project in Partnership with Oregon Pediatric Partnership**

Pathways from Developmental Screening to Services:

Ensuring Young Children Identified At-risk Receive Follow-Up



and family with the most appropriate follow-up providers based on the child's developmental screening risk scores and other child/family factors.

The referral pathways will be within health care, EI, and the priority early learning providers identified at the community-level meetings. A component of the pathways developed will be **secondary referral and support strategies for children found ineligible** for the initial referred services. Referral processes will include **feedback loops to support communication and coordination**.

### **Piloting Improvements**

The sites that will **pilot the improved processes** are: 1) Three primary care practices serving a large number of publicly insured children residing in these counties; 2) Early Intervention – Northwest Regional Early Service District; and 3) Priority early learning providers within the NWELH, such as home-visiting and the NW Parenting Hub. Implementation in the sites will be staggered over the two-year project. Sites will receive improvement and transformation tools developed by OPIP, monthly implementation support, and refinements to the improvement tools will be made based on lessons learned and barriers identified.

### **Spreading Innovation & Sharing Lessons Learned**

At the end of the project a number of **generalizable tools** will be developed to support the spread of innovation more fully across all three counties in the CPCCO region including the following:

- a) A toolkit for primary care practices;
- b) EI referral and care coordination methods;
- c) Family resource management and care coordination tools for early learning providers.

As the backbone organization of early learning across all three counties, **NWELH will also convene all county-level stakeholders together semi-annually** to share the learnings, discuss implications for spread, and to **inform priorities for the NWELH**.

#### **NW EL Hub Mission:**

*Work collaboratively to support coordinated systems that are child-centered, family-friendly, culturally and linguistically appropriate, and community-based to meet the needs of the populations and communities of Clatsop, Columbia and Tillamook Counties.*

[www.nwelhub.org](http://www.nwelhub.org)

## A Rural Approach to Bridging Health Care and Social Determinants

Reliance eHealth Collaborative (Reliance) is a cross-sector organization supporting seamless exchange of health information. Reliance receives data from physical health, oral health and behavioral health



organization across the State and processes the information to discern Social Determinants of Health (SDoH) concepts that identify children at risk as well as to support population health, quality metric reporting and clinical notifications.

In collaboration with the Bridges to Health (B2H) a care coordination program using the Pathways model, the project seeks to create a seamless workflow for those traversing the health and social service sectors. The project, funded by a Robert Wood Johnson grant, has 2 primary goals:



- 1) Integrate social service and HIE eReferral applications to support closed loop referrals across health and social service organizations, reducing duplicate data entry and tracking progress toward achieving early childhood goals.
- 2) Integrate SDoH and health information exchange across technology platforms in the Columbia Gorge to identify children at risk, assign a care coordinator and get them into appropriate care settings to achieve appropriate early childhood health outcomes



### Impact and Outcomes

The B2H program participants currently work in three systems to manage information and share information:

- Reliance's eReferrals and, where credentialed, Reliance's Community Health Record
- VistaLogic Clara™ for Pathways care coordination and social service referrals
- Electronic Health Record (EHR) systems which vary by organization

While Reliance integrates with the EHR for data exchange, eReferrals work outside of native systems requiring multiple screens and logins. Bridging these systems through a single-sign-on will streamline care coordination and reduce the burden on participants for cross-sector exchange. The project is expected to enhance information gathering about successes and challenges in addressing unmet needs in the community. Such data can help collaboration participants improve services and supports for the community.

### Replicability

Because this project will become foundational to the capabilities of both Reliance and Clara, the approach, lessons learned, and solutions will be replicable to other communities and projects using Reliance and/or CLARA.

### Presenter contact information

Coco Yackley, Columbia Gorge Health Council  
Scott Tse, Reliance eHealth Collaborative  
Paula Weldon, Reliance eHealth Collaborative

## **About Reliance eHealth Collaborative**

Reliance provides a robust suite of health information exchange services covering 16 counties as well as bordering communities. Reliance services include:

**Insight.** The Reliance Insight platform uses parsed and indexed data provided by Reliance Members for analysis against quality metrics and provides reporting for meeting care management, population health and incentive based contracting models. Standard dashboard reporting includes the ability to report at the network, practice, provider and custom cohort level. Current and future quality metric and gaps in care reporting dashboards are included.

**Community Health Record (CHR):** Reliance's CHR provides a query-based exchange environment whereby providers who have a relationship to a patient and a need to know their health information may query Reliance and receive a community record that aggregates information from any participants who have treated the same patient and who contribute information to Reliance. *Reliance will soon launch a consent model that supports sharing protected substance use treatment information based on the patient's signed informed consent. The consent model is fully compliant with State and Federal law and supports all auditing and reporting to maintain confidentiality and meet charting and documentation requirements.*

**eReferrals.** eReferrals is designed to improve workflow efficiencies with user-friendly features and easy access to patient information. eReferrals is Meaningful Use compliant and the closed loop environment lets the sending organization track the status of the referral and receive a progress note when the referral is complete. eReferrals users report they can see patients up to four days faster because the eReferral is more complete and the data is electronic so it can be imported into an EHR.

**Qualified Clinical Data Registry Services (QCDR).** The Centers for Medicare & Medicaid Services (CMS) has approved Reliance as a QCDR for the 2018 performance period of the Merit-based Incentive Payment System (MIPS). These measures are listed on the Reliance website at: <http://reliancehie.org/reliance-accepted-as-a-cms-qualified-clinical-data-registry-qcdr/>.

**EHR Integration.** Members who wish to receive data from Reliance and place lab orders through Reliance.

**Direct Secure Messaging.** For those who do not have a way to securely communicate across organizations, Reliance provides a "Direct Trust" accredited secure messaging system including a web-based inbox, which can also be used to communicate with non-HIPAA-covered entities, such as social services, or when data is specially protected, like substance abuse treatment.

## **About Columbia Gorge Health Council**

The Columbia Gorge Health Council consists of healthcare, county, and other community leaders in Hood River and Wasco Counties who work together to recommend and guide solutions and improvements to the region's healthcare system. They work in partnership with PacificSource Community Solutions to guide the area's Coordinated Care Organization as well as develop strategies and policies to address the needs of the poor and vulnerable in the region.

## **About VistaLogic**

Vistalogic supports those who support their communities. We offer vital data collection and management tools to public agencies, non-profits, and healthcare organizations aiming to provide efficient and compassionate services to their clients, while also executing requirements of funders and supporters. We strive to improve the integration and delivery of services by providing intelligently designed and intuitive IT solutions that can be adapted to meet the unique organizational and community needs.

### **GROWING TOGETHER**

On-going, personalized connections and support that grows with the children from age 0 to 5.



### **PROMOTING COLLABORATION**

Ensuring all new parents are cared for through supportive services, networks, and relationships that exist, and creating new ones where needed.

### **STABLE AND ATTACHED FAMILIES**

Bridge health care and early learning education through shared care coordination to support the individualized needs of the whole family.

### **READINESS FOR KINDERGARTEN**

Support and promote on-going engagement in prenatal and parenting education and other early learning opportunities within the local community.

### **RESOURCES AND TOOLS**

Ensuring all new parents are aware of and have access to resources, tools, and information that will allow them to be the best parents they can possibly be.



## A system of support for prenatal parents and families with children, birth to 5

### *Background*

As a parent, the path to finding appropriate services and resources for education and child care can be bewildering and difficult to navigate. A network of partners in Linn, Benton and Lincoln counties are working towards streamlining a process to help parents and families connect to their requested services and engage in a continuum of prenatal education, parenting education, early childhood education opportunities and community supports.

This work was initially supported by a grant from the regional Coordinated Care Organization (CCO) to the Early Learning Hub. The development of this project began by gathering key partners (IHN-CCO, five Samaritan Medical Centers, the Early Learning Hub of Linn, Benton & Lincoln counties, LBCC Parenting Education and Family Connections) to assess interest and potential next steps.

The vision of the Pollywog project is to establish:

- A regional prenatal and parenting education system that provides a continuation of support and linkage between the Health Care setting and Early Learning community
- A system that collects unduplicated data to identify parent requested services and service gaps by community for potential Early Learning Hub targeted investments and grant opportunities

The Pollywog project operates as one integrated system for parents and families to receive services and referrals tailored to meet their individual needs. Each of our partner organizations provide one or more areas of personalized support for our families and offer assistance with linkages through Pollywog; a closed-loop/warm hand-off channel that includes two family friendly access points:

- Access through the website, <https://pollywogfamily.org/> that provides a portal for parents and families to begin services with Pollywog. The website offers updated listings of prenatal, parenting education and early childhood education classes and resources within all three counties. All information on the website is available in English and Spanish and is adaptable to the mobile device or tablet.
- Access by telephone, 541.917.4884, staffed by Family Connection consultants who offer personalized help for class registration and provide access to parenting advice on child development and early learning opportunities. Family Connections is located at Linn-Benton Community College in the Family Resources and Education Center.

# Breastfeeding Support Services: East Linn County

## Summary:

Health promotion and disease prevention includes access to breastfeeding support. Many major health organizations and government health groups acknowledge the need to promote exclusive breastfeeding for the first six months of life, and breastfeeding for the first year or more, with the addition of complimentary foods as an ideal start to good health and nutrition. The majority of pregnant women plan to breastfeed their babies from birth, but many women struggle to meet this objective and to obtain all the health benefits for mother and child. Barriers to this goal include poor access to breastfeeding support at critical postpartum times, intense marketing of infant formula, and societal barriers that may include a lack of knowledge regarding breastfeeding benefits within a mother's local support network. This is evidenced by 2015 Linn County WIC data that states 92% of WIC moms start breastfeeding, but only 38% exclusively breastfeed for six months. By providing convenient and skilled postpartum case management of breastfeeding issues, it is our belief that this service contributes to the InterCommunity Health Network Coordinated Care Organization's (IHN-CCO) triple aim goal of better health, better care, and lower cost.

## Project Description:

The granting of transformation funds to the Linn County Public Health WIC Program's proposal has allowed the placement of a Spanish speaking International Board Certified Lactation Consultant (IBCLC) in the Samaritan Mid Valley Pediatric office in Lebanon and the expansion of breastfeeding support services in Linn County WIC clinics. Since December 2016 the IBCLC has been working approximately 15-20 hours per week providing evidenced based lactation education and counseling and WIC nutrition education contacts. Her work includes approximately 1-2 days per week in the pediatric office and an additional approximately one-half day per week for documentation, data collection and communication with primary care providers.

## Project Goals:

1. To provide linguistically appropriate access to breastfeeding support services.
2. To provide quality specialty care by an extensively trained Lactation Professional (IBCLC).
3. Care coordination and communication with the primary care provider.
4. Decreased use of infant formula as a result of successful breastfeeding.
5. Increased percentage of women who receive lactation counseling and support.
6. Increased availability of provider time for medical care other than breastfeeding counseling and support.
7. Improved maternal and child health outcomes impacting quality of life and health care costs for IHN members.

## Presenters:

Jessica Barton, MA, IBCLC  
Linn County WIC  
jbarton@co.linn.or.us

Leah Brunson, BS, IBCLC  
Linn County WIC  
lbrunson@co.linn.or.us

## Impact and Outcomes:

- From December 2016 to April 2018 the IBCLC has met with over 400 mother-baby dyads.
- There have been many opportunities for increased communication between the IBCLC, WIC, and the pediatricians in the clinic.
- Families like having their WIC and pediatric visits coordinated because it saves them taking extra trips out of the house with a newborn.
- The IBCLC taught a 6 hour breastfeeding class for 18 participants including mostly public health nurses and a few participants from other organizations in the area that support breastfeeding families.
- The IBCLC has been involved in the implementation of 2 breastfeeding support groups in the Lebanon community. A monthly group began in spring 2017 offering support, celebration and mother-to-mother

companionship for mothers in the Linn County WIC program. The grant-funded IBCLC and the Lebanon hospital IBCLC began a collaboration in April 2018 to offer a weekly drop-in breastfeeding support group for families in the area needing breastfeeding support. Both groups have been well attended since their beginnings reaching 2-10+ mothers each meeting.

- The IBCLC was involved in meetings and planning that lead to Oregon being the 4<sup>th</sup> state in the USA to license IBCLCs.
- Logistic regression analyses of our data collection examining the relationship between seeing the grant-funded IBCLC after discharge and exclusive breastfeeding showed that seeing the grant-funded IBCLC is a statistically significant predictor of exclusive breastfeeding at the 2-month appointment but not at the newborn appointment.
- The three pediatricians report that this position has been a benefit to their patients and to their practice.
- February and March meetings with pediatric providers revealed strong interest in continuing the lactation support and WIC service even when the grant ends.
- We continue to work toward insurance reimbursement options for IBCLC consultations and discussions to determine how the position will continue after the grant ends.

### **Challenges:**

- Communication between IBCLC and pediatricians was a challenge initially. The IBCLC was charting in the electronic medical records, but this was not alerting the providers that their patient had received breastfeeding support. After discussion, the providers requested the IBCLC to send the patient's PCP a staff message in the EMR after each visit with a brief summary of the plan of care. The pediatricians usually message the IBCLC back with a comment or question, or a brief thanks. This has been an opportunity for communication, collaboration and learning.
- Finding space in the office for the IBCLC has been a challenge off and on. The clinic is seeking to hire a 4<sup>th</sup> pediatrician, and when this happens, space may become an issue again.
- Because the IBCLC is not an employee of the clinic, her schedule cannot be maintained by clinic staff, but must be maintained by WIC. This means pediatricians cannot schedule their patients to be seen by the IBCLC and that patients or clinic staff must call WIC to make the appointment.
- We have attempted to coordinate WIC appointments the same day as pediatric well-child visits, but this has been very difficult because the schedules are maintained by different organizations, and the IBCLC is only available 2 days each week.

### **Lessons Learned:**

Integrating two large programs (WIC and a pediatric practice) takes time and creative problem solving. Issues can include finding office space, scheduling, finding time for participating providers and staff to talk and collaborate, as well as finding ways to communicate with providers about their patients. On-going communication and problem solving is important to make sure the program is as effective as possible.

### **Organizations Involved:**

- Linn County Health Services – WIC Program
- Samaritan Lebanon Health Services Pediatric Practice
- Linn Benton Lincoln Breastfeeding Coalition
- Samaritan Lebanon Community Hospital
- InterCommunity Health Network Coordinated Care Organization

### **Funding Source:**

Currently the position is still funded by the initial grant from InterCommunity Health Network Coordinated Care Organization. Now that IBCLC licensure is in place, we continue to work toward insurance reimbursement options for IBCLC consultations and discussions to determine how the position will continue after the grant ends.

# Prospective Analysis of Immunization Data

## Using ALERT data to target outreach for Combo2

### Project Summary:

Health Share developed a methodology for using the quarterly ALERT data delivered from OHA to CCOs to prospectively assess the Combo2 status of the 2 year old population throughout the measurement year. Knowing when children turn 2 and what vaccinations they need to be compliant helps support targeted outreach to kids. Analyzing patterns in missing vaccine doses helped identify barriers with scheduling of well child visits and messaging to parents and providers that create challenges in meeting Combo2 status by age 2.

### Impact & Outcomes:

- Helped Health Share achieve 3% improvement in 2017
- More children got fully immunized by their 2nd birthday, a key step toward kindergarten readiness
- Identified challenges that fostered change in clinic practice to ensure future 2 year olds are immunized in a timely way

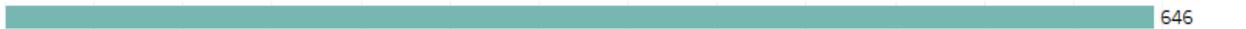
**Methods:** Using dose-level data from ALERT and children’s date of birth, we identify kids who are not yet 2 years old and are missing Combo2 by a single dose or multiple doses that could be delivered in a single shot. The views below link member lists that include a child’s PCP, contact information and any spacing constraints to facilitate outreach and appointment scheduling.

### Current 2018 immunization population status tracking

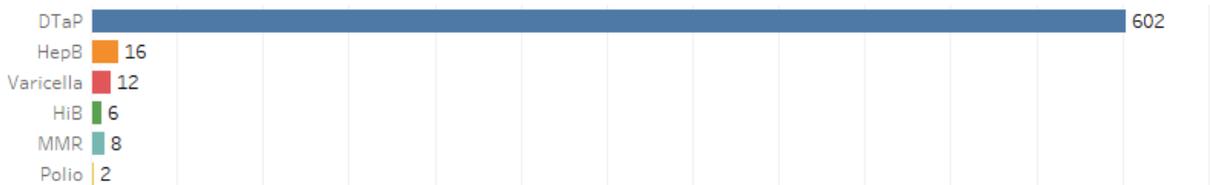
Kids still under 2, Combo 2 not met



Kids missing last dose of a single vaccine



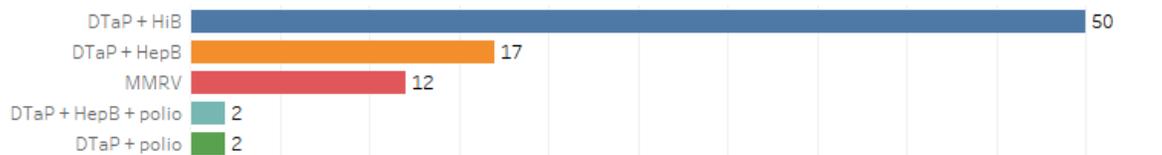
Vaccine missing final dose



Kids missing multiple vaccines that could be delivered in single shot



Multiple vaccines missing, single shot delivery



We also look at children who are 6-11 months and 12-17 months old who are behind the recommended immunization schedule to help catch them up and be on track to meet Combo2 by their second birthday.

## Immunization status tracking at 6 & 12 months

■ On track    ■ Off track    DTaP: 3 doses    HepB: 2 doses    HiB: 2 doses    Polio: 2 doses

### After 6 month milestone



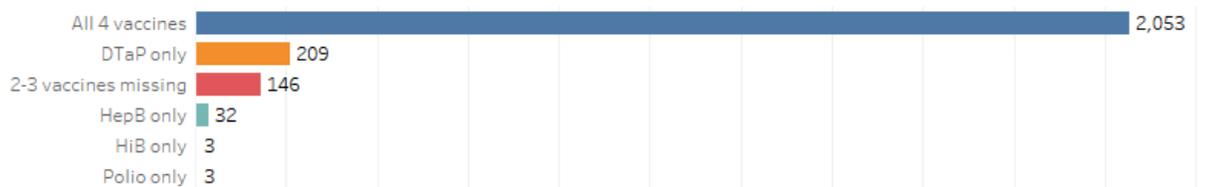
### Missing vaccines after 6 months:



### After 12 month milestone



### Missing vaccines after 12 months:



**Challenges & Lessons Learned:** While our ultimate goal is to ensure all children are fully immunized, limited resources often need to be employed strategically to achieve the greatest improvement. Identifying children who can be caught up with one visit helps maximize the impact of outreach and highlights patterns that can be addressed upstream, including changing clinic scheduling practices and messaging around the importance of the 15- and 18-month well child visits. These visits are critical to ensuring the fourth DTaP dose is administered in time, which is overwhelmingly the culprit in missing Combo2 compliance by 24 months.

Clinics are able to run reports in ALERT but are not able to filter to the CCO population. Using ALERT data on our membership allows clinics to see what disparities their Medicaid population may be experiencing and respond accordingly. Centralizing this analysis at the CCO-level allows us to identify patterns experienced across our community, while also creating customized views for individual systems or clinic locations to address the unique needs of their patient population. Quarterly views of the ALERT records is a limitation but the information generated is still actionable and effective in supporting improvement.

For more information please contact Chandra Elser, Quality Improvement Analyst  
[chandra@healthshareoregon.org](mailto:chandra@healthshareoregon.org) | [www.healthshareoregon.org](http://www.healthshareoregon.org)



## ENGAGING YAMHILL COUNTY YOUTH IN PREVENTATIVE HEALTH SERVICES

Student Wellness And Games (SWAG Night) and Toothtastic Vaxapalooza are unique student wellness events in Yamhill County. Each model facilitates collaboration between community based organizations, schools, and medical clinics. Both feature extended hours, youth-focused activities, raffles, and giveaways.

## MODEL SUMMARY



	SWAG Night	Toothtastic Vaxapalooza
Ages	12 - 21 yo	0 - 14 yo
Event locations	Clinics	Clinics (1st event) Public Health Dept (2nd) Middle School (3rd)
Metrics of focus	AWC, CRAFT/SBIRT, ECU, Immunizations, Dental Sealants	Immunizations, Dental Sealants
Impact	Began in 2015 6 county-wide events 850+ visits 700+ immunizations 49 sealants at 1 event so far ~150 visits per event ~100 imms per event ~50 sealants per event	Began in 2016 3 county-wide events 200+ visits 230+ immunizations 100+ sealants over 2 events ~70 visits per event ~80 imms per event ~50 sealants per event
Other notes	15% of teens surveyed say they would not have gotten AWCs otherwise  Difficult to engage all of these ages at one event	Hosting at central locations is ideal but difficult to carry out (rather than at clinics)  Difficult to engage all of these ages at one event

[www.swagnight.org](http://www.swagnight.org)

[hello@swagnight.org](mailto:hello@swagnight.org)

[@teenswagnight](https://www.instagram.com/teenswagnight)

## Lessons Learned

FOR STUDENT WELLNESS EVENTS

### CREATIVE COLLABORATION IS KEY

Colleges, K-12 schools, and other local organizations may offer a variety of in-kind support such as student volunteers, facilities and transportation, raffle and door prizes, and more.

### SET EVENT DATES WITH INTENTION

- Avoid holidays + popular vacation times
- Host events prior to school sports physical nights
- Consider relevant health observances
- If a date works, stick with it (e.g. 1st Weds in August)

### START SMALL + SET A GOAL

Set a goal of piloting an event workflow that feels doable for staff involved. Consider vaccine transport and secure wifi options if hosting off site from a clinic.

### INVOLVE YOUR AUDIENCES

- Brainstorm incentives to get parents involved
- Provider-to-provider training may help buy-in
- Teen focus groups and college interns inform outreach for adolescent-focused events

### PERSONALLY INVITE PATIENTS

90% of guests surveyed said they heard about our events from their health provider or a call from their clinic

### TRUST THE PROCESS + TRY AGAIN

- Distribute surveys + host a meeting within 1 week
- Include patients, parents, staff, and volunteers
- Be open-minded to changing things up
- Don't give up after your first event!

## funding sources

**Grant Awards:** YCCO & Immunize Oregon  
**In-kind donations:** Local partners donate gear for swag bags, raffle prizes, and other giveaways  
 We seek sponsorship by local partners



*contact us:*

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Baillie Maxwell, LPN  
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**2018 Innovation Café: Strategies for Improving Children’s Health**  
**Improving Childhood Immunization Rates Using Practice-Focused Population Health Strategies**

**Project Description:**

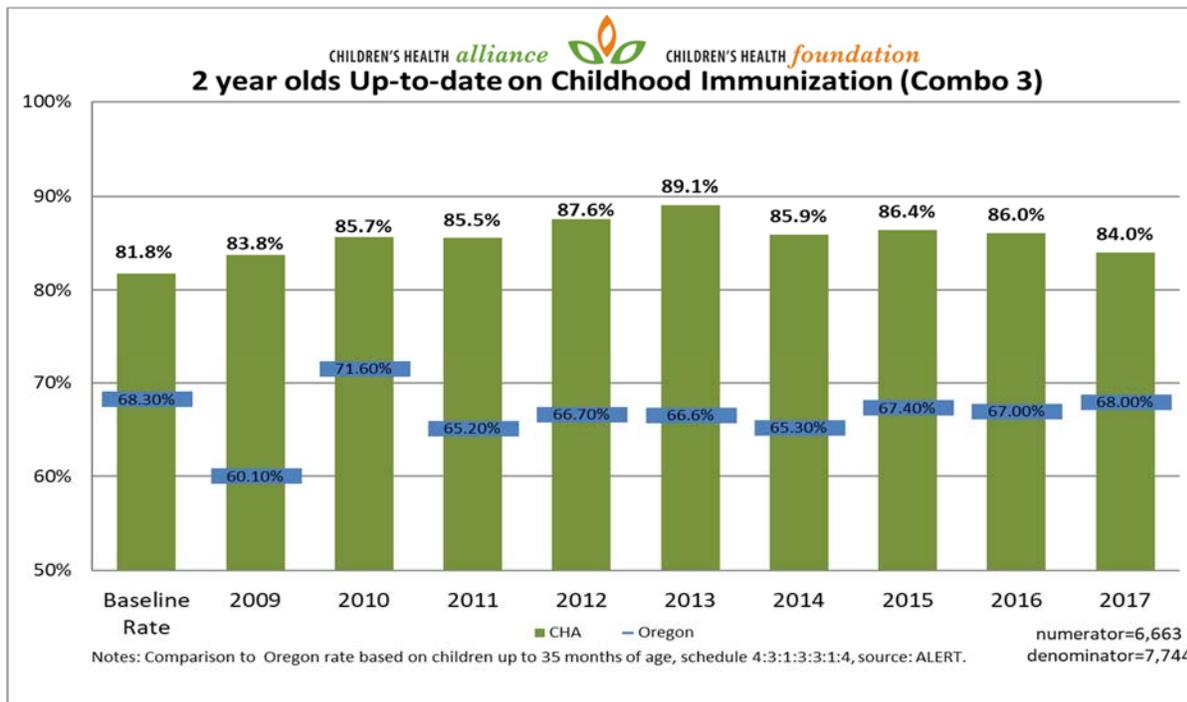
For over a decade, Children’s Health Alliance providers and practices in the Portland, Salem and Vancouver areas have collaborated on a quality improvement initiative to improve childhood immunization rates. Currently, the Children’s Health Alliance immunization initiative is managed and continually improved using care gap analysis by a population health management tool, Wellcentive™ Outcomes Manager.

The following have been key components of the success of the immunization quality improvement initiative:

- 1) Identifying immunization gaps and tracking reasons patients were not up-to-date
- 2) Quarterly and annual reporting of immunization results through practice comparison reports
- 3) Providing support to practice teams through training and workflow evaluation
- 4) Providing education and shared learning to providers for overcoming vaccine hesitancy

**Impact/Outcomes:**

- Providers and practices experienced steady/significant improvement in childhood immunization rates, particularly in comparison to the State of Oregon (see comparison chart below)
- Children’s Health Alliance Immunization Initiative is certified for Maintenance of Certification (MOC) credit, through the American Board of Pediatrics, allowing providers to receive MOC credit for participation.



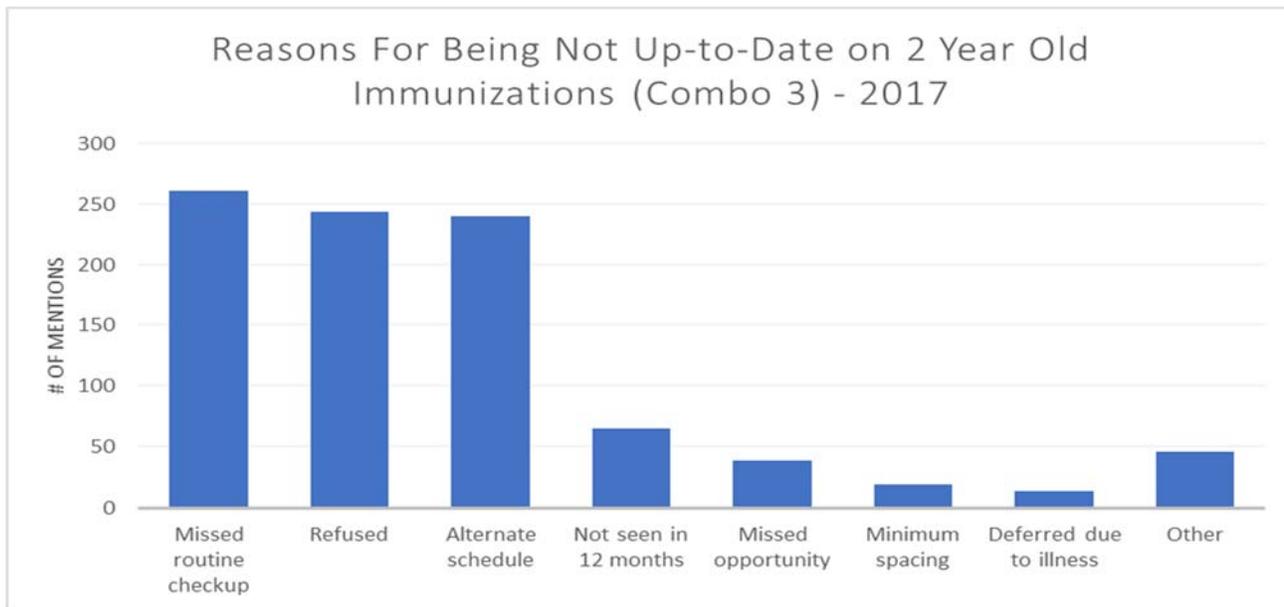
**Challenges:**

- Timing of patient recall
- Educating providers and practice on importance of a being up to date by 2 year birthdate particularly when moving from “self-reporting” to electronic reporting (Wellcentive)
- Reconciling patient records with Oregon IMM ALERT
- Patients under age 2 transferring/ joining practice and effect on immunization rates

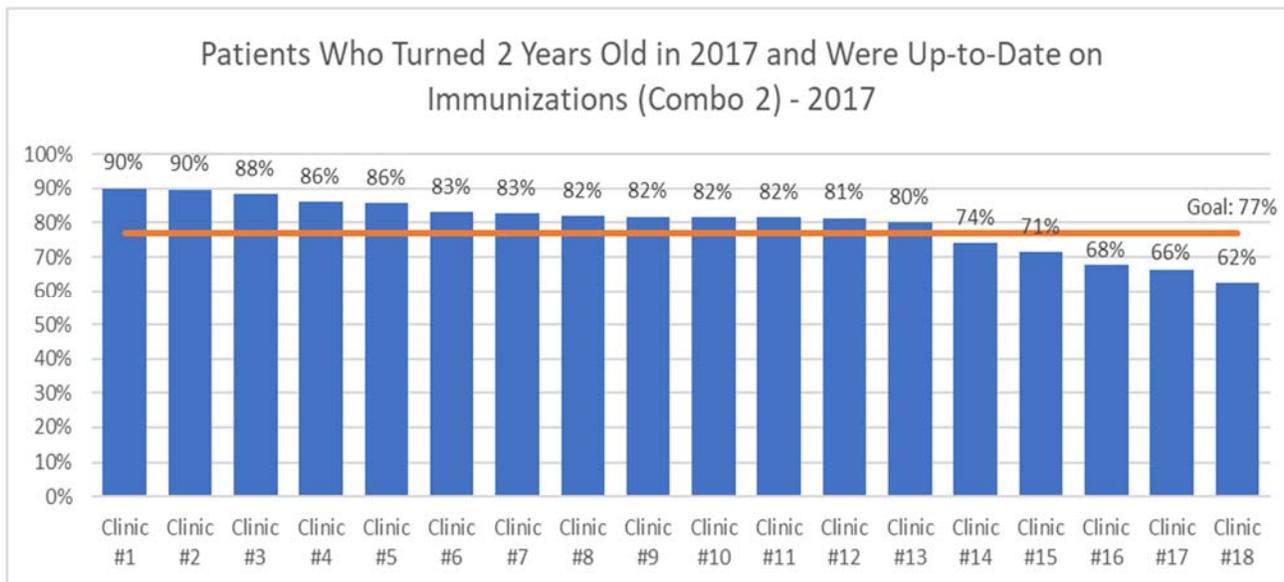
**Lessons Learned:**

- Important to identify an immunization champion/project point of contact at each practice
- Identifying reasons patients were not up to date was key to improving immunization rates (see Chart 1)
- Most effective to work with each practice individually to meet specific workflow needs
- Utilize alerts for patient recall to close care gaps
- Utilize reports to monitor progress
- Publish quarterly/annual comparison reports (see Chart 2)

**Chart 1:**



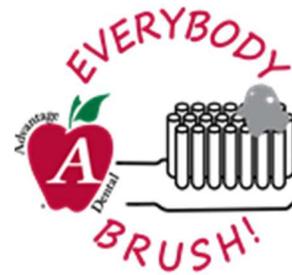
**Chart 2:**



**Organizations Involved:**  
 Children's Health Alliance  
 Member practices

**Funding Source:**  
 Children's Health Alliance

**Organization Website:**  
[www.ch-alliance.org](http://www.ch-alliance.org)  
[www.ch-foundation.org](http://www.ch-foundation.org)



## Improving Oral Health Outcomes for Young Children and Families with Everybody Brush

**Project Description:** Advantage Dental has been serving Early Head Start in Jackson and Josephine Counties for over two years. Our services include oral health screening, risk assessment, prevention, and the medical management of caries with the use of Silver Diamine Fluoride. We believe that in order to achieve the Triple Aim and improve population health, we must serve and educate individuals in the environments they live, work and play in.

### **Project Objectives:**

- Risk Assess 100% of Advantage membership – approximately 300,000 lives in the State of Oregon by conducting screenings, prevention, and medical management in the community.
- Reduce the oral health disease burden in children and families living in poverty.
- Educate families and the community about oral health issues, the communicability of caries, and how they can keep their teeth a lifetime.

**Project Activities:** Through the partnership with Early Head Start and Advantage, an Expanded Practice Dental Hygienist is integrated into the educational setting in a variety of ways to both offer treatment/prevention and provide education.

- **Education** regarding oral health, nutrition, and prevention, is provided to individuals and families in a variety of ways.
  - **Formal classes for students and parents** – The Expanded Practice Dental Hygienist delivers “lecture” educational sessions in parenting classes, as well as early learning classes with literacy appropriate tools and methods. Through these opportunities participants learn about the communicability of caries and oral disease, the importance of good nutrition, and proper hygiene techniques.
  - **Individual screening opportunities** – the above learnings are then re-enforced during individual screening and prevention services.
- **Risk Stratification/Prevention/Treatment/Triage** – All children and desiring family members are screened to determine caries risk. Individuals are categorized into the following categories and offered the corresponding services based on risk. All services are delivered through a trauma-

informed lens and model. Our goal is to reduce shame and fear often associated with the dentist. Individuals are categorized as below:

- **Low Risk (0A)** – Toothbrush and fluoride tooth paste provided.
- **Moderate Risk (0B)** – Silver Diamine Fluoride (initial and subsequent application provided in community), toothbrush kit.
- **High Risk (1A,1B,2)** – Toothbrush kit provided, Silver Diamine Fluoride application, Betadine/fluoride varnish, sealants (age appropriate), glass ionomer temporary restorations, triage to care. All services are provided on-sight, reducing the barrier to care.

**Project Outcomes to Date (September 2016 – May 2018):**

Date of Service	September 2017/May 2018	September 16/August 2017
<b>Total Screenings by Year</b>	<b>92</b>	<b>152</b>
<b>Total # of 0A</b>	<b>72</b>	<b>101</b>
<b>Total # of 0B</b>	<b>14</b>	<b>35</b>
<b>Total # of 1A</b>	<b>3</b>	<b>9</b>
<b>Total # of 1B</b>	<b>3</b>	<b>5</b>
<b>Total # of 2</b>	<b>0</b>	<b>2</b>
<b>SDF Prevent</b>	<b>10</b>	<b>37</b>
<b>SDF Treatment</b>	<b>8</b>	<b>19</b>
<b>Fluoride Varnish</b>	<b>0</b>	<b>3</b>
<b>Protective Restoration</b>	<b>0</b>	<b>3</b>

**Community Partners:** Early Head Start has been a significant partner in the success in this program. We have found that it is best to do mutual education of staff members to ensure understanding and communication. The use of silver diamine fluoride in the community setting is relatively new in Oregon, and so comprehensive education as to what can be expected from medical management approach is explained in detail with staff through a staff presentation. Early Head Start plays a key role by ensuring consent return, educating parents on the benefits of services, and coordinating service and education days.

**Funding:** This population health initiative is supported through the capitated contracts with regional CCOs. This is a public health initiative, made available to all individuals regardless of insurance status and ability to pay, and does not impact clinical OHP benefits available to member.

**Contacts:**

Heidi Hill, MHA – Integration Coordinator, Advantage Dental - [heidih@advantagedental.com](mailto:heidih@advantagedental.com)

Jessica Allen, EPDH – Regional Expanded Practice Dental Hygienist, Advantage Dental - [jessicaA@advantagedental.com](mailto:jessicaA@advantagedental.com)

## Oral Health Integration Menu

### COORDINATED

- Low effort
- Separate locations and systems
- Communication driven by provider need
- Limited understanding of each others roles and resources
- Example: Salem Clinic pregnant women program

### CO LOCATED

- Some shared systems
- Located in same facility
- Communicate regularly
- Oral health provider a part of larger healthcare team
- Example: Childhood Health Associates of Salem, Central SBHC

### INTEGRATED

- Close collaboration
- Shared space within facility
- Frequent communication
- Integrated record is ideal
- In depth understanding of roles and culture
- Example: Sweet Home Family Medicine

### Impact

- Expand access to dental services for underserved populations
- Demonstrate sustainability of delivery care model
- Improve the oral health of patients seen

### Barriers

- We are from siloed systems
- Educated separately
- Licensed separately
- Practice independently
- Non-integrated benefit/ins. programs
- PCP's, Dentists, and patients see the mouth as the property of the dentists
- Sharing of information rarely occurs

### Outcomes

- Early intervention
- Prevention intervention
- One stop shopping
- Increased access
- Improved OH Literacy
- Reduce OH disparities
- Innovative finance and service delivery

# Oral Health Integration

## Menu

Definitions, “How to’s”, Barriers, & Outcomes

**Jennifer Clemens, DMD, MPH**

*ClemensJ@interdent.com*

**Linda Mann, EPDH**

*MannL@interdent.com*



## Café Session 2: Project Descriptions

Round 1: 1:30-1:57 p.m. / Round 2: 2:00-2:27 p.m. / Round 3: 2:30-2:57 p.m.

### Croisan Creek Room

<b>Cross-Sector #9: Starting Strong: A CCO Cross-sector Member Incentive Program</b>
Trish Styer, Quality Improvement Analyst, Jackson Care Connect; Riki Rosenthal, Starting Strong Program Specialist, Jackson Care Connect
Starting Strong is a Jackson Care Connect program that supports pregnant members and children age 0–4 by offering vouchers for participating in healthy activities with community partners like Head Start, WIC, YMCA and behavioral health service providers. Members redeem vouchers for baby and household items and receive additional support from CCO staff.
<b>Cross-Sector #10: Community UPLiFT</b>
Vanessa Pringleton, Regional Home Visiting Systems Coordinator, South Central Early Learning Hub; Rhonda Janecke, RN, Maternity Case Manager, Cascade Health Alliance
Uplift is a project between Klamath, Lake and Douglas County home visiting associations to work collaboratively to offer early childhood services to birth-to-five children and families. The key players are Cascade Health Alliance, Early Learning Hubs, Sky Lakes Medical Center, Public Health, Department of Human Services, Early Intervention, Early Childhood Special Education, Head Start, Early Head Start, Klamath Basin Behavioral Health, WIC, Take Root, and The Ford Family Foundation. Our purpose is to achieve better coordination of services to people with social disparities, focusing on people who have fallen through the cracks.
<b>Cross-Sector #11: Beyond Silos: Supporting Kids and Families through CCO and Early Learning Partnerships</b>
Debi Farr, Manager, Community Relations, Trillium Community Health Plan; Bess Day, MBA, Director of Education, United Way of Lane County/Lane Early Learning Alliance
Trillium Community Health Plan (Lane County's CCO) and the Lane Early Learning Alliance have successfully partnered to implement several important childhood health initiatives, particularly those aimed at improving shared metrics. These initiatives include community-based parenting education, parenting resources, and developmental screenings with an eye toward kindergarten readiness.
<b>Cross-Sector #12: Integrating Health Care and Early Education through Innovation Collaboration</b>
Maria Weer, Executive Director, Building Healthy Families
For the past 5 years, Winding Waters Medical Clinic and Building Healthy Families have been partnering to integrate parent and early childhood education into our health care system. This includes co-facilitated, evidence-based parent education, universal ASQ screenings, developmentally appropriate and educational waiting rooms, establishing ROAR programs and the joint development of family resources and materials. Presenters will share resources and materials and an outline of lessons learned as our partnership has developed and expanded to include other clinics throughout the region. Other partners in this effort include The Oregon Community Foundation, The Ford Family Foundation, The Campaign for Grade Level Reading, The Kelley Family Foundation, EOCCO and the Institute for Youth Success.

## Pringle Creek Room

### **Prenatal/Postpartum #2: Family-Centered Neonatal Opioid Withdrawal**

Lisa Kipersztok, MD, MPH, Resident, OHSU Family Medicine

The incidence of neonatal opioid withdrawal (NOW), has increased similarly to the over-prescription, overuse and misuse of opioid medications. There is no current standard of care for treatment of NOW, but the majority of hospitals assess signs and symptoms with a formal scoring system, which has remained relatively unchanged and focuses on medication management. Some hospitals have recently challenged the historic approach to NOW management, moving care out of the NICU, rooming-in infants with parents during NOW care, starting with and maximizing non-pharmacologic management prior to medication administration, decreasing medication administration, and avoiding complex scoring systems like Finnegan Scales. These hospitals have demonstrated drastic reductions of pharmacologic treatment and length of stay without adverse outcomes or increased hospital readmission rates. As of January 2017, OHSU Doernbecher Children's Hospital adopted a few of these new evidence-based practices and began the process of changing NOW care. This presentation describes the implementation of these new evidence-based concepts to improve the outcomes for patients and families managing NOW.

## Willamette Room A

### **Developmental Screening #3: Help Me Grow Oregon: Advancing Developmental Promotion, Early Detection and Linkages to Services**

Cate Drinan, Help Me Grow Program Manager, Providence; Dr. Sherri Alderman, MD, MPH, IMH-E Policy & Clinical, FAAP, Developmental Behavioral Pediatrician, Oregon Infant Mental Health Association

Help Me Grow is a national model that builds a cross-sector system of collaboration and coordination to ensure that young, developmentally at-risk children are screened, identified and linked to services. Implementation in the tri-county metro area is supported by a partnership including Health Share of Oregon, Providence Health, MIECHV and the three county-based early learning hubs.

### **Cross-Sector #13: Building a Trauma-Informed Community**

Dr. Bhavesh Rajani, Medical Director, Yamhill Community Care; Jenn Richter, Early Learning Administrator, Yamhill Community Care

Yamhill CCO and Early Learning Hub work together to build a trauma-informed community through conferences, workshops, CME events, facilitated tours, book groups, film screenings, focus groups and community cafes. This presentation will cover the community's journey over the last three years and address challenges, gaps and next steps.

### **Cross-Sector #14: Why You Should Ask: Screening for Childhood Food Insecurity in the Medical Home**

Heidi Davis, MSW, Program Manager, Providence Milwaukie Community Teaching Kitchen; Charlotte Navarre, RN-BC, Faculty Nurse Clinician, Providence Family Medicine-Milwaukie

Screening for food insecurity was implemented in two family medicine residency clinics four years ago. This presentation will explore how using a two-item screening question on food security was predictive of other social needs in the family and how practices can partner with community-based support services to meet those needs. Our sponsoring institution, Providence Milwaukie Hospital, embraced the concept and expanded on it by adding a community teaching kitchen and food pharmacy on campus.

## Willamette Room A

### **DHS Custody #1: Universal Evaluations Involving Multi-Faceted Risk Factors for Youth Entering Foster Care: The RAPID Program**

Roxanne Edwinston, PhD, Licensed Psychologist and RAPID Lead Clinician, MindSights, P.C.; Freda Bax, PsyD, Psychologist, Co-owner, MindSights, P.C.

Presenters will discuss the pioneering RAPID program that has been a collaboration of a practice of psychologists (MindSights), health coverage providers, community programmers and local DHS authorities. All children ages 1–17 years entering custody within District 2 of Oregon are now eligible for a RAPID assessment within their first 60 days in care. Beyond providing the standard mental health examinations and screening, RAPID assessments include a combination of standardized psychometric tools that more comprehensively inform child welfare case planning, community service referrals, early needs identification, and overall integrated care.

### **DHS Custody #2: Using the Pathways Model to Provide Additional Supports to Children Coming into DHS Custody**

Suzanne Cross, MPH, CHW, Senior Project Manager, Columbia Gorge Health Council; Alison Donnelly, RN, Nurse Home Visitor, Hood River County Health Department; Elke Geiger Towey, MA, MBA, Practice Coach, PacificSource Columbia Gorge CCO; Katy Williams, LPN, Bridges to Health Pathways HUB Coordinator, Columbia Gorge Health Council

The Columbia Gorge CCO has taken its collaborative energy and systems thinking approach to utilize their local implementation of the Pathways Model, “Bridges to Health (B2H) Pathways,” to help meet the DHS metric and improve overall support for children and foster families entering the DHS custody system. The program has three goals: 1) empower community members most in need to improve their overall health and well-being; 2) assist clients with access to services and resources by addressing disparities; and 3) improve integration of services in and out of health care. We will describe the system processes, workflow and lessons learned in the creation of this partnership amongst the Columbia Gorge Health Council (the B2H hub), PacificSource Community Solutions, Hood River Health Department and North Central Public Health District and the Region 9 DHS to provide community care coordination services (CHWs and RNs) to improve care to our communities’ most vulnerable children.

## Willamette Room B

### **Childhood Immunization #4: Improving 2-year-old Immunization Rates in Southwest Oregon**

Brian J. Mahoney, MPH, Public Health Modernization Coordinator, Douglas Public Health Network; Bailey Burkhalter, MPH, Epidemiologist, Douglas Public Health Network; Christin Rutledge, MPH, Program Specialist, Douglas Public Health Network

This presentation will describe the process of convening a regional 2-year-old Vaccination Campaign Community Group (VCG) involving three CCOs, three public health departments, WIC, early learning hubs, clinics, home visitors, and other health system partners and health care organizations. Goals of the VCG include sharing immunization rates, establishing a unified regional best practices approach to increase 2-year old immunization rates, and developing and advancing a set of common priorities and strategies.

**Childhood Immunization #5: A Regional Approach to Address Childhood Immunization Rates: AFIX Project**

Jill Johnson, RN, BSN, MEM, AFIX Project Coordinator, Deschutes County Health Services

The CDC's AFIX Program is an evidence-based quality improvement program that is a recommended strategy for improving immunization rates and practices at the provider level. The Central Oregon Regional Immunization Improvement Project is a successful example of how the AFIX Program has been implemented at the regional level in an effort to increase 2-year-old immunization rates.

**Oral Health Integration #3: Back to the Basics Prevention**

Trina McClure-Gwaltney, Healthy Kids Outreach Program Manager, Mercy Foundation

In 2006, we discovered that no prevention services were being provided for our children in Douglas County. We started with putting nurses in our schools, and they discovered the #1 problem students were facing was dental pain. We started a dental initiative in 2011 that provided twice-a-year prevention clinics that screen, provide fluoride varnish and sealants, and connect to a dental home. We added an interactive, hands-on dental learning lab for grades K-12 to empower students in oral hygiene education. Our program has now grown in our prevention services with classroom health awareness education, nutrition and physical activity in the classroom, violence prevention support, school-based dental program, parent education, and community connection for service homes. We collaborate with multiple community partners to reach further and sink deeper in preventive care in our community.

**Oral Health Integration #4: Integrating Oral Health into Well-Child Visits**

Alexa Jett, BSDH, EPDH, Dental Innovations Specialist, CareOregon; Maranda Varsik, Transformation Specialist, Columbia Pacific CCO

CareOregon's innovative method enhances the First Tooth Early Childhood Caries Prevention Program. Our integrated team of primary care and dental innovations specialists work in the Metro, Jackson Care Connect, and Columbia Pacific service areas to provide site oral health readiness assessments, technical assistance for workflows, and new tools to simplify dental referrals. Presenters will share lessons learned from both unsuccessful and sustainable implemented sites.

**DHS Custody #3: Medical Home for Children in Foster Care**

Holly Hermes, LCSW, Pediatric Social Worker, Randall Children's Clinic at Randall Children's Hospital – Legacy Health Systems; Alison McEwing, LPC, Child and Family Therapist, Randall Children's Clinic at Randall Children's Hospital – Legacy Health Systems; Christian Huber, RN, BSN, Manager Randall Children's Ambulatory Services, Randal Children's Hospital – Legacy Health Systems

Children in foster care represent a uniquely disadvantaged and vulnerable group. They have a high prevalence of chronic medical, dental, mental health and developmental issues. These children have often experienced episodic, fragmented and inadequate health care prior to entering foster care. In addition, studies have shown a link between childhood exposure to trauma and an increase in the physical, mental and social pathologies of adults. The purpose of our program is to provide dedicated care coordination for children entering foster care and to address gaps in services and supports to improve utilization of health care resources in this high-risk population. An additional aim is to build support services for foster parents and biological parents to assist with the stabilization and the transition of children between homes. Our program consists of a nurse case manager and a social worker who provide care coordination to our patients who are currently in foster care and those children transitioning out of foster care.

# Starting Strong

## A CCO Cross-sector Member Incentive Program

Starting Strong is a Jackson Care Connect program that supports pregnant members and children age 0-4 by offering vouchers for participation in healthy activities with community partners like Head Start, WIC, YMCA, and behavioral health service providers. Members redeem vouchers for baby and household items and receive additional support from CCO staff.

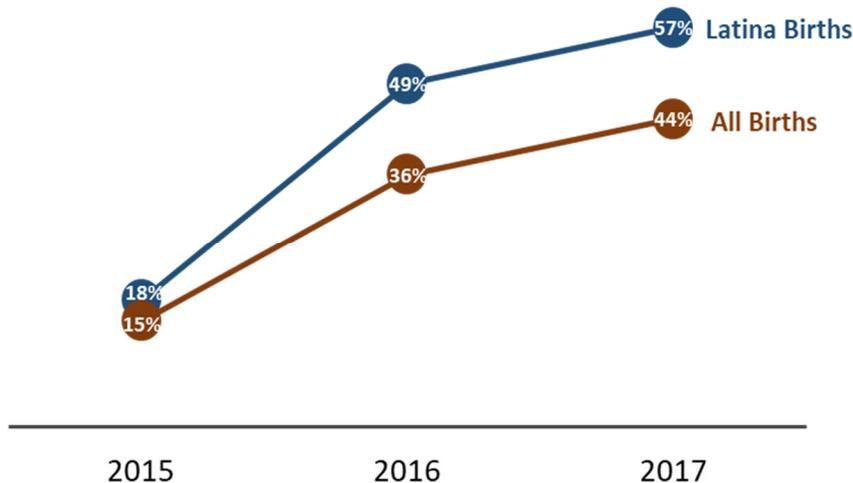
### 2017 Utilization

**1,200** Parents & children served

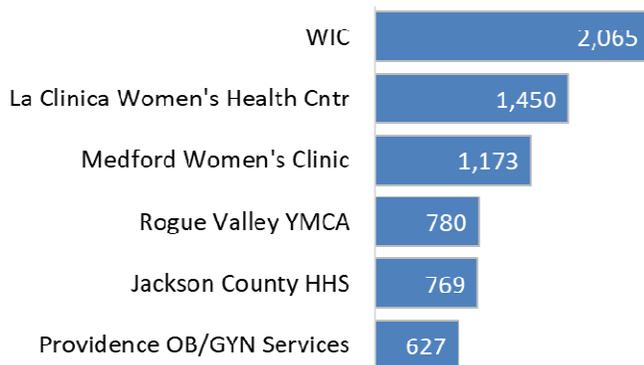
**57%** Pregnant Latina members engaged

**60** Partners distributed vouchers

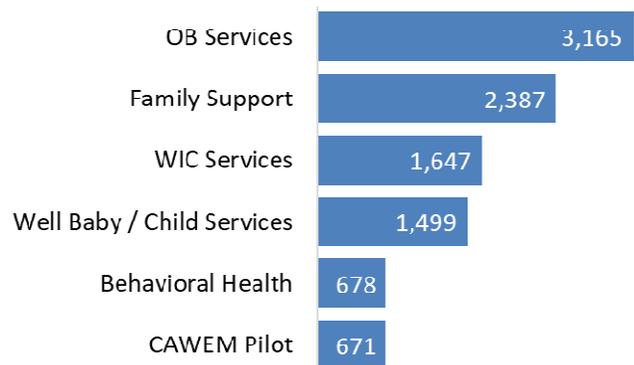
Our engagement rate for pregnant members has increased each year, especially for our Latina members.



Vouchers are distributed in many locations. Our top 6 partners gave out 61% of our 2017 vouchers.



Members receive vouchers for many types of healthy activities. 90% of vouchers earned were from our top 6 services.



# Starting Strong Voucher

## Good health is rewarding!

As a Jackson Care Connect member, you can earn vouchers for taking care of yourself and your children under 4 years old.

### You can redeem this voucher at our Starting Strong store

702 W Main St Medford  
(across from the Rogue Valley Family YMCA)

#### You can earn vouchers for:

- Pre-natal and postpartum doctor visits
- Well-child visit and vaccinations
- WIC appointments and classes
- Home visiting and early intervention programs
- Dental visits for mom and baby
- Much more — see our website for a full list

Member name: \_\_\_\_\_

Provider/Partner: Please complete this section

Community Partner:

[Partner name goes here like this  
and can be two line long, centered]

Date: \_\_\_\_\_

Purpose of visit: \_\_\_\_\_

\_\_\_\_\_



Redeem this voucher  
at the Starting Strong store  
for helpful supplies.

Visit [Jacksoncareconnect.org/startingstrong](http://Jacksoncareconnect.org/startingstrong)  
for full list of eligible activities and participating  
providers and partners.

- Diapering and potty training ..... 1 to 10 vouchers
- Cooking supplies ..... 1 to 8 vouchers
- Breastfeeding ..... 2 to 8 vouchers
- Car seats ..... 13 to 15 vouchers
- Health and safety ..... 2 to 5 vouchers
- Baby gear ..... 6 to 12 vouchers
- Gift cards ..... 3 to 6 vouchers

*Selection, styles and voucher amounts may  
change without notice.*

*Vouchers expire 60 days after Starting Strong  
eligibility ends.*

## Starting Strong store

702 W Main St Medford  
(across from the Rogue Valley Family YMCA)

Hours: Tues - 9 a.m. to 3 p.m.; Thurs - noon to 6 p.m.

Phone: 541-494-1004

Email: [startingstrong@jacksoncareconnect.org](mailto:startingstrong@jacksoncareconnect.org)

Website: [jacksoncareconnect.org/startingstrong](http://jacksoncareconnect.org/startingstrong)

Jackson Care Connect

*To get this information in large print, in another  
language, Braille or another way that is best for  
you, please call our Customer Service number  
toll-free at 855-722-8208 (TTY: 711)*



JCC-SS 17/10-1-EN-05/16/18

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## Overview of Project

Community UPLiFT is a coordinated referral system that connects expectant women and families with children from birth through the age of five to early childhood service providers. These providers include such organizations as Family Development Center, Head Start, Early Head Start, Healthy Families, Healthy Start, Babies First, CaCoon, Maternity Case Management, Early Intervention, Family Relief Nursery and Early Childhood Special Education. Community UPLiFT is a collaborative community effort made up of many agencies, organizations, and individuals dedicated to developing a referral system in Douglas, Klamath, and Lake Counties. We identify families needing early childhood support by creating partnerships linking families to resources.



## Expected Outcomes and Benefits:

Community UPLiFT desires to build a community of care that breaks down barriers and works with all sectors within our tri-county region. We want to:

- Improve access for the most vulnerable families and reduce disparities by connecting families to the program that best suits their needs.
- Provide Early Childhood professionals across the region with the training and support they need.

## Barriers

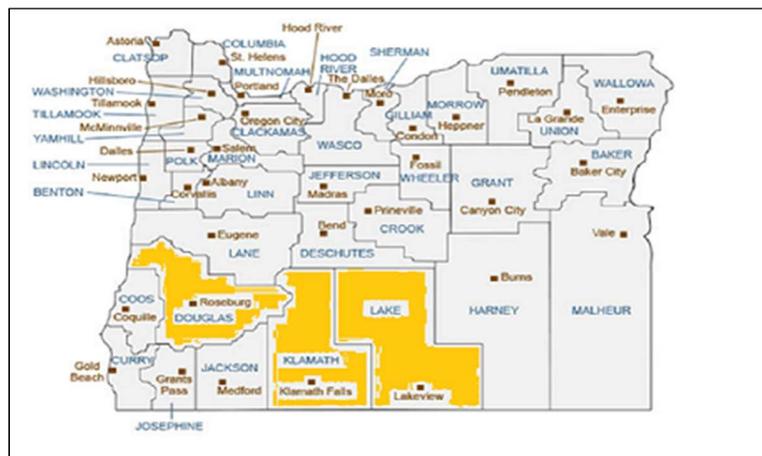
- There are three counties covering 19,628 square miles.
- All counties and providers have limited funds.
- Finding the best way to work within HIPAA (Health Insurance Portability and Accountable Act) and FERPA (Family Educational Rights and Privacy Act) regulations and guidelines.
- Many partners fear losing referrals for their individual programs.
- Overcoming past conflicts between organizations and being ready to forge new, stronger relationships with partner programs.

We would like to send our thanks to the Ford Family Foundation for funding the Home Visiting Project Grant. Originally, we ran a trial program utilizing only two providers in each county. We did this to test both the programs and our internal systems to see if they could be coordinated easily. Because of the Ford Family Foundation's ongoing funding, we have moved past the analytical phase, and have successfully launched the program in all three counties. With their ongoing support and guidance, we look forward to expanding this initial program into a full-fledged project working successfully in Douglas, Klamath and Lake Counties.

**Contacts:** Vanessa Pingleton: [Vanessa.pingleton@douglasesd.k12.or.us](mailto:Vanessa.pingleton@douglasesd.k12.or.us) or Rhonda Janecke: [Rhondaj@cascadecom.com](mailto:Rhondaj@cascadecom.com)

**Community Partners include:**

□ **Douglas County ESD** □ South Central Early Learning Hub □ Take Root Parenting Connection □ Early Intervention □ Early Childhood Special Education □ **Care Connection & Education** □ **Lake County ESD** □ **Department of Human Services** (Klamath, Lake and Douglas Counties) □ **Cascade Health Alliance** □ **Umpqua Health Alliance** □ **Douglas Public Health Network** □ **Klamath County Public Health** □ WIC □ Babies First □ CaCoon □ **Lake County Public Health** □ Babies First □ CaCoon □ Maternity Nurse Case Management □ **Sky Lakes Hospital** □ **Lake District Hospital** □ **Klamath County Public Health** □ WIC □ Klamath Public Health Nurses □ **Klamath County Library** □ **Klamath Basin Behavioral Health** □ Healthy Families □ **Family Development Center** □ **Family Relief Nursery** □ UCAN □ Healthy Start □ Early Head Start □ Babies First □ Babies First □ Extended Babies First □ CaCoon □ Healthy Families □ **Klamath/Lake Early Head Start** □ Head Start □ **Oregon Child Development Coalition (OCDC) Head Start** □ **Klamath Falls City Schools** □ Early Intervention □ Early Childhood Special Education □



Douglas, Klamath and Lake Counties

# Beyond Silos: Supporting Kids & Families through CCO & Early Learning Partnerships

**Project Description:** Healthy children come from healthy families, meaning parental health and child health are connected. Cross-sector collaboration between CCOs and regional Early Learning Hubs can break down the traditional silos of health and education to develop and support prevention and intervention efforts to best meet the needs of all children and families in our communities.

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## Presented by:

**Debi Farr**, *Manager, Community Relations*, Trillium Community Health Plan  
Ph: 541.799.3119, Email: dfar@trilliumchp.com

**Bess Day, MBA**, *Director of Education*, United Way of Lane County/Lane Early Learning Alliance

Ph: 541.741.6000 x. 162, Email: bday@unitedwaylane.org

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## Integrated Efforts:

- Shared governance, work groups, & measures which inform and catalyze each other's work
  - Evidence-based parenting education groups (*e.g., Make Parenting A Pleasure*)
  - *Triple P: Positive Parenting Program* – brief intervention & online education
  - Developmental screenings
- 

## Impacts & Outcomes

- Significant developmental screening rate increase from 17% in 2011 to 73.6% in 2016
- Since 2010, 89 evidence-based parenting education series have been offered in English and Spanish in Lane County, serving 731 parents and 691 children.
- 10,921 parents have attended parenting workshops and support activities.
- 8,901 children and adults attended family activities.
- 258 facilitators have been trained in evidence-based curricula. 18 new providers trained to offer Triple P brief intervention and discussion groups.
- Since 2016, 250 families have completed Triple P online education
- 95% of parents report the information and resources received via their parenting education series to be helpful.
- The greatest gains for parents include “knowing normal behavior for my child’s age level” and “set and stick to reasonable limits and rules”



### **Lessons Learned:**

- Innovative partnerships and funding streams can build sustainability.
  - Commit to using an equity lens with any decision that will impact the families you serve.
  - There's always room for improvement with parent engagement, meeting families where they are, and expanding the options for accessing education and healthcare. Never stop trying to raise the bar.
- 

### **Partner Organizations:**

- Lane County Public Health
  - Oregon Parenting Education Collaborative
  - Oregon Research Institute
  - Parenting Now!
  - Cornerstone Community Housing
- 

### **Funding Sources**

- Trillium Community Health Plan (\$1.33 per Oregon Health Plan member per month to fund prevention programs)
  - Oregon Parenting Education Collaborative: Oregon Community Foundation, The Ford Family Foundation, Meyer Memorial Trust, & The Collins Foundation
  - Oregon Department of Education, Early Learning Division
- 

### **For more information:**

- [Trilliumohp.com](http://Trilliumohp.com)
- [Lanekids.org](http://Lanekids.org)
- [Earlylearningalliance.org](http://Earlylearningalliance.org)
- [Orparenting.org](http://Orparenting.org)



# Winding Waters & Building Healthy Families Improving Healthcare & Early Education Through Innovative Collaboration

1



## Universal Screenings

- Universal Screenings at all Well-Child Visits
- Prenatal screenings
- New Baby Questionnaires
- Teen Screens for Adolescents

2



## Positive Parent/Child Interaction

- Waiting Room Libraries
- Educational Activities while you wait
- Take Home Activity Ideas
- Parent Connection to programs in the Community

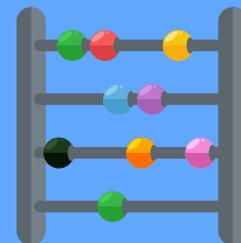
3



## Kindergarten Readiness

- ASQ Bags
- Reach Out & Read
- Free Age Appropriate Books & Activities

4



## Parent & Child Education

- Evidence-Based Parent Education Classes
- Well-baby Bags
- Health & Safety Workshop
- In-School Health /Hygiene Series

5



## Building Community Brain Power

- Shared Professional Developments
- ACES & Trauma Informed Care
- Community Awareness Campaigns
- Collaborative EOCCO projects



# Family-Centered Neonatal Opioid Withdrawal Syndrome (NOWS) Care; A Quality Improvement Project

Creating and implementing an evidence-based, family-centered NOWS protocol for Oregon Health and Science University (OHSU) Doernbecher Children's Hospital (DCH)

Lisa Kipersztok, MD, MPH  
OHSU Family Medicine Resident  
[kiperszt@ohsu.edu](mailto:kiperszt@ohsu.edu)

## What is NOWS?

Formerly known as Neonatal Abstinence Syndrome, a post-natal opioid withdrawal syndrome that can occur in 55 to 94% of newborns whose mothers were addicted to or treated with opioids while pregnant

## Signs & symptoms of NOWS?

Central nervous system (tremors, cry, exaggerated Moro, increased tone), gastrointestinal (weight loss, poor feeding, vomiting, loose stool), respiratory (tachypnea), autonomic (hyperthermia, tachycardia)

## Complications and comorbidities of NOWS?

Associated with SIDS, respiratory diagnoses, low birth weight, feeding difficulty, increased length of stay

## Historic approach to NOWS?

Most hospitals use the Finnegan method to treat babies based on signs & symptoms monitored with a "Finnegan Score." Infants are treated with morphine or methadone with a long titration up and wean down  
Length of stay 16.9 days compared to 2.1 days for babies without NOWS. Babies sent to NICU, separated from mom.

## New evidence?

In-Rooming, baby-centered scoring, increased family involvement, focus on function, morphine as needed, rapid morphine weaning, empowering parents can reduce length of stay, decrease pharmacologic therapy without adverse events

## Changes to Care

### 1. Prioritize Rooming In

- Unless other NICU-level medical issues are present, infants remain with their families in the MBU or Doernbecher wards.

### 2. Encourage Infant Comfort and Parental Engagement

- Focus is on trauma-informed care & non-pharmacologic interventions like quiet room, dim lights, skin to skin, swaddle, etc.

### 3. Focus on Function with Eat-Sleep-Console Approach

- No more Finnegan Scoring
- No scoring in the first 24 hours.
- If the infant is Eating, Sleeping, and Consoling appropriately, they are tolerating NOW & do not require escalated care.

### 4. De-emphasize Pharmacologic Management

- If infant function is affected by NOW, non-pharmacologic care will be maximized first; morphine is second line treatment.
- Morphine starts as PRN (as needed) and hopefully does not need to be titrated up and down.



## Organizations Involved

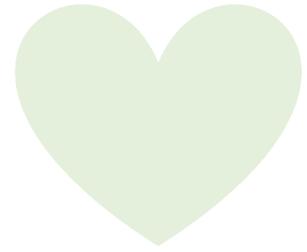
OHSU NOWS Group  
Coda Project Nurture  
OHSU Family Medicine  
OHSU Pediatrics  
NeoQIC Team

## References

1. McQueen et al. *N Engl J Med*. 2016
2. National Institute on Drug Abuse Website. 2017
3. Bogen et al. *Academic Pediatrics*. 2017
4. Holmes et al. *Pediatrics*. 2016
5. Grossman et al. *Pediatrics*. 2017
6. Patrick et al. *JAMA*. 2012

## Successes

- Focus on family-centered, trauma-informed care
- Collaboration between departments, specialties, & professionals
- Focus on comfort & consoling as prevention & first-line treatment
- Following best practices & new evidence
- Decreased prejudice among staff for families affected by NOW
- Treating babies like babies has been widely accepted
- Focus is on function, not symptoms
- Teaching new evidence-based concepts at the bedside



### EAT – SLEEP - CONSOLE

EAT – SLEEP - CONSOLE		
<b>EAT</b>	<b>Poor eating due to NOW?</b>	
	POOR EATING	Unable to coordinate feed within 10 mins of showing hunger cues due to NOW symptoms such as fussiness, tremor, or excessive suck
	EATING WELL	8 - 12 feeds per day with effective latch and milk transfer by breast or at expected volumes by bottle
<b>SLEEP</b>	<b>Sleeping less than 1 hour (after a feeding) due to NOW?</b>	
	POOR SLEEP	Unable to sleep for more than 1 hour due to NOW symptoms such as fussiness, restlessness, increased startle, or tremors
	SLEEPING WELL	Able to sleep for more than 1 hour at a time
<b>CONSOLE</b>	<b>Unable to console within 10 minutes due to NOW?</b>	
	POOR CONSOLING	Unable to be consoled within 10 mins with caregivers effectively providing consoling
	CONSOLING WELL	Able to be consoled within 10 mins with self-soothing, rocking, skin to skin, swaddle, non-nutritive sucking, feeding, or other consoling

## Challenges

- Inter-observer differences in perception of NOWS symptoms
- Resistance to change of tradition going back to 1970s
- Variation in parental, familial, RN ability to participate in consoling
- RNs anxious about workload of consoling
- Implementation of concepts prior to policy adoption
- Difficulty identifying & coding infants with NOWS
- Different prenatal practices & continuity for pregnant women
- Separating NOWS symptoms from non-NOWS complications
- Concerns about monitoring after morphine dose (not required at low doses)

## How to Change NOWS Care:

1. Form a multidisciplinary committee with stakeholders
2. Collect data if possible to study outcomes as changes are made
3. Review your hospital's practices, guidelines, policies, compare to new evidence
4. Learn more about the Eat Sleep Console method
5. Review outside hospital policies and use to make a draft policy
6. Review draft with all stakeholders and involved teams (OB/GYN, NICU, Pediatrics, Family Medicine, MBU, L&D, nurses, etc.)
7. Finalize policy and submit for approval
8. Using policy, develop tools within the EMR to facilitate implementation (dotphrases, order sets, flowsheets for nurses)
9. Move care from NICU to Pediatric Ward to allow in-rooming
10. At bedside, discuss the problems with the old method, benefits of the new method
11. Focus on more objective parts of Finnegan Score
12. Educate ALL staff at once, together PRIOR to implementation
13. Implement, continuously elicit feedback on issues, concerns



# Help Me Grow Oregon

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*Advancing Developmental Promotion, Early Detection and Linkages to Services*

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**What is Help Me Grow?** Help Me Grow (HMG) is a national model that builds a system of collaboration and coordination across sectors to assure that children at risk of developmental delay are identified and connected to the services they need. The goals of HMG are to improve child health and developmental outcomes by strengthening links between child health and early learning systems and creating a model for screening and referral that is consistent, robust and replicable.

## **Project Description**

Child Health Providers, Early Childhood Professionals and families can contact the Help Me Grow Centralized Access Line when there are questions about a child's development. Help Me Grow Resource Specialists provide information and referrals to appropriate services to meet family needs and support their children's development.

- No qualifying criteria such as income, insurance, or diagnoses;
- HMG Team has a Program Manager, two Resource Specialists and a HMG Liaison based in Multnomah, Clackamas and Washington Counties. HMG Physician Champion and Advisory Board provide guidance regarding implementation and expansion;
- Analysis and identification of gaps and barriers families face in accessing services will demonstrate need for improvement of service array;
- HMG launched in partnership with select primary care clinics in February 2018. Pediatricians from four clinics refer identified at-risk children to Help Me Grow. HMG Specialists follow up with families, stay in communication with the referring provider, and then close the referral loop;
- Currently expanding to include more clinics, as well as Early Childhood Service Providers such as EI/ECSE, WIC, Focused Childcare Networks and Community Health and Education Workers.

## **Project Background**

- Health Share of Oregon, as part of their Ready and Resilient Strategic Plan, funds HMG in partnership with Providence Health and Services at Swindells Resource Center;
- Contributing partners include MIECHV, Multnomah County, and The Early Learning Hubs of Washington and Clackamas and Multnomah Counties;
- HMG implementation helps achieve Health Share and Early Learning Hubs' shared metric of increased developmental screening for young children through coordinated regional referral system.

## Impact

- HMG has provided an excellent model for Hubs and CCO to organize around and deepen collaborative working relationships through region-wide implementation.

## Preliminary Outcomes

- Of the families referred to HMG from both clinics and the community since February 2018:
  - 77% were reached on follow up;
  - 68% of families were offered developmental information and/or referral to community resources;
  - 94% of referral loops were closed with providers;
  - 33% of families were bilingual or monolingual in their own language.

## Challenges

- Questions from community partners at outset about the nature and purpose of HMG;
- Local implementation sometimes hampered by larger state policies/systems;
- Coordinating data systems across the early childhood system regionally and statewide.

## Lessons

- Siting HMG in a health system allows greater connectivity between medical and social service domains;
- Flexible funding from Health Share allows for tailored implementation;
- Working with Early Learning Hub Parent Councils for their feedback about everything from materials to operations to staffing ensures it will be relevant to families;
- Recruit and hire staff from the communities served;
- HMG can serve families by working with them directly, and also indirectly, through supporting those who serve them;
- Learning continues about how families prefer to receive information and support;
- Bringing in a partner to support implementation in clinics will enhance the operation and workflows of HMG in healthcare settings.

*HMG Oregon Program Manager, Cate Drinan: [catherine.drinan@providence.org](mailto:catherine.drinan@providence.org)*

*HMG Physician Champion, Dr. Sherri Alderman: [sherialderman23@gmail.com](mailto:sherialderman23@gmail.com)*





**Yamhill Community Care Organization**  
**Building a Trauma-Informed Community**

**Yamhill CCO Vision:**

*A unified healthy community  
that celebrates physical, mental, emotional, spiritual, and social well-being.*

**Project Description:**

Adverse Childhood Experiences (ACEs) impact health and well-being outcomes across the lifespan – at significant cost to the individual as well as to society. ACEs have been linked with numerous negative health outcomes and lower life potential. The more ACEs an individual is exposed to as a child, the higher their risk of developing heart disease or cancer, of experiencing mental illness, of failing to graduate from high school, and of experiencing unemployment or underemployment.

Early in the development of Yamhill CCO, it became clear that interrupting ACEs and creating a trauma-informed community was critical to improving population health and increasing educational outcomes. Over the last three years, this has become a shared endeavor across health, social services and education as we seek to promote holistic well-being for all.

**Timeline:**

June 2015	Lunch with Dr. Robert Anda
October 2015	Family Resiliency Conference: Vicarious Trauma
April 2016	Applying TIC Principals in Home Visiting Practice
2016-17	Family Resiliency Community Conversations
Summer 2017	Three focus groups/ Two community cafés
2018-19	Book group
February 2018	Agency walkthrough & workshop: Creating Trust
March 2018	Continuing Medical Education event



**What is Trauma Informed Care?**

*Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.*

~Trauma Informed Care Project, Iowa



**Next Steps:**

Current	TIC as Public Health CHIP focus area
Pending	Training at local hospital
October 2018	Workshop: Collaborating with Families
2019	Train the Trainer with SAMHSA

### Impact/outcomes

- Increased/improved conversation between providers and those they serve
- Increased understanding of importance of training all staff, including front office
- Developed pathway toward implementation of TIC community-wide beginning

### Challenges

- Initiative fatigue: Address the WIFM (What's in it for me?)
- Lack of community-wide planning: Partner with other agencies to integrate into work that is already happening
- Lack of consumer voice in conversation: Include consumers not only in trainings but in planning discussions & structure encounters around their needs.

### Lessons learned

- Involve consumers in the conversation early and often.
- Make training concrete and applicable to the community you're in. "What does TIC look like for me and my agency?"
- Trainings are important, but the work only begins there. Progress is achieved through repeated conversations within and across sectors.

### What organizations were involved

- 70+ agencies have participated in some capacity, including hospital systems & clinics, DHS, HHS, Head Start, and many more

### Funding sources

- Yamhill CCO and ELH
- Willamette Valley Medical Center
- OHSU
- Catholic Community Services
- CareOregon
- PH Tech
- Advantage Dental
- United Way of MWV
- Providence Newberg Medical Center
- Yamhill County HHS
- First Transit
- SAMHSA
- Oregon Health Authority

### Contact:

- Dr. Bhavesh Rajani – Medical Director  
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- Jenn Richter – Early Learning Administrator  
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- www.yamhillcco.org

It is easier to build strong children  
than to repair broken men.

Frederick Douglas

# Why You Should Ask: Screening for Childhood Food Insecurity in the Medical Home

Providence Milwaukie Hospital & Providence Oregon Family Medicine Residency Program

## Project Description

- **Nearly 15%** of Oregon's households are **food insecure**
- In Clackamas and Multnomah Counties, **11-16%** are **food insecure or hungry**
- **Poor nutrition and inconsistent access to food** are especially harmful during the **prenatal period and first 3 years of life**
- In Oregon, the **obesity rate of 2-4 year olds** enrolled in WIC is **15%**

Screening for food insecurity at well child checks was implemented in two Family Medicine Residency clinics four years ago. Our 2 year grant funded pilot project evaluated whether using one, two-item screening question on food security was predictive of other social needs in the family. We also explored models of primary care practices partnering with community based support services to meet those needs.

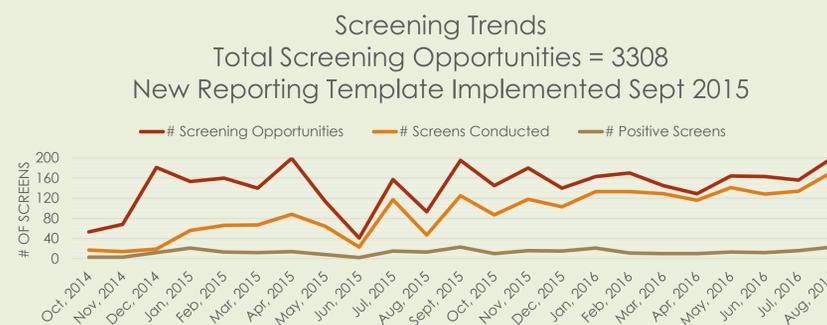


## Program Impact, Outcomes

- **3308** well child checks
- **63.4%** completed screens
- **14.1%** positive screens
- **81%** food security is a health issue and should be asked at doctor appointments
- **88%** were comfortable talking about issue with medical assistant or provider
- Pre-Post provider and staff surveys **showed increased comfort & confidence** in asking about food security and believed these questions belonged in the medical home
- **96** families connected with a community patient navigator

## Challenges

- Inaccurate data pulling from Epic, Providence's Electronic Health Record (EHR) system
- Changes in Epic reporting templates
- Changes in provider and clinic staff workflow
- High staff turnover at the clinics with variable screening rates



## Key Lessons Learned

- ✓ Involve and educate all staff and providers in the clinic for buy-in
- ✓ Have a resource that families screening positive can be referred to and create a way to follow up on the referral
- ✓ Work flows should not be provider dependent
- ✓ Avoid workarounds! Your EMR should be capable to document the screens and the results
- ✓ This is continuous quality improvement, create reports to give monthly feedback to staff on screening rates
- ✓ Keep the reasons you are screening front and center. Share patient stories and invite your resource to present at clinic meetings
- ✓ Be patient. Behavior change takes time. Don't be discouraged by a slow start or periodic drops in screening rates

## Partners

CORE (Center for Outcomes, Research and Evaluation)  
Familias en Acción  
Impact NW  
Project Access Now  
Providence Community Health Division  
Providence Milwaukie Foundation

## Funding

Providence Milwaukie Hospital Foundation and the Meyer Memorial Trust provided the funding for the two year pilot demonstration project.

Using community benefit dollars, Providence contracts with Impact NW to staff Community Resource Desks at key locations across the metro area.

## Contact information

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# When the Prescription is a Kitchen: Community Teaching Kitchen & Outpatient Nutrition Services

Providence Milwaukie Hospital

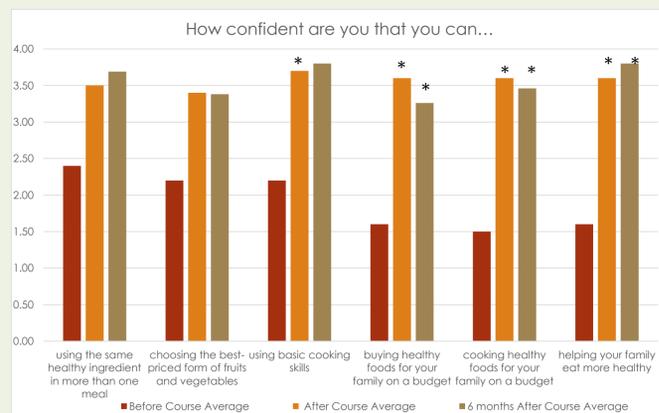
## Project Description

The Community Teaching Kitchen opened its doors in February of 2016 and serves physician referred patients who lack access to healthy foods, suffer from hunger, or need to build healthier eating habits in order to prevail through disease and illness. We work to create a healthier community through;

- One-on-one outpatient nutrition counseling
- Regular screening for food insecurity
- Access to a navigator for individualized resources
- Onsite food pantry
- 6 week hands-on cooking courses, *Cooking Matters*.
- Community classes; nutrition education, food resource management and disease specific

## Program Impact, Outcomes

- 2,400 people screened for food insecurity
- 24,000 lbs. of food donated to nearly 700 families
- 342 people impacted by 11 six week hands-on cooking courses graduated
- 2,398 hours of work completed by 40 volunteers
- Physician referral to classes associated with highest graduation rate for state of Oregon at 96%
- Persistent, statistically significant health behavior change



0= Not confident at all 1 = Not very confident 2 = Neutral 3 = Somewhat confident 4 = Very confident \* = p < 0.05

## Challenges

- Building electronic medical record customizations for screening, documentation and reporting
- Timing of enrollment from referral to classes
- Sustainability of volunteer instructors



## Key Lessons Learned

- ✓ Increase community class offerings to provide range of schedules, language and disease specific accommodations
- ✓ Shorten wait time from point of referral to enrollment in class
- ✓ Offer paid instructor positions
- ✓ Provide flexible, individualized family market visiting hours



## Partners

- AG Specialty Foods
- Bob's Red Mill
- Oregon Food Bank
- OSU Extension Services
- Pacific Foods
- Providence Milwaukie Foundation
- Share our Strength

## Funding

- Juan Young Trust
- Meyer Memorial Trust
- Randall Charitable Trust
- Spirit Mountain Community Fund
- Walmart Foundation



## Contact information

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# THE R.A.P.I.D. PROGRAM

R.A.P.I.D.: Relational health, Academic skills, Psychological Functioning, Intellectual capabilities, & Developmental status

## PRESENTER INFORMATION

Roxanne Edwinston, PhD  
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Freda Bax, PsyD  
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## PARTNER ORGANIZATIONS

Health Share of Oregon (HSO)

Multnomah County Behavioral Health

Department of Human Services (DHS) for Multnomah County

## FUNDING SOURCE

The RAPID project is funding through the HSO's existing Medicaid program. Specific services codes (90791, 96101, 90887, and H2000) are preauthorized. There is a service unit maximum and billing cap-per-child maximum in effect.

## BACKGROUND

**Need for Initial Assessment:** State requirements paired with organizational leadership proclamations require DHS to ensure that all kids over 1 year of age entering their custody receive a mental health assessment within 60 days of their enrollment into care. Additionally, through Oregon legislature and OHA standards, it is the responsibility of the Coordinated Care Organizations (CCOs) to ensure that all children 3+ years entering foster care in the state receive mental health assessments within 60 days of their enrollment into Medicaid.

**Former Standard of Care:** In Multnomah County, the standard was for children to receive a traditional interview-based Mental Health Assessment (MHA) through a community outpatient provider. This process typically relied solely upon an interview with child and caregiver. Standard MHAs included an evaluation of a child's mental health/mental status, conditions present (if applicable), and treatment recommendations for mental health services (if applicable).

## PROJECT DESCRIPTION

MindSights' R.A.P.I.D. Program offers an enhanced mental health evaluation process for youth entering foster care. All youth ages 1-17 years entering custody within District 2 of Oregon are eligible.

**Process:** Interviews with the child and caregiver are conducted as well as psychological testing and relational observations of the child with their caregiver. Testing, child interviews, and observations are conducted over the course of a half-day appointment. Following the appointment, the aim is to have the report completed within 24 hours. A debriefing of results is set for the following week. This debriefing session typically involves the evaluator, DHS caseworker and current caregiver; however, other providers and family

members are welcome to come. Finally, the evaluator completes the Child and Adolescent Needs and Strengths assessment (CANS; the required level of care screening tool for DHS cases), typically on the day of assessment.

**Scope:** A R.A.P.I.D. evaluation involves the assessment of a child's most prominent needs and screening for emotional, behavioral, developmental, and educational issues for which children involved with the child welfare agency are at elevated risk. There are set testing batteries and child-caregiver activities based on the age of child (12-18 months, 18-35 months, 3-5 years, 6-7 years, 8-12 years, 13-16 years, and 17 years). The results are to be used to identify initial service needs and to inform initial Child Welfare case-planning efforts.

**Anticipated Improvement to Care:** Children involved with child protective services are at elevated risk for issues that go beyond a standard assessment of mental health or need for therapeutic intervention. For example, research has outlined risks related to their general development, academic achievement, and relational health. Studies have also shown that the use of well-validated instruments (rather than reliance on clinical judgment alone) greatly increases the likelihood that developmental and behavioral health issues will be accurately identified, and the American Academy of Pediatrics has recommended thorough assessment services for this population. R.A.P.I.D. assessments address these additional risks and include a combination of tools that can more comprehensively inform child welfare case planning, community service referrals, early needs identification, and overall integrated care. Our hope is that providing these enhanced screening assessments at enrollment leads to the following:

- Initiating well-informed services early on in the foster care process,
- Educating a child's child welfare team about various aspects of the child's functioning,
- Requiring fewer children to participate in lengthy comprehensive assessments due to unmet needs,
- Having additional providers (e.g., pediatricians, therapists, and educators) gain access to this data and be keyed into the child's immediate service needs.

## IMPACT/OUTCOMES

From the time the program launched in April 2017 through April of this year, 295 children were referred to the R.A.P.I.D. program. During that same time frame, 250 youth completed a R.A.P.I.D. assessment. Of the remaining 45 referred, 23 children (7.8%) were not assessed due to cancellation or no-shows and the rest had situations that called for the cancellation or disqualification of the referral. In the first year of the program, only 15 R.A.P.I.D. assessed kids had been re-referred for a full psychological assessment.

**Quality Assurance Efforts:** Efforts are in works to collect data that will help answer questions regarding the impact of this process regarding a higher quality of care and receipt of targeted services. This involves data tracking through the clinic as well as data collected through the partnering CCO and local DHS office. The data we track at this time includes basic demographics, assessment dates, debriefing details, placement factors, prior assessments at MindSights, and referrals for a full evaluation; this system will be advanced over time to include more specific screening factors, such as diagnoses and services recommended.

## CHALLENGES

The frequency with which children enrolled in the State Medicaid program get dropped from various CCO enrollment, get re-enrolled in a different CCO, or have a lapse in coverage that may or may not be retro-dated complicates the scheduling process, since billing for this program is specifically supported by and authorized by Health Share alone.

## LESSONS LEARNED

To overcome the previous issues with not achieving assessment within the 60-day window, MindSights employed a specific support staff responsible for moving DHS referrals (which come directly from the branch placement team) through the scheduling process in a timely manner. Dedicated support staff availability is necessary anywhere the R.A.P.I.D. program is implemented.



## ABOUT MINDSIGHTS

MindSights offers a wide array of psychological testing, assessment, and consultation services. We aim to help young people and/or their families gain a much more robust and practical understanding of the unique ways in which any neurodevelopmental, cognitive, emotional, and/or behavioral differences affect a specific individual's adjustment, adaptation, success, and comfort in the world.

516 SE Morrison Street, Suite 400, Portland OR 97214  
(530) 222-0707 [www.mindsightspx.com](http://www.mindsightspx.com)

# Using the Pathways Model to Provide Additional Supports to Children Coming into DHS Custody

## Presenters:

**Suzanne Cross, MPH, CHW**- Senior Project Manager, Columbia Gorge Health Council  
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**Alison Donnelly, RN** - Nurse Home Visitor, Hood River County Health Department  
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**Elke Geiger Towey, MA, MBA** - Practice Coach, Columbia Gorge Coordinated Care Organization, PacificSource elke.towey@pacificsource.com

**Katy Williams, LPN**- Bridges to Health Pathways Program HUB Coordinator, Columbia Gorge Health Council katy@gorgehealthcouncil.org

## Bridges to Health Program Background:



The Bridges to Health Pathway Program has three goals:



- 1) Empowering community members most in need to improve their overall health and well-being
- 2) Assisting clients with access to services and resources by addressing disparities
- 3) Improve integration of services in and out of healthcare

- Ability to address the needs of the **HOUSEHOLD**
- Engaging clients where they are, “no wrong door” approach
- Limit duplication of services
- Build on community strengths and collaboration
- Standard process regardless of agency (CLARA software)
- Data-driven decision making

Community Care Coordinators (CCCs) employed by Community Care Agencies (clinics, health departments, social service agencies) help coordinate needed services for clients & their households. Agencies contract with the HUB to get paid when evidence- based outcomes are met.

CORE PATHWAYS (Needs)	
Behavioral Health	Employment
Developmental Screening	Health Insurance
Developmental Referral	Housing
Education	Medical Home
Family Planning	Medical Referral
Food	Medication
Immunization	Tobacco Cessation
Pregnancy	Postpartum
Social Service Referral (transportation, clothing, legal, etc.)	



## Supports for Children Coming into Custody through Bridges to Health Project Description:

The Columbia Gorge CCO has taken its collaborative energy and systems thinking approach to utilize its local implementation of the Pathways Model, “Bridges to Health (B2H) Pathways” in an effort to help meet the DHS QIM and improve overall support for children and foster families entering into DHS custody system.

The creation of this partnership among the Columbia Gorge Health Council (the B2H HUB), PacificSource Community Solutions, Hood River Health Department (HRPHD), North Central Public Health District (NCPHD) and the Region 9 DHS has allowed us to provide community care coordination services (by CHWs and RNs) to improve care to our communities most vulnerable children.

As part of the Bridges to Health Pathways Program, we have dedicated Community Care Coordinators (CCCs) at NCPHD and HRPHD to support DHS in their guardianship for the children and the related family units – both foster and biological. The CCCs wrap around the child/children and their foster family to help assess and meet their needs throughout their transition. The CCC assists in ensuring that the foster child/children attend the physical, dental and mental health appointments.

The dedicated CCC meets with DHS, CASA, foster parents and children to learn about their needs, connect children to the services and resources and provide feedback to the CCO on where gaps in services exist. Having a robust understanding of the needs of the children and the barriers foster parents face when addressing those needs will provide much needed information for future investments into the community.

## Outcomes:

- 60 children have been enrolled in the DHS B2H program since inception.
- In 2017, the PacificSource Gorge CCO maintained over 90% success rate on the DHS custody metric; the rate in 2016 was 50%.
- Thus far for 2018, PS Gorge CCO has a 100% success rate on the DHS metric.

## Challenges:

- The workflow is complex and involves many individuals from several organizations.
- Communication is challenging – different systems, HIPAA.
- Provider assignments after custody may be different than child’s former medical home.
- Foster parents don’t always have all the medical information they need.
- Staff resources are limited, especially as a rural DHS district.
- Cumbersome enrollment process at DHS causes Medicaid disenrollment and reenrollment.

## Successes:

- Relationships among Health Departments, the Health Council, PacificSource and DHS District 9 have strengthened.
- The team is working on getting DHS District 9 on Reliance HIE system.
- Created a region-specific foster parent letter with foster parent information for primary care clinics.
- DHS agreement allowing CCCs to work on behalf of DHS District 9 with health plan and primary care.
- CCCs are recognized by health plan to be able to assist in provider re-assignment and coordination of care.
- Funding Source: The original funding source of the pilot work came from PacificSource Health Plan as part of the Community Health Excellence grant. The new sustainable model has allowed for CCO funding through health-related services.

## **Improving 2-year-old Immunization Rates in Southwest Oregon (Coos, Curry, and Douglas Counties)**

- **Project description:** Public Health Modernization Grant plan of action is to: Form a Leadership group and an Advisory Group; Share immunization rates; Meet with CCOs in the region; Form a Vaccine Campaign Community Group; Identify at least one strategy to improve rates; Plan to implement the strategy; Implement the strategy and evaluate its effects; Report on the project.
- **Presenter contact information:** Brian Mahoney, MPH; Bailey Burkhalter, MPH; Christin Rutledge, MPH. Douglas Public Health Network, 541-440-3568
- **Impact, outcomes:** Process will be described; tangible developments and learning will be described; project is ongoing; begun in February 2018 and to conclude June 2019. Held a dozen key informant interviews with vaccinators and representative of groups that support vaccination and the health of 2-year olds; participated in several site visits with the AFIX program Health Educator and vaccine providers; identified potential strategies, including getting more vaccine providers into the AFIX program and the VFC program; created new collaborative partnerships; planning commenced for a vaccine training workshop in the region to identify root causes of low immunization rates.
- **Challenges and how you overcame them (if relevant):** Challenges remain. Communication with collaborative partners is mostly asynchronous although there may be an opportunity to convene. Have not selected a key strategy yet, but participating in AFIX seems to be promising. There could be other strategies. Will have the Advisory Group and Leadership Group decide on strategies. Enlisting clinics and other partners to implement and support the project.
- **Lessons learned:** What would you recommend doing the same or differently if this project were replicated elsewhere in Oregon? Identify all the vaccine providers in the area; assess their rates using AFIX; find out what they think would help them improve; help them with any tool or process improvement they select.
- **What organizations were involved:** Ford Family Foundation; United Community Action Network/Child Services; South Central Early Learning Hub; Mercy Medical Center Family Birthplace; Cow Creek Health and Wellness; Umpqua Community Health Center; Lower Umpqua Hospital/Dunes Family Health Clinic; WIC; Umpqua Health Alliance; Healthcare Coalition of Southern Oregon; Perinatal Taskforce; Advanced Health; Dr. DeLeon (pediatrician); South Coast Regional Early Learning Hub; Curry County; Coos County
- **Funding source – How is this project being sustained?** There is no budget outside of the Modernization Grant. However, vaccine providers can participate in the AFIX program at no cost, and the Oregon Immunization Program has its staff in place to support the program.
- **Website address for more information:** <http://douglaspublichealthnetwork.org/>



# A Regional Approach to Address Childhood Immunization Rates: The Central Oregon Immunization Rate Improvement / AFIX Project

## Goal:

Increase immunization rates of Crook, Deschutes, and Jefferson County two-year-olds by implementing the AFIX Program in CCO participating clinics who see two-year-olds and younger.

## Funding Source:

Funding was provided by PacificSource Health Plans (Central Oregon CCO) through Quality Incentive Metric (QIM) performance funds. Project objectives are in alignment with the Childhood Immunization QIM and the \$149,000 budget covers staffing, operational expenses and incentives for the 3 year project duration.

## Common Strategies:

- ◆ Routinely measure rates and share with clinic staff
- ◆ Implement 15 month well-child visit
- ◆ Reminder/Recall – Identify patients due or past due for vaccines and schedule appointments
- ◆ Reschedule “No Shows”
- ◆ Pre-schedule next appointment
- ◆ Data review and clean-up (cross-check Electronic Medical Record with ALERT Registry data, inactivate patients no longer being seen by clinic, enter historical immunizations)

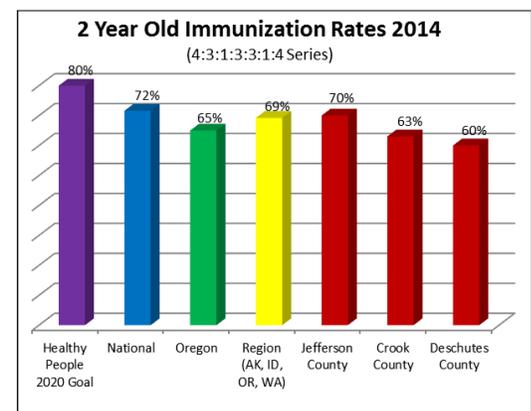
## Project Description

This is a three-year project to increase two-year-old immunization rates at the local level using the Center for Disease Control’s (CDC) AFIX Program in Central Oregon. The project includes all two-year-olds being seen at Oregon Health Plan participating clinics regardless of insurance type.

## Background

In 2014, low two-year-old immunization rates in the Central Oregon Region were designated as a priority for a subcommittee of the Central Oregon Health Council. A workgroup comprised of county health department and clinic staff was assigned to make recommendations to address the low rates and meet the Childhood Immunization Quality Incentive Metric (QIM). The group

recommended implementation of the existing, evidence-based CDC Program called AFIX at the local level. A project proposal was created and submitted to PacificSource for funding. The project was approved and funded in March, 2016.



## What is AFIX?

AFIX is a quality improvement program developed by the CDC to raise immunization coverage levels and improve standards of practice at the provider level.

- **Assessment** of the healthcare provider's vaccination coverage levels and immunization practices. ALERT Registry Assessment Reports were used to gather quantitative data such as the two-year-old immunization rate and percentage of patients meeting age appropriate benchmarks for each vaccine series. A Site Visit Questionnaire was used to gather qualitative data about the clinic’s current policies and practices to support vaccine coverage.
- **Feedback** of results to the clinic along with a facilitated discussion and selection of 2-3 strategies annually to improve processes, immunization practices, and coverage levels.
- **Incentives** to encourage clinic participation, provide immunization education and reward improved performance. Examples include clinical resources, education events, funds for staff to attend immunization trainings and conferences.
- **eXchange** of information with clinics to monitor progress towards quality improvement in immunization services and vaccine coverage levels. Immunization Champions from each clinic attend “Best Practice” Meetings twice annually to share successes, challenges and best practices for quality immunization services.

## Challenges

- Staff turnover is inevitable. When key staff involved in immunization quality improvement leave, someone new needs to be identified, brought up to date and motivated to continue the effort.
- Clinics also have competing priorities. It is important that strategies to improve vaccine coverage be flexible and align with the clinic's broader goals.

## Lessons Learned

- Immunization rates decreased across all clinics during the second year of a child's life. Clinics that implemented a 15 month well-child visit saw improvement in the 24 month up-to-date rate.
- There are many opportunities for better data, i.e. historical immunization entry, accurate patient lists, correct addresses.
- On-going education makes a difference in keeping immunizations a priority for clinics!

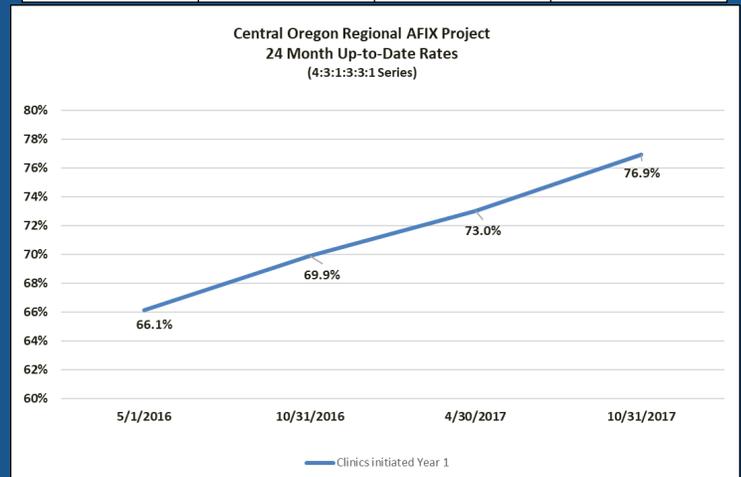
## Results to Date

**10.8% increase in 24 month old up-to-date rate across participating clinics**

- 24 month old UTD rate increase from 66.1% to 76.9% in 18 months
- 14 clinics across the Central Oregon Region implementing strategies to improve immunization coverage
- Improved partnerships
- CCO policy change to reimburse for 15 month well-child visit
- Most clinics now doing 15 month well-child visit

## Compiled Data from ALERTiis Assessments

Date	24 Month UTD Rate (4:3:1:3:3:1 Series)	% Increase Last 6 Months	% Increase Since Baseline
5/1/16 (Baseline)	66.1%	N/A	N/A
10/31/16	69.9%	3.8%	3.8%
4/30/17	73.0%	3.1%	6.9%
10/31/17	76.9%	3.9%	10.8%



## Next Steps

Participating clinics are reviewing data and selecting strategies for the final year of the project. The project team will begin to plan for sustaining and improving upon the positive results so far once the project comes to an end in Spring, 2019. Best Practice Meetings will likely continue for education, motivation, accountability and support.

## Partnerships

**Presenter:**  
**Jill Johnson, RN BSN MEM**  
 AFIX Project Coordinator  
 Deschutes County Health Services  
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# Back to Basics

## Prevention



### Project Description

- In 2005, a task force of Mercy Foundation board members identified significant disparities in children's health. They heard from school administrators reporting that increased number of under-served, low-income children were coming to school without basic knowledge and skills regarding personal hygiene, communicable disease prevention, nutrition and physical activity, as well as having unmet medical and dental needs. Many of these issues stemmed from poverty, limited access to medical and dental care and a wariness of reaching out to social service programs. To help meet the needs of Douglas County children, the Healthy Kids Outreach Program (HKOP) was formed.

- HKOP's team of school nurses, nutrition education specialists, dental specialists, outreach coordinator, hygienists and dental assistants are providing on-site health education, connection to care and preventative oral health services that are improving the health of Douglas County children.

- **Healthy Kids Outreach Program Rural Dental Health Initiative** HKOP's presence in the schools showed that children were reporting tooth pain as the third most prevalent health problem, following colds and flu. While Health Resource RNs were providing health education, children clearly needed more oral health services. In 2010, Mercy Foundation expanded services to provide oral health care and education through on-site, school-based dental clinics.

- HKOP's dental clinics include complete dental assessments; fluoride varnishes and sealants for untreated, erupted molars; oral health education; take home dental kits; and treatment coordination. This school-based dental program has reduced dental cavities in children by an average of 10% each year.

- Since inception, 32,000 Douglas County students have received preventative dental services. The return on an investment of \$800,000 has provided \$3 million in dental care back to the children in our County. The number of emergency room visits in children under the age of 12 for dental problems has been reduced by 63%.

- To encourage oral hygiene, HKOP's Dental Learning Lab expanded opportunities for students to learn the "how" and "why" of dental care through interactive grade-specific learning modules. Currently, 75% of Oregon's dental programs funded through Oregon Community Foundation's Rural Dental Health Initiative are now using HKOP's curriculum. Demand for the methods has led to the development of a Train-the-Trainer program where instructors have been trained in 19 Oregon counties.

- School-based clinics and health services support our working families by reducing or eliminating the need for a parent to take time off work for dental or medical appointments. A family may have insurance coverage, but has a job without paid leave. Unpaid time off means a direct loss of income along with the added expense of a co-pay. Two thirds of the students we screen through HKOP are dependent upon the Oregon Health Plan (OHP), or are uninsured; only one third have private insurance.

- Since our humble beginnings in 2006, we have now grown our prevention services to include classroom-based health awareness education, nutrition/physical activity in the classroom, violence prevention support, school based dental program, parent education, and community connection for service homes. We also collaborate with multiple community partners to extend our reach with preventative care in our community.

### Presenter Contact Information

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HKOP Program Manager  
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## Impact & Outcomes

- Program Impacts
  - Close to 10,000 children have been screened at 29 schools throughout Douglas County
  - 7500 students have participated in our dental learning labs at 34 schools
  - Reduced dental caries by 10%
  - Reduced dental ER visits by 63% in 12 and under
  - Average school dental return consent form rate above 75%
  - Robert Wood Johnson Foundation identified School based dental prevention programs along with nutrition/physical activity classroom education as action items to decrease disparities and improve health outcomes within communities.
  - Working with local providers to ensure families with all Medicaid eligible children are connected to a dental provider.
  - Collaborate with state-wide oral health coalitions to develop policy recommendations to address oral health issues.
  - Conduct Dental Learning labs and educational outreach to parents and children at various community events and schools to promote oral health literacy.

### THE SPECTRUM OF PREVENTION



## Challenges

- Our challenges first came with building trust with our school partners. They had seen many programs come and go offering services then leaving a gap when the program was unable to sustain funding. We worked with families to help break down barriers, including helping solve transportation issues by providing fuel vouchers, assisting with access to care by triaging with local urgent cares and helping get appointments with dental providers and more oral health services. In 2010, Mercy Foundation expanded services to provide oral health care and education through on-site, school-based dental clinics.

## Lessons Learned

Now that there are CCO's in place, we would work within our County cultures by including our CCO to ensure:

- a. funding is available;
- b. resources are available for families to refer to;
- c. build a data collection system so we can share information with CCO providers to increase connection to care and establish dental homes for mutual clients

## What Organizations were involved

- Advantage Dental, Oregon Community Foundation, Ford Family Foundation, Umpqua Community Health Center, Oregon Health Authority, Oregon Dept. of Education, Douglas County ESD and 13 School Districts

## Funding source – How is this project being sustained?

- HKOP is funded by support from Mercy Foundation Endowment, Mercy Medical Center, private grants, community fundraising, events/appeals and donors.

## Website address for more information

[www.mercygiving.org](http://www.mercygiving.org)



# Integrating Oral Health into Well Child Visits

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## Cross-Organizational Oral Health Integration Initiative

Increase the number of children ages 0-5 with an oral health intervention in the primary care or dental setting by 5% over baseline.

## CareOregon’s strategy: Enhanced First Tooth

Oregon’s early childhood caries prevention program integrates oral health services into existing medical services. CareOregon primary care and dental practice coaches partner to provide site specific planning, training, and technical assistance for program implementation and sustainability.



## Cross Organization Total

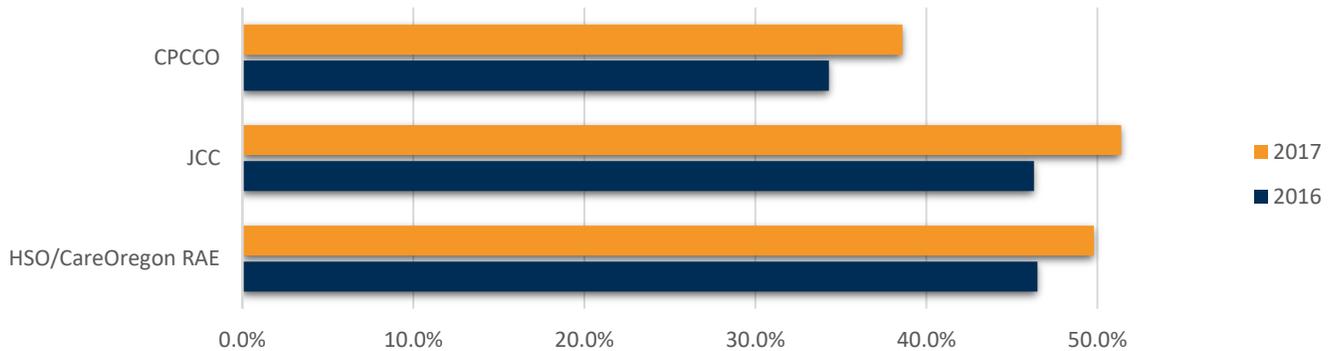
**48.4%**

**2017**

**44.8%**

**2016**

% 0-5 year old members with an oral health intervention



## Key components for successful integration

- ✓ Engaged Executive and Clinical Leadership
- ✓ Organizational Goals
- ✓ CCO Regional First Tooth Strategy Development
- ✓ Integration Begins Internally: bidirectional upskilling of CareOregon’s practice coaches
- ✓ Navigational tools- Ability to request dental services in the medical provider portal
- ✓ First Tooth Enhanced Implementation program
  - Site readiness assessment
  - Workflow development
  - Data informed program sustainability
  - Post-training support and feedback of implementation
  - Funding source: reimbursable codes D0191, D1206/CPT99188

Lessons Learned

Systems: Successful implementation of First Tooth is driven by the organization’s set expectation, associated goals, and performance measurement.

Programs: CareOregon developed an expanded First Tooth toolkit to addresses key program components prior to the site-specific training:

- Site readiness assessment
- Action plan
- First Tooth implementation checklist

Sample site readiness assessment prior to First Tooth training

<b>What’s Your First Tooth Readiness?</b>	Yes	No	Not Sure
<b>Oral Health Awareness</b>			
Are there oral health prompts during visits?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Staff support oral health integration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is an oral health champion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Workforce Capacity</b>			
Leadership supports all-staff involvement in new initiatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providers want to prioritize oral health integration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The clinic utilizes data driven reports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Workflows</b>			
The clinic has a dental referral process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral health services are documented in the EHR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The billing/coding department allows dental codes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



# Medical Home for Children in Foster Care

Randall Children’s Clinic—Legacy Emanuel, Portland, Oregon



## Presenter Information:

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## Partner Organizations:

**Health Share of Oregon**, a local coordinated care organization (CCO) serving Oregon Health Plan members in Clackamas, Multnomah and Washington counties

**CareOregon**, Oregon Health Plan managed health care company providing health plan services to four CCO’s

## Funding Sources:

Funding has been provided through grants from the Portland Children’s Levy, CareOregon, Health Share of Oregon and FamilyCare. We are currently funded through a grant provided by Health Share.

## Purpose:

The purpose of our program is to provide dedicated care coordination for children entering foster care and to address gaps in services and supports in order to improve utilization of healthcare resources in this high-risk patient population. An additional aim is to build support services for foster parents and biological parents to assist with the stabilization and the transition of children between homes.

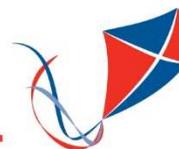
## Background:

The American Academy of Pediatrics (AAP) has found that children and adolescents in foster care have a high prevalence of chronic medical, dental, mental health and developmental issues. A significant percentage of children enter foster care as a result of child abuse or neglect, which frequently includes neglect of a child’s health needs. Children often enter foster care with incomplete or missing documentation of prior health care, including immunizations, medications, allergies, and prior diagnoses. These children have often experienced episodic, fragmented and inadequate health care prior to entering foster care. In addition, studies have shown a link between childhood exposure to trauma and an increase in the physical, mental and social pathologies of adults.

The AAP has published standards for health care for children and teens in foster care. These standards are designed to help professionals from all disciplines understand the complexity of health problems and the quality-of-care issues that arise in foster care.

Randall Children’s Clinic (RCC) historically has had a large number of children in Foster Care who receive primary care at our clinic. Our pediatricians began to recognize that this high-risk population of children often present with barriers to care and gaps in service. We also recognized an opportunity to intervene to aid in prevention of long-term effects.

In 2009, with support from the Portland Children’s Levy, RCC created a formal program for children in foster care with enhanced care management support to intervene on behalf of children who experience gaps in service, barriers to care and are at high risk for long term effects.



**RANDALL CHILDREN’S HOSPITAL**  
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[www.legacyhealth.org/kidsonly](http://www.legacyhealth.org/kidsonly)

## Program Components:

- Coordination of Care
- Track, Monitor and Follow-up on Preventative Care, Immunizations, Screenings, Referrals and ED Utilization
- Transition Support
- Co-Located Mental Health Services
- Education and Support for Foster Parents

## Outcomes:

The Randall Children's Clinic Medical Home Program for Children in Foster Care has worked to achieve:

- Improved clinical care
- Improved access to care
- Improved collaboration with DHS and community providers
- A high level of satisfaction as expressed by foster parents and caseworkers
- Improved utilization of preventive and referral services, and decreased utilization of more expensive emergency and hospital admissions

63 foster parents have completed our Trauma Workshop "Caring for Children Who Have Experienced Trauma"



## Randall Children's Foster Care Medical Home Outcome Data 2009-2014:

Data 2009 - 2014	Foster Children in Coordination Program (190)	Foster Children not in Program (191)
% Well Visits Completed	76%	58%
% Vaccines Current	73%	67%
% Developmental Screenings Completed	57%	31%
% Referrals Completed	68%	45%
Avg # of ED Visits per Child	0.59	2.39
Avg # of Hospital Admissions per Child	0.036	0.505

## FamilyCare Data January 1, 2016 through December 31, 2016:

Metrics	Number In of Foster Children	AWC Rate	Dev Screen Rate	Childhood Immunization Status Rate
Randall's Foster Care Program	106	50%	100%	100%
All other Foster Children	1,457	55%	69%	74%
<b>Utilization</b>				
	Ave. # of Days per Admission	IP per 1000	Ave. # of ED Visits per Child	ED Utilization per 1000
Randall's Foster Care Program- All	3.40	5.4	0.30	34.5
* Randall's Foster Care Program without BRS	NA	NA	0.21	22.7
All other Foster Children	4.59	4.3	0.30	37.1

\* Patients placed in Behavioral Rehabilitation Services (BRS) residential programs have higher behavioral and psychosocial needs. We have seen this patient population have a higher emergency department utilization

## Conclusion:

By recognizing a need, following the guidelines set forth by the AAP, and implementing a dedicated care management program, Randall Children's Clinic has shown improvement in the health and well-being of children in foster care through the provision of high quality, coordinated primary care.



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# 2018 Innovation Café Planning Committee

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2018 Innovation Café: Strategies for Improving Children’s Health

My Action Plan

Project/topic I learned about today	My questions or next steps for follow-up

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