



Umpqua Health Alliance

AN ARCHITRAVE HEALTHCARE SERVICE

Caring for our community

Community Health Improvement Plan

Progress Report

June 2016

BACKGROUND

In 2012 and 2013, Umpqua Health Alliance (UHA) and Douglas County Public Health (DCPH) sponsored the 2013 Douglas County Community Health Assessment (CHA), which was released in the fall of 2013. The Douglas County Community Health Improvement Plan (CHIP), based on the CHA, was released in June 2014. The CHIP is a plan that resulted from an attempt to make sense of the data included in the CHA and prioritize issues that community organizations feel are important to address in Douglas County. Strategies were then chosen from community input and based on the [Core Planning Principles](#) (Appendix A) and values of the Community Advisory Council (CAC), Umpqua Health Alliance and Douglas County Public Health. The 2014 Douglas County CHIP represents the first time the Douglas County community has crafted a Community Health Improvement Plan and embodies the collaborative principles of active community collaboration.

COLLABORATION & KEY PLAYERS

The UHA CAC membership has contributed efforts toward activities that support identified focus areas. Partnership and collaboration on CHIP activities has included representation of local physical and oral health providers, the public health authority, mental health authority, domestic violence prevention agency, addiction treatment and prevention provider, early learning council, first responders, Department of Human Services, teachers, librarians, and local citizens.

2014 CHIP HIGH LEVEL STRATEGIES MAP:

| Community Health Improvement Plan (CHIP) <i>2014 High Level Strategies Map</i> | |
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| Access <i>Provider recruitment and retention</i> Increase understanding of new providers about UHA model of care <i>Transportation</i> Non-emergent medical transportation group to increase access and coordination <i>OHP Member Engagement</i> Expanded care clinic to improve coordination of care for Members with severe and persistent mental illness, develop strategies to enhance Member engagement for implementation in 2015 | |
| Addictions <i>Tobacco Free Policy Change</i> Advocate for increased number of tobacco-free environments in Douglas County <i>Tobacco Cessation</i> Explore expansion of tobacco cessation benefit for OHP Members <i>Prescription drug misuse/abuse</i> Provider training and support: prescribing utilization | Mental Health <i>Mental Health Services</i> Identify opportunities for CHIP strategies in 2015 <i>Diversion</i> Explore opportunities to collaborate in the development of a local Mental Health Court |
| Parents & Children <i>Well Child Visits</i> Provide health related reading materials at well child visits to encourage parent to child reading <i>Early Learning Hub</i> Collaborate with Early Learning Hub to incentivize parents to complete voluntary child assessments and increase the number of at-risk children getting services <i>Adverse Childhood Experiences (ACEs)</i> Increase CAC and provider awareness of ACEs research | Healthy Lifestyles <i>Kick Start Douglas County</i> Sponsor and promote 100 Healthy Lifestyle events summer of 2014 <i>Worksite Wellness</i> Support comprehensive worksite wellness initiatives addressing healthy food, physical activity and tobacco-free environments <i>Community Gardens & Farmers Market Promotion</i> Identify opportunities for promotion to OHP Members |

HIGH LEVEL STRATEGIES PROGRESS:

The strategies and activities directed toward improvement in these focus areas since the last UHA CHIP Progress Report (June of 2015) include:

| Priority Heath Issue | High Level Strategy | Objectives/Tasks | Activities |
|---|----------------------------------|--|---|
| Improve Access to Health Care Services | | | |
| Access | Provider Recruitment & Retention | Provide tools and resources about the UHA model of care to recruit and retain providers and to increase access to providers accepting Oregon Health Plan Members | <p>Since June 2015, UHA has made significant efforts to continue the expansion and growth of the UHA provider network. The following describes the number of providers who have been added to the panel since June of 2015:</p> <p>Primary Care Physicians: 11 Specialists: 23 Mental Health Providers: 21</p> <p>Network providers receive key health update information from UHA as well as a quarterly newsletter that provides links to resources and information about the UHA model of care and tools to assist them with patient care. Oregon Health Authority (OHA) communication of the OHP renewal and closure updates are sent to provider staff.</p> <p>UHA will continue to expand and distribute available resources to providers to help retain and recruit providers who accept OPH patients.</p> |
| | Transportation | Convene non-emergent medical transportation (NEMT) workgroup to increase access and coordination of transportation in Douglas County | UHA has contracted with Bay Cities Brokerage to provide Non-Emergent Medical Transportation services to UHA members. Service began on October 1, 2015. Since beginning service, over 23,000 rides have been provided. Members may schedule rides to the pharmacy, medical appointments, alcohol and drug treatment, and mental health services. Bay Cities Brokerage has provided excellent customer service with a satisfaction rating of 97.6%. |
| | OHP Member Engagement | Expanded care clinic (ECC) to improve | Expanded Care Clinic – The Expanded Care Clinic model was attempted at two |

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| | | <p>coordination of care for Members with severe and persistent mental illness, develop strategies to enhance Member engagement for implementation in 2015</p> | <p>primary care clinics who serve a significant portion of UHA members. Due to burn out, a smaller than expected number of positive outcomes, and other factors, the ECC clinics were unsuccessful. The model may be revisited in the future, but has been deemed ineffective and unsustainable at this time.</p> <p>Community Care Transitions Team - A Community Care Transitions Team has been established and located inside of the hospital to assist UHA members with navigating the healthcare system, discharge instructions, follow up appointments, and prescription information. The team works to communicate with UHA members and assist them in the transition between the ED/inpatient services and outpatient services.</p> <p>Palliative Care - A Palliative Care Nurse, working for Architrave, helps to assist members of the community who may need assistance with comfort care, POLST forms, and general healthcare navigation assistance. The Palliative Care Nurse serves both UHA members and all other insurance groups. Her services are free to the community. The Palliative Care Nurse at Architrave also works closely with the hospital's Palliative Care department to help in the transition of care.</p> <p>Member Services - UHA chose to move member services back in house allowing for better coordination of member assistance, more efficient communication between member services, prior authorizations, care management, and all other departments. The move has made the service more effective and easier to navigate for UHA members. Member Services is playing an active role in</p> |
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| | | | <p>member engagement efforts.</p> <p>CAC Recruitment – The UHA CAC has committed focused efforts to recruit more CCO or OHP membership (or parents/guardians of members). To accomplish this, the CAC worked with community collaborators to find CCO or OHP members or parents/guardians of members who are active with our community partners. Since our partners work directly with the members, they were able to refer many OHP/CCO members/parents/guardians of members for CAC membership. UHA is also working towards providing resources to the UHA CAC members to help with things like transportation, child care, etc. to help encourage continued engagement and ease any obstacles that may prevent members from continuing to attend and be active CAC members.</p> <p>Member Newsletter – UHA publishes a quarterly newsletter for members. This newsletter can consist of healthy living tips, health education articles, healthy recipes, CCO benefit changes/additions, member services contact information, and other resources that CCO members may find helpful. This newsletter is distributed in hard copy to physician offices, email, on the UHA website, and is shared on social media (Facebook).</p> <p>Health Information Alerts – UHA periodically sends members email alerts with pertinent health information, important information about their benefits or provides information on programs and resources available to the members.</p> | | |
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| Priority Heath Issue | High Level Strategy | Objectives/Tasks | Activities |
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| Reduce Number of Individuals Addicted to Alcohol, Tobacco and Other Drugs | | | |
| Addictions | Tobacco Free Environments | Advocate for increased number of tobacco-free environments in Douglas County | UHA continues to support efforts by various organizations to create more tobacco free environments in Douglas County. Harvard Medical Park, where UHA is located, and other complexes in Douglas County have adopted a Tobacco Free Policy. The CAC continues to promote the implementation of Tobacco Free Environments and plans to continue this work in 2016/17. Adapt, a UHA collaborator, has worked with Coca-Cola to provide technical assistance on new signage with respect to the revised Indoor Clean Air Act. The following entities have been new additions to the Tobacco Free campuses since July of 2015: City of Roseburg Parks (updated to include inhalant delivery systems) and Casa de Belen. Adapt also provided policy technical assistance to the cities of Winston and Reedsport on the Tobacco Free efforts. Adapt provided consultation services with the County Human Resources director, Risk Manager to assess readiness and approach to advance tobacco-free policy covering library and courthouse complexes as well as provided technical assistance to Douglas County Wellness Committee on adoption of tobacco-free campus policies. |
| | Tobacco Cessation | Explore expansion of tobacco cessation benefit for OHP Members | Adapt, UHA and the CAC have worked together to develop, promote and execute an extensive program for smoking cessation. Adapt now offers the Mayo Clinic's evidence-based tobacco cessation program. In 2015, Adapt offered 8 one hour information motivation sessions to raise awareness about available services and readiness to quit and/or participate in one-on-one counseling. Adapt conducted extensive |

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| | | | <p>outreach through various media channels with the assistance of UHA and the CAC and other local organizations, one-on-one counseling at Adapt, provided a voucher for two weeks' worth of tobacco replacement therapy and 3 two-hour intensive tobacco cessation group seminars. In total the 2015 tobacco cessation program served over 180 individuals. In 2016, Adapt is continuing to offer their program to the community with 7 four week sessions and continued one-on-one counseling services at no cost to the participant.</p> <p>www.adaptoregon.org/quitnow</p> <p>UHA and the CAC have supported and assisted with the promotion of several other local tobacco cessation efforts put on by other community collaborators.</p> <p>In addition to the Adapt program, UHA is now pleased to offer coverage for both Nicotine Patches and Nicotine Gum without prior authorization for up to two quit attempts each year to UHA members.</p> |
| | <p>Prescription drug misuse/abuse</p> | <p>Provider training and support for prescribing utilization</p> | <p>UHA has been focused on the issue of prescription drug misuse and abuse since its inception. Since June of 2015, UHA has continued its education of providers and members on the dangers of prescription drug misuse/abuse. UHA has lowered its total morphine equivalents coverage from 120mg/day to 90mg/day for chronic therapy and has begun reviewing utilization reports on anyone who is receiving greater than 90 mg of morphine equivalents per day. UHA is working to meet with prescribers who have been identified as outliers in the amounts of morphine equivalents prescribed and are working with any provider who is an outlier to assist in tapering their patients down to appropriate doses.</p> |

| Priority Heath Issue | High Level Strategy | Objectives/Tasks | Activities |
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| Increase Integration of Services for Severe and Persistent Mentally Ill | | | |
| Mental Health | Diversion | Explore opportunities to collaborate in the development of a local Mental Health Court | UHA and the CAC have received information and presentations about Diversion programs and have looked for ways to collaborate on the development of a local Mental Health Court. There has been some funding provided for housing relative to this effort. UHA will consider opportunities to collaborate on this effort in the future, however, this project has been set aside at this juncture. |
| | Mental Health Integration | Identify future opportunities for CHIP to support mental health integration in 2015 | <p>Since June of 2015, UHA has continued to work to expand the mental health panel to increase access and capacity for UHA assigned OHP members. Since June of 2015, UHA has credentialed and contracted with 21 new mental health providers. UHA also works to publish a weekly “stop light” matrix that describes the UHA mental health panel, each of their specialties or areas of focus, and their ability to accept new UHA members. The matrix is distributed to UHA’s member services as well as many key providers and collaborators in the community.</p> <p>Currently four primary care clinics have in house mental health providers. These clinics are responsible for a significant percentage of the UHA assigned OHP membership. This mental health integration into primary care practices has made the transition of care between primary care to mental health services easier for members to navigate.</p> <p>In an effort to help those in need after the UCC Tragedy, UHA worked very closely with State Emergency Registry of Volunteers in Oregon (SERV-OR) to establish a mental health clinic</p> |

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| | | | <p>specifically for those who were affected by the UCC shooting (students, faculty, first responders, family of victims and students, and any other affected individuals). UHA established a location, provided IT infrastructure, and staffed the mental health clinic to help SERV-OR with scheduling, outreach, and any other administrative needs. UHA also established the 4UCC phone number; a phone line that rang directly to member services and bypassed the normal process to expedite assistance to those in need. UHA worked with countless other local healthcare and other organizations to support those affected by the tragedy. UHA continues to provide the 4UCC phone line and will continue to be supportive to UCC and the community.</p> |
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| Priority Health Issue | High Level Strategy | Objectives/Tasks | Activities |
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| Increase Access to Physical Activity and Healthy Food Choices | | | |
| Healthy Lifestyles | Kick Start Douglas County | Sponsor and promote 100 healthy lifestyle events | Kick Start Douglas County – UHA has chosen to continue offering the Kick Start Douglas County program in collaboration with the Roseburg YMCA, South County YMCA, Roseburg Parks and Recreation, CHI Mercy Health, Boys and Girls Club, and many other organizations in our community. The program was a success in 2014 and 2015 offering over 300 events each year. This year, Kick Start will again have a wide variety of active living events in various locations across the county and at various days and times. Kick Start includes events such as: Zumba in the Park, Yoga in the Park, 5k Fun Runs, Healthy Cooking and Shopping Classes, Health Fairs, Tai Chi, Walk with a Doc, Golf, Swimming, and more. The 2016 Kick Off Event was successful with an estimated 140 participants. Events run |

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| | | | <p>from June 1st through August 31st with the wrap up event at the end of September. Events are free or low cost to anyone in the community. Health surveys will be conducted at several of the Kick Start events to collect information on how the program is positively impacting lives in Douglas County.</p> <p>Healthy Living Challenge – In conjunction with Kick Start Douglas County, UHA works with the Roseburg YMCA to provide a 12 week exercise and healthy living program for UHA members. UHA has held two challenges since 2014 and plans to hold a third in 2016. The program is a doctor referred program to UHA members who are interested in and would benefit from exercise. The 12 week program includes full access to the YMCA facilities, health coaches, healthy eating and nutrition classes, and shopping tours to help participants purchase healthier foods. The program allows for up to 80 participants at no cost to them.</p> |
| | Worksite Wellness | Support comprehensive worksite wellness initiatives addressing healthy food, physical activity and tobacco-free environments | <p>UHA and Architrave have established an extensive worksite wellness plan within our company. Architrave encourages healthy eating, active lifestyles, and provides many health events and opportunities to improve the health of its employees. The wellness program has included many events since June of 2015. Some of these programs include: free registration to various fun run events (1m, 5k, etc.), fit bit walking challenges, weight watchers, cross fix demos, bod pod challenges, comprehensive blood testing, and more. Architrave is also located on a tobacco free campus. Architrave, UHA and the CAC encourage other organizations in Douglas County to establish similar programs for their employees. The CAC is currently considering project proposals for</p> |

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| | | | worksite wellness in 2016. |
| | Community Gardens Farmers Markets Promotion | Identify opportunities for promotion to OHP members (e.g., food stamp accessibility) | The CAC and UHA have continued their promotion of both community gardens and farmers markets on the UHA website, as well as other outreach tools like the member newsletter and monthly Ask a Health Question article published in the newspaper. The CAC is considering projects to continue the previous SNAP benefit match at farmers markets and explore ways to better support both community efforts. |

| Priority Health Issue | High Level Strategy | Objectives/Tasks | Activities |
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| Parents & Children | Improve Outcomes for Children by Investing Early and Addressing Core Risk Factors for Health | | |
| | Well Child Visits | Improve kindergarten readiness by promotion of parent-child reading at well child visits | The CAC continues to look for opportunities to work with the Early Learning Hub, Head Start and other programs to encourage early childhood reading and improve kindergarten readiness. One of the primary care clinics who serve primarily UHA members attended the Celebrate Children Event to promote health and wellness to parents and children as well as inform parents on the importance of child wellness exams. |
| | Early Learning Hub | Collaborate with Early Learning Hub to incentivize parents to complete voluntary child assessments and increase the number of at-risk children getting services | CAC champions are working closely with the South Central Oregon Early Learning Hub to identify opportunities to distribute developmental screening tools to parents and to support opportunities for engaging families in the process for developmental promotion. |

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| | Adverse Child Events (ACEs) | Identify opportunities for promotion to UHA Members | <p>The CAC received a presentation on the research and health implications of Adverse Childhood Experiences (ACEs).</p> <p>UHA is collaborating with our local violence prevention organization, who was awarded a Northwest Health Foundation community-planning grant to develop strategies to integrate ACEs and trauma-informed care across sectors and increase protective factors and resiliency in the community.</p> <p>CAC members participated in and facilitated two ACE presentations and a consumer focus group.</p> |
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Appendix A

Core Planning Principles

- Based on 2013 Community Health Assessment
- Cost effective strategies that leverage local assets and resources
- Creates positive, measurable change in individuals and community
- Coordinated with efforts that are already successful in Douglas County
- Evidence-informed
- Population-specific strategies, addressing health disparities
- Meets Oregon Health Authority and Public Health Accreditation rules and mandates
- Strategies established on a 1-3 year time line

The purpose of the CHIP is to outline strategies and metrics that support improved health of individuals and the community.





June 30, 2016

Oregon Health Authority
Health Systems Division

**RE: CCO Community Health Improvement Plan Progress Report
Response to Supplemental Questions**

OVERVIEW

In addition to the attached UHA CHIP Progress Report, below are the responses to OHA Health Systems Division's additional questions as requested in the CCO Community Health Improvement Plan Progress Report Guidance document.

KEY PLAYERS

1. Which of the following key players are involved in implementing your CHP? (select all that apply)

A: The Early Learning Hub has been a key player in the UHA Community Health Improvement Plan. Several members on the CAC are members of the Early Learning Hub.

2. Describe how these key players in the CCO's service area are involved in implementing your CHP.

A: Representatives of the Early Learning Hub are members of our Community Advisory Council. The CAC's main responsibility is the implementation of the CHIP.

UHA also works with Umpqua Community Health Center who provides the services at the school based health centers in Douglas County.

3. If applicable, identify where the gaps are in making connections.

A: UHA and the CAC will continue to look for more opportunities to work more closely with the Early Learning Hub, school based health centers, and others to expand and deepen our working relationship and collaboration with these entities.

HEALTH PRIORITIES AND ACTIVITIES

4. For CHP priorities related to children or adolescents (prenatal to age 24), describe how and whether the CHP activities improve the coordination of effective and efficient delivery of health care to children and adolescents in the community.

A: UHA and the CAC work to establish programs and outreach to educate the members and parents/guardians of members on the importance of child and adolescent well-care visits along with encouragement for healthy relationships between parents/guardians and children. The outreach and education materials help encourage the coordinator of



effective and efficient delivery of health care to children and adolescents in the community. The CAC is also working with Battered Persons Advocacy to implement Adverse Childhood Experiences Science (ACEs) and Trauma Informed Care (TIC) practices and awareness across all sectors.

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

A: UHA and the CAC have done extensive outreach and education of the community. Some of these efforts include: outreach in the form of emails, print, and other medias on child and adolescent well care visits, education on childhood diseases and prevention of those diseases, information on required and recommended vaccinations in cooperation with Public Health, the schools, and physicians to inform parents/guardians about the importance of vaccinations and where to get the vaccinations done, support of the local Celebrate Children event, training and education across all sectors on Adverse Childhood Experience Science and Trauma Informed Care, education on child and adolescent oral health needs with our dental services provider, among other projects. Adapt, UHA and the CAC worked to establish a tobacco cessation program that is continuing in 2016 that serves adolescents between the age of 18 and 21.

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

A: UHA and the CAC works with Public Health and schools, the Early Learning Hub and child and adolescent primary care doctors to connect to the child and adolescent population and their parents/guardians to encourage and educate the UHA members and the community on the importance of healthy living habits and health and wellness exams. In addition, many members of the CAC are also part of the Early Learning Hub.

HEALTH DISPARITIES

7. For each chosen CHP priority, describe how the CCO and/or CAC(s) have worked with OHA's Office of Equity and Inclusion (OEI) to obtain updated data for different populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data.

A: Because of low racial and ethnic diversity in Douglas County, UHA and the CAC have been focused on the culture of poverty as our Community Health Needs Assessment indicated this issue outweighed the issue of racial and ethnic effect on health of the community. Douglas County/UHA's service area has a high occurrence and issue with generational poverty and the health disparities related to the socio-economic factors related to it. UHA works to provide trainings and education on the culture of poverty and explore ways to mitigate issues related to it among other efforts to encourage healthier lifestyles, access to healthy food, and transportation and/or access to healthcare in the outlying areas. In addition, UHA is working with the Early Learning Hub to share data relative to race and ethnicity.



8. Explain whether updated data was obtained by working with other state or local agencies/organization(s) and what data sources were utilized.

A: UHA continues to monitor health disparities and prevalence of specific issues like food or housing in our members in clinical practice and working with our local government and public health agencies. In addition, UHA is working with the Early Learning Hub to share data relative to race and ethnicity.

9. Explain CCO attempts to compare local population data to CCO member data or state data. If data is not available, the CCO may choose to access qualitative data from special populations via focus groups, interviews, etc.

A: UHA and the CAC have worked with focus groups and interviewed members to determine what the barriers to care, health and wellbeing are for the UHA population. UHA has established several efforts to help mitigate barriers to accessing care and educate members on healthy living. In addition, UHA is working with the Early Learning Hub to share data relative to race and ethnicity.

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

A: The largest challenge presented in accessing health disparities data is engaging members in their own healthcare and making connection with members and the community who would benefit from assistance from the CCO.

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

A: UHA has contracted with Bay Cities Brokerage to provide non-emergent medical transportation to overcome the transportation issue as it relates to accessing care. The CAC has also worked with farmer's markets and community garden projects to create a larger awareness of healthy eating and access to healthy foods. Some other projects include: the Community Care Transitions Team, a Palliative Care Nurse, intensive case management and patient advocacy, implementation of the Kick Start Douglas County and Healthy Living Challenge for access to healthy exercise, CAC meetings in rural areas, and others.

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

A: The CAC has made the inclusion of individuals from populations experiencing health disparities a priority through working to recruit as many OHP members and/or parents and guardians of members to become part of the CAC. The CAC has interviewed several individuals from this population to determine what the barriers are to participation in the CAC. UHA and the CAC are establishing several programs to overcome participation barriers related to transportation, child care, and time. The CAC is mindful of decisions



made relative to process and meeting format to encourage OHP member, member parent/guardian participation.

ALIGNMENT, QUALITY IMPROVEMENT, INTEGRATION

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

A: UHA encourages and works towards integration of services. In addition to the Community Care Transitions Team, Palliative Care, and case management, several large UHA providers have implemented integrated mental health services within their clinic. In addition, UHA has established a large expanded panel of mental health providers. Each week, UHA published a report to key providers and physicians in the community to describe the mental health provider panel, their specialties and their availability to take on new members. The CAC is also working to implement ACEs and TIC across all sectors.

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

A: Many of the goals in the Community Health Improvement Plan are similar to or correlate with goals and priorities in the Transformation Plan, Quality Improvement Plan and/or Performance Improvement Projects. One example is that the CHIP has a focus area working to prevent prescription drug misuse/abuse. One Performance Improvement Project aligns with this effort. All of these plans include aspects of integration of care and care coordination. Staff working on these reports and efforts and the CAC work together to ensure coordinated efforts towards common goals so as to ensure efficient and effective programs as well as elimination of duplicating efforts.

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

A: UHA and the CAC have worked on many programs both community wide and with UHA members to improve the overall health and well-being of the population. UHA has dedicated staff who work towards improving the health of our members and to attempt to "move the needle" on the population's overall health outcomes. The UHA Community Care Transitions Team also works to serve members being discharged from inpatient services or the ED to ensure that those members have the follow up appointments they needs, they are able to pick up and understand their medications, can refer to case management in the case of a high risk patient, and other items to assist in the coordination and effectiveness of care.

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

A: Overall, the CHIP has encouraged countless efforts and outreach on improving the overall health of our community, integration of services and coordination and collaboration between many organizations. The CHIP work has brought organizations



across sectors together to work towards common goals. The CAC's main responsibility is the CHIP. The CAC is made up of individuals who have connections to, work for, or are involved with many of our community collaborators including first responders, Adapt, primary care clinics, members or parent/guardians of members, the local tribal health clinic, and members of the Early Learning Hub among others.

Respectfully submitted,

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