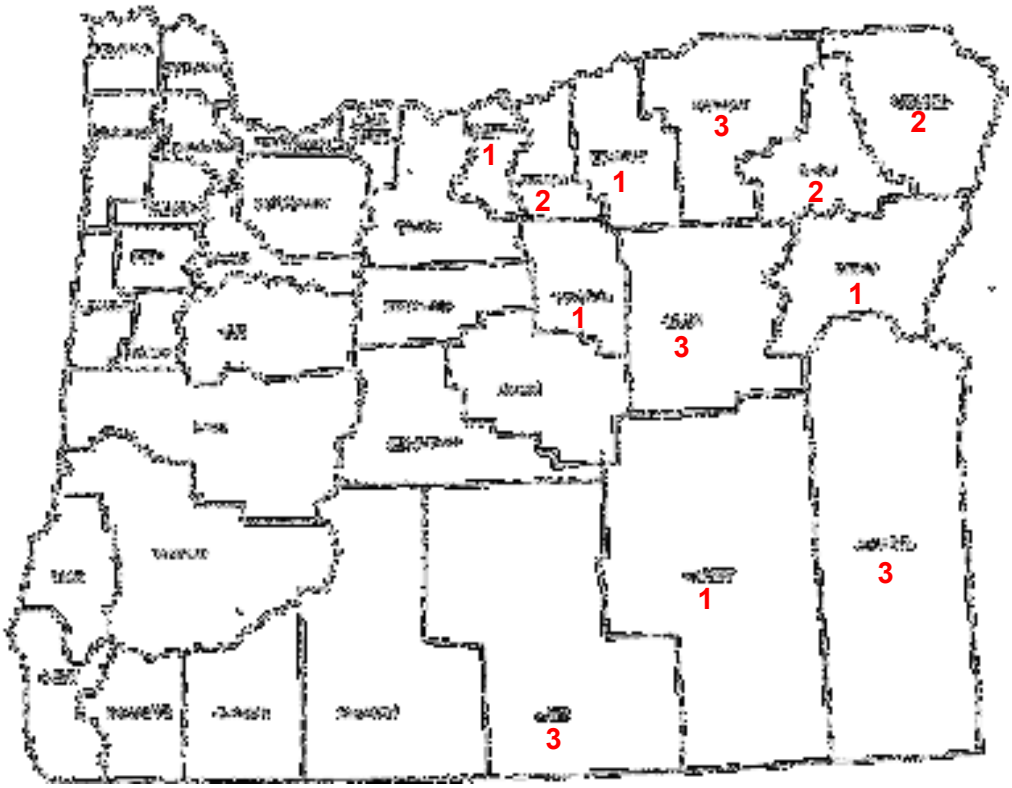
Transformation Grants Progress Report

Date: January 15, 2015
Name of CCO: Eastern Oregon Coordinated Care Organization
Reporting Period: Through December 1, 2014
Contact person for this report: Anne King
Contact information: kinga@ohsu.edu; (503) 494-3094

PROGRESS TO DATE- EOCCO TRANSFORMATION GRANTS PROGRAM

In August, 2014, 23 organizations in Eastern Oregon embarked on innovative projects aimed to increase health, improve the patient experience and lower overall health care costs for Eastern Oregon's Medicaid population. The Eastern Oregon Coordinated Care Organization (EOCCO) pursued a grassroots effort to elicit ideas from throughout its 12-county area and from a broad range of providers. It was an intensive, but fruitful process that resulted in 48 applications for funding. Of these, the EOCCO awarded 23 grants for innovative transformation projects across the EOCCO area (see Figure 1 for the geographic distribution of the awards).

Figure 1. Geographic Distribution of EOCCO Grants



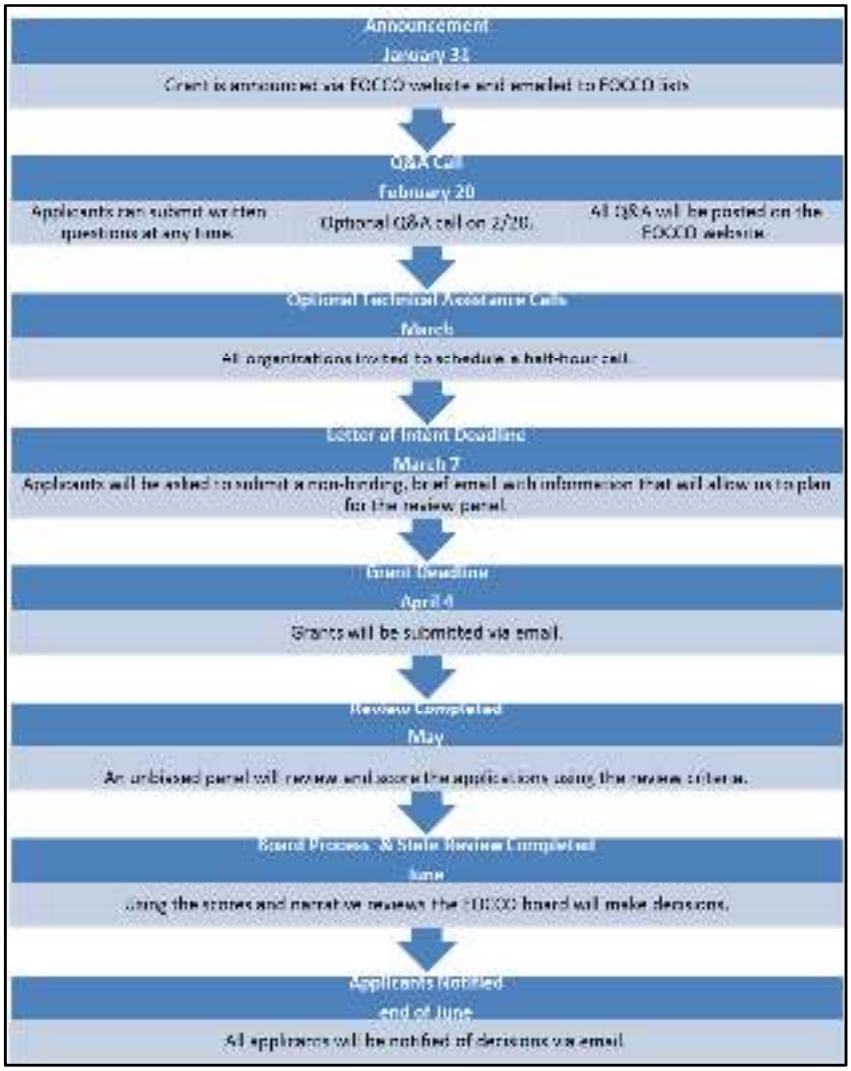
The objective of the EOCCO grants program is to support projects that are innovative, scalable, transferable and related to overall transformation goals. Specific areas of emphasis include:

- Information technology systems and infrastructure, including additional investment in electronic medical records (EMR) and claims processing systems.
- Population health management, case management, disease management and achieving quality metrics.
- Provider panel and clinic enhancements to provide extended primary care services to high risk Oregon Health Plan members.
- Projects designed to improve patient engagement in and accountability for a patient's own health, disease prevention and wellness activities.
- Pilot projects testing the use of flexible or otherwise innovative services.

The EOCCO encouraged submission of projects that represented collaborative applications between caregivers and community partners. (See Appendix 1 for the EOCCO grant guidelines.)

The EOCCO wanted to ensure that the grant making process was rigorous and objective, and that applicants and, ultimately, grantees were given feedback and support to help build capacity to develop, implement and evaluate improvement projects. It enlisted the support of the Center for Evidence-based Policy (CEbP) at Oregon Health & Science University to manage the grant process and provide technical assistance and educational opportunities to grantees. Moda Health funded CEbP's contract so that 100 percent of the funds from the Transformation Center could be awarded to grantees.

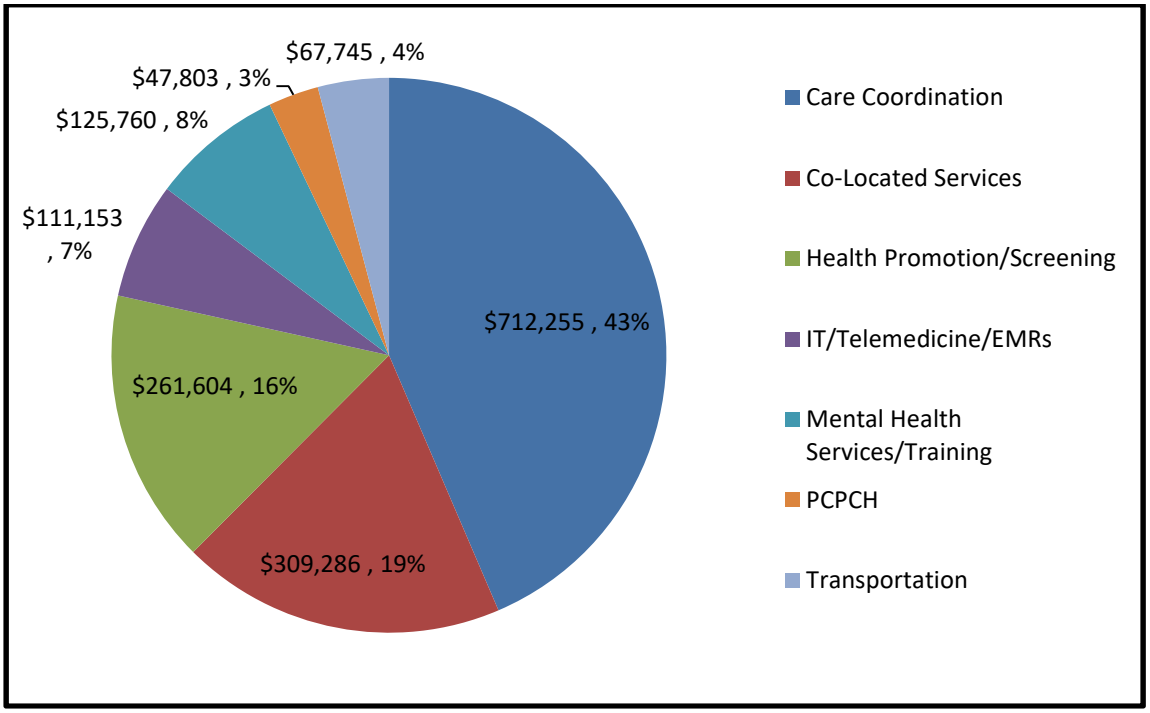
Figure 2. Timeline and Steps in Grant Process



A question and answer session and follow up technical assistance calls were offered to grantees early on in the application process and a panel of reviewers from academia and the community were recruited to review proposals. A sub-committee of the EOCCO Board of Directors considered the reviews and proposals and recommended a slate of grants to the full board which approved them in June 2014. The timeline and steps taken by the EOCCO to award these grants are depicted in Figure 2.

Nearly half of the funded proposals involve piloting or expanding care coordination for EOCCO patients in a range of settings. Co-location of mental health into primary care and community settings comprise nearly 20 percent of the funding, and health promotion projects are the third largest funding category at 16 percent of the dollars awarded. (See Figure 3 for a chart of the distribution of funds by topic.)

Figure 3. Distribution of EOCCO Transformation Funds by Topic



To help grantees successfully plan, implement and evaluate their projects, a Technical Assistance (TA) team was formed consisting of Anne King from CEbP, Jim Foley from Moda Health and Jordan Rawlins a quality specialist from Moda Health who was hired to work with the EOCCO. The TA team has, thus far, provided the following activities and opportunities to support grantees:

Orientation, August 2014

Grantees participated in a phone conference where the logistics of the grant program, training and technical assistance were discussed.

Training on Planning, Measurement and Evaluation, September 2014

Two leaders from each organization were convened in Baker City for a day of training. In preparation for the meeting, grantees were given project charter and evaluation templates as well as examples to use in drafting these documents. The meeting itself consisted of group exercises to discuss and revise the charters and evaluation plans and talks by Ron Stock, MD of the Transformation Center, Jim Foley and Anne King, MBA. These speakers provided training on improvement methodologies, selecting metrics and evaluating projects. After the training, each grantee was required to submit a revised charter and evaluation plan. (See Appendix 2 for the training agenda and Appendix 3 for the charter template, charter assessment tool and metrics worksheet).

Technical Assistance on Project Development and Measurement, Fall 2014

Over the course of the fall, the TA team met with each grantee to provide feedback on their charters, metrics and evaluation plans. The TA team also provided ad hoc advice and connection to experts and resources. Examples include identifying external data sources for measurement, providing consult on hiring objectives and challenges, connecting grantees to other grantees and community partners, helping grantees obtain health promotion materials available through the EOCCO, tailoring EOCCO mailings to include messages related to grantee projects, obtaining answers about EOCCO benefits, setting up consults with the OHSU IRB and other resources and answering numerous questions, such as "What do residents typically get paid" and "How can I find an IT consultant for my project?"

Upcoming Activities

Grantees will continue to receive technical assistance from the team through planned conference calls and ad hoc requests throughout the remainder of the grant period.

CEbP is providing a Care Coordination Learning Collaborative (6, 1.5 hour sessions) for all EOCCO grantees. The focus of the collaborative is to provide evidence on care coordination and care management, share projects occurring outside the EOCCO that could be useful to inform participants' efforts and share the successes and challenges of the care coordination projects funded through the EOCCO grants.

What have you shared about your projects with other CCOs and what would you like to share?

The EOCCO recognizes the importance of disseminating information about our funded transformation projects and our grant making and technical assistance content and processes. Efforts thus far to share what we've learned include the following:

- The EOCCO web page includes a descriptions and funding amounts of the projects.
- A press release sent out to media outlets resulted in an article in the East Oregonian about some of our projects and the impact they are having on their communities (see Appendix 4).
- A panel of administrators and grantees from the EOCCO presented our projects during the opening session of the CCO Summit in Portland.
- A member of our TA team presented a talk on measurement and evaluation to the Lake County Community Advisory Council.
- We shared our grant materials with the IHN-CCO to help them improve their grant making process.

We look forward to additional opportunities to share what we've done and learned with other CCOs and organizations.

PROGRESS TO DATE- INDIVIDUAL PROJECTS

EOCCO grantees are required to submit progress reports on November 15th, March 15th and at the end of the grant period. The November progress reports provide a status update that includes the information requested by the Transformation Center for this report. Below a brief synopsis of each project is followed by reports from each grantee.

BAKER COUNTY

St. Alphonsus Medical Center

This project places a nurse navigator in the hospital and care coordinators in primary care and behavioral health settings (e.g. Saint Luke's Clinic- Eastern Oregon Medical Associates, Eagle Cap Clinic and Mt. Valley Mental Health/New Director Northwest) who function as a team to coordinate care for patients with complex medical conditions. The goals of this project include fewer ER visits, increased access to care and increased preventive screenings (e.g. depression, colorectal cancer, high blood pressure).

Progress to date:

We have been able to narrow down our metrics in order to more appropriately capture what we are attempting to do through care coordination. New Directions, NW has hired a new provider who started on November 10, 2014. She will train within New Directions and will then be ready to start in the two Saint Alphonsus Medical Group Clinics. This provider will work in each clinic two half days per week.

Major successes of your project so far:

Finding and hiring a Behavioral Health Specialist

Challenges and how you have addressed them:

How we are identifying needs throughout the care continuum (ER, OB, Med-Surg, Inpatient, Clinics, Behavioral Health, etc.) We need to define the Nurse Navigator role and responsibilities. Our current electronic records system (medical and behavioral) is difficult to pull information from and track data. It is not readily available to all.

GILLIAM COUNTY

South Gilliam County Health District

The South Gilliam Health District is building a wellness facility attached to the Mid-Columbia Medical Center. EOCCO funds will supply equipment and expert consultation fees to assist in design and layout of the equipment, which would include space for physical therapy, currently unavailable in the region. The facility will be free to patients and the public. Patients will be enrolled by their clinicians, set fitness goals during office visits and receive follow up by clinic staff. Their progress toward physical fitness goals will be tracked in the clinic EMR. The goals of this project are to decrease obesity rates, decrease disease burden and increase access to physical therapy.

Progress to date:

- We have been able to enter baseline BMIs on approximately 80% of our patients.
- We have picked a couple of patients for a pilot program that would help in the design and help define a wellness program.
- We are also working on putting together an evaluation form to help us in determining the best course of action to help in our patients' wellness journey.

Major successes of your project so far:

- Contacts and networking contacts that we have received.
- Hired a consultant to help in the layout of equipment.
- Purchased a couple pieces of equipment to evaluate and promote for the wellness center.
- We have received positive feedback and enthusiasm from patients when describing and explaining the concept/idea of the wellness center.

Challenges and how you have addressed them:

- Time line of the construction.
- Most optimal equipment to purchase that will be able to meet the needs of our clients.

Gilliam County

This project has three components: to address the negative stigma associated with obtaining mental health services by implementing a local media campaign, to support a school counselor position in the Condon School District which is currently without a school counselor and to address older adult depression by providing a part-time peer mentor in the locations where they receive care (e.g. senior meal sites, Summit Springs and Columbia Hills Manor). The goals of this project are to improve public opinion about the use of mental health services and to increase the supply of mental health services for school-aged children and seniors.

Progress to date: see below

Major successes of your project so far: We have gotten the school counselor position started and going from the beginning of September when school started. Our counselor has been seeing students on a regular basis. Our Media Campaign is up and going. Senior Citizens are being met with and talked to and can be referred for full counseling services if it rises to that level.

Challenges and how you have addressed them:

Getting the senior mentor going. We are utilizing our current mental health providers and they started in October attending the senior meal sites and just talking to seniors--getting to know the folks and just having conversations. They are also gathering information for Senior Services in the community so that they can share what resources are available. The challenge is having enough time for these providers to make time in their very full schedules.

It has been noted that we may be able to get some additional assistance from Community Counseling Solutions, our Mental Health Provider, with an intern that they may have coming on board. This intern could possibly make up some time that the providers are lacking to meet with seniors in the County.

GRANT COUNTY

Blue Mountain Home Health & Hospice

This project will enable charting and communications with providers in the field for hospice and home health workers by purchasing encrypted tablets. The addition of this technology should reduce travel time for home health and hospice staff to the office for charting. The goal of this project is to increase efficiency so that workers can spend more time with each patient and so patients and their families have a shorter wait time to first visit.

Progress to date:

Electronic devices have been purchased and are here in our department. I will begin developing policies and procedures related to HIPPA and how the devices will be handled.

IT and the Home Health/Hospice Director are in the due diligence process of an intermediary program to capture our data, place it in the Cloud and transmit it into Healthland (our current software).

I also have been breaking down a pre-populated productivity report down into each discipline that is in the field to get a better data set of what progress we will show in productivity during this process.

Major successes of your project so far:

The main purchase has been completed.

Challenges and how you have addressed them:

Some challenges related to needing to have an intermediary data program that was unanticipated.

Community Counseling Solutions

Community Counseling Solutions, Strawberry Wilderness Community Clinic, Advantage Dental and Families First proposed a health promotion project focused on obesity, oral health and children's health. The project consists of monthly educational and participatory group meetings for patients and their families led by health professionals. Also offered are weekly walking or activity groups. For children, the partners will provide health promotion activities at an existing day camp for children grades K-3. Finally, the project will provide health promotion and screening booths at an annual community event. Primary project goals include engaging high risk community members in developing personalized health plans and increasing health awareness and education among at-risk community members.

Progress to date:

The Transformation Grant Coordinator was hired November 1, 2014. Our first workshop is scheduled for December 8, 2014. We have the first workshop planned and details outlined. The committee has developed an invitation format to engage high risk, at risk and community members which includes scheduled advertising, personal invites, social media and flyers to be distributed throughout the county. Community partners are being contacted and organized networking taking place. The committee is preparing attendance sheets, pre and post knowledge tests and a data tracking ledger that will be used for data collection and metric reporting.

Major successes of your project so far:

The coordinator position being filled by someone with community project experience, data collection experience and great people skills was a major success.

Challenges and how you have addressed them:

One challenge is coordinating community partners in respect to time and conflicting schedules and getting structured networking started. To address this issue the Coordinator is using already scheduled community meetings to meet with and engage these partners as well as looking at ways to engage new partners and businesses to participate in the project.

Blue Mountain Hospital District

This project adds five health IT modules to the hospital district's electronic health record (immunizations interface with state agencies, laboratory report interface, radiology picture archiving and communication system, ePrescribing, provider to provider messaging, reporting system and a patient portal). The grant will also enable necessary hardware purchases. The goals of this project are to improve communication among providers, enable patients to access their information and communicate with their healthcare team and enable reporting on usage and core measures.

Progress to date:

Item 1 "Improve communication among providers (provider to provider)" has started implementation. I am waiting on feedback to update. Item 2 "Enable patients to access their patient information (Clinic)" the required hardware/computer server and appropriate disk space has been set up and allocated for the project. On November 7, 2014, we opened a ticket with the e-MD (Vendor) to load the software and to schedule the staff's training. Item 3 "Enable patients to access their patient information (Hospital)" implementation has been completed. The Assistant Medical Record Director and Director of Nursing Services have been trained. Item 4 "Patient communication with their healthcare team" this implementation should follow within the next 60 days, because item 3 has been completed. Item 5 "Enable reporting on usage and core measures" this software has been partially implemented. We current have a dashboard for core measures. However, some of the core measures are still waiting additional E.H.R. software updates and some staffing training for those core measurers. The E.H.R. update that was schedule for this weekend failed. We are currently waiting for Healthland (Vendor) System Analysis to determine why.

Major successes of your project so far:

Item 2-- all required hardware/computer servers are installed and disk space has been allocated. Item 3 has been completely implemented.

Challenges and how you have addressed them:

We are dealing with two vendors for our E.H.R. who have partnerships with other vendors to meet the different core measurements. Our largest challenge is having staff available at the last minute to handle our requirements regarding the measurements and running reports to document those measurements.

HARNEY COUNTY

Harney District Hospital

This project embeds a part time LCSW from Symmetry Care into the Harney District Hospital Family Care Clinic. Co-location enables care management for behavioral health needs within the primary care clinic and referral to Symmetry Care for services. The goals of the project are to achieve a formal process of integrated care between Harney District Hospital and Symmetry Care, increase enrollment of patients in Symmetry Care for mental health care and reduce the number of psychiatric crisis visits to the Harney District Hospital Emergency Department.

Progress to date:

- We have had three LCSWs show interest in our position, but none of them have developed into firm candidates for various reasons. One of the major reasons has been that candidates have not been interested in a position that is split between two organizations.
- While all of our recruiting thus far has been through our website, local job postings, several general online job boards, Craigslist, 3Rnet and The National Health Service Corp, we just signed a recruitment agreement with Hunter Ambrose on November 7th, which is a national recruitment firm which has been successful in the past in finding healthcare professionals for our hospital.
- Discussions have taken place within our administrative staff at HDH confirming our desire to move forward with the mental and behavioral health integration in the primary care and hospital setting even if we 1. have to look at mental health professionals that are not a LCSW or higher degree (MSW for example) and 2. we are prepared to hire the professional to work full time, solely for HDH and HDH Family Care.

Major successes of your project so far:

- We have had contact with three different potential candidates and, while none of them have been successful to date in filling the position, we have learned a mountain of information from each of them which will assist us as we move forward with this process.

Challenges and how you have addressed them:

- Recruiting: As stated above, we have hired a recruitment firm to assist us in finding a candidate from the national level.
- Two out of three potential candidates have voiced that a shared position was not desirable; this has been an ongoing concern for us as well. Key administrators have met and decided that we are prepared, if we have a desirable candidate, to offer them full time employment under the hospital only and not make this a shared position with Symmetry Care.

LAKE COUNTY

Warner Mountain Medical Clinic

This project will enable the clinic to obtain PCPCH status for the first time. This will be the only PCPCH recognized clinic in the county. As part of this transformation, the clinic will hire a MSW/LCSW to provide behavioral healthcare services at the clinic one day a month and contract with a dental hygienist to provide dental fluoride varnish to 3-6 year olds.

Progress to date: See below

Major successes of your project so far:

The clinic has completed several of the steps necessary to obtain PCPCH status including implementing an EHR.

Challenges and how you have addressed them:

The clinic is finding it difficult to provide 24 hour coverage due to workforce issues.

Lake County Mental Health

To raise awareness of mental health needs and treatment resources, Lake County Mental Health will train staff from the law enforcement community, the medical community, DHS, EMS, school staff and crisis centers using the training program "Mental Health First Aid". They expect to provide 18 training sessions to a total of 350 individuals. The outcomes are expected to be increased early referrals to mental health services and decreased crisis services.

Progress to date:

Trainings have taken place and future ones are being scheduled with outreach to community partners. Those who have taken the training report an increased understanding of mental illness.

Major successes of your project so far:

Most of the individuals trained have requested the additional training targeting the population not addressed in the training they attended. They all report a better understanding of what to look for and how to appropriately refer to services.

Challenges and how you have addressed them:

Scheduling with the schools has been difficult as most, if not all, of the professional development days for the teachers have been scheduled so far. We are going to have the counselors trained and use them to help us gain training time with the rest of the school staff.

Lake Health District

This project creates a patient navigation team within the Home Health and Hospice Department to help patients access appropriate care in optimal settings. The team includes a social services worker to enroll patients and coordinate care, a registered nurse to develop care plans, and a patient advocate to coordinate follow up. The target population is frequent emergency department users due to non-urgent needs and patients with chronic conditions who have been recently hospitalized. The expected outcomes are a decrease of inappropriate use of the emergency department and an increase in patient engagement in and accountability for their own health.

Progress to date:

Thirteen navigation referrals have been offered and accepted services to date. We collected 8 self-assessments from the 13. We have another 14 referrals that we have attempted to make contact with but have not succeeded in a first meeting with. One of our first clients was a young pregnant mother who had not carried any of her previous pregnancies past 28 weeks resulting in very high hospital and NICU bills and increased lifetime

risks for her babies. This last pregnancy last well past 28 weeks, the baby was born healthy and had a normal hospital course for it and the mother.

Major successes of your project so far:

Young maternity case was able to deliver for the first time. No time was spent in the NICU (for the first time ever) and hospital birth and post-partum time was average for her and her baby.

Multiple clients were assisted in moving out of town to areas where more support was available to them (through family or social services.)

Challenges and how you have addressed them:

Making contact with some clients is difficulty due to the size of our service area and the propensity for clients to have no phone. Other potential clients are reachable but then difficult to pin down for the first meeting. We have placed a 1 month attempt time limit on referrals: if unable to make contact AND a first visit in 4 weeks the referral is dropped. Attempting contact takes a lot of time from the Navigators that could be spent assisting clients.

Also, it has been challenging to get the self-assessment done within the first visit. We have learned that if it isn't finished at first visit it becomes more difficult to get completed. Only 61% have been completed and a few of these were completed further into the navigation, making the data less significant because all/any of our interventions will likely increase their self-assessment scores. We have changed our process to have the assessment completed first visit as a priority. If unable then it must be done by the 2nd visit.

Metrics for collection of confidence was not true to the data we are actually collecting in the self-assessments. We have changed the wording of our metrics to reflect this.

Collecting all our metric data at this point was a challenge as we are continuing to develop and tweak our process and paperwork to collect meaningful data and information. When paperwork was first built it wasn't done with data collection for metrics in the forefront of our minds. Because of this, much data was not collected or was collected in narrative only and has not been easy to mine from the charts. The CHW class has been completed and with this new knowledge, as well as lessons learned up to now, the paperwork and charts will be revamped to quickly and easily record the data needed for metrics so it will be easy to mine for the next report.

MALHEUR COUNTY

<u>Lifeways, Inc.</u>

This project provides a school-based adolescent health program at Ontario High School to provide health promotion and services in the areas of physical health, prevention and wellness, parenting skills, behavioral health and dental screening. Grant funds will be used for a full-time community health worker. The objective of the program is to develop culturally and linguistically competent service delivery, co-management and referral services for school age youth and Hispanic families.

Progress to date:

- The AHA! Cultural Competency Taskgroup has designed a bilingual survey and focus group protocol to assess health needs and barriers commonly experienced by parents and adolescents. Tailoring needs

assessment tools to the unique cultural influences of Hispanic and adolescent populations is vital to targeted action in this project.

- The AHA! Cultural Competency Taskgroup has conducted and analyzed parent surveys and student survey and focus groups to gather information on service/support barriers and make recommendations to strategies and areas of need. Data and recommendations to inform and develop culturally and linguistically relevant service delivery efforts is currently in draft form, but has had preliminary review by stakeholders.
- The AHA! Workforce Taskgroup has finalized a standardized job description and interview guide for hiring of the CHW. This has been utilized successfully to secure a fully qualified candidate within project budget and timeline of mid-October.
- The AHA! Workforce Taskgroup has successfully designed and deployed a process of mapping and outlining comprehensive health and social services orientation for the CHW. The completion of the local resource orientation is anticipated December 1st.
- The AHA! Project Committee successfully constructed and negotiated a Memorandum of Understanding with the Ontario School District administration to support the activities of the CHW on site at Ontario High School, within project timelines.
- The AHA! Project Committee selected and supported training of two project committee members from the local area to receive a two-day training on supervision of Community Health Workers in rural settings, as provided by Northeast Oregon Network (NEON). The value of this training is estimated at $1,500 per attendee, and was delivered to two individuals with MSW and RN level credentials.
- The AHA! Project Committee has identified and begun integration of forms for data collection within the ideal work flow of the CHW on site at OHS. Initial concerns regarding privacy of information have been identified and budget allocation to accommodate the concern will be pursued.

Major successes of your project so far:

The largest success of the project to date has been the initiation of a multi-disciplinary team of professionals to inform and advise on project strategies, including representatives of the Malheur County Health Department, Ontario High School, Oregon Child Development Coalition, Valley Family Health Care, Wettstein Dental, Advantage Dental, Treasure Valley Pediatrics, Department of Human Services, Malheur Co. Juvenile Dept., and other community members. These professionals meet three to four times monthly to guide strategies and advance the AHA! projects' goals. Sustained effort through Q2-4 of the project of these project committee members is vital to success of this pilot.

Challenges and how you have addressed them:

There was difficulty in recruiting fully qualified bilingual candidates for the key project staff position of Community Health Worker. We attempted to address this challenge through extended recruitment timelines and significant targeted recruitment through Community Advisory Council stakeholder organizations. The final candidate pool lacked fully qualified individuals which possessed sufficient bilingual skill, therefore, school translation resources and the provision of training in basic Spanish were utilized to overcome the Community Health Worker's language limitations.

Initial assessments of school technology that were to be shared by the Community Health Worker and school staff show challenges to maintaining security of students' PHI when entering information into the electronic health record. As this is a primary source of data for metrics associated with the project, we requested

reallocation of project budget resources to allow for purchase of equipment needed to have desktop scan and fax capabilities when transmitting information to providers for referrals from the school site.

A final challenge identified recently involves the complexities of age of consent to services. The definition of Community Health Worker services as a preventative or wellness service does not fall neatly into the classifications of health or social services as is presently understood by project committee staff. We are seeking to afford students with access to linkage activities that promote health and wellness; but recognize that parental consent for these linkage activities may be needed. OHSU grant management staff have responded to our request for technical assistance in this matter, and we will pursue opportunities for consultation with OHSU Institutional Review Board staff on this issue.

Saint Alphonsus Medical Center

This project transforms post-discharge care for emergency department patients with mental health and substance use disorders and reduces excessive emergency department use by providing customized navigation services to meet medical and behavioral health treatment needs, and reducing social, psychological and financial barriers to care. The goal of the project is to reduce emergency department readmissions among EOCCO members by effectively transitioning patients to outpatient behavioral health services, primary care and community supports.

Progress to date:

Lifeway's is interviewing possible candidates for the liaison position. At this point, we were informed Lifeway's has a candidate to hire and will proceed with a possible start date of November 18, 2014. Screenings have been added to better meet patient healthcare needs when incorporating them in the health resource center. We have just instituted the PHQ 9 screening tool as necessary per social work discretion. Adult Mental Health 1st Aid Class shared jointly with Lifeway's grant has been scheduled for Nov. 13, 2014. Through the grant we are able to provide needed education to the hospital staff (30 employees) for dealing with mild/moderate mental health patients. ED staff is becoming familiar with this program and has begun to call the HRC staff with patients they feel may meet the criteria for admission to the program.

Major successes of your project so far:

Procedure(s) for communication with Lifeways have been developing. Getting all staff oriented and trained for dealing with mild/moderate mental health cases. Melody attended a small community health fair to educate the public regarding our program. Attendance was around 75 for the health fair in Vale, Oregon. I have had multiple reports of hospital staff satisfaction related to the resource for patients which come in with mild/moderate mental health concerns. They feel the staff are good at deescalating the situation and also helping to provide more valuable resources for the patient. The ER staff state they feel the "high utilizers" have gone down since the start of the HRC staff interventions. The metrics at the next evaluation should prove that theory.

Challenges and how you have addressed them:

Functional understanding of the role of program staff and needed resources is difficult to locate in rural areas. Education has been the key with staff understanding and getting appropriate patients that meet criteria. Also, the patients we are working with are a difficult population in regards to getting a hold of once they have left the

facility. We are diligently working to stay in contact with them and make appointments in advance to keep their interest in the program and the direction for their healthcare needs. A few patients have chosen not to get involved in the program and trying to find reasons why they refuse and work with them around the barriers to improved healthcare access. Building a program from the ground-up can be extremely challenging, we are continually making process improvements to help the program grow to its maximum potential.

Malheur County Health Department

This project, a collaboration of the Health Department and Lifeways, will develop a community health worker program for the county. Activities included in the proposal are to coordinate a county-wide training on the 80-hour "We Are Health" Community Health Worker (CHW) curriculum for up to 25 local agency staff and community leaders, conduct a local campaign to identify and recruit a culturally and linguistically diverse set of "natural helpers" based in the community, and create and administer a flex fund to support child care, travel costs, scholarships, stipends, and meeting expenses for the training project attendees.

Progress to date:

Our CAC met and produced a list of agencies to contact/notify regarding CHW training. We held a very successful natural helper campaign to recruit trainees. In less than a week we already had over 25 interested parties. Since we only received the confirmed dates of the training, we have notified all potential trainees and already have 17 confirmed registrations.

Major successes of your project so far:

We have had a great deal of interest in the training. Also, we have been able to partner with other agencies in our county that received the EOCCO grant to offer the CHW training.

Challenges and how you have addressed them:

None.

MORROW COUNTY

Morrow County CAC

This project creates an inter-disciplinary community care team and hires two nurse care managers to mobilize community resources and address unmet health needs for women and children. The focus of the care team is prenatal care, well-child checks including behavioral health services and developmental screening for underserved children and pregnant women. The care team is comprised of Morrow County Health Department and Juvenile Services, Umatilla Morrow county Head Start and WIC, Morrow County and Ione School Districts, Morrow County Health District, Columbia River Community Health Services, Morrow County Veteran's Services/Senior and Special Transportation, Advantage Dental, Oregon DHS Self-sufficiency Program, Community Counseling Solutions, Oregon State University Extension, Hispanic community liaison and Morrow County Sheriff's Office. The goals of this project are to improve access to prenatal care, well-child checkups including behavioral health services, and developmental screening for underserved children age 0-18 and pregnant women.

Progress to date:

There have been a total of 17 referrals, 9 from the Northern sector and 8 from the Southern area. Referrals and coordination with community partners have included applications for: Developmental Disability Services, Department of Human Services, HUD housing and Medicaid. We have also made referrals for Eastern Oregon Center for Independent Living, Vocational-Rehab, use of Medical transportation program (for Medicaid), as well as providing our own transportation for clients to dentist, primary care, vision appointments and Health Department. We are also working on behalf of our clients with Head Start, CCS, BMCC, IMESD and the schools. Approximately $268.00 was used to purchase a specialized set of glasses. The student's family and school reports that he is benefiting from them.

The Nurse Case Manager and the Care Coordinator were both able to complete Karly's law training and Portland State University's Wraparound training in October.

The wraparound program is now poised to progress on using the Wrap- TMS data base. However, at this time, work is being done to determine "permissions" so that CARE Client data can be entered once login and password matters are resolved.

Major successes of your project so far:

Additional Resources for Morrow County identified include Care Packets (with program information, referral forms, brochures, etc). Packets were distributed to schools and community agencies. Additionally a post survey has been created (also included in separate update).

Challenges and how you have addressed them:

There is need for continued outreach to educate community partners of the availability of the newly created wrap around system.

SHERMAN COUNTY

<u>North Central Public Health District</u>

This project provides home visits from a public health nurse to provide services and care coordination. The target population is chronically ill, high utilizers of healthcare services in the Sherman County Medicaid population. Referrals to the program come from clinicians at the Moro Clinic, the Sherman County Ambulance Service, and eventually the Mid-Columbia Medical Center discharge planning and emergency department staff. The goals of the project are to decrease emergency department utilization and hospital readmission.

Progress to date:

The model has been purchased and staff has been trained. Paper documentation forms have been created. Policy and procedure for this new program has been created.

Major successes of your project so far:

Training in the new program which is an innovative model of patient disease self-management.

Challenges and how you have addressed them:

The small numbers of clients in Sherman County and wide variety of providers outside of the County is challenging. We have made contact with the Moro Clinic provider, who was the main supporter of the program,

and he will be contacting patients. We will be also contacting the social work/case management staff from Mid-Columbia Outpatient Clinics to let them know of the program and how to refer. Emails to set up appointments have been sent. We also plan to work with MODA case management and see if a model of direct referral from the insurer is possible.

UMATILLA COUNTY

Yakima Valley Farm Workers Clinic

This project improves access to behavioral health services by co-locating a behavioral health clinician in the Mirasol Family Health Center in Hermiston. The target population is underserved patients with chronic conditions and behavioral health disorders. The goals of the project include increasing access to behavioral health services, implementing SBIRT, improving behavioral health outcomes and increasing patient satisfaction.

Progress to date:

We are currently on track to achieve our project goals and have many established reports/processes already in place. Any remaining reports will be generated in the coming months as needed.

Major successes of your project so far:

We hired a bilingual Behavioral Health Consultant who started on 9/8/14 and has been practicing in the clinic for about 6 weeks. She has already had a tremendous impact on patient care and medical providers' ability to manage challenging patients.

Challenges and how you have addressed them:

Our initial project lead (Brian Williams) for this grant decided to leave the organization. The co-project lead (Brian Sandoval) was able to step into the lead role given our experience with implementing this integrated behavioral model at other clinics. Our regional operations director (Cathy Murphy Thomas) has also stepped in to support this project from an administrative standpoint. We will have the new Mirasol Clinic administrator step into the project lead role once this individual is hired.

Good Shepherd Health Care Systems

In collaboration with the Community Action Program East Central Oregon, Umatilla Public Health and the Hispanic Advisory Committee, this project creates a workforce of community health workers who conduct community outreach, assist with health promotion and coaching, case management, referrals, follow-up services and basic health screenings. The community health workers are part of the Lifeways health care team. The overall goal of the project is to reduce health disparities among low-income families, children, elderly and racial/ethnic minorities.

Progress to date:

Several important milestones were achieved—recruitment, training, and certification of staff; demonstrated competency by staff in community health worker knowledge; location of office space, phone lines, and additional office needs; completion of referral and communication forms and a beginning draft of a unified referral system; community and agency web access to forms/program details; purchasing of health screening equipment/supplies; finalized health screening assessment forms and screening process; established data

collection method and reporting standards; organizing and hosting EOCCO grantee collaborative monthly meetings; verifying internal referral process between ConneXions and ER, case management and medical providers; researching and obtaining IT equipment and software for program use; creation of CHW calendar of events; and serving clients referred to CHW's.

Major successes of your project so far:

One of the major objectives of ConneXions is access to quality, patient-centered care—we have already made great strides in this area with the implementation of both measurable output(s) and outcomes. Beginning the end of October our community health workers began assisting their first client—referred by GSMC Medicare/SHIBA office. The referral system was implemented and a CHW assigned to follow through with client needs. The CHW has been instrumental in helping the client seek additional needed community services, as well as provide other resources and alternatives to using Good Shepherd's ER.

This success story involved activities that analyzed, assessed and mentored the client and spouse towards healthier outcomes. Trainings were held to assist with positive client in-take (Motivational Interviewing) and services provided (counseling and tutoring). The goal was to disseminate knowledge for the purpose of encouraging positive action and reinforcing positive outcomes…which has been successful. Current impact—a change in knowledge and actions by the client to perform decision-making and self-efficacy for better lifestyle choices. The client has not returned to the ER and will call the CHW for additional health and wellness information.

Challenges and how you have addressed them:

1. Recruiting and/or referral of high-risk patients-attempts were made to obtain ER high-user list as shared by statistics from EOCCO, but unable to locate. It would be advantageous to prioritize referrals by those that are in need of services the most.

2. Use of technology and appropriate software—understanding which software programs and databases were needed to better serve clients, as well as efficiently make use of CHW's time has been a challenge. For instance, knowing that the MMIS system was needed would have helped with client in-take.

3. Community Health Worker training/certification—while we have remained in contact with OHA and encouraged their forwarding of information, there seems to be a lack of support and information sharing needed by agencies wanting to establish CHW's as a viable connection to improving health outcomes. Current CHW training programs we are aware of that are sanctioned and recognized by the OHA are cost prohibitive and time consuming. We all want and need well-trained CHW's but feel some compromises are needed to have training readily available, especially in rural areas.

<u>Lifeways, Inc.</u>

This project will hire two 1.0 FTE community health workers focused on behavioral health services to be housed at the Umatilla County Public Health Department to provide care coordination at the St. Anthony and Good Shepherd Emergency Departments. One FTE will be paid for by Lifeways and the Umatilla County Health Department. The focus of the community health workers is on patients in the emergency departments that appear to have active behavioral health or crisis issues. Services include crisis intervention, SBIRT, and case management. The goals of the project are to reduce readmissions and effectively transition patients to

outpatient behavioral health services, primary care and community supports and to provide training to the ED staff using Mental Health First Aid.

Progress to date:

- Both FTEs have been trained in the CHW curriculum.
- A universal referral system has been created in a joint effort by Lifeways, UCHS, and GSMC.
- The FTEs have worked with GSMC on outreach activities, including tabling at the Umatilla County Project Community Connect/Veterans Stand Down, holding a community partner question and answer session, presenting at Hermiston Healthy Communities Coalition meetings, presenting at a Lifeways staff meeting, and creating and distributing postcards and flyers for the project.
- The FTEs have received outside agency referrals, inter-partnership agency referrals, and self-referrals.
- Both FTEs are now developing their caseloads and working with patients in the community.

Major successes of your project so far:

- Lifeways and UCHS collaborated with GSMC to create a universal referral system with forms and processes for working together**.**
- One FTE now works three days per week out of the St. Anthony clinic, and he is often available to see patients immediately upon receiving referrals from their doctors.

Challenges and how you have addressed them:

- The UCHS CHW was not receiving referrals from St. Anthony clinic in a timely manner because the referrals were going through a middle person. He was able to work out an improved system in which he receives the referrals directly from the doctors when they see the patients at the clinic**.**
- Tracking referral data between the two agencies involved in the grant is challenging. A cooperative tracking system for behavioral health referral and service data is being developed.

UNION COUNTY

<u>Community Connection of Northeast Oregon</u>

This project expands an existing transportation call center to facilitate same-day healthcare appointments and pharmacy deliveries to outlying communities in very rural areas of Union County, Oregon. The goals of this project are to reduce the rate of missed appointments due to lack of transportation and increase the rate of same day deliveries of medication to communities not served by a pharmacy.

Progress to date:

We're pleased to report that most of our framing work is complete. The call center has almost reached our capacity goal and we've actually assigned CCO trips to ARC Cab Company as an active partner – even before formalizing our relationship with a Blanket Purchase Agreement. Same Day Medical deliveries are up dramatically relative to our baseline. Based on the immediate response we've had to recent outreach meetings with our medical care partners we anticipate even greater utilization in the coming weeks.

Major successes of your project so far:

1) Development of a partnership with the MCCOG to facilitate same day medical trips through Medicaid that serve the objectives of this project without costing it any money.
2) Broad distribution of reminder cards to our medical care partners. Irrespective of how the service is paid for (Medicaid, CCO, Private Pay, etc.) we've cost effectively removed one more barrier to medical access. When transit challenges are resolved at the same time medical appointments are booked it is our belief that missed appointments will drop. Even if the long term data doesn't end up supporting our hypothesis, we've created a value added customer service that isn't time consuming for clinicians or transit.
3) Broad distribution of outreach materials to our medical care partners. Staff is developing another quick read pamphlet that helps clinicians and other busy medical professionals understand the power of this project. It is anticipated to be in distribution before the next CCO report. We now believe that as many as half of the trips delivered by this project will come as a result of referrals from the medical providers who are relying on us to be a one stop shop to meet the mobility challenge.

Challenges and how you have addressed them:

We were surprised by how challenging it was to get our medical partners on board with FREE and broad distribution of their public service messaging. We found ourselves starving for content. We now believe that it was one of those concepts that may have seemed too good to be true and was therefore not highly prioritized. After meeting with stakeholders at Grande Ronde Hospital in November we were able to launch our first campaign. We're pleased (at least so far) that this part of the project has functioned the way we drew it up.

<u>Center for Human Development, Inc.</u>

This project implements a social marketing campaign targeting primary factors for low weight births in Union County, OR: tobacco use by pregnant women and periodontal disease in pregnancy. The LCAC is responsible for developing the marketing campaign. The objectives of the project are to increase timeliness of prenatal care, increase availability of and utilization of preconception and interconception health care services, increase access to health insurance and PCPCH medical homes, and decrease tobacco use and periodontal disease by pregnant women.

Progress to date:

1. Workgroup has been established. First meeting was October 20, 2014. Meeting schedule has been set for one time per month. Representatives include: Grande Ronde Hospital Children's Clinic; Grande Ronde Hospital Women's Clinic; Tobacco Prevention Coordinator; Eastern Oregon University Student Health; School Based Health Centers for La Grande and Union School Districts; Advantage Dental; and Red Cross Pharmacy.
2. Outreach materials are being developed and will be reviewed/approved at November 24th Workgroup meeting. To date: template for webpage interface and participant response cards (to be signed off by provider, completed by participant, and redeemed for incentive gift card).
3. Next step: To review/revise/refine the content and components for each 'type' of provider visit.

4. Working to develop mechanism for using incentives including engaging partners, how they are distributed to participants, and how to track their use. This includes developing a card that providers and clients can fill out and return to Center for Human Development so the incentive can be mailed to the client along with additional health education information.

Major successes of your project so far:

1. Establishing workgroup with broad representation from key community partners.
2. Partnership with MODA to conduct introductory project mailer to all EOCCO target clients in Union County.

Challenges and how you have addressed them:

1. Framing 'right' questions to ask participants to capture matrix data. Technical Assistance call on November 5th was very helpful. We look forward to having this resource throughout the project.

WALLOWA COUNTY

Wallowa County

This project provides physical education programming & nutrition education for children who are currently not engaged in activities outside the home on Fridays due to the four-day school week. "Fit Fridays" provides health promotion and physical activity sessions for 5th through 8th graders on 16 Fridays throughout the school year. "SwimFit" provides health promotion and swimming lessons also on Fridays. Numerous community partners have agreed to help provide programs or space, including: Wallowa Resources, Wallowa Valley Network of Care, Community Connection, Wallowa Mountain Medical, Winding Waters Clinic, Wallowa Valley Center for Wellness/US Forest Service, Nature Conservancy, Community Parks, Wallowa County ESD, Eagles' View Inn, Extension Office, Trauma Nurses Talk Tough. The goals of the project are to decrease the percentage of overweight children by increasing knowledge about nutrition and diet and fostering healthy behaviors.

Progress to date:

Fit Friday started this fall (October 3 for Wallowa Resources Exploration of Nature (WREN) and October 17 for Swim Fit). Twenty 5-8th graders signed up for WREN and10 K-1st graders for Swimfit. Classes are wrapping up for WREN this fall in mid-November. SwimFit will continue into early December. Students and parents from both programs will be assessed after their last class. Partner support has exceeded expectations with 9 partners contributing either time or materials. Both programs are in full swing and running smoothly. We have received positive verbal feedback from students, parents, and partners about these programs. A second session of SwimFit and WREN will occur April and May. We feel we will reach and possibly grow our process metrics during the spring session.

Major successes of your project so far:

Our biggest success has been partner and community support. Partners are willing to donate time and materials to ensure its success and to help teach valuable life skills. Through the WREN program, we connected with Oregon Department of Forestry to help teach forestry skills and Leave No Trace in donating materials that teach proper outdoor recreation ethics. These were two organizations we didn't foresee contributing to Fit Fridays. As we move into the spring season, we could see additional growth in partner support.

Challenges and how you have addressed them:

SwimFit is new in our community. With any new program, it takes time to generate community awareness and interest. We were also targeting families and kids that were overweight and didn't know how to swim and low-income. Past swim classes in our community were open to select few families that could pay for this service. Since we were targeting a specific segment of our population, it took some additional time to get families signed up and to attend. We followed up with phone calls and letters to ensure participation. The first class had low attendance but now the classes are nearly 85% full and with consistent attendance. The parents have shared that they like the individual attention and small group size.

An additional challenge is the school schedule during weekday holidays (i.e. Veteran's Day). Some schools take the holiday off and have school on Friday while others continue to have a 4 day school week and no school on Friday. Within Wallowa County, we have four school districts and each school district has their own school calendar and not every school calendar is up to date on their website. This can be a logistical challenge when offering a county-wide kid program. Due to this, we have had to adapt our programs. SwimFit had to alter dates of classes and Friday WREN offered a nighttime astronomy program on Friday.

Wallowa Memorial Hospital

This project implements the Complete Health Improvement Program (CHIP) an 18 session education program developed by the Lifestyle Medicine Institute. The sessions are a combination of live and video-lectures, Q &A sessions, reading assignments with a text book and work book, along with different workshops such as cooking classes, demonstrations of plant-based meals, food shopping tours, and clinical breakout sessions. The target population is the middle to upper age population who are more likely to be suffering from one or more chronic diseases. The goals of the CHIP program are to adopt healthier lifestyle habits and decrease utilization of healthcare services.

Progress to date:

The whole project will entail three complete CHIP programs of 18 sessions each over a 2 month period for each program. As of this report, the first CHIP program was completed on November 13, 2014. The second CHIP program will begin January 13, 2015, and the third and last program will begin April 14, 2015. We are one-third way through the project at the time of this report.

Major successes:

We are overjoyed with the results and, more importantly, with the enthusiasm and motivation that we've seen in the majority of the participants to date. As a whole, as seen in the responses to the questionnaire, the participants have been very happy with the instruction and knowledge that they have gained from the program and how to implement that knowledge in a meaningful way in their lives. With knowledge, they are now able to make the needed changes, and make the best choices for their health. The overwhelming consensus has been that they feel better and this will motivate and encourage them to continue along this journey for life-long sustaining health habits.

Challenges and how you have addressed them:

One change in the project metrics was the change in the "Desired Attendance Rate" from 95% to an 89% attendance rate (only missing 2 of the 18 sessions). For reasons mentioned earlier, the participants often have

pre-scheduled activities that conflict with the fairly intense CHIP schedule. However, we are also providing the opportunity for make-up session in the following CHIP courses so that they can gain the full benefit of the program.

WHEELER COUNTY

Wheeler County CAC

For this project, the CAC will implement a health education and outreach campaign and an exercise incentive program. The education campaign focuses on cancer screening, early childhood screenings, exercise promotion, depression screening and treatment options for alcohol and drug abuse. The CAC plans to use local newspapers, community radio, direct mail and a health fair to distribute health promotion materials. The exercise program uses tablet computers with an exercise and diet tracking application which will be provided to 50 individuals enrolled in the program. The project is in partnership with the Asher Community Health Center.

Progress to Date:

1. 1 of 4 quarterly community mailings has been sent to every household in Wheeler County. The first one emphasized weight, risk factors and the availability of 2 options for people who wished to reduce their weight: join the BMI reduction group (transform yourself) or join a Stanford Living Well Class. Asher Community Health Center (ACHC) providers directly mailed letters to ACHC patients who would benefit from the BMI reduction program.

Major Successes of your project so far:

1. Response to outreach was good and both groups achieved capacity although attrition is expected before the end of each. Attrition will be measured.
2. All but 1 member of the BMI reduction group lost weight in the first month.

Challenges and how you have addressed them:

1. Some participants are finding it hard to use the tablets we provide to monitor their dietary intake and exercise. We provide coaching and if the participant still does not wish to use the tablet will provide a calorie counter book so they can monitor their intake on paper.

APPENDIX 1.
EOCCO Grant Guidelines

APPENDIX 2.
EOCCO Grantee Training Agenda

Agenda

Monday, September 15, 2014		
11:00 AM	**Welcome and Logistics** • **Introduce staff and state participants** • **Agenda overview** • **Lunch, breaks and refreshment logistics** • **Restrooms**	**James Foley**
11:15 AM	**Project Charters & Planning (homework- charter/planning template)** • **Usefulness of charters** • **Charter example to walk through** • **Small group charter assessment exercise (introductions, assessments, discussions) (faculty circulate among groups)** • **Presentations from each table (one per table)** • **Conclusion and discussion of importance of project planning going forward.**	**Anne King**
12:00-12:20	**Lunch/Break** • **Buffet line- once participants have their food Ron will start**	
12:20-1:20 PM	**Metrics and Evaluation (homework- metrics and evaluation template)** • **Why measurement and evaluation are important** • **Definitions of outcome, process and balance measures** • **Metrics worksheet example to walk through** • **Small groups present evaluation plans and give feedback to each other (faculty circulate among groups)** • **Presentations from each table (one per table)** • **Concluding remarks**	**Ron Stock**
1:20-1:40 PM	**Required Evaluation Tools (handout- evaluation tools)** • **Due date for final charters and metrics template which will feed into evaluation forms** • **Evaluation schedule** • **Review evaluation template & timeline** • **Q&A**	**Anne King**
1:40 -2:00 PM	**Discussion and Next Steps**	**James Foley**
	Adjourn	

APPENDIX 3.
Charter and Metrics Tools

APPENDIX 4.
East Oregonian Article