Columbia Gorge Regional Community Health Improvement Process

Collective Impact for Optimum Health and Optimized Healthcare

A summary of the focus areas for improved health for the residents of the Columbia Gorge region including Hood River, Wasco, Sherman, Gilliam counties in Oregon and Skamania and Klickitat counties in Washington. A companion document to the Columbia Gorge Regional Community Health Assessment – December 2013

June 2014

The participants of the Community Advisory Council of the Columbia Gorge Health Council and PacificSource Community Solutions – Columbia Gorge CCO were instrumental in creating this document

Columbia Gorge Regional Community Health Improvement Process

Collective Impact for Optimum Health and Optimized Healthcare

Our Community Health Improvement Approach

The formation of the Columbia Gorge Health Council and the Community Advisory Council (CAC) provided a catalyst for a collaborative approach to the Columbia Gorge Regional Community Health Assessment (CHA) and the Columbia Gorge Regional Community Health Improvement Process (CHIP).

The CHA was completed in December 2013 with the support of the organizations listed in the sidebar. In the few short months since December, individual organizations have utilized the CHA as the basis for meeting state and federal community health assessment requirements. As an added bonus, the community-wide health assessment information supported local organizations in completing grant applications seeking to address highlighted gaps.

Collaborators for Community Health Assessment (CHA)

- Columbia Gorge Health Council
- Hood River County Health Department
- Klickitat Valley Health
- Klickitat Valley Health Department
- Mid-Columbia Center for Living
- Mid-Columbia Medical Center
- North Central Public Health District
- One Community Health
- PacificSource Community Solutions
- Providence Hood River Memorial Hospital
- Skyline Hospital

The success of the CHA has fortified our resolve in working towards a regional approach to improving community health and optimizing healthcare. Historically, health improvement plans were often created separately for various populations and areas in the Columbia Gorge Region. Local organizations have been independently implementing health improvement activities – each with varying degrees of success. Following on the heels of our first collaborative Community Health Assessment, we are embarking on a collective impact approach for our Community Health Improvement Process – a community engagement technique that has ongoing impact. As a result, this Columbia Gorge Regional Community Health Improvement Process (CHIP) describes not only the top focus areas but also a method for ongoing collaboration in the region. As part of this ongoing process, we intend to bring together the healthcare ecosystem partners as well as the social service agencies and non-profits that serve the vulnerable populations in our area.

Community Advisory Council (CAC)

The Community Advisory Council (CAC) is the central body chartered with the Community Health Improvement Process (CHIP). Our region is small with limited resources, yet our relationships are strong across healthcare, agencies and members. A cornerstone element of this CHIP is to have an inclusive

approach within our community. We have varied representation from Healthcare, Social service agencies and non-profits as well as a diverse member perspective at the table (See Table 1 on Page 3)

Table 1 - Community Advisory Council

Healthcare	Social & Economic Conditions	Member Perspectives
• Hood River Fire & EMS • Hood River County Health Department • Klickitat County Health Department • Klickitat Valley Health • Mid-Columbia Center for Living - behaviroal health services • Mid-Columbia Fire & Rescue • Mid-Columbia Medical Center • North Central Public Health District • One Community Health (Federally Qualified Health Clinic) • Providence Hood River Memorial Hospital • Skyline Hospital	• Aging and People with Disabilities • Area Agency on Aging • DHS - Department of Human Services; child welfare and self-sufficiency • HAVEN - Help Against Violent Encounters Now! • Hood River County Health Promotion and Prevention • Meals on Wheels – The Dalles • Mid-Columbia Children's Council • Mid-Columbia Community Action Council • Mid-Columbia Council of Gov'ts • Oregon Health Authority • Sherman County Court • The Next Door, Nuestra Comunidad Sana • Wasco County YOUTHTHINK (prevention)	• Parent of child with disabilities • Grandparent of child with disabilities • Adult with disabilities • Adult with Dual diagnosis • Latino • Parent of child with behavioral issues • Low-income • English as a second language • Migrant/Seasonal Farmworker liaison

We also see a growing emphasis by institutions to establish or strengthen their member voice into program and process designs. Our hope is to be the CAC for those various organizations in addition to the Columbia Gorge Health Council and PacificSource Community Solutions. As a holistic Community Advisory Council, we strive to:

- Provide tangible member feedback on PacificSource - Columbia Gorge CCO services, programs and systems
- Be available for organizations beyond the traditional Oregon Health Plan/Medicaid services seeking member input on program and process designs
- Identify topics of concern from the Community Health Assessment
- Amplify the impact of agencies and healthcare providers by convening all participants on a specific focus area.
- Improve community integration by connecting organizations

The Focus Areas for the Columbia Gorge Region

Identifying the Focus Areas

The Community Advisory Council (CAC) used a 2-step process to identify the focus areas for the region. The group began with the full list of topics from the Community Health Assessment and added two topics noted below with a * based on member experiences with services in the region.

Full list of potential focus areas:

Income
Housing
Food
Transportation
Health insurance status
Have a Primary Care Provider
Have a usual place for care
Distance to usual place of care
Physical health access – adult
Physical health access – children & youth
Dental health access – adult
Dental health access – children & youth
Mental health access – adult
Mental health access – children & youth
Substance abuse treatment – adult
Substance abuse treatment – children & youth
Medications
General health and social isolation
Weight management
Physical health status
Mental health status
Physical and mental health together
Tobacco use
Problem drinking
Street drug use
Domestic/sexual violence
* Coordination across all healthcare providers
* Coordination between healthcare and social services

Each CAC participant selected five topics from the full list above of 28 topics. Based on the selections of all CAC participants with a special weighting on consumer member selections, the initial list of focus areas fell into three broad buckets: 1) Social and Economic Conditions (sometimes referred to as Social Determinants of Health), 2) Direct Healthcare Services and 3) Health and Healthcare Ecosystem. During the final review and group discussion, an additional category was added - Supporting Developmental and Healthy Growth in the Early Years.

Final focus areas for the Columbia Gorge Community Health Improvement Process

Social and Economic Conditions	Direct Healthcare Services	Health and Healthcare Ecosystem
• Housing & Food • Jobs • Transportation	• Dental Access for Adults • Physical and Mental health together • Mental Health access for Children & Youth	• Coordination across healthcare and social services • Health insurance re-enrollment • Coordination across the spectrum of healthcare providers (physical, mental, dental, pharmacy) • Supporting Developmental and Healthy Growth in the Early Years

The topics in the Social and Economic Conditions section are large in scale and typically not the purview of healthcare spending. However, the CAC recognizes the impact these circumstances have on the health of our community members. By highlighting the four focus areas in the Social and Economic Conditions category, the intention is to support the local agencies chartered with addressing these issues and to provide a strong CAC voice as needed.

Direct Healthcare Services category is just that – the healthcare services provided directly to members that have the highest concern from the Community Advisory Council. The three topics included are Dental Access for Adults, Physical and Mental health together and Mental Health access for Children & Youth. The combination of OHP expansion in the region, a limited number of dental providers serving OHP and the addition of preventive services for adults beginning in January 2014 led to Dental Access for Adults on the CHIP list. The CAC also recognizes that wellness includes mental health as well as physical health. The two other topics in this category are centered on the integration of mental and physical health in addition to a specific focus on services for children and youth.

The Health and Healthcare Ecosystem category highlights how organizations interact and coordinate health and healthcare services. Two of the topics listed focus on coordination across different providers and agencies. While these are often thought of as being 'behind the scenes', the Community Advisory Council is highlighting a need to improve coordination across institutions. The third topic of Insurance Enrollment is a complex process with multiple organizations often leading to the community member without insurance coverage. The absence of coverage is a concern and motivation for inclusion. The fourth topic - Supporting Developmental and Healthy Growth in the Early Years is recognition of Early Learning Hub work that is emerging and the need for healthcare and education to work in closer harmony.

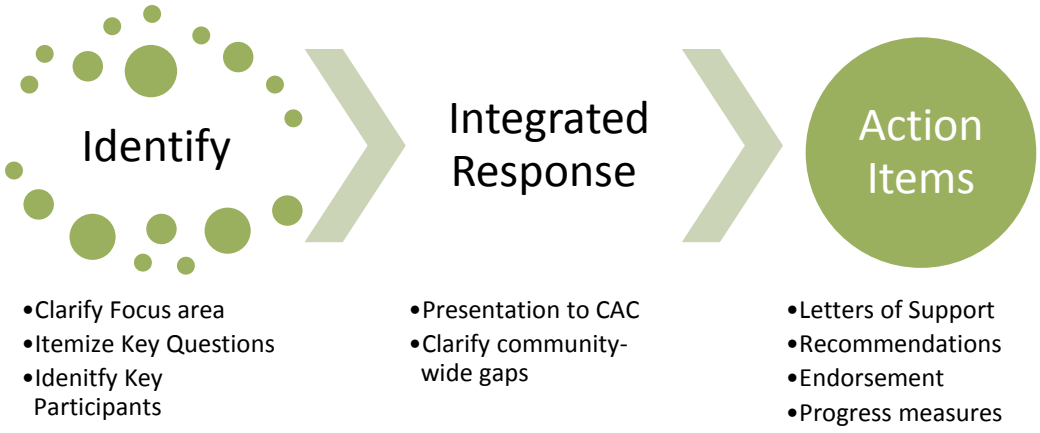
We are fortunate to have many organizations that care for our community. A topic highlighted in this CHIP is not intended to speak poorly of those who are involved with improving the lives of our most vulnerable. Our hope is that the CAC voice and our collective impact process will help bring community-wide focus and increased opportunity for support to make substantive improvements.

The Community Health Improvement Process

The Community Health Improvement Process consists of a repeating sequence of three steps:

1. Identify. While we are a small region, we are fortunate to multiple organizations providing services within the region. The CAC does not intend to replace or supplant these organizations but instead to act as a convener for a collective impact response to an identified focus area. By doing so, we hope to boost the awareness of these organizations in the community and to facilitate cooperative recognition of strengths and gaps in the area. To do this effectively, the CAC will clarify the focus area by itemizing a list of questions, which, in turn, will help identify the Key Participants needed as part of the integrated response team.
2. Integrated Response. This step represents the integrated response from the Key Participants or related partner organizations. The response is in the form of a presentation (or presentations) to the CAC. It also provides the Key Participants an opportunity to garner CAC endorsement of recommended changes that might affect the members of the community. A key component of the Integrated Response is a community-wide assessment of the As-Is situation. A comprehensive overview of the As-Is may identify services and options that may be currently available but under-utilized.
3. Action items. An expected output from the integrated response is a list of action items. The potential candidate list of action items include:
    a. Items needing CAC endorsement for process changes
    b. Letters of support for grants tied to identified gaps
    c. Recommendations for the Columbia Gorge Health Council Board and PacificSource Community Solutions
    d. Support of the agencies and/or other partners needed to implement improvements or to support interventions or innovations to fill gaps or needs
    e. Agreement on a common set of measures of success

Figure 1- Community Health Improvement Process



We are intentional in our use of 'collective impact' as we embark on this new Community Health Improvement Process for our region. The five conditions that must be present for collective impact success are:

1. *Common Agenda: All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.* Our regional approach has led to a shared list of focus areas.
2. *Shared Measurement: Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.* Each focus area will include recommending measures of success that all parties can support.
3. *Mutually Reinforcing Activities: Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.* Through the creation of the cross-industry and cross-organizational work teams, our hope is that proposals and recommendations help reinforce the best in the region and identify opportunities for improvements.
4. *Continuous Communication: Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and appreciate common motivation.* Our meetings are open and the intention is for inclusion and balance in all discussions.
5. *Backbone Organization: Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.* The Community Advisory Council along with the Columbia Gorge Health Council and PacificSource Community Solutions provides the backbone support.

How to Read the Focus Area Tables

The following pages will describe the focus areas for the Community Health Improvement Process. Each focus area will have a similar table summarizing the key information.

The organizations working together developing the integrated response

Focus Area: ←*Name of focus area*
CAC Liaison: *Name of CAC member to clarify questions for Integrated Response Team*
Integrated Response Team:

Why:	**Member Stories:**
Summary points on why it is a focus area Include references from CHA: • Community Survey results • ED utilization rates • Forces of change concerns • Agency or provider top concerns	personal stories from community members

Key Questions:

1. Summarize the current set of needs for a particular service . How do they a
2. How are services adapted services to meet the needs of the under-served p
   those with limited transportation options or limited English proficiency?
3. What is working well with the services provided? What opportunities exist
4. How is integration with other healthcare services working?
5. Over half of the Community Health Assessment survey respondents reporte
   overweight. In what ways does the team see encouragement for healthy lifestyles and nutritional eating in the course of receiving services? Any suggested improvements?
6. What are the measures of success that all partner groups can adopt?
7. What support do you need from the CAC?

The list of key questions as a means to focus the discussion

Outcome of Integrated Response
Do any gaps remain? If so, what actions and/or information are required?
Are there any key insights or learnings to be shared?

Actions to Be Taken – to be completed following Integrated Response

Task	**Who**	**By when**

Key summary points of the discussion.

Next steps to be completed.

List of Focus Areas

The Community Advisory Council (CAC) selected the following focus areas as part of the Community Health Improvement Process (CHIP). In addition to the technical expertise outlined for each Integrated Response Team, the Community Advisory Council (CAC) will assist with enlisting community members to be part of work groups as needed.

Category	Focus Area	Integrated Response Team	Page
Social and Economic Conditions	**Housing & Food**	Expertise in housing programs in the Gorge, homeless shelter programs, local food banks, local meal programs, Food programs (e.g. SNAP), ministries, school lunch programs, food programs for childcare services, food preparation programs and dieticians.	12
	Transportation	Regional Solutions Centers (RSCs) are places for state agencies to collaborate with each other, local governments, and with other public, private, and civic interests to solve problems and seize opportunities. Regional Advisory Committees, made up of Oregonians appointed by the Governor from business, civic organizations, government, foundations, and higher education, identify priorities to guide the work in each of the ten regions in the state. Both Transportation and Jobs are priorities for the North Central Region.	To be developed together with Regional Solutions
	Jobs		
Direct Healthcare Services	**Dental Access for Adults**	Expertise in local dental network, dental services, dental surgery services, hospital and Emergency Room services, programs for vulnerable populations (e.g. Gorge Dental Access Coalition – GDAC, Dental van)	12
	Physical and Mental health together	Integrated Care Work Team – established team through the Columbia Gorge Health Council. Members include a range of physical and mental health providers, clinic administration, PacificSource and health department expertise.	16
	Mental Health access for Children & Youth	Expertise in public and private mental health services and network, public and private schools, preschool and childcare programs, local early childhood development and treatment programs, primary care delivery, health departments, children advocacy programs.	17
Health and Healthcare Ecosystem	**Coordination across all healthcare providers**	Expertise in public and private health services and network, pharmacy, durable medical goods (e.g. crutches)	19
	Coordination across healthcare and social services	To be developed as follow-on work from Oregon Solutions work and formation of the Pathways Community Hub in the Columbia Gorge.	21
	Health insurance re-enrollment		

	Supporting Developmental and Healthy Growth in the Early Years	Expertise in Targeted Case Management services, Early developmental screening and treatments services in public and private organizations, primary care, mental health, oral health, DHS – Child Welfare, community preschools programs, child care providers	22

Some areas from the Community Health Assessment are difficult to address as stand-alone discussions. Instead, we chose to have a set of questions included into the above-mentioned focus areas where appropriate. The table below highlights the area of concern and includes sample questions for inclusion as needed:

Weight Management – addressing issues with community obesity and overweight	In what ways do you encourage healthy lifestyles and nutritional eating? In what ways do you encourage exercise and fitness? In what ways do you encourage nutritious food and health cooking?
Limited English proficiency	In what ways do you adapt services to meet the needs of those with limited English proficiency?
Transportation	In what ways do you adapt services to meet the needs of those with limited transportation options?

Focus Area – Housing & Food

Focus Area: Housing & Food -
CAC Liaison: Jim Slusher, Lori McCanna, Marvin Pohl
Integrated Response Team: Mid-Columbia Community Action Council, FISH, SNAP, WIC, Gorge Grown, Bread & Blessings, WGAP (Klickitat Food Bank), Mid-Columbia Housing Authority, Meals on Wheels, School lunch programs, Homeless shelters, Habitat for Humanity, OCDC, Registered dietician @ HRCHD, Regional Solutions

Why:
Premise is that to positively impact health and prevent disease, people need not only enough food, but the ability to nourish themselves.

From the Community Health Assessment, **Housing** insecurity is based on Question 50 – *Did you or family members have to move in the last 12 months due to inability to pay rent, mortgage or utilities?* 7.0% of the in-person survey respondents responded Yes with a higher rate for Low Income and Limited English Proficiency individuals.

Food insecurity is based on people saying that they had been worried that food would run out before they had money to buy more. Food insecurity is felt by:

- Nearly 1/3 of those living below 100% of the federal poverty line
- 36% of Hispanic or Latino respondents experienced it in the past year.
- Nearly two-thirds (65.2%) of Native Americans report experiencing food insecurity

Member Stories:

"Recently we were able to move into a new house that is wheelchair accessible. We didn't have enough money to cover the deposit plus last month's rent. The local Community Action Program (CAP) office in The Dalles came to our rescue as my wife is in a wheelchair and qualified for financial assistance."
OHP Dual eligible member

We have a client that suffers from multiple, severe chronic conditions. He was living in sub-standard housing that was expensive to heat in the winter, poor plumbing, drafty windows and doors, and mold in the bathroom. He was spending a large portion of his fixed-income on rent and was unable to pay all of his monthly bills. He was forced to relying on food stamps and the FISH Food Bank to feed himself. We were able to assist him to get into subsidized housing, where he now resides in a clean, safe and well-maintained environment that is much more conducive to healthy living. His rent is appropriately balanced to his income, and he is able to cover his monthly commitments, greatly decreasing his stress level. He is close to the hospital as well as his primary care provider. He now has a support system close to home with neighbors that check on him daily and provide companionship, essentially ending his social isolation.
Social Service agencies

"*I would put competent people that would guide all those who are sick, for example diabetes, to teach them how to eat healthier have workshops for this or groups by trained people on how to eat healthier for those who have diabetes, any disease. How to eat better and remove many foods that are bad for us.*"
Response from Latino focus group participant when asked 'What three things would you do immediately to improve health services for everyone in this community?'

Key Questions:

1. Housing:
    a. How do we make sure there is affordable housing for our population?
    b. How could we establish a renter education program in the community that could help prevent evictions/loss of housing?
    c. How can we establish short-term housing assistance (funding) for people temporarily unable to work for health reasons?
    d. How can we develop a community program that develops "tiny housing"
    e. Can we develop a community group or groups that can address top 5 issues related to homelessness so we can address gaps in the community?
    f. Do any population groups experience an uneven amount of housing issues compared to others? If so, how might we reduce that inequity?
    g. What are the measures of success that all partner groups can adopt?
2. Food:
    a. How are people educated and supported to make efforts to prepare healthy, nutritious meals on limited budgets?
    b. How can we ensure people receive education on the health dangers of over consumption of calories?
    c. How can we ensure people receive education on the health dangers of relying on processed foods to feed themselves and their families?
    d. Do any population groups experience an uneven amount of food issues compared to others? If so, how might we reduce that inequity?
    e. How should and can the community help prepare students and educate adults on how to budget their food dollars for optimal health and wellness? How do we begin to teach children at the school level how to choose healthy meals and snacks?
    f. What are the measures of success that all partner groups can adopt?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response

Task	Who	By when

Focus Area – Dental Access for Adults

Focus Area: Dental Access for Adults
CAC Liaison: Mark Thomas, Trish Elliott
Integrated Response Team: Advantage Dental, Capitol Dental, Moda/ODS, Hospital Emergency Room contacts, Hospital Community Benefit Funds, Gorge Dental Access Coalition (GDAC), Dental van, GAP, Private independent dentists

Why:
From the Community Health Assessment, dental care was the most common form of unmet healthcare need. From the mail survey, one in five adults reported that they had unmet dental care needs within the past year. For the In-person survey, more than one in four (27.5%) adults reported that they had unmet dental care needs within the past year.

Starting in 2014, we are worried about overall dental capacity due to the combination of OHP expansion and new preventive dental benefits for adults.

Dental issues are #5 in ED utilization for the region overall and #2 at MCMC in particular for 2013

Member Stories:
'I had to have a couple teeth pulled. The dentist wanted to pull one and then wait 30 days to pull the second. When I asked why, I was told they got paid more if they did it as two separate procedures. I had to pound my fist on the table to get them to do it the same way they would a regular [commercially] insured person.' **OHP member**

'When I started my medications, I was told by my therapist to brush my teeth and see the dentist. My medications caused dry mouth, which is bad for your teeth. I was lucky to be told that. What are we doing to make sure everyone gets that advice?" **Community Member**

"I am missing two teeth and that's why I haven't gone. I have not gone to the doctor. I will be going to Mexico to fix this, because it is cheaper over there." **Focus group participant**

"My husband was seeing a good dentist for a couple of years, but was unable to see him anymore because the clinic wouldn't take OHP." **New OHP member**

Key Questions:

1. With the growth in OHP members along with expanded benefits for adults, we are worried about overall appointment access for adults for preventive and non-ER urgent dental care.
    a. Does the team have a similar concern?
        i. If so, is this community wide regardless of insurance coverage? Please educate us. What suggestions/ideas does the team have to address access?
        ii. If not, what information can the team share with the CAC on why this is not a concern?
2. Our community has under-served populations that struggle with getting any type of care. Please educate us on how adult dental services are adapted for (or offer suggestions):
    a. People with limited transportation options
    b. People with limited English proficiency
    c. People with limited ability to pay uncovered services or are uninsured.
    d. People with low dental health literacy
    e. Any other population groups that experience an uneven access to care
3. As the team with dental expertise, what would be your prioritized suggestions for oral health

prevention in our community?

4. Dental services are one form of healthcare in the community.
    a. In what ways does the group see great integration with other healthcare providers (e.g. medical, mental, pharmacy)?
    b. In what ways could integration between dental and other healthcare providers be better?
    c. Over half of the Community Health Assessment survey respondents reported that they were overweight. In what ways does the team see encouragement for healthy lifestyles and nutritional eating in the course of receiving dental services? Any suggested improvements?
5. What are the team's thoughts on establishing a point-of-entry network of coordination for urgent care needs with residents without a dental home in the region, and what would that look like?
6. What are the measures of success that all organizations can adopt?
7. What support does the team need from the CAC?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response

Task	Who	By when

Focus Area - Physical and Mental health together

Focus Area: Physical and Mental health together – addressing issues with community members with both physical and mental health issues
CAC Liaison: Debby Jones, Susan Lowe, Karen Polehn
Integrated Response Team: Wasco Youth Services, CGHC, Health Departments, MCCFL, CGFM, COIPA, OCH, MCMC, MCOC, PacificSource, Pharmacy, Providence, Gorge Counseling, Mental Health Residential, OHA, Central Washington Comprehensive Mental Health

Why:
From the Community Health Assessment, 20.6% overall reported having both a mental health and chronic physical health condition.

Cost was primary concern for not using Physical Health Services. With OHP expansion, more people have coverage for services. However, other factors such as 'Didn't think it would help or worried what others would think' were more prevalent on why people did not seek mental health services.

OHA is expecting Integration of Physical Health and Behavioral Health services- both in Quality Incentive Measures and in Transformation Plan deliverables.

Member Stories:

"It's really important that we have someone to just unload on… I think for women especially…" **Senior focus group participant**

"For some, the loss of independence affected their mental health and increased depression. As stated by one participant, "I just gave up my car last month and feel like I lost my right arm. It makes me more dependent on my children…" **Senior focus group participant**

Key Questions:

1. Summarize the local community need for integrated care. How do the service offerings align with the needs? What do you collectively see as the biggest gap for Physical and Mental Health Services together in the community?
2. Briefly describe the range of integrated physical health and behavioral health care services for individuals with: Asthma, Diabetes, High Blood Pressure, High Cholesterol, Depression, Anxiety, PTSD, Problem drinking or Drug Use for all insurance categories: [OHP, Medicare, Commercial, Uninsured]
3. If the community options vary greatly by condition or insurance status, are there plans underway to remove disparity in the community? If no plans, what recommendations does the team have?
4. The Consumer Survey responses on reasons for not seeking Mental Health services are different from physical or dental care. How will integration address these reasons?
5. How does the team see services adapting to meet the needs of the under-served populations including those with limited transportation options or limited English proficiency?
6. What are the measures of success that all partner groups can adopt?
7. What support do you need from the CAC?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response

Task	Who	By when

Mental Health Access for Children & Youth

Focus Area: Mental Health Access for Children & Youth
CAC Liaison: Joella Dethman
Integrated Response Team: Mid-Columbia Center for Living, Public Schools, Mid-Columbia Children's Council, Early Intervention, OCDC, PCPs, Health Depts, NPS, Children's Advocacy Center, Child care providers, community preschools, private schools, private mental health providers, Central Washington Comprehensive Mental Health

Why: From the Community Health Assessment, 10.6% of those with children said that at least one of their children had needed treatment or counseling for an emotional, developmental or behavioral problem and did not get all the care that he or she needed. Although the numbers of parents whose children require behavioral health treatment may be smaller, behavioral health care for children may be a significant unmet need in the Columbia Gorge area.

The Agency sessions called out Mental Health Access for Children and Youth as an unmet need in the community. In particular, bi-lingual therapist access was noted as a particular gap.

Early Childhood Committees identified unmet mental/behavioral health needs as a primary issue for the region. Mid-Columbia Children's Council identified 17% of enrolled children on a Social Emotional Support Plan (2013-14).

Member Stories:

'When my son was a senior in high school, I knew he was drinking and smoking pot. I went to every agency I could think of to try to get help for him. I was told that until he got in trouble with the law, there really wasn't anything anyone could do.' **OHP Member**

'When we inquired about family counseling and multi-family groups, we were told that I could sit in on his one on ones but that specific family therapy and education were not available locally. I was stunned because of the research I had done; offering these services along with intensive outpatient has proven to have a 72% better success rate.' **Parent of OHP Member**

Children's Advocacy Center refers abused children to the public mental health agency and private counselors but do not hear if children receive needed support. In-home services may be indicated for some children/families.

A home visiting program serving both Hood River and Wasco counties reports that they do not make referrals to the public mental health agency as they were unable to access services for clients and gave up making referrals.

Key Questions:

1. Summarize the mental health services needed in the local area for all children, youth and their families. When looking across all the organizations (public & private) in the region, do the local services seem sufficient to serve the needs of the community? If not, what areas have the biggest gaps? Do the gaps vary by insurance?
2. Some communities have established community wide processes such as a common form. Does the team have any specific suggestions for standards that would improve the delivery of mental health services in the community?
3. Referrals and coordination of care are often needed with youth and families seeking mental health services. In what areas are referrals and coordination working well? In what areas are referrals and coordination problematic? What recommendations does the team have for improving referrals and

coordination?

4. Our community has under-served populations that struggle with getting any type of care. Please educate us on how Mental Health Access for Children and Youth services are adapted for (or offer suggestions):
    a. Families and children with limited transportation options
    b. Families and children with limited English proficiency
    c. Families and children with limited ability to pay uncovered services or are uninsured.
    d. Any other population segment that experiences uneven access to care
5. In view of health care and early learning transformation, what does the team see as the top three changes needed?
6. What are the measures of success that all organizations can adopt?
7. What support do you need from the CAC? What about support needed from the Clinical Advisory Panel (CAP)?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response

Task	Who	By when

Focus Area – Coordination across all Healthcare service providers

Focus Area: Coordination across all Healthcare service providers
CAC Liaison: TBD
Integrated Response Team: TBD

Why:

Some of the new OHP members as part of 2014 Medicaid expansion are utilizing the Emergency Department as first point of care rather than PCP.

Complex medication regimes are difficult to achieve adherence.

The eco-system inhibits providers or caregivers from trying or leveraging alternative options (e.g. 'air conditioner fund').

Variations across organizations on referral process, timelines and feedback to the referring provider make it nearly impossible for PCPs and their staff to effectively track progress and outcomes.

Member Stories:

"*People talk that healthcare is too expensive when there are simple solutions that cost less. I need a knee replacement, and instead of getting an elastic support brace (less than $100) I had to have a fancy brace with a metal hinge. The fancy brace does not fit so it is on the shelf unused but paid for by Medicaid. The elastic brace (which worked better) I had to pay for*." **OHP Member**

"My Dr. told me that I needed to lose weight and I wanted to use the Medifast program. Unfortunately, Medifast is not a covered benefit. I cannot afford the weight loss program but somehow healthcare can afford to pay for all my medical services." **OHP Member**

"It is difficult for us to know exactly which services will be covered and which won't. It frustrates me even more that sometimes doctors or dentists don't tell us beforehand that a service won't be covered. I had a tiny surgery done on my lip three months ago, and I assumed that OHP would cover it because I had undergone those kinds of surgeries two other times in the past and it paid for them. This time was different, however, because I received a letter in the mail that the insurance wouldn't pay for it." **OHP Member**

Key Questions:

1. How has information exchange or lack thereof affected your ability to provide client services? Please provide an example of your inability to obtain needed information or a barrier to you providing information to another provider or agency. (Examples: patient no show, delay in making appointment, cancellation of appointment due to lack of information, etc.)
2. Do you feel that there is redundancy in the collection of patient information? If so, what kinds of client information, if available across the continuum of providers would be most helpful? Example: Real-time notification of hospital admissions of Emergency Room visits by patients receiving service from other agencies.
3. Do you see any value in a universal release of information form?
4. What would be the top three region-wide recommendations you would make to improve coordination?
5. What are the measures of success that all partner groups can adopt?

Summary of Integrated Response – to be completed
Actions to Be Taken – to be completed following Integrated Response **Task Who By when**

Focus Area – Coordination across Healthcare and Social Services; Health Insurance re-enrollment

Focus Area: Coordination across Healthcare and Social Services; Health Insurance re-enrollment
CAC Liaison: Catherine Whalen, Kris Boler
Integrated Response Team: TBD

Why:	**Member Stories:**
For community members at 100% of Federal Poverty Level or lower, 60% are struggling with any combination of having enough food, ability to pay rent and borrowing money, skip paying other bills, or pay other bills late in order to pay health care bills. 9% of OHP kids and 11% of adults fall off OHP enrollment due to confusion on re-enrollment steps	"*When I see my Physician, it helps if I have a social worker or one of my sisters with me at the appointment. Then things about my care don't get so overwhelming and shut me down. I often don't hear what is being said. The other person can help guide me back to reality and when I am done with the appointment, I can ask questions and not rely on my own memories.*" **Medicare Member** *"I am a disabled person living in a subsidized house. Business changes are threatening the ongoing availability of this housing and causing aggravation of my mental health issues."* **Community Member**

Key Questions:

1. How has information exchange or lack thereof affected your ability to provide client services? Please provide an example of your inability to obtain needed information or a barrier to you providing information to another provider or agency. (Examples: patient no show, delay in making appointment, cancellation of appointment due to lack of information, etc.)
2. Do you feel that there is redundancy in the collection of patient information? If so, what kinds of client information, if available across the continuum of providers/agencies would be most helpful? Example: Real-time notification of hospital admissions of Emergency Room visits by patients receiving service from other agencies.
3. Do you see any value in a universal release of information form?
4. What would be the top three region-wide recommendations you would make to improve coordination?
5. What are the measures of success that all partner groups can adopt?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response

Task	**Who**	**By when**

Supporting Developmental and Healthy Growth in the Early Years

Focus Area: Supporting Developmental and Healthy Growth in the Early Years
CAC Liaison: Joella Dethman, Ellen Larsen
Integrated Response Team: North Central Public Health District, Hood River County Health Department, OCDC, Head Start, Early Intervention programs, primary care providers, mental health, oral health, DHS – Child Welfare, community preschools programs, child care providers

Why: From the Community Health Assessment, 10.6% of those with children said that at least one of their children had needed treatment or counseling for an emotional, developmental or behavioral problem and did not get all the care that he or she needed. Although the numbers of parents whose children require behavioral health treatment may be smaller, behavioral health care for children may be a significant unmet need in the Columbia Gorge area.

18% of children at Mid-Columbia Children's Council have an identified disability.

Member Stories:
Hood River Early Intervention/Early Childhood Special Education (EI/ECSE) has only received one referral from public mental health agency in the last seven years.

An EI/ECSE staff person ran into a parent of a child with a cleft pallet at a community playground and asked if they were working with EI/ECSE. The child was being seen by a local doc but had not been referred for speech therapy. Over the next year, the child's speech improved substantially with therapy.

Key Questions:

1. Summarize the types of child and youth mental health services available in the community overall from public and private organizations. When looking across all the organizations (public & private) in the region, do the local services seem sufficient to serve the needs of the community? If not, what areas have the biggest gaps?
2. Do any population groups experience an uneven access to supportive services? If so, how might we reduce that inequity?
3. Summarize what developmental assessment tool(s) are being used in which locations in the community and how improvement is measured. Are there opportunities to streamline or standardize?
4. Some communities have established community wide processes such as a common form. Does the team have any specific suggestions for standards that would improve healthcare in the community?
5. Referrals and coordination of care are often needed with youth and families seeking mental health services. In what areas are referrals and coordination working well? In what areas are referrals and coordination problematic? What recommendations does the team have for improving referrals and coordination?
6. In view of health care and early learning transformation, what does the team see as the top three changes needed?
7. Summarize which access points ask if families run out of food and how follow-up and referrals happen. Does the group have observations to share?
8. In view of health care and early learning transformation, what are our future goals and plans for services?
9. What does the group think would be a solution to providing & coordinating services?
10. What are the measures of success that all partner groups can adopt?

Summary of Integrated Response – to be completed

Actions to Be Taken – to be completed following Integrated Response **Task Who By when**

Getting Started – Team formation and reviewing recommendations

With the focus areas selected, many of the questions initially drafted and liaisons identified, the next phases will be convening the various Integrated Response Teams and presenting the current situation and recommendations to the CAC.

Our goal is to weave a combination of current state information, CAC input and Integrated Response Team recommendations over the course of the next 24 months. In addition, some of the focus areas have Transformation Fund projects and will have progress reports to the CAC over the next 12 months.

As Integrated Response Teams complete their current state assessments and finalize recommendations, the team content will be added to this Community Health Improvement Process document. The intention is to continue to evolve our community-wide base of information in these ten focus areas. Our hope is that this community-wide information assists local organizations in meeting their regulatory reporting requirements and provides necessary information for organizations seeking grants to address community-wide needs.

By 2016, we hope to have reviewed all the topics in advance of the update to the Community Health Assessment work.

Appendix

Full list of Candidate Categories with brief definition

- Income- addressing issues tied to overall financial hardship.
- Housing- addressing issues tied to affordable housing.
- Food – addressing issues tied to affordable and health foods.
- Transportation – addressing issues tied to accessible transportation.
- Health insurance status - access to and maintaining enrollment in any type of health insurance.
- Have a Primary Care Provider (PCP)
- Have a usual place for care
- Distance from usual place of care – addressing issues tied to distance to travel to get care.
- Physical health access – adult – addressing issues with appointment access and receiving services needed for adults.
- Physical health access – children & youth - addressing issues with appointment access and receiving services needed for children and youth.
- Dental health access – adult - addressing issues with appointment access and receiving services needed for adults.
- Dental health access – children & youth - addressing issues with appointment access and receiving services needed for children and youth.
- Mental health access – adult - addressing issues with appointment access and receiving services needed for adults.
- Mental health access – children & youth - addressing issues with appointment access and receiving services needed for children and youth.
- Substance abuse treatment – adult addressing issues with appointment access and receiving services needed for adults.
- Substance abuse treatment – children & youth - addressing issues with appointment access and receiving services needed for children and youth.
- Medications – addressing issues with filling prescriptions, affording medications.
- General health and social isolation – addressing issues with populations or areas.
- Weight management- addressing issues with overweight community members.
- Physical health status- addressing issues with chronic physical health.
- Mental health status -addressing issues with chronic mental health.
- Physical and mental health together.- addressing issues with community members with both physical and mental health issues.
- Tobacco use – both prevention and cessation programs
- Problem drinking – treating problem drinking as well as prevention efforts
- Street drug use – treating drug use as well as prevention efforts
- Domestic/sexual violence – treatment and prevention efforts
- Coordination across different health, mental and dental providers- addressing issues with care coordinating across physical, mental and dental health services
- Coordination between healthcare and social services - addressing issues with coordinating issues with health care organizations and social service organizations. (DHS, Housing, Food Banks).