Community Health Improvement Plan Progress Report

June 2019

PacificSource Community Solutions - Columbia Gorge

Community Health Improvement Plan Progress Report

Background - the 2016 Community Health Assessment

The Coordinated Care Organization (CCO) operating in Hood River and Wasco Counties in Oregon is a collaborative effort of PacificSource Community Solutions, which holds the CCO contract with the state, and the Columbia Gorge Health Council, an independent 501(c)(3) nonprofit organization that serves as the CCO's governing board. The Community Health Assessment (CHA) and resulting Community Health Improvement Plan (CHP) are completed by the Columbia Gorge Health Council, while responsibility for implementing the CHP is shared by all participants in the CCO and broadly in the community.

In 2016, the Columbia Gorge Health Council led a collaboration of the following community partners, known collectively as "the cohort," that needed to complete Community Health Assessments for their regulatory or legal requirements:

- Columbia Gorge Health Council
- Four Rivers Early Learning Hub
- 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
- United Way of the Columbia Gorge

The Community Advisory Council (CAC) and the cohort share various parts of the decision making for the Community Health Assessment. In accord with the collaborative agreement, the CHA process meets the most rigorous requirement placed on any member of the cohort. The third iteration of the CHA is starting now, in 2019, in order to meet the IRS requirement that nonprofit hospitals conduct the process every 3 years.

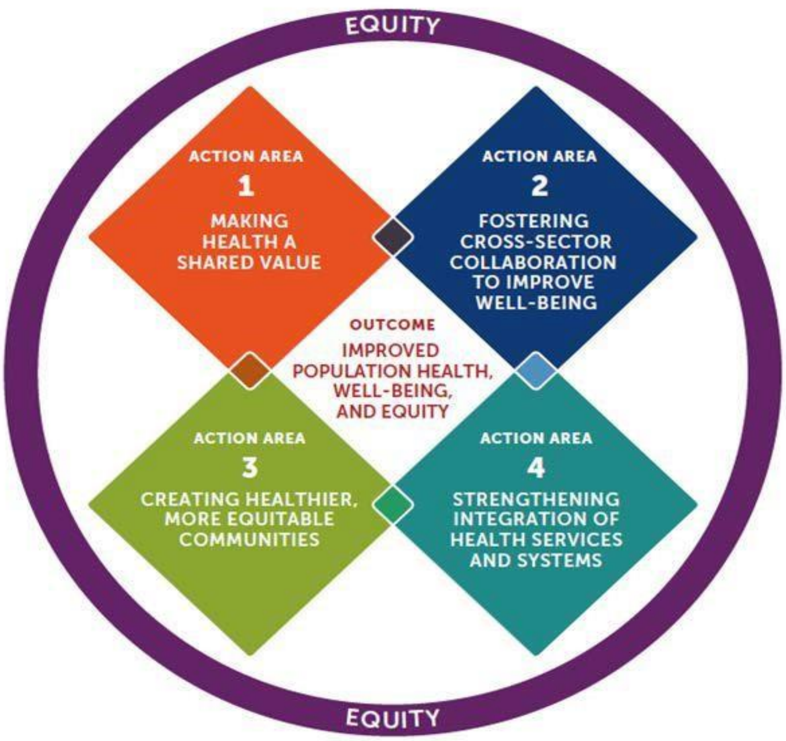
The CAC played an integral role in reviewing, refining, and crafting questions for the community survey as part of the 2016 Community Health Assessment, utilizing a collective impact approach to create effective and aligned community engagement. The CAC includes voting members who are Medicaid consumers and community partner agencies, as well as multiple other attendees who represent community and government agencies. Many of the consumers and community partners helped distribute hand-fielded surveys and assisted in facilitating focus groups reaching targeted populations, contributing to better data about harder-to-reach populations.

The Community Health Assessment process was recognized in 2016 when the Columbia Gorge Region was awarded the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize. This prestigious recognition further engaged the community in a conversation about what defines health and measurements for monitoring progress towards health.

Adopting a Framework – the 2017 Community Health Improvement Plan

Using the 2016 Community Health Assessment, the CAC identified focus areas that represent the highest need areas from the CAC's point of view. The 2017 CHP represents the second iteration of a similar Gorge-wide process. Through creating a community-endorsed CHP, the CAC supports proposals and programs from local organizations to address highlighted areas. As a result, the CHP describes not only the top focus areas but also a method for ongoing collaboration in the region.

During the development of the 2017 CHP, the Gorge region was introduced to and adopted the RWJF Culture of Health Action Framework.



Using the framework, the CAC selected three focus areas (known as Drivers) to become the 2017 Community Health Improvement Plan:

- Sense of Community
- Built Environment/Physical Conditions
- Access to Health Care

Each Driver in the Culture of Health Framework has a set of measures used to track progress towards improving health. The collaborative process used by the Community Advisory Council included reviewing the Culture of Health Framework standard measures and adapting those definitions to the local community. As noted earlier, collaboration is a fundamental ingredient in how the work is conducted in the Gorge region. Therefore, the set of metrics for each Driver also includes a "measure of collaboration."

Overview of Drivers and Measures – 2017 CHP

Action Area 1: MAKING HEALTH A SHARED VALUE		
DRIVER: SENSE OF COMMUNITY	**MEASURES**	***Sense of community*** - Percentage of population who feel safe in their community and feel people in their community are willing to help and can be trusted ***Social support*** – 1) Percentage of people who think they have someone available to love them and make them feel wanted, give good advice about a crisis, confide in or talk to about problems, and help if they were confined to a bed 2) Percentage of caregivers who feel they have adequate support ***Effective referrals*** - Percentage of cross-organization referrals based on service type and frequency of closed-loop referrals
Action Area 3: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES		
DRIVER: BUILT ENVIRONMENT and PHYSICAL CONDITIONS	**MEASURES**	****Housing affordability*** – 1) Percentage of families that are housing burdened or paying more than 50% of their income on housing 2) Percentage of households that feel at risk of losing housing ****Access to healthy foods*** – 1) Percentage of population who had to go without food 2) Percentage of population having 2 or more servings of fruits or vegetables per day ***Youth safety*** – 1) Percentage of people feeling that Adults watch out for children 2) Percentage of students not attending school because they do not feel safe 3) Percentage of teens who report being bullied ***Equity in physical activity opportunities*** – Obesity rates across elementary schools ****Mobility and transportation*** – 1) Percentage having transportation barriers 2) Percentage going without healthcare due to transportation
Action Area 4: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS		
DRIVER: ACCESS TO HEALTH CARE	**MEASURES**	***Access to comprehensive primary care*** – Percentage of the overall population who state they had a primary care visit and got all the services they needed ****Access to stable health insurance*** – Percentage of population with stable health insurance for 12 months ****Access to mental health services*** – Percentage of population who needed mental health services and got all the care the needed ****Routine dental care*** – Percentage of the overall population who state they had a dental care visit and got all the services they needed ****Collaboration on information sharing*** – 1) Rate of care coordination for shared patients 2) Rate of repeated assessments due to lack of information sharing

*Priority also identified in CHP from 2014

CHP Progress – 2018 and 2019

The CHP priorities have not changed since implementation, and the CHP has supported improved health in the region through aligning the work of multiple organizations, including the CCO. The activities listed below represent the subset of CHP-related strategies that are funded by the CCO and, in some cases, operated by PacificSource or the Columbia Gorge Health Council (CGHC). Funding comes from shared savings funds generated by the CCO and distributed for reinvestment under the authority of the Columbia Gorge Health Council. In addition to projects funded through direct contracts, the CCO conducted a community grant award process in 2017 to support local organizations in addressing the needs from the CHP, the CCO Quality Incentive Metrics, and the CCO Transformation and Quality Strategy. Awards were announced in February 2018, and those grant-supported programs have now been running for slightly over a year.

The Community Advisory Council is reviewing interval progress on this work against the RWJF Action Areas, determining next steps for community-driven outcomes on the drivers chosen, and articulating how they relate to the funded activities and other CCO and community work. Project status and outcomes are included with the description of activities for projects where enough time has elapsed to allow interim evaluation.

ACTION AREA: MAKING HEALTH A SHARED VALUE		
DRIVER	**MEASURE**	**ACTIVITIES**
1.2 SENSE OF COMMUNITY	***Sense of community*** – Percentage of population who feel safe in their community and feel people in their community are willing to help and can be trusted	• The Power of Play is an evidence-based, sustainable recess program that increases physical activity and improves social interactions among students. It has been offered at no charge to every elementary school across the CCO region and implemented in many. • Imagination Yoga addresses childhood inactivity, anxiety, distractibility, and bullying by teaching yoga to second graders and teachers. To date, eight second grade teachers received the yoga teacher training are implementing it in their schools. Approximately 400 second grade students have received the 10-class series and 100% of the teachers rated the program as having a positive effect on their students. • One Community Health, a CCO partner organization, has sponsored Gorge Happiness Month and the Making Health a Shared Value community education program. • Blue Zones-The Dalles has established a health improvement structure that includes events such as walking Moais, Community Clean Up, Purpose Workshops, Community Bike Nights, Walking School Buses and other events promoting community engagement around healthy activities.

ACTION AREA: MAKING HEALTH A SHARED VALUE		
DRIVER	**MEASURE**	**ACTIVITIES**
	Social support – 1) Percentage of people who think they have someone available to love them and make them feel wanted, give good advice about a crisis, confide in or talk to about problems, and help if they were confined to a bed 2)Percentage of caregivers who feel they have adequate support	• Safer Futures improved access to care and social support for survivors of intimate partner violence by partnering with healthcare and other social service providers and providing integrated community-based advocacy services to 54 survivors via mobile advocacy, co-located health care sites and a walk-in facility. • YouthThink implemented a Building Resiliency project providing training to 6 organizations and 77 individuals on Toddlers to Teens Boost Camps which focuses on social-emotional learning to create secure parent attachments as a foundation for health and resiliency. They have also taught six Parent Boost Camps, including three in Spanish.
	Effective referrals – Percentage of cross-organization referrals based on service type and frequency of closed-loop referrals.	• Bridges to Health Pathways Hub, a program operated by CGHC, is tracking referrals through the CLARA health information technology platform. • Reliance Health Information Exchange has been fully funded to establish a community-wide referral system and community health record. • CLARA and Reliance have created a single-sign on linking the two systems to provide closed loop referrals between them.

ACTION AREA: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES		
DRIVER	**MEASURE**	**ACTIVITIES**
3.1 BUILT ENVIRONMENT/ PHYSICAL CONDITIONS	***Housing affordability*** – 1) Percentage of families that are housing burdened or paying more than 50% of their income on housing 2) Percentage of households that feel at risk of losing housing	• Bridges to Health Pathways serves a housing challenged population through Community Care Coordinators (CCCs) working at organizations across multiple sectors. Thus far, CCCs have worked with over 500 clients to address issues creating housing insecurity as well as other social and medical needs. Eighty-four clients in the program have found secure, affordable, and stable housing.
	Access to healthy foods – 1) Percentage of population who had to go without food 2) Percentage of population having 2 or more servings of fruits or vegetables per day	• The Gorge Food Security Coalition, which seeks to fill gaps in the food system, established its Mission, Vision, Values, and Equity Statements. They created A Gorge Food Resource Guide and distributed it widely in primary care and social service organizations. They're supporting tribal communities in work to create tribal food

ACTION AREA: CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES		
DRIVER	**MEASURE**	**ACTIVITIES**
		sovereignty and have started a subgroup working on farmland preservation and access. • Blue Zones-The Dalles has certified sixteen organizations that have made commitments and changed practices to making healthy food choices the easy choice in their workplace.
	Youth safety – 1) Percentage of people feeling that adults watch out for children. 2) Percentage of students not attending school because they do not feel safe. 3) Percentage of teens who report being bullied	• Building Resiliency in the Columbia Gorge has made eight presentations to youth in middle and high schools focusing on helping youth understand how their emotional health plays into their physical health.
	Equity in physical activity opportunities – Obesity rates across elementary schools	• Summer Swim RX responds to a priority of the Clinical Advisory Panel, addressing childhood obesity, through allowing children enrolled in Medicaid to get a family summer swim pass. 157 families participated in the program in 2018. • Imagination Yoga (see Sense of Community) has provided a 10-class series to over 400 students. Classroom teachers learned how to make accommodations, including modifications of poses for children who are obese. • Mejor Juntos employed a health promotion coordinator who created and shared accurate information about weight control with agencies and service providers. A website, "Jump! In The Gorge" was created with activities for children and families. Also, the Active Rx referral system was started with Summer Swim Rx being the first referral program. Additionally, the health promotion coordinator collected BMI data for the CDC school BMI calendar and is participating in the statewide Health Active Oregon which promotes policy change to prevent and reduce obesity.
	Mobility and transportation – 1) Percentage having transportation as a barrier 2) Percentage going without healthcare due to transportation	• The Transportation Innovations Collaborative is working with stakeholders across the region to convene dialog, collect data, and analyze critical needs. The group is developing solutions as well as preparing for upcoming state funding and implementation activities.

Action Area: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS		
DRIVER	**MEASURE**	**ACTIVITIES**
4.1 ACCESS	***Access to comprehensive primary care*** – Percentage of the overall population who state they had a primary care visit and got all the services they needed	• Safer Futures provided 18 trainings to health care partners, community health workers and social service providers on how to respond and effectively intervene for intimate partner violence. They are also providing 10 consecutive trainings to One Community Health (FQHC) and also planning around the intersections of IPV, chronic pain, substance abuse disorders and opioid usage.
	Access to stable health insurance - Percentage of population with stable health insurance for 12 months	• 30% of the clients enrolled in Bridges to Health Pathways received a referral to enroll in health insurance because they were uninsured and eligible for coverage. These referrals and enrollment services are paid for using funds from sources other than the CCO. • Each month an average of five Bridges to Health clients fall off the CCO membership and CCC's refer them to enrollment assistors to re-establish coverage if eligible. • CCO Practice Coach shares health plan data with PCP offices to facilitate clinic outreach to their patients who are OHP members due for redetermination. • Organizations outside the CCO are supporting Enrollment Assistors to provide outreach to the regional jail and other targeted audiences throughout the region.
	Access to mental health services - Percentage of population who needed mental health services and got all the care the needed	• Patients with Mental Illness in Local Emergency Departments: Mapping Processes to Improve Outcomes led to the initiation of assessing the viability of establishing a Crisis/Substance Use treatment capability locally. The assessment work started in late 2018 and will continue into Fall 2019. • Safer Futures project (see above). Post training survey data reports increased knowledge and comfort level in screening for IPV.
	Routine dental care – Percentage of the overall population who state that they had a dental care visit and got all the services they needed	• The Columbia Gorge Health Coalition initiated a community-wide oral health messaging campaign (based on the Arcora Foundation's Mighty Mouth campaign) designed to increase perceived value of children and adolescents receiving routine dental care in Hood River and Wasco counties to increase dental visits during childhood.

Action Area: STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS		
DRIVER	**MEASURE**	**ACTIVITIES**
		• Increasing preventive diagnostic dental visits for diabetic members is a current Transformation Quality Strategy project. An element of this project is to increase adoption and use of Health Information Technology tools - and eReferral and a clinical Community Health Record - by all Columbia Gorge provider types, including dental providers, to enable increased dental visits through interprofessional collaboration, referrals, and care coordination. As a result, about 30% of members with diabetes received an oral or periodontal exam in 2018. Our goal is to reach at least 50% and we will continue to make progress over time. • Increasing dental visits during pregnancy has been a longstanding Performance Improvement Project. As a result of this focus, about 50% of pregnant members received a dental visit during pregnancy. Our goal is to reach at least 60% and will continue to make progress over time.
	Collaboration on information sharing – *1) Rate of care coordination for shared patients* *2) Rate of repeated assessments due to lack of information* sharing	• Maupin Fiber Network provided connections to new high-speed internet service that brought digital parity to the healthcare facilities in a rural location. • Strengthening Collective Impact increased partners' capacity to better gather and analyze data by hiring a Learning Specialist. The Learning Specialist studied 12 organizations and 22 projects and showcased how data was collected, analyzed and shared. Next steps were determined to be a central platform for data sharing and hands on learning workshops. The first workshop on Program Evaluation was attended by 18 participants and four more workshops are planned for the remainder of 2019 • CCO has partnered with Reliance eHealth Collaborative and the Vistalogic CLARA platform to implement grant funding integrating the two systems across multiple sectors. Single sign-on has been implemented between CLARA and Vistalogic, and user rollout will follow a user interface upgrade for CLARA. • There are 58 unique organizations using the Reliance platform with approximately 30% of those being non-healthcare organizations

CCO Community Health Improvement Plan Progress Report: Appendix

Key Players in Child and Adolescent Health

1. **Which of the following key players are involved in implementing the CCO's CHP? (select all that apply)**
   - ☒ Early Learning Hubs
   - ☒ Other early learning programs[1]
     Please list the programs: Bridges to Health Pathways Program (contracts with Headstart and Early Head Start and school districts)
   - ☒ Youth development programs[2]
     Please list the programs: CCO partners collaborated on a grant from the Youth Development Council for a youth outreach worker in the schools. CCO also funded grants for youth development: Building Resiliency (YouthThink), Imagination Yoga (CultureSeed), Mejor Juntos (North Central Public Health District), The Power of Play (Columbia Gorge ESD),
   - ☒ School health providers in the region
   - ☒ Local public health authority
   - ☒ Hospital(s)

2. **For each of the key players involved in implementing the CCO's CHP, indicate the level of engagement of partnership:**

	No engagement 1	2	3	4	Full engagement 5
Early Learning Hubs	☐	☐	☐	☐	☒
Other early learning programs[1]	☐	☐	☒	☐	☐
Youth development programs[2]	☐	☐	☐	☒	☐
School health providers in the region	☐	☐	☒	☐	☐
Local public health authority	☐	☐	☐	☐	☒
Hospital(s)	☐	☐	☐	☐	☒

3. **Describe how these key players in the CCO's service area are involved in implementing your CHP.**
   The regional Community Health Assessment (CHA) and resulting Community Health Improvement Plan (CHP) has been based on a collaborative agreement developed through extensive outreach to leaders in various organizations. The third iteration of the Community Health Assessment is underway, and each cycle has included the same original partners as well as additional organizations. The cohort of organizations that commit either time or money in the creation of our updated CHA includes all of the key entities in the list above. As a cohort, we prioritize collaboration with each other and the CCO's Community Advisory Council, including a commitment to have standard data to track over time, flexibility to adapt to changing knowledge, and a strong role for

[1] This could include programs developed by Oregon's Early Learning Council.
[2] This could include programs developed by Oregon's Youth Development Council.

community members and health care consumers in structuring data collection questions. As a result, we have a wide variety of community programs supporting progress in our CHP priority areas.

The key players listed in question 2, above, were all collaborators on our CHA and engaged in the following ways:

- ✓ The Four Rivers Early Learning Hub (4Rivers) and CCO subcommittees have a significant number of shared members. The Director of 4Rivers is a member of the Columbia Gorge CCO's Community Advisory Council (CAC) and is working on collaboration between Our Kids Network, a resource hub for all families with young children, and the Bridges to Health Pathways Program of the CCO, a community care coordination program for community members in need. This role has been to advocate for inclusion of childcare workers as health advocates, connectors and educators and to disseminate information about CCO activities back to childcare settings.
- ✓ Mid-Columbia Children's Council (Regional HeadStart and Early HeadStart) are contracted partners in the Bridges to Health Pathways Program. They employee Community Care Coordinators who work with housing challenged families with young children to connect them to resources related to medical or social determinant of health needs. As part of the program, they share data with the other partners and the program overall.
- ✓ Youth Think received a community grant to build resiliency.
- ✓ The Youth Empowerment Shelter (Y.E.S.) recently became a contracted partner in the Bridges to Health Pathways Program serving homeless youth.
- ✓ The Next Door, a nonprofit social service organization, is also a contracted partner in the Bridges to Health Pathways Program serving children and their families in the two school districts.
- ✓ School Based Health Center Operators. There is one School Based Health Center in the region, operated by One Community Health (an FQHC) and the Hood River County Health Department. Both organizations are engaged at every level of the CCO (Health Council, CAC, Clinical Advisory Panel (CAP), the Systems Integration Team, and other sub-committees).
- ✓ The two public health departments in our region, North Central Public Health District and Hood River County Health Department, are also active members at all levels of the CCO and actively involved in the design, implementation and measurement of our CHP. The departments are also collaborators on our CHA and other cross-sector programs that have been implemented through the Community Grant process. The Hood River Health Department Director holds as voting position on the CAC as a liaison to the Clinical Advisory Panel. Both Health Departments are also contracted partners in the Bridges to Health Pathways Program serving Housing Challenged Families as well as every child in the region newly entering DHS custody.
- ✓ Representatives of the two hospitals in our region, Providence Hood River Memorial Hospital and Mid-Columbia Medical Center, are members of our Health Council, CAC, and CAP as well as contracted partners in various cross-sector programs supported by the CCO, such as Bridges to Health Pathways and Health Information Exchange.

4. **If applicable, identify where the gaps are in making connections.**
   - ✓ The CAC has prioritized recruiting one or more youth members but has not yet been successful.
   - ✓ While 4Rivers staff is actively engaged in multiple committees of the CCO, direct service child care providers have not been involved at the committee level.
   - ✓ The school districts in our region are collaborative and maintain cross-sector partnerships among numerous programs but have not yet become deeply engaged with the CCO.

- ✓ Data sharing agreements and shared software continues to be a challenge, but resources have been committed towards utilizing systems that can allow for information to be shared and putting agreements in place to do so.
- ✓ Although there are many benefits to having a regional shared CHP across state lines and multiple organizations, measuring improvement at the local level has been challenging. The process to create our new CHP will need to include measurable outcomes as well as clear expectations of where the data will come from and who is responsible for gathering and reporting on it.

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

The CCO has improved the coordination of effective and efficient delivery of health care to children and adolescents by supporting the following activities:

CHP Priority: Sense of Community

- ✓ Building Resiliency in the Columbia Gorge focuses on social- emotional learning to create secure parent attachments as the future of health and resiliency. Over 100 individuals have attended the Toddlers to Teens Boost Camps thus far. The Boost Camps provide social-emotional literacy training that also includes knowledge of resources and where to go for help.

CHP Priority: Access

- ✓ Bridges to Health Pathways DHS Support has improved the CCO's rate of timely assessment for children in DHS custody from 63% to over 90%. It has provided better support and coordination of services for children in foster care and their caregivers.
- ✓ In the Bridges to Health Pathways population of people with housing challenges, 36% of clients are under the age of 18. These children and their families are being connected to services and resources both within and outside of healthcare. The biggest needs of these families in order of greatest need are: social service, transportation, food, housing and medical referrals.
- ✓ Reliance Health Information Exchange: DHS Child Welfare staff use the Reliance eReferral system to securely exchange and track CANS assessment results from the Community Mental Health Program.

6. What activities is the CCO doing for this age population?

- ✓ The CCO is contributing funds to support all of the activities listed above.
- ✓ The CCO has funded, through the Clinical Advisory Panel, the Family Swim Rx program.
- ✓ The Columbia Gorge Health Council is the operating hub for the Bridges to Health Pathways Program.

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

- ✓ The CCO participates in the Early Learning Hub, and Hub representatives participate in the CAC.
- ✓ The Clinical Advisory Panel continues to work with healthcare providers on outreach for adolescent well care visits and has shared best practices amongst them. One activity was creating an evening with music and raffles to bring teens in to the clinic.

- ✓ The CCO has funded the Deschutes Rim Medical Clinic, in the rural community of Maupin, to perform an assessment of the feasibility of establishing a school-based health clinic.
- ✓ Bridges to Health Pathways has contracted with The Next Door to employ Community Health Workers to provide care coordination in two school districts.
- ✓ The CAC has regular attendance from staff working in the schools on violence prevention, medical education programs, and substance use prevention.
- ✓ The CCO has supported expanded mental health services in the region with a specific focus on Spanish speaking providers focused on children. These providers are able to see children in the schools or where ever is most convenient.

Health Disparities

8. For each chosen CHP priority, describe how the CCO and/or CAC(s) engages with local stakeholders (for example, community-based organizations or local public health) to obtain updated data for different populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data.

- ✓ The Bridges to Health Pathways Program collects REALD data from their clients with a focus on looking for disparities in outcomes.
- ✓ CCO staff has been a part of a regional health equity workgroup looking at improving health equity practices across organizations, through work supported by the National Academy of Medicine Enhance Incubation Communities Health Equity Program. This work came out of the previous year's OHA Office of Equity and Inclusion DELTA training that CCO staff and local public health employees attended.
- ✓ The CCO is in the process of partnering with organizations region wide to field Community Health Assessment surveys to historically marginalized populations
- ✓ The CCO is engaged with the Regional Health Equity Coalition to both gather input on the design of the next Community Health Assessment survey as well as to gather data for the Assessment

9. In obtaining updated data for different populations, explain what data sources were used and the process to acquire it.

- ✓ The CCO facilitates a regional collaborative effort to conduct a joint Community Health Assessment using multiple sources of data, including public health, vital records, Oregon Heathy Teens, Behavioral Risk Factor Surveillance System, and demographic data.
- ✓ The CAC oversees the design of the local Community Health Survey including what questions get included and how they are written. The survey is then edited to incorporate plain language practices as well as translated into Spanish.
- ✓ Data from partner agencies and programs are also included when relevant, and sources include the local housing authority, primary care clinics, HeadStart, and the Bridges to Health Pathways Program.

10. Explain CCO process, if any, to compare local population data to CCO member data or state data. If data was not available, the CCO may have chosen to access qualitative data from special populations via focus groups, interviews, etc. Include whether disparities were discovered that were not otherwise evident.

- ✓ The CCO looks at data from our CHA and analyzes it across multiple categories such as race/ethnicity, income level, and insurance type. Thus, we can identify disparities and track them over time through successive CHA processes.
- ✓ Disparities by race/ethnicity were found in a number of areas particularly those related to social determinants of health.
- ✓ The CHP process involved facilitated focus groups to collect qualitative data from underserved populations regarding experiences with CHP priority topics.

11. What successes or challenges has the CCO had in engaging populations experiencing health disparities in the CHP development and implementation?

- ✓ The partnerships amongst other groups working with people experiencing health disparities have been very beneficial to our CHP process. Many organizations such as food banks, the Regional Health Equity Coalition, and service programs for seniors were willing to help hand field surveys to gather good data
- ✓ It continues to be challenging to engage Tribal communities in our region as we have multiple Tribes living in our region without an organized leadership structure to partner with.
- ✓ The multi-racial, multi-lingual nature of our community makes communication challenging and providing translation and interpretation has become important but is time consuming and expensive.
- ✓ The Gorge Regional Health Equity Coalition has begun a Tribal community group which has recently grown and has been a partner in the next CHA.
- ✓ Community Care Coordinators of the Bridges to Health Pathways Program have developed good relationships with the Celillo Village tribal members.
- ✓ Members of the Health Council were involved in the implementation of a regional poverty simulation to improve cultural responsiveness to the needs of people living in poverty.

12. What successes or challenges has the CCO had in recruiting OHP members that represent communities disproportionately affected by health disparities to the CAC?

- ✓ The CAC is demographically representative of our community and those disproportionately affected by health disparities including members from the Latinx and LGBTQ community, people living with mental illness, and older adults.
- ✓ The CAC has not been successful at engaging members of Tribal communities, Samoans, or youth populations.
- ✓ The CAC also lacks members from some of the more rural, outlying communities of our counties.

Alignment, Quality Improvement, Integration

13. Describe how local mental health services are provided in a comprehensive manner. Note: this may not be in the CHP, but may be available via the local mental health authority (LMHA) comprehensive local plan document. The CCO does not need to submit relevant local plan documents.

- ✓ The need for a continuum of behavioral health services, encompassing both mental health and substance use disorder treatment, is met through services provided by the Community Mental Health Program (CMHP) for each county, services provided by other regional providers, and, where necessary, higher-intensity services provided by organizations outside of the region.

- ✓ For low acuity, outpatient, specialty behavioral health services, the CCO contracts with multiple entities. This supports a diverse range of organizations in order to maximize patient choice and meet needs that include culturally specific services and treatment for eating disorders.
- ✓ An existing provider in the region, The Next Door, has augmented their mental health services specifically geared towards youth and families who are Spanish speaking.
- ✓ Behavioral Health Services are integrated into most primary care sites.

14. If applicable, describe how the CHP work aligns with work through the Transformation and Quality Strategy (TQS) and/or Performance Improvement Projects (PIPs)?

- ✓ The CHP prioritizes three areas from the Robert Wood Johnson Foundation (RWJF) Culture of Health Action Framework: Sense of Community, Built Environment, and Access to Care. The Transformation Quality Strategy (TQS) developed by the CCO focuses on the CHP element Access to Care. Within the TQS there are ten projects, six of which will impact Access to Care.
- ✓ Specifically, dental care access is an area of overlap as the TQS includes a project that targets a specific population with Special Health Care Needs to ensure that they have coordinated access to dental care. In addition, one of the Performance Improvement Projects (PIP) also addresses access to dental care during pregnancy. One of the related CAP-funded projects is on oral health messaging for Primary Care Providers.
- ✓ Bridges to Health Pathways is called out in the TQS report to screen and provide access to services addressing social determinants of health. This program overlaps with multiple priority areas in the CHP.

15. OHA recognizes that the unique context of each CCO region means there is a continuum of potential collaboration with local public health authorities (LPHAs) and hospital systems on the CHA and CHP. Please choose the option that best applies to your CCO:

☒ CCO's CHA and CHP are a shared CHA and CHP with LPHAs, other CCOs in region, and/or hospital systems. Note which organizations share the CHA and CHP:

- LPHA(s): Hood River County Health Department, North Central Public Health District, and two others outside of our CCO region, Klickitat Public Health Department and Skamania County Public Health.
- Hospital(s): Providence Hood River Memorial Hospital, Mid-Columbia Medical Center, and two outside of our CCO region, Skyline Hospital and Klickitat Valley Hospital.

☐ CCO's CHA is a shared CHA with LPHAs, other CCOs in region, and/or hospital systems, but the CCO has a unique CHP. Note which organizations share the CHA:

- LPHA(s): Click or tap here to enter text.
- Other CCO(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ CCO's CHP is a shared CHP with LPHAs, other CCOs in region, and/or hospital systems, but the CCO has a unique CHA. Note which organizations share the CHP:

- LPHA(s): Click or tap here to enter text.
- Other CCO(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ CCO's CHA and CHP are a unique CHA and CHP from LPHAs, other CCOs in region, and/or hospital systems, but the CCO collaborated with LPHAs and/or hospital systems in CHA and CHP development. Note which organizations the CCO collaborated with:

- LPHA(s): Click or tap here to enter text.
- Other CCO(s): Click or tap here to enter text.
- Hospital(s): Click or tap here to enter text.

☐ Other (please describe): Click or tap here to enter text.

16. If applicable, check which of the upcoming 2020-2024 State Health Improvement Plan (www.oregon.gov/oha/PH/ABOUT/Pages/ship-process.aspx) priorities listed below are also addressed in the CHP.

☐ Institutional bias
☒ Adversity, trauma and toxic stress
☒ Economic drivers of health (including issues related to housing, living wage, food security and transportation)
☒ Access to equitable preventive health care
☒ Behavioral health (including mental health and substance use)

17. Describe how the CHP work aligns with Oregon's population health priorities included in the State Health Improvement Plan:

✓ Adversity, trauma, and toxic stress are addressed under Sense of Community and the programs funded through this CHP priority are closely linked
✓ Economic drivers of health are addressed under Built Environment and Physical Conditions
✓ Access to equitable preventative health care and mental health care is addressed under Access.
✓ The measures under each linked driver in the CHP include an evidence-based measure chosen by the RWJF alongside some local additions.

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

✓ A CCO partner, Providence Hood River Memorial Hospital, responded to the collaborative CHP effort by financially supporting a Collective Heath Impact Specialist whose position provides resource development and grant writing for any organization in the service area addressing a CHP priority with a requirement that the funded project be collaborative as well.
✓ The CCO has reinvested funds back into the community through a community grant process now on year two of program implementation specifically addressing CHP priorities.
✓ The Health Council has obtained grants to bring in additional funds to address CHP priorities such as trauma informed care and expanding the scope of the Bridges to Health Pathways program.

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

The collaborative CHA and CHP process has created a new normal in which organizations collaborate across sectors, counties, and organizations, such as in the following examples:

✓ NCPHD has a Tobacco Cessation specialist who serves clients in both counties.

- ✓ Enrollment Assistors in different organizations assemble on a monthly level to share, learn, and improve processes.
- ✓ A monthly Community Health Worker Collaborative provides a forum to share resources, learn from others’ experiences, and collaborate around CHW-focused projects, regardless of the CHW’s employer and sector.
- ✓ In addition to the Regional Health Equity Coalition a related group has formed to focus on organizational policies, shared training, and resources to help organizations progress along the health equity spectrum.