1. 7:00-7:05  Introductions & Updates—All

2. 7:05-7:15  Healthy Hearts Northwest (H2N)—Kristin Chatfield

3. 7:15-7:55  Regional Health Improvement Plan Group Feedback (5 minutes for each section)
   - Diabetes—Dr. Mills and Dr. Sharma
   - CVD—Dr. Sharma
   - BH (Screening)—Dr. Pennavaria, Dr. Mann, and Dr. Perryman
   - BH (SUD)—Dr. Pierson and Dr. Swanson
   - Oral Health—Dr. Allen and Ms. Ludwig
   - MCH/RH—Ms. DeLaVergne-Brown and Dr. Pennavaria
   - Social Determinants—All

4. 7:55-8:00  2016 QIM Preparation: Brief Update—Maria Hatcliffe & Rebeckah Berry

Consent Agenda:
   • Approval of the draft minutes dated December 9, 2015 subject to corrections/legal review
EvidenceNOW: Advancing Heart Health in Primary Care is an initiative of the Agency for Healthcare Research and Quality (AHRQ) to transform health care delivery by building a critical infrastructure to help smaller primary care practices improve the heart health of their patients by applying the latest medical research and tools. EvidenceNOW establishes seven regional cooperatives composed of public and private health partnerships that will provide a variety of quality improvement services typically not available to small primary care practices. The goal of this initiative is to ensure that primary care practices have the evidence they need to help their patients adopt the ABCS of cardiovascular disease prevention: Aspirin in high-risk individuals, Blood pressure control, Cholesterol management, and Smoking cessation. The initiative also includes an independent national evaluation designed to determine if and how quality improvement support can accelerate the dissemination and implementation of new evidence in primary care.

Northwest Cooperative

Cooperative Name: Healthy Hearts Northwest: Improving Practice Together

Principal Investigator: Michael L. Parchman, M.D., M.P.H., Group Health Cooperative

Cooperative Partners:
- MacColl Center for Health Care Innovation and the Center for Community Health Evaluation, both at Group Health Cooperative
- Qualis Health
- Oregon Rural Practice-based Research Network (ORPRN) at Oregon Health & Science University
- University of Washington School of Medicine

Geographic Area: Washington, Oregon, Idaho

Project Period: 2015-2018

Region and Population
The Pacific Northwest has a mix of highly agricultural and sparsely populated counties with a growing Hispanic population and large and growing urban centers. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Specific Aims
1. Identify, recruit, and conduct baseline assessments in 320 small- to medium-sized primary care practices across Washington, Oregon, and Idaho during the project’s first year.
2. Provide comprehensive practice support to build quality improvement capacity within these practices.
3. Disseminate and support the adoption of patient-centered outcomes research (PCOR) findings relevant to aspirin use, blood pressure and cholesterol control, and smoking cessation (ABCS) quality measures.
4. Conduct a rigorous evaluation of strategies that enhance the effectiveness of external practice support to improve QI capacity, implement patient-centered outcomes research findings, and improve ABCS measures.
5. Assess the sustainability of changes made in QI capacity and ABCS improvements and develop a model of scale-up and spread for improving QI capacity in primary care practices.

Reach
- Goal for Number of Primary Care Practices Recruited: 250-320
- Goal for Number of Primary Care Professionals Reached: 750-960
- Goal for Population Reached: 1.13-1.44 million
Comment from Principal Investigator

Michael Parchman, M.D., M.P.H.

“Our goal is to build a sustainable infrastructure for ongoing improvements in the delivery of primary care in the Pacific Northwest that contributes to the Triple Aim, improves the experiences of those who provide care within the practice, and prepares primary care providers for value-based care reimbursement models. We will make a substantial contribution to the field of implementation science by advancing understanding of how to effectively provide external practice support to build QI capacity and improve cardiovascular risk factors for a substantial number of people served by small- to medium-sized primary care practices.”

Notable Project Features

- Project will have significant participation by rural practices.
- Regional design allows the Cooperative to understand how specific State factors affect health care delivery.
- Design will study rapid scale-up and spread of practice support to build QI capacity.

Approach and Methods

Practice Recruitment and Enrollment

Primary recruitment targets are practices that need significant help in building their QI capacity, but have an Office of the National Coordinator 2014 certified electronic health record that can assist with their QI efforts. Target practices will be small (<10 practitioners) and independently owned and operated. Smaller practices affiliated with larger organizations also will be recruited if the larger organizations have limited experience with providing support for primary care QI. The Cooperative will recruit by:

- Reaching out to practices with which the Cooperative already has strong relationships.
- Leveraging relationships within social networks of already-recruited practices and reaching out to members of the Cooperative’s State-level organizational partners.

Support Strategy

Each participating practice will receive 15 months of support in two key areas:

- **Health Information Technology Support and Use of Data for Physician Quality Reporting System (PQRS) Reporting and Quality Improvement.** The Cooperative will help the practices improve PQRS reporting of ABCS measures by creating a tailored Action Plan to guide the support. The practices will be divided into three tiers, depending on how experienced they are in PQRS reporting and how much information technology support they need. Health information technology staff will support practices through ongoing phone and secure Internet communication.

- **External Practice Quality Improvement Support.** This support will enhance the practices’ capacity to use new PCOR findings to change their care practices and improve ABCS measures. This content will be disseminated to the practices using academic detailing (i.e., educational outreach through self-paced learning modules and phone calls). To build their QI capacity to adopt and implement PCOR heart health findings, practices will be assessed using PCMH Change Concepts and then receive tailored external support through (1) practice facilitation (i.e., a kick-off meeting, face-to-face visits, regular phone calls); (2) shared learning opportunities (i.e., Regional Improvement Collaboratives led by the practice facilitators with monthly phone calls and Webinars); and (3) affinity groups to conduct “deep dives” on improvement work across the smaller regional groups of practices.

Evaluation

Practices will be divided into small regions of 20 practices each. Each small region will be assigned to one of 16 practice facilitators. Each region of practices also will be randomized to one or more strategies hypothesized to enhance the effectiveness of the external practice support for more rapid adoption of PCOR heart health findings and improvement of QI capacity. This design efficiently uses participating practices and enables estimation of interactions between strategies.

Strategies for Disseminating Study Findings and Lessons Learned:

The Cooperative will disseminate findings through an external website, social media, presentations, manuscripts and outreach to key opinion leaders and potential early adopters.
There is a need for building critical infrastructure to help smaller, primary care practices throughout the Pacific Northwest use the latest evidence to improve heart health. Heart health indicators vary considerably across the region. They are worse in small rural counties where primary care has fewer internal quality improvement (QI) resources than in more populated urban areas. For example, heart attack deaths in some small rural counties are almost twice as high as in larger metropolitan counties. In addition, mortality rates from stroke are higher in the region than in the United States as a whole.

Achieving better heart health outcomes for patients is an ongoing priority for the Oregon community. As our healthcare environment continues to evolve rapidly, smaller practices face challenges around the ability to effectively use data and improve quality. This is increasingly important for reimbursement eligibility. Many smaller practices lack the internal resources for optimizing health information technology (HIT) and building QI capacity.

Healthy Hearts Northwest: Improving Practice Together (H2N) is part of EvidenceNOW, the AHRQ grant initiative to transform health care delivery. With partners Qualis Health, and the MacColl Center for Health Care Innovation (recipient of the AHRQ funding for this initiative and H2N PI office), the Oregon Rural Practice-based Research Network (ORPRN) at the Oregon Health & Science University (OHSU) will select 130 small- and medium-sized primary care practices throughout Oregon to participate in H2N. ORPRN seeks to help these practice build their quality improvement (QI) capabilities and infrastructure, and to transform practices into learning organizations that engage in sustained, continuous, systematic QI. The practices will learn practical strategies that can strengthen their organizations and restore the joy to primary care. The initial focus of H2N will be implementing Patient-Centered Outcomes Research (PCOR) to improve heart health, as described within the Million Hearts campaign related to ABCS: Aspirin, Blood pressure, Cholesterol and Smoking cessation.

Over the course of 15 months, ORPRN will:

1. Provide a Practice Enhancement Research Coordinator (PERC) to support improving ABCS heart health measures, including how to use EHRs for QI purposes. The PERC will visit the practice regularly, with monthly calls in between visits, and will be accessible by phone.
2. Assist with producing reports of ABCS clinical quality measures.
3. Provide benchmark reports on ABCS clinical quality performance measures to the practice on each measure, with benchmarks at a regional, state, and national level.
4. Provide high-value information about how to participate in value-based reimbursement programs, such as PQRS and meaningful use.
5. Provide survey results back to the practice that indicate opportunities for improving QI infrastructure.
6. Conduct webinars every other month to assist practices with meeting H2N improvement milestones.
7. Convene phone-based office hours to discuss different topics and share lessons learned.
8. Support participation in this study as meeting ABFM and ABIM MOC Part IV requirements.
9. (For those selected) Identify and coordinate a site visit to an exemplar practice.
10. (For those selected) Provide training in the use of evidence-based cardiovascular risk reduction calculation and care planning.
11. Keep the practice informed about the overall study. We want to help participating practices as much as we can, so we may adjust specific aspects as the study progresses.
The practice agrees to improve ABCS performance measures and will:

1. Schedule a two-hour, in-person "Welcome visit" with a PERC.
2. Complete surveys at 3 time points: upon project enrollment, at the end of the 15 months of practice support, and 6 months after completing 15 months of practice support:
   a. A practice or clinic-level survey completed by a practice manager or leader.
   b. A survey completed by all clinicians and staff who work in the practice.
3. Designate a “Healthy Hearts Champion”, usually a physician or non-physician (nurse practitioner or physician assistant) clinician and a point of contact for the H2N project team.
4. Convene a Healthy Hearts Improvement Team of at least three individuals comprising the Healthy Hearts Champion and a representative from the front and back office.
5. Provide protected time for the Healthy Hearts Improvement Team to meet internally weekly to develop and work on improvement milestones and conduct small cycle tests of change to improve ABCS heart health measures.
6. In addition to the internal Improvement Team meeting, at least two members of the Improvement Team will:
   a. Participate in face-to-face visits or a monthly phone call with the PERC.
   b. Attend a Healthy Hearts Webinar with all practices across the 3 states for one hour every other month.
   c. Participate in phone-based office hours.
7. Collect and provide the study team with aggregate practice-level data (unique to each practice location) on clinical quality measures related to aspirin use, blood pressure control, cholesterol control, and smoking cessation (ABCS) quarterly from enrollment until April 30, 2018.
8. (For those selected) At least two individuals from the practice will conduct a one-day site visit to an exemplar clinic within the first 12 months after enrollment.
9. (For those selected) Clinicians, nurses, and medical assistants will participate in training on the effective use of a cardiovascular risk calculator.
10. Agree to be (publically) recognized as a participant in this project.

Please contact ORPRN’s H2N project manager, Caitlin Dickinson, at summerca@ohsu.edu or 503-494-9106. More information about H2N is available http://www.ohsu.edu/xd/outreach/oregon-rural-practice-based-research-network/.
## Quality Measures Crosswalk – Million Hearts and Other Incentive Programs

**BLUE** = Required  **GREEN** = Optional

<table>
<thead>
<tr>
<th>Million Hearts Domain</th>
<th>Million Hearts Clinical Quality Measure</th>
<th>CMS Physician Quality Reporting System (PQRS)</th>
<th>CPC 2015 eCQMs</th>
<th>CMS EHR Incentive Program (MU)</th>
<th>PCPCH</th>
<th>CCO Incentive eCQMs</th>
<th>UDS</th>
<th>ACO Medicare Shared Savings Program (SSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin When Appropriate NQF: #0068</td>
<td>Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic Percentage of patients aged 18 years and older who were discharged for AMI/CABG/PCI OR diagnosed with IVD AND documented use of aspirin or other antithrombotic</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Blood Pressure Control NQF: #0018</td>
<td>Hypertension (HTN): Controlling High Blood Pressure Percentage of patients aged 18 through 85 years who had a diagnosis of HTN AND whose blood pressure was adequately controlled (&lt;140/90) during the most recent visit in the measurement year</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cholesterol Management NQF: n/a</td>
<td>Cholesterol— Statin Therapy for the Prevention and Treatment of Cardiovascular Disease Patients who are at high risk of cardiovascular events who were prescribed or are on a statin. High Risk definition categories 1. Patients &gt;= 21 years of age who were previously diagnosed</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Smoking Cessation NQF: #0028</td>
<td>Preventive Care and Screening: Tobacco Use Percentage of patients aged 18 years and older who had two visits or one preventive care visit within 24 months who were screened about tobacco use one or more times AND who received cessation counseling intervention if identified as a tobacco user</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes - as of 2016</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Priority Area: Diabetes

Team Members: Steve Strang, Karen Steinbock, Tom Kuhn, Kate Wells, Sarah Worthington & Therese McIntyre

Clinical Expert: Divya Sharma, MD, MS, Regional Medical Director, Mosaic Medical, and Medical Director, Central Oregon IPA

The Problem
Diabetes is characterized by having high blood sugar levels and can lead to serious adverse outcomes if left untreated. There are several types of diabetes, including type 1, type 2, and gestational diabetes. Type 1 diabetes is an autoimmune disorder usually diagnosed at an early age. Type 2 diabetes, which makes up 95% of diabetes cases, is often diagnosed in adulthood (Lloyd-Jones D, et al., 2009). Gestational diabetes is a condition that affects pregnant women and often goes away once the baby is born. If left untreated, gestational diabetes may cause problems for the mother and baby. In addition, gestational diabetes puts women at increased risk for later developing type 2 diabetes. Prediabetes is a condition in which an individual has blood sugar levels that are elevated but not high enough to be considered diabetes.

In all cases, a diagnosis of diabetes has significant impacts on quality of life. If left untreated or poorly managed, diabetes can lead to major life-threatening and costly complications including kidney disease, blindness, cardiovascular disease and lower extremity amputations.

Many of the risk factors for prediabetes, diabetes and cardiovascular disease are the same and include physical inactivity, overweight/obesity, high blood pressure, tobacco use, and an unhealthy diet. This means that many individuals can focus on adopting the same healthy strategies to prevent the most common chronic health problems. Strong evidence shows that lifestyle interventions for persons at risk for developing diabetes significantly reduces risk of developing type 2 diabetes (DPP Research Group, 2009). These programs include coaching and counseling to maintain a healthy weight, increase physical activity, eat healthy, and control hypertension, and can reduce the risk of developing type 2 diabetes, as well as cardiovascular disease.

In Oregon, 9% of adults reported having diabetes in 2013, reflecting a doubling in prevalence over the past 20 years (Oregon Health Authority, 2015). For these adults, a key element of diabetes control is self-management education. Recent studies estimate that more than 1 out of 3 US adults (38%) – or 1 million Oregon adults have prediabetes; 9 out of 10 adults with prediabetes are not aware they have it (CDC, 2014). American Indians/Alaska Natives, African Americans and Latinos have a higher prevalence of diabetes than non-Latino Whites.
Goals

Clinical Goal: Improve control of type 2 diabetes.
Prevention Goal: Decrease the proportion of adults and children at risk for developing type 2 diabetes.

Health Indicators by 2019

<table>
<thead>
<tr>
<th>QIM (*) State Measure (v)</th>
<th>Healthy People 2020 (v)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Decrease the prevalence of adults who are overweight (BMI 25 to 29.9) from 33% to 31% (Oregon BRFSS 2010-13)</td>
<td>✓</td>
</tr>
<tr>
<td>2. Decrease the prevalence of 11th graders and 8th graders who are overweight from 14% and 16%, respectively to 13% and 14%, respectively (Oregon Healthy Teens, 2013)</td>
<td>✓</td>
</tr>
<tr>
<td>3. Decrease the percentage of OHP participants 18–75 years of age with diabetes who had HbA1c &gt;9.0% from a baseline of 14.7% to 11% (QIM NQF 0059 - Diabetes: HbA1c Poor Control, 2014)</td>
<td>* ✓</td>
</tr>
<tr>
<td>4. Increase the percentage of OHP participants 18-75 years of age with diabetes who received an annual HbA1c test from a baseline of 77% to 87% (NQF 0057 – Oregon State Performance Measure, 2014)</td>
<td>* ✓ ✓</td>
</tr>
<tr>
<td>5. Decrease the percentage of OHP participants with BMI greater than 30 from 31.5% to 30.9% (Oregon State Core Performance Measure, MBRFSS 2014)</td>
<td>✓ ✓</td>
</tr>
</tbody>
</table>

Action Area | Strategy
--- | ---
Prevention and | • Implement a Diabetes Prevention Program (DPP).
 | • Increase availability of diabetes self-management programs.
| Health Promotion                  | • Engage employers to offer worksite health promotion programs that support improved employee weight status by targeting nutrition and physical activity.  
|                                  | • Create Healthy Eating and Active Living (HEAL) coalition(s) with members from a variety of sectors, and economic and cultural backgrounds.  
|                                  | • Partner with grocery stores to increase pre-diabetes and diabetes awareness programs.  
|                                  | • Develop targeted strategies to improve Diabetic Medication Adherence (i.e.: refrigeration, MedMinders, etc.).  
|                                  | • Create partnership with Parks and Recreation offices to offer peer led exercise sessions in conjunction with the Diabetes Prevention Program. |
| Clinical                        | • Increase referrals to diabetes self-management and prevention programs.  
|                                  | • Improve medication adherence among patients with diabetes.  
|                                  | • Increase postpartum screening and follow-up for patients with gestational diabetes.  
|                                  | • Increase the use of case management interventions for patients with diabetes with CCO support for clinic innovations.  
|                                  | • Improve coordination between medical and dental providers to provide the tools and education needed about the correlation between oral health and diabetes (i.e.: Dental Medical Integration (DMI) Project). |
| Policy                          | • Institute transportation and zoning policies that encourage mass transit, walking, biking, and use of green space for physical activity.  
|                                  | • Increase the number of schools using the CDC School Health Index to improve their health policies and programs. |
| Health Equity                   | • Increase provider and community referrals to the Spanish language Tomando Control chronic disease self-management program.  
|                                  | • Create diabetes awareness campaigns that are culturally aligned, health literate, and community specific.  
|                                  | • Please refer to the chapter on social determinants of health. |
| Health System/Access            | • Engage health systems to implement systematic EHR referrals to diabetes self-management and prevention programs.  
|                                  | • Improve provider and community awareness of diabetes self-management programs. |
**Childhood Health**

- Promote coordinated school health programs that prevent risk behaviors that contribute to heart disease and stroke:
  - Maintain or establish enhanced physical education classes.
  - Serve heart-healthy food in cafeterias and vending machines.
  - Prohibit withholding recess as punishment.
- Engage schools to provide evidence-based interventions such as “Let’s Move! Active Schools” to promote physical activity and nutrition education in schools.

**Examples of Key Partnerships:**

- Health systems and healthcare providers
- Public health departments
- Grocery stores
- Schools (policies around PE and physical activity during school hours)
- Parks and Recreation officials
- Pharmacies
- Employers
- Health clubs
- Places of worship
- Non-profit organizations
Priority Area: Cardiovascular Disease

Team Members: Kate Wells, Christy McLeod, Leslie Neugebauer, Kathy Drew, and Tom Kuhn

Clinical Experts: Rick Koch, MD, FACC, Bend Memorial Clinic & Bruce Brundage, MD, St. Charles Health System

The Problem
Cardiovascular disease (CVD) is a classification of diseases of the heart and blood vessels that includes chest pain, heart attack, and other conditions that affect the heart muscle, rhythm, or valves. Cardiovascular diseases are preventable with good nutrition, exercise, and by remaining tobacco free. People with cardiovascular disease or who are at high cardiovascular risk (due to the presence of one or more risk factors such as hypertension, diabetes or hyperlipidemia) need early detection and management using counseling and medications, as appropriate.

Smoking causes one of every three deaths from CVD, according to the 2014 Surgeon General’s Report on smoking and health. It is a leading cause of preventable death in the US and doubles a person’s risk for stroke (USDHHS, 2014). Nearly one in three adults in Crook County, one in six adults in Deschutes County, and one in four adults in Jefferson County report smoking tobacco.

Age-adjusted prevalence of adult current smokers (Oregon BRFSS, 2010-2013)

% National Health Interview Survey, 2011

The most common type of CVD in the United States is coronary artery disease, which affects the blood flow to the heart. It is one of the leading causes of death in Oregon and the US. In fact, among males and females admitted to St. Charles facilities in Central Oregon, 21% and 14%, respectively, were for CVD events (St. Charles Health System, 2014).

Cerebrovascular disease is another major form of CVD that affects blood flow in the brain. Stroke is one of the cerebrovascular diseases and is a leading cause of death and disability. A stroke is caused by a blood vessel breaking or an artery becoming clogged in the brain, which leads to reduced blood flow and brain damage. Knowing the signs and symptoms of stroke can save lives.
Goals

Clinical Goal: Improve hypertension control
Prevention Goal: Increase awareness of the risk factors for cardiovascular disease including tobacco use, uncontrolled hypertension, high cholesterol, obesity, physical inactivity, unhealthy diets, and diabetes.

Health Indicators by 2019

<table>
<thead>
<tr>
<th>QIM (*)</th>
<th>Healthy People 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Measure (v)</td>
<td></td>
</tr>
</tbody>
</table>

1. Increase the percentage of OHP participants with high blood pressure that is controlled (<140/90mmHg) from 64% to 68% (Baseline: QIM NQF 0018 - Controlling high blood pressure, 2014)

2. Decrease the prevalence of cigarette smoking among adults from 18% to 16% (Baseline: Oregon BRFSS, 2010-13; QIM Cigarette Smoking Prevalence)

3. Decrease the prevalence of smoking among 11th and 8th graders from 12% and 6%, respectively to 9% and 3%, respectively (Baseline: Oregon Healthy Teens Survey, 2013)

Action Area Strategy

Prevention and Health Promotion

- Support health care providers to increase referrals, including electronic referrals, to the Oregon Tobacco Quit Line.
- Promote the Oregon Health Authority statewide Smokefree Oregon campaign for youth.
- Offer training and assistance to healthcare providers to implement “2As and R” or “5As” tobacco cessation counseling.
- Implement a place based educational campaign on blood pressure control (e.g.: Measure Up/Pressure Down).
- Engage at least 2 community-based organizations (schools, dentists, colleges, employers, hospital, etc.) in an educational program/campaign around BP control and monitoring and CVD relationship.

Clinical

- Implement evidence-based guidelines for the control of hypertension.
- Provide assistance to patients to self-monitor blood pressure, either alone or with additional support.
- Increase referrals to the Oregon Tobacco Quit Line.
- Implement “2As and R” or “5As” tobacco cessation counseling.

Policy

- Implement a tobacco retail licensing program that will eliminate illegal sales to minors, prevent retailers from selling tobacco
within 1000 feet of schools, and eliminate sales of flavored tobacco products.
- Increase the number of schools using the CDC School Health Index to improve their health policies and programs.

**Health Equity**
- Identify, develop and implement culturally competent materials and programs such as Smokefree Oregon ads for culturally disparate populations.
- Please refer to the chapter on social determinants of health.

**Childhood Health**
- Engage schools to promote CVD prevention using best-practice, school-based model (TBD).

**Examples of Key Partnerships:**
- Health systems and Healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School Boards
- Churches
- Employers
- Colleges
- State health promotion and prevention programs
Priority Area: Behavioral Health Identification and Awareness

Team Members: Rick Treleaven, DeAnn Carr, Wade Miller, Christine Pierson, Kristin Powers, Scott Willard, and Ken House

Clinical Expert: Michael Franz, M.D., Medical Director of Behavioral Health, PacificSource Health Plans

The Problem
Stigma and the lack of integrated care pathways lead to a dramatic under-assessment and treatment of behavioral health issues in primary care settings.

There is considerable overlap between poor outcomes for chronic diseases and significant mental health and substance use problems. Approaches for preventing or treating chronic diseases need to address the whole person and their environment, particularly targeting screenings and support for mental health and substance use issues. Per capita costs among Medicaid-only beneficiaries with disabilities for coronary heart disease is nearly triple for people who also have co-occurring mental health and substance use disorders compared with people without either (Boyd, et al., 2010). Per capita costs are 3.8 times higher for diabetics with co-occurring mental health and substance use disorders than for diabetics with neither mental health nor substance use disorders (Boyd, et al., 2010). Individuals with depression average twice as many visits to their primary care doctor than do non-depressed patients and have nearly twice the annual health care costs. (Mauer & Jarvis, 2010).

The risk factors for depression and chronic diseases are bi-directional, with chronic diseases increasing the risk of depression, and conversely, depression increasing the risk of chronic diseases. Depression and unhealthy alcohol use is present in a significant percentage of people with diabetes and cardiovascular disorders. Depression has been proven to be such a risk factor in cardiac disease that the American Heart Association has recommended that all cardiac patients be screened for depression (AHA 2008). The presence of Type 2 diabetes nearly doubles an individual’s risk of depression and an estimated 28.5% if diabetic patients meet criteria for clinical depression (Mauer & Jarvis, 2010). People with mental illness, substance use disorders (SUDs), or both are at increased risk for developing diabetes. Untreated behavioral health disorders can exacerbate diabetes symptoms and complications. In addition, companion features of behavioral health disorders – such as poor self-care, improper nutrition, reduced physical activity, and increased barriers to preventive or primary care – can adversely affect management of co-occurring diabetes (SAMHSA Advisory, 2013).

The majority of people who use alcohol at levels that impact their health and mental health do not meet dependency criteria and are inappropriate for specialty treatment programs. Screening, Brief Intervention and Referral to Treatment (SBIRT) is an evidence-based practice that targets patients in primary care with nondependent substance use. It is a strategy for intervention prior to the need for more extensive or specialized treatment. The utilization of
SBIRT in Central Oregon remains at a fraction of the State benchmark, blunting the impact of this evidence-based practice. When primary care practitioners do identify a severe substance use disorder in a patient, the rate of successful referral to specialty SUD care remains very low, mainly due to low readiness-to-change in the patient and no system to develop the motivation and close collaboration necessary for a successful treatment referral.

**Goals**

**Clinical Goal(s):** (1) Increase screenings for depression, anxiety, suicidal ideation and substance use disorders.

(2) When screenings are positive, increase and improve primary care-based interventions, and, when appropriate, referrals and successful engagement in specialty services.

**Prevention Goal(s):** Normalize the public’s perception of accessing resources for depression, anxiety, suicidal ideation and substance use.

### Health Indicators by 2019

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM (*)</th>
<th>Healthy People 2020 (v)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of SBIRT/CRAFFT screenings provided in health care settings shall exceed 12% (Oregon Health Authority, 2015).</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>2. Number of Depression screenings and follow-up care provided in health care settings shall exceed 25% (Oregon Health Authority, 2015).</td>
<td>*</td>
<td></td>
</tr>
<tr>
<td>3. First year develop a baseline of successful referral and engagement in specialty care from primary care. Second year develop performance improvement benchmarks.</td>
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</tr>
</tbody>
</table>

### Action Area | Strategy

**Prevention and Health Promotion**

- Implement a program like the “Mind Your Mind” campaign.
- Social/emotional health curriculum taught in schools aligned with Oregon Department of Education (ODE) standards for health and evidence based practice.
- Alcohol, tobacco, and other drug health curriculum taught in schools aligned with ODE standards for health and evidence based practice.
- Implement a low risk drinking guideline (compliment to SBIRT) in the community.

**Clinical**

- Create a comprehensive identification and response system that is reflective of the entire primary care practice (from appointment scheduling to office visit).
- Use SBIRT/CRAFFT, PHQ 2 & 9, GAD-7 and other evidence-based screening tools within healthcare settings.
- Create a common response matrix that clinics could adopt, including physician intervention, BHC intervention, short-term
BH intervention at PCP clinic, and referral to specialty BH services.
- Create pathway/mapping for referral to specialty care.
- Create clear referral and communication protocols.
- Health information shared with primary care coordination team for review and provider follow up.
- Ongoing regional trainings in screening tools and brief intervention response.

### Policy
- Promote policies that support routine screening and follow-up care for substance abuse, depression and anxiety.
- Promote policies that support public awareness and acceptance of mental health and substance use wellness strategies.

### Health Equity
- Screenings, interventions, and specialty services need to be culturally and linguistically specific in order to be successful.
- Please refer to the chapter on social determinants of health.

### Health System/Access
- The creation of a common response matrix to screenings (e.g., brief provider intervention, BHC, or referral to specialty clinic) will improve the number of screenings and spread the cost-effective utilization of behavioral health interventions in health care settings.
- Increased public awareness of the role of behavioral health wellness in overall wellness will improve patient acceptance of behavioral health screenings.
- Assessment of resource needs within the community that will be addressed in partnership through multiple organizations, such as payees, public health, hospital, etc.

### Childhood Health
- Substance abuse and depression are significant contributors to poor childhood health. Regular screening and follow-up care will increase childhood health outcomes.

### Examples of Key Partnerships:
- Health systems and Healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School Boards
- Churches
- Employers
- Colleges
- Addictions and treatment centers
- State health promotion and prevention programs
Priority Area: Behavioral Health: Substance Abuse and Chronic Pain

Team Members: Rick Treleaven, DeAnn Carr, Wade Miller, Christine Pierson, Kristin Powers, Scott Willard, and Ken House

Clinical Expert: Michael Franz, M.D., Medical Director of Behavioral Health, PacificSource Health Plans

The Problem
People with severe Substance Use Disorders (SUDs) also carry a high medical burden and respond poorly to medical interventions, leading to extremely high utilization rates. The current disjointed practice pattern between medical care and specialty SUD services actually contributes to poor medical and behavioral health outcomes and increases the number of people with Opioid Use Disorder.

In a large scale review of adult Medicaid beneficiaries in six states in 1999, between 16% and 40% of beneficiaries had diagnoses of moderate to severe substance use disorders (SUDs). In all states SUDs were associated with higher rates of hospitalization for inpatient psychiatric and medical care. Importantly, beginning at age 50, medical costs for persons with SUDs almost doubled (Clark, Samnaliev, & McGovern, 2009). People with moderate to severe substance use disorder have nine times greater risk of congestive heart failure (Mertons, et al., 2003), likely due to poor nutrition, little exercise, and high rates of smoking in combination with the impact of their substance use. The comorbid combination of alcohol abuse, depression, and diabetes is often common in homeless and Native American populations (Am Indian Alsk Native Mental Health Rev, 2007). According to a 2008 study by the Oregon Division of Addiction and Mental Health, people with co-occurring mental health and substance use disorders have an average age at death of 45 years. Providing alcohol/drug treatment to those who need it has been shown to slow disease progression and growth in medical costs (Mancuso & Felver, 2010).

There has been a dramatic increase in opioid prescription drug availability over the past 15 years, which has resulted in an equally dramatic increase in prescription drug abuse and the related increase in heroin use in Central Oregon. In this manner, prescription practices by physicians can have serious public health consequences. The opioid-related unintentional prescription drug mortality rate has tripled in Oregon since 2000. The 5-year average age-adjusted opioid-related unintentional prescription drug mortality in Central Oregon was 3.6/100,000 population (95% CI 2.5-5.1) (CDC Wonder, 2009-2013). The 5-year average rate in Oregon during this time period was 4.1/100,000 population (95% CI 3.8-4.4). Injection drug users are the largest single risk group for Hepatitis C (CDC Surveillance for Viral Hepatitis 2013). Surveys have indicated that within one year of use, 50-80% of injection drug users test positive for the Hepatitis C antibody. Nationally, there was a 151.5% increase in acute Hepatitis C cases from 2010 to 2013, largely attributed to drug use (CDC 2013). With Central Oregon experiencing a significant increase in prescription opiate and heroin use, we can expect to see an increase in Hepatitis C rates. Finding alternative resources to opioids for people suffering
from chronic, non-cancer pain is one of the highest priorities identified by local physicians. To decrease the chronic over-availability of prescription opiates in our community requires, in part, providing evidence-based holistic approaches to chronic, non-cancer pain.

**Goals**

**Clinical Goal(s):** Create a bi-directional integration approach for people with severe substance use disorders.

**Prevention Goal(s):** Implement a community standard for appropriate and responsible prescribing of Opioids and Benzodiazepines.

**Health Indicators by 2019**

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM (♦) State Measure (v)</th>
<th>Healthy People 2020 (v)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the number of successful referrals from medical settings to specialty SUD services of people with moderate to severe Substance Use Disorders.</td>
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<td></td>
</tr>
<tr>
<td>2. First year develop a baseline on the pharmacy, hospital, acute psychiatric, and emergency department expense related to people with moderate to severe Substance Use Disorders. Second year set performance improvement benchmarks.</td>
<td>v (PIP)</td>
<td></td>
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<tr>
<td>3. First year develop a baseline for number of people receiving greater than 120 mg morphine equivalent for more than three months. (OHA PIP)</td>
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</table>

**Action Area**

**Prevention and Health Promotion**

- Expand Prescription Drug Monitoring Program (PDMP) use by primary care providers.
- Develop plan for implementing alternative & complimentary pain treatment therapy.
- Compassionate care education for community providers.
- Expand needle exchange programs.
- Expand the availability of Naloxone.
- Expand medication disposal programs.
- Process and care path for affected family and children to impact ACEs and behavioral health factors.

**Clinical**

- Develop high functioning patient pathways from hospital and primary care settings into SUD specialty care.
- Create a “Hub and Spoke” model for Medically Assisted Treatment (MAT) that links the MAT specialty provider and (a) other SUD and mental health providers, and (b) primary care providers.
- Create an efficient, effective, and coordinated system of outreach, engagement, and care coordination services to
medically significant populations, including: pregnant women who still use drugs, people who use illicit IV drugs, identified high utilizers of medical and pharmacy services, identified utilizers of mental health acute care services, and identified hospital patients.

- Provision of cost-effective medical/nursing support and alternative chronic pain management/chronic disease management skills training in selected SUD specialty care programs.
- Implementation of an outcomes system for each of the above four strategies focused on engagement and retention in specialty SUD services and on patterns of health care utilization.

<table>
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<tr>
<th>Policy</th>
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<tr>
<td>• Support the efforts of the Chronic Pain Task Force to educate physicians to best practice standards and to support alternative pain management strategies.</td>
</tr>
<tr>
<td>• Advocate with OHA to make alternative and complimentary pain treatment therapy a reimbursable service.</td>
</tr>
<tr>
<td>• Support legislation to make Naloxone available through the pharmacy without a physician’s prescription.</td>
</tr>
<tr>
<td>• Expand needle exchange and harm reduction education for people injecting illicit drugs.</td>
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<tr>
<td>• Expand prescription drug return programs.</td>
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<tr>
<th>Health Equity</th>
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<tr>
<td>• Cultural and language specific treatment strategies for Latino clients.</td>
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<td>• Safe and sober housing availability.</td>
</tr>
<tr>
<td>• Intentional Peer Support outreach for severely disadvantaged people with Substance Use Disorders, including people who are homeless, Native American public inebriates, IV drug users, and pregnant women who use drugs.</td>
</tr>
<tr>
<td>• Supported employment strategies for people with criminal records.</td>
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<tr>
<td>• Please refer to the chapter on social determinants of health.</td>
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<thead>
<tr>
<th>Health System/Access</th>
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<tbody>
<tr>
<td>• Make available SUD engagement services at hospitals and primary care clinics.</td>
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<tr>
<td>• Identification of clients in SUD services who have high medical burden and the development, with the PCP, of a whole-health care and support plan.</td>
</tr>
<tr>
<td>• Development of alternative and complementary pain programs widely available in the community.</td>
</tr>
<tr>
<td>• Develop a community care plan for impacted children and</td>
</tr>
</tbody>
</table>
Childhood Health

- Substance abuse is a significant predictor to all of the Adverse Childhood Events. Treating the parent, who has a severe substance use disorder, decreases the number of ACEs a child experiences and increases that child’s resiliency, thus improving long-term health status.

Examples of Key Partnerships:
- Health systems and Healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School Boards
- Churches
- Employers
- Colleges
- Addictions and treatment centers
- State health promotion and prevention programs
- Sheriff and Police Departments in Central Oregon
Priority Area: Oral Health

Team Members: Nikole Zogg, Kat Mastrangelo, Leslie Neugebauer, and Mary Ann Wren

Clinical Experts: Gary Allen, DMD, MS, Dental Director, Advantage Dental; Heather Simmons, MS; Sharity Ludwig, BS, RDH, EPP; Central Oregon Dental Society (via Brad Hester), and the Central Oregon Oral Health Coalition (via Suzanne Browning)

The Problem
The health of the mouth and surrounding structures is central to a person’s overall health and well-being. Dental caries (cavities) is a communicable infectious disease most frequently caused by the bacterium *Streptococcus mutans*. Preventing the transmission from one person to another or controlling bacteria load in the mouth is possible and can eliminate or decrease tooth decay.

Dental caries is the most common chronic disease among children and is 5 times more common than asthma. Untreated decay or other health problems in children can result in attention deficits, learning and behavior challenges in school, and problems speaking, sleeping and eating. In Central Oregon, one-quarter to one-half of first and second graders that were screened in selected Central Oregon schools had untreated tooth decay. Moreover, between 71.7% and 76.3% of Central Oregon 8th graders reported ever having a cavity and between 4.8% and 6.4% missed one or more hours of school due to going to the dentists because of tooth or mouth pain.

Among adults, poor oral health may negatively affect a person’s ability to obtain or keep a job and form relationships. In Central Oregon, one safety net clinic reports 40% of low-income patients seeking care for their physical health had dental issues that impacted their ability to eat or sleep (Volunteers in Medicine, 2013). Nationally, employed adults lose more than 164 million hours of work each year due to dental disease and dental visits. Poor oral health is also associated with adverse pregnancy outcomes and other disease and conditions such as diabetes, cardiovascular disease, stroke and respiratory disease. Minorities and low-income populations are significantly more likely to report oral health problems.

Goals
Clinical Goal(s): Improve oral health for pre and post-natal women
Prevention Goal(s): Keep children cavity-free

<table>
<thead>
<tr>
<th>Health Indicators by 2019</th>
<th>QIM (*)</th>
<th>Healthy People 2020 (v)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase the percent of pre and postnatal women who had a dental visit from 55.2% to 60%. (<em>Baseline: PRAMS, 2011)</em></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>2. Increase the percent of children 6-14 years who received a dental sealant to 20%. (<em>Baseline: Oregon Health Authority, 2015)</em></td>
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<td>✓</td>
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<tr>
<td>3. Decrease the percent of first and second graders with untreated</td>
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</table>
dental decay in schools that participate in the School Dental Sealant Program by 5%. *(Baseline: School Dental Sealant Program, 2013-2014)*

4. Decrease the percent of 8th graders who missed one or more hours of school due to going to the dentist because of tooth or mouth pain by 0.5%. *(Baseline: Oregon Health Teens Survey, 2013)*

5. Increase the percent of children 0-5 years who received a dental service within the reporting year to 40%. *(Baseline: PRAMS, 2011)*

<table>
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<tr>
<th>Action Area</th>
<th>Strategy</th>
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</table>
| Prevention and Health Promotion | • DCOs partner with pediatricians to provide post-natal moms with oral hygiene instruction and 90 day supply of xylitol at two-week post-natal visit.  
• Provide education to providers asking the One Key Question® regarding importance of a dental visit prior to pregnancy.  
• Decrease fear of the dentist by increasing provider awareness of adverse childhood experiences.  
• Work with schools to ensure children receive toothbrush kits on a regular basis.  
• Assess oral health literacy.  
• Implement Brush, Book, Bed (AAP).  
• Provide nutrition counseling.  
• Provide tobacco cessation resources. |
| Clinical | • Patients who indicate they plan to get pregnant in the next year get referred into dental care.  
• Deliver preventive dental services to children and pregnant women in non-traditional settings.  
• Primary care clinician prescribes oral fluoride supplementation starting at 6 months of age for children whose water supply is deficient in fluoride.  
• Primary care clinicians apply fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption. |
| Policy | • Oral and other health providers and dental plans will develop policies and practices to fast track pregnant women into dental care.  
• Work with legislators to include fluoridated toothpaste in the SNAP benefits.  
• Work with legislators to get fluoridated toothpaste to be covered as a prescription benefit for OHP members.  
• Dental practices adopt trauma-informed care model policies. |
<table>
<thead>
<tr>
<th><strong>Dental offices adopt a policy to see patients in the first year of life.</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Establish optimally fluoridated community water systems.</strong></td>
</tr>
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</table>

**Health Equity**

<table>
<thead>
<tr>
<th>• Screenings, interventions, and services need to be culturally and linguistically specific in order to be successful.</th>
</tr>
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<tbody>
<tr>
<td>• Please refer to the chapter on social determinants of health.</td>
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</table>

**Health System/Access**

<table>
<thead>
<tr>
<th>• Integrate oral health care into the standard practice of care for all health care settings.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All providers, including school-based health centers, adopt a minimum of 2 questions to assess oral health status and refer as appropriate.</td>
</tr>
<tr>
<td>• All primary care providers and primary care dentists adopt the One Key Question® and make appropriate referrals based on intent to become pregnant.</td>
</tr>
<tr>
<td>• All primary care providers, behavioral health professionals, and primary care dentists administer or have knowledge of their patients’ Adverse Childhood Experience Score.</td>
</tr>
<tr>
<td>• OB/GYN practices adopt policies/practices to assess oral health and refer to care.</td>
</tr>
<tr>
<td>• Expand comprehensive community-based oral health.</td>
</tr>
<tr>
<td>• Expand First Tooth program beyond clinic providers to include home visitors and lay persons such as licensed childcare workers and school nurses.</td>
</tr>
</tbody>
</table>

**Childhood Health**

*See previous Action Areas and Strategies that address Childhood Health.*

**Examples of Key Partnerships:**

- Health systems and Healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School Boards
- Churches
- Employers
- Colleges
- State health promotion and prevention programs
Priority Area: Reproductive & Maternal Child Health

Team Members:
Muriel DeLaVergne-Brown, Tom Machala, Jane Smilie, Jeff Stewart and Pamela Ferguson

Clinical Expert:
Laura Gratton, DO (Medical Director – Mosaic Prineville, Madras)

The Problem

Maternal and child health indicators describe the health and well-being of mothers, infants, children, and families. A mother’s health and well-being before, during, and after pregnancy has direct and sometimes lifelong effects on the health of her child.

As a focus of maternal child health, low birth weight (LBW) is a serious public health challenge. Babies who have very LBW can be at higher risk of death and other complications as they grow up. LBW infants are more likely to die before their first birthday and more likely to suffer from cognitive development issues and chronic health conditions, such as high blood pressure and asthma. The problems associated with LBW also continue into adulthood: Compared to their peers, LBW individuals attain less education and earn less income. LBW is associated with tobacco, alcohol, and drug use; lack of early prenatal care, lack of maintaining a healthy weight.

In Central Oregon, 77.9% of infants received prenatal care in the first trimester as compared to 77.8% in Oregon (OHA – Performance Measures, 2015). Differences between the counties in 2014 show Deschutes at 81%, Crook at 70.4%, and Jefferson at 68.5% (OHA, 2014). Timeliness of prenatal care is a 2015 metric and 2016 metric for the CCO.

The rate per 1000 for smoking during pregnancy was six times higher among women enrolled in OHP in Central Oregon than those with private insurance as demonstrated by the following:

<table>
<thead>
<tr>
<th></th>
<th>Oregon</th>
<th>Crook</th>
<th>Deschutes</th>
<th>Jefferson</th>
<th>Central Oregon</th>
</tr>
</thead>
<tbody>
<tr>
<td>OHP</td>
<td>19.1</td>
<td>28.0</td>
<td>17.7</td>
<td>14.4</td>
<td>17.9</td>
</tr>
<tr>
<td>Private</td>
<td>3.9</td>
<td>6.6</td>
<td>2.5</td>
<td>3.1</td>
<td>2.8</td>
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Cigarette smoking prevalence will be a 2016 CCO incentive measure.

Unintended pregnancy refers to pregnancies that are mistimed, unplanned, or unwanted. About 51% of pregnancies in the United States are unintended (Guttmacher Institute, 2015). Measuring rates of unintended pregnancy helps gauge a population’s needs for contraception and family planning. Unintended pregnancy is associated with increased risk of health problems for the baby as the mother may not be in good health or delay prenatal care upon learning of the pregnancy. Almost 50% of pregnancies in Oregon are unintended, and have been for more than three decades (Finer & Kost, 2011). In 2011, the most recent year for which there is state-level data on pregnancy intentions, there were 45,136 births, 37% of which were considered unintended. That year there were 9,567 elective abortions. Also in 2011, the unintended pregnancy rate was 36.6% for Oregon, 38.8% for Central Oregon, 37.7% for
Deschutes County, and 35.3% for Jefferson County. The total unweighted denominator for Crook County was too small to report. (OHA, 2011; PRAMS, 2011).

A published study in 2013 found that Medicaid paid for approximately 63% of unintended births in Oregon (Sonfield & Kost, 2013). Among women ages 19 and younger, more than four out of five pregnancies were unintended. The proportion of unintended pregnancies is highest among teens younger than 15 years, with 98% of these pregnancies being unintended (Finer and Zolna, 2014).

Immunizations are a key public health measure for preventing the spread of disease. A series of immunizations are delivered to children to ensure their immunity to many diseases. The trend over the past few years has shown a decrease in the immunization rates and there have been outbreaks throughout the nation. Central Oregon’s rates have decreased to a point of concern. As noted in the 2015 Regional Health Assessment, two year olds in Jefferson County were more frequently up to date with immunizations than were two-year-olds in Crook and Deschutes County. Central Oregon practices and Public Health Departments who provide vaccinations should assess and develop approaches to increase immunization rates in their practices to improve the health of Central Oregon children.

**Goals**

**Clinical Goal:** Reduce the prevalence of low birth weight among live-born infants by improving prenatal/postnatal care for mothers and infants.

**Prevention Goal:** (1) Prevent unintended pregnancies. (2) Improve immunization rates of children birth to two years.

**Health Indicators by 2019**

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>QIM (*) State Measure (V)</th>
<th>Healthy People 2020 (V)</th>
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</thead>
<tbody>
<tr>
<td>1. By 2019, increase the number of women in Central Oregon who receive prenatal care beginning in the first trimester from 86% to 90% (Baseline OHA: Performance Measures – Central Oregon Region – PS – May 2015; Oregon Health Authority 2013: Crook (77.8) Deschutes (81.0) Jefferson (66.3)) (Baseline: Healthy 2020 – 70.8%)</td>
<td>* √</td>
<td>√</td>
</tr>
<tr>
<td>2. By 2019, decrease the percent of tobacco use among Central Oregon pregnant women from an average of 12.1% to 7.0%. (Baseline: Oregon Health Authority Annual Report, 2013; Crook (15.0%) Deschutes (9.8%) Jefferson (11.4%) (Tobacco Smoking Prevalence – 2016 Metric)</td>
<td>* √</td>
<td>√</td>
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<tr>
<td>3. By 2019, reduce low birth weight (LBW) (less than 2500 g {less than 5 lbs. 8 oz.}) to an incidence of no more than 5% of live-born infants in Central Oregon. (Baseline: OHA, 2014; Healthy People 2020 - Goal)</td>
<td>√</td>
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<tr>
<td>4. By 2019, increase effective contraceptive use among women of...</td>
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childbearing age in Central Oregon from 31.4% to 50%. *(Baseline OHA: Performance Measure – Central Oregon Region – PS – May 2015)*

5. By 2019, increase the Central Oregon State Performance Measure – Child Immunization Status rate (0-24 months) (NQF 0038) from 62.1% to 80%. *(Baseline OHA: Performance Measure – Central Oregon Region – PS – May 2015; Immunization Rates, Oregon, 2014 (4.3.1.3.1.4) Crook (63%) Deschutes (60%) Jefferson (70%); Healthy People 2020 – 80%)

<table>
<thead>
<tr>
<th>Action Area</th>
<th>Strategy</th>
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| Prevention and Health Promotion | • Increase 2-year-old children immunization rates by implementing the Central Oregon Regional Immunization Rate Improvement Project (IRIP) in Deschutes, Crook and Jefferson County using the AFIX Program in Coordinated Care Organization (CCO) participating clinics.  
• Expand prenatal and postnatal home visiting services to high-risk women in Central Oregon. *(NQF 1517)*  
• Provide home visits with the intent of educating on topics that include vaccinations, tobacco, alcohol, and key referrals for community resources.  
• Screen women for their pregnancy intention on a routine basis by implementing “One Key Question®” with all providers in Central Oregon.  
• Provide evidence-based community messaging and curricula to adolescents focusing on unintended pregnancy, HIV/AIDS, and STDs.  
• Ensure timely access to contraceptives and STD support.  
• Support the initiation and sustainment of breastfeeding for new mothers with programs such as WIC, home visiting, and “Baby-Friendly” hospitals. |
| Clinical | • Screen 100% of pregnant women and refer them to appropriate medical, dental, behavioral and social services.  
• Implement the “2As and R” and “5As” tobacco cessation and counseling in all health care settings.  
• Increase referrals of pregnant women who use tobacco to the Oregon Tobacco Quit Line. |
<table>
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<tr>
<th>Policy</th>
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| • Promote the inclusion of age appropriate, medically accurate sexual health education in our schools (ODE, HB2509 – ORS336.455).  
• Promote policies that support barrier free access to contraceptives.  
• Promote policies that increase access to prenatal care with equity and rural concerns considered.  
• Promote policies that support the use of LARC (long acting reversal contraceptives) as the most effective birth control option for women at highest risk for pregnancy. |

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<td>• Please refer to the chapter on social determinants of health.</td>
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<tr>
<th>Health System/Access</th>
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</table>
| • Implement universal nurse home visiting (Family Connects) as part of a regional perinatal continuum of care system in partnership with public health, primary care medical providers and the CCO.  
• Expand access/marketing to improve effective contraceptive rates in primary care and public health. |

<table>
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<tr>
<th>Childhood Health</th>
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</table>
| • Reduce child maltreatment using evidence-based home visiting programs (i.e., Family Connects, Healthy Families) that work to improve family well-being and to reduce child maltreatment by coordinating services for high-risk families.  
• Provide referrals that link clients to community services, resources and support. (Early Learning Metric) |

**Examples of Key Partnerships:**
- Health systems and Healthcare providers
- Public health departments
- High schools (school nurses, school-based health centers)
- School Boards
- Churches
- Employers
- Colleges
- State health promotion and prevention programs
Social Determinants of Health Spotlight: Education and Health

The Problem
Healthy People 2020 highlights the importance of addressing the social determinants of health (SDOH) by including “Create social and physical environments that promote good health for all” as one of its four overarching goals for the decade. The initiative has created a “place-based” organizing framework that categorizes SDOH into five (5) key areas:

- Economic Stability
- Education
- Social and Community Context
- Health and Health Care
- Neighborhood and Built Environment

The SDOH span a wide range of complex and intertwined social conditions. Few, however, would argue that without a good education, people are significantly less likely to find stable employment with living wage earnings. They are more likely to be living in poverty – which involves unstable/low-quality housing, unsafe neighborhoods, limited access to health care, transportation disadvantage and limited access to basic needs like affordable, healthy food (Low et al, 2005). While this is logical, what may be less intuitive is how strongly educational attainment is linked to health outcomes.

Robert Wood Johnson, arguably the largest and most powerful think tank related to SDOH in the United States, commissioned a white paper in 2011 highlighting strong evidence that consistently connects educational attainment and health, even when other SDOH factors, such as income, are taken into account (Mirkowsky et al, 1999 and 2003). The study examined the interrelated pathways in which education is linked with health, including health knowledge and behaviors; employment and income; and social and psychological factors, including sense of control, social standing, familial context and social networks. One could conclude from this study that to effectively impact SDOH at a population level, educational achievement should be a primary focus.

Figure 1: PERCENT OF ADULTS, AGES 25-74 YEARS, IN LESS THAN VERY GOOD HEALTH*

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† Based on self-report and measured as poor, fair, good, very good or excellent.  
* Age-adjusted.
Kindergarten Readiness and Third-grade Reading Scores
There are several early milestones that are closely linked to a child’s future academic achievement. In elementary school, these include kindergarten readiness, third grade reading and fourth grade math. Data from across the states suggest that as a child’s kindergarten readiness scores improve, the later milestone scores rise accordingly (Duncan et al., 2008). Furthermore, reading level scores at the third grade has been linked to high school graduation (Silver and Saunders, 2008). Both kindergarten readiness and third-grade reading are key indicators of future success because children with low scores at these milestones face a confounding learning disadvantage going forward (Maryland Department of Education, 2010).

Equity, Disparities and Vulnerable Populations
There are a variety of SDOH factors that are barriers to educational achievement. These include adverse family context, food insecurity, culture and language differences and presence of childhood trauma (toxic stress). Though we know less education is linked with worse health across all racial and ethnic subgroups (see Figure 1), there are populations that have different experiences and levels of exposure to these barriers. Many school boards across Oregon struggle to meet the needs of students and families who have cultural or linguistic needs, special needs, live in poverty or have other barriers such as adverse family situations. Just as healthcare reform highlights the need for an equity lens as a key strategy, education reform has a very similar calling. This focus on equity on both sides means that programs and policies aimed at outcomes such as increasing educational achievement should take all differences between and within subgroups into account and all programs should be tailored to address such differences.

In Central Oregon, geographic differences also need to be examined and any programs and efforts to address educational achievement need to be in balance with community needs and demographics. For example, the 501J School District in Jefferson County is one of the most diverse in the state. One-third of students are Latino, one-third White non-Hispanic and one-third Native American.

Early Childhood Adversity, Toxic Stress, and the Role of Community
Neuroscience is catching up with what we have long suspected about social determinants of health affecting children’s learning and development. The original study on Adverse Child Experiences (ACEs) was published almost 20 years ago in a collaboration between the CDC and Kaiser. But recently, growing understanding of the science behind toxic stress outcomes is generating renewed interest and investment, resulting in a push for strategies and practices that would prevent ACEs by targeting
protective changes in the child’s early life context. The American Academy of Pediatrics calls these contexts “early childhood ecology.” In their 2012 policy statement, the AAP states: “The effective reduction of toxic stress in young children could be advanced considerably by a broad-based, multisector commitment in which the profession of pediatrics plays an important role in designing, implementing, evaluating, refining, and advocating for a new generation of protective interventions.”

The Opportunity – Connecting the Dots
More than any time in our history, Central Oregon has the right combination of state and local sponsored health care, community-based, public health and education system reform initiatives that if properly aligned, could have the potential to significantly change health-shaping contexts for children and families. At the current time, the following initiatives are either in development or being implemented:

- Coordinated Care Organizations (CCO) – transformation of the Medicaid delivery system (60 +% children, disproportionate poverty)
- Cradle to Career: Early Learning Hub/Regional Achievement Coalition (Better Together)
- Health and housing
- Public health/primary care partnership (Perinatal Collaborative) to improve outcomes for at-risk moms, children and families
- A growing interest in addressing Adverse Childhood Experiences (ACEs) and toxic stress (EL Hub/United Way of Deschutes County, PacificSource CCO)

Rather than coming at ACEs, child development and education from our separate silos, what if all these stakeholders were to come together and adopt one, unified and powerful goal – that all children in Central Oregon enter kindergarten ready to learn, graduate from high school and go on to college? Given the strong and conclusive evidence that intertwines ACEs, educational achievement and long-term health, impact indicators, such as kindergarten readiness, could be easily tracked – with positive results giving us good

COMMUNITY SPOTLIGHT: UNITED WAY

United Way in Central Oregon is pursuing collective impact methods to heighten its impact on important social determinant needs and issues. As part of a long-term planning process, childhood trauma or ACEs has emerged as a critical issue of strategic importance to both United Way and its partnering agencies. The organization has initiated a broad-based effort to advance the prevention and treatment of childhood trauma. Goals include:

- Increasing awareness of ACEs and their negative impact on health and education outcomes
- Developing shared understanding and language for discussing ACEs, toxic stress, and resiliency
- Aligning agencies and programs around common goals
- Integrating trauma informed practices in programs and services
- Ensuring consistent, quality training and support for front-line workers

As a community based organization, United Way is uniquely positioned to build the capacity of the community to address ACEs and trauma. They have a track record of community impact as well as competencies that include a broad-based network of partner agencies and donors and a proven ability to raise and manage significant funds. For all these reasons, United Way will be a critical partner throughout implementation of the RHIP education and health strategy.
confidence that we are knocking down other SDOH barriers for both children and their families. Furthermore, if we were to target our perinatal population and follow those families through their first 4-5 years, with strong evaluation supports in place, we will learn and improve upon how our multi-sectoral approach is performing with data and information as soon as the end of this regional health improvement plan cycle.

**Example Successful Cross-sectoral Interventions**

Fortunately, Central Oregon would not have to start from scratch in organizing and developing a strategy to change the early childhood ecology for vulnerable children and families. There is already momentum and planning taking place with health care representation through the work of the Early Learning Hub. There are also many best practices that could be studied to inform a community strategy that addresses ACEs by wrapping education, health and social supports (e.g. housing, transportation, employment) to impact children and youth educational achievement goals (Department of Vermont Health Access, 2015). Listed below are a few examples of cross-sectoral programs that are showing positive results:

- **Child-Parent Education Centers (CPC):** CPC programs provide comprehensive educational, family support and healthcare services to economically disadvantaged children from ages 3-9. First developed in the 1960s, CPC initially launched in 25 sites in Chicago. The key goals were to improve school achievement, attendance, and parent engagement.

- **Northside Achievement Zone:** The Northside Achievement Zone (NAZ) exists to permanently close the achievement gap and end generational poverty for communities of color in North Minneapolis. Similar to Harlem’s Children Zone, NAZ uses a family-centered, wraparound framework (housing, health care, parenting education supports) starting in the perinatal years, effectively supporting low-income families overtime so that their “scholars” will graduate from high school and be prepared for college. NAZ-enrolled families are making remarkable strides. Children are not only showing improved academic outcomes at key kindergarten and third grade benchmarks, but families are stabilizing their housing, employment, and health. A study by Wilder Research demonstrated that each dollar invested in NAZ provides more than a $6 societal return.

- **Durham Connects:** Increases child well-being by bridging the gap between new parent needs and community resources. The project is a collaborative effort among the Center for Child & Family Health, The NC Department of Social Services, and the Durham County Health Department. Durham Connects hires and trains nurses to provide in-home health assessments of mothers and newborns, as well as to discuss the social conditions affecting the family. A study conducted between July 2009 and December 2010 showed increased positive parenting behaviors, father involvement, child care selection, and reduced infant hospitalization among Medicaid recipients.

- **Center-Based Early Childhood Education:** Prepares children by providing skills development and readiness training, while also focusing on health and social development. ECE programs aim to improve the cognitive or social development of children ages 3 or 4 years.
Implementation Recommendations

There are five key strategies that the Central Oregon CCO and larger health system can take to advance educational achievement (e.g. kindergarten readiness) as a central SDOH goal (depicted as inputs in figure 2):

1. Inventory and understand the potential confluences that could be strengthened in partnership with community and education-based systems, such as the Early Learning Hub and public health nurse home visiting programs.

2. Align with and leverage the growing interest from healthcare, education and community-based organizations (e.g. United Way), in the prevention and treatment of early childhood trauma.

3. Support the formation of a workgroup that would bring together, education (Early Learning/Better Together), community-based and health system partners to identify achievement gap “hot spots” and develop strategies to health, social service and education supports around children and families.

4. Intervene as early as possible to build resiliency in children and families, but also support youth whose lack of basic needs or poor health gets in the way of learning while already in school. The health system can support all children, youth and families by:
   - Promoting and providing annual well-child visit and conducting developmental screenings in the first 3 years of life
   - Promoting and providing annual adolescent well-visits
   - Screening for ACEs (parents and children) and referring to treatment when appropriate
   - Meaningful and measurable collaboration with education, community and social support system
   - Develop innovative funding mechanisms to sustain outcome-producing models

The Central Oregon Health Council, through the Operations Council, needs to develop a three-year work plan, in partnership with the above mentioned stakeholders, to implement strategies that pertain to the health system’s role, starting with Board adoption of kindergarten readiness as a system metric. This work plan should be vetted by numerous stakeholder groups and by the COHC, to be given final approval by no later than April 1, 2016.

Figure 2: Strategy at a Glance

References:
• Department of Vermont Health Access. Integrating ACE-Informed Practice into the Blueprint for Health. 2015.
MINUTES OF A MEETING OF
PROVIDER ENGAGEMENT PANEL
CENTRAL OREGON HEALTH COUNCIL
December 9, 2015 from 7-8:00am – PacificSource Boardroom

**Members Present (In-Person)**
Steve Mann, Chair (COIPA and High Lakes Healthcare)
Gary Allen (Advantage Dental)
Rebeckah Berry (COHC)
Maria Hatcliffe (PacificSource)
Alison Little (PacificSource)
Donna Mills (COHC)
Kyle Mills (Mosaic Medical)
Laura Pennavaria (La Pine Community Health Center)
Dana Perryman (COPA)
Christine Pierson (Mosaic Medical)
Divya Sharma (Mosaic Medical and COIPA)

**Members Present (Call-in)**
Sharity Ludwig (Advantage Dental)

**Guests Present**
Angela Saraceno (Healthy Beginnings)
Holly Remer (Healthy Beginnings)
Randy Moss (American Medical Transit)

**Absent:**
Sheila Albeke (PacificSource)
David Holloway (Bend Memorial Clinic)
Jennifer Laughlin (St. Charles Medical Group)
Rob Ross (St. Charles Medical Group)
Kim Swanson (St. Charles Medical Group)
Introductions
• Dr. Mann welcomed all attendees and guests were introduced.

Healthy Beginnings Overview
• Holly Remer of Healthy Beginnings presented to the group. She explained that they see themselves as a gateway program. They recruit volunteers from the community including RNs and specialists to provide one-on-one screening, referral and parent education using evidence-based assessment tools such as ASQ. They require the parent to always be present and there are no eligibility requirements.
• Ms. Remer explained that they have 18 full-day screening clinics per year in all of Central Oregon. She shared that 40% of children do not enter Kindergarten "prepared to learn."
• Healthy Beginnings reports that they are strong in referrals to community services. They collaborate with the High Desert Education Service District, United Way of Deschutes County, EL HUB, and OSU – Cascades. They receive referrals from various avenues in the community such as schools, homeless shelters, WIC, FAN, DHS, among many others.
• Ms. Remer explained that they are always in need of volunteer professionals.
• She explained that the population has a lack of understanding of the importance of these screenings. Of the 697 children that were screened last year, 631 of those screenings identified concerns. Additionally, over 1/3 of children had not seen a dentist.
• Ms. Remer also noted that HB has sustained an 8-year partnership with OHA to provide OHP Application Assistance.
• Dr. Allen requested a breakdown of the numbers for each type of care. Ms. Remer stated that this was possible and that the rates in dental are the highest. They have a goal to increase the amount of child screenings that they refer to as “4 B4 5” which consists of health, behavioral, vision, and dental).
• Dr. Allen asked why this has program has not caught on more in Oregon and other areas. Ms. Remer stated that they believe it is relative to funding and the need for a volunteer coordinator as well as office space.
• Dr. Little asked what there target age is. Ms. Remer responded that they target birth to 5 years with some exceptions.
• Ms. Hatcliffe noted that many of these children that are screened are not yet insured. Ms. Remer confirmed this information and stated that they would like for PCPs to make referrals because they are able to provide more in-depth screenings. She referred the group to their website www.myhb.org and said that they do try to help children get connected with a PCP when there is none.

ACTION: Holly will email Rebeckah screening dates and Rebeckah will share with all COHC contacts in the future.

Assignment of RHIP Priority Review
• Dr. Mann reviewed the priority areas with the PEP and noted the clinical experts that have been assigned to each area:
Reproductive and Maternal Child Health: Muriel DeLaVerge-Brown & Laura Pennavaria
Diabetes: Kyle Mills & Divya Sharma
Behavioral Health:
  - Identification and Awareness: Laura Pennavaria, Steve Mann, and Dana Perryman
  - Substance Abuse and Chronic Pain: Christine Pierson & Kim Swanson
Cardiovascular Disease: Divya Sharma
Oral Health: Gary Allen and Sharity Ludwig

Action: Each group will review their portion of the RHIP and come prepared to present their feedback to the group at January’s meeting (1.13.16).

QHOC Monthly Update

- Dr. Little informed the group that syphilis screenings have increased among both males and females, noting that there were 4 cases of congenital syphilis in 2015. OHA has new syphilis screening recommendations based on the increase in prenatal/congenital syphilis. They recommend screening all pregnant women for syphilis at their first prenatal visit, at the beginning of the 3rd trimester, and again at delivery.
- Dr. Little reported that there is a new Chief Health Systems Officer, Dr. Varsha Chauhan.
- Regarding out of hospital births, Dr. Little shared that CCOs will now be notified when a member moves to FFS for an OOH birth pregnancy. She shared the following highlights:
  - More than 800 members have asked for OOH birth (50% of these need to submit additional information related to risk and 25% have not been approved because they are not low risk).
  - HERC will be finalizing the coverage guidance on Nov 12 and OHA will be following the outcomes.
  - There is no newborn care reimbursement to providers following an OOH birth (the newborn must be referred back under CCO care); mother comes back to CCO after 60 days PP.
  - Issue of adverse selection was again raised. The OHA representative determined that QHOC was not the forum to address this issue, and that it will be discussed with CCO contractors (regarding additional reimbursement to address adverse selection).
- HERC is looking at the effectiveness of a treatment and making recommendations around the back pain guidelines. If the treatment results in >1% cost increase, actuarial services need to evaluate the impact.
- MRI guideline modifications are coming and feedback is being sought. Right now it reads so that anyone with back pain >4 weeks could receive an MRI.
- Guideline note 127 gender dysphoria is finalized.
- OOH Birth is not finished. They are still defining what needs to be demonstrated/rulled out. US will be required.
• Indications for Proton Beam Therapy. Pediatric cancers are being added because it decreases the risk of secondary malignancies. They are still determining what lines it should be added to. Deleting from thoracic lines. They are unsure yet regarding brain tumors.
• Healthy Hearts Northwest. AHRQ grant initiative to transform health care delivery. ORPRN will select 1230 small- and medium-sized primary care practices throughout Oregon to participate in H2N. Practices need to have 10 FTE or fewer.
• During the presentation by the Immunization Program of the Public Health Division, a draft document titled “Evidence-based Strategies for Improving Childhood Immunization Rates: A Guide for CCO’s” was distributed and feedback was requested.

**ACTION:** Rebeckah will send Think Out Loud link to PEP and PSTF

• There will be no HERC meeting in December.

**Consent Agenda**
• Dr. Mann made a motion to accept the minutes dated November 11, 2015. The minutes were approved and accepted in full.