Central Oregon Health Council

RHIP Substance Use & Chronic Pain Workgroup
PacificSource – Suite 210 (2nd Floor)
2965 NE Conners Ave, Bend

Agenda: July 20, 2016 from 4:00pm-5:00pm

Call-In Number: 866-740-1260
7-Digit Access Code: 3063523

1. 4:00-4:05 **Introductions—All**

2. 4:05-4:25 **Review of Draft Substance Use & Chronic Pain Work Plan—All**

3. 4:25-4:55 **Standardizing a Pathway for Populations Who Are "Risky" (AUDIT 8-19)—All**

4. 4:55-5:00 **Action Items—All**
   - **Next steps**

Next Meeting: **August 17 from 4-5pm**

BH Substance Use & Chronic Pain (19)	Organization
Steve Baker	Mosaic Medical
Mike Franz	PacificSource
Erica Fuller	Rimrock Trails Adolescent Treatment Services
Nicole Lemmon	Wellness & Education Board of Central Oregon (WEBCO)
Alison Litte	PacificSource
Leslie Neugebauer	PacificSource
Matt Owen	Bend Treatment Center
Laura Pennavaria	La Pine Community Healthy Center
Sally Pfeifer	Pfeifer & Associates
Christine Pierson	Mosaic Medical
Kristin Powers	St. Charles Health System
Beth Quinn	Cascade Peer & Self-Help Center & Intentional Peer Support
Elizabeth Schmitt	CAC Consumer Representative
Julie Spackman	Deschutes County Health Services
Ralph Summers	PacificSource
Kim Swanson	St. Charles Medical Group
Karen Tamminga	Deschutes County Behavioral Health
Rick Treleaven	BestCare Treatment Services
Scott Willard	Lutheran Community Services Northwest

2016-2019 Central Oregon Regional Health Improvement Plan Work Plan

RHIP Priority: Behavioral Health Substance Use & Chronic Pain

I. RHIP Goal: Create a bi-directional integration approach for people with severe substance use disorders

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
Increase the rate of successful referrals from medical settings to specialty SUD services for people with moderate-to-severe SUDs.	Develop high functioning patient pathways from primary care settings into SUD specialty care.	1. Implement widespread adoption of the SBIRT 2. Develop a standard clinical algorithm based on the AUDIT. 3. Develop and implement training for BHCs in region on: (a) the AUDIT clinical algorithm, (b) brief interventions for risky and harmful drinking, (c) strategies for people with severe SUD including motivational enhancement, recovery maintenance and support, and harm reduction. 4. Development of embedded SUD and/or BH engagement specialists in key PCP clinics, part-time to full-time as needed.	1. Completed 2. Completed 3. January 1, 2017 4. Begin now and gradually implement through July 1, 2018.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	• ?	• ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Increase the rate of successful referrals from medical settings to specialty SUD services for people with moderate-to-severe SUDs.	Create a "Hub and Spoke" model for Medication Assisted Treatment (MAT) that links the MAT specialty provider with (a) other SUD and mental health providers, and (b) primary care providers.	1. Integration of MAT into traditional drug-free SUD programs as is clinically beneficial to the client. 2. Training for SUD staff on MAT integration 3. Implementation of a MAT learning collaborative for MAT physician providers	1. In process 2. November 1, 2016 3. December 1, 2016

Parties Responsible/Responsibility	Target Metric	Implementation Progress and Status	
	• ?	• ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Increase the rate of successful referrals from medical settings to specialty SUD services for people with moderate-to-severe SUDs.	Provision of cost-effective medical/nursing support and alternative chronic pain management/chronic disease management skills in selected SUD specialty care programs.	1. *I need to consult with staff on this one, will do by Aug 1. (Rick T)*	?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	?	?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
Increase the rate of successful referrals from medical settings to specialty SUD services for people with moderate-to-severe SUDs.	Identification of clients in SUD services who have high medical burden and develop, with the PCP, a whole healthcare and support plan.	1. Increase collaboration and coordination of care between Bridges and BestCare Residential *I need to consult with staff on this one, will do by Aug 1. (Rick T)*	?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	?	?	

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
First year develop a baseline on the pharmacy, hospital, acute psychiatric, and emergency department expense related to people with moderate-to-severe SUDs. Second year set a performance target.	Create an efficient, effective, and coordinated system of outreach, engagement, and care coordination services to medically significant populations, including: 1. Pregnant women who use drugs and alcohol 2. People who use illicit IV drugs 3. Identified high utilizers of medical or pharmacy services 4. Identified utilizers of mental health acute care services and identified hospital	1. Implementation of an outreach and engagement program for pregnant women who are still using drugs. 2. With the expansion of needle exchange programs, utilize peer engagement specialists 3. In collaboration with PSCS, ERs, and medical clinics, implement teams of outreach and engagement specialists for high utilizers 4. Embed a SUD clinician at the hospital to provide screening,	1. Currently have two small pilot projects, will take to scale before July 1, 2017. 2. July 1, 2018 3. July 1, 2019 4. Implemented and gathering data.

	patients.	engagement, and referral services for Sageview and the medical floors	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	?	?	

II. RHIP Goal: Implement a community standard for appropriate and responsible prescribing of opioids and benzodiazepines.

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Expand Prescription Drug Monitoring Program (PDMP) use by primary care providers.	1. One-on-one clinic meetings to register prescribers and their delegates for PDMP 2. PDMP registration booths at PSTF related Grand Rounds, workshops, or presentations. 3. Continue to offer PDMP registration opportunities at PSTF-related events and work with PDMP to engage prescribers who are not registered or actively using PDMP.	1. By March 30, 2017, register 95% of prescribers currently prescribing opioids but do not have a PDMP account.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Pain Standards Task Force (Dr. Kim Swanson, Rebeckah Berry) and Deschutes County Health Services (Harriett Godoski)	1. Percentage of prescribers in Central Oregon registered with the PDMP.	• One-on-one clinic meetings began June 21, 2016. • To date, a registration booth is currently scheduled for the statewide Dental Conference on 7.29-7.30.16, the Chronic Pain 101 Provider Workshop on 9.23.16, and a Grand Rounds presentation on 10.7.16.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Develop plan for implementing alternative and complimentary pain treatment therapy.	1. PacificSource's implementation of the back pain guidelines, which include cognitive behavioral therapy, physical and occupational therapy, osteopathic manual therapy,	1. 7.1.16 rollout

		acupuncture, and chiropractic.	
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Alison Little, Kim Swanson, Rebeckah Berry, Pain Standards Task Force	?	?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Compassionate care education	1. Compassionate discussions and safer prescribing presentations with clinics.	1. By June 2016 begin to offer educational opportunities for clinics and providers throughout the region.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Kim Swanson, Rebeckah Berry, clinic Medical Directors.	1. By 7.1.2017 a minimum of 12 clinics will have received a presentation throughout the region.	1. Rollout on 6.21.16 and on going throughout the region.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Expand needle exchange programs	1. Needs assessment of need of a needle exchange within Jefferson County completed. 2. ?	?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Crook, Deschutes, and Jefferson County Health Departments, Rick Treleaven, Kim Swanson, Rebeckah Berry	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Expand the availability of Naloxone	1. Participating in statewide Naloxone Access Meeting to remain up-to-date on statewide education efforts that may support Naloxone efforts within Central Oregon.	1. Ongoing, every other month.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Rebeckah Berry	1. ?	1. Participation in statewide Naloxone rollout/education workgroup.	

Health Indicator(s) addressed	RHIP Strategy	Activity addressing strategy	Timeline
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Support the efforts of the Pain Standards Task Force to educate physicians to best practice standards and to support alternative pain management strategies.	1. Monthly meetings of PSTF members continue to occur with consistent and robust participation. 2. Weekly email updates are sent out to a broader audience to offer educational opportunities and best practice standards.	1. Ongoing, weekly or monthly.
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Members of the Pain Standards Task Force, Kim Swanson, Rebeckah Berry	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Advocate with the OHA to make alternative and complimentary pain treatment therapy a reimbursable service.	1. ?	1. ?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Alison Little?	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Support legislation to make Naloxone available through the pharmacy without a physician's prescription.	1. Letters of support sent to Representative Buehler, Representative Buckley, Senator Devlin, and Senator Bates to pass HB 4124 in February 2016.	1. ?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Pain Standards Task Force, COHC Board of Directors, Provider Engagement Panel, Kim Swanson, Rebeckah Berry	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than	Expand needle exchange and harm reduction education for people injecting illicit drugs.	1. ?	1. ?

three months.			
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
	1. ?	1. ?	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Expand prescription drug return programs.	1. Met with pharmacies to consider offering prescription disposal units for their communities. 2. Press release and locations posted on the CO Pain Guide website, along with tips about safe storage and disposal.	1. By August 2016 2. By November 2016
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Kim Swanson, Rebeckah Berry, pharmacy managers.	1. A prescription drug take-back unit will be available to the public in Bend, La Pine, Madras, Prineville, and Redmond for safe disposal and decreased risk of diversion.	1. New prescription disposal units are being placed in Redmond and La Pine with funds to support the first 12 months provided by the Pain Standards Task Force.	
Health Indicator(s) addressed	**RHIP Strategy**	**Activity addressing strategy**	**Timeline**
First year develop a baseline for number of people receiving greater than 120mg MED for more than three months.	Development of alternative and complimentary pain programs widely available in the community.	1. Key experts have met with Mark Altenhofen to discuss the possibility of a Pain Program for the region.	1. ?
Parties Responsible/Responsibility	**Target Metric**	**Implementation Progress and Status**	
Alison Little, Kim Swanson, Rick Treleaven, Christine Pierson, Mike Franz, Rebeckah Berry	1. ?	1. ?	

Standardized Community Algorithms

Three populations to consider for Intervention and possible Expedited Referral:

1. The population who has an AUDIT score between 8-19 (Risky/Harmful level)

2. The population who has an AUDIT score of 20 or more (High Risk level) and in a "Pre-Contemplation" stage of change

3. The population who has an AUDIT score of 20 or more (High Risk level) and in a "Contemplation" or "Preparation" stage of change

Box 6

Risk Level	Intervention	AUDIT score*
Zone I	Alcohol Education	0-7
Zone II	Simple Advice	8-15
Zone III	Simple Advice plus Brief Counseling and Continued Monitoring	16-19
Zone IV	Referral to Specialist for Diagnostic Evaluation and Treatment	20-40

*The AUDIT cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgment should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

Box 7

Elements of Brief Interventions

- Present screening results
- Identify risks and discuss consequences
- Provide medical advice
- Solicit patient commitment
- Identify goal—reduced drinking or abstinence
- Give advice and encouragement

How to Help Patients

Using the AUDIT to screen patients is only the first step in a process of helping reduce alcohol-related problems and risks.

Health care workers must decide what services they can provide to patients who score positive. Once a positive case has been identified, the next step is to provide an appropriate intervention that meets the needs of each patient. Typically, alcohol screening has been used primarily to find "cases" of alcohol dependence, who are then referred to specialized treatment. In recent years, however, advances in screening procedures have made it possible to screen for risk factors, such as hazardous drinking and harmful alcohol use. Using the AUDIT Total Score, there is a simple way to provide each patient with an appropriate intervention, based on the level of risk.

While this discussion will focus on helping those patients who score positive on the AUDIT, sound preventative practice also calls for reporting screening results to those who score negative. These patients should be reminded about the benefits of low risk drinking or abstinence and told not to drink in certain circumstances, such as those mentioned in Box 5.

Four levels of risk are shown in Box 6. Zone I refers to low risk drinking or abstinence. The second level, Zone II, consists of alcohol use in excess of low-risk guidelines[5], and is generally indicated when the AUDIT score is between 8 and 15. A brief intervention using simple advice and patient education materials is the most appropriate course of action for these patients. The third level, Zone III, is suggested by AUDIT scores in the range of 16 to 19. Harmful and hazardous drinking can be managed by a combination of simple advice, brief counseling and continued monitoring, with further diagnostic evaluation indicated if the patient fails to respond or is suspected of possible alcohol dependence. The fourth risk level is suggested by AUDIT scores in excess of 20. These patients should be referred to a specialist for diagnostic evaluation and possible treatment for alcohol dependence. If these services are not available, these patients can be managed in primary care, especially when mutual help organizations are able to provide community-based support. Using a stepped-care approach, patients can be managed first at the lowest level of intervention suggested by their AUDIT score. If they do not respond to the initial intervention, they should be referred to the next level of care.

Box 5

Advise Patients *not* to Drink

- When operating a vehicle or machinery
- When pregnant or considering pregnancy
- If a contraindicated medical condition is present
- After using certain medications, such as sedatives, analgesics, and selected antihypertensives

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Brief interventions for hazardous and harmful drinking constitute a variety of activities characterized by their low intensity and short duration. They range from 5 minutes of simple advice about how to reduce hazardous drinking to several sessions of brief counseling to address more complicated conditions[36]. Intended to provide early intervention, before or soon after the onset of alcohol-related problems, brief interventions consist of feedback of screening data designed to increase motivation to change drinking behaviour, as well as simple advice, health education, skill building, and practical suggestions. Over the last 20 years procedures have been developed that primary care practitioners can readily learn and practice to address hazardous and harmful drinking. These procedures are summarized in Box 7.

A number of randomized controlled trials have evaluated the efficacy of this approach, showing consistently positive benefits for

Box 7

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patients who are not dependent on alcohol[36, 37, 38]. A companion WHO manual, *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*, provides more information on this approach.

Referral to alcohol specialty care is common among those primary care practitioners who do not have competency in treating alcohol use disorders and where specialty care is available. Consideration must be given to the willingness of patients to accept referral and treatment. Many patients underestimate the risks associated with drinking; others may not be prepared to admit and address their dependence. A brief intervention, adapted to the purpose of initiating a referral using data from a clinical examination and blood tests, may help to address patient resistance. Follow-up with the patient and the specialty provider may also assure that the referral is accepted and treatment is received.

Diagnosis is a necessary step following high positive scoring on the AUDIT, since the instrument does not provide sufficient basis for establishing a management or treatment plan. While persons associated with the screening programme should have a basic familiarity with the criteria for alcohol dependence, a qualified professional who is trained in the diagnosis of alcohol use disorders[4] should conduct this assessment. The best method of establishing a diagnosis is through the use of a standardized, structured, psychiatric interview, such as the CIDI[39] or the SCAN[40]. The alcohol sections of these interviews require 5 to 10 minutes to complete.

The Tenth revision of the *International Classification of Diseases* (ICD-10)[4] provides detailed guidelines for the diagnosis of acute alcohol intoxication, harmful use, alcohol dependence syndrome, withdrawal state, and related medical and neuropsychiatric conditions. The ICD-10 criteria for the alcohol dependence syndrome are described in Box 8.

Detoxification may be necessary for some patients. Special attention should be paid to patients whose AUDIT responses indicate daily consumption of large amounts of alcohol and/or positive responses to questions indicative of possible dependence (questions 4-6). Enquiry should be made as to how long a patient has gone since having an alcohol-free day and any prior experience of withdrawal symptoms. This information, a physical examination, and laboratory tests (see Clinical Screening Procedures, Appendix D) may inform a judgment of whether to recommend detoxification. Detoxification should be provided for patients likely to experience moderate to severe withdrawal not only to minimize symptoms, but also to prevent or manage seizures or delirium, and to facilitate acceptance of therapy to address dependence. While inpatient detoxification may be necessary in a small number of severe cases, ambulatory or home detoxification can be used successfully with the majority of less severe cases.

Box 8

ICD-10 Criteria for the Alcohol Dependence Syndrome

Three or more of the following manifestations should have occurred together for at least 1 month or, if persisting for periods of less than 1 month, should have occurred together repeatedly within a 12-month period:

- a strong desire or sense of compulsion to consume alcohol;
- impaired capacity to control drinking in terms of its onset, termination, or levels of use, as evidenced by: alcohol being often taken in larger amounts or over a longer period than intended; or by a persistent desire to or unsuccessful efforts to reduce or control alcohol use;
- a physiological withdrawal state when alcohol use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for alcohol, or by use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms;
- evidence of tolerance to the effects of alcohol, such that there is a need for significantly increased amounts of alcohol to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol;
- preoccupation with alcohol, as manifested by important alternative pleasures or interests being given up or reduced because of drinking; or a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of alcohol;
- persistent alcohol use despite clear evidence of harmful consequences, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

(p.57, WHO, 1993)

Medical management or treatment of alcohol dependence has been described in previous WHO publications[41]. A variety of treatments for alcohol dependence have been developed and found effective[42]. Significant advances have been made in pharmacotherapy, family and social support therapy, relapse prevention, and behaviour-oriented skills training interventions.

Because the diagnosis and treatment of alcohol dependence have developed as a specialty within the mainstream of medical care, in most countries primary care practitioners are not trained or experienced in its diagnosis or treatment. In such cases primary care screening programmes must establish protocols for referring patients suspected of being alcohol dependent who need further diagnosis and treatment.

RHIP Workgroup Updates: June

Behavioral Health: Identification & Awareness

- This group meets the fourth Tuesday of every month from 9-10am and currently has 20 members.
- In June, the group began problem solving how to track referrals to behavioral health (BH) from primary care (PC). The group discussed coding for a referral even though one is not necessarily required for BH in order to track and follow-up with PC after a patient seeks BH services. In July, the group will review a draft work plan and continue to strategize how to successfully refer to BH and allow PC to receive patient updates. The group will also receive updates on the "Mind Your Mind" project, discuss how to talk about suicidal ideation with patients, and delve more deeply into peer navigators as a strategy to support successful referrals for the region.

Behavioral Health: Substance Use and Chronic Pain

- This group meets the third Wednesday of every month from 4-5pm and currently has 19 members.
- In June, the group discussed a treatment algorithm to support primary care toward better addressing substance use. The group plans to focus their efforts during next month's meeting to develop an expedited and standardized process for intervention and referrals to treatment based on level of risk. This algorithm will be shared broadly throughout the community to offer better alignment and provider education of process. The group will finalize their work plan at the July meeting and have it ready to review by OPs in August.

Cardiovascular Disease—Clinical

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 9 members.
- In June, the group discussed blood pressure standardization in greater detail. Other clinics were invited to participate in the discussion and the decision was made to explore the developing a proposal for a regional blood pressure standardization attestation contest. COIPA, St. Charles, and PacificSource will develop a draft of this in the next four weeks, and it will be part of this group's work plan.

Diabetes—Clinical

- This group meets the second Thursday of every month from 9-10am and currently has 12 members.
- In June, the group decided to develop a standardized care pathway for treating pre- and type 2 diabetes throughout the region. The group will develop this pathway in July and begin to draft their work plan.

Cardiovascular Disease & Diabetes—Prevention

- This group meets the fourth Tuesday of every month from 4-5pm and currently has 25 members.
- This was the first combined prevention workgroup meeting. They spent time familiarizing what each workgroup had in the works prior to combining. Presentations were given on the CDC's School Health Index (SHI) and a CVD and diabetes program resource guide for providers and the community. The workgroup decided to add the SHI to their work plan and were in favor, but will make their final decision by email on adding the resource guide once they have additional information. They will review their draft work plan in July.

RHIP Workgroup Updates: June

Oral Health

- This group meets the third Tuesday of every month from 11-12pm and currently has 19 members.
- Virginia Olea, Mosaic's new dental hygienist, presented Phase I of their new dental pilot. This pilot includes hygienists in each of the Mosaic clinics, with the 'dentist' following the next week. Virginia has become a regular member of the workgroup. Maria Hatcliffe provided a quick training on 'One Key Question'. A great deal of discussion followed regarding how we integrate this initiative at ALL levels/disciplines of care. Brenda Comini and MaryAnn Wren presented on Early Literacy and Health Outcomes – Brush, Book and Bed is a component of their concept paper. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Reproductive Health/Maternal Child Health

- This group meets the second Tuesday of every month from 4-5pm and currently has 22 members.
- Two presentations were given to the workgroup; first was a data presentation given by Elizabeth Fitzgerald and Jennifer Weeks from Deschutes County Health Department around Adverse Childhood Experiences, the second a proposal presentation given by Tricia Wilder from Planned Parenthood. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Social Determinants of Health

- This group meets the third Friday of every month from 10-11am and currently has 27 members in kindergarten readiness and 26 members in housing.

Education & Health

- Brenda Comini presented the Kindergarten Readiness Assessment data to the workgroup. There was much discussion and interest in defining the 'whys' around the data. A draft work plan will be presented to the workgroup between now and their next meeting for review prior to submission to the Operations Council (probably August).

Housing

- In June, the workgroup solidified their purpose, bridging housing solutions with the health system. They will focus their efforts on policy around affordable housing and homelessness; advocacy in regarding to helping pass legislation, impacting state and federal housing policies and/or countering NIMBY; outreach and awareness; and new initiatives by being a resource in developing new cross sector (health and housing) initiatives. They will review their draft work plan in July.