Columbia Pacific CCO
Part of the CareOregon Family

2022 Progress Report

An update to Columbia Pacific CCO's Community Health Improvement Plan

Overview

As with all of Oregon, the lingering impacts of the COVID-19 pandemic can still be felt in Columbia Pacific CCO's rural, coastal service region. The current shift away from crisis and towards rebuilding as we manage a "next normal" has required that our communities continually adapt, even in the face of economic impacts, workforce shortages, and fatigue from the two-plus years of demanding work and constant change.

In the face of such systemic challenges, our communities have worked tirelessly to shore up challenged systems, to take care of each other, and to continue the push for innovation, including in ways not originally expected in this CHP. Together with our Community Advisory Councils, the voices and stories of our members, and partners in healthcare, education, government, public health, food systems, housing, and more, we collectively hold a common determination to address underlying causes and needs while working towards healthier communities together.

Progress Report

Columbia Pacific CCO's Community Health Improvement Plan (CHP) includes eight priority areas:

- Community Resilience and Trauma Informed Care
- Access to Care: Primary Care
- Access to Care: Behavioral Health
- Access to Care: Oral Health and Dental Care
- Access to Care: Social Safety Net
- Chronic Disease Prevention
- Suicide Prevention
- Housing

For this progress report, each priority area has its own section denoted by a header. Under each priority there are high-level goals that span the five-year period of the CHP denoted by a sub-header. Under a second sub-header "Progress to Date" are multiple objectives as stated in the current CHP, and under each objective there are strategies and metrics as written in the current CHP. The *progress reports* for each strategy and metrics are denoted by the bullets labeled "Update" beneath the item being updated. Any changes to an objective, strategy, or metric are listed at the end of each objective. While most progress updates reflect the work of reporting year 2021-2022, updates that reach further back will be highlighted as needed for context.

Community Resilience and Trauma Informed Care

High-Level Goals:

1. Understand baseline readiness of organizations for trauma informed care in multiple sectors;
2. Improve capacity and reach of trauma informed supports and services in programs, organizations, and across sectors;
3. Implement best practices that create resilience in children and families using the trauma informed lens.

Progress to Date:

- Objective 1: By 2024 increase the number of programs, organizations, and sectors aware of the trauma informed perspective and its relation to engaging individuals in the services that support improvement of health and well-being.
    - Strategy 1: Collaborate to access resources, data, and shared investment opportunities that support the implementation of trauma informed care across programs, organizations, and sectors in the region.
        - Update: Columbia Pacific CCO supported the trauma-informed collective impact networks post-launch to set up **eight sector workgroups** (health care, education, child welfare and community) in Clatsop and Columbia Counties. Member organizations have submitted action plans for their organization to implement trauma informed care within their programs and organizations and to bring activities for collaboration among and between sectors to support resiliency and trauma-informed care throughout their region. CPCCO's Program Specialist has worked to develop relationships with member organizations, build the networks' infrastructure through governing bodies and sector workgroups, and develop baseline data for networks to gauge progress of their strategies. Additionally, CPCCO is working to develop the Trauma Informed Care (TIC) and Resilience Fund. The purpose of the TIC and Resilience Fund is to help the trauma informed networks in Clatsop and Columbia counties move towards becoming self-sufficient and sustainable.
    - Metric: Increased number of organizations committed to trauma awareness for their service recipients and within their workforce.
        - Update: Outreach, recruitment, and community education about the trauma informed networks continued throughout 2021. By January 2022, **26 organizations in Clatsop County and 34 in Columbia County** had formally joined the networks by signing a letter of commitment. Columbia Pacific CCO continued to facilitate participative processes in each county to support the member organizations to continue to design the network by finalizing the steering committee responsibilities, launching the sector workgroups, and working together to roll-out the community launch events. Network membership continues to grow each

year, with community partners now taking on the role of recruiting new member organizations. Additionally, with the launch of the networks, interest has grown in Tillamook County through participation in network activities.

- Changes to Objective, Strategies, or Metric:
  - No changes.

- Objective 2: By 2024, increase the number of community-based organizations participating in community trauma informed networks and participating in trauma informed, closed-loop referrals among trauma informed services.
  - Strategy 1: Increase coordination and engagement among the health care, education, child welfare, community, and criminal justice sectors to integrate trauma informed care across systems and organizations.
    - Update: As mentioned above, Columbia Pacific CCO supported leaders in both networks to formally launch the networks in public virtual launch events. Launch events in both counties included speakers and action-planning, raised awareness of ACEs, childhood trauma, and resilience, and shared the aims of the networks to combat these issues in the larger community. Following the launch events, each network also launched four sector workgroups, one for each of the following sectors: healthcare, education, child welfare, and community. Each sector workgroup examined priority areas in their sector from the strategic plan and developed a timeline for 2022 to prioritize what they will be working on together so they can all be on the same page with their goals and plans for moving forward. Trauma informed care, ACEs and resiliency building training began in April 2022 in partnership with Trauma Informed Oregon, for all member organizations. Columbia Pacific CCO will help member organizations develop plans to implement these tenets in their organizations as well as support cross-sector activities to promote resiliency and trauma informed care collectively in communities.
  - Strategy 2: Increase the utilization of, and support for, Traditional Health Workers across all sectors.
    - Update: Columbia Pacific CCO advocated for updates and changes to the Connect Oregon platform to make THW services more visible as its own service category on the platform (specifically starting with doulas). We supported outreach and onboarding efforts for Connect Oregon for our clinical and community networks, including co-hosting three informational sessions and 1:10 organizational follow-up discussions. Also, the CPCCO Board of Directors approved a [redacted] into the THW Capacity Building Program. The grant funding will support [redacted] **FTE** (Full Time Equivalents) at six community-based organizations in the region: [redacted]

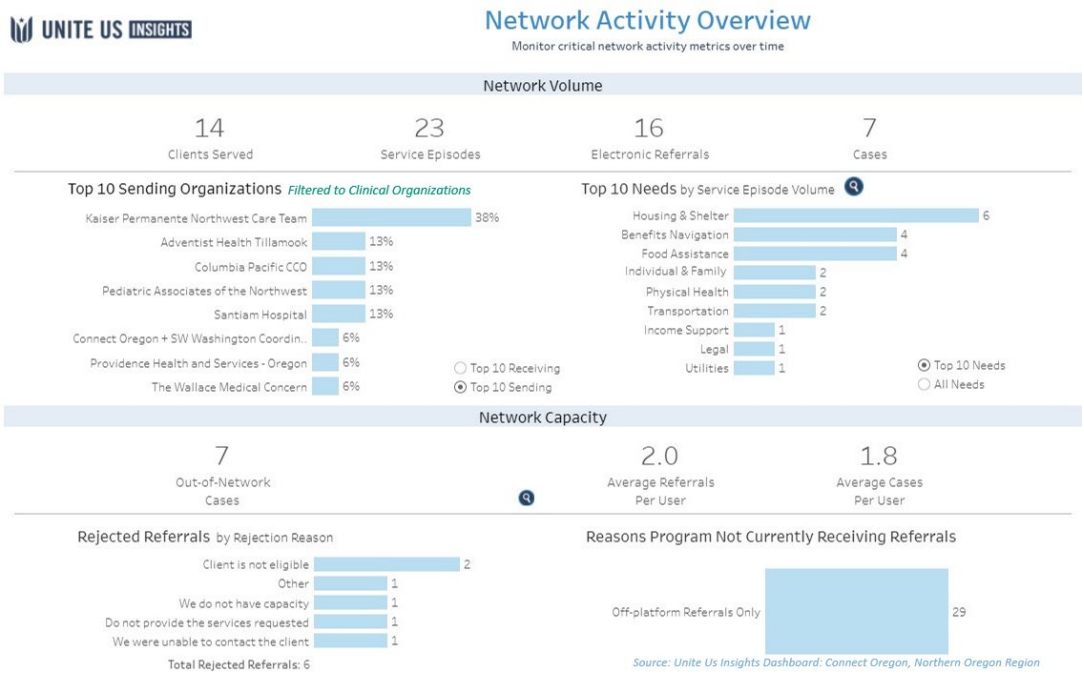
- Strategy 3: Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks.
  - Update: Through its 2021 grant to Dual Diagnosis Anonymous (DDA), CPCCO helped support peer leaders in the region working with the communities impacted by the opioid crisis and COVID-related mental health challenges. Through the Better Outcomes Thru Bridges program at Providence Seaside, which began in 2022, peers spend most of their time in the community alongside clients, aiding them in connecting to the resources that address their unmet needs. CPCCO is not currently working to support messaging campaigns.
- Metric 1: Reduced entry into foster care.
  - Update: In all three counties in our region, the number of children in the foster care system has decreased (improved) as compared to the baseline in 2017. The statewide trend is the same.

Children in Foster Care

Number of children per 1,000 population	2017 *Baseline*	2018	2019	2020	Direction from Baseline
Clatsop (N=41,072)	12.7	10	9.7	9.2	**Improved**
Columbia (N=52,589)	15.8	12.9	10.2	9.7	**Improved**
Tillamook (N=27,390)	7.2	6.8	7.1	6.3	**Improved**
Oregon (N=4,237,256)	**9.2**	**8.8**	**8.2**	**7.3**	**Improved**

Source: DHS 2020 Child Welfare Data Book. The 2021 Child Welfare Data Book was not available at time of compilation.

- Metric 2: Increased access via behavioral health and primary care providers to coordinated services that address the social determinants of health.
  - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. The image below shows only the referrals from clinical organizations, and what social health and health services the referrals were for.



- Changes to Objective, Strategies, or Metrics:
  - No changes.

Access to Care: Primary Care

High-Level Goal: Eliminate barriers to primary care, including geographic and transportation inconveniences, lack of knowledge, unavailability of internet, and lack of insurance coverage.

Progress to Date:

- Objective 1: Increase referrals using Connect Oregon to primary care from community-based organizations as well as referrals from primary care to community-based organizations.
  - Strategy 1: Increase the number of referrals and stronger partnerships between primary care and community-based organizations that support the growth of transitional and supported housing for those with special needs who are working on recovery from addiction, substance abuse, and mental illness.
    - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. As of now we have recently onboarded our first Community Mental Health Program to the network, and they have not yet sent referrals. The result is that currently we cannot know if any referrals would have been related to a mental health need, because no programs related to mental health or substance misuse have accepted or sent referrals to date. However, in the same period, there were **six referrals** related to housing, making it

the top need among all referrals sent or received. Please refer to the Housing Update for more information.

- Strategy 2: Increase awareness of and access to quality interpretation and translation services across sectors.
  - Update: In 2021, Columbia Pacific's Community Engagement Team built out workflows and best practices for hosting bilingual community-facing meetings. This includes our three Community Advisory Councils. Since November 2021, Columbia and Tillamook Counties' CAC meetings have been bilingual as needed for our attendees. The team has also continuously worked on naming needs for translation to facilitate meaningful access to CAC meetings, such as PowerPoint presentations, reports, surveys and forms, and new CAC Member Binders.
  - Our clinical Quality Improvement team sends our quarterly language access & interpretation services report, which requires ongoing monitoring and improvement on access to language services in clinical spaces. Additionally, CareOregon recently completed a procurement process for language services and increased our vendors from **two to six**, which should provide more flexibility for Columbia Pacific CCO and our partner organizations to meet the varied language needs of our members.
- Strategy 3: Increase the number of organizations in the region that offer help desks and community-based referral supports that:
  a. Support discharge from acute and sub-acute health care settings to community-based care settings;
  b. Increase access to Traditional Health Workers and health care navigators that can support access to primary care;
  c. Collaborate across sectors to increase participation in a volunteer driver network
  - Update: Through our grant programs, multiple organizations throughout our region now have help desks (also referred to as community resource desks, or CRDs) and community navigators who work with the Connect Oregon platform. In Tillamook County, help desks are located at CARE and the YMCA; in Clatsop County, one is at Clatsop Community Action; in Columbia County, St. Helens Parks & Rec has a help desk. These were funded in 2020 and continue to run effectively and connect our community members to needed services and resources.

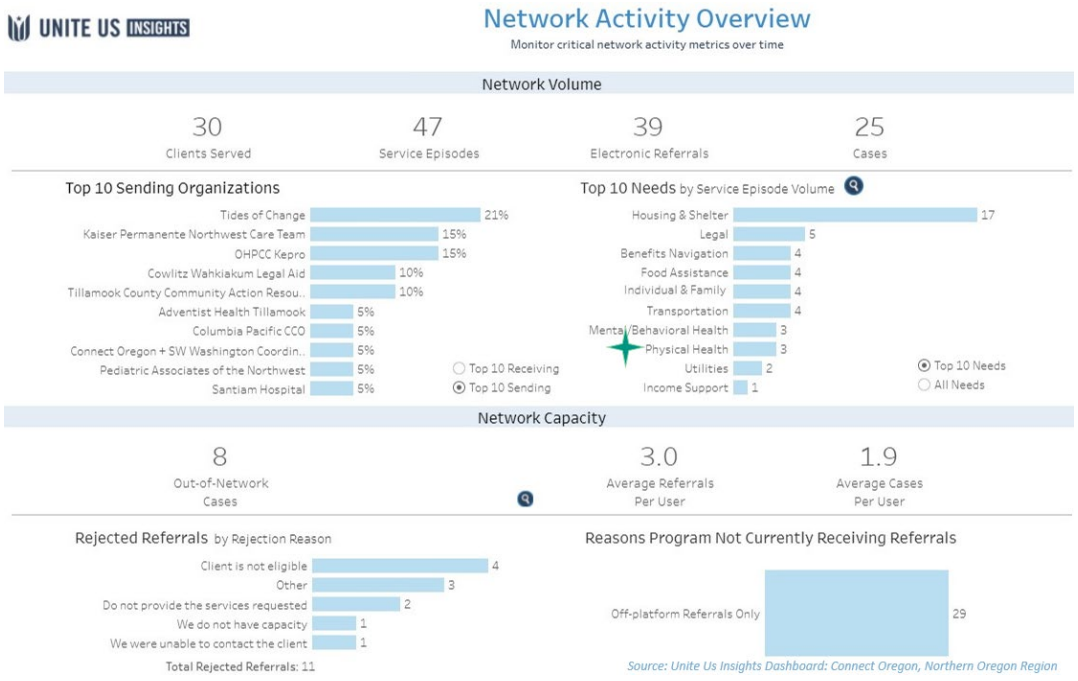
    As mentioned above, CPCCO is investing [redacted] into the THW Capacity Building Program, which will support [redacted] **FTE** who can support access to primary care. These THWs will be located at six community-based

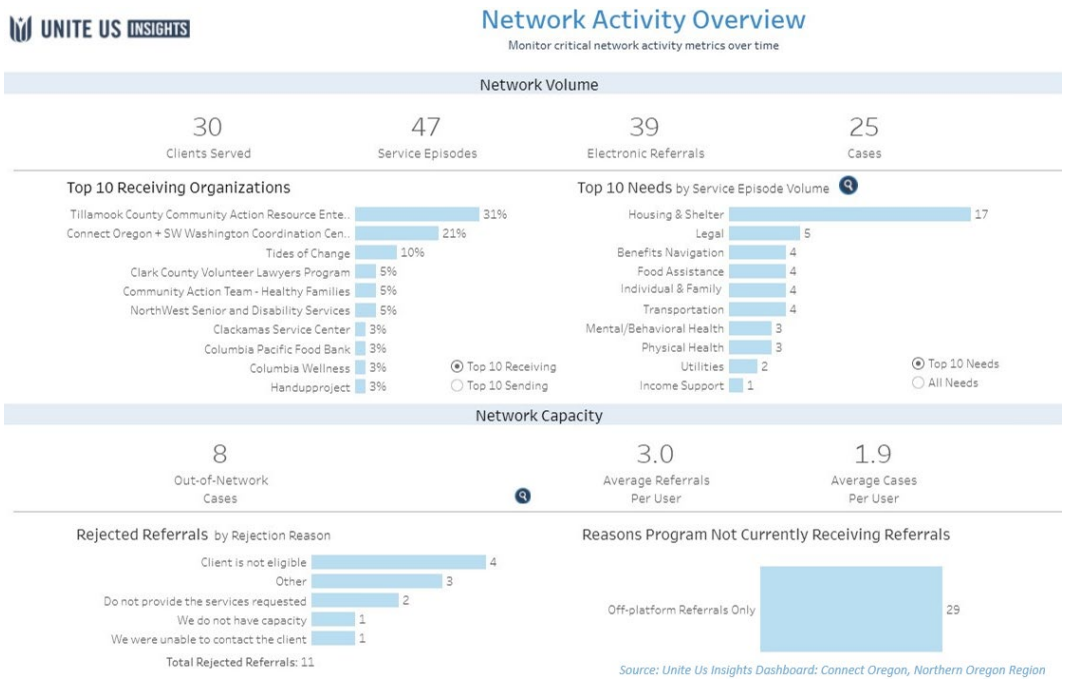
organizations in the region: [redacted].

Lastly, with our support, Providence Seaside started the Better Outcomes thru Bridges program (BOB) in 2022. The BOB Emergency Department (ED) Outreach Specialists work directly with hospital staff and community partners to identify behavioral health patients with frequent ED visits that may need added support and services after discharge. BOB outreach peers spend most of their time in the community alongside clients, aiding them in connecting to the resources that address their unmet needs.

The volunteer driver network has been paused due to COVID-19 and will be excluded from future CHP Progress Reports.

- Metric: Increased referrals using Connect Oregon to primary care from community-based organizations as well as referrals from primary care to community-based organizations.
  - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. The images below show referrals that were sent (top) and received (bottom), and what social health and health services the referrals were for.





  - Changes to Objective, Strategies, or Metrics:
    - No changes.
- Objective 2: Collectively address the primary care and health professional provider shortage.
  - Strategy 1: Identify incentives to recruit and retain highly qualified health care providers at every level and profession with a focus on integration.
    - Update: As with the rest of Oregon, our region is currently facing an unprecedented shortage of providers caused by a confluence of pandemic related factors. Delays in care have led to changes in demand at all levels of all kinds of care; our providers have struggled with burnout and compassion fatigue, workforce housing is in short supply when trying to bring new providers to the region, and the pipeline for new providers cannot address immediate needs. In 2021, Columbia Pacific CCO has continued to invest in efforts to hire and retain workers in physical and behavioral health and has also awarded grants to begin increasing access to Traditional Health Workers to open new opportunities that can lead to low-barrier “home grown” care.
  - Strategy 2: Increase the number of Traditional Health Workers in any setting within the region.
    - Update: CPCCO created a THW training scholarship program to help subsidize the costs of completing approved training programs and later certification. We partnered with ORCHWA and Oregon State University Extension to bring training into the CPCCO region, where training options

are limited. We took part in the development and delivery of a CareOregon Meds Ed focused on integrating CHWs into clinical settings, which had the highest number of attendees in the history of the Meds Ed program (**over 300 attendees**). We completed outreach to people working in CHW-like roles in our region who were not formally trained or certified and connected them to training opportunities.

- Strategy 3: Increase the utilization of telehealth in the region.
  - Update: Primary care clinics in CPCCO have increased their telehealth and/or phone services to include primary care appointments in 2022. Currently, all the clinic systems that serve OHP patients are providing telehealth services. However, as of May 1st, 2022, two clinic systems have reported lower utilization as the year progresses, claiming that more patients are having their appointments in person (*anecdotal self-reports from all clinics*).
- Metric: Increased number of primary care and health professionals including those who are certified as Traditional Health Workers.
  - Update: There is currently no uncomplicated way to combine data about primary care and health professionals including THWs as one total group. As access to Traditional Health Workers expands, Columbia Pacific CCO will work to create data pathways that reflect an inclusive look at access to care.
- Changes to Objective, Strategies, or Metrics:
  - No changes.

Access to Care: Behavioral Health

High-Level Goal: All people in Clatsop, Columbia, and Tillamook Counties have the services and supports they need to achieve optimal behavioral health and emotional well-being.

Progress to Date:

- Objective 1: By 2024, expand and improve access to the full range of behavioral health services.
  - Strategy 1: Develop alternative payment models that support enhancement of behavioral health services, including developing components of the array of services that do not currently exist.
    - Update: Columbia Pacific CCO continues to develop and refine our integrated payment to support integrated service in primary care. All the community mental health programs (CMHPs) have transitioned to alternative payment models (APMs) with program-specific targets that roll up to a quality payout. The most recent developments that we have supported are to integrate the Primary Care Payment Model with the Integrated Behavioral Health Payment Model. The payment is now

integrated into one comprehensive per member per month (PMPM) program that incorporates behavioral health program elements rather than being a standalone program. We have also rolled our expanded access to traditional behavioral health codes into primary care settings that will allow more flexibility for financial sustainability and to offer services anywhere the patient presents at the outpatient level without a payment barrier. In 2022, the slow shift to value-based payments is an area of focus.

- Strategy 2: Recruit behavioral health care providers to work in the region.
  - Update: In 2021, Columbia Pacific CCO and our parent company CareOregon partnered to invest nearly **$600,000** in efforts to stabilize our region's behavioral health workforce through direct cash incentives aimed at recruiting and retaining mental health providers. As with the rest of Oregon, our region is currently facing an unprecedented shortage of providers caused by a confluence of pandemic related factors: our communities have experienced a surge of need for behavioral health services across the spectrum of care, our providers have struggled with burnout, and shortages in services at the state level have caused a "crunch" locally. Though CPCCO and CareOregon have invested in our region's behavioral health system, including efforts to expand services, provider capacity is still constrained by these factors.
- Strategy 3: Integrate behavioral health and primary care services to provide coordinated care and a whole person approach.
  - Update: In 2021, CPCCO and CareOregon provided more than $1.5 million to expand and enhance our behavioral health system, including over **$450,000** to efforts in expanding integrated behavioral healthcare. Partners who received funding included: OHSU Family Medicine Clinic in Scappoose, Tillamook County Community Health Centers, and Providence Seaside Hospital Foundation. Behavioral Health Integration and Access is still a high priority for our work in 2022, including:
    - Expanding behavioral health in primary care
    - Increasing bi-directional referrals
    - Monitoring and supporting throughput
    - Member navigation to care
    - Developmental screening pathways
    - In all priorities, expanding equitable access to culturally and linguistically appropriate services
- Metric: Increased number of behavioral health care providers and service components and collaboration across sectors to address behavioral health needs.

        - Update: Due to the pandemic's strain on our system, we are currently engaging in efforts to assess the current number of providers by December 2022 as part of Year 1 of the Social Emotional Health metric. Anecdotally we understand that we have fewer providers currently than we had last year.
    - Changes to Objective, Strategies, or Metric:
        - No changes.
- Objective 2: Increase behavioral health-related prevention activities and awareness and understanding of behavioral health supports and services that are peer driven.
    - Strategy 1: Support the increase of services that are peer driven and are distributed throughout the continuum of care.
        - Update: CPCCO has funded multiple programs aimed at increasing access to peer-driven behavioral health care, including:
            - Youth Era in Columbia County for continued support of peer support for youth and young adults aged 14-25 who are experiencing behavioral health challenges
            - Providence Seaside Hospital for expansion of the health system's Better Outcomes thru Bridges program, including access to peer support and outreach specialists
            - Tillamook Family Counseling Center to add a full-time peer support specialist to its mental health crisis response team
    - Strategy 2: Integrate behavioral health and primary care services to provide coordinated care and a whole-person approach.
        - Update: In 2021 and 2022, CPCCO and CareOregon provided more than $1.5 million to expand and enhance our behavioral health system, including over **$450,000** to efforts in expanding integrated behavioral healthcare. Partners who received funding included: OHSU Family Medicine Clinic in Scappoose, Tillamook County Community Health Centers, and Providence Seaside Hospital Foundation. Behavioral Health Integration and Access is still a high priority for our work in 2022, including:
            - Expanding behavioral health in primary care
            - Increasing bi-directional referrals
            - Monitoring and supporting throughput
            - Member navigation to care
            - Developmental screening pathways
            - In all priorities, expanding equitable access to culturally and linguistically appropriate services

Additionally, we continue to contract with Dual Diagnosis Anonymous, which offers **10-12 in-person, peer-led meetings** in the region each week. They also offer **18 online-only, peer-led meetings** based in Oregon.

  - Metric: Implemented prevention and outreach activities across sectors that are peer driven.
    - Update: As of April 27, 2022, our region is served by a total of **30 certified peers**, with more due to be trained this summer. Additionally, we continue to contract with Dual Diagnosis Anonymous, which offers **10-12 in-person, peer-led meetings** in the region each week. They also offer **18 online-only, peer-led meetings** based in Oregon.
  - Changes to Objective, Strategies, or Metric:
    - No changes.
- Objective 3: Increase access to harm reduction and addiction treatment resources in the region.
  - Strategy 1: Support the increase of services that are peer driven and are distributed throughout the continuum of care.
    - Update: As of April 27, 2022, our region is served by a total of **30 certified peers**, with more due to be trained this summer. Additionally, we continue to contract with Dual Diagnosis Anonymous, which offers **10-12 in-person, peer-led meetings** in the region each week. They also offer **18 online-only, peer-led meetings** based in Oregon.
  - Strategy 2: Increase the number of needle exchange programs in the region.
    - Update: As of 2022, **all three of our counties** currently have needle exchange programs in full operation.
  - Strategy 3: Support the increase of modalities and interventions that help individuals to access services for behavioral health, including medication-assisted treatment (MAT).
    - Update: In 2022, CPCCO funded an expansion to OHSU Scappoose's existing Medication Assisted Treatment (MAT) program to support its more than eightfold increase in patients (30 to 250). Additionally, we continue to support CODA's Seaside Recovery Center and the other existing MAT programs in the region. In 2022, our behavioral health staff are focused on:
      - Expanding MAT
      - Implementing the Community Reinforcement and Family Training (CRAFT) Model to support families in effectively engaging loved ones towards treatment readiness
      - Building continuity with residential and detox treatments
      - Recovery-oriented housing

- Metric: Implemented programs and services supporting harm reduction and increasing awareness of services for behavioral health.
  - Update: There are currently approximately **nine harm reduction programs** serving OHP members, as described above.
- Changes to Objective, Strategies, or Metric:
  - As we have met the aim of Strategy 2, it will be retired for the rest of our Regional Health Improvement Plan and excluded from future CHP Progress Reports.

Access to Care: Oral Health and Dental Care

High-Level Goal: Improve capacity and use of affordable, preventive, and integrated oral health services for children, youth, and underserved populations.

Progress to Date:

- Objective 1: Increase the number of oral health care professionals who treat children, youth, and underserved populations.
  - Strategy 1: Support tele-dentistry programs.
    - Update: Telehealth continues to contribute to patient care and system capacity. Dental plans have maintained and enhanced delivery of asynchronous and synchronous tele-dentistry appointments at both the plan and practice level.
  - Strategy 2: Collaborate with dental care organizations to improve efforts to recruit and retain dental health care professionals for low-income and underinsured people in each county.
    - Update: Advantage Dental has continued its development of a Dental Assistant training pilot program. ODS is opening a new dental clinic in Scappoose. CareOregon Dental worked with Tillamook County Community Health Center to open a dental clinic in Tillamook. All Dental Care Organizations are offering significant sign-on bonuses to recruit providers.
  - Metric: By 2024, increase access and utilization by Medicaid members ages 0-20 years by five percentage points.
    - Update: Although dental utilization has increased from 2020 levels, dental utilization in 2021 remains below 2019 performance. Utilization for members aged 0-20 years were: **45.8% in 2019, 31.4% in 2020, 37.5% in 2021.** (*Source: All Payers All Claims DCO Data.*) While utilization of dental services is increasing in 2022, we anticipate post-COVID recovery and engagement to be slow. There is still hesitancy among the population to return to the dental office and the widespread workforce shortages in the dental field will pose a significant challenge in both the short and long term. Columbia Pacific CCO will continue to monitor dental access and

utilization by Medicaid members. This metric may be revisited if COVID resurges, or patient hesitancy continues to suppress utilization.

- Changes to Objective, Strategies, or Metric:
  - No changes.

- Objective 2: Expand access to full service and mobile dental care services for underinsured and low-income individuals.
  - Strategy 1: Improve access through shared investment in supports and services that provide community services.
    - Update: After the public health emergency, Columbia Pacific CCO plans to work with Tillamook County Community Health Center (TCCHC) to further develop its community-based mobile strategy.
  - Strategy 2: Work to expand evidence-based, best practice oral health programs in schools and communities.
    - Update: Columbia Pacific CCO continues to work with OHA and Providence "Healthy Smiles" to conduct evidence-based, best practice school-based dental sealant and fluoride programs. Columbia Pacific CCO is also working with OHA to convert their current program to one operated by Columbia Pacific CCO. Efforts to expand these programs were stalled due to COVID but will resume in 2022. Columbia Pacific CCO and partners are also planning the transition of school based dental sealant programs from OHA Oral Health Unit to local communities in Clatsop and Tillamook Counties beginning in the 2022-23 school year.
  - Strategy 3: Develop ongoing partnerships in medical-dental alignment, dental home development, and other mechanisms to better integrate care across multiple disciplines by leveraging and developing cross-disciplinary systems.
    - Update: Tillamook County Community Health Centers (TCCHC) and CareOregon Dental continue to deepen their partnership in medical-dental alignment and dental home development. TCCHC now participates in CareOregon Dental's alternative payment methodology – a value-based payment program. In addition, Columbia Pacific CCO continues to offer oral health training and workflow implementation support to primary care with a focus on preventive services for children, pregnant members, and members with diabetes.
  - Strategy 4: Increase care coordination efforts supporting access to the continuum of dental health care across sectors.
    - Update: Columbia Pacific CCO continues to train its staff and network providers about the importance of oral health to overall health, and that all members have a dental benefit and can be connected to their dental plan for care coordination. To make this connection easy and efficient, Columbia Pacific CCO providers have access to a secure online form to submit a request for dental outreach and scheduling. In addition,

embedded panel managers are being trained to include dental messaging in their outreach to members and to support dental care coordination efforts for whole person care.

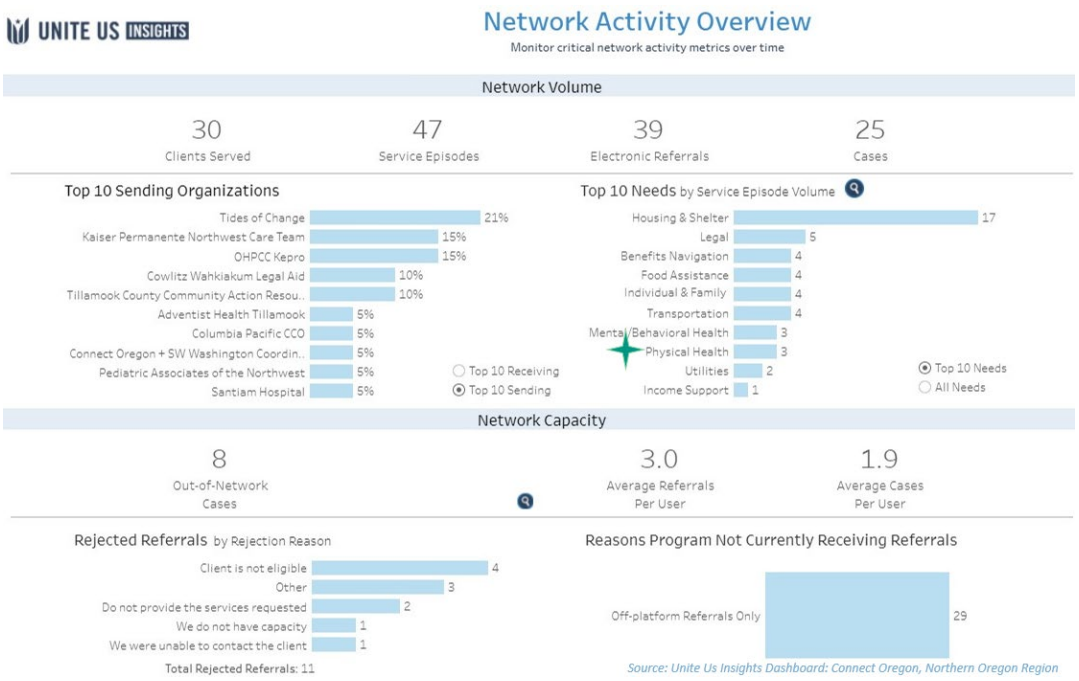
- Metric 1: By 2024, increase individuals accessing oral health services in a primary care or community-based setting by five percentage points.
  - Update: In 2021, we saw the highest percentage to-date of individuals ages 1-6 years accessing oral health services in primary care. Preliminary data shows: **2019=12.6% 2020=16.7%; 2021=18.2%**. (*Source: All Payers All Claims DCO Data.*) This is likely due to all the efforts of the CCO to upskill primary care providers in the importance of oral health and fluoride varnish for children.
- Metric 2: By 2024, increase the number of Columbia Pacific CCO Primary Care Providers (PCPs) that have a referral mechanism to dental care by 50%.
  - Update: In 2019, **two primary care programs** had a documented referral mechanism to dental care. A **third site** completed First Tooth training and is currently undergoing recertification. A **fourth site** is beginning initial training this year. Columbia Pacific CCO is working with these sites to establish and sustain a referral mechanism to dental care. In addition, our primary care payment model (PCPM) now includes implementation of a referral mechanism from primary care to dental. The program is being developed in 2022 and will be a required element in 2023's PCPM.
- Changes to Objective, Strategies, or Metric:
  - Change Metric 1 to "By 2024, increase members aged 1-6 years accessing oral health services in a primary care setting by five percentage points."

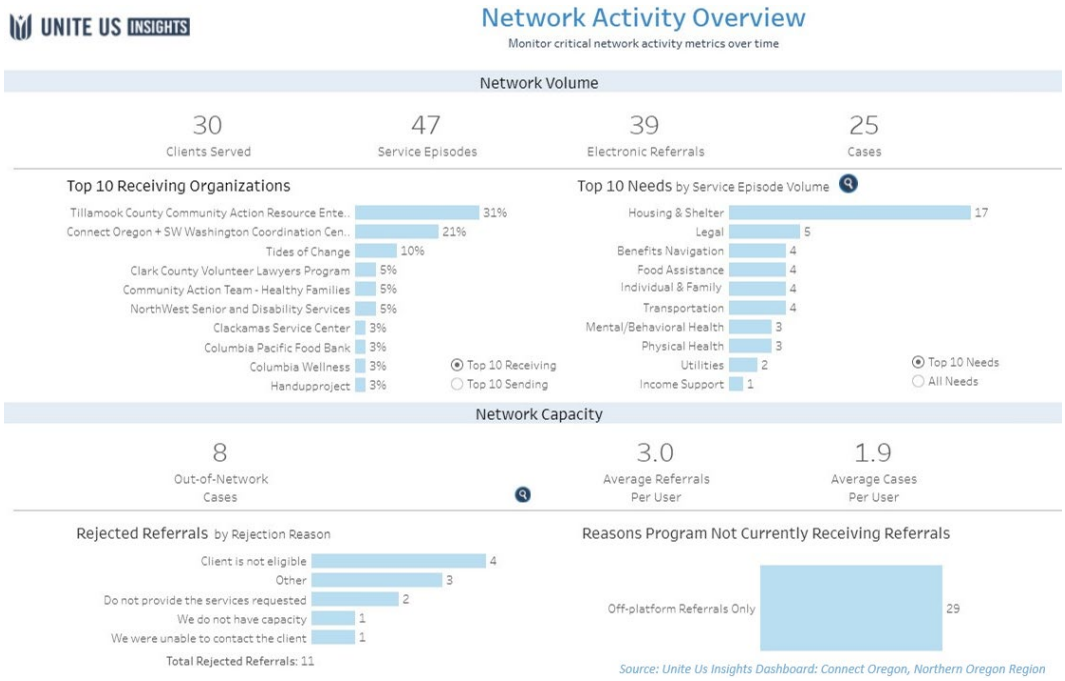
Access to Care: Social Safety Net

High-Level Goal: Ensure individuals and community stakeholders can easily and accurately identify, access, and locate health and community services including healthy foods.

Progress to Date:

- Objective 1: Collaborate to support the establishment and expansion of a comprehensive, cohesive network on Connect Oregon for conducting social needs screening and coordinating care between hospitals, community action programs, and primary care settings.
  - Strategy 1: Increase community awareness of resources and supports through screening for social determinants of health in clinical settings and the coordination of referrals across sectors.
    - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. The images below show referrals that were sent (top) and received (bottom), and what social health and health services the referrals were for.





- <u>Strategy 2:</u> Deploy community resource navigators to key locations throughout the region.
  - <u>Update:</u> In 2020, CPCCO supported Clatsop Community Action, CARE Inc, Tillamook County Family YMCA (YMCA), and St. Helens Parks & Rec in

setting up community resource desks (CRDs). These CRDs continue to effectively support the community in these four locations.

- Strategy 3: Collaborate to increase the options for transportation, including the development of a volunteer driver network.
  - Update: CPCCO continues to collaborate with our Non-Emergency Medical Transportation (NEMT) provider, NW Rides, to stabilize traditional NEMT services as well as to consider the potential for innovative solutions for social health needs. However, the COVID-19 pandemic has required that we pause this strategy for the near future. It will be excluded from future CHP Progress Reports.
- Metric: Increase number of organizations that coordinate services and have community resource navigators on staff.
  - Update: As mentioned above, CPCCO has supported Clatsop Community Action, CARE Inc, YMCA, and St. Helens Parks & Rec in setting up community resource desks (CRDs) at their locations. Through our THW Capacity Building Program, we are also supporting the [redacted] of Traditional Health Workers throughout the region.
- Changes to Objective, Strategies, or Metric:
  - As explained above, Strategy 3 has been paused and will be excluded from future reports.

- Objective 2: Increase availability of nutritious food options for individuals with limited access to fresh food.
  - Strategy 1: Establish broad cross-sector support for and investment in food banks, food recovery, and programs that support the reduction of chronic health conditions.
    - Update: Since June 30, 2021, CPCCO has invested **$40,000** in food pantries. Last year much more was invested to help our partners adapt and stay afloat during shutdown and COVID-19 surges.
  - Strategy 2: Establish broad cross-sector support for and investment in Rx for Health, food banks, food recovery, and other health programs that support the reduction of chronic health conditions.
    - Update: Since June 30, 2021, CPCCO has invested **$40,000** in food pantries. Last year CPCCO invested more to help our partners adapt and stay afloat during shutdown and COVID-19 surges. While nutrition education has not fully resumed since the shutdown, we expect that next year our partners may have more capacity to consider expanding and integrating food and nutrition services.
  - Metric: Increased number of organizations that have community resource navigators, community resource desks, and/or take part in the Connect Oregon network.

- Update: Since 2020, CPCCO has supported Clatsop Community Action, CARE Inc, Tillamook County Family YMCA, and St. Helens Parks & Rec in setting up **four** community resource desks, which continue to help community members get connected to resources. We also have supported **39** clinical and community partner organizations in using the Connect Oregon network.

- Changes to Objective, Strategies, or Metric:
  - No changes.

Chronic Disease Prevention

High-Level Goal: Decrease chronic disease prevalence through focus on reducing chronic disease risk factors.

Progress to Date:

- Objective 1: Prevent tobacco use and drug and alcohol misuse.
  - Strategy: Increase the number of evidence-based social health promotion programs available for youth aged 12-19.
    - Update: CPCCO now funds the youth-focused organization, Youth Era, through a large grant, and more recently through a Traditional Health Worker capacity building grant. This provides evidence-based youth service programs that address social, emotional, and/or physical health. We are currently exploring ways to fund Youth Era Peers that could be supported more sustainably, for example through THW contracts, and expanding to other counties. Additionally, The Harbor, Inc. received grant funds to hire a youth coordinator who will focus on helping young survivors of violence to navigate resources and to support them in their path of healing.
  - Metric: Increased number of evidence-based youth service programs that address social, emotional, and/or physical health.
    - Update: As explained above, this year CPCCO has funded at least **two new** youth service programs in the region. Additionally, we expect that the completion of the action plan for the Social-Emotional Health metric will identify further opportunities to invest in programs for our region's youngest community members.
  - Changes to Objective, Strategies, or Metrics:
    - No changes.

- Objective 2: Increase opportunities for whole-health education and programming.
    - Strategy 1: Community and school-based education, exercise, and access to affordable, healthy food options, such as Rx for Health, farm-to-school programs, community-based activities, Food Bank Fresh, or Fresh Food Farmacy.
        - Update: Columbia Pacific and the Tillamook County Family YMCA are partnering to transition our five-year-long partnership to share the costs of membership and preventive programs from grants to a more sustainable model of funding, which will expand access to exercise for members of all ages and their households. Most other efforts are currently still paused because of lingering capacity issues related to the COVID-19 pandemic.
    - Metric: Increased implementation of community and school nutrition programs.
        - Update: Due to continued capacity strains, most school nutrition programs are still paused or only just restarting.
    - Changes to Objective, Strategies, or Metric:
        - No changes.

Suicide Prevention

High-Level Goal: Reduce to zero the number of suicides in Clatsop, Columbia, and Tillamook Counties.

Progress to Date:

- Objective: Increase community awareness campaigns and education for the public about suicide as a public health problem that is preventable.
    - Strategy 1: Identify, develop, and implement suicide prevention programs in every county, with specific outreach on suicide prevention and awareness for youth.
        - Update: CPCCO continues to fund Columbia Health Services in Columbia County for a Suicide Prevention Coordinator; their prevention team continues to provide outreach and education around suicide prevention with a specific youth emphasis. In 2021 they implemented a campaign, "Save a Number, Save a Life," which reached over **1,000 individuals** via social media, as well as around **600 individuals** who participated in community vaccine events, and another **30 individuals** that they met in the community at pop up in the park events. CPCCO also provides funding to Youth Era in Columbia County, which provides community-based peer support for at-risk youth with the overarching goal of prevention of suicidal ideation.

          CPCCO has done significant outreach to Clatsop and Tillamook County partners to encourage organizations to expand suicide prevention services, presenting our funding framework and the work in Columbia

County. We are hopeful that organizations will begin to apply for suicide prevention funding with the relaxation of COVID-19 restrictions and reduction in cases and we are exploring releasing a suicide prevention-specific request for proposals if we do not receive more regional suicide prevention proposals in Q1 and Q2 this year.

- Strategy 2: Facilitate community collaborations across sectors to increase the number of community-based education and trainings that are evidence based and address suicide prevention, intervention, and postvention.
  - Update: In the past two years in Columbia County, CPCCO has funded **two successive Suicide Prevention Coordinators** as suicide prevention trainers and trainers of trainers (with **13 trainers** total trained), as well as sponsoring an Applied Suicide Intervention Skills Training (ASIST) trainer at the local Community Mental Health Program organization. Over **15 organizations** and **705 people** have been trained in Columbia County in Question, Persuade, Refer (QPR), ASIST, and Youth Mental Health First Aid (YMHFA). **Six people** were trained to conduct QPR trainings, **four** have trained to conduct ASIST, and **one** has trained to conduct YMHFA. A trainer has also been trained to implement Sources of Strength, a school-based suicide prevention EBP, and **two school districts and three schools** have started the program (one each at high school, middle school, and elementary school levels), with **two other school districts** in the planning process. Several small awareness campaigns and a larger campaign were implemented in Columbia County as well as a county-wide postvention plan.

    Prevention trainings are also held in Tillamook County, and we support those efforts through staff and community engagement (see Strategy 1), but the work is funded through prevention funds so we would not include those efforts in this report. We continue to outreach to Clatsop County to encourage partners there to reboot and redesign past suicide prevention strategies and campaigns. As mentioned in the earlier strategy, our aim is to fund prevention activities in all counties.
- Metric: By 2024, reduce number of individuals dying by suicide to zero.
  - Update: **Please note that data has changed for this update to the crude rate per 100,000 rather than the age-adjusted rate. This is due to the age-adjusted rate not being available for more recent years. Once that data is available, we include both crude rates and age-adjusted rates in future CHP updates.*

    Sources: OHA Center for Health Statistics Dashboards (2022), "Leading Cause of Death by County" Dashboard and "Deaths by manner, Oregon residents, preliminary data"

Suicide Death Rate per 100,000 (Crude)				
Year	Clatsop	Columbia	Tillamook	Oregon*
2017	23.2	17.5	22.9	19.9
2018	23	32.8	18.9	20.1
2019	20.3	17.1	15.1	21.4
2020	15.2	28.2	18.8	19.6

Total Deaths from Suicide				
	Clatsop	Columbia	Tillamook	Oregon
2017	9	9	6	825
2018	9	17	5	844
2019	8	9	4	908
2020	6	15	5	835

Years of Potential Life Lost (before age 75)			
	Clatsop	Columbia	Tillamook
2017	260	288	195
2018	219	346	78
2019	231	208	34
2020	158	299	155

While OHA's Public Health Division is still processing mortality data for recent months and is subject to change, preliminary data show the following from the above data source.

Preliminary Data 2021			
Suicide Death Rate per 100,00 (Crude)			
Clatsop	Columbia	Tillamook	Oregon
12.7	20.6	41.5	20.2

Preliminary Data 2021			
Total Deaths from Suicide			
Clatsop	Columbia	Tillamook	Oregon
5	11	11	861

- Changes to Objective, Strategies, or Metric:
  - No changes.

Housing

High-Level Goal: Partner across sectors to reduce the impact that housing insecurity has on health and well-being for all individuals in Clatsop, Columbia, and Tillamook Counties.

Progress to Date:

- Objective 1: Increase supportive programs that address housing needs, including: housing needs assessments, workforce and low-income housing stock, active and developing housing projects, and tenancy supports.
  - Strategy 1: Partner to support community action programs, Northwest Oregon Housing Authority, and community-based organizations in the region to generate county housing needs assessments, low-income and workforce housing stock, active and developing housing projects, and tenancy supports.
    - Update: During 2021 and 2022, our Regional Housing Investment Fund has supported **seven housing projects, four of which** relate to increasing housing stock and **two of which** relate to capacity building for houselessness services. Additionally, we are partnering with Community Action Team through our SHARE Initiative funds to expand their Healthy Homes program which makes home adaptations and safety improvements for people with health conditions.
  - Metric: Increased investment into housing stock, housing projects, transitional housing, and tenancy support.

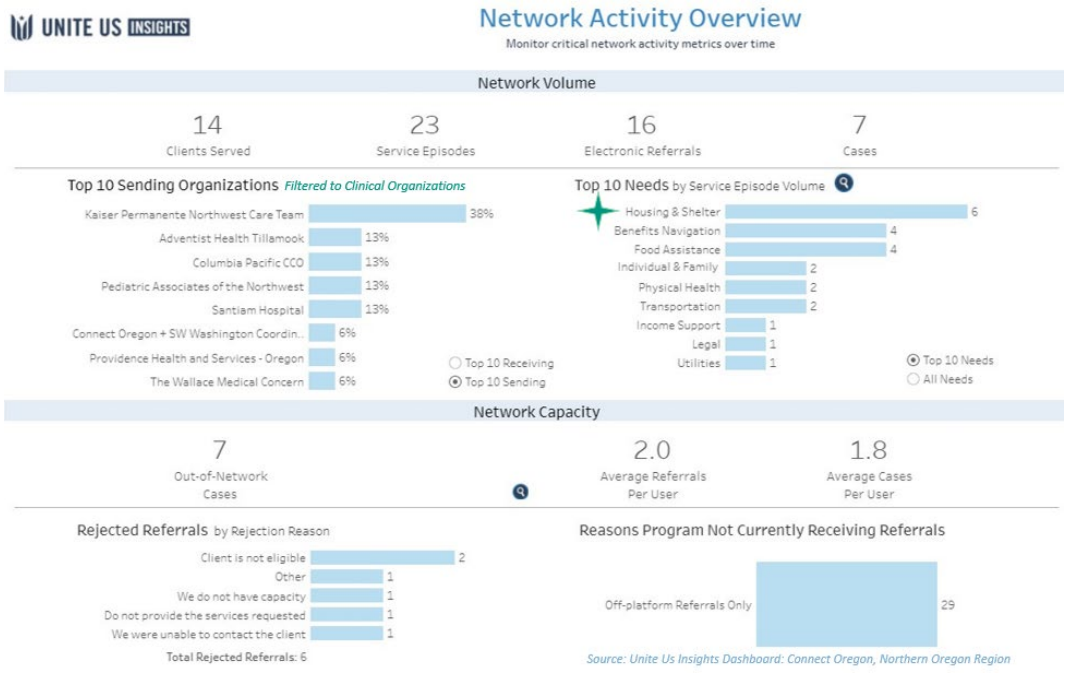
- Update: The table below details our housing investment projects.

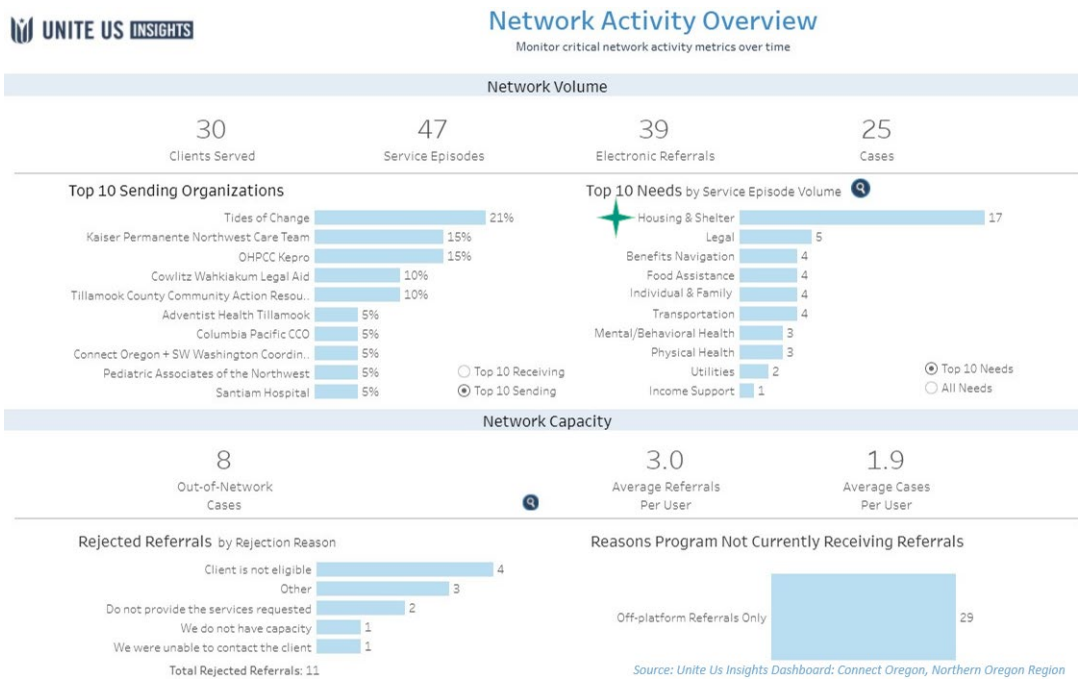
Approved or $ Spent *June 30, 2021-April 20, 2022* *Source: CPCCO Regional Housing Impact Fund*	Number of Projects	Grant Funds Awarded	Units Funded
Total	[redacted]		
Housing Stock			
Housing & Homelessness Services			
Capacity Building			
Direction from Baseline	Increase	Increase	Increase

  - Changes to Objective, Strategies, or Metric:
    - No changes.

- Objective 2: By 2024, increase the number of individuals and families whose health is supported by stable, safe, and affordable housing.
  - Strategy 1: Partner with existing local housing task forces/committees to develop pathways for increased access to shelter housing, transitional support to acquire permanent housing, and options for permanent housing.
    - Update: Columbia Pacific CCO staff are engaged in housing and houselessness task forces in Clatsop and Tillamook Counties. Through the Regional Housing Impact Fund, staff are partnering deeply with all three community action programs in the region, CMHPs, public health, developers, NOHA, and other agencies to increase access to shelters, supports, and permanent housing. Staff are currently collaborating with the same partners to assess the role Connect Oregon could play in increasing navigation and access to their services. Two community action programs are currently on the network, with CARE, Inc. being the most consistent referring/receiving partner in the region.
  - Strategy 2: Encourage local adoption of evidence-based recovery housing, supported housing, supported employment, and supported education programs.
    - Update: Columbia Pacific CCO developed a Regional Housing Impact Fund to help community partners in planning, developing, and implementing deeply affordable housing and housing support services. The fund has awarded over **$1.9 million in housing grants** to support local housing development and capacity-building. Additionally, CPCCO's Large Grant program funded a Homeless Service Specialist for the City of Tillamook to better coordinate services for unhoused community members.

- Strategy 3: Increase access to transportation systems such as Dial-a-Ride and volunteer ridesharing.
  - Update: CPCCO continues to collaborate with our Non-Emergency Medical Transportation (NEMT) provider, NW Rides, to stabilize traditional NEMT services as well as to consider the potential for innovative solutions for social health needs. However, the COVID-19 pandemic has required that we pause this strategy for the near future. It will be excluded from future CHP Progress Reports.
- Metric: Increased collaboration and referral between housing support programs and health care settings.
  - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. The first image below shows only the referrals from clinical organizations, and what social health and health services the referrals were for. Housing was the most cited referral need coming from clinical organizations. The second image shows all referrals regardless of sender. Housing was the most cited referral need overall.



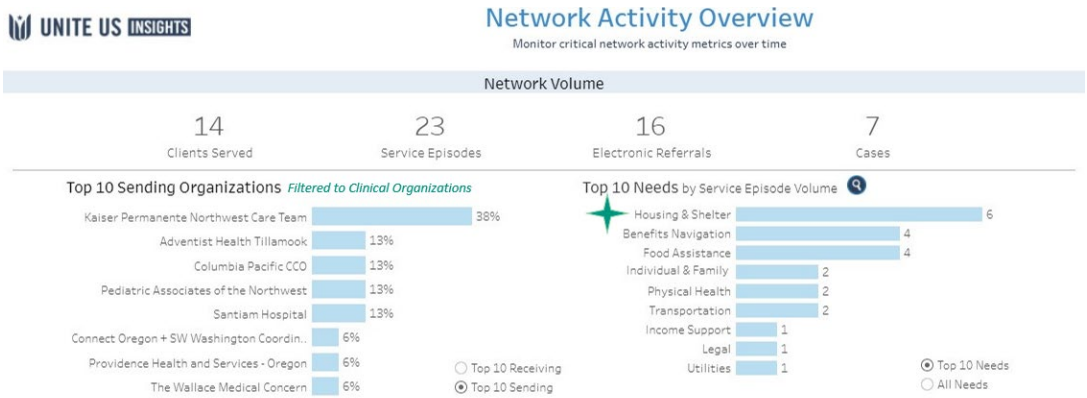


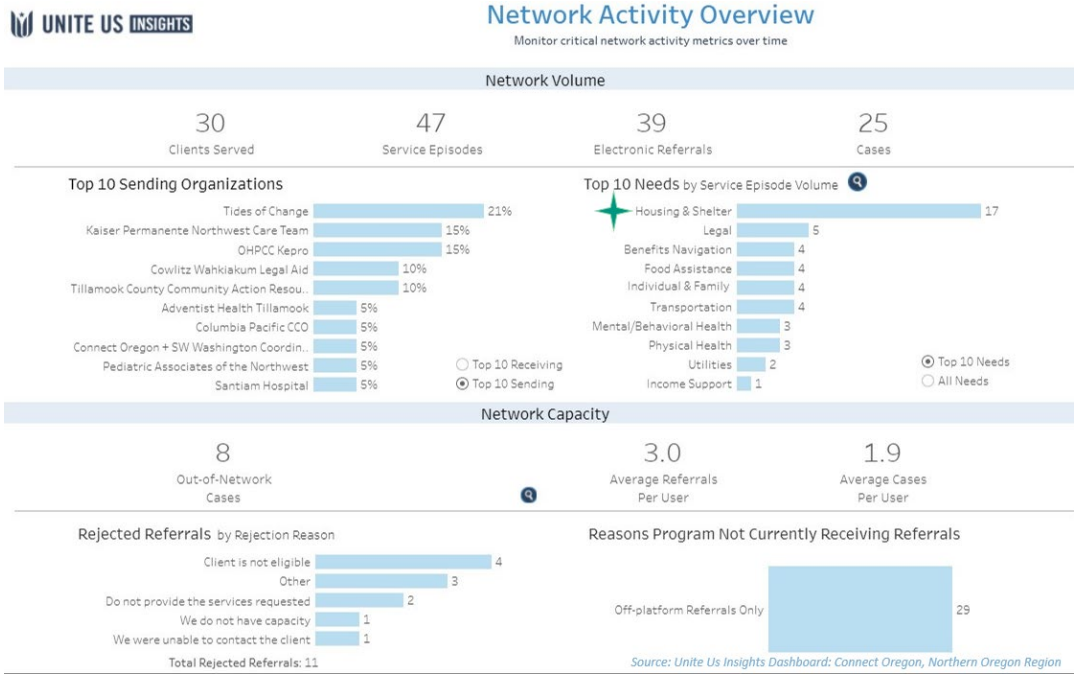
- Changes to Objective, Strategies, or Metric:
  - As explained above, Strategy 3 has been paused and will be excluded from future reports.

- Objective 3: Support and collaborate on increasing the number of initiatives and programs that provide stability, affordability, quality, and safety for low-income individuals who have housing needs.
  - Strategy 1: Increase the number of tenancy-sustaining services.
    - Update: We are partnering with Community Action Team (CAT) through our SHARE Initiative funds to expand their Healthy Homes program which makes home adaptations and safety improvements for people with health conditions. This program helps people maintain safe and secure tenancy by preventing loss of home due to inability to maneuver or safely live in their space. CPCCO also funded LiFEBoat Services to build capacity to expand its services that include programs to help unhoused community members to prepare for tenancy.
  - Strategy 2: Create transitional support services between higher and lower levels of care.
    - Update: During 2021 and 2022, we supported multiple housing-related projects which include transitional or ongoing supports that help community members transition to community-based care and improve their well-being, to mitigate the need for higher levels of care. Examples include:

- Ongoing work to add **13 more units of supportive housing** across the region dedicated to individuals or families with severe and persistent mental illness.
- Ongoing support for a project that includes adding **five units of transitional housing** in Clatsop County.
- Approving grant funds for a project that will add **20 family focused units of housing** in North Tillamook County that will include ongoing support from CARE Inc. and direct access to services.

- Strategy 3: Increase programs that support the remediation of unsafe or inadequate housing conditions.
  - Update: We are partnering with Community Action Team (CAT) through our SHARE Initiative funds to expand their Healthy Homes program which makes home adaptations and safety improvements for people with health conditions. Funds will help expand the program into all three counties, and to implement Connect Oregon. CAT has already joined the referral platform including Healthy Homes but will receive support to build out workflows.
- Metric: Increased number and coordination of housing support services.
  - Update: June 30, 2021-April 29, 2022 is our baseline period for monitoring referrals using the Connect Oregon platform. The first image below shows only the referrals from clinical organizations, and what social health and health services the referrals were for. Housing was the most cited referral need coming from clinical organizations. The second image shows all referrals regardless of sender. Housing was the most cited referral need overall.





- <u>Changes to Objective, Strategies, or Metric:</u>
  - No changes.

2022 Columbia Pacific CCO Community Health Improvement Plan Progress Report

This guidance helps CCOs address contractual requirements for the community health improvement plan (CHP) progress report deliverable. This deliverable can be found per **Exhibit K, Part 7.m** and **Oregon Administrative Rule** 410-141-3730.

A. The CHP progress report is due by June 30, 2022. It should be sent to the Oregon Health Authority's Health Systems Division by email to CCO.MCODeliverableReports@dhsoha.state.or.us. .

B. Two documents are required to complete your annual progress report:
   1) The progress information noted in item C below; and
   2) The completed CCO CHP Progress Report Questionnaire (starting on page two of this guidance document) as an appendix to the progress report. If your CCO has multiple CHPs, you must complete a separate questionnaire for each CHP.

C. The annual progress report should document progress made in implementing the CHP, including:
   1) Changes in community health priorities, goals, strategies, resources or assets;
   2) Strategies used to address the CHP health priorities;
   3) The role of the CCO and responsible partners who have been involved creating and implementing strategies to address CHP health priorities;
   4) Progress and efforts made (including services provided and activities undertaken) to-date toward reaching the metrics or indicators for CHP health priorities; and
   5) Identification of the data used; and the sources and methodology for obtaining that data, to evaluate and validate the progress made toward metrics or indicators identified in the CHP.
      - For CHPs that did not include quantifiable metrics or indicators for each health priority goal, the CCO should include the metric/indicator, data source, baseline data and year, and current year's data for each health priority goal. The CCO may include additional information to provide insight on data collection or context for why a metric/indicator has or has not made progress.
      - For CHPs that did include quantifiable metrics or indicators for each health priority goal, the CCO should include the metric/indicator, data source, baseline data and year, and current year's data for each health priority goal. The CCO may include additional information to provide insight on data collection or context for why a metric/indicator has or has not made progress.

D. The annual progress report evaluation criteria, includes ensuring the progress report:

1	Be published annually by the CCO. It must be reviewed by the CAC and then submitted to OHA. Publishing requires, at a minimum, publicly posting the progress report online to CCO and/or separate CHA/CHP website.
2	Report details changes in community health priorities, goals, strategies, resources or assets.
3	Include information about agencies and organizations, including the CCO, who created and implemented strategies to address CHP health priorities.
4	Detail progress and efforts to date in addressing CHP health priorities.
5	Detail progress to date towards meeting the CHP metrics and indicators for each CHP health priority.
6	Identifies what data, data sources, and data methodology were used to validate progress made towards meeting the CHP metrics and indicators for each CHP health priority.
7	Includes a completed OHA questionnaire.

CHP Progress Report Questionnaire

Key Players, Health Priorities and Activities in Child and Adolescent Health

1. Which of the following key players are involved in implementing the CCO's CHP? (select all that apply)

- ☒ Early learning hubs
- ☒ Other early learning programs[1]
  Please list the programs: NW Regional ESD; Tillamook Early Learning Center; trauma informed care networks
- ☒ Youth development programs[2]
  Please list the programs: YouthEra; Systems of Care; Tillamook Family YMCA; The Harbor; trauma informed care networks
- ☒ School health providers in the region
- ☒ Local public health authority
- ☒ Hospital(s)

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

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

Optional comments: Our region's trauma informed care networks in Clatsop and Columbia Counties have strategic plans that are focus on both early childhood and early learning, as well as resilient youth development. There are over 50 involved organizational partners engaged in that work.

3. Describe how these key players in the CCO's service area are involved in implementing your CHP.

Examples:

- ✓ *The early learning hub in our region is included in the prioritization and strategies.*
- ✓ *CCO is working with local youth development groups on homelessness.*
- ✓ The early learning hubs are deeply engaged in our social health/access to the social safety net work, and were/will be included in our CHA process as well. CPCCO paid NWRESD nearly $90,000 to support the early learning hubs for their efforts to connect children to preschool through a coordinated family outreach approach.
- ✓ CCO is working with the other early learning programs on resilience-building strategies for children age 0-5 that can be implemented across sectors.
- ✓ CCO is working with local youth development groups on trauma informed care and resilience, as well as health equity, chronic disease prevention, Traditional Health Worker strategies, and access to the social safety net.
- ✓ School health providers are engaged in prioritization and strategies, including resilience building, access to behavioral health, traditional health workers, and access to the social safety net.
- ✓ Both the local public health authorities and hospitals are engaged with the CCO in shared processes for our

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

assessments and prioritization; are also engaged in all of our priority areas. In the year between 2021-2022 this has been especially focused on access to the social safety net and access to care.

4. **If applicable, identify where the gaps are in making connections.**

Examples:

- ✓ *CCO did not work with school health providers as there is no school-based health center, but the CCO has reached out to the school district.*

One of the region's school-based health centers is the first in Tillamook County and new, so we aim to reach out to build connections in the coming year, particularly as we begin our next CHA. The pandemic has impacted our LPHAs and hospitals both acutely and chronically, so we are currently focused on engagement that is most critical.

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

- ✓ Community Resilience and Trauma Informed Care:
  - Building networks of trauma informed and resilience-building organizations and programs in the region is leading to coordination of services for children experiencing hardship. Example: the introduction to our region of programs that allow for police and schools to communicate when a child has experienced a trauma relating to justice involvement of a family member. This allows schools to help coordinate care for the child and avoiding punitive responses.
- ✓ Access to Care: Primary Care
  - Increasing referrals between community-based organizations and healthcare providers on the Connect Oregon network will improve the coordination of effective and efficient delivery of health and social care to children and adolescents as well as their families.
  - Increasing access to traditional health workers has included introducing youth-related peers in two of our counties, which will add a component of coordination that is youth-led and youth-centered.
- ✓ Access to Care: Behavioral Health
  - Expanding and improving access to a full range of services includes improving access to youth peer supports (mentioned above), as well as developmental health services for children and youth. Both are in tight supply in our region currently.
- ✓ Access to Care: Dental Care and Oral Health
  - Our work to increase the number of oral health professionals serving children and youth and to expand mobile options is increasing the number of children and youth accessing appropriate screenings, and strengthening the connection between oral health and primary care.
- ✓ Access to Care: Social Safety Net
  - Increasing access to navigation supports will reduce barriers to providing care to children and youth, and ensure that both they and their parents can meaningfully access benefits and services.
  - Increasing the availability of food-related services and programs through Connect Oregon and navigation services will reduce barriers to overall social and healthcare with fewer burdens on families and children experiencing poverty.
- ✓ Chronic Disease Prevention
  - Increasing access to evidence-based social health promotion programs for youth will long-term prevent the need for coordinated services related to chronic health needs.
  - Increasing opportunities for whole-health education and programming will both prevent the need for complex coordination needs, and also equip youth to advocate for their health and social care needs.
- ✓ Suicide Prevention
  - Increasing community awareness and education about suicide as a public health problem includes raising awareness about intervention and resources that are accessible to youth in crisis.
  - Upstream interventions in children before becoming youth will help build resilience and help reduce the need

for crisis intervention as older children and teens, and expose younger children to their available resources.

- ✓ Housing
  - Studies in Oregon have shown that increasing access to affordable housing reduces the need for complex coordination of care and improves overall health and quality of life.

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

Examples:

- ✓ *CCO is collaborating with its local SBHC and WIC program to improve oral health in their populations (0-18).*
- ✓ *CCO is working with youth, homeless, child welfare and mental health agencies on suicide prevention.*
- ✓ *CCO is coordinating prenatal services with local providers and public health agencies, including the SBHCs.*
- ✓ *Several CCO staff, CAC members and partner organization staff have attended ACEs trainings.*

- ✓ Community Resilience and Trauma Informed Care:
  - CPCCO provides backbone support for two trauma-informed care networks—one in Clatsop County and one in Columbia County. Each has developed a strategic plan with their own activities that address the need for trauma informed care and resilience-building organizations for children and youth.
  - CPCCO has awarded THW Capacity Grants to **six organizations** who provide services for children. The grants amount to [redacted] of which will focus exclusively on youth and children.
  - CPCCO awarded grants to two programs serving foster youth & families amounting to a total of over $80,000: Finding Kin which serves transition-age foster youth, and Foster Success to train and provide respite to foster parents in order to improve supports for the children in their care and retain foster parents.
  - Amani Center, Columbia County's Child Abuse Assessment Center, received over $40,000 to support their assessment and coordination of services for children who are survivors of abuse and neglect.
  - Dolly Parton Imagination Library received over $25,000 to support their in-region location, increasing access to books and particularly early intervention for reading.
  - Tillamook Early Learning Center received a grant for $20,000 to bring trauma informed care training and also general educational improvements to Tillamook County.
- ✓ Access to Care: Primary Care
  - We are partnering to provide the funding for Connect Oregon in our region through CareOregon. CPCCO provides significant staff support to help with outreach, technical assistance, and other needs. This includes working with partners who serve children, youth, and families such as NWRESD and multiple school districts, as well as programs like Healthy Families and Head Start.
  - CPCCO has also provided grants to stand up community resource desks and navigators who can help reduce barriers to care for families with children.
- ✓ Access to Care: Behavioral Health
  - CPCCO is refining our integrated payment to support behavioral health integration in primary care; we have also transitioned all community mental health programs to alternative payment models with program-specific targets that roll up to a quality pay out. This includes all providers who serve children and youth for behavioral and developmental care.
  - We partnered with CareOregon to invest more than $1.5million to stabilize, expand, and enhance our behavioral health system for all, and with foci for children and youth. This has included work on expanding primary care availability for all ages, increasing bi-directional referrals for appropriate services, member navigation, developmental screening pathways, in expanding equitable access to culturally and linguistically appropriate services.
  - We are engaging in efforts to study and support social and behavioral health networks whose services relate to social and emotional health in children age 0-5.
  - CPCCO gave $25,000 to support First Steps Center for Autism and Developmental Disabilities as well as nearly $20,000 in housing supports that included fees not covered for adult foster homes in the region.

- ✓ Access to Care: Dental Care and Oral Health
  - CPCCO continues to support tele-dentistry as a means of expanding access to care for children and youth.
  - CPCCO has also collaborated with Advantage Dental, ODS, and CareOregon Dental to open new clinics and develop the region's first Dental Assistant training pilot program.
  - We also continue to support full service and mobile dental care services for all ages, including for children. This includes continuing to work with Tillamook County Community Health Center on their mobile strategy, as well as with OHA & Providence's "Healthy Smiles" on school-based dental sealant and fluoride programs once schools resume allowing these services. CPCCO used $20,000 in HRS funds to support "Healthy Smiles" during CY 2021.
- ✓ Access to Care: Social Safety Net
  - See comments RE Traditional Health Workers, Community Resource Desks, and Connect Oregon.
  - CPCCO has invested over $40,000 in food pantries in the last year.
- ✓ Chronic Disease Prevention
  - We have funded YouthEra through a Large Grant and a Traditional Health Worker Capacity Building Grant. We are also exploring ways to sustainably support YouthEra.
  - We have funded The Harbor through a grant to hire a youth coordinator who will focus on helping young survivors of violence to navigate resources and to support them in their path of healing.
  - We are implementing a sustainable funding model for sharing the cost of members (including children and youth) to maintain memberships at the Tillamook Family YMCA. This increases access to healthy program for children and youth.
- ✓ Suicide Prevention
  - We continue to use grant funds to support Columbia Health Services in Columbia County's Suicide Prevention Coordinator, who provides outreach and education around suicide prevention with a special emphasis on youth. They implemented a campaign, "Save a Number, Save a Life" that reached deeply into the community.
  - CPCCO has funded the training of trainers (with 13 total trainers trained by them), and sponsored an ASIST trainer to be trained. This has increased access to: ASIST, QPR, and Youth Mental Health First Aid.
  - CPCCO supported the work to help two school districts and three schools to implement Sources of Strength, a school-based suicide prevention evidence-based program.
  - YouthEra's community-based peer will be focused on youth at risk of suicidality; this program received $50,000 in HRS funding to support this work.
- ✓ Housing
  - Our Regional Housing Impact Fund focuses on funding projects for housing insecure families with children, as well as housing and services for transition-age youth.

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

Examples:

- ✓ *Steering committee formed to identify gaps in school health needs.*
- ✓ *School nurse is an active member of CAC.*
- ✓ *CCO supported grant opportunities to improve mental health access in schools.*
- ✓ *CCO engaged with local early learning hub, and hub has cross membership with CAC.*

- ✓ During the year from June 30, 2021-June 30, 2022 our CACs included: 1 school board member, 1 founder of a nonprofit to support neurodivergent children and youth, 3 staff representing child or youth-specific programs, at least 8 parents of children or youth who have OHP, and the ED of the organization that oversees Columbia County's school-based health centers.
- ✓ Our Senior Program Development Specialist who supports the trauma-informed care networks in our region works directly with all 60 organizations who make up the two networks. This includes facilitating meetings and

guiding the networks through the process of developing and then implementing their strategic plans to improve resilience and trauma informed care for children and youth in their two counties. This includes partners from school districts, early learning hubs, the justice system, DHS, child-SANE providers, clinics who serve families including children and youth, and more.

- ✓ CPCCO provided grant funds that supported many programs (see question 6) regarding improving child and youth services and health. Additionally, we are currently implementing our first CBO-specific sustainable funding for programs that support youth and child access to physical activity and pro-social programming.
- ✓ CPCCO provides staff supports to expand the Connect Oregon network and increase its adoption and use in the region. This includes work with youth-facing programs.
- ✓ CPCCO's Community Engagement Team is currently engaged in the assessments and community outreach related to the Social Emotional Health: Kindergarten Readiness metric. This includes significant outreach to communities experiencing injustices who have children aged 0-5, as well as to key stakeholders such as the early learning hubs.

Health Disparities

CCO contract: Exhibit K, Part 6 & 7

8. Describe CCO and CHP partner efforts to address health disparities that were prioritized in the CHP. Include updated metrics or indicators to show progress in addressing the health disparity.

The health needs assessment conducted in 2018 identified, regardless of type of health insurance, the need to reduce barriers to health care and the social safety net. In our mostly rural region where all three counties are federally designated healthcare shortage areas, struggles to access care are nearly universal. Inequities based on geography intersect with race, poverty, language access, health access, and functional difficulties to create social care inequities. The pandemic has increased the need to access support and services for both social and health care for disparate populations but has also brought learnings on how to do so.

To address the disparities, CPCCO's eight priority areas focus on increasing support in the region for accessing health and social care services that increase individuals' and families' quality of life. For example, the plan includes strategies that address the social and emotional wellbeing of children and families through supporting the development of organizations across sectors that collaborate on implementing trauma informed practices to support resilience in children and families. It also includes working with clinical and community-based partners alike to increase access to Traditional Health Workers to extend care in a culturally appropriate way. Each priority area has an associated equity statement that gives context to how the priority area strategies address disparities. Additionally, the CCO's Equity Plan further outlines strategies and measures related to reducing health disparities for our members.

Regional efforts from the CHP in the last year to address health disparities include:

- Supporting the regional health equity coalition development. CPCCO has participated in the developing health equity coalition applicant in our service region. The coalition plans to apply for funds to support the coalition to develop and implement a strategic plan.
- Developing trauma informed networks in two counties with a plan to expand into the third county in our service area. The goal of the Community Trauma Informed Networks is to create resilience in children and adults through a community-wide initiative to prevent and address trauma. To date, **59 member organizations** have formally joined the network in Clatsop and Columbia Counties. Since their launch, the networks have launched **eight sector workgroups**. Organizations in Tillamook County have expressed interest in joining the trauma informed network and there will be efforts to engage the community in this work beginning in 2022.
- Working with clinical partners and internally to increase awareness of and access to quality interpretation and translation services across sectors. We have increased the options for interpretation and translation services. Columbia Pacific's Community Engagement Team built out workflows and best practices for hosting bilingual

community-facing meetings. This includes our Community Advisory Councils, **two of which have hosted bilingual meetings since November of 2021**. The team has also continuously worked on identifying needs for translation to facilitate meaningful access to participate in CAC meetings, such as PowerPoint presentations, reports, surveys and forms, and the CAC Member Binders. Our clinical Quality Improvement team submits our quarterly language access & interpretation services report, which requires ongoing monitoring and improvement work regarding access to language services in clinical spaces. Additionally, CareOregon recently completed a procurement process for language services and increased our vendors from **2 to 6**, which should provide more flexibility for Columbia Pacific CCO and our partner organizations to meet the varied language needs of our members.

- Continuing to develop Traditional Health Worker programs and payment models. CPCCO has implemented a grant program to support capacity building in CBOs for community health workers and navigators in their organizations. Applications in 2021 resulted in six organizations funded for a total of [redacted] in the region. All will focus on decreasing health disparities for specific populations.
- Launching Connect Oregon, a closed-loop referral and health information exchange platform, throughout CPCCO's three-county region. This platform is funded by both CareOregon and CPCCO and implemented in partnership. As of May 2021, **39 regional partners** have joined the Connect Oregon network and begun to implement the referral system. To date, the referrals sent have been CBO to CBO, but as clinics continue to join the network, CPCCO will continue to take baseline data. This will help us to measure change over time as we implement additional programs and best practices, which will increase access to services for those in our communities who are furthest from opportunities for care.

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

COVID highlighted many health inequities, particularly in our rural communities. Critical issues included health illiteracy, disinformation, and a disconnect from the usual resource and information networks.

Health inequities disproportionately affect our Latinx community members, who face a lack of professional interpreters and multilingual telehealth options and experience lack of trust, low health literacy, and reduced access to testing and vaccines. While vaccines were free and available, we witnessed high levels of disbelief and hesitancy. Public health efforts intended to reduce disease spread were not readily understandable across cultures and were not always presented in a culturally appropriate manner in our region.

CPCCO dedicated efforts to build trust and confidence while increasing vaccination in the Latinx community, including coordination with community partners on health campaigns to disseminate culturally appropriate messages regarding COVID and health literacy through a variety of means. CPCCO partnered with community leaders and organizations to increase access to testing and vaccines while addressing long-standing mistrust among historically marginalized rural communities. Outreach events were provided in established community gathering places, such as churches, community centers, and schools. As a result, vaccination levels have improved.

Telehealth reduced COVID exposures for both members and health care providers yet created new barriers due to unstable internet connectivity and lack of smartphones, tablets, etc. This limited telehealth access in rural areas. We provided tablets to OHP members who needed help to access our virtual meetings and fully participate in system improvement. We are also coordinating with partner agencies to increase equitable access to technology.

CPCCO is addressing the lack of Traditional Health Workers in underserved communities by investing in an expanded network of culturally specific THWs across the region.

CPCCO rolled out a successful pilot in two of the three counties to bring language access to the Community Advisory Councils. In addition, telehealth accommodations were made for members with limited mobility; we invited partners who serve marginalized populations to present at CAC meetings. Agencies such as the Q Center, which serves LGBTQIA+

members, and agencies that serve houseless individuals were able to share program information with our members while hearing their needs.

Building Toward CCO 2.0 Requirements

Per contract section Exhibit K, Part 6 and 7) OAR 410-141-3730, CCOs are required to develop shared CHAs and shared CHPs with local public health authorities (LPHAs), hospital systems and other CCOs that share a portion of the service area, and federally recognized Tribes in the service area that have or are developing a CHA and CHP. Please reference OHA's *CCO Guidance: Community Health Assessments and Community Health Improvement Plans* available here.

10. Is your CCO's CHA and CHP fully shared with LPHAs, hospitals, other CCOs, and Tribes that share a service area?

☐ **Yes**

Please name the entities that share the CHA and CHP.

☒ **Partially**

Please name the entities that share the CHA and CHP.

- Clatsop County and Clatsop County Public Health
- Columbia County and Columbia County Public Health
- Tillamook County Public Health
- Clatsop Behavioral Health
- Columbia Community Mental Health
- Columbia Memorial Hospital
- Providence Seaside Hospital

Please name the entities that do not yet share the CHA and CHP.

- Adventist Health, Tillamook: Although Adventist completed a separate health needs assessment, for their implementation strategy, they "assessed the health needs identified in the [Community Health Needs Assessment] and directly aligned community programs and outcome measures with the Columbia Pacific Coordinated Care Organization's (CCO) 2020 community health plan. This collaboration and alignment allowed for prioritization of community health programs which best provide for our community and the vulnerable among us." (*Adventist Health, Adventist Health Tillamook 2020 Community Health Implementation Strategy*)
- Tillamook Family Counseling Center (TFCC): TFCC joined with Adventist Health, Tillamook to complete a community health needs assessment and community health improvement plan.
- While we do not have federally recognized Tribes located in our service area, we did outreach to both the Confederated Tribes of Grande Ronde and Confederated Tribes of Siletz Indians, which are very close to our service area, prior to conducting our CHA. The CHA survey link was put into the Siletz community letter. There are members of the Siletz in all three of the counties in our service area. We will continue to outreach with Tribes as part of our outreach strategy and in partnership with our Tribal Liaison, and to continue to include them in all parts of the CHA/CHP process in which they would like to be involved.

☐ **No**

Please name the entities that do not yet share the CHA and CHP.

11. If your CCO CHA/CHP is not yet fully shared with LPHAs, hospitals, other CCOs and Tribes because it was submitted prior to 2020, does your CHP have health priorities and strategies aligned with other community health improvement plan health priorities and strategies?

Agency, Organization or Tribe	Aligned Health Priority	Aligned Strategy
Adventist Health, Tillamook	Housing and homelessness → Housing	Partner to support community action programs, and community-based organizations that provide shelter/transitional housing supports in the region.
	Mental health → Access to Care: Behavioral Health	Increase access to mental health and substance use disorders through new services, education, and partnerships.
	Access to healthcare → Access to healthcare: primary care	Increase access to primary care through programs that seek to address barriers by engaging the community
	Prevention and management of chronic disease → Chronic disease prevention	Provide follow up care to high-risk individuals and partner to increase lifestyle management programs targeted to those with chronic disease.

Per contract section Exhibit K, Part 7, CCOs are required to address at least two State Health Improvement Plan (SHIP) priorities, based on local need.

12. Please note which of your CCO's CHP strategies align with the 2020-2024 State Health Improvement Plan strategies.

- ✓ The SHIP (healthiertogetheroregon.org/priorities/) priority areas include 1) Institutional Bias, 2) Adversity, Trauma and Toxic Stress, 3) Economic Drivers of Health, 4) Access to Equitable Preventive Health Care, and 5) Behavioral Health.
- ✓ The SHIP priorities are being implemented with strategies in eight implementation areas, as outlined below. Each implementation area includes a link to a list of the associated strategies. Check the box to indicate where a specific CCO CHP strategy is in alignment with a SHIP strategy, and provide a brief narrative describing the alignment.

Narrative below outlines where SHIP strategy overlaps with our RHIP/CHP strategy. Bullets indicate which priority area from our RHIP/CHP it aligns with and our RHIP/CHP strategies are italicized.

Equity and Justice

☐ Declare institutional racism as a public health crisis

☐ Ensure State Health Indicators (SHIs) are reported by race and ethnicity, disability, gender, age, sexual orientation, socioeconomic status, nationality and geographic location.

☐ Require state agencies to commit to racial equity for BIPOC-AI/AN in planning, policy, agency performance

metrics and investment

☒ Reduce legal and system barriers for immigrant and refugee communities, including people without documentation.

- Access to Care: Primary Care- Increase referrals using Connect Oregon to primary care from community-based organizations as well as referrals from primary care to community-based organizations.
  - *Increase awareness of and access to quality interpretation and translation services across sectors*
  - *Increase the number of organizations in the region that offer help desks and community-based referral supports that: Increase access to Traditional Health Workers and healthcare navigators that can support access to primary care*
- Access to Care: Primary Care- Collectively address the primary care and health professional provider shortage.
  - *Increase the number of Traditional Health Workers in any setting within the region*
- Access to Care: Behavioral Health- By 2024, expand and improve access to the full range of behavioral health services
  - *Develop alternative payment models that support enhancement of behavioral health services, including developing new components of the array of services*
  - *Recruit behavioral health care providers to work in the region*
  - *Integrate behavioral health and primary care services to provide coordinated care and a whole-person approach*
- Access to Care: Behavioral Health- Increase behavioral health-related prevention activities and awareness and understanding of behavioral health supports and services that are peer driven.
  - *Support the increase of services that are peer driven and are distributed throughout the continuum of care*
  - *Integrate behavioral health and primary care services to provide coordinated care and a whole-person approach*
  - *Add to the components of the existing system to expand the continuum of care*
  - *Increase the systemic clinical interventions and screenings at all levels of the community*
- Community Resilience and Trauma Informed Care: By 2024, increase the number of community-based organizations providing trauma informed services, with an emphasis on organizations serving the greatest numbers of individuals and families experiencing health disparities.
  - *Increase the utilization of and support for Traditional Health Workers across all sectors*
  - *Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks*

☐ Ensure accountability for implementation of anti-racist and anti-oppression policies and cross-system initiatives.

☐ Ensure state agencies engage priority populations to co-create investments, policies, projects and agency initiatives.

☐ Build upon and create BIPOC-AI/AN led, community solutions for education, criminal justice, housing, social services, public health and health care to address systematic bias and inequities.

☒ Require that all public facing agencies and contractors implement trauma informed policy and procedure.

- Community Resilience and Trauma Informed Care: By 2024, increase the number of programs, organizations, and sectors aware of the trauma informed perspective and its relation to engaging individuals in the services that support improvement of health and well-being.
  - *Collaborate to access resources and share investment opportunities that support the implementation of trauma informed care across programs, organizations, and sectors in the region*
- Community Resilience and Trauma Informed Care: By 2024, increase the number of community-

based organizations providing trauma informed services, with an emphasis on organizations serving the greatest numbers of individuals and families experiencing health disparities.

- *Increase coordination and engagement among the health care, education, child welfare, community, and criminal justice sectors to integrate trauma informed care across systems and organizations*
- *Increase the utilization of and support for Traditional Health Workers across all sectors*
- *Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks*

Healthy Communities

☐ Provide safe, accessible and high-quality community gathering places, such as parks and community buildings.

☒ Expand culturally and linguistically responsive community-based mentoring and peer delivered services.

Access to care: Primary Care- Eliminate barriers to primary care, including geographic and transportation inconveniences, lack of knowledge, unavailability of internet, and lack of insurance coverage.

- *Increase awareness of and access to quality interpretation and translation services across sectors*
- *Increase the number of organizations in the region that offer help desks and community-based referral supports that: Increase access to Traditional Health Workers and health care navigators that can support access to primary care*

Access to Care: Primary Care- Collectively address the primary care and health professional provider shortage.

- *Increase the number of Traditional Health Workers in any setting within the region*

Access to Care: Behavioral Health- By 2024, expand and improve access to the full range of behavioral health services.

- *Develop alternative payment models that support enhancement of behavioral health services, including developing components of the array of services that do not currently exist*
- *Recruit behavioral health care providers to work in the region*
- *Integrate behavioral health and primary care services to provide coordinated care and a whole-person approach*

Access to Care: Behavioral Health- 1) Increase behavioral health-related prevention activities and awareness and understanding of behavioral health supports and services that are peer driven, 2) Increase access to harm reduction and addiction treatment resources in the region.

- *Support the increase of services that are peer driven and are distributed throughout the continuum of care*
- *Integrate behavioral health and primary care services to provide coordinated care and a whole-person approach*

Community Resilience and Trauma Informed Care- By 2024, increase the number of community-based organizations participating in community trauma informed networks and participating in trauma informed, closed-loop referrals among trauma informed services.

- *Increase the utilization of and support for Traditional Health Workers across all sectors*
- *Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks*

☒Develop community awareness of toxic stress, its impact on health and the importance of protective factors.

Community Resilience and Trauma Informed Care- By 2024 increase the number of programs, organizations, and sectors aware of the trauma informed perspective and its relation to engaging individuals in the services that support improvement of health and well-being.

- *Collaborate to access resources and share investment opportunities that support the implementation of trauma informed care across programs, organizations, and sectors in the region*

By 2024, increase the number of community-based organizations participating in community trauma informed networks and participating in trauma informed, closed-loop referrals among trauma informed services.
  - *Increase coordination and engagement among the health care, education, child welfare, community, and criminal justice sectors to integrate trauma informed care across systems and organizations*
  - *Increase the utilization of and support for Traditional Health Workers across all sectors*
  - *Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks*

☐ Enhance community resilience through promotion of art and cultural events for priority populations.
☒ Invest in workforce development and higher education opportunities for priority populations.

- Access to care: Primary Care- address provider shortage
  - *Identify incentives to recruit and retain high quality providers with focus on integration*
  - *Increase the number of Traditional Health Workers in any setting within the region*
  - *Increase utilization of telehealth*
  - *Increase collaboration and workforce opportunities for MAs, scribes, and healthcare extenders*

☐ Strengthen economic development, employment, and small business growth in underserved communities.
☐ Enhance financial literacy and access to financial services and supports among priority populations.
☐ Increase affordable access to high-speed internet in rural Oregon.
☐ Build climate resilience among priority populations.
☐ Center BIPOC-AI/AN communities in decision making about land use planning and zoning to create safer, more accessible, affordable, and healthy neighborhoods.
☒ Co-locate support services for low-income people and families at or near health clinics.

- Access to Care: Behavioral Health- By 2024, expand and improve access to the full range of behavioral health services.
  - Integrate behavioral health and primary care services to provide coordinated care and a whole person approach
- Access to Care: Primary Care- Increase referrals using Connect Oregon to primary care from community-based organizations as well as referrals from primary care to community-based organizations.
  - *Increase the number of organizations in the region that offer help desks and community-based referral supports that: Increase access to Traditional Health Workers and health care navigators that can support access to primary care*
- Access to Care: Social Safety Net- Collaborate to support the establishment and expansion of a comprehensive, cohesive network on Connect Oregon for conducting social needs screening and coordinating care between hospitals, community action programs, and primary care settings.
  - *Increase community awareness of resources and supports through screening for social determinants of health in clinical settings and the coordination of referrals across sectors*
  - *Deploy community resource navigators to key locations through the region*

☐ Expand programs that address loneliness and increase social connection in older adults.

Healthy Families

☐ Ensure access to and resources for affordable, high quality, culturally and linguistically responsive childcare and caregiving.
☐ Expand evidence based and culturally and linguistically responsive early childhood home visiting programs.
☒ Build family resiliency through trainings and other interventions.

- Community Resilience and Trauma Informed Care: By 2024, increase the number of community-based organizations providing trauma informed services, with an emphasis on organizations serving the greatest numbers of individuals and families experiencing health disparities.

- *Support the increase of supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support the increase of social networks*

☐ Increase patient health literacy

☒ Expand reach of preventive services through evidence based and promising practices.

Each of our priority areas' strategies have preventive services through evidence based and promising practices which we seek to expand

☐ Support Medicare enrollment for older adults through expansion of the Senior Health Insurance Benefits Assistance (SHIBA) program

☐ Increase access to pre and postnatal care for low-income and undocumented people.

☐ Improve access to sexual and reproductive health services.

☒ Use healthcare payment reforms to support the social needs of patients.

- Access to Care: Behavioral Health- Expand and improve access
  - *Expand and improve access via the development of alternative payment models*

Healthy Youth

☐ End school related disparities for BIPOC-AI/AN children and youth through teacher training, monitoring of data and follow-up with teachers, administrators, and schools.

☐ Increase use of mediation and restorative justice in schools to address conflict, bullying and racial harassment.

☐ Ensure all school districts are implementing K-12 comprehensive health education according to law.

☐ Expand recommended preventive health related screenings and interventions in schools.

☐ Increase access to dental care that is offered in schools, such as dental sealants and fluoride varnish.

☐ Provide culturally and linguistically responsive, trauma informed, multi-tiered behavioral health services and supports to all children and families.

Housing and Food

☐ Increase affordable housing that is co-located with active transportation options.

☐ Increase homeownership among BIPOC-AI/AN through existing and innovative programs.

☐ Require Housing First principles be adopted in all housing programs.

☒ Maximize investments and collaboration for food related interventions.

- Chronic Disease Prevention
  - *[Expand] community and school-based nutrition education, exercise, and access to affordable, healthy food options, such as Rx for health, to community-based activities, "food bank fresh," or "fresh food farmacy"*
  - *Increase opportunities for whole-health education and programming*
- Access to Care: Social Safety Net
  - *Establish broad cross-sector support for and investment in food banks, food recovery, and programs that support the reduction of chronic health conditions*
  - *Establish broad cross-sector support for and investment in Rx for Health, food banks, food recovery, and other health programs that support the reduction of chronic health conditions*

☒ Build a resilient food system that provides access to healthy, affordable, and culturally appropriate food for all communities.

See above

☐ Increase access to affordable, healthy, and culturally appropriate foods for people of color and low-income communities

Behavioral Health

☐ Enable community-based organizations to provide culturally and linguistically responsive information about behavioral health to people they serve.
☐ Implement public awareness campaigns to reduce the stigma of seeking behavioral health services.
☐ Conduct behavioral health system assessments at state, local and tribal levels.
☐ Create state agency partnerships in education, criminal justice, housing, social services, public health, and health care to improve behavioral health outcomes among BIPOC-AI/AN
☒Improve integration between behavioral health and other types of care.

- Access to Care: Behavioral Health- Increase behavioral health-related prevention activities and awareness and understanding of peer-driven supports and services
  - *Integrate behavioral health and primary care service*
  - *Increase peer driven services across continuum of care*

☐ Incentivize culturally responsive behavioral health treatments that are rooted in evidence-based and promising practices.
☒Reduce systemic barriers to receiving behavioral health services, such as transportation, language and assessment.

- Access to Care: Behavioral Health-
  - *Increase peer driven services across continuum of care*
  - *Increase systemic clinical interventions and screenings at all levels of community*

☒ Use healthcare payment reform to ensure comprehensive behavioral health services are reimbursed.

- Access to Care: Behavioral Health—Expand and improve access
  - *Develop alternative payment models that support enhancement of behavioral health services, including developing components of the array of services that do not currently exist.*

☐ Continue to strengthen enforcement of the Mental Health Parity and Addictions Law.
☒ Increase resources for culturally responsive suicide prevention programs for communities most at risk

- Suicide Prevention: Reduce number of suicides to zero
  - *Identify, develop, and implement suicide prevention programs in every county, with specific outreach on suicide prevention and awareness for youth*

Workforce Development

☐ Expand human resource practices that promote equity.
☒Implement standards for workforce development that address bias and improve delivery of equitable, trauma informed, and culturally and linguistically responsive services.

- Access to Care: Primary Care
  - *Increased awareness of and access to quality translation and interpretation*
- Community Resilience and Trauma Informed Care
  - *Leverage resources to support implementation of trauma-informed care across programs, organizations, and sectors*
  - *Increased coordination and engagement among the health care, education, child welfare, community, and criminal justice sectors to integrate trauma-informed care across systems and organizations*
  - *Increased supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support increase of social networks*

☐ Require sexual orientation and gender identity training for all health and social service providers.
☒ Require that all public facing agencies and contractors receive training about trauma and toxic stress.

- Community Resilience and Trauma Informed Care
  - *Leverage resources to support implementation of trauma-informed care across programs, organizations, and sectors*
  - *Increased coordination and engagement among the health care, education, child welfare, community,*

and criminal justice sectors to integrate trauma-informed care across systems and organizations
    - *Increased supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support increase of social networks*

☐ Support alternative healthcare delivery models in rural areas.

☐ Create a behavioral health workforce that is culturally and linguistically reflective of the communities they serve.

☒ Increase the cultural and linguistic responsiveness of health care through use of traditional health workers and trainings.

- Community Resilience and Trauma Informed Care
    - *Increased supportive adult advisors, diverse peer leaders, and strategic messaging campaigns to support increase of social networks*
    - *Increased utilization of and support for THWs across all sectors*
- Access to Care: Primary Care
    - *Increase the number of Traditional Health Workers in any setting within the region*
    - *Increased number of organizations who offer help desks and community-based referral and supports that support: 1) discharge from acute and sub-acute healthcare, 2) access to THWs and healthcare navigators that support access to primary care, 3) participation in volunteer driver network via cross-sector collaboration*
- Access to Care: Behavioral Health
    - *Increase peer driven services across continuum of care*

Technology and Health

☒ Expand use of telehealth especially in rural areas and for behavioral health.

- Access to Care: Primary Care—Address provider shortage
    - *Increase utilization of telehealth*
- Access to Care: Oral Health and Dental care—Increase the number of oral health professionals who treat specific populations
    - *Support tele-dentistry*

☐ Improve exchange of electronic health record information and data sharing among providers.

☐ Use electronic health records to promote delivery of preventive services.

☒ Support statewide community information exchange to facilitate referrals between health care and social services.

- Access to Care: Primary Care— Increase referrals using Connect Oregon to primary care from community-based organizations as well as referrals from primary care to community-based organizations.
    - *Increased referral and partnership between primary care and CBOs, specifically among people in need of transitional and supportive housing*