Community Health Improvement Plan

Progress Report—June 2018

UMPQUA HEALTH ALLIANCE

What is Umpqua Health Alliance?

Umpqua Health Alliance (UHA) is a Coordinated Care Organization (CCO) serving Oregon Health Plan members living in Douglas County. It is part of Umpqua Health.

What is a Community Health Improvement Plan (CHIP)?

A Community Health Improvement Plan (CHIP) is both a process and a document that outlines strategies to support health and well-being initiatives. UHA's CHIP outlines prioritized health issues, and ways to address them locally. The process included input from community members and people who provide health and social services in Douglas County. It is based on the 2013 Douglas County Community Health Assessment.

BACKGROUND

In 2012 and 2013, Umpqua Health Alliance (UHA) and what was then known as Douglas County Public Health (DCPH) sponsored the 2013 Douglas County Community Health Assessment (CHA), which was released fall 2013.

The Douglas County Community Health Improvement Plan (CHIP), based on the CHA, was released in June 2014. It integrated CHA data with issues that community leaders felt were important to address in Douglas County.

Strategies were chosen based on considerable community input, core planning principles, and the values of the Community Advisory Council, Umpqua Health Alliance and Douglas County Public Health. The development of the 2014 CHIP was the first time the Douglas County community crafted such a plan. The CHIP represents the principles of active community collaboration.

2014 CHIP Core Planning Principles

- Based on the 2013 Community Health Assessment
- Cost-effective strategies that leverage local assets and resources
- Creates positive, measureable change in individuals and community
- Coordinated with efforts already successful in Douglas County
- Evidence-informed
- Population-specific strategies, addressing health disparities
- Meets Oregon Health Authority and Public Health Accreditation rules and mandates

The UHA Community Health Improvement Plan focuses on five main strategies: access, addictions, mental health, parents & children and healthy lifestyles. Since the completion of the CHIP in 2014, the Community Advisory Council (CAC) has collaborated with community partners to work towards achieving these goals through various projects and efforts in Douglas County.
Below is a snapshot of the 2014 High Level Strategies Map.

Community Health Improvement Plan (CHIP)
2014 High Level Strategies Map

Access
Provider recruitment and retention
Increase understanding of new providers about UHA model of care

Transportation
Non-emergent medical transportation group to increase access and coordination

OHP Member Engagement
Expanded care clinic to improve coordination of care for members with severe and persistent mental illness, develop strategies to enhance member engagement for implementation in 2015

Addictions
Tobacco Free Policy Change
Advocate for increased number of tobacco-free environments in Douglas County

Tobacco Cessation
Explore expansion of tobacco cessation benefit for OHP members

Prescription Drug Misuse/Abuse
Provider training and support: prescribing utilization

Mental Health
Mental Health Services
Identify opportunities for CHIP strategies in 2015

Diversion
Explore opportunities to collaborate in the development of a local Mental Health Court

Parents & Children
Well Child Visits
Provide health related reading materials at well child visits to encourage parent to child reading

Early Learning Hub
Collaborate with Early Learning Hub to incentivize parents to complete voluntary child assessments and increase the number of at-risk children getting services

Adverse Childhood Experiences (ACEs)
Increase CAC and provider awareness of ACEs research

Healthy Lifestyles
Kick Start Douglas County
Sponsor and promote 100 Healthy Lifestyle Events summer of 2014

Worksite Wellness
Support comprehensive worksite wellness initiatives addressing healthy food, physical activity and tobacco-free environments

Community Gardens & Farmers Market Production
Identify opportunities for promotion to OHP members

COLLABORATION & PARTNERSHIPS

UHA CAC members have contributed efforts toward activities supporting the identified focus areas. Partnership and collaboration on CHIP activities has included participation from local physical and oral health providers, mental health services, domestic violence prevention experts, addiction treatment and prevention providers, education professionals, local government representatives, Tribal members, those associated with the faith community and Oregon Health Plan members.

Beyond representation on the CAC, many community organizations have partnered with UHA on projects related to the CHIP. Some of these organizations include Adapt, Battered Person's Advocacy, UC VEG, YMCA of Douglas County, Optimal Health Management, the South Central Oregon Early Learning Hub, and many others.

While UHA strives to improve the health of our members and our community, we realize that this impactful work cannot be done alone. The countless partnerships and collaborations have given our efforts a greater significance, helping UHA achieve the goal of improved health for our members and the Douglas County community as a whole.

UPDATING THE CHA, CHIP

Umpqua Health's first community Health Assessment was completed in 2013. In 2017, UHA's CAC partnered with Umpqua Community Health Center (an area Federally Qualified Health Center) and United Community Action Network, a local social service provider, and began working on a Community Health Assessment update. This update is following a similar creation process as the 2013 CHA, including community surveys, focus groups for targeted populations, and secondary quantitative data collection. CAC members will review the CHA update, and will provide feedback before a final version is completed.

Once the CAC has completed the CHA update, they will begin work on updating the Community Health Improvement Plan. This work will help Umpqua Health Alliance to more fully understand the findings of the CHA, and to formulate a plan on the best ways to address the needs identified through the Community Health Assessment Process. The updated Community Health Improvement Plan will be complete by June 30, 2019.

Community Health Improvement Plan Progress

This report describes progress made since June 2017 in each of the five focus areas:

- **Access**
- **Addictions**
- **Mental Health**
- **Parents & Children**
- **Healthy Lifestyles**

ACCESS

Case Management for Underserved Populations

UHA partnered with Optimal Health Management to provide case management services to individuals who were unable to obtain them through other agencies, or were in a waiting period before services were available. These case management services were relatively short-term, with an effort to help individuals navigate their available options and locate a more permanent case manager. Referrals came from our area hospital, local service agencies, the Douglas County jail, local homeless shelters and private practice therapists. On average, this partnership resulted in 21 visits a month. Most individuals were experiencing extreme circumstances, including physical and mental health needs, chronic homelessness, and substance abuse. Referral requests ranged from finding housing to requesting assistance in navigating resources and applying for services with other agencies.

New Day

In August 2017, Umpqua Health Alliance filled the position to manage the New Day program. New Day helps pregnant women struggling with substance abuse, as well as other challenges. From the time this manager began working with clients in August through the end of April 2018, 53 patients have enrolled in the program. This has thus far resulted in 33 healthy births (including two sets of twins), with 29 babies going home with mom after being released from the hospital. This project continues to be a success, with more than 440 pregnant women being monitored.

Provider Recruitment

Umpqua Health Alliance continues to expand our provider network. Since June of 2017, we have added the following providers to our panel:

Primary Care Physicians: 14

Specialists: 14

Mental Health Providers: 8

ACCESS

Healthy Kids Outreach Program

In 2018, UHA partnered with the Mercy Foundation to increase capacity for the Healthy Kids Outreach Program—Rural Dental Initiative. This program, which includes a partnership with our dental care organization Advantage Dental, provides dental care through school-based dental clinics, as well as oral health education through Dental Learning Labs. Dental care includes bi-annual dental assessments, fluoride varnish and dental sealants for children with untreated, erupted molars in first, second, sixth, seventh and ninth grades. Students are also given a take-home oral hygiene kit containing a toothbrush, toothpaste, flosser and tooth timer. If a student requires more dental care than the program routinely provides or the student is experiencing immediate and/or urgent dental care needs, organizers work with the student and their families to connect students to appropriate dental care. Advantage Dental also has a dental hygienist deployed in the community to work with additional agencies that serve children.

Healthy Households Home Visiting

UHA recently entered a partnership with Family Development Center, an organization that provides family support services with an aim to prevent child abuse and neglect. This partnership has resulted in expanded capacity for home visits performed by FDC staff, specifically increasing home visits by half an hour to include a health component. This partnership also increases capacity at all parent education classes to include a health component.

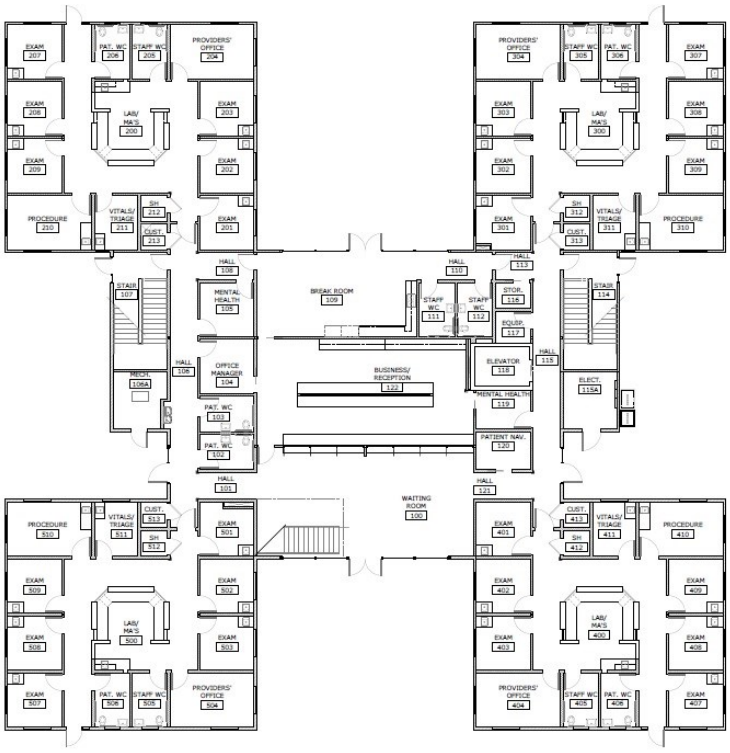
Oral Health for Pregnant Women

In 2018, UHA began a partnership with Douglas Public Health Network and the Douglas Oral Health Coalition to launch the Oral Health for Pregnant Women project. This project provides oral health education to pregnant women and interested Primary Care and OB-Gyn providers and office staff, as well as an oral health toolkit for all expectant mothers. An expected outcome for this project is 50% of participants will visit a dental provider within one month of the educational session and 75% will report the use of the items in the kit.

ACCESS

Umpqua Health—New Clinic

In the summer of 2017, Umpqua Health began construction on a new medical office building. The nearly-25,000 square foot building will initially feature fully integrated physical, behavioral, and dental services. The general layout of the two-story building is four separate pods, all of which connect to a central area.



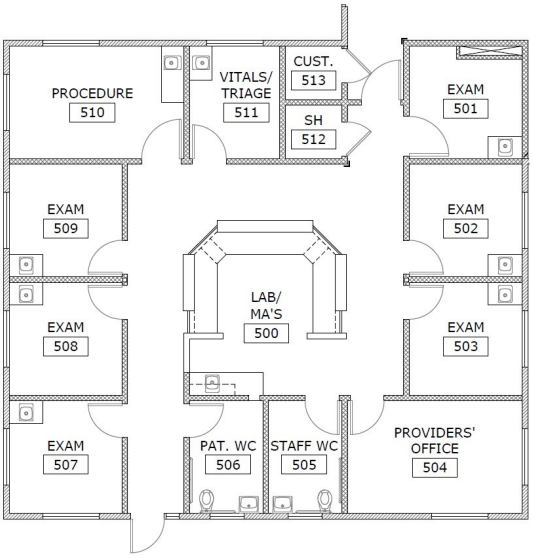
Floor plan of the first floor, showing the four pods

In addition to the clean, natural style of the building, our design team focused on enhancements to the workability of the offices. The entire building is completely ADA accessible, and protecting patient privacy was the driving factor behind many of structural design concepts.

UHA decided to embark on building the new facility to address a need in the community for greater access to high-quality primary care and other services, available at a single location.

Construction is on schedule, and the facility is expected to be completed in the fourth quarter of 2018.

Left: The front face of the building, taken March 2018.



Right: A floor plan of one of the first floor pods.

ADDICTIONS

My Path

In 2017, UHA entered into a partnership with Adapt, our area substance abuse treatment organization, to offer a tobacco cessation program to OHP members. The program included offerings of group sessions, as well as one-on-one counseling for adults and adolescents 13 years of age and older. Six people sought treatment, with all of them opting to utilize the one-on-one method.

Quit for Life

In 2017, UHA adopted an innovative approach aimed at helping our members battle nicotine addiction. The Quit for Life program includes an easy to use workbook, 24/7 phone, online and text support, and, if necessary, nicotine replacement therapy. The program helps participants quit tobacco usage at their own pace, conquer urges to smoke, and use medications so they really work. Quit for Life is available at no cost to UHA members.

Substance Abuse Screenings

In 2017, both of Umpqua Health's clinics (Umpqua Health—Harvard and Umpqua Health—New Clinic) increased efforts to screen patients for signs of a substance abuse disorder. This type of screening had been performed previously on a smaller scale, but positive benefits for both patients and providers led Umpqua Health to increase the screenings. In 2017 providers at both clinics began to screen all patients at a minimum of an annual basis. If the screen reveals a substance abuse disorder, our providers will work with the patient to get them the help they need. The idea behind the screenings is that identifying needs and coordinating care allows us to treat the whole patient.

MENTAL HEALTH

Alternative Health Classes

In 2017, UHA partnered with Optimal Health Management to offer Alternative Health Classes. These classes provide a range of alternative wellness options, including meditation, mindfulness, guided imagery and movement techniques. The free classes are open to the public, and focus on methods to cope, manage symptoms and manage stress. In 2017, classes were attended by a total of 294 community members overall. 99% of people who attended the classes indicated that the classes were a benefit to them. 32.5% reported a reduction in pain, a 48% reduction in stress, 44% drop in anxiety, 33% reduction in depressed feelings, and a 37.5% decrease in the urge to use a negative coping method. The partnership is continuing into 2018.

Alternative Health Classes Participant Quotes:

"I feel like a get a year of therapy from one class, feel wonderful."

"Highlight of my week. Valuable skills for self-care. Keep up the wonderful classes!"

"Just what I needed to rest and become more aware."

"Before class I feel not good, not good, after class I feel good, feel good."

Community Collaborations

Umpqua Health Alliance is committed to the Triple Aim, but we know it isn't a goal achieved alone. Through community collaborations, UHA staff is working on several avenues to impact the mental health of our members. UHA has formed an interdisciplinary team that meets twice a week to discuss members with high needs. This team also holds a monthly meeting where external organizations who work with these members are invited to discuss these cases, including items like medications or discharge plans. In addition, UHA staff is working closes with members from Douglas CARES, Advantage Dental, and DHS to ensure that all necessary screenings, including mental health exams, are completed during a one-stop-shop type of appointment. We are also currently working with community partners to sponsor free provider trainings, including a partnership with our area ER to organize a training regarding the ED Disparity Measure. Through our work with community partners, we are able to impact mental health in Douglas County.

MENTAL HEALTH

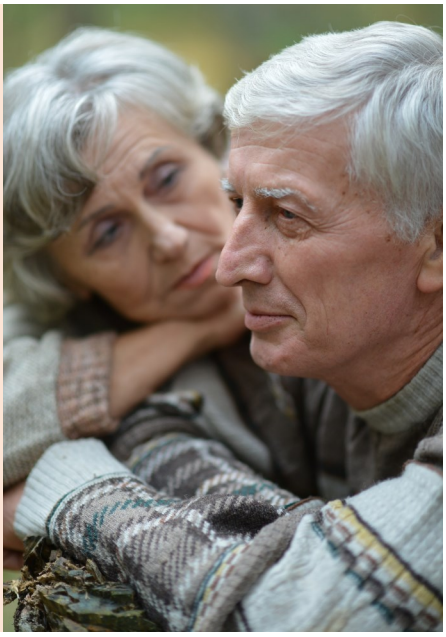
Safer Futures

In August of 2017, UHA entered into a partnership with the Battered Persons' Advocacy to support the Safer Futures Project. The primary goal of the Safer Futures Project is to partner with healthcare providers to improve the mental and physical health and safety of women and children exposed to intimate partner violence. The partnership between UHA and BPA

specifically aims to build capacity to be responsive and provide holistic services specifically for pregnant and new mothers, addressing their unique needs and significant risk of injury. While providing traditional services such as safety planning and assessment, the project also seeks to provide non-traditional services such as prenatal yoga, art-based support groups, breastfeeding education, and Doula services. Pregnancy is an especially dangerous time for people in abusive relationships, and abuse often being or escalates during the pregnancy. This is especially troubling because research reveals that intimate partner violence during pregnancy is associated with adverse newborn outcomes, including low birth weight and preterm birth, as well as long-term health effects on children. Additionally, complications during pregnancy include low weight gain, anemia, infections, and first/second trimester bleeding. Between August 2017 and January 2018, this project served 27 people, including one expectant teen, seven expectant women, and 19 parenting women.

Depression Screening

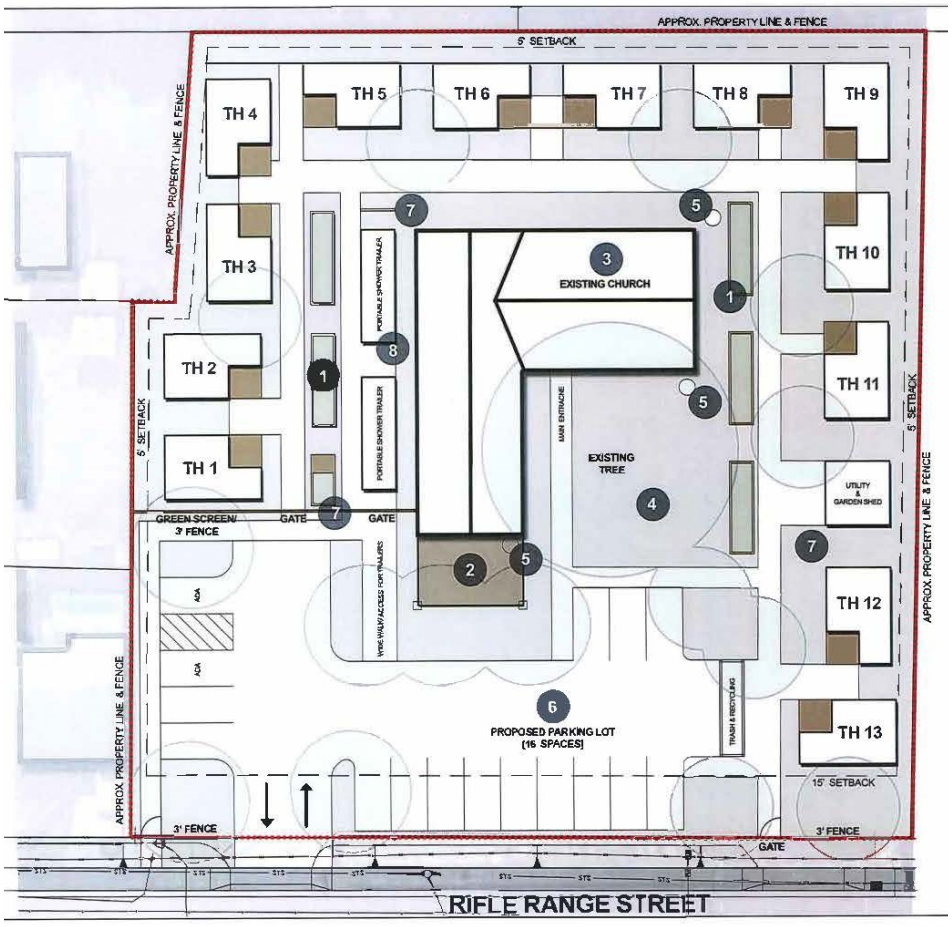
In 2017, both Umpqua Health—Harvard and Umpqua Health—New Clinic increased their use of depression screenings. These screenings are a series of questions that are designed to determine if there is a need for a follow up regarding depression. Our clinics began this type of screening in 2012 on a small scale, but realized it was needed to treat the whole patient. They're now being done with every patient on at least an annual basis, more often if the provider feels that a patient needs an additional screening. If a patient indicates a high risk for depression, their provider then discusses this with the patient and our offices coordinate the additional care needed.



MENTAL HEALTH

NAMI Clubhouse

UHA is working with the Douglas County chapter of the National Alliance on Mental Illness (NAMI) to establish a Clubhouse. A Clubhouse is a place for individuals living with mental illness to find opportunities for friendship, employment, housing, education, and access to medical and psychiatric services in a single and caring environment. This Clubhouse will follow the Clubhouse International model. This partnership began in spring of 2018, and NAMI representatives plan to have the Clubhouse operational by the end of the calendar year.



Tiny Home Village

In spring 2018, UHA entered into a partnership with several local organizations working to establish a Tiny Home Village in Roseburg. The tiny home village plans include space for 13 dwellings, as well as an onsite engagement center. Each tiny home will feature a kitchenette and shower, and onsite facilities will include a community kitchen, gardens, classrooms, computers, laundry services, and more. One of the tiny homes will be reserved for a veteran, while the other 12 will be open to all populations.

PARENTS & CHILDREN

Adverse Childhood Experiences

In 2017, UHA began working with several other local entities to organize a Resilience Summit. The organizing entities, including UHA, felt that the provider community in our service area is aware of Adverse Childhood Experiences, and how ACEs determine the likelihood of the 10 most common causes of death, and a person with six or more ACEs dies 20 years earlier on average than those without ACEs. But what wasn't talked about as much was how to incorporate trauma informed care into the medical office setting. The goal of the summit was to teach providers and office staff how to integrate ACE and TIC practices into everyday care in the medical office setting. UHA was a proud sponsor of the 2018 Resilience Summit, a free, full day event. 450 participants registered for the event.

This photo shows a section of the audience at the 2018 Resilience Summit, held in Canyonville on April 25.

In addition to the 2018 Resilience Summit, UHA partnered with the Creating Community Resilience team, led by our local violence prevention agency, the Battered Persons' Advocacy. This partnership worked to establish a program to implement Adverse Childhood Experiences Trauma Informed Care practices across all sectors by embedding a trauma informed culture into practices in Douglas County. Three Trauma Informed Pilot Projects were established, including Cow Creek Health & Wellness center, Phoenix Charter School, and Battered Persons' Advocacy.

PARENTS & CHILDREN

Early Learning Hub

CAC representatives continue to engage with the South Central Early Learning Hub to identify opportunities of collaboration. Several UHA members attend Early Learning Hub meetings, and are voting members of both the Professional Advisory Council and the Governance Board. In 2017, UHA entered into a partnership with our area Early Learning Hub and our regional Parenting Hub to offer free parenting education opportunities, as well as parent-child social groups that promote kindergarten readiness and social-emotional competency. In the fall of 2017, 18 families attended Play2Learn series opportunities, and 18 parents attended a Growth Mindset workshop. We are continuing this partnership in 2018, doubling the number of both series and workshops offered to parents.

Partner Sports Camp

Through a partnership with the Douglas Education Service District, UHA is sponsoring the 2018 Partner Sports Camp. This program is a summer camp atmosphere for children with intellectual, developmental, physical or mental health needs. Campers are paired with a volunteer student, and are encouraged to form relationships through the facilitation of positive interaction in a structured strength-based environment. Campers go fishing, hiking, and participate in structured activities throughout the two week camp.

Full Tummies, Happy Kids

UHA partnered with the FISH Pantry, a local food pantry, to provide funding for an increase in infant supplies. Before our partnership, FISH Pantry clients with children under one year of age received diapers, wipes and formula for two to three days. This partnership allowed the FISH Pantry to double their food, diaper and wipe supply for clients with infants. This project served roughly 225 infants per month from August-December of 2017.

Breastfeeding Class Series

UHA is working with Umpqua Valley Breastfeeding Coalition members to present six separate series of Breastfeeding Education Classes to new parents free of charge throughout Douglas County in 2018. This research-based lactation education curriculum includes how breastfeeding works, hunger cues, accessing support, and more.

PARENTS & CHILDREN

Community Youth Tennis Development

UHA is partnering with the Umpqua Valley Tennis Center to offer a free introductory tennis program for youth in Douglas County. This partnership provides four introductory tennis series throughout 2018. Each series can accommodate 18 participants, and features a class each week for eight weeks, and a tournament on the ninth and final week. This class is open to any youth who are not members of Umpqua Valley Tennis Center. The first series began in February 2018. Participants are also given a new tennis racquet and balls, as well as other incentives.

Food Hero at the Farmers' Markets

In 2018, UHA began a partnership with United Community Action Network (UCAN) to grow the capacity for a program that encourages youth and their families to attend their local farmers' market. Participants are given a "passport" and receive stamps for attending the farmers' market and engaging in activities, like trying new fruits and vegetables. With UHA support, program managers have doubled the number of farmers' markets that offer Food Hero to youth. Families also receive a reusable grocery bag, a healthy cookbook, and vouchers to obtain fresh food or plant starts. The program is free of charge and open to all youth.

Targeted Donations

In addition to the project funding recommended by the Community Advisory Council, Umpqua Health Alliance also has a funding stream for targeted donations designated through an internal process. In 2018, UHA resolved to align this funding with the goal of supporting children and families throughout our service area. So far this year, UHA has helped to sponsor a Community Baby Shower, several high school sports teams, the Umpqua Valley Youth Orchestra, and more.

HEALTHY LIFESTYLE

Mobile Food Market

Umpqua Health Alliance is working with several organizations, including the Mercy Foundation, Blue Zones Project—Umpqua, OSU Extension office, and others to collaborate on a Mobile Food Market. The organizations are retrofitting a vehicle to carry groceries to identified food deserts. The Mobile Food Market will travel to Glendale, Sutherlin and southeast Roseburg each once a week, bearing local fresh, seasonal produce. Volunteers with the MFM will also offer free cooking demonstrations.

Double Up Bucks

Umpqua Health Alliance is partnering with South East Roseburg Voices In Community Enhancement (SERVICE) to double the food benefits for low-income families who shop at the Southside Community Farmers' Market. This program allows people to double their SNAP benefits, up to $10, at the market every Tuesday evening from June through October 2018. The program also offers cooking classes with recipes featuring the available produce at least once a month during the market's regular hours.

Total Health Improvement Plan Classes

In 2017, Umpqua Health Alliance worked with Umpqua Community Veg Education Group (UC VEG) to offer Total Health Improvement Plan classes. The free classes are open to the public, and focus on helping participants reduce disease factors by improving dietary choices, enhancing daily movement, increasing social support and decreasing stress. UC VEG began a 12-week THIP series in August of 2017, which 144 individuals attended. Of those, 88% saw at least some weight loss while 25% lost at least 5% of their body mass, 37% had a significant change in blood Lipids, and 43% had a significant change in their HbA1c numbers. This partnership is continuing into 2018, with 104 participants graduating from the first series, that began in January. The second series will be completed at the end of June.

HEALTHY LIFESTYLE

Kitchen Garden Project

In 2017, Umpqua Health Alliance worked with Neighborworks Umpqua to sponsor the build of 15 raised-bed vegetable gardens for individuals or families identified as being in need of food assistance. Participants receive the soil, seeds, starts and all necessary supplies (as well as physical help building the beds), along with nutrition and gardening education help for two years. 100% of 2017 project participants report that they plan to continue gardening, and that gardening helps them reduce their stress. 85% report spending more time outside, and 70% say they were able to share what they grew with others. Neighborworks Umpqua elected not to offer this service in 2018, so Umpqua Health Alliance is partnering with Umpqua Community Veg Education Group (UC VEG) to continue supporting this project. In 2018, UHA has provided funding for 20 individuals or families to participate in this program.

Small Group Shopping Tours

For the first time, UHA is working with UC VEG to offer small group shopping tours. These free tours help participants understand how to read food labels, navigate the bulk food section, learn ways to eat healthy on a budget and exploring new options for cooking. Attendees also receive a resource kit with shopping lists, cooking charts, and more.

Meals on Wheels

In 2018, Umpqua Health Alliance contributed significantly to the Friendly Kitchen/Meals on Wheels. The Friendly Kitchen serves a hot, nutritious lunch every weekday at a central location in Roseburg, while the Meals on Wheels program delivers a hot meal Monday through Friday to homebound adults. UHA's financial contribution in 2018 represents 10% of the organization's operating budget for the year.

HEALTHY LIFESTYLE

Kick Start Douglas County

In 2017, Umpqua Health Alliance partnered with YMCA of Douglas County and several other organizations to bring to life Kick Start Douglas County, a project that supports healthier lifestyle choices by offering free community-wide health and fitness events. 15 unique activities were offered at least weekly throughout the programming period. Zumba in the Park saw the most participants, with over 750 people taking part. 715 people reported participating in community swim events, and 700 people attended one of the health fairs. Altogether, more than 3,200 people participated in at least one activity offered in Kick Start Douglas County. 88% of participants who completed a post-program survey reported seeing health improvements because of Kick Start Douglas County, and 82% said they would continue to participate in healthy activities beyond Kick Start Douglas County.

Healthy Living Challenge

UHA worked with the YMCA of Douglas County to sponsor the Healthy Living Challenge. This 12-week program offered participants access to the Roseburg YMCA, as well as nutrition and exercise coaching and plans, all at no cost to the participants. 71 people took part. In the fall session, 56% reported weight loss, with an average Body Mass Index decline of 1 and an average body fat reduction of 1.65%.

Blue Zones Project—Umpqua

Umpqua Health is a proud sponsor of our area Blue Zones Project. In addition to providing a substantial portion of the financial contributions, Umpqua Health also has representatives involved in several layers of leadership with the BZP–Umpqua initiative. Additionally, Umpqua Health is evaluating the possibility of adopting Blue Zones practices internally, in order to satisfy the requirements to take the Blue Zones Worksite Pledge and become a Blue Zones Approved Worksite.

If there's one certainty in health care, it's change. As we look to the future, there are exciting transitions coming to Umpqua Health Alliance: completing work on our new building, a deeper focus on efforts that impact social determinants of health, and beginning work on a new Community Health Improvement Plan. But through these changes, one thing remains constant: Umpqua Health Alliance is committed to serving our members, and helping our community become healthier.

We understand that we have been tasked with the transformative work of providing better care, improved health and lower costs for our members, and we are excited to continue exploring new opportunities to realize this goal.

UMPQUA HEALTH
ALLIANCE

CCO Community Health Improvement Plan Progress Report Guidance

The purpose of this document is to guide CCOs in addressing contractual requirements for the community health improvement plan (CHP) progress report submission per **Exhibit B, Part 1, #4 (pages 29-31)**, **Oregon Revised Statute 414.627**, **Oregon Administrative Rule 410-141-3145** and **Senate Bill 902** (effective 2015).

A. The CHP progress report is due to the Oregon Health Authority's Health Systems Division (CCO.MCODeliverableReports@state.or.us) by June 30, 2018.

B. Two documents are required to complete your annual progress report:

    1) The progress information noted in item C below; and

    2) The completed template (pages 2–6 of this document) as an appendix to the progress report.

C. The annual progress report should document progress made in implementing the CHP. This could include the following:

    1. Changing health priorities, resources or community assets;

    2. Strategies being used to address CHP health priorities;

    3. Responsible partners involved in strategies; and

    4. Status of the effort or results of the actions taken.

Key Players in Child and Adolescent Health

1. **Which of the following key players are involved in implementing the CCO's CHP? (select all that apply)**
   - ☒ Early Learning Hubs
   - ☐ Other early learning programs[1]
     Please list the programs:
   - ☒ Youth development programs[2]
     Please list the programs: Partner Sports Camp, Community Youth Tennis Development
   - ☒ School health providers in the region
   - ☒ Local public health authority
   - ☒ Hospital

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	☐	☐	☐	☒	☐

Optional comments:

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.*

   We are partnering with the Early Learning Hub in our region on initiatives that impact parents and children, including offering multiple parent education opportunities.
   UHA is partnering with the Douglas Education Service District to help sponsor Partner Sports Camp, a summer camp for children with intellectual, developmental, physical or mental health needs.
   UHA is has close partnerships with several agencies that work to deliver health services to school-aged children, including our local Education Service District, our area Head start, and others.
   UHA also works with Umpqua Community Health Center, an entity which provides services at school-based health centers in Douglas County

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*

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

CCO has reached out to the school district.

- ✓ *CCO is planning to develop next CHA and CHP in partnership with early learning partners.*

UHA did not work with the Early Learning Council or Youth Development Council, as we do not have representation on these two councils in our service area.

Health Priorities and Activities in Child and Adolescent Health

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.**

Much of our work since July 1, 2017 has centered around Adverse Childhood Experiences and Trauma Informed Care practices. UHA helped sponsor and plan a Resilience Summit, a cross-sector discussion on ways to incorporate ACE and TIC practices into the medical practice/workplace. 450 people registered for the event. UHA also helped to sponsor a community effort to bring the Sanctuary Model to Douglas County to embed a trauma informed culture into three pilot sites. These efforts will undoubtedly lead to improved coordination of care, specifically trauma informed care, for children and adolescents in the community.

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

Examples:

- ✓ *CCO has connected 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.*
- ✓ *CCO is focusing on transition age youth (15-26) for service coordination needs in that population.*

UHA partnered with several other organizations to sponsor and plan the 2018 Resilience Summit.
UHA helped to sponsor an effort to bring the Sanctuary Model of care to three identified Trauma Informed Pilot Projects.
UHA is working with the South Central Early Learning Hub to offer several parent education opportunities.
UHA provided funding to a local food bank to double the amount of formula, diapers and wipes given to clients with infants.
UHA is sponsoring multiple Breastfeeding Class series, to be held throughout Douglas County.
UHA is engaged with the Douglas Education Service District to offer Partner Sports Camp, a summer camp that partners children with intellectual, developmental, physical or mental health needs with a volunteer student.
UHA is working with the Umpqua Valley Tennis Center to offer an introductory tennis program to interested youth.
UHA has partnered with the United Community Action Network to grow the capacity for Food Hero at the Farmers' Markets, a program that encourages youth and their families to attend their local farmers' market and try new foods.

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 has cross membership with CAC.*

   UHA is continually working with the South Central Oregon Early Learning Hub on multiple initiatives, and has cross-membership with the CAC.
   A Lead Staff member with Head Start is an active member of UHA's CAC.
   UHA helped to plan and sponsor the 2018 Resilience Summit, which had more than 450 people registered from multiple sectors, including health care, education and social services.

Health Disparities

8. **For each chosen CHP priority, describe how the CCO and/or CAC(s) have worked with OHA's Office of Equity and Inclusion (OEI) to obtain updated data for different populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data.**
   Examples:
   - ✓ *CCO connected with OEI through its Innovator Agent to assess CCO race and ethnicity data.*
   - ✓ *CAC worked with OEI on community engagement to look at meaningful community health priorities.*
   - ✓ *CCO engaged in one-on-one consultation with Ignatius Bau, OEI and the Transformation Center to identify strategies for achieving measurable progress on equity.*

   UHA has been working with Vanessa Becker to identify data relating to diverse populations within the community, including socio-economic, race/ethnicity, health status and health outcomes data. Once this data is gathered, it will become the updated Community Health Assessment. UHA will work with its CAC members and Innovator Agent to finalize this data tool.

9. **Explain whether updated data was obtained by working with other state or local agencies/organization(s) and what data sources were utilized.**
   Examples:
   - ✓ *CCO engaged with local public health authority or state public health department to collect data.*
   - ✓ *CCO has identified new sources of data to reflect health disparities in the region.*
   - ✓ *New data sources include local public health race/ethnicity data, focus group information, and school-based data.*

   UHA engaged with local Federally Qualified Health Center Umpqua Community Health Center, as well as a local service organization United Community Action Network to gather both qualitative and quantitative data surrounding the health and demographics of our community.

10. **Explain CCO attempts to compare local population data to CCO member data or state data. If data is not available, the CCO may choose to access qualitative data from special populations via focus groups, interviews, etc.**
    In the most recent Community Health Assessment, UHA compared local population data with member data and state data. This was done through several measures, including secondary data collection as well

as focus groups and personal interviews for some priority populations. As UHA nears completion on an updated Community Health Assessment, these methods were also employed.

11. What challenges has the CCO encountered in accessing health disparities data?

One challenge UHA has faced is engaging members in their own healthcare, as well as making connections with members and the community regarding opportunities to benefit from UHA assistance.

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

Examples:

- ✓ *CCO staff sits on local Regional Health Equity Coalition.*
- ✓ *CCO worked with the Adults and People with Disabilities office to increase transportation access to persons with disabilities.*
- ✓ *CCO engaged in community's effort to address poverty through training on poverty in the community and with providers.*

UHA has a partnership with Bay Cities Brokerage to offer free non emergent medical transportation to all of our members.

UHA helped to plan and sponsor the 2018 Resilience Summit, which was free to all participants. More than 450 people registered for the summit. The summit focused on ways to integrate ACE and TIC practices into everyday interactions in multiple sectors.

13. What successes or challenges has the CCO had in recruiting CAC members from populations experiencing health disparities?

Examples:

- ✓ *CAC has 20% engagement from communities of color, similar to our local community.*

Our current CAC member recruitment efforts include considering experience with health disparities, as well as familiarity with one of our priority areas.

Alignment, Quality Improvement, Integration

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

Examples:

- ✓ *CCO endorses LMHA's local plan which is aligned with CCO's CHP.*
- ✓ *CHP is incorporated into the LMHA local plan.*
- ✓ *CCO and LMHA have updated the memorandum of understanding to strengthen the comprehensive local service delivery plan.*
- ✓ *LMHA representative sits on CAC or informs CAC of local plan.*

Umpqua Health Alliance works closely with Adapt and Compass Behavioral Health to ensure the mental health needs of our members are met. Mental health is a key priority of UHA's current CHP.

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

Examples:

- ✓ *CCO is aligning TQS work on cultural competency with health equity focus in CHP.*
- ✓ *CHP focus on health equity is aligned with the TQS health equity component.*
- ✓ *CHP focus aligns with PIP on opioids.*

Many of the goals of the CHP align with work reflected in the TQS and PIPs. For example, a focus area for UHA's CHP work is addictions, including tobacco usage, with directly correlates with a focus area of the TQS.

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

☐ CCO's CHA/CHP is a shared CHA/CHP with LPHAs and/or hospital systems. Note which organizations share the CHA/CHP:
- LPHA(s):
- Hospital(s):

☒ CCO's CHA is a shared CHA with LPHAs and/or hospital systems, but the CCO has a unique CHP. Note which organizations share the CHA:
- LPHA(s): At the time of their creation, what was then known as Douglas County Public Health partnered with UHA to create a shared CHA, but UHA has a unique CHP.
- Hospital(s):

☐ CCO's CHP is a shared CHP with LPHAs and/or hospital systems, but the CCO has a unique CHA. Note which organizations share the CHP:
- LPHA(s):
- Hospital(s):

☐ CCO's CHA/CHP is a unique CHA/CHP from LPHAs and/or hospital systems, but the CCO collaborated with LPHAs and/or hospital systems in their development. Note which organizations the CCO collaborated with:
- LPHA(s):
- Hospital(s):

☐ Other (please describe):

17. If applicable, check which of the State Health Improvement Plan (http://Healthoregon.org/ship) priorities listed below are also addressed in the CHP.

☒ *Tobacco*
☒ *Obesity*
☐ *Oral health*
☒ *Alcohol and substance use*
☐ *Suicide*
☐ *Immunizations*
☐ *Communicable diseases*

Though not all of the areas checked are directly referenced in the CHP, a broader picture of the issue is reflected there. For example, one of the CHP key priority areas is Addictions, which touches on tobacco, alcohol and substance abuse.

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

Examples:

- ✓ *CCO CHP shares one or more priorities with the SHIP.*
- ✓ *CCO used the SHIP to identify evidence-based interventions to include in the CCO CHP.*

UHA's CHP shares several priorities with the SHIP.

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

Examples:

- ✓ *CCO hosted community forums and collected survey information for targeted data on a specific population.*
- ✓ *CCO has worked with local agencies to apply for population based health grants to improve perinatal health.*

UHA and CAC members have worked extensively on programs and projects that benefit not just members, but the community as a whole.

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

Examples:

- ✓ *CCO partnered with local organizations to provide funding for trauma informed care work.*
- ✓ *CCO's CAC and clinical advisory panel formed subcommittee to address integration of oral health services with a focus on the adolescent population.*

One of the most impactful outcomes of UHA's CHP is the resulting community collaborations. Since July 1, 2018, this includes cross-sector trainings for ACE and TIC practices, multiple agencies partnering to begin a campaign to help improve oral health for pregnant women, and a team of interested parties coming together to start a Mobile Food Truck, to deliver groceries to designated food deserts. This transformative work is made possible through efforts by UHA staff and CAC members to realize the vision of the CHP.