CPCCO Supporting Health for All through REinvestment (SHARE) Initiative

Healthy Homes: Increasing the number of tenancy sustaining services through remediation of unsafe or inadequate housing conditions

- Partnership with Community Action programming in Clatsop, Columbia and Tillamook Counties
- Capacity building of existing programming
- Supporting outreach to specific sub-populations

Our Community Partner(s)

Community Action Team, Columbia County

- Partnership with Community Action programming in Clatsop, Columbia and Tillamook Counties
- Long term, established anti-poverty programming in all three counties
- Healthy Homes, 30-year program that there is organizational readiness to increase capacity
- Organizational readiness to explore sustainable funding models for specific programming
- https://cat-team.org/

Project Description

Healthy Homes

- Provide home assessments, no cost repairs and/or enhancements to the home environment.
- Focus on OHP recipients for whom the home environment may negatively affect their health.
- Provide mitigation of health condition contributors, reduction of symptoms, increase health and decreased health care needs and costs.
- Support navigation to supports and services in the health and social systems of care.

SMARTIE GOALS

Healthy Homes

S	M	A	R	T	I	E	Final
Specific. What is it you want to achieve? (Five Ws can help)	Measureable. How will you know when you hae achieved your goal? How much/how many?	Action-oriented. To keep you motivated, are there identifiable actions or milestones?	Relevant. What results can be achieved given your available resources?	Time-Bound. What is an appropriate deadline?	Inclusive. How will you include traditionally marginalized people into processes, activities, and decision-making in a way that shares power?	Equitable. How will you include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression?	What is the full language of the draft SMARTIE goal?

Healthy Homes SHARE Initiative

Year One SMARTI Goals

Goal #	S	M	A	R	T	I	E	Final
	Specific. What is it you want to achieve? (Five Ws can help)	Measurable. How will you know when you have achieved your goal? How much/how many?	Action-oriented. To keep you motivated, are there identifiable actions or milestones?	Relevant. What results can be achieved given your available resources?	Time-Bound. What is an appropriate deadline?	Inclusive. How will you include traditionally marginalized people into processes, activities, and decision-making in a way that shares power?	Equitable. How will you include an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression?	What is the full language of the draft SMARTIE goal?
1	Hire/Assign dedicated staff to support program capacity building	1.0 FTE for the region dedicated to HH program.	All three community action programs are aware of grant and FTE focus, how to be involved.	Build towards creating awareness and connecting to new resources for referrals	End of month three of funding.	Community Action programs in all three counties begin promotion to their clients.	Strategic planning begins to promote programming to sub-populations	By the end of month 3 1.0 FTE for the region is dedicated to the HH program and strategic planning occurs to promote programing to identified sub-populations.
2	**Update marketing communication materials in Spanish and English**	**Vendor and process have been identified including peer review group for all HH materials.**	**Vendor for translation and interpretation identified. Process in place for peer review.**	**Increased awareness in identified sub-populations on how to support access to programming.**	**End of month six of funding.**	**Peer review participants identified and given stipend to participate in short term focus group.**	**Participatory Action Research model deployed to create materials and offer translation/interpretation.**	**By the end of month 6 marketing and communication materials are available in Spanish and English with input from identified sub-populations.**
3	Create formal agreements with cross-sector partners. Could include partners who will refer into the program, Habitat, or contractors.	Three LOAs per county, in all three counties, for a total of nine.	LOAs signed; minimum partnership needed to close loops in each county.	Can be achieved in each county; is a necessary milestone in ability to complete projects in each county.	End of month 9 of funding.	Should ideally include at least one organization that partners with CPCCO and CAT in the RHIP priorities. Can use stories or COVID emergency funds to identify.	At least one of the organizations should explicitly serve: Latinx/o/a community, survivors of intimate partner violence, those with intellectual or physical functional difficulties, and/or OHP members.	By the end of month 9, sign at least 9 LOAs (3/county), including organizations that partner in meeting RHIP priorities and those who serve Latinx/o/a community, survivors of intimate partner violence, those with intellectual or physical functional difficulties, and/or OHP members

4	**Adoption and use of Connect Oregon to refer members into Healthy Homes.**	**Receive a minimum of 5 referrals per county on Connect Oregon, closing the loop (responding to sender) on 3 of 5 referrals. Would total 15 received referral, with 9 receiving a response.**	**Milestones could include receiving the first referral in each county, closing the loop on the first referral in each county, other measures that CO was used effectively. Could also include a marketing effort that reaches local CBOs on the network.**	**Is free and includes technical assistance both from Unite Us and from CPCCO as needed.**	**End of month six of funding.**	**Referrals should come from partner organizations who serve OHP members.**	**All referrals should be for OHP members, should focus on referrals for focus populations listed above.**	**By the end of month 6, receive at least 15 referrals through Connect Oregon, responding to at least 9, and with at least 3 coming on behalf of members who identify as part of the focus populations.**
5	Establish supports for low income, Section 8 housing that is run by NOHA.	Complete at least one "use case" Healthy Homes project that occurs in a NOHA housing unit and community mental health programs housing programs.	Milestones could include signing an LOA with NOHA, and establishing a workflow when needs are identified.	NOHA serves all three counties and maintains multiple properties that serve OHP members and those who are underinsured or uninsured.	End of month 12 of funding.	Most who qualify for housing through NOHA are OHP members and are disproportionately likely to belong to other focus populations as well. Would be ideal to include either stories or input from affected tenants in workflow development.	Workflow can and should include considerations specific to the needs of focus populations including wheelchair accessibility, the use of interpreters during case assessment, and consideration of trauma-informed workflow for those who have experienced violence and trauma.	By the end of month 12, complete at least one "use case" in a NOHA housing unit, using a process that is considerate of the needs of focus population members.
6	Successful projects completed in all three counties.	Complete at least one "use case" per county that establishes county-specific workflows and considerations.	Milestones could include signing LOAs with key partners, establishing county-specific or need-specific workflows. Particular focus on the expansion to Tillamook County.	One project per county (can include the NOHA use case) allows for footprint establishment and relationships to be built that will be necessary to function at an expanded level.	End of month 12 of funding.	Each county is unique in terms of resources available and the situations of those most likely to need referrals. Test cases will help inform scope expansion inclusively.	Community Based Organizations in the region are using the Connect Oregon platform to refer to specific programming and are aware of supports to access for english as a second language participants.	By the end of month 12, complete at least one "use case" in each county, using a process that is considerate of the needs of focus population members and their communities.
7	**Dedicated time to explore sustainability through Value Based Payments once SHARE funding has finished.**	**Complete at least two meetings with CPCCO staff to strategize, plan, and set goals regarding ramp-up to Value Based Payments.**	**Milestones could include setting each meeting, completing the first meeting, any "homework" between meetings, and completing the second meeting.**	**Sustaining a region-wide program will require a shift away from grant-based payment towards contract-based payment, particularly considering that liens can't be put on NOHA housing. Technical support and partnership with CPCCO is available in the design of the VBP arrangement.**	**End of month 12 of funding.**	**Ensuring continuity and quality improvement in the long term requires sustainable funding. Can/should include opportunities for feedback and partnership with focus population into the contracting process.**	**Contracting can/should "price in" varying levels of need that are most likely to come up for the focus populations in order to maintain fairness in payment. Could include levels of THW involvement, consideration of ED use averted, etc.**	**By the end of month 12, complete at least two meetings between CAT and CPCCO to strategize, plan, and set goals in building a glide path to long-term Value Based Payment upon completion of SHARE Initiative payment.**

Project Objectives

Healthy Homes

- Improve target population health quality and health outcomes in ways that measurable
- Be grounded in evidence-based criteria
- Reduce health disparities among specified populations
- Align with goals of the Regional Health Improvement Plan
- Address the need to provide supports to maintain tenancy
- Address the social determinants of health and health equity

Project Deliverables

Healthy Homes

- Work with OHP clients, including dually eligible Medicare/Medicaid clients, to make needed housing renovations to improve substandard living conditions and mitigate adverse health effects resulting rom the home in order to maintain tenancy
- Accept program referrals through Unite Us
- Extend outreach and enrollment in each of the three service area counties
- Verify and report on enrollment status of clients utilizing the program
- Work with CPCCO staff to develop value-based payment structure for Healthy Homes program
- Transition current grant-funded model to a value –based (pay for outcomes) payment contract

Thank you

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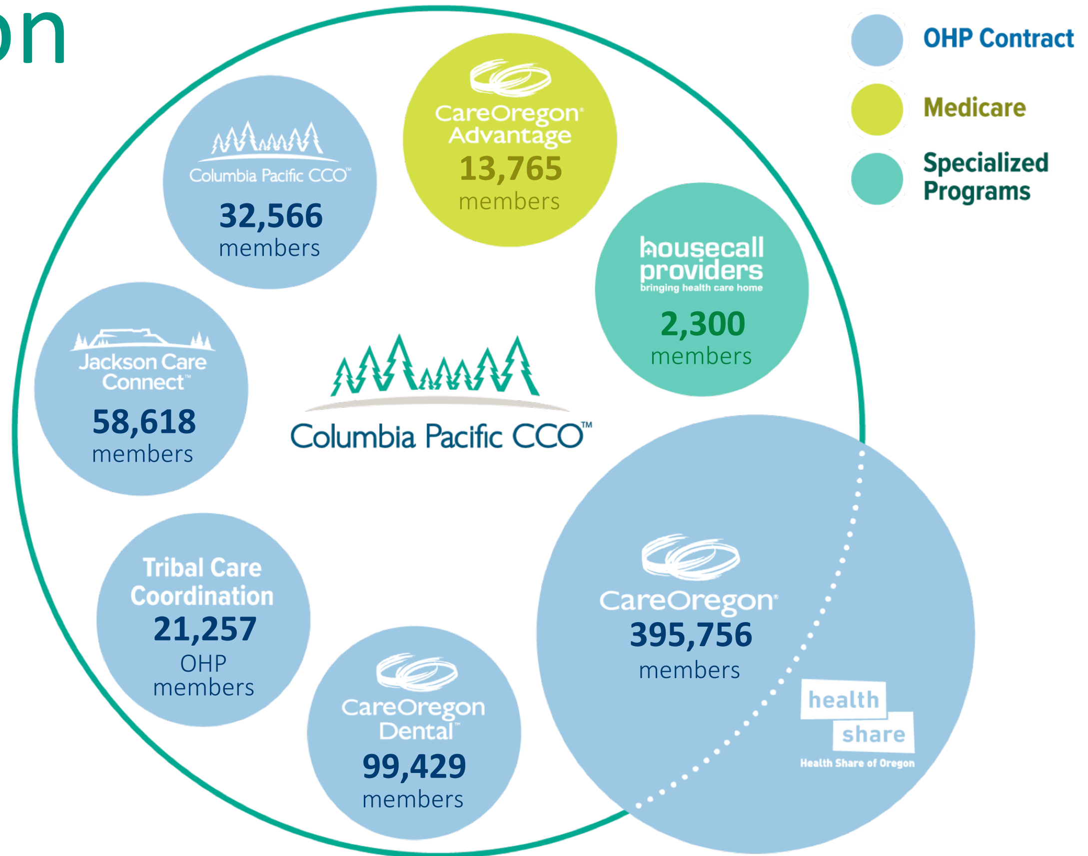
About Columbia Pacific CCO

Columbia Pacific CCO is proud to serve all Oregon Health Plan members living in Clatsop, Columbia and Tillamook counties. As a nonprofit coordinated care organization (CCO), we provide physical, dental and mental health care through a growing network of healthcare providers. Our priorities are guided by our local board of directors, community advisory councils and clinical advisory panel, and are informed by extensive community engagement. Columbia Pacific is committed to promoting the health of all those in our region. We especially focus on increasing access to language services, offering treatment for those experiencing substance use disorders, and fostering connections that promote social health. Columbia Pacific, part of the CareOregon family of companies, has offices in Seaside.

The CareOregon Family

For more than 25 years, CareOregon has offered health services and community benefit programs to Oregon Health Plan members. Today, we support the needs of over 500,000 Oregonians through three coordinated care organizations, a Medicare Advantage plan, a Tribal Care Coordination program, a dental care organization, and in-home medical care with Housecall Providers. CareOregon members have access to integrated physical, dental and mental health care, and substance use treatment. We believe that good health requires more than clinics and hospitals, so we also connect members to housing, fresh food, education and transportation services. CareOregon is a mission-driven, community non-profit with offices in Portland, Medford and Seaside, Oregon.



*** Membership numbers updated as of October 1, 2021