WHOLE CHILD HEALTH ALLIANCE

Advancing the Key Elements of Whole Child Health: Oregon Case Study

NEMOURS CHILDREN'S HEALTH

Table of Contents

Authors

Laura Hogan, MA, Consultant, Laura Hogan Consulting

Hannah Wagner, MPP, Senior Advisor, Policy Development and Partnership, Nemours Children's Health

Daniella Gratale, MA, Associate Vice President, Federal Affairs, Nemours Children's Health

We would like to thank the following individuals for participating in an interview, contributing content, and/or reviewing this paper.

Ignatius Bau, JD, Health Equity and Policy Consultant

Betsy Boyd, MA, Senior Associate Vice President for Federal Affairs, University of Oregon

Resa Bradeen, MD, MEd Chief Medical Officer, Metropolitan Pediatrics, LLC

Shannon Buckmaster, MDiv, PhD, Candidate, Wellness Fund Development Director, Yamhill Community Care

Maria Elena Castro, MBA, MEd, Health Equity Innovation and Implementation Unit Manager, Equity and Inclusion Division, Oregon Health Authority

Chris DeMars, MPH, Director, Delivery System Innovation Office, Oregon Health Authority

Danielle Droppers, MSW, Regional Health Equity Coalition Program Manager, Equity and Inclusion Division, Oregon Health Authority

RJ Gillespie, MD, MHPE, Pediatrician, The Children's Clinic

Stephanie Jarem, MAT, MPH, Director, Office of Health Policy, Oregon Health Authority

Peg King, MPH, MA, Child and Family Portfolio Manager, Health Share of Oregon

John Kitzhaber, MD, Former Governor of Oregon and Chair of Health Policy, The Foundation for Medical Excellence

Jennifer Laine, Early Learning Director, Yamhill Community Care

Cat Livingston, MD, MPH, FAAFP, FACPM, Medical Director, Health Share of Oregon

Seamus McCarthy, PhD, President and Chief Executive Officer, Yamhill Community Care

Suzanne McClintick, MD, Pediatrician, Childhood Health Associates of Salem

Marina Merrill, PhD, Director of Research & Strategy, Children's Institute

Colleen Reuland, MS, Director, Oregon Pediatric Improvement Partnership

Deborah Rumsey, Executive Director, Children's Health Alliance

Katie Unger, MPH, Children, Youth & Families Program Manager, Health Share of Oregon

Andi M. Walsh, JD, LLM, MSW, Senior Health Policy Advisor, Children's Institute

Courtney Westling, MPA, Senior Director of Public Affairs, The Ballmer Institute for Children's Behavioral Health at the University of Oregon

Kevin Wu, JD, MPP, Former Domestic Policy Advisor, Office of Senator Wyden

We would also like to thank the following individuals for reviewing this paper:

Suzanne Bierman, JD, MPH, Managing Director, Sellers Dorsey

Elisabeth Wright Burak, MPP, MSW, Senior Fellow, Center for Children and Families, Georgetown University

Allison Gertel-Rosenberg, MS, Vice-President, Chief Policy and Prevention Officer, Nemours Children's Health

Jeff Stellar, MSc, Director, Research and Innovation, Office of Population Health, Cincinnati Children's Hospital

Josh Traylor, MPH, Executive Director, Center for Health and Research Transformation

Kara Odom Walker, MD, MPH, MSHS, FAAFP, Executive Vice-President and Chief Population Health Officer, Nemours Children's Health

David Willis, MD, Senior Fellow, Center for the Study of Social Policy

Introduction

Whole child health engages multisector partners to support the developmental, physical, mental, behavioral health and social needs of children and youth, and foster healthy relationships with caregivers through individual, family-based, and community-level approaches. Whole child health *integrates eight key elements* that represent essential components of holistic, family-centered approaches that support optimal health, development and well-being.

This case study takes a deep dive into Oregon's whole child health approach, which coordinates health care, education, and social services to foster the development of lifelong health and success for children and families. Oregon founded its effort on a state-level policy vision that prioritizes prevention and cross-system integration. Its approach also prioritizes early childhood. Oregon's approach is grounded in community-led initiatives that strive to meet local needs and advance health equity. Over time, the state has built and improved upon early efforts, implementing requirements and financial incentives for providers and payers that have resulted in long-term investment in whole child health, including targeted efforts to address social drivers of health and narrow health disparities.

This case study from the *Whole Child Health Alliance* is a companion to recently released case studies of Massachusetts, North Carolina, and Washington described in *Advancing the Key Elements of Whole Child Health: State Case Studies and Policy Recommendations* and its corresponding *Executive Summary*.

Background

Oregon used sequential 1115 waivers, state plan amendments, and state legislation to advance integrated delivery systems and incentivize value in pediatric health care.

Oregon has a long history of innovation to improve access to health care and to prioritize prevention through whole-person approaches. Beginning in the late 1980s, *efforts to address the rising cost of health coverage* and the high rates of uninsured led to a series of legislative steps to create a matrix of public and private insurance options to expand coverage.

In the early 1990s, Oregon launched the Oregon Health Plan, a set of Medicaid policies authorized through an *1115 demonstration waiver*. The *Oregon Health Plan*, which was originally conceived of and championed by Former Oregon Governor and emergency room physician, John Kitzhaber, MD, expanded Medicaid eligibility, created the *Prioritized List of Medical Conditions and Treatments*, and implemented Medicaid managed care with the goal of creating a more equitable, accountable and transparent method of allocating public dollars that focused on population health.[1] The 2012–2017 1115 Waiver marked a significant step forward by enrolling most of Oregon's Medicaid members into 16 *Coordinated Care Organizations (CCOs)* that administer the Oregon Health Plan across the state (see the box on CCOs for more information). Subsequent 1115 waiver amendments advanced Medicaid transformation by keeping with the established whole-person, equity-centered approach and foundational principles of prevention and access for all. Subsequent state administrations continued efforts to lower costs, improve quality, and increase access through the use of 1115 waivers, State Plan Amendments

1 Until 2023, the Centers for Medicare and Medicaid Services (CMS) waived Oregon from the federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirement since the state managed coverage through the Prioritized List of Medical Conditions and Treatments. This list included Medicaid services determined by the legislature and a commission of medical experts. The state chose not to renew this waiver based on public feedback, and Oregon is no longer waived from the EPSDT mandate.

(SPAs), federal *State Innovation Model* (SIM) grants, state regulatory changes, and legislative measures that built on the original vision.[2,3] Importantly, in many instances, even when reforms did not specifically target the pediatric population, significant benefits have accrued to children.

The *current 1115 waiver*, which will be active from 2022–2027, makes Oregon the *first state to continuously enroll children* in Medicaid from birth to age 6. It also extends and clarifies CCO flexibility to invest in services that address social drivers of health, such as food assistance and housing supports. Children also benefit from a single online application enrollment system for medical, food, cash and childcare benefits.[4]

Coordinated Care Organizations
CCOs, which operate similarly to managed care organizations, are the backbone of Oregon's efforts to improve health outcomes and slow the rate of increasing health care costs. The Oregon Health Authority finances CCOs through flexible global budgets, which hold the CCO accountable for paying for and coordinating physical, developmental, behavioral, and oral health services, as well as providing some services to address social needs. CCOs have the opportunity to gain significant incentive payments for meeting health and developmental performance metrics. An important distinction between CCOs and managed care organizations is that CCOs are locally governed by Medicaid members, providers and other stakeholders.

Oregon's Approach to Promoting Whole Child Health

1. Financial Incentives, Flexibilities and Accountabilities that Address Social Needs and Promote Health Equity

The Oregon Health Authority (OHA) coordinates the state's health-related programs, including the Oregon Health Plan (i.e., Medicaid). Specifically, OHA oversees financial incentives and quality improvement accountabilities for the Oregon Health Plan to achieve prevention and equity goals. In 2020, OHA launched the *Value-Based Payment Roadmap*, which is a key tool to shift the majority of Oregon's Medicaid CCO expenditures away from volume-based payment and into arrangements that promote accountability for quality, cost and equity. The Value-Based Payment Roadmap **advances financing reforms that incentivize optimal health** through performance metrics.

The Value-Based Payment Roadmap requires CCOs to increase the following over time:

- Per member per month payments to Patient-Centered Primary Care Home[5]
- Percentages of CCO's payments to providers in the form of a value-based payment
- Amount of risk-based value payment arrangements as a percentage of total payments to providers
- Percentage of value-based payments in specific care delivery areas, including children's health care

2 A 2012 State Innovation Model award provided support for Coordinated Care Organization technical assistance and implemented global budgets.

3 Approved applications, administrative records, and related documents for Oregon's Oregon Health Plan 1115 waiver are available via Medicaid.gov, here.

4 In 2009, the Center for Medicare and Medicaid Innovation selected Oregon to participate in the Integrated Care for Kids model. Subsequently, Oregon withdrew from the funding opportunity and did not implement the model.

5 Per-member, per-month payments must increase each year over the five-year contract. OHA does not require a minimum dollar amount for the per-member, per-month payment, but the payments should support the clinics' work to provide patient-centered care.

Progress Report: The Path to Pediatric Value-Based Payment
The Center for Health System Effectiveness *reported* on CCO progress toward pediatric value-based payment arrangements. As of December 2022:

- Seven CCOs had at least one children's health value-based payment arrangement.
- Most CCOs incorporated quality metrics related to children or adolescents into existing primary care value-based payment agreements.
- Two CCOs worked with the *Oregon Pediatric Improvement Partnership* to incorporate the 2023 social-emotional health incentive metric into pediatric value-based payment models.
- Other CCOs focused on assessments and preventive care, pediatric inpatient cases, and piloting a total cost of care model.
- One CCO reported having a pediatric clinic terminate a value-based payment 3B arrangement in early 2022, at least temporarily, due to concerns about downside risk exposure.

While the Value-Based Payment Roadmap requires CCOs to make 70% of their payments to providers through value-based contracts by 2024, individual CCOs determine their specific value-based payment arrangements with their contracted providers.[6] CCOs have implemented contracts that include a focus on children's health. For example, CCOs are developing value-based payment contracts for outpatient models of pediatric and maternal behavioral health care that prioritize access for pregnant women and young children and increase wraparound services to all children and young adults. OHA provides *technical assistance resources* to support CCOs in accomplishing value-based payment for children's behavioral health.

Separate from the value-based payment requirements outlined in the Value-Based Payment Roadmap, CCOs have the opportunity to earn significant incentive payments through OHA. The CCO Quality Incentive Program provides bonus payments for improving care based on a set of quality measures recommended services provided by CCOs. The Committee reviews and may add or remove measures that span domains such as prevention, system integration, access and cost. The *Health Aspects of Kindergarten Readiness Measurement Strategy* is a uniquely innovative incentive metric designed to engage health care in improving kindergarten readiness. The measurement strategy includes:

- Well-visits for children ages 3–6
- Preventive dental for children ages 1–5
- System-Level Social Emotional Health Metric
- Follow Up to Developmental Screening

6 OHA promotes value-based payment models through technical assistance, including best practices and issue briefs such as Pediatric Value-Based Care, Social Determinants of Health, and Shifting to Life Course Impact.

Oregon launched the CCO incentive measure set for system-level social-emotional health in 2022 as the final component of the Health Aspects of Kindergarten Readiness strategy. This set of metrics gauges CCO readiness to meet the social-emotional needs of children and families. The Oregon Pediatric Improvement Partnership and the Children's Institute, in partnership with OHA, developed the four *components* of the *System-Level Social Emotional Health Metric*. To receive incentive payments, CCOs must undertake the following activities:

- Review Social-Emotional Health Reach Metric data assessment to understand services being received.[7]
- Asset map provider networks to understand current services available and gaps for historical and marginalized populations
- Conduct CCO-led, cross-sector community engagement to review the data and asset maps and to inform and guide the action plan
- Complete an action plan and implement activities to enhance social-emotional health capacity

2. Focus on Early Childhood

In addition to policy initiatives, such as continuous coverage for children birth to age 6 and incentivizing kindergarten readiness, Oregon's whole child health approach recognizes the benefits of focusing comprehensively on the early years of life. In 2013, Oregon established the *Early Learning Council* through *state statute* to coordinate an early learning system for children ages birth to 8. The council is led by gubernatorial-appointed members. The council oversees 16 regional Early Learning Hubs that bring together local partners, including CCOs, to coordinate across health, education, and social services on behalf of young children. In 2021, Oregon created the Tribal Early Learning Hub to coordinate on behalf of nine tribal nations. The Early Learning Hubs focus on kindergarten readiness, with the aim of holding multiple child-serving sectors accountable to the shared vision of improving kindergarten readiness through pediatric care improvements, data integration, and community engagement.

The Early Learning Council also brought together government leaders across early care and education, public education, higher education, health, housing and human services to develop Oregon's comprehensive state plan for early childhood, *Raise Up Oregon 2024–2028*. The plan has three goals:

- The early childhood system is equitable: integrated, accessible, inclusive, anti-racist, and family-centered.
- All families with young children are supported to ensure their well-being.
- All children are thriving in early childhood and beyond.

The state tracks progress against the goals (including kindergarten readiness) on a dashboard of 40 indicators across state agencies.

> "A healthy America can only be built on a foundation that ensures that every child, family and community has an equitable opportunity to succeed."
>
> **— John Kitzhaber, MD**
> Former Governor of Oregon

7 The metric captures clinically recommended social emotional services, such as Bright Futures, recommended screenings as well as assessment and interventions for children identified with social-emotional issues.

3. Cross-Sector Data Sharing and Integration

Oregon's strategic use of data infrastructure supports population level efforts to advance whole child health. One example is the analysis and dissemination of child health complexity data, a report that combines social and medical data to identify children's overall health complexity.[8] From 2019–2022, OHA produced reports using *Child Health Complexity Data* to support CCOs, providers and communities in their efforts.[9] Some CCOs use the child health complexity data reports to inform their approach to the social emotional metric.

The *Oregon Child Integrated Dataset* is a **cross-sector data partnership** encompassing a child well-being dashboard that uses standardized data use agreements across state agencies, including the OHA, Department of Education, Department of Human Services, Youth Authority, and Integrated Client Services to deliver a whole child dataset, rather than the program-specific view that is more often available. No identifiable, protected information is shared; however, the state can analyze the data to predict individual- and population-level outcomes. These analyses support system efforts to improve whole child outcomes and identify policy change, resource allocation, and service improvement areas.

Oregon leverages *Connect Oregon*, a statewide technology platform, to facilitate and track closed-loop referrals between health care and social service providers.[10, 11] Support for Connect Oregon comes from CCOs, health system partners, and the state. The network is free for community-based and safety net organizations such health centers, tribal clinics, and mental health centers.

4. Integrated Care Delivery and Social Needs Implementation Bolstered by Community-Level Investments

Oregon's payment models, use of technology, and technical assistance infrastructure together help create an integrated approach that enables health care providers to address social needs for children and families. The impact is amplified by community investments that go beyond addressing needs at the individual level to support community-wide conditions to address whole child health.

Flexible spending facilitates CCO investments to address individual and community needs: Oregon has leveraged regulatory and contractual mechanisms with CCOs to require and incentivize flexible health spending investments that support the **integration of care delivery and social supports.** In Lieu of Services, Health-Related Services, the Supporting Health for All REInvestment (SHARE) Initiative and Performance Incentive Payments *complement each other* to achieve large scale and interconnected goals to address the social needs of children and families. Moreover, Oregon's *CCO contract* specifies that the local CCO Community Advisory Committee (CAC) must play a role in directing the CCO's investments to **foster healthy communities.**

8 The Oregon Pediatric Improvement Partnership, Office of Health Analytics at the OHA, Oregon Enterprise Data Analytics, and Oregon Department of Human Services partnered to produce this data for children enrolled in Medicaid and the Children's Health Insurance Program.

9 As of September 2023, OHA will no longer produce children's health complexity data reports. Some of the information in these reports will be available in the system-level social-emotional health reach metric reports.

10 The Oregon Health Leadership Council is the state-level convener for the network that relies on an Oregon-based Unite Us community engagement and support team and Unite Us software to complete referrals. 211info serves as a coordination center for the effort.

11 A closed-loop referral occurs when a provider sends a referral to a community organization to address a patient's social need, and the community organization responds to the provider confirming the outcome of the referral.

- *In Lieu of Services,* which are approved by CMS annually, allow CCOs to offer cost-effective services as an alternative to traditional benefits. Examples of services that Oregon provides via the In Lieu of Services authority include but are not limited to breastfeeding supports provided by a Traditional Health Worker, a postpartum doula, or family training and counseling for child development in a home or community setting.
- *Health-Related Services* are authorized through the state's 1115 waiver and supplement covered benefits to improve health and well-being. They include flexible services (i.e., individual-level services) and community benefit initiatives. CCOs may choose which health-related services they provide based on the needs of the *communities* they serve. Examples of CCO activities that could be covered as a health-related service include transportation services, education, food assistance, housing supports, and climate-related resources.
- Through 2018 legislation, Oregon implemented a Medicaid reinvestment requirement called the *Supporting Health for All Through REInvestment (SHARE) Initiative*, which requires CCOs to invest some profits back into the community. CCO investments must align with the local health improvement plan, be informed by a *community advisory council*, and respond to social drivers of health and equity. Examples of investments have included renovations for childcare centers to effectively serve children with behavioral health needs and community health campaigns.

On-the-Ground Example of Integrating Care Delivery and Social Supports: Metropolitan Pediatrics
Metropolitan Pediatrics is the largest pediatric practice in Oregon, operating in the Portland area with six sites, 45 medical providers and 10 behavioral health providers. In addition to many screenings in the areas of developmental, parental trauma, and social emotional health, Metropolitan Pediatrics is beginning to screen for social drivers of health for all patients and places a high value on relational health to ensure resiliency and social emotional support. The practice uses an integrated, team-based model that relies on team meetings 1–2 times each month with physical health providers, behavioral health providers, care managers (including foster care case managers), medical assistants, and other team members to identify needs and develop solutions. Through integrating care delivery and social supports, aligning care for families and leveraging a diverse, multidisciplinary workforce, Metropolitan Pediatrics demonstrates a provider whole child health approach.

Centralized Technical Assistance and Quality Improvement Activities Support Care Integration and Value-based Payment:
The *Oregon Health Authority Transformation Center* provides centralized support for care integration and quality improvement to providers and CCOs through training, technical assistance, reports, and other resources. It provides support in the areas of behavioral health integration, population health integration, oral health integration, incentive measures, value-based payment, health equity, and clinical delivery.

Additionally, the Transformation Center focuses on supporting providers and CCOs to achieve the quality incentives related to kindergarten readiness. For example, they offered a *series of webinars* on topics related to the kindergarten readiness incentive measures and increasing well-child visits for children ages 3–6. They also partnered with the *Oregon Rural Practice-Based Research Network* to support implementation of the social emotional health metric, including *communications for parents and providers* about social emotional health for children and developing a *social emotional health system map*.

On-the-Ground Example of Quality Improvement: The Children's Health Alliance
The Children's Health Alliance is a clinically integrated group of 140 pediatric providers in the Portland and southwest Washington region that collaborate to develop and implement transformational quality improvement programs that drive quality care delivery, care experience, and cost management for children and their families. The Children's Health Alliance helps primary care pediatricians by supporting Medicaid contracting, providing tools for value-based payment reporting, and assisting with the implementation of initiatives to meet contract requirements.

5. Prioritizing Health Equity

Oregon's health reform initiatives focus on **promoting health equity** through a state-level Equity and Inclusion Division, regional structures, and data collection processes. State policy creates the structure to support a focus on health equity, but local ownership and implementation are critical. OHA established 10 *Regional Health Equity Coalitions* that represent 19 counties. The Regional Health Equity Coalitions, which are funded by OHA but led and operated locally, are independent community-led alliances, comprised of local multisector stakeholders. The Regional Health Equity Coalitions, focus on advancing equity across social drivers of health.

OHA, led by the Equity and Inclusion Division, established a goal to eliminate health inequities by 2030. To advance equity in health care practice, in 2021, CCOs began to work on a new language access incentive metric that measures the provision of quality interpreter services. Beginning in 2023, CCOs also implemented new incentive measure requirements for social needs screening and referral. To meet the requirements, OHA provides technical assistance on screening, referrals, and data collection and exchange.

Another aspect of promoting health equity is *defining and standardizing* data collection on race, ethnicity, language, disability, sexual orientation, and gender identity across the Oregon Department of Human Services and OHA. Providers shared that it can be difficult to deliver meaningful insights based on the race, ethnicity, language, and disability data that they collect, as the numbers become quite small once segmented by race, ethnicity, language, or disability. The OHA Transformation Center and Division of Equity & Inclusion host a learning series focused on the use of race, ethnicity, language, and disability data for CCOs, clinics and other health care leaders to address the challenges.

> "Regional Health Equity Coalitions are a way of holding the complexity of the challenges that folks are facing because the issues that communities are facing in one part of the state are different from another."
>
> **— Danielle Droppers, MSW**
> Regional Health Equity Coalition Program Manager, Equity and Inclusion Division, Oregon Health Authority

6. Innovations That Accelerate a Diverse, Multidisciplinary Workforce to Support Whole Child Health

Policymakers in Oregon have long recognized the necessity of promoting workforce diversity within the health care sector. The Oregon Health Policy Board and Oregon Health Authority partnered on the recently released *fourth biennial assessment* of health care workforce needs across Oregon. The report highlights that Oregon's goal of eliminating health inequities requires the preparation, recruitment and retention of a diverse workforce that can deliver culturally and linguistically responsive health care. Other recommendations call for funding workforce training initiatives, investments in workforce resiliency, expansion of a community-based workforce, and continuing to improve the consistency of race, ethnicity, language, and disability data collection to inform workforce needs.

Oregon has several initiatives underway to address the recommendations. Oregon received federal approval to incorporate additional workforce providers into Medicaid reimbursement to **support a diverse, multidisciplinary workforce.** Traditional Health Workers and *Tribal Traditional Health Workers,* including community health workers, personal health navigators, birth doulas, and four categories of peer support/peer wellness specialists (e.g., family support specialist, youth support specialist, recovery peer, mental health peer) are new multidisciplinary workforce professions targeted toward prevention and support for whole child health.

Ballmer Institute
The University of Oregon recently launched the *Ballmer Institute*, which trains undergraduates to become child behavioral health specialists through a new undergraduate degree. The new degree program prepares students to join the workforce sooner than traditional clinical tracks. The Ballmer Institute is funded through a significant philanthropic gift and provides some scholarships to students.

Local Approaches to Whole Child Health in Oregon

The select examples below highlight a few of the many local providers that demonstrate elements of whole child health approaches. The examples represent only a few of the many Oregon providers implementing whole child health approaches.

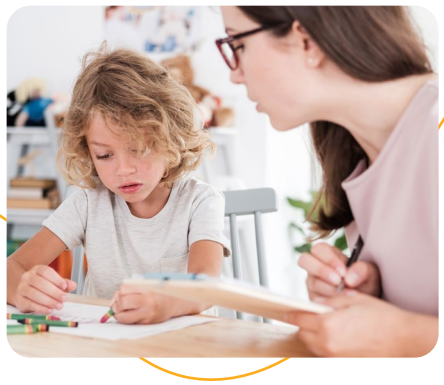
Health Share of Oregon

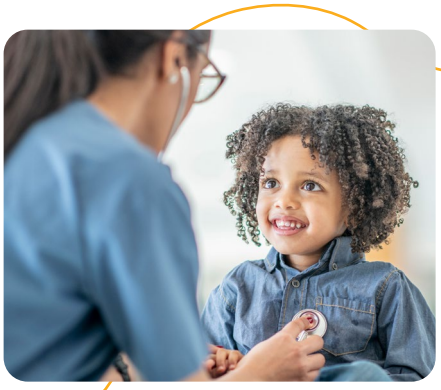
Health Share of Oregon is the largest CCO in the state, covering the urban Portland metro area of Clackamas, Multnomah, and Washington counties and serving 170,803 members from birth to age 21. Health Share of Oregon focuses on advancing long-term strategic priorities as well as implementing special initiatives that support whole child health. Since its inception, Health Share has prioritized early childhood as a cornerstone of all its strategic plans. It has created a long-term roadmap to support the well-being of children, families and communities through prevention, support for recovery, and a focus on health equity. Health Share of Oregon uses the roadmap to guide funding investments. Some examples of what Health Share of Oregon invests in include:

- *EveryStep Community of Care* - The EveryStep model of care was developed to provide enhanced services to support the health and well-being of children in foster care. These clinics function as Centers of Excellence within their provider networks, and they have established eight Standards of Care including behavioral health and oral health integration. The EveryStep model has also been recognized by the American Academy of Pediatrics as a best practice model for children in foster care. Health Share of Oregon has provided financial support to sustain these clinical services and facilitated a collaborative to support shared learning and best practices for eight years.
- *All:Ready Network,* which began at Health Share of Oregon, now operates as a community collective action partnership of more than 70 organizations. The north star of the All:Ready network is to ensure that race, class and disability will not be predictors of school readiness.
- *Help Me Grow (HMG)* is a national model that builds a stronger, more coordinated system across early childhood and health sectors. For example, HMG offers support and outreach to families, connects families and clinicians to local resources, tracks referrals, and collects data to inform solutions. Health Share of Oregon funds staff at the regional HMG office as well as liaisons in three counties.
- *Project Nurture* leverages a Center of Excellence model that integrates maternity and pediatric care with substance use services for pregnant people with substance use disorders. Evaluation findings show that this program decreases foster placements and increases maternal and child health outcomes. Project Nurture families also benefit from the Safe Beginnings Pilot Project funded with health-related service investments to supply health and safety items for postpartum care such as baby carriers, lactation supplies, books for bonding, and more.

"A CCO does not just manage a Medicaid benefit. A CCO has the responsibility to do transformational work with accountability to the community."

— Cat Livingston, MD, MPH, FAAFP, FACPM
Medical Director, Health Share of Oregon





Yamhill Community Care

Yamhill Community Care (YCCO) serves more than 38,000 members in rural Yamhill County and parts of Polk and Washington Counties. It is the only CCO that is also an Early Learning Hub.

YCCO is also the only CCO with a Community Prevention & Wellness Fund that awards funding for community-based initiatives in alignment with the Community Health Improvement Plan, the priorities of the CPW Committee, Community Advisory Council, and YCCO Board of Directors. The Wellness Fund receives allocations from the YCCO global budget and accepts external private and public funding that allows it to braid funds and mount larger initiatives, such as expanding the workforce capacity of childcare providers. For example, YCCO partners with Child Care Resource and Referral organizations for apprenticeships, professional support for existing and new in-home and center-based child care providers, and with Willamette Educational Service District for childcare Career and Technical Education to create child care spots in classrooms. In addition, YCCO partners with private foundations to expand the availability of Spanish language childcare. YCCO also provides funding for a range of community projects, such as family home visiting services, parenting classes, and trauma-informed care in support of prevention, early childhood education and family engagement.

Larger initiatives funded by YCCO include:

- *Oregon Health and Education Collaborative Upstream Initiative* where community organizations will design a Child Success Model that focuses on prevention in the first 1,000 days of a child's development from conception. Yamhill CCO is part of a five-site pilot with a goal of developing a 2025 legislative policy recommendation.
- *Service Integration Teams* meet monthly to address needs for members of their community, from food and utility bills to youth leadership and literacy programs. Each team includes people from schools, partner organizations, social service agencies, local government, faith groups and community leaders. There is one Service Integration Team for each school district in Yamhill County.
- *The Community Health Hub* offers community health workers to provide connections, tangible help, and support to families, including families with children.
- *FamilyCore* is a community services network that connects parents with a local advocate to help navigate the broad system of support available to help meet challenges head-on and nurture strong families.

> "The model for a CCO is that it is formed at the community level, owned by the community, and run by the community."
>
> **— Shannon Buckmaster, MDiv, PhD Candidate**
> Wellness Fund Development Director, Yamhill Community Care

Conclusion: Accelerators and Lessons for Implementing Whole Child Health Approaches

Oregon has demonstrated a decades-long commitment to a vision of whole child health, leveraging a collaborative mindset and a willingness to take the long view. Oregon has used a mix of successive 1115 waivers, federal grants, SPAs and state legislation to finance and implement health care transformation. Medicaid has served as a driver for widespread investment for children across the health system, and CCOs have played a vital role in the design and implementation of strategy. The Transformation Center, as a central convener and source of technical assistance, offers a venue for CCOs and providers to learn and exchange best practices. Oregon also uses integrated state-level data analyses, dashboards, and external evaluation to track progress.

Accountability is a fundamental lever for ongoing transformation — accountability to equity, to community ownership, to paying for health, and to flexible, locally driven practices. Consistent funding over extended periods of time in structures such as the Early Learning Hubs and Regional Health Equity Coalitions has spearheaded local accountability. Oregon pairs this system-level accountability for improvement with local flexibility and autonomy for implementation. Innovations with pediatric-specific metrics tied to incentive payments help create sustainability for the overarching approach, as well as an imperative to specifically address the needs of an often-overlooked population. This is emerging as a powerful combination for sustained investment in child health and development, starting in the early years.

Oregon, alongside the *examples* of Massachusetts, North Carolina, and Washington, offers mechanisms for other states to employ through locally tailored approaches based on their unique needs and assets. The approaches in these states underscore how federal policy, investments, and flexibilities, paired with state-level policy, infrastructure, data integration, and resources, can accelerate momentum towards whole child health and drive adoption and progress over time. A clear and sustained vision based on values that are inclusive of all and implemented with intention and shared accountability across child-serving systems can advance the promise of whole child health.