2026 Oregon Rural Health Conference Presentation Slides

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Connecting Care: How Health and Social Service Partnerships Improve Rural Access

Lavinia Goto and Kate Drummond, October 8, 2026

Today's Objectives

By the end of this session, you will:

1. Understand how health and social service partnerships improve rural access to evidence-based programs.
2. Learn how CINO helps connect health providers, community organizations, and people who can benefit from these services.
3. Identify opportunities to leverage CINO resources and partnerships in your own community.
4. Understand the role of a community care hub, such as OWN, can help CBOs sustain their programs in the community.

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Comagine Health is nonprofit organization that partners with communities, providers, payers and policymakers to advance health and health care for the good of all.

We solve complex challenges others cannot through the combination of data intelligence, clinical rigor, community insight and applied research.

Our work supports improvements throughout the systems shaping health care today.

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Supporting Rural Health Through Community-Based Partnerships

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The Rural Reality

Rural communities face unique challenges in chronic disease management:

- Higher burden of chronic disease
- Workforce shortages
- Higher barriers to care (e.g., access, travel distances)
- Increased financial pressure on clinics, hospitals, and community-based organizations that provide health-related services

Where does chronic disease management occur?

- Primary care is responsible for the diagnosis, treatment, and monitoring of chronic disease among their patients and yet they may see an individual for 15-20 minutes once or twice a year.
- We need to equip people with everyday habits, nutrition, and activities that lead to better outcomes because changing habits takes knowledge, skills, and practice
- For real change and better outcomes, people need support that is integrated into their everyday lives
- More support is needed for health-related community-based organizations that provide support to individuals and their families outside of the doctor's office

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Evidence-Based Programs Fill the Gap

- Evidence-Based Program support healthy behavior changes
  - Examples: National DPP, CDSMP, DSMP, Walk With Ease, Falls Prevention Programs, etc.
- Proven outcomes
  - Improved self-management
  - Increased physical activity
  - Better health outcomes
  - Reduced healthcare utilization

These programs help people put clinical recommendations into practice.

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Why Community Organizations Matter

- Behavior change happens in communities

- Community-based organizations provide:
  - Trusted relationships
  - Local access
  - Ongoing support
  - Connection to social services

Local organizations are uniquely positioned to support rural residents through EBP delivery.

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CBOs are Critical Partners…and Face Real Challenges

CBOs often face challenges with:

- Receiving participant referrals
- Navigating healthcare partnerships
- Contracting and billing requirements
- Sustaining programs without grant funding

Result: Many effective programs struggle to reach the people who could benefit most.

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Challenges Compounded in Rural Communities

Rural organizations often face:

- Smaller staffs
- Fewer resources
- Geographic isolation
- Limited administrative capacity
- Smaller referral networks

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The Opportunity

- Providers want to refer
- CBOs want to serve
- People need these services
- Yet, connections are often difficult to create and sustain
  - Providers may be unaware of programs
  - CBOs may not know of people that could benefit
- This where organizations like CINO to address policy change, and OWN to address community provider support for training, billing and contracting can help

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The Community Integrated Network of Oregon (CINO)

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CINO was created to address these issues

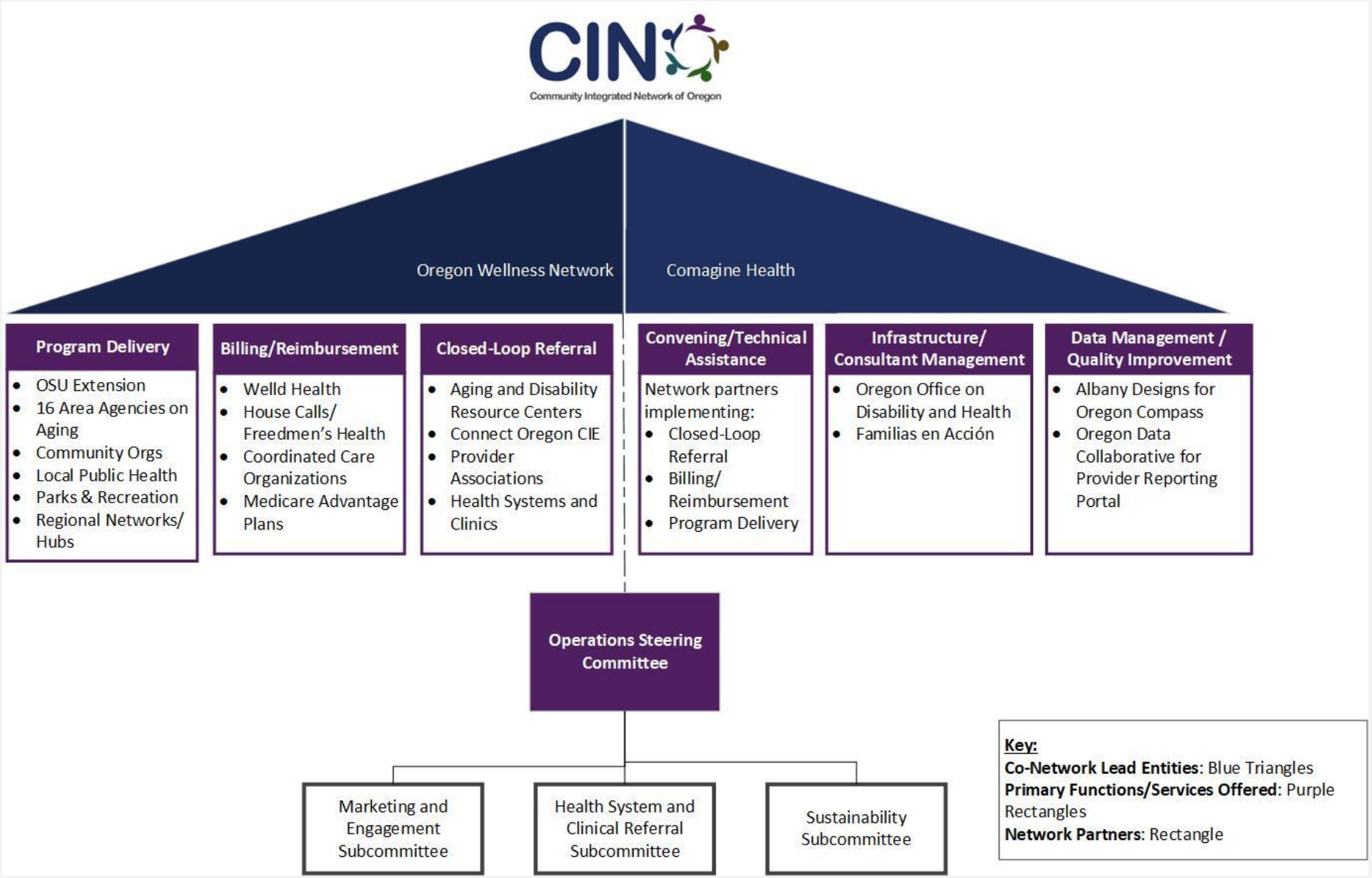
Mission

- As a statewide network, CINO is building a sustainable, equitable, and accessible infrastructure to provide services that support engagement in and access to evidence-based health education with a goal to improve self-efficacy of all people in Oregon to manage their health now and into the future.

CINO brings partners together to address challenges that are difficult to solve individually

- Referral pathways
- Program awareness
- Reimbursement strategies and sustainability
- Shared infrastructure

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COMMUNITY INTEGRATED NETWORK OF OREGON (CINO)



Our Purpose: CINO serves all people in Oregon by designing an equitable integrated network that supports the collaborative work of improving lives and reduces the burden of chronic disease. CINO recognizes the system as it currently exists does not benefit everyone and strives to create a more equitable system for access to evidence based-health education and support programs

Our Vision: An integrated and equitable health model free, accessible, and inclusive to all people in Oregon by providing equal access to all individuals regardless of race, ethnicity, sex, gender, ability, religion, other background or identity, health status or chronic condition.

Our Mission: As a statewide network, we are building a sustainable, equitable, and accessible infrastructure to provide services that support engagement in and access to evidence-based health education with a goal to improve self-efficacy of all people in Oregon to manage their health now and into the future.

Unique Network Approach

Rather than one organization trying to serve the entire state:

- Local organizations remain local
- Community knowledge stays local
- Resources and infrastructure are shared statewide

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How CINO helps

Challenge	CINO Response
Limited program awareness	Shared outreach and education
Referral barriers	Coordinated referral pathways
Billing complexity	Shared expertise and infrastructure development
Sustainability concerns	Funding, partnership, and reimbursement strategies
Rural isolation	Statewide network and peer connections

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CINO's Evolution and Impact

- ACL grant supported the development of CINO from 2021-2023
- Since 2023 CINO has been a statewide partnership partially funded by OHA and grants

Initial results:

- 40+ participating organizations
- Over 3,000 participants served
- Expanded by 2023 to over 12 evidence-based programs

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From Partnership to Practice

How does CINO actually make these connections work?

How do organizations

- Receive referrals?
- Reduce and manage administrative burden?
- Navigate complex healthcare billing and reimbursement systems?

That’s where the Oregon Wellness Network (OWN) comes in…

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Oregon Wellness Network

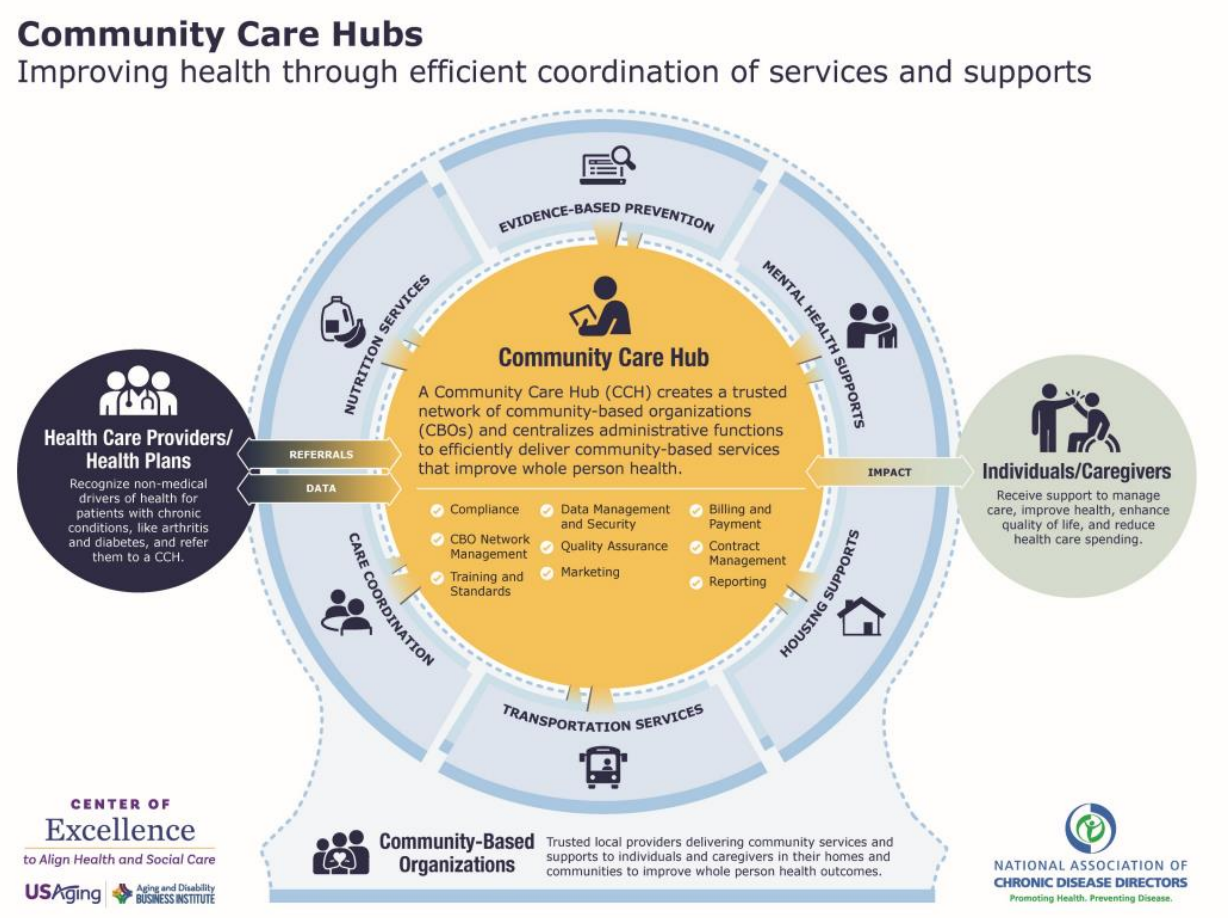
A STATEWIDE COMMUNITY CARE HUB SERVING OREGON SINCE 2017

Website: OregonWellnessNetwork.org

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COMMUNITY CARE HUBS

- NCOA defines CCH as an evolving model designed to align health and social care & encourages evidence-based program provider participation in a network led by a community care hub to ease various contracting and administrative burdens and enables providers to bring in new resources to serve more people.
- CCHs are community-focused, where they organize and support a network of CBOs providing services to address health-related social needs (HRSNs). The services they provide include:
  - centralizing administrative functions such as billing and workforce training
  - operational infrastructure, including, but not limited to, contracting with healthcare organizations, licensing and accreditation, and payment operations
  - management of referrals, service delivery fidelity and compliance, technology, information security
  - data collection, and reporting
- A community care hub has trusted relationships with and understands the capacities of local community-based and healthcare organizations



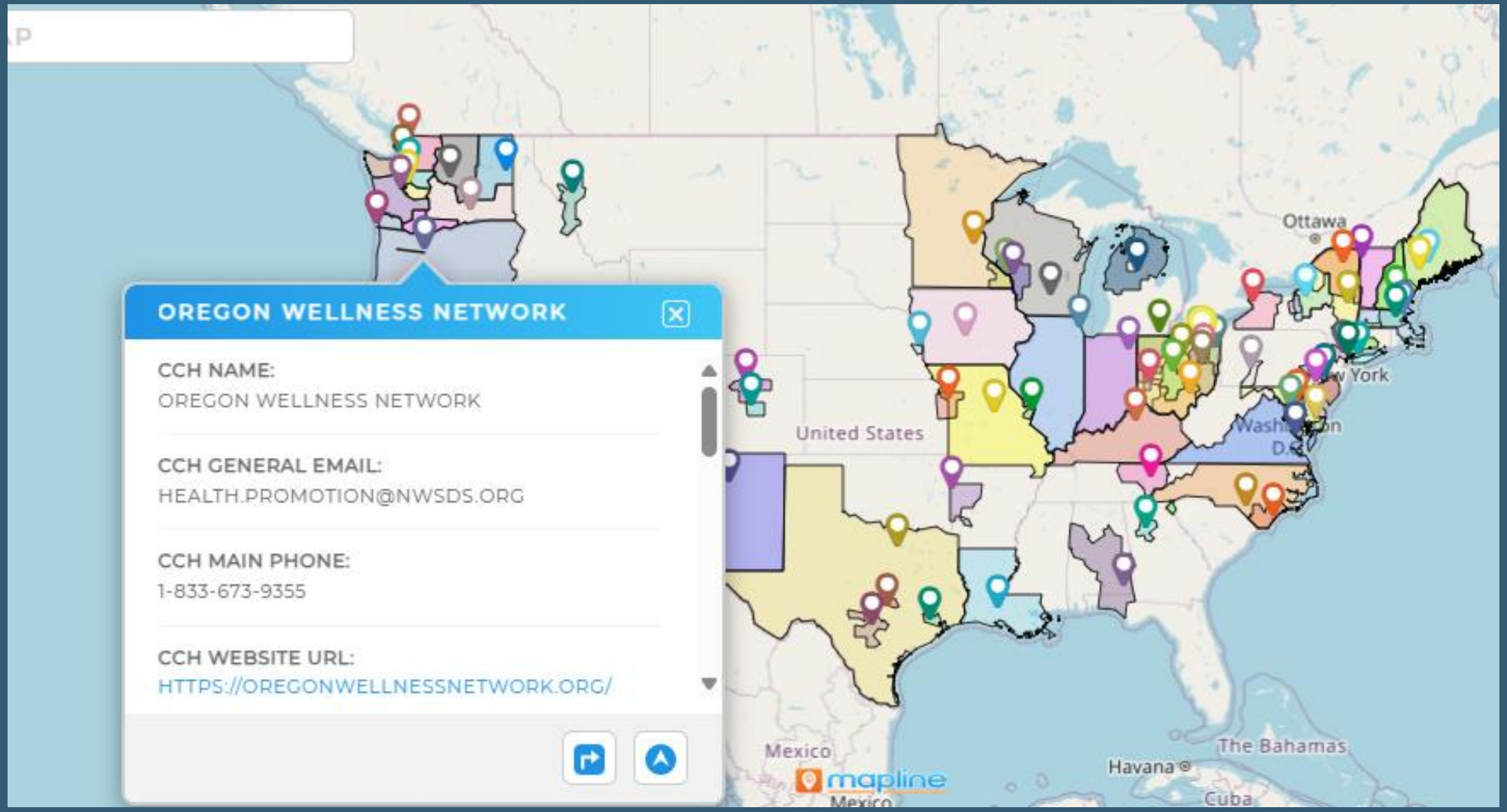
COMMUNITY CARE HUB MODEL

https://coe.aginganddisabilitybusinessinstitute.org/what-is-a-community-care-hub/

FEATURES OF A COMMUNITY CARE HUB

CCH Role	Service Delivery Partner Role
One stop contracting and billing for payers and providers	Capacity to meet deliverables, metrics
Oversight of contract compliance, program quality and fidelity	Meet compliance requirements for service delivery, standards, protocols, quality, and fidelity to evidence-based programs and interventions
Diversification of funding streams (e.g., Medicare Advantage Plans, Medicaid, commercial health insurers)	Receive payments from diversified funding streams through the CCH
Training or lower cost training such as EBP leaders/trainers, HIPAA, and data security	Abide by consent, confidentiality, data privacy federal and state laws, regulations, rules, and policies
Technical assistance	Consistency in service delivery
Marketing/ marketing assistance	Expect some level of marketing standardization

NATIONAL MAP OF COMMUNITY CARE HUB



https://coe.aginganddisabilitybusinessinstitute.org/national-cch-map/

OWN'S CCH MODEL & SERVICES

OREGON WELLNESS NETWORK
A COMMUNITY CARE HUB



OWN is a Community Care Hub that provides a number of administrative services for its network of provider partners; the 16 AAAs and Community-Based Organizations (CBOs)

These services include: centralized contracting and billing, centralized referral hub, statewide training, and umbrella licensing & accreditation

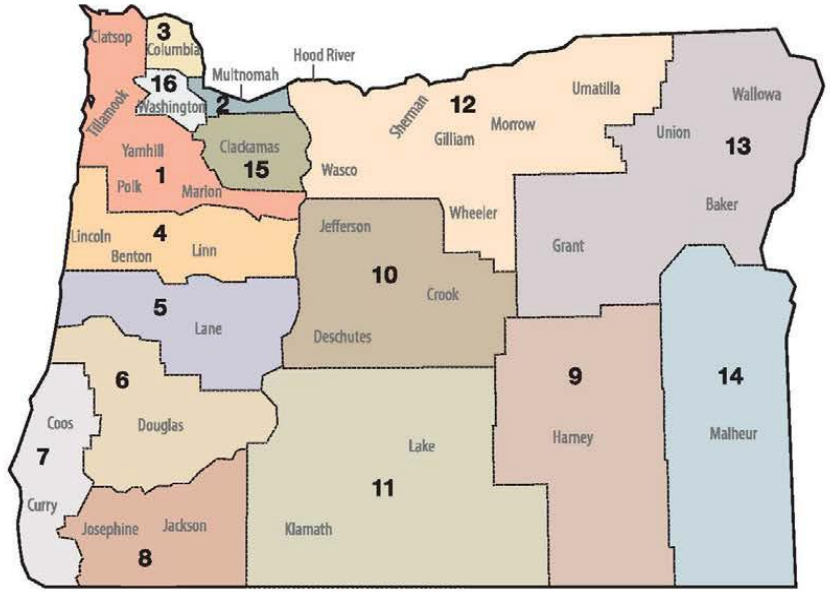
OWN is part of a larger integrated community network called CINO or Community Integrated Network of Oregon.

OWN'S RELATIONSHIP WITH AAA PARTNERS

OWN contracts with each of Oregon's 16 AAAs to allow data sharing and to spell out the level of support the hub will provide.

- Each AAA may subcontract with other CBOs that deliver the evidence-based programs. These agencies and independent contractors come under the OWN network hub by virtue of these contracts.
    - Any umbrella licensing or contracting would extend to these CBOs.
- Payers generally like to contract with CCHs because instead of 16 contracts they only need one with OWN.
- Medical providers and health care organizations can make a referral to OWN for any one of our services; after completing the person's intake, we determine all the different services they may need and arrange for them to be provided; ideally through a warm handoff rather than just handing them a brochure or a list of phone numbers to call

Oregon Area Agencies on Aging Planning and Service Areas



1. **NWSDS** - *(Type B Transfer)* Northwest Senior & Disability Services
2. **MCADVS** - *(Type B Transfer)* Multnomah County Aging, Disability & Veterans Services
3. **CAT** - *(Type A)* Columbia Action Team
4. **OCWCOG** - *(Type B Transfer)* Oregon Cascades West Council of Governments
5. **LCOG** - *(Type B Transfer)* Lane Council of Governments
6. **DCSS** - *(Type B Contract)* Douglas County Senior Services
7. **SCBEC** - *(Type A)* South Coast Business Employment Corp.
8. **RVCOG** - *(Type B Contract)* Rogue Valley Council of Governments
9. **HCSCS** - *(Type A)* Harney County Senior & Community Services Center
10. **COACO** - *(Type A)* Council on Aging of Central Oregon
11. **KLCCOA** - *(Type A)* Klamath & Lake Counties Council on Aging
12. **CAPECO** - *(Type A)* Community Action Program of East Central Oregon
13. **CCNO** - *(Type A)* Community Connection of NE Oregon
14. **MCOACS** - *(Type A)* Malheur Council on Aging and Community Services
15. **CCSS** - *(Type A)* Clackamas County Social Services
16. **WCDAVS** - *(Type A)* Washington County Disability Aging & Veteran Services

OWN'S MISSION & PURPOSE/ SERVICES OUR PARTNERS PROVIDE

OWN's Mission: Build and sustain the capacity of our AAA and CBO partners to help adults and people with disabilities living with ongoing conditions to live and thrive in the homes and communities of their choice. This is done by providing evidence-based community services designed to empower consumers to better manage their chronic conditions.

These services include but are not limited to:

- National Diabetes Prevention Program (DPP) and Diabetes Self Management Services (DSMES)*
- Health Related Social Needs (HRSN) and Social Determinants of Health (SDOH) Screening and Referral
- Health Education and Lifestyle Management
- Fall Prevention Programs (e.g., Tai Chi: Moving for Better Balance, Otago, Walk with Ease)
- Behavioral Health Services (e.g., PEARLS, OPAL, Peer Mentoring)
- Care Coordination e.g. Care Transition, Chronic Care Management
- Nutrition Services and home delivered meals
- Caregiver Support Services

* Explained in greater detail in the following slides

OWN INTEGRATES COMMUNITY SERVICES WITH HEALTHCARE PARTNERS

Integrating community services with healthcare partners such as health plans, hospitals, primary care clinics, and pharmacies is a key role that community care hubs play. Examples of these services are:

- Linking to Social Supports, e.g., home-delivered meals, non-medical transportation
- Care coordination, such as through Care Transition from hospital to home
- Assisting with access to services, e.g., helping to complete a SNAP application
- Preventing further deterioration of health by helping to connect them to appropriate and timely services, e.g., helping to arrange transportation to see their PCP after a hospitalization
- Raising their awareness of what they can do to help themselves through self-management education and practicing healthy habits, e.g. Healthy Heart Ambassador – CDC approved program to teach consumers how to self-manage their hypertension.

EXAMPLE OF WORKING WITH HEALTH SYSTEMS

Care Transition contract with Providence Health System

OWN contracts with Providence Health System to provide Care Transition home for their Medicare Advantage members with complex medical needs with diagnoses that are common among the hospital's readmissions. Unique features of this program:

- OWN's staff monitor all admissions to 6 hospitals and follow cases that meet the health plans pre-established criteria. In other words, we do our own casefinding.
- We use an evidence-based care transition model that focuses on non-clinical social issues that directly impact a person's likelihood to readmit. For example, we help them reconcile the meds they have at home with their discharge medications. All initial home visits are done in the home whenever possible.
- We maintain statistics on readmission rates and reasons for readmissions, and meet regularly with our partners to share our outcome results. Contract just entered its 10th year

EXAMPLES OF WORKING WITH LOCAL CO-ORDINATED CARE ORGANIZATIONS

Health Related Social Needs

- Currently contracted with 5 CCOs to provide some HRSN services; outreach and engagement, climate-related resources, housing supports, and nutrition services.

Special Projects

- Recently contracted with a CCO to outreach to a hard to reach population that had their health plan but were not using it, and instead were using the ED
- Working with another CCO to promote and scale up a home-based fall prevention program with tribal members known to be falling at home. The plan is to train up trusted members of their community to do the home visits.

Key:
Co-Network Lead Entities: Blue Triangles
Primary Functions/Services Offered: Purple Rectangles
Network Members: Rectangle

CIN

Community Integrated Network of Oregon

Oregon Wellness Network

Comagine Health

Program Delivery

- OSU Extension
- 16 Area Agencies on Aging
- Regional Networks/ Hubs
- Local Public Health

Billing/Reimbursement

- Welld Health
- House Calls/ Freedmen's Health
- CCOs
- Medicare Advantage Plans

Closed-Loop Referral

- ADRCs
- Connect Oregon CIE
- Provider Associations
- Health Systems and Clinics

Partner Convener and Technical Assistance

Network members and partners implementing:

- Closed-Loop Referral
- Billing/Reimbursement
- Program Delivery
- Infrastructure and Consultant Management
- Data Management and Quality Improvement

Infrastructure and Consultant Management

- Oregon Office on Disability and Health
- Familias en Acción

Data Management and Quality Improvement

- Albany Designs for Oregon Compass
- Oregon Data Collaborative for Provider Reporting Portal

Operations Steering Committee

- Engagement and Enrollment Subcommittee
- Health System and Clinical Referral Subcommittee
- Sustainability Subcommittee

COMMUNITY INTEGRATED NETWORK OF OREGON

Three Things You Need to Know

Key Partners

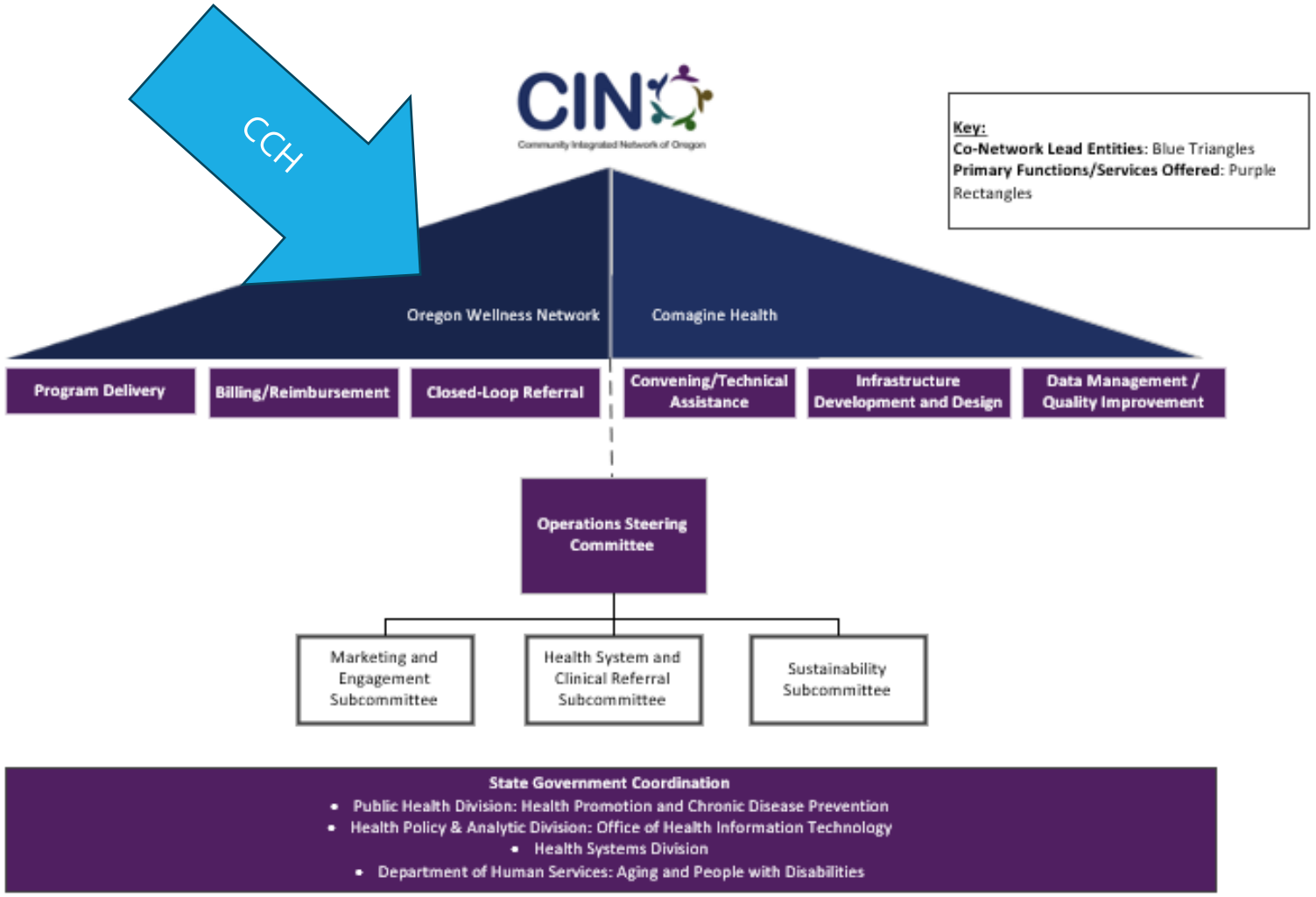
- Oregon Wellness Network
- CINO Network partners
- Oregon Health Authority
- Comagine Health

Primary Funding Streams

- ACL and CDC Grants
- State Funding
- Medicaid and Medicare Claims

Evidence-based programs

- National DPP
- Diabetes Self-Management Education
- Falls Prevention Programs



QUESTIONS?

Contact: Lavinia.Goto@nwsds.org or
Call: 503-304-3408 (ofc) or 503-602-8384 (cell)

1-833-ORE-WELL or 1-833-673-9355

OregonWellnessNetwork.org

Next steps

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Call to action!

Three things we ask that you consider doing next:

1. **Joining CINO – anything from informational partner to active steering committee member**
2. **Connecting with OWN – determining how they can help you with launching and delivering programs, referrals, billing, and sustainability**
3. **Contacting us for more information:**
   - **Lavinia Goto: Lavinia.Goto@nwsds.org**
   - **Kate Drummond: kdrummond@comagine.org**

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Thank you!