Agenda
Delivery System Transformation Committee

March 5, 2020 4:30 – 6:00 pm
Samaritan Walnut Building, Endeavor Conference Room

1. Introductions		**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**4:30**
2. Transformation Update • Census101 • Planned and Crisis Respite Care Scorecard Results • Quarterly Reporting	p. 8	**Charissa White,** IHN-CCO	**4:35**
3. Request for Proposal Discussion	p. 9-17	**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**4:50**
4. Wrap Up • Announcements • Next Meeting: March 19, 2020		**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**5:55**

Commonly Used Acronyms

Acronym	Meaning
ACEs	Adverse Childhood Experiences
APM	Alternative Payment Methodology
CAC	Community Advisory Council
CCO	Coordinated Care Organization
CEO	Chief Executive Officer
CHIP	Community Health Improvement Plan
CHW	Community Health Worker
COO	Chief Operations Officer
CRC	Colorectal Cancer
DST	Delivery System Transformation Committee
ED	Emergency Department
EHR	Electronic Health Records
ER	Emergency Room
HE	Health Equity
HN	Health Navigator
HRS	Health Related Services
IHN-CCO	InterCommunity Health Network Coordinated Care Organization
LCSW	Licensed Clinical Social Worker
MOU	Memorandum of Understanding
OHA	Oregon Health Authority
PCP	Primary Care Physician
PCPCH	Patient-Centered Primary Care Home
PMPM	Per Member Per Month
PSS	Peer Support Specialist
PWS	Peer Wellness Specialist
RFP	Request for Proposal
RHIC	Regional Health Information Collaborative
RPC	Regional Planning Council
SDoH	Social Determinants of Health
SHP	Samaritan Health Plans
SHS	Samaritan Health Services
SOW	Statement of Work
TI	Trauma Informed
THW	Traditional Health Worker
TQS	Transformation and Quality Strategy
UCC	Universal Care Coordination
VbP	Value Based Payments
WG	Workgroup

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
BRAVE	Bravery Youth Center	Olalla Center for Children and Families	Lincoln	1/1/20	12/31/20
DOUL	Community Doula	Heart of the Valley Birth and Beyond	Benton; Lincoln; Linn	1/1/18	12/31/20
HEWG	Health Equity Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/1/15	present
HSPO	Helping High School Students to Understand Pain, Opioid Addiction, & Healthy Self-Care	Corvallis School District 509j	Benton	1/1/19	12/31/20
HTEM	Homeless Resource Team	Samaritan Health Services	Benton	1/1/19	6/30/20
HUBV	Hub City Village	Creating Housing Coalition	Linn	1/1/20	12/31/20
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton; Lincoln; Linn	1/1/19	12/31/20
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/20	12/31/20
PWST	Peer Wellness Specialist Training	Family Tree Relief Nursery	Benton; Lincoln; Linn	1/1/18	12/31/20
RDUC	Reduce and Improve	Capitol Dental Care, Lebanon Community Hospital	Linn	1/1/19	6/30/20
SDoHWG	Social Determinants of Health Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	11/16/17	present
SKIL	Skills and Connections to Support Housing	Corvallis Housing First	Benton	1/1/20	12/31/20
THWWG	Traditional Health Workers Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/21/13	present
UCCWG	Universal Care Coordination Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	6/26/17	present
WINS	Wellness in Neighborhood Stores	OSU Center for Health Innovation, Linn County Public Health	Linn	1/1/20	12/31/20
WtoS	Wellness to Smiles	Advantage Dental from DentaQuest	Lincoln	1/1/20	12/31/20

Delivery System Transformation Committee (DST) 2020 Calendar

January	9	Strategic Planning: Accessiblity & Charter				
	23	Strategic Planning: Partnerships & Evaluation				
February	6	Strategic Planning: Workgroups		Taking the Stigma Out of Mental Health		
	20	CORO	PCRC	Equity in Voting	Strategic Planning: Pilot History	
March	5	RFP Discussion				
	19	Board Disc.	RFP Discussion			
April	2	CORO	Health Equity Training OR RFP Discussion			
	16	RFP Decisions				
	30	Health Equity Training OR Spreading Promissing Practices				
May	14	Health Equity Training OR Spreading Promissing Practices				
	28	Board Disc.		Pilot Update		

June	11	LOI Decisions				
	25	Board Disc.	Spreading Promising Practices			
July	9	Health Equity Training				
	23	Closeout	Closeout			
August	6	Proposal Presentations				
	20	Proposal Presentations				
September	3	Proposal Decisions				
	17	Closeout	Closeout			
October	1			Workgroup Update		
	15					
	29	Board Disc.				
Nov	12					
Dec	10					

KEY

Tentative closeout	Booked closeout
Tentative RFP	Booked RFP
Tentative strategic planning	Booked strategic planning
Tentative miscellaneous	Booked miscellaneous
Tentative training	Booked training
Tentative update	Booked update
Tentative workgroup	Booked workgroup

Minutes
Delivery System Transformation Committee

February 20, 2020 4:30 – 6:00 pm
Samaritan Health Plans Walnut Building: Endeavor (conference room)

Present			
Chair: Sherlyn Dahl	Kedo Baye	Giovanni Galvez	Angel Parmeter
Stephanie Jensen	Melissa Jackson	Shirley Byrd	Kitty Carter
Jeff Blackford	Larry Eby	Stacey Bartholomew	Clarice Amorim Freitas
Heidi May-Stoulil	Ronda Lindley-Bennett	Allison Hobgood	Shannon Rose
Allison Myers	Priya Prakash	Britny Chandler	Kimberly Lane
Erin Sedlacek	Paulina Kaiser	Kara Cuevas	Tyra Jansson
Lalori Lager	Annie McDonald	Rebekah Fowler	Marcy Shanks
Dick Knowles	Deb Fell-Carlson	Christine Mosbaugh	
Video	Nicole Fields	Elijah Johnson	Alicia Bublitz

Transformation Update: Stephanie Jensen

- Welcome to Kedo Baye, the Transformation Intern responsible for coordinating the Trauma Informed Community Development project.
- Unite Us/Community Connect information session and training is March 16, 2020 at the Newport Center for Health Education.

Planned and Crisis Respite Care Closeout: Melissa Jackson and Kitty Carter

Timeframe: January 1, 2019 – December 31, 2019
Budget: $105,451.09
Summary: Planned and Crisis Respite Care (PCRC) provides respite services using Morrison certified foster homes in the tri-county area for IHN-CCO members ages 3 to 17. The aim of the pilot is to stabilize families at risk of disruption due to reoccurring mental health and behavioral challenges.
Key Activities:

- Advertise the need for respite providers/foster homes.
- Attend community events.
- Collaborate/outreach with community partners to increase awareness and general referrals (e.g., Volunteer at Lincoln City half-marathon, Lincoln County Chamber of Commerce, KNPT-AM Radio Interview, Open Houses).
- Certify/re-certify foster homes (pre-service training, quarterly safety checks).
- Match providers with child and youth referrals, schedule respite.
- Provide bi-monthly foster/respite provider support nights.

Key Outcomes:

- Increase the overall number of certified foster homes.
- Increase the utilization of respite services.
- Reduce barriers to accessing respite services.
- Examples:
    - Total of 13 foster parent applicant inquires.
    - Total of 6 certified beds, 1 new certification in Lincoln County.
    - There is 1 applicant in process for Lincoln County.
    - Increased utilization of respite homes.
    - In fiscal year 2019, received 30 referrals, served 24 unique clients.
    - Increased utilization to over 294 respite nights.

Learning Experiences

- Utilized new recruitment strategies for this pilot with support from community partners which included local radio stations interviews, press releases, open house events, volunteered at the Lincoln City Half Marathon, and increased advertising in Newport News Times.
- Recruiting strategy in Lincoln County that worked best was relational based.

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- Relationship with community partners (e.g., System of Care Coordinator, Olalla Center, Lincoln City Chamber of Commerce, and Board of County Commissioners).

Partnerships & Collaboration

- New partnerships included System of Care Coordinator and the Newport and Lincoln City Chamber of Commerce Memberships.
- Continued collaboration with Olalla Center for Children and Families.
- The ABC House supported referrals and foster parents training opportunities.
- Lincoln County Mental Health referrals.
- Department of Human Services Child Welfare Offices.

Remaining Challenges

- Need more respite providers.
    - There are currently 5 homes in Benton, Lincoln, and Linn counties.
        - There is 1 in Lincoln County and 1 in process in Lincoln County.
    - Recruitment:
        - Limited funds for advertising and marketing.
        - New strategies needed.
    - Length of time it takes for certification.
    - One local full-time employee to support efforts in the region, remaining full time employees in Portland.

Post Pilot Sustainability

- Working on obtaining continuation funding through IHN-CCO to continue to support efforts at recruitment in the region.
- IHN-CCO increased respite rates to help with sustainability.
- Currently billing 25 nights per month and need 60-65 nights per month to sustain the pilot.

Discussion

- Suggested to reach out to local tribes for partnership.
- A concern was raised about negative connotation with foster care and its impact on recruitment.
- Morrison Child & Family Services does not have a robust marketing department.
- The length of time for respite care normally range from weekend to two weeks.

<u>Equity in Voting Subcommittee: Stephanie Jensen</u>

- See packet pages 22-23.
- Transformation created a scoring rubric to assist with aligning voters and reducing bias.
- Changed reduced cost to influences cost.
    - It was agreed to soften the wording and will bring back for discussion on the exact wording at the next DST meeting.
- There was an ask to make the font size on the rubric bigger to ease readability.

<u>Pilot Heatmap and Sustainability: Stephanie Jensen</u>

- See packet pages 24-26.
- Crosswalk:
    - Review Oral Health Integration category and ensure appropriate pilots are given credit.
    - Look at this information to inform group about what has been unique about successful pilots and how to incorporate that into future pilots.
- Recommendation to monitor results and spread promising practices.
- Pilots and Sustainability Status
    - Suggestion: Add a bucket for system changes that have gone into effect.
    - Dental Medical Integration for Diabetes pilot should go under operationalized bucket.

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- Compare pilots scoring in "ended" status to check for missed opportunities for sustained/operationalized status.

Announcements

- The Reduce and Improve pilot is presenting at a national health conference in San Francisco in April 2020.

Next Two Meetings

- How can focus be on the outcome indicators for impact areas and start to measure pilots and encourage them to address those areas?
- Review promising practices from the consultant recommendations and the Prioritizing Pilot committee to understand what to scale and spread moving forward.
- Potentially earmark funding to certify more Doulas, Peer Supports, and other Traditional Health Workers to build capacity up.
    - Add workforce development to discussion.
- Review the Community Health Improvement Plan and the CCO 2.0 Summary to align priorities and narrow focus.

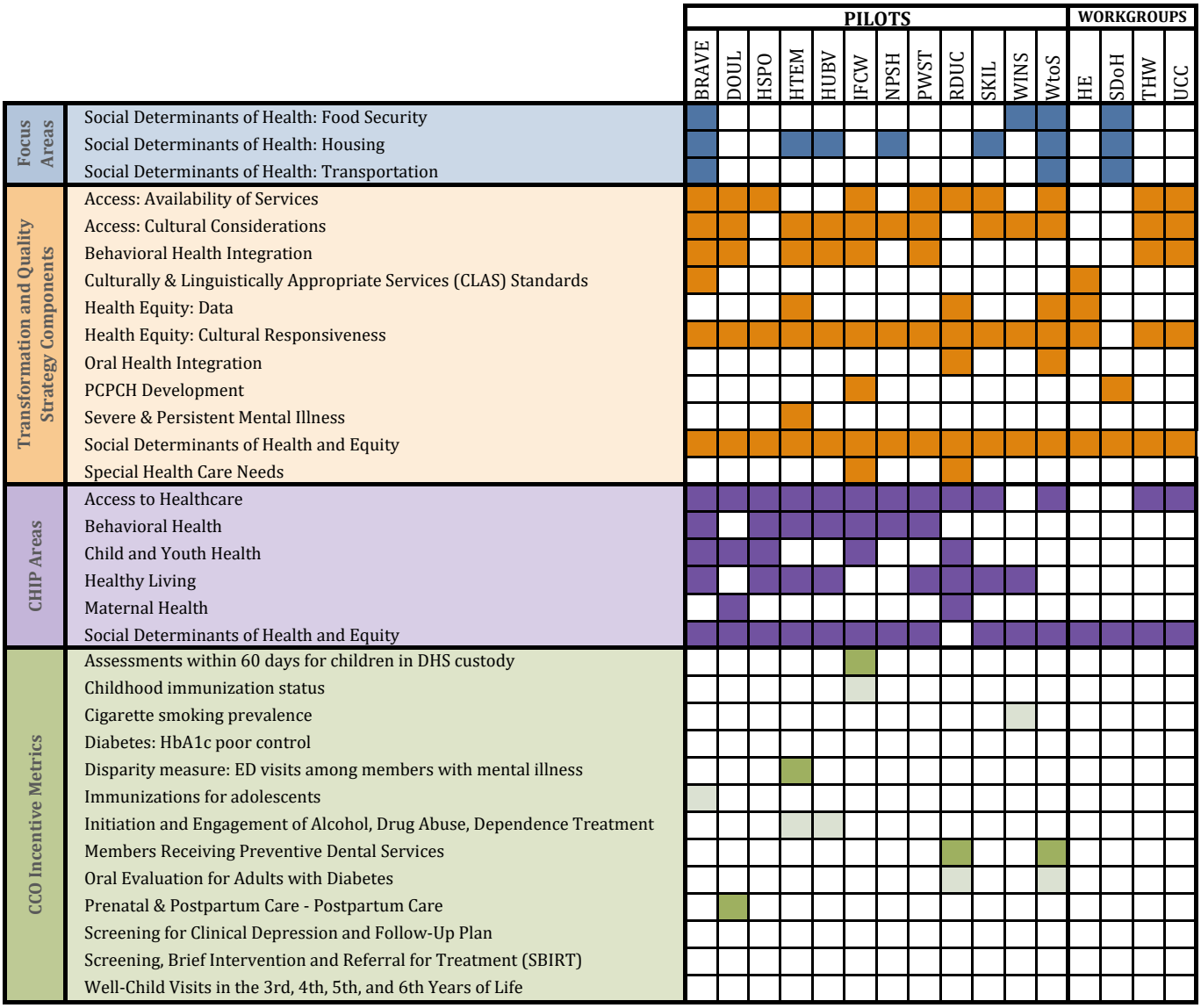
IHN-CCO DST Pilot Scorecard Results

Planned and Crisis Respite Care

Key Outcomes Achieved	5.33
Health Improvement	5.25
Health Equity	5.29
Improved Access	6.13
Transformational	5.43
Barriers	5.63
Partnerships and Collaboration	6.25
Resource Investment	5.25
Reduced Costs	4.88
Sustainability	4.38
Reviewers	**8**

IHN-CCO DST Transformation Crosswalk

Transformation and Quality Strategy Components (TQS), Community Health Improvement Plan Health Impact Areas (CHIP Areas), and CCO Incentive Metric Areas



KEY

BRAVE: Bravery Center

DOUL: Community Doula

HE: Health Equity Workgroup

HSPO: Helping High School Students Understand Pain, Opioid Addiction, and Healthy Self-Care

HTEM: Homeless Resource Team

HUBV: Hub City Village

IFCW: Integrated Foster Child Wellbeing

PWST: Peer Wellness Specialist Training

RDUC: Reduce and Improve

SDoH: Social Determinants of Health Workgroup

SKIL: Skills and Connections to Support Housing

THW: Traditional Health Workers Workgroup

UCC: Universal Care Coordination Workgroup

WINS: Wellness in Neighborhood Stores

2020 IHN-CCO DST Scoring Rubric

	0	3	5	7	10
Transformational	No innovation aspects; strategy has been done in this region or type of organization	Little innovation; potentially to new region	Some innovation	New and innovative; new partnerships among agencies with new strategy for one or more partner	New and innovative strategy for all partners involved
Health Equity	No health equity plan	Targets IHN-CCO members but plan unclear OR does not clearly target IHN-CCO members but has a health equity plan	Little context, approach not clear	Clear approach, target population identified OR plan not clear, but target population obviously high-risk	Hits high-risk population and outlines plan for health equity approach clearly and effectively
Health Improvement	Unlikely to result in improvement in the health or healthcare of IHN-CCO members	May result in improvement in the health or healthcare of IHN-CCO members	Likely to result in improvement in the health or healthcare of IHN-CCO members	Likely to result in significant improvement in the health or healthcare of IHN-CCO members	Will result in significant improvement in the health or health care of IHN-CCO members
Improved Access	No improved access for IHN-CCO members	Some improved availability of services, culturally considerate care, or quality and appropriate care	Likely to result in some improved access (availability of services, culturally considerate care, and quality and appropriate care)	Likely to result in improved access (availability of services, culturally considerate care, and quality, appropriate care)	Will result in significantly improved access (availability of services, culturally considerate care, and quality, appropriate care)
Need	No need established and demographics not indicated	Need is not clearly defined but demographics are indicated	Need defined, demographics outlined	Need established and demographics of IHN-CCO members clearly defined	Substantial need established and demographics of IHN-CCO clearly defined
Outcomes	Outcomes are not aligned with the Community Health Improvement Plan (CHIP)	Outcomes and measures are aligned to the CHIP but not pilot goals	Outcomes and measures are aligned to pilot goals and the CHIP	Outcomes and measures are aligned to pilot goals, the CHIP, and will be sufficient to evaluate pilot success	Outcomes and measures are aligned to pilot goals, the CHIP, will be sufficient to evaluate success, and yields outcomes that are new or different
DELETE: Reduces Costs	Does not address reducing costs, cannot determine	Has the potential to reduce costs and does not target area of healthcare associated high or rising costs	Has the potential to reduce costs	Has the potential to reduce costs and targets areas of healthcare associated with high or rising costs	Likely will reduce cost and targets areas of healthcare associated with high or rising costs
ADD: Influences Cost	Does not influence costs, cannot determine	Has the potential to influence cost, does not target area of healthcare associated high or rising costs	Has the potential to influence cost	Has the potential to influence cost and targets an area (s) of healthcare associated with high or rising costs	Likely will influence cost. Targets an area (s) of healthcare associated with high or rising costs
Resource Investment	Budget is unreasonable and inappropriate to the work proposed	Budget is not well justified and not tied to pilot goals	Reasonable and appropriate budget	Budget is reasonable, appropriate to the work, and well justified	Budget is reasonable, appropriate to the work, and well justified. Directly tied to the pilot goals; exhibits consideration for other funding sources
Social Determinants of Health	Does not address Social Determinants of Health (SDoH)	Addresses SDoH but not clearly defined OR does not address food security, housing, or transportation	Little context, approach not clear, does address food security, housing, or transportation	Clear approach to addressing food security, housing, or transportation	Clearly addresses food security, housing, or transportation in a new and innovative way
Sustainable	No sustainability plan	Plan not clearly defined	Has a defined plan, potential to sustain	Clearly defined sustainability plan including replicability and continued funding	Clearly defined sustainability plan including replicability and continued funding; likely to sustain, continue, and replicate after DST funding ends

Community Health Improvement Plan 2019: Health Impact Areas Outcome and Indicators

Access to Healthcare (A)

Outcomes	Indicators
A1: Increase the percentage of Members who receive appropriate care at the appropriate time and place.	Indicator Concepts a. Length of time from IHN-CCO enrollment to first appointment b. Length of time from appointment request to appointment for behavioral, physical, and oral health services c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Appropriate physical, behavioral,
A2: Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.	Indicator Concept a. Percentage of Members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care
A3: Improve integration of oral health services with behavioral and physical health services.	Indicator Concepts a. Percentage of Members who have a dental visit during pregnancy compared to total percentage of Members who have a dental visit b. Percentage of dental assessments for youths in Department of Human Services custody c. Percentage of adults with diabetes who access dental care d. Percentage of Emergency Department visits with a caries-related diagnosis that are followed-up on in a dental care setting

Community Health Improvement Plan 2019: Health Impact Areas Outcome and Indicators

Behavioral Health (BH)

Outcomes	Indicator Concepts and Areas of Opportunity
BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.	Indicator Concepts a. Number of community Members, employers, landlords, teachers, elected officials, and service providers (e.g. law officers, firefighters, Emergency Medical Technicians) trained in Mental Health First Aid, or trauma informed care, or other basic mental health awareness training b. Peer-delivered behavioral health education and services
	Areas of Opportunity i. Behavioral health stigma within the community ii. Community supports in the community to normalize behavioral health issues
BH2: Increase the behavioral health expertise of healthcare providers and staff to reduce stigma and improve access and appropriate utilization of services.	Indicator Concepts a. Oregon Psychiatric Access Line about Adults (OPAL-A) utilization
	Areas of Opportunity i. Members receive behavioral health services, screenings, and referrals in primary care settings ii. Co-located primary care and behavioral health providers iii. Primary care providers and Emergency Department staff exposed to behavioral health education, information, and Continuing Medical Education
BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.	Indicator Concepts a. Screening, Brief Intervention, Referral to Treatment (SBIRT) rates b. Rates of suicidal ideation, attempts, suicide, and/or self-harming behaviors c. Overdose rates
	Areas of Opportunity i. Mental health and substance use services, screenings, and referrals in venues other than traditional medical facilities, including schools ii. Peer delivered education and support iii. Mental health service wait-times iv. Lack of mental health services for those not in crisis
BH4: Improve care for Members experiencing mental health crisis.	Areas of Opportunity i. Quality of mental health care ii. Appropriate care at the appropriate time and place for people experiencing a mental health crisis iii. Time from appointment request to appointment with a mental health care provider iv. Care coordination
BH5: Improve care for Members experiencing severe and persistent mental illness.	Areas of Opportunity i. Non-mental health care (i.e., physical & oral) ii. Continuity of care iii. Ongoing engagement with a behavioral health provider iv. Health equity for this marginalized population v. Stigma reduction vi. Assertive Community Treatment (ACT)
BH6: Behavioral health funded and practiced with equal value and priority as physical health.	Indicator Concepts a. Implement and report progress on a behavioral health parity plan
	Areas of Opportunity i. Number of mental health providers ii. Preventative behavioral healthcare and promotion of general wellbeing

Community Health Improvement Plan 2019: Health Impact Areas Outcome and Indicators

Healthy Living (HL)

Outcomes	Indicator concepts and Areas of Opportunity
HL1: Increase the percentage of Members who are living a healthful lifestyle.	Areas of Opportunity i. Disease prevention, management, and recovery ii. Nutrition iii. Physical activity iv. Weight shaming and blaming v. Stress vi. Sleep quality vii. Social supports, such as family, friends, and community
HL2: Reduce the percentage of Members who use and/or are exposed to tobacco.	Indicator Concepts a. Tobacco prevalence (Quality Incentive Metric), including tracking prevalence among Members who are under age 18, pregnant, or who are a Member of another at-risk group b. Use of cessation resources and tools
	Area of Opportunity i. Youth introduction to tobacco products
HL3: Reduce sexually transmitted infection (STI) rates.	Indicator Concepts a. Sexually transmitted infection rates b. Expedited Partner Therapy utilization rates

Child & Youth Health (CY)

Outcome	Indicator Concepts and Areas of Opportunity
CY1: Increase the percentage of children, youth, and families who are empowered in their health.	Areas of Opportunity i. Utilization of advocacy services and supports ii. Children, youth and families partner with their healthcare provider
CY2: Decrease child abuse and neglect rates.	Indicator Concepts a. Neglect; emotional, physical, and sexual abuse rates
CY3: Increase breastfeeding initiation and duration rates.	Indicator Concepts a. Percentage of women who receive lactation consultation and support during pregnancy and following childbirth b. Breastfeeding rates
	Area of Opportunity i. The ability to conveniently pump breast milk at work
CY4: Increase integration of behavioral health and oral care as part of routine primary pediatric care.	Indicator Concepts a. Number of regular behavioral health screenings occurring for pediatric IHN-CCO Members b. Oregon Psychiatric Access Line about Kids (OPAL-K) utilization c. Mental, physical, and dental health assessments for children in DHS custody (Quality Incentive Metric) d. Percentage of teens who had a dental check-up, exam, teeth cleaning, or other dental work
	Area of Opportunity i. Occurrence of care coordination between primary care and behavioral health providers when working with children, youth, and families, including consultations and referrals.

Community Health Improvement Plan 2019: Health Impact Areas Outcome and Indicators

Maternal Health (M)

Outcomes	Indicator Concepts and Areas of Opportunity
M1: Reduce unplanned pregnancy rates.	Indicator Concept a. Effective contraceptive use among partners
	Area of Opportunity i. Data availability for effective contraceptive use among all Members
M2: Increase the percentage of Members who receive early and adequate care and support before, during, and after pregnancy.	Indicator Concept a. Behavioral health screenings and access to treatment with a behavioral health provider
	Areas of Opportunity i. Healthy weight gain during pregnancy ii. Utilization of postpartum care and support iii. Partner education and involvement

Social Determinants of Health and Equity (SD)

Outcomes	Indicator Concepts and Areas of Opportunity
SD1: Increase the percentage of Members who have safe, accessible, affordable housing.	Indicator Concepts a. Number of homeless persons b. Number of homeless students
	Areas of Opportunity i. Stable housing upon discharge from hospital or emergency room visit ii. Evictions prevention and reduction iii. Housing-related, closed-loop referral between clinical and community services iv. Social Determinants of Health claims data
SD2: Increase the percentage of Members who have access to affordable transportation.	Areas of Opportunity i. Non-medical transportation access ii. Distance between Members' homes and public transportation iii. Member utilization of available, covered transportation services iv. Provider knowledge of, and referral to, available transportation services
SD3: Increase the percentage of Members who have access to healthy food.	Indicator Concept a. Percentage of Members living in a food desert
	Areas of Opportunity i. Food security ii. Availability of fresh, affordable produce
SD4: Increase health equity.	Areas of Opportunity i. Health disparities experienced by Members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc. ii. Availability of health equity data

Definitions for IHN-CCO Pilots by CHIP Area Document

Community Health Improvement Plan (CHIP) Areas (2019)	
Access (A)	Increasing the number of members who receive appropriate care and care communicated in way they understand and integration of oral health with behavioral and physical health services.
Behavioral Health (BH)	Spans a continuum of behavioral disorders including, but not limited to, prevention, diagnosis and treatment of mental health disorders, mental illness, substance use, and addictive disorders. It includes wellness and provides differentiation between lesser behavioral health issues attributed to mental health and more intrusive disorders described as severe and persistent mental illness.
Child and Youth Health (CY)	Includes health and wellbeing from birth through 17 years of age.
Healthy Living (HL)	Disease prevention, management, and recovery through nutrition; physical activity; stress prevention, management, and resiliency; good sleep; and responsible behavior.
Maternal Health (MH)	Begins at preconception and continues postpartum. This is the time before, during, and after pregnancy when supportive services enhance a woman's physical and mental health and wellbeing.
Social Determinants of Health and Equity (SD)	(SDoH) are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. The Social Determinants of Equity are factors such as ableism, racism, sexism, and others that determine how different groups of people may experience SDoH.

Status	
Operationalized	IHN-CCO is paying for the services and the services sit outside the 'normal' billing system.
Sustained	The champion organization has sustained the project.
Ended	Pilot was not sustained to our knowledge.
One-Time Project	Pilot was not expected to be sustained.

Champion	
Available	Known champion - not engaged but likely to be able to contact.
Engaged	Consistently attends the DST or workgroups.
Unknown	Unknown

IHN-CCO DST Pilots by CHIP Area (2019)

A	BH	CYH	HL	MH	SD	YEAR	PILOT NAME	STATUS	CHAMPION ENGAGEMENT LEVEL
						2019	Community Roots	Sustained	Engaged
						2019	Planned and Crisis Respite Care	Sustained	Engaged
						2019	Health Equity Summits and Trainings	Sustained	Engaged
						2019	Regional Health Education Hub	Sustained	Engaged
						2019	Veggie Rx in Lincoln County	Sustained	Engaged
						2018	CHANCE 2nd Chance	Operationalized	Engaged
						2018	Traditional Health Worker Hub	Operationalized	Engaged
						2018	Children's SDoH and ACEs Screening	Sustained	Engaged
						2018	SDoH Screening with a Veggie Rx Intervention	Sustained	Engaged
						2018	Breastfeeding Support Services	Operationalized	Available
						2018	Community Paramedic	Ended	Available
						2018	Improving Infant and Child Health in Lincoln County	Sustained	Engaged
						2018	Oral Health Equity for Vulnerable Populations	Sustained	Engaged
						2018	Pharmacist Prescribing Contraception	Sustained	Available
						2018	Expanding Health Care Coordination	Sustained	Available
						2018	Family Support Project	Sustained	Available
						2018	The Walden Project: Nature Therapy	Sustained	Engaged
						2018	Youth & Children Respite Care	Sustained	Engaged
						2018	Eating Disorders Care Teams	Sustained	Available
						2017	Community Health Workers in North Lincoln	Sustained	Available
						2017	Pain Management in the PCPCH	Sustained	Available
						2017	Pre-Diabetes Boot Camp	Sustained	Available
						2017	SHS Palliative Care	Sustained	Available
						2017	Health & Housing Planning Initiative	Operationalized	Engaged
						2017	Sexual Assault Nurse Examiner	Sustained	Available
						2017	Home Palliative Care	Operationalized	Unknown
						2017	Physician Wellness Initiative	Operationalized	Engaged
						2017	Chrysalis Therapeutic Support Groups	Sustained	Available
						2017	Improving the Pain Referral Pathway in the PCPCH	Sustained	Available
						2017	School/Neighborhood Navigator	Sustained	Engaged
						2017	CHANCE	Operationalized	Engaged

IHN-CCO DST Pilots by CHIP Area (2019)

						2017	CMA Scribes	Sustained	Available
						2017	Dental Medical Integration for Diabetes	Operationalized	Engaged
						2016	Colorectal Screening Campaign	One-time project	Available
						2016	Prevention, Health Literacy, and Immunizations	One-time project	Available
						2016	Alternative Payment Methodology	Operationalized	Engaged
						2016	Child Abuse Prevention & Early Intervention	Operationalized	Engaged
						2016	Community Health Worker	Operationalized	Engaged
						2016	Maternal Health Connections	Sustained	Engaged
						2016	Tri-County Family Advocacy Training	Sustained	Available
						2016	Youth WrapAround & Emergency Shelter	Sustained	Engaged
						2016	Pediatric Medical Home	Operationalized	Engaged
						2016	Childhood Vaccine Attitude & Information Sources	One-time project	Available
						2016	Child Psychiatry Capacity Building	Operationalized	Unknown
						2016	Primary Care Psychiatric Consultation	Operationalized	Unknown
						2016	Licensed Clinical Social Worker PCPCH	Sustained	Unknown
						2016	Universal Prenatal Screening	Operationalized	Engaged
						2016	Complex Chronic Care Management	Sustained	Unknown
						2016	Public-Health Nurse Home Visit	Operationalized	Engaged
						2016	Medical Home Readiness	One-time project	Unknown
						2015	Behavioral Health PCPCH	Operationalized	Available
						2015	Medical Neighborhood PCPCH-Behavioral	Ended	Available
						2015	Mental Health, Addictions, and Primary Care Integration	Ended	Available
						2015	Mental Health Literacy	One-time project	Available
						2015	Member Access Plan	One-time project	Unknown
						2015	Patient-Centered Primary Care Home	One-time project	Unknown
						2015	Patient Assignment & Engagement	One-time project	Unknown
						2015	Hospital to Home	Sustained	Unknown
						2014	PCP Engagement Fee	One-time project	Unknown