Agenda
Delivery System Transformation Committee

April 2, 2020 4:30 – 6:00 pm

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1. Introductions		**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**4:30**
2. Transformation Update		**Charissa White,** IHN-CCO	**4:35**
• COVID-19		**Stephanie Jensen,** IHN-CCO	
• Location			
• Scoring Rubric	p. 8		
3. Target Area Discussion		**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**4:50**
• Access	p. 13-20		
• Behavioral Health	p. 21-25		
• Social Determinants of Health and Equity	p. 9-11, 12-31		
4. Wrap Up		**Sherlyn Dahl,** Community Health Centers of Benton and Linn Counties	**5:55**
• Announcements			
• Next Meeting: April 16, 2020			

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 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.	Census101	RFP Target Area Discussion		
April	2	RFP Discussion				
	16	RFP Decisions				
	30	Spreading Promising Practices				
May	14	Health Equity Training				
	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	Health Equity Training				
	29	Board Disc.				
Nov	12					
Dec	10					

KEY

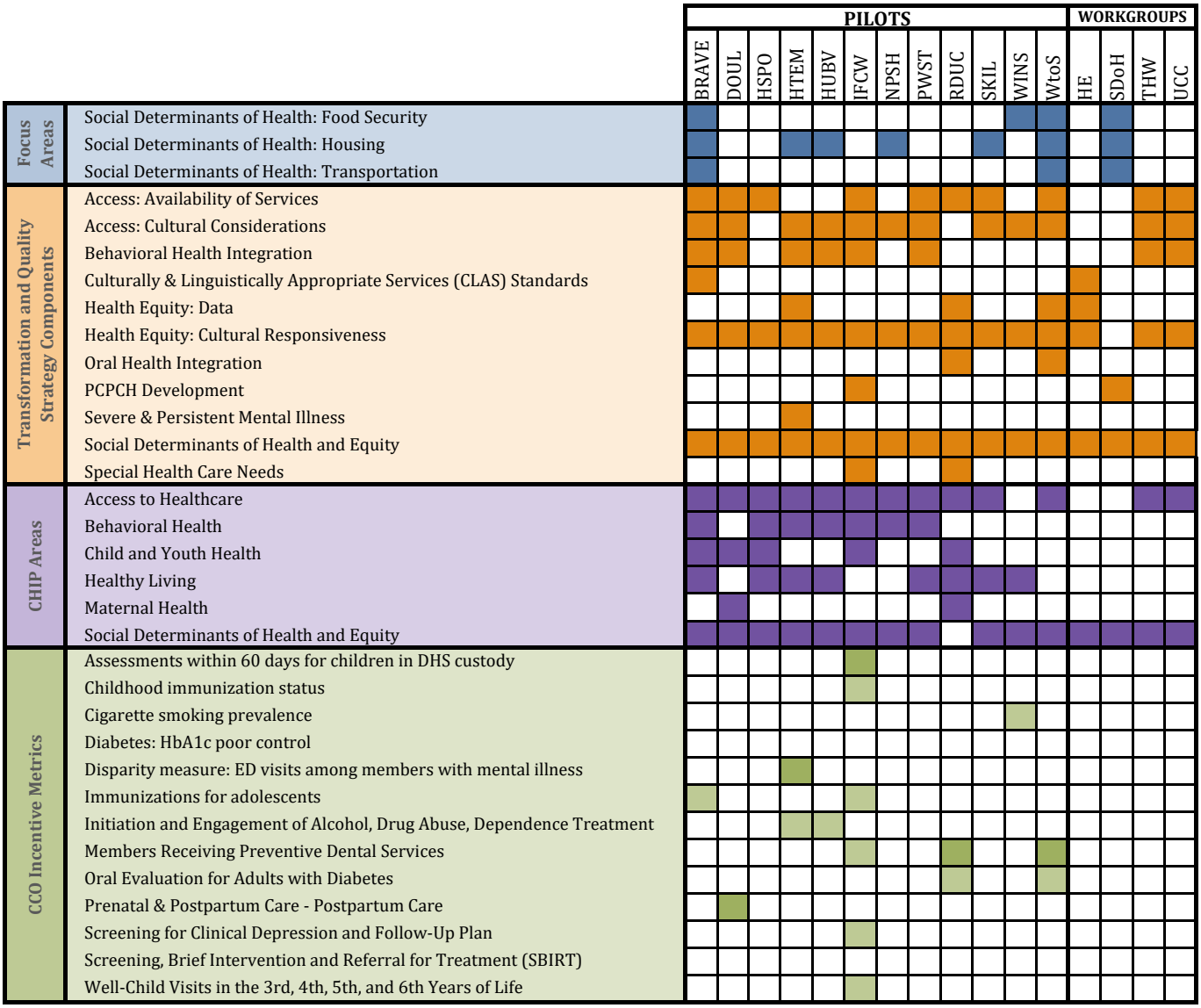
Tentative closeout	Booked closeout
Tentative RFP	Booked RFP
Tentative strategic planning	Booked strategic planning
Tentative miscellaneous	Booked miscellaneous
Tentative training	Booked training
Tentative update	Booked update
Tentative workgroup	Booked workgroup

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

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

Minutes
Delivery System Transformation Committee

March 5, 2020 4:30 – 6:00 pm

Samaritan Health Plans Walnut Building, Endeavor Conference Room

Present			
Paulina Kaiser	Kevin Ewanchyna	Christine Mosbaugh	Jeff Blackford
Dick Knowles	Larry Eby	Ronda Lindley-Bennett	Kedo Baye
Giovanni Galvez	Charissa Young-White	Angel Parmeter	Britny Chandler
Priya Prakash	Shirley Byrd	Crystal Scheese	Shannon Rose
Sherlyn Dahl	Nancy James	Rebekah Fowler	Kimberly Lane
Lalori Lager	Allison Myers	Kara Beck	Melissa Cheyney
Phone:	Bettina Schempf	Erin Sedlacek	Nicole Fields
Karen Hall	Elijah Johnson	Deb Fell-Carlson	

Transformation Update: Charissa White

Census 101

- An outreach program to encourage community members to fill out their Census that would like to present to the DST.
- Agreed to invite for presentation.

Planned and Crisis Respite Care Scorecard Results

- Scored low on all areas.
    - This is not necessarily a failure; the DST learns from challenges.
    - DST can proactively ask about reach and offer scaling-up support to future pilots.
    - Pilot does not feel transformative. Spread practice to a new area but did not offer a new solution.
    - Upstream concern is lack of foster care homes intervention.

2019 Quarterly Report

- 2019 Quarter 4 pilot reports are posted to IHNtogether.org.
- New template for the future that will hopefully enable the reports to be a bit more digestible.

Request for Proposal Discussion

Scoring Rubric

- Cost is difficult to measure, language changed to influence rather than reduces.
    - Discussed what different aspects of cost are being addressed.
        - Claims cost, health care services, social services.
        - Acknowledge cost increase as well as decreases.
- **To Do:** Adjust to represent total costs rather than reduces costs. Mirror language in health improvement section.

Community Health Improvement Plan (CHIP) Health Impact Areas

- The DST decided to focus on Access, Behavioral Health, and/or Social Determinants of Health and Equity.
- Lincoln City as a focus as it is often the least resourced area in the region.
- Transformation to pull information on the following pilots in those categories.
- Access
    - Traditional Health Workers:
        - Child Abuse Prevention and Early Intervention
        - Traditional Health Worker Hub
        - Community Health Workers
        - Community Health Workers in Lincoln County
        - Health and Housing Planning Initiative
        - School/Neighborhood Navigator
        - Communities Helping Addicts Negotiate Change Effectively (C.H.A.N.C.E.)
    - Community Paramedic
    - Expanding Health Care Coordination

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- Behavioral Health
  - Focus on reducing the stigma of mental health concerns and integration into primary care.
  - Integration pilots:
    - Child Psychiatry Capacity Building, Licensed Clinical Social Worker in the Patient-Centered Primary Care Home (PCPCH), Behavioral Health in the PCPCH, Primary Care Psychiatric Consultation
  - The Walden Project: Nature Therapy (formerly The Warren Project)
  - Mental Health Literacy
- Social Determinants of Health (SDoH)
  - Housing: The SDoH Workgroup will finalize a set of housing funding recommendations and present to the DST.
  - Transportation
    - CHANCE 2nd Chance
    - Non-DST pilot: Rideline and IHN-CCO's Well Care Pilot.
  - Food Security
    - Social Determinant of Health with a Veggie Rx Intervention
    - Veggie Rx in Lincoln County
    - Breastfeeding Support Services
    - Children's SDoH and ACEs Screening

Next Meetings

- Concerns about meetings moving forward due to emerging illness.
- One to two meetings could be missed without impacting deliverables severely.
- Potential to meet via Microsoft Teams only, no in-person.

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
Total Cost of Care	Unlikely to result in improvement of the total cost of care for IHN-CCO members	May result in improvement in the total cost of care for IHN-CCO members	Likely to result in improvement in the total cost of care for IHN-CCO members	Likely to result in significant improvement in the total cost of care for of IHN-CCO members	Will result in significant improvement in the total cost of care for IHN-CCO members
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	Likely to result in significant improvement in the total cost of care for IHN-CCO members	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

Social Determinants of Health Workgroup
Draft Recommendations for Housing Funding, Policy, and System Change

Background
The recommendation to IHN-CCO from the Social Determinants of Health Workgroup begins with establishing desired goals and outcomes for Social Determinants of Health (SDoH) work. This is achieved by aligning with CCO 2.0 metrics to develop more specific work plans to achieve desired outcomes and to establish promising practices to move to system integration or community commitments.

The SDOH workgroup would also like to encourage internal operations of IHN-CCO to consider integration of priority areas outlined within these recommendations through documentation (policies, processes, and procedures) to assist in fulfilling contractual obligations outlined by the State of Oregon for the use of Medicaid funds.

The priority areas of Housing, Food Security, and Transportation were developed through evaluation of the Community Advisory Council's Community Health Improvement Plan, the regional Community Health Improvement Plans, and the Delivery System Transformation (DST) Committee's four workgroups; Social Determinants of Health (SDOH), Health Equity, Traditional Health Workers (THW), and Universal Care Coordination (UCC).

Vision

We can live in a community where everyone has access to a decent, stable and affordable place to call home.
When we focus on housing as a social determinant of health, we create a better future for all of us in the CCO service area.

A broad **definition** of housing is used to include not only under-housed, but also safe housing, assuring housing is free from health risks, and affordable housing options for individuals and families. Throughout these recommendations, the SDoH workgroup will strive for connectives of services to ensure closed loop referrals and assistance.

Key Takeaways:
- Ensure rural communities are included in the conversation and recognize lack of resources in these communities.
- Align funding streams.
- Create mechanism for communication about different assistive services.

Thank you to all the organizations and individuals that worked to create these recommendations:

Albany Partnerships for Housing and Community Development, C.H.A.N.C.E., Community Advisory Council Coordinator, Community Health Centers of Benton and Linn Counties, Creating Housing Coalition, Early Learning Hub, IHN-CCO Director of Government Affairs, Provider Network and Contracting, and Transformation, Jackson Street Youth Shelter, Lincoln County Health and Human Services, Linn Local Committee of the Community Advisory Council, Live Longer Lebanon, Olalla Center for Children and Families, Oregon State University Center for Health Innovation, Oregon West Cascades Council of Governments, Regional Health Assessment, RideLine, Samaritan Health Plans Care Coordinators, Samaritan Health Services Care Coordinators, Samaritan Health Services Public Relations, Signs of Victory.

FUNDING RECOMMENDATIONS TO IHN-CCO

Recommendation	Funding Stream
1. Support traditional health workers (THWs) in the housing sector to connect members to supportive services. Increase the number of THWs in the housing sector by at least one per county. Partnerships include: o Current or past DST pilots such as DevNW, Creating Housing Coalition, and Corvallis Housing First. o Engaged partners such as Albany Partnerships for Housing and Community Development and Signs of Victory. o New ones such as with the Community Services Consortium, Lincoln County School District, and other like entities.	• Delivery System Transformation Committee (DST)
2. Increase reimbursement and funding to improve mold abatement, home repair, pest management, and home safety modifications made by current residents and proactively by lot managers/owners. o Convene agencies doing similar work to ensure gaps in current funding streams are addressed. Conduct environmental scan to reduce duplication of services.	• SHARE Initiative
3. Prioritize flexible funding to support reimbursement and funding for temporary housing support such as transition to stable housing, temporary rental assistance, and budgeting gaps. o The Social Determinants of Health Workgroup requests a conversation with the IHN-CCO Medical Management Department to discuss referral pathways for flexible services to ensure awareness of the community, members, and providers.	• Health Related Services: Flexible Services

OTHER RECOMMENDATIONS

Policy	
• Create and publish a policy statement for safe, healthy, and affordable housing supporting: o Prohibition of substandard housing conditions; o Anti-discrimination laws in the housing sector; and o Equity in access to safe and affordable housing.	• IHN-CCO Leadership
System Change	
• Improve discharge planning to better meet the needs of those who are or are at risk of becoming homeless (e.g. screening for stable housing and having closed loop referral pathway for those who present as high risk).	• Health Care System (SHS)/RPC
Data	
• Define, collect, measure, and report housing status outcomes of interest associated with housing and traditional health worker initiatives.	• Housing Entities
• Identify process for data collection regarding housing status.	• IHN-CCO
• Utilize existing and future data to view disparities such as: o Neighborhood/zip code and indicators. o Pockets of members who are currently living in substandard or supportive living.	• IHN-CCO
Trainings	
• Increase awareness of prevention-oriented trainings in the housing sector such as Housing 101 for partners.	• Housing Entities
• Develop clinical staff training in: o Data collection o SDoH screening tools o Closed loop care model	• IHN-CCO/Traditional Health Worker Hub

DST Pilot Summaries – Let's look at our success stories

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Child Abuse Prevention & Early Intervention
Family Tree Relief Nursery
1/1/2015 – 12/31/2016

The Child Abuse Prevention and Early Intervention pilot increased collaboration between Family Tree Relief Nursery's (FTRN's) Home-Based program, IHN-CCO medical providers, and Oregon Department of Human Services (DHS) Child Welfare. The project increased access and transition for high-risk IHN-CCO families using a blended service model of FTRN's Home-Based Interventionist and Traditional Healthcare Workers (THWs) as an innovative way to assist families. FTRN is a private, nonprofit organization that provides child abuse and neglect prevention services to low income families with children under the age of six. FTRN provided complete and integrated services to help children and their families stay together as a family unit.

Pilot Activities:

1. A therapeutic classroom and nursery
2. Parent education and support
3. Home visits and outreach services
4. Respite care and crisis intervention
5. Referral for drug and alcohol treatment and services
6. Referral to other community resources such as housing, food, or the Department of Health and Human Services (DHS)

Key Findings:

1. Creation and utilization of a common touches report; this allows Traditional Health Workers (THWs) to track the services they provide in order to show the value of the work they do in the community.
2. Training of 6 Peer Support Specialists (PSSs).
3. Training of a Community Health Worker (CHW).
4. Strengthened communication and better referral pathways with Mid-Valley Children's Clinic
5. Creation of an Alternative Payment Methodology (APM) that led to a contract with IHN-CCO for THW services as of January 2017.
6. 53 families screened for Adverse Childhood Experiences (ACEs); a common screening tool that helps identify trauma in childhood.
7. Increased access for IHN-CCO members to the Patient-Centered Primary Care Home (PCPCH).

Additional Findings:

1. Operationalized! Services and activities continue to expand.
2. After 2 years of the pilot project, FTRN and IHN-CCO entered an APM contract in January 2017.
3. The contract sustains and expands funding as well as the number of members served.
4. Aligns Touch Report with multiple organizations for targeted services impacting CCO metrics.

Traditional Health Worker Hub

Benton County Health Services and Traditional Health Worker Hub Workgroup

7/1/2017 – 12/31/2018

The Traditional Health Worker (THW) Hub supports, trains, and supervises Birth Doulas, Community Health Workers (CHWs), Health Navigators (HNs), Peer Support Specialists (PSSs), and Peer Wellness Specialists (PWSs) for primary care and community agencies in the IHN-CCO region. The THW Hub is a collaborative approach based upon a collective impact model to facilitate change in the healthcare delivery system through coordination of multiple organizations. The Hub monitors curriculum and THW program fidelity, provides technical assistance in how to incorporate THWs into a hiring agency, and maintains a local THW Support Network.

Pilot Activities:

1. Adapted Multnomah County's "We are Health" CHW training curriculum to suit the region.
2. Renamed it the "Tri-County CHW Curriculum" and received approval from the Oregon Health Authority.
3. Held two THW trainings: one targeted for Benton and Linn Counties and one in Lincoln County.

Key Findings:

1. Successful development of the Tri-County CHW Curriculum.
2. Trained 33 THWs who are eligible for certification and registration with the Oregon Health Authority.
3. Developed a team of trainers/facilitators among participating community partners.
4. Developed a sustainable financial model.

Additional Findings:

1. Operationalized.
2. The Traditional Health Worker Hub collaborated with community agencies to strengthen partnerships in the Benton and Linn region and created new partnerships in Lincoln County.
3. The THW Hub is sustained through billing IHN-CCO, charging for services, and expansion of continuing education tracks.

Community Health Worker
Benton County Health Department
10/1/2014 – 12/31/2016

This pilot provided qualified Community Health Workers (CHWs) and Health Navigators (HNs) as part of the IHN-CCO members care team. CHWs/HNs provided assistance that is culturally and linguistically appropriate to members who need to access services and participate in processes affecting their care. The pilot used CHWs/HNs who share ethnicity, language, socioeconomic status, and/or life experiences with the residents of the communities they serve to provide a range of services. These services included health education and information, health care system navigation, care coordination, limited case management, outreach, chronic disease self-management education and support, and referrals to social service and community resources.

Pilot Activities:

1. Uses CHWs to provide a range of services, including health education and information, health care system navigation, care coordination, limited case management, outreach, chronic disease self-management education and support, referrals to social service and community resources. CHWs work closely with Nurse Care Coordinators.
2. Builds on the Health Navigation Program at Benton County Health Services, which began in 2008, and further develops the infrastructure to hire, train, supervise, and evaluate a Clinical Community Health Worker program that can be integrated within provider clinics in the IHN-CCO service area.
3. Decreases health care costs and health disparities while improving health outcomes and satisfaction.

Key Findings:

1. Benton County Health Services (BCHS) successfully hired, trained, and integrated CHWs/HNs into their new clinical care teams.
2. Touch data showed increasing use of CHW services across all sites and which services CHWs/HNs most connected to.
3. It was important to have a project champion; provider or nurse; and a project lead, ideally clinic manager or supervisor.
4. Developed a comprehensive list of documents that can be shared with other agencies or CCOs and that can act as a roadmap to integrating CHWs/HNs into a clinical setting.

Additional Findings:

1. Operationalized!
2. Currently, the CHWs/HNs are being contracted with IHN-CCO through a per member per month payment methodology. BCHS is working with IHN-CCO to determine if this is the best way to do this and, if so, what is the best methodology going forward.

Community Health Workers in North Lincoln

Women's Health Clinic and Samaritan North Lincoln PCPCH's

9/1/2016 – 12/31/2017

With funding from IHN-CCO, this pilot integrated Community Health Workers (CHWs) within Patient- Centered Primary Care Homes (PCPCHs) and the North Lincoln County community. CHWs in the clinic further engaged patients in their care and helped patients make connections within their own community. The CHWs helped create barrier-free access to healthcare, a closed loop referral system for accessing community resources, and taught healthcare/lifestyle classes. Due to recruitment issues in the region, the pilot also worked to create a training center with other area organizations.

Pilot Activities:

1. Trained a CHW in the state approved CHW training program.
2. Established electronic recording system based on the Oregon Health Authority's Touches Report to track CHW encounters.
3. Developed a referral tracking system to track referrals between clinic and other agencies using the Electronic Health Record (EHR).

Key Findings:

1. Established tracking system for the CHWs to show the value of their work.
2. Decreased urgent care visits while increasing PCPCH visits.
3. Increased provider satisfaction.

Additional Findings:

1. Sustained.
2. The work will continue with the CHWs in the clinics and the work that was not completed in the pilot timeframe will be focused on.

School/Neighborhood Navigator
Benton County Health Department
4/1/2016 – 6/30/2017

This pilot addressed the Social Determinants of Health by imbedding bilingual, bicultural school/neighborhood navigators into a Title-I school community that serves the highest number of low-income, minority children in Benton County. This facilitated linkages between families, schools, community resources, and the healthcare delivery system to improve community health outcomes. The pilot focused on linking the intervention directly to improved health outcomes, such as increased healthcare visits for well-child checks, provider visits, vision, and dental services for students and their family members.

Pilot Activities:

1. Engaged "hard-to-reach" families and parents by catching their ear at school drop-offs and pick-ups
2. Presented "Teen Health Talks" in English and Spanish to educate parents and teens.
3. Helped families in poor housing situations find new places to live.
4. Helped children and families connect with their Patient-Centered Primary Care Home (PCPCH).
5. Verified immunization status and helped parents set up appointments.
6. Connected families to food programs and other community resources.
7. Provided transportation to medical appointments that were too difficult for families to attend.
8. Requested interpreter services for medical appointments.
9. Connected children to counseling and other behavioral health services.

Key Findings:

1. Increased number of IHN-CCO members served.
2. Increased the percentage of Primary Care Physician visits by IHN-CCO members.
3. Built strong relationships and community trust between Benton County Health Services and other organizations.
4. The pilot is replicable with well-trained Health Navigators.

Additional Findings:

1. The School/Neighborhood Navigator program is in place and has been sustained through the school district and Benton County Health Services.

Health & Housing Planning Initiative
Willamette Neighborhood Housing
1/1/2016 – 8/31/2017

The main goal of this pilot was to provide health navigation services to connect residents with healthcare and social services delivered where people live. The focus was on residents of Willamette Neighborhood Housing Services properties in Linn and Benton Counties. The pilot developed new cross-sector partnerships that integrated affordable housing with improved access to healthcare services and opportunities for healthy living.

Pilot Activities:

1. Developed internal systems for earlier interventions on evictions using a Trauma Informed lens.
2. Created and enhanced relationships with local nutrition experts to provide educational opportunities to residents around gardening and nutrition.
3. 81 new health-related activities held on or near the properties during the pilot.

Key Findings:

1. Community Health Workers (CHWs) made 733 referrals to healthcare providers and services.
2. 97 evictions were prevented through pilot interventions.
3. CHW services most valued by residents were one-on-one connections, eviction intervention and prevention, health navigation, and appointment support.
4. Engaged 588 residents with health-related programming delivered onsite or near-site.
5. Decrease in Emergency Department (ED) visits (22 less visits) and cost savings of $33,290.

Additional Findings:

1. Operationalized!
2. The Health and Housing Planning Initiative is scalable and replicable; however, funding is limited, and work is being done to find an Alternative Payment Methodology (APM), or other fundraising for the program.

ACCESS: Other

Community Paramedic
Albany Fire Department
7/1/2017 – 6/30/2018

With funding from IHN-CCO, the Albany Fire Department piloted Community Paramedic. Community Paramedic was a model of community-based healthcare in which paramedics functioned outside their customary emergency response and transport roles to facilitate more appropriate use of emergency care resources and enhanced access to primary care for medically underserved populations. Development of the referral system and alternative payment methodologies (APM) was a large goal of this pilot to ensure long-term sustainability.

Pilot Activities:

1. Worked to establish sustainable APM.
2. Provided in-home evaluation and services to reduce repeat patient entrance into the healthcare system.
3. Established referral criteria and process with healthcare providers that also targets IHN-CCO members.
4. Established patient status communication system between healthcare providers, particularly Patient-Centered Primary Care Homes (PCPCHs), and the Community Paramedic pilot.
5. Provided medical bracelets for patients with Traumatic Brain Injury (TBI).
6. Installed fall prevention devices in patients' homes to reduce falls.
7. Conducted medication reconciliation and evaluated/updated in-home care for dementia.
8. Identified and tracked issues that cause IHN-CCO members to call 9-1-1 and developed resolutions to reduce the most common issues.
9. Conducted a cost- effectiveness analysis.
10. Held monthly meetings with law enforcement and mental health providers to determine frequent users of emergency response systems and developing coordinated care plans for those users.

Key Findings:

1. As reported, they had 481 participants.
2. Referred 159 IHN-CCO members to alternate care.
3. Made 79 referrals to mental health providers.
4. Reduced number of ambulance transports to the emergency department.
5. Saw a reduction of 9-1-1 calls from members in the program.

Additional Findings:

1. Lots of talk about APM and SHS contracts with the pilot.
2. Unfortunately, this pilot has not been operationalized, although we know at least some services are continued with the Albany Fire Department.

Expanding Health Care Coordination

Samaritan Family Medicine Residency Clinics in Corvallis, Albany, and Lebanon

11/1/2016 – 4/30/2018

This pilot examined and compared different methods for Medical Assistants (MAs) to extend care coordination to IHN-CCO members. In one approach, MAs proactively engaged members to attend necessary follow-up care. Another expanded the role of MAs to work side-by-side with the provider in the exam room during patient visits to document and assist with orders. The MAs wrapped up the visits and helped patients arrange testing, treatments, and follow-up. Shifting appropriate tasks to the MAs ensured better care coordination and allowed providers to engage with patients and manage more complex medical care.

Pilot Activities:

1. Improved patient access to care and patient satisfaction.
2. Established workflow processes to be utilized by all clinical care teams.
3. Empowered MAs to manage population health and work to their highest credentials.
4. Transformed the culture of the clinics to a proactive approach to health by creating a stable infrastructure.
5. Developed and implemented training to enhance MA role to include pre-visit planning, rooming workflow, scribing and after visit care.

Key Findings:

1. Improved key metrics for diabetes care.
2. Improved colon cancer, hypertension, tobacco and chlamydia screening rates.
3. Created and established protocols and workflows for MA training.

Additional Findings:

1. Sustained.
2. The educational resources and training provided will be maintained and integrated more into staff education. Outreach to patients will continue within the clinic when time permits.

BEHAVIORAL HEALTH: Integration

Child Psychiatry Capacity Building
Samaritan Mental Health Family Center
9/1/2014 – 8/30/2016

Access to specialty mental health care for children and adolescents is very limited both nationally and locally. This leaves kids with complex psychiatric needs, both diagnostic and medical, with significantly limited access to care. Behavioral Health integration projects such as this pilot take some of the workload off specialty mental health by shifting care for relatively straightforward cases to the primary care provider, allowing the specialty mental health psychiatrist to focus on the more complex cases. The specialty mental health provider worked with the primary care provider to offer on-going support and care coordination.

Key Findings:

1. As reported, at 140 patients, the new model has almost doubled the patient capacity of the old model, greatly increasing capacity for psychiatric services in the area.
2. No-show rate has plummeted. People come when they need help and appreciate not coming when they do not need help.
3. Psychiatrist burnout did not increase even though patient panel has shifted to high acuity patients. Model allows for lighter daily schedule.
4. Model could be adopted by other specialties.

Additional Findings:

1. Operationalized!
2. The new model uses a Mental Health Specialist (MHS) that is trained to gather psychiatric data. The initial data gathered by the MHS reduced the initial visit time from 90 minutes to 30 minutes. Follow up visits every 3 months instead of monthly, or as needed. The MHS kept in touch by phone, usually 2-6 phone calls in between visits.
3. The payment model used was a capitated service paid out per patient per month initially based on the cost to IHN-CCO for a monthly medication recheck visit.

Licensed Clinical Social Worker in the PCPCH

Samaritan Mental Health

9/1/2014 – 6/30/2016

This pilot provided a lower cost way of delivering mental health services in a Patient-Centered Primary Care Home (PCPCH) and increased the number of IHN-CCO members that can access mental health care. Samaritan Mental Health provided a Licensed Clinical Social Worker (LCSW), with over 20 years of Oregon experience, to serve as a Student Field Instructor to select, supervise, and provide additional training for medical and social work student trainees. Services for IHN-CCO members included individual and group psychotherapy, behavioral activation (an evidence-based intervention), supportive assistance, development and implementation of group classes, and help connecting to outside community resources.

Key Findings:

1. Bringing Master of Social Work interns into the delivery system expanded access by providing low/no cost care for patents while also serving as an important form of workforce development by training future employees at low cost.
2. Demonstrated how LCSWs can be used to decrease wait time, stigma, costs, and other barriers to accessing mental health service.
3. An experienced LCSW in the PCPCH provide opportunities to educate patients and staff and improves understanding of the connection between mental and physical health in treating stress related illness.
4. Produced several examples of how patients were able to transform their physical health once they had the tools to address their mental health.

Additional Findings:

1. Curriculum for psychoeducational classes developed as part of this pilot is available to providers serving IHN-CCO members.

Behavioral Health in the PCPCH

Corvallis Family Medicine

10/1/2014 – 12/31/2015

The Corvallis Family Medicine offered behavioral specialist services to IHN-CCO members. By having a behavioral specialist perform behavioral services in a clinical setting, it allowed doctors and mid-level practitioners to remain available to function at the highest clinical level in their skillset. This allowed the provider base to maintain the depth necessary to serve the increasing numbers of IHN-CCO members in need and assist with timely treatment of depression, anxiety, ADHD, PTSD, ASD, OCD, and behavioral disorders which often cripple individuals and families. These slower paced visits offered a chance to improve health literacy, adherence to treatment protocols and improved outcomes for the member.

Key Findings:

1. Integration/collaboration was successful: It was found that, especially given the moderate size of our clinic, collaboration between Mental Health (MH) practitioner and Primary Care Physicians (PCPs) was easily forged. There have been frequent and ongoing correspondences regarding the overall well-being and treatment of patients. In addition, on occasion, the therapist has been able to briefly join the PCP for patient visits in order to offer a team approach toward treatment.
2. Treatment of patients was successful according to ongoing verbal and written patient assessments.
3. Billing avenue was successful: By the final quarter, our billing staff successful submitted all IHN-CCO encounters for mental health.
4. Consistent expedited services offered: 9 of 30 patients reported an inability to find immediate mental health support elsewhere in the community. Received approximately five calls from IHN-CCO patients with PCPs in other clinics wishing to start access MH services at CFM. Received an additional 6 calls from patients with referrals from Benton County Mental Health.
5. Increasing health literacy: Much of this was done by exploring individual and family barriers to treatment protocol and offering education. Implementing SBIRT screening and intervention helped 3 patients recognize problem drinking and consequential effects on health.

Additional Findings:

1. Operationalized!
2. Pilot site now continuing services using fee for service to provide integrated BH in PCPCH.

BEHAVIORAL HEALTH: Other

The Warren Project: Nature Therapy
Olalla Center for Children and Families
11/1/2016 – 4/30/2018

Olalla Center for Children and Families, a mental and behavioral health provider, collaborated with Community Services Consortium on this outdoor-based therapeutic care model. This pilot integrated physical and mental health therapies with experiential learning in a natural setting and offered early intervention strategies for adolescents and families. Through an equity lens, the pilot worked in a very rural and underserved county to overcome health obstacles, such as poverty and literacy, while utilizing culturally appropriate methods, bilingual and multi-cultural staff and partners, and specialized training in family dynamics, adolescents, and LGBTQ needs.

Pilot Activities:

1. Created a mentoring program connecting youth and community members.
2. Provided transportation and support, court, Child Welfare, and other appointments.
3. Served over 50 youth with over 70 referred to the Warren Project.
4. Provided equine therapy through the Pegasus Program.
5. Overnight camping trips for program graduates.
6. Held family classes on Saturdays so families could participate.
7. Partnerships with Oregon Coast Community Forest and Seal Rock Stables to access over 200 acres over two locations.
8. Created a nature connection for therapeutic activities.

Key Findings:

1. Created lasting partnerships and collaborations between community members and organizations.
2. Staff morale increased with no staff turnover.
3. Increased access to services.
4. Better outcomes compared to the traditional outpatient model.
5. Created the sense of a village to support youth.

Additional Findings:

1. The Warren Project: Nature Therapy has been sustained. Now known as the Walden Project.

Mental Health Literacy
Samaritan Marketing
7/1/2013 – 8/1/2015

Samaritan Marketing developed an effective communications campaign to increase awareness among primary care providers, community and faith-based organizations, and local schools in Linn County, and within IHN-CCO, of the ways they can take action to improve the wellness of people with mental health problems. This pilot looked at a bigger meaning of wellness – emotional, physical, intellectual, environmental, financial, social, spiritual, and occupational. This pilot took a three-phase approach:
Phase I – Linn County
Phase II – Expansion to Lincoln and Benton County
Phase II - Tri-County Latino Campaign
The Marketing team developed and implemented culturally appropriate, mental health literacy campaigns in English and Spanish language for Benton and Lincoln counties to build on the success of the initial pilot project in Linn County and benefit from the post-campaign research.

Additional Findings:

1. One-time project.

Children's SDoH and ACEs Screening
Mid-Valley Children's Clinic's Children's
1/1/2018 – 12/31/2018

MidValley Children's Clinic (MVCC) implemented a combined social determinants of health (SDoH) and Adverse Childhood Experiences (ACEs) screening tool at well child checks. MidValley Children's Clinic is a large and diverse pediatric clinic in Linn County, Oregon. Positive screens are referred to the Community Health Worker (CHW) or Social Worker. The pilot uses the existing Center for Youth Wellness (CYW) screening tool for ACEs and evidenced based questions to screen for food security, housing, and utility stability, childcare availability, transportation, and health and dental care accessibility. The primary pilot goal is to improve the health and wellbeing of families who are experiencing, or who have experienced, violence and trauma, and who have a need for connection with social resources.

Pilot Activities:

1. Determine the most appropriate screening tools for the clinic.
2. Establish a workflow incorporating these screenings.
3. Determine increased demand on Social Worker and Community Health Worker due to screening.

Key Findings:

1. Screened 80% of children for SDoH, 15% had a least one need.
2. 172 referrals made for families in need.
3. Families currently not in need were made aware of the assistance available at MVCC.
4. ACE Screening: Over 140 families screened.
    - 13% have a score of 4 or higher
    - 26% have a score of 2 or higher
    - 13% have at least 2 additional stressors
5. Building trauma awareness and resilience through Trauma Informed Care (TIC) training for staff and parenting education.

Additional Findings:

1. Screening will continue in the clinic given that there is a staff member to provide connections with resources. The SDoH screening was the most successful.
2. Sustained.

SOCIAL DETERMINANTS OF HEALTH: Food Security

Social Determinant of Health Screening with a Veggie Rx Intervention
Benton County Health Services and Corvallis Environmental Center
7/1/2017 – 12/31/2018

With funding from IHN-CCO, Community Health Centers of Benton and Linn Counties and Corvallis Environmental Center (CEC) implemented the Veggie Rx model to increase capacity for food screening in the Patient-Centered Primary Care Home (PCPCH) and created partnerships with local food agencies and food security programs. The Veggie Rx model increases the availability of fresh fruits and vegetables to meet the daily needs of individuals and families.

Pilot Activities:

1. Connection to the Oregon Community Food Systems Network (OCFSN) to:
    - Learn about Veggie Rx models in Oregon.
    - Standardize data and evaluation for Veggie Rx model.
    - Sustain the concept and model.
2. Partnership between health care and Community Based Organization to address a Community Health Improvement Plan (CHIP) area.
3. Presented pilot process and outcomes at the CCO Oregon Winter Conference, Oregon Health Authority Innovation Café, Oregon Primary Care Association event, and Coast to Cascades Annual Education event.

Key Findings:

1. Experience using Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) as a tool to collect social determinants of health (SDoH) data.
2. Provided tokens for food resource to patients who were food insecure.
3. Increased access and opportunity to interact with the local food system.
4. Presented education and held training on the importance of SDoH data collection.

Additional Findings:

1. The next steps will be to continue the work with Oregon Community Food Systems Network (OCFSN) for evaluation of Veggie Rx and how to have a sustainable model with the new CCO contracts starting in the year 2020.
2. Operationalized!

Veggie Rx in Lincoln County

Lincoln County Health and Human Services, Lincoln County School-Based Health Center and Food Share of Lincoln County

Timeframe: 1/1/2018 – 6/30/2019

The Lincoln County Health and Human Services partnered with Lincoln County School-Based Health Centers and Food Share of Lincoln County to successfully implemented a food insecurity screening process in four School-Based Health Centers and subsequent referral process to Food Share of Lincoln County. Food Share then provided nutrition education through seasonal toolkits and Cooking Matters classes to families who screen positive and redeem their Veggie Rx vouchers. In addition to assisting with the development of nutrition-education toolkits, this pilot has strengthened existing and new partnerships with local vendors and volunteers.

Pilot Activities:

1. Decrease rate of food insecurity among Lincoln County youth and their families through a system of screening at schools and referral to Food Share of Lincoln County.
2. Increase the knowledge of healthy eating and self-efficacy of families to cook healthy meals through nutrition education and family cooking classes.
3. Increase the capacity of Food Share of Lincoln County to provide fresh produce and nutrition education through volunteer recruitment and supplementation by local growers.
4. Decrease rates of chronic disease in Lincoln County by increasing access to healthy food and giving students and their families the tools, they need to make healthy meals.
5. Increase the physical and mental wellbeing of youth and their families by reducing stigma associated with food insecurity and providing for their basic needs.

Key Findings:

1. As reported, 100% of students who go to a School-Based Health Center are now screened for food insecurity.
2. 100% of students who screen positive for food insecurity are given the chance to enroll in the Veggie Rx program.
3. 118 IHN-CCO members received fresh produce through the Veggie Rx program.
4. Over 1,600 pounds of fresh produce was distributed through this pilot.

Additional Information:

1. The Veggie Rx program will continue with the help of their existing partners. The partner organizations on this project are willing to take on additional duties to make the Veggie Rx program sustainable.
2. Sustained.

Breastfeeding Support Services
Linn County Public Health WIC Program
7/1/2016 – 9/30/2018

The Linn County Women, Infant, and Children (WIC) reduced the barriers new mothers have in being able to successfully breastfeed their children. The pilot achieved this through the placement of a Spanish speaking International Board-Certified Lactation Consultant (IBCLC) in the Samaritan Lebanon Health Center pediatric office and by expanding breastfeeding support services in WIC clinics. By the placement of a Lactation Consultant in the clinic setting, evaluation and consultation to the mother-baby is provided in coordination with the other medical services delivered by primary care staff. An IBCLC's contribution to the care of the new breastfeeding family meets the American Academy of Pediatrics recommendations that breastfed babies be seen within 3 to 5 days of birth.

Pilot Activities:

1. Client consultations.
2. Started two breastfeeding support groups for breastfeeding families.
3. Held breastfeeding classes for public health nurses.

Key Findings:

1. Babies who saw the lactation consultants were more likely to be exclusively breastfed at 2 months.
2. Credentialing and billing insurance companies are new modes of sustainability for IBCLCs.
3. Increased collaboration among WIC and pediatric providers.
4. Breastfeeding groups provide support for families that breastfeed.

Additional Findings:

1. Linn County Women, Infant, and Children is pursuing sustainability through provider credentialing and billing.
2. Operationalized!

SOCIAL DETERMINANTS OF HEALTH: Transportation

CHANCE 2nd Chance

Communities Helping Addicts Negotiate Change Effectively (CHANCE)

7/1/2017 – 12/31/2018

Communities Helping Addicts Negotiate Change Effectively (C.H.A.N.C.E.) developed a program to set in place a system of support for peers. C.H.A.N.C.E. is an addiction and recovery center that engages with people at all levels of their recovery with mental health and substance abuse disorders. The program focuses on meeting daily needs, reducing health disparities, and increasing health engagement. Goals of the pilot include increasing permanent housing, employment, education, and other necessary support networks for those with the challenges associated with mental health and addiction recovery.

Pilot Activities:

1. Emergency and transitional housing support.
2. Education around quality health, healthcare, and navigation.
3. Transport support.
4. Reintegration back into the community.
5. Case management and peer support to help individuals overcome barriers.

Key Findings:

1. Helped 278 people get into or keep housing.
2. Assisted with over 100 resumes, 32 food handler cards, and 35 gift cards for employment purposes.
3. Helped 38 peers with identification and birth certificate needs.
4. Provided transportation to detox and inpatient treatment facilities, over 300 bus tickets, individual trips to the grocery stores, doctor appointments, support groups, job interviews, and related needs.

Additional Findings:

1. This project will be sustained as 5-6% of the monthly Per Member Per Month (PMPM) contract with IHN-CCO will be allocated for continuation of services.
2. Operationalized!

Rideline's Well Care Program
(**NOT** a DST pilot, but an IHN-CCO pilot)
Oregon Cascades West Council of Governments (OCWCOG)

The Cascades West RideLine's Well Care Program aims to provide transport to additional services that will enhance overall wellness and quality of life for members by improving social determinants of health, ultimately reducing possible hospital admissions, emergency department, and urgent care visits. The Well Care Program is intended to be a short-term support for IHN-CCO members. Referrals to the program should be made by Health Care Navigators/Guides, Care Coordinators, medical or public health staff or other specified facility staff. Well Care assistance is intended to provide short term transportation support to elevate a participant's health status.

Eligibility Criteria:

1. Medicaid eligible
2. Resident of Linn, Benton or Lincoln County
3. Little to no transportation options
4. Chronic illness/disorder or multiple chronic health conditions
5. Complex medical, social, financial needs
6. Lack of social support
7. Cognitive, willing participant

Examples of Services:

1. Health education/self-management classes
2. Access to healthy foods
3. Social isolation
4. Emotional, behavioral and/or mental health support.

Additional Findings:

1. Unfortunately, this pilot could not be sustained.

Discussion Points

- Do we want to use these pilots as examples to provide for the Request for Proposal for Innovative Strategies?

- Do we want to spread these specific pilots? Do a Request for Proposal with these specific projects in mind as Spreading Promising Practices?

- Do we want to do a two-pronged approach? A mix of the two strategies above?