Agenda
Delivery System Transformation Committee

September 17, 2020 4:30 – 6:00 pm
Online Click Here: Join Microsoft Teams Meeting
Phone: +1 971-254-1254
Conference ID: 518 694 035#

1. Introductions		**Stephanie Jensen,** IHN-CCO	**4:30**
2. Transformation Update		**Charissa Young-White,** IHN-CCO	**4:50**
3. Request for Proposal Update		**Charissa Young-White,** IHN-CCO	**5:00**
4. Homeless Resource Team Closeout	p. 8-12	**Miranda Miller, Anita Earl, & Chiho Sakamoto Gunton,** Samaritan Health Services	**5:15**
5. SHARE Initiative	p. 13-16	**Charissa Young-White,** IHN-CCO	**5:35**
6. Wrap Up • Announcements • Next Meeting: October 1, 2020		**Stephanie Jensen,** IHN-CCO	**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 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
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	12/31/20
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	12/31/21
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	NO MEETING				
April	2	RFP Discussion				
	16	RFP Decisions				
	30	Strategic Planning: Universal Care Coordination		Finalizing RFP		
May	14	Health Equity Training				
	28	Transformation Update		LOI Process Review		
June	11	LOI Decisions				
	25	Board Disc.	Proposal Scoring Matrix			
July	9	Health Equity Training				
	23	Training and Updates	Pilot Updates			
August	6	Proposal Presentations				
	13	Proposal Presentations				
	20	Proposal Presentations				
September	3	Proposal Decisions				
	17	HTEM	RFP Follow Up	Strategic Planning		
October	1	Workgroup Updates		Strategic Planning		
	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

Minutes
Delivery System Transformation Committee (DST)

September 3, 2020 4:30-6:00 pm
Microsoft Teams (Online)

Present			
Chair: Beck Johnson	Charissa Young-White	Stephanie Jensen	Shawn Collins
Kim Lane	Melissa Cheyney	Renee Smith	Aimee Snyder
Priya Prakash	Annie McDonald	Elizabeth Gartman	Larry Eby
Andrea Myhre	Alicia Bublitz	Dick Knowles	Bill Bouska
Britny Chandler	Stacey Bartholomew	Bettina Schempf	Paulina Kaiser
Sharon Oldsfield	Rich Blum	Lynn Hall	Shannon Rose
Clarice Amorim Freitas	Linda Mann	Allison Myers	Kevin Ewanchyna
Rebekah Fowler	Stacey Bartholomew	Roslyn Burmood	

Transformation Update: Charissa Young-White

- IHN-CCO was able to apply more funds to this Request for Proposal for a total of $1.1 million.

Pilot Proposal Discussion and Funding Recommendation Decision

- The scoring summary (page 7) shows the average of all raters scores by component.
    - The ranking is left to right based on the sum total of each components scores.
    - The lower graphic shows the standard deviation among scores indicating agreement and disagreement among raters.
    - Darker red shows more deviation or disagreement.
- The ranking summary (page 8) is a heatmap showing the different groups by scores based on the raters scoring.
- The Regional Planning Council (RPC) will provide final decisions October 1, 2020.
- 19 eligible voters
- Using PollEverwhere (online platform) for anonymous voting, one voter could not get in and used the chat function of Microsoft Teams.
- **Decision:** Vote on moving the top four forward.
- **Decision:** The top four pilots per the scorecard are recommended for funding and will go to the RPC.
    - Community Doula Program
    - Healthy Homes Together
    - Hepatitis C Virus Outreach Screening & Treatment
    - Mental Health Home Clinic
- **Decision:** Vote on not moving the bottom two pilots forward.
- **Decision:** The bottom two pilots will not move forward.
    - Building a Trauma-Informed Community
    - Youth Peer Support
- **Decision:** Discuss the remaining 11 pilots then vote on each individually.
- Something to consider with all of these proposals is if they hinge on in-person, community-building work - some populations are harder to serve virtually - we may want them to ask again next round due to the pandemic.
- Sustainability is a low scoring component for many of the proposals. Sustainability as far as the DST is concerned is the ability to operationalize within the organization or receive consistent funding. Not being dependent on grants or fundraising activities.
- Comments and concerns over county equity:
    - Benton County does have significant pockets of poverty and inequity and need so the anti-Benton comments are concerning.

Minutes
Delivery System Transformation Committee (DST)

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  - The comments are not meant to be anti-Benton, but that the DST needs to consider that historically there have been more resources and funding invested in Benton county compared to Linn and especially Lincoln.
  - The DST has the ability to apply an equity lens to how funds are distributed to remedy some of those disparities, which other organizations may not.
- Unity Shelter Service Coordination
  - Many committee members felt ambiguous about awarding 1/6 of the total funds to a pilot that serves only the most well-resourced county.
    - The project could serve members from other counties, but it is based in Benton County.
  - The Social Determinants of Health connection will reduce future costs to the system.
- Linn County Crisis Outreach Response
  - There are virtually no services for people experiencing homelessness in that area.
  - High needs, high cost population.
  - It seems like a pilot with a high degree of partnership which allows it to be successful and therefore garner even more support.
- ENLACES
  - Linn County has few culturally aligned services for the Latino community members.
  - Huge gap in services that are needed especially in the Latino community.
  - Direct positive impact on historically under-served and under-represented population
- Disability Equity Center
  - Concerned about the Corvallis-centric possibility of this pilot, especially considering transportation as a large issue.
  - High virtual engagement that might be very useful for certain folks living with disabilities.
  - Example of effective engagement and empowerment for a historically disempowered group,
  - Benton County is a highly disability friendly environment - it would be Corvallis that would succeed.
- CommCard Program
  - Solid proposal, good return on investment, affordable, and easily transferable to other counties.
- Coastal Kids Mentoring Program
  - Mentor programs are very difficult to carry out.
  - Hard to see this one working in the COVID-19 environment.
- Partners with Parents and Children
  - Partnerships and collaboration are transformational.
- Culture of Supports
  - Should reach many IHN-CCO members due to dual eligibility as well as younger members with disabilities, even though this is a senior-based organization.
  - Called dual members because they are covered by both Medicare and Medicaid programs.
  - Difficult to compare to the CAHOOTS program in Eugene. Be cautious as this type of program is very difficult to carry out.
- Community Based Peer Support
  - Too high of a budget compared to other peer support projects.
- Hippotherapy Expansion Program
  - Transformational but not the right time.
  - Concerns the amount of budget per the number of IHN-CCO members it would impact.
- **Decision:** The below six proposals are recommended for funding and will move forward to the RPC for final approval.
  - ENLACES

Minutes
Delivery System Transformation Committee (DST)

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  - CommCard Program
  - Linn County Crisis Outreach Response
  - Culture of Supports
  - Partnership for Oral Health
  - Disability Equity Center
- **Decision:** The below five proposals are not being recommended for funding.
  - Unity Shelter Service Coordination
  - Coastal Kids Mentoring Program
  - Community Based Peer Support
  - Partners with Parents and Children
  - Hippotherapy Expansion Program

	Proposal Name	Yes	No	Abstain	Total	% Yes	Budget
Approved to go to the Regional Planning Council	Community Doula Program	17	0	2	17	100%	$151,455
	Healthy Homes Together	17	0	2	17	100%	$95,480
	Hepatitis C Virus Outreach Screening & Treatment	17	0	2	17	100%	$39,404
	Mental Health Home Clinic	17	0	2	17	100%	$149,155
	ENLACES	18	0	1	18	100%	$147,660
	CommCard Program	16	2	1	18	89%	$24,998
	Linn County Crisis Outreach Response	14	4	1	18	78%	$149,500
	Culture of Supports	13	5	1	18	72%	$75,438
	Partnership for Oral Health	12	6	1	18	67%	$49,601
	Disability Equity Center	10	8	1	18	56%	$157,500
Not Moving Forward	Unity Shelter Service Coordination	8	9	2	17	47%	$199,916
	Coastal Kids Mentoring Program	6	12	1	18	33%	$119,999
	Community Based Peer Support	6	12	1	18	33%	$165,813
	Partners with Parents and Children	2	17	0	19	11%	$148,740
	Hippotherapy Expansion Program	0	19	0	19	0%	$100,000
	Building a Trauma-Informed Community	0	18	1	18	0%	$76,413
	Youth Peer Support	0	18	1	18	0%	$186,165

Wrap-Up/Announcements

- Flyers and information will be sent out in the DST follow up email tomorrow.
- The next meeting is September 17, 2020.

IHN-CCO TRANSFORMATION PILOT SUMMARY

InterCommunity Health Network CCO

HOMELESS RESOURCE TEAM

January 2019 to June 2020

Overview:

With funding from InterCommunity Health Network Coordinated Care Organization (IHN-CCO), the Homeless Resource Team was developed by Samaritan Health Services (SHS) and other partners. The Homeless Resource Team includes a case manager, health navigator, and Homeless and Vulnerable Patient Committee. The goals of the pilot were to:

- Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions;
- Increase primary care utilization among homeless adults with chronic medical conditions;
- Decrease emergency department (ED) utilization among homeless adults with chronic medical conditions; and
- Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.

Successes:

* 98 IHN-CCO members served
* 16 IHN-CCO members (16%) were placed in permanent housing
* 81 IHN-CCO members (83%) had 1+ barriers to housing resolved
* Collaboration between Benton County health navigators and Samaritan LCSWs (licensed clinical social workers)
* Being able to address some immediate needs that are difficult to fill with standard resources, such as shoes for safe walking or phone access
* Increased awareness for providers and staff

Key Activities:

* Outreach and coordination
* Monthly Homeless & Vulnerable Patients Committee meetings
* Presentations to SHS physicians & staff

IHN-CCO TRANSFORMATION PILOT SUMMARY

InterCommunity Health Network CCO

HOMELESS RESOURCE TEAM

January 2019 to June 2020

Learning Experiences:

There are many unresolved barriers to helping homeless clients including:

- Delays in establishing care with a primary care clinician
- Limited transportation to urgent care clinics (compared to going to the ED)
- Limited access to mental health treatment and substance abuse interventions
- Housing availability, particularly low-barrier housing.

The Homeless Resource Team worked to address these barriers by leveraging networks & resources to find solutions wherever possible. The flexibility provided by this pilot project to cover expenses that would have been difficult to cover through other means was important in addressing some barriers.

Next Steps:

The Homeless Resource Team will continue. The LCSW position has been sustainably funded via cost-share between IHN-CCO and Samaritan's Care Hub. Pilot partners continue to meet monthly.

There have been conversations about expanding to Linn and Lincoln counties, but barriers including funding for outreach positions exist. It is unlikely the exact model will be replicable in other counties but the core idea of improving collaboration between Samaritan (or other clinical partners), county health departments, and community-based service agencies is definitely scalable.

Key Terms:

- Health navigator: a person who provides information, assistance, tools, and support to help a patient to make the best health care decisions
- Licensed Clinical Social Worker (LCSW): professionals that provide emotional support, mental health evaluations, therapy, and case management services to those in need of such services

Homeless Resource Team

January 2019 – June 2020

Summary:
This pilot created a Homeless Resource Team including a case manager, Health Navigator, and Homeless and Vulnerable Patient Committee to achieve the following goals:

- Facilitate placement into permanent supportive housing for patients with homelessness and chronic medical conditions.
- Increase primary care utilization among homeless adults with chronic medical conditions.
- Decrease emergency department utilization among homeless adults with chronic medical conditions.
- Improve healthcare providers' knowledge and sensitivity about caring for patients with homelessness.

Budget:

- **Total amount of pilot funds used:** $188,075
- **Please list and describe any additional funds used to support the pilot.**
  No additional funds; in-kind support from Samaritan, Benton County Health Dept, and community partners

B. Provide a brief summary of the goals, measures, activities, and results and complete the grid below.

Goal	Measure(s)	Activities	Results to Date
Document all IHN-CCO members served by the pilot.	IHN-CCO members served by the pilot.	Track members served & submit documentation to IHN-CCO	98 IHN-CCO members served
Actively participate in at least one DST workgroup; DST recommends Social Determinants of Health.	Attend either by phone or in person.	Participation in workgroup	Pilot representatives contributed & provided leadership to SDOH and Care Coordination workgroups in 2019-2020.
Facilitate placement into permanent supportive housing.	A) Proportion of adults served who are placed into permanent housing. B) Proportion of adults served with one or more barriers to housing resolved.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	A) 16 IHN-CCO members (16%) were placed in permanent housing B) 81 IHN-CCO members (83%) had 1+ barriers to housing resolved
Increase use of primary care services.	A) Number of primary care visits before & after engagement with the pilot (for patients served). B) Trend in number of primary care visits among the homeless population as a whole. C) Trend in number of primary care visits among all Samaritan patients.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	Among IHN-CCO members served, 58% had not seen primary care in the prior 6 months; in the 6 months after contact, 51% had at least one primary care visit. Among all IHN-CCO members identified as homeless in SHS Epic, 56% did not have a primary care visit in 2019; among all IHN-CCO members in SHS

			Epic, 45% did not have a primary care visit in 2019.
Decrease emergency department (ED) use.	A) Number of ED visits before & after engagement with pilot (for patients served). B) Trend in number of ED visits among the homeless population as a whole. C) Trend in number of ED visits among all Samaritan patients.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	Among IHN-CCO members served, 58% had not seen primary care in the prior 6 months; in the 6 months after contact, 51% had at least one primary care visit Among all IHN-CCO members identified as homeless in SHS Epic, 67% had 1+ ED visit in 2019; among all IHN-CCO members in SHS Epic, 33% had 1+ ED visit in 2019.
Improve primary care providers' knowledge and sensitivity about providing care for homeless adults.	Primary care providers will report more knowledge of the issues related to providing care to homeless adults and available resources for support.	Multiple presentations to SHS physicians & staff	Positive feedback & increased referrals to HRT from SHS clinicians
Improve drug adherence rates.	Primary care clinic coordinators, Hospital case manager and hospital Licensed Clinical Social Worker (LCSW) will work directly with the patients, in contact at least once per month and seen once quarterly.	Requires IHN-CCO data	Analysis not yet started
Decrease incarceration rates.	Primary care clinic coordinators, Hospital case manager and hospital LCSW will work directly with the jail nurse to monitor/track rates of patients served and their incarceration.	HRT outreach & coordination, and monthly Homeless & Vulnerable Patients Committee meetings	20 IHN-CCO members served had spent 1 or more days in jail in the 6 months prior to contact with HRT; of these, 50% (N=10) had 0 jail days in the 6 months after contact. Among all IHN-CCO members served, average days in jail dropped from 5.4 in the 6 months prior to 3.4 in the 6 months after contact with HRT.

C. What were the most important outcomes of the pilot?

Helping vulnerable members of our community; strengthening relationships between organizations that serve the homeless population; increasing physicians and medical staff's awareness of people's needs and struggles.

D. How has the pilot contributed to Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care?

Health outcomes have definitely been improved among clients served by the pilot, as a result of direct outreach and facilitating appropriate medical care. By increasing utilization of primary care services, we expect that we have lowered the cost of care by preventing acute ED or hospital visits.

E. What has been most successful?

At the program level – adding another LCSW at Samaritan to be focused on homeless outreach was instrumental in increasing bandwidth; the collaboration between Benton County health navigators and Samaritan LCSWs to care medical care for people who need it; building partnerships with other agencies

At an individual level – helping clients address their trauma so they can make sense to their emotions and behaviors; being able to address some immediate needs that are difficult to fill with standard resources (e.g. phone, phone minutes – even though there is a lifeline government assistance, it takes time to get it and also have to have a physical address and go through the verification process for most of people, even properly-fitting shoes (important for people who spend a lot of time on foot!).

F. Were there barriers to success? How were they addressed?

There are many unresolved barriers to helping homeless clients: delays in establishing care with a primary care clinician; limited transportation to urgent care clinics (compared to going to the ED); limited access to mental health treatment and substance abuse interventions; housing availability, particularly low-barrier housing.

We did our best to address these barriers by leveraging networks & resources to find solutions wherever possible. The flexibility provided by this pilot project to cover expenses that would have been difficult to cover through existing mechanisms was instrumental in addressing some barriers.

G. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)

We have had preliminary conversations about expanding to Linn and Lincoln counties; barriers including funding for outreach positions. It's unlikely the our exact model will be replicable in other counties but the core idea of improving collaboration between Samaritan (or other clinical partners), county health departments, and community-based service agencies is definitely scalable.

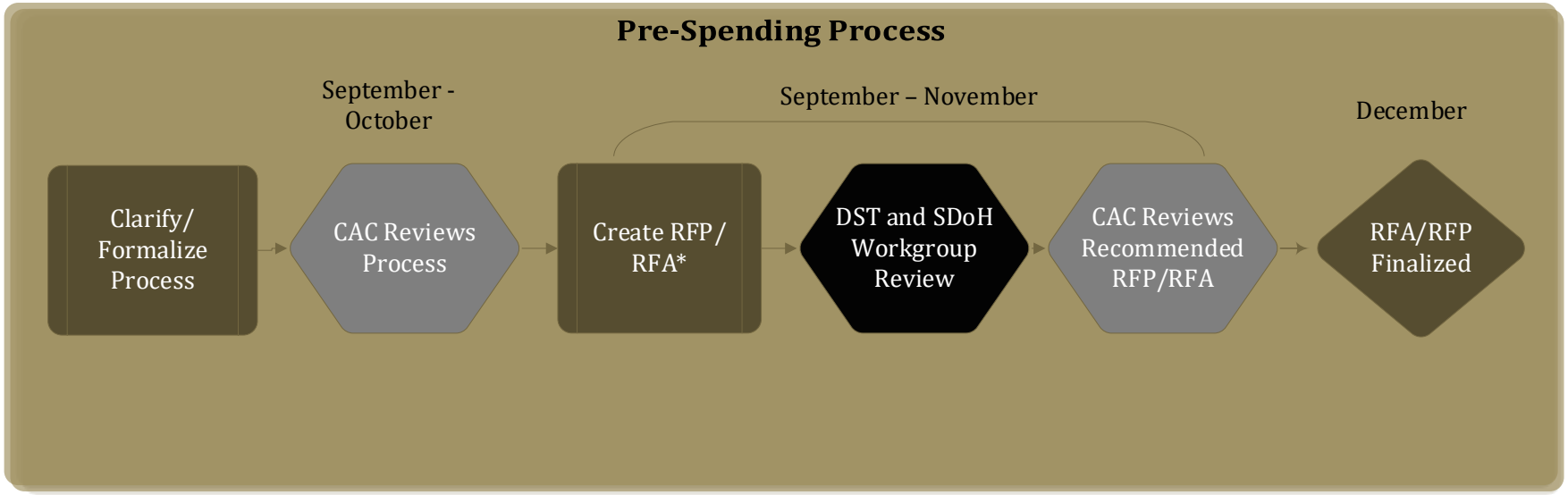
H. Will the activities and their impact continue? If so, how? If not, why?

Yes – the LCSW position has been sustainably funded via cost-share between IHN-CCO and Samaritan's Care Hub; monthly meetings between pilot partners are ongoing.

SHARE Initiative Process

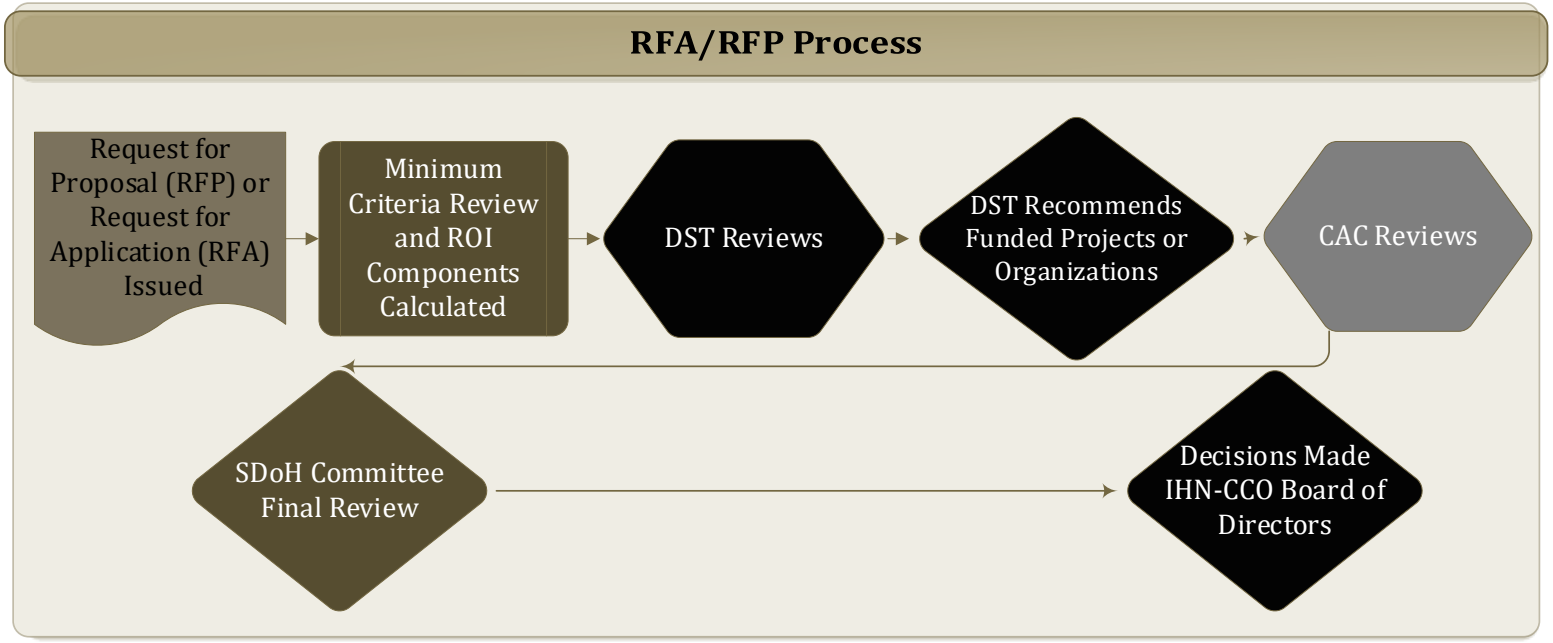
Supporting Health for All Through Reinvestment

Funding Process



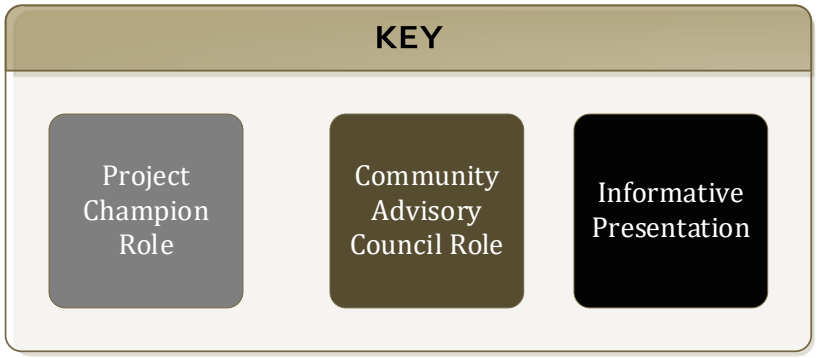
Key

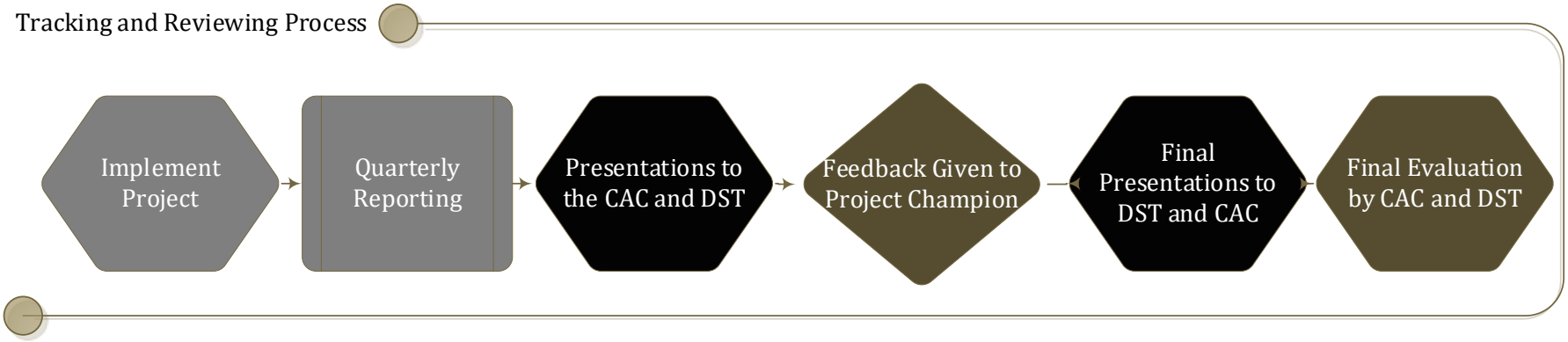
- Community Advisory Council Role
- SDoH Spending Committee Role
- Community or External Committee Role



*RFA/RFP created based on the CAC's Community Health Improvement Plan, the State Health Improvement Plan, and the SDoH Workgroup's priority areas

Tracking and Reviewing Process





Acronym List

Acronym	Meaning
BOD	Board of Directors
CAC	Community Advisory Council
CHIP	Community Health Improvement Plan
DST	Delivery System Transformation Committee
IHN-CCO	InterCommunity Health Network Coordinated Care Organization
RFA	Request for Application
RFP	Request for Proposal
ROI	Return on Investment
SDoH	Social Determinants of Health