STRATEGIC PLAN 2021

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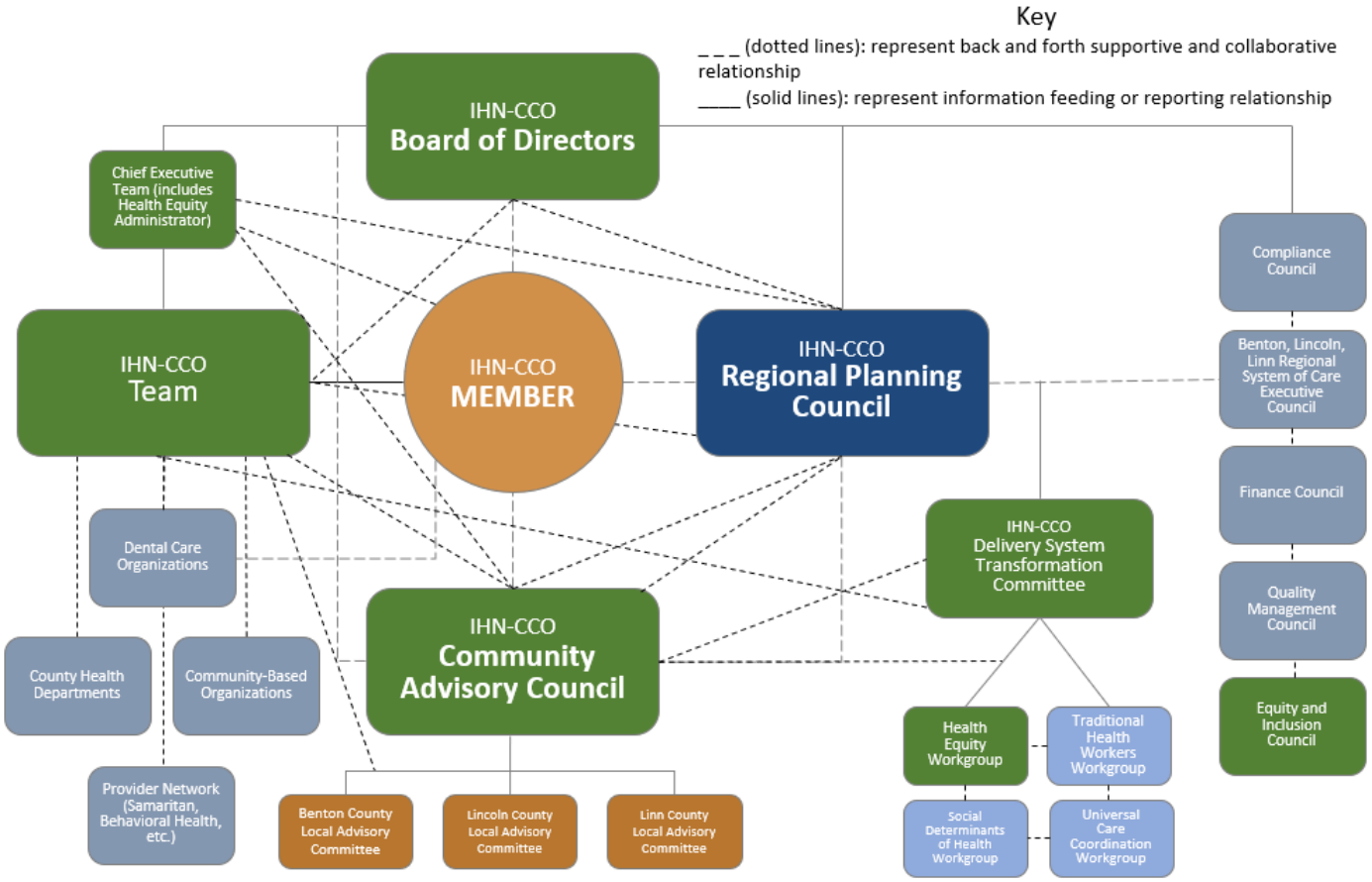
Delivery System Transformation Committee (DST) Introduction

The Delivery System Transformation Committee, known as DST, is open to anyone who can positively affect the health outcomes of IHN-CCO (InterCommunity Health Network Coordinated Care Organization) members. The DST is improving healthcare by bringing the community together. The DST members include individuals from all levels of the service, from Executive Directors to front desk staff, traditional health workers, medical providers, and more. Each member who has voting rights (attending six times in the last five months) has equal voice in the voting process and everyone who is participating in the meetings has a voice at the table.



This shows the web of supports around the IHN-CCO member including the IHN-CCO team, IHN-CCO driven committees and councils, and community partners. Teams, committees, or councils colored in green have roles in the health equity governance structure.

DST Objectives and Membership

2021 DST Charter

See Appendix A. 2020 DST Charter

Roles and Responsibilities

See Appendix B. IHN-CCO DST Roles and Responsibilities

- Updated Winter 2020

Health Equity Facilitated Conversations

- Focus on developing leadership in equity at the DST
- Convene health equity conversations throughout the year during regularly scheduled DST meetings
    - Post-training: discuss in depth how we have seen issues in our community, in our partnerships, and our own organizations

Fostering the Message and the Spirit of the DST

Reach out to Transformation for a copy of the below as a postcard intended to engage members.

IHN-CCO DST History 2020

See Appendix C. IHN-CCO DST History and Evolution 2012-2019

2020

Membership

- Average attendance: 32 attendees per meeting
- Drop in attendance April – June but on par with 2019 January – March, July – December

Planning/Focus of the DST

- Moved entirely online using Microsoft Teams beginning April 2020 due to COVID-19
- Request for Proposal focus areas chosen ensuring alignment with the IHN-CCO Community Advisory Council's Community Health Improvement Plan
    - Access: Traditional Health Workers
    - Behavioral Health: Integration
    - Social Determinants of Health: Food Security, Housing, Transportation
- Health Equity Trainings:
    - Transgender Healthcare
    - Implicit Bias
    - Racial Justice
- Reviewed consultant work and used as a base for strategic planning
    - *See Appendix D. Health Management Associates Transformation Pilot Projects 2.0*

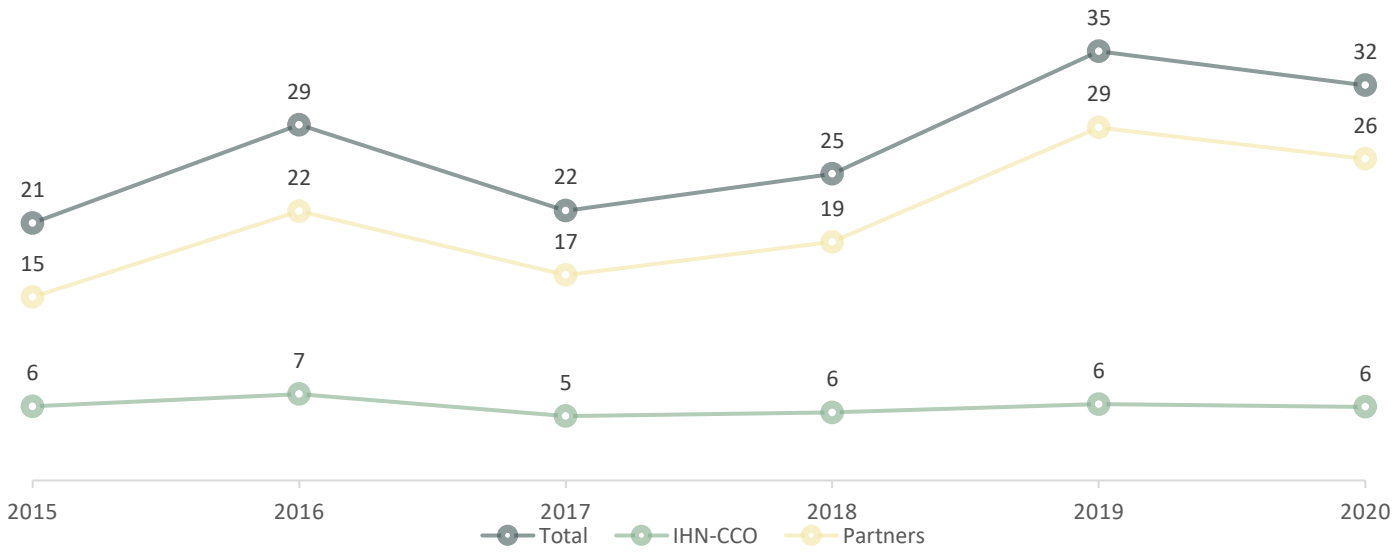
Pilots

- 11 active pilots
- 10 new pilots approved through 1 focused RFP process

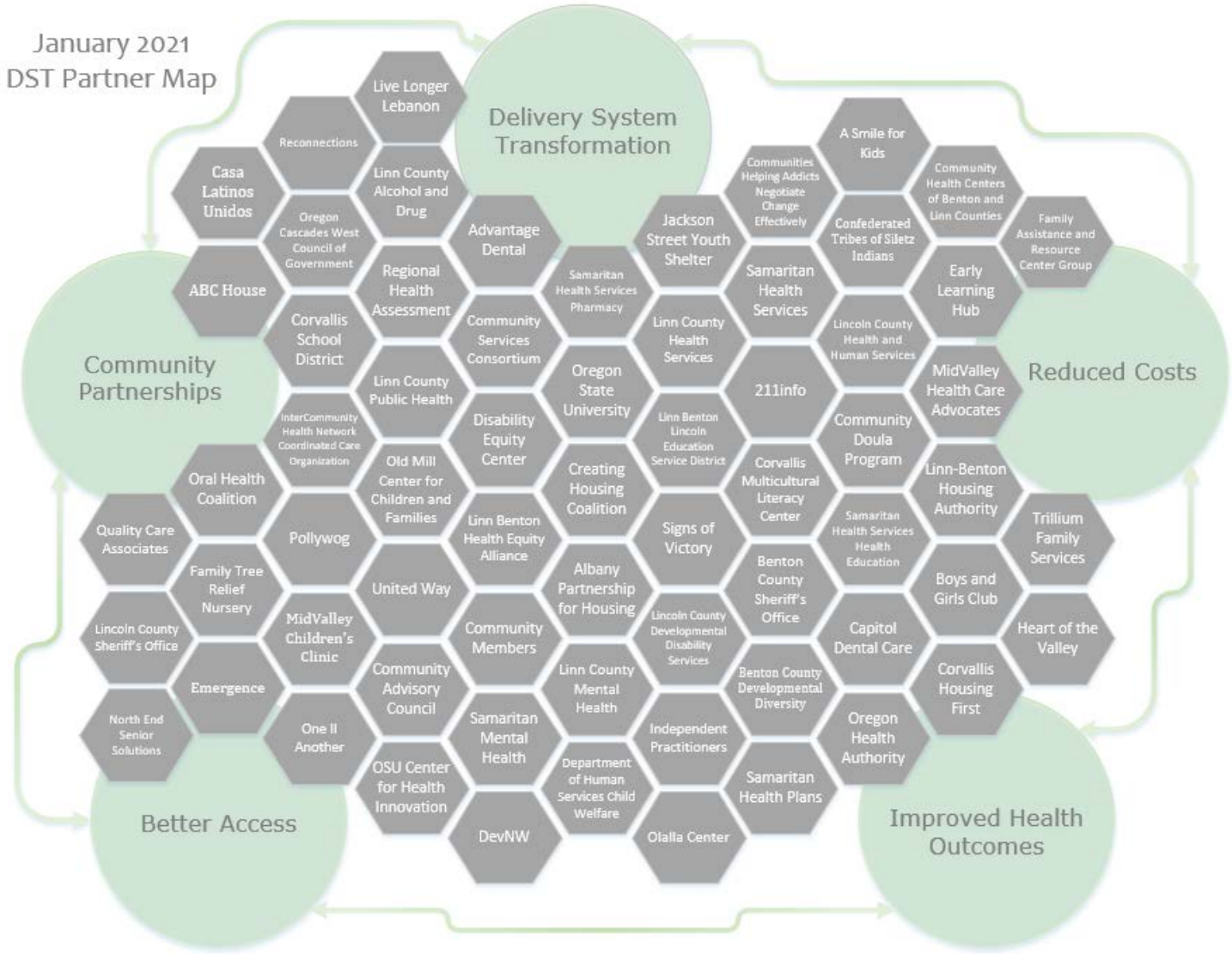
Workgroups

- 3 active workgroups
    - Universal Care Coordination was not active in 2020
    - The Traditional Health Worker Workgroup was given funds to support the Traditional Health Worker Strategic Plan.
    - The Health Equity and Social Determinants of Health Workgroups received funds to share an intern; however, this was shortened due to COVID-19 and funds were transferred to health equity trainings.

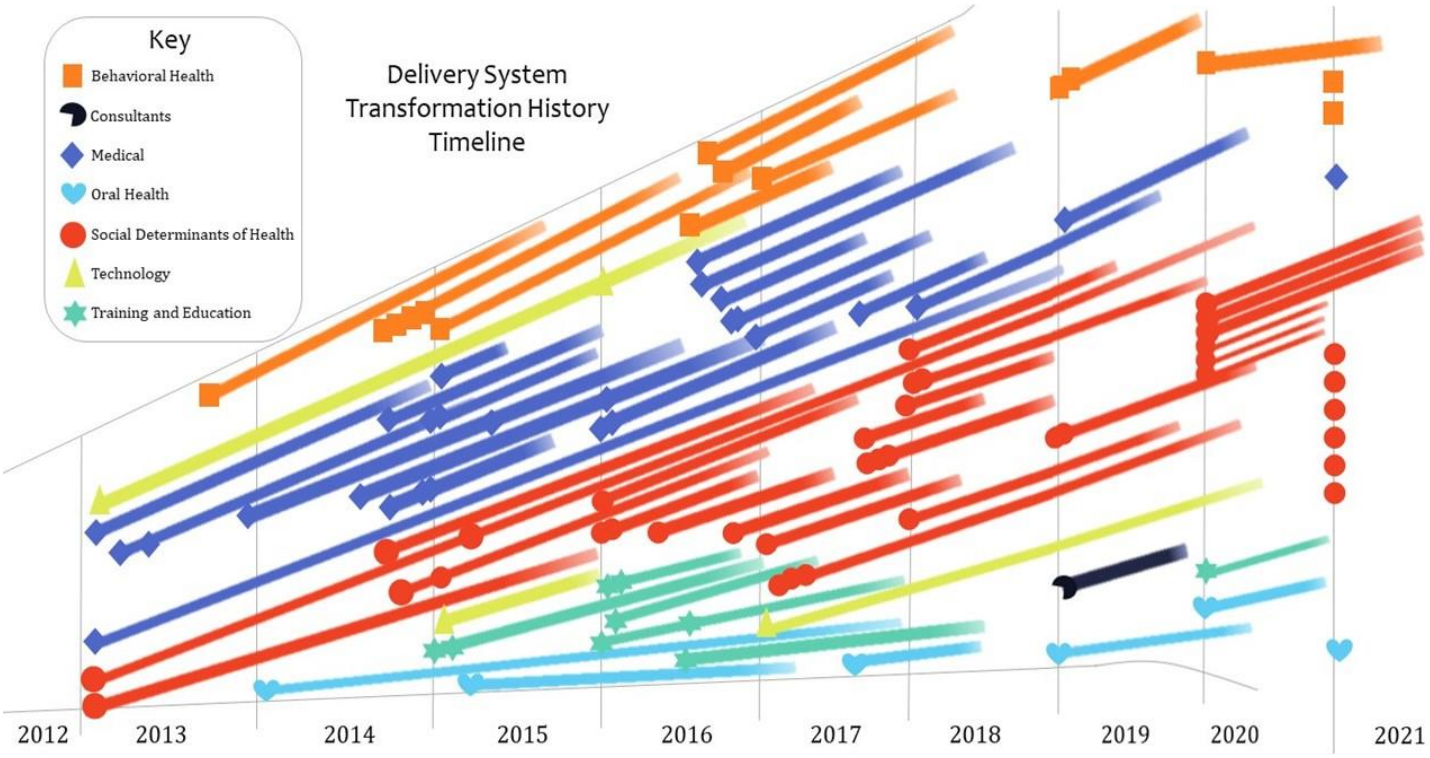
Figure 1. Average Attendance of the Delivery System Transformation Committee by Year



Community Partners and Stakeholders



Pilots Through the Ages



Pilot Categorization

Table 1. Number of Pilots by Entity, Samaritan Health Services versus Non-Samaritan Health Services and Collaborations

	Samaritan Health Services	Non-Samaritan Health Services	Collaboration	Total
Current	1	14	2	17
Total	18	55	8	81

Table 2. Number of Pilots by County

Numbers do not equal total due to many pilots being in multiple counties.

	Benton	Lincoln	Linn	Total
Current	5	9	11	17
Total	52	43	52	81

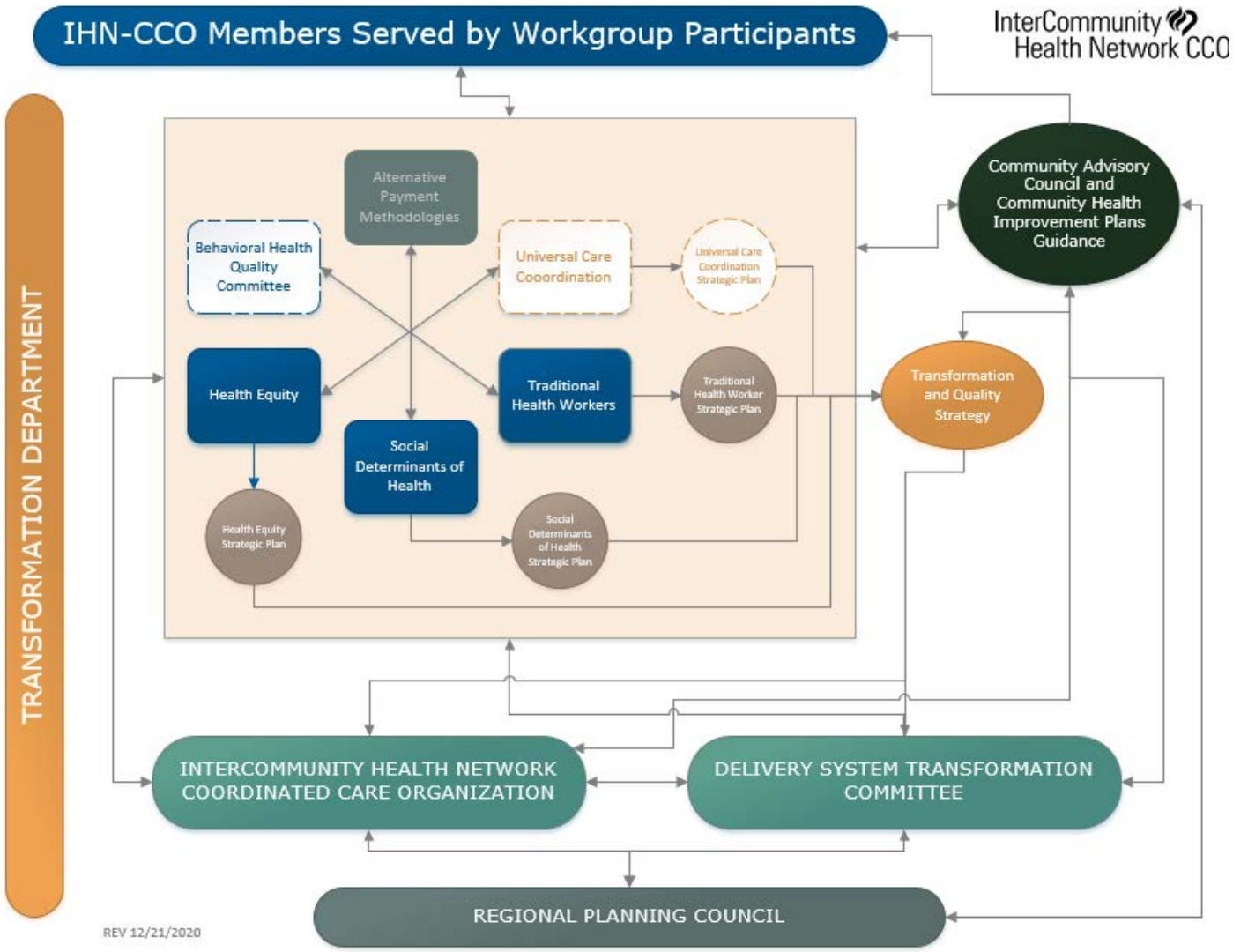
Closed Pilots Heatmap and Crosswalk

Coming Soon! Pending 2020 Closeouts.

What Do You Want to Know About Pilots?

- What is helpful to learn from pilot champions?
- What else do you need from Transformation to understand or connect with pilots better?
- Additions or changes to the semi-annual reports?

Workgroups



Health Equity

See Appendix E. Health Equity Workgroup Key Message Framework

- Need a co-chair
- Finalized Communications and Messaging Project with Brink Communications
- Shared intern with the SDoH Workgroup

Social Determinants of Health

See Appendix F. April 2020 SDoH Housing Recommendations

- Finalized Housing Recommendations to IHN-CCO
- Working on Food Security and strategic planning for 2021
- Shared intern with the Health Equity Workgroup

Traditional Health Workers (THWs)

- Moving trainings from in-person to online
- Developing a welcome packet for all THWs and organizations who hire THWs
    - Big picture of IHN-CCO landscape and state
    - Overview of THW types

- Goals and vision for the group
- Community partners
  - Pictures and bios for all involved in the workgroup
- History and details of the work
  - What has been accomplished to date
- Where are we going and what do we want to accomplish

Universal Care Coordination

- Not currently active

Request for Proposal (RFP)

See Appendix G. Request for Proposal Documents 2020

- Provide info on LOI rankings versus DST rankings versus funded
- Target RFP with example projects (best practices) and ask for organizations that can best fulfill the goals of the project
- 1 "large" RFP with set budgets of $100,000-$200,000 and multiple "small" RFP's for $25,000-$50,000 projects
- 2020's RFP indicated the DST is uncomfortable spending over ~$180,000 for 1 pilot
  - Limit the budget to a range (i.e., $50,000-$200,000)?
- Continuing concerns over sustainability and replicability
- Spreading promising practices – see 2020 RFP

Letter of Interest (LOI)

With feedback from DST members and those who sent letters of interest, the Transformation Department recommends (if continuing with a similar RFP process as prior):

- Continue the process as previously done including Transformation's 'gatekeeping' process
- Move to an online form

Thoughts/Ideas

- Focus on bringing communities of color to the table – funding mechanism?
- Further the environmental scan – what organizations in or out of the area are already doing this? What works best? Can you partner with them?
- Weight certain scorecard aspects higher, such as transformation and need
  - This shows there are certain proposal aspects that are integral to the DST
  - Weight NEW partnerships higher, such as bringing in smaller or non-traditional partners
- Allow for "small" amounts to provide to organizations to spread promising practices based on previous pilot successes
  - Could be a new organization
  - Could be spreading around a workflow that was created
- Prioritize current pilots by working with them on replicability and spread

90% (45 of 50) of pilots that were expected to be sustained have been operationalized through IHN-CCO or the sponsoring organization as of 2020*

**9 of the 59 closed pilots were expected one-time-projects*

Appendix A. IHN-CCO DST Charter 2020

Delivery System Transformation Committee (DST)

(Committee of the Regional Planning Council)

2020 Charter

Objectives:

- Improve the health delivery system by bringing the community together.
- Using the collective impact[i] model building on current resources and partnerships.
- Support, sustain, and spread transformational[ii] initiatives keeping the PCPCH (Patient-Centered Primary Care Home) as the foundation of IHN-CCO.
- Welcome innovative ideas; plan and implement transparent collaborative strategies that are aligned with IHN-CCO goals and objectives for their members.
- Pursue the Triple/Quadruple Aim (increased access, reduce cost, improve health outcomes, and staff/provider engagement.)

Structure:

- The Committee reports to and takes direction from the IHN-CCO Regional Planning Council (RPC). The Co-Chairs are responsible to report to the RPC.
- The Committee meets at least monthly to develop priorities and identify strategies to facilitate transformation.
- Committee workgroups and pilots have broad membership to further healthcare delivery system strategies.

Membership: Anyone that can support, promote, or positively affect the health outcomes of IHN-CCO members in the tri-county region.

Key Deliverables and Activities:

- Utilize a trauma informed approach[iii] and health equity lens[iv].
- Support components of the Transformation and Quality Strategies (TQS)[v].
- Use data and information to align initiatives.
- Identify champions and support new partnerships and linkages.
- Prioritize the workgroups and pilots that develop and execute strategies to achieve the Committee's goals.
- Align with the Community Advisory Council (CAC) and its Community Health Improvement Plan (CHIP) for priorities.
- Create and evaluate two-way communication between community agencies, the traditional healthcare system, community health, and PCPCHs.
- Recommend system changes, report gaps and barriers, and provide information to the RPC.

Committee Member Responsibilities:

- Serve as a vocal champion of the DST's work.
- Commit to developing strategies that strengthen the community.
- Identify members to join the Committee, workgroups, and pilots to successfully complete objectives.
- Share data and information with the Committee.
- Attend at least five meetings within the last six months to vote.
- Foster and promote the spirit and message of the Committee.
- Review materials and be prepared for engaged discussion, active listening, and respectful dialogue.

[i] Collective impact model brings people together in a structed way, to achieve social change. There are five components to the framework: common agenda, shared measurements, mutually reinforcing activities, continuous communication, and backbone support.

[ii] Transformation is defined as keeping the Patient-Centered Primary Care Home (PCPCH) at the center, but includes creating different relationships, community connections, and linkages outside of the traditional health services setting. Includes upstream health and recognizes there are pieces outside of the PCPCH setting that influence an individual's health. Being willing to risk trying something different, even failed projects provide a learning opportunity. Transformation is constantly changing and is not static, has elements of innovation, but is broader and involves system change.

[iii]

According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) concept of a trauma-informed approach, "A program, organization, or system that is trauma-informed:	SAMHSA'S Six Key Principles of a Trauma-Informed Approach:
1. *Realizes* the widespread impact of trauma and understands potential paths for recovery; 2. *Recognizes* the signs and symptoms of trauma in clients, families, staff, and others involved with the system; 3. *Responds* by fully integrating knowledge about trauma into policies, procedures, and practices; and 4. Seeks to actively resist *re-traumatization*."	1. Safety 2. Trustworthiness and Transparency 3. Peer support 4. Collaboration and mutuality 5. Empowerment, voice and choice 6. Cultural, Historical, and Gender Issues

[iv] Health Equity means that everyone has a fair and just opportunity to be as healthy as possible. Health Equity broadens the disparities concept by asking, "Why are some populations at greater risk of illnesses and preventable deaths than others?" This question leads to a deeper analysis and exploration of the causative factors that contribute to disparities. Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. **Equality is not equity. Those with worse health and fewer resources need more efforts expended to improve their health.**

[v] TQS 2020 Components

1. Access: Quality and Adequacy of Services
2. Access: Cultural Considerations
3. Access: Timely
4. Behavioral Health Integration
5. CLAS Standards
6. Grievance and Appeals System
7. Health Equity: Data
8. Health Equity: Cultural Responsiveness
9. Oral Health integration
10. Patient-Centered Primary Care Home (PCPCH)
11. Serious and Persistence Mental Illness (SPMI)
12. Social Determinants of Health & Equity (SDOH-E)
13. Special Health Care Needs (SHCN)
14. Utilization Review

Appendix B. IHN-CCO DST Roles and Responsibilities

IHN-CCO DST Roles and Responsibilities Form

As a member of the InterCommunity Health Network Coordinated Care Organization (IHN-CCO) **Delivery System Transformation Committee** I agree to the following principles:

Adopt and support the objectives of the Delivery System Transformation Committee:

- Improve the health delivery system by bringing the community together.
- Use the collective impact model building on current resources and partnerships.
- Support, sustain, and spread transformational initiatives keeping the PCPCH (Patient-Centered Primary Care Home) as the foundation of IHN-CCO.
- Welcome innovative ideas; plan and implement transparent collaborative strategies that are aligned with IHN-CCO goals and objectives for their members.
- Pursue the Triple/Quadruple Aim (increased access, reduce cost, improve health outcomes, and staff/provider engagement.)

Provide strategic guidance, vision, and oversight for the Committee:

- Commit to developing strategies that strengthen the community.
- Share data and information with the Committee.
- Encourage attendance and participation of the DST workgroups.

Play an active role:

- Participate in the meetings.
- Review materials and be prepared for engaged discussion, active listening, and respectful dialogue.
- Foster and promote the spirit and message of the Committee.
- Identify other partners to join the efforts of the Committee.
- Serve as a vocal champion of the DST's work.

Avoid conflicts of interest:

- Abstain from voting on pilots that I am actively involved in.
- Communicate conflicts of interest that arise to the committee and abstain from voting.
- Always act in the best interests of IHN-CCO members.

Name **Date**

Sign_____

Print_____

Appendix C. IHN-CCO DST History and Evolution 2012-2019

2019

Membership

- Average attendance: 35 attendees per meeting

Planning/Focus of the DST

- CCO 2.0
- Unite Us
- Spreading Promising Practices
- Request for Proposal target area of Social Determinants of Health chosen, aligned with the IHN-CCO Community Health Improvement Plan
- Consultants reviewed and evaluated the DST and pilots

Pilots

- 11 active pilots
- 6 new pilots approved through 1 targeted RFP process
- 1 pilot approved for expansion
- Addition to pilot funding criteria:
    - Must be at least a two-sector collaboration

Workgroups

- 4 active workgroups
    - Alternative Payment Methodologies (APM) workgroup was operationalized
- 3 applied for and received funding to spend in 2020 to support and further the goals of the workgroups
    - Social Determinants of Health and Health Equity received funds for a shared intern
    - Traditional Health Workers received funds to for a Traditional Health Worker Liaison

2018

Membership

- Average attendance: 25 attendees per meeting
- Videoconferencing utilized

Planning/Focus of the DST

- How to Get the Story Out
    - Roadshow Documents
    - Elevator Speech
    - Attendance and Awareness Survey
    - Press Releases
- Request for Proposal Targeted Areas used:
    - Community Health Improvement Plan Areas
    - Eight Elements of Transformation
    - Transformation and Quality Strategies
    - CCO Incentive Metrics
- Consultant engaged for pilot evaluation and transformation best practice recommendations for 2019

Pilots

- 19 active pilots
- 6 new pilots approved through 1 targeted RFP process
- Addition to pilot funding criteria:
    - Must outline an approach to address social determinants of health

Workgroups

- 5 active workgroups
    - Alternative Payment Methodologies (APM) workgroup moved to holding quarterly forums
- All 5 received funding to spend in 2018
- Workgroups asked to attend 4 DST meetings per year to provide updates

2017

Membership

- Average attendance: 22 attendees per meeting

Planning/Focus of the DST

- Deliberate strategic planning occurred early in the year resulting in the definition of the DST's purpose:
    - Strengthening partnership
    - Collaboration
    - Development of the PCPCH
- Pilot focus areas:
    - Peer Support
    - Navigation
    - Behavioral Health and Collaboration

Pilots

- 21 active pilots
- 7 pilots from the 2nd 2016 RFP process funded and 6 new pilots approved through 1 targeted RFP process
- Addition to pilot funding criteria:
    - Must outline an approach to address health equity

Workgroups

- 7 active workgroups
- 2 workgroups formed:
    - Universal Care Coordination
    - Social Determinants of Health

2016

Membership

- Average attendance: 29 attendees per meeting
- Voting rules established:
    - Attend at least 5 meetings in 6 months and sign DST Member Roles and Responsibilities agreement

Planning/Focus of the DST

- Deliberate strategic planning occurred early in the year resulting in the following focus areas:
    - Effectiveness and sustainability
    - Person-centered and person-driven
    - Expanded access
    - Upstream health
    - Coordinated, integrated care
    - Learning systems that honor and demonstrate innovation
- Targeted Request for Proposal (RFP) process
- Requested pilots that affect 7 areas recommended by Workgroups and approved by the DST as a priority focus area

Pilots

- 32 active pilots
- 19 pilots are approved through 2 funding cycles (though pilots approved in 2nd funding cycle carried over to 2017 due to availability of funds)

Workgroups
- 7 active workgroups
    - Website Workgroup formed

2015

Membership
- Average attendance: 21 attendees per meeting
- DST Charter reaffirmed and updated to reflect less specific attendees and to include leadership representation from key stakeholder groups
- Continued increased representation and participation from nontraditional clinical setting organizations such as community service agencies

Planning/Focus of the DST
- Through the work of the IHN-CCO Transformation Evaluation Analyst, structure put in place to evaluate individual pilots and the collective impact
    - Crosswalk of pilots to the Eight Elements of Transformation, Community Health Improvement Plan (CHIP) Health Impact Areas, and the CCO Incentive Metrics
    - Evaluating pilots became more deliberate with a scorecard around measuring impact
- Created priority funding areas for pilots

Pilots
- 25 active pilots
- Pilots proposed throughout the year and 11 are approved
- Additions to pilot funding criteria:
    - Outcomes
    - Sustainability
    - Must address a CHIP area

Workgroups
- 9 active workgroups
- 3 workgroups are formed:
    - Health Equity
    - CHIP*
    - Training and Education

2014

Membership
- Shift from “clinical” to “clinical and those who can positively affect the health outcomes of IHN-CCO members”

Planning/Focus of the DST
- IHN-CCO expansion population leads to increased focus on Patient-Centered Primary Care Home (PCPCH) development
- Shift in industry to APM; DST discussions began in this area of focus

Pilots
- 15 active pilots
- Pilots proposed throughout the year and 11 are approved

Workgroups
- 6 active workgroups
    - Dental Integration (DI) Workgroup formed

2013

Membership

- Primarily clinical leadership

Planning/Focus of the DST

- Established funding criteria for pilots:
    - Cost savings
    - Eight Elements of Transformation
    - SMART Goals
    - Bring together siloed resources
    - Compelling to health care reform
    - Document best practices and share with the broader CCO community

Pilots

- 4 active pilots
- Pilots proposed throughout the year and 4 are approved

Workgroups

- 5 workgroups formed
    - Alternative Payment Methodology (APM)
    - Screening, Brief Intervention, Referral, Treatment (SBIRT)
    - Quality Initiative: Race/Ethnicity
    - Health Information Technology (HIT)
    - Traditional Health Worker (THW)

2012

Membership

- Primarily clinical leadership comprised of cross-sector groups; physical, oral, mental, and alcohol and drug dependency
- Early discussions facilitated partnerships, trust and transparency, creating a common purpose, and aligning focus and strategy

Planning/Focus of the DST

- Movement towards 2% cost savings and addressing high cost/high risk IHN-CCO members
- Goals include Medical Homes and defining multi-morbidity
- Nontraditional health workers a focus in the short term

Appendix D. Health Management Associates Transformation Pilot Projects 2.0

HMA

HEALTH MANAGEMENT ASSOCIATES

Transformation Pilot Projects 2.0: Review and Recommendations

PREPARED FOR IHN & THE DELIVERY SYSTEM TRANSFORMATION WORK GROUP

BY

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SEPTEMBER 2019

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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Background and Review of Initial Phase of Project

HMA was asked to review IHN's Transformation Pilot Project Program and provide recommendations to enhance the program, particularly with the new focus on behavioral health integration, social determinants of health and health equity as directed by "CCO 2.0", the State's recent direction to Coordinated Care Organizations (CCOs) for contract re-procurement to serve Oregon's Medicaid population. We were also asked to provide strategic advice and technical assistance to the Delivery System Transformation (DST) Workgroup as they considered funding for 2020 pilots.

Our Approach

HMA undertook the following steps to provide IHN CCO and the DST with the contract deliverables:

- **Review of DST and Transformation Pilot Project materials:** HMA reviewed all DST pilot project final reports and other program documentation going back to 2016.
- **Review of similar programs in Oregon and across the country:** HMA researched and reviewed health system innovation project funding programs to identify those similar to the DST's. A handful of programs were selected for learnings relevant to the DST: pilot programs of two other CCOs and the Northwest Health Foundation were highlighted, along with the Robert Wood Johnson Foundation's Culture of Health.
- **Review of evidence-based practice:** The HMA team reviewed and summarized best practices in the areas emphasized in CCO 2.0: social determinants of health, health equity and behavioral health integration.
- **Gathered input and feedback from DST members:** HMA conducted key informant interviews with DST members, and presented and gathered feedback from DST members in three DST meetings throughout the course of this project (March 21st, July 11th and September 19th).
- **Developed recommendations:** The HMA team developed recommendations based on their analysis, review of best practices and other programs, as well as DST input and feedback. An initial set of recommendations was delivered on July 11th, focused on opportunities to strengthen the current year pilot project funding cycle. A final set of recommendations was provided to the DST on September 19th.

Initial Key Themes review

The HMA team conducted about a dozen key informant interviews on the DST pilot project program throughout March 2019 and facilitated focus group discussions with DST members during the March 21st meeting. The following key themes were identified from these discussions:

Table 1: Transformation Pilot Project Initial Review - Key Overall Themes
Strength: • Excellent program with strong community participation over the years • Selection approach supports applications and identifies projects with strong potential • Reporting and documentation of pilot projects over the years is strong
Opportunities for Improvement: • Support sustainability / scale and spread of successful pilots • Deepen emphasis on work to support CCO 2.0. particularly health equity and social determinants of health (SDoH) • Continue to strengthen cross-sector partnerships

Some of the details we heard during the April DST meeting discussion included:

1. **The DST Pilot Project Program is an excellent program with strong community participation over the years:**
    - Many projects that wouldn't have been funded anywhere else were funded through DST.
    - DST members love the support and flexibility offered to pilot projects.
    - Community partners have maintained a high level of engagement over the past 6 years, which is unique and remarkable.
    - There is an opportunity now to shift to a different phase of the work, not make corrections to the efforts that have taken place to date.

2. **The program should Support sustainability and the scale and spread of successful pilots, rather than just funding new pilots every year:**
    - DST members used the term "plague of pilots" to describe the current funding approach.
    - DST members feel it is now time to reflect back on all the successful work that has been done and shift more to spread of what has worked.
    - Many stakeholders felt that one year not enough time to test innovative models.
    - Pilots that were successful in the past struggle with sustainability once the DST funding runs out.
    - People who implemented pilots don't always understand payment mechanisms that could support sustainability.

3. **The work of the DST should align with the goals of IHN CCO and the pilot program should deepen its emphasis on work to support CCO 2.0 requirements:**
    - Make sure work of DST is closely connected to CCO goals

- Stronger emphasis on assessing and addressing social determinants of health (SDoH) and health equity. These two areas were identified as critical focus areas for the DST.
- Stronger emphasis on behavioral health integration
- Push to increase value-based payments to 70% over the next five years

4. **The DST should work to further strengthen cross-sector partnerships:**

- Next phase of DST pilot projects could further deepen partnerships between and among organizations in the region
- There is a need for more community-based and clinical partnerships
- Strengthening these cross-sector relationships could also help support scalability and sustainability
- Geographic equity of funding projects and making sure all geographic areas of the region are represented on the DST is important
- The DST should work to make sure important partners are at the table. For example, housing and clinical partners are not currently well-represented at DST meetings.

2019 Pilot Project Funding Recommendations

Based on the early discussions and HMA initial set of recommendations, DST implemented the following recommendations for the current year pilot project program:

1. **Target dollars** to priority focus areas: Social Determinants of Health and Equity
    - Prioritize projects than can be scaled up
    - Consider geographic equity of funded projects
2. **Require proposals be collaborations** of two or more cross-sector organizations
    - Encourage stronger community-clinical partnerships
3. **Hold out a small percentage of funds out to support staffing of DST workgroups**

Review of Pilot Funding Approaches in Oregon and Nationally

The HMA team reviewed several other programs with similar goals to the DST Pilot Projects. A handful of programs were selected for learnings relevant to the DST:

- Eastern Oregon Community Care Organization's Community Benefit Initiative Reinvestments
- PacificSource's Community Health Excellence Program
- Northwest Health Foundation / Kaiser Permanente Community Fund
- Robert Wood Johnson Foundation's Culture of Health initiative

Eastern Oregon Community Care Organization (EOCCO)

EOCCO, the CCO for the eastern half of Oregon covering 12 counties, has a "Community Benefit Initiative Reinvestment fund. The purpose of this fund is to "help providers and members learn, plan and implement strategies to reduce health concerns in Eastern Oregon[i]." The fund has four funding streams:

1. **Transformation:** "Opt-In" projects identified by the CCO and aimed at specific incentive measures and opportunities for continuing a previous funded project
2. **LCAC**: opportunity for Local Community Advisory Councils to focus on incentive measures or community health plan (CHP) components the community is having trouble improving.
3. **New Ideas:** Proposals to implement innovative new ideas that have high potential to improve the health and health care of EOCCO members and their communities.
4. **Focus areas:** Proposals focused on the current key focus areas for the CCO. For 2019 those are, **"**Incentive Measures, Collaborations, Access to Care and Workforce Issues, and Behavioral Health Integration."

Applicants are required to propose a plan to collect data using available sources in order to track their progress and collaborations with clinics, hospitals, or other organizations are encouraged. Previously funded projects may be eligible for a continuation project but must provide sufficient evidence (quantitative and qualitative) that their current project is having the desired impact on their selected incentive measure(s), does not overlap with other projects and must have a robust sustainability plan.

PacificSource Community Health Excellence Program

PacificSource Foundation has had a longstanding grant program called the Community Health Excellence Program. It is described as a "collaborative community health improvement program that makes financial contributions and other resources available to the healthcare initiatives of providers in Oregon, Idaho, Washington, and Montana." Launched in 2009, funded projects have been focused on care improvement, usually clinics or hospitals, occasionally social service entities. The supported initiatives are independently evaluated to assess if they will have a significant positive impact for their patients, regardless of their insurance status as well as the impact of the initiative on the community's health. There is consideration as to the potential for "spread" of the initiative as well.

Some examples of questions they ask of their pilot applicants:

- Describe how different clinicians, hospitals or other members of the community will learn about your project
- Provide information on any plans for sustaining the project beyond the one-year project cycle
- Describe how the project fits into your organization's strategic or long-range plans
- Describe elements that would contribute to success; cause the initiative to not meet its goals

Northwest Health Foundation / Kaiser Permanente Community Fund

Northwest Health Foundation created the Kaiser Community Fund was created 15 years ago to support community-led and collaborative efforts to improve health. $32 million total was invested in 207 projects led by 146 different organization in Oregon and Southwest Washington. After first 8 years, it was decided to target funds more specifically, using following guiding values[ii]:

- Social and racial equity
- Collaborative partnerships
- Community-driven solutions
- Systems change

Northwest Health Foundation developed a "Lessons Learned" publication[iii] that is very useful in thinking about Transformation Program's future approaches. These include the following:

- Focus on the roots of health, even when it pushes you out of your comfort zone
- Set the stage without defining the script
- Commit to growing organizations, not just funding programs
- Formalize and articulate the approach with guiding values

Robert Wood Johnson Foundation (RWJF) Culture of Health

RWJF's Culture of Health is a broad initiative to improve population heath and health care delivery system with a strong emphasis on health equity[iv]. Its focus is to foster cross-sector collaboration to improve well-being. One aspect of the initiative is "**Pioneering Idea"** that provides funding for projects that "look into the future and put health first to design changes; support work that will help us learn what a Culture of Health can look like – and how we can get there **".** Some of the questions they ask of those proposing projects include:

- How might your proposed project contribute to or fit into a larger vision for the future?
- How might your project, and the larger vision, inspire or inform progress toward a Culture of Health?
- How might your proposed project challenge conventional thinking and/or contribute new ideas to the Foundation's efforts to build a Culture of Health?
- How will your proposed work address and advance health equity?

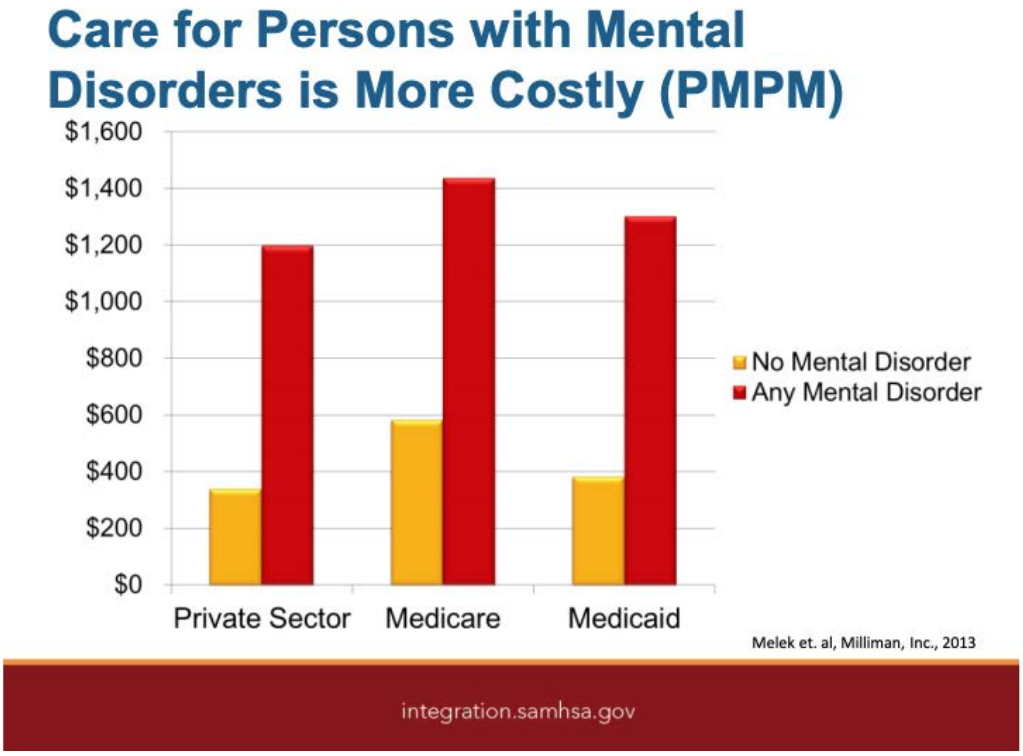
Review of Evidence-Based Practices

The HMA team reviewed and summarized the evidence base for interventions in the DST's three areas of focus: behavioral health integration, social determinants of health and health equity.

Behavioral Health Integration

Integration of medical and behavioral health is a key component of original CCO vision and CCO 2.0. Nationally (and in Oregon), mental health and substance use needs are not being met. Only 43% of individuals with mental health conditions receive mental health services[v] despite the fact that mental health and substance use is responsible for numerous cost drivers in health care. Evidence show that these conditions drive higher utilization of more acute services such as the emergency department. As Figure 1 below illustrates, the overall cost of care is significant higher for people with mental health disorders. Individuals with a behavioral health conditions cost nearly four times more than individuals without behavioral health conditions.

Figure 1



Kamal, R. (2017) Peterson-Kaiser Health System Tracker: What are the current costs and outcomes related to mental health and Substance abuse disorders? *Kaiser Family Foundation.*
Available online at: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple healthcare needs.[vi]

Collaborative Care Model

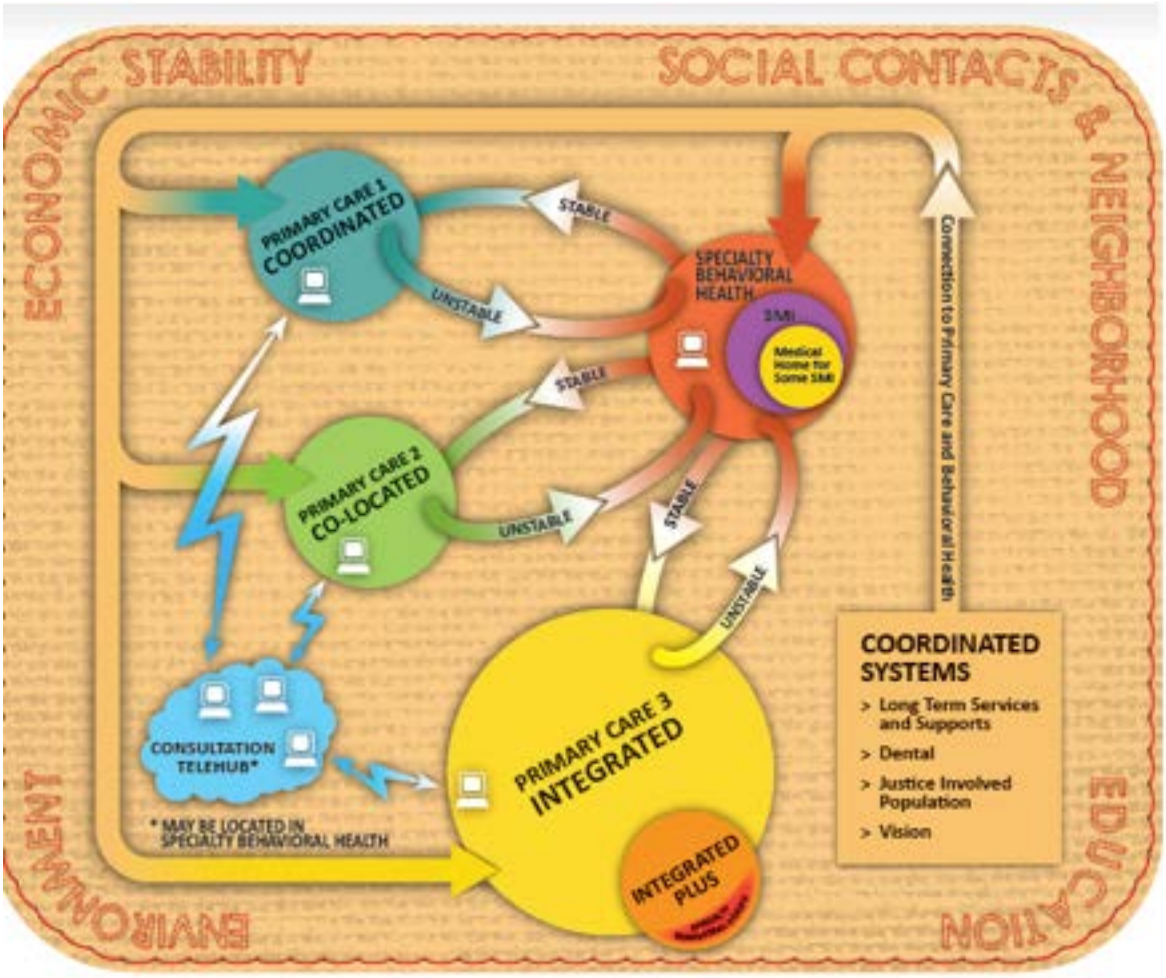
The Collaborative Care Model is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety, based on principles of effective chronic illness care. Trained primary care providers and embedded behavioral health professionals provide team-based, coordinated care and are supported by regular psychiatric case consultation and treatment adjustment for patients who are not improving as expected. The Collaborative Care Model Collaborative for integrated care has a substantial evidence base for its effectiveness. A panel of experts at the AIMS Center at the University of Washington identified five core principles of effective integrated care[vii]. These are:

1. **Patient Centered Team Care:** Primary care and behavioral health providers collaborate effectively using shared care plans that incorporate patient goals.
2. **Population-Based Care:** The care team shares a defined group of patients tracked in a registry. Practices track and reach out to patients who don't improve, and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.
3. **Measurement-Based Treatment to Target:** Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured by evidence-based tools. Treatments are actively changed if patients are not improving as expected.
4. **Evidence-Based Care:** Patients are offered treatments with credible research evidence to support their efficacy in treating the target condition.
5. **Accountable Care:** Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

Collaborative Care System: A Stepped System of Care

Stepped healthcare is a widely used approach of delivering and monitoring health care treatment so that the most effective, yet least resource intensive treatment, is delivered first. This approach, when taken at a systems level, frees up resources so that patients with the highest level of need have access to more intensive and specialized services, while patients with lower levels of need can be care for appropriately in primary care home settings. Dr. Lori Rainey, an HMA colleague and one of the authors of the Collaborative Care Model, developed the following illustration (Fig. 2) to demonstrate a stepped system of collaborative care.

Fig. 2: Collaborative Care System



Copy righted Lori Raney. Reprinted from Raney, Lasky and Scott (2017). *Integrated Care: A guide to effective implementation.* American Psychiatric Association.

The social determinants of health (economic stability, the environment, social contacts and neighborhood and education) are reflected in this model as key factors in the model. A strong **community care coordination**[viii] system that addresses social determinants can strengthen and reinforce a collaborative care model approach. Community care coordination addresses the social determinants of health as an integrated component of the care team. A care coordinator serves as a key point of contact, building connections between primary care and behavioral health providers and support resources available in the community, such as housing supports and food assistance. Care coordinators develop sustained and continuous relationships with patients, with an emphasis on face-to-face contact and routinely connect patients with relevant community-based resources. Traditional Health Workers (THWs) and peer support specialists also play an integral role on community care teams. The Pathways Community Hub model is one approach to community care coordination[ix]. A centralized "Hub" serves as a clearinghouse for community resources and referrals, helping to identify those at greatest risk within a community are identified and that an individual's medical, behavioral health, educational and

social risk factors are addressed. Risk factors are addressed using "Pathways" – a standardized process that identifies, defines, and resolves an at-risk individual's needs by connecting the individual to community-based, culturally proficient services that are coordinated.[x]

Social Determinants of Health

Definition

Social Determinants of Health (SDoH) have been defined by several entities as they have become a critical aspect of improving the health of populations. Under the newest cycle of procurement for Coordinated Care Organizations (CCOs) to serve Oregon's Medicaid population, termed "CCO 2.0", there is the following definition:

- ***"Social Determinants of Health and Health Equity"*** *or* ***"SDOH-HE" SDOH*** *means 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. Social determinants of health include, but are not limited to: Poverty, education, employment, food insecurity, diaper insecurity, housing, access to quality child care, environmental conditions, trauma/adverse childhood experiences, and transportation.*

- ***SDO-HE*** *means the Systemic or structural factors that shape the unfair distribution of the social determinants of health in communities. Institutional racism is one example. Together* ***SDOH-HE*** *is the combined factors of the social determinants of health and the social determinants of health equity.*

Oregon's CCO 2.0 has asked the CCOs to focus on SDOH-HE over the life of the next contracts starting in January 2020, including investments to improve them. For the first two years of SDOH-HE spending, OHA has designated a statewide priority for spending on Housing-Related Services and Supports, including supported housing.

The Evidence for Social Determinants of Health (SDoH) interventions

There is a mix of evidence that exists on SDoH interventions. The literature has a variety of studies with different patient populations, measurement tools, processes, funding and outcomes.

To date, the findings include:

- Have seen that unmet SDoH needs are repeatedly related to adverse health outcomes
- Evidence continues to expand showing a beneficial impact on health outcomes when SDoH are addressed
- Evidence-based interventions to address SDoH include:
    - Screen for SDoH consistently
    - Create appropriate processes to deliver SDoH interventions
    - Use standardized care plans or approaches consistently
    - Ensure an ability to measure results that can draw insights to improve outcomes

- Evidence can support potential value-based payment for sustainability

Collecting SDoH information

Collecting SDoH information can inform others which can enhance spread and replication. It is very valuable to ensure data is collected especially if piloting a new innovation, to help determine potential benefits of what can be limited funding in grant programs. To improve the assessment of pilots so that the limited dollars are most effective, the grant program should consider if the proposal is using an approach on the evidence-based list of CDC or other well-documented interventions. This provides validation to the approach and gives credibility that the proposal's structure will result in positive outcomes.
SDoH Evidence-Based Resources Databases include:

- Healthy People 2020- Office of Disease Prevention and Health Promotion
  https://www.healthypeople.gov/2020/tools-resources/Evidence-Based-Resources
- Centers for Disease Control and Prevention:
  Community Health Improvement Navigator Database of Interventions:
  www.cdc.gov/chinav/database/index.html
- Institute for Alternative Futures:
  Database of specific health center efforts, programs, and activities to leverage the social determinants of health:
  www.altfutures.org/leveragingSDH

Health Equity

Definition

The federal Centers for Disease Control (CDC) has a Community Preventive Services Task Force defines health equity as follows:

> *"Health equity exists when individuals have equal opportunities to be healthy. The ability to be healthy is often associated with factors such as social position, race, ethnicity, gender, religion, sexual identity, or disability. Health inequities are caused by the uneven distribution of social determinants of health, such as education, housing, the neighborhood environment (e.g., sidewalks, parks), and employment opportunities. "*

In a report designed to increase consensus around meaning of health equity, the Robert Wood Johnson Foundation (RWJF) provides the following definition:

> *"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."*

Evidence of Health Equity

Like SDoH, the evidence basis of Health Equity interventions is emerging. A recent article from the Public Health literature states: "…growing number of high-quality evidence-based reviews that identify interventions that are effective in promoting health equity at the individual patient level, and at broader community and structural levels."[xi]

The World Health Organization (WHO) states:

> *"Assessment with a health equity perspective identifies health status and trends, but it also indicates where health differences that are the result of differences in the* ***opportunity for health*** *exist between population groups. This adjustment in the assessment process can disclose health differences between population groups that are addressed through changes in policy, programs, or practices."*[xii]

Previous work by the WHO emphasized that a key approach to health equity is through action on the social determinants of health.[xiii] They set out key areas of daily living conditions and of the underlying structural drivers that influence them in which action is needed. It provides concrete examples of types of action that have proven effective in improving health and health equity in countries at all levels of socioeconomic development, focused on social determinants. Their look at the evidence took a broader view of evidence than just traditional biomedical research. It included also observational studies, case studies, field visits, expert and lay knowledge and community intervention trials where available. Some of the findings in the report include:

- Investment in the early years provides one of the greatest potentials to reduce health inequities within a generation
- The daily conditions in which people live have a strong influence on health equity.
- Achieving health equity requires safe, secure and fairly paid work, year-round work opportunities, and healthy work-life balance.
- Access to and utilization of health care is vital to good and equitable health

Guiding projects to include Health Equity

CDC's Equity Guides

The Centers for Disease Control (CDC) National Center for Chronic Disease Prevention and Health Promotion has created "Equity Guides".[xiv] to guide projects emphasizing the following:

- Without a focus on health equity, the effects of an intervention on addressing health disparities and inequities can go unnoticed
- If focus only on improvements in health, could widen the gap in inequities
- Integrate health equity considerations through the strategy development, design, implementation *and* the evaluation of the project

An example of how to apply the Equity Guides is the work by the Boston Public Health Commission (BPHC) who:

- Developed evaluation questions to gauge their impact on health inequities.
- Required partners to routinely collect data on race/ethnicity, age, gender, and zip code for all of their initiatives. The data documented how activities benefitted the community in general, as well as population groups/areas experiencing health inequities.
- Increased sample size for the Communities Putting Prevention to Work (*CPPW)* Behavioral Risk Factor Surveillance System in order to ensure sufficient power to assess neighborhood-level changes over time.
- Designed an analysis plan to assess the overall effect of the selected strategies, as well as the effect(s) across population groups.
- Set up their performance monitoring to identify areas where additional efforts may be needed to enhance intervention effects in underserved communities.

This strategic evaluation design enabled BPHC to make mid-course adjustments and enhanced their ability to contribute to the evidence-base regarding the influence of their initiative on advancing health equity.

Centers for Disease Control (CDC) Community Guide:

Developed by the Community Preventive Services Task Force (CPSTF) developed a community guide for health equity The CPSTF is an independent, nonfederal panel of public health and prevention experts whose members represent a broad range of research, practice, and policy expertise in community preventive services, public health, health promotion, and disease prevention. The guide provides evidence-based findings and recommendations about preventive services, programs and other interventions aimed at improving population health. Information is available at:

- Health Equity Findings: https://www.thecommunityguide.org/topic/health-equity
- Fact sheet: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-HealthEquity.pdf

Additional Tools for Health Equity

The Health Equity Assessment Tool/Workbook is designed for organizations to examine their efforts towards equity. It is similar to what the CCOs were required to complete for their proposals for the CCO 2.0 procurement. It is available at:
http://www.health.gov.on.ca/en/pro/programs/heia/docs/workbook.pdf

Another examples of approaches to equity efforts include CDC supported Racial and Ethnic approaches to Community Health (REACH). Since 1999, REACH has supported projects that used community-based, participatory approaches to identify, develop and disseminate effective strategies for addressing health disparities. More information is available at
https://www.cdc.gov/nccdphp/dnpao/state-local-programs/reach/

Assessment of Pilots

The HMA team reviewed all of the final reports on pilot projects that were funded through the DST since 2016 in order to identify 1) pilots with the potential for further spread or expansion, and 2) to identify any gaps in DST funding and recommendations for potential focus areas going forward. Our analysis considered the following factors:

1. **Impact:** *number of lives or high-priority target population impacted*
2. **Outcomes:** *health outcomes and cost savings/value*
3. **Sustainability:**
    a. *Is there a longer-term financial model identified?*
    b. *Organizational or leadership sustainability or other development needs.*
4. **Potential for spread:** *expanded population or expanded geographic areas*
5. **Alignment with IHN CCO's strategic framework for CC0 2.0:**
    a. Behavioral Health Integration
    b. Social Determinants of Health and Equity

Early in the analysis, it became clear that there were limited data on lives impacted, outcomes, and cost savings. These data limitations required a change in focus. The HMA team refined its approach to focus on the following factors:

1. Sustainability
2. Potential for spread
3. Evidence-Based Approaches
4. Alignment with IHN CCO's strategic framework for CC0 2.0:
    a. Behavioral Health Integration
    b. Social Determinants of Health and Equity

Assessment Findings

Overall, our review of the DST Pilot Projects found the program has been tremendously successful. All of the funded projects have made a contribution to the region. Our assessment identified which projects (using the framework of evidence-base, sustainability, spreadability and focus on priority areas) DST should consider funding for spread / expansion. The following tables identify the pilots that fit within this framework by each year of the program.

Table 2: 2016 Promising Pilots to Consider for Spread / Expansion

Behavioral Health	SDoH / Equity
• Universal Prenatal Screening • LCSWs in PCPCH • Primary Care Psychiatric Consultation • Child Psychiatry Capacity Building • Child Abuse Prevention & Early Intervention • Tri-County Family Advocacy Training • Youth Wraparound & Emergency Shelter	• CHWs – Benton County • Maternal Health Connections

Table 3: 2017 Promising Pilots to Consider for Spread / Expansion

Behavioral Health	SDoH / Equity
• Chrysalis Therapeutic Support Groups	• School/ Neighborhood Navigator • Health & Housing Planning Initiative • CHWs – North Lincoln • Pre-Diabetes Boot Camp

Table 4: 2018 Promising Pilots to Consider for Spread / Expansion

Behavioral Health	SDoH / Equity
• Family Support Project • Community Paramedicine • The Warren Project: Nature Therapy • Improving Infant & Child Health – Lincoln County	• Oral Health Equity for Vulnerable Populations • CHANCE 2nd Chance • Children's SDoH and ACEs Screening • SDoH Screening with a Veggie Rx Intervention

For our review of 2019 pilots, we focused only on those in operation for a full year in order to have some information as to their impact. Of those operating for a full year to date, all of them fit within the framework:

Table 5: 2019* Promising Pilots to Consider for Spread / Expansion

Behavioral Health	SDoH / Equity
• Peer Wellness Specialist Training • Regional Health Education Hub • Planned and Crisis Respite Care	• THW Hub • Veggie Rx in Lincoln County • Health Equity Summits and Trainings • Homeless Resource Team

**Only those pilots that have been operating for a full year were considered.*

RECOMMENDATIONS FOR FUTURE PILOTS AND THE PROGRAM

Approaching our recommendations for the Transformation Program, we considered the following:

- What types of projects should the DST invest in / support going forward?
- Recommendations for improved evaluation/Return on Investment (ROI) Assessment
- Recommendations for improved data collection, including equity data
- Recommendations for assessing and strengthening CBO / partner relationships to support health systems transformation

Types of projects DST should invest in and/or support going forward

Considering the emphasis outlined in CCO 2.0 on behavioral health integration, social determinants of health and health equity, the future focus of the Transformation Program should be in the following areas:

- **Community Care Coordination**- by working across the community, the care of the IHN members and other members of the three-county area would be significantly improved by enhancing community care coordination. It should continue efforts to bring together the health delivery system with community-based organizations to work on behavioral health integration, social determinants and health equity. The current investment in the software of UniteUs will help to support community-wide care coordination by enhancing the organization of care and ensuring closed-loop referrals so that services reach the populations. This focus will need ongoing work in governance as well as leadership and organizational development to ensure sustainability of the community-based organizations, especially the smaller ones. Collaborative governance and engagement of cross-sector partners across the region will be a critical component to establishing a successful community care coordination system.
- **Universal screening of SDoH, BH and Chronic Disease –** There have been successful pilots in this area and the DST SDoH workgroup has committed to universal screening. Working on the spread of universal screening across the delivery system in the three-county region will provide the information to target resources. Analysis of the needs of the population will identify the key areas of investment IHN and other community partners could consider for collaborative investments over the next few years.
- **Traditional Health Workers –** Community Health Workers, Peer Support Specialists and Doulas can play a key role in screening and addressing the social determinants of health and health equity. The Transformation Program has supported successful pilots that have enhanced the THW workforce in the region to date. The program should continue to assess ongoing investments in the sustainability of training and support increase the use of THWs.
- **Housing –** Some smaller projects have started to address this significant SDoH. IHN and DST will need to assess potential investment projects that can take these initial steps further to be able to make significant impacts. There is potential return on investment, as shown by the "Housing First" model and others in stabilizing the health of populations and reduce the

use of expensive health services such as use of the Emergency Department, hospitals and nursing facilities. Housing efforts can also be a means to provide "Housing with Services" to bring care coordination to the community level where people live. Housing projects with a strong community-based care coordination component will enhance the impact of these investments.

Recommendations for improved evaluation/Return on Investment (ROI) Assessment

As the DST continues to support innovation through the Transformation Program, key elements to consider in initiating and evaluating funded projects include:

- Ensure adequate information is being collected across the grant projects with a lens on Behavioral Health Integration, Social Determinants and Equity to understand the impact by subpopulations, regions, other parameters.

- Develop common project metrics for the Transformation Pilots
  - Develop initial metrics for grantees to use to monitor for Behavioral Health integration, SDoH and Equity across the projects, that align with CCO 2.0 expectations and best evidence/best practices
  - Allows IHN and DST to look across the projects more broadly
  - Support learning opportunities and sharing of data needed to enhance analysis

Recommendations for improved data collection, including equity data

Improve Social Determinants Data Collection

DST Social Determinants Workgroup has committed to universal screening and could work towards it broadly across the medical, dental, behavioral and social service entities in the three-county region. To assist in these efforts, would suggest to further examine how other states have or starting to focus on SDoH. One good example is the Iowa SDoH toolkit which is a compilation of resources for states, plans and community groups to enhance SDoH information collection and applying it to inform both patient care planning and community response capacity level to meet the patient needs.[xv]

Improve Health Equity Data Collection

DST's Health Equity WG has a strategic plan to assess approach to address health equity data collection and analysis in order to improve and monitor strategies to reduce disparities. The "REAL+D" is an effort by Oregon to increase and standardize race, ethnicity, language and disability data collection across the Dept of Human Services and the Oregon Health Authority (OHA), driven by legislation in 2013. An expectation of CCO 2.0 to collect and analyze REAL+D data. This will need to be further education and best practices sharing across with partnering community-based organizations and the delivery system entities to assist IHN to be successful in this.[xvi]

Minnesota Health Equity Data Collection Efforts

Minnesota has done a lot of work in this area to assist their local public health departments and others on Health Equity Data Analysis. The most recent guide (updated Feb 2018)[xvii] was designed to inform local public health departments. From their Guide:

> *"Analyzing health inequities requires a process that actively engages community members (including those experiencing health inequities) and uses data to identify health differences between population groups instead of only examining the population as a whole. The process continues by identifying and examining the causes of these population differences in health. Identifying the causes of health inequities requires the use of both quantitative and qualitative data collection and analysis methods."*

Washington State Health Equity Review Planning Tool

Washington State Dept of Health partnered with CDC to develop a Health Equity Review planning tool.[xviii] It is an assessment for use while developing a project to consider the strategies and evaluation through a health equity lens. It has several ways to benefit the Transformation Program including that it:

- Could be used by future grantees to develop stronger projects that ensure health equity is a consideration
- Could be used in the RFP to evaluate projects for grant consideration to ensure DST is supporting projects that consider health equity impacts
- Has elements that could be folded into performance monitoring and final evaluations to help DST identify areas where additional efforts may be needed; future grant focus

Recommendations for assessing and strengthening Community-based Organizations (CBOs) and other partner relationships to support health systems transformation

Two aspects to consider for the Transformation Program to assess and strengthen community-based organizations and other partner relationships that will support health systems transformation include:

Support Spread and Scale

One effective approach to support spread and scaling of projects include shared learnings and collaboratives – IHN and the DST could sponsor more shared learning opportunities such as:

- Sharing best practices around data collection especially focused on SDoH/Equity screenings
- Sharing best practices around data analysis
- Sharing best practices around partnership development
- Sharing around workflow to ensure Behavioral Health Integration/SDoH/Equity is integrated in a systematic approach for sustainability

Efforts to consider that will build and grow capacity include:

- Technical assistance to implement the pilots
- Technical assistance for entities to scale their activities more broadly (or to help others spread)
- Leadership and Organizational Development

Strengthen CBO Partnerships and Networks

To strengthen the partnerships and networks, some further examination of community-based organizations (CBOs) would be valuable to not only identify synergies and potential cross-collaboration on efforts, but also to ascertain the needs of the CBOs to be sustainable over time to ensure longevity of initiatives and success for community wide efforts. One approach to this is a community-based organization (CBO) assessment tool**.** Key elements in such tools are designed to:

- Help CBOs determine their program strengths and opportunities for growth
- Help IHN engage and more effectively partner with CBOs as they reach out to address social determinants and equity.

One example is HMA's CBO Assessment Tool.[xix] Developed by SDoH and H. Equity experts, it provides:

- Is a rapid scan of the CBO and their environment/community assets
- Assists with strategy and support for the CBO in partnership with the CCO
- Provides a resource gap analysis and plan for addressing social needs of those being served by the CBO/CCO

The DST could apply the tool in the future in the following ways:

- Could be used to further assess current or past grantees' capacity as consider additional resources/support needed;
- Could be used to assess new CBOs for future partnering, especially as address more SDoH;
- Could be used to enhance Health Equity efforts when working with current or future CBOs

ENDNOTES / RESOURCES

[i] https://www.eocco.com/providers/grants

[ii] https://www.northwesthealth.org/kpcf/what-we-learned

[iii] Northwest Health Foundation Kaiser Community Fund Final Report https://static1.squarespace.com/static/52b20be1e4b09f7904dfa46f/t/5c774905e5e5f04d08223b3a/1551321353438/KPCF+Final+Report+Web_Overview.pdf

[iv] Robert Wood Johnson Foundation's Culture of Health https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html

[v] https://www.mhanational.org/issues/mental-health-america-access-care-data

[vi] Purington, K. & Townley, C. (2017). Physical and Behavioral Health integration: State Policy Approaches to Support Key Infrastructure. *National Academy for State Health Policy.*

[vii] https://aims.uw.edu/collaborative-care/principles-collaborative-care

[viii] https://innovations.ahrq.gov/topic-collections/community-care-coordination-glance

[ix] https://innovations.ahrq.gov/sites/default/files/Guides/CommHub_QuickStart.pdf

[x] https://www.cjaonline.net/pathways-community-hub-model-of-care-coordination/

[xi] Health Equity Evidence Review – *from Public Health Reviews* **volume 39**, Article number: 19 (2018) https://publichealthreviews.biomedcentral.com/articles/10.1186/s40985-018-0094-7

[xii] WHO (2013) Handbook on health inequality monitoring: with a special focus on low-and middle-income countries. Geneva: World Health Organization. Retrieved from: www.who.int on September 10, 2019.

[xiii] **Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health:** 2008 Final Report of the World Health Organization's Commission on Social Determinants of Health. Available at: https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

[xiv] Links to CDC's Equity guides:

- https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity-guide/pdf/health-equity-guide/Health-Equity-Guide-sect-1-7.pdf
- https://www.cdc.gov/nccdphp/dnpao/state-local-programs/health-equity-guide/pdf/health-equity-guide/Health-Equity-Guide-sect-1-5.pdf

[xv] Iowa Social Determinants of Health Toolkit - More information is available at https://www.ihconline.org/filesimages/Tools/Pop%20Health/SIM/SDOH%20Toolkit/SIM_SDOH_Toolkit_1.pdf

[xvi] More information on REALD

- Data Collection Standards https://www.oregon.gov/oha/OEI/REALD%20Documents/REAL-D%20rules.pdf
- OHA's questionnaire for assessing race, ethnicity, language and disability background: https://apps.state.or.us/Forms/Served/le0074.pdf

[xvii] More information on Minnesota's health equity data collection guidance is available at:

- https://www.health.state.mn.us/data/mchs/genstats/heda/healthequitydataguideV2.0-final.pdf
- Additional details and health equity frameworks are on the state website: https://www.health.state.mn.us/data/mchs/genstats/heda/index.html

[xviii] Washington State Health Equity Planning Guide: https://www.doh.wa.gov/Portals/1/Documents/8300/140-044-HERtool-en-L.pdf

[xix] Community-based Organizations Community Assessment Tool: More information available for one example is at https://www.healthmanagement.com/who-we-help/community-based-organizations/

BRINK

Achieving Health Equity for Linn, Benton and Lincoln Counties

FNL Key Message Platform | July 2, 2020

TONE

The tone for the InterCommunity Health Network Coordinated Care Organization (IHN-CCO) Health Equity Workgroup's communications should help potential partners and champions for health equity feel welcome and valued as they consider joining hands to tackle inequities impacting community health. In all communications, the Health Equity Workgroup should be:

- Collaborative
- Straight-forward
- Factual
- Welcoming

AUDIENCES

Key messages can be used to communicate with the diverse audiences identified as a priority by the Health Equity Workgroup:

- IHN-CCO leadership
- Delivery Systems Committee
- Health care providers
- Support staff (clinic managers, navigators, social workers, etc.)
- CCO members
- Local policymakers
- Community-based organizations
- Community members

KEY MESSAGES

Key Message #1: Health and equity are shared values in the region

We believe that everyone in our region deserves the same opportunities to be healthy, no matter who we are, where we live, or how much money we make.

- We envision a future where everyone has access to healthy foods, safe spaces for play and exercise, and connection to community. Over the years, our region has shown collective commitment to deliver on this vision.
- Together, we've made real progress to ensure that all of our community members have what they need to be healthy.
    - Providing community members access to fresh produce from local farmers markets through a fruit and vegetable prescription program
    - Ensuring that every kid has the health coverage they need to stay healthy, regardless of their immigration status
    - Driving policy change to ensure more people have healthy and affordable housing that supports their wellbeing
- Health equity is a vision and the confidence that together, we can solve the societal inequities that impact the health outcomes of our loved ones, colleagues and neighbors.
- We also envision a health system that is welcoming for all — without judgement, stigma and language or cultural barriers.

Key Message #2: Healthy choices are not equally available to all

Despite progress, we still don't have the same access to the building blocks of a healthy life: good jobs with fair pay, quality education, stable housing, health care. This is especially true for Communities of Color and Tribal Communities living in Linn, Benton and Lincoln counties.

- The inequities in our region are greatest among Communities of Color and Tribal Communities.
- Our racial identity has a direct impact on our opportunities to be healthy. But that's not all. The intersection of our race, gender and sexual orientation all shape how we are treated in our systems and cultures.
- For example:
    - Health outcomes: Black women are 5.2 times more likely to die during childbirth than their white counterparts, according to the CDC.
    - In Oregon, Latinx and Pacific Islander communities have the highest prevalence for diabetes.

- COVID infection rates: The Oregon Hispanic community only makes up 12 percent of the state's population, but 35 percent of all COVID-19 cases since January 2020 (as of July 2020).
- Access to healthy food: 12.2 percent of white Oregon residents experience food insecurity while that number is 31 percent for American Indians in Oregon. Food insecurity is caused by both low income and the lack of grocery stores close to home.
- Education: Oregon adults living below the federal poverty limit or who have not completed high school are more than twice as likely to report frequent mental distress.

Key Message #3: Inequities are deeply rooted in our history.

The inequities that Communities of Color and Tribal Communities face are deeply rooted in the history of our state and our nation, and this history continues to drive negative impacts on their health and safety.

- Health inequities are not caused by the choices that we make. They are the result of the historic and systemic injustices that deny Communities of Color and Tribal Communities access to power and resources.
- The institution of slavery in the United States has created hundreds of years of generational trauma and lost wealth for Black Americans. The consequences of slavery remain relevant to the health and wellness of Black Americans — showing up in wealth attainment, hiring practices, educational achievement and unequal criminal justice practices.
- [Placeholder for regional historical context]
- Many more historical and current policies and practices threaten the well-being of Communities of Color and Tribal Communities, including institutional discrimination, hate crimes, stigma and gentrification.
- By addressing the inherently racist systems and structures that deny Communities of Color and Tribal Communities opportunities for health and well-being, we will improve access to resources for those who need it the most.

Key Message #4: We must continue to come together to improve health equity.

Now is the time to prioritize our Communities of Color and Tribal Communities and make sure everyone has what they need to thrive. By working together, we will invest in solutions and remove barriers that for generations have denied Communities of Color and Tribal Communities the opportunities to be healthy.

- We'll create healthier, more equitable communities by ensuring everyone has what they need to thrive. Here's what it will take: [customize based on audience and messenger]

- Health is not only impacted by doctors and nurses. Health exists in our homes, schools and neighborhoods, which means all sectors can help in improving our communities' health.
- Join the IHN-CCO Health Equity Workgroup in our work to improve health for everyone in Linn, Benton and Lincoln counties.

Social Determinants of Health Workgroup
Recommendations for Funding, Policy, and System Change in the Housing Sector

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 Services, Lincoln County Health and Human Services, Linn Local Committee of the Community Advisory Council, Live Longer Lebanon, Olalla Center for Children and Families, Old Mill 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 Improvements 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)/Regional Planning Council (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

LETTER OF INTENT COVERSHEET

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) and the Delivery System Transformation (DST) Committee of the Regional Planning Council invite interested providers and agencies in Benton, Lincoln, and Linn counties who can positively impact the health outcomes of IHN-CCO members to submit a pilot proposal that transforms the healthcare delivery system. The full Request for Proposal (RFP) Guidelines are available at **www.IHNtogether.org** or by emailing Transformation@samhealth.org. A non-binding Letter of Intent (LOI) is required to be considered for funding.

Please use this template and limit your LOI to no more than three pages including this coversheet.

The LOI must be submitted to Transformation@samhealth.org no later than **June 1, 2020 at 8:00 am.**

Primary Organization:
Primary Contact:
Partnering Organization:
Pilot Name (4 words or less):

1. Briefly describe your pilot proposal. (2-3 paragraphs)
2. What target area (access, behavioral health, social determinants of health) does your pilot focus on?
3. What component (innovative strategy, spreading promising practices, or THWs in the housing sector) of the RFP are you addressing? See pages of the Pilot Proposal Guidelines for information.
4. Describe how your pilot is aligned with the Community Health Improvement Plan Health Impact Areas on pages of the Pilot Proposal Guidelines.
5. Describe how the two or more cross-sector organizations will work together.
6. List all other major partners that have stated they actively support this project.
    - Include the name and contact information (email address or phone number) for your primary contact in the organization.
    - What will make collaborating with these partners successful?
7. Describe the plan to promote health equity and reduce health disparities. (2-3 paragraphs)
8. List other resources or funding that you are planning to consider (such as an agency matching funds). (1-2 paragraphs)
9. Describe how you plan to sustain the pilot after this funding is completed. (1-2 paragraphs)
10. What is your planned pilot budget? Consider expenses such as care coordination time, materials and supplies, meetings, education, travel, indirect, etc.
    - ☐ Less than $50,000
    - ☐ $50,001 - $100,000
    - ☐ $100,001 - $150,000
    - ☐ $150,001 - $200,000
    - ☐ Other:

In compliance with the Americans with Disabilities Act, this document can be made available in alternate formats such as large print, Web-based communications, and other electronic formats. To request an alternate format, please send an e-mail to Transformation@samhealth.org.

InterCommunity Health Network Coordinated Care Organization

Issues the Following Request for Pilot Proposals

Date of Issuance:	May 4, 2020
Letter of Intent Due Date:	**June 1, 2020 by 8:00 am**
Proposal Due Date:	**July 27, 2020 by 8:00 am** via electronic submission to: Transformation@samhealth.org
Issuing Office:	Transformation Department, IHN-CCO
Point of Contact:	Transformation Department IHN-CCO 2300 NW Walnut Blvd Corvallis, OR 97330 Transformation@samhealth.org

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InterCommunity Health Network Coordinated Care Organization (IHN-CCO) is committed to improving the health of our communities by building on current resources and partnerships within the tri-county region to support transformation of the delivery system. IHN-CCO and community partners, through the Delivery System Transformation Committee (DST), welcome innovative ideas and collaborative strategies to ensure all individuals have equal opportunities to be healthy where they live, work, learn, and play. IHN-CCO is committed to improving the health of our communities through the Triple Aim of better health, better care, and lower cost.

REQUEST FOR PROPOSALS

IHN-CCO and the Delivery System Transformation Committee (DST) of the Regional Planning Council invite interested providers and agencies in Benton, Lincoln, and Linn counties who positively impact the health outcomes of IHN-CCO members to submit pilot proposals that transform the healthcare delivery system.

Transformation is defined as keeping the Patient-Centered Primary Care Home (PCPCH) at the center of healthcare delivery, but includes creating different relationships, community connections, and linkages outside of the traditional health services setting. Transformation pilots should include upstream health and be willing to risk trying something different. Even failed projects provide a learning opportunity. Transformation is constantly changing and is not static, has elements of innovation, but is broader and involves system change.

Purpose

- Promote and strengthen partnerships and create new linkages that support transformation of the healthcare delivery system in the tri-county region through collaborative workgroups and pilots
- Expand and integrate collaborative partnerships that are aligned with CCO goals and the Triple Aim
- Promote, foster, support, share innovation, and expand the model of the Patient-Centered Primary Care Home as the foundation of the CCO's transformation of health care delivery

REQUIRED LETTER OF INTENT

A non-binding Letter of Intent (LOI) is required to be considered for funding. Please submit the LOI form to Transformation@samhealth.org no later than **June 1, 2020 at 8:00 am.**

The LOI must address all required pilot components and will be scored on how transformational the proposed pilot project is and on the health equity approach.

The Letter of Intent form can be found at www.IHNtogether.org/transforming-health-care/request-for-pilot-proposals or by emailing Transformation@samhealth.org.

PILOT REQUIREMENTS, PROPOSAL REVIEW, AND EVALUATION CONSIDERATIONS – WILL ADD TARGET AREAS SECTION ONCE APPROVED BY DST

Social Determinants of Health

SDoH are "the conditions in which people are born, grow, live, work and age" per the World Health Organization (WHO). These conditions include housing, food, employment, education, and many more. SDoH can impact health outcomes in many ways, including determining access and quality of medical care.

Health Equity

Identify how the pilot project will promote health equity and reduce health disparities. Include how health equity data will be tracked for IHN-CCO members served during the pilot project timeframe. Possible tracking categories include; age, race/ethnicity, disability status, mental health status, language, gender identification, rural or urban, housing status, household income, employment status, education level, food security status, and more.

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. Health equity broadens the disparities concept by asking, "Why are some populations at greater risk of illnesses and preventable deaths than others?" This question leads to a deeper analysis and exploration of the causative factors that contribute to disparities. Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Additional Evaluation Considerations

In the process of selecting pilot projects for funding, the DST will give priority to proposals that meet the following criteria and qualities:

- Create opportunities for innovation and new learning for the DST
- Yield measurable outcomes that are new or different from previously funded pilot projects
- Establish new connections within and between the healthcare delivery system and the community
- Plan to sustain and continue project after DST funding ends
- Exhibit consideration of alternative funding sources
- Clearly articulate what part of the Medicaid population is affected and how
- Target areas of healthcare associated with escalating healthcare costs
- Develop and validate strategies for collaboration and creating interconnections between community services and healthcare systems
- Demonstrate clear linkage to the Patient-Centered Primary Care Home

TIMELINE

Activity	Expected Date(s)
Request for Proposal (RFP) Announcement	May 4, 2020
Question and Answer (Q&A) Session	May 19, 2020
Letter of Intent (LOI) Due – Required	**June 1, 2020 by 8:00 am**
Invitations Issued to Submit Full Pilot Proposal	**By June 17, 2020**
Technical Assistance Meeting – Required	June 17, 2020 to July 17, 2020
Pilot Proposal Due	**July 27, 2020 by 8:00 am**
Pilot Presentations to the DST Committee	August 6, 2020 and August 20, 2020
DST Committee Decisions	September 3, 2020
Pilot Proposers Notified of DST Decision	By September 7, 2020
Regional Planning Council Funding Decisions	TBD
Proposers Notified of Pilot Denial or Approval	**By September 30, 2020**
Transformation Department Creates Pilot Contracts	By November 1, 2020
Pilot Contracts Finalized	By November 30, 2020
Pilot Invoicing/Payments Begin	January 1, 2021
Although we do our best to adhere to this timeline, it is subject to change as circumstances occur.	

BUDGET

Transformation of the healthcare delivery system is process driven by outcomes. Pilot budgets should be written in terms of outcomes not positions.

Cost Allocation or Indirect Rate: Indirect cost may not exceed 15% of the Total Direct Costs. Expenses, such as equipment and/or supplies, should not be included in the Indirect Expenses category but should be itemized in the other budget categories. IHN-CCO reserves the right to request additional detail on cost allocation or indirect rates.

Funds Cannot be Used to Support the Following

- Construction or renovation
- Equipment costs in excess of $20,000
- Vehicle purchases
- Work for which results and impact cannot be measured
- Current organizational expenses

TECHNICAL ASSISTANCE

Technical assistance is required for anyone submitting a pilot proposal. Please direct all questions and inquiries to Transformation@samhealth.org. The IHN-CCO Transformation staff work with proposers to ensure that pilot proposals are aligned with the Request for Proposal. Technical Assistance is offered from June 17, 2020 to July 17, 2020.

PILOT PROPOSAL PRESENTATIONS

Pilot Proposal Presentations will be scheduled on August 6, 2020 and August 20, 2020 at the regularly scheduled DST meeting from 4:30 to 6:30 pm. Please let the Transformation Department know if you have a date preference as soon as possible.

PILOT CONTRACTING PERIOD

Pilots that are recommended for funding can begin on or after January 1, 2021 and continue through December 31, 2021.

DST MEETING PARTICIPATION

The Delivery System Transformation Committee (DST) would like to invite representatives interested in proposing a pilot to attend DST meetings. This an opportunity to become part of the learning community committed to transformation of the healthcare delivery system. If you would like to participate via videoconferencing, please contact the Transformation Department for instructions. Meetings occur every other Thursday at 4:30 pm. Please visit the DST Section of www.IHNtogether.org or email Transformation@samhealth.org for more information.

REQUIREMENTS OF THE PILOT PROJECT

Progress Reporting

Quarterly and final reports are required. Reporting templates will be distributed at the time of contracting. It is required that presentations and reports show pilot impact through:

- Measurement and evaluation
- Communication and dissemination of results
- Sharing of best practices
- Sustainability
- Member and system impact
- Health equity and social determinants of health approaches

DST Presentations

To foster learning and guide future direction of transformation efforts, pilot projects are asked to present to the DST committee. Presentations are scheduled during regular DST meetings.

Workgroup Participation

Pilot projects are required to be involved in and attend a DST workgroup during the funding timeframe. DST workgroups are comprised of individuals working towards a common agenda that help develop and support transformational work efforts. The workgroups focus on the cross-sector collaboration between Patient-Centered Primary Care Homes and community efforts and services, to achieve better health, better access, and to reduce costs. Pilots will be recommended to attend a workgroup by the DST.

PILOT PROPOSAL DETAILS

The following are required components for any pilot proposal. If invited to submit a full proposal, the template and attachments will be sent to you electronically by the IHN-CCO Transformation Department.

1. Cover Sheet
   This page should be included as the top page of the Application.

2. Proposal Narrative
   A. Executive Summary (1/2 page)
      Provide a summary of the pilot including the overall pilot aims.
   B. Pilot Description (5-7 pages)
      Detailed description of the proposed pilot including:
      - Pilot goals and how they will be measured as indicators for achieving the outcomes
      - Target population; ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members
      - Describe the intervention and detailed activities
      - List all partners that will be working on the pilot and the tasks they will undertake
      - Describe how the pilot will promote health equity and reduce health disparities; include how health equity data for IHN-CCO members will be tracked
      - Explain the social determinants of health lens the pilot will be incorporating
      - Describe the individuals tasked with portions of the pilot and their roles and experience
      - Describe how the project fits into your organization's strategic or long-range plans
      - Describe how members of the community will hear about your project
      - Explain the expected outcomes and how they help meet the pilot goals
      - Describe potential risks and how the pilot plans to address them
   C. Pilot Timeline (1 page)
      Provide a timeline of major activities and goals.
   D. Sustainability Plan (1/2 page)
      Explain how the pilot is innovative, scalable, and transferable. Describe how the pilot, if successful, will be sustained within your organization and how it could be spread to other organizations. Describe other organizations that have a vested interest in the pilot. Be sure to include other resources and organizations contributing to the success of the pilot. Explain how funding will continue after DST funding is completed.

3. Budget Worksheet
   Provide a budget using the Budget Template (this template will be in Microsoft Excel).

4. SMART Goals and Measures Table
   Use the Measures and Evaluation Template to show the evaluation plan (this template will be in Microsoft Word). Include one or more of the outcomes and indicator concepts/areas of opportunity listed on page 8.

OUTCOMES, INDICATOR CONCEPTS, AND AREAS OF OPPORTUNITY

The information below is from IHN-CCO's Community Advisory Council's 2020 Community Health Improvement Plan. Pilots must align with one or more of the outcomes and indicator concepts/areas of opportunity. Areas of opportunity are areas where data may be lacking; but the CAC considers integral to measuring the outcome.

<table>
<tr><th colspan="2">ACCESS</th></tr>
<tr><th>Outcomes</th><th>Indicator Concepts and Areas of Opportunity</th></tr>
<tr><td rowspan="2">A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.</td><td>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, and oral preventive healthcare for all ages</td></tr>
<tr><td>Areas of Opportunity
i. Culture of support for healthcare providers</td></tr>
<tr><td>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.</td><td>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 effectively engaged in their care</td></tr>
<tr><td>A3: Improve integration of oral health services with behavioral and physical health services.</td><td>Indicator Concept
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 assessment 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 it a dental care setting</td></tr>
</table>

BEHAVIORAL HEALTH	
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 Concept 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 Concept 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, screening, 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 and 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

SOCIAL DETERMINANTS OF HEALTH	
Outcomes	**Indicator Concepts and Areas of Opportunity**
SD1: Increase the percentage of members who have safe, * accessible, affordable housing. *Safe housing: a structurally sound, secure, sanitary, nontoxic residence with basic utilities, timely repairs, and adequate space for residents	Indicator Concepts b. Number of homeless persons c. 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