Agenda

Delivery System Transformation Committee

June 24, 2021 4:30 – 6:00 pm

Online Click Here: Join Microsoft Teams Meeting

Phone: +1 971-254-1254

Conference ID: 826 171 835#

1. Welcome and Introductions	Beck Fox, Olalla Center	4:30
2. Transformation Update	Charissa Young-White, IHN-CCO	4:45
3. Pilot Updates • Disability Equity Center • Integrated Foster Child Wellbeing	Pilot Champions	5:05
4. Wrap Up • Announcements • Next Meeting: July 8, 2021	Beck Fox, Olalla Center	5:55

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

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
BRAVE	Bravery Center	Olalla Center	Lincoln	1/1/20	6/30/21
CCP	CommCard Program	The Arc of Benton County	Benton	1/1/21	12/31/21
CDP	Community Doula Program	Heart of the Valley Birth & Beyond	Benton, Lincoln, Linn	1/1/21	12/31/21
CSUP	Culture of Supports	North End Senior Solutions	Lincoln	1/1/21	12/31/21
DEC	Disability Equity Center	Disability Equity Center	Benton, Lincoln, Linn	1/1/21	12/31/21
ENLACES	ENLACES	Casa Latinos Unidos	Benton, Linn	1/1/21	12/31/21
HEWG	Health Equity Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/1/15	present
HHT	Healthy Homes Together	Albany Partnership for Housing, Family Tree Relief Nursery	Linn	1/1/21	12/31/21
HUBV	Hub City Village	Creating Housing Coalition	Linn	1/1/20	12/31/21
HVOST	Hepatitis C Virus Outreach Screening & Treatment	Lincoln County Health and Human Services, Confederated Tribes of the Siletz Indians	Lincoln	1/1/21	12/31/21
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton; Lincoln; Linn	1/1/19	12/31/21
LCCOR	Linn County Crisis Outreach Response	Family Assistance and Resource Center Group	Linn	1/1/21	12/31/21
MHHC	Mental Health Home Clinic	Samaritan Health Services, Linn County Mental Health, C.H.A.N.C.E.	Linn	1/1/21	12/31/21
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/20	12/31/21
POH	Partnership for Oral Health	Capitol Dental Care	Linn	1/1/21	12/31/21
RDUC	Reduce and Improve	Capitol Dental Care, Lebanon Community Hospital	Linn	1/1/19	12/31/21
SDoHWG	Social Determinants of Health Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	11/16/17	present
SKIL	Skills and Connections to Support Housing	Corvallis Housing First	Benton	1/1/20	12/31/21
THWWG	Traditional Health Workers Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	5/21/13	present
UCCWG	Universal Care Coordination Workgroup	InterCommunity Health Network CCO	Benton; Lincoln; Linn	6/26/17	On Hiatus
WINS	Wellness in Neighborhood Stores	OSU Center for Health Innovation, Linn County Public Health	Linn	1/1/20	12/31/21
WtoS	Wellness to Smiles	Advantage Dental from DentaQuest	Lincoln	1/1/20	12/31/21

Delivery System Transformation Committee (DST) 2021 Calendar

January	7	Strategic Planning: Overview and Charter			
	21	Strategic Planning: Charter, Workgroups, Engagement			
February	4	HSPO	PWST	Strategic Planning: UCC & Health Equity	
	18	DOUL	RDUC	Strategic Planning: UCC Workgroup	
March	4	Strategic Planning: Pilots/RFP			
	18	Pilot Updates	Strategic Planning: Request for Proposal (RFP)		
April	1	RFP Decisions			
	15	Finalizing RFP			
	29	Workgroup Updates	RFP Final Decisions		
May	13	Proposal Criteria/Scorecard Review			
	27	Board Update	LOI Discussion	Scoring Matrix	
June	10	Intern Presentations	LOI Decisions		
	24	Transformation Update	Pilot Updates		
July	8	Transformation Update	Pilot Updates		
	22	Proposal Review and Discussion (RFP2)			
August	5	Proposal Decisions (RFP2)			
	12	Proposal Presentations (RFP1)			
		August 19: Regional Planning Council for Pilot Final Approval (RFP2)			
	19	Proposal Presentations (RFP1)			
September	2	Proposal Presentations (RFP1)			
	16	Proposal Decisions (RFP1)			
	30	Workgroup Updates			
October		**October 7: Regional Planning Council for Pilot Final Approval (RFP1)**			
	14	Trauma Informed Care Facilitated Discussion			
	28				
Nov	11	Safe and Inclusive Spaces Training			
Dec	9				

KEY

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

Minutes
Delivery System Transformation Committee (DST)
June 10, 2021 4:30-6:30 pm
Microsoft Teams (Online)

Present			
Chair: Beck Johnson	Charissa Young-White	Lyrica Stelle	Amanda Martin
Annie McDonald	Lance Liden	Tony Howell	Abby Mulcahy
Mona Manwaring	Jenny Glass	Paige Jenkins	Danny Magana
Stephanie Wiegman	Chris Folden	Bettina Schempf	Sheree Cronan
Linda Lang	Elizabeth Hazlewood	Paulina Kaiser	Priya Prakash
Britny Chandler	Jeff Blackford	Kevin Ewanchyna	Alex Llumiquinga
Dick Knowles	Marci Howard	Renee Smith	Rebekah Fowler
Deb Fell-Carlson	Christine Mosbaugh	Alicia Bublitz	Linda Mann

Transformation Update: Charissa Young-White

- Resources & Opportunities to be sent out in the follow up email:
  - Trauma Informed Modules and Trainings Save the Date
  - Behavioral Health Assessment Survey
  - COVID-19 Complaint process from OHA
  - IHN-CCO Press Release on Joining COHO
- Kelly Volkmann
- Kevin Ewanchyna (DST co-chair) will be facilitating upcoming decision-making meetings.
- There is $800,000 of funds available for pilots this funding season.
- SHARE (Supporting Health for All through REinvestment) Initiative proposals. IHN-CCO will be reviewing these internally and recommend that any denied proposals come to the DST as the housing priority area overlaps.
  - Decision: Approved via consensus.
- Final reports for the Traditional Health Worker Messaging project and Pilot Evaluation Study will be emailed out in the follow up email.

Traditional Health Worker Messaging Project Update: Amanda Martin

- See packet for presentation.

Pilot Evaluation Study Project: Lyrica Stelle

- See packet for presentation.
- Possible barriers for survey completion include COVID-19 and short time frame for completion.

Letter of Intent and Invitations to Submit Full Proposal Discussion

- Transformation ranked the Letter of Intent (LOI) submissions on priority areas, health outcomes affecting health inequities, and partnerships and collaboration.
- The ranking was very close in terms of points.
- The ranking represents the information presented only in the LOI.
- There is enough time for all eleven proposals to present to the DST.

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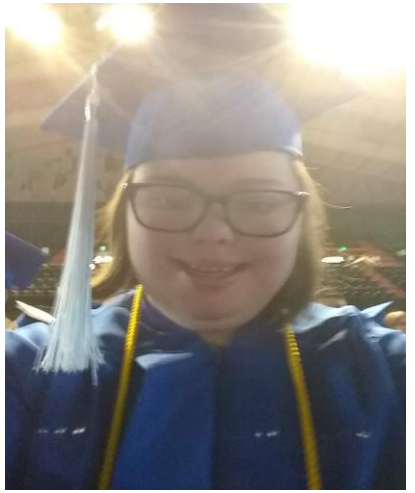
- There is enough time for all seven RFP2 proposals to submit and the DST to discuss in July 2021.
- Decision via consensus: Invite all eleven proposals for RFP1 to submit a full proposal and present to the Committee.
- Decision via consensus: Invite all seven proposals for RFP2 to submit a full proposal.



Disability equity center

Laura Estreich /Allison Hobgood/Abby Mulcahy
disability equity center team

[This slide contains three small portraits of the DEC team: Abby Mulcahy, Allison Hobgood, and Laura Estreich. Laura is dressed in a blue graduation cap and gown and is wearing glasses. Abby has short wavy hair and glasses. Allison has short curly hair and is wearing spiral earrings.]

DEC Intern Laura Estreich

I am Laura Estreich 20 years old. am wings student

I am born with down syndrome with heart defect repair found out have down syndrome with disability with heart defect repair

I am intern at disability equity center am research partner i do research project with on people with disability. am part of DST Grant. why we chose disability equity center corvallis community

[There are two pictures of Laura on this slide; in both she is smiling at the camera. In one picture she is wearing a black blazer and standing in front of a tree. In the second picture she is wearing a floral dress and standing in front of a red rose bush.]

What is disability equity center?

below is a black and white image that is a sketch of diverse disabled people holding a sign that says "Access for All."

The disability equity center in corvallis is a place made by and for disabled people it is an organization that believes disability can be powerful and beautiful you can discover yourself at disability equality center or help someone else discover who they are we are about disability pride and changing the world to make it better for disabled people the disability equality center can help educate people about things related to disability and be a resource for disabled people in our community

Disability equity center corvallis community

This about this is place people with disability and for disabled people orangzation around corvallis community the disability equity center that believes people with disability. The DEC is a community center made by and for disabled people. We are an organization built on disability culture, pride, anda fierce determination to make the world equitable for everyone. DEC brings disabled people from the margins of scoeity to the center and offers a safe space for coalition, community building, and social connection. DEC serves as a resource cneter for disabled poeopel and their allies, and it enables concrete connetcions bewteen people across the disablity community in the Willamette Valley. We alos help edutae out local community about abliesm and change social misperceptions about people with disabilities.

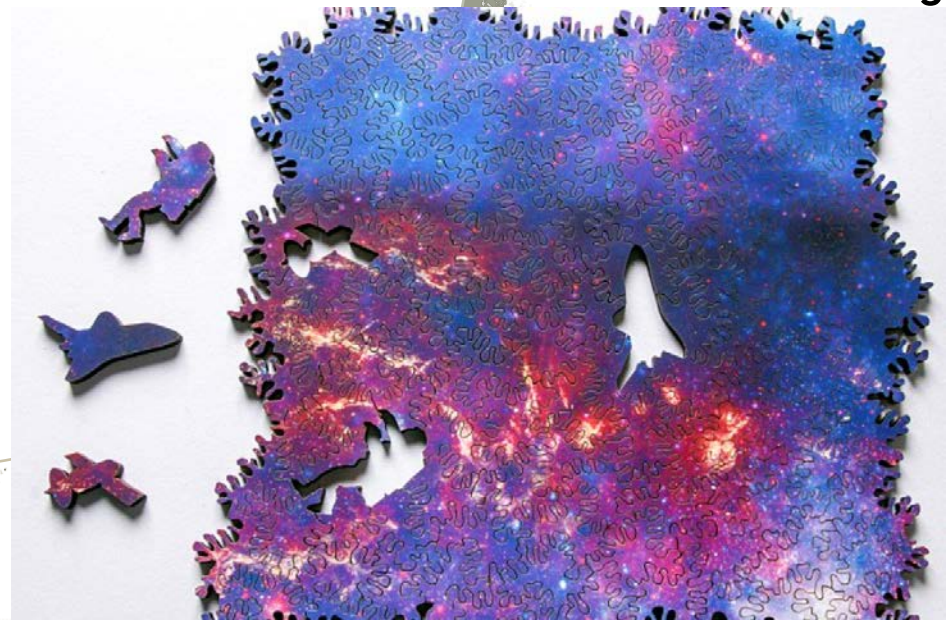
Integrated Foster Child Wellbeing

Carissa Cousins, M.D., MPH

Amy Hamann, BS, HDFS

Capri Kirkpatrick, RN, BSN

Encompass, Care Coordination for Children



- Reporting Period: January 2021-June 2021
- Budget $223,000
- Project duration: January 2019 to current
- Providing care coordination for children in foster care, including in-home placements, relative placements, adoption and reunification.
- Highlights of the past 6 months

  Highlights-Lincoln County, positive feedback

  Learning experiences-It's an ever expanding puzzle.

Successes

- 2020 Metrics
- Weekly key partner meeting
- Lincoln County 2021
- Epic integration
- Notebooks
- The word is out

Challenges

- Medical Insurance barriers (SOC EC)
- Dental Insurance barriers (IHN-CCO)
- Information sharing
- Consent, timely care (Policy vs Statute)
- Intensive Care Coordination/ Time/ Staffing
- In-home placements

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Assess needs of foster families and foster children.	Number of families and children participating in the assessments of needs	Focus groups and surveys to foster families	To be completed in the first quarter.	Completion of focus groups and surveys.	Focus groups for foster parents held. Due to lack of interest, foster youth group was not held. Summary report generated from the focus groups and available upon request. On-line survey completed in December, summary report available upon request. Results will help guide program development and services
Assess medical providers, mental health providers, dental and developmental providers needs and capabilities.	Number of providers from each field participating in needs/ capacity assessments.	Planned meetings with medical, mental health, dental and developmental/ educational providers.	To be completed in the first quarter.	Completion of meetings, structed feedback that will guide development of model/s of care.	Pediatricians in the IHN-CCO area prefer to remain the child's PCP with assistance from a child abuse/ foster care expert for children with more complex needs or who do not have an established PCP, preference to have a care coordination team specifically for foster children. Assessment regarding needs at the coast is ongoing. Meetings with multiple clinics to discuss integration of foster child care coordination into their individual clinic system.
Establish tiered level of care system.	Tiered levels of care created.	Examine existing needs in all domains for children in care, determine levels of needs for services.	To be completed in the first/second quarter.	Tiered levels established.	Experimenting with tiering system based on time. First 60 days is most time consuming for care coordination, child may drop to a lower level after first 60 days.
Determine medical, mental health, dental needs, developmental assessments and current capacities and alternative strategies.	Number of medical, mental health, dental and developmental assessments that need to be completed on average monthly.	Analysis of existing cases integrated with tiered levels of care.	To be completed in the first/ second quarter.	Number of medical, dental, mental health and developmental assessments needed per month on average established.	Approximately 10 children in each Linn and Benton County come into care per month, average of 5 children per month in Lincoln County, each needing initial medical and dental appointments within 30 days and mental health within 60 days. Approximately 450 children (300 in Linn and Benton and 150 in Lincoln) who would benefit from care coordination

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Establish parenting support system (biological and foster).	Formalize parenting support for foster and biological families in all three counties.	Define need and establish formal relationships with Family Tree Relief Nursery, Olalla Center and Old Mill to provide parenting support, work with IHN-CCO and the Department of Human Services (DHS) to establish reimbursement for these services.	To be completed in the second quarter.	Defined relationships, Memorandums of Understanding (MOUs) and/or contracts established.	System of Care Youth and Children in Foster Care workgroup has met and this activity as well as other supports for foster children and families will be addressed in future workgroup meetings so that there is no duplication of efforts.
Determine most effective billing strategy for medical, mental health, care coordination.	Effective, sustainable billing/ payment strategy established.	Explore various options for reimbursement/ payment for services based on model/s selected.	To be completed in the third quarter.	Billing/ payment strategies established to ensure sustainability of services.	Ongoing discussions with IHN-CCO and Samaritan Health Plans regarding payment for services. Exploring opportunities at the state level for changes.
Determine staffing needs and write job/ role descriptions.	Roles, care team time needed to provide services established, roles and responsibilities established.	Based on information gathered earlier in pilot, the roles and staffing needs will be established.	To be completed in the third quarter.	Defined roles, service hours needed to provide care and care- coordination.	Most programs have a care coordinator to foster child ratio or 1:250. Care coordinators in Linn and Benton counties with 1:75 ratio, also doing program development and assisting with Lincoln County program. Two part time Community Health Workers for Lincoln County. Ongoing assessment of staffing needs, efficiency.
Establish locations for providing services.	Defined location/s for providing services.	Work with existing facilities, including mobile unit, do determine most appropriate, accessible locations for services.	To be completed in the third quarter.	Established location/s for services.	Determined that children should be seen in their medical home if established. If not established, or needing to change, care coordinators are working with families and physicians for optimal placement.
Write clinic protocols, including scheduling, intake, case management, confidentiality, transitions.	Defined intake process, return on investment (ROI) processes, scheduling, requirements for comprehensive case management for children in care and transitioning out of care.	Will using existing resources from other foster care programs to develop protocols, state laws to define ROI and confidentiality protocol, case management for children in care and transitioning out of care.	To be completed in the third quarter and revised as needed.	Established protocols, scheduling management, confidentiality guidelines and case management.	Workflow protocols defined for Care Coordinators, ongoing development of guidelines and discussions with partners regarding confidentiality and information sharing. Working with courts, attorneys, DHS on consent, timely care.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Determine best methods to obtain medical records (Primary Care Physician [PCP] assignment and visits/oral health assignment and visits/mental health visits) in a timely manner for all IHN-CCO members served by the pilot.	Within 72 hours of notification, the following data is provided to the pilot from IHN-CCO: PCP assignment Last PCP visit Oral health physician and last visit Mental health visits Any other applicable health information.	IHN-CCO claims and membership data.	As needed.	Pilot receives PCP/Oral/Mental Health information from IHN-CCO for 100% of IHN-CCO members within 72 hours.	Partners meeting regularly to discuss the timely notification of placement of children in care. Contacts within DHS established for information sharing. Weekly meetings with care coordinators, DHS, Mental Health, IHN-CCO and DCOs. Care coordinators are notified within 2 days following shelter hearing, list routinely verified against list from OHA.
Determine most effective case management tool.	Management tool chosen.	Explore existing case management tools and determine the most appropriate for this program.	To be completed in the third quarter.	Case management tool chosen.	Developed system in Epic for documentation and reporting, modifications and reporting tool are ongoing. Exploring IDENTITY information sharing platform from Cincinnati Children's Hospital.
Establish MOUs and contracts with partner agencies	MOUs/ contracts completed with partner agencies.	Involve SHS contracts/ legal department and reimbursement to establish contracts/ MOUs with partner agencies.	To be completed in the third quarter.	MOUs, contracts signed.	Not indicated at this time given that information being shared is within the regulations on information sharing for care coordination.
Establish metrics that will be measured.	Defined measurements for care team members, foster parent, foster child and partners established, defining satisfaction with services. Define health outcomes to be measured.	Investigate other foster care programs exploring what metrics and outcomes are measured, define measurements for this program, determine how this will be tracked.	To be completed in the third quarter.	Defined metrics of satisfaction of services and health outcomes.	Metrics as defined by OHA for children in foster care. Additionally monitoring well checks, routine dental care, vaccinations, psychotropic medication follow up.

Goals	Measure(s)	Methodology	Frequency	Definition of Success	Progress to Date
Develop templates in Epic, discrete fields for data tracking.	Defined templates for initial, comprehensive and follow up medical visits established in Epic as well as case management templates.	Work with care team, investigate existing templates used by other programs, define discrete fields for data tracking.	To be completed in third quarter.	Defined templates for medical visits, care coordination.	Smart phrases developed and available for providers. Flowsheet developed for care coordinators for data tracking and note writing simplicity.
Trauma informed training for staff, self-care.	All staff trained in trauma informed care (TIC).	Determine most appropriate training for all staff not currently trained in TIC, have staff trained.	To be completed in second and third quarter.	All staff have received training in TIC.	Care coordinators have been trained in TIC, ongoing training will occur.
Develop post visit evaluations.	Post- visit survey for foster parents, foster children and biological families defined.	Work with survey developer to most appropriately select information to be collected on post visit surveys.	Survey to be completed in the third quarter.	Defined surveys for appropriate services.	We will be repeating the on-line survey in two years to see if progress has been made regarding care coordination and communication.
Foster children cared for in clinic.	Number of children seen in clinic and participating in the care-coordination program.	Work with DHS in at least one county to have children seen in at least one location, following the implementation, we will review sustainability and perform ongoing Plan Do Study Act (PDSA) cycles.	To be done in fourth quarter.	Number of children cared for by IFCW program.	Over 150 children have been serviced by the foster child care coordinators in the past 12 months. Starting to provide services for children in Lincoln county as of November 15 2020.

Sustainability

- Working with IHN-CCO on Alternative Payment Methodology, Per Member Per Month Payment options
- Foster Child Rate

Opportunities

- American Academy of Pediatrics recommendations for children in foster care
- Parenting resources
- Statewide collaboration
- IDENTITY information sharing platform
- Care coordination for biological parents

Conferences and Presentations

- Health Share Every Step Community of Care meeting, May2021
- Project ECHO Foster Care, January 2022
- Linn and Benton County Juvenile Court Improvement Program, May 2021

Stories from the Field

- First time foster mother and she stated she is very overwhelmed and she said the care coordinator is the first person who has fit all the pieces together for her.
- "It's been really wonderful having you coordinate these things for our foster kids-obviously very beneficial for the children, but also so very helpful me personally and I'm sure all our clinic staff." *Samaritan Physician*
- "If all the people involved in the foster program were like you guys (certifier from Linn DHS & foster child care coordinator) I would take any child that ever needed a home." *Foster mom*

Stories from the Field

- “I’m so glad you are doing this in Lincoln County, our kids really need this. We know how it’s helped for the kids in Linn and Benton.” *Community partner in Lincoln County*
- “This is so helpful, I know what’s been going on with their care.” *Care notebook being given to a mother when her children were reunified*.
- “It was great to have everyone on the same page. It was really helpful for the parents.” Comment from clinic RN after a meeting with biological parents, medical provider, DHS worker and care coordinators

Questions and Discussion