Agenda
Delivery System Transformation Committee

March 17, 2022 4:30 – 6:00 pm
Online Click Here: Click here to join the meeting
Phone: +1 971-254-1254
Conference ID: 869 236 043#

1. Welcome and Introductions	**Beck Fox,** Olalla Center	**4:30**
2. Transformation Update • IHN-CCO Is Your Oregon Health Plan Video • IHN-CCO Job Postings • Roles & Responsibilities	**Melissa Isavoran,** IHN-CCO	**4:40**
3. Pilot Close Out: Linn County Crisis Outreach Response	**Shirley Byrd,** Family Assistance Center and Resource Group	**4:50**
4. Strategic Planning: Pilots Through the Ages	**Beck Fox,** Olalla Center	**5:10**
5. Wrap Up • Announcements • Next Meeting: March 31, 2022	**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
ARCC	Arcoíris Cultural	Olalla Center	Lincoln	1/1/22	12/31/22
CCP	CommCard Program	The Arc of Benton County	Benton, Lincoln, Linn	1/1/21	12/31/22
CDP	Community Doula Program	Heart of the Valley Birth & Beyond	Benton, Lincoln, Linn	1/1/21	12/31/22
CRPS	Culturally Responsive Peer Services	Family Tree Relief Nursery	Benton, Linn	1/1/22	12/31/22
CSUP	Culture of Supports	North End Senior Solutions	Lincoln	1/1/21	12/31/22
DBHS	Decolonizing Behavioral Health Supports	Corvallis Daytime Drop-in Center	Benton, Lincoln, Linn	1/1/22	12/31/22
DDDW	Developing a Diverse Dental Workforce	Capitol Dental Group P.C.	Benton, Linn	1/1/22	12/31/22
DEC	Disability Equity Center	Disability Equity Center	Benton, Lincoln, Linn	1/1/21	12/31/22
DSDP	Depression Screenings in Dental Practices	Advantage Dental Services	Benton, Lincoln, Linn	4/1/22	12/31/22
EASYA	Easy A	Old Mill Center for Children and Families	Benton	1/1/22	6/30/23
HHT	Healthy Homes Together	Albany Partnership for Housing, Family Tree Relief Nursery	Linn	1/1/21	12/31/22
HUBV	Hub City Village	Creating Housing Coalition	Linn	1/1/20	12/31/22
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton, Lincoln, Linn	1/1/19	12/31/22
MHHC	Mental Health Home Clinic	SHS, Linn County Mental Health, C.H.A.N.C.E.	Linn	1/1/21	12/31/22
NAMRX	Namaste Rx	Namaste Rx LLC	Benton, Lincoln, Linn	2/1/22	12/31/22
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/20	12/31/22
OBFY	Overcoming Barriers, Foster Youth	CASA-Voices for Children	Benton	10/1/21	12/31/22
PBHT	Pathfinder Behavioral Health Transformation	Pathfinder Clubhouse	Benton, Lincoln, Linn	1/1/22	12/31/22
PCPT	Primary Care Physical Therapy	Lebanon Community Hospital	Linn	1/1/22	12/31/22
PEERC	Peer Enhanced Emergency Response	C.H.A.N.C.E.	Linn	1/1/22	12/31/22
PSHR	PSH Respite and Housing Case Management	Corvallis Housing First	Benton	1/1/22	6/30/23
PSLS	Pain Science Life Stories	Oregon Pain Science Alliance	Benton, Lincoln, Linn	1/1/22	6/30/23
PUENTE	PUENTES: Improving Language Access and Culturally Appropriate Messaging	Casa Latinos Unidos	Benton, Linn	10/1/21	12/31/22
TTH	Therapeutic Treatment Homes	Greater Oregon Behavioral Health Inc.	Benton, Lincoln, Linn	1/1/22	12/31/22
WINS	Wellness in Neighborhood Stores	OSU, Linn County Public Health	Linn	1/1/20	12/31/22
WVC	Women Veterans Cohort	Red Feather Ranch	Benton, Lincoln, Linn	10/1/21	12/31/22
Workgroups					
COWG	Connect Oregon Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/1/21	present
HEWG	Health Equity Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/1/15	present
SDoHWG	Social Determinants of Health Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	11/16/17	present
SUSTWG	Sustainability Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	1/26/22	present
THWWG	Traditional Health Workers Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/21/13	present

Delivery System Transformation Committee (DST) 2022 Calendar

January	6	Strategic Planning: Overview and Charter				
	20	Strategic Planning: Roles and Responsibilities				
February	3	POH	Strategic Planning: Priority Areas/Message of DST			
	17	HVOST	WtoS	Strategic Planning: DST History/Stakeholders		
March	3	BRAVE	ENLACES	Strategic Planning: Workgroups		
	17	LCCOR	Strategic Planning: Pilots through the Ages			
	31	Strategic Planning: Request for Proposal (RFP)				
April	14	RFP Decisions				
	28	CO WG	HE WG	SDoH WG	SUST WG	THW WG
May	12					
	26	Board Update				
June	9	Pilot Updates				
	23	Pilot Updates				
July	7	Board Update	Proposal Presentations/ Discussion and Scoring			
	21	Proposal Presentations/Discussion and Scoring				
August	4	Proposal Presentations/Discussion and Scoring				
	11	Proposal Presentations/Discussion and Scoring				
		TENTATIVE Regional Planning Council for Pilot Final Approval				
September	1					
	15	Oregon Center for Health Innovation				
	29	Workgroup Updates				
October		**TENTATIVE Regional Planning Council for Pilot Final Approval**				
	13	Oregon Center for Health Innovation				
	27					
Nov	10					
Dec	8					

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)
March 3,2022 4:30-6:00 pm
Microsoft Teams (Online)

Present			
Chair: Beck Fox	Dick Knowles	Britny Chandler	Annie McDonald
Chris Folden	Melissa Isavoran	Paige Jenkins	Ricardo Contreras
Carissa Cousins	Emma Chavez	Susan Ibarra	Kristty Zamora-Polanco
Jay Yedziniak	Jeannette Campbell	Marci Howard	Kevin Ewanchyna
Shelagh Baird	Alicia Bublitz	Abby Mulcahy	Priya Prakash
Larry Eby	Allison Myers	Rebekah Fowler	Elizabeth Hazlewood
Rolly Kinney	Sadie Peterson	Vanessa Adames	Charissa Young-White
Jude Lubeck	Andrea Myhre	Stacey Bartholomew	Jan Molnar-Fitzgerald

Transformation Update

- Developing a Traditional Health Worker(THW) orientation toolkit to assist in the training of THW.
- Concentrating on a specific process for Value-Based Payment contracts.
- There has been considerable discussion about case management software for organizations, particularly as they acquire value-based payment contracts.
- Looking into Unite Us platform for value-based payments.
- Rescheduling and reorganizing the Regional Health Assessment. The goal is to involve groups such as the Community Advisory Council and others to better understand the region's goals in terms of health-related socioeconomic determinants of health and population health in general. Schedule has been extended until 2023.
- Reinvigorating the IHN-CCO newsletter to include information about community support and how to connect and program accessibility.
- The Early Learning Hub is looking for representation on their board, someone who represents housing and county.
- Received final approval for the new IHN-CCO positions and will communicate them as soon as they are posted.

Pilot Close Out: Bravery Center

- See PowerPoint attached.
- Is parental or guardian permission ever an obstacle or a challenge?
  - A youth must be 14 years old in order to access the virtual drop-in social support group, this is in accordance with the age of consent in Oregon. If younger, they need to have parental permission.
  - The age criteria are very carefully chosen to allow adolescents to participate independently of their parents.
- \What about the youth who may require your services the most but are unable to access you?
  - It's a problem that has emerged and for which there is no easy solution.
  - With the resumption of more in-person activities and the strengthening of collaborations with schools, will be able to provide additional support in the classroom, even if just for 30 minutes or an hour a day.
- Could you share any comments or stories from any of the youth that were served by this pilot?

- Through the program, the youth were able to contribute to the creation of Pride Month in Lincoln City.

Pilot Close Out: ENLACES

- See PowerPoint attached.
- What does the acronym GAPS stand for?
  - Greater Albany Public Schools
- Are collaborations or partnerships with Lincoln County possible? Or replication of the program?
  - Open to partnership.
  - Provide advice on how to execute a similar initiative or program.
  - Offer advice from our perspective and from the perspective of community health workers.
  - Having a formal evaluation would be beneficial.
  - We are receptive and would welcome the opportunity to meet with partners in Lincoln County to discuss how we might collaborate.

Strategic Planning: Workgroups

- Reviewed the document on strategic planning that was included in the meeting materials.
- Connect Oregon is Unite US.
- Researching the United US platform and how to implement it in the Tri County area.
- Thinking strategically as a community of how to get all our members connected better and eliminate the duplication of care coordination efforts.
- The Social Determinants of Health Workgroup provided transportation recommendations to the DST.
- The Health Equity Workgroup has been examining data and determining how to obtain information through nontraditional channels.
- The Behavioral Health Quality Committee is not one of the workgroups, but it is closely linked to all the workgroup's bodies of work. Keep in mind the behavioral health component and how to incorporate it into these settings.
- Consider whether these workgroups are the most important ones, will reintroduce in June or September.

Linn County Crisis Outreach Response

Shirley Byrd
Executive Director

Budget: $149,900

Reporting Period: Jan 21 to Dec 21

Summary: FAC mission is to establish TRUST and inspire HOPE by providing access to resources, services, and education to those who are experiencing homelessness and housing instability.

Highlights:

- Winter Shelter
- Shower Trailer
- 1st Resilience worker
- 1st transitional housing Sweet Home
- Leading SH Sleep Center effort
- Led unsheltered PIT count in East Linn County
- Create East Linn County Resource Book

Learning Experiences:

- Understand and relate to people that are in vulnerable marginalized groups.
- We may not share the same experiences but we do share the same feelings.
- It takes 15-50 contacts to build trust & 1 broken promise to destroy it

Successes

- 1st Transitional placement in Sweet Home
- Showers/Shower Trailer
- Client wellness check resulted in 1yr sobriety
- Sweet Home City partnership
- East Linn Harm Reduction Program & Partnership
- Laundry Love Start-up
- Community Health Worker training

Challenges

- Covid BH Case Increase from 30 to 120 police Dispatch requests 2021, sustainability impacted
- Partner participation pull-back (New Partnerships formed)
- 1st Hub implementation partnership failed, resulted in delay 4 months
- Finding non-traditional health workers for outreach (We now have CHW, MS RN, medical school students)
- No Client mgmt system
- Volunteers (Specialized and professional skills)
- Getting Clients to trust traditional health care workers

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)	Outcome
On the street many no-show's to appointments. Unable to access medication. Behavior problems (acting out) on the street in public spaces.	Monitor behavior through personal interaction on the street.	No missed appointments.	12/1/2021	Difficult to track, from inquiry ~50% appointments are missed. reports of BH impacts increased from 30 to over 120 >80% OHP Members
No usage of telehealth or telephone visits from street outreach program. (Mobile outreach vehicle, outreach hub).	Implement and track use of telehealth and telephone for: Behavioral health with Linn County Public Health Samaritan appointments. Legal Appointments	Increase telehealth and telephone appointments.	April-21	Implemented a telehealth solutions that was utilized several times. Appointment coordination is difficult, missed appointments and availability difficult when required or needed. Conversation to changes to availability etc. with Linn Co Health. Still talking to get MH crisis workers on Outreach (severe shortage)
Chronic homelessness individuals and family units.	At 6 month and 12 month updates through case management activity reporting.	Increase in stably housed individuals and families.	6/1/21 12/1/21	34 individuals served at winter shelter, scarcity of transitional housing continues to be a problem 6-8 others served for transitional / respite housing needs. Partnered CSC for rent assistance, Partnered Chance for outreach peer support, Partner Hope Center

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)	Outcome
There is no formalized continuum of care	Implement a case management system that links and strengthens collaborations with partners, programs, services, and education to people experiencing homelessness and the unstably housed.	Increased utilization of services, programs, and referrals.	December-21	Health resiliancy worker hired, formalized case management needs to be selected and implemented. Impacted by SH political delays
Ineffective and inefficient education.	Track client utilization of educational opportunities. Increase in awareness of partners understanding of the marginalized homeless population. Increase community awareness and understanding of the marginalized homeless population.	Offer one class on life skills per quarter to clients. Provide partners with information and trainings dealing with highly marginalized populations. Provide community with information and trainings dealing with the marginalized homeless population.	4/1/21 7/1/21 10/1/21 12/1/21	Partner information sharing strong regardless of covid, Client ed. how to find housing, access SS, ID, Glasses, Phones Client Covid education. Community resource fair (27 partners) Resource Book, Community ed
Inequity in medical services	Monitor treatment of clients through case management and street outreach reporting .	Decrease usage of acute care. Increase adherence to treatment plans. Improvement of clients care and treatment. Increase client engagement and usage of primary and preventive healthcare services. Promote and build relationships between partners and clients.	December-21	Promotion of client care and some successes from advocacy. Clients clean and sober for 1 yr Narcan overdose prevention On street wound care
There is no formalized continum of care	Implement a case management system that links and strengthens collaborations with partners, programs, services, and education to people experiencing homelessness and the unstably housed.	Increased utilization of services, programs, and referrals.	December-21	In Progress, Health resilience worker hired. Formalized case management needs to be selected and implemented

Sustainability

- Samaritan & Linn County Health-
  - Grant $, covid ed materials, and covid supplies
- Confederated tribes of Siletz Indians Charitable Contribution Board
  - Grant $ for Sleeping bags tents and backpacks
- Partner CSC, Chance
  - Rental Assistance
  - Transitional / Respite Housing
- One Sweet Home - Grant $
- Private donations - Grant $, Resources
- Organization Fundraising Can Drive

Conferences and Presentations

- Live Longer Lebanon
- Housing Equity and Resource Coalition East Linn County (HERC)
- Linn Local Advisory Committee
- Helping Hands
- Lebanon Rotary Club
- Albany Police Dept
- Linn County Health
- Sweet Home Health Committee
- Various Partner Conferences: (CSC, Chance, Sweet Home Pregnancy center, Helping Hands, Samaritan, Oregon Red Cross, Linn County Behavioral Health
- Led Sweet Home Health Sub-Committee on Homelessness
- Samaritan Foundation

Stories from the Field

Covid Response

Winter Shelter

Harm Reduction

Hygiene

Outreach

Questions and Discussion

Linn County Crisis Outreach Response

January 2021 to December 2021

Summary:
The pilot project was successful. We were able to add a RN with a Masters degree to our board. She assists with advice and goes on outreach regularly. We trained two CHW's to help with health issues and resource navigation with assistance. Medical students are volunteering their time to help increase street medicine access. Unfortunately, some volunteers and partners had to limit their outreach time due to Covid. Our hygiene and shower program helped reduce the spread of illness and was a long running success. We rented a motel room twice monthly to open for showers. Samaritan outreach partnered with us during this time. A shower trailer was also acquired to use throughout Linn county to provide hygiene access to the unhoused and unstably housed people and families. It is currently being modified to ADA standards with a mechanical engineering team donating most of their time. We have been in discussion with Sweet Home and Lebanon school districts to design a partner program to provide showers for unhoused families in the school districts. It will also be used at a Sweet Home unhoused community site. With the help of our partner, CSC, we were able to access office space for a Resource Hub in Lebanon. This allows us to have a space to meet with clients and assist with services. We do continue to look for a space that is better suited for our vision. We have successfully worked with partners to provide alcohol and drug treatment and mental health services from street outreach. STARS and CHANCE are providing peer counseling and LCMH provides crisis workers on street outreach for our clients in need of behavioral health help. Making and attending appointments was hit and miss, as with most scheduled activities while living unsheltered. We participated in Sweet Home's Community Court for the unhoused providing services such as obtaining identification cards, snap benefits, stimulus and tax returns, phones, and social security requests. We wrote, published, and distributed an East Linn County Resource Guide and hosted a successful resource fair with 27 partners and included a Covid vaccination clinic. At the beginning of the year we helped manage and maintain a winter camp for the unsheltered at a Sweet Home church. We provide respite motel beds for unsheltered people who are leaving the hospital and have nowhere to go to heal and recuperate. We assisted in providing the first transitional housing in Sweet Home and are currently working to provide a community resource center and a managed sleep center for the unsheltered there also.

A. Budget:

- **Total amount of pilot funds used:** $149,500.
- **Please list and describe any additional funds used to support the pilot.**
  We acquired private and other grant funding of over $50,000 (OHA, United Way, CSC, Private, Fundraisers)

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

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C. In 2021, did your pilot utilize Traditional Health Workers? If so, please fill out the table below:

Type of THW (CHW, Doula, PSS, PWS, Navigator)	Full time or Part time	Race/Ethnicity	Disability (Yes, No, Unknown)	Preferred Language (English, Spanish, Sign Language)	Payment Type (FFS, Contract, Grant, Direct Employment, APM)	Location of THW (Clinic based or Community based)
CHW's	Full time	white	no	english	employment	EastLinn Co

D. In 2021, did your pilot receive referrals for THW services? If so, please fill out the table below:

Number of referrals received from members for THW services	N/A
Number of referrals received from care team for THW services	N/A

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

Bringing healthcare to the people living on the streets of East Linn County.

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

Increasing the quality and reliability of street medicine was achieved since no other programs exist. Availability of care was sporadic at times due to Covid outreach restrictions on volunteers and partners.

F. What has been most successful?

Providing wound care on the streets to prevent more serious health conditions and eliminated costly ER visits.

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

The biggest barrier was partners street outreach Covid restrictions and schedules. Mental Health help on Sweet Home streets was very hard to achieve due to lack of providers availability. We adjusted schedules without breaking from routine outreach.

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

The pilot would be replicable. Considerations would. include access to an outreach health care social worker, more access to mental health crisis workers, site availability. Trauma informed care and harm reduction knowledge are invaluable.

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

The pilot activities will continue and even grow post Covid. The program will be continued through billing for CHW services, donors, fundraising, partner support, volunteer support, and grant money.

IHN-CCO Closed Pilot Crosswalk to CHIP Areas

	AH	BH	CYH	CDPM	HL	MH	SDHE
Alternative Payment Methodology	■						
Behavioral Health PCPCH	■	■					
Breastfeeding Support Services	■		■			■	
CHANCE	■	■					■
CHANCE 2nd Chance	■	■					■
Child Abuse Prevention & Early Intervention	■	■	■				
Child Psychiatry Capacity Building	■	■	■				
Childhood Vaccine Attitude & Information Sources			■				
Children's SDoH and ACEs Screening		■	■				
Chrysalis Therapeutic Support Groups		■	■				
CMA Scribes	■						
Colorectal Screening Campaign	■			■			
Community Doula	■		■			■	■
Community Health Worker	■			■			■
Community Health Workers in North Lincoln	■			■		■	■
Community Paramedic	■	■		■	■		■
Community Roots	■	■	■				■
Complex Chronic Care Management	■			■			
Dental Medical Integration for Diabetes	■			■			
Eating Disorders Care Teams	■	■	■	■			
Expanding Health Care Coordination	■	■	■	■		■	■
Family Support Project	■		■	■			■
Health & Housing Planning Initiative	■			■			■
Health Equity Summits and Trainings	■						■
Helping High School Students	■		■	■	■		
Home Palliative Care	■			■			
Homeless Resource Team	■	■					■
Hospital to Home	■						
Improving Infant and Child Health in Lincoln County			■				
Improving the Pain Referral Pathway in the PCPCH	■			■			
Licensed Clinical Social Worker PCPCH	■	■					
Maternal Health Connections	■	■	■			■	
Medical Home Readiness	■						
Medical Neighborhood PCPCH-Behavioral	■						
Member Access Plan	■						
Mental Health Literacy		■					
Mental Health, Addictions, and Primary Care Integration		■					
Oral Health Equity for Vulnerable Populations	■			■			■
Pain Management in the PCPCH	■			■			
Patient Assignment & Engagement (1)	■						
Patient-Centered Primary Care Home	■						
PCP Engagement Fee	■						
Pediatric Medical Home	■	■	■	■			■
Peer Wellness Specialist Training	■	■					■
Pharmacist Prescribing Contraception	■					■	
Physician Wellness Initiative	■						
Planned and Crisis Respite Care	■	■	■				
Pre-Diabetes Boot Camp				■			
Prevention, Health Literacy, and Immunizations	■		■	■			■
Primary Care Psychiatric Consultation	■	■					
Public-Health Nurse Home Visit	■	■				■	
Reduce and Improve	■						■
Regional Health Education Hub	■			■			■
School/Neighborhood Navigator	■	■	■				■
Sexual Assault Nurse Examiner	■						■
SHS Palliative Care	■			■			
Skills and Connections to Support Housing	■	■					■
Social Determinant of Health Screening	■			■			■
The Warren Project: Nature Therapy	■	■	■				■
Traditional Health Worker Hub	■						■
Tri-County Family Advocacy Training			■				
Universal Prenatal Screening	■	■	■			■	
Veggie Rx in Lincoln County				■			■
Youth & Children Respite Care		■	■				
Youth WrapAround & Emergency Shelter	■	■	■				■

KEY		
Acro	Health Impact Area	#
AH	Access to Health Care	55
BH	Behavioral Health	27
CYH	Child and Youth Health	23
CDPM	Chronic Disease Prevention & Management	22
HL	Healthy Living	2
MH	Maternal Health	8
SDHE	Social Determinants of Health & Equity	26