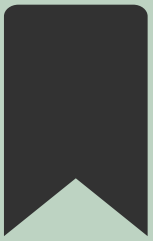


STRATEGIC PLAN

Version 2:
March 17, 2022

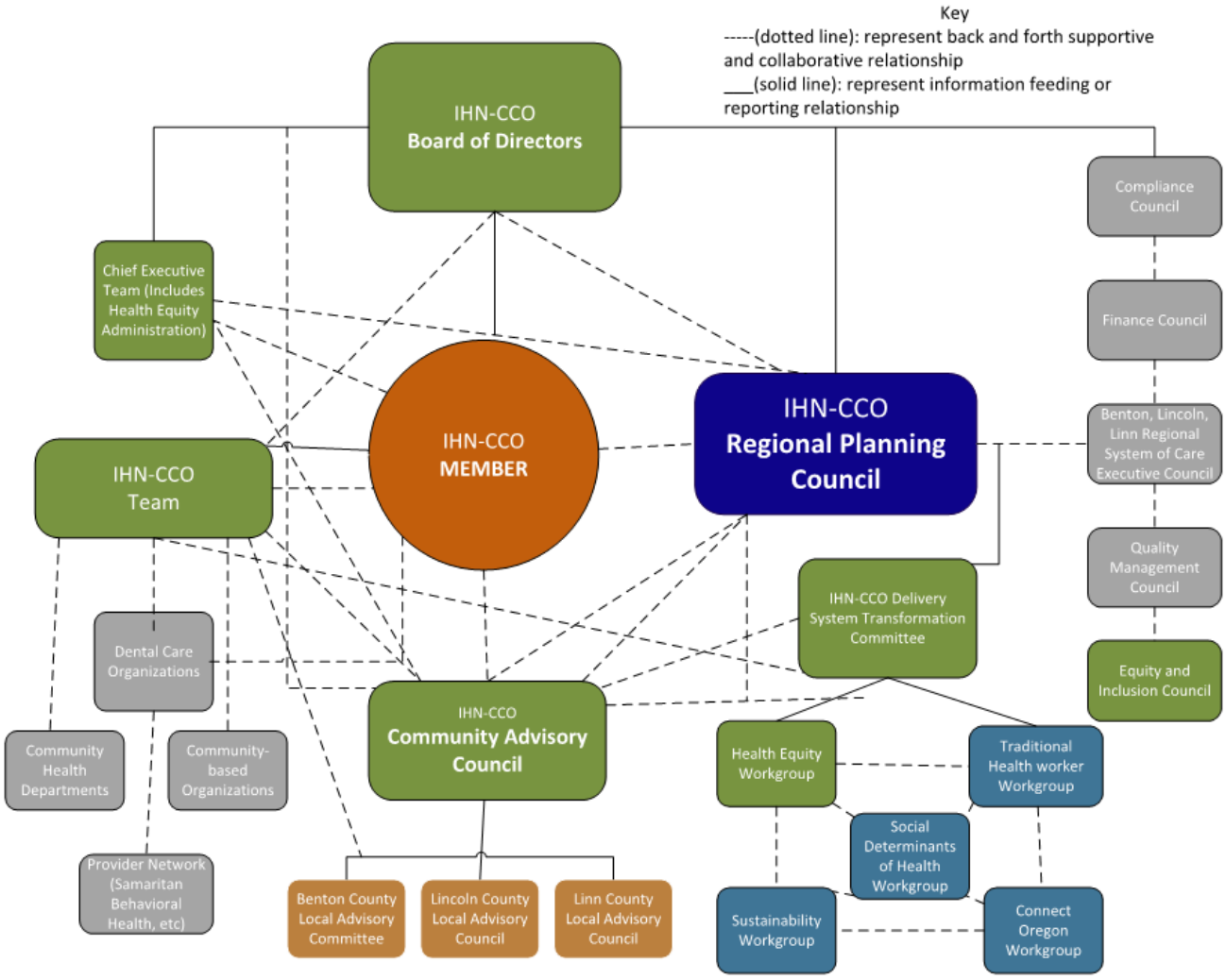
Table of Contents

Delivery System Transformation Committee (DST) Introduction 3
DST Objectives and Membership 3
2022 DST Charter 3
Roles and Responsibilities 3
Fostering the Message and the Spirit of the DST 4
2022 Priority Areas 5
IHN-CCO DST History 2021 6
Community Partners and Stakeholders 7
Workgroups 8
Health Equity 8
Social Determinants of Health 8
Traditional Health Workers (THWs) 8
Connect Oregon 9
Sustainability 9
Overall Feedback/Continuous Improvement 9
Pilots Through the Ages 9
What Do You Want to Know About Pilots? 9
Pilot Categorization 9
Closed Pilots Sustainability & Crosswalk 9
Improved Evaluation Processes 10
Request for Proposal (RFP) 10
Letter of Interest (LOI) 10
Thoughts/Ideas 10
Appendix A. DST Charter 2021 11
Appendix B. DST Roles and Responsibilities 13
Appendix C. IHN-CCO DST History and Evolution 2012-2020 14
Appendix D. Health Equity Workgroup Recommendations 18
Appendix E. Connect Oregon Workgroup Scope of Work 20
Appendix F. Intern Projects 21
Appendix G. Request for Proposal Documents 2021 47

Delivery System Transformation Committee (DST) Introduction

The 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. 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 has an equal voice in all votes while everyone who is participating in the meetings has a voice at the table.

The below chart shows the web of supports around IHN-CCO members. This includes the IHN-CCO Team, IHN-CCO and community driven councils, committees, and workgroups as well as community and health system partners. Teams, councils, and committees colored in green have roles in the health equity governance structure.



DST Objectives and Membership

2022 DST Charter

See Appendix A. 2021 DST Charter

Roles and Responsibilities

See Appendix B. IHN-CCO DST Roles and Responsibilities

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.

The lightbulb is a "wordcloud" based on conversations the Committee had in past strategic planning.
Additional suggested themes or words:

- Compassion, care, caregiving
    - The focus of this theme is on providers of care, such as reduction of burnout and staff support.
    - Remove "triple" and have "quadruple/quintuple aim". The Triple Aim is outdated and is no longer being used as a frame of reference for the Committee in the Charter or Roles and Responsibilities document.
- Integration
- Opportunity
- Solutions

The Committee agrees via consensus that with these changes, this captures the spirit and the message of the DST.

2022 Priority Areas

Developed by reviewing 2021 priority areas, new themes discussed, and ensuring fit with the Community Advisory Council's Community Health Improvement Plan Health Impact Areas.

- Addressing trauma, including environmental. Examples include:
    - Improving access to behavioral health services in non-traditional ways
    - Increasing and improving access to behavioral health care in light of COVID-19
    - Reduction of wait times for mental health services
- Addressing technology disparities for members and providers of healthcare
- Developing a bilingual and bicultural workforce
- Innovative programs supporting housing
- Language access including health literacy, interpreter services, and translation of materials
- Oral health integration
- Pay equity through building and sustaining the workforce
- Reengaging the community in personal health and community resources
- Rural community impact
- Subpopulations of IHN-CCO members that experience health disparities. For example:
    - Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, youth in transition from foster care

IHN-CCO DST Transformation Priority Area Crosswalk to Community Health Improvement Plan (CHIP) Areas

	Access to Health Care	Behavioral Health	Child & Youth Health	Healthy Living	Maternal Health	Social Determinants of Health & Equity
Addressing trauma, including environmental						
Addressing technology disparities						
Developing a bilingual and bicultural workforce						
Innovative programs supporting housing						
Language access including health literacy, interpreter services, and translation of materials						
Oral health integration						
Pay equity through building and sustaining the workforce						
Reengaging the community in personal health and community resources						
Rural community impact						
Subpopulations of IHN-CCO members that experience health disparities						

IHN-CCO DST History 2021

See Appendix C. IHN-CCO DST History and Evolution 2012-2020

2021

Membership

- Average attendance: 33

Planning/Focus of the DST

- Request for Proposal priority areas:
    - Addressing trauma
    - Developing a bilingual and bicultural workforce
    - Improving access to behavioral health services in non-traditional ways
    - Increasing and improving access to behavioral health care in light of COVID-19
    - Innovative programs supporting housing
    - Language access including health literacy, interpreter services, and translation of materials
    - Pay equity through building and sustaining the workforce
    - Subpopulations of IHN-CCO members that experience health disparities
        - E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, youth in transition from foster care
- Bringing grassroots organizations to the table
- Focus on health equity work
- Improved accessibility through 2 RFP processes and altering RFP documents and process to simplify

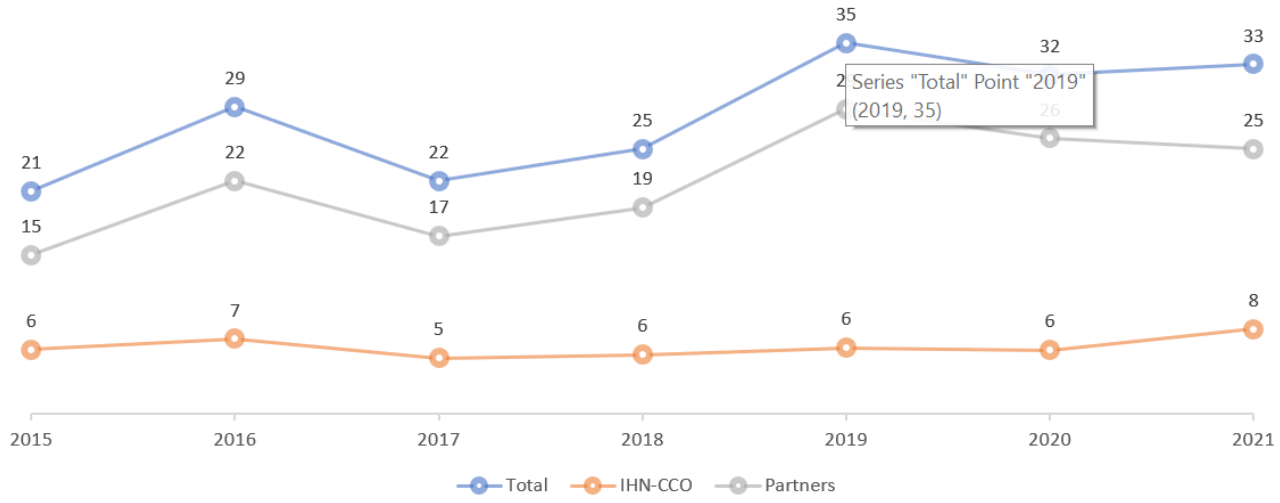
Pilots

- 17 active pilots

Workgroups

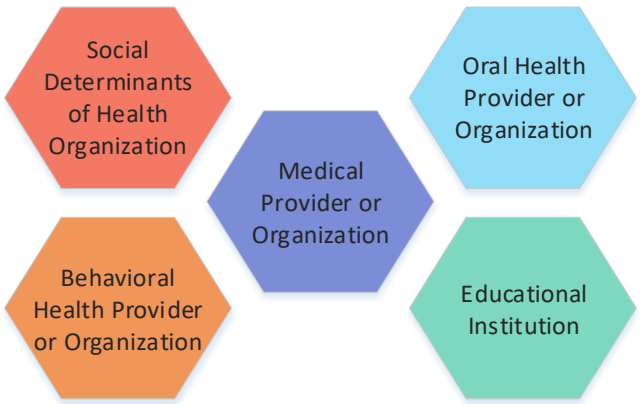
- Continued: Health Equity, Social Determinants of Health, Traditional Health Worker
- Sunsetted Universal Care Coordination after yearlong hiatus
- Began Connect Oregon
    - Focus on community drivers of the Unite Us platform
- Began Sustainability Workgroup

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

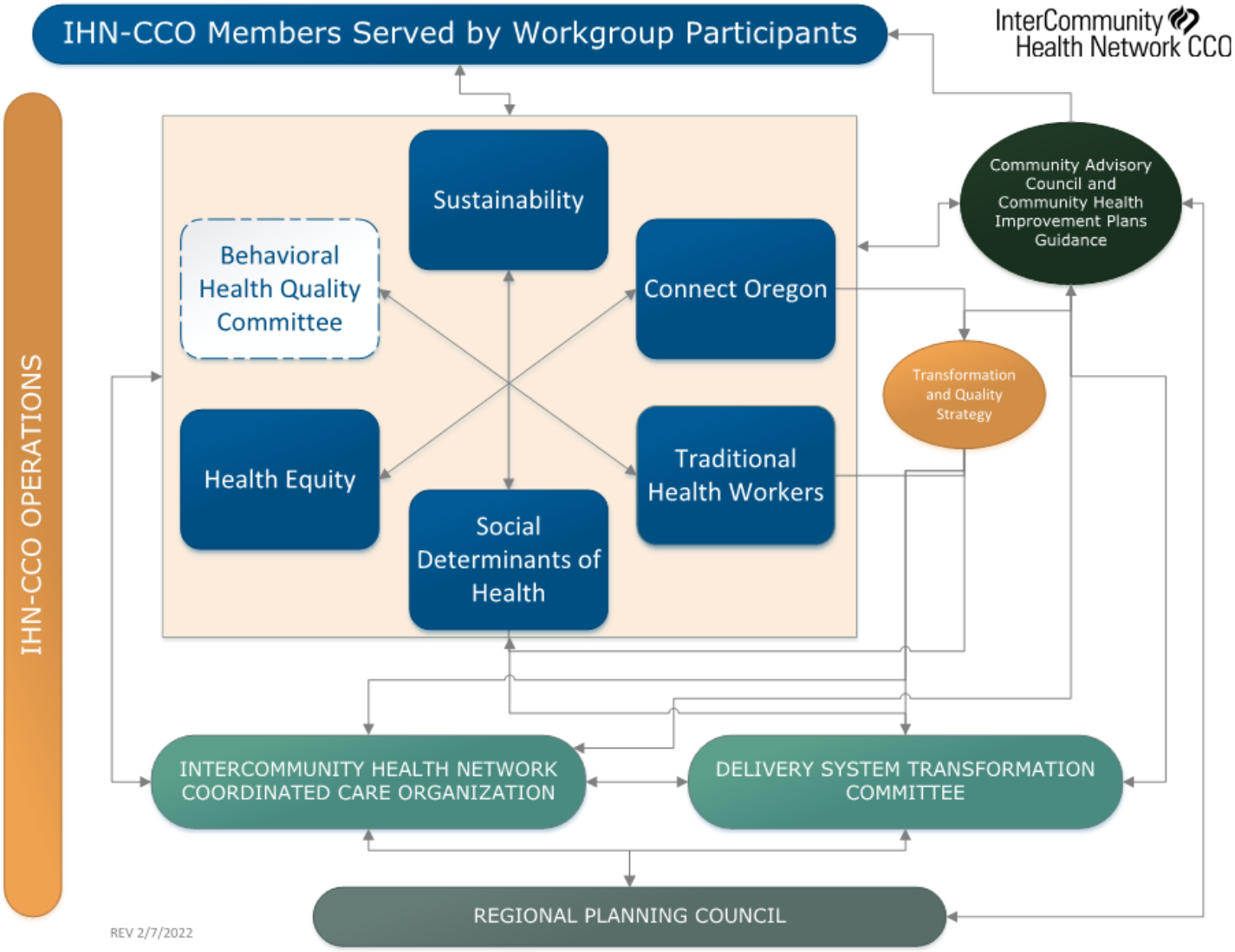


Community Partners and Stakeholders

Key:



Workgroups



Health Equity

See Appendix D. Health Equity Workgroup Recommendations

- Need a co-chair
- Provided recommendations to the DST on health equity processes including accessibility, evaluation, and analysis

Social Determinants of Health

- Worked on COVID-19 response and community engagement
- Focused on transportation and providing recommendations to IHN-CCO later in the year

Traditional Health Workers (THWs)

- Lost a primary co-chair
- Took a hiatus to ensure strategies were aligned with IHN-CCO
- Supported the Transformation Intern work on education materials for THWs

Connect Oregon

See Appendix E. Connect Oregon Workgroup Scope of Work

- Developed Scope of Work including strategic goals and purpose of workgroup
- Partnering with Unite Us on supporting Connect Oregon

Sustainability

- Developed workgroup purpose and strategic goals
- Currently developing short- and long-term goals
- Recruiting co-chairs

Overall Feedback/Continuous Improvement

- IHN-CCO and the DST continuously ask for and address feedback on DST strategies and planning to ensure continuous improvement.

Pilots Through the Ages

What Do You Want to Know About Pilots?

- What is helpful to learn from pilot champions?
- How can we help pilots spread or replicate their successes?
- What else do you need to understand or connect with pilots better?

Pilot Categorization

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

SHS	Non-SHS	Collaborations	Total
15	38	12	65

Table 2. Number of Pilots by County

Benton	Lincoln	Linn	Total
48	34	41	65

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

Closed Pilots Sustainability & Crosswalk

See attachment in DST packet 3/17/2022 for closed pilot crosswalk to Community Health Improvement Plan (CHIP) Areas.

Table 3. Number of Pilots by Final Sustainability Status

Ended	One-time project	Operationalized	Sustained	Total
5	9	19	32	65

Ended: did not continue after DST funding was completed.
One-time project: intended to be a short-term project providing analysis or information; not intended to be sustained.
Operationalized: continued with at least some resource support directly by IHN-CCO.
Sustained: continued through funding by the champion organization, through various means.

91% (51 of 56) of pilots that were expected to be sustained have been operationalized through IHN-CCO or sustained by the champion organization as of 2022*

**9 of the 65 closed pilots were expected one-time-projects*

Improved Evaluation Processes

- Health Equity Workgroup Recommendations – *See Appendix D. Health Equity Workgroup Recommendations*
- Health Management Associates (HMA) consultant work – *see Appendix E. Health Management Associates Transformation Pilot Projects 2.0.*
- Intern work on pilots and traditional health workers – See *Appendix F. Intern Projects*
- Semi-annual pilot reports
- Close out reports and presentations
- Pilot follow up presentations in the years following closing
- Evaluation should include qualitative and quantitative analysis
    - Quantitative analysis on collected member data is currently in progress
- Available data:
    - IHN-CCO member enrollment and claims data
    - Pilot data – began collecting in 2016
    - Stories from the field
- How do we tell the story of our successes? How do we evaluate whether the DST is working or not?

Request for Proposal (RFP)

See Appendix G. Request for Proposal Documents 2021

- Provide a mentorship channel for past pilot champions to mentor through the process
- Provide technical to assistance to approved pilots on data collection and evaluation as well as contracting and payment mechanisms (this includes sustainability)
    - The DST now has the Sustainability Workgroup supporting this
- Number of RFPs - historically was one big RFP, 2021 had two (1 $~50k, 1 over $50K)
- Add details on the environmental scan to reduce duplication of efforts and increase partnerships and collaboration during the technical assistance process
- Use number of partners brought to the table as a measure of success
- Encourage proposers to go to the Community Advisory Council (CAC) or the local advisory committees with their ideas
- Add a question about mentoring in pilot final reports

Letter of Interest (LOI)

The LOI is required as a short form that allows the DST and IHN-CCO to review proposal prior to submitting the full proposal. Adds a touchpoint or engagement point for folks that do not attend DST.

- Evaluate the process to determine if the LOI continues to be necessary
- In 2020 & 2021 all who submitted a LOI were invited to submit a full proposal

Thoughts/Ideas

- Evaluate language used at the DST to ensure full understanding of folks at the table
- 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
- Prioritize current pilots by working with them on replicability and spread

Appendix A. IHN-CCO DST Charter 2021

Delivery System Transformation Committee (DST)

(Committee of the Regional Planning Council)

2021 Charter

Objectives:

- Support, promote, and/or positively affect the health outcomes and wellbeing of IHN-CCO members.
- Advance health equity in all Committee projects including pilots & workgroups.
- Improve the health delivery system by engaging and elevating voices that historically have not been heard.
- 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.
- Understand the impact of pilots through qualitative and quantitative analysis and evaluation.

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.
- The 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 and wellbeing 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.
- Build integrated communication pathways 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] The Committee has adopted the Oregon Health Authority's health equity definition to ensure alignment with IHN-CCO. "Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.

Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- The equitable distribution or redistributing of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices."

[v] TQS 2021 Components

1. Access: Cultural Considerations
2. Access: Quality and Adequacy of Services
3. Access: Timely
4. Behavioral Health Integration
5. CLAS (Culturally and Linguistically Appropriate Services) Standards
6. Grievance and Appeal System
7. Health Equity: Cultural Responsiveness
8. Health Equity: Data
9. Oral Health Integration
10. PCPCH: Member Enrollment
11. PCPCH: Tier Advancement
12. Serious and Persistent Mental Illness (SPMI)
13. Social Determinants of Health & Equity
14. Special Health Care Needs (SHCN)
15. Utilization Review

Appendix B. IHN-CCO DST Roles and Responsibilities

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

2020

Membership: note attendance dropped the first few months of COVID but picked up again post-June 2020

- Average attendance: 32 attendees per meeting

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

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 THW 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.

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
    - Universal Care Coordination and Social Determinants of Health Workgroups formed

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

Workgroups

- 7 active workgroups
    - Website Workgroup formed

2015

Membership

- Average attendance: 21 attendees per meeting
- 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

- 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 include outcomes, sustainability, and CHIP area focus

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 Equity Workgroup Recommendations

Background and Context:

Utilize the **Quadruple Aim** as a **framework** for data collection.

Collecting **quantitative data** and analyzing pilots on this level is important. (reduced costs, improved health outcomes, increased access)

However, **qualitative data** and storytelling are an important piece in system change and the evaluation of system change. (reduced costs, improved health outcomes, increased access, improved provider and staff satisfaction) Pilots are infrastructure building with the primary goal of systems change, not individual/behavior only change. Some takeaways specific to pilots:

- Systems change takes time.
- Building/gaining the trust of the community is difficult and long but is a key component to pilot and system change success.
- Bridging the gaps between medical & community organizations take breaking down silos through relationship building, technology, and so much more.

Bring an **equity lens** into the data collection and evaluation process.

How can the DST help projects capture their data (stories, trainings, events, activities) in a meaningful way?

- Centralization/aggregation of pilots to show the big Picture.
- Enable pilots to collect data that is meaningful to their project/organization and work with data they are already collecting.
    - Provide tools or resources to support such as data analysis and how to collect stories and data.
- Showing impact through the smaller, community-based grassroots organizations that truly affect health equity – communities of color, LGBTQIA2S+, and the disabled are prime examples of communities that generally have smaller organizations supporting them.
- Mandate budget line item for health equity to show accountability to supporting communities experiencing inequities including components such as training staff, investments in bias training, and research and development of equity practices.

- Focus on creating recommendations that encourage the quantitative aspect but also consider and support the qualitative data collections that innovative and small pilot organizations have access.
    - Some pilots are incredibly important from a health equity perspective and they will never be the type of programs that collect insurance cards. This could present a serious barrier for these communities we want to reach.

Process Recommendations:

- Support the application process by creating language that is more accessible and remove barriers by providing materials in different languages and with universal design standards.
- Measure number of partners brought to the table as a definition of success.
- Approve pilots for two years with the understanding that funding will be provided only during the first year. The first year could be focused on infrastructure building while the second year would be focused on data collection and/or evaluation.
- Remove barriers to the application process:
    - Many organizations or individuals feel intimidated by the application process including the length and components required.
    - The application is not particularly approachable for individuals and/or organizations with little or no grant writing experience.
    - May be missing out on some great community partners with innovative ideas.

DISCLAIMER: Our members (community or IHN-CCO) are not responsible to provide more information. We are not proposing a new process to collect data from our members (no surveys, no REALD additions), but to support creating a framework and standardization of the stories and data we already have collected through pilots, enrollment data, claims data, encounter data, and more.

Appendix E. Connect Oregon Workgroup Scope of Work

Workgroup Purpose:
Community driver of Connect Oregon in Benton, Lincoln, and Linn counties, the Oregon network of Unite Us, and to explore connections with other systems, particularly referral platforms used in the region. Unite Us is a community driven, participation required, and locally sustained tool for social determinants of health screening and referrals. The Connect Oregon Workgroup is focused on improving individual and community health while keeping the individual at the center.

Strategic Goals:
- Identify and overcome barriers to implementing Connect Oregon
- Identify areas of opportunity to increase usage and better support community health
- Integrate with other communication technology including electronic health records and screening and referral platforms

Short Term Goals:
- Understand the current state of Connect Oregon
- Build networking opportunities by sharing successes and discussing limitations
- Facilitate ongoing development of the network
- Problem solve issues and concerns

Desired Outcomes and Actions:
- Demonstrate the value of the network through data gathering and evaluation
- Standardize screenings for use throughout the healthcare and social service system
- Support and facilitate training opportunities with Connect Oregon
- Provide community awareness and education to the resources within Unite Us
- Support ease of use and integration/interoperability for all sectors with the focus on full bi-directional integration
- Communicate and liaise with Unite Us on community needs and improvements
- Review and improve understanding of workflow particularly for organizations that are not clinical or social need focused
- Foster connections and provide awareness around out-of-region referrals

Workgroup Chairs:
- Christian Moller-Anderson, Executive Director, A Smile for Kids
- Miranda Miller, Director of Primary Care Practice, Samaritan Health Services
- Sheryl Fisher, Behavioral Health Director, IHN-CCO

Meeting Frequency:
- Monthly, fourth Tuesday of the month
- 1:00 pm – 2:00 pm

EVALUATION OF PAST TRANSFORMATION PILOTS: ASSESSING SUSTAINABILITY

LYRICA STELLE

OVERVIEW

Introduction

Evaluation objectives

Methods

Findings

INTRODUCTION

- Lyrica Stelle she/her
- Masters of Public Health, June 2021
- Health Promotion and Health Behavior
- IHN-CCO Transformation Intern Spring 2021

INTRODUCTION

- Intended Uses:
  - to inform the DST on the sustainability of past pilots including barriers encountered by pilots and elements that helped to successfully sustain pilots.
  - to provide DST with an overview of past transformation pilots and to share the story of pilots with the community.
- 17 current transformation pilots and 65 past pilots in Benton, Lincoln, and Linn counties.

EVALUATION OBJECTIVES

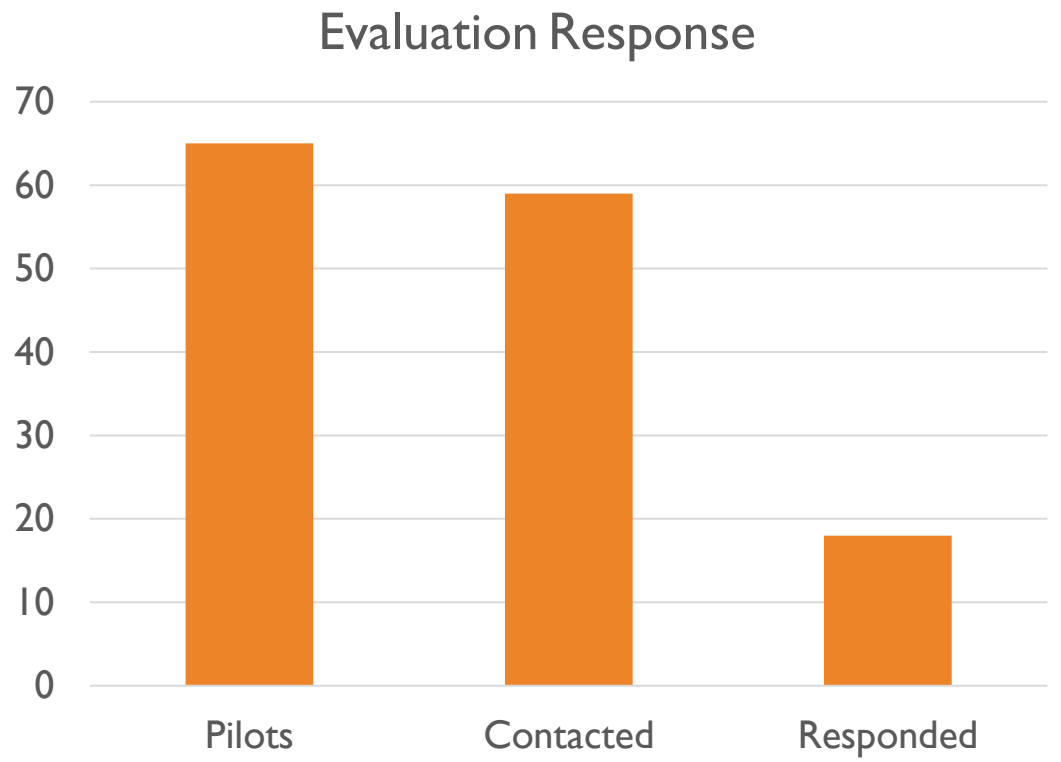
- Identify if pilots are continuing, the organizational commitment, and current funding
- Inquire about replicability, spread, and pilot successes
- Better understand barriers and challenges encountered by pilot
- Determine if any studies or data analysis has been completed and request access to materials or stories from the field
- Enhance partnership and collaboration

METHODS

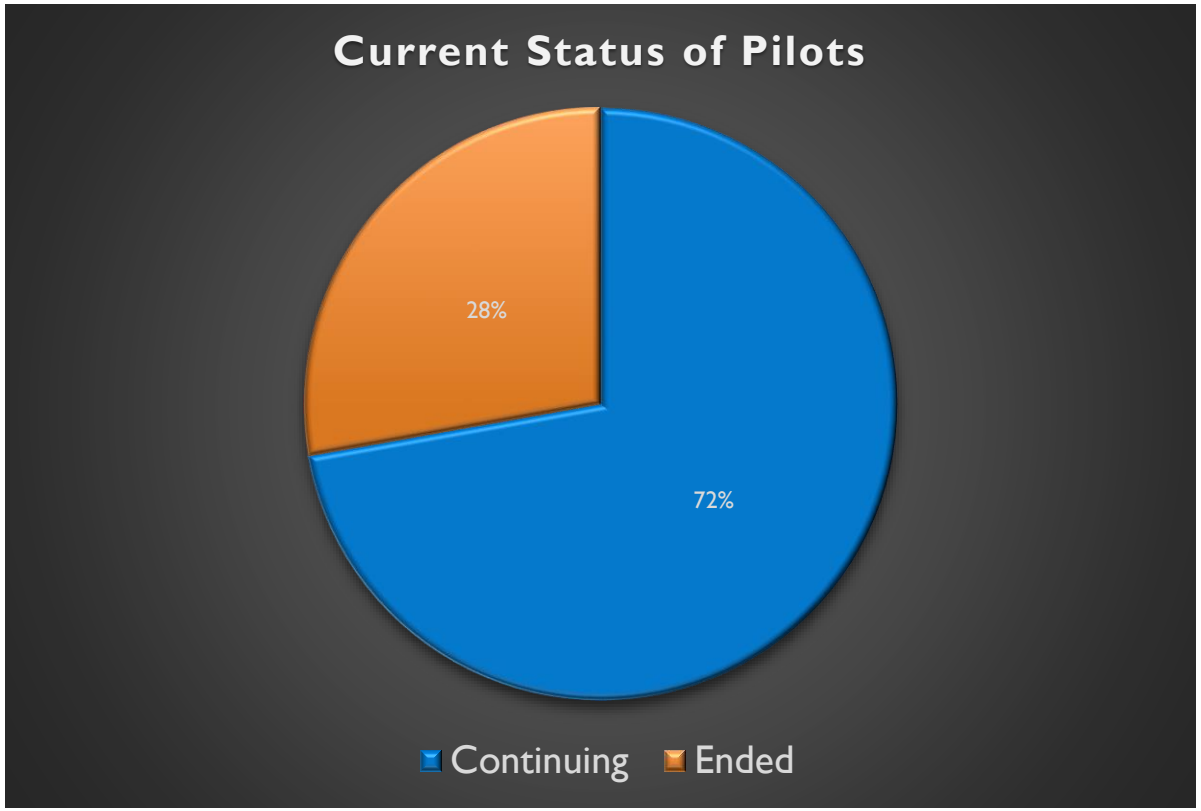
- Survey sent to all past pilots with contact information available
- In-depth interview offered to all survey respondents
- In-depth interviews and survey responses combined and coded for themes in three categories:
  - Positive impact
  - Barriers
  - Learning experiences and reflections

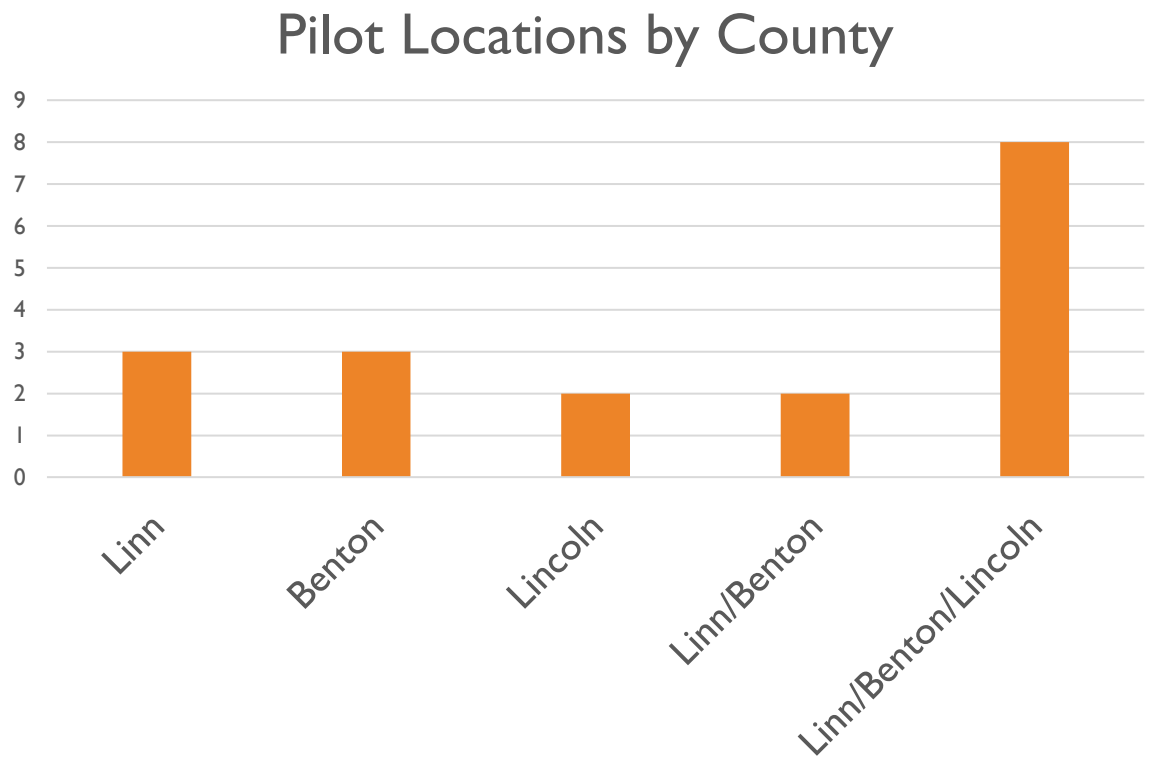
RESULTS

- 18 total responses
  - Email only (n=3)
  - Survey only (n=5)
  - In-depth interview only (n=6)
  - In-depth interview & survey (n=4)
- Response rate= 30.5%

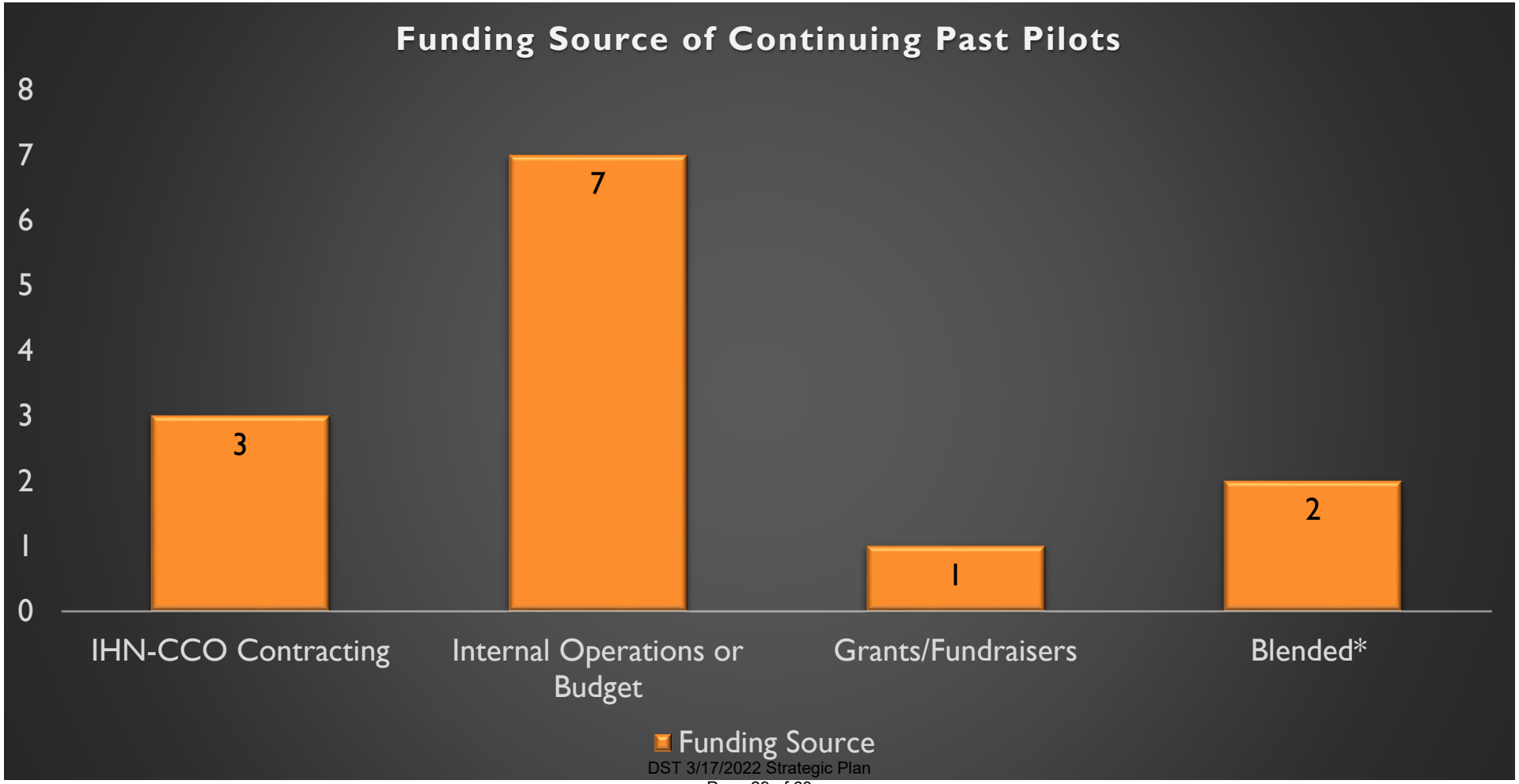


RESULTS


Current Status of Pilots
28%
72%
Continuing
Ended


Pilot Locations by County
9
8
7
6
5
4
3
2
1
0
Linn
Benton
Lincoln
Linn/Benton
Linn/Benton/Lincoln

FUNDING SOURCES OF CONTINUING PILOTS



FINDINGS

Positive Impacts (n=14)

- Funding (4)
- Integration into existing services (6)
- The right people (3)
- Community (2)
- Community Health Workers (1)
- Partnerships (2)
- Positive DST process (10)

Barriers (n=9)

- Evaluation (2)
- Funding (3)
- Time (3)
- Integration into existing services (4)
- Data collection (1)
- COVID-19 (2)

POSITIVE IMPACTS

"We hired the right person into this role. She went through the training and built her resource guide from the ground up. Having someone with vision, determination and passion about the position is key. They need to be self motivated".

"IHN-CCO has been the best funder, the way it's structured–and the workgroups–has been really amazing to have this network of other people who are doing this "

"Hospital appreciates services. Patients appreciate services. Our company values the innovation"

"This is so much about the partnership; the clinic can be the space to screen and provide tokens and they just need to know where to send people and to tell people where they can go. Goal was to integrate with a local food system, not to replicate it–most farmers markets already used tokens, so it wasn't a stretch to add these tokens"

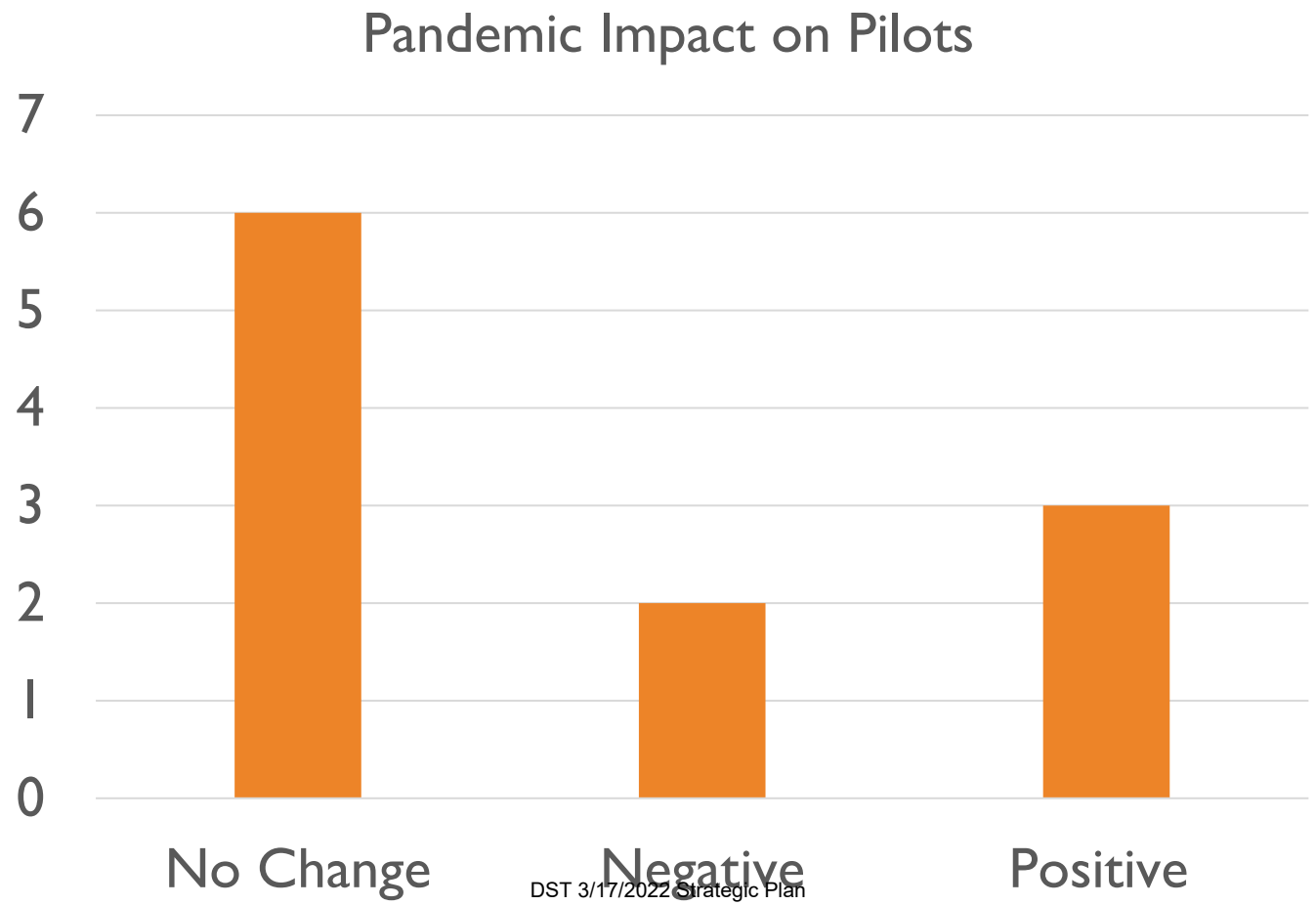
BARRIERS

"The school district partially funded it the second year, however, they lost funding from the county the third year and so they could no longer pay for it"

"Research and evaluation is a lot to do in addition to the execution of the pilot—if they [IHN-CCO] could find a way to outsource or find other connections, or if this could exist internally"

"Developing a sustained referral process from the hospitals became a real challenge and then most hospitals designed their own transitions teams, and we just decided the program was duplicative at that time so focused our efforts elsewhere"

COVID-19 PANDEMIC

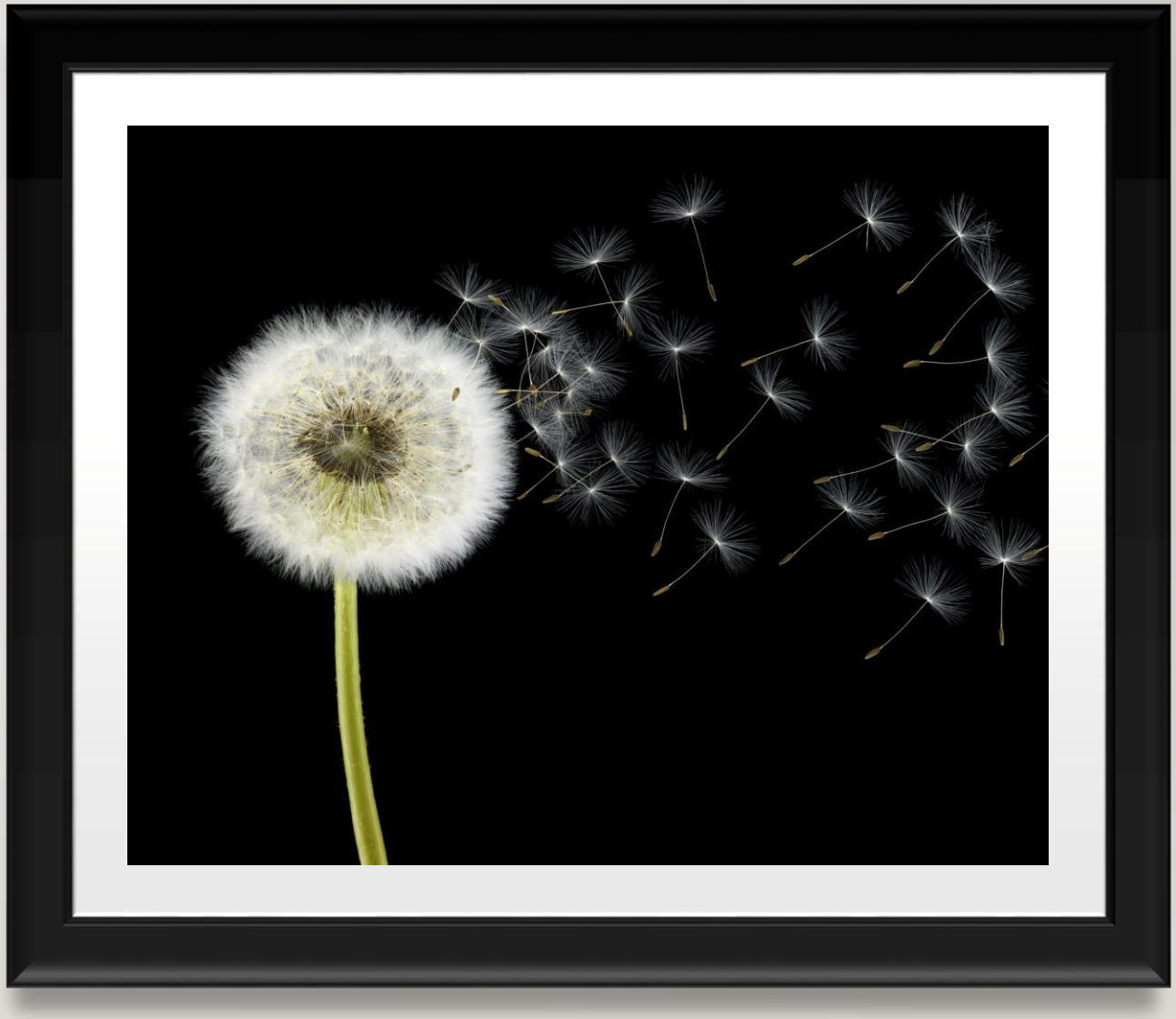


IHN-CCO TRANSFORMATION

PILOT PROGRAMS

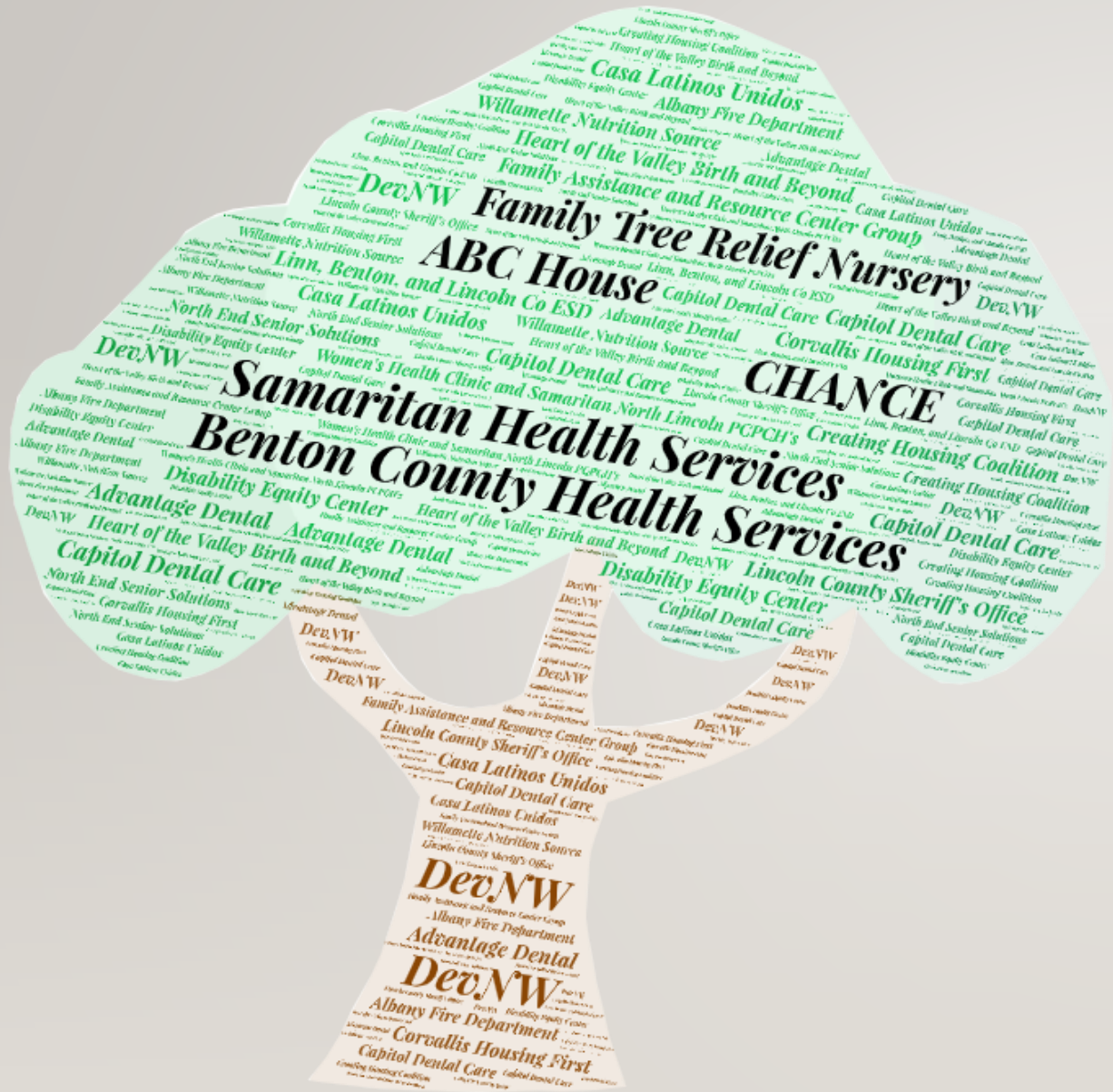
2021

IHN-CCO Transformation pilots began with the Traditional Health Workers Workgroup in 2013. One pilot has since seeded a forest of Traditional Health Worker programs.

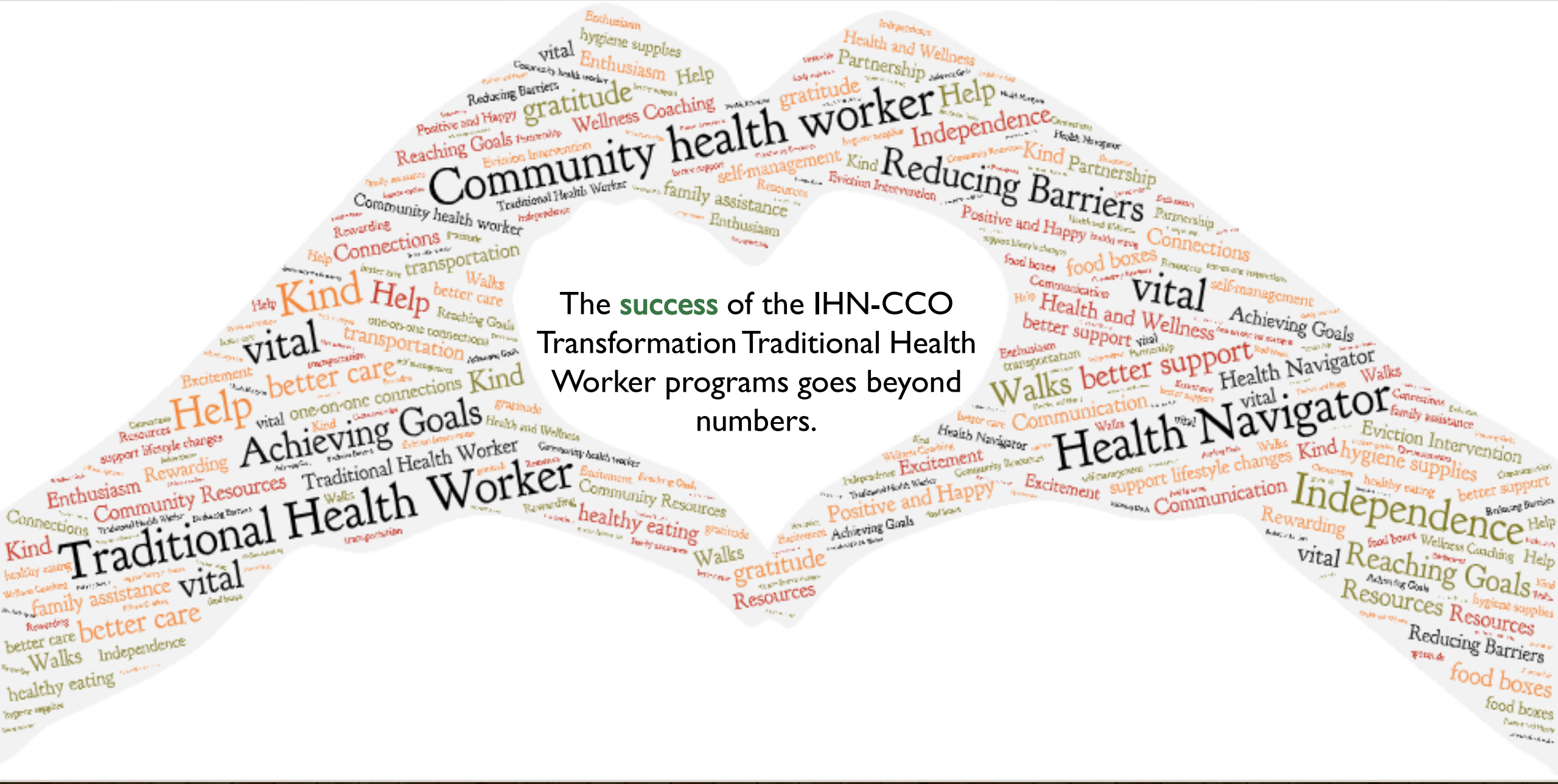


IHN-CCO Transformation Pilot Programs

IHN-CCO Transformation Pilot Programs



Since 2013, IHN-CCO Transformation has partnered with 22 community partners for 32 Traditional Health Worker programs. Organizations such as CHANCE, Samaritan Health Services, Benton County Health Services, and Family Tree Relief Nursery have partnered with Transformation on multiple pilot programs.



The **success** of the IHN-CCO Transformation Traditional Health Worker programs goes beyond numbers.

STORIES FROM THE FIELD

Recently a resident with a history of homelessness, addiction and mental health issues was dealing with a broken dominant arm and was in danger of losing housing benefits. After being contacted by the Housing Authority, the Community Health Worker was able to locate and assist the resident with completing and returning the paperwork needed by the 24-hour deadline. These tough encounters can be Community Health Worker opportunities, during that process it was discovered the resident was very stressed because they were having a difficult time completing basic activities like cleaning, cooking and self-care. The Community Health Worker was able to connect them with a volunteer organization that provides those kinds of services on a short-term basis.

~Health & Housing Planning Initiative:
Willamette Neighborhood Housing (2017)

STORIES FROM THE FIELD

One client lived on the streets for two years before she connected with CHANCE. She found stable housing, became engaged in treatment, had her rent paid, and obtained a birth certificate and ID. She began talking about changing her life. She was connected with a PCP, got nicotine patches, had a Nexplanon birth control implant, and got a job! Now she pays her own rent, makes positive life choices, and is a productive member of the community. It is because of this pilot that there were funds to help her stay focused on her recovery. She did not have to stress about staying warm, dry, or to find food. Her basic needs were taken care of, she is not starving, and she no longer needs assistance.

~CHANCE 2nd Chance (2018)

BARRIERS

DEFINING TRADITIONAL HEALTH WORKERS

PROFESSIONAL DEVELOPMENT

RECRUITMENT AND RETENTION

DEFINED SCOPE OF PRACTICE

Defining Roles

- Clearly define what a Traditional Health Worker is for community and other health practitioners.
- Define scope of practice for these roles.
- Connect regularly with community members and community partners through marketing to raise awareness of available resources.

Recruitment

Finding the right individual can be tricky. The need for bilingual Traditional Health Workers is high for health equity with non-English speaking communities, and personality plays a role in THW success.

Solutions:

- Communication skills
- Interpersonal skills
- Teaching skills
- Service coordination skills
- Advocacy skills
- Capacity-building skills
- Knowledge base

Retention

The World Health Organization estimates that turnover for Traditional Health Workers is as high as 50 percent.

Solutions:

- Increase awareness of burn out and self care.
- Providing adequate career-development training for THW supervisors and THW based on the program model.
- Increasing the visibility of THWs within the organization, especially to leadership through:
  - Quarterly education
  - Including THW updates in "huddle" communications
  - Providing adequate training and staff development

"The challenge of the work and reward of the work--we really need to show its variety and that it's beautiful work … and what it means to [illegible] traditional health workers." –Alicia Bublitz

PATHWAYS TO THW PROFESSIONAL DEVELOPMENT

Develop	Develop evidence and tools in support of statewide THW initiatives. Example: Stakeholders in Minnesota developed a CHW employer toolkit and the Pathways Community HUB model, which includes training for THW and workforce.
Create	Create statewide opportunities for proficiency assessment/credentialing to recognize THW by establishing THW certification, offering certified THW titling, and/or granting THW certificates.
Leverage	Leverage investments from CMS and CDC for statewide THW workforce development.
Include	Include THWs in statewide health system change efforts.
Support	Support statewide THW organization and leadership efforts.
Assess	Assess THW interests in professional development and create statewide training and development opportunities based on that assessment.
Create	Create statewide training/technical assistance opportunities for THW employers.

References

1. Barbero, C., Mason, T., Rush, C., Sugarman, M., Bhuiya, A. R., Fulmer, E. B., Feldstein, J., Cottoms, N., & Wennerstrom, A. (2021). Processes for Implementing Community Health Worker Workforce Development Initiatives. Frontiers in public health, 9, 659017. https://doi.org/10.3389/fpubh.2021.659017

2. Sabo, S., Wexler, N., O'Meara, L., Dreifuss, H., Soto, Y., Redondo, F., Carter, H., Guernsey de Zapien, J., & Ingram, M. (2021). Organizational Readiness for Community Health Worker Workforce Integration Among Medicaid Contracted Health Plans and Provider Networks: An Arizona Case Study. Frontiers in public health, 9, 601908. https://doi.org/10.3389/fpubh.2021.601908

LETTER OF INTENT

InterCommunity Health Network Coordinated Care Organization (IHN-CCO) invite interested parties who can positively impact the health outcomes of IHN-CCO members to submit a letter of intent for funding through the SHARE (Supporting Health for All through REinvestment) Initiative or Delivery System Transformation Pilot Projects. 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.**

The LOI must be submitted to Transformation@samhealth.org no later than **8:00 AM May 31, 2021.**

Primary Organization:
Primary Contact:
Primary Contact Email Address:
Partnering Organization (s):
Project Name (4 words or less):

1. Describe your project in a few paragraphs. Consider if your project is innovative and will provide new and different learning or is focused on evidence-based practices.
2. Which of the following does your project focus on?
    - Subpopulations of IHN-CCO members that experience health disparities
        - E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, youth in transition from foster care
    - Addressing trauma
    - Increasing and improving access to behavioral health care in light of COVID-19
    - Housing
        - Does the project focus on medical respite, supports in housing, or building a regional coordinated coalition (SHARE Initiative focus areas)?
    - Language access including health literacy, interpreter services, and translation of materials
    - Developing a bilingual and bicultural workforce
    - Pay equity through building and sustaining the workforce
    - Improving access to behavioral health services in non-traditional ways
3. What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?
4. How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations?
5. What is your approximate budget? Consider expenses such as staff time, materials and supplies, meetings, education, travel, indirect costs, etc.

    ☐ Less than $50,000

    ☐ Over $50,000

    ☐ Unsure

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 Issued:	May 11, 2021
Letter of Intent Due Date:	**June 2, 2021 by 8:00 am**
Issuing Office:	Transformation Department, IHN-CCO
Point of Contact:	Charissa Young-White
	Transformation@samhealth.org

TABLE OF CONTENTS

INTRODUCTION 3
DST Meeting Participation 3
DEFINITIONS 4
Transformation 4
Social Determinants of Health 4
Health Equity 4
PROCESS OVERVIEW & TIMELINE 5
Required Letter of Intent 5
Process Overview 5
Funding Options: RFP1 & RFP2 5
Technical Assistance 5
Timeline 6
PILOT PROPOSAL REQUIREMENTS 10
RFP1 10
RFP2 11
BUDGET DETAILS 12
Funds Cannot be Used to Support the Following: 12
Pilot Contracting Period 12
EVALUATION OF PROPOSALS 12
EXPECTATIONS OF FUNDED PROJECTS 13
Progress Reporting 13
DST Presentations 13
Workgroup Participation 13

INTRODUCTION

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. 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.

IHN-CCO and the DST invite interested providers and agencies in Benton, Lincoln, and Linn counties who can positively impact the health outcomes of IHN-CCO members to submit pilot proposals that transform the healthcare delivery system.

IHN-CCO and the DST are committed to not only our own health equity policies and practices, but working to support the development, growth, and sustainability of equity-focused, transformational work throughout our region. It is with this commitment in mind that we strongly encourage providers, agencies, and community-based organizations working within and for marginalized communities to apply. Additionally, to ensure that our committee membership, community partners, and pilot champions are reflective of the communities being served, we strongly encourage that proposals are led by innovative change-makers and leaders within marginalized communities. It is our belief that in the pursuit of supporting truly equitable and transformational work, we must ensure that the voices, perspectives, and invaluable lived experiences of the diverse communities of our region are heard, valued, and amplified.

Purpose:

- Promote and strengthen partnerships and create new alliances 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 Quadruple Aim (reduced costs, better health, improved access, and improved provider and staff satisfaction)
- 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

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.

DEFINITIONS

Transformation

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.

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

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.

Patient-Centered Primary Care Home

The Patient-Centered Primary Care Home is a care delivery model where treatment is coordinated through the member’s primary care physician to ensure they receive the necessary care when and where they need it and in a manner they can understand.

PROCESS OVERVIEW & TIMELINE

Required Letter of Intent

A non-binding Letter of Intent (LOI) is required to be considered for funding. The LOI must be completed no later than **June 2, 2021 at 8:00 am.**

The Letter of Intent form can be found at IHNtogether.org/RFP.

Process Overview

The first step is to submit a Letter of Intent. Selected pilots will be invited to submit a full pilot proposal. New for 2021, there are two separate pathways, with distinct requirements and timelines, for pilots with a budget of over $50,000 (“RFP1”) vs. those with a budget of over $50,000 (“RFP2”). The goal of creating two pathways is to simplify the process and reduce barriers for newer/smaller organizations.

Funding Options: RFP1 & RFP2

Pilot proposals with budgets greater than $50,000 (RFP1) will be required to fill out an application including a detailed budget, SMART goals and outcomes, and detailed timeline. Pilot proposals with budgets of $50,000 or less (RFP2) will be required to fill out a simpler proposal application that will be reviewed by the DST.

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.

Timeline

Activity	Expected Date(s) RFP1	Expected Date(s) RFP2
Request for Proposal (RFP) Announcement	May 11, 2021	May 11, 2021
Question and Answer (Q&A) Session	May 25, 2021	May 25, 2021
Letter of Intent (LOI) Due – Required	June 2, 2021 by 8:00 am	June 2, 2021 by 8:00 am
Invitations Issued to Submit Full Pilot Proposal	By June 17, 2021	By June 17, 2021
Technical Assistance Meeting – Required	June 17 to July 23, 2021	June 17 to July 14, 2021
Pilot Proposal Due	July 27, 2021 by 8:00 am	July 15, 2021 by 8:00 am
Pilot Presentations to the DST Committee	August 12, 2021 August 19, 2021 September 2, 2021	N/A
DST Committee Decisions	September 16, 2021	August 5, 2021
Pilot Proposers Notified of DST Decision	By September 30, 2021	By August 12, 2021
Regional Planning Council Funding Decisions	October 7, 2021	August 19, 2021
Proposers Notified of Pilot Denial or Approval	By October 31, 2021	By August 31, 2021
Contract Negotiations	November 2021	September 2021
Pilot Contracts Finalized	By November 30, 2021	September 30, 2021
Pilot Invoicing/Payments Begin	January 1, 2022	October 1, 2021
Although we do our best to adhere to this timeline, it is subject to change as circumstances occur.		

PRIORITY AREAS

Applicants may choose to submit a proposal that addresses both one or more priority areas as well as a specific subpopulation of IHN-CCO members.

- Addressing trauma
- Developing a bilingual and bicultural workforce
- Improving access to behavioral health services in non-traditional ways
- Increasing and improving access to behavioral health care in light of COVID-19
- Innovative programs supporting housing
- Language access including health literacy, interpreter services, and translation of materials
- Pay equity through building and sustaining the workforce
- Subpopulations of IHN-CCO members that experience health disparities
    - E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, youth in transition from foster care

Outcomes, Indicator Concepts, and Areas of Opportunity

The information below is from IHN-CCO's Community Advisory Council's (CAC) 2019 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.

ACCESS	
Outcomes	Indicator Concepts and Areas of Opportunity
A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.	Indicator Concepts c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Appropriate physical, behavioral, and oral preventive healthcare for all ages
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 a. Number of homeless persons b. 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
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

PILOT PROPOSAL REQUIREMENTS

RFP1

The following are required components for all pilot proposals with a budget greater than $50,000. 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 (½ 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 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 (½ 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.

All proposals submitted with a budget greater than $50,000 (RFP1) are expended to present their proposal to at a DST meeting. Pilot Proposal Presentations will be scheduled on August 12, 2021, August 19, 2021, and September 2, 2021 (all meetings scheduled for 4:30 to 6:30 pm). Please let the Transformation Department know if you have a date preference as soon as possible after you are invited to submit a full proposal.

RFP2

The following are required components for all pilot proposals with a budget of $50,000 or less. 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 (½ page)

   B. Pilot Description (2-4 pages)

      Detailed description of the proposed pilot including:

      - Pilot goals, activities, and how they will be measured as indicators for achieving the outcomes
      - 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
      - Describe the individuals tasked with portions of the pilot and their roles and experience
      - Describe how members of the community will hear about your project
      - Describe potential risks and how the pilot plans to address them

   C. Sustainability Plan (½ 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).

BUDGET DETAILS

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

Pilot Contracting Period

Three months to two years though generally one to two years. Subject to negotiation during the proposal period. All funds must be distributed by IHN-CCO by December 31, 2022.

EVALUATION OF PROPOSALS

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

- Create opportunities for innovation and new learning for the DST and the pilot proposers
- 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

EXPECTATIONS OF FUNDED PROJECTS

Progress Reporting

Semi-annual may be required depending on pilot timeframe. 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 share updates and lessons learned 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. The currently active workgroups are:

- Connect Oregon
- Health Equity
- Social Determinants of Health
- Traditional Health Workers