Agenda
Delivery System Transformation Committee

April 28, 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		**Sadie Peterson,** IHN-CCO	**4:40**
3. Social Determinant of Health Workgroup Update and Transportation Recommendations	p. 9-12	**Britny Chandler,** IHN-CCO/Namaste Rx	**4:50**
4. Traditional Health Worker Workgroup Update		**Renee Smith,** Family Tree Relief Nursery **Andrea Myhre,** Corvallis Housing First	**5:10**
5. Health Equity Workgroup Update	p. 13	**Alicia Bublitz,** Community Doula Program/Heart of the Valley Birth & Beyond	**5:20**
6. Sustainability Workgroup Update	p. 14	**Elizabeth Hazlewood,** Pathfinder Clubhouse	**5:30**
7. Connect Oregon Workgroup Update	p. 15	**Christian Moller-Anderson,** Smiles for Kids	**5:40**
8. Wrap Up • Announcements • Next Meeting: May 12, 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

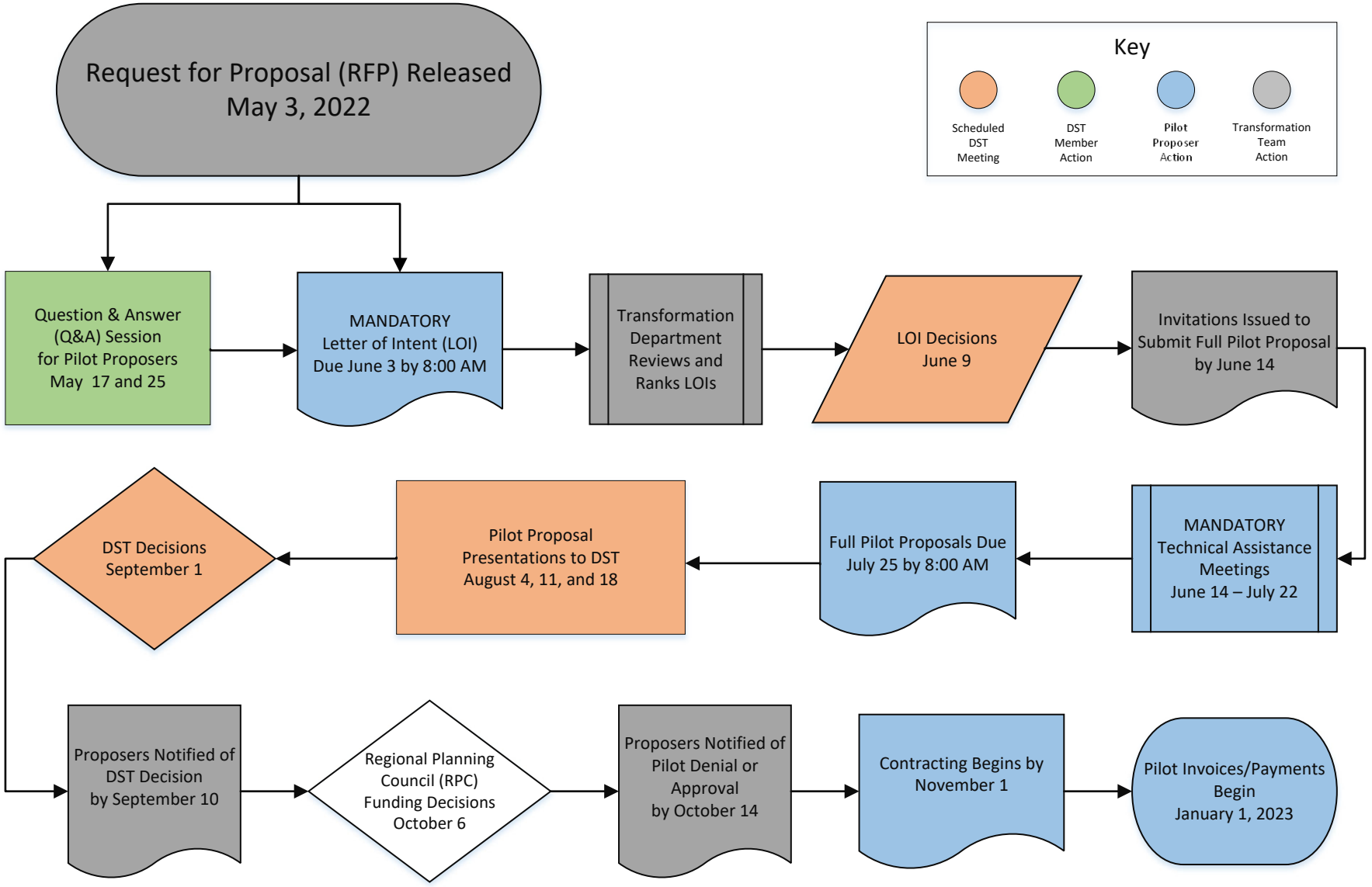
Delivery System Transformation Committee (DST) 2022 Calendar

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	SDoH WG	THW WG	HE WG	SUST WG	CO WG
May	12	Board Update	Workgroup Discussion			
	26	Review Proposal Slides	DST Chair Discussion			
June	9	Letter of Intent Decisions				
	23	Board Update	Pilot Updates			
July	7	Pilot Updates				
	21	Small RFP Decisions				
August		**Regional Planning Council for Small RFP Final Approval**				
	4	Large RFP Proposal Presentations				
	11	Large RFP Proposal Presentations				
	18	Large RFP Proposal Presentations				
September	1	Large RFP Decisions				
	15	Oregon Center for Health Innovation				
	29	Workgroup Updates				
October		**TENTATIVE Regional Planning Council for Large RFP Final Approval**				
	13	Oregon Center for Health Innovation				
	27	Board Update				
Nov	10					
Dec	8	Board Update				

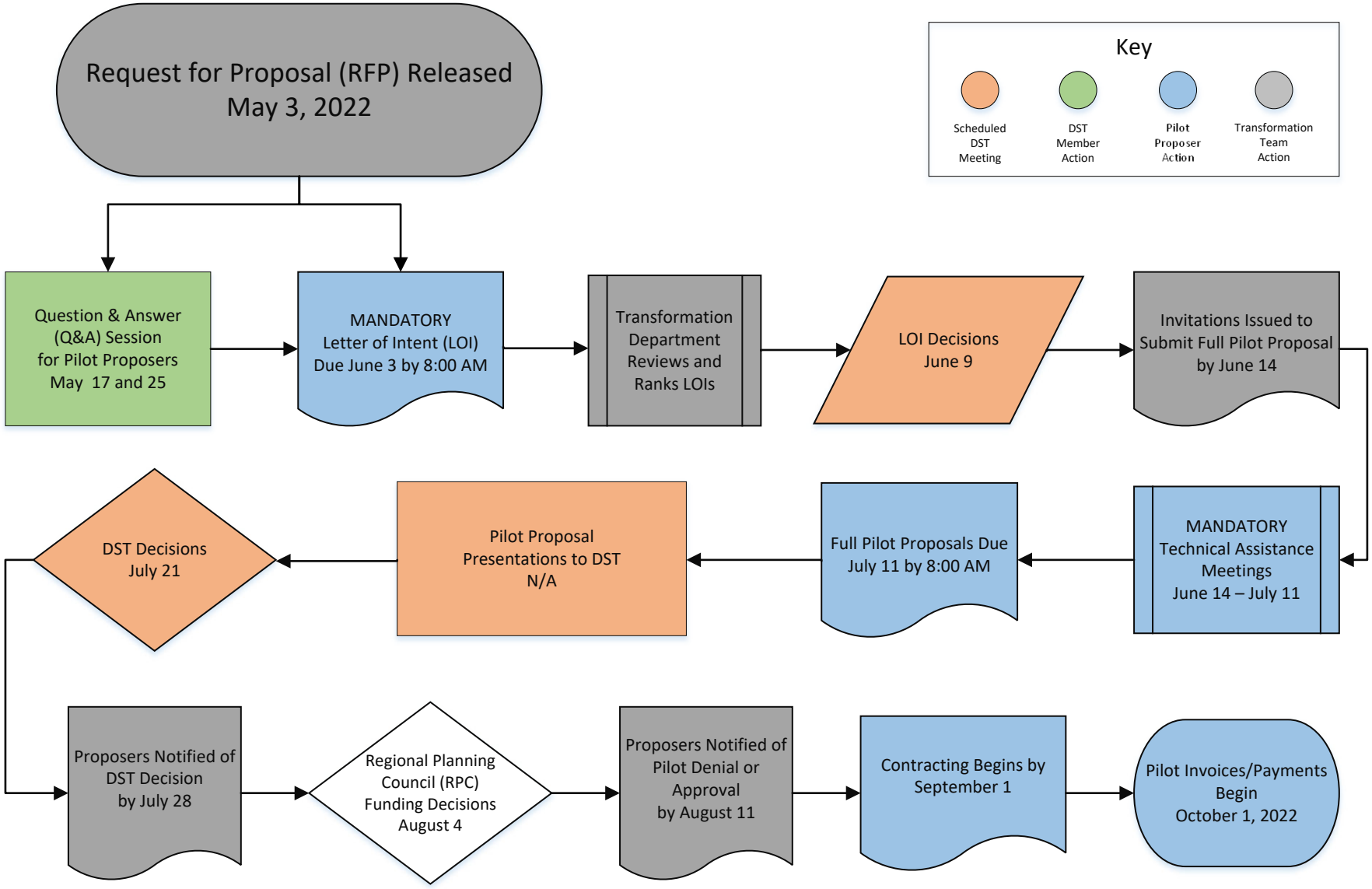
KEY

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

IHN-CCO DST Request for Proposal Timeline – Large RFP



IHN-CCO DST Request for Proposal Timeline – Small RFP



Minutes
Delivery System Transformation Committee (DST)
April 14, 2022 4:30-6:00 pm
Microsoft Teams (Online)

Present			
Chair: Beck Fox	Georgia Smith	Shannon Rose	Charissa Young-White
Andrea Myhre	Annie McDonald	Melissa Isavoran	Elizabeth Hazlewood
Alicia Bublitz	Emma Chavez	Nicole Breuner	Jeannette Campbell
Danny Magaña	Jay Yedziniak	Dick Knowles	Stacey Bartholomew
Allison Hobgood	Larry Eby	Caleb Larson	Kacey Urrutia
Linda Mann	Sadie Peterson	Misty Sorte	Kristty Zamora-Polanco
Rebekah Fowler	Paulina Kaiser	Rolly Kinney	Ricardo Contreras
Shirley Byrd	Alex Llumiquinga	Britny Chandler	

Transformation Update

- Beck Fox will be transitioning out of being the DST chair due to accepting the position of Health Equity Liaison with IHN-CCO.
    - Melissa Isavoran will chair the DST with the community chair.
    - Will be looking for a new community chair to facilitate and lead the DST.
    - Please email transformation@samhealth.org by **May 14, 2022** if you are interested or would like to nominate someone.
    - Nominations will be gathered and interested parties will present to the DST at the May 26, 2022 meeting.
- Pilot Visit: Healthier Homes Together
    - Positive experience with Albany Partnerships for Housing and Community Development for both IHN-CCO staff and the pilot champions.
    - Member who has received services had great things to say about how this pilot has supported them through resource navigation.
- Community partner survey to help identify support services to possibly implement at a clinic in Albany.
    - Questions via poll asked of the DST.
        - Of the following, what are the 1-3 biggest barriers to getting Primary Care Physician (PCP) services in Albany?
        - What services would help address the identified barriers?
    - Results will be brought back to the DST and presented to Samaritan.
    - Overall positive feedback on the process of polling/surveying during DST meetings. Some technical glitches we need to work out. Members may always email Transformation and/or type in the chat as well.
- Social Determinants of Health Workgroup Chair position open.

Request for Proposal (RFP) Decisions

- Timeline(s)
    - **Decision:** Keep the separate timelines but ensure information for the Large RFP Letters of Intent are available and part of the conversation.
- Priority Areas:

  - Positive feedback, moving forward with these priority areas and examples.
- Proposal Requirements: Description items
  - Add environmental scan to the third bullet to ensure folks are looking at other programs in the region and avoid duplication.
  - Remove second to last bullet.
- Evaluation and scorecard:
  - Positive feedback, moving forward with these evaluation components, scorecard, and rubric.

Social Determinants of Health Workgroup

Recommendations to IHN-CCO for Community Transportation

October 2021

Background

The recommendation to IHN-CCO from the Social Determinants of Health Workgroup begins with the ask to establish desired goals and outcomes for SDOH work, aligning with CCO 2.0 metrics, develop more specific work plans to achieve desired outcomes, and to establish promising practices to move to system integration or community commitments.

The SDOH workgroup would also like to encourage internal operations of IHN-CCO to consider integration of priority areas outlined within these recommendations through documentation (policies, processes, and procedures) to assist in fulfilling contractual obligations outlined by the State of Oregon for the use of Medicaid funds.

The priority areas of Housing, Food Security, and Transportation were developed through evaluation of the Community Advisory Council's Community Health Improvement Plan, the regional Community Health Improvement Plans, and the Delivery System Transformation (DST) Committee's four workgroups; Social Determinants of Health (SDOH), Health Equity, Traditional Health Workers (THW), and Universal Care Coordination (UCC).

Vision

We can live in a community where everyone has reliable and accessible transportation that accommodates the needs of the individual.

When we focus on transportation as a social determinant of health (SDOH), we create better access to SDOH and non-SDOH services and supports.

Transportation Recommendations

Recommendations	Recommendation Category
Advocate for regulation on car insurance industry to keep prices affordable and assist with coordination in filing car insurance claims.	• Policy
Advocate to assist with costs of regular oil changes, tune ups, tires, etc.	• Policy
Establish a workflow connection between NEMT services with up to date and current address location within the Medicaid Management Information System (MMIS) to align with the correct Coordinated Care Organization and NEMT provider.	• System Change
Establish and roll out training to front line workers (THWs, case managers, coordinators, front desk staff, shelter staff, etc.) within community-based organizations and clinical settings on how to assist members with utilizing NEMT options.	• Trainings
Expansion of Non-Emergent Medical Transportation (NEMT) Coverage for Samaritan Advantage Health Plans.	• System Change
Increase acceptance of public use of lobby phones for transportation access (phones available to patients in the lobby, or waiting room, of a provider's office). Increase the use of Lifeline phones (a federally funded program that offers a phone, unlimited coverage, and discounted internet options at no cost to the qualifying member) for those who don't have access to their own cell phone.	• Trainings • System Change
Increase member awareness and assess barriers with Uber and Lyft as new NEMT service options.	• Trainings • Data
Increase member awareness of shared ride options (as social distancing allows) and reimbursement programs.	• Trainings

Increase member awareness of the availability and use of at home services, testing kits, and remote monitoring devices when possible and appropriate to member's needs.	• Trainings
Increase member awareness of the availability and use of pharmacy mailing and delivery options when possible and appropriate to member's needs.	• Trainings
Increase member awareness of the availability and use of Telehealth services to reduce the need for transportation when and where possible and appropriate.	• Trainings
Increase provider workforce within the region (general and specialist service types).	• System Change
Increase transportation support for social determinants of health needs such as trips to obtain vital records (DMV, Social Security office, etc.), job interviews, grocery stores, local food banks, etc.	• Policy
Review, monitor, and advocate for updated bus routes that support the populations needs, focusing on access for individuals in rural communities and placing stops closer to Hospitals, popular clinic sites, COVID testing/vaccine sites, grocery stores, food banks, housing resources, and areas with a low median income.	• System Change
Utilize virtual platforms to support cross-organization communication and member coordination. By increasing the use of technological resources (UniteUs), we help to reduce IHN-CCO's carbon footprint.	• System Change

IHN-CCO Social Determinants of Health (SDoH) Workgroup Scope of Work

Workgroup Purpose

To develop and promote the transformational integration of Social Determinants of Health (SDoH) into the health care delivery setting. The focus of this work will be at two levels; 1) identify and promote strategies within IHN-CCO to support awareness and positively impact SDoH, AND 2) promote identification of SDoH, create connections to community resources, and foster agency relationships.

Workgroup Chair(s)

- Christine Mosbaugh, Community Health Centers of Benton and Linn Counties
- TBD

Meeting Frequency

2nd Thursday of the month from 3:00-4:00 pm

Short Term Goals

1. Building on the framework to develop strategies/goals for the community, to IHN-CCO, practice, community, and policy level.
2. Present recommendations to the Delivery System Transformation (DST) Committee (who reports to the Regional Planning Council) to act on recommendations for desired IHN-CCO initiatives and service level pilots.
3. Utilize tools and resources to ensure recommendations/goals are data driven.

Long Term Goals

1. Increase awareness in the community regarding what is being done to address SDoH through initiatives and pilots within the region.
2. Influence the direction and provide input to IHN-CCO for the 5-year CCO application, SHARE Initiative, DST pilots, community-based organizations, CMS waivers and any other pertinent project or initiative
3. Identify and act on structural and policy barriers to recommendations/goal.
4. Assessing the social needs impact of health interventions and how that affects community and healthcare providers' job satisfaction.

Social Determinants of Health & Equity: A definition for Oregon CCO's

(from MAC Framework and Recommendations for Addressing Social Determinants of Health through Oregon CCOs)

Health begins where we live, learn, work, and play. The social determinants of health are the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. The social determinants of health are not fairly distributed in communities. Distribution is shaped by a wider set of transformation agendas and structure, such as norms, policies and political system, both historical and current. The social determinants of equity are structural factors, such as racism, that determine how different groups of people experience social determinants of health.

IHN-CCO Health Equity (HE) Workgroup
Scope of Work

Workgroup Purpose

The IHN-CCO Health Equity Workgroup supports delivery system transformation that identifies and reduces inequities and advances health equity by: supporting the diverse needs of members; supporting quality improvement focused on eliminating inequities in access, quality of care, experience of care, and outcomes; building a workforce that reflects IHN-CCO membership; supporting the equitable implementation of the quadruple aim; and supporting IHN-CCO's Community Health Needs Assessment and Community Health Improvement Plan.

Workgroup Chair(s)

- Alicia Bublitz, Community Doula Program- Heart of the Valley Birth and Beyond
- Beck Fox, Bravery Center, Olalla Center

Meeting Frequency

Fourth Thursday of every month from 3:00 – 4:00 p.m. Annual joint meeting with Traditional Health Worker Workgroup.

Short Term Goals

1. DATA: Support and monitor quantitative and qualitative data to inform, prioritize, and monitor strategies to meet the needs of culturally diverse members and to reduce health disparities.
2. TRAINING: Support health equity trainings for the IHN-CCO Health Equity Workgroup, IHN-CCO staff, IHN-CCO providers, and other community stakeholders.
3. REALD: Inform Race, Ethnicity, Language, and Disability conversations as they relate to community partners.

Long Term Goals

1. Support the Health Equity goals of community partners.
2. Support and retain IHN-CCO provider and staff composition that reflects member diversity including removing barriers to participation.
3. Informing and addressing health equity services, access, trainings, scope of practice and supports for Traditional Health Workers to address health disparities across IHN-CCO services and in Linn, Benton and Lincoln counties.
4. Ensure regular communication between the IHN-CCO Health Equity Workgroup, IHN-CCO staff, IHN-CCO DST Steering Committee, IHN-CCO CAC, and IHN-CCO workgroups about health disparities and health equity activities in the community.

Acronyms:

CAC: Community Advisory Council
DST Steering Committee: Delivery System Transformation Steering Committee
IHN-CCO: InterCommunity Health Network Coordinated Care Organization
Quadruple Aim: Enhancing patient experience, improving population health, and reducing costs, improving the work life of health care providers, including clinicians and staff.
REALD: Race, Ethnicity, Language, and Disability
THW: Traditional Health Workers

IHN-CCO Sustainability Workgroup
Scope of Work

Workgroup Purpose

The Sustainability Workgroup's purpose is to identify best practices and solutions for billing, staffing, funding, data collection, replicability, and overall sustainability. Support and collaborate with community partners for advancement into sustainable practices and organizations to better the community's available resources, providers, and services.

Workgroup Chair(s)

- Elizabeth Hazelwood, Pathfinder Club House

Meeting Frequency

Fourth Wednesday of each month from 3:00 – 4:00pm.

Strategic Goals

1. Understand, document, and address current and past Pilots' challenges, successes, and areas for opportunity.
2. Create and inform integrated and streamlined pathways for sustainable community-led support services.
3. Identify simplified, affordable, and effective data collection and reporting tools and how to leverage data for additional funding opportunities.
4. Build a strong community partner network to support great alignment of resources.

Short Term Actions

1. Improve the process for pilot analysis to understand challenges, successes, and areas for opportunity.
2. Ensure access to IHN-CCO supports especially billing and provider credentialing.
3. Develop tools to educate and inform community partners about IHN-CCO's current funding mechanisms.
4. Identify tools useful for community partners' collecting, reporting, and tracking.
5. Explore developing forums for networking, sharing best practices, and resource sharing.
6. Improving the process for engaging and contracting with DST pilots.

Long Term Actions

1. Increasing sustainability of the DST Pilots in the community to extend resource, provider, and service access within the Benton, Lincoln, and Linn counties.
2. Creating a sustainability resource guide informed by community partners for newly funded DST Pilots to include best practices and support services for billing, staffing, funding, and data collection.
3. Implement tools identified as useful for required reporting and tracking outcomes.

Sustainability Definition:

Sustainability is the ability of pilot projects and community-led services to continue and spread after DST pilot funding ends. Sustainability includes financial continuation of funding, but also replicability, the ability to spread lessons learned to new organizations or regions, and depth of support in the community.

IHN-CCO Connect Oregon (CO) 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.

Workgroup Chair(s)

- Christian Moller-Anderson, Executive Director, A Smile for Kids
- Miranda Miller, Director of Primary Care Practice, Samaritan Health Services

Meeting Frequency

Quarterly

Short Term Goals

1. Understand the current state of Connect Oregon
2. Build networking opportunities by sharing successes and discussing limitations
3. Strategize ways to engage end users with the Unite Us platform
4. Identify and overcome barriers to implementing Connect Oregon
5. Identify areas of opportunity to increase usage and better support community health

Long Term Goals

1. Demonstrate the value of the network through data gathering and evaluation
2. Standardize screenings for use throughout the healthcare and social service system
3. Support and facilitate training opportunities with Connect Oregon
4. Provide community awareness and education to the resources within Unite Us
5. Support ease of use and integration/interoperability for all sectors with the focus on full bi-directional integration
6. Communicate and liaise with Unite Us on community needs and improvements
7. Review and improve understanding of workflow particularly for organizations that are not clinical or social need focused
8. Integrate with other communication technology including electronic health records and screening and referral platforms