STRATEGIC PLAN

2023

Version 1

IHN-CCO

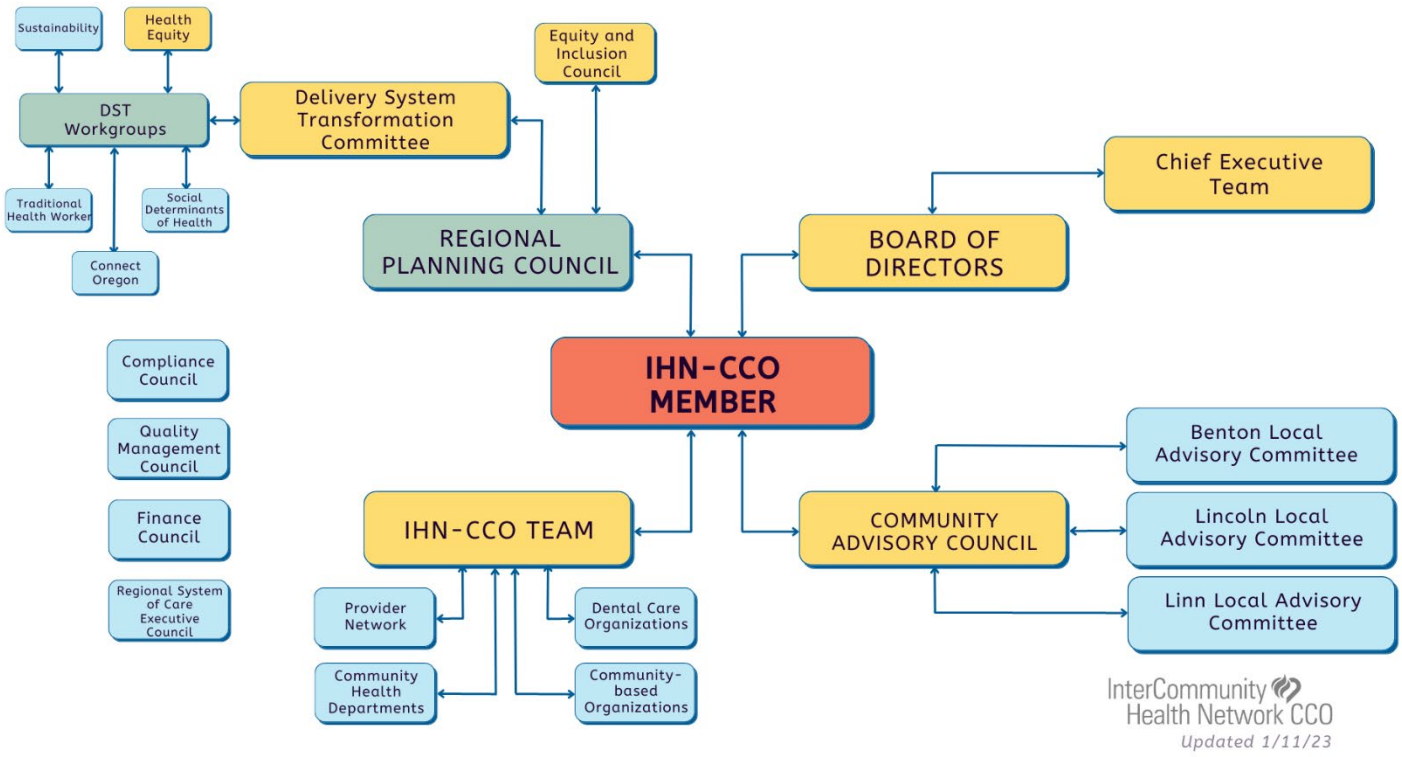
DELIVERY SYSTEM TRANSFORMATION

Table of Contents

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 to explore innovative, transformational ways of approaching health and wellness with a focus on equity. 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 chart below depicts the pathways of communication and collaboration, as well as the surrounding structure of support 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. Pathways of collaboration, communication, support, and channels of reporting flow between these different areas. Visually centering IHN-CCO members is in alignment with IHN-CCO's health equity priorities. Teams, councils, and committees colored in yellow have roles in the health equity governance structure.



IHN-CCO DST History 2022

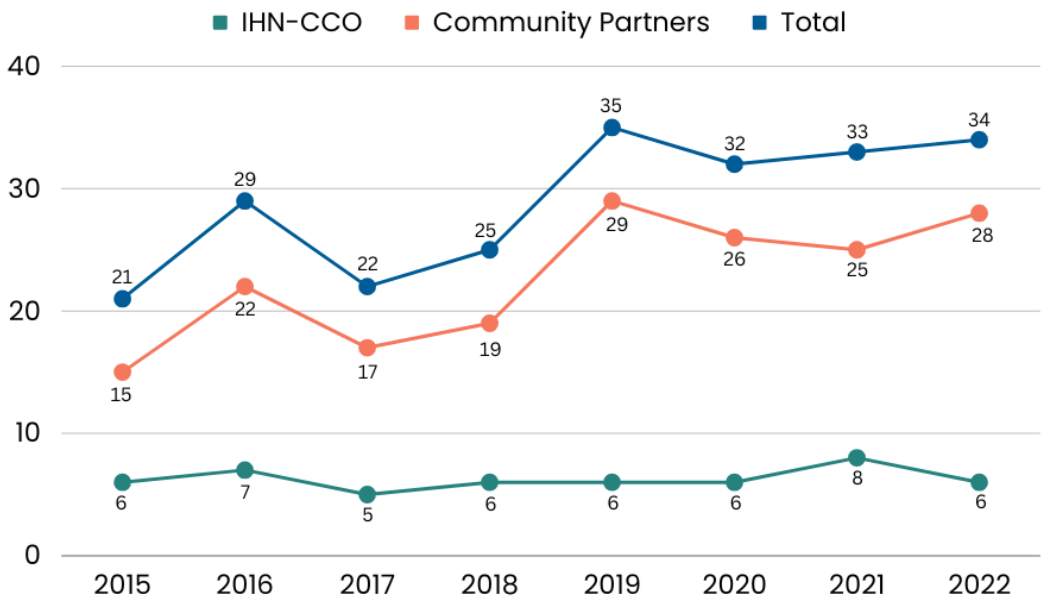
See Appendix A. IHN-CCO DST History and Evolution 2012-2021

2022

Membership

- Average attendance: 34

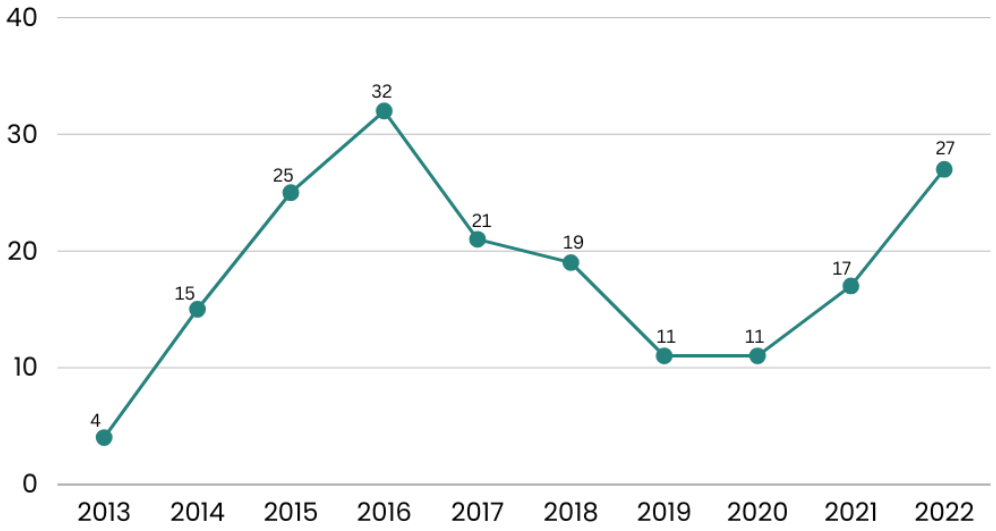
Figure 1. Average Attendance of the Delivery System Transformation Committee by Year



Pilots

- 27 active pilots

Figure 2. Number of Delivery System Transformation Pilots by Year



Planning/Focus of the DST

- Bringing grassroots organizations to the table
- Opportunities for pilot peer connection, supported by IHN-CCO, through the Sustainability Workgroup
- Focus on health equity work
- Request for Proposal priority areas:
    - 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
- Discussion/parking lot topic areas:
    - Increasing committee engagement
        - Voting requirements, reducing barriers for participation, etc.
        - Considering who is missing from the table
    - Inviting past pilot champions to participate in the DST long-term
        - Pilot champion panels
    - DST/pilot summit
    - Pilot proposal scoring process
        - Should health equity, innovation and transformation be weighed more heavily?
        - How to ensure support of culturally focused pilot projects

Workgroups

- Continued: Health Equity, Social Determinants of Health, Traditional Health Worker, Connect Oregon, Sustainability

DST Objectives and Membership

2022-2023 Racial Equity Workshop

See Appendix B. Racial Equity Workshop Materials & Resources

- Angel Harris facilitated three workshops at the regularly scheduled November & December 2022 and January 2023 meetings on racial equity.
- White supremacy, racism, prejudice, stereotypes, and implicit bias can sneak in so subtly that we are not even aware. Awareness is important but how do we practice every day to move from awareness to action and then transformational change?

- Are our actions reflective of the DST Charter? What is going well? Where can there be improvement or change? How can you be a part of that change?

2022 DST Charter

See Appendix C. 2022 DST Charter

Roles and Responsibilities

See Appendix D. IHN-CCO DST Roles and Responsibilities

Engagement

DST member engagement is a crucial piece of the process, helping to ensure decisions are based on vibrant, productive discussion, that the committee continually innovates and acts to further equity, and that diverse perspectives are included. An engaged committee has members that attend regularly, come prepared, actively participate in discussion or related activities such as scoring and/or voting, and collaborate and support one another to build meaningful partner relationships.

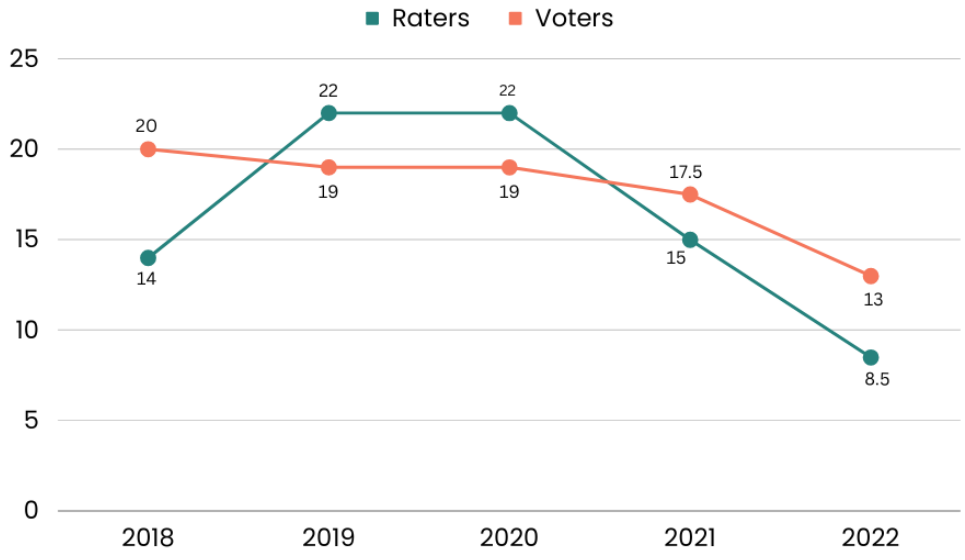
Thoughts/ideas from past DST discussions:

- What barriers exist for members to engage at DST? For new members?
- Fostering an inclusive space where all members feel valued and like their voice matters
- Representation without tokenizing
- Considering equity in every aspect (e.g., materials, process, etc.) - in what ways do the current committee structures reinforce dominant culture values?
- Would a different voting process/structure be better?

Voting:

- Possible change to being year to date attendances? Or possibly last rolling year? Attendances from last scoring time period is more difficult to analyze.

Figure 3. Average Number of Raters and Voters by Year



Priority Areas

Pending Community Health Improvement Plan Crosswalk

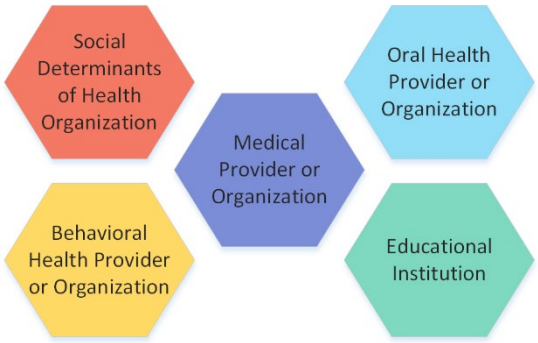
Fostering the Message and the Spirit of the DST

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

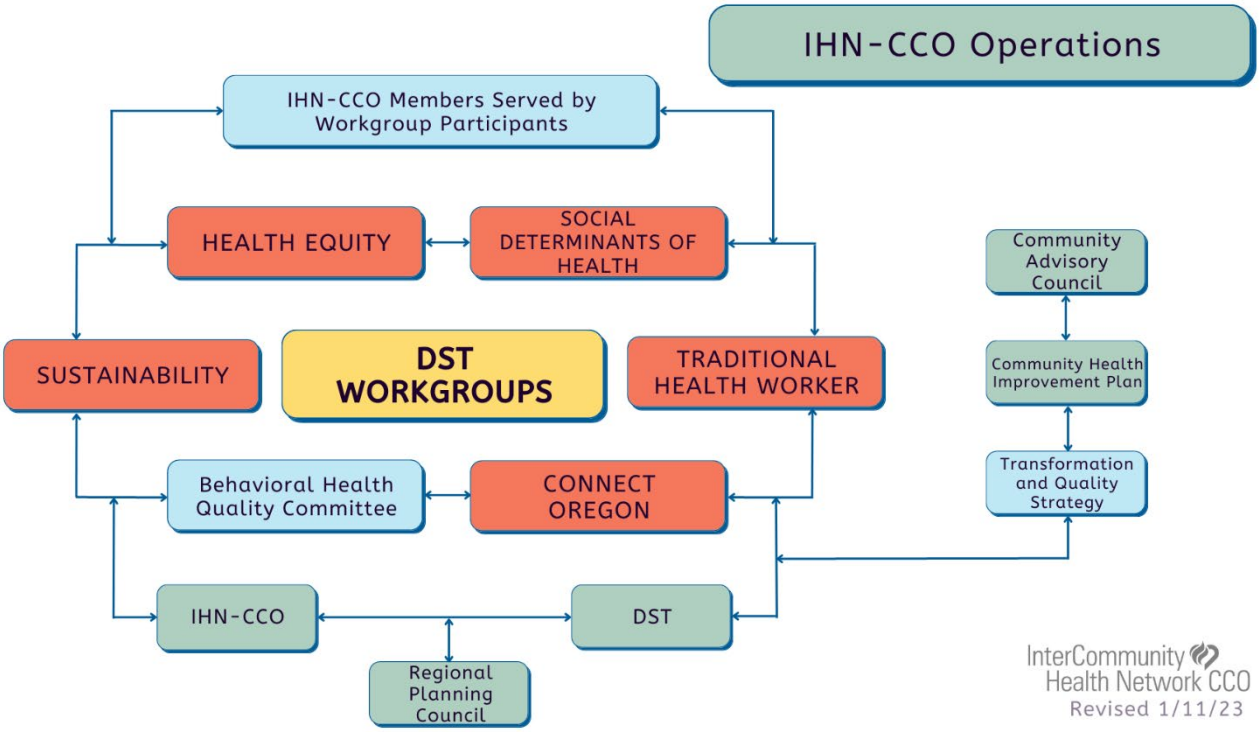
The lightbulb is a "wordcloud" based on conversations the Committee has had in past strategic planning. Together, the words inside the image represent the core values and priorities of the DST.

Community Partners and Stakeholders

Key:



Workgroups



Health Equity

See Appendix E. 2021 Health Equity Workgroup Recommendations

- Need a co-chair
- Focusing on bringing guest speakers to the workgroup on topics such as the development and implementation of health equity tools and organizational/programmatic plans
- Will be providing feedback and recommendations to the Health Equity Liaison regarding IHN-CCO's 2023 Health Equity Plan
- Will be providing feedback and recommendations to the DST on the RFP process through the lens of health equity

Social Determinants of Health (SDoH)

- Creation of Scope of Work including strategic goals and purpose of workgroup
- Informal presentations from various guest speakers on topics related to SDoH, including resources and services
- Focused on transportation and providing recommendations to IHN-CCO later in the year

Traditional Health Workers (THWs)

- Completed extensive SWOT analysis of THW landscape in the tri-county region
- THW Toolkit focus group and review
- Community of Practice framework developed
- Healthier Oregon Population

Connect Oregon

- Moved to quarterly cadence and longer meeting
- Supporting community-based organization engagement as well as configuration of the larger health system
- Partnering with Unite Us on supporting Connect Oregon via increased engagement and additional opportunities for organizations

Sustainability

- Chair selected
- Needs Assessment
- Calendar for 2023 developed

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

Figure 4. Number of Pilots by Entity, Samaritan Health Services (SHS) versus Non-SHS and Collaborations

SHS	22
Non-SHS	74
Collaborations	10
Total	106

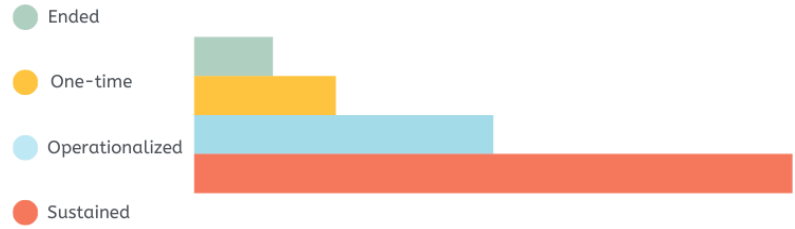
Figure 5. Number of Pilots by County

Benton	71
Lincoln	57
Linn	7
Total	106

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

Closed Pilots Sustainability

Figure 6. Number of Pilots by Final Sustainability Status



Ended	5
One-time project	9
Operationalized	19
Sustained	38
Total	71

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% (57 of 62) of pilots that were expected to be sustained have been operationalized through IHN-CCO or sustained by the champion organization as of 2023*

**9 of the 71 closed pilots were expected one-time-projects*

Evaluation Processes

- 2021 Health Equity Workgroup Recommendations – *See Appendix E. 2021 Health Equity Workgroup Recommendations*
- Health Management Associates (HMA) consultant work – *see Appendix F. Health Management Associates Transformation Pilot Projects 2.0.*
- Intern work on pilots and traditional health workers – See *Appendix G. Intern Projects*
- Reports including semi-annual and final that include successes, barriers, outcomes, stories, and more
- Provide technical assistance to approved pilots on data collection and evaluation as well as contracting and payment mechanisms (this includes sustainability)
    - Sustainability Workgroup, Connect Oregon Workgroup in conjunction with Oregon State University
- Pilot follow up presentations in the years following closing
- How do we tell the story of our successes? How do we evaluate whether the DST is working or not?

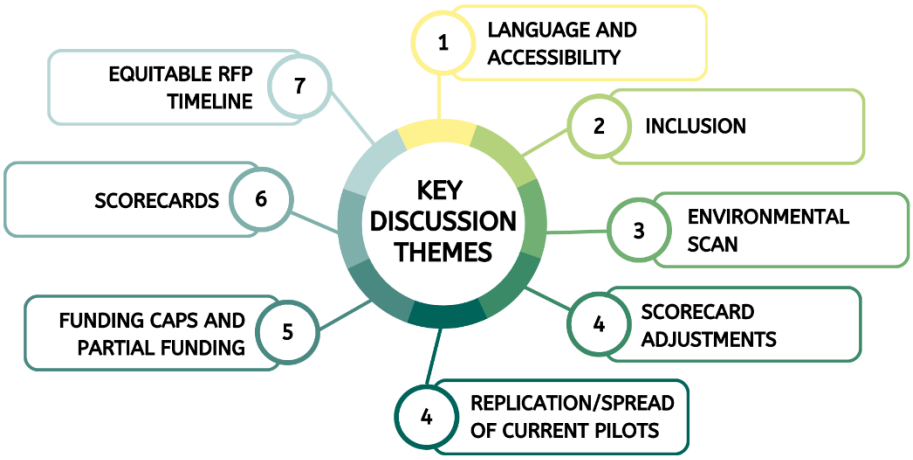
Request for Proposal (RFP)

See Appendix H. Request for Proposal Documents 2022

- Priority Areas Chosen (placeholder)
- Technical Assistance with the Engagement & Transformation Department includes at the very least:
    - Overall support for connections and networking
    - Explanation of the health system, IHN-CCO, and the DST through visuals and discussion
    - Encourage in depth environmental scan to reduce duplication of efforts and increase partnerships and collaboration
    - Encourage multiple methods of measures and outcomes including process-based outcomes, qualitative, and quantitative data (stories and numbers)
    - Encourage proposers to go to the Community Advisory Council (CAC) or the local advisory committees with their ideas
    - Present health equity focused examples and projects

- Discuss logistics including budget and capitol expenses
- Discuss sustainability options
- Provide resources and encourage attendance at the DST to learn throughout the process

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
  - Prioritization for proposals that address equity areas such as language access or culturally specific services
- Prioritize current pilots by working with them on replicability and spread
- Should a clear funding cap be included? What about considerations for partial funding?
- Are scorecards a meaningful tool for setting the foundation for discussion and decision-making?
- What is the decision-making timeline for a two RFP process? What is equitable?

Appendix A. IHN-CCO DST History and Evolution 2012-2021

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

2020

Membership

- 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 B. Racial Equity Workshop Materials & Resources

Racial Equity Workshop Series with Angel Harris
Homework Materials and Additional Resources

Session 1 Homework Materials:

1. Oregon Black History Timeline

2. White Privilege Checklist (Peggy McIntosh)

Please note: ***Complete the checklist based on race*** *and not by your other identities such as disability, gender, socioeconomic status, and/or sexuality.*

3. Samaritan Health Services/IHN-CCO Equity and Inclusion Plan 2020-2023

4. Systemic and Structural Racism: Definitions, Examples, Health Damages, and Approaches to Dismantling

Session 2 Homework Materials:

1. Three Myths About Racism
"But the fact of the matter is someone is depending on you to do nothing at all."

2. 5 Myths – and 5 Truths – About the Reality of Racism in the US

3. "Confronting Racism is not about the feelings and needs of white people" by Ijeoma Oluo

4. Interrupting Bias: Calling Out vs. Calling In

5. Examples of Racial Microaggressions

Session 3 Homework Materials:

1. Adaptive Leadership

2. Adaptive Leadership – Technical and Adaptive Challenges – Stop Solving the Wrong Problem Perfectly (7:04)

3. Dr. Joy Degruy: "A Trip to the Grocery Store"

4. Create Your Racial Autobiography

Additional Resources:

What's the Difference Between Prejudice and Racism?

Beginning Courageous Conversations About Race (The 4 Agreements)

The Art of Mindful Inquiry, 9 Healthy Ways to Communicate, and Unhealthy Ways of Communicating

Calling In and Calling Out Guide

How to Promote Racial Equity in the Workplace by Robert Livingston

The Alliance's Racial Equity Network Action Steps: Addressing Racial and Ethnic Disparities in the Homelessness System

Get Comfortable with Being uncomfortable| Luvvie Ajayi Jones

Appendix C. DST Charter 2022

Delivery System Transformation Committee (DST)

(Committee of the Regional Planning Council)

2022 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 through system transformation.
- Ensure the PCPCH (Patient-Centered Primary Care Home) and Community-Based Health Initiatives are included as key foundational pieces 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 Quadruple Aim: improving patient experience, improving the health of populations, preventing provider and staff burnout, and reducing the per capita cost of health care.
- Understand the impact of pilots through qualitative and quantitative analysis and evaluation.
- The DST understands and seeks innovative proposals to impact the conditions in which individuals can achieve optimal health. Primary health care is an important individual foundation for health; the DST seeks to impact systems broader than clinical care[iii].

Structure:

- The Committee reports to and takes direction from the IHN-CCO Regional Planning Council (RPC). The Co-Chairs are responsible for reporting 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[iv] and health equity lens[v].
- Support components of the Transformation and Quality Strategies (TQS)[vi].
- 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), its Community Health Improvement Plan (CHIP), and the State Health Improvement Plan (SHIP) priority areas.
- 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.
- Fifty percent participation measuring from the end of the previous year's voting period to encompass the spirit and commitment of the DST.
- 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] A Framework for Public Health Action: The Health Impact Pyramid (nih.gov)

[iv]

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

[v] 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."

[vii] TQS 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 D. DST Roles and Responsibilities

IHN-CCO DST Roles and Responsibilities Form

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

Adopt and support the objectives of the DST:

- 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 model building on current resources and partnerships.
- Support, sustain, and spread transformational initiatives through system transformation.
- Ensure the PCPCH (Patient-Centered Primary Care Home) and Community-Based Health Initiatives are included as key foundational pieces 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 Quadruple Aim: improving patient experience, improving the health of populations, preventing provider and staff burnout, and reducing the per capita cost of health care.
- Understand the impact of pilots through qualitative and quantitative analysis and evaluation.
- The DST understands and seeks innovative proposals to impact the conditions in which individuals can achieve optimal health. Primary health care is an important individual foundation for health; the DST seeks to impact systems broader than clinical care.

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.
    - A member must attend at least fifty percent of meetings measuring from the end of the previous year's voting period to vote on funding recommendations or proposals.
- Review materials and be prepared for engaged discussion, active listening, and respectful dialogue.
- Foster and promote the spirit and message of the Committee.
- Identify members to join the Committee, workgroups, and pilots to successfully complete objectives.
- 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 E. Health Equity Workgroup Recommendations

IHN-CCO Health Equity Workgroup
Recommendations to the Delivery System Transformation Committee for Consideration for 2021 the Request for Proposal

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.

HMA

HEALTH MANAGEMENT ASSOCIATES

Transformation Pilot Projects 2.0: Review and Recommendations

PREPARED FOR IHN & THE DELIVERY SYSTEM TRANSFORMATION WORK GROUP

BY

JEANENE SMITH MD, MPH
CATHY KAUFMANN, MSW

SEPTEMBER 2019

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

Table of Contents

Background and Review of Initial Phase of Project

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

Our Approach

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

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

Initial Key Themes review

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

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

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

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

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

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

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

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

2019 Pilot Project Funding Recommendations

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

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

Review of Pilot Funding Approaches in Oregon and Nationally

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

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

Eastern Oregon Community Care Organization (EOCCO)

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

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

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

PacificSource Community Health Excellence Program

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

Some examples of questions they ask of their pilot applicants:

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

Northwest Health Foundation / Kaiser Permanente Community Fund

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

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

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

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

Robert Wood Johnson Foundation (RWJF) Culture of Health

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

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

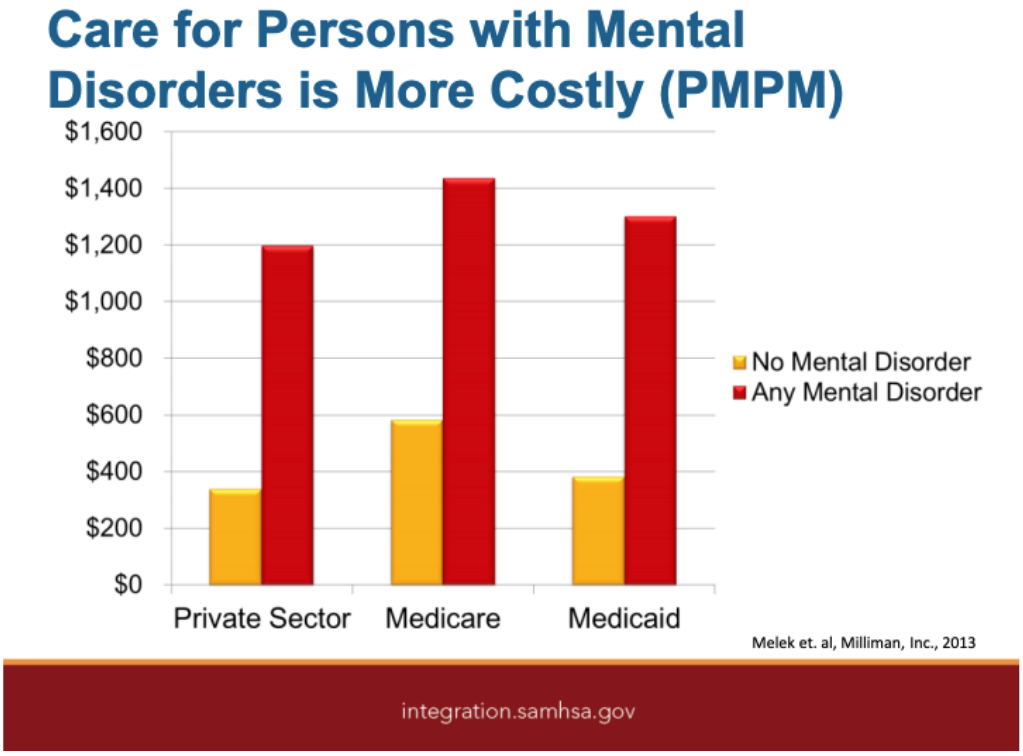
Review of Evidence-Based Practices

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

Behavioral Health Integration

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

Figure 1



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

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

Collaborative Care Model

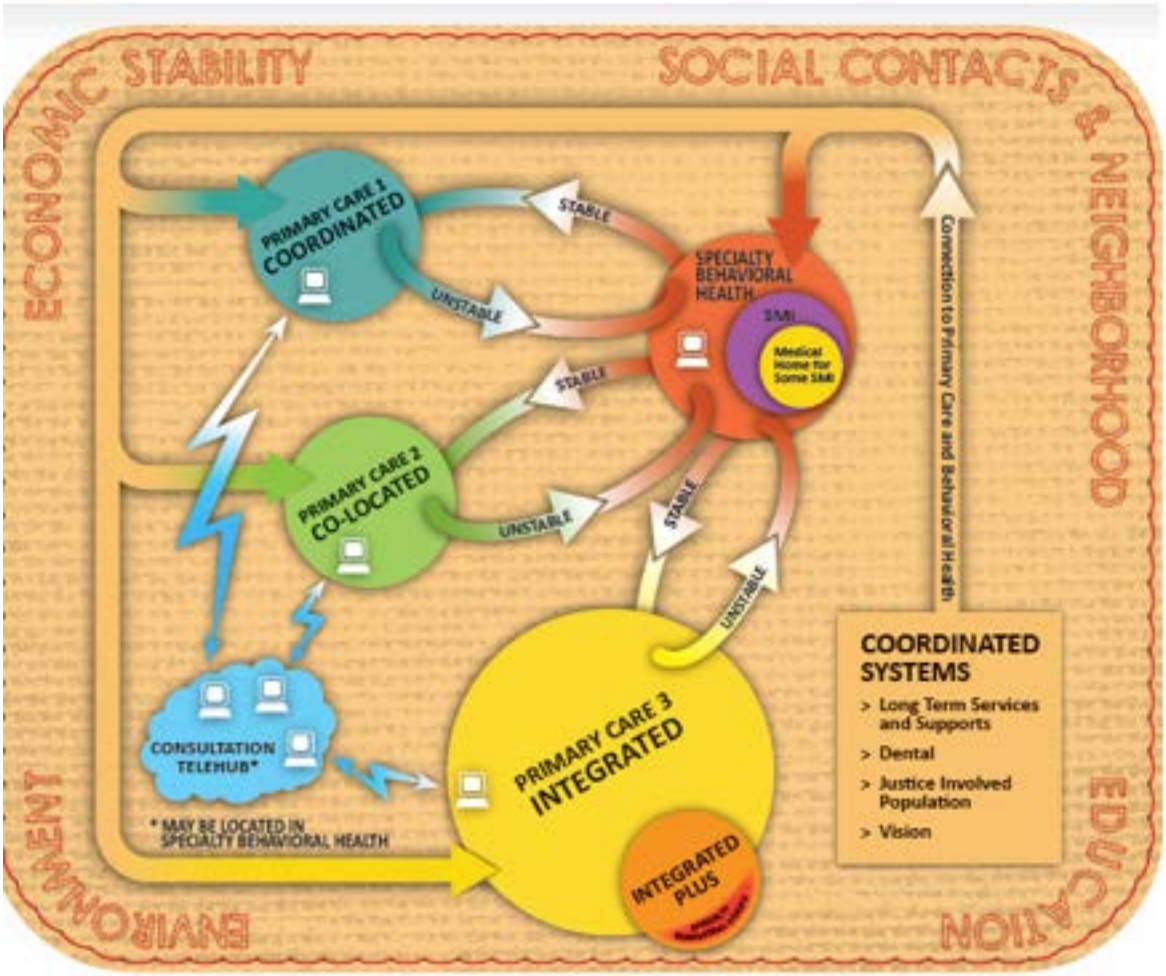
The Collaborative Care Model is a specific type of integrated care developed at the University of Washington that treats common mental health conditions such as depression and anxiety, based on principles of effective chronic illness care. Trained primary care providers and embedded behavioral health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

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

Collaborative Care System: A Stepped System of Care

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

Fig. 2: Collaborative Care System



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

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

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

Social Determinants of Health

Definition

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

- ***"Social Determinants of Health and Health Equity"*** *or* ***"SDOH-HE" SDOH*** *means the social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities. Social determinants of health include, but are not limited to: Poverty, education, employment, food insecurity, diaper insecurity, housing, access to quality child care, environmental conditions, trauma/adverse childhood experiences, and transportation.*

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

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

The Evidence for Social Determinants of Health (SDoH) interventions

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

To date, the findings include:

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

- Evidence can support potential value-based payment for sustainability

Collecting SDoH information

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

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

Health Equity

Definition

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

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

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

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

Evidence of Health Equity

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

The World Health Organization (WHO) states:

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

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

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

Guiding projects to include Health Equity

CDC's Equity Guides

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

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

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

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

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

Centers for Disease Control (CDC) Community Guide:

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

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

Additional Tools for Health Equity

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

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

Assessment of Pilots

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

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

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

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

Assessment Findings

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS FOR FUTURE PILOTS AND THE PROGRAM

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

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

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

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

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

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

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

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

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

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

Recommendations for improved data collection, including equity data

Improve Social Determinants Data Collection

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

Improve Health Equity Data Collection

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

Minnesota Health Equity Data Collection Efforts

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

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

Washington State Health Equity Review Planning Tool

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

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

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

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

Support Spread and Scale

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

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

Efforts to consider that will build and grow capacity include:

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

Strengthen CBO Partnerships and Networks

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

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

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

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

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

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

ENDNOTES / RESOURCES

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

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

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

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

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

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

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

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

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

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

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

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

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

[xiv] Links to CDC's Equity guides:

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

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

[xvi] More information on REALD

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

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

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

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

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

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

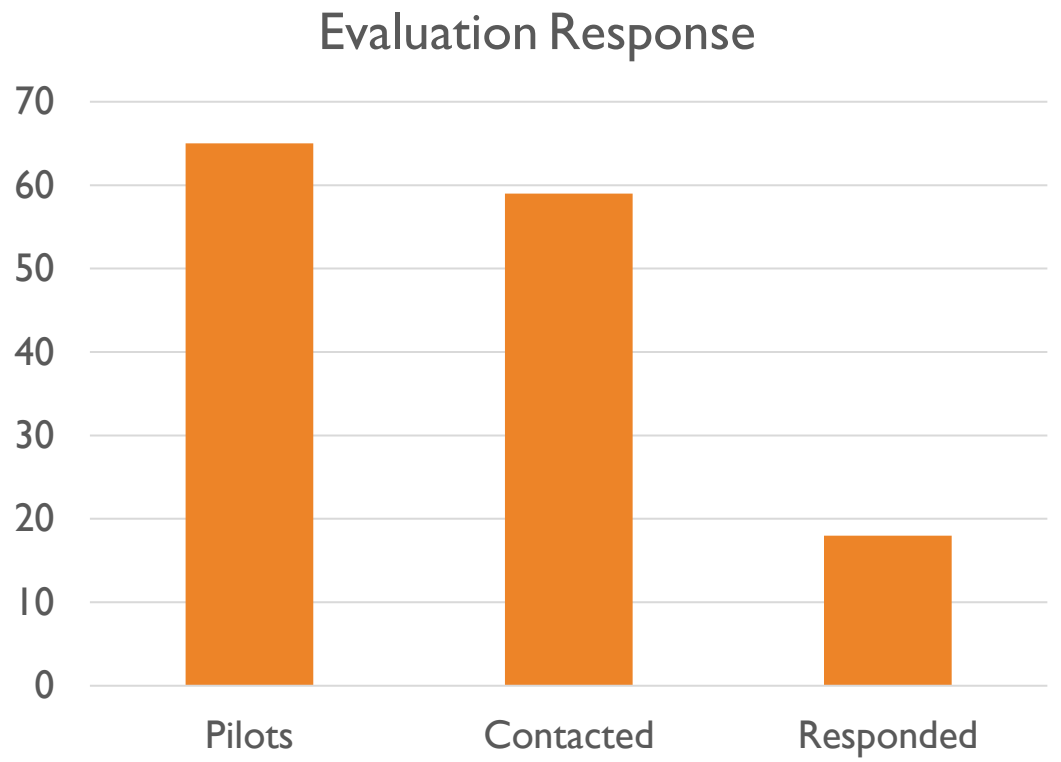
- Identify if pilots are continuing, the organizational commitment, and current funding
- Inquire about replicability, spread, and pilot successes
- Better understand barriers and challenges encountered by pilot
- Determine if any studies or data analysis has been completed and request access to materials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

METHODS

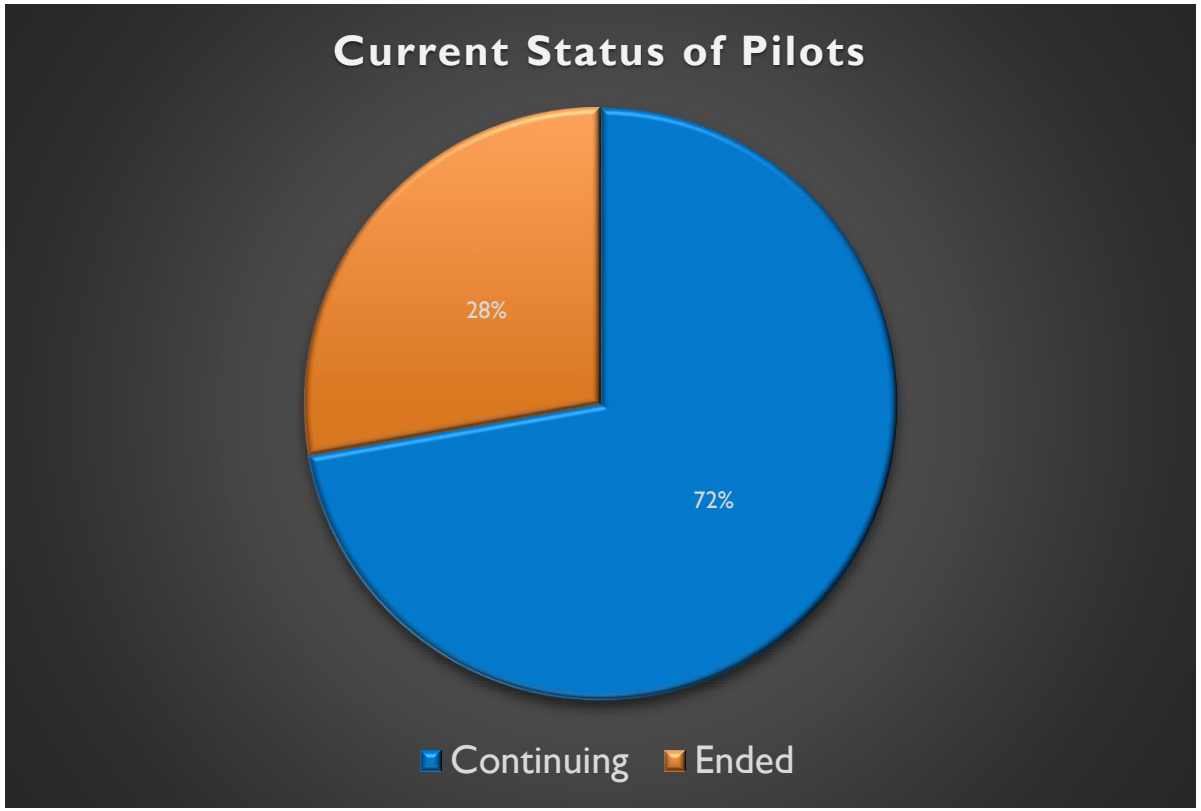
- Survey sent to all past pilots with contact information available
- In-depth interview offered to all survey respondents
- In-depth interviews and survey responses combined and coded for themes in three categories:
  - Positive impact
  - Barriers
  - Learning experiences and reflections

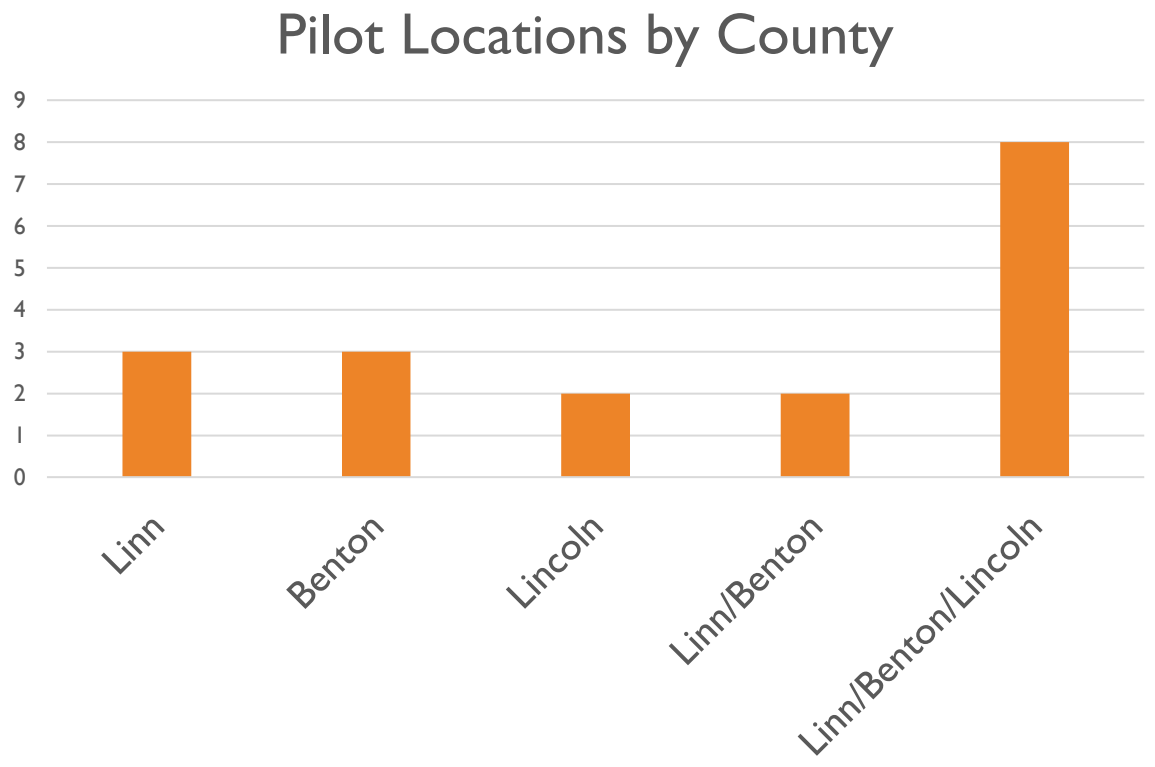
RESULTS

- 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%

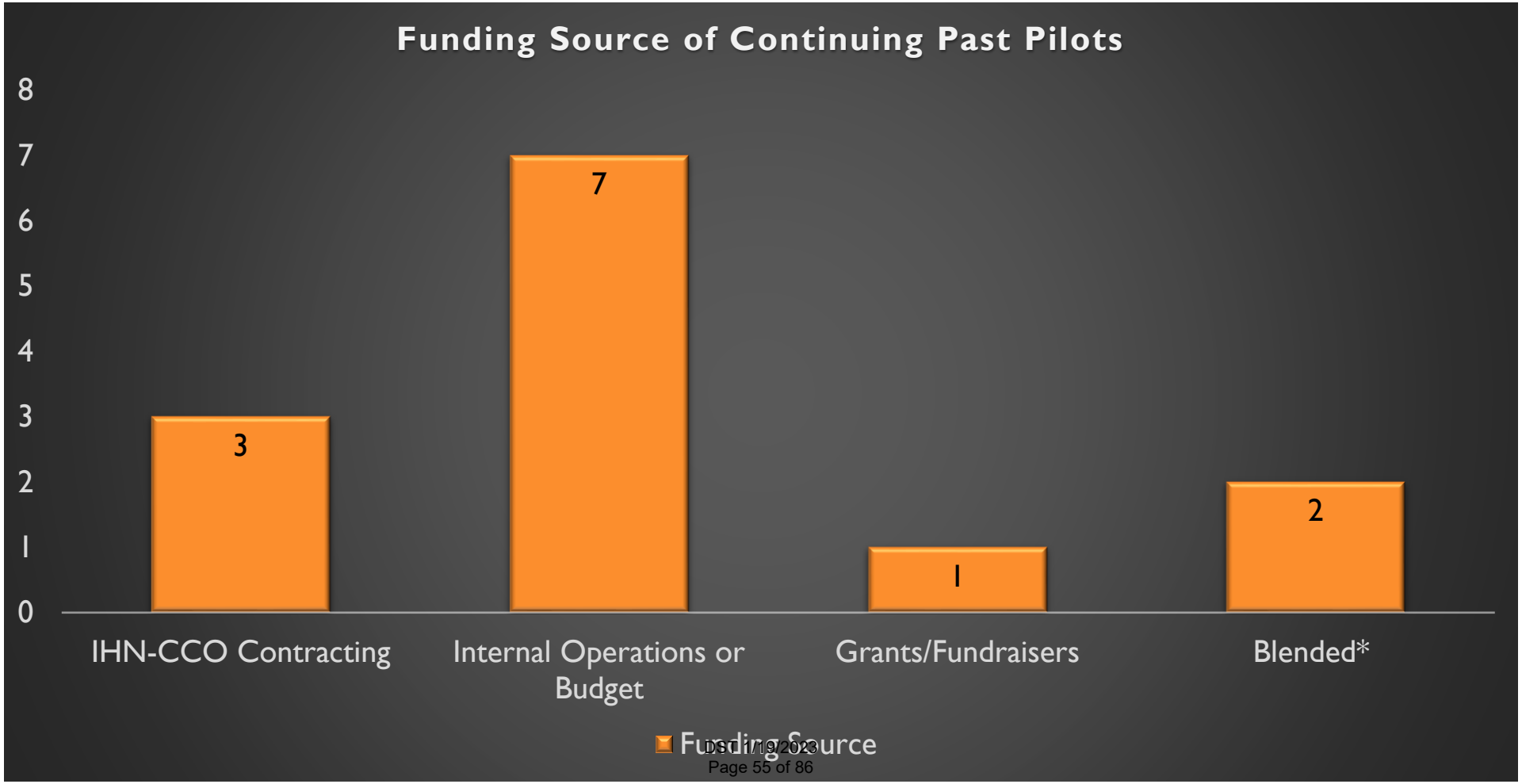


RESULTS


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"

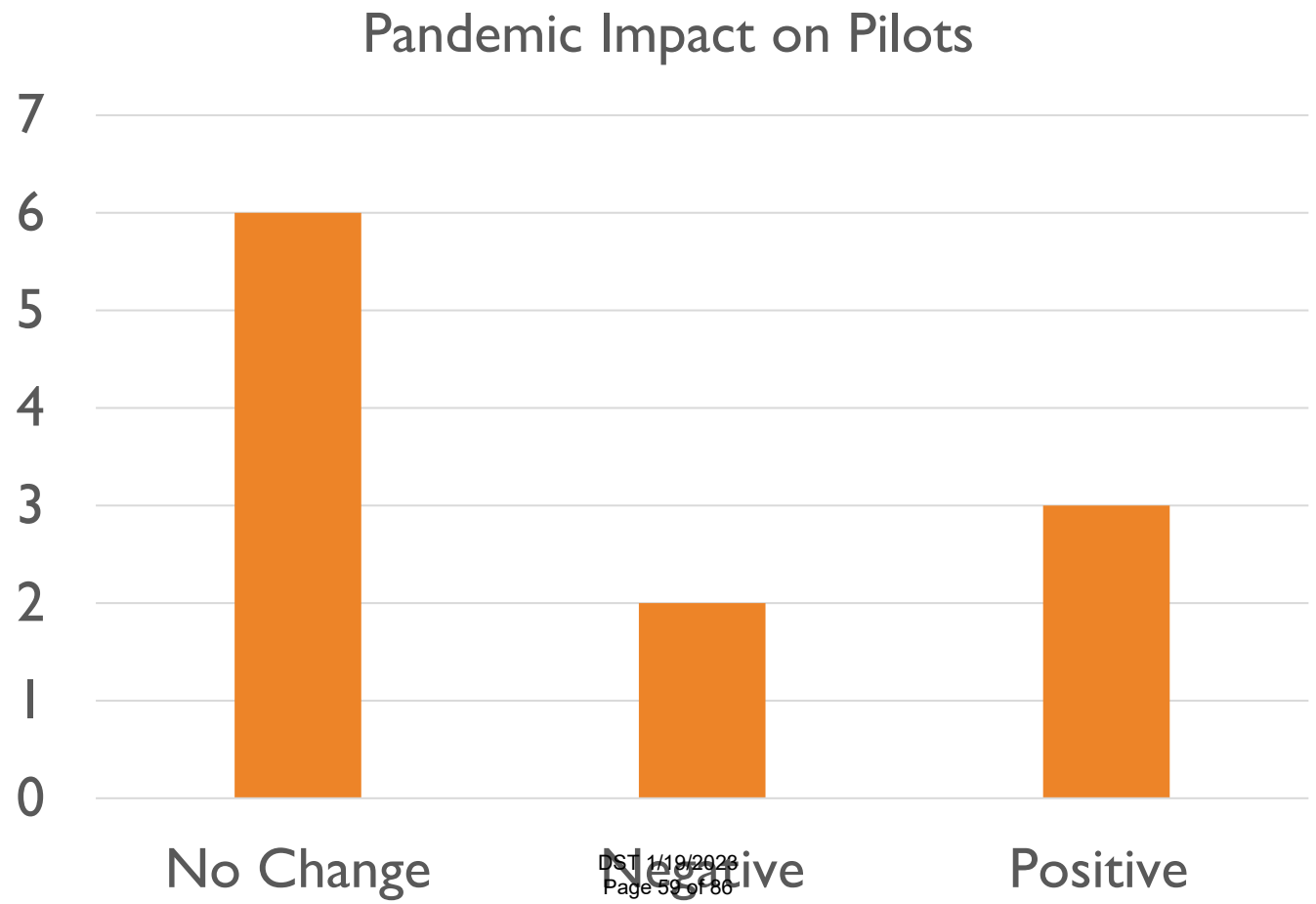
BARRIERS

"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

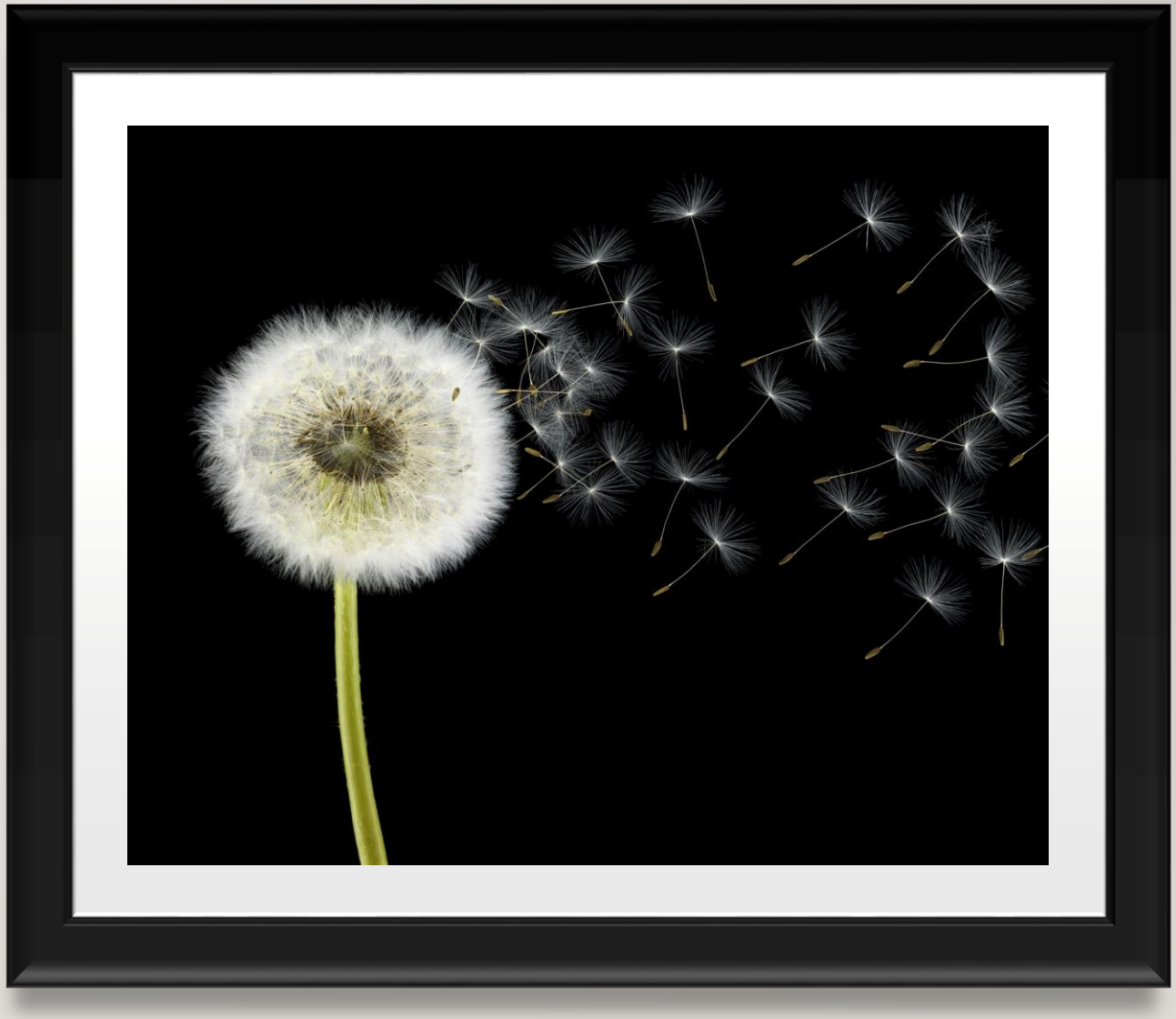


IHN-CCO TRANSFORMATION

PILOT PROGRAMS

2021

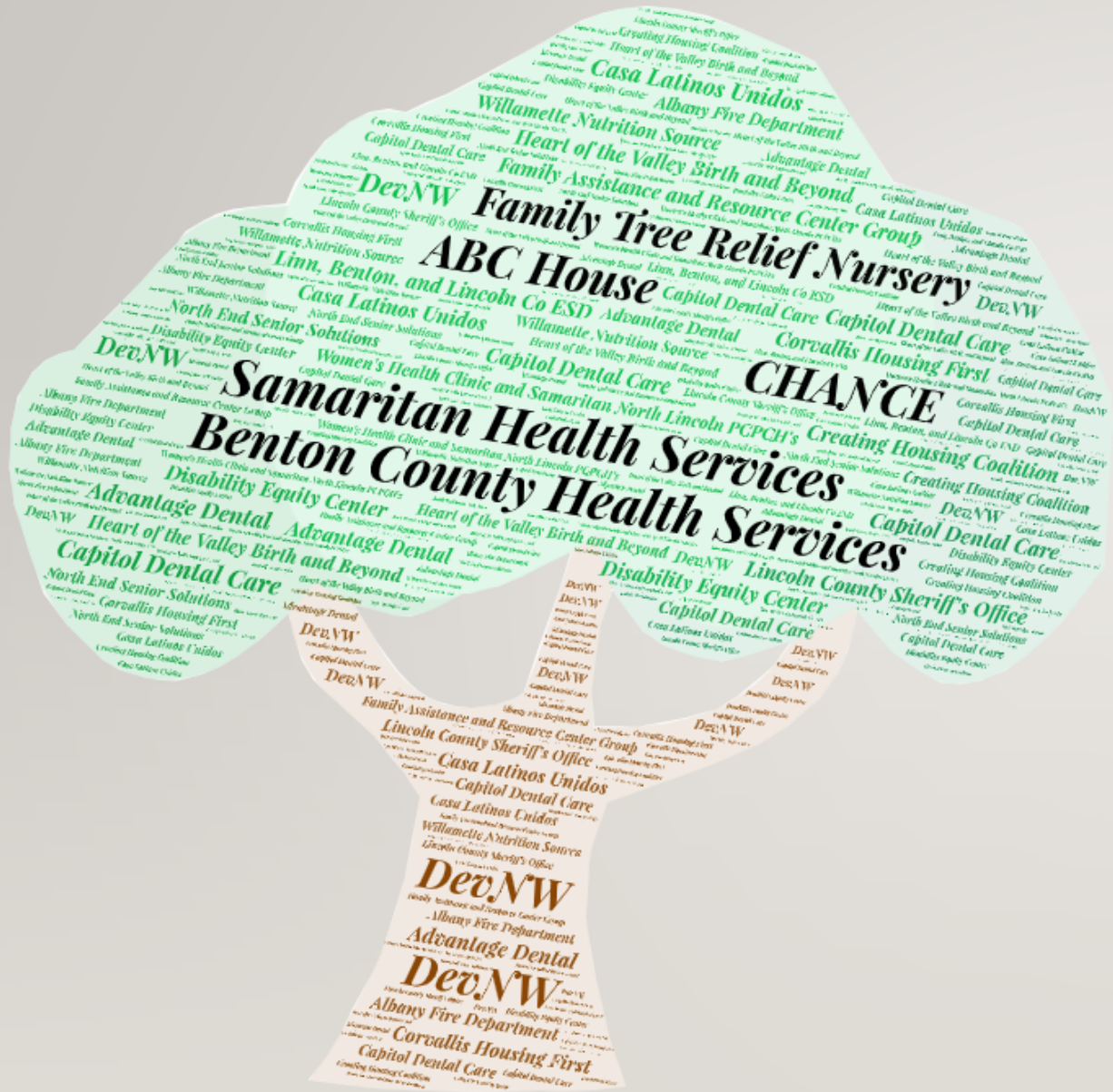
IHN-CCO Transformation pilots began with the Traditional Health Workers Workgroup in 2013. One pilot has since seeded a forest of Traditional Health Worker programs.



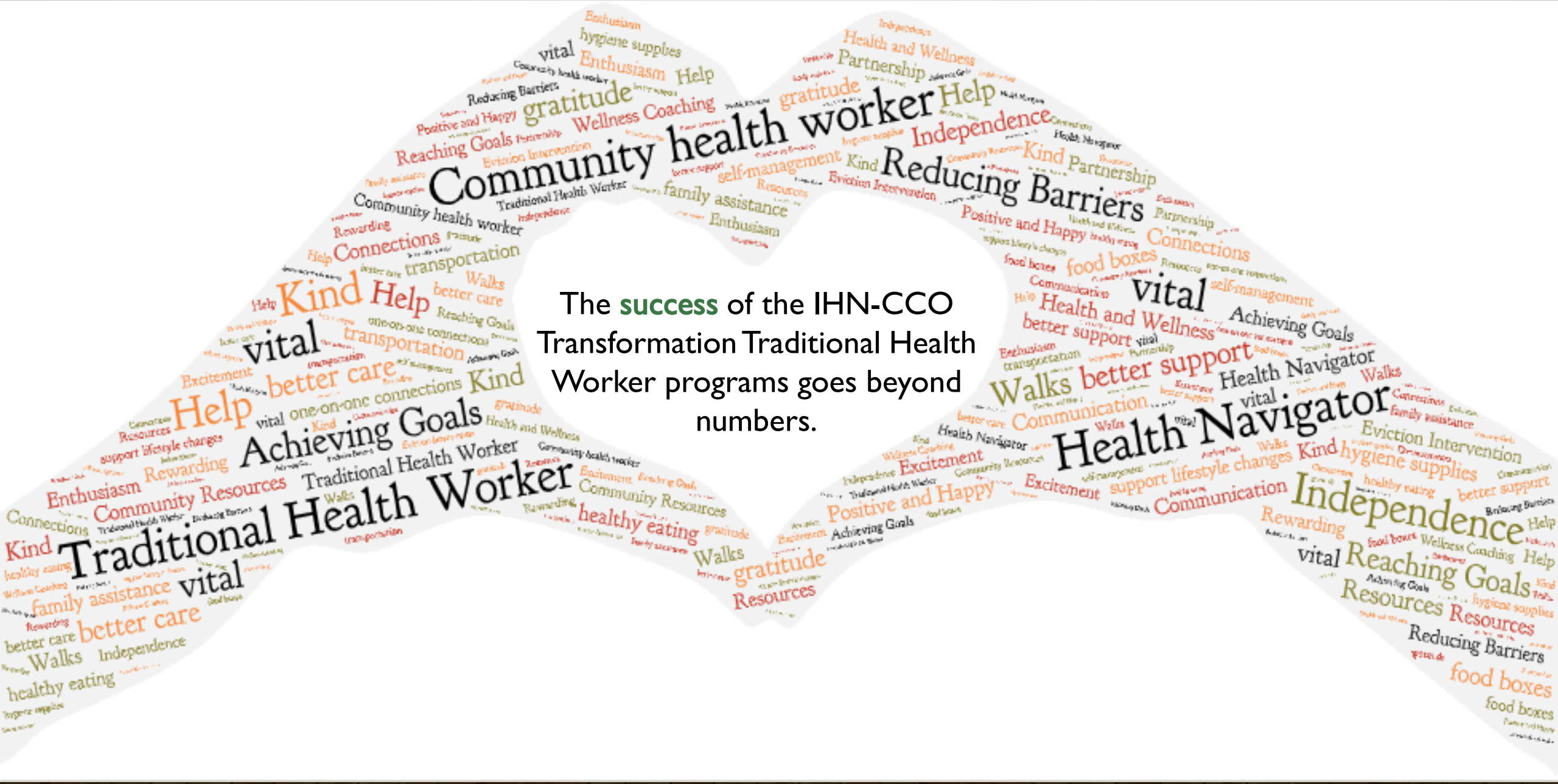
IHN-CCO Transformation Pilot Programs

InterCommunity Health Network CCO

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 hire 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 Delivery System Transformation. The full Request for Proposal (RFP) Guidelines are available at **www.IHNtogether.org/RFP** or by emailing Transformation@samhealth.org. A non-binding Letter of Intent (LOI) is required to be considered for funding.

The LOI must be submitted via IHNtogether.org/RFP no later than **8:00 AM June 3, 2022.**

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 including how it is innovative and will provide new connections or partnerships for IHN-CCO.
2. Which of the following does your project focus on?
    - 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
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 3, 2022
Letter of Intent Due Date:	**June 3, 2022 by 8:00 am**
Issuing Office:	IHN-CCO Transformation
Point of Contact:	Charissa Young-White
	Transformation@samhealth.org

TABLE OF CONTENTS

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 Quadruple Aim of reduced costs, better health, improved access, and improved provider and staff satisfaction.

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 promoting strategies for health equity as an organization and committee, but are also working to support the development, growth, and sustainability of equity-focused, transformational work throughout the region. It is with this commitment in mind that IHN-CCO and the DST strongly encourage providers, agencies, and community-based organizations working within and for marginalized communities to apply. Additionally, to ensure that committee membership, community partners, and pilot champions are reflective of the communities being served, proposals led by innovative change-makers and leaders within marginalized communities are strongly encouraged. In the pursuit of supporting truly equitable and transformational work, the voices, perspectives, and invaluable lived experiences of the diverse communities of the 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
- 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 is 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 IHN-CCO Transformation 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

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 and submitted no later than **June 3, 2022 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. There are two separate pathways, with distinct requirements and timelines, for pilots with a budget of over $50,000 (Large RFP) vs. those with a budget of $50,000 or less (Small RFP). The goal of creating two pathways is to simplify the process and reduce barriers for newer/smaller organizations.

Funding Options: Large and Small

Pilot proposals with budgets greater than $50,000 (Large RFP) will be required to fill out and present to the DST an application including a detailed budget, goals and outcomes, and detailed timeline. Pilot proposals with budgets of $50,000 or less (Small RFP) 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. IHN-CCO Transformation staff work with proposers to ensure that pilot proposals are aligned with the Request for Proposal. Although we do our best to adhere to this timeline, it is subject to change as circumstances occur.

Timeline

Activity	Expected Date(s) Large	Expected Date(s) Small
Request for Proposal (RFP) Announcement	May 3, 2022	May 3, 2022
Question and Answer (Q&A) Sessions	May 17, 2022 May 25, 2022	May 17, 2022 May 25, 2022
Letter of Intent (LOI) Due – Required	**June 3, 2022 by 8:00 am**	**June 3, 2022 by 8:00 am**
Invitations Issued to Submit Full Pilot Proposal	By June 14, 2022	By June 14, 2022
Technical Assistance Meeting – Required	June 14 - July 22, 2022	June 14 - July 11, 2022
Pilot Proposal Due	July 25, 2022 by 8:00 am	July 11, 2022 by 8:00 am
Pilot Presentations to the DST Committee	August 4, 2022 August 11, 2022 August 18, 2022	N/A
DST Committee Decisions	September 1, 2022	July 21, 2022
Pilot Proposers Notified of DST Decision	By September 10, 2022	By July 28, 2022
Regional Planning Council Funding Decisions	October 6, 2022	August 4, 2022
Proposers Notified of Pilot Denial or Approval	By October 14, 2022	By August 11, 2022
Contract Negotiations	November 2022	September 2022
Pilot Contracts Finalized	By November 30, 2022	September 30, 2022
Pilot Invoicing/Payments Begin	January 1, 2023	October 1, 2022

PRIORITY AREAS

Applicants may submit a proposal that addresses one or more priority areas or a subpopulation of IHN-CCO members. Examples of potential areas of focus are included. All proposals must impact a Community Health Improvement Plan (CHIP) Health Impact Area (see tables on pages 6-9).

- Addressing trauma, including environmental
  - Post-pandemic cultural trauma
  - Reduction of wait times for mental health services
  - Toxic stress
- Addressing technology disparities
  - Phone and internet access
- Developing a bilingual and bicultural workforce
  - Traditional health workers reflective of the communities being served
- Innovative programs supporting housing
  - Building a regional coalition of housing programs and partners
- Language access
  - Health literacy
  - Interpreter services
  - 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
  - Disparity in care for rural communities
- Subpopulations of IHN-CCO members that experience health disparities
  - E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, and more

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 (CHIP). Pilots must impact 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. The following is pulled directly from the CHIP. The full plan can be accessed here.

Access to Healthcare	
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 a. Length of time from IHN-CCO enrollment to first appointment b. Length of time from appointment request to appointment for behavioral, physical, and oral health services c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures d. Appropriate physical, behavioral, and oral preventive healthcare for all ages
	Area of Opportunity

	i. Culture of support for healthcare providers
A2: Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.	Indicator Concept a. Percentage of Members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care
A3: Improve integration of oral health services with behavioral and physical health services.	Indicator Concepts a. Percentage of Members who have a dental visit during pregnancy compared to total percentage of Members who have a dental visit b. Percentage of dental assessments for youths in Department of Human Services custody c. Percentage of adults with diabetes who access dental care d. Percentage of Emergency Department visits with a caries-related diagnosis that are followed-up on in a dental care setting

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 Concepts 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 Concepts 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, screenings, 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 & 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*
Child & Youth Health	
Outcomes	**Indicator Concepts and Areas of Opportunity**
CY1: Increase the percentage of children, youth, and families who are empowered in their health.	*Areas of Opportunity* *i. Utilization of advocacy services and supports* *ii. Children, youth, and families partner with their healthcare provider, set their own goals, and follow through on those goals*
CY2: Decrease child abuse and neglect rates.	Indicator Concepts a. Neglect; emotional, physical, and sexual abuse rates
CY3: Increase breastfeeding initiation and duration rates.	Indicator Concepts a. Percentage of women who receive lactation consultation and support during pregnancy and following childbirth b. Breastfeeding rates
	Area of Opportunity *i. The ability to conveniently pump breast milk at work*
CY4: Increase integration of behavioral health and oral care as part of routine primary pediatric care.	Indicator Concepts a. Number of regular behavioral health screenings occurring for pediatric IHN-CCO Members b. Oregon Psychiatric Access Line about Kids (OPAL-K) utilization c. Mental, physical, and dental health assessments for children in DHS custody (Quality Incentive Metric) d. Percentage of teens who had a dental check-up, exam, teeth cleaning, or other dental work
	Area of Opportunity *i. Occurrence of care coordination between primary care and behavioral health providers when working with children, youth, and families, including consultations and referrals.*
Healthy Living	
Outcomes	**Indicator Concepts and Areas of Opportunity**
HL1: Increase the percentage of Members who are living a healthful lifestyle.	*Areas of Opportunity* *i. Disease prevention, management, and recovery* *ii. Nutrition* *iii. Physical activity* *iv. Weight shaming and blaming* *v. Stress* *vi. Sleep quality* *vii. Social supports, such as family, friends, and community*
	Indicator Concepts a. Tobacco prevalence (Quality Incentive Metric), including tracking

HL2: Reduce the percentage of Members who use and/or are exposed to tobacco.	prevalence among Members who are under age 18, pregnant, or who are a Member of another at-risk group b. Use of cessation resources and tools
	Area of Opportunity *i. Youth introduction to tobacco products*
HL3: Reduce sexually transmitted infection (STI) rates.	Indicator Concepts a. Sexually transmitted infection rates b. Expedited Partner Therapy utilization rates
Maternal Health	
Outcomes	**Indicator Concepts and Areas of Opportunity**
M1: Reduce unplanned pregnancy rates.	Indicator Concept a. Effective contraceptive use among partners
	Area of Opportunity *i. Data availability for effective contraceptive use among all Members*
M2: Increase the percentage of Members who receive early and adequate care and support before, during, and after pregnancy.	Indicator Concept a. Behavioral health screenings and access to treatment with a behavioral health provider
	Areas of Opportunity *i. Healthy weight gain during pregnancy* *ii. Utilization of postpartum care and support* *iii. Partner education and involvement*
Social Determinants of Health and Equity	
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*
SD2: Increase the percentage of Members who have access to affordable transportation.	*Areas of Opportunity* *i. Non-medical transportation access* *ii. Distance between Members' homes and public transportation* *iii. Member utilization of available, covered transportation services* *iv. Provider knowledge of, and referral to, available transportation services*
SD3: Increase the percentage of Members who have access to healthy food.	Indicator Concept a. Percentage of Members living in a food desert
	Areas of Opportunity *i. Food security* *ii. Availability of fresh, affordable produce*
SD4: Increase health equity.	*Areas of Opportunity* *i. Health disparities experienced by Members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.* *ii. Availability of health equity data*

PILOT PROPOSAL REQUIREMENTS

Large RFP

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 IHN-CCO Transformation.

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, including an environmental scan of similar projects in the region
      - 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
      - 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 (Specific, Measurable, Attainable, Relevant, Timely) Goals and Measures Table

   Use the Measures and Evaluation Template to show the evaluation plan (this template will be in Microsoft Excel). Include one or more of the outcomes and indicator concepts/areas of opportunity listed on pages 6-9.

All proposals submitted with a budget greater than $50,000 (Large) are expected to present their proposal at a DST meeting. Pilot Proposal Presentations will be scheduled on August 4, 2022, August 11, 2022, and August 18, 2022 (all meetings scheduled for 4:30 to 6:00 pm). Please let IHN-CCO Transformation know if you have a date preference as soon as possible after you are invited to submit a full proposal.

Small RFP

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 IHN-CCO Transformation.

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 (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.

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. All funds must be distributed by IHN-CCO by December 31, 2023.

EVALUATION OF PROPOSALS

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

- **Transformational:** The pilot will be transformative and creates opportunities for innovation and new learning.
- **Health Equity:** The pilot has a defined approach for fair opportunities for members to be as healthy as possible.
- **Health Improvement:** The pilot holds promise for making a significant improvement in the health or health care of members.
- **Improved Access:** The pilot activities will result in improved access of healthcare; availability of services, culturally considerate care, and quality and appropriate care to members.
- **Need:** The proposer has established that there is a substantial need for this pilot and has indicated the demographics of the Medicaid population impacted.
- **Outcomes:** Proposal outcomes and measures are aligned to pilot goals and will be sufficient to evaluate pilot success. The pilot yields measurable outcomes that are new or different. The

pilot outcomes are aligned with the Community Health Improvement Plan's Outcomes and Indicator Concepts.

- **Total Cost of Care:** The pilot will likely result in improvement in the total cost of care for members. The pilot targets areas of health care associated with rising costs or provides upstream healthcare that will reduce costs long-term.
- **Resource Investment:** The budget is reasonable and appropriate to the work proposed. It is well justified and directly tied to the pilot goals. The pilot has exhibited consideration for other funding sources.
- **Priority Areas:** The pilot has a new or innovative way to address one or more priority areas.
- **Financial Sustainability:** The pilot has a sustainability plan including continued funding and new reimbursement models. The project will likely continue after DST funding ends.
- **Replicability:** The pilot has a clearly defined plan to spread lessons learned to new organizations or regions such as rural or urban or a new county in the IHN-CCO community.
- **Depth of Support:** The proposer shows clear and strong depth of sponsoring organization support as well as community backing.

EXPECTATIONS OF FUNDED PROJECTS

Progress Reporting

Semi-annual reporting 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
- 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 currently active workgroups are:

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