Agenda

Delivery System Transformation Committee

June 10, 2021 4:30 – 6:30 pm

Online Click Here: Join Microsoft Teams Meeting

Phone: +1 971-254-1254

Conference ID: 826 171 835#

1. Welcome and Introductions		Beck Fox, Olalla Center	4:30
2. Transformation Update		Charissa Young-White, IHN-CCO	4:45
3. Traditional Health Worker Messaging Project Update	p. 7	Amanda Martin, IHN-CCO Intern	4:50
4. Pilot Evaluation Study Project	p. 13	Lyrica Stelle, IHN-CCO Intern	5:05
5. Letter of Intent/Invitations to Submit Full Proposal Discussion and Decisions		Beck Fox, Olalla Center	5:20
• Request for Proposal 1 (over $50,000)	p. 25		
• Request for Proposal 2 (under $50,000)	p. 58		
6. Wrap Up		Beck Fox, Olalla Center	6:25
• Announcements			
• Next Meeting: June 24, 2021			

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

Delivery System Transformation (DST) Pilots and Workgroups

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

Delivery System Transformation Committee (DST) 2021 Calendar

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

KEY

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

Minutes
Delivery System Transformation Committee (DST)

May 27, 2021 4:30-6:00 pm
Microsoft Teams (Online)

Present			
Chair: Beck Johnson	Charissa Young-White	Abby Mulcahy	Linda Mann
Christine Mosbaugh	Connie Kay	Paulina Kaiser	Crystal Rowell
Richard Blum	Priya Prakash	Renee Smith	Allison Myers
Bettina Schempf	Jenny Glass	Britny Chandler	Kevin Ewanchyna
Shannon Rose	Paige Jenkins	Larry Eby	Dick Knowles
Missy Cheyney	Seynabou Niang	Dawn Donato	Lance Liden
Rebekah Fowler	Gabriel Parra	Sheree Cronan	

Transformation Update: Charissa Young-White

- Letters of Intent (LOIs) are due Wednesday, June 2, 2021 at 8 am.

IHN-CCO Board of Directors Update

- Clean audit reported via KPMG.
- Annette Fowler has been hired as the Chief Operating Officer. Annette came from Cascade Health Alliance, a CCO in Southern Oregon.
- Arcadia, a population health management platform, has been put in place to support IHN-CCO data analysis and metric recording and reporting. This includes gaps in care and to ensure members are achieving optimum health outcomes.
- A Maternity Care Management program being stood up at IHN-CCO.
- Concerning costs of pharmacy drugs compared to the nation. Oregon is working to keep healthcare costs down, but "orphan" drugs often have higher than national costs associated with them.
- IHN-CCO looking at a diabetes management program. Diabetes management is a costly disease partially due to the rising costs of insulin.
- Behavioral health:
    - Lack of beds at the Oregon State Hospital (mental health hospital). CCOs are looking at how they can assist with the capacity issues at OSH.
    - COVID has exacerbated the issue.
    - New rules include that CCOs must pay for members until they reach OSH. These capacity issues are highly concerning to CCOs due to the bottom line and appropriate care for members.
    - Network of providers
- LOCI: Leadership and Organizational Change Initiative is being looked at. The project goal is to improve evidence-based medicine and evidence-based practices.
- Suggestion to including an overview of System of Care (SOC) at a future meeting.
- Community partners are available to assist with programs especially with vaccine outreach to populations.
- Linkage for community partners to peers that have experience especially around the Maternity Care Management program.
- IHN-CCO vaccination rates from 70-79 (55% vaccinated), 65-69 (55%), 15+ (report coming).

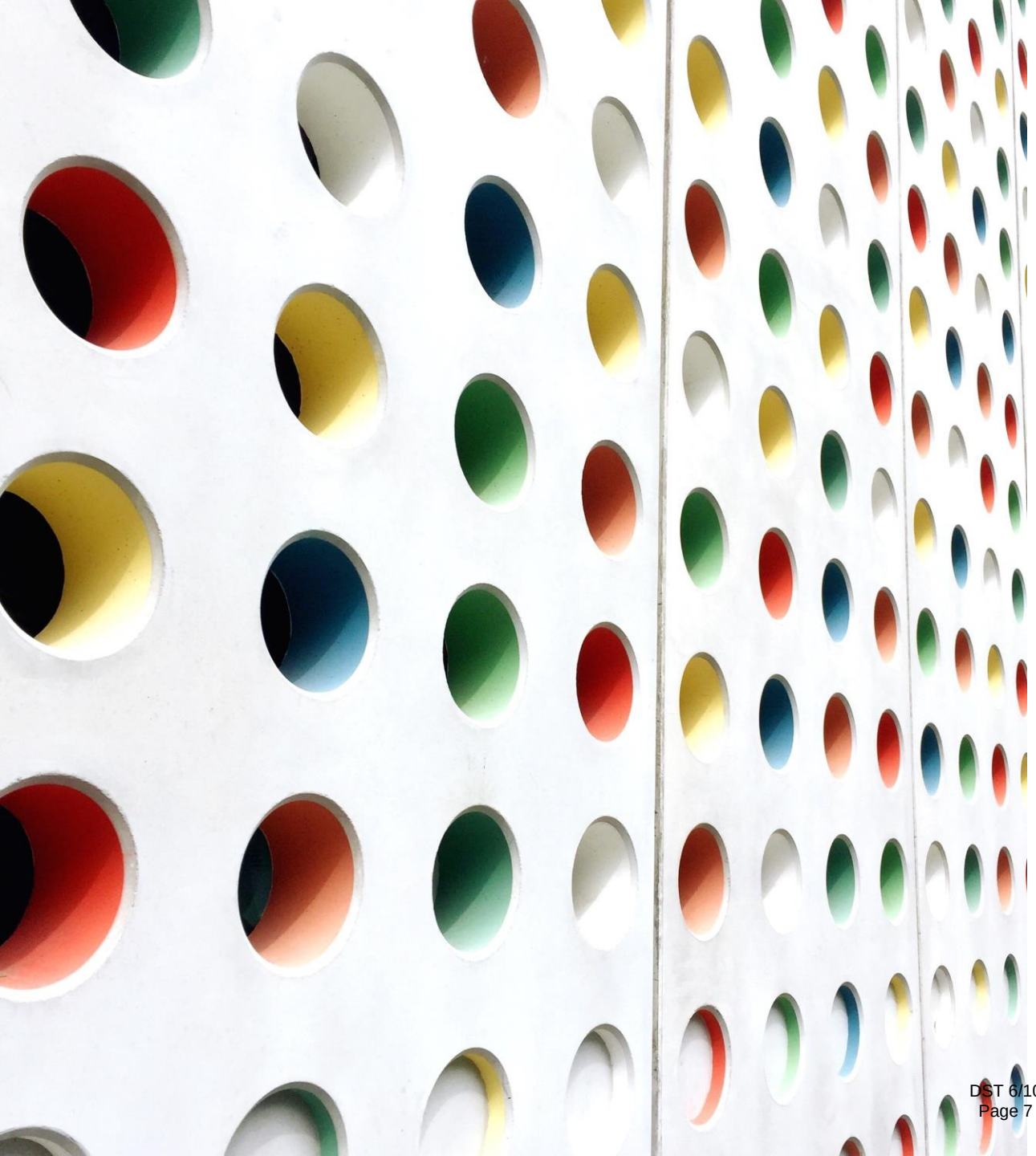
Transformation and Letter of Intent Process

- Discussion on how Transformation (now just one person) should rank the LOIs.
- The process supports the Committee's discussion while choosing what organizations to invite to submit a full proposal.
- The process is in no way decision-making.
- Consensus given that Transformation should continue the process as similar to last year.

- **Decision:** Transformation will rank the LOIs on a 10 point scale for each question of the LOI except description and budget. The ranking will be on priority areas, health outcomes that impact health equity, and partnerships and collaboration.

Proposal Criteria

- The updated matrix and scorecard are agreed on as appropriate by the Committee.
- **Decision:** Adoption of the matrix and scorecard is approved.



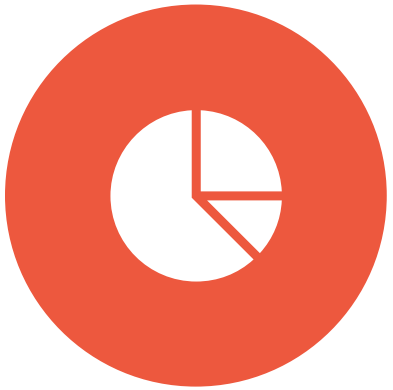
Communication Strategies for THWs and Beyond

AMANDA MARTIN

OREGON STATE UNIVERSITY

PUBLIC HEALTH PROGRAM INTERN

Three Communication Approaches



Broadly applicable for a variety of public health interventions

Applying previous learnings to the THW initiative

Recommendations based on research and partner feedback

Broad Overview of Public Health Communication Strategies

- Using images helps audiences of all literacy levels
- Identify the goal of communication up front
- Learn about specific populations to ensure communication efforts are appropriate
- Input and feedback from stakeholders is crucial
- Combine organization goals and stakeholder feedback for optimal messaging

Situational Application of Public Health Communication

- Potential barrier to successful communication:
  - Interchangeable use of Traditional Health Worker and Community Health Worker
  - Inconsistent definitions across settings and literature
- Potential solutions:
  - Reinforce Oregon Health Authority definitions
  - Build relationships and provide opportunity for questions and clarifications

Recommendations and Community Partner Requests

- Use narrative stories, photos, and other relatable content
- Clarify THWs are not medical interpreters
- Identify stakeholder goals and create unified messaging
- Consult specific community populations regarding appropriateness of messaging
- Be specific about referral criteria and reason for referral
- Incorporate those who are unable to read written English

References

Houts, P. S., Doak, C. C., Doak, L. G., & Loscalzo, M. J. (2006). The role of pictures in improving health communication: a review of research on attention, comprehension, recall, and adherence. Patient education and counseling, 61(2), 173–190. https://doi.org/10.1016/j.pec.2005.05.004

Olaniran, A., Smith, H., Unkels, R., Bar-Zeev, S., & van den Broek, N. (2017). Who is a community health worker? – a systematic review of definitions. Global Health Action, 10(1). https://doi.org/10.1080/16549716.2017.1272223

Oregon Health Authority. (2021). How to Become a Certified Traditional Health Worker. Office of Equity and Inclusion. https://www.oregon.gov/oha/OEI/Pages/THW-Become-Certified.aspx.

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USAID. (2019). Effective Health Communication Strategies. Toolkits. https://toolkits.knowledgesuccess.org/topics/effective-health-communication-strategies.

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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

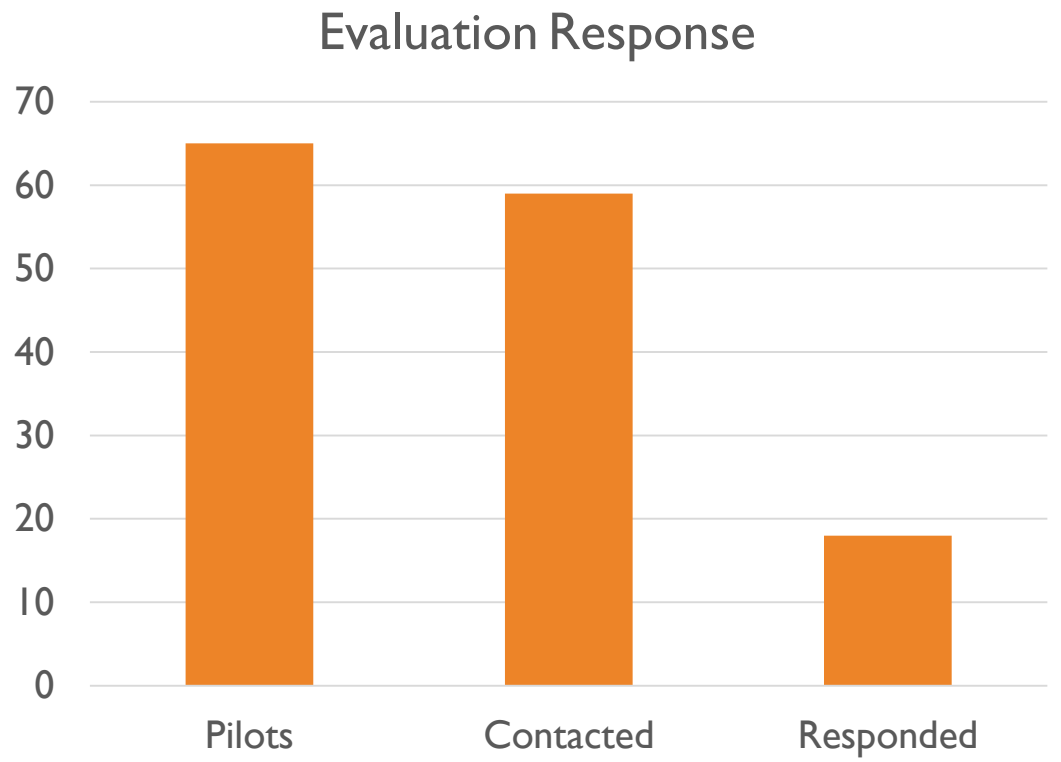
- Identify if pilots are continuing, the organizational commitment, and current funding
- Inquire about replicability, spread, and pilot successes
- Better understand barriers and challenges encountered by pilot
- Determine if any studies or data analysis has been completed and request access to materials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

METHODS

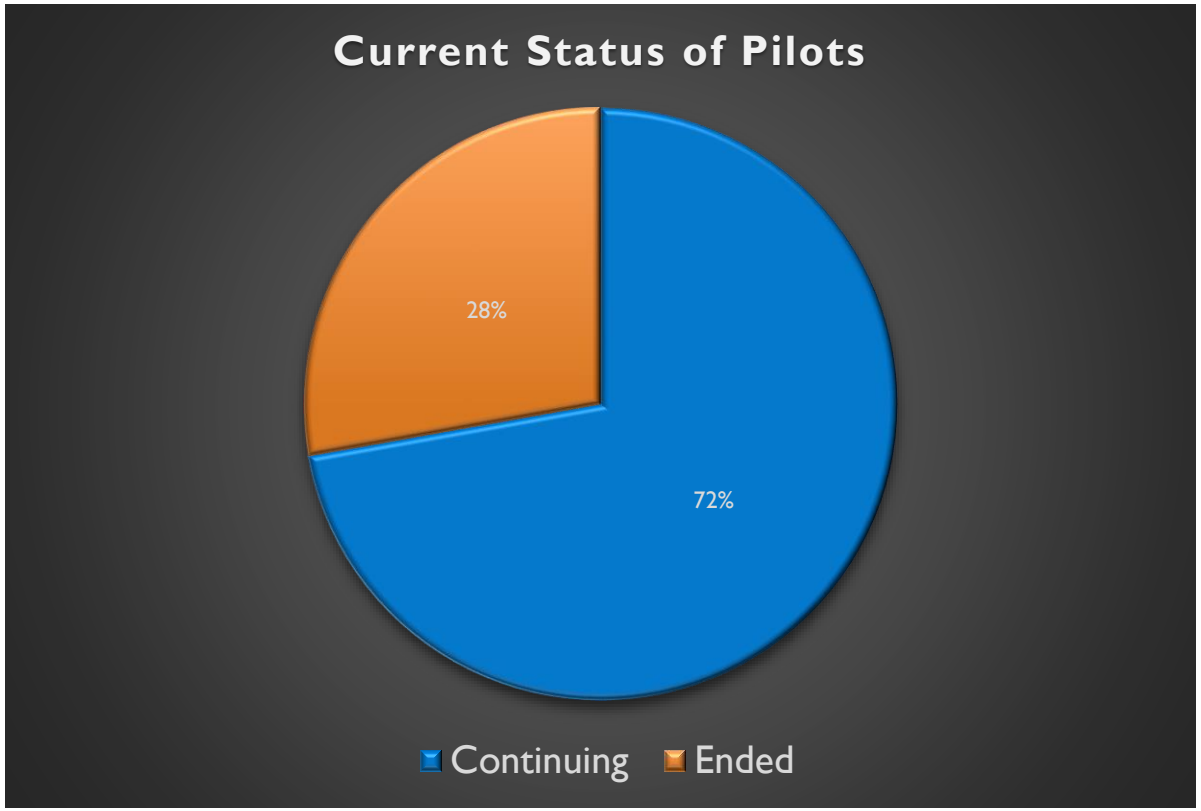
- Survey sent to all past pilots with contact information available
- In-depth interview offered to all survey respondents
- In-depth interviews and survey responses combined and coded for themes in three categories:
  - Positive impact
  - Barriers
  - Learning experiences and reflections

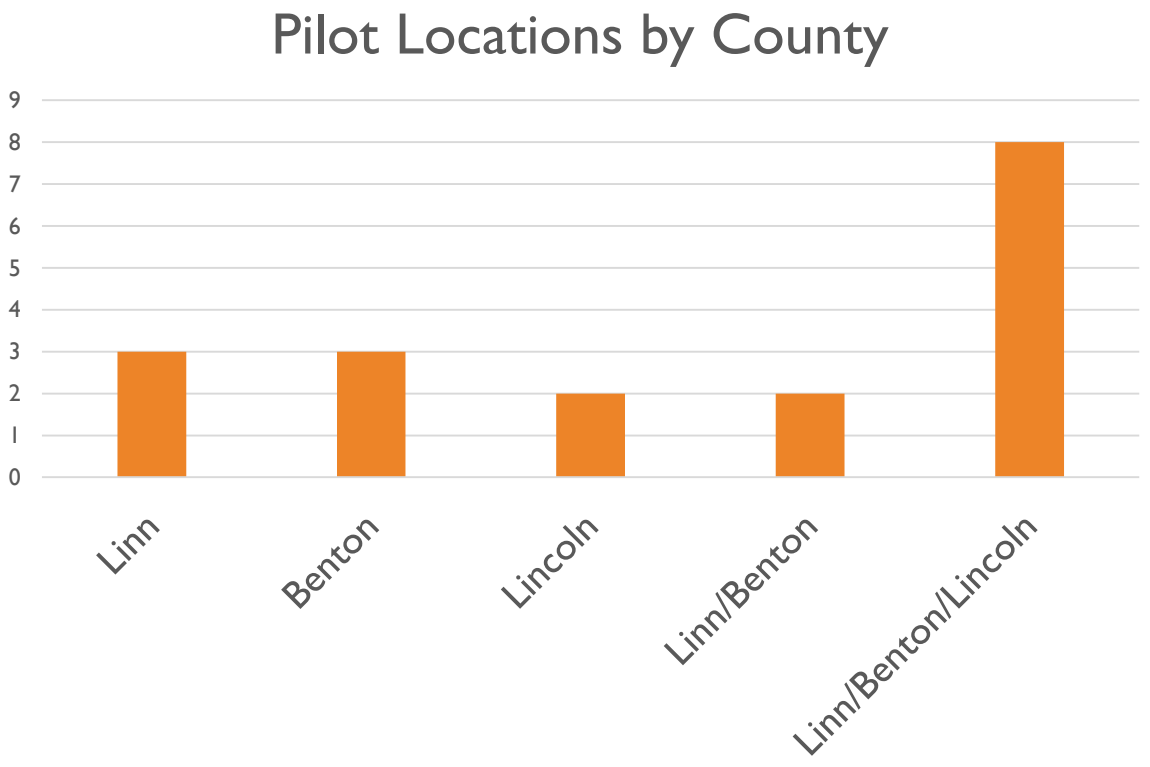
RESULTS

- 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%

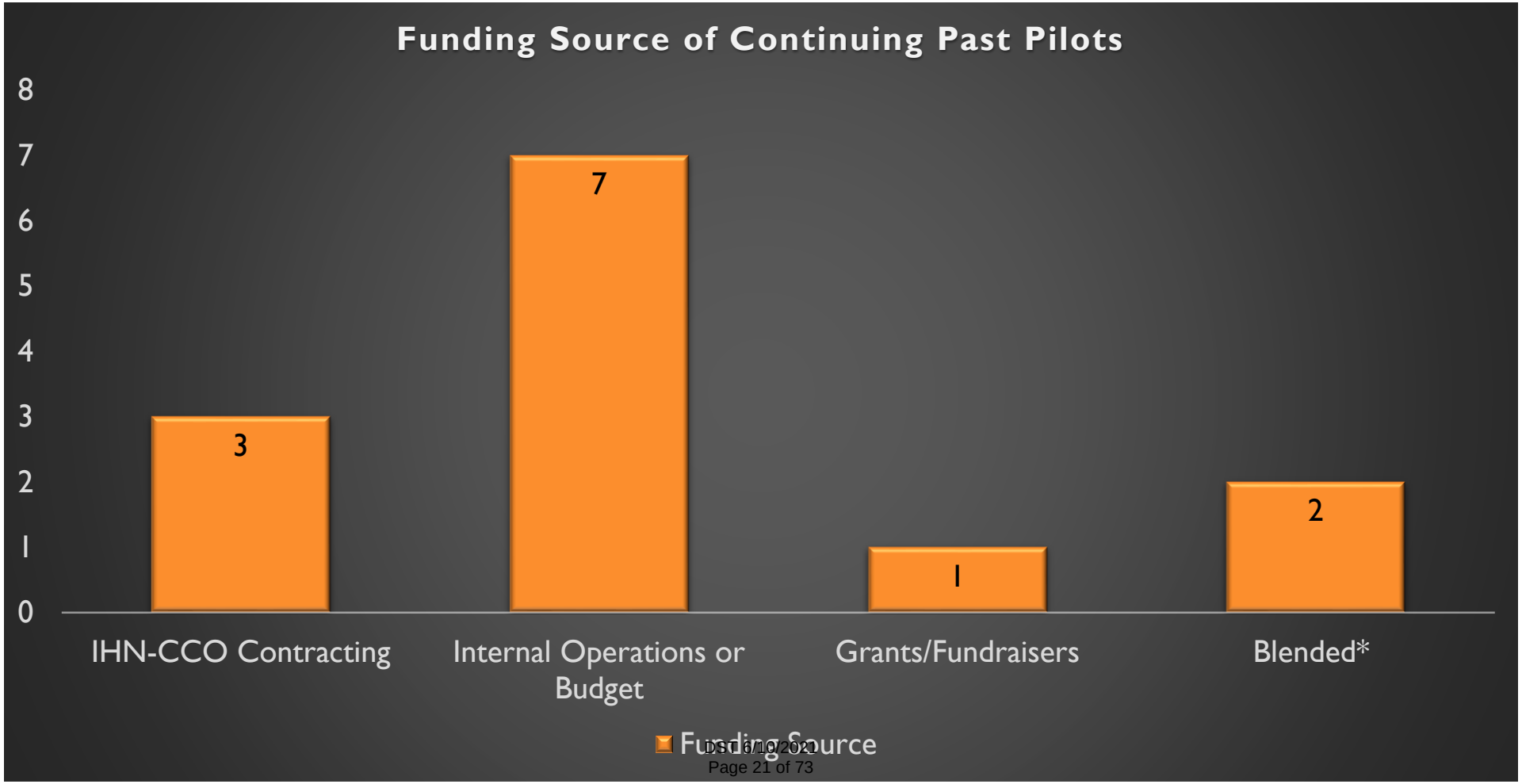


RESULTS


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"

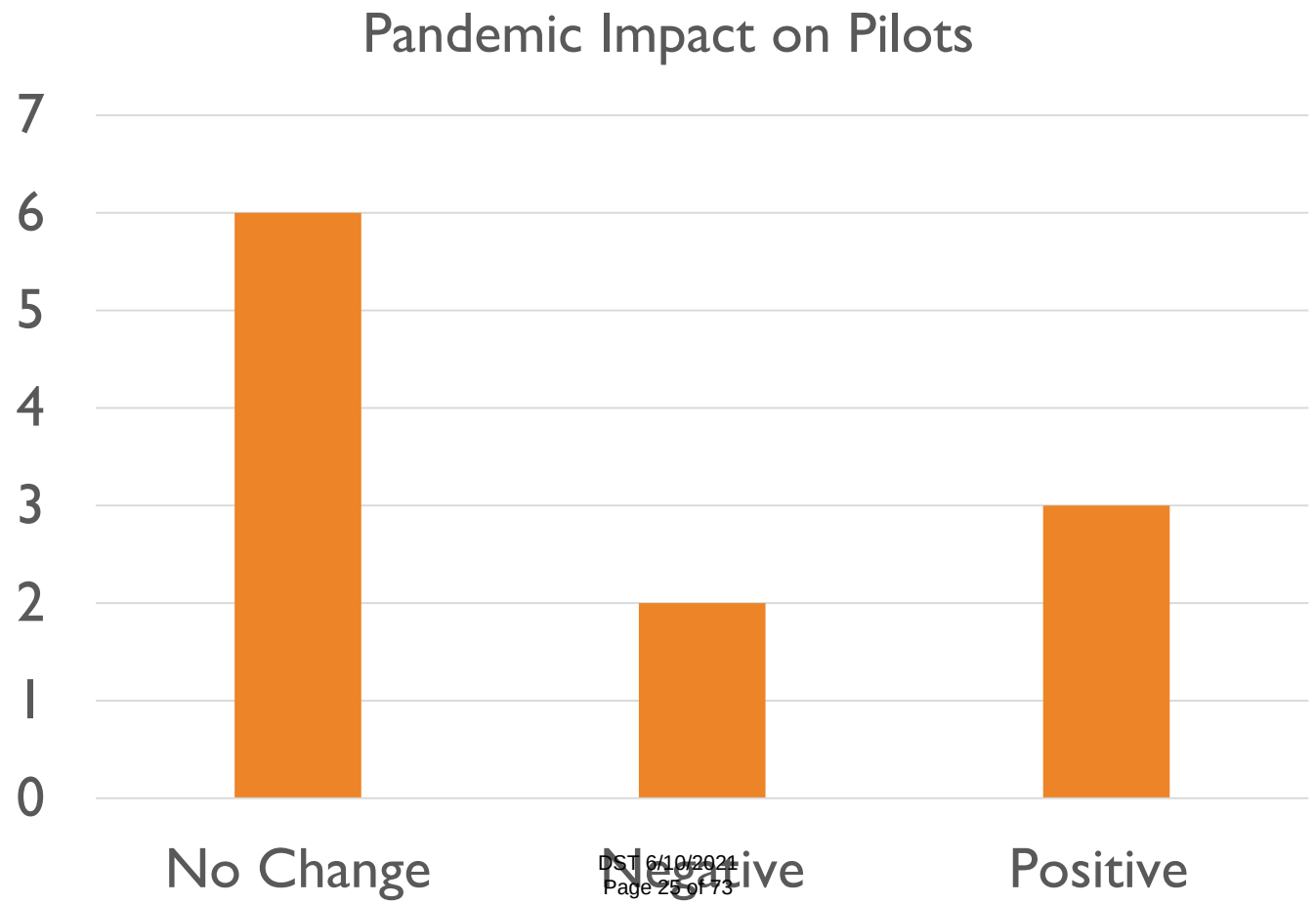
BARRIERS

"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 DST Pilot Letter of Intent Rankings RFP1

	Name	Organization	Priority Areas	Score
Dark Green	Arcoíris Cultural	Olalla Center	Subpopulations; addressing trauma; language access.	27
	Pathfinder Behavioral Health Transformation	Pathfinder Clubhouse	Subpopulations; addressing trauma; behavioral health; pay equity.	27
Green	Culturally Responsive Peer Services	Family Tree Relief Nursery	Subpopulations; addressing trauma; bilingual and bicultural workforce; behavioral health.	26
Light Green	ANNEX-Community Recovery Center	ReConnections Alcohol and Drug Treatment, INC.	Addressing trauma; behavioral health.	25
	Easy A	Sol4ce LLC	Subpopulations; Addressing trauma; behavioral health; language access.	25
Yellow	Therapeutic Treatment Homes	Greater Oregon Behavioral Health Inc.	Subpopulations; bilingual and bicultural workforce; behavioral health.	24
Light Orange	Depression Screenings in Dental Practices	Advantage Dental Services	Behavioral health.	23
	Namaste Rx	Namaste Rx LLC	Subpopulations; addressing trauma; behavioral health.	23
	Parenting Today Forward	OneIIAnother	Subpopulations; addressing trauma; behavioral health.	23
Dark Orange	ED Prevention	C.H.A.N.C.E.	Subpopulations; addressing trauma; behavioral health; pay equity.	21
Red	Primary Care Physical Therapy	Samaritan Lebanon Community Hospital	Addressing trauma; behavioral health.	19

ANNEX-Community Recovery Center

Primary Organization: ReConnections Alcohol and Drug Treatment, INC.

Primary Contact: Lalori Lager

Primary Contact Email Address: lalori.lager@reconnectionscounseling.com

Partnering Organization(s): Options Counseling, My Safe Place, Samaritan House, Next Step Mentoring, SMART Recovery, FAIR

Project Description:

ANNEX PROGRAM SUMMARY:
In January 2021 ReConnections Counseling had the opportunity to lease the old Oregon Coast Community College building on HWY 101 in Newport, Oregon. We consulted with other professionals regarding this opportunity and decided to open it with a focus on being a Community Recovery Center. This Community Recovery Center is operated by peer mentors and case managers to serve those within our community needing supportive services and to connect with local resources. ReConnections Counseling currently has very strong HARM REDUCTION programs. This includes Prime Plus and Nurture Oregon. To us, this translates into a relationship of respect, care, and support for the lived experiences and decisions of each of our clients, no matter their history or present reality. We offer support without judgement in a way that prioritizes needs. The person coming into the community recovery center does NOT have to be a client of ReConnections Counseling to get services and navigation services provided.

At the Community Recovery Center, multiple resources will be offered to help individuals build capital at the community level by providing advocacy training, recovery information, and resource mobilization. Another goal of the Community Recovery Centers is to help facilitate supportive relationships among individuals with substance abuse and mental health disorders. In turn, the increase in resources in one facility helps individuals initiate, sustain, and support healthy behaviors over time. Community Recovery Centers also play a unique role that builds on professional services and mutual-help organizations by connecting individuals to social services, employment, and life skills training in one facility. ReConnections Counseling will have multiple peer staff onsite to support and refer community clients to social services available in Lincoln County. ReConnections Counseling believes in the use of Peer Support and Behavioral Health Navigation. These positions are evidence-based and are shown to increase retention and satisfaction with social service referrals.

THE ANNEX Current Harm Reduction Community Intervention Partners Include;
Prime Plus Peer Program- a response to the continuing challenges of the substance overdose and health epidemic, and aims to mitigate the negative effects of substance use by actively and proactively engaging people who are at risk of substance overdose

or who have been hospitalized for substance use related medical conditions, but are not at readiness to pursue substance use treatment. Peer services are a proven method of fostering readiness for treatment while reducing harm of ongoing substance use, thus increasing the likelihood of recovery and leading to better health outcomes.

Lincoln County Health and Human Services Harm Reduction-Syringe Exchange

Next Step Mentoring- Leanne Walsh

Nurture Oregon- Nurture Oregon is an integrated care model providing services for pregnant families with peer support, maternity care, substance use treatment, and social service coordination.

FAIR-(Families Actively Improving Relationships)

LEADS-Law Enforcement Assisted Diversion Navigation

OPTIONS COUNSELING, MY SAFE PLACE, TURN KEY, SAMARITAN HOUSE and other community resources will be utilizing the facility to provide services in a non clinical location that improves access to behavioral health and social services in a non traditional facility.

ReConnections will be asking for $5000. per month for the rent of this facility to be paid. This allowing the social service community partners to use the facility for FREE. This being the example of community partners working together to improve access. ReConnections Counseling recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively engaging in services. The community recovery center is a non traditional approach to access, that allows Reconnections and community partners to engage people meeting them were they are at.

I would encourage DST to discuss this Community Recovery Center with Sheryl Fisher as she attended the open house.

Which of the following does your project focus on?

- Addressing trauma
- Increasing and improving access to behavioral health care in light of COVID-19
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

ReConnections Counseling currently has very strong HARM REDUCTION programs. This includes; Prime Plus and Nurture Oregon. To us, this translates into a relationship

of respect, care, and support for the lived experiences and decisions of each of our clients, no matter their history or present reality. We offer support without judgement in a way that prioritizes our clients' needs.

ReConnections Counseling recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively engaging and accessing services. When a person enters into The ANNEX the Behavioral Health Navigator starts with offering them food, coffee, and to enter into a trauma informed facility that is very non traditional.

The Behavioral Health Navigator completes a 2 page Strength and Needs Assessment when a person feels comfortable in the facility. Based on this assessment the Behavioral Health Navigator with a hands on approach helps people identify their social determinants of health, and makes appropriate referrals to reduce disparities.

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?

$5000.00 per month to pay rent for one year. $5000.00 x 12 months=$60,000

Arcoíris Cultural

Primary Organization: Olalla Center

Primary Contact: Kendall Cable

Primary Contact Email Address: kendallc@olallacenter.org

Partnering Organization(s): Lincoln County School District, Juntos en Colaboracion, Oregon State University, Community Services Consortium

Project Description:

Conversations about health equity and health disparities are so often conducted in dominant culture spaces. This inevitably leads to needs assessments, strategizing, and solutions work done through a dominant culture lens, which may or may not reflect the actual needs of the community being served, or those needs not being met in a culturally appropriate manner. It is one thing to tell a community, “We are going to support you,” and another to ask them, “How can we support you?”

Over our 40-year history as a non-profit in Lincoln County, Olalla Center has remained dedicated to our mission to help strengthen and heal individuals, families, and our community. The depth of this mission has grown as we have, and has expanded far beyond mental health services to include community health and outreach as an integral part of the work we do, because we believe that healthy people start with healthy communities.

We invite you to imagine you are Hispanic, Latina/o/x or Indigenous, and have relocated to a different country where the culture, society, language, rules, lifestyle are unlike your own. You have left everything you have ever known behind. You find yourself in a place where you may not know anyone, and information is not presented in your language. You may face daily instances of harassment, discrimination or microaggressions, and feel disconnected from everything that reminds you of home.

Now, imagine you were told about a place that would welcome you with open arms - a place built by and for people perhaps similar to you. In this place, you could feel safe; you could hear and speak your language, find opportunities to socialize with community members, and engage in the deeply meaningful joys of traditional art, music, and food. In this space, you could access a wide variety of educational resources on topics such as nutrition, language, and preventative health, as well as receive navigation assistance to help you move through unfamiliar healthcare and social service systems. Many of the people you encounter would already have ties here, and be able to be a source of understanding and support for you as you work through the difficult, and oftentimes very painful, transition to life in a new country. In this space, your cultural identity is not something to be changed or forgotten, but honored and encouraged to thrive in an environment of respect, compassion, and the beauty of exchanging new ideas with

people that may be different from you, with stories different from your own. This center, Arcoíris Cultural, is the vision of Olalla Center. Arcoíris in Spanish means rainbow, and is reflective of the vibrant diversity of our many different cultures.

Research has shown us time and time again that community connection increases health outcomes, decreases mortality, and creates a buffer from the impacts of depression and stress. Additionally, it has shown us that this work is most impactful when it is championed from within the communities being served. Honoring the importance of lived experience, Arcoíris Cultural would grow through the leadership of bilingual, bicultural staff, along with a rich network of community support. DST pilot funding would allow Arcoíris Cultural to lay the groundwork of this vision - promoting the growth of Hispanic, Latina/o/x and Indigenous communities in Lincoln County through culturally-specific arts and services - and later create a free-standing, physical center where these communities can find, and build together, a home away from home.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Language access including health literacy, interpreter services, and translation of materials

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

The overall health and wellbeing of the service population (Hispanic, Latina/o/x and Indigenous communities, including migrant and seasonal workers) would improve through access to culturally-specific arts, health education, and service navigation provided at Arcoíris Cultural. Specifically speaking, mental health (feeling connected to community, feeling safe, reduced stress and feelings of depression, and access to trauma-informed services), physical health (building good nutritional habits, and access to translated educational materials, healthcare interpretation services and trusted providers), and spiritually (the arts and meaningful social connection as a driver) are the trifecta of our goals.

Equity would be also achieved through Arcoíris Cultural continuing Olalla Center's current role of advocacy, Oregon Health Plan application assisting, healthcare navigation to population-appropriate health care and dental practitioners, and other assistance such as vaccination. Arcoíris Cultural would focus on the Hispanic, Latino/a/x and Indigenous population of Lincoln County in terms of leveling health disparities, lowering the trauma of cultural acclimation through community engagement, and promoting health literacy and access through interpretation and translation. Additionally, this project will benefit IHN-CCO member children whose parents are undocumented and receiving CAWEM, thereby improving access to healthcare and health education for the entire family.

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?

The concept of Arcoíris Cultural would be unlike any other organization or program in Lincoln County in that it is culturally-specific in tailoring both service and creating community of the Latina/o/x and Indigenous population in tandem.

1. Arcoíris Cultural's vision fits hand in glove with Lincoln County Community Health Department's Health Improvement Plan 2019-2024 by: Improving nutritional access and education, promoting activity, and community building. Thus, Arcoíris Cultural would partner with Lincoln County Public Health, and Samaritan Health Services, to reach the Latina/o/x and Indiginous populations through health education and activities.

2. Arcoíris Cultural would continue Olalla Center's work with Juntos en Colaboracion and Oregon State University Extension Office in regards to community gardening and nutrition education - with the goal to expand access in both areas. These two organizations along with Acompañar, and Lincoln County School District have been imperative in reaching Olalla Center's service communities. It is the plan of Arcoíris Cultural to continue to partner in this effort.

3. Arcoíris Cultural would work with Lincoln City Cultural Center, Newport Visual Arts Center, Newport Performing Arts Center, and city and county governments for space and coordination of culturally-centered events.

4. Arcoíris Cultural would continue Olalla Center's partnership with OHA in terms of funding of OHP assisting, health navigation, and other programs.

5. Arcoíris Cultural would continue partnerships with Newport Food Share, local Mexican grocery stores, and restaurants to promote healthy, culturally-appropriate meals, as well as opportunities to learn about nutrition, cooking, and the importance of sharing food as a community.

6. Arcoíris Cultural would partner with Dr. Gavin Shumate of Integrity Women's Health and Wellness in promotion of health education events, particularly in relation to reproductive health and transgender/gender diverse health.

7. Arcoíris Cultural would also collaborate with Oregon Central Coast PFLAG to provide outreach, education, and advocacy to the benefit of both LGBTQ+ individuals and allies.

8. Arcoíris Cultural would partner with local churches and faith communities, including Iglesia de Dios (Guatemalan church) and St. John's Episcopal Church.

9. Arcoíris Cultural would partner with Community Services Consortium for workforce and education, housing and utilities assistance, and other community resources.

10. Arcoíris Cultural would partner with Oregon Latinx Leadership Network, continuing the Olalla Center partnership.

Culturally Responsive Peer Services

Primary Organization: Family Tree Relief Nursery

Primary Contact: Renee Smith

Primary Contact Email Address: rsmith@familytreern.org

Partnering Organization(s): Milestones Treatment Centers, Linn County Alcohol and Drug

Project Description:

This innovative project will bring together three regional partners in a coordinated, collaborative and innovative approach to expand access to culturally responsive peer services in our region. The project will focus on improving access to behavioral health services in non-traditional ways while developing a bicultural and bilingual workforce to support the Indigenous and Latino/a/x IHN members in our communities impacted by Substance Use Disorder (SUD). The goal of this project is that this innovative model embedded in the community where members experience their disease, coupled with expanded culturally responsive peer services for communities of color will lead to more positive health outcomes for IHN Latino/a/x and Indigenous members that are suffering from Substance Use Disorder.

According to a 2017 report by the Oregon Substance Use Disorder Committee 6.4 % of Latino/a/x individuals and 9.7% of Native Americans meet the diagnostic criteria for SUD, compared with 6.1 percent of whites. This project will incorporate the learnings and research that informs evidence based services for members of these communities in accessing treatment for SUD including assessments and peer support.

The first component of the project will be to gather information by holding listening sessions and conducting surveys with IHN members who identify with the Latino/a/x and Indigenous communities and discover what needs they have for SUDS services, what challenges they face and what gaps exist. Each organization will leverage their contacts with these communities for these listening sessions and surveys. The results of these listening sessions will inform the creation of an advisory group with representation of each community along with A & D professionals with experience in this area to guide the formation and implementation of these services. This information will be used to develop culturally responsive peer services by peers that identify with the Latino/a/x community and the Indigenous members communities. This will include credentialing as Peer Support Specialists as well as specialized training components for the specific needs of the communities they align with. Ensuring the creation and delivery of these educational opportunities will be in consultation with and led by members is a priority of this program. Developing training and models that ensure cultural responsiveness is critical for the project. Milestones Recovery Centers with their connections and shared lived experiences with the Native community and tribes will lead the culturally

responsive work for the training creation for Indigenous Peers and we are consulting with Kelly Volkmann and Benton County Health Services CHW and Health Navigator teams to assist us in connecting with other collaborators in the Latino/a/x community as well as sharing their expertise. organizations who can assist with training and cultural knowledge for our Latino/a/x communities.

This approach will provide workforce development opportunities for PSS and PSW positions held by members of the Latino/a/x and Indigenous communities with a goal of delivering fully culturally responsive PSS and PSW supports to individuals of these identified underserved populations of IHN members.

An additional innovative approach will be developing a pathway for IHN members to access assessments in a community or home setting outside of the medical care homes. Partnering with Linn County A & D, Family Tree will credential CADC1 staff that can perform SUD assessments in the field including, community settings, individuals homes, parks, cars, wherever the member is, in that moment that they recognize they want something to change. This will allow for quicker and supported access to treatment opportunities as the assessment will come to them and not require them to leave their location and travel to an assessment provider's location. PSSs will support members in this moment and assist with the support needed to transition from their community location to treatment provider locations Payment for these assessments will be coordinated through Linn County A & D in a process created during this pilot for a long term sustainability of this portion of the pilot. Additionally, Milestones will assess their organization's capacity to have their PSS provide services out in the community rather than only at their organization’s sites. This would be an innovation for their organization as they have not previously considered this change in service delivery.

The project’s overarching goal is that with the combination of these approaches, we can create innovative access to assessments for SUDs with a shorter time from assessments to treatment with culturally competent peer support services for the Indigenous and Latino/a/x IHN members for support throughout the intervention treatment and recovery services.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Developing a bilingual and bicultural workforce
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

The project expects to impact and improve the following health outcomes for IHN members, particularly, Latino/a/x and Indigenous members by:

- A1: Increase the percentage of members who receive appropriate care at the appropriate time and place
    - Provide services with trauma informed and culturally responsive approach for IHN Members experiencing systemic trauma in their lives and in their cultural communities.
    - Provide appropriate SUD assessments and peer services for Latino/a/x and Indigenous IHN members in non traditional ways.
- BH3: Increasing substance use screenings, services, referrals, and access to peer and parent support.
    - Increasing SBIRT rates of participating members.
    - Decreasing rates of suicidal ideation, attempts, suicide, and/or self harming behaviors of participating members.
    - Overdose rates in participating members.
    - Making available and increasing SUD use services, screening, and referrals in venues other than traditional medical facilities.
    - Delivering culturally responsive peer delivered education and support. Referral to family stability services for individuals with children.
- SD4: Increase health equity
    - Reduce health disparities experienced by members due to race or ethnicity when accessing SUD services with addition of culturally responsive peer services for Latino/a/x and Indigenous IHN members.

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?

This project connects with the growing work of spreading THW practices and services across IHN's service region. Additionally, we believe that this project aligns with our region's focus on increasing equity in healthcare and social service to address the impact of structural racism that exists in our region today. We acknowledge we are a part of the dominant culture and that we are working to dismantle this racism within and throughout our region. This project goes beyond the spread of practice, by looking deeper at how to develop and deliver peer support services that are culturally responsive to the Latino/a/x communities and members of Indigenous communities.

Family Tree's participation in the THW workgroup connects us to the variety of THW and peer services developing in our region. We are aware of a variety of other organizations developing peer services and are not aware of others considering this development at this time. We recognize the overwhelming impact of COVID on organizations with THWs and that many have pivoted multiple times to serve the growing, changing and acute needs of individuals suffering from SUD in our communities. We look forward to working closely with other peer organizations and supporting their work as we recover from the impact of COVID on not only the members we serve but our organizations.

We plan on listening to community members and partners who identify and align with

these cultural groups and learn from their ideas and knowledge on how to best serve their communities with assessment and peer services. We recognize that our organizations will need to change and be responsive to the unique needs of this staff and the IHN members we offer services to. We plan on expanding our connections and collaborations with additional organizations and individuals as we progress with this project. As part of the pilot, we will be looking for additional community organizations and connections with native tribes beyond the project partners to collaborate and learn from so that we can meet the goals of this pilot and the goal of increasing healthcare equity for IHN members across our region . We have connected with Kelly Volkmann and the Benton County Health Services CHW team and they have agreed to assist us with these connections during the early stages of the pilot.

Depression Screenings in Dental Practices

Primary Organization: Advantage Dental Services

Primary Contact: Molly Johnson

Primary Contact Email Address: mollyp@advantagedental.com

Partnering Organization(s): IHN CCO Care Coordination Department, Benton County Mental Health, Linn County Mental Health, Lincoln County Mental Health

Project Description:

Patients with behavioral health issues can access the behavioral health system in numerous ways and places but there remains an important missing portal to mental health and addictions treatment, specifically the oral health system. Dental providers are an integral part of the health care system yet those who see OHP enrollees have no easy way to refer IHN members to behavioral health services.

To bridge this gap, Advantage Dental would like to implement depression screening in dental practices, and create a referral pathway to behavioral health for members with behavioral health needs as identified through the screening process. The depression screenings will be conducted using the vetted Patient Health Questionnaire (PHQ-2) and PHQ-9 forms, which are widely used in primary care. The PHQ-2 will be used first. If positive, the PHQ-9 will be used. The depression screenings will be piloted in three Advantage Dental practices - Albany, Corvallis and Newport. All completed screenings will be sent to an Advantage Dental Care Coordinator. The Care Coordinator will initiate a referral to behavioral health based on answers to the screening questions. Referrals will be made by contacting IHN CCO's Care Coordination Department. Members in crisis will be referred directly to the applicable County Mental Health Program.

Which of the following does your project focus on?

- Increasing and improving access to behavioral health care in light of COVID-19
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Advantage Dental is committed to Oregon's vision of coordinated health care and breaking down the silos between dental, physical, and behavioral health. We know that depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning. Identifying and treating depression in its early stages is critical. Our goal is to increase access to depression screenings by providing them in dental offices. This also promotes equity and strives to reduce health disparities.

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?

This project strives to improve access to behavioral health services in non-traditional ways. We plan to collaborate with IHN CCO's Care Coordination Department and the County Mental Health Programs, as appropriate.

Easy A

Primary Organization: Sol4ce LLC

Primary Contact: Sharna Prasad, PT DPT

Primary Contact Email Address: sharnapras@aol.com

Partnering Organization(s): Corvallis School District, Oregon State University College of Public Health, American Physical Therapy Association-Oregon, Ralston Academy. in Lebanon

Project Description:

Our project is innovative because it seeks to take a primary preventative approach to pain and substance abuse in youth, in grades 6 to 12. We want to create an online educational module that empowers youth to self-manage their health by educating them about pain, substance abuse and the culture around it. We chose to make this training online because of the effects of the COVID-19 pandemic. Many people lost access to resources to support their health because we could not convene in person; to prevent this from occurring again in the future we want to create a training that can be implemented virtually.

The goal of the training will be to give youth experiences and the tools to make sustainable behavioral changes that support reduction in future substance use and abuse. The training will use innovative techniques, such as experiential learning, to introduce various concepts of pain and its interaction with substance use; thus linking physical health with behavioral health.

This training will use empirical evidence to create and implement the training module. Specifically, the latest research on: (1) substance use and abuse in youth; (2) pain science as it relates to substance abuse; (3) lifestyle medicine and healthy self-care; (4) Trauma informed care (5) the physiological changes that are specific to youth and how it relates to pain and substance abuse.(6)the psychosocial factors that affect youth like bullying, loneliness, leading to significant increase in depression, anxiety and sleep disorders.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Increasing and improving access to behavioral health care in light of COVID-19
- Language access including health literacy, interpreter services, and translation of materials
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

The behavioral health outcomes that we expect to improve are:

- Self reported self compassion
- Self reported self efficacy
- Self reported Sleep Quality
- Self reported physical activity engagement
- Self reported loneliness
- Self reported substance usage

Through our investigation, we have found that improvements in these behavioral health categories are associated with reduction in substance abuse.

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?

This project is in direct connection with related activities in our region. In 2019, DST-IHN approved a grant to create a curriculum on opioids, pain science and healthy self care for teachers in the Corvallis School district which was successfully completed. In 2020, we created a plan to train teachers in Ralston Academy Lebanon, but that did not happen due to COVID. We have been gaining a lot of community support for this work because Oregon is 7th in the nation with substance abuse in youth and 49th in the nation for providing resources to youth to assist with substance abuse.

Lebanon community hospital is a community organization that has been successful with implementing programs regarding managing pain. We plan to partner with this organization, as well as several others including:
- Corvallis School District
- Oregon State University College of Public Health
- American Physical Therapy Association-Oregon
- Ralston Academy in Lebanon

ED Prevention

Primary Organization: C.H.A.N.C.E.

Primary Contact: Jeff Blackford

Primary Contact Email Address: jblackford@chancerecovery.org

Partnering Organization(s): Albany Community Partners

Project Description:

CHANCE is building a pre ED support program that will partner with community partners to prevent people from going to the Emergency room and jails.

In addition to the crisis programs County Health have, many times they don't have the resources to do much once they make contact in the middle of the night. Our program works with the county programs and other supports and takes it a step further. We can meet with them, buy them a meal, talk, case manage, connect them, and provide peer support and connect with them. To find out the reason why they might be trying to go to the ER or being released to us from the police because they are stranded with no place to go at 2 am. We can offer some temporary housing supports, hotel vouchers, respite beds, or take them to the shelter. We will enroll them into CHANCE programs and other community partner programs to ensure there is wrap-around support to reduce potential ER and Jail time.

This program will also help us create the tracking we will need to show the CCO "Pre ED prevention" that cannot be measured by claims data. The goal is the prevent them from even getting to the ED and we have to measure that. We have some dedicated staff and board members who are ready to take it on.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Increasing and improving access to behavioral health care in light of COVID-19
- Pay equity through building and sustaining the workforce
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

ED reduction, Mental health supports, A&D supports, connect to primary care. Case managed supports to CHANCE support services. Connect to other community partners.

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?

Reduction in cost to the hospital systems and the CCO. Connection with Mental Health and Addiction supports. We are focusing on Albany but would like to expand to Corvallis, then to the rest of the tri-county once we figure out how to make it all work and how to track "pre ED encounters" and to show the value to the CCO and cost savings.

Namaste Rx

Primary Organization: Namaste Rx LLC

Primary Contact: Britny Chandler & Haripriya Prakash

Primary Contact Email Address: namasterx2020@gmail.com

Partnering Organization(s): C.H.A.N.C.E., Valley Birth & Beyond, Behavioral Quality Improvement Committee

Project Description:

Namaste Rx is a membership platform that provides access to trauma-informed yoga as an effective treatment option for individuals suffering from medical and behavioral health conditions.

Our overarching aim at Namaste Rx is to integrate yoga and meditation within the healthcare industry. This will allow for patients to have affordable access to these services. Currently in the local yoga industry, access to these services are available to the most affluent in our community. On average, an individual seeking a one hour group yoga session once a week will pay approximately $1,040[1] annually in class fees alone.

In the US, yoga is widely seen as only a low impact exercise. It is because of this the most affordable insurance options do not usually include a yoga benefit. Emerging in recent years, evidence-based research[2] has taught us that yoga and meditation hold many benefits and simultaneously help improve different medical and behavioral health conditions. Research[2] shows that yoga and meditation improve so many symptoms and present the argument that there is no prescription drug on the market that improves as many symptoms without risk of negative side effects. Namaste Rx believes in holistic medicine and we want members of our community reaping the same benefits.

Namaste Rx aims to connect the three industries (insurance coverage, yoga, and medical/behavioral health providers). By integrating these services, we will increase access and coverage options for medical and behavioral health conditions. Additionally, we want this to be offered as a treatment plan that Doctors can rely on.

We will also provide an innovative and new income stream for current Yogis in the community. This will create a stable patient population for Yogis to be sustainable providers in the community, especially post pandemic.

The one year Namaste Rx Pilot will be executed within three phases:

- Phase I - Trauma Informed Training.
    - The Yogis will be required to complete Trauma-Informed Care Training.

- Phase II - Service Implementation.
    - Connecting our subpopulations with a trauma-informed Yogis to deliver the yoga treatment.
    - Create affordable yoga and meditation treatment access options.
- Phase III - Community Outreach & Education.
    - Building sustainable referral pathways to Namaste Rx.
    - Integrating access points into existing behavioral health care systems.
    - Increase affordable yoga & meditation treatment options.
    - Build individual resiliency.
    - Educating the community of the benefits of utilizing trauma-informed yoga as an additional treatment option for their care plan.

References:
1.) https://lessons.com/costs/yoga-classes-cost
2.) https://breathetogetheryoga.com/about/why-practice-yoga/#toggle-id-3

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Namaste Rx aims to achieve the following outcomes from this pilot:

- Increase the number of trauma-informed Yogis within the IHN-CCO service area. (Phase I desired outcome).
- Reduce the symptoms of depression and anxiety within our subpopulations. This will be measured pre and post yoga treatment, using standardized screening tools. (Phase II desired outcome - also a CAC recommended measure).
- Increase the number of member care plans that include yoga as a treatment option. (Phase III desired outcome - also crucial for sustainability).

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?

We have seen a shift in Oregon's health care system to focus on improving Behavioral Health systems, delivering trauma informed care, crushing mental health bias, and increasing resiliency post pandemic. Namaste Rx focuses on the same efforts. The main partners through the life of the pilot are CHANCE and Valley Birth and Beyond. We have also partnered with IHN-CCO's Behavioral Quality Improvement Committee to guide the pilot based on already existing resources, local efforts, and data.

There are other yoga services in the area, however, no other organization that partners with the medical community nor do they provide affordable services to the Medicaid population. Namaste Rx delivers on affordable options for yoga as we help reduce mental health stigma and build post COVID community level resilience.

In regards to post pilot sustainability, we wish to build future partnerships with the following organizations:

- IHN-CCO
- Samaritan Advantage Health Plans
- Samaritan Choice Plans
- Painwise Taskforce
- VA
- Local HR and benefit firms
- County Public Health Systems
- Community Based Organizations
- Sarah's Place
- Mental Health Clinics
- OB service providers
- Physical Therapists
- Sam Fit
- Etc.

Parenting Today Forward

Primary Organization: OneIIAnother

Primary Contact: Connie Kay

Primary Contact Email Address: ckay@o2aprograms.com

Partnering Organization(s): Linn County Mental Health, Youth Era, C.H.A.N.C.E., Albany Greater Public Schools, Lebanon Community Schools, Albany Boys and Girls Club

Project Description:
OneIIAnother is a nonprofit organization that provides parenting classes, support groups, Peer Support Services to the communities within Linn County, Oregon. OneIIAnother has a mission to provide families and individuals support, bridging their challenges to their strengths toward lifelong success. We believe in and demonstrate a strengths-based culture where everyone is welcome and accepted right where they are at in their life.

OneIIAnother is seeking to offer parenting classes using the Parenting Today Forward Step 1 curriculum, Support Groups for the parents, caregivers and grandparents in our communities, Step 2 classes, Adult Skills Training, and topic centered Workshops. OneIIAnother will offer a minimum of one in person Step1 class quarterly. We will offer a quarterly online class through Zoom Video Conferencing to allow those that have a barrier to attending in person classes a chance to learn the skills taught in Parenting Today Forward. We will offer a Step 2 class to continue building on and taking a deeper look into the skills that were introduced in the Step 1 class. A Support Group for the parents, caregivers, and grandparents to offer one another support while building natural supports and seeing that they are not alone in their struggles will be available. Adult Skills Training is another class that has been highly sought from our community where skills such as empathy, listening skills, organizational skills will be among those covered. Our Workshops are another option for parents, caregivers and grandparents to build on the skills taught in Step 1. These are topic specific covering topics such as developing and implementing house rules, expectations, and routines, power struggles, skill development and more. There is a Peer Support program within OneIIAnother that can be accessed through a support request process that is available to those attending our groups and classes that works with individuals on the skills taught in Step 1, as well as helping to make the connections and referrals to agencies and professionals for those needs outside of our program.

This funding opportunity will allow us to pay for the spaces that we will be using to host these classes and groups, as well as the required liability insurance and technology improvements that will allow for reliable connection for our Zoom classes in the form of a larger screen and booster for internet connection. We will have paid staffing to coordinate these groups, classes and volunteers to the equivalent of a full time position.

This staff position will be critical to the organization of materials, registration of attendees, coordination of buildings and to coordinate the volunteers that assist in the setup and take down of each class or group.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Increasing and improving access to behavioral health care in light of COVID-19
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

We expect to reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced through our classes and groups. Having a safe space where parents, caregivers, grandparents and individuals can come together to learn through shared experiences and build both natural supports within one another, as well as access to professional and community supports that have been needed but not accessed from not knowing that programs exist or the fear of accessing services due to the stigma surrounding behavioral and mental health. OneIIAnother welcomes all and accepts all people regardless of where they are at in their life. There will be no out of pocket cost associated with our introductory classes which affords the ability for those that may have had financial barriers preventing them from seeing help in the past. Introducing classes online also allows those with barriers preventing them from attending in person classes the ability to access our classes and groups when they are unable to be there physically.

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?

OneIIAnother is planning to connect with the communities that we serve by sponsoring events for families. The families we serve are often not able to attend community activities due to behavior struggles. We open those doors and create a safe place for fun activities such as a bounce house that is planned through a partnership with the Albany Boys and Girls Club and a swimming time at Albany's Cool Pool. We have hosted barbecues and holiday meals for the communities that we serve giving an opportunity for a sit-down meal and time of social connectedness.

OneIIAnother has a relationship with Linn County Mental Health that allows us to assist families in accessing professional behavioral and mental health services. This relationship also brings families and individuals to OneIIAnother during times of struggle so that they can learn important skills to build a foundation of lifelong success. We are working with Youth Era in training youth involved with OneIIAnother to build a Youth Peer Support program for the youth in our community. C.H.A.N.C.E. has been a

business that we have been able to look towards and ask questions regarding business practices as OneIIAnother is growing and developing our programs. We have collaborations with the local school districts to help with sharing information to families with school age children. We also partnered with Greater Albany Public Schools to coordinate a school supply drive and distribution when kids were going back to in-person school for the first time in 2021 during COVID-19. The churches in our local communities have been a great support in allowing our use of their grounds for various events. We look forward to expanding our partnerships as our programs build and expand.

Pathfinder Behavioral Health Transformation

Primary Organization: Pathfinder Clubhouse

Primary Contact: Elizabeth Hazlewood

Primary Contact Email Address: Elizabeth@PathfinderClubhouse.org

Partnering Organization(s): Good Sam Behavioral Health Unit, Benton, Linn, Lincoln Health Department, Benton A.C.T. Team, Community Outreach Inc., C.H.A.N.C.E, OR State Hospital, Sacred Heart Hospital, Good Sam Hospital & Health System, Voc Rehab, OR Dept. of Self-sufficiency

Project Description:

Pathfinder Clubhouse breaks away from the paradigm of traditional mental health practices with an innovative yet evidenced-based Clubhouse International model of psychosocial rehabilitation that is making a radical and transformative change to the way our community responds to mental illness. Pathfinder Clubhouse will increase access to non-traditional behavioral health services that help disabled adults living with mental illness resolve socio-economic inequities, homelessness and trauma experienced or compounded by COVID-19. After a community assessment, feasibility study and two years of planning, Pathfinder Clubhouse was created to make a transformative difference to the community by bringing innovative evidenced-based non-traditional mental health services to fill the urgently needed gap in behavioral health services.

Our project is an ambitious endeavor as this evidenced based model, while proven to reduce rates of hospitalizations and crisis, has not previously been available to this community; let alone tested with the enhanced transformative scope of services. Pathfinder will address all social determinants of health in a non-traditional way through non-clinical mental health services to address the damaging effects and consequences of a global pandemic on our community. The daunting task this project looks to take on is to meet the immediate need and overwhelming demand for increased access to behavioral health care for individuals.

Our program will implement an innovative approach to the damaging aftereffects of the COVID-19 Pandemic by expanding access to care for the 1 in 5 adults living with severe and persistent mental illness who have been disproportionately affected by COVID-19. Adults living with severe and persistent mental illness have been historically marginalized and underserved as our clinical mental health system is overwhelmed in attempts to meet this demand. Oregon experiences the highest prevalence of mental illness in the nation while ranking only 49th in outcomes as the ever increasing for demand in services continue to rise. This prevalence is being compounded by the COVID-19 virus as it has forced many into isolation, joblessness, and homelessness leading to increased symptoms as a result. The ramifications of the lasting aftereffects

of generational poverty and adverse childhood experiences have been triggered from this forced isolation and economic distress of COVID-19 and has created huge disparities in socio-economic status.

This program will bring a transformative approach by utilizing Community Health Workers from diverse backgrounds for the first time in an untraditional way to deliver culturally linguistic Clubhouse services while also filling the traditional role of THW's in helping to navigate and coordinate care to various community partners. With a specific focus on meeting immediate needs of housing, employment, transportation, food security, socialization, education, health and wellness, financial stability and access to non-traditional mental health services, Pathfinder Clubhouse works in coordination and conjunction with various community partners to ensure success. Through the side-by-side work with trained CHW staff in meaningful hands-on work that creates equitable opportunities to increase stamina, confidence and employment that improves rates of housing and financial self-sufficiency while learning how to build and maintain healthy relationships and important social skills needed to reintegrate back into the community. This approach overcomes barriers that encompass all social determinants of health at once which we anticipate will be the most transformational and effective approach in helping people achieve housing, employment, improved physical and mental health and ultimately recover from traumas related to the COVID-19 Pandemic.

While Pathfinder Clubhouse model of recovery through meaningful work shows promise, this program does carry some risks of not being able to meet the increased demand for non-traditional mental health services as a result of the COVID-19 pandemic as Pathfinder Clubhouse is less than a year old and this increased scope of work utilizing Community Health Workers from diverse culturally linguistic backgrounds has never been undertaken before. There is also a risk of not being accessible to all rural areas however Pathfinder Clubhouse is currently serving 10% of its population from rural areas as well as situated a couple blocks from the Tri-region transportation hub. However, this program does show promise to be replicated successfully throughout the IHN service region and beyond. In fact, the Executive Director of Pathfinder Clubhouse has over 18 years in the Clubhouse International Model, including having served on the Clubhouse International Faculty as well as assisted with the startup and development of 6 clubhouses, is the Chair of the Oregon Clubhouse Coalition and currently serves as a mentor for 5 clubhouses as designated by Clubhouse International to promote the growth of Clubhouses in areas with little to no access to non-traditional mental health services. We feel this program will transform the way behavioral health services are delivered by meeting people in a culturally linguistic way to better help adults living with mental illness improve all social determinants of health and become overall self-sufficient, while achieving better health, better access to health care and reduced cost of care.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma

- Increasing and improving access to behavioral health care in light of COVID-19
- Pay equity through building and sustaining the workforce
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

The outcomes expected for this project are to improve discharge planning to better meet the needs of those who are most at risk and in need of behavioral health supports, utilize THWs in to connect members to supportive services which will reduce hospitalizations by 50%, emergency department usage by 10%, increase services to non-traditional behavioral health treatment for 70 IHN-CCO Members, as well as creating equitable opportunities that increase stable housing for 8, help 50 members retain housing of IHN-CCO members and employment of 15 IHN-CCO members.

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?

Pathfinder Clubhouse was brought to this region out of a community need to fill the identified gap in non-traditional mental health services to work in coordination and conjunction with existing agencies to help adults living with mental illness overcome social determinants of health. No other agencies are providing the comprehensive evidenced-based non-clinical services mental health services that address social determinants of health that Pathfinder Clubhouse provides to assist in securing housing within 87 miles from our location in Corvallis. This project works in coordination and conjunction with state and local mental health authorities to fill the gap in non-traditional behavioral health services as well as community partners to ensure there are no unnecessary duplication of services. We work closely with our members and community partners to provide or connect individuals with the services they need to thrive.

Primary Care Physical Therapy

Primary Organization: Samaritan Lebanon Community Hospital

Primary Contact: Ryan Combs

Primary Contact Email Address: rcombs@samhealth.org

Partnering Organization(s): George Fox University PT Dept, Samaritan Lebanon community Hospital Rehab dept, Samaritan

Project Description:

The traditional path to receive physical therapy services starts with an initial visit to the provider followed by a waiting period, followed by another visit, followed by referral to imaging , specialist and then possibly physical therapy. During this times 8 weeks have been consumed and the patient is no longer acute but has now fallen into the category of chronic and using medications, possibly opioids and maybe unnecessary imaging because it has become a chronic issue.

In our pilot we have teamed with George Fox University and provided and the Lebanon Samaritan Family Resident clinic to provide evidence based practice in a new and innovative delivery design. In this project we focus on upstream service in which the therapist receives a warm hand off from the provider to the physical therapist. In that visit the physical therapist is able to assess the injury; help in the decision of whether this patient needs formal Physical therapy services and/or provide valuable patient education and self care information for that patient's condition.

Our initial data found that ~55% of those patients seen in this Primary Care Model felt that with the information provided, and self care tools provided they could comfortably continue with a home physical therapy program. Only about 34% were actually referred on to PT with ~ 11% stating they either did not, or could not continue with PT services. Those that were impaired by finances were provided a follow up home exercise program and also given the opportunity for financial aid for this service.
The overall beauty of this program is that it meets the patient where they are, and addresses their needs at that moment and that time thus improving patient access and decreasing patient cost.

One other advantage of this program is that it addresses provider burden. We are able to help the provider see musculoskeletal injury much more affectively, providing them the feedback they need for important decision making, addressing musculoskeletal injury up front and providing the provider space in an already hectic schedule. Currently this has been extremely well received by those providers involved.

Which of the following does your project focus on?

- Addressing trauma
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

- Same day PT intervention for musculoskeletal (MSK) conditions.
- Enhancing the patient experience by:
    - Decreasing the wait time for PT services from the initial PCP visit
    - Providing immediate access to valuable evidence-based advice related to MSK conditions
    - Improve patient access to PT services when referred to traditional PT and being able to provide guided access to those rehab providers of specialty services such as pelvic floor, TBI, Balance, Parkinson's, Chronic Pain, pediatrics, sports medicine, lymph edema and neuro services. Patient access would also improve for services outside our hospital, like community services, group classes etc.
- Share provider burden:
    - PT is an extension of the provider, reduced provider burden.
- Reduce costs (Value based):
    - Reduced imaging, opioid use, ED visits, inappropriate visits to ancillary svcs, expedites referral to appropriate services including possible surgical intervention and reduces physician burn out.

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?

This is very much a value based patient centered model of care with the focus on improving patient access, decreasing overall medical costs, and sharing provider burden. In our community there are no other programs like this. We are currently one of 2 programs in the state providing this service. We have started to spread out to our Sweet Home facility and are looking at expansion to our Family Medicine clinic on Mullins drive. We are also entertaining the possibility of expanding this model to our emergency department or urgent care. This is a very flexible program that can be adaptable to many health care settings.

Therapeutic Treatment Homes

Primary Organization: Greater Oregon Behavioral Health Inc.

Primary Contact: Katelyn Hershberger

Primary Contact Email Address: khershberger@gobhi.org

Partnering Organization(s): Old Mill Center, Lincoln Community Health Center, and Linn County Mental Health.

Project Description:

Greater Oregon Behavioral Health Inc. (GOBHI) is a therapeutic foster care agency that recruits, trains and certifies foster homes across the state of Oregon for full time, part time, and crisis care. GOBHI serves youth ages 4-21 that have a mental health, behavioral health, or emergency need. GOBHI provides this service for youth involved in the child welfare system as either full time placements or respite (short term) placements. GOBHI has expanded its services to provide mental health respite to contracted CCO's as well as traditional foster placements. This service is accessible to any youth enrolled in IHN CCO that has mental health respite authorized as a service in their treatment plan. This service is utilized to stabilize youth in their communities, prevent higher levels of care (or entering into child welfare custody), and to support families and youth that may not have any other natural resources. GOBHI utilizes the evidenced-based practice of Collaborative Problem Solving ™ as a program model and trains all families to provide interventions to youth using this framework.

GOBHI's Therapeutic Treatment Homes project will increase efforts in recruitment and retention of culturally diverse foster families in the Linn, Benton, and Lincoln counties. GOBHI is passionate about providing culturally appropriate homes for all youth referred and meeting the needs of those in the community. GOBHI has certified three homes in Linn, Benton, and Lincoln county through general statewide foster home recruitment that is being done. However, GOBHI has been unable to dedicate the resources needed to actively and specifically recruit and develop the respite program in Linn, Benton, and Lincoln counties. GOBHI has identified there is a significant need in IHN's region for respite/emergency care for youth experiencing mental health/behavioral challenge as seen by the referrals being received by GOBHI compared to the number of homes available to serve these youth. Through this project, GOBHI will actively begin focused recruitment work in these counties to better support the needs of the community.

GOBHI is aware that similar efforts have been attempted in the community previously by another organization. GOBHI is confident that GOBHI's model will allow for success in the certification and retention of foster homes and an increase in the youth being referred and served through the respite program. GOBHI is unique in comparison to other agencies that provide foster care services in that it does not operate out of brick and mortar. All of GOBHI's foster care work is done in the community or from remote

work locations. This allows GOBHI to utilize program resources to provide for their employees, foster families, and the community without having to dedicate to costly overhead expenditures. Infrastructure is already in place to support program functions, regardless of location. GOBHI also has other avenues of business that provide financial security, which support continuation of services once a grant has ended. For the Therapeutic Respite Care project, once foster homes are developed in a community, all daily costs are supported through services provided through the contracts held through ODHS (Oregon Department of Human Services) or the CCO's (Coordinated Care Organizations).

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Developing a bilingual and bicultural workforce
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

GOBHI hopes to target multiple health outcomes through this project. First and foremost is outcome A1: Increase the percentage of members who receive appropriate care at the appropriate time and place. GOBHI is able to provide high quality respite services which include crisis support, continuous training for foster families and staff, and case management/care coordination supports for youth being treated in our program. Our goal is to increase the amount of youth that are able to be served in IHN CCO and also reduce the wait time between a referral received and respite being offered.

The second outcome GOBHI will be targeting is BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced. GOBHI will be doing this by increasing recruitment of foster homes and thus increasing community members trained in Collaborative Problem Solving ™ (CPS) and increasing awareness of mental health, behavioral health, and foster youth's needs. GOBHI's initial and on-going training program for foster parents and foster parent applicants addresses these topics directly with a trauma informed lens and practice.

Finally, GOBHI will focus on SD4: Increase health equity. GOBHI as an agency is prioritizing DEI (diversity, equity and inclusion) work as a whole. In the Foster Care Program, GOBHI is targeting recruitment and certification of families of diverse and varied backgrounds to better serve youth and families in need of services. This project would include such a focus. GOBHI also intends to diversify its recruiting, training, and certification materials to support families that speak languages aside from English.

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?

At this time there are no programs in the community aside from GOBHI attempting to support providing certified homes for mental health respite. ODHS is in these communities as well as Every Child and they provide full time foster care homes as well as non-trained respite homes. These services are only available for youth in foster care. In Lincoln County SAFE Families provides temporary respite care for families that are experiencing a crisis and need a place for their child to go without involving child welfare. These services are primarily for families experiencing a hardship and the families are not trained to provide mental health supports to the youth in their home. GOBHI is meeting an unmet need in the community by providing full time, crisis, and temporary homes for youth with mental health and behavioral health needs.

GOBHI is currently receiving referrals from Old Mill Center, Lincoln Community Health Center, and Linn County Mental Health. GOBHI will be expanding to collaborate with and receive referrals from any mental health organization in these counties that serves youth with IHN Medicaid.

IHN-CCO DST Pilot Letter of Intent Rankings RFP2

	Name	Organization	Priority Areas	Score
Dark Green	CDDC Behavioral Health Innovations	Corvallis Daytime Drop-in Center	Subpopulations; addressing trauma; behavioral health.	26
	Overcoming Barriers, Foster Youth	CASA-Voices for Children	Subpopulations; addressing trauma.	26
Yellow	Multicultural approach to Health Outreach	Corvallis Multicultural Literacy Center	Language access.	25
	Developing a Diverse Dental Workforce	Capitol Dental Group P.C.	Bilingual and bicultural workforce; pay equity.	25
	PUENTES: Bridging Cross-Cultural Communication	Casa Latinos Unidos	Subpopulations; behavioral health; bilingual and bicultural workforce.	25
Orange	Women Veterans Hybrid Cohort	Red Feather Ranch	Subpopulations; addressing trauma; behavioral health.	24
Red	Pain Science Life Stories	Oregon Pain Science Alliance, Inc. (OPSA)	Addressing trauma; behavioral health.	21

CDDC Behavioral Health Innovations

Primary Organization: Corvallis Daytime Drop-in Center

Primary Contact: Allison Hobgood

Primary Contact Email Address: allison.hobgood@gmail.com

Partnering Organization(s): Community Services Consortium, Portland State University, City of Corvallis, HOPE Board, Disability Equity Center

Project Description:

CDDC's vision is to create a diverse community "Where Needs Are Met," and since 2002, the organization has fulfilled its mission of being a crucial resource hub for information, referral, and direct services for individuals experiencing poverty in the Linn-Benton county community. CDDC meets people's basic needs, provides dignified advocacy, offers opportunities for building community and social networks, and supports individuals' welfare across emergency, transitional, and ongoing life circumstances. We serve 50-80 unduplicated individuals daily M-F, many of whom are chronically homeless, disabled, and face substantial social disparities due to co-occurring behavioral health disorders, transition from incarceration, lack of education, and generational poverty. Our innovative grant project, one that provides new and different learning, aims to decrease systemic barriers and promote increased health equity for homeless and low income community members through more robust behavioral health direct support. With an eye to decolonizing traditional behavioral healthcare, we propose to pilot a more equitable, responsive, targeted model of behavioral healthcare that is low-barrier, trauma-informed, and specifically tailored to meet the needs of CDDC guests.

The need for more robust behavioral health direct support in the Linn-Benton homeless community is undeniable, and the economic impact of the pandemic has only intensified that need. Trends show homelessness growing in Oregon. Conditions such as trauma, mental illness, and substance abuse are strongly associated with being chronically unsheltered. People experiencing behavioral health issues, houselessness, or living in poverty (all part of our target population) face far worse health outcomes than the general population. Our work at CDDC always emphasizes social determinants of health and decreasing systemic barriers that make it difficult for marginalized, historically excluded people to fully thrive. Our project acknowledges how deep social biases as well as conditions in which people are born, grow, and age can unjustly impact everything from access to care to life longevity. Our project is a response to the fact that the majority of our low income and homeless neighbors have significant behavioral health needs, from addressing depression to PTSD to schizophrenia to substance abuse to childhood trauma. It is also a response to the reality that traditional behavioral health models are deeply inequitable and, through racism, ableism, and the drive for profit, have actively harmed many of the individuals we serve.

Designed for wealthier, non-minoritized populations, traditional “counseling” models do not suit the unique needs and circumstances of many CDDC guests. For instance, making appointments scheduled far in advance and waiting months to see a professional miss the mark for a population with no or unreliable transportation, unpredictable life schedules, and more acute, immediate needs. Telehealth is a non-starter for people with no access to technology. Costs for conventional care and medication are out of reach for most of our guests. The model of compassionate care we aim to develop at CDDC is a culturally relevant, inclusive model tailored to the specific access and equity needs of homeless and low income individuals. It meets people where they are. It acknowledges that micro-interactions over coffee in a moment of hospitality constitute a kind of “therapy.” This model is never punitive (no penalties for missing appointments). It realizes that a “clinical setting” might be outside at a community table or during street outreach at the door to someone’s tent. It understands that pain and depression, for instance, operate in the context of historically oppressive social structures that create negative feelings we have been taught to imagine as wholly individualized. This model aims to decolonize and destigmatize behavioral health, as well as help CDDC guests self-advocate for their wellness, even if that is in a single conversation or one-off interaction.

Put more simply, we want to ensure that CDDC guests are more fully seen and heard in a low-barrier, low-stakes, highly accessible way. We propose to pilot a collaborative, tiered behavioral health support system that includes a team of volunteers, interns, and staff that have different approaches, strengths, and skill sets that might resonate with CDDC guests depending upon where they are in their life journeys. While the precise shape of the support system is still evolving in consultation with the individuals we serve, we are imagining that one foundational rock of this flexible, innovative, non-traditional model will be our “familiar face” staff member that guests can count on every single day when they are at CDDC. This “counselor” will practice compassionate listening, thoughtful hospitality, and low-pressure invitation for guests to share their stories so as to initiate healing. This staff will offer warm hand-offs to two or three, clinically-trained counselors who explicitly believe in the power of non-traditional milieu work, decolonizing approaches, and unconventional opportunities for connection and advocacy around mental wellness. They will meet with guests literally where they are--often sitting outside our building or in brief passing, and then in more confidential settings for longer durations as trust evolves. Ideally, this support team will also include a staff member trained in acute behavioral health crisis management who can attend to the behavioral health needs of guests who are decompensating in real time and who need different kinds of support and safety while at CDDC.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Increasing and improving access to behavioral health care in light of COVID-19
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Our project addresses the behavioral health needs of homeless and low income community members so that they can improve quality of life, begin to heal trauma or daily stress, and overcome fundamental barriers that keep them from obtaining and/or maintaining housing, employment, relationships, or other elements of healthy, sustainable lives. Per CHIP, we especially aim to reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced, and improve care for members experiencing mental health crises. The behavioral health model we propose is more just and equitable than conventional counseling supports and thus will increase the percentage of members who receive appropriate care at the appropriate time and place because they can actually access care if they desire it. Employing a non-traditional behavioral health model at CDDC reduces health disparities and promotes positive outcomes because people are respected in their full diversity and humanity, and they share power over the decisions, resources, and stories that shape their mental health and well-being.

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?

As a community resource hub, CDDC is fundamentally committed to promoting and strengthening partnerships and creating new alliances that support transformation of the healthcare delivery system. We are always considering how to give individuals better health and improved access at reduced costs. None of this is possible without support from local community partners. This project is broadly connected with related activities happening in our region insofar as behavioral health support is a key health equity issue across healthcare systems and community-based organizations. From supplemental grant funding to thought partners to material supports, some key collaborators in this pilot will include Community Services Consortium, Portland State University, the City of Corvallis, the HOPE Board, and Disability Equity Center.

Developing a Diverse Dental Workforce

Primary Organization: Capitol Dental Group P.C.

Primary Contact: Linda Mann

Primary Contact Email Address: mannl@interdent.com

Partnering Organization(s): Lebanon High School, Corvallis High School, hopefully others as well

Project Description:

Developing a Diverse Dental Workforce aims to fast-track high school graduates into a dental career as dental assistants soon after graduation. “There was a shortage of dental assistants even before the COVID-19 pandemic, but now the shortage is worse,” according to the national dental publication DentistryIQ. Dental assisting is a career that’s in high demand and is expected to grow over the next decade. According to the Bureau of Labor Statistics (BLS), “employment of dental assistants is projected to grow 19 percent from 2016 to 2026, much faster than the average for all occupations." By partnering with two local high schools, bilingual and bicultural students will be selected for this funded pilot. Upon completion, graduates will have radiology and dental assisting certification through our OHA certified program and full-time placement as dental assistants in a dental office.

Which of the following does your project focus on?

- Developing a bilingual and bicultural workforce
- Pay equity through building and sustaining the workforce

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

We are expecting that we will see our members who speak the language our new students/graduates speak will have a greater comfort level while being treated in the dental office. Research such as "Bridging Literacy and Language Differences for Better Health Outcomes: Characterizing a Bilingual Health Specialist" emphasize how important the role of having bilingual and biracial support staff is and their role in improving oral health outcomes. Our plan is to collect subjective data through stories gathered by graduates from the pilot sharing patient responses to their experiences during clinical care.

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?

High schools working with other organizations to provide career options for graduates. Lebanon and Corvallis High School each have robust programs designed for students who wish to enter careers directly out of high school. Working with the career counselors at each of these high schools, we will select bilingual and biracial applicants for this pilot to enter our OHA certified dental assisting program. Our partners at these high schools are enthused to add this profession to the offerings for their student graduates.

Multicultural Approach to Health Outreach

Primary Organization: Corvallis Multicultural Literacy Center

Primary Contact: Elena Valdés Chavarría

Primary Contact Email Address: info@cmlcenter.org

Partnering Organization(s): International Moms Group (includes International Dads Group initiative), Casa Latinos Unidos, Crossroads Conversation School for Women, Here to Stay (DACA), Dreaming Beyond Borders, Portland State University School of Social Work, etc.

Project Description:

A complete project has not yet been developed, but the CMLC is in a unique position to offer a multicultural approach to Community Health Engagement, Education and Outreach including in the priority area of language access including health literacy, interpreter services, and translation of materials as well as developing a bilingual and bicultural workforce through the CMLC's English language program.
The Corvallis Multicultural Literacy Center is a safe, equitable, cross-cultural learning community providing educational and community resources. The CMLC fosters connection, serving over 6,000 participants annually consisting of immigrants, refugees, families and other underserved populations in Linn-Benton counties. Programs include English/health/language classes, tutoring of English Language Learning children and for naturalization, and a resource center for social injustice, COVID-19, wildfires and census.

The CMLC offers a trusted connection to individuals, families and communities which is a critical way to share accurate information about health education and literacy. Information about healthcare must be culturally and linguistically responsive to meet the needs of communities most impacted by racism and oppression or other circumstances caused or exacerbated by toxic stress, trauma, intergenerational trauma and social determinants of equity including mental health, substance use, job loss, housing and food and nutrition. Communities we serve may also be experiencing stigma related to misinformation about the source and spread of COVID-19 and other health issues.
Proposal includes engaging our community through education and outreach related to IHN-CCO topics and priorities through:
(a) Regularly communicating with community members in their primary or preferred language, including alternate format, about health care and outcomes (newsletters, social media, group classes, emails, texting or WhatsApp or other methods of engagement). This may include use of health care interpreters and existing language access contracts.
(b) Creating and sharing culturally relevant information;
(c) Amplifying IHN-CCO information by re-posting social media posts;
(d) Educating the community about safe practices, answering community questions, and

acting as liaison between the community and state and local public health authorities; (e) Informing the community about where to go for services like heath care and social services;

Which of the following does your project focus on?

Language access including health literacy, interpreter services, and translation of materials.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Referring minority populations to join the IHN-CCO Community Advisory Council (CAC) to offer their diverse feedback (to have a voice at the table). I (the Development Coordinator submitting this application) is not versed in health care or disparities so is open to feedback and other ideas on what actions or program would be most effective for IHN-CCO).
A1: Increase the percentage of members who receive appropriate care at the appropriate time and place
BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.
SD4: Increase health equity.

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?

The CMLC offers a unique hub to other cultural, literacy and health organizations in Linn-Benton including strong partnerships with International Moms Group (immigrant and nonimmigrant mothers and children usually ages 0-5+), Casa Latinos Unidos, Crossroads International (offering English conversation for international women), Here to Stay (Linn-Benton and beyond DACA students), Dreaming Beyond Borders (undocumented students), Portland State University School of Social Work (students participating in an internship at local nonprofits), among others at Linn-Benton Community College and Oregon State University international offices, as well as recent partnerships with local affordable housing, etc.

Overcoming Barriers, Foster Youth

Primary Organization: CASA-Voices for Children

Primary Contact: Kari Pinard

Primary Contact Email Address: executive.director@casa-vfc.org

Partnering Organization(s): Our informal partnerships, Systems of Care, Foster Care Coordinator (Encompass), school districts, and more (see narrative)

Project Description:

As we have continued to work with foster youth, we have noticed barriers that they encounter which increases health disparities. We have been working to identify these barriers and find ways to overcome them whether that is by working with other agencies or piloting new programs within our organization.

As part of CASA-VFC's mission, we follow the well-being of each of our foster youth. This includes requesting medical records, talking with biological parents/foster parents about medical needs and concerns as well as speaking with medical professions about individual youths. We ensure that each child is receiving consistent medical care and that their medical needs are being addressed with the appropriate services.
One way we have been doing this is by partnering with the Foster Care Coordinators to discuss how we can work together to ensure this consistency and break down any barriers a foster parent may have when making appointments for their youth. CASA-VFC attends JCIP (Juvenile Court Improvement Program) which is a project designed to improve court practice in child abuse and neglect cases. We have worked with the Foster Care Coordinators so that they could present their ideas regarding the best interest of the health of children to the rest of the legal parties including the judge. CASA-VFC is currently chairing a subcommittee to continue this work and will be presenting more information to the JCIP team as barriers and improvements are identified.

CASA-VFC is also designing and piloting an Independent Living Program which will work with foster youth preparing to exit the foster care system. We will be teaching skills that are necessary for adulthood - one of the focuses being on health care. We will help them develop the skills to understanding why consistent medical care is important, how to contact their doctor, making an appointment, and advocating for themselves when it comes to their own medical needs.
We have also implemented a trauma informed tutoring program that works with our foster youth who are behind in school. We have all our tutors attend a trauma informed training to better meet the specific needs of our foster youth who have experienced trauma in an appropriate way.
We will be creating a pilot Cultural Advocate Partner Program to work with our foster

children that come from a community that experience heath disparities which our Cultural Advocates represent.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

CASA-VFC expects to improve the medical experience for foster youth and youth transitioning out of the foster care system. Our goal is to reduce barriers and ensure foster youth, foster parents, and biological parents understand the importance of health care, how to navigate the health care system, and advocate for themselves or their children. Many biological parents are reluctant to engage with medical providers for a number of reasons - one aspect of this project would be working with them to build relationships with medical professionals and breaking down any stigma that may be a barrier for them. This ultimately helps ensure foster youth will have consistent medical care once they exit the foster care system.

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?

CASA-VFC is a community collaborator that focuses on child abuse advocacy, prevention, and awareness. Staff and volunteers provide and work with a variety of organizations in the development of curriculum and educational programs, conferences, workshops, and forums.

CASA-VFC frequently collaborates with DHS Child Welfare, Juvenile Court System, Jackson Street Youth Shelter, ABC House, Old Mill Center, Benton County Mental Health, Foster Care Coordinators, school districts and local service providers. Specifically, some ways we are working with others are - CASA-VFC will be working with Jackson Street Youth Shelter for the Independent Living Program to ensure no services are duplicated and that each program is specifically geared to their target audience and meets their audiences needs. This project connects with Jackson Street as they have mentorship programs that work with at-risk youth in our community. We will partner with Foster Care Coordinators to ensure consistent and timely medical care for foster youth. This project relates to their mission of engaging youth and families.

Pain Science Life Stories

Primary Organization: Oregon Pain Science Alliance, Inc. (OPSA)

Primary Contact: John R. Kinney

Primary Contact Email Address: jrolly@afiassociates.com

Partnering Organization(s): We anticipate collaborating with all IHN-CCO entities, Samaritan Health Lebanon MMaPS program, Marble Jar, Linn Co. Mental Health, Straight Shot Health, and public access media channels in Sweet Home, Lebanon, Albany, Corvallis, and Newport.

Project Description:

Neuroscience research in the last several decades has provided a new BioPsychoSocial understanding of pain, which expands from the dominant BioMechanical explanation dominant in the health community and the general population. The BioPsychoSocial understanding offers broad opportunities for anyone to take control of their pain experiences.

Our project would develop a system for OPSA to capture high-quality, edited video of the stories of health care workers whose practices are based on the BioPsychoSocial model and the stories of their patients whose lives have been changed. OPSA has offered such story meetings throughout the mid-Willamette valley for more than 4 years but has not had the high, quality video capture and editing capability, or the on-demand access to those videos that this project would provide.

The project will include a large venue conference on self-managing pain to kick-off the new access service and pre/post surveys of attenders will measure changes in understanding and pain-beliefs that vitalize self-management. While the meetings and conference will be advertised to the general public, the notices and access information will be offered to all IHN-CCO entities for distribution to their members, along with the survey opportunity. The project offers new practices and avenues for addressing trauma and improving healthcare through self-care (behavioral services).

Which of the following does your project focus on?

- Addressing trauma
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Our project provides state-of-the-art understanding of pain experiences and pain self-management, through venues accessible at no direct cost to IHN-CCO members.

Reduction in pain is directly related to improvement of quality of life when pain experiences hinder normal activities.

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?

Our project will broaden the exposure of the existing classes offered by Straight Talk Health to educate healthcare workers on the BioPsychoSocial model, and complement the existing MMaPS (MovementMindfulnessandPainScience) program at Samaritan Health Lebanon, Marble Jar Support group, and the Linn County AACT mental health program. We anticipate collaborating with all the IHN-CCO entities to link to their members, and with public media access services in the three counties to connect with our service to the general public.

PUENTES: Bridging Cross-Cultural Communication

Primary Organization: Casa Latinos Unidos

Primary Contact: Miriam Cummins

Primary Contact Email Address: executive.director@casalatinosunidos.org

Partnering Organization(s): Undetermined

Project Description:

PUENTES: Facilitating cross-cultural communication between agencies and families in Linn and Benton counties.

One of the major barriers that continues to affect the Latinx community in Linn and Benton counties is the inconsistent availability of documents translated into the home languages of the families we serve. The proposed PUENTES Program will facilitate cross-cultural communications between agencies and families by providing access to translation and interpretation services in the family's native language. In the past, our organization has provided in-person interpretation of personal and professional documents, however, we have also received requests from individuals and other agencies to translate longer and more complex documents. For example, notarized documents from another country that need to be translated into English and vice versa.

In order to reach as many IHN-CCO members as possible, PUENTES will provide the means of connecting language services to families and agencies at no cost to them. As so many of us have learned during the pandemic, our communities now require a more personal level of assistance that requires us to build trust and demonstrate our commitment to the community. To do this, PUENTES will provide the option of in-person advocacy in addition to traditional methods of interpretation and translation. Because of the personal nature of much of the documents that must be translated, it may become more effective--both in terms of funding and impact--to create a position, or positions, within our organization. Our intention with this funding is to establish the bridge between the people and the services required to improve health literacy and comprehension, as well as access to health services and information. As the only culturally specific organization in Linn and Benton counties, we are in a unique position to act as this bridge because we have established trust within the Latinx community that relies on our services in order to overcome systematic disparities.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Increasing and improving access to behavioral health care in light of COVID-19
- Language access including health literacy, interpreter services, and translation of materials
- Developing a bilingual and bicultural workforce

- Improving access to behavioral health services in non-traditional ways.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

Our plan increases access to health services and information for non-English speakers in Linn and Benton counties.

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?

The services offered through this program directly correlate to all areas of the social determinants of health. Cooperation with multiple agencies will be necessary for this plan to succeed. Increasing comprehension and access is an ongoing process that has the potential to increase the effectiveness of organizations that choose to partner with us.

Women Veterans Hybrid Cohort

Primary Organization: Red Feather Ranch

Primary Contact: Paige Jenkins

Primary Contact Email Address: paige@redfeatherranch.org

Partnering Organization(s): Olalla Center

Project Description:

This innovative program disrupts isolation with daily, weekly, and monthly activities through nature-based and peer support practices, resulting in long-term support networks and greater self-awareness. This is a six-month peer-support cohort program for approximately 12-16 women veterans. It is an intensive program that addresses multiple sources of trauma (including military sexual trauma, childhood, cultural, ancestral, family, and combat) by providing a safe and nurturing space where participants learn how to address their own triggers that have led to isolation. The programming is flexible to address the needs of each individual, yet also firmly rooted in clear and simple instruction with repeated learning in developing and practicing personal boundaries as well as learning new approaches to triggering situations.

The cohort will meet in person for a full day each month and partners will meet by phone for one hour every week. The curriculum includes daily individual practices of writing in a journal and sitting in a natural space sensing nature. Connecting with the natural world is a large component of the practice, with daily grounding and finding that the natural world provides immediate peace. Expressing gratitude and setting intentions are also part of the daily, weekly, and monthly routines.

The curriculum begins with a self-directed life assessment, examining all aspects of the woman's life, identifying a focus area that each participant wants to prioritize, and using exercises to envision a more balanced life, which includes their priority focus area. A woman veteran social worker will facilitate the monthly meetings and will meet privately via Zoom or phone with participants once per month and on an as needed basis.

Throughout the cohort, individuals have opportunities to understand and discuss their triggers, projections, and judgements. An ideal result of completing this program is that a participants move beyond destructive behavior resulting from trauma triggers and actually makes significant progress toward their vision for their focus area and other areas of their life. At a minimum participants build bonds with other women veterans and given their experience within the cohort they feel safe to reach out to their sisters beyond the end of the program.

Which of the following does your project focus on?

- Subpopulations of IHN-CCO members that experience health disparities
- Addressing trauma
- Improving access to behavioral health services in non-traditional ways

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

We expect to see a reduction in suicide, suicidal ideations, emergency room visits, mental health crises, substance use disorders, eating disorders and other potentially damaging personal behaviors. By creating a peer support community where none currently exists, we anticipate long-term positive health benefits to members that feel isolated, invalidated, and forgotten. Because we represent, value, and support non-traditional, minority, and non-conforming members in the demographics of race, ethnicity, sexual orientation, religion, and marital status, we know we are skilled and competent in communicating and serving those who fall into one or more of these demographics.

The very nature of our peer-support program is a gentle and mutually agreed upon intervention to address isolation with accountability and encouragement built into the program.

Through regular peer support meetings, we anticipate building relationships that go beyond the termination of the program. We foresee facilitating alumni meetings and training some peers to become co-leaders for future cohorts.

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?

Walden Project at Olalla Center