2021 Delivery System Transformation
Request for Proposal 2 Summary

Name	Organization	Region	Budget
Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members	Corvallis Daytime Drop-in Center	Benton, Lincoln, Linn	$51,700
Developing a Diverse Dental Workforce	Capitol Dental Group P.C.	Benton, Linn	$52,785
Overcoming Barriers, Foster Youth	CASA-Voices for Children	Benton	$49,335
Pain Science Life Stories	Oregon Pain Science Alliance, Inc.	Benton, Lincoln, Linn	$50,000
PUENTES: Improving Language Access and Culturally Appropriate Messaging to Address Health Inequities in the Latinx Communities of Linn and Benton Counties	Casa Latinos Unidos	Benton, Linn	$52,500
Red Feather Ranch Women Veterans Cohort	Red Feather Ranch	Benton, Lincoln, Linn	$43,231

Total $299,551

Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members

Backbone Organization: Corvallis Daytime Drop-in Center

Billing Address: PO Box 1705, Corvallis, OR 97339

Site: 530 SW 4th St., Corvallis OR 97333

Counties: Benton, Linn, Lincoln (some)

Priority Areas:

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

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:

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.

BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.

BH4: Improve care for members experiencing mental health crisis.

BH5: Improve care for members experiencing severe and persistent mental illness.

BH6: Behavioral health funded and practiced with equal value and priority as physical health.

SD4: Increase health equity.

Pilot Contacts	Name	Email
Primary	Allison Hobgood	Allison.hobgood@gmail.com
Proposal	See above	See above
Contracting	See above	See above
Financial	See above	See above
Reporting	See above	See above

Corvallis Daytime Drop-in Center, Proposal Narrative: Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members

A. Executive Summary (½ page)

Corvallis Daytime Drop-in Center is 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. *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.*

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. CDDC's pilot 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. CDDC proposes to pilot a collaborative, tiered behavioral health support system that includes a team of volunteers, interns, and staff. We envision a flexible, innovative, non-traditional model of "counseling" invested in decolonizing approaches and unconventional opportunities for increased mental wellness that employs compassionate listening, thoughtful hospitality, and low-pressure invitation for guests to share their stories so as to initiate healing.

B. Pilot Description (2-4 pages)

General Description: 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. 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 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.

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 building an innovative, non-traditional model of "counseling" invested in decolonizing approaches and unconventional opportunities for increased mental wellness that employs compassionate listening, thoughtful hospitality, and low-pressure invitation for guests to share stories so as to initiate healing.

Goals and Activities: addressing trauma; improving access to behavioral health services in non-traditional ways; increasing and improving access to behavioral health care in light of COVID-19; supporting subpopulations of IHN-CCO members that experience health disparities. CDDC's pilot specifically forwards the following SMART goals, all of which are innovative strategies that will help increase health equity in our target population:

Goal 1: By the end of 2022, offer 100% of desiring CDDC guests greater access to behavioral health services that address their distinct needs; Goal 2: By the end of 2022, see 20% increase in CDDC guests using in-house behavioral health services; Goal 3: By the end of 2022, directly engage via street outreach 20% more individuals experiencing homelessness to link them to CDDC behavioral health supports; Goal 4: By the end of 2022, directly engage 40-50% of CDDC guests who are BIPOC about the program's strengths/weaknesses as they impact racial minorities, and make changes.

These specific goals are in alignment with our broader goals to help promote people's decreased need for crisis interventions and increased mental wellness. Our pilot's goals also align with the DST's global mission to help people achieve better health and access at lesser cost. Our pilot will be transformative and create opportunities for innovation and learning, even as it directly and holistically impacts the wellness of people in poverty, many of whom identify as disabled. Further in line with the DST's health equity

initiatives, this pilot creates new and different relationships between marginalized people and their allies, transforms community and healthcare connections, and bolsters crucial linkages between individuals outside of traditional health services settings.

Health Equity Outcomes: Attaining the above goals will correspond directly to the following, measurable IHN-CCO Community Health Improvement Plan (CHIP) desired outcomes: 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; BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support; BH4: Improve care for members experiencing mental health crisis; BH5: Improve care for members experiencing severe and persistent mental illness; BH6: Behavioral health funded and practiced with equal value and priority as physical health; SD4: Increase health equity.

Roles, Responsibilities, and Partnerships: One significant strength of CDDC's pilot lies in its foundational collaborations and the network of partners it already has established. Our pilot team will consist of:

Hezekiah Franklin--CDDC Frontline Community Wellness Support staff
Kristin Moen--CDDC volunteer, Psychiatric Nurse Practitioner in training
Greg Smith--CDDC consultant, Licensed Clinical Social Worker
Pamel Kolbas--CDDC volunteer, Licensed Professional Counselor in training
Molly Hartshorn--CDDC intern and PSU student, clinical MSW in-training
Chris Gray--Benton County Health Department Harm Reduction staff
Maddie Bean--CDDC Street Outreach and Response Team Coordinator
2-3 volunteers--support "Conversation Table" for listening/witnessing guests
Allison Hobgood--CDDC, Executive Director

We have been envisioning and beginning to build some core components of this flexible, innovative, non-traditional model. One key player will be our Frontline Community Wellness Support staff, a familiar face that guests can count on every single day when they are at CDDC. This "counselor" will practice compassionate listening and thoughtful hospitality, as well as trauma-informed care and low-barrier access. This staff will offer warm hand-offs to our more 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 briefer passing during street outreach, and then in more confidential settings for longer durations as trust evolves. Ideally, this support team will include a staff member trained in acute behavioral health crisis management. Benton County Health Department Harm Reduction and SORT staff will augment our efforts both at CDDC and out in the field, and 2-3 rotating volunteers will support ongoing "Conversation Tables" at CDDC for listening to guests and witnessing them and their stories. CDDC Executive Director will oversee this pilot and team.

Community Engagement: As a community resource hub, CDDC is deeply committed to 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 (or no) costs. None of this is possible without support from local community partners. This pilot is broadly connected with related activities happening both regionally and nationally 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 to spreading the word, some key regional collaborators in this pilot likely will include Community Services Consortium (tri-county), Portland State University, the City of Corvallis, the HOPE Board, Disability Equity Center, Benton County (Mental) Health Department, Corvallis Police Department Crisis Co-Response Team, Assertive Community Treatment Team, and SORT.

Risks and Challenges: The main risk/challenge we anticipate is 1) guests' resistance to behavioral health support given the depth of their traumas and previous experiences with the medical industrial complex. Our unique model of care aims to address that challenge head on by offering counseling supports that are radically different from what people are accustomed to. Other risks/challenges are: 2) need for more material space in which to offer confidential services; 3) balancing formal necessities typical to behavioral health support (case notes and ROIs, for example) with low-barrier access principles. CDDC is exploring space expansion possibilities to ameliorate challenge 2. Our partnership with PSU and our clinical intern, who will also explicitly partner around behavioral health systems management, will be a boon in addressing challenge 3.

C. Sustainability Plan (½ page)

The behavioral health model we want to further explore and grow has already met with enthusiastic support at CDDC. We successfully hired Hezekiah Franklin into the CDDC Frontline Community Wellness Support staff position he started last year as a volunteer. Greg Smith currently sees guests for counseling Monday-Wednesdays, while Pamela Kolbas does both milieu work and holds confidential conversations on Mondays. The addition of a few more volunteers to hold "conversation tables" will augment our low-barrier hospitality that is a first step toward building necessary trust with guests. Kristen Moen and Molly Hartshorn will join the team over summer and fall to significantly amplify our capacity to offer services. As SORT also expands under Maddie Bean's leadership, our ability to reach people who are living in encampments will also dramatically increase.

For financial sustainability, we will continue to seek other grant support as well as establish a formal fundraising strategy that builds on a campaign we did last year to create space for confidential counseling at CDDC. Indeed, CDDC's Executive Director has a demonstrated history of successful grant writing and fundraising and has the knowledge and skills necessary to create long-term funding opportunities from a variety of sources, streams, and partnerships.

CDDC is very excited about the possibility of replicability and scalability of our pilot. This behavioral health model could be implemented at day centers around the region/state. Legislation lately has brought funding to support new navigation centers for unhoused people in numerous counties throughout Oregon. Mental health support of this kind could be integrated into services in those new hubs. Replicability and transferability might also impact street outreach crisis response. Ongoing collaborations with CPD and BCMHD, for example, will allow for conversation about decolonizing, non-enforcement models of crisis response that emulate and expand on CDDC's model of compassionate, trauma-informed, low-barrier, harm reduction-focused behavioral health interventions.

Activities and Monitoring Grid

Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
ACCESS and EQUITY: need for increased access to behavioral health services that address CDDC guests' distinct needs	identify and implement	decolonized, non-traditional options for filling behavioral health support gaps	12/31/2022
SDOH, ACCESS, and EQUITY: need to ensure services are meeting needs of BIPOC community members	research, communication, outreach, and implement	targeted services attuned to impacts of settler colonialism and white supremacy	12/31/2022
EQUITY and SUSTAINABILITY: informal community outreach plan	development, communication, implement	formal community outreach plan in collaboration with partners, especially SORT	12/31/2022
SDOH, ACCESS, and EQUITY: effect increase in CDDC guests using in-house behavioral health services	develop and implement	measurable increase in CDDC guests using in-house behavioral health services	12/31/2022
SDOH and EQUITY: lack of resources about behavioral health support impacts and destigmatizing care	identify, advise, and communicate	offer resources about behavioral health support impacts and and destigmatize care	12/31/2022
ACCESS and EQUITY: minimal supported resource navigation around behavioral health options, traditional & non	identify, advise, and communicate	amplified supported resource navigation around behavioral health options, traditional & non	12/31/2022
REPLICABILITY and SCALABILITY: need for increased partnership/collaboration to scale and replicate services in region/state	development, communication, implement	replicate trauma-informed, low-barrier, harm-reduction focused behavioral health interventions	12/31/2022

Pilot: Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members

Pilot Start Date:	**1/1/2022**		**Pilot End Date:**	**12/1/2022**
Direct Costs			**Total Cost**	**Amount Requested***
offer greater access to behavioral health services through adequate resources and supports			$30,000.00	$30,000.00
ensure services are meeting needs of BIPOC community			$10,000.00	$10,000.00
increase service use through community outreach, including street outreach			$7,000.00	$7,000.00
Total Direct Costs		**Rate (%)**	**$47,000.00**	**$47,000.00**
Indirect Expenses		10.00%	$4,700.00	$4,700.00
Total Project Budget			**$51,700.00**	**$51,700.00**

Developing a Diverse Dental Workforce

Backbone Organization: Capitol Dental Care

Billing Address: 3000 Market St NE, Suite 228 Salem, OR 97301

Sites: Lebanon, Corvallis

Counties: Linn, Benton

Priority Areas:

- Developing a bilingual and bicultural workforce
- Pay equity through building and sustaining the workforce
- Subpopulations of IHN-CCO members that experience health disparities o E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, youth in transition from foster care

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:

A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.

Indicator Concepts

d. Appropriate physical, behavioral, and oral preventive healthcare for all ages

SD4: Increase health equity.

Areas of Opportunity

i. Health disparities experienced by members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.

Pilot Contacts	Name	Email
Primary	Linda Mann	mannl@interdent.com
Proposal	Karen Hall	hallka@interdent.com
Contracting	Linda Mann	mannl@interdent.com
Financial	Linda Mann	mannl@interdent.com
Reporting	Karen Hall	hallka@interdent.com

2. Proposal Narrative

A. Executive Summary

Developing a Diverse Dental Workforce aims to fast-track high school graduates into a dental career as certified dental assistants and interpreters after graduation. Capitol Dental Care (CDC) has a dental assisting (DA) program to train dental assistants, but getting applicants to utilize this training program is difficult in the current employment environment. “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. We will be relying heavily on the schools’ expertise and experience in their career counseling programs to advertise and identify applicants for this program. Upon completion, graduates will have radiology and dental assisting certification and will be contracted for full-time placement with full-time benefits as dental assistants in a CDC dental office. In addition, they will have fulfilled the requirements for the Oregon Health Care Interpreter Program.

B. Pilot Description

Detailed description of the proposed pilot including:
- Pilot goals, activities, and how they will be measured as indicators for achieving the outcomes

Goal 1: Create partnerships and applicant pool			
Activity 1:	Create MOU contracts with Lebanon and Corvallis High Schools		
Activity 2:	Create application for DA program		
Activity 3:	Select applicants for DA program		
Intervention		Activities	Measurement
In collaboration with partnering high schools, we will develop the Memorandum of Understanding (MOU) with Lebanon and Corvallis High Schools to create this unique partnership. In addition, we will work with these partners to develop the application and select students from the applicant pool. This will need to be done prior to January 1 so that students can start program in winter term.		We anticipate it will take several meetings with our high school partners to develop the MOU and application for the pilot. The partners will need to advertise the project and encourage participation. We will speak at the high school and be available to answer questions for students.	Measurement of success is having the MOU and application completed within one month, and the applicants selected within three months.
Goal 2: Train and place DAs into workforce			
Activity 1: Utilize CDC DA program for training			
Activity 2: Place newly trained DAs into full-time CDC employment			
Activity 3: Guide students through Oregon Health Care Interpreter Program			

Intervention	Activities	Measurement
Using CDC's DA training program, provide education to students during their senior year of high school (either during regular school hours or after school, depending on what the school will allow). Upon graduation, place them into contracted full-time employment into a CDC dental office with full-time benefits. Students will also fulfill the requirements for certification as Health Care Interpreters. CDC will pay for all tests and licensing requirements and provide opportunities to get the mandatory documented interpreting experience.	After discussing with high schools, determine when the training can take place for students- during high school hours or before/after school. Work with students to determine which CDC office would be most convenient for hands on training and placement upon graduation.	Measurement of success will be 75% completion of the program. In addition, we anticipate that of those who complete the program, all will become contracted full time employees. Another measurement of success will be if the students can successfully pass all the exams for dental assisting, radiology and Health Care Interpreting.
Goal 3: Improve patient experiences and health outcomes		
Activity 1: Completion of DA survey @ 4,12 months		
Activity 2: Completion of staff surveys @ 4,12 months		
Activity 3: Completion of patient surveys @ 4,12 months		
Intervention	Activities	Measurement
The new DAs and staff will complete surveys which will be subjective in nature. The survey will focus on if the DA and staff feel like the patient experience and health outcomes of patients are improved with having the bilingual/biracial DA on staff.	We will create and distribute surveys to the offices where the DAs are placed upon graduation. The offices will be responsible to distribute and collect the surveys to staff and patients at 4 months	A return rate of 50% surveyed from staff and patients and 100% of DAs would be a measure of success. We anticipate that of those surveyed, 75%

The patient surveys collected from patients who were non-English speakers and of the same race and spoke the same language of the DA will also be collected.	and 12 months after the new DA starts. The DA or dentist will be responsible to determine which patients should be surveyed.	would say that patient experiences and health outcomes improved by having a biracial/bilingual support staff available.

• List all partners that will be working on the pilot and the tasks they will undertake

Lebanon High School- Craig Swanson, Principal - craig.swanson@lebanon.k12.or.us will assign and oversee staff to-

- Help create MOU
- Help create DA Program application
- Help select applicants
- Evaluate program for improvements for following year
- Liaison between students and DA coordinator

Corvallis School District- Rynda Gregory, Teaching and Learning Coordinator- rynda.gregory@corvallis.k12.or.us

- Help create MOU
- Help create DA Program application
- Help select applicants
- Evaluate program for improvements for following year
- Liaison between students and DA coordinator

• Describe how the pilot will promote health equity and reduce health disparities

We are expecting that our members whose primary language is a 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. According to the Oregon Health Authority, 80% of Oregon dentists and 87.5% Oregon dental hygienists reported their race as “white” in the Oregon’s Dental Workforce Report 2015-16.
(https://www.oregon.gov/oha/HPA/ANALYTICS/HealthCareWorkforceReporting/1_Dental_Wkfc_2016.pdf). This is a large number of dental providers who could benefit from having support staff who are not only biracial, but bilingual. We will survey the DA, staff and patients after the new DA has been employed for 4 and 12 months to verify the effect of having a bilingual/biracial support staff available. The students will also complete the requirements for Oregon Health Care Interpreter certification so they will be certified to provide mandated interpretation services for patients in the dental office, as per newly passed HB2359 which requires coordinated care organizations (and therefor dental care organizations) to work with health care interpreters listed on health care interpreter registry.

• Describe the individuals tasked with portions of the pilot and their roles and experience

Capitol Dental Care-Linda Mann, Director of Community Outreach, mannl@interdent.com will provide oversight and direction to the pilot.
Jessica Andrews, Expanded Functions Dental Assistant and DA Educator, AndrewsJ@interdent.com will be DA educator, coordinator and liaison to the high schools and students.
Deanna Lambert, Director of Operations Region 5, LambertD@interdent.com will ensure staffing operations and educational qualifications are met.

Lebanon High School- Craig Swanson, Principal - craig.swanson@lebanon.k12.or.us will assign high school staff members to help with details of the program as needed to ensure successful implementation including: assisting in writing the MOU and application, helping in the selection process of candidates and providing input for evaluating the program.

Corvallis School District- Rynda Gregory, Teaching and Learning Coordinator- rynda.gregory@corvallis.k12.or.us will assign high school staff members to help with details of the program as needed to ensure successful implementation including: assisting in writing the MOU and application, helping in the selection process of candidates and providing input for evaluating the program.

• Describe how members of the community will hear about your project

In addition to the IHN DST community, the high school will advertise the program through their networks to engage senior students and their parents. Our network of dental offices which extends throughout Oregon, Washington and California will learn about the project through our corporate newsletter.

• Describe potential risks and how the pilot plans to address them

As in all pilots which involve staffing, there are risks of staffing changes. As an organization we mitigate those risks by our ability to cross-train many members of our team. In addition, we anticipate that circumstances may cause the DA students to have difficulty completing the program by graduation. We have team members who can spend additional time providing assistance with studying or hands on training as needed.

C. Sustainability Plan

We are very excited about the potential for this project to be replicated to other regions if successfully implemented in these two high schools. Providing an avenue for a career with upward mobility for graduating seniors with full-time work and full benefits is valuable for high schools to offer. Since we have dental offices in many regions throughout the state, we would be able to employ graduating DAs in many regions. After spending the time to create MOUs, applications, workflows and fine tuning the DA training, the cost of replicating in other high schools would be less than the initial pilot and much easier to accomplish for our organization.

Activities and Monitoring Grid
Developing a Diverse Dental Workforce

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Create partnerships	Create MOU contracts with Lebanon and Corvallis High Schools	Contracts will be finalized	October-21
Create applicant pool	Create application for program, interview applicants	Applicants will be chosen for the DA program	December-21
Integrate CDC DA training program into school programming to educate students and provide training for DA certification	DA instructor will provide classroom education for students and coordinate in-office training for students.	Students will have classroom education completed upon graduation, most or all in-office training completed by graduation	June-22
Support students to complete Oregon Health Care Interpreter Program	Pay for and provide dedicated classroom and in-office time for completing requirements for the Oregon Health Care Interpreting Program and certification process.	Completion of requirements for certification	July-22
Completion of surveys by DA students, staff and patients	Improved health outcome surveys will be distributed to DA students, staff and patients at 4 months and 12 months after DA enters workforce.	75% of those surveyed will say patient experience and health outcomes were improved.	October-22

Pilot: Developing a Diverse Dental Workforce

Pilot Start Date:	**1/1/2022**		**Pilot End Date:**	**12/31/2022**
Direct Costs			**Total Cost**	**Amount Requested***
DA Educator/Coordinator			$39,000.00	$37,000.00
laptop, projector, IT			$2,000.00	$2,000.00
training for interpreter certification			$4,400.00	$4,400.00
Travel for DA Educator/Coordinator			$2,500.00	$2,500.00
Host dental office for students			$7,500.00	$0.00
Total Direct Costs		**Rate (%)**	**$55,400.00**	**$45,900.00**
Indirect Expenses		15.00%	$8,310.00	$6,885.00
Total Project Budget			**$63,710.00**	**$52,785.00**

Overcoming Barriers, Foster Youth

Backbone Organization: CASA-Voices for Children

Billing Address: 129 NW 4th Street, Suite B., Corvallis, OR 97330

Site: Home base will be at our office, 129 NW 4th Street, Suite B., Corvallis, OR 97330

County: Benton

Priority Area: Subpopulations of IHN-CCO members that experience health disparities, addressing trauma

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: Access (A 1), Social Determinates of Health (SD 4)

Pilot Contacts	Name	Email
Primary	Kari Pinard	executive.director@casa-vfc.org
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Reporting	Kari Pinard	executive.director@casa-vfc.org

Overcoming Barriers, Foster Youth

CASA-Voices for Children

Executive Summary

With this pilot, CASA-Voices for Children plans to expand our services to include a number of new projects that focus on the overall well-being of a child in foster care. We have created these programs as we have identified barriers in our community that have put our foster children at a disadvantage when it comes to health equity and health disparities. Some of these barriers include lack of access to health care, lack of continuity with providers, and lack of self-advocacy skills when it comes to one's own health.

One project that we will be focusing on during this pilot includes monitoring medical, dental, vision, mental health, and service referrals for our foster children. We will ensure that our foster children will attend medical appointments as recommended and any subsequential referrals are made. CASA-VFC will work with community partners like Old Mill, Encompass, and other service providers to request records from and communicate with.

Additionally, other projects include engaging with the Juvenile Court Improvement Program and the implementation of the Independent Living Program, our Trauma Informed Tutoring Program, and Cultural Advocate Partner Program. With these projects, CASA-VFC will help combat the disparities that our foster children face.

Pilot Description

• Pilot goals, activities, and how they will be measured as indicators for achieving the outcomes

CASA-Voices for Children's mission is to ensure the best outcome and future for each abused and neglected child in Benton County and beyond by training volunteers to provide advocacy, life skills and expanding services to help kids thrive. CASA-VFC does this by appointing a community volunteer to advocate for the needs and best interests of each child.

While this is the foundation of our organization, CASA-VFC is also creating new programs to expand our services to meet the needs of our children. As part of our new pilot, we will follow the well-being of each of our foster youth. This includes requesting medical records, talking with biological parents/foster parents about medical, dental, vision, and mental health needs and concerns as well as speaking with medical professions about individual children and 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 Encompass 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. We request records quarterly to ensure doctor's appointments have been attended and that the child is in good health and follows ups are attended as necessary with referrals being made if needed. We meet with Encompass quarterly. CASA staff and advocates will have access to all appropriate services a child is engaged in during the duration of their case to ensure a child's needs are fully considered when making recommendations to the court and other parties.

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 Encompass 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 attends JCIP monthly and will attend all subcommittee meetings.

CASA-VFC is also designing and piloting an Independent Living Program which will work with foster youth preparing to exit the foster care system by meeting their specific needs. 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 understand why consistent medical care (this includes but is not limited to physical health, dental, vision, mental health) is important, how to contact their doctor, how to make an appointment, and how to advocate for themselves when it comes to their own medical needs. CASA-VFC will engage 75% of teens in the Independent Living Program to equip them with specific skills needed to be successful in adulthood during this pilot. CASA-VFC will be provided training to our advocates to support and teach life specific life skills unique to our population of teens.

We have also implemented a trauma informed tutoring program that works with our foster youth who are behind in school. All CASA-VFC's tutors attend a trauma informed training during which they gain skills and are better equipped to work with foster youth who have experienced trauma in an appropriate way. Tutors will stay with their youth for at least one semester/term, if not the entire year. Tutors will meet with their youth once a week, the length of the tutoring session will be determined by the youth's need. By the end of this pilot, CASA-VFC will provide 100% of children/youth who have

been identified as needing a tutor with a trauma informed tutor. CASA-VFC will monitor and record our children/youth's academic progress.

We will be creating a pilot Cultural Advocate Partner Program to work with our foster children that come from a community that experiences heath disparities. CASA-VFC will work to ensure our Cultural Advocate Partners will represent the demographic of our children and families. Nationally, foster care includes a disproportional demographic of children who identify as a minority culture or identify with the LGBTQ+ community. CASA-VFC will continue to strive for diversity amongst our board, staff, and advocates – this includes the inclusion of people whose first language is one other than English.

• List all partners that will be working on the pilot and the tasks they will undertake

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 collaborates with the following organizations most frequently:

DHS Child Welfare - Work to ensure that children and their parents received the services and support needed to reunify the family or in some cases move to and finalize adoptions and other permanency plans.

Juvenile Court System - Work with all legal parties to improve the experiences for families and children/youth involved in the legal system. Develop best practices to ensure that each legal part was aware of their expectations and those of others.

Jackson Street Youth Shelter - Collaborate with regarding common youth, assist with referrals and utilize each other's area of expertise. Collaborate with for the Independent Living Program to ensure there is no duplication in services and meets specific target audience's needs.

ABC House – Collaborate with for community trainings and utilize their expertise in our advocate training. We also serve as CART (Child Abuse Response Team) members together which staffs child abuse and neglect cases within Benton County.

Old Mill Center - Large scope of collaboration; therapy, recommendations, referrals, supports for our children, foster families, and biological families.

Benton County Mental Health - Member of WRAP teams to collaborate with service providers to meet children and family needs.

Encompass – Will work with Encompass and Dr. Cousin's to ensure consistent and timely medical care for foster youth.

School districts - Collaborate with school districts and ensure CASA-VFC attends school meetings, requests records, and monitors academic performance and behavior.

Local Service Providers - CASA-VFC will work with all service providers that a foster care youth in engaged with; we will request records and discuss progress and ensure they receive all necessary services.

• Describe how the pilot will promote health equity and reduce health disparities

CASA-VFC serves all children that are in the Child Welfare System in Benton County. Therefore our demographic is reflective of the open legal DHS cases in our county and our work is done within the boundaries of said demographic.

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. Some of these barriers are lack of access to health care, being waitlisted for services, lack of continuity with providers, lack of follow through for necessary referrals for services, and lack of self-advocacy skills when it comes to one's well-being and health.

By reducing barriers, CASA-VFC will 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. We will collaborate with Encompass, to ensure children receive timely and consistent medical care while they are in foster care and will request medical records so that CASA-VFC is able to advocate appropriately for recommended services.

This past year, CASA-VFC implemented a required training for all staff members, board members, and advocates that focuses on LGBTQ+ best practices. This fall, we will be participating in an All Children, All Families training program that help us grow our knowledge surrounding LGBTQ+ issues. This knowledge will help promote health equity and reduce health disparities as we will be more familiar with how best to advocate for youth who identify as LGBTQ+ in appropriate manners.

• Describe the individuals tasked with portions of the pilot and their roles and experience

Alyssa received her bachelor's degree in Sociology from OSU. She has been with CASA-VFC for 3 years. Alyssa will be overseeing the Independent Living Program.

Kari Pinard went to OSU and has been an advocate for 18 years and the Executive Director for CASA-VFC for 9 years. Kari will oversee all new and on-going programs and attend JCIP.

Katie Gregory received her undergraduate degree in Educational Foundations from U of O and her master's degree in Curriculum and Teaching from U of O. She has been at CASA-VFC for 4 years. Katie will be ensuring the well-being of all foster child are being met by staff and advocates. She will also oversee the Trauma Informed Tutoring Program and will attend JCIP.

Megan Ellertson received her undergraduate degree in Political Science from OSU and her master's degree in Economics from The University of Texas, Austin. Megan has been with CASA-VFC for 2.5 years. Megan requests records from service providers and tracks our data through our database.

Lisa Kropf received her undergraduate degree in marketing and management from Northwest University. Lisa is our newest addition to our CASA-VFC. Lisa will provide oversight to our advocates who will be monitoring the well-being of our foster children and will also directly monitor some of her own cases.

• Describe how members of the community will hear about your project

Members of our community will hear about our pilot through our community newsletter, our foster parent newsletter, and outreach events such as our annual Child Abuse Awareness month in April which is composed of different community events and provides exposure to our projects. We will collaborate with community partners to help grow our reach when it comes to our mission and organization.

• Describe potential risks and how the pilot plans to address them

Some potential risks that our target population of foster children face are not graduating from high school, homelessness, and perpetuating generational abuse. Our pilot plans to address these issues through the trauma informed tutoring program, Independent Living Program and through services. Engaging in mental health services/medical services will provide our foster children with the best chance to heal from trauma.

- Explain how the pilot is innovative, scalable, and transferable. Describe how the pilot, if successful, will be sustained within your organization and how it could be spread to other organizations. Describe other organizations that have a vested interest in the pilot. Be sure to include other resources and organizations contributing to the success of the pilot. Explain how funding will continue after DST funding is completed.

CASA-VFC's pilot has worked to fill the gaps in services in our community and is an unduplicated program. At the end of this pilot, CASA-VFC would like to take this to other CASA programs in Oregon to implement based on their own community needs. The pilot is also unique to the CASA community and would help programs expand their reach and services they provide to foster youth.

CASA-VFC is a non-profit funded through community donations (in-kind and financial), grants and events. To ensure our continued financial stability we will continue developing our major donor base, engaging in fundraising events and applying for grants.

In addition, community collaborations and partnerships are vital to continue the success of our program. Community collaboration has been vital in opening and maintaining our advocacy center and donation center, and will continue to play an important role in the future. CASA-VFC has been shown lots of community support through in-kind donations of baby items, clothing, school supplies, quilts, and more. We are constantly striving to expand community relationships and increase our collaboration with other agencies. These relationships not only strengthen our organization, but also increase community awareness and support.

Activities Monitoring Grid
Overcoming Barriers, Foster Youth

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Foster children's medical, dental, vision, mental health services have required timelines that are sometime met.	Requesting records and communicating with service providers.	100% of foster children's medical, dental, vision, and mental health services will be monitored.	December-22
Community partners meet for the Juvenile Court Improvement Program monthly.	Attend monthly JCIP meetings and all subcommittee meetings. CASA-VFC will continue to chair the subcommittee.	CASA-VFC staff will attend 100% of JCIP and JCIP's subcommittee's meetings.	Dec-22
Foster children age out of the system with optional life skill services, most of which do not meet their specific needs.	Equip teens will self-advocacy skills, life skills, and readiness skills for adulthood. Train advocates on how to teach these skills to teens.	75% of teens will engage with the Independent Living Program that meet their unique needs.	Dec-22
Foster children enter the Child Welfare System academically below grade level.	Monitor the academic progress of each foster child. Request academic records. Attend school meetings.	100% of foster children that have been identified as needing a tutor, will be assigned one.	Dec-22
Nationally, foster care includes a disproportional demographic of children who identify as a minority culture or identify with the LGBTQ+ community.	Recruit and train Cultural Advocate Partners. Create resources that represent our Cultural Advocate Partners. Diligently work to create and maintain diversity amongst the organization.	CASA-VFC will have implemented the Cultural Advocate Partner Program with partners who reflect the demongraphic of our foster children.	Dec-22

Pilot: Overcoming Barriers, Foster Youth

Pilot Start Date:	**9/1/2021**		**Pilot End Date:**	**12/31/2022**
Direct Costs			**Total Cost**	**Amount Requested***
Collaboration/coordination to ensure child/youth receives timely, appropriate and consistent medical, mental health, dental and vision care while they are in foster care.			$85,000.00	$20,000.00
Engaging partners; service providers, legal parties, school staff, foster parents, bio parents and any others involved with the child to ensure that the child/youth's needs are identified and being met. Ensure that the child/youth is treated with respect and dignity by everyone regardless of their status as a foster child and/or their gender identity and their preferred pronouns/name.			$65,000.00	$17,000.00
Data tracking all information regarding a child and their well-being, gaps in services, identify issues within the system that causes harm/trauma to child/youth. Identify and develop process improvements to improve health equity and the overall well-being of the child.			$30,000.00	$5,900.00
Total Direct Costs		**Rate (%)**	**$180,000.00**	**$42,900.00**
Indirect Expenses	(not to exceed	15.00%	$27,000.00	$6,435.00
Total Project Budget			**$207,000.00**	**$49,335.00**

*if amount requested is different from total cost, please describe the source of the additional funds in the narrative.

Pain Science Life Stories

Backbone Organization: Oregon Pain Science Alliance

Billing Address: 3565 NW Van Buren Ave, Corvallis OR 97330

Sites: Community venues in Sweet Home, Lebanon, Albany, Corvallis and Newport

Counties: Linn, Benton, Lincoln

Priority Areas:

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

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:

- Behavioral Health

Pilot Contacts	Name	Email
Primary	John R Kinney	jrolly@afiassociates.com
Proposal	John R Kinney	jrolly@afiassociates.com
Contracting	John R Kinney	jrolly@afiassociates.com
Financial	John R Kinney	jrolly@afiassociates.com
Reporting	John R Kinney	jrolly@afiassociates.com

IHN-CCO Pilot Proposal Project

‘Pain Science Life Stories’

Oregon Pain Science Alliance, Inc. (OPSA)

Contact: John R Kinney
jrolly@afiassociates.com
541-231-5816

A. Executive Summary

Neuroscience research in the last several decades has provided a new BioPsychoSocial understanding of the pain experience, which expands from the 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 rather than depend on the healthcare system. Learning, and gaining confidence in self-care for pain experiences represents an innovation in healthcare. This would be a positive change for health outcomes and expectations of the healthcare system, and an effective alternative to opioids. Since pain is a factor in the majority of complaints presented to healthcare workers, innovations that effectively address the management of pain can be a systemic change for the healthcare system.

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 people whose lives have been changed by understanding Pain Science and the BioPsychoSocial model. 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 objective of OPSA is ‘To transform society’s understanding of pain and improve pain care options and outcomes; and to offer individuals, families and communities hope and choices by promoting education relating to: pain science, the emergent construction of pain experiences, and the potential for deconstruction of pain experiences with a primary focus on the merits of self-management and empowerment strategies in the transformation process.’ OPSA is a nonprofit corporation with a membership of healthcare workers and community members that began offering pain story community session in four mid-valley communities about 4 years ago.

The project will include a larger venue conference on self-managing pain to kick-off the new access service and pre/post surveys of participants 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). The healthcare system will realize cost savings to the extent that people can develop effective self-care for pain experiences, and self-care offers greatly increased access to relief during pain experiences. Also, to the extent that patients can effectively manage their pain experiences, their demand for healthcare worker services should decrease the stress and burnout of workers.

The desired content of each story would be:

1. Healthcare worker story elements: experience in healthcare, beliefs about pain cause and management in the past and now, personal introduction to Pain Science, how Pain Science fits into current practice, how some specific healthcare concept fits into the pain experience and self-care, story of personal and/or un-named patient’s experience(s), how that story relates to our current understanding of Pain Science and self-management, and a next step the listener might consider.
2. Self-care story elements: personal beliefs about pain cause and management in the past and now, personal introduction to Pain Science or to the practices based on Pain Science, pain self-management practices I find useful, and the difference in my pain experiences before and after my introduction to Pain Science.

B. Pilot Description

Goals:

1. To make life stories of Pain Science based healthcare practice and pain experience self-management **readily available** to IHN-CCO members at community sessions and on the internet.
2. To **promote change** in IHN-CCO member‘s, and their healthcare worker’s beliefs based on Pain Science understanding, concerning the factors contributing to pain experiences and to a person’s ability to manage their pain experiences,.
3. To provide **logical and emotional life stories** of Pain Science based healthcare practice and pain experience self-management to IHN-CCO members, and the general public, through community sessions and on-demand via the internet, in order to change their beliefs about pain.

Outcome measurements: (This project does not fit directly into the RFP Outcomes categories, but should impact them in the long-term, because pain experiences frequently interact with trauma and behavioral issues, and Pain Science self-care addresses behavioral beliefs about the causes of pain.)

1. The number of IHN-CCO entities willing to collaborate by **proactive recommendation** of the Pain Science Life Stories sessions and web site to their healthcare workers and members, who are in the target group.
2. The number of IHN-CCO **healthcare workers** who choose to **access** the Pain Science Life Stories sessions and media.
3. The number of IHN-CCO **members** who choose to **access** the Pain Science Life Stories sessions and media.
4. The change reported by IHN-CCO **healthcare workers**, of their **beliefs** concerning Pain Science-based practices and self-care after each community session and each media access session.
5. The change reported by IHN-CCO **members**, of their **beliefs** concerning Pain Science-based practices and self-care after each community session and each media access session.
6. The change reported by **general public individuals** of their **beliefs** concerning Pain Science-based practices and self-care after each community session and each media access session.
7. The number of IHN-CCO **members scheduling pain-science-based healthcare** after encountering the project stories.

Expected outcomes with respect to project goals:

1. The project is expected to produce changes of beliefs within the IHN-CCO members and the general public toward the Pain Science based understanding of pain experiences and self-management.
2. Beliefs are very difficult to directly change but belief change must occur for pain suffers to realize any benefit from Pain-Science-based understanding of pain causes and management developed in the last 40+ years.
3. Our experience with past OPSA community sessions is that individuals engage best with personal stories of pain belief changes and personal outcome benefits of that change in belief, compared to only the delivery of Pain-Science information content. We have no

basis for estimating how effective the stories will be in changing listener's beliefs, so do not have an expectation of a quantitative result.

T

Target population:

IHN-CCO members with interest in, or experiencing pain related to trauma or behavioral issues with pain symptoms and the general public.

Intervention and detailed activities:

1. The primary project intervention is to **change** IHN-CCO **member beliefs** about the BioPsychoSocial factors of pain and evolving self-management of pain experiences through the **logic and emotion** of life stories.
2. The secondary project intervention is to **provide access/contact information** to IHN-CCO members for available **Pain-Science-based healthcare** sources and information.

Anticipated Partners and their tasks:

1. Healthcare providers: IHN-CCO healthcare workers, Sharna Prasad and the Samaritan Health Lebanon MMaPS program, Tina Corey at Linn Co. Mental Health, and Dr. Kevin Cuccaro at Straight Shot Health
2. Health support groups: Wendy Trent at Marble Jar
3. Media providers: public access media channels in Sweet Home, Lebanon, Albany, Corvallis, and Newport to provide advertising for the community and conference sessions.
4. Tasks: To provide encouragement to the IHN-CCO healthcare workers and members to engage with Pain Science Life Stories, to regularly distribute the story event schedules and topics, to provide the internet link to the stories, and to identify healthcare services based on Pain Science understanding of the pain experience.

Equity and tracking IHN-CCO members:

The Oregon Pain Science Alliance Inc. is not a healthcare entity and has no ability to track IHN-CCO members. We must rely on the IHN-CCO entities to connect the project services with their members, to track individual members, and to provide HIPPA suitable results for inclusion in the project statistics.

Social Determinants of Health lens:

This project does not specifically address SDoH factors, except to the extent IHN-CCO entities collaborate with the project, but some of our advertising will be in Spanish, the videos are planned to have a Spanish translation option, and OPSA will explore adding other languages in the future. The project will also seek to engage unions and minor community retail outlets for advertising the project services. Since the understanding of Pain Science and the associated self-care based healthcare is not yet wide spread, not many in the minor communities have benefited. So Pain Science Life Stories from those communities may not be available during the project, but would be sought for future inclusion as those stories emerge.

Project tasks: who, experience, roles:

1. Project management: John Kinney OPSA President, retired engineer and educator.
2. Video capture and edit system: John Kinney OPSA President, current videographer for OPSA, with the assistance of a hired professional videographer.
3. Web system development: John Kinney OPSA President, retired engineer with the assistance of a hired professional web site developer.

4. Promotional material development and advertising: Cyndee Pekar OPSA member with the assistance of a hired media design professional.
5. Collaboration with IHN-CCO entities: Sharna Prasad OPSA member will facilitate the collaboration.
6. Community story events: Sandra Ragan OPSA member will coordinate the events, she has coordinated all the past community events.
7. Large venue events: OPSA member to coordinate these events.
8. Outcome survey design and tabulation: John Kinney OPSA President, retired engineer and educator, with the assistance of a hired professional

Project alignment with OPSA long term goals:
The proposed project is one of the primary goals of OPSA as quoted in the Description section above.

Advertising:
1. Primary advertising to IHN-CCO members by project coordinator collaboration with IHN-CCO entities to provide project promotional materials, event schedules, and internet links.
2. By paid advertising on local newspaper, radio and TV outlets.
3. By event notice distributed to local retailers and unions for public display.
4. By event notice distribution to collaborating IHN-CCO healthcare and pain science support entities for client and public display and distribution.

Potential risks and plans to address risks:

1. Reluctance of IHN-CCO entities to collaborate with the project would limit access to IHN-CCO members. Barriers to collaboration might be:
    a. Perception of IHN-CCO entities that OPSA is not a recognized party in the delivery of credible healthcare information.
    b. The lack of understanding of IHN-CCO decision makers of the difference between pain-science based practice and current practice, and the potential benefits to their members.
    c. Our plan to address this risk is to enlist the assistance of Dr. E, to facilitate OPSA communication and collaboration with IHN-CCO entities.
2. The proposed budget for the project is an estimate based on our current understanding of the needs and costs, so execution of the project may allow us to do more or less than outlined. Our plan to address this risk as the project moves forward is to adjust tasks and costs within the budgeted total to realize the maximum benefit.

C. Pilot Timeline 2022

Collaborate with IHN-CCO entities ..... Oct 31, 2021 - Dec 31, 2022
Identify, order, receive, and learn video equipment ..... Nov 1, 2021 - Mar 31, 2022
Create operational template for video and editing of pain stories ... Nov 1, 2021 - June 30, 2022
Stream, capture, and edit 4 Story sessions in the fall of 2021 ..... Sep 2021 - Dec 2021
Stream, capture, and edit 4 Story sessions in the spring of 2022 ..... 1 Feb - June 30, 2022
Stream, capture, and edit 4 Story sessions in the fall of 2022 ..... Sep 1 - Dec 31, 2022
Develop web site criteria, select and contract web site developer .. Nov 1, 2021 - Mar 31, 2022
Purchase and setup web server equipment..... Apr 1 - Jun 30, 2022
Develop and implement the OPSA web site ..... Jul 1 - Sep 30, 2022
Plan and implement 12 story session venues..... Aug 1, 2021 - Aug 31, 2022
Plan and implement 4 conference venues..... Aug 1, 2021 - Aug 31, 2022
Produce event advertising and engage media providers ..... Aug 1, 2021 - Aug 31, 2022
Develop outcome measurement surveys..... Nov 1, 2021 - Feb 28, 2022
Conduct 4 fall Story conferences..... Sep 1, 2022 - Dec 20, 2022
Evaluate outcomes ..... Jan 1 - Dec 31 2022
Write project report ..... Dec 1 - Jan 31 2023

D. Sustainability Plan

1. The equipment and procedures funded by the project provide the base for OPSA to continue providing free access to Pain Life Stories as the understanding of Pain Science and pain self-care management continues to evolve.
2. OPSA will continue to collaborate with IHN-CCO entities to provide current access information to the evolving Pain Science Life Stories.
3. The current OPSA community meeting program will sustain the Story sessions in the future.
4. OPSA will train 2 volunteers to stream, capture, and edit the Story videos following the project template.
5. OPSA will train two volunteers to maintain and update the web site with current Story events promotion.
6. The OPSA Education committee will continue to evaluate Story session and web site surveys and to attempt to publish the results.
7. We anticipate the increased visibility of the conferences and advertising will increase OPSA membership, so that member dues plus other fund-raising projects will cover the costs of future session venues, advertising, and web site service costs.

Activities Monitoring Grid
Pain Science Life Stories

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Add Lincoln County to venues/life story speakers for eight monthly OPSA community education sessions (held September thru May) for promotion to tri-county IHN-CCO members and other interested individuals through clinicians. Stories share learned tools and self-care for chronic pain based on current pain science.	OPSA Education Committee to coordinate venues, speakers for Corvallis, Albany, Newport/Lincoln City, Lebanon/Sweet Home. OPSA Committee and other volunteers post flyers and contact clinicians in tri-county area, focusing on primary care clinicians who may serve IHN-CCO members.	Adding Lincoln County to rotating roster for monthly community education events provides IHN-CCO members and clinicians, and others in addition to the Linn and Benton County area, access to networking with peers and health professionals who are using pain science in their practice.	Start sessions Winter of 2022, then ongoing
Purchase video and streaming equipment, editing software. OPSA has had to borrow equipment to create video for past meetings. Video quality and sound has been marginal and editing the video time comsuming.	Videographer establish needed equipment and software specs and procedures	To create a library of high-quality recordings of individual and healthcare professional life stories suitable for website	beginning 01/15/2022
Develop and maintain website to share recorded personal stories from professionals who use pain science in their practice, and the pain experience of their patients and other individuals who use pain science tools to overcome persistent pain. Each community meeting event will also be live streamed to reach those who cannot or may not wish to attend live sessions.	Receive professional estimates to develop website, and for hosting service. Also explore in-house development of same through hosting service offering basic web templates.	Live stream and record/edit high-quality video of community education events and conferences for website use. This website library provides accessible video and Spanish translation to IHN-CCO members and others for review. We will monitor number of visitors to website and will work to determine a method that does not violate HIPAA to be able to count IHN-CCO members from general public. We hope the IHN-CCO may be able to give direction on this task.	Complete by 12/31/2022 then ongoing
Create survey to query session participants about understanding of their pain experience before and after participating in community meetings and conferences.	OPSA Education Committee develop survey with input from OPSA members, compile then analyze data to determine effect on IHN-CCO community outcomes. Continue to refine survey as more data is received.	OPSA Education Committee maintain and refine survey using input from IHN-CCO members and others attending community meetings, in person or via live stream. Include checkboxes for community member vs clinician.	Complete by 1/31/22 then ongoing to refine

Activities Monitoring Grid
Pain Science Life Stories

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
OPSA and collaborators present mini conferences (approx 4 hours), each with multiple speakers, to IHN-CCO members/participants and other interested individuals in the community.	Have a mini conference at each of four sites: Albany, Corvallis, Lebanon/Sweet Home, Newport/Lincoln City to introduce OPSA and pain science to communities. Ask for pre-signup, at no charge to participants, to determine interest ahead of conference.	Collaborate and coordinate with Kevin Cuccaro, Straight Shot Health; Tina Corey, Linn County Mental Health; Sharna Prassad, Samaritan Health Lebanon MAPS; Marble Jar self-help support group. Continue to explore new collaborations through networking with attendees.	Through proposal life (2/1/22 - 12/20/22)
Order promotioinal pens/tablets with OPSA logo for conference distribution	OPSA Education Committee select and order	For promotion of OPSA website	Order before first conference
Design and print material to promote OPSA community meetings to PCPs and their IHN-CCO patients and all interested individuals.	OPSA Education Committee and other OPSA Volunteers	Community meeting dates, venues, and speaker info using individual, flyers.	Begin September 2021
Design and print material to promote OPSA conferences to PCPs and their IHN-CCO patients and all interested individuals.	OPSA Education Committee and other OPSA Volunteers	Conference venues, and speaker info using individual, flyers.	by Aug 31, 2022
Distribute OPSA promotional materials to clinicians for introducing pain science self-care to IHN-CCO and other patients; and to local retailers, libraries, fraternal organizations, for public display.	OPSA Education Committee and other OPSA Volunteers	After original promotion, periodically check that promotional material is still prominent and easily available	Ongoing through project
Advertise in local areas through radio, newspaper, and public access media channels to reach IHN-CCO members who may use these services.	OPSA Education Committee	Targeting Albany, Corvallis, Lincoln City, Newport, Lebanon, and Sweet Home	Just prior to events held in area

Pilot: Pain Science Life Stories

Pilot Start Date: 11/01/2021	Pilot End Date: 12/31/2022	
General and Contracted Services Costs:		
	Total Cost	**Amount Requested**
Video and Website Development Costs:		
Core cost to purchase video equipment to record and live stream Story Sessions:		
Video, audio and streaming equipment	5,000	5,000
Computer equipment for video editing and serving website	5,000	5,000
Videographer develoment assistance	1,500	1,500
Editing software (reduced rate for non-profit)	500	500
Website development for OPSA website and streaming Story Sessions		
Web domain	1,000	1,000
Hosting service for website	1,000	1,000
Website developer charges for creation and instruction	15,000	15,000
Subtotal, Equipment/Software/Website Development:	**29,000**	**29,000**
Story Session Community Meeting Costs:		
Venue costs for eight total, 1.5-hour Story sessions in Spring/Fall 2022		
Corvallis	750	750
Albany	750	750
Lebanon/Sweet Home	750	750
Newport/Lincoln City	750	750
Subtotal, Story Session Community Meetings:	**3,000**	**3,000**
Venue/Catering for Four Large Conferences:		
Corvallis	2,500	2,500
Albany	2,500	2,500
Lebanon/Sweet Home--Lebanon Samaritan Community Hosp.	2,500	2,500
Newport/Lincoln City--Education Center at Newport Samaritan Community Hosp.	2,500	2,500
Travel costs for featured clinicians and patients	3,000	3,000
Handout merchandise to participants	500	500
Copying for conference handouts	500	500
Subtotal, Venue/Catering for Four Large Conference:	**14,000**	**14,000**
Advertising Costs for Conferences:		
Radio in local areas	1,000	1,000
Newspaper in local areas	1,000	1,000
Color copying for handouts to clinicians to share with their IHN-CCO patients and others	1,000	1,000
Subtotal, Story Session Community Meeting:	**3,000**	**3,000**
Consulting and Supply Costs for Survey		
Survey design and analysis model development	1,000	1,000
Total Direct Costs:	**50,000**	**50,000**

PUENTES:

Improving Language Access and Culturally Appropriate Messaging to Address Health Inequities in the Latinx Communities of Linn and Benton Counties

Backbone Organization: Casa Latinos Unidos

Billing Address: 1555 SW 35th Street, Corvallis, OR 97333

Sites/Counties: Benton and Linn Counties

Priority Areas:

- Language access including health literacy, access to information in their target language, collaboration with health agencies and providing supports/feedback on the needs of the Latinx community to address health inequities

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:

SD4: Improve health equity.

Pilot Contacts	Name	Email
Primary	Miriam Cummins	executive.director@casalatinosunidos.org
Proposal	Miriam Cummins	executive.director@casalatinosunidos.org
Contracting	Miriam Cummins	executive.director@casalatinosunidos.org
Financial	Miriam Cummins	executive.director@casalatinosunidos.org
Reporting	Miriam Cummins	executive.director@casalatinosunidos.org

Proposal Narrative

A. Executive Summary

Casa Latinos Unidos is committed to ensuring that the Latinx community members of Benton and Linn counties have access to health materials that are culturally and linguistically appropriate. Through partnership with public health systems and the involvement of the Latinx community, we aim to establish our presence as advocates for our community by assessing written materials and messaging available to Latinx IHN-CCO members of Benton and Linn Counties. As a culturally-specific organization rooted in the Latinx community, our organization is well positioned to represent the needs of that community to access information and knowledge in ways that are relevant to the intended audience and that will increase sustainable access to services and resources. To do this, Casa Latinos Unidos will be the bridge (hence the project name 'PUENTES') between the IHN-CCO Latinx community of Benton and Linn Counties and public health services and will take responsibility for identifying challenges with the linguistic and cultural appropriateness of current written and oral materials and messaging, as well as identifying the need for new information when that is not available. Ultimately, the aim of this project is to begin the process of erasing health inequities that continue to disrupt the lives of Latinx people and that can be addressed by improving communication and cross-cultural understanding.

B. Pilot Description

Introduction

Casa Latinos Unidos (CLU) has a more than decade long history of facilitating communication and cross-cultural understanding between Latinx individuals and families and the system of services in Benton and Linn Counties. In general, we do this by acting as a bridge or broker between the community and the system of services, making each one aware of the characteristics and needs of the other. This translates into activities such as participating in service partnerships and coalitions as advocates for the Latinx community, translating into Spanish correspondence or emails in English that clients cannot read, helping clients complete forms online and make appointments with a

variety of service providers, and by accompanying clients to appointments so that we can help with communication.

Our aim for this project is to focus our communication and cross-cultural understanding work on IHN-CCO members that are part of the Latinx community and receive health benefits from OHP and/or Medicare. We propose to work in partnership with Samaritan Health Services (SHS) to improve the quality of materials and messaging available to Latinx community members. We will provide information to SHS about how to create material and messaging that are linguistically understandable and culturally appropriate to ensure that this messaging achieves the intended purpose. The cultural diversity that characterizes the Latinx communities of Benton and Linn County will be reflected in the findings and recommendations we provide SHS; included in these communities are people whose first language is Spanish as well as those who are speakers of Mam and other indigenous languages.

Goals and Activities

These are the goals of the PUENTES project:

Goal A: To identify problems and issues with the linguistic and cultural appropriateness of the written material and messaging Samaritan Health Services uses to reach out to their Latinx IHN-CCO clients.

Goal B: To identify in the Latinx IHN-CCO community of clients, areas of need that are currently not addressed through existing material and messaging.

Goal C. To propose to Samaritan Health Services ways of improving the linguistic and cultural appropriateness of the existing material and messaging, or to create new ones if needed, used to reach out to their IHN-CCO clients.

To accomplish these goals, the project will engage in the following data collection, analysis, and report writing activities:

1. Establish a committee with SHS to monitor the progress of the project. The committee will inform the project about materials and messaging that requires a quality assessment through PUENTES data collection activities. Also, we will regularly provide the committee with current information gathered through focus groups and other data related activities, as well as with suggestions about how that information can be used to improve materials. Finally, the committee will provide to us the materials they have improved with our recommendations so that we can assess quality and effectiveness in the community in the final focus group. The final report will be provided to the committee as well.
2. Collect data through a (simple) semi-structured questionnaire. The questionnaire will focus on problems and issues with the current material and messaging Samaritan Health Services uses to reach out to the Latinx community, as well as on areas of need that are not currently addressed through those materials and messaging. This involves the following specific activities:
    a. Develop a semi-structured questionnaire to collect the information.
    b. Collect information from our clients that are IHN-CCO members using the form created. Our office intake staff and the ENLACES promotoras will collect the information from their clients.
    c. Analyze the data collected through this form to identify dominant themes.

3. Collect data through focus groups. Four focus groups will address problems and issues with the current material and messaging Samaritan Health Services uses to reach out to the Latinx community, as well as identify areas of need that are not currently addressed through those materials and messaging. One additional focus group will be conducted closer to the end of the grant period to assess improvements made to material by SHS.

    This involves the following specific activities:
    a. Create a focus group interviewing guide to collect information on problems and issues with the current material and messaging Samaritan Health Services uses to reach out to the Latinx community, as well as on areas of need that are not currently addressed through those materials and messaging.

b. Conduct 4 focus group sessions with IHN-CCO members using the previously created interviewing guide. The focus groups will be conducted with IHN-CCO Latinx members in two urban (Corvallis and Albany) and two rural (Monroe and Lebanon) settings.
c. Conduct 1 focus group close to the end of the project period to assess the point of view of the Latinx community regarding material SHS has improved through the feedback we had provided through the year. The decision on where to do this focus group will be made later on based on how well the previous focus group sessions worked.

4. Collect data through photovoice. Request our clients to take photographs of written printed material or online material they consider to be both good and bad examples of effective messaging on health. Also, ask them to explain their choices in a few sentences.

5. Analyze the collected data. Using professional software, we will perform qualitative data analysis and create engaging reports to identify dominant themes in data collected through the questionnaire, focus groups, and photovoice.

6. Provide regular feedback to SHS on emerging findings from research. Will will regularly inform SHS about what the people we have interviewed tell us about the material SHS produces in Spanish and Mam languages.

7. Write a report of findings and recommendations to Samaritan Health Services. Write an executive report listing and describing key findings and recommendations. Additionally, Casa Latinos Unidos will be available throughout the grant period to provide information from our findings that can be used for making immediate decisions regarding the need to improve the linguistic and cultural appropriateness of material and messaging.

8. Write an executive summary with findings and recommendations for the Latinx community. Write a short report (only a couple of pages) in Spanish with key findings and recommendations from the project. This will be published on the

organization's website and through our social media channels. This report is intended for the Latinx community.

Promotion of Health Equity and Reduce of Health Disparities

Through the PUENTES project we will promote health equity and aim at reducing health disparities by contributing to improve SHS communication effectiveness when reaching out to Latinx IHN-CCO members. As mentioned in the National Culturally and Linguistically Appropriate Services Standard[1], providing culturally and linguistically appropriate services is instrumental in advancing health equities and eliminating health disparities. For members of the Latinx community to make use of services effectively, they first need to understand all that is related to those services. To achieve that, it is not enough to have well-done translations of written material. Rather, it is necessary for the messages to be meaningful from the point of view of the cultural nuances of the intended audience. The working assumption is that if Latinx IHN-CCO members fully understand the messages, they will improve their health literacy and therefore be able to "find, understand, and use information and services to inform health-related decisions and actions for themselves and others."[2]

Individuals tasked with portions of the pilot

The PUENTES project pilot will be managed by Miriam Cummins, CLU Executive Director. Administrative support will be provided by Paige Hook, Executive Administrative Assistant for CLU. Data collection, focus groups, and photovoice recruitment, analysis, and report writing will be managed by Dr. Ricardo Contreras, Applied Cultural Anthropologist and External Consultant with Casa Latinos Unidos. Dr. Contreras will be supported by Tye Vossler-Shipp, Executive Communications Specialist for CLU and a paid student intern studying public health or applied anthropology. Data collection questionnaires will be administered by Cynthia Salgado, CLU Office Intake Coordinator, and the ENLACES Community Health Workers/Promotoras de Salud, Cynthia de la Torre, Melissa Sanchez, Karina Ruiz Lopez and Susy Ibarra.

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[1] Think Cultural Health (n.d.). National CLAS Standards. Retrieved July 14, 2021, from https://thinkculturalhealth.hhs.gov/clas

[2] CDC. (n.d.). WhatIs Health Literacy? Retrieved July 14, 2021, from https://www.cdc.gov/healthliteracy/learn/index.html

How the community will hear about it

We will inform the Latinx community about this project, and recruit participants for the focus groups and photovoice, through our social media channels as well as direct communication with clients. For this, our community health workers/promotoras will play a key role, given their knowledge of the Latinx community in Albany, Corvallis, Lebanon, and Monroe, the four sites where we will conduct the focus groups. Our many established connections with local business and community leaders will significantly increase awareness about PUENTES. Additionally, we will write an executive summary of the project in Spanish that will be made available to the Latinx community through our website and social media channels.

Potential risks and how we will address them

We do not anticipate potential risks for this project. Still, we will ensure confidentiality of the data collected through informed consents and we will request approval for the project from the Oregon State University IRB. The report provided to Samaritan Health Services, as well as any communication with the organization, will never include names of the individuals in the Latinx community that provided the data.

C. Sustainability Plan

This project is innovative in the sense that it will use research to inform the production of written material and messaging that is linguistically and culturally appropriate. Not only does this exploratory stage strengthen the relationship between SHS and CLU, it provides a uniquely personal perspective through systematic data collection allowing the PUENTES committee to make recommendations to SHS that represent the points of view of members of the Latinx community that are IHN-CCO clients. We envision a future for PUENTES that will transcend this particular project by incorporating a research methodology that will act as a replicable model that is vital to sustainability of this project and future projects focused on messaging and audience. Furthermore, we foresee that our organization will play an ongoing, dynamic role in supporting other agencies in Linn, Benton, and other counties that need to tailor their services to the cultural characteristics of Latinx communities. At the same time, the data we collect through this project, as well as the recommendations we make to Samaritan Health

Services, will be useful to inform other projects related to cross-cultural communication and outreach that our organization implements in the future.

Activities Monitoring Grid
PUENTES

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
There is a lack of systematically collected information on the linguistic and cultural appropriatness of material and messaging related to health and health services.	Collect data through the following procedures: a) questionnaires administered by CLU staff. b) 5 focus group sessions. c) Photovoice.	The project will collect and analyze data from the Latinx community about how to best tailor health material and messaging to the linguistic and cultural characteristics of that community.	Data will be collected starting on month 2 and throughout the project period. The last focus group will be conducted by month 10.
A committee will be established to oversee the project.	Bi-monthly meetings, meeting agendas, meeting notes.	a) The committee will have provided the material and messaging whose linguistic and cultural appropriatness the project will assess in the community. b) The committee will be informed throughout the project period of emerging findings and recommendations about improving materials and messaging. c) The commitee will provide the project the material and messaging SHS will have improved based on the project's recommendations. d)The project will inform the committee of the findings from the focus group conducted closer to the end of the project period to assess the linguistic and cultural appropriatness of the material that was improved based on the project's recommendations. e) the project will submit to the commitee the final report with findings and recommendations.	a) Committe established by Month 1; b) Comittee will work throughout the duration of the project.
At least some of the material and messaging that SHS produces aimed at the Latinx community requires improvent so that it is better understood by their Latinx clients.	The project commitee will provide the material whose linguistic and cultural appropriatness needs to be improved.	a) The material will be written in a way that is fully understood by the Latinx clients. b) Whenever appropriate, the project will recommend alternative modes of communication to transmit the messages that best suit the characteristics of the community (e.g., videos, fotonovelas, comic books, acting).	Throughout the project period.
There are areas of community need that are not addressed by the current health-related material that SHS produces in Spanish.	The project staff will collect the data through focus groups sessions.	a) The project will have identified areas of community need that are not currently addressed by the SHS health-related material. b) The project will propose how to communicate in a linguistically and culturally appropriate way aout these areas of community needs.	Throughout the project period. Recommendations on this will be included in the regular commitee meetings and in the final report.

Pilot: PUENTES - Improving Language Access and Culturally Appropriate Messaging to Address Health Inequities in the Latinx Communities of Linn and Benton Counties

Pilot Start Date:	**11/1/2021**		**Pilot End Date:**	**2/1/2023**
Direct Costs			**Total Cost**	**Amount Requested***
Collaboration with Samaritan - Research, Data Collection, Consultation, Meetings FTE			$28,800.00	$20,000.00
Software - Qualititive Data/Analysis and Report Writing software			$6,050.00	$5,000.00
Latinx Focus Group - Food, Childcare, Materials			$29,000.00	$25,000.00
Total Direct Costs		**Rate (%)**	**$63,850.00**	**$50,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)		5.00%	$3,192.50	$2,500.00
Total Project Budget			**$67,042.50**	**$52,500.00**

*if amount requested is different from total cost, please describe the source of the additional funds in the narrative.

Red Feather Ranch Women Veterans Cohort

Backbone Organization: Red Feather Ranch

Billing Address: P.O. Box 815, Philomath, OR 97370

Site(s): Virtual, In-person site – TBD (COVID permitting)

County(s): Benton, Lincoln, Linn

Priority Areas: Addressing Trauma; Improving access to behavioral health in non-traditional ways; Increasing and improving access to behavioral health care in light of COVID-19; Subpopulation that experiences health disparities

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity:

Outcomes:

1. Increase the percentage of women veterans who receive appropriate care at the appropriate time and place. (A1)
2. Reduce stigma and increase community awareness about behavioral health issues experienced by women veterans. (BH1)
3. Increase mental health and substance use screenings, services, referrals, and peer and parent support for women veterans. (BH3)
4. Improve care for women veterans experiencing severe and persistent mental illness. (BH5)
5. Behavioral health funded and practiced with equal value and priority as physical health. (BH6)
6. Increase health equity for women veterans. (SD4)

Indicator Concepts:

Trauma-informed care (A1 c), (BH1 a),
Peer delivered (BH1 b), (BH3 ii),
Suicide, self-harm (BH3 b) overdose (BH3 c)

Areas of Opportunity:

Stigma (BH1 i), (BH5 v)
Peer delivered ((BH3 ii)
Not in crisis (BH3 iv)
Health equity (BH5 iv)
Preventative behavioral healthcare promotion wellbeing (BH5 ii)
Health disparities (SD4 i)
Health equity data (SD4 ii)

Pilot Contacts	Name	Email
Primary	Paige Jenkins	paige@redfeatherranch.org
Proposal	Paige Jenkins	paige@redfeatherranch.org
Contracting	Paige Jenkins	paige@redfeatherranch.org
Financial	Paige Jenkins	paige@redfeatherranch.org
Reporting	Paige Jenkins	paige@redfeatherranch.org

Executive Summary:

Women veterans are the fastest growing subpopulation of veterans. Oregon Department of Veterans Affairs (ODVA) estimates 1500-3000 women veterans live in the Benton, Linn, Lincoln tri-county area. Service women are marginalized during their military service and again when they become veterans in the civilian community due to their unconventional gender roles and experience. Women vets are known to have poor health outcomes; they are twice as likely to suicide and 3-4 times more likely to become homeless as compared to civilian women. Due to military related traumas and exposures women experience more chronic physical and mental health issues than male veterans or civilian women. More than half who experienced Military Sexual Trauma (MST) also experienced childhood trauma resulting in complex trauma. Women veterans remain disadvantaged in attaining their full health potential.

Evidence suggests that self-destructive behaviors including neglecting preventative care, can be improved through bonding in culturally informed and trauma-informed social support networks. The **Women Veteran Cohort Pilot** provides a framework to build a local community peer support network wherein participants are given tools to identify aspects of their own health that they would like to improve and ways to visualize and attain those improved outcomes. Women participants will finally be seen, mirrored, validated, and honored for their service and sacrifice. The pilot addresses all forms of trauma and grief, especially MST and institutional betrayal trauma. The Cohort resolves the isolation and internalized stigma that occurs from not fitting in with the largely male veteran community and not fitting in with civilian women.

Red Feather Ranch: A Place for Women Veterans in Philomath, Oregon has successfully provided virtual peer-support programs for women veterans since March 2020. With minimal outreach we have served 43 unique individuals in our online Healing Room for 74 weeks with an average of 9 women participating weekly. Last year we conducted an online 6-month beta-cohort with 4 women. In our **Women Veteran Cohort Pilot**, we intend to expand and enhance our Cohort to include 16 women and, Covid permitting, include two in-person weekend gatherings at the beginning and end.

Pilot Description

The first goal of the Women Veterans Cohort Pilot is to identify at least 300 women veterans in the tri-county area, with targeted outreach to rural veterans and Siletz and Grand Ronde tribal members.

The primary activities include communications and public relations campaigns. Specific activities include developing and distributing press releases, public service announcements, pre-recorded videos, social media content, and marketing materials including a flyer and brochure. Communications will be shared online (email, social media, pre-recorded videos on our website) and offline for those people and places that we cannot reach online. We will target military and veteran organizations and institutions, primary care providers, behavioral healthcare providers, other relevant community service providers, and colleges and universities in the tri-county area. (Also see page 5: **How members of the community will hear about Red Feather Ranch and the Cohort Pilot**)

We will track and record our efforts and results by the:

- Number of contacts made
- Number of referrals received
- Number of women veteran responses via our website, email, social media, and phone

The second goal of our pilot is to conduct a needs assessment survey and interviews.

Develop, coordinate, and distribute 100 surveys and conduct 50 interviews with women veterans in the tri-county area, including Siletz and Grand Ronde. This effort will add to existing health equity data on women veterans that is currently fragmented and deficient. To encourage survey and interview participation, we plan to offer the first 150 participants cash cards of $25 for the survey and another $25 for the interview, for a maximum expense of $3750. We will continue our communications outreach and needs assessment surveys beyond our baseline goals. By 2/2022 we will provide a comprehensive report based on the first 150 needs assessment survey/ interviews to describe the health disparities and barriers women veterans experience in the tri-county area. In 12/2022 we will update the report with additional survey data.

We will track our efforts and results by:

The number of women veterans who complete the survey and/or interview
Compiling health disparity and barriers to receiving behavioral and physical health care
The number of women reporting a lack of mental health services when not in crisis
The number of women veterans who report a diagnosis of severe and persistent mental illness and the care they are receiving.

The third goal of the Cohort Pilot is educating 100-150 community service providers, primary care providers, and academic public health departments about the experiences of women veterans in an effort to reduce stigma and normalize behavioral health issues.

Activities include developing a fact sheet, a white paper, pre-recorded video, and presentation materials. Scheduling virtual live presentations and Q & A sessions. In-person presentations will be accommodated as requested, COVID permitting.

Tracking the:

- Number of community service providers who attend educational presentations
- Number of white papers distributed
- Number of fact sheets distributed
- Number of video views

The fourth and final goal of the Cohort Pilot is to develop and facilitate an innovative, sustainable, scalable, and transferrable peer support community for women veterans to improve general well-being and health outcomes.

Cohort Participant Goals and Activities

- Develop and expand women veterans' knowledge, skills, and abilities toward improving their own behavioral and physical health care and general well-being, through self-advocacy, peer advocacy, and skill development.

    - Encourage participants to focus on their own health and wellbeing to reduce self-harming behaviors, (e.g., overeating, substance use, suicidal ideations and attempts, overdose, etc.), introduce practices associated with improved health outcomes, and prevent mental health crises.

    - Throughout and upon completion of the pilot, participants will identify triggers resulting from trauma, projections, judgments, and boundaries, practice setting personal boundaries, and develop better communication skills.

    - The peer community provides regular and ongoing opportunities to practice and receive feedback on new levels of awareness, challenges, and accomplishments. Pilot participants practice communicating regularly with their peers and developing supportive relationships.

    - Participants graduate with new and refined tools to enhance their self-care and wellness. Their actions and reactions will become more intentional toward their own highest good. They will learn how they can ground themselves at any time and how to pause before engaging in self-destructive behavior.

Activities:

- Develop participant brochure, application, agreement, and participant materials.
- Provide staff trainings, debriefings, and trauma-informed care.
- Coordinate and conduct Cohort activities that include scheduling and interviewing prospective applicants, assessing for conflicts or obstacles to participation, e.g., internet access, transportation, employment or care-giving duties, mental health and substance use disorders (SUDs).
- Plan and facilitate two 3-day, 2 night in person gatherings (COVID permitting) at the beginning and end of the Cohort.
- Facilitate monthly virtual group meetings.
- Coordinate monthly Battle Buddies assignments.
- Conduct monthly individual assessments.

- Administer Davidson Trauma Scale Assessment at beginning of Cohort, end of the Cohort, and 6 months after the Cohort ends.

Tracking:

- How the subpopulation is hearing about the Cohort Pilot
- The number of women veterans receiving peer-delivered education and support
- Davidson Trauma Scale (DTS) results, e.g., track suicidal ideation, attempts, self-harming behaviors, and overdose rates within this subpopulation
- Monthly individual biopsychosocial assessment

Partners include:

- Kyle Hatch, Samaritan Veterans Outreach: provide relevant data about members of this subpopulation and offer warm introductions to community service and healthcare providers.
- Dr Jamie Lusk, PsyD, Salem Vet Center: professional staff for in-person Cohort meetings.

This pilot promotes health equity and addresses health disparities by targeting a population that has been and continues to be underserved. Much of the public assumes that military veterans receive or should receive their healthcare at VA facilities which is both impractical and untrue. Rural veterans and tri-county veterans have to travel significant distances to get to a VA facility. Women veterans face additional challenges at VA facilities. Many women report feeling unwelcome and invisible by staff assuming that they are wives and not veterans themselves. Many women veterans are also retraumatized at VA facilities due to sexual harassment or assault, reliving their military trauma experience.

Women Veterans Cohort Pilot provides local behavioral health support services in a safe, supportive, non-traditional (non-medical) environment and reduces some of the inequities and disparities they typically experience. Our goal is to bring these women out of isolation and provide a local, culturally informed and trauma-informed peer-support community for short-term (6 month Cohort) and longer term support. We seek to reduce stigma and normalize concerns about behavioral health issues and mental health diagnoses within the peer community. Members experiencing severe and persistent mental illness who meet the requirements of the Cohort are welcome participants. The peer community will result in increased mental health and substance use screenings, services, and referrals through peer-delivered education and services. To remove barriers to access, we would like to offer financial assistance with transportation, childcare, or other caregiving duties. We will be ADA compliant, including service dogs.

The individuals tasked with this pilot include:

- **Paige Jenkins, MSW, military veteran and founder of Red Feather Ranch**, will lead in person groups and virtual groups, provide staff training, educational presentations, outreach, and provide ultimate oversight for all aspects of the pilot.
- **Jennifer Vazqueztell, MSW Intern,** will conduct initial interviews, monthly assessments, and interviews with Cohort participants.
- **Gillian Chandler MSW Intern, Program Manager.** Gillian and Jennifer will share administrative duties of communications, record keeping, developing and conducting surveys, researching and preparing fact sheet, white paper, educational presentation, and press releases.
- **Dr Jaimie Lusk, PsyD** will co-lead in person groups.

How members of the community will hear about Red Feather Ranch and the Cohort Pilot:

- **Brochures and videos shared via email and social media**
- **Within tri-counties – Benton, Lincoln, Linn**
  - Flyers at grocery stores and retail stores that offer veterans discounts
  - Press releases to local media
  - Public service announcements
  - Referrals from:
    - Primary care providers
    - Behavioral health providers
    - Community services providers
    - Local colleges and universities
    - Military and Veteran institutions, organizations, and networks
    - Siletz Tribal Veterans Rep.
- **Outside tri-counties –** ODVA, VA Portland, Roseburg, Eugene, Salem, Grand Ronde Tribal Veterans Rep.

Potential risks of this pilot include COVID-19, climate/natural disasters, personal emergencies or health issues that change participant's lives in substantial ways, or a triggering episode or relapse beyond our scope of practice. We expect some attrition and plan to address that by thoroughly vetting participants before they are approved to participate and by starting with a larger group. Should a participant have a triggering episode or relapse beyond our scope we will refer them to one of our partner organizations.

Sustainability Plan

The Cohort is innovative in that there are no peer support communities specifically for women veterans outside a clinical setting in the VA. It is innovative in using nature-where-you-are for trauma recovery. It is innovative in primarily meeting through online platforms. The pilot is scalable in that it can be offered indefinitely with new and former participants taking part. It can be duplicated in other locations. Former participants can repeat the pilot further refining their skills and may also become peer leaders in future Cohorts. The pilot is transferable to other populations with a common experience, language, or interest. Sustainability is built in as past participants will be encouraged to become peer leaders in future Cohorts.

Organizations with a vested interest in this pilot include Samaritan Health, Portland and Roseburg VA Healthcare, ODVA, Salem and Eugene Community Based Outpatient Clinics (VA), Salem Vet Center, local mental health providers with women veteran clients as this pilot supports and dovetails with their existing services, local law enforcement and domestic violence support organizations, like CARDVA, local hospitals and emergency services as improved health outcomes result in fewer calls to emergency services, fewer emergency room visits, and fewer or shorter hospital visits.

Future funding could come from ODVA, as they have previously offered grants up to $50,000 and will likely do so again. Larger veteran foundations like Wounded Warrior may also provide financial assistance once we are able to show success with this pilot.

Activities and Monitoring Grid
Red Feather Ranch Women Veterans Cohort

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
A1 - Unknown how many women veterans are receiving appropriate care at appropriate time and place	Administer Davidson Trauma Scale at beginning, end, and 6 months* after the Cohort ends	See reduction in frequency and severity of trauma scores for the 16 women participating in the Cohort	11/2022
BH1-a - Unknown how many community members & providers understand the experience of women veterans, including Military Sexual Trauma (MST) and Institutional Betrayal Trauma	Tracking number of community members and providers who receive training through presentations, white paper, or video	100-150 community members and providers who attend presentation, receive white paper, or watch video	11/2022
BH1-b - Women veterans feel shame, guilt, and stigma around behavioral health issues that resulted from Military Sexual Trauma (MST), Institutional Betrayal Trauma, and not fitting into traditional gender roles	Administer Davidson Trauma Scale at beginning, end, and 6 months* after the cohort ends and monthly assessments during Cohort	See reduction in frequency and severity of trauma scores for the 16 women participating in the Cohort	11/2022
BH3-ii - Peer-delivered education and support for women veterans is non-existent	Track number of participants in Cohort	Provide peer-delivered education and support to 30 applicants and 16 Cohort participants	11/2022
BH3-b - Unknown rates of suicidal ideation, attempts, suicide, and/or self-harming behaviors	Administer Davidson Trauma Scale at beginning, end, and 6 months* after the Cohort ends, monthly assessments during cohort, and self-report	Reduce or eliminate all instances of suicidal ideation, attempts, suicide, and/or self-harming behaviors	11/2022
BH3-iv - Unknown number of women veterans lacking mental health services when not in crisis	Administer Davidson Trauma Scale at beginning, end, and 6 months* after the cohort ends, monthly assessments during Cohort, and self-report	Red Feather Ranch Cohort and other programs provide mental health services to women veterans who are not in crisis	11/2022

Activities and Monitoring Grid
Red Feather Ranch Women Veterans Cohort

BH5-iv - Unknown what care women veterans experiencing severe & persistent mental illness are receiving	Track number of women veterans who are diagnosed with severe and persistent mental illness and the care they are receiving through our survey or interview process	Provide health equity data to IHN-CCO	2/2022
BH5-v - Women veterans are often diagnosed with severe and persistent mental illness following Military Sexual Trauma (MST) and Institutional Betrayal Trauma resulting in feelings of shame and stigma	Interviews and monthly assessments throughout Cohort	A percentage of women veterans diagnosed with severe and persistent mental illness participate in the Cohort and show a reduction in their self-stigmatization via monthly assessments	11/2022
BH6-ii - Women veterans have many physical health issues that are linked or related to their mental health issues	Monthly assessments during Cohort, and self-report	Through the Cohort, 16 participants will engage in more preventative behavioral health care and become more focused on their general well being on an ongoing basis	11/2022
SD4-i - Based on national research on women veterans, we know there are health disparities, but we don't know the specific experiences of women veterans in tri-county area	Conduct survey and interviews to understand health disparities and acquire health equity data	To survey 100 women veterans and interview 50 women veterans to understand health disparities	1/2022
SD4-ii - Incomplete and sparse information about health equity for women veterans in tricounty	Conduct survey and interviews to understand health disparities and acquire health equity data	To survey 100 women veterans and interview 50 women veterans to understand health disparities	1/2022
	* Cohort ends 10/2022. Third Davidson Trauma Scale to be administered six months later in 4/2023.		

Pilot: Red Feather Ranch Women Veterans Cohort

Pilot Start Date:	**10/1/2021**	**9/30/2022**	
Direct Costs		**Total Cost**	**Amount Requested***
Development, coordination, and implementation of public relations campaigns to reach as many women veterans as possible in the tri-county area		$8,500.00	$8,500.00
Development, coordination, and distribution of women veteran surveys and scheduling and completion of interviews		$8,500.00	$8,500.00
Development, coordination, and delivery of educational presentations about women veterans to community and service providers		$8,500.00	$8,500.00
Planning, coordinaton, and facilitation of Cohort Pilot		$10,000.00	$10,000.00
Materials & Supplies: printing, Cohort journals, and art supplies		$600.00	$600.00
Cohort participant travel and/or care giving (child or adult) expenses that would otherwise be barriers to participation		$6,000.00	$6,000.00
Local travel for outreach to post flyers where digital dissemination is not an option		$500.00	$500.00
Staff travel for in-person Cohort meetings		$1,000.00	$1,000.00
Debriefing and trauma informed care for staff		$3,000.00	$3,000.00
Cash card incentives for surveys and interviews		$3,750.00	$3,750.00
In kind hours		$8,500.00	$0.00
Total Direct Costs	**Rate (%)**	**$50,350.00**	**$41,850.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	3.30%	$1,661.55	$1,381.05
Total Project Budget		**$52,011.55**	**$43,231.05**

*if amount requested is different from total cost, please describe the source of the additional funds in the narrative.