IHN CCO DST Pilot Proposal Summary: RFP1

Date Presenting	Name	Organization	County (s)	Budget
August 12	Primary Care Physical Therapy	Samaritan Lebanon Community Hospital	Linn	$105,000
	Pathfinder Behavioral Health Transformation	Pathfinder Clubhouse	Benton, Linn, Lincoln	$131,795
	Culturally Responsive Peer Services	Family Tree Relief Nursery	Benton, Linn	$150,700
	PSH Respite and Housing Case Management Pilot	Corvallis Housing First	Benton	$145,036
August 19	Depression Screenings in Dental Practices	Advantage Dental Services	Benton, Lincoln, Linn	$71,800
	Arcoíris Cultural	Olalla Center	Lincoln	$104,650
	Namaste Rx	Namaste Rx LLC	Benton, Lincoln, Linn	$210,060
	Peer Enhanced Emergency Response (P.E.E.R.)	C.H.A.N.C.E.	Linn	$107,994
September 2	Easy A	Sol4ce LLC	Benton	$202,650
	Therapeutic Treatment Homes	Greater Oregon Behavioral Health Inc.	Benton, Lincoln, Linn	$130,000
	Parenting Today Forward	OneIIAnother	Linn	$53,469
			Total	**$1,413,153**

Arcoíris Cultural

Backbone Organization: Olalla Center

Billing Address: 321 SE 3rd St, Toledo, OR 97391

Site(s): TBD

County(s): Lincoln

Priority Areas: Language access (health literacy, interpretation services, translation of materials), addressing trauma, and IHN-CCO sub-populations (Latino/a/x and Central American Indigenous communities)

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: A1c, A1d, BH1b, BH1*i,* BH1*ii*, BH6*ii*, SD4*i,* SD4*ii*

Pilot Contacts	Name	Email
Primary	Dee Teem	deet@olallacenter.org
Proposal	Alex Lluminquinga	alexll@olallacenter.org
Contracting	Jim Graham	jgraham@olallacenter.org
Financial	Jim Graham	jgraham@olallacenter.org
Reporting	Alex Lluminquinga	alexll@olallacenter.org

Executive Summary

There are many reasons why someone might leave their home and make the journey to another country. None of them are easy. Whether the catalyst is hardship or hope, peril or promise, violence or vision, each journey holds a complex rainbow of emotions and experiences. Each journey, and the person or family that undertakes it, carries a story, and those stories should be heard, rather than lost.

According to the American Immigration Council, one out of every ten Oregon residents was born outside of the United States, and of those, a significant percentage are from Mexico and Central America. Within Lincoln County, data from the 2018 Community Health Assessment reports that figure to be around 8.6% of a total population of 48,000 residents. These members of our community come from many different places and have many different backgrounds, but through the diversity of experiences and cultures runs the common thread that binds together those trying to find safety, belonging, and community in a new place. Though the United States holds the image of freedom, safe haven and opportunity, the experience of life here is often quite different for many immigrants, migrants, and refugees. Discrimination, harrassment, racism, and even violence are everyday realities, and these experiences are only compounded by language barriers, disconnection from support networks, lack of access to resources, struggling to cope with past and continuing traumatic experiences, and the rippling impacts of general culture shock.

Led by the bilingual, bicultural Community Health & Outreach team of the Olalla Center, the Arcoíris Cultural pilot project will focus on the Latino/a/x and Central American Indigenous communities of Lincoln County in the creation of a vibrant, arts-centric, community-driven space. The center will promote community health and wellness within some of our most marginalized populations through deep community building, providing culturally-specific resource navigation, health education and outreach, and creating a place for traditional arts and culture to thrive. Arcoíris Cultural seeks to honor and connect with the resiliency, creativity, and diversity of our immigrant, migrant and refugee communities while leveraging the resources, partnerships, and experience of the Olalla Center to build health through building community.

Pilot Description

Arcoíris Cultural is the vision of several of our bilingual, bicultural team. Through many conversations with Latino/a/x and Central American Indigenous community members, it became clear that there was a strong need for connection, community, and celebration. So many of our immigrant, migrant and refugee community members feel out of place,

isolated, and disconnected, without anywhere to go and seek to build meaningful connections, create a sense of home and belonging, and express their cultural identities. Arcoíris Cultural is the answer to the call from our community members. This project fits well with Olalla Center's strategic plan to strengthen and heal individuals, families, children and community. It also ensures Olalla Center continues to strive to be inclusive of all community members, honor their unique, diverse backgrounds and experiences, and provide opportunities for them to thrive as complex, whole human beings. Over the past couple of years, Olalla Center's strategic plan has included expanding existing community health and outreach services to focus more specifically on our Latino/a/x Central American Indigenous populations.

The Arcoíris Cultural Team

Dee Teem (she/her/hers): Executive Director of Olalla Center. Dee brings thirty years experience in nonprofit and public service with 25 years in leadership. She has overseen two past DST pilots, both now fully sustained, and one current DST pilot project for Olalla Center.

Jim Graham (he/him/his): Finance Director. Jim will be in charge of the budgets and finances of Arcoíris Cultural under Olalla Center. He brings fifteen years general business experience.

Alex Llumiquinga (he/him/his): Bilingual, bicultural Community Outreach Manager. Alex provides OHP application assistance, coordinates outreach events for Olalla Center, has assisted extensively with COVID-19 outreach and response, and will be responsible for leading the coordination of Arcoíris Cultural operations. Alex is also planning to complete the necessary training to become a certified Community Health Worker, as well as a certified interpreter.

Alex Guevara (she/her/hers): Bilingual, bicultural Community Health Manager. Alex is a certified Community Health Worker, qualified Health Care Interpreter, and provides OHP application assistance. She has also assisted extensively with COVID-19 outreach and response. She will perform the services above, as well as assist with events, Spanish translation and interpretation, and provide resource navigation.

Martha Varo (she/her/hers): Bilingual, bicultural Outreach Worker. Martha is currently in training to assist with OHP enrollment and will be training to become a certified Community Health Worker. She will assist with events, outreach and education, resource navigation, and OHP enrollment.

Beck Fox (they/them/theirs): Bravery Center Program Director. Beck will provide

LGBTQ+ advocacy and resource navigation, community support, and community and healthcare provider education. They also chair Olalla's Diversity, Equity and Inclusion Committee. Outreach and support to the Spanish-speaking LGBTQ+ community will be supported by our bilingual staff and/or bilingual community volunteers.

Kendall Cable (she/her/hers): Communications. Kendall is a former journalist and current RN of seven years. She will assist with communications work for Arcoíris Cultural.

Goals and Measures:

1. **Address impacts of trauma**: Through providing culturally-specific resource navigation, health education and outreach, this pilot will mitigate the impacts of trauma in our Latino/a/x and Central American Indigenous communities through building community support networks, honoring culturally-appropriate practices and approaches, connecting community members with mental health information and resources, and providing a space to share and process stories and experiences. In addition to drawing upon invaluable lived experience, Arcoíris Cultural staff will be trained in trauma-informed care. To track this goal, optional, short surveys (in various formats to ensure equitable language access) will be offered to community members that access Arcoíris Cultural resource navigation services. It is imperative that these surveys be both optional and brief so that the burden placed upon community members is minimized.

2. **Building health through building community: Increasing health outcomes through increasing feelings of community, safety, and wellbeing**: The premise of Arcoíris Cultural is viewing social connection and opportunities for cultural identity development and connection as a facet of health. As such, this pilot will strive to foster whole-person wellness through community building, establishing a safe place to gather and connect, and creating space to engage with traditional arts and culture. This will be measured through optional, short surveys (in various formats to ensure equitable language access) will be offered to community members that access Arcoíris Cultural resource navigation services. Again, minimization of the burden upon our community members is a priority.

3. **Improving access and increasing awareness around resources and services**: Our Latino/a/x and Central American Indigenous communities face many barriers when it comes to accessing critical resources and services, including language access, lack of trusted providers, lack of awareness of available resources, and more. Additionally, service and resource providers may try to impose a one-size-fits-all approach rather than acknowledging a person's intersecting identities and responding in a culturally humble, appropriate way. Resource navigation at Arcoíris Cultural will be provided by our bilingual, bicultural staff, who have already built trust within the community.

Outreach and health education events will promote awareness of Olalla Center resources and services, as well as our established network of culturally competent providers throughout Lincoln County. Progress towards this goal will be monitored through diligent client tracking, tallying outreach event participation, and optional, brief surveys targeting service awareness.

4. **Creating a rich and robust, more connected, and more welcoming Lincoln County through the reciprocal sharing of arts and culture**: While Arcoíris Cultural is conceptualized as a space by and for our Latino/a/x and Central American Indiginous community members, it is also, by design, something to be shared with everyone. This is integral to the meaningfulness and success of the pilot. By sharing traditional arts and culture with everyone, Arcoíris Cultural hopes to increase awareness and acceptance. This goal will be tracked through tallying attendance at the cultural center and related events, as well as tracking new and developing community partnerships.

IHN-CCO Membership Impact

Arcoíris Cultural is a cultural center pilot project led by and for the Latino/a/x and Central American Indigenous populations of Lincoln County. Although many of these community members are ineligible to enroll with IHN-CCO due to immigration status, oftentimes their children are eligible, and thereby the whole family is able to access health information and benefit from Arcoíris Cultural services and programming. Regardless of immigration status, all of our community members deserve health and wellbeing. This includes access to safe spaces and culturally appropriate resources and services, as well as opportunities to engage with traditional arts and culture, as these are all very much important aspects of whole person health.

According to “InterCommunity Health Network CCO: Community Health Improvement Plan, June 2019,” there are 15,400 IHN-CCO members in Lincoln County. Our Latino/a/x community represents the largest ethnic population, comprising approximately 5% of IHN-CCO membership throughout Lincoln, Linn and Benton counties. It is the goal of Arcoíris Cultural to reach Lincoln County’s share of this percentage, as well as our Latino/a/x and Central American Indigenous community members that are not eligible to enroll with IHN-CCO.

This pilot project specifically centers these populations because they are underserved, lack access to critical resources and supports, face numerous inequities and health disparities, and their voices are not heard. These communities have communicated that what they need in order to feel safe, welcome, and healthy is to be able to create community; a sense of home in a new place, where they can connect, share, celebrate, and grow together. Arcoíris Cultural strives to center immigrant, migrant, and refugee

voices through leadership, community involvement and empowerment, and direct service in a way that is truly transformational within our rural community.

Intervention and Activities

As a hybrid of resource navigation, arts and culture, Arcoíris Cultural is unique in its conceptualization and implementation of interventions. In terms of resource navigation, health education and outreach, Arcoíris Cultural will provide the following services through Olalla Center's bilingual, bicultural Community Health & Outreach team: language access (translation and interpretation services), in-person and phone/virtual resource navigation, food access, and health education events and community outreach. Arts and culture programming will include cooking and sharing traditional foods, music and dance performances, interactive workshops, storytelling, art exhibits, language classes, and more. The center will truly be a vibrant place to socialize, engage with traditional art, share cultural experiences between different communities, and access important resources and information from trusted sources.

As transportation often poses a barrier in our rural community, Arcoíris Cultural will be located in Newport, which is both in close proximity to other key resources and centrally located within our county. Events will be held throughout the county such as Driftwood Library in Lincoln City, Lincoln City Cultural Center, Newport Performing Arts Center, Newport Visual Arts Center, and Yachats Commons. Arcoíris Cultural strives to be as accessible as possible, and is ready to be responsive to the needs of the communities being served.

The barrier of language access will be decreased through the interpretation and translation skills of Olalla Center's bilingual, bicultural Community Health & Outreach team. Additionally, this team has experience producing linguistically appropriate outreach materials, including alternative formats such as video for our Mam-speaking community. The team also includes a certified medical interpreter, who will be invaluable in helping our Spanish-speaking community members access quality healthcare services.

Through continued partnership with the Oregon Health Authority, our Community Health & Outreach team will continue to assist our Latino/a/x and Central American Indigenous community members with Oregon Health Plan (OHP) application assistance.

Those who come to Arcoíris Cultural with food insecurity will receive referrals to Lincoln County Food Share and local food pantries, such as Newport Baptist Church, and food vouchers from culturally-appropriate grocery stores and restaurants with whom our team has already worked to establish positive, meaningful relationships. In addition,

Arcoíris Cultural will offer events with traditional foods where community members can socialize, learn traditional recipes, and strengthen community relationships through the making and sharing of food. Incorporating traditional foods will also be a way to help bridge the gap between immigrant, migrant and refugee communities and health education. Arcoíris Cultural will host educational events, where community partners will come to share information about health topics relevant to these communities. One of our identified community partners, Oregon State University Extension Office, will create conversations around nutrition and gardening as ways to both build community, engage with traditional foods and practices, and also improve health outcomes. And classes on banking and personal finance will be taught.

Finally, and perhaps most exciting, Arcoíris Cultural will host and co-host events with our many wonderful community partners that embrace the vibrantly rich dance, art, music, storytelling, and celebrations of our Latino/a/x and Central American Indigenous communities. These events, led by and for these communities, will create joy, connection, a sense of belonging, and help begin to build a glowing presence within Lincoln County as the history, stories, and culture are shared with everyone. There is so much talent, creativity, and rich tradition within the diverse communities that live here, and Arcoíris Cultural seeks to give it all a place to truly blossom. Being able to participate in one's culture, develop and express cultural identity, share and learn with one another despite differences, build relationships, and find a sense of belonging are all critical pieces of health that are too often overlooked. This pilot project is rooted in the belief that growing vibrant community is key to whole person health, particularly for those who are struggling beneath the weight of systemic racism, violence, and marginalization.

Addressing Health Equity and Social Determinants of Health

Arcoíris Cultural is inherently grounded in health equity and directly addresses social determinants of health. The project will employ a multi-faceted approach to centralize building health equity and reduce health disparities. Language access, location, resource navigation, food security, health education, and rich, arts and culture-focused community building are at the forefronts of our strategy. It is also fundamental to the mission of this work that it is championed by team members with lived experience within the communities being served, and that community voices are given a space at the table in regards to providing input and guiding Arcoíris Cultural forward in a way that is truly reflective of the needs of the community.

The populations Arcoíris Cultural will serve are largely experiencing the impacts of poverty including housing insecurity, food insecurity, unemployment, underemployment,

or no employment due to immigration status. As the single largest determinant of health, poverty has numerous ramifications regarding health outcomes including social exclusion, poorer mental and physical health, and shortened life expectancy. Within the social and community context, immigrant, migrant and refugee populations also face racism, discrimination, harassment, and even violence. These may come in the form of more subtle microaggressions, but often occur in very overt, plainly visible ways. Certainly, within our community, at the interpersonal level all the way up to the systemic level, racism is very much a reality for these communities and *cannot* be overlooked. In order for this work to be meaningful, it must be acknowledged that our Latino/a/x and Central American Indigenous community members do not have equitable access to fair and safe housing, quality education, culturally competent healthcare, or safe, welcoming communities to live in.

Language often serves as a barrier between access to services and those in need. Arcoíris Cultural will utilize our own qualified Spanish interpreters and contract with identified translators and interpreters to help us serve our Mam-speaking community members. We also plan to develop an engagement and training program for local youth and young adults who may be interested in becoming certified/qualified interpreters, as there is a significant need to continue to build the availability and accessibility of this critical resource. Linguistically appropriate services and programming are core to the work and mission of Arcoíris Cultural, as the program is championed by a bilingual, bicultural team.

Food security will be addressed through collaboration with a number of our community partners, such as Lincoln County Food Share and area churches. Arcoíris Cultural will assist in providing support so healthy food is available to those in our service populations. As food is such a central piece of many cultures, fun and warm, inviting events surrounding cooking, gardening, and food preparation will be offered in a culturally-specific manner. Food is not only about health in the literal sense, but is a means of social connection and wellbeing for so many.

Arcoíris Cultural is about fostering community. It has been proven time and again that connection to others lowers risk of disease and depression, buffers against stress, and increases overall health outcomes. By connecting people to one another and providing space for cultural identity development and expression, we are centering the importance of culturally-specific space, honoring diverse, intersecting identities, and creating community resilience through connection.

Finally, health education, both for community members and healthcare providers, will decrease inequities and disparities. For community members, learning about disease prevention, good nutrition, dental hygiene, health habits, and system navigation will all

contribute to positive health outcomes. For healthcare providers, it is important to recognize the unique needs of our immigrant, migrant and refugee community members. By increasing awareness, building professional competency and cultural humility, we hope to decrease health disparities and increase access to competent, culturally-appropriate care.

Olalla Center tracks demographics but does not require clients to report their personal information. Health equity data specific to this pilot project will be tracked in three ways: 1) diligent tracking of event attendance, walk-ins, and service referrals, 2) maintaining current practices of tracking and reporting OHP enrollment assistance data, and 3) offering brief, optional, verbal and/or written surveys to community members that have accessed arts events or resources at Arcoíris Cultural. For the latter, the intention is to provide community members with the opportunity to give feedback and share their stories in a way that is linguistically appropriate and makes every effort not to place undue burden on the community members themselves. In doing so, we hope to engage these communities in meaningful conversations about their unique needs, experiences, and ideas, which in turn will help guide our work and ensure that Arcoíris Cultural is truly a place by and for the community members being served.

Community Partners

1. Community Services Consortium: Assistance with housing referrals, rental assistance, workforce referrals, Head Start service referrals, utility assistance, and other services.

2. City of Newport: The city of Newport has expressed support for this project in terms of providing venue space, and is open to exploring further ways to partner.

3. Acompañar: Food security, emergency expenses, and referrals to other services.

4. Lincoln County School District: The school district may partner with Arcoíris Cultural through co-hosting events and offering outreach/communication support to Spanish-speaking students and their families.

5. Oregon Health Authority: OHA is an established partner of the Olalla Center's Community Health & Outreach program and provides funding for Oregon Health Plan enrollment assistance.

6. OSU Extension Service: Co-hosting events and offering educational programs and resources.

7. Oregon State Senator Dick Anderson: Senator Anderson will help seek additional funding for Arcoíris Cultural.

8. Driftwood Library of Lincoln City: Venue, Co-hosting.

9. St. Stephen Episcopal Church in Newport: Vouchers, event assistance, co-hosting, food pantry.

10. St. Luke Episcopal Church in Waldport: Vouchers, event assistance, co-hosting, food pantry.

11. Oregon Coast PFLAG: OCC PFLAG is willing to provide outreach support and community education for the LGBTQ+ community, their family members, and allies.

12. Lincoln County Commissioner Kaety Jacobson: Commissioner Jacobson will support Arcoíris Cultural through facilitating use of city parks as venue spaces.

13. Newport Public Library: Language-specific books and materials

14. Department of Human Services: Meeting venues, collaboration for events

15. La Juquilita Mexican Grocery Store: Vouchers, event space

16. Lincoln City Cultural Center - Venue for visual and performing arts, complimentary tickets or vouchers, collaborative programming, and presentation of events.

17. Lincoln County Food Share: Food for events and goody bags

18. Luis Acosta/Acosta Services: Culturally-specific personal banking and finance workshops.

19. Dr. Gavin Shumate, OBGYN: Culturally humble health education, outreach and services regarding cancer, STDs, health during pregnancy, breast cancer, etc., cervical and breast cancer screening, and trans/gender-diverse affirming healthcare services.

20. Oregon Coast Council for the Arts: Venue space

21. Lincoln County Public Health: Covid-19 health education in Spanish and English, co-hosting COVID-19 vaccine events, STI Prevention, educational materials, and co-hosting outreach events.

Additionally, Arcoíris Cultural is currently in the process of exploring potential partnerships with: Samaritan Health System, Juntos en Colaboración, Oregon Coast Community College, Iglesia de Dios, Oregon Latinx Leadership Network, and the Rural Organizing Project.

Addressing Risks

Potential risks for this pilot project may include safety, lack of community engagement/awareness, and longevity. Safety will be addressed per city and county regulations regarding the number of people allowed to attend events throughout pandemic and otherwise, utilizing face masks and social distancing when and if necessary (per OHA and CDC guidance), and implementing security measures to ensure the safety of community members when visiting Arcoíris Cultural or attending Arcoíris Cultural events.

Lack of community engagement/awareness will be addressed through a robust outreach campaign including social media, local news outlets, and engaging with community members in frequented spaces. We will utilize Olalla's current Community Health & Outreach Program's connection to the community to inform community members about Arcoíris Cultural, which may include hosting events to reach community members in-person as well as contacting community members through accessible channels such as Whatsapp, texts and phone calls. We will also advertise through Facebook (Olalla Center, Olalla en Español, and other program pages such as Bravery Center); KYAQ radio station (Spanish), The Wave radio station, KSHL radio station, KLCC radio station, Pacific Northwest News and Entertainment online and Coffee with Keira Radio Show, News-Time Newspaper, Yachats News online, Oregon Coast Today newspaper and online, News Guard newspaper and online, Lincoln County School District communication network, OHA networks, fliers in Mexican grocery stores, restaurants and churches, and Univision Portland. Word of mouth is also a very powerful tool, and our Community Health & Outreach team has done extensive work over the past 18 months to establish a solid reputation as a trusted resource within our immigrant, migrant and refugee communities. Additionally, Arcoíris Cultural will draw in the community through hosting fun, vibrant entertainment.

As with many rural pilot projects, particularly those that focus on grassroots community building, longevity is an expected hurdle. Olalla Center has an established history of supporting innovative pilot projects as they work towards sustainability, and has an excellent success record. Our organization has experience managing and seeking additional grants, fundraising, and developing relationships with community partners and donors. Arcoíris Cultural will not be able to succeed without the engagement and support of our local community, and it is with this in mind that we have developed a robust list of dedicated community partners who are committed to helping the project thrive in the long-term.

Pilot Timeline

January: Media campaign to introduce the center and grand opening

February: Latino/a/x and Central American Indigenous art exhibit (local artists), cooking class, OHP spotlight; media outreach

March: Diabetes prevention and management class, housing spotlight, media outreach

April: Band concert, traditional gardening, food resources spotlight, media outreach

May: Fundraiser #1, elder voices event, personal finances spotlight; media outreach

June: Summer health fair, dental hygiene outreach and education, nutrition classes, cultural cooking classes

July: Concerts in the lawn week, artisan craft fair, community resources spotlight, media outreach

August: Back to school programming (clothing drive, school supply assistance, friend match, etc.) Club de Amigos, soccer meet, Resources for Kids spotlight

September: Cultural dance event, artisan market, library resource spotlight; media outreach, Hispanic Heritage Month celebration

October: Concert; Know Local Law spotlight event (bias crime hotline and support services, DWI, underage dating, car insurance, etc.), media outreach, Halloween event

November: Fundraiser #2, Dia de los Muertos celebration, cultural crafts fair for winter holiday season, media outreach

December: Las Posadas, winter concert, winter holiday meal, community gift Exchange, survey, media for event

Sustainability

Arcoíris Cultural is innovative in that it is primarily directed to help the Latino/a/x and Central American Indigenous populations with both culturally-specific services and arts and culture. There is nothing like it in Lincoln County, and our community members have communicated that having such a space would truly be a critical step towards holistic health.

The pilot project is scalable in that Arcoíris Cultural can continue to grow as it becomes sustainable. Programming may expand to include additional services and larger scale arts and culture events. Additionally, Arcoíris Cultural may be able to connect with other Latino/a/x and Indigenous focused organizations and programs across the region, and throughout the Pacific Northwest, which would not only create a stronger, wider network

of partnerships, but also allow for larger, collaborative events, a broader reach, and possibly plant the seeds for similar work in other counties.

To sustain Arcoíris Cultural, we recognize that a strong resource development approach is imperative. Olalla Center has extensive experience in this domain, and will also be able to utilize existing relationships with local, regional, and state funding sources to ensure that Arcoíris Cultural is not only sustained, but able to grow and thrive. Currently, Olalla's Community Health & Outreach team is partially sustained through grants and contracted services with the Oregon Health Authority. In addition to grant funds, Arcoíris Cultural will work to build a donor base both inside and outside of the county for the project, as well as develop fundraising strategies.

As Olalla Center has grown, our organization has demonstrated a commitment to encouraging new, innovative work, as well as supporting those projects as they find their footing. With three innovative pilot projects already part of the Olalla family, our organization is well positioned to support this important work. Additionally, because Olalla has a fierce commitment to promoting health equity both internally and within our community, our organization will support the costs of leadership development and equity-related training for our team members.

The Arcoíris Cultural team has put in considerable work in developing trust and relationships within the community being served. Particularly through the COVID-19 pandemic, they have demonstrated their commitment to the community, ability to respond with compassion, humility, and creativity, as well as connect on a meaningful level through shared language and drawing upon lived experiences. Additionally, the project has received enthusiastic support for our project from not only community members, but local healthcare providers, community leaders, non-profit organizations, local and regional government officials and agencies, educational institutions, local businesses, and the faith community. IHN-CCO DST funds would allow this vibrant vision to take flight, bringing something just as beautiful as it is desperately needed to some of the most marginalized members of our community - and to each and every one of us. When we learn together, honor and embrace what makes us uniquely different, and yet the same, approach with openness and kindness, and enrich our spirits with art, we are *all* healthier together as a community for it.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Outside of church there is no place for service populations to create a community that marries service navigation and culture.	Survey of Latina/o/x, Guatemalan, and Indigenous population, tracking service usage	Survey results to indicate service populations are aware and/or utilized services or events through Arcoíris Cultural; experienced an increase in feeling of community, happiness, safety, quality of life.	December-22
Currently, the reputation of Olalla Center and its service to the community is growing. Many are knowledgeable about the services provided, but many have stated they were unaware of their personal eligibility for these services.	Survey of Latina/o/x, Guatemalan and Indigenous population, and tracking service usage	Improved awareness and access of services available for Latina/o/x, Guatemalan, and Indigenous populaiton at Olalla Center	December-22
Currently, there are very few art exhibits and events surrounding Guatemalan, Indigenous, and Latina/o/x cultures.	Number of events, tracking attendance	Increase number of culturally-appropriate events.	December-22

Pilot: Arcoíris Cultural

Pilot Start Date:	**1/1/2022**	**Pilot End Date:**	**12/31/2022**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Entertainment: Culturally appropriate musicians, artists, speakers, teachers, chefs		$10,000.00	$10,000.00
Outreach and support for Spanish-speaking LGBTQ+ community		$5,000.00	$5,000.00
Culturally-specific resource navigation		$40,000.00	$40,000.00
Interpretation and translation services for Mam, Spanish		$2,000.00	$2,000.00
Creation of arts and culture space/resource navigation office (office and venue rental)		$20,000.00	$20,000.00
	Subtotal Resource Costs	**$77,000.00**	**$77,000.00**
Materials & Supplies			
Marketing materials and advertising		$1,000.00	$1,000.00
Desks, tables, chairs, phones		$1,000.00	$0.00
Materials for events (art supplies, food, drinks, goody bags)		$5,000.00	$5,000.00
	Subtotal Materials & Supplies	**$7,000.00**	**$6,000.00**
Travel Expenses			
Scout talent for center		$1,000.00	$1,000.00
Travel to venues for events		$1,000.00	$1,000.00
	Subtotal Travel Expenses	**$2,000.00**	**$2,000.00**
Professional Training & Development			
Leadership Training		$2,500.00	$0.00
Interpretation and Translation Certification/Continued eduation		$3,000.00	$3,000.00
Health Equity Training		$3,000.00	$0.00
Mam language classes		$3,000.00	$3,000.00
Conferences		$2,000.00	$0.00
	Subtotal Training & Development	**$11,500.00**	**$6,000.00**
Total Direct Costs	**Rate (15%)**	**$97,500.00**	**$91,000.00**
Indirect Expenses	15.00%	$14,625.00	$13,650.00
Total Project Budget		**$112,125.00**	**$104,650.00**

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

Arcoíris Cultural

Pilot Summary and Goals

- A warm and welcoming place where Latino/a/x, Central American Indigenous/Guatemalan populations can both seek assistance to navigate systems and mitigate trauma through our Olalla specialists and build community engagement through art and culture
- Mitigate trauma
- Increase feeling of community, safety, wellbeing
- Increase knowledge and usage of Olalla Center services

Member and Community Need

- Talking points:
  - **Target Population** Latino/a/x, Guatemalan/Central American Indigenous populations of Lincoln County
  - **IHN-CCO Member Impact** 3,490 IHN-CCO members, or 5%
  - **Community Needs** Language and literacy barriers, transportation, financial security, affordable housing, healthy fresh food, immigration status, childcare are all factors which decrease health outcomes
  - **And so on**

System Transformation

How is your proposal transformational?
By improving health through a supportive community, available resources, art, education, and the acknowledgement/appreciation of diverse cultures. We would encourage the migrant community to embrace both cultures and to pass their traditions to future generations.

- **Possible talking points:**
- **Focus on collaboration between entities not previously connected**
  Arcoíris will build on Olalla's efforts to create and expand collaboration with entities such as Public Health and OSU
- **Will your proposal reduce costs, positively affect CCO metrics, or improve IHN-CCO member's health?**
  Our proposal will positively affect metrics by reducing language, literacy barriers when accessing care and when communicating with public agencies
- **What makes this pilot innovative?**
  Arcoíris is a proposal focused on the whole individual and the need for culturally-responsive support. We will reconnect generations and prevent the loss of cultural knowledge that families experience after immigrating.

Partnerships/Collaboration

- **Describe any partnerships and collaborative relationships you have or are planning to create.**

Community Services Consortium: Will assist with housing referrals, rental assistance application pass through work to Olalla Center, workforce referrals, Head Start service referrals, utility assistance, other ways as determined

City of Newport: Venues, and open to discussion of other ways to help

Acompañar: transportation to immigration appointments, emergency expenses

La Juquilita Mexican Grocery Store - vouchers, event space

Lincoln City Cultural Center - Venue for visual and performing arts, complimentary tickets or vouchers, co-operative programs presentation of events

Lincoln County Commissioners (Kaety Jacobson): County parks for venues

Lincoln County Food Share: Food for events and goody bags

Focus primarily on the required cross-sector collaborator. ********

Health Equity Plan

- **How will you address health equity and reduce health disparities?**

Arcoíris Cultural will employ a multi-faceted approach to centralize building health equity and reduce health disparities. Language, location, navigation, food security, community and education are at the forefronts of our strategy.

Example: CV Not IHN member

Undocumented,

Uninsured,

Non-English speaker

Lost sight, work and income

Connected him to the Lions

Access to cataract surgery

Advocated

Received surgery

Recover sight, work, income, independence

Definition of Success

- **Measures & Outcomes**
- **What data will you use to measure success?**
- **At the end of your pilot, what will have changed?**

Health equity data specific to this pilot project will be tracked in three ways:

1) diligent tracking of event attendance, walk-ins, and service referrals,

2) maintaining current practices of tracking and reporting (OHP) navigation, assistance data, and ????

3) offering brief, optional, verbal and/or written surveys to community members that have accessed arts events or resources at Arcoíris Cultural

The people we serve will gain essential knowledge, feel a sense of belonging and that they in turn have enriched our community

Sustainability Plan

- **Specifically address how the pilot activities will be funded or continue on after DST funds are completed.**

To sustain Arcoíris Cultural we will partner with other community organizations, donors, and entities to offer continued services and events through grants, support, and dollars. We will continue to seek grants that address health equity and follow the mission of Arcoíris Cultural. We will build a donor base both inside and outside of the county for the project, as well as develop fundraising strategies and connect with the community for support. We will seek donations from regional foundations, seek donations for events, and leverage existing OHA grants.

DST Member Questions?

Culturally Responsive Peer Services

Backbone Organization: Family Tree Relief Nursery

Billing Address: PO Box 844, Albany, OR 97321

Site(s): Family Tree RN, Linn County A & D Treatment, Milestones Treatment Services

County(s): Linn and Benton Counties

Priority Areas:

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

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

SD4 Increase health equity

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

A1: Trauma informed care and resiliency measures, appropriate behavioral healthcare for all ages. Appropriate care at the appropriate time and place for people experiencing mental health crisis.

BH3: Screening, Brief Intervention, Referral to Treatment (SBIRT) rates, Suicidal ideation, attempts, and or self-harming behaviors, overdose rates, Peer delivered education and support, mental health and substance use services, screening and referrals in venues other than traditional medical facilities

SD4: Health disparities experienced by members due to age, disability, gender identity, income race or ethnicity, available health equity data

Pilot Contacts	Name	Email
Primary	Renee Smith	rsmith@familytreern.org
Proposal	Renee Smith	rsmith@familytreern.org
Contracting	Renee Smith	rsmith@familytreern.org
Financial	Gwendolyn Morris	gmorris@familytreern.org
Reporting	Gwendolyn Morris	gmorris@familytreern.org

Proposal Narrative Community and Culturally Responsive Peer Services

A. Executive Summary

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

The phases of the pilot will include listening to those we serve, building a foundation for those we serve, designing services for those we serve and implementing the service in the community. All of this with a focus on cultural responsiveness and trauma informed practices to break down the systemic barriers for these IHN members who experience implicit bias and barriers to care that reflects their beliefs, culture, values and lived experiences. The goals of the project lead to three outcomes:

- Increased percentage of IHN members who have or are experiencing systemic trauma in their lives and in their cultural communities to receive appropriate, trauma-informed and culturally responsive care at the appropriate time and place.
- Increase substance use screenings, services referrals and access to peer and parent support for IHN members requesting services.
- Increase of health equity for IHN members who receive community responsive peer services.

Creative and innovative billing strategies, leverage with other SUD funding sources and IHN contracts will be the focus of sustainability for the project past the pilot period. The pilot's goal is to take action in increasing access for these IHN members to services that they connect with, reflect their life experiences and that honor their ability to create their own healthier lives.

B. Pilot Description:

This innovative project brings together three regional partners in a coordinated and collaborative approach, expanding access to culturally responsive peer services for Latino/a/x and Indigenous/Tribal IHN members.

According to Mental Health America implicit bias, prior health conditions, stress and immunity, and essential work and service jobs magnify these communities' experience with the pandemic. Mental distress and illness are closely linked with substance use and misuse. COVID coupled with the existing opioid epidemic are having an extreme impact on the Latino/a/x and Indigenous/Tribal communities with a lack of access to behavioral health and treatment services. While research on how substance use affects susceptibility to COVID-19 is evolving, smoking and substance use disorders are on a list of underlying medical conditions associated with high risk for severe COVID-10 illness compiled by the Centers for Disease Control and Prevention. Overall, people with a previous diagnosis of substance use disorder at any point in their lifetime were 1.5 times more likely to have

COVID-19 than those who did not. (National Institute on Drug Abuse) These disparities are growing. Without focused interventions individuals of color within our communities will continue to suffer at increasing rates. This project aims at impacting this.

The project will focus on improving access to behavioral health services in non-traditional ways while developing a bicultural and bilingual workforce to support the Indigenous/Tribal and Latino/a/x IHN members impacted by substance use disorder (SUD). The overarching goal of this project is that by developing and implementing an innovative model embedded in the community where members experience their disease, coupled with expanded culturally responsive peer services for Latin/a/x and Indigenous/Tribal communities will lead to more positive health outcomes for IHN Latino/a/x and Indigenous/Tribal members that are suffering from SUD and other behavioral health issues.

Pilot goals and how they will be measured as indicators for achieving outcomes

Goal One

IHN members who have or are experiencing systemic trauma in their lives and or in their cultural communities receive trauma-informed and culturally responsive care at the appropriate time and place.

- Measured by ratings of 3 or greater on Service Satisfaction Survey that will be created and implemented.
    - Indicators will include ease of accessing peer services and assessments, consideration of cultural beliefs, values and customs, self-reported satisfaction of care and self-reported improvement of daily life.
- Review of existing survey data indicating IHN member's satisfaction in key areas to set a base point and identify opportunities for improvement in areas of importance to members.
- Gather information by listening sessions, interviews or other interactions with current IHN members receiving services that identify with these communities about what is working and where there are gaps. This information will be used in project development, implementation and evaluation.
- Consult with local professionals that align with Latino/a/x and Indigenous/Tribal communities to provide information, guidance, design, implementation and review of culturally responsive peer services and assessments.

Goal Two

Provide appropriate SUD assessments and peer services for Latino/a/x and Indigenous/Tribal IHN members delivered in nontraditional ways and in nontraditional locations.

- Credentialing of CADC 1 employed by Family Tree RN to deliver substance use screenings, assessments in the field or other nontraditional locations and referrals for culturally responsive and trauma informed peer services and family support as needed.
- Credentialing of peer support specialists that aligns with the Indigenous/Tribal community and Latino/a/x community.
- Measured by the number of SUD assessments completed outside of a clinic or practitioner's office during pilot period.
- Measured by completion of training information designed and delivered by pilot partner on cultural considerations and trauma informed care for serving members of the focused communities.

Goal Three

Milestones explores the viability of existing peer staff providing services in the field, outside of their treatment facilities.

- Strengths, Weaknesses, Opportunity and Threat (SWOT) analysis of service model change for Milestones' Peer Support Specialists working with clients in the field
- Measured by the completion and outcomes of:
    - Cost analysis of service change
    - Revenue analysis of service change
    - Agency decision regarding service delivery change.
    -

Outcome: Increased percentage of IHN members who have or are experiencing systemic trauma in their lives and in their cultural communities to receive appropriate, trauma-informed and culturally responsive care at the appropriate time and place. (A1)

Goal Four

Increase access for IHN Members identifying as Latino/a/x or Indigenous/Tribal to culturally responsive substance uses screenings, assessments, community referrals and peer and parent support services.

- Hire and train peer support staff who identify with Latino/a/x and Indigenous/Tribal communities to deliver culturally responsive peer services
- Increasing SBIRT screening rates of participating members
- Decrease rates of suicidal ideation, attempts, suicide, and/or self-harming behaviors of participating members
- Decrease rates of overdose in participating members
- Increase referral to family stability services for individuals with children for participating members.
- Increase number of referrals to peer services for Latino/a/x and or Indigenous/tribal participating members
- Increase number of referrals to community resources for participating members
- Increase number of referrals to parent support programs for participating members

Goal Five

Create and implement a contractual billing process between Family Tree RN, LCAD and Milestones for FTRN CADC 1 to provide SUDs assessments, SBIRT, and other screenings in the field and billed through LCAD and or Milestones.

- Measured by designing and implementing contractual billing process between FTRN and LCAD
- Measured by FTRN employing at least one staff credentialed as CADCI.
- Measured by FTRN CADC performing SUD assessments in the field.

Outcome: Increase substance use screenings, services referrals and access to peer and parent support for IHN members requesting services.(BH3)

Goal Six
Reduce health disparities experienced by members due to race or ethnicity when accessing SUD services with addition of culturally responsive peer services for Latino/a/x and Indigenous/Tribal IHN members.

- Measured by ratings of 3 or greater on Service Satisfaction Survey that will be created and implemented.
    - Indicators will include ease of accessing peer services, consideration of cultural beliefs, values and customs, self-reported satisfaction of care and self-reported improvement of daily life.

Outcome Increase of health equity for IHN members who receive community responsive peer services. (SD4)

Focus Population for Pilot
The focus will be to support IHN members identifying as Latino/a/x or Indigenous/tribal and those experiencing systemic trauma based upon their lived experiences who want to access SUD services. Linn County A & D treatment services and Milestones Treatment Services will be the primary source of referrals for the program. We anticipate receiving over 100 referrals for peer services in a twelve month period and anticipate serving 95% of those referrals. We anticipate receiving 50 referrals for A & D assessments during the pilot period. All of these referrals and served individuals will be IHN members.

Pilot intervention and Activities
Phase One: Listening to those we serve
In collaboration with Milestones and LCAD, FTRN Program Manager and Peer team will develop questions aimed at uncovering what is meaningful to current clients of Latino/a/x community and Indigenous/Tribal community members when accessing peer or substance use services. The pilot team will hold listening sessions, interviews and conversations with community members and current IHN members receiving services with the three partner organizations. Cultural responsiveness and humility will guide the process to ensure respect is given to all participants. These uncovered priorities and needs for services will serve as the foundation for developing the culturally responsive peer and assessment services.

Phase Two: Building the Foundation for those we serve
Professionals in the fields will be interviewed or surveyed to ensure best practices are followed in developing both assessment services and peer services. This information will be used to design both the assessment services and peers services ensuring cultural sensitivity and alignment through collaboration with Milestones, Family Tree and Linn County A & D. During this phase, the data collection for the pilot will be created to ensure that goals can be measured and various performance indicator points can be collected including health equity information. Design team will review UNITUS as well as Family Tree’s client data system for tracking systems for pilot. Pilot design team will work with IHN to determine what claims data could be used as well to measure pilot goals and outcomes noted above.

Phase Three: Designing Services for those we serve

Together the team will review information received and design assessment and peer services that will meet the culturally diverse needs of Latino/a/x and Indigenous/Trial individuals. Team will review intake processes and documentation, service plans, end of service satisfaction surveys and other materials and design to ensure cultural alignment for IHN members. Team will collaborate with identified professionals to ensure quality and best practices. During this phase, Family Tree will recruit a CADC1 and two peers, one identifying with the Latino/a/x community and one identifying with the Indigenous/Tribal community. Once hired they will obtain certification training as well as additional training specific to serving individuals who have experienced trauma as well as training to ensure cultural responsiveness.

Simultaneously, Family Tree and Linn Co A & D will explore and establish a protocol for Family Tree's CADC1 to complete assessments and referrals and bill for these services through Linn Co A & D with payment back to Family Tree for services rendered. Family Tree will explore this process with Milestones as well to see if this is viable. Milestones will determine strengths, weaknesses, opportunities and threats of offering peer services out in the community. Family Tree will collaborate and share training, policies, procedures as needed to assist Milestones in designing these services.

Phase Four: Implementing Services for those we serve

When ready and services in place, Family Tree, Linn Co A & D and Milestones will begin sharing information about the services. Family Tree will design flyers and brochures that could be shared in community settings and with service providers regarding the services focused for the Latino/a/x and Indigenous/Tribal IHN members. Materials will be in English and Spanish and align with health literacy guidelines. Outreach will include service organizations who serve members of culturally diverse communities in Linn and Benton Counties, health centers, food banks, family services, behavioral health practitioners and substance use disorder treatment providers and person to person connections.

Pilot Partners

Family Tree Relief Nursery

Family Tree Relief Nursery will be the lead in the pilot and oversee the project and act as the fiscal sponsor. To ensure best practices and that the pilot meets its goals and timelines, Family Tree will contract with an individual to be the Pilot Program Manager. This position will work closely with all partners and Family Tree's Program Manager to ensure smooth transitions. Family Tree will hire a CADC 1 who will be trained to provide A & D assessments and refer members to a variety of community services including the culturally responsive peer services developed in this pilot. Additionally, Family Tree will add two peer support specialists to their staff, one aligned with the Indigenous/Tribal community and one aligned with the Latino/a/x community to offer and support IHN members of their communities referred to this program and seeking services. Family Tree will work collaboratively with the other partners to create the data tracking and outcome tracking necessary for the pilot to report on it's goals and outcomes using UNITUS and Family Tree's current database. Family Tree will support Milestones in their planning and analysis of peer services expansion.

Linn County Alcohol and Drug Treatment

LCAD will be the primary referral source for this pilot in Linn County for both assessments and peer services. Collaboratively with Family Tree, the two organizations will explore, design and implement a sustainability process whereby the assessments and other services delivered by the CADC1 can be submitted through LCAD for claims billing and then a payment back to Family Tree for the services provided. Billing of peer services will also be explored in conjunction with Family Tree's APM contract currently in place with IHN. LCAD will provide guidance, best practices and knowledge in program development and implementation based upon their expertise.

Milestones

Milestones will be the primary referral source for the assessments and peer services in Benton County for the pilot period. Milestones currently serves a high percentage of Indigenous/Tribal women and men as well as parenting mothers and fathers. In addition to referring IHN Members, Milestones will work collaboratively with Family Tree in developing the culturally responsive peer services for Indigenous/Tribal individuals and Latino/a/x communities leveraging their cultural experience and knowledge in developing key trainings and learnings around culture, process, traditions and best practices in serving these communities. Milestones will also work within their organization to determine if they can expand their current peer services from an internal site service and expand it into the community in more natural settings where the members they treat and support live and seek treatment.

Each partner will provide a team member for the planning team and share their expertise to ensure the pilot's success. Each partner will reach out to additional community contacts and resources as needed to bring needed skills and knowledge to the group for success.

Community Engagement

Family Tree, Linn Co A & D and Milestones will leverage their community contacts and partnerships in Linn and Benton Counties and share information about the services for IHN members who align with focus members. Currently, all three partners are part of a regional SUD services plan task force coordinated by Samaritan Health in response to Measure 110 requirements for support to law enforcement when they encounter individuals under the influence of substances. The pilot partners will leverage these partnerships and share information about pilot services. Family Tree's peer staff will reach out with face to face outreach visiting homeless shelters, treatment facilities, ODHS offices, Oxford houses, housing organizations and other community spaces IHN members frequent with flyers and other marketing materials. Other electronic and other nontraditional messaging will be considered and developed based upon cultural norms and traditions.

Health Equity and Reducing Health Disparities

Each of the pilot partners' organizations have been actively promoting health equity throughout their programs for years. Each partner's organization believes that everyone, regardless of race, color, religion or other unique identifier should have an opportunity to be as healthy as possible. All community members are entitled to have access to all realms of health care and that they should be able to access services that align and respect their cultural beliefs, customs, traditions and beliefs. The partners acknowledge that for decades, in the Mid-Valley the healthcare system has been focused and delivered around the primary culture and has further committed systemic racism in

healthcare delivery. This pilot will intentionally focus on providing services that align, support and respect IHN members of color, Indigenous/Tribal, Latino/a/x and members that have experienced trauma and systemic abuse. We acknowledge that we will need to seek guidance and information from the members themselves to assure we tailor the services to meet and exceed their expectations. In the formation stages of the pilot, models of surveys or data instruments that respectively collect health equity will be researched and woven into the program documentation. Additionally the program team will develop and implement a service satisfaction survey that gives voice to the member's experiences and how service implementation can be improved to meet their expectations.

Peer services by nature are tailored to the individual and promote the individual as the expert in themselves and charting their own course. Peers serve as support and guide rather than lead the services. A trauma informed, strength based approach acknowledges that a person is not their disease, but rather they have experienced a series of traumas that have impacted their health. The members themselves have the knowledge and power to shape their treatment and health care to reflect their values, culture and beliefs that will lead them to better health.

Social Determinants of Health

Health care quality and access as well as social and community support will be the social determinants of health focus of this pilot. Providing services that are culturally responsive and trauma informed will be the foundation of increasing health access and quality for IHN members with SUD. Our belief is that if IHN members can work with a peer or SUD professional in accessing treatment and support who respects their values, understands and aligns with their cultural experiences and supports their ability to set their own healthcare goals based upon their needs and desires then they will improve their quality of life and health and feel heard. Gaining access will be critical and working early in the services to ensure IHN members have access to healthcare coverage, a primary care provider, dental care and behavioral health support without stigma or bias will be essential. Additionally, the peer services will support IHN members in increasing or discovering new social connections based upon their own life experiences. The peers will support members in exploring their natural supports and also assist them in discovering new community or family supports and resources that reflect their traditions, beliefs and customs.

Pilot Champions

Renee Smith, Family Tree RN: Renee will be the pilot lead and coordinate the fiscal, administrative and compliance tasks of the pilot. She will provide support in the listening sessions, surveys and interviews with IHN members and professional experts. She will work with Milestones and support and assist their strategic planning activities for their peer services expansion.

Tanya Pritt, Milestones Treatment: Tanya will take the lead in ensuring a culturally responsive lens is maintained and lead the program in culturally responsive training. Her contacts with the local tribes will be helpful in ensuring cultural responsiveness and potential sustainability resources.

Stephanie Cameron, Family Tree RN: Stephanie is the Program Manager and will be a member of the pilot planning team. She will work closely with the Pilot Program Manager to ensure adherence to Family Tree policies and ensure a smooth staff and service transition at the pilot's conclusion.

Tony Howell/Linn CO A & D: Tony will collaborate with Renee and Family Tree in designing and implementing a billing system to cover the cost of A & D assessments performed in the field by FTRN

CADC1. He will provide professional consultation during the pilot and share knowledge. He will ensure before his retirement who will be the Linn Co champion for this project.
Gwendolyn Morris, Family Tree RN: Wendy will provide data collection and analysis for the project.
Carla Ayers, Program Coordinator Consultant, and LCSW: Carla will be the Pilot Program Manager and work with the pilot team ensuring the coordination and pilot goals, objectives and outcomes are met.
CADC1 and 2 Peer Support Specialists: to be hired

Alignment with pilot partner's organization's strategic or long-range plans
Each pilot partner's organizations strategic and long range plans include expanding access for individuals of color and experiencing trauma to high quality, culturally responsive treatment and peer services. Each organization acknowledges that the existing healthcare system prioritizes the dominant cultures values, experiences and beliefs. This pilot will be a mark in the land, a place to stand and acknowledge that each organization can do better and improve services to the IHN members to meet the members' needs and expectations with actions, not just statements and policies.

Potential Risks and Possible Solutions for the Pilot
The partners acknowledge that it may take time to hire staff that align with the Latino/a/x community and the Indigenous/Tribal communities. If chosen to move forward, Family Tree will begin exploring non-traditional ways to recruit for these positions and the CADC1. We recognize that we may have to use new approaches, connect with new partners and share information with a large number of regional contacts. If we cannot find candidates that align with the communities then we will research and look at best practices for how to deliver services with respect, dignity and cultural responsiveness. We anticipate legal hiring issues as well and are working with our HR department proactively to see what is possible. Also, this will be the first time that these three organizations have worked closely together so it will take time to build trust and transparency on how to work as a team.

Pilot Timeline

Phase One ~ Listening to those We Serve	Goals	Jan-Mar 2022
Build the team, build connections with community partners, build listening sessions, meet with IHN members, and gather information. Share progress. Build team and trust	Goal One: IHN members who have or are experiencing systemic trauma in their lives and or in their cultural communities receive trauma-informed and culturally responsive care at the appropriate time and place	
Phase Two~ Build the foundation		Feb, Mar April 2022
Analyze member information, meet with subject matter professionals, research models, and build training. Strategically plan for Milestones peer expansion.	Goal Three: Milestones explores the viability of existing peer staff providing services in the field, outside of their treatment facilities	

Explore billing models between LCAD and Family Tree Analyze measurements and data collection strategies, identify tools for data collection	Goal Five: Create and implement a contractual billing process between Family Tree RN, LCAD and Milestones for FTRN CADC 1 to provide SUDs assessments, SBIRT, and other screenings in the field and billed through LCAD and or Milestones.	
Phase Three~ Design Services for those We Serve		Mar, April, May
Create service delivery plan and supporting policies, practices and documentation for service delivery Recruit and hire CADC1, and two Peer Support Specialists Credential Peer Support Specialist Provide training	Goal Four: Increase access for IHN Members identifying as Latino/a/x or Indigenous/Tribal to culturally responsive substance uses screenings, assessments, community referrals and peer and parent support services. Goal Six Reduce health disparities experienced by members due to race or ethnicity when accessing SUD services with addition of culturally responsive peer services for Latino/a/x and Indigenous/Tribal IHN members.	
Phase Four~ Implement services for those we serve		June-July 2022
Begin accepting referrals for peer supports and assessments Gather data Serve IHN members Evaluate services and pilot for goals and outcomes Test sustainability strategies	Goal Two: Provide appropriate SUD assessments and peer services for Latino/a/x and Indigenous/Tribal IHN members delivered in nontraditional ways and in nontraditional locations. Goal Six: Reduce health disparities experienced by members due to race or ethnicity when accessing SUD services with addition of culturally responsive peer services for Latino/a/x and Indigenous/Tribal IHN members.	July-Dec 2022

Sustainability Plan

The core of this pilot is to change the way IHN members' access care and SUD services from a traditional clinical/office model to a model that gives access to these services when and where the

members need them, in an environment that supports their unique needs and offers respect based upon their life experiences, culture and values. Our belief is that at the end of the pilot, at the minimum, similar delivery models could be implemented across multiple communities throughout the IHN service region and perhaps across other areas of the state and country. This pilot continues to build on the model of THWs creating a bridge between the IHN members in their homes and in their community to their healthcare team in the office/clinical setting. By bringing the services to the member where they are, multiple barriers are wiped away and members can start a path towards treatment and health when they have that initial motivation for change.

Beyond the programing limitations, the payment model must be created and tested for viability and sustainability of services. At the end of the pilot our goal is to have created and implemented a payment pathway for community based organizations (CBOs) offering peer services and assessments to submit documentation to a healthcare/treatment program that could be submitted for claims payment. Once payment is received, the billing organization would keep a percentage for administration and the rest of the payment would go back to the CBO to cover the cost of the services. Additionally, this model would be aligned or compared with Family Tree's current APM contract with IHN and could provide additional ways that this APM could be designed. Additionally, OHA is exploring a pathway for CBOs to bill for non-clinical services such as peer support. This pilot comes at an innovative time when financial systems are in flux. Our goal is to offer information and experience that could impact future payment strategies.

Each pilot partner will explore how these pilot services can be implemented within their current funding structure, if there is a gap, what is the gap and ideas or approaches to close that gap. Working collaboratively with IHN CCO, the pilot goals would combine current service contracts and new contracts that would cover the cost of delivering these community based services IN the community. LCAD is supportive of this model and has been promoting this approach for over a year and assessing the changes and opportunities through OHA and CCO 2.0. They are invested in supporting CBOs to provide the assessments and peers in the field as a natural partner for the work, based upon the trust these organizations have within the IHN members.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
IHN members who expereince systemic trauma and racisim or are culturally diverse have limited choices for care by professionals that align with their culture, values and beliefs	IHN members will give rating of 3 or better on Service Satisfaction Survey *Listening sessions with IHN members will inform services to meet specific cultureal needs of IHN members	IHN member who have or are experiencing systemic trauma in their lives or in their cultural communities receive trauma informed and culturally response care that the apporpriate tiem and place	December-22
SUD assessments are offered in traditional healthcare settings	*FTRN hire CADC1 and provide training for delievery services in non tradtional locations *# Assessments offered in the field *Increase in SBIRT screening rates *Decrease rates of suicidal ideation, attempts, suicides and/or self harming behaviors *Decrease rates of overdoses	SUD assessments will be provided in commuinty, natural and other non traditional settings settings based upon the need of the IHN member	October-22
Peer services offered but, peer may not be knowledgeable or aligned with cutural traditions, values and beliefs of IHN members seeking services and supports	*Hiring of 2 Peer Support Specialists one with lived experience with Latino/a/x and one with Indigenous/Tribal communtiies *Increase referrals to family stability programs *Increase referrals to community resources *Increase number of referrals to parent support programs	IHN members of Latino/a/x and Indigenou/tribal cultures will receive peer support services by indivivual algined with their cutlure, values and beliefs.	July-22
Milestone's peer support staff can only serve clients at their clinic locations	*Milestones do strategic planning, cost, revenue analysis and make organizational decision regarding peer services	Milestones peer support specialist will deliver services in the community setting outside of the clinic setting	October-22
Need for SUD assessments in field for IHN members when they decide they are ready to seek treatment but unable to go to traditional health care location	*FTRN Hire CADC1 *FTRN and LCAD design and implement a contractual billing process between the two organizations	FTRN has a CADC1 who can offer SUD assessments in the field at the place the IHN member feels comfortable and ready.	July-22

Pilot: Community Responsive Services

Pilot Start Date:	1/1/2022	Pilot End Date:	12/1/2022
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Assessment policy, practices and implementation development		$ 7,500.00	$ 7,500.00
Data collection and evaluation systems develoment		$ 7,500.00	$ 7,500.00
Peer services delivery		$ 50,000.00	$ 50,000.00
Milestones strategic planning for community peer services		$ 10,000.00	$ 10,000.00
Billing system development LCAD and FTRN		$ 7,500.00	$ 7,500.00
Assessment delivery		$ 25,000.00	$ 25,000.00
Program Coordination		$ 10,000.00	$ 10,000.00
	Subtotal Resource Costs	**$117,500.00**	**$117,500.00**
Materials & Supplies			
Laptops, cell phones, IT support, database subscription		$7,000.00	$7,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$7,000.00**	**$7,000.00**
Travel Expenses			
Mileage for peer support services and field assessments		$8,000.00	$8,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$8,000.00**	**$8,000.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Peer Support Training		$1,000.00	$1,000.00
Cultural Responsiveness training development		$2,500.00	$2,500.00
Assessment training		$1,000.00	$1,000.00
	Subtotal Training & Develop	**$4,500.00**	**$4,500.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$137,000.00**	**$137,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$13,700.00	$13,700.00
Total Project Budget		**$150,700.00**	**$150,700.00**

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

Culturally Responsive Peer Services

Family Tree RN

Linn Co A & D

Milestones Treatment Services

Pilot Summary and Goals

- Innovative and collaborative approach by Family Tree, Linn Co A & D and Milestones to expand access to culturally responsive peer services and assessments to IHN Members in the Latino/a/x and Indigenous/Tribal communities by bringing the services into the community to where the members experience their disease.
- Goal #1 IHN members who identify as Latino/a/x and Indigenous/Tribal members will receive trauma informed and culturally responsive care at the appropriate time and place
- Goal #2 Provide SUD assessments and peer services for Latino/a/x and Indigenous/Tribal IHN members delivered in non traditional ways and in non traditional locations.
- Goal #3 Milestones explore option to expand peers services into community setting
- Goal #4 Increase access for Latino/a/x and Indigenous/Tribal IHN members to culturally responsive screenings, assessments, community referrals and peer and parent support services.
- Goal #5 Create and implement a contractual billing process between FTRN and Linn CO A & D, Milestones for payment for A & D Assessments.
- Goal #6 Reduce health disparities experienced by IHN members due to race or ethnicity when accessing SUD services with addition of culturally responsive peer services for Latino/a/x and Indigenous/Tribal members.

Member and Community Need

- Talking points:
  - Focused on IHN members that identify as Latino/a/x and Indigenous/Tribal members who experience systemic and implicit bias, poor health outcomes
  - Meet needs of members where they are when they need assistance~ Assessments in hallways
  - Culturally Responsive, listen to needs, build the program to align with values, beliefs and cultures, close gaps in service
  - Provide hope~ see possibilities in people like themselves

System Transformation

How is your proposal transformational?

- New formal collaboration with Milestones, FTRN and Linn CO A & D
- Achieve outcomes for improving access to care and health outcomes for Latino/a/x and Indigenous/Tribal IHN members while respecting values, beliefs and traditions
- Listening to the members and building what is important to them
- Meeting them where they are “at”

Partnerships/Collaboration

- Family Tree partner with Linn Co A & D for decade, mutual respect, strong outcomes for mutual clients, each organization focuses on what they do well
- Family Tree work with women in Milestone's treatment facilities, particularly Indigenous/Tribal women
  - See challenges
  - Humbly listen to needs, frame services to meet needs
  - Anxious to provide by peers that share lived cultural experiences.
- Family Tree link Milestones and Linn Co A & D to build cross county relationships and collaboration.

Health Equity Plan

- All about health equity
- Listen to members and their communities
- Show value and respect to their beliefs, traditions and needs
- Meet them in their natural settings
- Offer support and hope for outcomes
- Open access to all health services for higher health outcomes

Definition of Success

- Outcomes:
- **Increased percentage of IHN members who have or are experiencing systemic trauma in their lives and in their cultural communities to receive appropriate, trauma-informed and culturally responsive care at the appropriate time and place.**
- **Increase substance use screenings, services referrals and access to peer and parent support for IHN members requesting services**
- **Increase of health equity for IHN members who receive community responsive peer services**
- Wide range of data collection
  - Service satisfaction survey, review resources for HE assessment/data, referrals, # of assessments
- At the end of your pilot, what will have changed?

Sustainability Plan

- Creation of billing process between FTRN and Linn CO A & D where assessment billings done through Linn Co and reimbursed to Family Tree
- Continue to work with IHN on peer mentor funding APM
- Leverage community funding for services under Measure 110
- Explore other contractual opportunities with tribes.

DST Member Questions?

Depression Screenings in Dental Practices

Backbone Organization: Advantage Dental Services, LLC

Billing Address: 442 SW Umatilla Ave, Suite 200, Redmond, OR 97756

Site(s): Advantage Dental Oral Health Centers in Albany, Corvallis, Lebanon and Newport.

County(s): Linn, Benton and Lincoln

Priority Areas:

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

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.

BH2: Increase the behavioral health expertise of healthcare providers and staff to reduce stigma and improve access and appropriate utilization of services.

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.

SD4: Increase health equity.

Pilot Contacts	Name	Email
Primary	Mary Ann Wren	maryw@advantagedental.com
Proposal	Mary Ann Wren	maryw@advantagedental.com
Contracting	Christine Chilingerian	Christine.Chilingerian@greatdentalplans.com
Financial	Wesley Williams or Fonda Looney	wesley.williams@greatdentalplans.com or flooney@advantagedental.com
Reporting	Mary Ann Wren	maryw@advantagedental.com

PROPOSAL NARRATIVE

Primary Organization: *Advantage Dental Services, LLC (Advantage)*
Primary Contact*: Mary Ann Wren, Director of Integration and Community Programs*
Primary Contact Email: *maryw@advantagedental.com*
Partnering Organizations*: Advantage Oral Health Centers, IHN CCO Care Coordination Department, Benton County Mental Health, Linn County Mental Health, Lincoln County Mental Health*
Project Name: *Depression Screenings in Dental Practices*

Executive Summary:

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

To bridge this gap, Advantage would like to implement depression screenings in dental offices, and create a referral pathway to behavioral health for members with behavioral health needs as identified through the screening process.

Depression is a serious medical illness associated with higher rates of chronic disease, increased health care utilization, and impaired functioning. Identifying and treating depression in its early stages is critical. As such, Advantage will implement depression screenings in all of its Advantage Oral Health Centers (dental offices) located in Linn, Benton and Lincoln counties (Corvallis, Albany, Newport and Lebanon).

This project strives to improve access to behavioral health services in non-traditional ways. Program participants include Advantage (DCO), Advantage dental offices, IHN Care Coordination and local County Mental Health Programs.

Pilot Description:

Office-based patient health questionnaire screening methods are already in use by physical and behavioral health providers and don't need to be re-invented for oral health providers. What does need to be determined is what to do when a dental patient has a positive screen.

Pilot dental offices will conduct depression screenings and provide all screening forms and referrals to Advantage's Care Coordinator who will then facilitate referrals as appropriate to IHN's Care Coordination Department and/or behavioral health providers directly. Advantage will use its current system to facilitate referrals, but also commit to exploring Connect Oregon as a viable alternative given that current licensing agreements are already in place.

If a patient needing a referral to behavioral health has already established care with a behavioral health provider, Advantage's Care Coordinator will initiate a referral directly with that provider of record. If a patient is unengaged with behavioral health or uncertain if they have a behavioral health provider, Advantage's Care Coordinator will initiate a referral by contacting IHN's Care Coordination Department. From there the IHN Care Coordinator will contact the patient and discuss the possibility of access to the behavioral health system. If successful, the IHN Care Coordinator will then contact the appropriate behavioral health provider/entity to make the referral. The IHN Care Coordinator will maintain contact with the referred patient though the transition to the behavioral health system intake and ongoing treatment process if necessary. (See attachment A: Workflow Diagram).

The screening tools that will be utilized include the Patient Health Questionnaire (PHQ)-2 and the PHQ-9. These are self-administered screening tools for signs and symptoms of depression. (See link to PHQ screening tools and scoring an overview: https://www.med-iq.com/files/noncme/material/pdfs/LI042%20IG%20tools.pdf.) To promote health equity and reduce disparities, the PHQ screening tools are also available in multiple languages (https://www.phqscreeners.com/).

The PHQ-2 refers to the first two questions of the PHQ-9. The dental offices will provide a printed copy of the PHQ-2 at check-in as a self-administered preliminary screening tool before entering the exam room. If the patient scores a 0-2 then they do not need to continue through the remaining questions. If the patient scores a three or greater, then the patient will answer the remaining seven questions of the PHQ-9 in the exam room with the dental provider.

Following the PHQ-9 screening, the dental provider (either a hygienist or dentist) will review the screening results. If a patient receives a score of 10 or greater on the PHQ-9 a referral will be made the patient's established behavioral health provider. If the patient is unengaged with behavioral health or uncertain if they have a behavioral health provider, then a referral will be made to IHN's Care Coordination Department. All referrals will be facilitated by Advantage's Care Coordinator. If the patient scores above 0 on question #9, which indicates immediate crisis or suicide risk, then an urgent call to the applicable County Mental Health Department would be made by the dental provider. (See Attachment B: Suicide Prevention Workflow). A dental provider may also recommend referral to behavioral health for any patient regardless of their PHQ-9 score if a need is recognized. (See Attachment C: Patient Talking Points).

Pilot Goals:

This pilot creates a bridge for IHN members to access a mental health solution. The overarching goal is to increase the number of members who access mental health services based on need identified – resulting in an overall healthier population.

Underneath the overarching goal, Advantage has three SMART goals:

1. Increase the number of IHN members 12 and older who complete a depression screening.
2. Increase the number of IHN members 12 and older who receive a referral to behavioral health within seven days of scoring 10 or higher on a PHQ-9.
3. Increase the number of IHN members 12 and older with have a behavioral health appointment following a referral based on PHQ-9 scoring

(See SMART Goals and Measures Table for more detail.)

Target Population:

According to the United States Preventative Services Task Force (USPSTF) adolescents aged 12 to 18 years, adults 18 years and over, and all pregnant and postpartum women should be screened at least annually for major depressive disorder (MDD). Based on this information, the pilot will focus on any IHN members 12+ years of age. The potential number of members impacted by this pilot would be 4,248. These are IHN members 12+ assigned to Advantage Oral Health Centers in Corvallis (1,158), Newport (788), Albany (1,053) and Lebanon (1,249).

Health Equity and SDoH:

Patients that experience mental health concerns are at greater risk of experiencing poor health outcomes, including oral health. This pilot seeks to reduce health disparities and promote health equity by adding four non-traditional access points (dental offices) to depression screenings for IHN members12 and older. These alternative access points will also reduce barriers to care, including transportation and childcare by addressing mental health concerns at the dental office, combining two potential health care visits into one.

Stigma is another barrier to accessing mental health services. Members engaging with oral health services that include depression screenings assists in breaking down barriers and de-stigmatizing behavioral health, thereby increasing the opportunity of members to experience optimal health.

Health equity data including language and demographics will be collected as part of the intake process at the dental office as racial/ethnic minority groups are less likely to receive mental health care, according to the American Psychiatric Association. Specific questions regarding languages spoken, ethnicity, LGBTQ+ identification and gender identity will be added to the PHQ-2 form for completion. This data will be tracked by Advantage and reviewed on a monthly basis. As part of the review process, Advantage will focus on identifying trends and augmenting screening procedures as appropriate. For example, if a particular dental office shows a high concentration of Spanish speaking patients engaging in depression screenings, preventive measures can be put in place to ensure screening forms are readily available in Spanish and that Spanish interpreters are available as well.

In general, this pilot seeks to increase mental health screening pathways for IHN members 12 and older, while ensuring populations traditionally underserved for mental health are a primary focus.

Pilot Partnerships:

Below is an outline of the roles and responsibilities of the individuals tasked with portions of the pilot:

Entity	Role	Responsibilities	Experience
Advantage Oral Health Center (OHC) · Newport · Albany · Corvallis · Lebanon	Front Office Staff	· Provide the PHQ-2 and determine if the patient needs to complete the PHQ-9 with the dental provider. · Submit completed screenings and/or referrals to the Advantage Care Coordinator.	The Advantage Oral Health Centers Director of Operations will oversee dental office participation. She has experience implementing a similar program in another CCO region.
Advantage Oral Health Center (OHC) · Newport · Albany · Corvallis · Lebanon	Dental Provider	· Completion of the PHQ-9 with the patient. · Determination of the appropriate referral pathway.	The Advantage Oral Health Centers Director of Operations will oversee dental provider participation. She has experience implementing a similar program in another CCO region.
Advantage Dental Services DCO	Care Coordinator	· Receive completed PHQ-2 and PHQ-9 screenings.	THW certified Care Coordinator to facilitate referrals and break down barriers to care.

		· Receive referrals from OHCs. · Refer members to IHN CCO's Care Coordination Department or behavioral health provider of record. · Follow-up on patient status with IHN or behavioral health provider until patient has engaged with behavioral health services.	
IHN CCO	Care Coordination Department	· Receive depression screening referrals. · Assist members with scheduling a behavioral health appointment. · Provide follow-up to Advantage's Care Coordinator on patient status.	Sheryl Fisher, Behavioral Health Director will assist with program implementation.
County Mental Health Program	· Benton County Mental Health	· Provide immediate intervention to members in	

	· Linn County Mental Health · Lincoln County Mental Health	crisis and/or suicide risk.	

To keep the program on track, Advantage will convene a steering committee on a quarterly basis representative of the entities outlined above. Pilot partners are “new” to working together but have an aligned mission to increase access to behavioral health for IHN members.

Program Promotion:

IHN members assigned to Advantage as their DCO will be made aware of the project as they receive dental services at the Advantage dental offices in the IHN region.

Potential Risks:

Potential risks of this pilot include the possibility of members not being truthful on the surveys, where there might actually be a critical concern. To address this possibility, a dental provider may refer any patient regardless of their score on the screening if the provider recognizes a need.

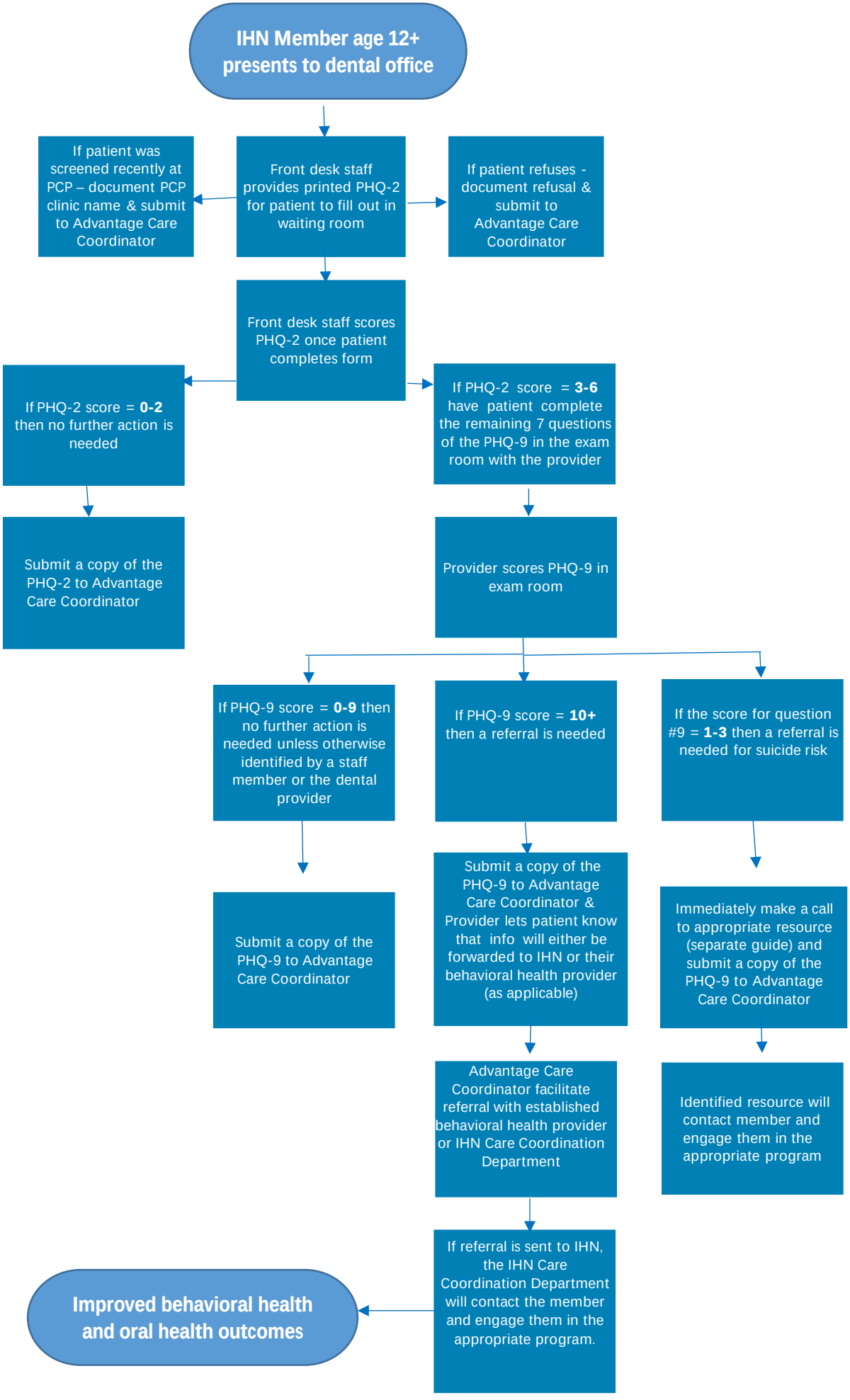
Pilot Timeline:

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Onboard Advantage Care Coordinator	Implement depression screenings at all four dental offices	Convene Steering Committee	Convene Steering Committee
Advantage Care Coordinator to achieve THW certification	Convene Steering Committee	Review data related to goals and augment processes as appropriate	Review data related to goals and augment processes as appropriate
Implement lunch and learns for pilot partners	Review data related to goals and augment processes as appropriate	Adjust workflows as needed	Ensure sustainability moving forward
Create program materials and workflows	Adjust workflows as needed		
Form Steering Committee			

Program Sustainability*:*

This program is innovative in that it creates a non-traditional pathway to behavioral health services; there is currently no existing model like this in the IHN service region. If successful, it will increase the number of IHN members who access mental health services based on identified need – resulting in an overall healthier population. The program also has the potential to positively impact the Depression Screening and Follow-Up Plan Metric. The majority of the funding will be used for initial set-up costs, including staff and training. Once appropriately trained staff is in place the program should be sustainable and scalable.

This pilot is modeled after a similar program developed by Eastern Oregon CCO in which Advantage has been a program participant.


IHN Member age 12+ presents to dental office
Front desk staff provides printed PHQ-2 for patient to fill out in waiting room
If patient was screened recently at PCP – document PCP clinic name & submit to Advantage Care Coordinator
If patient refuses - document refusal & submit to Advantage Care Coordinator
Front desk staff scores PHQ-2 once patient completes form
If PHQ-2 score = 0-2 then no further action is needed
Submit a copy of the PHQ-2 to Advantage Care Coordinator
If PHQ-2 score = 3-6 have patient complete the remaining 7 questions of the PHQ-9 in the exam room with the provider
Provider scores PHQ-9 in exam room
If PHQ-9 score = 0-9 then no further action is needed unless otherwise identified by a staff member or the dental provider
Submit a copy of the PHQ-9 to Advantage Care Coordinator
If PHQ-9 score = 10+ then a referral is needed
Submit a copy of the PHQ-9 to Advantage Care Coordinator & Provider lets patient know that info will either be forwarded to IHN or their behavioral health provider (as applicable)
Advantage Care Coordinator facilitate referral with established behavioral health provider or IHN Care Coordination Department
If referral is sent to IHN, the IHN Care Coordination Department will contact the member and engage them in the appropriate program.
If the score for question #9 = 1-3 then a referral is needed for suicide risk
Immediately make a call to appropriate resource (separate guide) and submit a copy of the PHQ-9 to Advantage Care Coordinator
Identified resource will contact member and engage them in the appropriate program
Improved behavioral health and oral health outcomes

Depression Screening in Dental Offices Pilot Project – Suicide Risk Process

1. If patient presents with immediate risk of harming themselves or others- Call 911
    a. If patient presents with acute suicide risk – Reach out to county suicide risk hotline
        i. Benton County Health Department
            1. Website: co.benton.or.us/health
            2. Phone: 866-266-0288
        ii. Lincoln County Health and Human Services:
            1. Website: co.lincoln.or.us/hhs/page/lincoln-community-health-center-4.
            2. Phone: 866-266-0288.
        iii. Linn County Mental Health:
            1. Website: linncountyhealth.org/mh/page/crisis-services.
            2. On-Site services: Monday through Friday from 8:30 a.m. to 5 p.m. at 445 Third Ave SW, Albany, Oregon by calling.
            3. Phone: 866-266-0288.

2. If patient presents with chronic suicide risk – Connect patient directly with IHN Care Coordination Team
        i. Direct #: 541-768-4877
        ii. Email: carecoordinationteam@samhealth.org

Patient Talking Points

Patient Question: Why do I need to fill this out? If I don't feel like I have these problems, should I still fill this out?
Answer: This information is just as important as taking your blood pressure or temperature. It helps your dentist understand your overall health and well-being.

Patient Question: Do I have to fill this out even if I'm not comfortable answering these questions?
Answer: You never have to fill out a form or answer questions that you're not comfortable with. If you have concerns about completing this, I'll tell your dentist you would like to talk about it.

Patient Question: I would rather just talk to my provider about these questions instead of filling this out. Is that OK?
Answer: Yes, of course.

Patient Question: I don't understand some of these questions. Can you help me?
Answer: If you have questions about the specific items on the form and how they apply to you, it would be best to talk about that with your dentist.

Patient Question: Who is my information being shared with?
Answer: Your information will only be shared with your health plan, IHN Coordinated Care Organization. The resources available are included in your benefit package.

Primary Organization: Advantage Dental Services, LLC (Advantage) Primary Contact: Mary Ann Wren, Director of Integration and Community Programs Primary Contact Email: maryw@advantagedental.com Partnering Organizations: IHN CCO Care Coordination Department, Benton County Mental Health, Linn County Mental Health, Lincoln County Mental Health Project Name: Depression Screenings in Dental Practices	
Outcomes	Indicator Concepts and Areas of Opportunities
A1: Increase the percentage of members who receive appropriate care at the appropriate time and place.	Indicator Concepts · Appropriate physical, behavioral, and oral preventive healthcare for all ages
BEHAVIORAL HEALTH	
Outcomes	Indicator Concepts and Areas of Opportunities
BH2: Increase the behavioral health expertise of healthcare providers and staff to reduce stigma and improve access and appropriate utilization of services.	Indicator Concepts · Oregon Psychiatric Access Line about Adults (OPAL-A) utilization
	Areas of Opportunity · Members receive behavioral health services, screenings, and referrals in primary care settings
BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.	Indicator Concepts · Rates of suicidal ideation, attempts, suicide, and/or self-harming behaviors · Overdose rates
	Areas of Opportunity · Mental health and substance use services, screening, and referrals in venues other than traditional medical facilities, including schools
BH4: Improve care for members experiencing mental health crisis.	Areas of Opportunity

	· Appropriate care at the appropriate time and place for people experiencing a mental health crisis
BH5: Improve care for members experiencing severe and persistent mental illness.	Areas of Opportunity · Non-mental health care (i.e., physical and oral) · Continuity of care
SOCIAL DETERMINANTS OF HEALTH	
Outcomes	Indicator Concepts and Areas of Opportunities
SD4: Increase health equity.	· Health disparities experienced by members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc. · Availability of health equity data

Specific Measurable Attainable Relevant Time-Nound (SMART) Goals	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Increase number of IHN members 12+ who complete a depression screening in an Advantage dental office	Currently no depression screenings are occuring in Advantage dental offices	Advantage will monitor the number of screenings completed on a monthly bassis	80% of all eligible members	12.31.2022
IHN members 12+ receive a referral to behavioral health within 7 days of scoring 10 or higher on a PHQ-9 administered at an Advantage dental office	Currently no depression screenings are occuring in Advantage dental offices	Advantage dental offices will send the Advantage Care Coordinator same day referrals for members who score 10+ on the PHQ-9. The Advantage Care Coordinator will open a care coordination case and send the referral to the IHN Care Coordination Department within 24 hours of receipt.	95% of all eligible members that received a referral based on PHQ-9 responses	12.31.2022
IHN members 12+ who had a behavioral health appointment after a referral was placed based on PHQ-9 scoring.	Currently no depression screenings are occuring in Advantage dental offices	IHN Care Coordination Department will follow up with the Advantage Care Coordinator on a monthly basis to close the loop on referrals.	75% of all eligible members that received a referral also completed a behavioral health appointment	12.31.2022

Pilot: Depression Screenings in Dental Practices

Pilot Start Date:	**1/1/2022**	**12/31/2022**	
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Bridging the gap between oral health and behavioral health		$80,000.00	$55,000.00
	Subtotal Resource Costs	**$80,000.00**	**$55,000.00**
Materials & Supplies			
Screening Materials		$2,000.00	$0.00
Marketing Materials		$7,500.00	$6,000.00
	Subtotal Materials & Supplies	**$9,500.00**	**$6,000.00**
Travel Expenses			
Travel related to meetings and trainings		$4,000.00	$2,000.00
	Subtotal Travel Expenses	**$4,000.00**	**$2,000.00**
Meeting Expenses			
Lunch and Learn Sessions with OHC and participating partners		$3,000.00	$3,000.00
	Subtotal Meeting Expenses	**$3,000.00**	**$3,000.00**
Professional Training & Development			
Community Health Worker Training & Certification		$1,000.00	$1,000.00
CHW CE Poverty and Related Social Determinants		$1,500.00	$1,500.00
Motivational Interviewing - Intro		$900.00	$900.00
Motivational Interviewing: Deepening Your Skills		$900.00	$900.00
CHW CE Mental & Behavioral Health overview		$1,500.00	$1,500.00
	Subtotal Training & Develop	**$5,800.00**	**$5,800.00**
Other Budget Items			
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$102,300.00**	**$71,800.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
Total Project Budget		**$102,300.00**	**$71,800.00**

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

DEPRESSION SCREENINGS IN DENTAL PRACTICES

IHN CCO Pilot Proposal

Proposed by: Advantage Dental

Advantage Dental
From DentaQuest

Pilot Summary and Goals

To bridge the gap between Oral Health and Behavioral Health, Advantage would like to implement depression screenings (using the PHQ-9 form) in dental offices, and create a referral pathway to behavioral health for members with behavioral health needs as identified through the screening process. The depression screenings will be piloted in the four Advantage Oral Health Centers in Linn, Benton and Lincoln Counties - Albany, Corvallis, Lebanon and Newport.

Pilot dental offices will conduct depression screenings and provide all screening forms and referrals to Advantage's Care Coordinator who will then facilitate referrals as appropriate to IHN's Care Coordination Department and/or behavioral health providers directly.

Goal 1:	**Increase number of IHN members 12+ who complete a depression screening in an Advantage Dental Oral Health Center**
Goal 2:	IHN members 12+ receive a referral to behavioral health within 7 days of scoring 10 or higher on a PHQ-9 administered at an Advantage Dental Oral Health Center
Goal 3:	IHN members 12+ who had a behavioral health appointment after a referral was placed based on PHQ-9 scoring

Member and Community Needs

Target Population:

- IHN members 12+

IHN-CCO Member Impact:

- Additional access points to behavioral health services
- Increased behavioral health utilization resulting in improved overall health outcomes
- Enhanced Care Coordination

Community Needs:

- Alternative Pathway to Behavioral Health
- Destigmatize behavioral health
- Reduce barriers to care

System Transformation

Systems Alignment:

- Collaboration among partners “new” to working together but have aligned missions
- Combining forces and focusing on systems improvement

Limitless Expansion:

- Resources and services

CCO Goal Alignment:

- Improved health outcomes
- Reduce costs
- Better care

Innovative:

- Integration of behavioral health into oral health setting

Partnerships/Collaboration

Advantage Dental:

- Provide the PHQ-2 and determine if the patient needs to complete the PHQ-9 with the dental provider.
- Refer members to IHN CCO's Care Coordination Department or behavioral health provider of record.
- Follow-up on patient status with IHN or behavioral health provider until patient has engaged with behavioral health services.

IHN-CCO Care Coordination Team:

- Receive depression screening referrals
- Assist members with scheduling a behavioral health appointment.
- Provide follow-up to Advantage's Care Coordinator on patient status.

Benton, Lincoln or Linn County Mental Health Program :

- Provide immediate intervention to members in crisis and/or suicide risk.

Health Equity Plan

- This pilot seeks to reduce health disparities and promote health equity by adding four non-traditional access points (dental offices) to depression screenings for IHN members12 and older. These alternative access points will also reduce barriers to care, including transportation and childcare by addressing mental health concerns at the dental office, combining two potential health care visits into one.

- Stigma is another barrier to accessing mental health services. Members engaging with oral health services that include depression screenings assists in breaking down barriers and de-stigmatizing behavioral health, thereby increasing the opportunity of members to experience optimal health.

- Health equity data including language and demographics will be collected as part of the intake process at the dental office as racial/ethnic minority groups are less likely to receive mental health care.

- This data will be tracked by Advantage and reviewed on a monthly basis. As part of the review process, Advantage will focus on identifying trends and augmenting screening procedures as appropriate.

Definition of Success

Goal 1: Increase number of IHN members 12+ who complete a depression screening in an Advantage Dental Oral Health Center	
Measurement 1:	80% of eligible members 12+ receive a depression screening
Goal 2: IHN members 12+ receive a referral to behavioral health within 7 days of scoring 10 or higher on a PHQ-9 administered at an Advantage Dental Oral Health Center	
Measurement 1:	95% of all eligible members that received a referral based on PHQ-9 responses
Goal 3: IHN members 12+ who had a behavioral health appointment after a referral was placed based on PHQ-9 scoring	
Measurement 1:	75% of all eligible members that received a referral also completed a behavioral health appointment

Sustainability Plan

- This program is innovative in that it creates a non-traditional pathway to behavioral health services; there is currently no existing model like this in the IHN service region.

- If successful, it will increase the number of IHN members who access mental health services based on identified need – resulting in an overall healthier population. The program also has the potential to positively impact the Depression Screening and Follow-Up Plan Metric.

- The majority of the funding will be used for initial set-up costs, including staff and training. Once appropriately trained staff is in place the program should be sustainable and scalable.

DST Member Questions

Easy A: Curriculum on Pain, Substance Addiction, and Healthy Self-Care

Backbone Organization: Old Mill Center

Billing Address: 1650 SW 45th St, Corvallis, OR 97333

Site(s): 1650 SW 45th St, Corvallis, OR 97333

County(s): Benton

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

Pilot Contacts	Name	Email
Primary	Sharna Prasad	sharnapras@aol.com
Proposal	Winston Kennedy	winston.s.kennedy@gmail.com
Contracting	Sharna Prasad	sharnapras@aol.com
Financial	Bettina Schempf	bettina_schempf@oldmillcenter.org
Reporting	Winston Kennedy	winston.s.kennedy@gmail.com

Proposal Narrative

A. Executive Summary

The data collected by the 2019 Oregon Healthy Teens Survey indicate that the number of eighth and eleventh grade students in Benton County who perceive misuse of prescription drugs as harmful is decreasing. At the same time, eleventh graders in Benton County report using prescription drugs without a prescription at higher rates than sixth and eighth graders. Over 20% of eleventh graders in Benton County report that it would be "very easy" to obtain prescription drugs that were not prescribed to them. These findings may have been exacerbated by the COVID-19 pandemic. Drug overdose deaths have risen by over 30% in the United states in 2020 (CDC, 2020) which may be associated with effects of the COVID-19 pandemic and the sudden environmental changes that have occurred.

This data tells us that there is a need to teach students about pain, opioid/substance misuse and healthy self-care. Drug addiction is not limited to opioids, so we will cover other substances (e.g., cocaine, fentanyl, alcohol, and tobacco). While we do not have data about opioid use for IHN members, the Centers for Disease Control and Prevention recognizes Medicaid subscribers as a high-risk population for fatal opioid overdose. To disrupt the trend of increased substance misuse that has been exaserbated by COVID-19 *the purpose of this project is to* develop an intervention that can be implemented in high schools to teach high school students about pain, opioid/substance misuse and healthy self-care with the support of the teachers and other school staff, that can be delivered in person and/or remotely. To achieve this purpose ***there are five aims for this project:***

1. ***Develop an evidenced based intervention (EASY-A) geared towards high school youth that can be delivered online or in person that provides students with knowledge about pain, opioids, and other substances, with a trauma informed lens and provides opportunities to practice healthy self-care.***
    a. ***Train coach(es) to implement EASY-A curriculum.***
2. ***Train high school teachers with behavioral tools, pain science and wellbeing to support students as they participate in the Easy-A intervention via a 4-week accelerated course.***
    a. ***Evaluate the effectiveness of training high school teachers immediately after the 4-week training course.***
3. ***Implement Easy-A intervention in high school over the course of 12 weeks with half the intervention being implemented in person via a coach and/or the other half implemented online via a coach.***
4. ***Conduct a process evaluation of stakeholders (teachers and students).***
5. ***Evaluate effectiveness of program for high school students by assessing Pre-post change on factors that are associated with decreased likelihood of substance misuse and increased healthy self-care.***

Through this project, students and teachers will gain an understanding of the biopsychosocial nature of pain and become aware of how the environment and contextual factors play a role in overall health and health management. Students and teachers will also understand what opioids/substances and certain behaviors do to our brains and their negative effects, which will help them conceptualize the science behind these behaviors in a fun and interactive way. Because of the increased knowledge and experiences with the content, students, with the support of teachers, will be empowered to be role models for their peers as well as advocates for their own health care and treatment, becoming ambassadors for positive behavioral management of their health.

B. Pilot Description

1. Project Goals/Measurable Objectives

The overall goal for this project is to develop an intervention that can support high school students and teachers understanding of behaviors related to pain, addiction and to promote healthy self-care. To achieve this goal, there are several measurable objectives that need to be met:

a. Creation of an evidenced based intervention that supports students' knowledge of pain, opioids and other substances, and that provides opportunities to engage in healthy self-care.
    i. The intervention will be developed using evidence-based strategies that support healthy behaviors (e.g., promoting self-efficacy, promoting physical activity engagement, addressing loneliness, and recording substance). A panel of seven experts, in the areas of behavior modification, pain, addiction, substance misuse, trauma, healthcare and rehabilitation will be utilized to review for face validity. All experts will have to agree that the intervention meets the criteria for achieving face validity. Once face validity is met coaches will be trained to deliver the curriculum to teachers and students. Once face validity is achieved coaches will be trained in its implementation.

b. Train high school teachers to support high school students as they participate in the Easy-A intervention.
    i. Teachers will participate in a 4-week accelerated version of the Easy-A intervention, so they can assist students as needed. The training will be led by a coach. Teachers will participate in a process evaluation, which will consist of qualitative and quantitative questions that assess, knowledge gained, confidence to support students and their thoughts on the content.

c. Implement Easy-A intervention in high school over 12 weeks.
    i. Intervention will be implemented 6-weeks in person and/or 6-weeks online as all content will be created to be implemented via both mediums via a coach.

d. Evaluate the effectiveness of the EASY-A intervention.
    i. Students will participate in the EASY-A Intervention over 12 weeks and will be given a battery of questionnaires that assess constructs that are associated with decreased substance misuse and increased healthy self-care (e.g., promoting self-efficacy, promoting physical activity engagement, addressing loneliness, and recording substance use) at base line, at 6-week mark, at the 12-week mark and at 2 months follow up.

e. Evaluate the process of implementing the EASY-A program.
    i. Teacher and students will be surveyed using quantitative and qualitative questions to understand what worked and what did not work with the Easy-A intervention.

2. **Target population:**

Our target population is Monroe High School students and teachers. The town of Monroe OR has 640 residents. Monroe High school has 116 students from the surrounding towns with a zip code of 97456, which has a population of around 3000 residents. Per IHN-CCO, there are 753 members in that area with 341 being children, which is about 25% of the population of that area. All high school

students and teachers will have the opportunity to participate in the curriculum pilot during the 2022/2023 school year, meaning this project has the potential to affect many teachers and students in that area.

3. **Description the intervention and detailed activities:**

The EASY-A intervention will include development and delivery of a curriculum that will teach high school students and teachers in Monroe High School about addiction, pain, and self-care. After the curriculum is developed, we will train coaches who will then implement the curriculum in the high school. We will be evaluating the process of implementing the EASY-A intervention at various stages, and we will also be evaluating various outcomes. Planned activities include:

- Curriculum development using evidenced based content
- Validation of EASY-A Curriculum with panel of experts
- Training of EASY-A coaches
- Teacher Accelerated training of EASY-A curriculum
- Evaluation of teacher accelerated training
- Baseline assessment and orientation of high school students
- 6-week in person EASY-A intervention
- 6-week assessment
- 6-week remote EASY-A intervention
- 12-week post EASY- A intervention outcome evaluation for teachers and students
- 2-month follow up for students

4. **Community partners and tasks:**

Community Partner	**Task**
Monroe High School	Participate in training to support students
Corvallis School District teachers	Curriculum development
Ralston Academy (Lebanon) teachers	Curriculum development
Lebanon High School	Curriculum development
Sweet Home High school	Curriculum development
Scio High School	Curriculum development
Central High School (Independence)	Curriculum development
Oregon Education Association	Marketing of EASY-A intervention
Oregon State University College of Public Health and Human Sciences	Assistance with designing and collecting data
Oregon State University College of Education	Assistance with delivering EASY-A intervention
STARS: Samaritan, Treatment and Recovery Services	Curriculum development
Benton County Health Department	Curriculum development
Western University	Assistance with delivering EASY-A intervention
Old Mill Center for Children and Families	Fiscal agent.

5. **Describe how the pilot will promote health equity and reduce health disparities; include how health equity data for IHN-CCO members will be tracked**

This project will promote health equity by including cultural humility within the creation of the curriculum. During the curriculum development stage, prior to the review of the curriculum by our panel of experts, we will have input from a variety of stakeholders, including teachers and youth in Linn-Benton County. Including diverse perspectives will ensure health equity is embedded in the curriculum. For example, we know that transgendered and queer youth experience high levels of trauma and are at higher risk than other youth for substance misuse and suicide. Including various individuals who identify as transgendered and queer, both youth and adults, ensures that their perspectives are included proactively. This same concept will be applied for various marginalized identities, e.g., racial/ethnic minorities, people with disabilities, etc.

By incorporating cultural humility and inviting diverse groups of people to provide input in the development of the EASY-A curriculum we also have an opportunity to reduce health disparities. Various health disparities are often perpetuated due to hegemonic (majority group) views being placed on minority/marginalized communities, e.g., outsiders coming into various marginalized communities and telling them what they need. By incorporating cultural humility, we can work with various communities, so that the EASY-A curriculum reflects those same communities, rather than another hegemonic led program that is not sustainable.

Health equity data will be tracked via an online questionnaire that will also capture various aspects of health and health behaviors that we hope to affect. The demographic data that we collect will help us track where specific health equity disparities exist in our population. We can also track the change for the various demographic groups we have through the same data collection process.

6. **Explain the social determinants of health lens the pilot will be incorporated**

The social determinants of health will be incorporated in the Easy-A curriculum explicitly. The social determinants of health include five domains; 1) economic stability; 2) Education access and quality; 3) healthcare access and quality; 4) neighborhood and built environment; and 5) social and community context. These five domains are directly related to substance misuse and health and will be addressed as we guide students through the paradigm of pain, substance misuse and overall health. One aspect of the social determinants of health that is a major priority of IHN-CCO and Monroe Oregon is housing/homelessness. Monroe high school has been proactive about providing resources for homelessness for its students, and we believe we can add in support for this by helping students learn that homelessness is a part of the social determinants of health and that it directly effects their health. The other aspects that will be addressed that are directly connected to the social determinants of health are, self-compassion, self-efficacy, physical activity engagement, loneliness, and substance usage.

7. **Individuals tasked with portions of the pilot and their roles and experience.**

Individual	Role(s)	Experience
Dr. Winston Kennedy, PT, DPT, MPH	Grant writer, Intervention evaluator	Winston is a licensed physical therapist and public health professional. He us currently completing research training to earn a PhD. He has experience with program adaptation and evaluation, as well as health policy and analysis. Winston places an emphasis on vulnerable

		populations and how to promote access to health resources in an equitable manner.
Dr. Sharna Prasad, DPT	Consultant, curriculum development, lead coach	Sharna has been a physical therapist for 34 years with a specialization in persistent pain. Sharna is trained in Acceptance and commitment therapy, pain science, self-compassion, and movement. She currently runs a group class for persistent pain patients with excellent results. She is passionate and committed about changing her community's awareness of pain, thus making her community a model community in the Country. Sharna believes that patient self-empowerment allows patients to manage their own pain.
Dr. Kevin Cuccaro, DO	Consultant	Kevin is a consultant and physician specialist on pain. He frequently speaks on pain and related topics to both physicians and the public in both small (local) and large (national) venues. He also consults health systems on chronic pain and opioids, and designs and runs highly rated (& participant recommended) pain training and education programs to diverse audiences.
Andra DeVought, PT, MPH	Curriculum development	Andra is a Physical therapist and a Public Health Professional. She specializes in the social determinants of health and health disparities. She has created curriculums in Washington State for students on the above topics with a trauma informed lens. She has also authored a chapter in integrative rehabilitation practice.
Velyn Din	Marketing	Velyn will be helping us develop the curriculum with a marketing lens. She is graduate of Wharton Business School with a specialty in Marketing. She will be selecting top of the line videographers and animators. She will keep a close eye on design and accessibility of information/graphics in a user-friendly way.
Dr, Michael Falcon, OTR	Curriculum development	Michael is an Occupational Therapist who has a lived experience of being on opioids and is in recovery after he lost his arm in an accident. He helped create the teacher curriculum for pain and addiction in 2019. He has worked with Pediatric patients for a most of his career and his specialty is coming up with experiential learning for this pilot. He currently works with Western University and brings collaborations with their OT program. He is also bilingual (Spanish and English).
Dr David Simmons, MD	Addiction Specialist	Dr Simmons is the medical director of the STARS(Samaritan, treatment and recovery

		services) program and has agreed to be a consultant for the curriculum.
Beau Sisneros	Monroe High School Principal	Beau is the principal of Monroe High School. They will be helping us coordinate the teachers and students for the training of the pilot.
Various diverse current and former students and teachers and adults in Benton and surrounding Counties	Consultant	We will be identifying students as well as former students from Benton County to participate in the creation of the curriculum so that the curriculum demonstrates cultural humility and can be implemented for diverse groups of students while considering their various identities (e.g., race, gender, sexuality, disability).

8. **Describe how the project fits into your organization's strategic or long-range plans:**

The creation of the Easy-A intervention will be inherently sustainable. This Easy-A curriculum will be an extension of a 2019 curriculum that was successfully implemented for teachers in the Corvallis School District; this was funded by DST-IHN. This curriculum also focused on health and opioid misuse and was meant to be delivered in person. With the unexpected lock down due to COVD-19, we realized that we need a curriculum that is adaptable in its delivery. As we move to develop the EASY-A curriculum, we plan to make it available as an in-person intervention and/or as an online intervention. The longer-term goal is for this to be integrated in high school education where students can take the course as an elective. We already have a version that is geared towards teachers, so they can be trained in this content. Eventually, we hope this program can be accessible statewide, then eventually nationwide for high school students.

Lastly, we want to make the EASY-A intervention available in not just high schools, for students and teachers but for a variety of people (young kids to elderly) in a variety of settings. For this stage we will expand our EASY-A coach aspect and create a "train the trainer" style program where we can get various types of people to deliver the EAS-A intervention in-person and/or online.

9. **Describe how members of the community will hear about your project**

The community will hear about this project via our marketing executive. Our Marketing executive will be helping us create the stories and will be shared in the local newspapers and media. We will also be using word of mouth and our professional networks in the area to recruit various stakeholders in the curriculum development stage. Stakeholders and participants will be given promotional materials to share with their networks to also help spread the message. Long-term, we plan to create a website that houses the curriculum and various promotional material, which can be accessed by anyone with internet access.

10. **Expected outcomes and how they help meet the pilot goals:**

<u>Measurement of outcomes</u>**:**

- Teachers will be given a process evaluation to assess their training on how prepared they feel to support their high school students. Teachers will be evaluated after the intervention to assess how the program can facilitate their support of students within the Easy-A intervention.

- Pre-post surveys that are associated with positive health behaviors will be used that are validated for youth.
    - Self-reported self-compassion (Neff, 2003)
    - Self-reported self-efficacy (Chen et al., 2001)
    - Self-reported physical activity engagement (Weston et al., 1997)
    - Self-reported loneliness (Hughes et al., 2004)
    - Self-reported substance usage (McNeely et al., 2016)
- Qualitative data will consist of responses to open-ended questions that ask about the implementation of the intervention, cultural humility, and accessibility.

Outcomes:

- The Easy-A curriculum will be developed and validated by various experts.
- Coach(es) will be trained on the implementation of the Easy-A curriculum
- Teachers will be trained on the EASY-A curriculum in 4-weeks
- Teachers will evaluate their training
- The Easy-A curriculum will be implemented over 12 weeks with support from teachers
    - Teachers and students will be able to recognize the bio, psycho, social, and environmental contextual factors that influence the experience of pain.
- Students will be evaluated at baseline, 6 weeks, 12 weeks, and 2 months post intervention, while accounting for demographic differences (i.e., race/ethnicity, gender, disability, etc.)
- Teachers and students will both give feedback on the implementation of the EASY-A intervention

How outcomes support goals:

Our pilot aims to educate and empower students (with the support of teachers) and provide an opportunity for self-discovery of behavioral health management options. We will accomplish this through the outcomes outlined above. Collectively, these actions will help students and teachers gain an understanding of the biopsychosocial nature of pain and build awareness of how the environment and contextual factors play a role in the experience of pain. Through these outcomes, students will also understand the negative impacts of opioids/substance misuse on health and the community and students will begin to develop lifelong healthy habits for maintaining and/or improving both their mental, behavioral, and physical health.

11. Potential risks and how the pilot plans to address them:

One risk of any new initiative in schools is fidelity. Fidelity is the commitment to policy and procedures when delivering an intervention. Teachers often feel overwhelmed by the amount of instruction they need to do and end up jettisoning lessons or entire units to adapt. In 2019 we implemented a similar curriculum in the Corvallis School District, and lack of fidelity was a part of the outcome. To counteract this risk to fidelity, we decided to teach the curriculum to the students with support from the teachers at the high school. Because of this, we will have to train coaches, depending on the amount of student participation that we get.

An additional risk is lack of student engagement. To avoid this, we will create incentives that promote participation for students and teachers. Some examples of incentives are food, Nike gift cards, Amazon gift cards etc.

There is the potential for some psychological risk, including negative affective states such as anxiety, depression, guilt, loss of self-esteem and altered behavior. To address this, students will be given an overview of the EASY-A intervention, then they will have to give informed consent with support from their legal guardian/caregiver to participate. Students will be able to discontinue participation in the intervention at any point.

C. Pilot Timeline

Major Objective	Key Tasks	Timeline
1. Easy-A Curriculum Development	1.1 Meet with consultants and review past research on factors that reduce addiction and promotes healthy behaviors	January 2022-March 2022
2. Assess Face Validity of Easy-A Curriculum	2.1 Panel of experts review Easy-A curriculum for face validity	March 2022
3. Train Easy A coach(es)	3.1 Ensure EASY-A coach understands and is comfortable delivering EASY-A intervention	March 2022
4. Implement an accelerated version of EASY-A intervention with teachers	4.1 Train high school teachers	April 2022- May 2021
	4.2 Evaluate teachers and obtain feedback	May 2022
	4.3 Adjust EASY-A curriculum as needed	May 2022
5. Implement easy A curriculum	5.1 begin in-person/online 6-week Easy-A intervention	May 2022-June 2022
	5.2 6-week assessment	June 2022
	5.3 begin 6-week in-person/online Easy-A intervention	Sept 2022-Oct 2022
	5.4 12-week post intervention assessment	Nov 2022
6. Evaluate data	Evaluate data for students and teachers	Nov 2022-Dec 2022
7. 2-month follow up for students	Contact student participants and assess if the changes in survey remained stable	Dec 2022
8. Write up study findings (anticipated 3 manuscripts)	6.1 Prepare manuscript 1: EASY-A Development	Dec 2022-Jan 2023
	6.2 Prepare manuscript 2: Outcomes from EASY-A pilot study	February 2023-March 2023
	6.3 Prepare manuscript 3: two-month follow-up of EASY-A Intervention	February 2023 - March 2023
9. Disseminate work at state and national conferences and submit manuscripts?	7.1 Submit abstracts for conferences	August 2022-March 2023
	7.2 Submit manuscripts to peer-reviewed journals. Potential candidate journals include disability	March 2023

	and health journal and journal of physical therapy	

D. Sustainability Plan

This is an innovative pilot because it integrates research about pain, opioid/substance misuse, and self-care. The understanding about the relationship between mental health, behavioral health and physical pain are only recently becoming more understood by practitioners. Because of research in these fields, we have an opportunity to change the ways that students assess and understand their own physical health. This is an area of innovation in education and the health field at large.
This pilot is scalable and transferrable because we will be using some of the funding to make the curriculum deliverable in-person or online. This curriculum can be adopted by districts across Oregon and nationwide. As far as we know, there is no current curriculum that addresses this gap in people's understanding of the connection between mental health, behavioral health, and pain. Through the pilot, we will create a model that other districts can follow.

If this pilot can show student success and growth in 2022 it will be replicable in neighboring Linn and Lincoln Counties. The primary resource needed for this pilot is funding for curriculum development for students and support to implement the curriculum. Additionally, we have reached out to colleagues in neighboring Linn and Lincoln counties to invite them to the teacher trainings in the future. We already have a health curriculum being implemented in the Corvallis school district, which demonstrates our commitment to building strong, sustainable, community partnerships. The education portion of the pilot is financially sustainable within Monroe School district because health will continue to be an ongoing part of high school learning in Monroe.

Budget Adjustment

The total project budget is $204,750. The total requested is $202,650. The amount requested is different from the total cost because some of the supplies requires in the amount of $2,000 has already been purchased from a grant received from DST-IHN in 2019-2020. This also led to a difference in the 5% indirect expenses, with the indirect expenses for the total cost being $9,750 and the indirect expenses for the amount requested is $9,650.

References:

CDC. (2020, December 21). *Overdose Deaths Accelerating During COVID-19*. Centers for Disease Control and Prevention. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

Chen, G., Gully, S., & Eden, D. (2001). Validation of a New General Self-Efficacy Scale. *Organizational Research Methods - ORGAN RES METHODS*, *4*. https://doi.org/10.1177/109442810141004

Hughes, M. E., Waite, L. J., Hawkley, L. C., & Cacioppo, J. T. (2004). A Short Scale for Measuring Loneliness in Large Surveys. *Research on Aging*, *26*(6), 655–672. https://doi.org/10.1177/0164027504268574

McNeely, J., Wu, L.-T., Subramaniam, G., Sharma, G., Cathers, L. A., Svikis, D., Sleiter, L., Russell, L., Nordeck, C., Sharma, A., O'Grady, K. E., Bouk, L. B., Cushing, C., King, J., Wahle, A., & Schwartz, R. P. (2016). Performance of the Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) Tool for substance use screening in primary care patients. *Annals of Internal Medicine*, *165*(10), 690–699. https://doi.org/10.7326/M16-0317

Neff, K. D. (2003). The Development and Validation of a Scale to Measure Self-Compassion. *Self and Identity*, *2*(3), 223–250. https://doi.org/10.1080/15298860309027

Weston, A. T., Petosa, R., & Pate, R. R. (1997). Validation of an instrument for measurement of physical activity in youth. *Medicine and Science in Sports and Exercise*, *29*(1), 138–143. https://doi.org/10.1097/00005768-199701000-00020

SMART Goals and Measures Table

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	1. Development of Easy-A curriculum	Develop with consultants	Face validity met by panel of experts of Trauma informed care, pain, substance misuse etc	03/2022
	2. Training of high school teachers	Implementing of accelerated EASY-A curriculum	Evaluation of training by teachers, to have basis of physical, emotional and behavioral health education	05/2022
	3. Baseline assessment of student participants	Issue questionnaire	Students complete baseline questionnaire	05/2022
	4. 6-week assessment	Issue questionnaire	Students complete mid-point assessment/questionnaire	06/2022
	5. 12-week assessment	Issue questionnaire	Students' complete outcomes assessment/questionnaire	10/2022
	6. Analysis of initial data	Data analysis and reporting	Data is cleaned then analyzed	10/2022
	7. 2 month follow up of student participants	Issue questionnaire to students	Students complete 2 month follow up questionnaire and have a culture of reduced stigma of substance misuse, compassion for pain and a healthy selfcare of physical, behavioral and mental health.	12/2022
	8. Completion of project with several conference and publications pending	Submit findings to grant agency and, various scholarly outlets	Findings write up	03/2023

Pilot:

Pilot Start Date:		Pilot End Date:	
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Collaboration and Expert consultation (Public health, Psychologist, teachers, Addiction physicians, pain providers, etc)		$55,000.00	$55,000.00
Curriculum development and coordination		$52,000.00	$52,000.00
Videographer/Animator		$50,000.00	$50,000.00
Researchers/designing/statisticians - research instruments		$10,000.00	$10,000.00
	Subtotal Resource Costs	**$167,000.00**	**$167,000.00**
Materials & Supplies			
PD supplies		$2,000.00	$0.00
Promotional materials (bracelets, magnets, stickers, decals, etc)		$6,000.00	$6,000.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$8,000.00**	**$6,000.00**
Travel Expenses			
Travel to and from conferences, hotels per diem		$6,000.00	$6,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$6,000.00**	**$6,000.00**
Meeting Expenses			
Renting rooms/food for training		$3,000.00	$3,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$3,000.00**	**$3,000.00**
Professional Training & Development			
Continuing Education (Trauma informed, SDOH, Health Equity, Pain, Behavioral health, cultural humility etc)		$6,000.00	$6,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Develop	**$6,000.00**	**$6,000.00**
Other Budget Items			
School projects		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$5,000.00**	**$5,000.00**
Total Direct Costs	**Rate (%)**	**$195,000.00**	**$193,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	5.00%	$9,750.00	$9,650.00
Total Project Budget		**$204,750.00**	**$202,650.00**

Easy-A

A curriculum for high school teachers and students on Opioid/substance misuse, addiction-pain-and healthy selfcare.

Pilot Summary and Goals

Our project is to develop a curriculum that can be implemented in high schools to teach high school students about pain, opioid/substance misuse and healthy self-care with the support of the teachers and other school staff, that can be delivered in person and/or remotely.

- Goal #1: Development of Easy-A with trauma informed lens and reducing stigma around substance misuse.
- Goal #2 To train the number of teachers and student peers with compassion about the biopsychosocial nature of pain with behavioral tools
- Goal #3 To change the culture of Monroe High School with integrating wellbeing, and preventive behavioral health.

.

Member and Community Need

- Talking points:
  - Target Population : Monroe high school teachers and students. Other high school teachers from Linn and Benton county.
  - Increase awareness of the science of pain in the community.
  - Reduce stigma around substance misuse.

System Transformation

- This Pilot will result in
  - Creation of innovative online curriculum that connects pain science, opioids,addiction, social determinants of health, social justice and self-care
  - Collaboration with new community partners
  - Strengthening of existing partnerships in Monroe and neighboring communities of Linn-Benton
  - Development of community hubs for wellness in key neighborhoods
  - Improvement in students' social, psychological and physical health
  - Reduction in claims

Partnerships/Collaboration

- Monroe High School
- Corvallis School District teachers
- Ralston Academy (Lebanon) teachers
- Lebanon High School
- Sweet Home High school
- Scio High School
- Central High School (Independence)
- Oregon Education Association
- Oregon State University College of Public Health and Human Sciences
- Oregon State University College of Education
- STARS: Samaritan, Treatment and Recovery Services
- Benton County Health Department
- Western University
- Old Mill Center for Children and Families

Health Equity Plan

- Increase knowledge, influence behaviors, and build resiliency for all high school school teachers and students in Monroe High School
- Improve access to wellness/ self-care options for students navigating poverty in targeted neighborhoods.

Definition of Success

- Teachers and students will demonstrate changed beliefs related to pain, opioids/substances, addiction and self-care
- Students will be more aware of and have experience with self-care (resulting in less experience of pain)
- **Measures of success:**
- o Self-reported self-compassion (Neff, 2003)
- o Self-reported self-efficacy (Chen et al., 2001)
- o Self-reported physical activity engagement (Weston et al., 1997)
- o Self-reported loneliness (Hughes et al., 2004)
- o Self-reported substance usage (McNeely et al., 2016)
- o Qualitative data will consist of responses to open-ended questions that ask about the implementation of the intervention, cultural humility, and accessibility.

Sustainability Plan

- This curriculum will be available online for access to teachers all over Oregon and other states.
- Students can take the Easy A class directly online

DST Member Questions?

Namaste Rx

Backbone Organization: Namaste Rx, LLC.

Billing Address: 38902 River Dr. Lebanon, Or. 97355

Site(s): C.H.A.N.C.E. 231 Lyons Street SE. Albany Or 97321

County(s): Linn, Benton, and Lincoln Counties

Priority Areas:

- Subpopulation Type 1 - Those recovering from substance abuse.
- Subpopulation Type 2 - Pregnant persons.
- Addressing Trauma.
- Increasing and improving access to behavioral health services with an emphasis on the impacts of COVID.
- Pay equity through building and sustaining the workforce.

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

- A1(c) - Trauma Informed Care, such as ACE's and resiliency measures.
- BH1(a) - Number of community members, employers, landlords, teachers, elected officials, and service providers trained in Mental Health First Aid or Trauma-Informed Care, or other basic mental health awareness training.
- BH3(a) - Screening, Brief Intervention, and Referral to Treatment (SBIRT) rates.
- BH6(ii.) - Preventative Behavioral Healthcare and promotion of general wellbeing.
- SD4(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	Britny Chandler	namasterx2020@gmail.com
Proposal	Haripriya Prakash	namasterx2020@gmail.com
Contracting	Britny Chandler	namasterx2020@gmail.com
Financial	Britny Chandler	namasterx2020@gmail.com
Reporting	Haripriya Prakash	namasterx2020@gmail.com

Proposal Narrative:

A. Executive Summary

Namaste Rx, LLC cares deeply about the resiliency of our community and our Mission is to help individuals on their journey to find inner peace through the practice of trauma informed yoga. Research[1] has shown that yoga and meditation provide relief to many behavioral health conditions, and Yogis can provide additional Behavioral Health access as they often hold their services outside of traditional clinic operating hours.

In a study[2] published in 2016 by JAMA Psychiatry titled, 'Efficacy of Mindfulness Cognitive Behavioral Therapy (MCBT) in Prevention of Depressive Relapse,' the conclusive findings state, "Mindfulness-based cognitive therapy appears efficacious as a treatment for relapse prevention for those with recurrent depression, particularly those with more pronounced residual symptoms."

In 2017, NCBI published a study[3] titled, 'Increased Gamma Brainwave Amplitude in Control in Three Different Meditation Traditions,' discovered that meditation can be effective with increasing creativity (helpful when solving day to day problems) and decreasing symptoms of depression.

Evidence-Based Research shows promising results of the positive effect that yoga can have, if used to treat certain Behavioral Health Conditions.

It is because of this data, and the fact that Oregon ranks 48th[4] in the U.S. on mental health, that Namaste Rx, LLC was founded.

The overarching aim of the Namaste Rx pilot is to create behavioral health access for Medicaid recipients, through the holistic approach of yoga service integration within our community's healthcare system.

This aim will be achieved through a three stage approach that includes:

- Trauma Informed Training (of contracted Yogis)
- Service Integration
- Community Outreach & Education

[1] https://breathetogetheryoga.com/about/why-practice-yoga/#toggle-id-34

[2] https://jamanetwork.com/journals/jamapsychiatry/fullarticle/2517515

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5261734/

[4] https://mhanational.org/issues/2021/ranking-states#overall-ranking

B. Pilot Description

Element 1 & 10 – Goals & Expected Outcomes

As mentioned within the Executive Summary, the pilot's overarching aim is to create behavioral health access for Medicaid recipients, through the holistic approach of yoga service integration within our community's healthcare system.

Within the current Western culture, the traditional yoga systems that include breathing exercises, stretches, postures, chants, and meditation provide a plethora of health and wellness benefits. There are many accounts of evidence-based research[5] that has been conducted to test the effectiveness of yoga as a treatment option for a number of different conditions. The results have shown significant improvement of health and wellness from a number of studies. Table 1 outlines the conditions that yoga has shown improvements in symptoms with research participants.

TABLE 1

Evidence-Based Research: Conditions that are positively impacted by practicing yoga	
Physical Health Benefits	**Behavioral Health Benefits**
• Arthritis • Brain Health • Cancer • Cardiovascular • Carpal Tunnel Syndrome • Chronic Heart Failure • Chronic Neck Pain • Chronic Lower Back Pain • Chronic Pain • Chronic Obstructive Pulmonary Disease (COPD) • Diabetes • Fibromyalgia • Migraines • Multiple Sclerosis • Parkinson's Disease • Prenatal • Stroke	• Addiction • Anxiety • Depression • Memory/Cognitive Function • OCD • PTSD • Sleep • Work Stress

[5] https://breathetogetheryoga.com/about/why-practice-yoga/#toggle-id-19

Element 2 - Target Population

Namaste Rx is requesting funding for 150 IHN-CCO members to participate in the pilot. C.H.A.N.C.E. will be given 50 referrals for those in recovery of substance abuse. V.B.B. will be given 50 referrals for those who are pregnant. The remaining 50 referrals are for the behavioral health provider's patients. 100% of the requested funds will be dedicated to serving the 150 IHN-CCO members.

Element 3 - Intervention & Activities

Trauma Informed Training

Prior to service implementation, Namaste Rx, LLC wants to ensure that Yogis are in alignment with the Behavioral Health System when it comes to addressing membership in a Trauma-Informed way. Namaste Rx, LLC requires all sub-contracted Yogis to participate in the Trauma Informed Oregon Training. This is to ensure alignment of Quality of Care across each service type the member comes into contact with.

Education and Outreach

Prior to service implementation, lunch and learns will be conducted for the initial groundwork of outreach, education, recruitment, marketing, and workflow implementation. The outreach will target Yogis wanting to participate as service providers for the pilot population. The pilot aims to have two practicing Yogis within each county that is Subcontracted with Namaste Rx, LLC.

In addition to the Yogis, Behavioral Health Clinics and providers who wish to partner by sending referrals will also receive a lunch and learn education session that will train their staff on the importance of Yoga in the Behavioral Health System and aim to integrate Namaste Rx, LLC as a utilized resource for their patients.

Each existing partner will also receive a lunch and learn in the similar effort to educate and inform staff that Namaste Rx, LLC is a resource to their clients and can have a positive impact on symptoms they may be experiencing. This will allow staff the understanding of the importance of yoga and a referral pathway for membership.

In addition to the lunch and learns, Namaste Rx, LLC will be partnering with IHN-CCO's Behavioral Health Quality Committee (BHQC). The BHQC is comprised of local Behavioral Health Stakeholders that advise IHN-CCO on Quality Improvement of Behavioral Health Services within the Region. In partnership with the BHQC, Namaste Rx aims to develop criteria that would trigger referrals to and from Namaste Rx and Behavioral Health Clinics. All of these efforts will be documented and utilized to create an Integration Toolkit to support efforts of replicability and sustainability.

Service Implementation

Each partner will be responsible for referring IHN-CCO membership to participate in the pilot program. Membership will be routed to the online web portal to fill out an enrollment form. Included within this form will be first name, last name, date of birth, Subscriber ID, and current address. These fields allow IHN-CCO to be able to confirm eligibility in any future partnership and exchange of data. In addition to member identifiers, there will also be screenings offered at the time of enrollment, monthly, and at the end of the pilot that will set the baseline for measuring the success of the intervention efforts.

Once baseline information and member identifiers are collected through the enrollment process, members will fill out an ACE's survey, REAL-D data, and a Quality of Life survey. Once fully enrolled, members will gain access to the Namaste Rx web portal. Within the member's web portal, they will be able to access the Yogi network and schedule an appointment (private or group sessions), update member profiles and track their progress.

A Private Session is recommended prior to group sessions. This will allow a one on one with the member and the Yogi prior to any application of services to discuss medical history, mental health history, and range of motion. At this appointment, it may become clear that the member requires a physician's note prior to conducting yoga stretches. If this were to occur, Namaste Rx would require the assistance of IHN-CCO with coordination of care and services.

Each member will have access to one private yoga session a year and group yoga session once per week with guided meditation. The expectation is that membership will implement an at-home yoga and meditation routine from learned practices and poses. Each month, the member will be required to fill out the Quality of Life Survey to monitor progress at intervals of treatment as well. This data will be analyzed periodically to track efficacy of the program at different intervals of treatment.

Once the ACE's scores have been collected and enrollment information is complete. All members who reported having a high ACE's score and no utilization of a behavioral health clinic will receive an automatic referral to traditional behavioral health supports. Criteria for this referral, referral pathways, and EHR notations will be discussed and developed during the pilot through partnership with the BHQC.

Element 4 - Partnerships

C.H.A.N.C.E.
C.H.A.N.C.E. will be responsible for referring sub-population to the Namaste Rx Pilot in addition to hosting the Meditation Room (This is an existing space within C.H.A.N.C.E. and can be utilized by those practicing their meditation).

Heart of the Valley Birth and Beyond (V.B.B.)
Valley Birth and Beyond will be responsible for referring sub-population to the Namaste Rx Pilot in addition to sharing an FTE to assist with pilot activities and execution.

Behavioral Health Quality Committee (BHQC)
The BHQC will be an information only partner. Namaste Rx aims to gather integration knowledge pertaining to a traditional Behavioral Health Clinical setting and a roster of Behavioral Health Providers that seek access to these services for their patient panel. The BHQC Will be offered 50 referrals for the IHN membership to the Namaste Rx Pilot.

Ride Line
To provide trips to and from yoga services to any pilot participant who needs it.

Element 5 - Health Equity & Reduce Health Disparities

One of the first actions that Namaste Rx will conduct is to create and implement an Equity and Inclusion Plan for the organization. Once the Equity and Inclusion plan is finalized and integrated, Namaste Rx will partner with IHN-CCO to conduct a Health Equity Training for staff. This will ensure that all practices of Namaste Rx will be created through the scope of health equity. Namaste Rx, L.L.C. top priority is the effort to reduce health disparities

Namaste Rx, LLC was developed in the spirit of data driven results. Data will be gathered and analyzed on continuum to ensure regular monitoring of reported disparities from our membership. This will ensure that all business decisions are truly made in consideration of those most needing the services.

Namaste Rx also will be reaching out to the Disability Equity Center to ensure that services are accessible as possible to our community members living with a disability.

Element 6 - Social Determinant of Health (SDOH)

On average, the recommended yoga treatment can cost an individual approximately $1,040 a year. The high cost of these services is a barrier for those individuals lacking a high and/or consistent income. Namaste Rx has developed a tiered plan model that will assist in the support of this population utilizing these services, at an affordable rate to the system and no charge to the IHN membership.

In addition to income being a barrier, transportation may also be a barrier. We have partnered with Ride Line so that anyone who needs a ride to their covered yoga benefit, may also have coverage for a ride to and from the services.

Based on initial feedback from local Yogis, religion was noted as a barrier. Many living within the Western Culture align with a Christian based belief system. Many Christians will refrain from practicing yoga and meditation due to its roots within the Eastern Culture. The pilot aims to include the clarification of the evidence-based research when conducting outreach and education.

We understand finding affordable child care can be a barrier to care. While conducting research for this pilot proposal, Namaste Rx conducted a screening with local Yogis to better understand the landscape of our local yoga industry. One of the findings included that many Yogis operate outside of regular business hours to accommodate the working class. The typical hours of operation of our local county mental health programs for adult outpatient services is from 8AM-5PM. With Yogis operating earlier and later in the day and on the weekends, we open access for those who have child care as a barrier and offer access to behavioral health supports that are outside of regular operating hours of the traditional clinical settings.

Element 7 - Roles and Responsibilities

TABLE 2

Name	Role	Responsibility	Experience
Britny Chandler	Co-Founder	• Pilot Contact • Contracting Contact • Finance Contact • Yogi Contract Negotiation & Execution • Property Contracts • Lead referral discussions	• Experience drafting and managing two DST pilots. • 6 years of contract negotiation and execution experience. • Experience drafting and executing budgets and finances. • Experience integrating services within the Medicaid setting specific to the Tri-County Region.
Haripriya Prakash	Co-Founder	• Proposal Contact • Reporting Contact • Data Analytics Management • Lead Web Development discussions	• Masters of Science in Business - Data Analytics • Experience with business process re(engineering). • Experience with program and project management. • Experience operationalizing

			programs. • Experience with Change Management. • Experience with data analysis.
Amber Thompson	Communications Representative	• Social Media Coordination • Communications assisting	• Experienced Customer Service Rep. • Experienced in Communications.
.5 FTE	Project Manager	• Pilot Management • Leads educational development • Assist with Tool Kit development • Assist in formalizing referral pathways • Attend outreach events	• Master's Degree • Yogi Certified • Part time employment with one of our existing partners
.5 FTE	OSU Intern	• Internal documents development (Equity & Inclusion Policy, document templates, meeting minutes, etc.) • Assist with data analytics • Communications assisting	• Applicable degree that would meet the needs of the work being executed.

Element 8 - Strategic Plan

To put it simply, Namaste Rx believes that anyone should have access to these services. At Namaste Rx, our vision is to begin by servicing Linn, Benton, and Lincoln Counties. Once fully established within the Tri-County Region, we aim to expand to other CCO regions within the State of Oregon and eventually across State lines.

The efforts conducted during the pilot will become the foundation of service delivery for Namaste Rx.

Element 9 - Marketing and Communications

The outreach and marketing within the community is dependent on what population we are speaking to. Currently, we aim to disperse knowledge with any opportunity that presents. With that in mind, below in Table 3 are the activities of the pilot that naturally incorporate a component of information sharing.

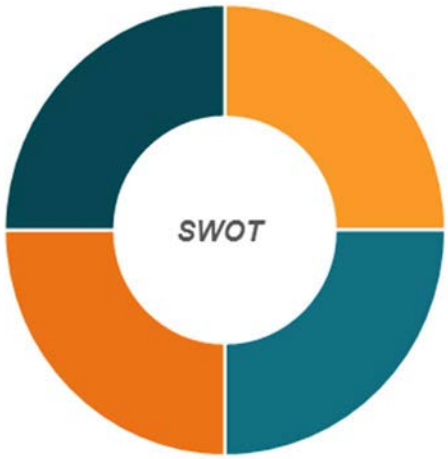
TABLE 3

Population	Outreach
Behavioral Health Providers, CBO's, and HR Reps	Lunch and Learns
Pilot referred IHN-CCO members	THW intervention, educational handout, and referral
Self-referred individuals	Social Media Campaigns
IHN-CCO referred members	Education for Care Coordination Department
Potential partners	Networking events such as conferences and community outreach events
Clinic managers	Integration Tool Kit
Medical Students	COMP-NW Mindfulness Curriculum

In addition to these efforts, Namaste Rx has one full time volunteer that will be utilized as the pilot's full time Communications Reprsentative. This individual will be responsible for coordination and execution of social media to ensure outreach to as many individuals needing this resource as possible.

Element 11 - Potential Risks

Namaste Rx conducted a SWOT Analysis (Strengths, Weaknesses, Opportunities, and Threats) in November 2020. This analysis was used to determine a strategy for funding. The grey highlighted items are mitigated with the help of DST funding and the purple highlighted items are bolstered with DST funding:

STRENGTHS • Creative approach to holistic health • Variety of benefits • Affordable • Small number of employees and low overhead expense • Stigma around behavioral health		WEAKNESSES • Lack of reputation • Administrative support • Limited # of trauma certified Yogis
OPPORTUNITIES • New partnerships with community agencies and programs • Student discounts • Future expansion of benefits • Creative collaborations to encourage sustainable funding mechanisms		THREATS • Funding • Economy movement • Stigma around behavioral health • Changes in regulations and certification requirements

In addition to the SWOT Analysis, the following risks have been considered during the development of this pilot.

Our largest risk is that the IHN population wishes not to fill out Quality of Life Surveys each month to continue to utilize services. To ensure continued participation, Namaste Rx will be donating incentives and prizes that will be raffled to each participant that completed at least three surveys.

Our direct competitors would be yoga studios and yoga providers who do not wish to collaborate with Namaste Rx. This is a risk if we only partnered with yoga studios. Initial feedback from Yogis has been that many Yogis do not have a large enough

clientele to practice full time and many want to. The yoga studios in the area will train Yogis and then have them sign a contract that they will not practice within the geographic locations surrounding the studio to refrain from taking business away from that studio. This drives Yogis out of the system or out of our region. By executing a contract with Namaste Rx, these Yogis gain access to an entire population that is currently not utilizing those studios. The Yogis will still be receiving compensation from an innovative stream of income that allows them to continue to practice what they love with people who truly need these services as a treatment option.

One Yogi mentioned in a survey that Namaste Rx conducted, "I've thought about doing this, but I have no clue where to start." Namaste Rx brings knowledge of the Oregon Health System that will mitigate the risk for Yogis to attempt to navigate the system wide partnership. The Co-Founders of Namaste Rx have an accumulative of 15+ years in the Health System field ranging from clinical practice to Medicaid, Medicare, and Commercial insurance experience.

An additional potential risk is that post pilot close-out, IHN-CCO won't execute a contract with Namaste Rx. Our pilot activities have taken this risk into consideration and are attempting to mitigate by bolstering efforts and activities around our sustainability plan (*See page 12 for Sustainability Plan)*.

As mentioned above while defining the SDOH lens of this pilot, childcare was also determined to be a potential risk that would also hinder participants to utilize these services. Although this pilot does not directly address the shortage of affordable childcare, our screening conducted with Yogis and the local yoga industry presented the information that Yogis provide usable access to the IHN-CCO working class population.

Finally, COVID-19 forced many Yogis to practice virtually or quit altogether. Our aim is to bring people out of isolation and reinforce these Yogis sustainability with an additional stream of income. By partnering with Namaste Rx, Yogis have access to an additional and sustainable stream of income. The pilot efforts will support job growth within this industry and an opportunity to be a part of something truly innovative.

C. Pilot Timeline

GOAL I - Trauma Informed Training		
Start/End Dates	**Activity**	**Measurable Outcome(s)**
10/2021 - 2/28/2022	Yoga Recruitment - Scheduling and execution of Yogi Lunch and Learns.	**(1)** 100% of contracted Yogi's have completed the Trauma Informed Oregon Training. **(2)** 70% of contracted Yogis have a positive experience working with Namaste Rx.
1/1/2022 - 3/31/2022	Yoga Recruitment - Fully execute Yogi contracts.	
4/1/2022 - 12/1/2022	Yogi Recruitment - Execute group Trauma Informed Oregon Training.	
GOAL II - Service Integration		
10/2021 - 1/31/2022	Meet with Web Developers and outline website needs.	**(1)** 70% of participants see an improvement in their reported baseline symptoms. **(2)** 35% of participants see an improvement in unreported baseline symptoms. **(3)** 95% of participants see an improvement in their overall baseline quality of life.
2/1/2022 - 2/28/2022	Invite Beta Testers to test the website and Yogi referral workflow	
2/1/2022 - 3/31/2022	Connect to Unite Us platform	
4/1/2022 - 4/30/2022	Beta Test for Quality Assurance of website, referrals, and Yogis.	
GOAL III - Community Outreach & Education		
1/1/2022 - 3/31/2022	Outreach and develop referral pathways with the BHQC.	**(1)** Increased membership to ensure post pilot sustainability. **(2)** Increase the number of member care plans that include yoga as a treatment option. **(3)** 70% of referring behavioral health
4/1/2022 - 6/30/2022	Lunch and learn outreach to Behavioral Health Clinics, HR organizations, and local CBO's.	
4/1/2022 - 12/31/2022	Social Media Campaign for organic leads.	

7/1/2022 - 12/31/2022	Participating in outreach events and educational seminars.	providers have a positive experience working with Namaste Rx and would refer future patients to the program.

D. Sustainability Plan

Namaste Rx, LLC will need community support and integrated partners to sustain the Medicaid population's use of the program. As mentioned previously, the pilot aims to create behavioral health access for Medicaid recipients through the holistic approach of yoga service integration within our community's healthcare system. This is achievable by connecting the following services: Insurance, Yoga, and Healthcare Providers. By integrating these service types, we will increase access and coverage options for medical and behavioral health conditions in an innovative way. Additionally, this integrated approach has been executed by previous IHN-CCO DST pilots (i.e. Medical-Dental Integration Pilot, Community Doula Program, etc.) that have proven to be successful as well as scalable.

In the future, we wish to supply access to all Medicaid recipients. Namaste Rx will use this pilot as an opportunity to create an integration toolkit that is specific to efforts of integrating within the Oregon CCO systems. These toolkits, as well as consultation services will allow transferability of these necessary services and will be offered at a cost. This will ensure an additional stream of income that will assist in post pilot sustainability efforts.

We also want this to be offered as a treatment plan that Doctors can rely on regardless of insurance carrier. Our sustainability model accommodates this need by offering tiered plan benefits. The evidence-based yoga and guided meditation services are covered on all plan tiers and additional fringe benefits (that are not supported by evidence-based research) are available with the mid and high-cost plans.

Plan Tier Options	Monthly Premium
Tranquility • Free Group Sessions (1x a week). • One private session at no charge. (60-minute session only)	$40.00
Serenity • Free group sessions (up to 1x a week). • Discounted Private Session.	$78.00
Nirvana • Free group sessions (up to 1x a week). • Discounted Private Sessions. • Access to quiet, serene, private campgrounds across Oregon for a personal yoga retreat. (reservation fee applies)	$130.00

Our pricing allows for equitable access for all levels of income. Namaste Rx believes that income should not be a determining factor when you begin your brave journey of healing and self-discovery.

To support post pilot sustainability, during the life of the pilot, efforts will be made to extend coverage and benefit contracts with the following organizations:

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

Once integrated, Namaste Rx, LLC will be self-sustaining. This form of sustainability holds the lowest risk of losing these behavioral health access points within the community.

Budget Narrative

The budget was drafted to ensure the lowest financial commitment could be made with the highest return on investment for IHN-CCO members.

This is made possible through in-kind donations of our partners and the Namaste Rx Co-Founders. Heart of the Valley Birth and Beyond and Namaste Rx will be utilizing a shared workforce model for 1 FTE. Half of this FTE salary will be provided by Heart of the Valley Birth and Beyond.

Ride Line agreed to a discounted trip rate by implementing a PMPM rate, rather than collect at 100% of private reimbursement rate. The estimated in kind donation of the reimbursement is included within the 'total cost' column.

Other discrepancies between 'total cost' and the 'amount requested' are the in-kind donations of the Co-Founders of Namaste Rx, LLC. By donating personal time and resources, this shortens the timeframe of implementation and integration within the community. This ensures these services reach community members as soon as possible.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Data unknown	Manual tracking and record keeping of contractual requirements.	100% of contracted Yogi's have completed the Trauma Informed Oregon Training.	(12/2022)
	No data available	Yogi satisfaction survey will be conducted and collected during the close of the pilot.	70% of contracted Yogi's have a positive experience working with Namaste Rx.	(12/2022)
	No data available	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.	70% of participants see an improvement in their reported baseline symptoms.	(12/2022)
	No data available	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.	35% of participants see an improvement in unreported baseline symptoms.	(12/2022)

	No data available	Quality of Life survey (World Health Organization) will be taken upon enrollment and will establish the baseline and monthly thereafter.	95% of participants see an overall improvement in their baseline reported quality of life	(12/2022)
	150 members	Weekly monitoring of unique member count of enrolled individuals across each plan tier.	Increased membership to ensure post pilot sustainability.	(12/2022)
	No data available	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.	Increase the number of member care plans that include yoga as a treatment option.	(12/2022)
	No data available	Provider satisfaction survey will be conducted and collected during the close of the pilot.	70% of referring behavioral health providers have a positive experience working with Namaste Rx and would refer future patients to the program.	(12/2022)

Pilot: Namaste Rx

Pilot Start Date:	1/1/2022	Pilot End Date:	12/31/2021
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Benefit Coverage		$72,000.00	$72,000.00
Pilot's Overarching Aim: To create behavioral health access points for Medicaid recipients, through the holistic approach of yoga service integration with our community's healthcare system.		$153,000.00	$32,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$225,000.00**	**$104,000.00**
Materials & Supplies			
Laptops (x3)		$2,500.00	$2,500.00
Website Infrastructure		$30,000.00	$30,000.00
Marketing Materials		$20,000.00	$20,000.00
	Subtotal Materials & Supplies	**$52,500.00**	**$52,500.00**
Travel Expenses			
Mileage		$1,000.00	$500.00
Conferences		$5,000.00	$5,000.00
Meals and Lodging		$5,000.00	$2,000.00
Ride Line Trip Coverage		$90,000.00	$22,500.00
	Subtotal Travel Expenses	**$101,000.00**	**$30,000.00**
Meeting Expenses			
General meeting expenses		$1,000.00	$500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$1,000.00**	**$500.00**
Professional Training & Development			
Group Trauma Informed Oregon Training		$1,000.00	$1,000.00
Lunch and learns		$5,000.00	$5,000.00
Workforce Professional Development		$3,000.00	$1,500.00
	Subtotal Training & Develop	**$9,000.00**	**$7,500.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$388,500.00**	**$194,500.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	8.00%	$31,080.00	$15,560.00
Total Project Budget		**$419,580.00**	**$210,060.00**

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

Namaste Rx

Namaste Rx, LLC
C.H.A.N.C.E.
Heart of the Valley Birth and Beyond
Behavioral Health Quality Committee

Pilot Summary and Goals

- The overarching aim of the Namaste Rx pilot is to create behavioral health access for Medicaid recipients, through the holistic approach of yoga service integration within our community's healthcare system.
- This will be achieved through integrating certified Trauma Informed Yogis into the local Behavioral Health network and by restructuring the reimbursement of Evidence-Based Yoga services to be included as a covered benefit to the IHN-CCO population.
- The aim of the pilot will be met through a three stage approach:

1. Trauma Informed Training
2. Service Integration
3. Community Outreach & Education

Member and Community Need

- IHN-CCO Member Impact: 150 IHN-CCO dedicated referrals. Aiming to increase an individuals Quality of Life by integrating yoga as a covered benefit.
- Member need: There is a lack of universal coverage of yoga services, disallowing regular use in a treatment or care plan.
- Behavioral Health need: The Evidence-based research supports the hypothesis that yoga and meditation help improve symptoms associated with many behavioral health disorders.
- Yogi need: Yogis see the benefit of practicing yoga to aid in health and wellness. However, many find it difficult to gain enough clients to practice full-time. Independent practicing Yogis also had a difficult time navigating through COVID-19.

System Transformation

How is your proposal transformational?

- There are currently no yoga services partnered with IHN-CCO or the partners within the pilot (CHANCE, Doula Program, and BHQC). Namaste Rx, LLC is a new partner to the community offering an innovative behavioral health resource.

- Our pilot aims to have a positive impact on IHN-CCO member's health and wellness. In the long term we aim to reduce health care system costs by integrating our services within the system.

- Yoga being integrated within the healthcare system to be used as a regular tool within member care plans is innovative and supported by Evidence-Based Research.

Partnerships/Collaboration

Partner	Pilot Activities	Cross-sector?(Y/N)	New partner?(Y/N)
CHANCE	Education, outreach, referrals.	Y	Y
HVBB	Education, outreach, pilot management (supported by internal staff), referrals.	Y	Y
Ride Line	Transportation to services.	Y	Y
BHQC	Education, outreach, feedback, Behavioral Health referrals.	Y	Y

Health Equity Plan

- How will you address health equity and reduce health disparities?

1. Creation and adoption of an organization Equity and Inclusion Plan.

1. Health Equity Staff Training

1. Data driven decision making based on member needs.

1. Outreach to the Disability Equity Center.

Definition of Success

Measurement of Success	Monitoring Activities
100% of contracted Yogis have completed the Trauma Informed Oregon Training.	Manual tracking and record keeping of contractual requirements.
70% of contracted Yogis have a positive experience working with Namaste Rx.	Yogi satisfaction survey will be conducted and collected during the close of the pilot.
70% of participants see an improvement in their reported baseline symptoms.	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.
35% of participants see an improvement in unreported baseline symptoms.	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.
95% of participants see an overall improvement in their baseline reported quality of life.	Quality of Life survey (World Health Organization) will be taken upon enrollment and will establish the baseline and monthly thereafter.

Definition of Success

Measurement of Success	Monitoring Activities
Increased membership to ensure post pilot sustainability.	Weekly monitoring of unique member count of enrolled individuals across each plan tier.
Increase the number of member care plans that include yoga as a treatment option.	A qualitative member Satisfaction Survey to be conducted at the time of member enrollment and at the close of the pilot. Member reported.
70% of referring behavioral health providers have a positive experience working with Namaste Rx and would refer future patients to the program.	Provider satisfaction survey will be conducted and collected during the close of the pilot.

Sustainability Plan

Plan Tier Options	Monthly Premium
Tranquility ● Free Group Sessions (1x a week). ● One private session at no charge (60-minute session only).	$40.00
Serenity ● Free Group Sessions (1x a week). ● Discounted Private Sessions.	$78.00
Nirvana ● Free Group Sessions (1x a week). ● Discounted Private Sessions. ● Access to quiet, serene, private campgrounds across Oregon for a personal yoga retreat. (Reservation fees apply).	$130.00

DST Member Questions?

Parenting Today Forward

Backbone Organization: OneIIAnother

Billing Address: 1645 9th Ave SE, Suite 203 Albany, OR 97322

Site(s): Albany, Lebanon and Sweet Home communities

County(s): Linn

Priority Areas: 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: (BH1) Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced. (b)Peer delivered behavioral health education and services, (i)behavioral health stigma within the community and (ii)community supports in the community to normalize behavioral health issues. (BH3) Increase mental health and substance use screenings, services, referrals, and peer and parent support, (a) Screening, Brief Intervention, Referral to Treatment rates, (ii)Peer delivered education and support, (SD4) Increase health equity, (i) health disparities experienced by members.

Pilot Contacts	Name	Email
Primary	Connie Kay	ckay@o2aprograms.com
Proposal	Alison Hellums	ahellums@o2aprograms.com
Contracting	Connie Kay	ckay@o2aprograms.com
Financial	Crystal Rowell	crowell@o2aprograms.com
Reporting	Connie Kay	ckay@o2aprograms.com

Parenting Today Forward

OneIIAnother

1645 9th Ave SE, Suite 203

Albany, OR 97322

(541) 570-0284

Primary Contact: Connie Kay

Primary Contact Email: ckay@o2aprograms.com

Proposal Narrative

A. Executive Summary (½ page)

OneIIAnother is a non-profit based in and serving the residents of Linn County, Oregon. Our mission is to provide families and individuals support, bridging their challenges to their strengths toward lifelong success. This is accomplished through teaching skills and demonstrating a strengths-based culture where all are welcome and supported wherever they may be in their life's journey. OneIIAnother strives to be a strengths-based community which accepts and respects everyone's journey, promotes positive words and actions, encourages safe and healthy relationships, bridges communication, supports community connections and empowers individual's growth and strengths.

To provide supports to the families and individuals of our communities, OneIIAnother will be hosting parenting education classes and support groups both in-person and through the Zoom Video Conferencing platform. We will also be hosting Workshops, a Youth Support Group, and Children's Activities programs which will enable parents to attend our classes and groups while having a safe place for their children. The online classes allow us to reach the clients that we may not have been able to reach due to barriers of transportation, location or other factors including mental, behavioral, or physical health. We have a growing Peer Support program that is accessed through a Support Request Form available to those attending classes and support groups.

Our goal is to provide families and individuals the tools necessary for successful communication not only within the home but in all aspects of life. These tools will assist the community members that we see to thrive and grow while establishing a support network of peers facing similar struggles, learning from one another in addition to the facilitators leading the groups and establishing community relationships with professionals in many areas that may not have otherwise been accessed.

B. Pilot Description (5-7 pages)

OneIIAnother received non-profit status in 2017 but has been holding parenting classes and providing parenting support for 15 years currently. Before COVID, we held a thriving program hosting classes in three towns within Linn County. Our Albany class regularly had upwards of 50 people attending the evening group. In March of 2020, we had to immediately close the doors to our in-person groups and classes. We are now in the stage of rebuilding our program to fit the new guidelines that have been established. We are unable to utilize the buildings that we were gifted use of, and we are tasked with finding new locations to hold our groups. We are going to reestablish our program with more options in a way that is better fitting to the needs of those that we serve.

A piece of rebuilding our program is that we need to be able to compensate the time for which the classes and groups are being facilitated, community support following groups and classes by phone and in person, coordination of volunteers that help with setup and cleanup of each class, and a liaison between our organization and the properties that we are using. This is needed to build the connections that have been severed with the community members that we serve. After our classes and groups were suspended, we lost the face-to-face communication with many of our families and individuals during a time that they needed the most support. Having a person designated to be present and available for our community offers a place where our families can come to have their questions and concerns heard and allows them to feel heard and supported.

OneIIAnother is committed to offering a minimum of one in person Step 1 introductory class quarterly in Lebanon, 2 classes annually in Sweet Home and 2 classes quarterly in Albany. These classes run in 10-week sessions and cover the Parenting Today Forward curriculum that has been developed by OneIIAnother and is unique in that it incorporates Collaborative Problem Solving ideas along with user friendly techniques that provide a strong sense of success as the skills are learned and implemented in the home. Our attendees learn how to effectively communicate with everyone that they may encounter both inside and outside of their home with empathy and using a strengths-based approach. We cover how to establish and implement house rules and routines, absent and delayed skill sets, skills for effective listening and how to have empathetic conversations, which opens successful communication in all areas of a person's life. We look at grieving what someone expected their life to look like and how to find the strengths and look for the gifts in your life. This is where the foundation of Parenting Today Forward is built. Attendees can learn in a variety of ways from hands-on activities and lectures, but also by building natural supports and seeing that there are other families having similar struggles and challenges within their homes.

To best support our community during COVID, we began holding an online Step 1 class through the Zoom video conferencing platform. This is something that has become a normal in our current times and even as our area continues to re-open, we still have families that are unable to attend our classes in-person due to barriers with transportation, location, mental or physical health needs. We plan to continue this as an option for those people that need this access point. To better serve this population, we will need to expand our technology base with a better screen for the facilitator and a device to boost our internet accessibility to be able to hold classes without the struggles of slow or unreliable internet connection. We are planning on continuing this as an option and will hold a class quarterly as interest is present.

We will offer a Step 2 class that expands on the skills learned through the Step 1 class. Those attending Step 2 will have a chance to dive deeper into the concepts of Parenting Today Forward by learning about the science behind why this curriculum is so successful while still receiving the support from one another, practicing the skills with hands-on activities and lecture formats.

OneIIAnother Support Groups give parents, caregivers, grandparents, and individuals an opportunity to build natural supports with others experiencing similar struggles and see that they are not alone. This is another new piece to OneIIAnother as we were always a support group style of class, but the need for a designated Support Group has been voiced. We began this component online during COVID and it is something that has been heard that our communities want this to continue.

Adult Skills Training is a highly requested class in Linn County communities. This is a group in which skills such as empathy, listening skills, and organizational skills will be a few of the topics covered.

Workshops offered by OneIIAnother are an option to build on the skills learned during the Step 1 classes. Workshops will be topic specific covering an in-depth look at things such as implementing house rules, expectations, routines, power struggles, skill development, coping skills, and more. These Workshops will be offered quarterly.

The OneIIAnother Peer Support program is accessed through a request process that is available to all attending our groups and classes. This is a program that is individualized support based on the

curriculum and skills taught through our Step 1 classes. We can assist in making referrals to agencies, community partners and professionals for those needs outside of our programs.

During each of our groups and classes, we offer a Children's Activities program that allows parents to bring their children so that they can attend our classes and learn knowing that their children are in a safe place with our trained, experienced, and caring staff having fun with their peers in a social setting while being introduced to the same model that they are learning. This also allows parents and children to see the strengths-based model in action and experience the acceptance and support while they are all learning. The families that we serve are often isolated when they have a child that has difficult behaviors. They do not have options for childcare during appointments whether it is family or professionally provided, causing missed appointments and fewer opportunities to learn skills to strengthen the communication within the family. OneIIAnother can help address this barrier by providing this program. We will have paid staffing at each location for this program. In the rehiring process, we are hopeful to have a Spanish speaking applicant join our team to provide better communication with our families.

The goal of OneIIAnother is to teach parents, caregivers and individual's tools and skills that will be used by the families that we serve to help them feel supported and the children to feel accepted. Having the support and acceptance that comes with adopting this strengths-based culture and using the tools learned will reduce the number of families that seek emergency services and reduce the involvement of agencies in the home. This will be tracked through our attendance system and in partnership with Linn County Mental Health.

Our target population is the residents of Linn County, Oregon. We receive referrals from outside agencies, local school districts, Linn County Courts, and word of mouth among other sources. With a population of approximately 125,000 in Linn County, we served 177 families in 2020; 136 families to date in 2021, in which 65.2% were Oregon Health Plan members.

OneIIAnother has partnerships with Linn County Mental Health in which we receive referrals to our programs and help facilitate families and individuals seeking services through Linn County Mental Health. We have a relationship with Greater Albany Public Schools in which they distribute information about our classes and groups to the community. We have collaborated with GAPS to hold a School Supply Drive when children were returning to school for the first time during COVID-19. We provided a donation of supplies for the district to distribute following the end of our Supply Pick-up Day. We are partnered with Greater Albany Public School District's FACT program in which schools, students and families are linked to community services helping to eliminate barriers to the success of the students in our community. We have standing relationships with the many local churches in many communities within Linn County. We have used First United Methodist Church in Albany, Free Methodist Church, Foursquare Church, Church of the Nazarene, and Crowfoot Baptist Church in Lebanon as well as churches in Sweet Home.

OneIIAnother approaches Health Equity using an open-door policy where all people, individuals, families, caregivers, and children are welcomed to any of our programs, regardless of their circumstances. Introductory classes and programs will be free of charge so that there are not any financial barriers to attending. Step 2 classes will be available on a sliding fee scale with the option of giving back in the way of helping before and after our groups during setup and cleanup, to avoid the financial barriers to our community members. We want to ensure that all our programs are available

to anyone that desires to attend. Online groups and classes will be available to those with barriers due to location, transportation, health, or other obstacles preventing in-person attendance. With our partnerships, we are helping to address the difficulty of access to services in Linn County. To track the data collected to increase health equity, we will use a registration form with survey questions asking type of insurance coverage that each person will fill out, it will then be entered into a data base. We are looking into more efficient ways to collect data around the demographics that we serve and how to best address the needs of those community members.

We see a large percentage of our attendees are white/Caucasian at 93.3% however, this is proportionate to our area population. 83.6% of our attendees have identified themselves as a parent, 13.2% identified as guardian or caregiver and 8.2% were grandparents. We do not have information on the gender of our population, we are looking at the best way to incorporate additional demographic survey questions to collect these statistics.

We have been looking into expanding our programs to include the Spanish speaking population and hope to develop this soon.

To further increase attendance and accessibility for those seeking to attend our classes, we are looking at ways to address transportation barriers.

In all programs offered by OneIIAnother, we see that many of our attendees have experienced health disparities based on socioeconomic status, gender identification, mental health struggles, disabilities of physical, mental, developmental, or cognitive nature, education, sexual orientation and many more. We provide a safe place where everyone is welcomed and accepted. We strive to support each person through our strengths-based culture during their journey of learning how to live from today forward.

Social Determinants of health widely affect the population that we serve, and we are helping to break down the elements by having established relationships with many agencies and programs within our community in which we can work together to best serve our community members. Having access to behavioral and mental healthcare can have a positive impact on many other areas in the individual or family’s life, including but not limited to stable housing and food security by utilizing resources available to them. Networking with Linn County Mental Health, Greater Albany Public Schools, local churches, and many other agencies gives OneIIAnother the option to pass on the knowledge of the options available to people who may not know where to look. We have a developing Peer Support program that helps refer our clients to other agencies and services.

Many of our partnerships are based on the need of the members of our community and the different places that offer different options for services. We have relationships with Family Tree Relief Nursery to make and receive referrals based on the needs of the family. We have developed a working relationship with C.H.A.N.C.E to be able to serve their clients through our programs but also as a great business resource as we develop and expand our programs and services.

Debbi Barreras is the Executive Director of OneIIAnother has held a position with Linn County Mental Health for nearly 30 years. During her time with LCMH, she was the Family Support Specialist serving families and children during the most difficult times of their lives. She has educated families and helped them to implement the tools she teaches so that the families build a foundation for success in their homes, school, and community. Many of the families that have formerly received the

skills and tools that Debbi has taught to their families are currently volunteering with OneIIAnother because of the impact that the things that they learned had such a positive impact in their lives and the lives of their children.

Parenting Today Forward is the foundation curriculum of OneIIAnother. Holding parenting classes and support groups that are easily accessible for everyone in the community is the mission of our organization. OneIIAnother is in the business of helping families and children. Our long-term plan is to expand this curriculum throughout the communities and counties surrounding Linn County.

Information about our groups can be found in many physical places in the Linn County area, doctor's offices, Health Department bulletin boards, our local school districts distribute our fliers to their families, we get many referrals from local therapists and counselors. We have a website for OneIIAnother that has information on current and upcoming classes and groups as well as resources and contact information and can be found at https://one2another.net. There is a OneIIAnother Facebook page where information can be found, www.facebook.com/groups/oneiianother. We have a large number word of mouth referrals from our community members and supporters.

By providing the programs that we have, we are looking to reduce the stigma and increase awareness that behavioral health issues are normal and widely experienced. We will accomplish this by hosting parenting groups and classes for the community. We have a Peer Support program that is easily accessed by our attendees through a Support Request form. We are a community support that normalizes the behavioral health struggles by accepting each person and providing a safe place for them to learn and feel supported.

Risks of our program are not enough attendees; in which case we will begin more intensive community outreach. This could include volunteers going to community events and being able to answer questions and distribute information. Having too many attendees is another concern as we must abide by the capacity limits of our buildings and any COVID guidelines. In this situation, we will put a limit on the number of attendees in each class or group and then add classes and groups at alternate times in the communities that are seeing high demand, we can also offer classes in alternative towns. We are currently looking at options for a place to host our classes and groups and we risk not being able to find something long-term. In this case, we will find a short-term option and continue looking for our permanent location.

In order to make all of the necessary preparations, and coordinate locations, process interest and registration of all of the attendees, we are in need of a paid staff position within OneIIAnother. This would be the equivalent of a fulltime position and would be tasked with all of the administrative needs to make our groups happen.

Pilot Timeline:

September 2021: Fall In-Person groups and classes to begin.

January 2022: Winter In-Person groups and classes to begin.

March 2022: Spring In-Person groups and classes to begin.

June 2022: Summer In-Person groups and classes to begin.

Sustainability:

OneIIAnother will sustain our program through contracts for services provided by our Peer Support Program, generous donations and sponsorships and the funding of future grants. Currently, we have contracts with Linn County Mental Health to assist in our startup. We will have contracts for funding for services provided during our Children's Activities program through LCMH as well as DHS in addition to grants that are being considered for funding.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Albany- no in-person Step 1 class	Interest sign up by phone and online; registration from attendees	Two in-person Step 1 classes per quarter (10 week sessions)	December-22
Lebanon- no in-person Step 1 class	Interest sign up by phone and online; registration from attendees	One in-person Step 1 class per quarter (10 week sessions)	December-22
Sweet Home- one in-person Step 1 mini-class	Interest sign up by phone, online; registration from attendees	Two in-person Step 1 classes per year	December-22
Online Step 1 Class via Zoom	Interest sign up by phone and online; registration from attendees	One online Step 1 class quarterly or as interest is demonstrated	December-22
Workshops- none currently held	Interest sign up by phone and online; registration from attendees	One topic centered workshop held quarterly.	December-22
Step 2 Class- none currently held	Interest sign up by phone and online; registration from attendees	Two classes held during the year	December-22

Pilot:

Pilot Start Date:	1/1/2022	Pilot End Date:	12/31/2022
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Building Fees to include costs associated with hosting our groups.		$6,000.00	$6,000.00
Liability Insurance		$3,969.00	$3,969.00
	Subtotal Resource Costs	**$9,969.00**	**$9,969.00**
Materials & Supplies			
Computer upgrades for Zoom classes and groups		$3,500.00	$3,500.00
	Subtotal Materials & Supplies	**$3,500.00**	**$3,500.00**
Travel Expenses			
Client Transportation Assistance Exploration		$2,000.00	$2,000.00
	Subtotal Travel Expenses	**$2,000.00**	**$2,000.00**
Meeting Expenses			
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
		$0.00	$0.00
	Subtotal Training & Develop	**$0.00**	**$0.00**
Other Budget Items			
Facilitator and Coordination		$32,000.00	$32,000.00
Children's Activities Staffing and Coordinator		$19,725.00	$0.00
	Subtotal Other	**$51,725.00**	**$32,000.00**
Total Direct Costs	**Rate (%)**	**$67,194.00**	**$47,469.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	13.10%		$6,000.00
Total Project Budget		**$67,194.00**	**$53,469.00**

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

PARENTING TODAY FORWARD

Pilot Summary and Goals

OneIlAnother will address transportation and other barriers, supporting families and individuals within our community through the following goals

1 – To provide families and individuals the tools necessary for successful communications

2 – To provide supports to families and individuals in our communities through online and in person parenting groups

3 – To provide child activities with our parenting groups to provide acceptance and skill modeling to both parents and their children.

Member and Community Need

- Gratitude
  - COVID taught us how to connect to people while staying separate.
  - We were given an opportunity to collaborate and problem solve to better serve our communities.
  - In the transition back to “normal” we get to take these lessons with us.

Member and Community Need

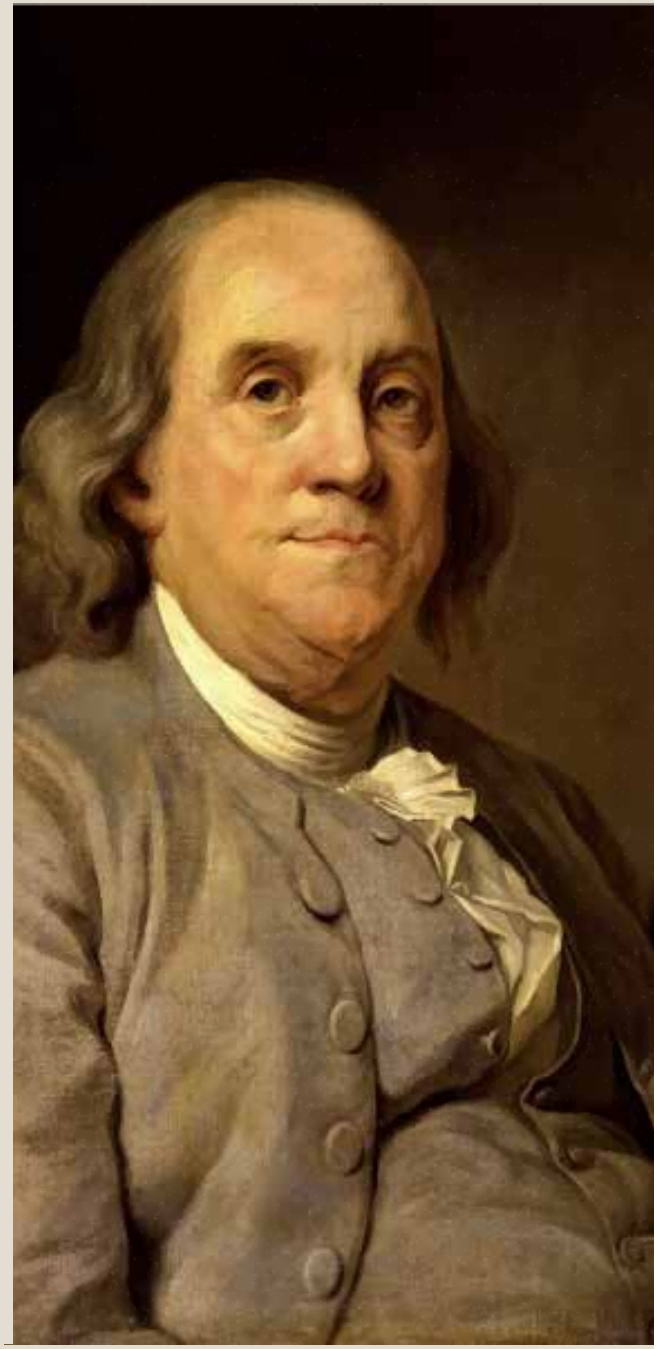
- Barriers addressed
  - Transportation
  - Technology access
  - Respite
- Target Population
  - Parents, Grandparents, Caregivers, Foster Families, Personal Support Workers, Teachers, and so many more in Linn county, Oregon.

Member and Community Need

- IHN-CCO Member Impact
  - In 2020, OnelIAnother served 177 families
  - So far in 2021 OnelIAnother has served 136 families
  - 65.2% of the families served receive services through Oregon Health Plan.

System Transformation

- “An ounce of prevention is worth a pound of cure.” -Benjamin Franklin
- While parents attend parenting groups, children and youth also experience our strengths-based culture and their own version of Collaborative Problem Solving at their level.
- By focusing on education and community building, we hope to keep families from needing the level of crisis and emergency services that they would otherwise need.



Partnerships/Collaboration

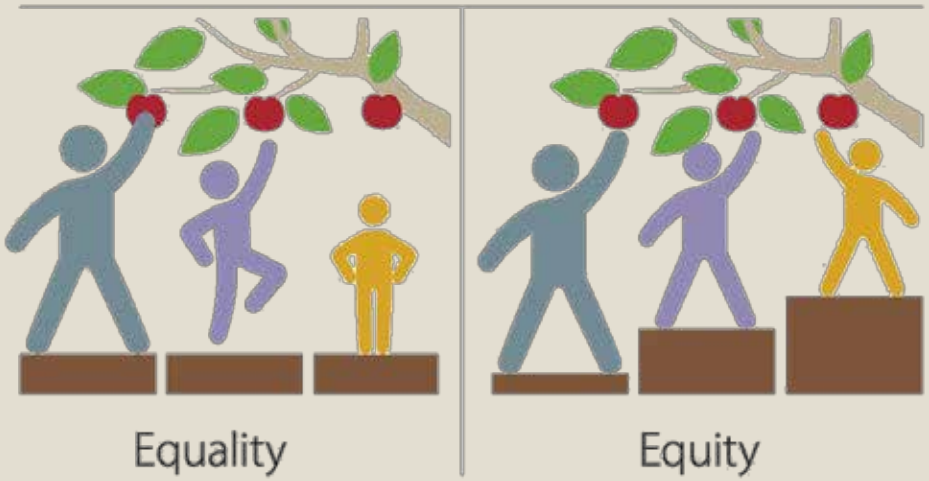
- Partnerships
  - Linn County Mental Health
    - Refers many families to our programs
    - We can help facilitate families seeking services
  - Greater Albany Public Schools
    - Distributes our fliers to the community
    - We have provided a donation of supplies for the district to distribute to students as needed.
  - Families and Communities Together of GAPS
    - Refers families to our services.

Partnerships/Collaboration

- Collaboration
  - Family Tree Relief Nursery
    - We make and receive referrals based on the needs of the family
  - C.H.A.N.C.E.
    - Provides a great business resource as we develop and grow.
    - We serve their clients through our programs

Health Equity Plan

- Open-door policy.
- Cost-free introductory groups.
- Advanced classes available on a sliding fee scale with scholarships available.
- Online availability for those unable to travel to us.

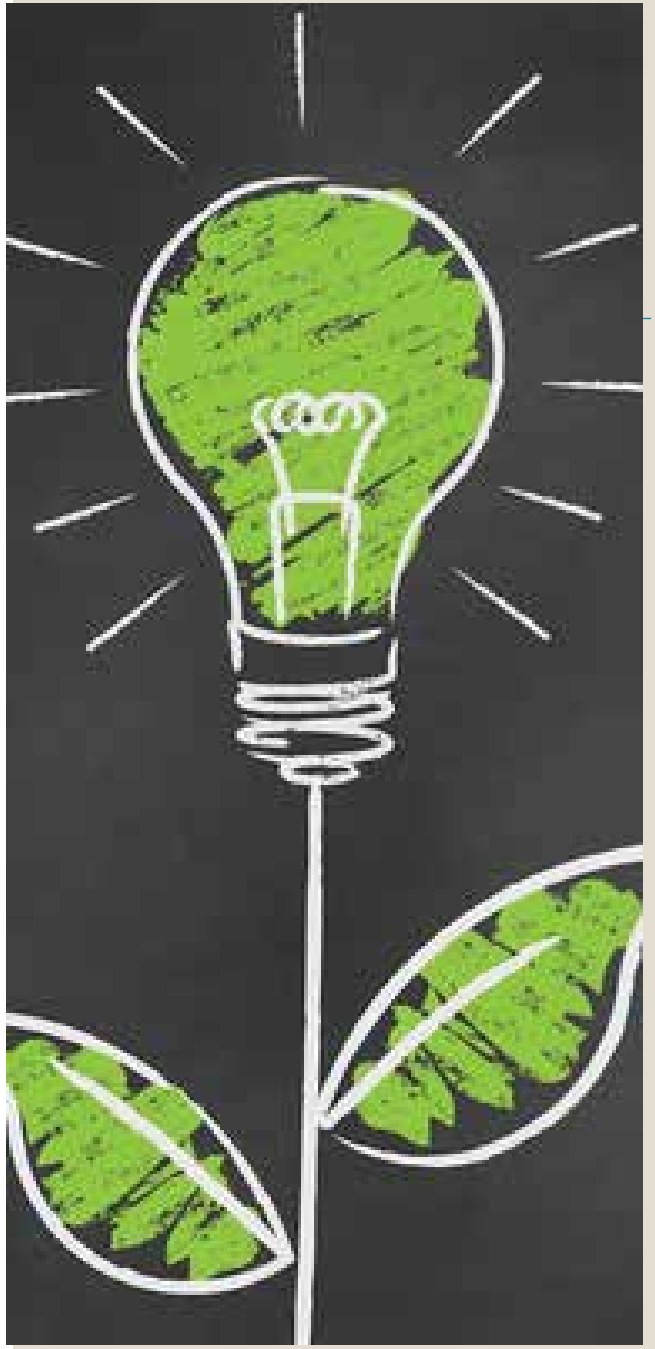


Definition of Success

- Measure of success – Reduce stigma and increase awareness that behavioral health issues are normal and widely experienced.
- Path to success – Hosting parenting groups and classes for the communities we live in.

Definition of Success

- Measure of success – Normalize the behavioral health struggles of families and individuals in our communities
- Path to success – Accepting each person and providing a safe place for them to learn and feel supported.



Sustainability Plan

- Funding sources
  - Contracts for services through our Peer Support program
    - Currently with Linn County mental health
    - Future contracts being considered include the Department of Human Services.
  - Donations and sponsorships
  - Organizational Fundraising
    - Plant sale
    - Pictures in the park
    - Bottle and can drive

DST Member Questions?

Pathfinder Behavioral Health Transformation

Instructions: Email completed coversheet and other required elements to Transformation@samhealth.org. Please reference the IHN-CCO Request for Proposal Guidelines for additional instructions. The proposal narrative should be submitted in Word format with narrow margins, 12 point Arial or Verdana font, 1.15 spacing. The budget and activities monitoring grid must be in Excel and the presentation in PowerPoint (attachments). Please fill out this coversheet completely.

Required Elements:

- ☒ Coversheet
- ☒ Proposal Narrative (see pages 10-11 RFP1 of Guidelines)
- ☒ Budget
- ☒ Activities Monitoring Grid
- ☒ Presentation

Backbone Organization: Pathfinder Clubhouse

Billing Address: PO Box 1414, Corvallis, OR 97339

Site(s): 250 NW 1st street Suite 110 & 120, Corvallis, OR 97330

County(s): Benton, Linn, Lincoln

Priority Areas: (see page 7 of Guidelines) Subpopulations of IHN-CCO members that experience health disparities. E.g. Latino/a/x, LGBTQ, disabled folx, indigenous, foster care youth, youth in transition from foster care. Addressing trauma. Increasing and improving access to behavioral health care in light of COVID-19.Pay equity through building and sustaining the workforce. Improving access to behavioral health services in non-traditional ways.

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: (see pages 7-9 of Guidelines) A1 (C), BH1 (B, i, ii), BH3 (A,B,C, i,ii,iii,iv), BH4 (i,iv), BH5 (I, ii, iii, iv,v), BH6 (ii), SD1 (A, ii,iii), SD4 (i),

Pilot Contacts	Name	Email
Primary	Elizabeth Hazlewood	Elizabeth@PathfinderClubhouse.org
Proposal	Chris Folden	Chris@PathfinderClubhouse.org
Contracting	Elizabeth Hazlewood	Elizabeth@PathfinderClubhouse.org
Financial	Elizabeth Hazlewood	Elizabeth@PathfinderClubhouse.org
Reporting	Elizabeth Hazlewood	Elizabeth@PathfinderClubhouse.org

Pathfinder Behavioral Health Transformation

Executive Summary - Pathfinder Clubhouse breaks away from the paradigm of traditional mental health practices with an innovative yet evidenced-based Clubhouse International model of psychosocial rehabilitation that is making a radical change to the way our community responds to mental illness. Pathfinder Clubhouse will increase access to non-traditional behavioral health services that help adults living with mental illness resolve socio-economic inequities, homelessness and trauma experienced or compounded by COVID-19. This program will improve access to care becoming part of the community discharge plan from inpatient and partial hospitalization and bring a transformative approach by bringing on and utilizing Community Health Workers from diverse backgrounds for the first time in an un-traditional way to deliver culturally responsive Clubhouse services. These services are not something contracted in place, and we feel this would be a great project to launch in attempts to increase access to care and supports while reducing the need for crisis level response including inpatient hospital care. Community based mental health services typically involve getting a referral with often long wait times post hospital discharge. Pathfinder is transforming this process to embrace people when they need support the most, helping them become stabilized in the community. The scope of service starts while inpatient where members and staff together (if covid protocols allow) go to the unit to do a presentation for the person establishing a relationship and implementing supports when they are needed most. If the individual is interested, we work with the discharge planners to set an appointment and transportation to the clubhouse within 48 hours of discharge. This immediate support allows the individual to transition out of the inpatient setting with supports that better algin them for success. Helping meet immediate needs of housing, employment, transportation, food security, socialization, education, wellness, financial stability and access to non-traditional mental health services, Pathfinder Clubhouse members work side-by-side with trained CHW staff in meaningful hands-on work that creates equitable opportunities to increase stamina, confidence & employment while modeling how to maintain healthy relationships and social skills needed to reintegrate back into the community. This culturally responsive approach overcomes barriers to social determinants of health which we anticipate will be the most transformational & effective approach in helping people achieve employment, housing, improved physical and mental health and ultimately recover from traumas related to the COVID-19 Pandemic.

Pilot Description –

Goals and Indicators:

- Improve access to nonclinical behavioral health supports and services through the innovative use of discharge planning to better meet the needs of those who are most at risk and in need of behavioral health supports
- Increase staff diversity by bringing on 2 new THW's to be able to provide innovative evidenced-based Clubhouse services in culturally responsive ways
- Reduce Hospitalizations by 50% for members actively participating in clubhouse services
- Reduce Emergency Department utilization by 10% among members actively participating in clubhouse services
- Increase services to non-traditional behavioral health treatment for 70 IHN-CCO Members
- Creating equitable opportunities that increase stable housing for 8, help 50 members retain housing
- Creating equitable opportunities that increase employment for 15 members

Target Population and Community Need:

The goal and target population for this project is to serve 100 vulnerable, marginalized and underserved adults living with mental illness. Pathfinder Clubhouse will accept adults who meet program criteria of 18 years of age and older, diagnosed with a mental illness and is found to be site safe by both the provider and the Clubhouse. These services are offered to anyone who meets the above criteria regardless of insurance status or economic position. Membership is voluntary and members will not have to pay for services provided. Of the 100 members we expect to serve, we expect the demographics to be served by this project to be 100% disabled, 98% extremely low income, 20% from the BIPOC community, 10% identifying as LGBTQIA+, and based off current utilization we anticipate 70% will be IHN-CCO members.

After a comprehensive 2-year feasibility study, no community agencies are available at discharge from inpatient or partial hospitalization that are providing the interventional non-clinical mental health supports and services that reach adults living with mental illness in the region that provide culturally responsive ongoing support, services, and evidenced-based preventative healthcare delivered by CHW/THW's. Pathfinder Clubhouse is looking to bring a transformative program to fill this gap by becoming an integral part of the community discharge plan for those in need of community supports and services after inpatient hospitalization as well as a vital part of the increased community supports for partial hospitalization. Pathfinder is also looking to take the opportunity to increase access to care, supports and services with the addition of 2 CHW's to help members navigate and connect to other community-based resources.

Interventions and Activities:

- Forging strong community partnerships with local hospitals and mental health authorities by active outreach and presentations to partnering agency staff and potential members who are currently hospitalized, in partial hospitalization or transitioning into the community to spread awareness of this resource and project. We have begun preliminary test with the Good

Samaritan Regional Medical Center Behavioral Health Unit to see how the referral and presentation process would work for feasibility of such a project.

- Another key activity is recruiting and training a culturally diverse staff as CHW's to provide non-clinical mental health supports and services through side-by-side work that removes barriers to social determinants of health in a culturally responsive way transforming the way clubhouse services are delivered.
- Engagement of members is Meaningful side-by-side work with trained CHWs that creates equitable opportunities to increase stamina, confidence and important social skills needed to reintegrate back into the community. This approach overcomes barriers that encompass all social determinants of health at once which we anticipate will be the most transformational and effective approach in helping people achieve housing, employment, improved physical and mental health and ultimately recover from traumas related to the COVID-19 Pandemic reducing need for crisis, ED and inpatient services.
- Offering opportunities that improve employment, rates of housing and financial self-sufficiency while learning how to build and maintain healthy relationships and with a specific focus on meeting immediate needs of housing, employment, transportation, food security, socialization, education, health and wellness, financial stability and access to non-traditional mental health services.
- Pathfinder Clubhouse will continue to work in coordination and conjunction with various community partners to ensure success and no unnecessary duplication of work by referring members to partnering agencies and working with our partners to truly wrap-around each individual to make sure they have what they need.

Community Partnerships / Referral Sources:

Account-ability	Counseling Center of Linn County
Albany Counseling Center	Daytime Drop in Center
Benton A.C.T. Team	Good Samaritan Regional Medical Center Behavioral Health Unit
Benton County Developmental Diversity Program	Good Samaritan Regional Medical Center Partial Hospitalization Unit
Benton County Drug Treatment Court	HOPE Advisory Board
Benton, Linn, Lincoln County Behavioral Health	Jackson Street Youth
C.H.A.N.C.E.	Janus House
Clubhouse International	Linn Benton County Food Share
Community Health Centers of Benton and Linn Counties	Mental Health Developmental Disabilities Addiction Advisory Committee
Community Outreach Inc.	Michelle M. Harbach-Bachand, Bachand Therapy
Community Services Consortium	NAMI
Cornerstone	Oregon Department of Self-sufficiency
Corvallis Clinic	Samaritan Health System
Corvallis Housing First	Voc Rehab
Corvallis Wednesday Farmers Market	Work Unlimited

If successful within the Good Samaritan Regional Medical Center, partnerships to grow as a long-term goal are also expanding to Oregon State Hospital, Sacred Heart Hospital. Roles for clinical partnerships will include staff and potential member education on this pilot by providing benefits of having Pathfinder Clubhouse as a part of the community discharge plan as well as making referrals to Pathfinder Clubhouse. Roles for other community-based agencies will include staff and potential member education increasing utilization of resources for both the pilot and community-based agencies that address immediate or long term needs to improve various areas of social determinants of health by referring and working in partnership to wrap around each member's unique support needs in a collaborative team approach environment.

Increasing Health Equity and Decreasing Health Disparities:

Pathfinder Clubhouse is ready to fill this identified gap in needed services by taking a health equity approach, improving access to immersive behavioral healthcare providing equitable behavioral supports and services to marginalized and disparaged adults living with mental illness. We believe implementing culturally responsive services is critical to filling the gap in services in supplement to traditional healthcare. This is why we are so committed to implementing this project in advancing diversity, equity and inclusion to better recognize, address and relate to our members helping to eliminate disparities and barriers our members face. We have already addressed our physical space to ensure that our space is ADA accessible, trauma informed and welcoming to all individuals. We have invested in sit stand desks to ensure that all work areas are accessible to all people including our cash register in our bistro, training kitchen, QuickBooks learning station and computers where members learn new skills and can search for jobs, housing and other needed resources. We are planning our hires strategically to represent our membership directly from our members demographic data including but not limited to race, ethnicity, sexual orientation, age, disability, veteran and language. Pathfinder is training and certifying two THW/CHW staff and looking to hire another 2 staff from culturally diverse backgrounds to better deliver supports and services in a culturally responsive and specific way. Our members demographics, which is all voluntarily self-reported, are collected in orientation one-on-one with staff who record information in our secure database and in their secure member files. This information collected helps guide us in what areas we need to grow to become more culturally competent and inclusive in order to ensure everyone has access to equitable opportunities and access to care that they both need and deserve. Member surveys are also taken twice a year to capture any change or movement in disparities to better meet our membership needs.

Our current staff makeup brings different cultural priority areas representing the LatinX, Native American, Veteran, and Disabled communities. Currently serving 59 members, our membership is 100% living with a disability, 32% of our membership is from the BIPOC community, 11% identifies as LGBTQIA+ and 98% of membership falls into the extremely low-income category. Members do not pay for the services they receive regardless of insurance or economic status. While most we currently serve live in Benton County, we have found up to 10% of our members have been willing to travel from Lincoln, Linn and rural Benton counties in order to receive services as we are located next to the Tri-County transportation hub which offers free and or adequate public transportation. With the addition of culturally responsive services and integrated into community discharge plans, Pathfinder Clubhouse staff will continue to track the health equity data and outcomes in our database in order to track the efficacy of this pilot which will be reviewed at least quarterly to see if adjustments to the pilot needs to be made.

Social Determinants of Health:

Pathfinder will address social determinants of health in a non-traditional way through non-clinical mental health services to combat the damaging effects and consequences of a global pandemic on our community. With a specific focus on meeting social determinants of health and immediate needs of housing, employment, transportation, food security, socialization, education, health and wellness, financial stability and access to non-traditional mental health services, Pathfinder Clubhouse works in coordination and conjunction with various community partners to ensure success of individuals discharging form inpatient or partial hospitalization by implementing Pathfinder Clubhouse as an integral part of the community discharge plan. This will increase access to behavioral health care and health equity for those who need supports that are not currently in place within the community. Through the side-by-side work with trained CHW staff in meaningful hands-on work that creates equitable opportunities to increase stamina, confidence and employment that improves rates of housing and financial self-sufficiency while learning how to build and maintain healthy relationships and important social skills needed to reintegrate back into the community. This approach overcomes barriers that encompass all social determinants of health at once which we anticipate will be the most transformational and effective approach in helping people achieve housing, employment, improved physical and mental health and ultimately recover from traumas related to the COVID-19 Pandemic.

Pilot Tasks, Roles and Experience:

Elizabeth Hazlewood, Executive Director – Leading this project, Elizabeth who is a certified THW/CHW will directly oversee designing and implementing this project from providing direct services, conducting presentations and reporting of outcomes and progress of the pilot. Elizabeth has over 18 years in the Clubhouse International Model, including having served on the Clubhouse International Faculty as well as assisted with the startup and development of 6 clubhouses, is the Chair of the Oregon Clubhouse Coalition and currently serves as a mentor for 4 clubhouses as designated by Clubhouse International to promote the growth of Clubhouses in areas with little to no access to non-traditional mental health services. Elizabeth also has successfully managed a $1.2 million capital campaign to purchase and renovating a building and helped to secure an entire years' worth of funding for Compass House in Medford before transitioning out to start Pathfinder Clubhouse.

Chris Folden, Associate Director - Certified THW/CHW is charged with designing and implementing this project from providing direct services, conducting presentations and reporting of outcomes and progress of the pilot. Chris has over 5 years' experience in the Clubhouse International Model including Comprehensive Clubhouse International Training, was hand selected and sponsored by the Gordon Elwood Foundation to attend Development school, helped successfully manage a $1.2 million capital campaign to purchase and renovating a building and helped to secure an entire years' worth of funding for Compass House in Medford before transitioning out to start Pathfinder Clubhouse.

Jennifer Schmidt - Hired to be our Resource Coordinator who has just completed her THW/CHW training and is applying for certification. She brings a wealth of experience in business management/skills training as well as in helping people navigate complex systems.

Mari Cisneros - Hired to be our Culinary Coordinator bringing with her a plethora of experience in the food industry training underserved individuals not only on nutrition and wellness but also with the

skills needed to become culinary professionals within the culinary industry. Mari has her THW/CHW training scheduled to begin on June 29, 2021 and brings a bi-lingual and bi-cultural voice to our staff.

Areas of priority for the two additional THW/CHW hires we look to bring are representative of the LGBTQIA+ and BIPOC communities. All staff will be tasked with providing direct supports and services side-by-side with members helping to improve behavioral health by improving social determinants of health and immediate needs of employment, transportation, food security, housing, socialization, education, health and wellness, financial stability and access to non-traditional mental health services. They will also work in coordination and conjunction with various community partners to ensure success of individuals reintegrating into the community and overcome traumas and barriers faced by COVID-19.

How Pilot Advances Pathfinders Strategic and Long-Range Plans:

This pilot will directly advance Pathfinder's strategic and long-range plans of:

- Bringing a new evidence-based service to the area to fill a gap in mental health services improve access to behavioral health services in non-traditional ways
- Building a diverse membership, staff and board of directors
- Increasing equitable employment opportunities for our members
- Increasing our members opportunities to obtain and maintain safe and secure housing
- Increasing and improving access to behavioral health care in light of COVID-19
- Improving the lives of adults living with mental illness who experience health disparities
- Providing services that directly address social determinants of health

How members of the community will hear about this project:

While most of our members will hear about our services through clinical providers as a continuum of care as part of their community discharge/integration plan, such a needed and incredibly transformative pilot for non-traditional behavioral health services will be spread through a multifaceted media campaign. Releasing a approved press release in partnership with community partners to bring attention to work they are doing as well as with IHN-CCO for making this pilot possible in media throughout our region in both local and state level media as well as social media. Pathfinder will also give community presentations in the community when covid allows to inform people of the resources available. Pathfinder will also send a press release to Clubhouse International on how this pilot is aiming to transform and improve access to care through increased supports bridging community integration as a framework for other clubhouses to potentially replicate in our area as well as internationally.

Outcomes:

- Improve discharge planning to better meet the needs of those who are most at risk and in need of behavioral health supports by becoming a part of the community discharge/integration plan
- Utilize THW/CHWs in a culturally competent way to provide and connect members to support services
- Reduce inpatient hospitalizations by 50% for active members by December 2023
- Reduce emergency department usage by 10% for active members by December 2023

- Increase services to non-traditional behavioral health treatment for 100 individuals,70 of which are expected to be IHN-CCO Members
- Creating equitable opportunities that increase stable housing for 8, help 50 members retain housing
- Create equitable opportunities that increase employment of 15 members

These outcomes will be met through partnerships forged with community partners and our THW staff who are providing direct services to address barriers our members may face while improving social determinants of health. Staff will engage members in their own recovery working side-by-side with them in meaningful work as they learn how to overcome barriers they face, build confidence, stamina and learn how to build healthy appropriate working relationships taking ownership of their recovery.

Pilot Identified Risk, Mitigation, and Plan to Achieving a Successful Pilot:

While this pilot shows a great deal of promise, it does carry some risks. The largest risk being not being able to meet the increased demand for non-traditional mental health services as a result of the COVID-19 pandemic. Since opening Pathfinder Clubhouse has grown much quicker than anticipated and this increased scope of work utilizing Community Health Workers from diverse culturally linguistic and responsive backgrounds has never been undertaken before. There is also a risk of not being accessible to all rural areas. Overcoming the barrier of transportation is hugely important as Pathfinder Clubhouse is currently serving 10% of its population from rural areas. Our plan is to build partnerships with local transportation providers as we are situated a couple blocks from the Tri-region transportation hub. However, this program does show promise to be replicated successfully throughout the IHN service region and beyond. In fact, the Executive Director has a proven history of implementing successful programming and replicating projects from the ground up. With experienced leadership at the helm and strong community partnerships we feel secure in the outcomes of this pilot.

Pilot Sustainability Plan:

Program-Pathfinder Clubhouse is excited about the viability and sustainability of this pilot. We have performed preliminary testing to ensure the viability. We have tested our organizational capacity and logistics of presenting in a limited capacity to patients awaiting discharge on the inpatient unit of Good Samaritan Regional Medical Center both in person and via electronic interface. In partnership with Good Samaritan Regional Medical Center Behavioral Health Unit we have also tested out if one-on-one presentations vs group presentations would work better and both yielded surprisingly positive results. With the addition of staff, we feel this pilot will be successful by both integrating into the Behavioral Health Unit as well as the Partial Hospitalization Unit as we will be able to send staff with the most culturally relevant background to bridge services in a culturally responsive way.

Financial- We have developed a comprehensive fundraising plan leveraging individual donations, grants and contracts to ensure this pilot is financially sustainable after the pilot program. We have put a great deal of resources into supporting this pilot securing $86,400 in leverage to this grant showing the community has a vested interest in filling this vital gap in services for those who need it most. Moving forward we will utilize the outcomes of the pilot to secure sustainable funding from contracts, grants and individual donors.

Replicability / Scalability- This program shows great promise to be replicated successfully throughout the IHN service region and beyond. In fact, the Executive Director has a proven history of implementing successful programming and replicating projects from the ground up. She currently serves as a mentor for clubhouses as designated by Clubhouse International to help with the startup, implementation and growth of Clubhouses and clubhouse services in areas with little to no access to non-traditional mental health services. We feel these are needed services and this pilot will transform success of community integration as this pilot significantly increases access to non-traditional behavioral health and the way behavioral health services are delivered by meeting people in a culturally linguistic way to better help adults living with mental illness improve all social determinants of health and become overall self-sufficient, while achieving better health, better access to health care and reduced cost of care.

Pilot Timeline –

The timeline for this project is as follows:

Timeframe for funding will go from January 1, 2022 to December 31, 2022.

Timeline for reporting will continue out until December 31, 2023 to be able to have sufficient data to accurately capture efficacy of the program.

January, 2022

- Pilot begins formalizing partnerships becoming the community discharge plan for those in need of community supports and services after inpatient hospitalization as well as a vital part of the increased community supports for partial hospitalization.
- Begin presentations (when possible) at least bi-monthly to members being discharged for those in need of community supports and services after inpatient hospitalization as well as a vital part of the increased community supports for partial hospitalization.
- Begin hiring, training, certifying, and utilizing culturally diverse CHW staff to provide non-clinical mental health supports and services through side-by-side work that removes barriers to social determinants of health in a culturally responsive way transforming the way clubhouse services are delivered.

Feb-Mar 2022

- launch media campaign announcing the DST Pilot with community partnerships and staffing and partnerships in place we will release a pre-approved press release in partnership with community partners to bring attention to work they are doing as well as with IHN-CCO for making this pilot possible in media throughout our region in both local and state level media as well as social media.

December 2022

- Increase services to non-traditional behavioral health treatment for 70 IHN-CCO Members
- Provide Innovative Evidenced-Based Clubhouse culturally responsive services to 100 members
- Create equitable opportunities that increase stable housing for 8 members
- Help 50 members retain housing of IHN-CCO members
- Create equitable opportunities that increase employment of 15 IHN-CCO members

December 2023

- Reduce hospitalizations by 50% for members actively participating in clubhouse services
- Reduce emergency department usage by 10% among members actively participating in clubhouse services

	Baseline or Current State	Monitoring Activities
	Pathfinder Clubhouse opened in August of 2020 and in 10 months have built a membership base 53 members	Partner with community agencies to receive referrals from a wide range of behavioral health and community agencies to ensure when people are vulnerable and needing help the most that nonclinical mental health supports and services are provided
	Two staff are currently certified CHW's, 1 has been trained and is awaiting state ceritification and on is currently in CHW training. Current staff demographics cover different cultural priority areas representing the LatinX, Native American, Veteran, and Disabled communities.	Hire 2 additional THW/CHW staff with a specific focus around prioritizing individuals representative of the LGBTQIA+ and BIPOC communities to be able to provide culturally responsive services to our members improving access
	Since opening we have assisted 4 members and 1 minor child to increase or further their stable housing. We have 7 members who are currently homeless and continue to grow and get new members who are houseless or at imminent risk of houselessness	Pathfinder Clubhouse will provide supports and services that remove barriers to and end the cycle of homelessness which will be monitored by member touch report and via self-reporting on survey 2 times per year

Specific Measurable Attainable Relevant Time-Bound	As Oregon ends the Eviction Moratorium, many of our members may be at risk of losing their housing. Many of our members already experience difficulty in maintaining housing due to inability to maintain professional relationships, employment, financial stability, as well as remain out of inpatient hospitalization	Members will maintain or better their housing situation as evidenced by self reporting via surveys 2 times per year Member will particpate in clubhouse services imporving relationship skills and rates of employment
	Since opening we have helped 10 members secure employment in the community. Now as businesses reopen in increasingly competitve labor market, helping our members secure and maintain employment is vital for the economic stability and financial security of our members	Members will maintain or better their Employment situation as evidenced by self reporting via surveys 2 times per year Member will particpate in clubhouse services imporving relationship skills and rates of employment
	Pathfinder Clubhouse is now in contract with IHN-CCO and is working with IHN-CCO to develop a baseline for Emergency Department Usage. Beginning in August, we will have enough members and staff to begin to track Emergency Department Usage for Pathfinder Clubhouse IHN-CCO members	Pathfinder Clubhouse will provide supports and services the address all social determinants of health improving health outcomes and reducing need for emergent crisis services. Measures of success will be evidenced by member participation in services as well as reduction in ER utilization

	Pathfinder Clubhouse is now in contract with IHN-CCO and is working with the Good Samaritan Behavioral Health Unit to develop a baseline for Inpatient Hospitalization Usage. Beginning in August, we will have enough members and staff to begin to track Inpatient Hospitalization Usage for Pathfinder Clubhouse IHN-CCO members	Pathfinder Clubhouse will provide supports and services the address all social determinants of health improving health outcomes and reducing need for emergent crisis services. Measures of success will be evidenced by member participation in services as well as reduction in Inpatient Hospitalization utilization

Benchmark or Future State	Met By (MM/YYYY)
Increase access to non-traditional community based mental health services providing evidenced-based Clubhouse services to at least 100 members Adults living with mental illness are being referred from all 3 counties	December-22
Increase staff diversity to be able to provide innovative evidenced-based Clubhouse culturally responsive services to 100 members	December-22
Assist 8 members to secure and sustain stable and secure housing during the project period	December-22

50 members will remain housed as evidenced by self reporting via surveys 2 times per year	December-22
Create equitable opportunities that increase employment of 15 members	December-22
Reduce Emergency Department utilization by 10% among members actively participating in clubhouse services	December-23

Reduce Hospitalizations and by 50% for members actively participating in clubhouse services	December-23

Pilot: Pathfinder Behavioral Health Transformation

Pilot Start Date:	1/1/2022	Pilot End Date:	12/31/2022
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Increase staff diversity by bringing on 2 new THW's to be able to provide innovative evidenced-based Clubhouse services in culturally responsive		$113,400.00	$74,844.00
Creating equitable opportunities that increase stable housing for 8, help 50 members retain housing		$64,395.00	$32,197.50
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$177,795.00**	**$107,041.50**
Materials & Supplies			
Printed materials for presentation		$2,417.74	$1,208.87
Dedicated Computer- 1 laptop		$1,129.99	$1,129.99
Dedicated Computer- 1 desktop		$1,099.98	$1,099.98
	Subtotal Materials & Supplies	**$4,647.71**	**$3,438.84**
Travel Expenses			
Travel and per diem for Clubhouse International Training for 4 staff		$5,166.00	$2,583.00
Milage for presentation		$750.00	$750.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$5,916.00**	**$3,333.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
THW Training for 2 staff		$2,000.00	$2,000.00
Clubhouse International Comprehensive Training for 4 staff		$8,000.00	$4,000.00
		$0.00	$0.00
	Subtotal Training & Develop	**$10,000.00**	**$6,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$198,358.71**	**$119,813.34**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$19,835.87	$11,981.33
Total Project Budget		**$218,194.58**	**$131,794.67**

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


Pathfinder
Clubhouse
Pathfinder
Behavioral
Health
Transformation

Pilot Summary and Goals

This Pilot will transform access to non-traditional behavioral health services that help adults living with mental illness resolve socio-economic inequities, homelessness and trauma experienced or compounded by COVID-19.

Transform behavioral health care for adults living with mental illness by:

Become part of the community discharge plan

Hire 2 CHW staff with a specific focus around prioritizing individual's representative of the LGBTQIA+ and BIPOC communities

Reduce need for hospitalizations and crisis services for IHN CCO members participating in the Pilot

Pilot Summary and Goals

This pilot will improve access to care becoming part of the community discharge plan from inpatient and partial hospitalization and bring a transformative approach by bringing on and utilizing Community Health Workers from diverse backgrounds for the first time in an un-traditional way to deliver culturally responsive Clubhouse services.

Creating equitable opportunities that increase Employment for 15 members

Increase services to non-traditional behavioral health treatment for 100 individuals 70 of which we expect to be IHN-CCO Members

Creating equitable opportunities that increase stable housing for 8, help 50 members retain housing

Utilize CHW's in a culturally competent way to provide members supportive services that address social determinants of health

Target Population

Culturally responsive non-clinical behavioral health treatment

- This pilot seeks to positively impact 100 adults living with mental illness
- We expect a minimum of 70% will be IHN-CCO members (*based on current agency utilization*)
- 100% of those we serve live with a disability and 98% live in the extremely-low income bracket
- Target population will come from Benton, Lincoln and Linn Counties

Member and Community Need

Culturally responsive non-clinical behavioral health treatment

- There is a need to fill the gap in non-clinical preventative behavioral healthcare in a culturally responsive non-traditional way
- Need for access to behavioral healthcare and support services connected at during discharge/community integration planning from inpatient hospitalization
- Need for increased health equity while helping address disparities in socio-economic stability
- Increasing access to behavioral healthcare in light of COVID-19

System Transformation

Breaking the paradigm of how the community responds to mental health

This Pilot will transform access to non-traditional behavioral health services that help adults living with mental illness resolve socio-economic inequities, homelessness and trauma experienced or compounded by COVID-19.

This will be accomplished by:

- Increasing access to healthcare through participation in discharge/community integration planning
- Increasing health equity while helping address disparities in socio-economic stability
- Meeting people where they are at in a culturally responsive way

Partnerships/Collaboration

After initial testing of pilot feasibility, Pathfinder Clubhouse is most excited about formalizing a partnership with Good Samaritan Regional Medical Center Inpatient and Partial Hospitalization Units to become part of the community discharge plan.

Pathfinder is also excited about continuing to expand our collaboration and partnerships to help our members succeed without unnecessary duplication of services

Partnerships/Collaboration

Community Partnerships and Referral Sources

Account-ability	Counseling Center of Linn County
Albany Counseling Center	Daytime Drop in Center
Benton A.C.T. Team	Good Samaritan Regional Medical Center Behavioral Health Unit
Benton County Developmental Diversity Program	Good Samaritan Regional Medical Center Partial Hospitalization Unit
Benton County Drug Treatment Court	HOPE Advisory Board
Benton, Linn, Lincoln County Behavioral Health	Jackson Street Youth
C.H.A.N.C.E.	Janus House
Clubhouse International	Linn Benton County Food Share
Community Health Centers of Benton and Linn Counties	Mental Health Developmental Disabilities Addiction Advisory Committee
Community Outreach Inc.	Michelle M. Harbach-Bachand, Bachand Therapy
Community Services Consortium	NAMI
Cornerstone	Oregon Department of Self-sufficiency
Corvallis Clinic	Samaritan Health System
Corvallis Housing First	Voc Rehab
Corvallis Wednesday Farmers Market	Work Unlimited

Health Equity Plan

- We believe implementing culturally responsive services is critical to filling the gap in services in supplement to traditional healthcare. This is why we are so committed to implementing this project in advancing diversity, equity and inclusion to better recognize, address and relate to our members helping to eliminate disparities and barriers our members face
- We have already addressed our physical space to ensure that our space is ADA accessible, trauma informed and welcoming to all individuals. We have invested in sit stand desks to ensure that all work areas are accessible to all people including our cash register in our bistro, training kitchen, QuickBooks learning station and computers where members learn new skills and can search for jobs, housing and other needed resources
- We are planning our hires strategically to represent our membership directly from our members demographic
- Our current staff makeup brings different cultural priority areas representing the LatinX, Native American, Veteran, and Disabled communities

Health Equity Plan

- Most importantly, our members have a voice in every aspect of the pilot side-by-side with staff from hiring of culturally diverse workforce of CHW's to making the community presentations side-by-side with staff (when COVID allows)
- Each member is given every equitable opportunity to grow into leaders within the clubhouse community and beyond as they are involved in every aspect possible in the operation and reporting of the Pathfinder Behavioral Health Transformation Pilot

Definition of Success

Success of the Pilot will:

- Improve discharge planning to better meet the needs of those who are most at risk and in need of behavioral health supports by becoming a part of the community discharge/integration plan
- Utilize CHW's in a culturally competent way to provide members supportive services that address social determinants of health
- Reduce inpatient hospitalizations by 50% by 2023 of active membership
- Reduce emergency department usage by 10% by 2023 of active membership
- Increase services to non-traditional behavioral health treatment for 100 individuals, 70 of which are expected to be IHN-CCO Members
- Creating equitable opportunities that increase stable housing for 8, help 50 members retain housing
- Create equitable opportunities that increase employment of 15 members

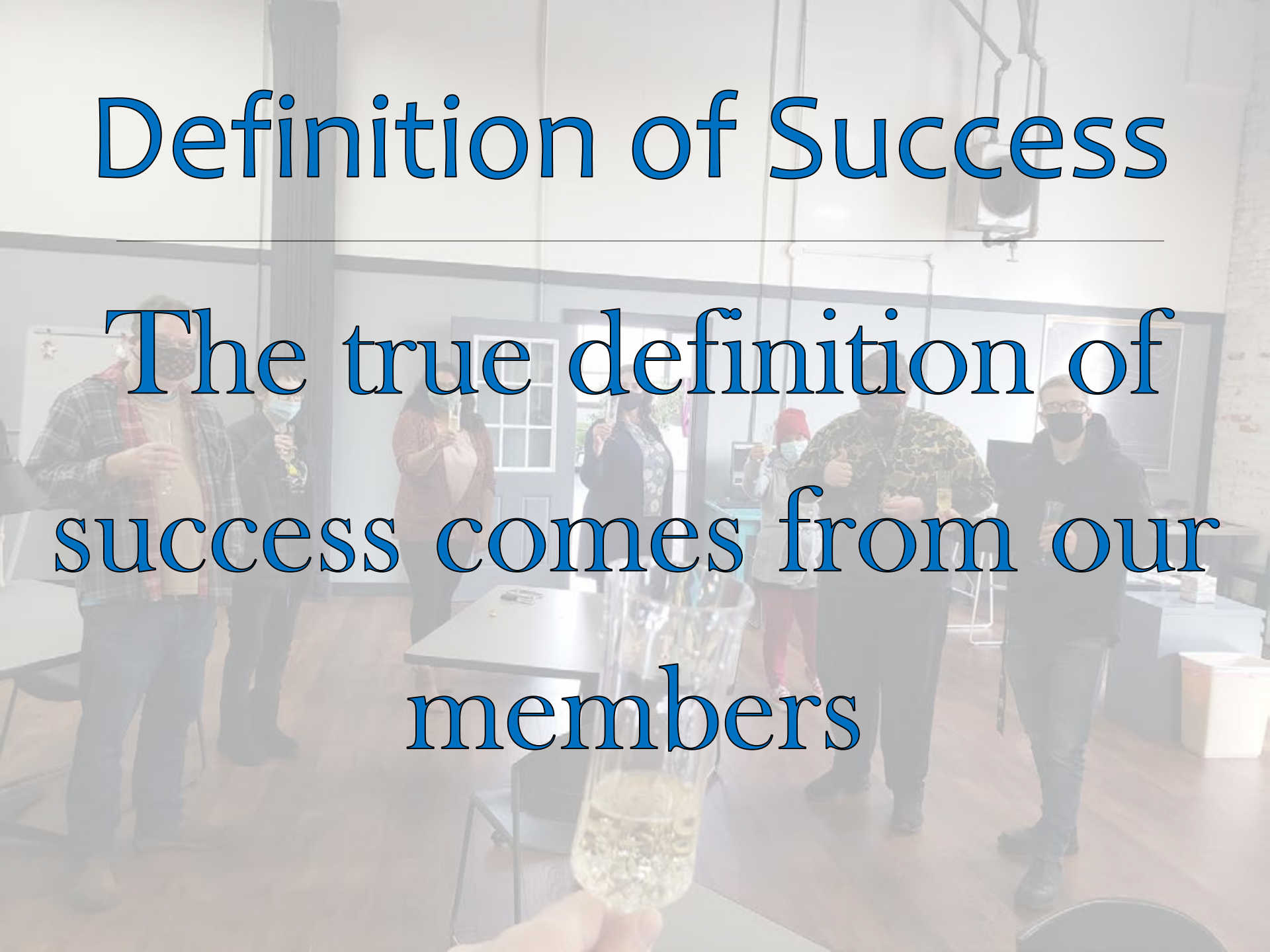
Definition of Success

We will measure our success by:

- Tracking number of community discharge plans Pathfinder Clubhouse participates in
- Member self-reporting via survey 2 times per year
- Tracking of referral sources
- Tracking number of participants receiving clubhouse services
- Increase diversity of certified CHW staff (data collected upon hire and updated annually)
- Tracking member housing and employment
- Partnering with IHN-CCO to track inpatient and ED utilization

Definition of Success

The true definition of success comes from our members



Sustainability Plan

Program:

- We have tested the logistics of presenting in a limited capacity to patients awaiting discharge on the inpatient unit of Good Samaritan Regional Medical Center both in person and via electronic interface with positive results
- With the addition of staff, we feel this pilot will be successful by both integrating into the Behavioral Health Unit as well as the Partial Hospitalization Unit as we will be able to send staff with the most culturally relevant background to bridge services in a culturally responsive way

Sustainability Plan

Financial:

- We have developed a comprehensive fundraising plan leveraging individual donations, grants and contracts to ensure this pilot is financially sustainable after the pilot program. We have put a great deal of resources into supporting this pilot securing $86,400 in leverage to this grant showing the community has a vested interest in filling this vital gap in services for those who need it most
- Moving forward we will utilize the outcomes of the pilot to secure sustainable funding from contracts, grants and individual donors

Sustainability Plan

- <u>Replicability / Scalability:</u>
- This program shows great promise to be replicated successfully throughout the IHN service region and beyond
- In fact, the Executive Director has a proven history of implementing successful programming and replicating projects from the ground up
- She currently serves as a mentor for clubhouses as designated by Clubhouse International to help with the startup, implementation and growth of Clubhouses and clubhouse services in areas with little to no access to non-traditional mental health services
- These are vitally needed services and this pilot will transform success of community integration as this pilot significantly increases access to non-traditional behavioral health and the way behavioral health services are delivered by meeting people in a culturally responsive way to better help adults living with mental illness improve all social determinants of health and become overall self-sufficient, while achieving better health, better access to health care and reduced cost of care

DST Member Questions?

Peer Enhanced Emergency Response (P.E.E.R.)

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

Billing Address: 231 Lyons St. S. Albany, OR 97321

Site(s): 2nd CHANCE Shelter- Albany, Albany General Hospital, and on the streets of Albany.

County(s): Linn

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
- Pay equity through building and sustaining the workforce

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

- A1(c) - Trauma Informed Care, such as ACE's and resiliency measures.
- BH1(b) – Peer delivered behavioral health education and services.
- BH1(*ii.)* – Community supports in the community to normalize behavioral health issues.
- BH3(a) – Screening, Brief intervention, Referral to Treatment rates.
- BH3(ii.) – Peer delivered education and support.
- BH4(ii.) – Appropriate care at the appropriate time and place for people experiencing a mental health crisis
- BH4(iv.) – Care coordination
- BH5(iv.) – Health equity for this marginalized population
- BH5(v.) – Stigma reduction
- BH6(i.) – Number of mental health providers.

Pilot Contacts	Name	Email
Primary	Amelia Wyckhuyse	awyckhuyse@chancerecovery.org
Proposal	Amelia Wyckhuyse	awyckhuyse@chancerecovery.org
Contracting	Amelia Wyckhuyse/ Kami Beard	awyckhuyse@chancerecovery.org
Financial	Michele Castle	mcastle@chancerecovery.org
Reporting	Kami Beard	kbeard@chancerecovery.org

Proposal Narrative

A. Executive Summary

C.H.A.N.C.E. partners within the tri county region with a host of agencies to provide after hours and weekend peer support for people facing mental and/or physical health crisis. Through this work, we have identified service area gaps, and areas of opportunity to better service our peers who are experiencing crisis. We are already doing this but believe these things can be done more appropriately and effectively with staff that is trained properly and are able to access the tools necessary to sustain these types of crisis intervention and care coordination among agencies.

The program will focus on meeting the unique needs of someone experiencing a mental and/or physical health crisis, reducing emergency department utilization, and unnecessary jail visits. We will focus on five primary areas. Certified Peer Wellness Specialists trained in MH first Aide, de-escalation and crisis intervention, A safe place to de-escalate and find support, Social Determinants of Health screening and referral for services, PWS meeting the Linn County mental health crisis team in the field to support their efforts and connections to community-based support programs.

B. Project Description

C.H.A.N.C.E. engages with people at all levels of their recovery with mental health and substance abuse disorders. We assist with physical health, mental health and behavioral health and serve to promote individual and group programs that foster health and resilience. We are missing people who are in crisis and either have not found recovery or those who have gotten off their recovery path. Our goal is to create a “safety net” for peers who are in crisis and could easily fall through the cracks because of the behaviors associated with their crisis, that make it hard for them to access services in a traditional place or way.

We are seeking $107,993.60 for our proposed funding.

We have five focus areas for this grant. Strengthening existing community partners and by developing new ones, we will be able to offer additional assistance and support to people who are often overlooked or underserved. We will integrate the goals of this program within already existing programs, such as 2nd CHANCE Shelter’s No to low barrier warming center and C.H.A.N.C.E.’s 24-hour crisis phone line. We have existing contracts that will offer a base support and new grant and contract consideration to offer a sustainability plan moving forward.

C.H.A.N.C.E. currently contracts with Linn County Mental Health through many of its treatment programs to provide peer support, and our 2nd CHANCE Shelter partners closely with their crisis team to provide a safe place to stay for peers experiencing

homelessness and in crisis. The majority of the population we serve are, no to low-income individuals who are on Medicaid. We partner with Linn County Alcohol and drug, Linn County Mental Health, Linn County Health Services, Linn County Parole and Probation, CSC, Albany Helping Hands Shelter, Oxford and God Gear Transitional Recovery Homes, Samaritan Health Services, and many more.

Focus Areas:

Certified Peer Wellness Specialists with Specialized Training

Currently C.H.A.N.C.E.'s 24-hour crisis phone line is served by a single certified peer support specialist with minimal specialized training in handling crisis situations. Our goal is to provide a team of Certified Peer Wellness Specialist who are fully trained and skilled in crisis intervention, mental health first aide and de-escalation, as well as basic CPR and first aid. Each shift will be staffed by a team of trained and certified Peer Wellness Specialists equipped with the 24-hour emergency phone and a C.H.A.N.C.E. transport vehicle. They would be tasked with supporting individuals in crisis, managing the warming center, fielding calls and responding to calls from the emergency department, police department, and mental health's crisis team.

2nd CHANCE Shelter's Warming Center is currently staffed by one volunteer each night, this often leads to having to exit peers who are in crisis and are exhibiting behaviors that are disruptive and potentially dangerous. Many behaviors that occur during a crisis can be better managed by a person with more training and skills in mental health specific crisis intervention and de-escalation. On average 2nd CHANCE Shelter's warming center services 12 guests a night but can house up to 20 individuals. We will be including security to provide support and help keep staff and guests safe. It is our goal to have trained in trauma informed care as well as mental health first aide.

A Safe Place to De-escalate and Find Support

We are currently utilizing 2nd CHANCE Shelter's main day room for the warming center at night, and this space is used for peers to lay down and get a good night's rest. We have a secondary space that connects to the warming center lobby, and it is our goal to make this a safe space for peers in crisis to be if they are not able to lay down and sleep. This area will be outfitted to have comfort furnishing, food and drinks, supplies and resources for managing difficult emotions. The peers being served would have access to clean clothes, bathroom with a shower, and direct peer support from a peer wellness specialist.

Social Determinants of Health Screening and Referral for Services

C.H.A.N.C.E.'s PWSs will screen peers experiencing mental and/ or physical health issues for social determinants of health and come alongside peer to develop and an

action plan and provide referrals to the appropriate services from mental health services to primary care, to name a few. It is C.H.A.N.C.E.'s goal to create peer-led action plans. These action plans will identify clear referral pathways to appropriate services and supports for people experiencing crisis, helping to fill the gaps in the continuum of care, as well as reduce Emergency Department utilization and incarceration.

PWS Meeting the Linn County Mental Health Crisis Team in the Field to Support Their Efforts

It is our goal that Linn County Mental Health's Crisis Team will be able to call C.H.A.N.C.E.'s Team of PWSs and request them to come support them on their crisis calls at the Emergency Department, at the Jail or in the streets. C.H.A.N.C.E.'s PWSs will be able to transport people in crisis home, to 2nd CHANCE Shelter's warming center or other places identified by the crisis team. The crisis team will be able to bring someone in crisis to 2nd CHANCE Shelter's warming center and be met by a PWS to assist in de-escalation and a safe place to be off the streets.

Connections to Community Based Programs and Supports

C.H.A.N.C.E. and 2nd CHANCE Shelter is currently referring peers to community-based programs and supports. C.H.A.N.C.E. currently utilized Unite US platform to do this. It is our goal to get 2nd C.H.A.N.C.E. Shelter's staff trained to use Unite Us, so we can continue to strengthen these relationships and referral and reporting pathways. We will continue to coordinate service through partner agencies like Linn County Mental Health, Alcohol and Drug, Health Services, and Parole and Probation, Samaritan Health Service Care Hub and hospital systems, and social service agencies and nonprofits.

Partners:

- Linn County Mental Health Crisis team – They will refer people in crisis to our program and call our team to come provide peer support in the field as needed.
- Samaritan Health Services Chronic Care Management team – They will reach out to our team when they have folks in crisis and are in need of a safe place to go.
- Albany Police Department – They will call us when they encounter people in the line of their duty who might be in crisis and need a safe place to go and support.
- Samaritan Albany General Hospital Emergency Department – They will call our crisis line when they need a PWS to come and provide peer support to someone who is utilizing the ED for not emergency issues or needs to access SUD or mental health resources.

Promoting Health Equity

C.H.A.N.C.E. serves a population of peers who experience an often-complex combination of physical, mental, and behavior health issues which makes it harder for them to access care in tradition ways. This project would allow C.H.A.N.C.E. and it's partnering agencies to rely on Peer Wellness Specialists with training in de-escalation and crisis intervention to get the people we serve connected to the appropriate physical, mental and behavior health services and treatment despite the behaviors associated with the crisis they are experiencing. Health equity data for IHN-CCO members will be collect through our data collection system.

Crisis Intervention Through a Social Determinants of Health Lens

This program will allow C.H.A.N.C.E. to increase access to care by assisting with insurance enrollment, providing transportation to and from, and assisting peer with health literacy issues. By providing these support services C.H.A.N.C.E.'s PWSs are able to connect the people they serve to employment support, housing resources, and support communities that will improve the peer's ability to access safer places to live, work and play. This program enables PWSs to connect peers to much needed food resources such as food pantries, meal sites, WIC and food stamps. PWSs are also able to model healthy physical, mental, and behavioral health choices, and provide resources and education around how to make healthier decisions, such a freedom from smoking classes and getting check up with their primary care provider.

Project Roles:

Amelia Wyckhuyse is responsible for proposal development and presentation to DST, as well as being the project manager tasked with community and partnership outreach and contracting.

Kami Beard, Peer Support Manager is tasked with clinical supervision with PWS, and reporting for project.

Jon Phelps is responsible for onsite supervision of this team.

Michele Castle is responsible for contract oversight and financial management of the project.

Amelia Wyckhuyse and Kami Beard are responsible for contracting.

C.H.A.N.C.E.'s Vision Statement

C.H.A.N.C.E. offers peer guided wellness services and supports for community members seeking personalized recovery from life crises. We achieve this through compassion, advocacy and understanding.

Potential Risks

Safety and security of our staff, the people we serve, and our community partners is paramount, so during our partner and community outreach, we will clearly define process and policies with our partner to help protect everyone involved. We will also hire security staff to support our Peer Wellness Team.

C. Pilot Timeline

Activity	Expected Date
Develop Policy and procedure Manual for Crisis intervention Pilot	September 30th, 2021
Identify and schedule training for Pilot team members	October 1st, 2021
Prepare Comfort Room	October 15th, 2021
Post Job Openings for PWS and Security	November 1st, 2021
Schedule Community partner outreach meetings	November 8th, 2021
Develop data collection for pilot program	November 15th, 2021
Train and on board PWS Team	December 15th, 2021
Pilot Goes Live	January 1st, 2022
Survey P.E.E.R. Team members	April 1st, 2022
Semi-annual Report out	July 1st, 2022
Survey Community Partners	November 1st, 2022
Evaluate Program	December 2022
Final Report to DST	TBA

D. Sustainability Plan

This program is innovative as it is one of the first in the Willamette Valley to utilize peer services, and peers who are trained in crisis response to respond with law enforcement and mental health professionals on a 24-hour basis. Chance is currently serving the tri county region with offices in Linn, Benton, and Lincoln County's and as the project shows effectiveness Chance has the infrastructure in place to implement within the entire region and has local partnerships for future sustainability as well as skilled staff that will be applying for local, state, and federal grants as local crisis response teams become woven in the fabric of care in our community.

C.H.A.N.C.E. will continue to evaluate this pilot and build and strengthen relationships with other organizations to create the support necessary to replicate this pilot in other

counties. C.H.A.N.C.E. has existing relationships with other emergency housing providers in Benton and Lincoln counties, and will share its progress with these partners to find opportunities to spread this model throughout the rest of the tri-county region. We are relying on the fact that there will be a Peer Wellness Specialist Training program within our CCO region, which will allow us to get people trained to do the work more easily then going outside of the region for training.

2nd CHANCE Shelter accepts guests from across our CCO region making the replicability to Benton County a natural steppingstone. Lincoln County because of its geographical location and its current lack of emergency shelter seems to be a more challenging step, but we are hopeful with the development of programs like project turnkey, we will be able to find opportunity to use a model very close to this one to bring these supports to that county as well.

Budget Worksheet

Pilot Start Date:	**10/1/2021**	**Pilot End Date:**	**12/31/2022**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Provide a safe environment for peers experiencing a crisis		$24,192.00	$12,096.00
PWS trained and using UniteUs Platform		$24,192.00	$12,096.00
SDoH Screening and referrals for services		$24,192.00	$12,096.00
Connections to community-based programs and supports		$24,192.00	$12,096.00
Operating skilled specialists trained in crisis intervention, mental health first aide and de-escalation		$24,192.00	$12,096.00
Meeting mental health crisis teams in the field		$24,192.00	$12,096.00
	Subtotal Resource Costs	**$145,152.00**	**$72,576.00**
Materials & Supplies			
Cell Phone		$1,200.00	$600.00
Food/Other		$18,000.00	$9,000.00
	Subtotal Materials & Supplies	**$19,200.00**	**$9,600.00**
Professional Training & Development			
PWS Training		$8,000.00	$8,000.00
Security		$8,000.00	$8,000.00
	Subtotal Training & Develop	**$16,000.00**	**$16,000.00**
Total Direct Costs	**Rate (%)**	**$180,352.00**	**$98,176.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$18,035.20	$9,817.60
Total Project Budget		**$198,387.20**	**$107,993.60**

SMART Goals and Measures

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Single certified peer support specialist with minimal specialized training in handling crisis situations handling C.H.A.N.C.E.'s 24-hour crisis line; no team of Certified Peer Wellness Specialists (PWSs)	Develop Policy and procedure Manual for Crisis intervention Pilot Identify and schedule training for Pilot team members Number of people hired and trained	Fully trained team (4 PWSs) skilled in crisis intervention, mental health first aide and de-escalation, as well as basic CPR and first aid	January-22
	No comfort space for the warming center	Number of people utilizing warming center's comfort space	Provide a safe environment for peers experiencing a crisis; report out on utilization	October-21
	Create peer-led action plans	Number of action plans created	30% of the people referred to our PWS team creating an action plan	December-22
	PWS meet Linn County Crisis team in the field	Number of Crisis calls that CHANCE's Team is called to.	90% of Crisis calls are responded to	December-22
	PWS trained and using UniteUs Platform	Number of PWS trained and using UniteUs	75% of Referrals are made through Unite Us	December-22

P.E.E.R.

CHANCE

Peer Enhanced Emergency Response

NICK

PILOT SUMMARY AND GOALS

- P.E.E.R. teams will staff the 2nd CHANCE Shelter's no to low barrier warming center and comfort room. Team members will respond to calls from the Emergency and Police Department and Linn County Mental Health's Crisis Team overnight. P.E.E.R. Team members will be Peer Wellness Specialists with specialized training in de-escalation and crisis intervention and will provide a safe place for people experiencing a crisis, screening and referrals for social determinants of health, and support in the field to the LCMH Crisis team.

- Goal #1: Create a safe place for people who are experiencing a crisis.
- Goal #2 Create P.E.E.R. teams with specialized training.
- Goal #3 P.E.E.R. teams using Unite Us Platform to make SDoH Referrals.

MEMBER AND COMMUNITY NEED

- Our target population is people who are experiencing mental, physical and behavioral health crisis.
- Peers that are experiencing a crisis who have low to no income are often struggling with a lack of support as well. Homelessness or lack of adequate housing resources is a growing need in our community. When the people we are serving are fighting to have their most basic of needs such as housing, food and hygiene met, things like mental, physical, and behavioral health treatment land lower on the priority list.
- Currently, IHN-CCO members who are experiencing a mental, physical or behavioral health crisis outside of regular business hours are instructed to go to the emergency department, and this pilot would allow us to present another option beside a costly E.D. visit, and an opportunity to provide more appropriate supports around de-escalation and crisis intervention.

SYSTEM TRANSFORMATION

- Collaborative Partnerships/ Interdisciplinary teams
- Address the whole peer from basic needs to SDoH
- This pilot will positively impact the ED utilization metric, by address the reasons people are using the ED for things that are not necessarily medical emergencies.
- This pilot is innovative because it is based on the lessons, we have learned in previous crisis intervention projects, and we have used creative problem solving to adjust our model of crisis intervention to serve our peers more appropriately and effectively.

PARTNERSHIPS/COLLABORATION

- C.H.A.N.C.E. and it's 2nd CHANCE Shelter Program work closely with Linn county Mental Health, specifically their Crisis Team. We often coordinate support services for peers in crisis, as well as LCMH Clients in many other program they have.
- C.H.A.N.C.E. is a part of the City Solutions Team, which consists of partners like Albany Police Department, the Fire Department, Albany General Hospital Emergency Department, Linn County Mental and Public Health to help support peers who have been identified as a having a large amount of interaction with these agency and often a complex set of mental, physical and behavioral health needs.

HEALTH EQUITY PLAN

- The majority, but not all the peers served by this pilot experience health disparities due to lack wealth, power and prestige. Often experiencing issues with no to low income, lack of housing, limited access to things like technology, a mailing address, and health literacy.
- This pilot will allow C.H.A.N.C.E. to connect these peers to resources around SDoH that will positively improve health disparities. This pilot will also help provide access to things like safe mail services, computers and telephones, as well as support navigating through different treatment systems.

DEFINITION OF SUCCESS

- Creation of a P.E.E.R. Team that is fully trained in De-escalation and crisis intervention.
- Creation of a comfort space for people in crisis to utilize while in crisis.
- Facilitating the creation of peer-led action plans with the people we serve.
- P.E.E.R. team members responding to calls in the field.
- P.E.E.R. team members using Unite Us platform to make referrals for the people we serve.
- We will collect data on each of these measure with various data collection systems and will report out about success to community partners and DST.

SUSTAINABILITY PLAN

- C.H.A.N.C.E.'s 2nd CHANCE Shelter program has been awarded an Emergency Shelter Grant that covers shelter operations, programs and services, and the continuation of this pilot program was written into our grant project plan, so we will be able to sustain this program moving forward. We are also looking at opportunities for ongoing contracting to help sustain this pilot even further into the future.

NICHOLIAS MCGUIRE CERTIFIED PEER SUPPORT SPECIALIST

- Has been drug and alcohol free for over 5 years and 9 months.
- Has been in his own apartment for almost two years.
- Has been trained as a Peer Support Specialist for 3 years.
- Has been a C.H.A.N.C.E. employee for over 2 and a half years, serving under a contract with Linn County Mental Health to provide Peer Delivered services.

DST MEMBER QUESTIONS?

Primary Care Physical Therapy

Backbone Organization: Samaritan Health Systems

Billing Address: 525 N. Santiam Highway

Site(s): Lebanon Community Hospital Sweet Home Family Medicine

County(s): Linn

Priority Areas: A1, increasing access.

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: BH6, behavioral health equal priority to physical health; SD4 Increase health equity.

Pilot Contacts	Name	Email
Primary	Ryan Combs	rcombs@samhealth.org
Proposal	Robert Long	rlong@samhealth.org
Contracting		
Financial		
Reporting		

Executive Summary

This Proposal is about the development of a project which leads the Samaritan Lebanon Community Hospital Rehabilitation department teaming with the George Fox University Physical Therapy school in the development of a Primary Care model of physical therapy.

The driving force behind this request is for the development of a sustainable training program that allows us to train physical therapists in the patient-centered primary care model (PCPMC). We believe that the role of physical therapy is needed in primary care due to the many patients not having the means to attend traditional outpatient physical therapy due to cost, limited transportation, and time restraints. We offer a new clinical pathway available for anyone accessing primary care by removing barriers and meeting the patient where they are at for their rehabilitation and musculoskeletal concerns. We officially started this project on July 20, 2020, in conjunction with the Samaritan Family Medicine Resident Clinic in Lebanon, Oregon. Since the advent of this program, we have seen over 2000 patients in this model. The purpose of this model is to provide those patients with musculoskeletal or neuro pathology with more immediate access to rehab services. This program will decrease overall wait times; meets individuals at the front end who may otherwise have difficulty accessing rehab services; aids in decerning the need for physical therapy or other services like mental health for psychosocial issues that may be contributing factors to chronic and persistent pain patients. Our initial data shows that 55% or more did well with the one-time visit in the primary setting and that 34% went on to formal Rehab services, there was also a sliver in the middle ~11% that did not want to attend physical therapy due to various social detriments to health care could not participate in formal rehab services.

The driving force again behind this request is for the development of a sustainable training program that allows us to train more physical therapists and primary care providers in embedding physical therapists into the patient-centered primary care home model. Our plan is to address the patients musculoskeletal and neurorehabilitation needs at the right place and at the right time which has shown to reduce cost , improve care and reduce provider burden.

Since the advent of the Affordable Care Act, (ACA) patient access to physical therapy in the Samaritan system has taken a on new twist. Many individuals who had no health care access prior ACA immediately sought access. This was complicated further by the Opioid Crisis. Physical rehabilitation services became an important treatment for addressing both the physical psychosocial issues of Chronic pain. These new demands pushed the work queue for services to 700 to 800+ in all three offices in Lebanon and Sweet Home. Our current challenge is to find ways to effectively address the physical rehabilitation needs of our community with limited manpower and space.

An exploratory primary care physical therapy program, seeking start care at the patients first encounter, was started July 20, 2020. This was the result of a collaboration of the Samaritan Lebanon Community Hospital Rehabilitation Department, the George Fox University Physical Therapy Education Program, and the Lebanon Samaritan Family Medicine Resident Clinic. Traditional path to physical rehabilitation services takes 6-8 weeks and may include many other services (i.e. imaging, injections, other specialist), with little coordination between providers. This system of care makes it difficult to deliver the right care, at the right time, to the right patients, leading to “wait and see” approaches to patient problems. The primary care physical therapy program takes a "targeted approach”, stratifying and triaging patients, working alongside medical staff, to better coordinate care. Patient problems are addressed immediately, reducing opioid use and utilization of unnecessary services (e.g. imaging, specialist referrals, etc).

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

Assessment is a key part of the primary care physical therapy program. Person centered outcomes (Patient Reported Outcomes Information System (PROMIS)) address the biopsychosocial component of patient care and stratification outcomes (e.g. Keele MSK (musculoskeletal) address risk of persistent symptoms, targeting care to physical therapy and other health services in collaboration with medical staff. The third tool is PASS (patient accepted symptom state) in which the patient is asked: “Considering your [body region] function, do you feel that your current state is satisfactory?”

This allows the patient to provide input into how satisfied they are with their current care.

Our initial data indicated that ~55% of those patients seen in this Primary Care Model took a “PASS”, feeling that with the information provided, and self-care tools provided they were satisfied with the targeted approach to care. Roughly, 34% were referred to formal PT with approximately 11% stating they either did not or because of various social deterrents to health, could not continue with PT services. Individuals limited by the financial burden of rehab services are provided a follow up home exercise program and given the opportunity (should they qualify) for financial assistance to receive this service if finances are a deterrent.

This program was designed with the Quadruple Aim in mind: Reduce costs, Enhancing the Patient Experience, Improve Population Health and Optimizing provider burden.

Reducing Costs

In the past year that we have been running this program we have noted a decrease in the number of images requested by providers. In this system we have noted a decrease in imaging by 69% since the advent of our program. We have also noted an increase in the number of musculoskeletal visits in the clinic of 260% over the previous year. (This is possibly due to more of an increased awareness of MSK issues and the ability to see and treat MSK conditions in the same episode of care as a nonrelated condition.) One hope is that we will start to see an overall decrease therapy same day cancelation and No-Show rates as well as decreased wait times to get into physical therapy services.

These are value-based items that can save insurance, facilities, and patients a great deal of expense and at the same time provides a higher standard of medical care to those patients involved.

Enhancing Patient Experience

The overall beauty of this program is that it meets the patient where they are. In this program the therapist can address patient issues and concerns in real time. It is here we can put the patients mind at ease, provide them appropriate educational tools, and address concerns or fears that may relate to their condition. In some cases, we can recommend a referral to services other than Physical therapy, such as mental health, orthopedics, neurology, or pain management. It is at this point we were able to provide the feedback to the provider that physical therapy is not appropriate at this juncture and

the patient would be better served by an outside specialty. It is the simple interaction with the patient that helps to improve the patient experience. They now feel and realize their concerns and needs are being addressed in a single visit with the provider.

The outlying issue is that we can address medical concerns or issues that may allow the patient to continue functioning without formal physical therapy intervention and the ability to direct them to ways they can access programs within our community that they may benefit from as they address their medical concerns. This program also allows us to improve access for those patients who need more personal attention. We are now improving patient access to valuable physical therapy services, for those patients with more severe issues.

Improve population Health

Improving population health is a big issue that currently overwhelms our communities' current model of delivering medicine. We need to be able to meet the needs of the underserved populations in our community such as the elderly, Hispanic, LBGQT+, financially burdened, mental health, chronic pain, and chronic disease patients. Programs like this allow us the opportunity first to meet them at the front door with a targeted approach to care. We can now address their needs and concerns regarding their condition and help to get them to the resources they may need to address health care concerns. The value based savings in a program like this may in turn provide opportunity for the development more community based programs to address the population needs such as a fall risk assessment, obesity, outreach programs for the Hispanic or LBGQT+ population, possibly clinics for homeless or financially burdened populations.

Optimizing Provider Burden

One other advantage of this program is that it addresses provider burden, this is the new arm of the Triple Aim (now the Quadruple Aim). We are the extended arm of that provider able to assist with the assessment and management of musculoskeletal and neurological injury, diabetes, Chronic pain, fall issues and obesity. This is done by supplying the feedback to the provider needed for important decision making and providing the patient with education, proper exercise or selfcare for a particular medical issue.

Most of all, this is program is helping to reduce provider burn out. Shiloh Erven, VP SMG Administration, provided the following information: "Primary Care Physician turnover at Samaritan is estimated to cost $500,000 on average at the local clinic level which includes increased recruiting, start up,

and relocation costs as well as a decrease in revenue. In addition, there is also approximately a 40% decrease in access for patients in the first 12 months after Samaritan loses a highly trained physician in exchange for someone new to the system. This analysis does not look at the downstream costs and impacts as 40% less patients are referred to ancillary and specialty services. This would increase the average cost to the system in lost revenue opportunity in addition to the $500,000 in average direct measurable cost listed above. The American Medical Association estimates the cost to be between $500,000 and $1M per replace an existing physician."

Current Surveys with our physicians are overwhelming positive about the program. Below are open-ended responses to 4 questions from this survey by 9/13 MD providers.

Would you be more likely to choose to work in a clinic that had a PT on site?

- Yes!
- After this experience, absolutely. I don't know how we got along before this!
- Yes
- Moving forward it is a model I will seek out and push for in the future primary clinics for employment.
- Yes
- Yes
- It definitely would now, since I know how amazing it is!
-Yes – Awesome to work together
-It would now that I've experienced it

Overall, how would you rate your experience with the Physical Therapists in the office?

-Out of 10? 10/10! Excellent

-Fantastic. They are all available, highly competent, supportive, skilled, and thoughtful.
- (+)!
-Fantastic.
-Excellent

-10/10 loved having them in the office
-It is LOVELY! You have a great group of PTs in the office, wonderful communication. It has improved patient care and satisfaction.
- Excellent addition to help augment care. Creates a positive change environment.
- It has been so great. Everyone is helpful and act as great team members.

The above was all very positive and demonstrates the providers satisfaction in this program. Below are a few responses to questions from the questionnaire that address possible areas of improvement:

In what ways do you feel we could serve our patient's better?

- Maybe 1 more PT for this clinic's size? Dedicated PT room?
- Phone follow up on how patients are doing.
-Processing referrals quicker – 1.5-2 months wait for some patients ☹ need more PT's!
-Unclear – if PT backlog can be improved? Aware we have taken PT out of own clinic and placed it in ours.
-I think the PTs have been doing so awesome. I feel like they are often pulled in many directions, maybe a back-up PT when needed?

How can we serve you as the provider better?

- Promote usage, confidence – otherwise no change
- Access
-I would like a better idea of how much evaluation we as clinicians should do, and if physical observation/eval info to include in my note after the PT visit.
- Knowing where to reach/page you – info in resident room
- The only challenge in out clinic is space/rooms. Not always an issue, but occasionally will put me behind because my next patient can't be roomed.
- We seem to have close to lunch and end of day (rushes) if shifting in schedule to accommodate would be great.

In all, the responses were very good and constructive. The results of this survey do provide insight to possible areas of improvement which seems to hedge toward education for both the physical therapists and providers. This program is well supported by the providers, but our overreaching goal is to fine tune this program and utilize its capability to improve delivery of these services through **Partnership, Quality, and Engagement in Movement and Physical activity**.

Goal: Increased physical function and self-efficacy in managing chronic conditions through movement and physical activity.

1) **Partnership:**
    a. The Primary care provider/PT team now can identify and prioritize (i.e. targeted care) and needs to best address the needs of primary care patients and the community.

        1. Prior to the development of this program collaboration between providers was Fair at best. Primary care providers were not understanding the issues behind the high work queues and PTs were not understanding why the providers were not more sympathetic to our space and manpower issues.
        2. With our current model we are beginning to share the burden and collaborate on innovations to address the needs of patients and the community.

3. The future is exciting, new programs focusing on education, treatment and prevention of chronic pain, diabetes, fall risk, obesity and cardiac disease are more feasible and within the reach.

b. Samaritan Health has had the fortunate opportunity to partner with George Fox University in the development of this physical therapy in primary care program.

    1. George Fox is recognized as a leader in the development, and implementation of, the primary care protocol for physical therapy. They have been able to demonstrate the importance of self-report tools like PROMIS and the Keele MSK to enhance a targeted approach to MSK care and meet the patient's biopsychosocial need.
    George Fox University also has helped us in providing the expertise and assistance by providing real time statistical feedback to providers using these same outcome tools.

c. Samaritan Health Systems has number of community resources to help in the development and extending this program to its fullest potential.

    1. There are various wellness programs in our community to assist with patients that include: The Lebanon Senior Center, Lebanon pool, Sam Fit, and access to facilities for addiction, financial assistance, food assistance, housing assistance and domestic violence/abuse.
    2. We are also now working in collaboration with Western Health Sciences, Osteopathic and Physical Therapy program. This collaboration with the PT program has promised to lead in the development of more community-based programs to address population health issues.

2) Quality:

a. The baseline information provided from our first statistical analysis of our program has provided us some insight in opportunities for training of our staff and other staff as we move forward. The early analysis also noted some opportunities for education of our providers to what physical therapy and therapy services can provide them in aiding the assessment and treatment of their patients. With collaboration from George Fox

University we can utilize their experience and expertise to provide training programs and the training mediums to include:

1. Training that would focus on **differential diagnosis** to identify red flags for low back, cervical and thoracic spine, Concussion syndromes, Vestibular issues, Upper and lower extremity issues. This will include other pathologies such as cancer, cardiopulmonary disease, diabetes, balance issues, neurological disorders, fall risk and obesity.
2. Training must also include **soft skills** like communication with physicians, motivational interviewing with patients, behavior strategies and communication approaches, understanding pain science and other psychosocial approaches to care.
3. Training in how PROMIS, Keele MSK and PASS can enhance a targeted public health focus to care.
4. Training regarding **psychological models of care**, that incorporate suicide awareness, compromised populations, issues, and awareness of LBGQ and transgender populations.
5. Training to be provided through:
    a. Boot camps or retreats that would be biannually.
    b. Development of online modules for physicians that help them understand the role and value of physical therapy as an extended arm of care.
    c. Development of a residency program or fellow ship to promote the primary care model and develop primary care within our system.
        i. This program would encourage mentorship
        ii. Train the trainer,
        iii. Requirement of participants to develop a community education program.
        iv. Include Behavior strategies of Care to increase physical activity,
            1. Pain science/biopsychosocial
            2. Motivational interviewing
            3. MAPs participation

6. Informatics would include quarterly tracking of metrics that would reflect the potential success of this program this would include:

    a. Impact on the current work queue, base line is currently at 781 (7/23/2021).
    b. Impact on no/show cancelation rate (456 last quarter).
    c. Patient satisfaction with Program ( )
    d. Impact of PASS (yes/No).
    e. Impact on FOTO Efficiency and Function scores of patients who were referred on to formal physical therapy.
    f. Physician Satisfaction, currently 9/13 responses with overwhelming support of the program (to be done biannually).
    g. We are currently doing a study with GFU on 7 day and 45-60 day follow ups with patients in this program with the intention from the results of this study to determine the best time frame to follow up with patients who have taken a PASS in this program. We do not want patients getting lost in the shuffle.

3) Engagement:

a. The IHN-CCO serves approximately 54,000 members in the tri-counties of Linn, Benton and Lincoln Counties. Roughly, 20-25% of the rehab population we serve are members of the IHN-CCO. Unfortunately, many members remain underserved due to patient access issues.
    1. This provides the opportunities address the peer groups and community leaders of the underserved populations such as LGBQT+, Hispanic, and elderly groups.
    2. Develop health care teams to carve out opportunities interact with existing wellness programs for Chronic pain, balance, elder care issues, chronic disease and cardiovascular issues.

There are close to 90 Physical therapists on staff in the Samaritan system whom a majority hold a clinical doctorate or specialty certification. They

have skills and abilities that are extremely underutilized. When performing at the top of their license, Doctor of Physical Therapy professionals make diagnosis, recommend imaging, refer to specialty, collaborate with medical staff, manage a range of MSK and other conditions. Empowerment means more targeted care for the community resulting in quicker access and quality care. Being an extension of the physician arm is only a start, and training to support this can/will lead to therapist stepping up to the training that prepared them to seek a new role in improving the health care quality and access of the tri-county communities the IHN CCO serves.

Timeline for

Primary Care Physical Therapy

1. July 20,2020, Current project underway in Lebanon SFMRC. (Done)

2. April 2021, begin data collection with GFU, monitoring outcomes scores on 7-10-day call backs and 45–60-day call backs.(Done)

3. September (2021) begin sharing quarterly data with providers at involved clinics.

4. In October 2021, compile data from call backs to implement clinician training (for physicians and therapists).

5. Provide data / presentation for upper management to support Physical therapy in Primary care model expansion.

6. January 2022, provide first training for therapists and providers.

7. Begin development of training video for Primary Care providers

8. Arrange meeting with Local community representatives of underserved populations to discuss how we can best serve them.

9. February 202, begin development and primary care model residency program in Lebanon.

10. February 25-20, 2022 present Primary care data with George Fox University to APTA combined sections meeting.

11. June 2022 next training session for providers and physical therapists.

12. September 2022, recap data and determine appropriate timelines for call backs. Revisit and Plan for 2023.

13. September 2022, first Candidates for Residency program in Lebanon for primary care and continue monitoring primary care progress.

Sustainability

The sustainability of this program is driven by the outcomes data. As we continue to move this program forward our goal is to show the value-based care that we have been able to bring to the table. Medicare now looks at patient satisfaction as part of their reimbursement model. Other savings that this program brings is in what we save by being present, our program has already seen drastic changes in imaging patterns, we have nearly cut imaging in half over the last year. We have noted increased MSK visits because of our being there and this is actually a good thing because we are addressing this problem in an acute condition as apposed to a chronic condition. We are interested in how we affect overall medical costs we hope to show this with current and future data collection.

Most important this program thrives on its ability to be patient centered, to meet the patient upstream when they are with the physician. This affords the opportunity to introduce the patient with appropriate physical therapy options in a single meeting and the opportunity to provide valuable information to the patient to deal with their condition. To provide value-based care our therapists must train to that level of care. They must understand where their skill set lies within the medical community. Training of the therapists will provide them the tools to perform as a primary care PT. Training of the physician is needed to understand the value of the tool that is provided with that therapist in the clinic. As we move into the future of this program training is of the most important. The development of a residency program in primary care affords us another opportunity to make training sustainable and an efficient way to spread our program into our medical community and continue providing research that will prove our efficacy.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Wait time for physical therapy services: 4-6 weeks	Monitor work queue and schedule	2 days to 2 weeks based on acuity standards.	December-22
Patient satisfaction of 7-10 day call backs, Currently: 4.8/5 from 52 respondents	Call backs at 7-10 days follow up from PC visit	Current bench mark 4.5/5 (achieved currently 4.8/5) cont. follow-up	December-22
No-Show Rate (2nd quarter 2021) 456 NS	Monitor quarterly	Decrease No Show by 50%	December-22
PASS yes (54%) / PASS no (46%)	Monitor quarterly	ongoing monitor to determine trends or possible training issues.	December-22
Physician satisfaction	Biannual monitoring reviewing open ended questionnaire	Continue monitoring for valuable physician feed back.	December-21
FOTO Efficiency/Function Scores of patients who have been refered to formal PT from PC	Quarterly review of FOTO Efficiency and Functional outcomes	Goal to be in the upper 70th percentile in the nation.	December-23
Physician training for PT Role in primary care	Monitor utilization of Primary care PT	10+ visits /day	December-22
Primary Care PT Training	Biannual Boot camps competencie demonstrated	Competencie of approved standards.	December-21
Primary Care Residency	Yearly APTA or industry guidelines	National and /or state research presentation platform	December-23

Physical Therapy in Primary Care

Pilot Start Date:	Current	Pilot End Date:	12/1/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Data consultation/monitoring/collection		$40,000.00	$30,000.00
Management of the residency program for PT PC		$70,000.00	$35,000.00
		$0.00	$0.00
	Subtotal Resource Costs	**$110,000.00**	**$65,000.00**
Materials & Supplies			
Laptops/ PT educational supplies/printed materials		$40,000.00	$20,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$40,000.00**	**$20,000.00**
Travel Expenses			
Travel expenses for GFU trainings /APTA/OPTA presentations		$25,000.00	$12,500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$25,000.00**	**$12,500.00**
Meeting Expenses			
biannual group meetings		$5,000.00	$2,500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$5,000.00**	**$2,500.00**
Professional Training & Development			
instructional training for trainers		$10,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Develop	**$10,000.00**	**$5,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$190,000.00**	**$105,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
Total Project Budget		**$190,000.00**	**$105,000.00**

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

Primary Care Physical Therapy

Pilot Summary and Goals

- Physical therapy functioning in Primary Care.
  - Extension of the medical arm of the phsyician
  - Seeing the patient upstream,
  - Addressing their needs at that particular point and time.
- **Goal:** Increased physical function and self efficacy in managing acute and chronic conditions through education, movement and physical activity.
- Overreaching goals: Enhance the patient experience, reducing costs, Improving population health, Optimizing the provider burden.

Member and Community Need

- Talking points:
  - Target population: All patients serviced by participating primary care setting, needing attention to conditions served by physical therapy

    .
  - IHN-CCO Member Impact: 20%-25% of patients served in our department are IHN patients.

  - Community Needs: Value based care provides the opportunity to serve the underserved.

System Transformation

How is your proposal transformational?

- Seeing the patient upstream during their physician visit.
- Empowers the patient.
- Improved communication between providers
- Decreases overall medical costs.

Partnerships/Collaboration

- Strong collaboration and partnership with George Fox Universities Physical Therapy Education department.
- Future collaboration/ possibilities with Western Universities Health Sciences Program.
- Opportunity for collaboration and partnership with the underserved in our community to address their social deterrents to health care.

Health Equity Plan

- Meet patient upstream
- Address social deterrents to health care
- Meet with community leaders and peers of the underserved populations
- Utilizing the assets of other community partners, help to create opportunities to more easily address issues of the underserved.

Definition of Success

- There are no failures!
- Metrics: No/show rates, decreased work queue, patient satisfaction scores, efficiency scores, functional outcome scores (FOTO), patient wait times to get into physical therapy, decreased medical costs, physician/provider satisfaction.
- At the end of your pilot, what will have changed?
- Improved access to physical therapy services for all participants, We will have changed the way we deliver patient services.

Sustainability Plan

- Therapist and physician / provider education
- Development of a Residency program in Primary Care PT
- Spread this concept into the Samaritan system
- Physician satisfaction
- Alternative billing options
- Incident to billing model
- Improved therapist satisfaction (working at the top of their license). .

DST Member Questions?

Questions????

PSH Respite and Housing Case Management

Backbone Organization: Corvallis Housing First

Billing Address: 2311 NW Van Buren Ave. Corvallis, OR 97330

Site(s): 5 sites in Corvallis

County(s): Benton

Priority Areas:
Innovative programs supporting housing

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: (see pages 7-9 of Guidelines)

SD1: Increase the percentage of members who have safe, * accessible, affordable housing.

*Safe housing: a structurally sound, secure, sanitary, nontoxic residence with basic utilities, timely repairs, and adequate space for residents

SD4: Increase health equity.

Pilot Contacts	Name	Email
Primary	Andrea Myhre	director@corvallishousingfirst.org
Proposal	“	
Contracting	“	
Financial	“	
Reporting	“	

SHARE PROPOSAL Cover Sheet

Project Name: PSH Respite and Housing Case Management Pilot

Organization: Corvallis Housing First

Contact: Andrea Myhre – director@corvallishousingfirst.org

541-250-9479

Projected budget amount: $490,186

Ask to SHARE: $144,761

Focus area: Housing Supports including Traditional Health Workers and Transitional Housing

Executive Summary

For some who have experienced homelessness, having access to supportive services is essential in helping them find and stay in housing. Corvallis Housing First provides housing and supportive services, including case management, to people who have experienced homelessness in our community, with a special focus on serving those who are in need of Permanent Supportive Housing (PSH). People who are in need of PSH generally have experienced chronic homelessness (more than a year or homeless multiple times over a period of years), experience a disability (that can be mental or physical, or both), and are especially vulnerable (as determined by assessment scores). Through evaluation of data on homelessness in Corvallis/Benton County, we know there are likely at least 150 individuals who fit this criteria, most of whom are IHN-CCO members, are disproportionally from underserved groups, who are also likely very expensive to serve and treat because they are living on the street, often using emergency services to address their health needs. Essential components to PSH are supportive services and appropriate housing. Currently, aside from private donor and grant funding, there is no mechanism to pay for these services. This project aims to establish a framework and procedures for sustainable funding through IHN-CCO, drawing on the framework established Traditional Health Worker (THW) reimbursement. The model of THW services, specifically Community Health Worker (CHW) services, utilize many of the same concepts our staff currently employ, including Trauma-Informed Care, Motivational Interviewing, knowledge of community resources, and cultural competency. This project will also leverage deep partnerships with Unity Shelter and Samaritan Health Services, as well as over 8 million in funding for increased shelter, transitional housing, and PSH that has been approved in 2021. We are asking IHN-CCO to cover costs associated with training our staff and paying for staff time to integrate and implement the framework and reimbursement process.

Project Description

Corvallis Housing First (CHF) was established in 2007 as the Corvallis Homeless Shelter Coalition to provide increased low-barrier shelter in our community. The organization quickly evolved to provide housing for people who had experienced chronic homelessness with the addition of Partners Place, an 8-unit apartment complex that featured shared housing and supportive services. CHF chose to follow the concepts of Housing First, which is an evidence-based, low-barrier approach that focuses on providing housing with support services to people experiencing homelessness first instead of requiring sobriety and treatment compliance prior to housing. From that time, we have added three other properties to our housing portfolio, a total of 39 units, as well as increased the number of case managers and case workers to provide supportive services. Additionally, we have established a partnership with Unity Shelter to provide case management services to their clients in shelter (Men's Cold Weather Shelter and Room at the Inn Women's Shelter) and transitional housing (Safe Place microshelter program). We also have a contract with Samartian Health Services to provide respite housing and support services, working in partnership with their Care Hub/Homeless Outreach program staff.

We have recently been approved significant funding to increase shelter/transitional housing and PSH in our community. Most recently, we have acquired the Budget Inn, a former motel with 25 units, located just off of 99W in South Corvallis which is currently being used as a co-ed shelter in partnership with Unity Shelter. Immediate plans are to allow current residents to stay at the site for an indefinite period of time while we work to try to find them more permanent housing, as well as using the property to expand the number of micro-shelters in the community.

However, we have plans to develop additional units of housing at the site through retro-fitting the current buildings to be studio apartments, as well as new construction, which could include up to 45 additional units of a mix of PSH, studio/1-bedroom apartments for low-income individuals, as well as space for community services. The total project costs are estimated to be upwards of 20 million, a quarter of which has been approved, and we would likely start construction sometime in mid-to-late 2023:

Budget Inn site development funding:

Approved

- Oregon Community Foundation – 2.45 million for site acquisition and rehab
- Rural Oregon Continuum of Care, Emergency Services Grant - $300,000 for housing retrofit
- State of Oregon Lottery Bonding – 5 million

Pending

- US Congressional Earmark request, Rep. Defazio – 3 million

Planned (estimates)

- City of Corvallis - $750,000
- Oregon Housing and Community Services, PSH program, LIFT - $8,130,000
- Private Donations - $270,000

As a part of our recent funding and growth, we have doubled the number of support staff to work with clients in outreach and in our housing. We currently employ Caseworkers and Case Managers, both of whom follow best practices as recommended by the Department of Housing and Urban Development (HUD) and the Corporation for Supportive Housing. Staff are supervised by a Lead Case Manager. We also have a Housing Specialist/Life Skills trainer, a position that has partially been funded by IHN-CCO, who assists with housing application processes and communication with our contracted property management company, as well as other property management companies to advocate for clients. Caseworkers are responsible for providing day-to-day support and management of our housing sites, while Case Managers are tasked with working directly with clients toward our three goals of assisting individuals with housing stability, achieving self-sufficiency, and increasing well-being. Our work is successful, as we have seen 75-80% of residents remain in housing, with positive outcomes for improving self-sufficiency and well-being.

Need

As suggested in the Executive Summary, Housing First and Permanent Supportive Housing are both evidence-based practices utilized across the country and recommended by the US Department of Housing and Urban Services as effective strategies to help improve the lives of people who have experienced homelessness while reducing costs. Unfortunately, although Oregon is experiencing a housing and homelessness crisis, our state has been behind other parts of the country in developing and implementing these strategies (but is now on a path to establishing more housing and evidenced by recent legislative and agency action to fund housing development). Statewide implementation of strategies for funding housing services, however, is still an open question. Currently, funding for services are tied to specific grants funding housing projects. Federally-funded Continuums of Care, such as the Rural Oregon Continuum of Care, is severely underfunded to address the need for PSH housing and services in the 26 counties that it serves. Coordinated Care Organizations have implemented their own strategies to direct funding toward housing support services, as the traditional way of using Medicaid to fund housing supports is not available unless agencies are licensed Behavioral Health Providers. Some of these points were highlighted in the Oregon Health Authority "Oregon CCO Housing Supports Survey Report" from 2016.

Locally, we know from our own research that the numbers of people who are experiencing chronic homelessness, who are also facing huge health challenges, is significant. Based on data from Point In Time counts, information from local agencies compiled by the League of Women Voters, and our own internal data collection, we estimate that there are at least 150 people

who need supportive housing in Corvallis and Benton County. In 2019, data from the men's emergency shelter was compared to information from our local health provider, Samaritan Health Services. In 2018/19, of the 181 men who stayed at emergency shelter, 152 were Samaritan patients. They accounted for 533 emergency room visits and 47 total hospital admissions. A total of 29 patients were admitted to the hospital and had a combined length of stay of 367 inpatient days – just over one year of care – between 8/1/18 and 7/31/19.

As a small nonprofit, working with other small nonprofits and organizations such as Samartian Health Services, we have steadily worked toward providing more supportive housing and support services to the unhoused, often through grants and donations. This is not sustainable, both in terms of meeting the actual need in the community, and being able to support a professional and effective workforce. While we have been granted significant resources to dedicate to services as a result of the national and statewide COVID response, these funds end in January and June 2022.

Goals, Objectives, Activities and Project Impact

Our overall goal of this project is to create a replicable, sustainable pathway for providing for housing support services in Benton County, with positive implications for other programs and possible CHF expansion to Linn and Lincoln Counties. We are not under the impression that this would cover all costs associated with housing support services in our programs, but that it would be an important income source and a professional framework with local continuing education opportunities.

We have four main goals of our pilot project (see attached Initiative Grid):

1. **Establish a model of utilizing framework of THW, combining with the principles of PSH, to support people in housing.**

As previously mentioned, our staff are already employing many of the approaches that are in the CHW training. We need to take some time at the beginning of the project to outline how the CHW training and framework fit into the current procedures and job descriptions of our staff, and rewrite job descriptions in some cases. Staff need to attend training (ALL staff, including our Housing Specialist/Life Skills Trainer, a total of 10). Some of these integrations will be revised, so having some months to experiment and assess is important. The goals of our services are to increase client's self-sufficiency, well-being, and housing stability. Staff being trained as CHW will only serve to improve their skills in helping clients achieve these goals, in ways specific to their desires, needs and strengths.

2. **Establish a reporting/billing mechanism for THW staffing expenses.**

We assume that the best path forward would be to draw on current billing/reimbursement procedures for CHW and Peer-Support staff, such as those contracts established with DevNW and CHANCE. This would be a joint effort between the CHF Executive Director, Lead Case Manager, and IHN-CCO staff. We currently use Shelterware to track our activities but could

integrate changes to reflect the billing procedure requirements, including “touches”. We anticipate these processes being completed toward the end of the grant period after some experimentation with a small group of staff. We are hoping that the outcome results in clear reporting on activities and outcomes for IHN-CCO clients, as well as a sustainable funding source for our staffing that could pay for at least a third or more of costs.

3. **Increase housing opportunities for those who have experienced homeless and who are in need of supportive housing.**

We anticipate at the conclusion of our development project at the Budget Inn site, that we will have a total of at least 50 units of housing, at least half of which would be dedicated to PSH clients, with other units being available to very-low income individuals, as well as units that could be leased to Samaritan Health Services/IHN-CCO for the purpose of respite transitional housing for patients (to be negotiated). As outlined in the first part of the proposal, we have already applied and been approved a third of the anticipated funding needed for this project, and will work throughout 2021-22 to apply for other funding opportunities with ground breaking to happen in mid-late 2023. The development will also include 10,000 sq. ft. of community space, which we will work with partners to develop associated service sites, such as health or mental health services, food distribution, etc.

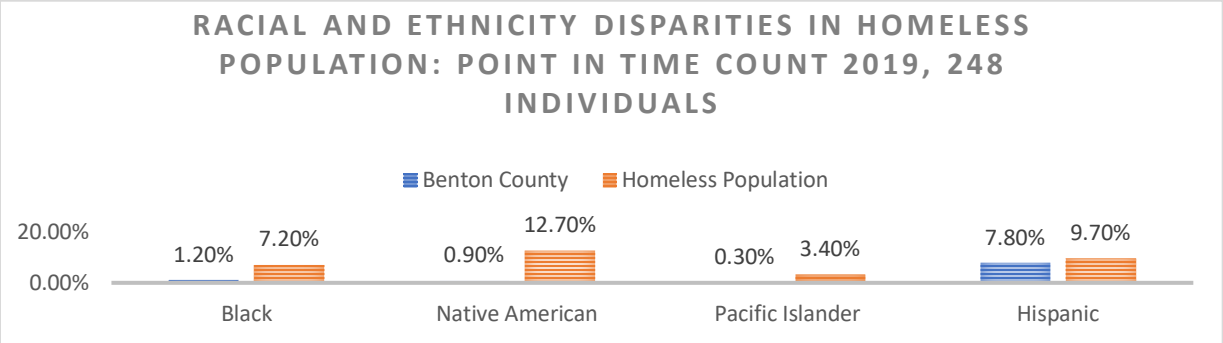
4. **Establish protocol for IHN-CCO members to access supportive housing, especially those who are facing critical health care challenges.**

We currently have a strong partnership with the Samaritan Homeless Outreach/Care Hub staff, but have limited contact with IHN-CCO staff who might be working with individuals experiencing homelessness. With more housing and respite units available, we anticipate refining this process more. Right now, patients are referred to respite rooms by Anita Earl, Homeless Outreach and Care Hub Supervisor at Samaritan Health Services, who also provides case management for these individuals. As they are another applicant to the SHARE program, we are hopeful that they will also be able to expand staffing to provide additional supports to increased respite units.

Total Impacted and Health Equity plan

We believe that at least 30 people, at least 80% of whom are IHN-CCO members, will be housed and provided support services during the program time period, but more importantly, this project sets the stage for many more to be housed and served in the future because of the billing/reimbursement method being operationalized to provide a source of sustainable funding for additional 50 units to be developed. Again, because of past experience and knowledge of our clients, we anticipate 80% of the people housed will be IHN-CCO members (the remaining likely being covered through Medicare).

When we first applied to acquire the Budget Inn site, we made a commitment to address inequity in the populations of people who experience homelessness in our community. Recent community-wide collaborative efforts have collected extensive data on individuals experiencing homelessness and housing insecurity in Benton County. These data collection efforts have shown extreme racial and ethnic disparities among our community members experiencing homelessness. The data collection was spearheaded by the Home, Opportunity, Planning, and Equity (HOPE) Board and showed that community members experiencing homelessness are disproportionately Native American, Black and Pacific Islander (see chart below).



We made a commitment that move-ins to the Budget Inn site should be prioritize those from underserved populations, at least reflecting percentages of their populations experiencing homelessness. We have followed through on this commitment and have additionally hired staff that reflect a diverse population, including individuals who are Latina, Black, and Trans-Gender.

It is our intention to structure our services to address inequity using a theory of change suggested by All Home, a Housing First organization based in King County, Washington. Based on their theory of change our action model is to involve people experiencing homelessness, particularly people of color, to contribute to policy development and funding decisions; provide targeted training to staff and partners and obtain technical assistance provided by leaders and trainers of color; and integrate racial equity principles in all funding and policy decisions. We will continue to monitor system performance data disaggregated by race and will evaluate outcomes for people of color experiencing homelessness. Lastly, our policies and services will be developed and implemented through a targeted universalism framework, or providing more support services to those who have already experienced disparity in the system.

We envision having diverse service providers and partners to help us better serve participants, for example forming connections to the Native American community by hiring staff with this background, forming partnerships, and asking for assistance in training. We will work with BIPOC-serving agencies to ensure we are reaching members of color in need of PSH, as well

accessing the Linn Benton Health Equity Alliance which has been in operation for over 10 years and includes 20 organizations. Outreach, marketing and services can be provided in different languages if that is a possibility based on staffing expertise. Additionally, services will be designed based on the needs of different populations as a one-size-fits-all approach is unlikely to be successful, especially for communities of color.

We prioritize client voice have the capacity to build more significant involvement of people who have experienced homelessness/those who identify as BIPOC, and/or are from the LGBTQ, disability community. Our organization is working toward clear mechanisms for resident feedback as well as several approaches to including resident voice in project management (for example, a monthly resident meeting that allows residents to make decisions about housing issues, representatives on a project advisory council, and/or policy review committee).

Partnerships and Collaboration

As mentioned, we already work closely with Unity Shelter and Samaritan Health Services in housing and providing services to those experiencing homelessness in our community, and are planning to work more closely with groups who represent underserved populations. We also work closely with Community Services Consortium (CSC) on entering data into the local Coordinated Entry System/HMIS, which is a federal-and-state mandated database that tracks who is homeless and the types of services and housing they need. CHF currently co-manages with CSC 5 slots of PSH housing and services as a part of a federal PSH grant. We are working with them to enter data on clients to ensure that people are properly housed. We also work with the Daytime Drop-In Center to conduct outreach to potential clients and residents and anticipate working more closely with Benton County Health Services as they are able to direct more resources and staff to collaborate with us (they were a partner in our application to Project Turnkey, which resulted in the purchase of the Budget Inn).

Budget Narrative

While we have outlined opportunities for housing development at the Budget Inn site earlier in this proposal, funding for services is harder to predict, but there are some funds associated with these grants for services. For example, the PSH grant program through Oregon Housing and Community Services has services funding as a part of their awards. However, these funds are specifically tied to the location that is being developed. These funds would presumably not pay for costs associated with providing support at the other PSH sites we already have in operation. Additionally, we currently receive services funding through our federal PSH grant in partnership with Community Services Consortium, but it is focused on supporting 5 residents. Other local grant sources, such as United Way, Samaritan Social Accountability funding, etc. can provide for small amounts of staffing support.

Gratefully, because the majority of our sites are 100% owned by CHF, we do generate significant rent revenues from our properties. With the addition of the Budget Inn site, we

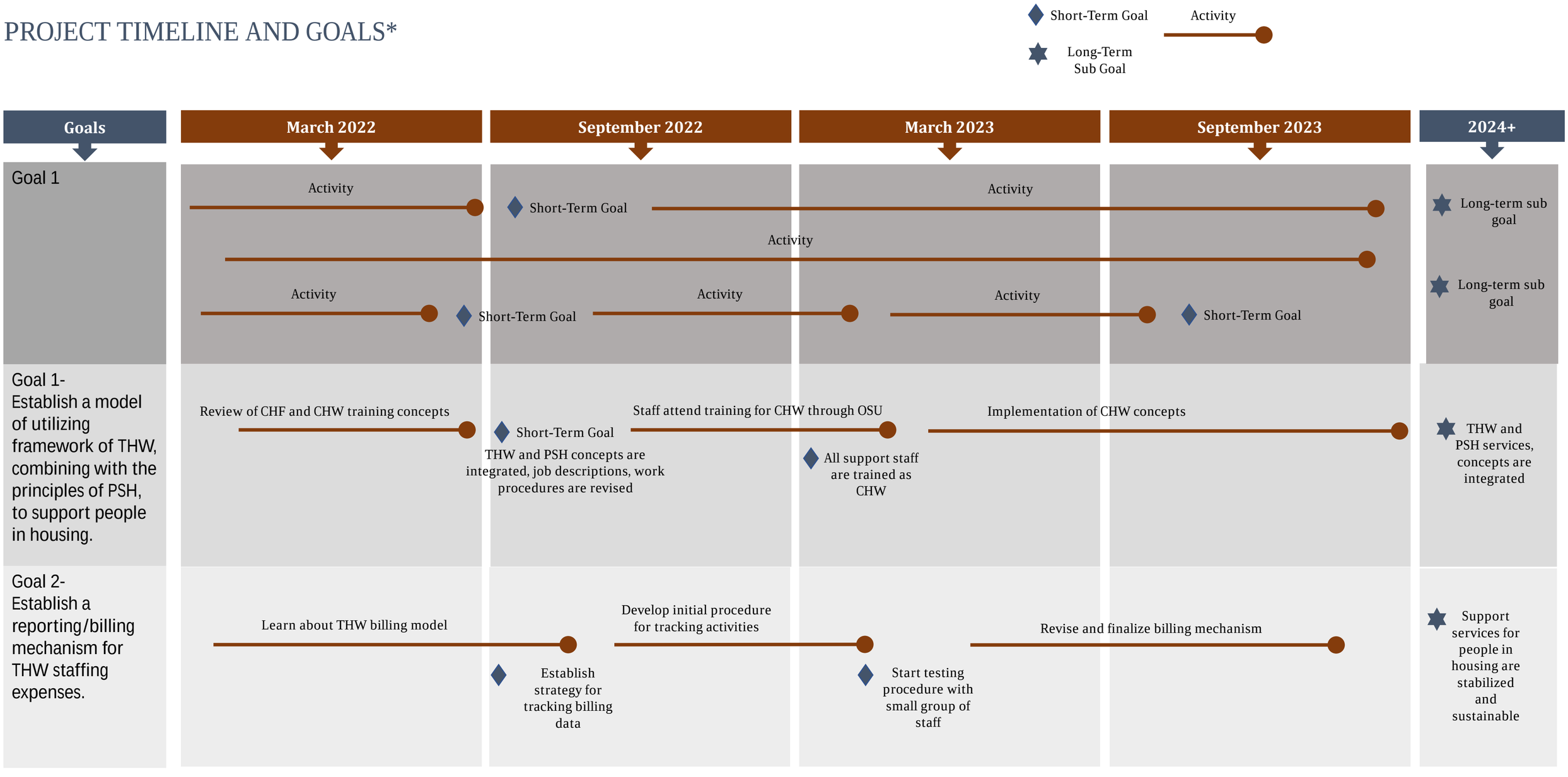
could be generating several hundred thousand dollars after expenses, which would go to help support staffing costs. Key to this is accessing Section 8/Housing Choice vouchers, as well as place-based vouchers, which is a priority of HOPE and is one our goals in developing housing at the Budget Inn site.

In conclusion, being able to access reimbursement/billing for services costs through IHN-CCO would help complete our funding landscape for services. In fact, this is KEY to ensuring that our PSH units, as well as offsite PSH units, in partnership with private landlords, and support for individuals in transitional housing can be developed to even come close to addressing the needs we see in the community. Our thought is that we would be able to sustainably pay for support services with a third of funds coming from grants, a third coming from property revenues, and third from reimbursement/billing, with private donor funds filling in the gaps and paying for administrative costs not covered by other sources.

Regional coordination

While CHF is currently focused on providing housing and supportive services to the Corvallis/Benton County community, we are experienced providers that have a lot to share with others. As a part of being awarded a pilot grant, we would be fully involved in efforts to expand these services, offering support, possibly training, as well as possible expansion beyond our community, if asked. We work with many of the organizations who have applied for SHARE funds and fully support their efforts, as we are all in this together.

PROJECT TIMELINE AND GOALS*



PROJECT TIMELINE AND GOALS*

Goals	March 2022	September 2022	March 2023	September 2023	2024+
Goal 3- Increase housing opportunities for those who have experienced homeless and and who are in need of supportive housing.	Continue to provide 26 units of transitional housing/shelter at the Budget Inn Solidify plans for Budget Inn site housing development	At least 10 units of Permanent Supportive and Respite Transitional Housing established at the Budget Inn Confirm funding, solidify plans for site development	Begin Construction at Budget Inn Site		People who have experienced homelessness have access to appropriate housing
Goal 4- Establish protocol for IHN-CCO members to access supportive housing, especially those who are facing critical health care challenges.	Meet with IHN-CCO, Samaritan staff to plan for additional respite units, referral process several times per month	Plan for respite rooms added to site plan, procedure for referral, staffing drafted	See Goal 3 for rest of Goal 4 timeline		Discharge of individuals who are sick to return to living on the street is a very rare occurance

Primary Strategic Goal	Baseline or Current State	Metrics for Success	Benchmark or Future State	Met By (MM/YYYY)
Establish a model of utilizing framework of THW, combining with the principles of PSH, to support people in housing	While they are utilizing many of the concepts from the framework of THW, support staff are not currently trained as THW, and PSH concepts are not integrated.	CHF residents are better supported in achieving well-being, stable housing, and self-sufficiency, as measured by utilization of services, at least 80% retention in housing, and increase in resident income.	THW and PSH concepts are integrated, job descriptions, work procedures are revised, CHF staff are trained as THW (specifically CHW).	6/2022
Establish a reporting/billing mechanism for THW staffing expenses	There is currently no mechanism for accessing medicaid reimbusement for supportive services in housing.	A pathway for reimbursement will be established, likely following pre-existing protcol for THW already established by IHN-CCO.	Support services for people in housing are stabilized and sustainable.	1/2023
Increase housing opportunities for those who have experienced homeless and and who are in need of supportive housing.	There are currently some supportive housing opportunities, including transitional housing available in our community, however there has been intermittent financial support for services.	Because of establishing a stable source of financial support for services, CHF would establish more supportive housing units (up to 45 units), as well as provide support to tranistional housing programs (in partnership with Unity Shelter).	People who have experienced homelessness have access to appropriate housing.	9/2023
Establish protocol for IHN-CCO members to access supportive housing, especially those who are facing critical health care challenges.	There is a formal partnership for some members to access respite rooms at CHF housing, however the number currently is quite small (2 units), and an informal, but strong partnership with Samaritan social workers who make referrals of IHN members to our programs.	There are increased numbers of units available for IHN members with critical health challenges.	Discharge of individuals who are sick to return to living on the street is a very rare occurance.	6/2023

Pilot: PSH Respite and Housing Case Management Pilot

Pilot Start Date:	1/1/2022	Pilot End Date:	6/30/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Supportive Services for IHN-CCO members in Permenent Supportive Housing during reimbursement process development		$424,054.00	$112,351.00
Direct Support for clients (to help pay for housing-related expenses)		$7,500.00	$7,500.00
	Subtotal Resource Costs	**$431,554.00**	**$119,851.00**
Materials & Supplies			
		$0.00	$0.00
	Subtotal Materials & Supplies	**$0.00**	**$0.00**
Travel Expenses			
Staff support for IHN-CCO members at appointments		$2,070.00	$0.00
	Subtotal Travel Expenses	**$2,070.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Housing support staff to be certified as THW/CHW		$12,000.00	$12,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Develop	**$12,000.00**	**$12,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$445,624.00**	**$131,851.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$44,562.40	$13,185.10
Total Project Budget		**$490,186.40**	**$145,036.10**

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

PSH Respite and Housing Case Management Pilot

Corvallis Housing First

CORVALLIS HOUSING FIRST

a roof over every head

Pilot Summary and Goals

Providing respite and supportive services to people who qualify for Permanent Supportive Housing

- Goal 1: Establish a model of utilizing framework of THW, combining with the principles of PSH, to support people in housing.
- Goal 2: Establish a reporting/billing mechanism for housing support staffing expenses.
- Goal 3: Increase housing opportunities for those who have experienced homeless and who are in need of supportive housing.
- Goal 4: Establish protocol for IHN-CCO members to access supportive housing, especially those who are facing critical health care challenges.

Member and Community Need

- Focusing on those experiencing chronic homelessness, a disability, and documented vulnerability.
- Improved health outcomes, many are IHN-CCO members, reduced costs for the CCO.
- At least 100-150 people fall under this category in our community.
- Example of who we are talking about: Individual who is in their mid 50's, homeless on and off for 10 or more years, diabetic, alcoholic, trauma resulting in mental health issues, cirrhosis, no known family connections.

System Transformation

How is this proposal transformational?

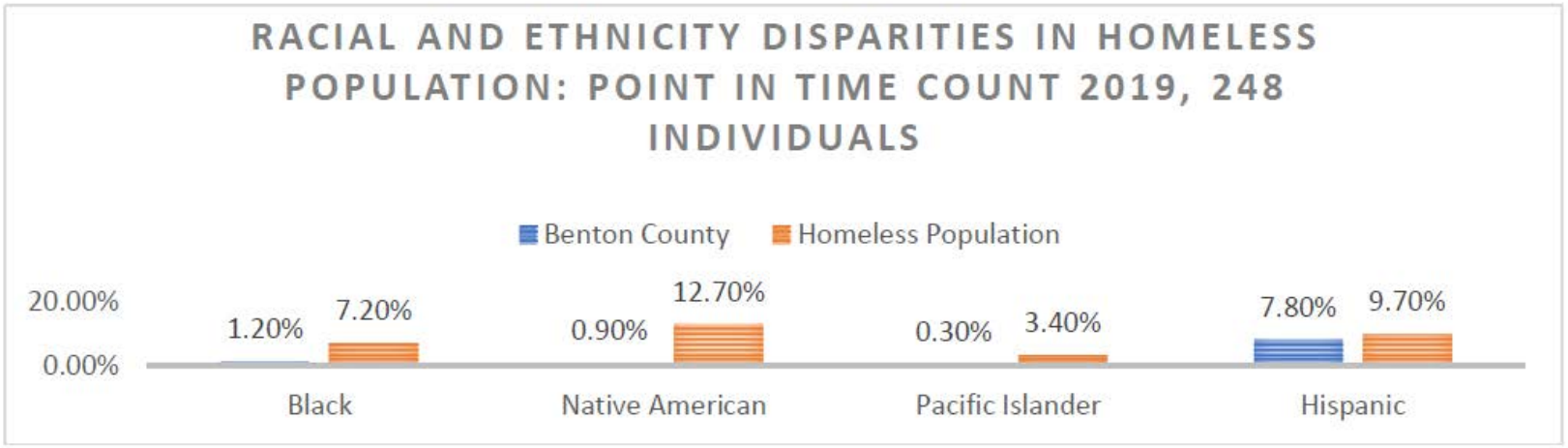
- Currently, there is no way to pay for supportive services for people in our housing through Medicaid – unlike other states, Oregon has not instituted an approach.
- Permanent Supportive Housing has been shown to greatly reduce health costs and is a best practice supported by HUD, HHS, SAMSHA, and organizations across the country.
- We are establishing Permanent Supportive Housing in our community, this proposal would provide a leg of the stool supporting this resource, using an established pathway for billing.

Partnerships/Collaboration

- Principles of Community Health Worker approach and training match principles followed in supportive services for people who qualify for PSH (examples, utilization of community resources, motivational interviewing, trauma-informed care).
- We are currently working with Samaritan Health Services on respite care, as well as Unity Shelter, Daytime Drop-In Center, Benton County Health Department.
- Allow us to take advantage of huge funding granted to develop housing (10 million and counting). However these funds DO NOT INCLUDE services.

Health Equity Plan

- Homelessness is a health equity issue, especially chronic homelessness:



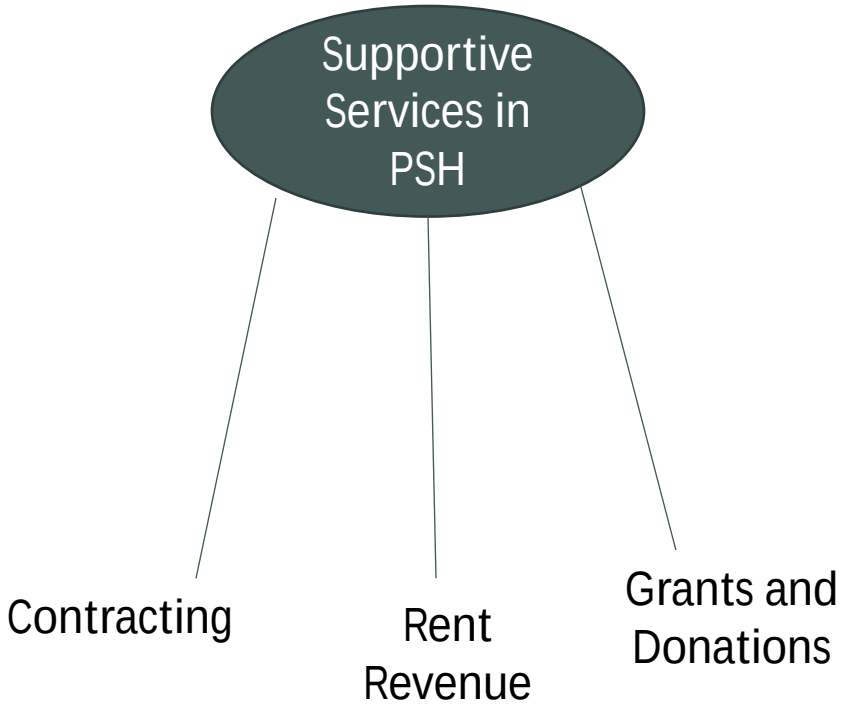
- Staffing should reflect this reality, we are well on our way to this goal in racial, ethnic, gender identity, as well as life experience

Definition of Success

CHF residents are better supported in achieving well-being, stable housing, and self-sufficiency, as measured by utilization of services, at least 80% retention in housing, and increase in resident income.	**THW and PSH concepts are integrated, job descriptions, work procedures are revised, CHF staff are trained as THW (specifically CHW).**
A pathway for reimbursement will be established, likely following pre-existing protcol for THW already established by IHN-CCO.	**Support services for people in housing are stabilized and sustainable.**
Because of establishing a stable source of financial support for services, CHF would establish more supportive housing units (up to 45 units), as well as provide support to tranistional housing programs (in partnership with Unity Shelter).	**People who have experienced homelessness have access to appropriate housing.**

Sustainability Plan

- We will establish an important pathway for paying for supportive services for people in housing, which will be used to leverage other resources:



DST Member Questions?

Therapeutic Treatment Homes

Backbone Organization: Greater Oregon Behavioral Health Inc.
Billing Address: 401 E 3rd St #101 The Dalles Oregon 97058
Site(s): Remote
County(s): Benton, Lincoln, Linn Counties

Priority Areas:

- Addressing trauma
- Developing a bilingual/bicultural workforce
- Improving access to behavioral health services in a non-traditional way
- Increasing access to behavioral health care in light of COVID-19
- Sub-populations of IHN-CCO members that experience health disparities (foster care youth, youth in transition from foster care, LGBTQ+)

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- D. Appropriate behavioral healthcare for youth.
- BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced- ii. Community supports in the community to normalize behavioral health issues.
- BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support- iv. Lack of mental health services for those not in crisis.
- BH6: Behavioral health funded and practiced with equal value and priority as physical health- i. Number of mental health providers (skilled respite providers), ii. Preventative behavioral healthcare.

Pilot Contacts	Name	Email
Primary	**Katelyn Hershberger**	**khershberger@gobhi.org**
Proposal	**Katelyn Hershberger**	**khershberger@gobhi.org**
Contracting	**Lindsay Gordon**	**contracts@gobhi.org**
Financial	**Lisa Chamness**	**lchamness@gobhi.org**
Reporting	**Katelyn Hershberger**	**khershberger@gobhi.org**

Executive Summary

Greater Oregon Behavioral Health Incorporated (GOBHI) is proposing a Therapeutic Treatment Homes pilot project as a part of GOBHI's therapeutic foster care program and GOBHI's therapeutic respite program. These terms may be utilized interchangeably throughout the proposal. The Therapeutic Treatment Homes pilot is working to increase certified therapeutic homes that will provide full time BRS (Behavior Rehabilitative Services) or part time mental health respite to youth ages 4-18 that live in Lincoln, Linn, or Benton counties and have IHN-CCO as an insurance provider. GOBHI aims to provide a unique service to the community to reduce out of home placements for youth and reduce higher levels of care for children by providing supports for youth with behavioral needs and providing a break for their families.

GOBHI understands it takes more than a strategy to recruit and certify foster families to successfully serve children in care. With over 30 years of combined leadership experience in developing and maintaining foster care programming, the foster care team has proven the ability to develop and implement program structure and improvements that meet and exceed the expectations of our contractors. A clear example of this was the recent audits completed in September 2020 by the ODHS Children's Care Licensing Program (CCLP) and ODHS Child Welfare Treatment Services (Agency). GOBHI received a 100% compliance score from CCLP, and 93.38% pattern of compliance from the Agency over a two-year review period at initial review. This included a pattern of compliance in Medicaid service documentation over the previous two years. GOBHI also has implemented Collaborative Problem Solving during this period, training staff, foster families, community partners, parents, and other community members in the model. The program has created case planning, goal structure, Medicaid progress notes and all other aspects of program structure under the umbrella of the Collaborative Problem Solving philosophy.

Throughout these achievements, GOBHI has continued to increase their presence in communities across Oregon by providing this needed service of therapeutic respite and full-time care.

Pilot Proposal

GOBHI is working to increase supports for Linn, Benton, and Lincoln counties to provide a needed service for children and families. The goals listed below will inadvertently aid in reducing out of home placements, providing a support to families, and increasing collaboration between agencies in these counties.

GOBHI's therapeutic foster care program primarily serves youth involved in Oregon Department of Human Services (ODHS) Child Welfare. These are full-time placements for youth that need a more structured and trained environment above a DHS foster placement, and yet the youth does not require a higher level of care such as Psychiatric Residential Treatment Services or other residential treatment. GOBHI provides therapeutic services in a home setting to help engage youth in stabilization and reaching permanency.

GOBHI has also expanded to provide therapeutic respite to families and partners unrelated to ODHS. GOBHI's respite program in Lincoln, Benton, and Linn counties serves youth that are enrolled in IHN-CCO. These youth do not have to be involved in foster care; they can live with any support system. There are three requirements for youth and families to access GOBHI's respite program.

1. Youth must have IHN-CCO insurance;
2. Be involved in mental health services; and
3. Have a behavioral concern that is supported in a therapeutic foster home.

GOBHI serves youth ages 4-18 in the respite program that are experiencing mental health concerns or behavioral concerns. This can look like attention difficulties, emotional regulation concerns, self-harming, running away, substance use, acting out (physical or verbally), and other behaviors not listed. Through

GOBHI's full time BRS program GOBHI serves youth ages 4-21 with at least two behavioral concerns that are at risk of placement disruption.

Goals

GOBHI will track the project's success in increasing foster homes and serving youth with IHN-CCO through a few key goals. First, GOBHI will triple the number of therapeutic foster homes currently certified by GOBHI in Linn, Lincoln, and Benton counties. GOBHI currently has two homes certified in Linn county and aims to grow to six throughout all the counties mentioned. GOBHI will measure this goal using the online tracking/certification system Binti. This program monitors the number of foster homes, dates of certification, and certification requirements.

GOBHI's second goal relates to increasing partnerships in the counties and increasing the youth served. GOBHI will add two referring partner agencies through this project. These agencies will be mental health providers in Linn, Benton and Lincoln counties who serve youth with IHN-CCO. GOBHI currently partners with Old Mill Center, Lincoln Community Health Center, and Linn Community Health Center. GOBHI will track these agencies using Binti, as this system can specify referral by source or agency. This will allow GOBHI to identify who is referring youth for services and how many youths are referred from each source.

The next two goals also relate to the number of IHN-CCO youth served. GOBHI will serve 10 unique youth with IHN-CCO. GOBHI is not currently actively tracking the number of IHN-CCO youth served. With this pilot, GOBHI intends to differentiate respite tracking by contract and referral source. By increasing referral sources, GOBHI will increase the number of youth served. GOBHI will track youth served using Binti and internal tracking sheets.

The last goal of the proposal is that 75% of GOBHI's youth served in GOBHI's therapeutic respite program in Linn, Benton, and Lincoln counties will be IHN-CCO youth. This goal will be tracked using Binti, as well as internal tracking sheets. Currently, GOBHI is not tracking the referral sources for youth. GOBHI will begin this at the start of the pilot.

Targeted Activities

To begin the pilot project, GOBHI will begin with the recruitment process. This recruitment process will entail providing materials to community partners, arranging speaking engagements in the community, taking part in events, building connections with organizations that have not yet been partnered, such as the school systems, medical offices, and religious entities, and developing an awareness of the program and the need for therapeutic homes. GOBHI will communicate via phone, email, and in person to provide both virtual and hard copy materials to all partners.

Once a family expresses interest, they will begin the certification process. To become a certified provider, a family must complete documentation, pass a background check, complete 36+ hours of training, an interview and a safety check of their home to ensure that the living environment meets Oregon Administrative Rule Criteria. During certification, foster parents take part in Collaborative Problem Solving training (they also have additional opportunities after certification to engage in Tier 1 and Tier 2, and parent groups specifically dedicated to parenting with collaborative problem solving). They also take part in Crisis Prevention Institute to learn verbal de-escalation skills. The final step of training is a comprehensive Foster Parent Institute which includes information related to policies, Oregon mandatory reporting laws, self-care, impact of grief and loss, trauma and its effects on the brain, gender and sexual identity, attachment, and other mandatory classes. It is also required that foster providers are trained in CPR/AED and first aid care.

Once a family is certified, they can then take in youth either for a full-time placement or respite. Both full-time and respite care can be offered simultaneously in a home, depending on the space available. GOBHI has an established referral process, in which community mental health providers or ODHS send referrals via email. Referring parties determine that a youth's needs meet criteria for services and GOBHI reviews for appropriateness for the program and current home openings. Once accepted, GOBHI will ask for any additional paperwork needed. GOBHI will coordinate with the referring party to identify dates of respite, home availability, and any other concerns. For each respite stay, foster providers will complete a respite note that detains any behaviors, any appointments during the stay, positives and praises of the youth, and any interventions performed over the respite time. If a youth is on mediation, respite families will also complete a Medication Administration Record (MAR) that will be filed in the youth's treatment file. GOBHI staff will also provide 24/7 crisis support to therapeutic foster providers, as needed, and will collaborate with referring mental health agencies for crisis support, as needed. GOBHI's crisis support is available by phone or in-person if needed.

Partnerships

To encourage communication and program awareness, GOBHI will connect with new agencies that serve IHN-CCO to notify them about our program and discuss the referral process. GOBHI plans on attending team meetings for agencies that are already referring to GOBHI respite program to ensure that all providers know how to complete a referral form, where to send it, and explain the therapeutic respite program.

GOBHI is currently working with the Old Mill Center, Lincoln Community Health Center, and Linn Community Health Center. These agencies complete and submit respite referrals to GOBHI, as well as authorize mental health services in their mental health treatment plans. GOBHI will set up training opportunities for the staff in these locations to ask questions about respite, learn how to complete the documentation, and provide input on how to access respite once approved for services. These agencies present therapeutic treatment homes to their clients and identifying youth that would benefit from this service. GOBHI also intends to engage Patient Centered Primary Care Homes across the region to increase knowledge of available resources and build connectivity to all areas of healthcare across the region.

GOBHI also has begun working with ODHS and Every Child. These agencies serve youth in foster/proctor care. GOBHI has engaged in team meetings with these agencies to increase collaboration in recruitment of foster homes, partner for events, and share strategies to ensure that in the future all youth that need support can access them. GOBHI also collaborates with these agencies to provide full-time and respite therapeutic services. These agencies will support GOBHI in working to increase the amount of foster homes recruited to better serve IHN-CCO youth.

Therapeutic Treatment Homes will also expand community partnerships to other mental health agencies in Linn, Benton, and Lincoln counties that serve youth on IHN CCO. GOBHI intends to develop relationships with primary care homes and educational services to increase awareness of the program. GOBHI will work throughout the proposed timeline below to develop connections with other agencies in these counties and set up training and presentations to increase the awareness of services and engage providers in submitting referrals.

Health Equity and Social Determinants of Health

Therapeutic Treatment Homes promotes health equity by ensuring that all families have access to a safe and reliable environment for their children. Many families with youth experiencing behavioral challenges "burn bridges," meaning they are not invited back, their children are ostracized from daycares or after-school programs, and even family and friends may refuse to house the child or provide care. This causes isolation and a lack of support for families that need support the most. This pilot intends to reduce these disparities by

providing opportunities for these youth and families that they otherwise would not have access to. GOBHI will track data on the amount of referrals received and the amount of youth served. GOBHI will maintain contact with families and referral sources to identify how the respite experience was, any changes they would make, and if they would access respite again.

GOBHI aims to address social determinants of health across our array of services. Therapeutic Treatment Homes addresses social/community inequities, health care access/quality, and also housing. GOBHI works to make communities safe and accessible for vulnerable children by implementing a unique service that is otherwise unavailable to these communities. The goal is to provide trained and supported families to be a resource to those that need support the most and may not have any other supports in their communities or options for relief/respite care. This includes training of providers in understanding mental health, trauma, brain development, and trauma informed approaches to working with children and families.

While in GOBHI's care, not only are youth receiving safe and supportive housing, youth in full-time BRS care are also receiving case management services to ensure physical, behavioral, mental health, and educational needs are met. Youth receiving respite services are accessing a mental health service that would not otherwise be available in the community. As briefly addressed in other areas, GOBHI is providing an alternative housing option. Many families that have youth with challenging behaviors become exhausted, frustrated, and display inappropriate discipline methods. This can lead to children being removed or families unable to continue caring for their children. By having a therapeutic respite program in these communities, it allows families and youth to have a break and reset so they can be in a better space to engage in other mental health services. This pilot can address many social determinants of health to improve the lives of those with IHN-CCO.

Organizational Plan

GOBHI is currently the largest Proctor Foster Care program in the state of Oregon. In less than four years, the Proctor Foster Care program has expanded by over 300%, demonstrating an ability to develop and execute a recruitment and certification strategy across the state of Oregon in both rural and urban settings. Through COVID-19 GOBHI has worked hard to maintain program stability. All around the world children and families have experienced significant impacts because of COVID-19. As a foster agency we have seen fewer families wanting to become supports and more children and families needing a support.

GOBHI plans on continuing expansion and growth across Oregon to help as many families as possible. Currently, GOBHI has not maintained targeted recruitment activities in some counties in Oregon due to staff availability, resources, and connections in a community. However, with this grant GOBHI can increase active recruitment in Benton, Lincoln, and Linn counties, allowing expansion of the full-time foster care program and the respite program. By increasing recruitment and certification, GOBHI will serve youth in these counties with homes designed to meet their needs. This reduces the need for higher levels of care such as PRTS and subacute. This also increases youth connections to their families, services, and environment. GOBHI is working towards developing culturally appropriate homes for all youth. This may happen through bilingual families and staff, culturally diverse staff and families, and expansion into a greater diversity of communities, rural and urban. GOBHI has become a leader in therapeutic foster care across Oregon and will continue to advocate and support the most vulnerable children in the state.

Community Messaging

The primary method for recruiting foster homes that has been proven to be most effective is word of mouth. This is primarily done by certified providers talking to others interested, professionals identifying families that may be a wonderful support, and staff connecting with their communities around them. This type of recruitment is free and families are more likely to move forward in the process when they are hearing firsthand information.

GOBHI can partner with local community members to connect with program staff and current foster parents to share firsthand experiences and information about fostering with GOBHI. Because GOBHI has recognized this is an important communication strategy, GOBHI offers a recruitment bonus to community members who recruit families. This can be provided to any community member who refers a family to be certified, and that family completes certification and begins accepting youth into their home.

GOBHI will also use other recruitment methods that the assigned Regional Child Placing Coordinator or other GOBHI staff will start. Additional strategies could include social media posts, holding information sessions to learn about the program, developing and coordinating advertising for radio or print media. Connecting with other programs, such as school groups, religious organizations, and medical offices is another effective way to increase program visibility and establish speaking engagements. GOBHI also will work with ODHS, EveryChild, and other agencies to increase the awareness for therapeutic foster care/therapeutic respite care.

The second key outreach effort will focus on educating the community about how to access therapeutic respite services. GOBHI has already built relationships with a few mental health agencies and has providers at these locations that are aware of this service. GOBHI will set up meetings with mental health agencies to provide insight into the program, provide referral information, and discuss the referral process. In addition, GOBHI will identify at least two other agencies in Linn, Benton, or Lincoln counties that serve IHN-CCO youth and engage in a collaboration with them on beginning a process between those agencies. The goal of this is to provide information to these agencies around alternative ways to support youth and families and begin providing this service

Outcomes

The first expected outcome is “A1: increase the percentage of members who receive appropriate care at the appropriate time and place; And, specifically D. appropriate behavioral healthcare for youth.” This ties in with therapeutic treatment homes goals by increasing appropriate behavioral healthcare services available for youth. With an increase in availability for mental health respite, youth will access services when needed.

Second, this project will address “BH1: reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced, such as ii. Community supports in the community to normalize behavioral health issues.” GOBHI will work with the community to increase awareness of behavioral health challenges and will train community members to provide therapeutic care to children with behavioral health needs. This normalizes mental health struggles and creates better support all around.

Third, this project will focus on “BH3: increase mental health and substance use screenings, services, referrals, and peer and parent support; iv. Lack of mental health services for those not in crisis.” While GOBHI’s therapeutic respite care program can support crisis respite, the primary goal is to provide proactive preventative intervention. This service should provide respite to youth not in crisis to help them learn skills and reduce the need for crisis respite, or out of home full-time placements or higher levels of care.

Finally, this project addresses outcome “BH6: behavioral health funded and practiced with equal value and priority as physical health; i. number of mental health providers (skilled respite providers) and ii. Preventative behavioral healthcare.” GOBHI is looking to increase the amount of respite providers and provide preventative healthcare for youth to avoid higher levels of care and out of home placements. With additional resources, more youth can be served, and this supports the community and health care.

Risks/Challenges

There are risks with any project. GOBHI has identified a few risks that could affect the project. The first risk can be found in any community, and that is the challenge of recruiting new foster homes. Opening one's home up to a child - specifically a child with challenging behaviors - is a big ask. GOBHI has identified many ways to support foster families and is confident in their ability to engage families in feeling comfortable in opening their

homes. The specialized training, individualized support from GOBHI Regional Child Placing Coordinators, and 24/7 crisis support that GOBHI provide are a few key ways the program structure provides a welcoming, supportive on-ramp to families considering providing care. Program staff complete thorough assessments of families in the certification process. This assessment is mutual, because it includes an extensive dialogue with applicants to highlight family strengths, address questions and concerns and develop a plan providing care. To aid families in their comfort levels, GOBHI performs a matching protocol for each placement and respite request. That entails GOBHI staff identifying whether the home has the skill and capability to support the youth. Families always are provided the option of saying no to a referral they do not feel they have the skill to support. In addition, GOBHI will offer monetary incentives to families that will become certified to support this project and IHN-CCO youth.

In addition, there is inherent risk in the certification process in that the agency cannot control the timeline and pace of applicants and certain procedural requirements (such as the processing of background checks) as they move through the certification process. GOBHI mitigates this by offering a flexible certification process that allows families to complete tasks as they are able and without being tied to a strict order of tasks. For example, families may apply and attend group training right away, or they may begin with self-paced documentation of self-paced online training requirements and attend group training later. This allows families to progress through the process and avoid undue delays.

Another challenge is hiring. GOBHI is looking to expand the program into Linn, Benton, and Lincoln counties, which means increasing workloads for current staff and bringing on additional staff. Recently there have been increased challenges in finding qualified staff to fill vacancies. GOBHI recently received another grant specifically for motivating staff. GOBHI will use this to offer an incentive for hiring and a higher incentive for bilingual staff to encourage bilingual staff to apply. GOBHI will reach out to organizations such as Oregon State University, Portland State University, and University of Oregon to post about open positions to increase interest. In addition, GOBHI offers an above-market benefits package that may further incentivize candidates.

Along with the other risks identified, COVID-19 has proven to be an unexpected challenge over the last 16 months. GOBHI has had to change its processes and strategies, moving to virtual engagement strategies, services and support. Now, with communities re-opening, GOBHI has resumed in-person services. GOBHI has been actively involved in the communities it works with. Being able to resume in-person meetings, recruitment, and training will allow the organization to thrive and connect more easily in the communities it serves.

The last risk identified is not having referrals of youth that need services. GOBHI is already actively working with agencies in these communities to ensure that youth are being referred. GOBHI has made it a priority in the goals set for this project to increase referral sources. This means that GOBHI will address this risk from the first moment. In addition, GOBHI will continue to work with already-established partner agencies currently to ensure that they maintain the referrals they are submitting.

Key Persons

Project Lead:

The identified project lead for the Therapeutic Treatment Homes implementation is Katelyn Hershberger. Katelyn is a Program Manager for GOBHI's Therapeutic Foster Care Program and has over 7 years of experience providing services to youth with intense behavioral needs as both a direct care staff and in a manager role. Katelyn has completed graduate programs in Infant and Toddler Mental health, Psychology and is completing a Project Management certification. Katelyn handled recruitment and development in Columbia County, which now maintains almost ¼ of the foster homes involved with GOBHI. Katelyn is directly responsible for providing supervision to the Regional Child Placing Coordinator and the Intake Specialist. Katelyn will collect and maintain data for this project, as well as take part in meetings, appointments, and recruitment efforts in Linn, Benton, and Lincoln counties.

Regional Child Placing Coordinator:
GOBHI will hire to fill this position upon award of this grant. The qualifications for this position are that the candidate must have a bachelor's degree in a helping profession (psychology, social work, sociology) and they must also have two years of experience in the care and treatment of children or youth. Or, they may have a master's degree in a helping field and one year of experience. GOBHI is looking to hire a candidate that is bicultural or bilingual. This candidate will need to be flexible and able to work independently. This position handles recruitment and certification of new foster homes in the region, developing partnerships with the proposed communities, and supporting the youth that are placed in these homes for respite or full-time placements.

Training Specialist
GOBHI is currently hiring for this position, as the current team member in this role is transitioning out. The qualifications for this position are that the candidate has a bachelor's degree and two years of experience in the care and treatment of children or masters and one year of experience. This person must also have at least one year of experience in a training role. This candidate will be certified or will become certified to train in Collaborative Problem Solving through Think: Kids and Verbal Intervention through the Crisis Prevention Institute. While this position is being refilled, GOBHI Sr. Program Manager Kate O'Kelley, is assuming these duties. Kate has 13 years of experience in Oregon's therapeutic foster care system. She has a Masters in Psychology and is a Certified Trainer in Collaborative Problem Solving with Think:Kids. Kate will train all foster parents that will be interested in becoming certified to provide care for this project.

Intake Coordinator
The identified person for this role is Andrea Lockner. Andrea has worked in a variety of roles involving the care and treatment of children and has worked for GOBHI's Foster Care team for over six years. Andrea has a bachelor's degree in Public Health with a focus on Community Action and Education and a certification in prevention specialty. Andrea handles all intakes of full-time and respite youth into GOBHI's therapeutic foster care programs. Andrea reviews all referrals and coordinates with providers to ensure the correct documentation is received. Andrea supports staff, families, and treatment providers in ensuring that all youth's needs are met while at respite. Andrea will be responsible for training the mental health agencies in completing the referrals and will coordinate all mental health respite placements of IHN-CCO youth.

Pilot Timeline

GOBHI plans to utilize a quarter timeline system with an outline of four quarters for the year 2022.
Quarter 1:
- GOBHI will continue with already established social media recruitment strategies including but not limited to utilizing the strategies and infrastructure in Foster Plus campaign.
- Hiring for full-time employee in this region will be conducted.
- GOBHI will connect with current providers that have been referring youth and will set up training with these agencies to improve the referral process and engage the community in understanding this new resource.

Quarter 2:
- Certification and training of homes recruited in previous quarter will occur.
- Begin targeted recruitment in community.
- Develop connection with additional community mental health agencies and begin partnerships for respite referrals.

Quarter 3:
- Two homes will be certified by this quarter.

- Training and certification of foster homes will continue.
- Respite youth can begin to be placed in these two homes.
- Engage community organizations in collaboration of recruitment, including but not limited to system of care, educational systems, Oregon Department of Human Services, mental health organization, religious organizations, and other social service organizations.
- Host two in-person recruitment events.
- Sustainability discussions occur.

Quarter 4:

- Two additional homes will be certified this quarter.
- Respite youth will be placed in these homes.
- Continued engagement and recruitment efforts.
- Training and certification of foster homes will continue.
- Planning for ongoing sustainability implemented.
- Data aggregated for post-reporting.

Sustainability Plan

GOBHI knows that similar efforts have been attempted in the community previously by another organization. GOBHI is confident that GOBHI's model will allow for success in the certification and retention of foster homes and an increase in the youth being referred and served through the respite program. GOBHI is unique compared to other agencies that provide foster care services because it does not operate out of brick and mortar. All of GOBHI's foster care work is done in the community or from remote work locations. This allows GOBHI to use program resources to provide for their employees, foster families, and the community without having to dedicate to costly overhead expenditures. Infrastructure is already in place to support program functions, regardless of location. GOBHI also has other avenues of business that provide financial security, which support continuation of services once a grant has ended. For the Therapeutic Treatment Homes project, once foster homes are developed in a community, all daily costs are supported through services provided through the contracts held through ODHS (Oregon Department of Human Services) or the CCO's (Coordinated Care Organizations).

This means that after implementation in a community, GOBHI can sustain employment, recruitment, and certification needs actively with the revenue generated from services provided in homes that have been developed. There are no programs in the community aside from GOBHI attempting to support providing certified homes for mental health respite. ODHS is in these communities and Every Child, and they provide full-time foster care homes and non-trained respite homes. These services are only available for youth in foster care. In Lincoln County, SAFE Families provides temporary respite care for families that are experiencing a crisis and need a place for their child to go without involving child welfare. These services are primarily for families experiencing a hardship and the families are not trained to provide mental health supports to the youth in their home. GOBHI is meeting an unmet need in the community by providing full-time, crisis, and temporary homes for youth with mental health and behavioral health needs. Once established, GOBHI will meet this community need as well as grow as a program; which creates more opportunities for youth, families, and community partners.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Currently GOBHI has two certified foster homes in Linn,Benton, or Lincoln counties	Binti certification and tracking platform	Triple homes- Increase from two homes to six homes	December-22
Currently GOBHI has partnered with three mental health agencies in Linn, Benton, or Lincoln counties.	Binti referral tracking platform	Partner with two additional mental health agencies	December-22
GOBHI is not currently tracking the number of IHN-CCO youth that are being provided respite	Binti child placing platform and interanl billing documentation	GOBHI will serve 10 unique IHN-cco youth for respite.	December-22
GOBHI is not currently tracking the type of youth being served in Linn, Benton, or Lincoln counties.	Binti child placing platfrom and internal tracking documents	75% of youth served in the therapeutic respite program in Linn, Benton, and Lincoln counties will be IHN-CCO youth.	December-22

Pilot: Therapeutic Treatement Homes

Pilot Start Date:	1/1/2022	Pilot End Date:	12/31/2022
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Recruitment efforts including (speaking engagements, setting up events, public events, and meetings)		$50,000.00	$25,000.00
Certification requirements (interviews, documentation, safety checks, and other needed duties)		$50,000.00	$25,000.00
Review referrals		$50,000.00	$5,000.00
Training mental health agencies		$40,000.00	$10,000.00
Case management (arranging respite, coordinating with providers, skill building with full time youth, coordination of care with providers)		$50,000.00	$20,000.00
Crisis response to youth and families		$10,000.00	$10,000.00
Review respite documentation		$10,000.00	$5,000.00
	Subtotal Resource Costs	**$260,000.00**	**$100,000.00**
Materials & Supplies			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$0.00**	**$0.00**
Travel Expenses			
Local travel for purpose of recruitment, certification, and in person-services.		$8,000.00	$8,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$8,000.00**	**$8,000.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Training for staff (CPS, CPI, Relias, etc.)		$1,500.00	$1,500.00
Trauma informed training, Collaborative Problem Solving training, crisis de-escalation, impact of trauma, and other training for prospective foster families		$6,500.00	$6,500.00
		$0.00	$0.00
	Subtotal Training & Develop	**$8,000.00**	**$8,000.00**
Other Budget Items			
Recruitment and marketing (Printing of materials for recruitment, media marketing of need, other materials required for holding events)		$10,000.00	$10,000.00
Foster parent incentive (Incentive for respite providers to specifically serve IHN-CCO youth)		$4,000.00	$4,000.00
Staff Hiring Bonus (Hiring bonus for staff who are bilingual and/or bicultural)		$5,000.00	$0.00
Recuitment incentive (Recruitment incentive for families that are referred by community partners)		$2,000.00	$0.00
	Subtotal Other	**$21,000.00**	**$14,000.00**
Total Direct Costs	**Rate (%)**	**$297,000.00**	**$130,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
Total Project Budget		**$297,000.00**	**$130,000.00**

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