Agenda
Delivery System Transformation Committee

July 21, 2022 4:30 – 6:00 pm
Online Click Here: Click here to join the meeting
Phone: +1 971-254-1254
Conference ID: 869 236 043#

1. Welcome and Introductions	**Renee Smith,** Family Tree Relief Nursery	**4:30**
2. Transformation Update	**Charissa Young-White,** IHN-CCO	**4:45**
3. Small Request for Proposal Scoring	**Charissa Young-White,** IHN-CCO	**4:55**
4. Small Request for Proposal Funding Recommendation Decisions	**Renee Smith,** Family Tree Relief Nursery	**5:05**
5. Wrap Up • Announcements • Next Meeting: August 4, 2022	**Renee Smith,** Family Tree Relief Nursery	**5:55**

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

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
ARCC	Arcoíris Cultural	Olalla Center	Lincoln	1/1/22	12/31/22
CCP	CommCard Program	The Arc of Benton County	Benton, Lincoln, Linn	1/1/21	12/31/22
CDP	Community Doula Program	Heart of the Valley Birth & Beyond	Benton, Lincoln, Linn	1/1/21	12/31/22
CRPS	Culturally Responsive Peer Services	Family Tree Relief Nursery	Benton, Linn	1/1/22	12/31/22
CSUP	Culture of Supports	North End Senior Solutions	Lincoln	1/1/21	12/31/22
DBHS	Decolonizing Behavioral Health Supports	Corvallis Daytime Drop-in Center	Benton, Lincoln, Linn	1/1/22	12/31/22
DDDW	Developing a Diverse Dental Workforce	Capitol Dental Group P.C.	Benton, Linn	1/1/22	12/31/22
DEC	Disability Equity Center	Disability Equity Center	Benton, Lincoln, Linn	1/1/21	12/31/22
DSDP	Depression Screenings in Dental Practices	Advantage Dental Services	Benton, Lincoln, Linn	4/1/22	12/31/22
EASYA	Easy A	Old Mill Center for Children and Families	Benton	1/1/22	6/30/23
HHT	Healthy Homes Together	Albany Partnership for Housing, Family Tree Relief Nursery	Linn	1/1/21	12/31/22
HUBV	Hub City Village	Creating Housing Coalition	Linn	1/1/20	12/31/22
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton, Lincoln, Linn	1/1/19	12/31/22
MHHC	Mental Health Home Clinic	SHS, Linn County Mental Health, C.H.A.N.C.E.	Linn	1/1/21	12/31/22
NAMRX	Namaste Rx	Namaste Rx LLC	Benton, Lincoln, Linn	2/1/22	12/31/22
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/20	12/31/22
OBFY	Overcoming Barriers, Foster Youth	CASA-Voices for Children	Benton	10/1/21	12/31/22
PBHT	Pathfinder Behavioral Health Transformation	Pathfinder Clubhouse	Benton, Lincoln, Linn	1/1/22	12/31/22
PCPT	Primary Care Physical Therapy	Lebanon Community Hospital	Linn	1/1/22	12/31/22
PEERC	Peer Enhanced Emergency Response	C.H.A.N.C.E.	Linn	1/1/22	12/31/22
PSHR	PSH Respite and Housing Case Management	Corvallis Housing First	Benton	1/1/22	6/30/23
PSLS	Pain Science Life Stories	Oregon Pain Science Alliance	Benton, Lincoln, Linn	1/1/22	6/30/23
PUENTE	PUENTES: Improving Language Access and Culturally Appropriate Messaging	Casa Latinos Unidos	Benton, Linn	10/1/21	12/31/22
TTH	Therapeutic Treatment Homes	Greater Oregon Behavioral Health Inc.	Benton, Lincoln, Linn	1/1/22	12/31/22
WINS	Wellness in Neighborhood Stores	OSU, Linn County Public Health	Linn	1/1/20	12/31/22
WVC	Women Veterans Cohort	Red Feather Ranch	Benton, Lincoln, Linn	10/1/21	12/31/22
Workgroups					
COWG	Connect Oregon Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/1/21	present
HEWG	Health Equity Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/1/15	present
SDoHWG	Social Determinants of Health Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	11/16/17	present
SUSTWG	Sustainability Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	1/26/22	present
THWWG	Traditional Health Workers Workgroup	InterCommunity Health Network CCO	Benton, Lincoln, Linn	5/21/13	present

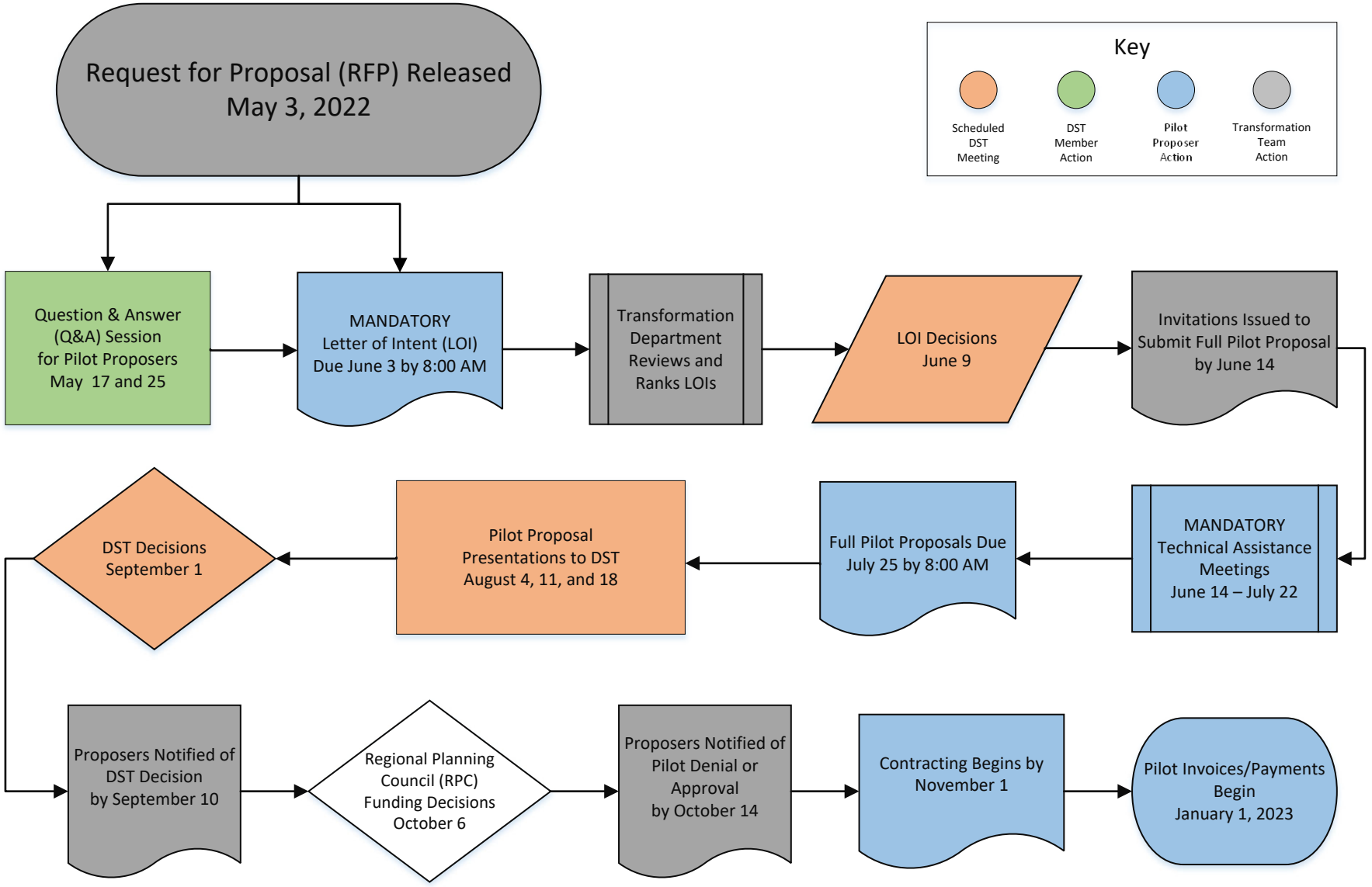
Delivery System Transformation Committee (DST) 2022 Calendar

January	6	Strategic Planning: Overview and Charter				
	20	Strategic Planning: Roles and Responsibilities				
February	3	POH	Strategic Planning: Priority Areas/Message of DST			
	17	HVOST	WtoS	Strategic Planning: DST History/Stakeholders		
March	3	BRAVE	ENLACES	Strategic Planning: Workgroups		
	17	LCCOR	Strategic Planning: Pilots through the Ages			
	31	Strategic Planning: Request for Proposal (RFP)				
April	14	RFP Decisions				
	28	SDoH WG	THW WG	HE WG	SUST WG	CO WG
May	12	Board Update	Workgroup Discussion			
	26		Review Proposal Slides			
June	9	Letter of Intent Decisions				
	23	Board Update	Pilot Updates			
July	7	Pilot Updates				
	21	Small RFP Decisions				
August		**Regional Planning Council for Small RFP Final Approval**				
	4	Large RFP Proposal Presentations				
	11	Large RFP Proposal Presentations				
	18	Large RFP Proposal Presentations				
September	1	Large RFP Decisions				
	15	Oregon Center for Health Innovation				
	29	Workgroup Updates				
October		**TENTATIVE Regional Planning Council for Large RFP Final Approval**				
	13	Oregon Center for Health Innovation				
	27	Board Update				
Nov	10					
Dec	8	Board Update				

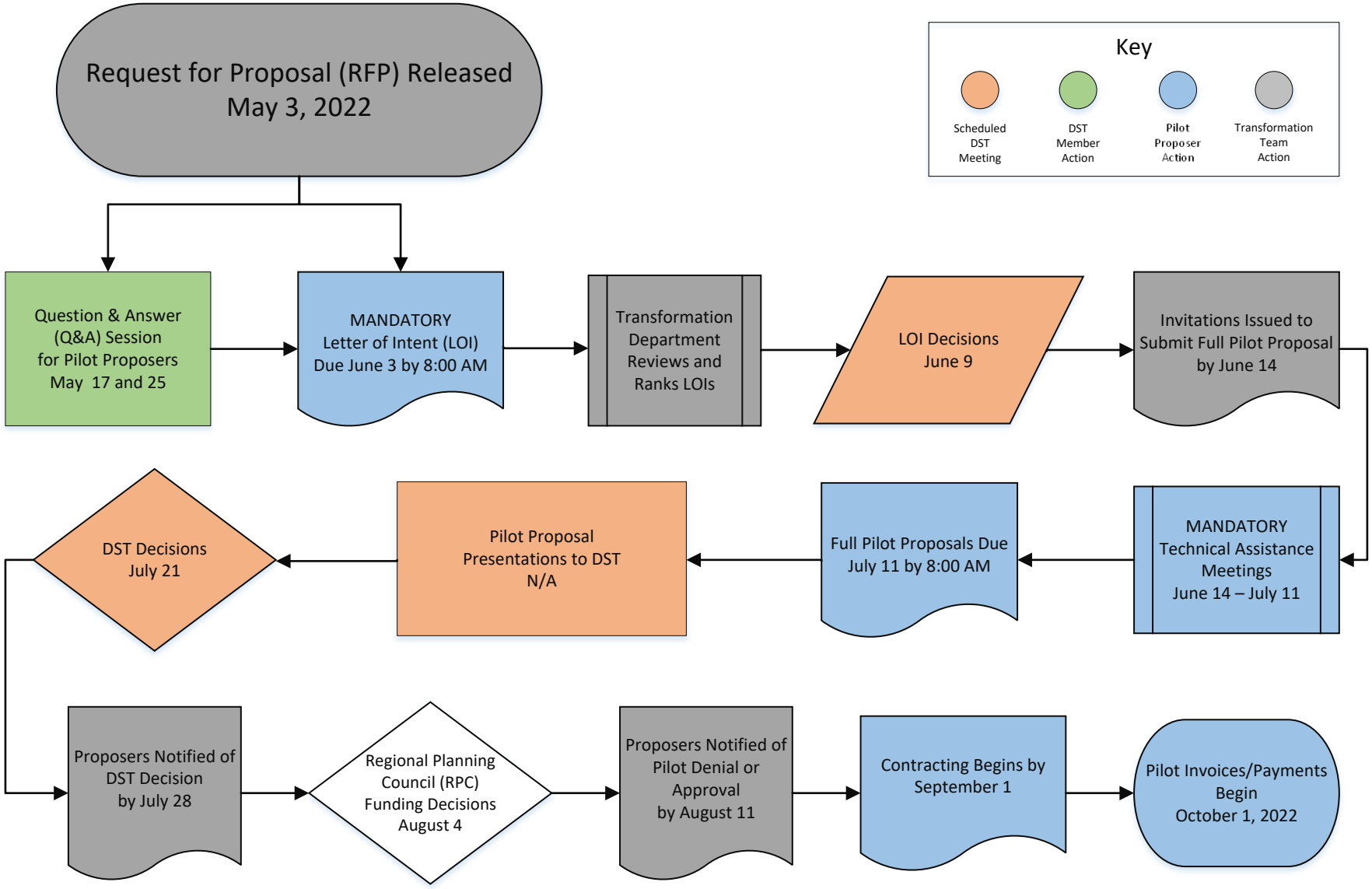
KEY

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

IHN-CCO DST Request for Proposal Timeline – Large RFP



IHN-CCO DST Request for Proposal Timeline – Small RFP



Minutes
Delivery System Transformation Committee (DST)
July 7, 2022 4:30-6:00 pm
Microsoft Teams (Online)

Present			
Chair: Renee Smith	Bettina Schempf	Caleb Larson	Charissa Young-White
Allison Hobgood	Bryan Decker	Beck Fox	Katelyn Hershberger
Alicia Bublitz	Carissa Cousins	Dena Everett	Jan Molnar-Fitzgerald
Dick Knowles	Emma Chavez	Eric Vinson	Erin Gudge
Georgia Smith	Jay Yedziniak	Melissa Isavoran	Stacey Bartholomew
Molly Johnson	Kami Beard	Mica Contreras	Laurel Schwinabart
Katie Gregory	Karen Weiner	Marie Long	Kevin Ewanchyna
Larry Eby	Melissa Cheyney	Allison Myers	Maritza Leon Gutierrez
Nancy Vargas	Paige Jenkins	Priya Prakash	Shana Palmer-Whalen
Rebekah Fowler	Robert Long	Rolly Kinney	Ricardo Contreras
Roslyn Burmood	Candace Russo	Sadie Peterson	Shannon Rose
Ruby Moon	Laura Estreich	Tristin Armstrong	Jeannette Campbell
Mary Ann Wren	Sara Jameson	Andrea Myhre	Sara Jameson

Transformation Update

- The proposals for the Small Request for Proposal funding are due Monday, July 11, 2022 at 8 am. IHN-CCO Engagement & Transformation will email them in a separate email with survey link. Committee members will have a week to fill out the scorecards and complete. Decisions will be made at the July 21, 2022 meeting.
- General reminder that the first quarterly Connect Oregon Workgroup is in August 2022.

Pilot Progress Report Updates

- Depression Screenings in Dental Practices
  - Implementing use of a PHQ9 (Patient Health Questionnaire 9) form during patient intake process. Purpose is to help create and bridge a gap between oral health and behavioral health. Allows for a referral pathway to begin where one has not previously existed.
  - Goal is to foster this referral pathway, destigmatize Mental Health and to broaden availability for Mental Health services. Already have had 19 new referrals.
  - Created a strong partnership with IHN-CCO Behavioral Health team.
  - Current need for readily available crisis contact handouts.
- Pain Science Life Stories
  - Intend to build a website that will make personal pain journeys available for others. Currently produced 7 of the 15 video story resources that will be featured on the website.
  - Current difficulties in communications while working with web producers. Challenges include concerns about building a website based on and for adult learning.

  - –To Do: IHN-CCO Engagement & Transformation will facilitate a conversation with pilot champions that are working on websites.
- PUENTES
  - Purpose is to improve language access and culturally appropriate messaging. Focus on how written messaging is being received by the Latinx community in Benton, Linn, and Lincoln counties.
  - Currently working on recruiting and then will be conducting data collection with focus groups. Three focus groups, one in each county. There will be recruitment for rural perspectives, as well as one focus group online with Latinx youth (9th-12th Grade) combining the three counties.
  - Additional focus on the interactions with the Latinx clients and Samaritan Health Services.
- Primary Care Physical Therapy
  - Held an interdisciplinary conference in collaboration with George Fox regarding Patient Centered Care for the Complex Patient. There has now been ask for this to be an annual conference. They have already seen over 3,200 patients in the Primary Care Physical Therapy setting.
  - Motivational factor in seeing patients in Primary Care, is taking obstacles away from the member, so that they can have the relief of hardships. This could include the relief of saving time, hardship in rides or gas usage, not having to miss work, and/or being able to make an appointment right away.
  - The care is patient centered, allows the provider to give better tools upfront that the member/patient needs to handle their concerns. Allows for the patient to lead with their needs.
- Overcoming Barriers, Foster Youth
  - Current focus on expanding services and expanding to other sub projects. Three programs were created after identifying needs.
    - Independent Living Program (ILP) – help children gain life skills and become advocates for themselves.
    - Trauma Informed Tutoring Program – help with success in the academic settings.
    - Cultural Advocates – help navigate the foster care system from racial and cultural inequality, mental disparities, and mentoring services.
  - Challenges at this time with ILP and getting youth involved with the programs. Although, this has really given the opportunity to really individualize to each child that is involved.
- Therapeutic Treatment Homes
  - Serving youth in the Mental Health system. To qualify for respite, must actively be working with Mental Health, therapy, med management.
  - Currently have 7 certified homes, with 3 additional homes in the certification process. Actively working with Linn County Mental Health and continue to get referrals.
  - Went to PRIDE and had 35 families express interest, currently following up on those.

- Challenges include working with therapists that are already overwhelmed. Also, hiring challenges but have an offer that is hopefully going out soon.

- Disability Equity Center (DEC)
  - DEC is for disabled people, by disabled people. Used to amplify voices, for people to connect and to create and empower. Focus on disability and the future.
  - Current goals include extending the grant to 24 months. Offering a lot of disability justice and trainings to other organizations.
  - Currently advocating directly at local level, for basic needs, holistic health and have graduated 12 youth from a sexual health and dating group.
  - Project Amplify will help launch disabled creators in their community, with a focus on black, indigenous, people of color (BIPOC).

Community Investment Collaboratives Brief

OHA has proposed the development of Community Investment Collaboratives (CIC) to distribute both federal and CCO funds to local equity based projects decided on by the CIC. The Statewide oversight Committee will develop process and outcome measures with the community; this is proposed to be done with a Collective Impact Framework.

In 2020 as part of Governor Brown's pledge to end health inequities by 2030 HB 3353 was passed requiring CCOs to increase investment in programs that improve Health Equity and demonstrate increased accountability to communities. This includes CCOs spending 3% of their population health budget on health equity investments with 30% of that going to a Community Investment Collaborative for community health equity investments. Currently OHA estimates spending $575M of funds freed up by Designated State Health Programs (DSHP) (in addition to the 3% of CCO funds) over the 5 year period as such:

- $7.5M to OHA to oversee and implement and support CICs
- $138M in infrastructure and capacity building funds for an estimated 30 CICs ($4.6M per CIC over 5 years)
- $334.5M statewide for Health Equity Grants through CICs to communities. No information on how each CIC will be awarded funds

IHN-CCO's Engagement and Transformation maintains such a group, the Delivery System Transformation Committee (DST), a community led system for investments in social determinants of health and equity, that would be ineligible to serve this role because of it having been convened by IHN-CCO.

Potential impact on the DST:

- Centralizing organization could remove local flexibility despite intentions
- Could inadvertently replace an existing and well functioning system with one that lacks the necessary infrastructure and will need significant time and investment to establish itself to effectively disburse funds and support local organizations in their projects
- Established effective programs could experience disruptions in funding and/or program closures during the development of this system
- Statewide investments can have disparate impacts on rural communities due to a focus on metro area populations
- The current plan does not include concrete steps to ensure continuation of capacity/administrative funding after the 5 years—it is expected that 2024-2027 will be the years of CIC investment
- Require significant funding to OHA to manage the CICs—funding for the local administrative burden is unclear beyond initial funding

Potential steps:

- Compose partner letter to regulatory agencies (CMS & OHA)
- Be prepared with a proposal that establishes the DST as clearly within the CIC model and defines possible changes to meet OHA requirements

2022 IHN-CCO DST Pilot Proposals Crosswalk: Small RFP

		Amplifying Voices	**Health Navigation Station**	**The Health Collective**	**Transitioning into a Home**	**Walk 'n Roll**
Pilot Champion		SHS ArtsCare Program	St. Martin's Episcopal Church	Samaritan Lebanon Rehab	Furniture Share	Newport 60+ Activity Center
Budget		$49,000	$9,900	$29,700	$52,000	$52,250
Counties	Benton					
	Lincoln					
	Linn					
CHIP Areas	Access					
	Behavioral Health					
	Child & Youth					
	Healthy Living					
	Maternal Health					
	SDoH & E					
DST Priority Areas	Addressing trauma					
	Technology disparities					
	Bilingual/bicultural workforce					
	Innovative housing					
	Language access					
	Oral health integration					
	Pay equity					
	Reengaging the community					
	Rural Impact					
	Subpopulations					

IHN-CCO DST Pilot Proposal Heatmap 2022 Small RFP

	Transitioning into a Home	Walk 'n Roll	The Health Collective	Health Navigation Station	Amplifying Voices
Transformational	7.07	7.08	7.06	7.06	7.03
Health Equity	7.55	7.62	7.45	7.48	7.40
Health Improvement	7.21	7.08	7.13	7.12	7.03
Improved Access	7.28	7.27	7.29	7.33	7.29
Need	7.21	7.31	7.13	7.09	6.94
Outcomes	7.10	7.04	7.06	7.06	6.91
Total Cost of Care	6.97	7.00	6.94	6.85	6.77
Resource Investment	7.97	7.92	7.90	7.91	7.89
Priority Areas	7.48	7.58	7.42	7.39	7.31
Financial Sustainability	6.59	6.58	6.45	6.45	6.46
Replicability	7.48	7.50	7.39	7.33	7.34
Depth of Support	7.41	7.35	7.29	7.18	7.11
# of Raters	7	7	7	7	7
Mean Score	7.28	7.28	7.21	7.19	7.12
Sum of Mean Scores	87.31	87.31	86.52	86.27	85.49
Rank	1	1	3	4	5

Standard Deviation of Rater Criteria Scores					
Transformational	0.16	0.15	0.16	0.17	0.20
Health Equity	0.32	0.39	0.22	0.26	0.17
Health Improvement	0.02	0.15	0.10	0.11	0.20
Improved Access	0.05	0.04	0.06	0.11	0.06
Need	0.02	0.08	0.10	0.14	0.28
Outcomes	0.12	0.19	0.16	0.17	0.31
Total Cost of Care	0.26	0.23	0.29	0.38	0.45
Resource Investment	0.73	0.69	0.67	0.68	0.66
Priority Areas	0.25	0.35	0.19	0.17	0.09
Financial Sustainability	0.64	0.65	0.77	0.77	0.77
Replicability	0.25	0.27	0.16	0.11	0.12
Depth of Support	0.19	0.12	0.06	0.04	0.11

Amplifying Voices

Backbone Organization: Samaritan Health Services (ArtsCare Program)

Billing Address: 3600 NW Samaritan Blvd., Corvallis, OR 97330

Sites: Newport and Lincoln City, Oregon

Counties: Lincoln (beginning year one - pilot), Linn (beginning year two), Benton (beginning year three)

Priority Areas:

- Addressing trauma, including environmental.
- Reengaging the community in personal health and community resources.
- Rural community impact.
- 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.

i. Behavioral health stigma within the community

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.

ii. Peer delivered education and support

iv. Lack of mental health services for those not in crisis

CY1: Increase the percentage of children, youth, and families who are empowered in their health.

i. Utilization of advocacy services and supports

HL1: Increase the percentage of Members who are living a healthful lifestyle.

v. Stress

vii. Social supports, such as family, friends, and community

Pilot Contacts	Name	Email
Primary	Erin Gudge	egudge@samhealth.org
Proposal	See above	
Contracting	See above	
Financial	See above	
Reporting	See above	

Executive Summary

The Amplifying Voices pilot project focuses on the process of creating art as a method of improving mental health outcomes for teens in the BIPOC, LGBTQIA2S+, disabled and other historically underrepresented and underserved subpopulations in the coastal community. The project, delivered by ArtsCare in partnership with local artists, community partners and mental health workers, will give a platform and restorative dignity to these subpopulations through therapeutic self-expression and art. Participants will explore different artistic mediums while also exploring their emotions and engaging with the power of their voices.

The art experiences will focus on developing healthy coping and processing mechanisms that address the social-emotional aspects of mental health challenges that underserved groups of teens experience. Amplifying Voices seeks to help these teens find their voice, and then through the power of art and community, amplify those experiences to a larger audience. Additional components of the program include a social media campaign serving as a virtual megaphone to the teens' voices and a public artwork installation created by program participants, under the guidance of professional artist mentors.

Amplifying Voices Pilot Description

Pilot goals

The primary goal of Amplifying Voices is providing art-as-healing experiences to historically underserved teens in the Lincoln County area (expanding geographic reach in years two and three). There will be tangible outcomes of this pilot, including a public art installation. The public art piece will be determined by the project participants, with guidance from professional artists and program mentors. The fundamental goal of this program is the experience and empowerment the participants will gain through their experiences, improved self-reported mental health and community building.

An additional focus area in this pilot project is creating a digital and social media awareness campaign to personal stories of the participants and the process of making art — using video, photos and testimonials. The campaign seeks to educate a broader cross-section of Lincoln County (and beyond) about the personal experiences of these teens regarding identity and mental health and the difficult experiences, but also seeks to demonstrate how inspiring and aspirational these stories are. The social media campaign will seek to reduce stigma and increase the empathetic response to mental health issues and to tell the individual participant's stories and experiences in the program, but also in life. This pilot will launch a continuing program that will expand across the tri-county area that Samaritan serves.

Program activities

This dual-located program will have monthly workshops in both Newport and Lincoln City, Oregon, and the program will also serve rural outlying areas around each city. Each workshop session will be two hours long. Themes will be introduced for each session, with participants gaining knowledge about the process of making art, expanding their creative thinking and amplifying their own voice through their art. Professional artists with special training in trauma-informed care will lead these sessions. The themes will be linked to the medium being explored in the sessions. The process of creation will be tied with concepts like: Processing how to reengage with the community as we emerge from the pandemic; How to build self-confidence and empower oneself to share experiences and perspectives; Coping tools for resilience and mindfulness. These concepts will be presented in tandem with art exploration in an integrated manner. Additionally, participants will be guided through methodologies to implement outside of the workshops for dealing with personal strategies for improving mental health.

Measuring outcomes

There are several metrics for measuring outcomes of this program. Program participation and attendance at each session is the first metric. Second, participants will be asked (not required) to fill out self-reporting screening surveys at intervals throughout the duration of the program using a standard screener (available in multiple languages). These reports will be reviewed by a licensed mental health professional

(MHP) and will only be available to the MHP group. That group will assess the data and provide a report of outcomes from these surveys. If individuals are identified as needing additional supports, these individuals will receive referral information to care providers and resources via contact from the MHP group. Providing resources to these individuals will have an impact on their health outcomes, as well as reduce the overall expenses for care by seeking to reduce need for emergent care. The artists and non-medical team members will not be involved in this process to protect individual privacy. All legal and HIPAA requirements will be followed carefully by all program leadership. Third, we will measure community attendance of the exhibit reveal, and ask for public comment in the form of email and other outreach measures to gather public response. Fourth, there will be analytics from the social media campaign to measure outreach outcomes.

Program partners

Samaritan ArtsCare will manage most of the work for this pilot project. The program manager will be tasked with all planning and administration, as well as community partnership development and outreach. In the first year of the program, ArtsCare plans to partner with several organizations in and around the Lincoln County area, including Project Bravery, Casa Latinos Unidos, the Lincoln County School District, Disability Equity Center and other agencies in Lincoln County that serve teens in the BIPOC, LGBTQIA2S+, disabled and other historically underrepresented and underserved communities. Additionally, the Samaritan Foundation, Samaritan social workers and local professional artists will be involved in the project in various capacities. The program will partner with the graduate medical education department during planning of the program to identify areas for potential advocacy and research. Licensed clinical social workers (or other mental health professionals) will be consulted with as the workshop curriculum is developed and will attend some sessions. ArtsCare will also work with local Samaritan Foundation directors to identify potential sustaining partners for the program. The Samaritan Marketing & Communications strategists will be tasked with developing and implementing the tactics for the social media campaign component of this pilot program. ArtsCare will contract professional artists who have received trauma-informed training and have experience working with and teaching teens.

ArtsCare also hopes to work with:

Benton and Lincoln County

- Lincoln County School District [outreach support]
- Confederated Tribes of the Siletz Indians [outreach support]
- Mid Willamette Trans Support Network [outreach support]
- Disability Equity Center [outreach support]
- Casa Latinos Unidos [outreach support]

Newport

- Newport, Toledo and Waldport High Schools (arts, resource and counseling staff members) [outreach support]
- Newport Public Library [outreach support]
- Project Bravery [outreach support]
- Arcoíris Cultural [outreach support and artists]
- Newport Cultural Center [artists]
- Oregon Central Coast PFLAG [outreach support]

Lincoln City

- Taft High School (arts, resource and counseling staff members) [outreach support]
- Driftwood Public Library [outreach support]
- Lincoln City Cultural Center [outreach support and artists]
- Artists' Studio Association [artists]

Promoting health equity and reducing health disparities

Lincoln County is ranked 27th among Oregon counties in health outcomes and 33rd for health factors according to the 2022 County Health Rankings (countyhealthrankings.org). 20% of Lincoln County children live in poverty and might not otherwise have access to art-as-healing opportunities. By offering this program to the coastal community, Amplifying Voices will increase access to healing art resources to an underserved sector. Working with community partners, the program will conduct outreach to give direct and personal invitations to participants.

Teens are a particularly vulnerable population, feeling the effects of the stigma of having mental health difficulties and/or belonging to a subpopulation that is underrepresented or left out of larger community conversations. The pandemic has resulted in isolation and missing out on developing interpersonal communication and self-expression. Amplifying Voices will help these teens reengage with their communities and form a new community of shared experiences. Mentors and professional artists will work to show these teens their inherent ability to communicate through visual and performance (music) art. Self-advocacy in communication is key, especially in health care. The participants will have increase confidence in being advocates for their health care needs.

Additionally, having increased access to mental health professionals throughout the pilot program experience will benefit program participants. There is a continual shortage of mental health providers, especially in rural communities. A recent search for mental health providers accepting IHN-CCO insurance for teen patients in Lincoln County resulted in only two providers.

Roles, responsibilities and experience

Program manager – program design and administration, scheduling, purchasing, advertising, community outreach

Artists and mentors – plan, prepare and lead workshop sessions

MHP – develop research plan, review self-reporting surveys and analyze data

Community partners – sharing advertising of program, assistance with communication and outreach to potential participants

Digital marketing team – execution and analysis of social media campaign

Participants – attend sessions, participate, complete self-reporting surveys (not required), attend final exhibition, potentially present a personal testimonial at exhibition

Describe how members of the community will hear about your project

The program manager will initiate outreach to local community partners to help identify and reach out to potential participants. This is included in the budget under advertising costs and equity payments. Additionally, there will be digital and print ads as a call for participation. The program manager will reach out to local school districts to get information to students in traditional and alternative education programs. The social media campaign will be an additional manner through which the community will hear about the project. The Samaritan Marketing & Communications team will work in support of these efforts.

Potential risks and how to reduce and address them

Access to this program is key and will be increased by the availability of transportation and translation services for those in need. Budget has been identified to pay for transportation and translation services. Additionally, a need was identified to have this program located in both north and south Lincoln County locations, and the program design was altered from initial concept to meet this need.

Attendance will be a risk factor of this program. To serve participants, we need to ensure continued participation. One manner of address this risk is addressed by the foundational design of this program. While professional artists and program mentors will be guiding the project, it will be fundamentally determined by the participants. Collaboration and feedback are key to addressing some attrition concerns. Additionally, the goal is that participants will form a community of support for each other.

Privacy and legal concerns are a risk factor in any program that addresses health care. The artists and program leadership have received training on HIPAA and other legally-relevant areas. Ongoing training will be provided, as needed. Additionally, program participants will create a community agreement in the early phases of the program where they will determine their community rules of engagement and respect.

Sustainability plan

Innovative: Delivering mental health services in combination with art is a transformative methodology. Neuroscience research findings show artistic activities are known to reduce stress and promote mental well-being (see links at end of this section).

By incorporating self-reporting and access to MHP with artistic expression and community-building, this program is an innovative concept for care.

Scalable: In years two and three, the program is intended to expand to include Benton and Linn counties as well as continuing to serve in Lincoln County. By planning the same activities for each location, scalability and streamlining will not only reduce overall time spent in administrative efforts but will also reduce the material costs of the program.

Transferable: The goal of this program is to have success measurables that can be shared with a broad audience for implementation in programs nationally. The ArtsCare program manager is involved in a national organization of Arts in Health programs and will share the pilot program with other professionals in the field. Additionally, the learning opportunities (in the form of successes as well as areas of identified improvement) from this program can be transferred to other ArtsCare programs.

Sustaining program and funding continuance: Samaritan will pay all indirect costs of this pilot program, including planning and administrative costs (as is reflected in the budget). Samaritan will pay staff salary and expenses. Samaritan will pay for a portion of the initial supply costs for this pilot. Once the pilot success metrics are reported, ArtsCare will seek continued program funding through operational budget allocations from Samaritan administration and working with the Samaritan Foundation directors to identify and develop sustaining partnerships.

Other organizations with a vested interest: Samaritan has several internal groups who will have a vested interest (financially and otherwise) in this program in addition to ArtsCare, including research, graduate medical education and mental health providers. The support for program continuance will be improved by involving multiple departments in the program.

Links:

https://doi.org/10.1080/07421656.2006.10129531

https://www.tandfonline.com/doi/abs/10.1080/07421656.2001.10129450

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804629/

https://www.rtor.org/2018/07/10/benefits-of-art-therapy/

https://www.ncbi.nlm.nih.gov/books/NBK279641/

Budget

(See additional document)

Activities monitoring grid

(See additional document)

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Pilot implementation planning	Secure locations, determine schedules, hire local artists, purchase supplies, secure community partnerships	Program implementation	6/1/2023
	Participation	Engage community outreach for teen participants, visit and present to community groups for engagement	24 partipants in each location (48 total) at first meeting	9/30/2023
	Workshop series	Administration of workshop sessions, self-reporting opportunities, art creation, mentorship and development	Complete initial year of workshop sessions (10 sessions)	6/30/2024
	Public art installation planning and implementation	Determine art medium; identify location; plan timelines, budget etc.; final installation	Art installation completed	7/1/2024
	Create social media campaign	Interview participants, take photos/video, participant approval, ad creation, implementation and post-analysis	Key metrics analyzed	9/1/2024
	Research outcomes	Research group to identify area of research, create research proposal and have approval for research, conduct research, report back results	Poster presentation, publication of outcomes	8/31/2024 (date may change)
	Program expansion	Planning and implementation for expansion into Linn and Benton counties in 2024 and 2025.	Launch program in tri-county area	09/01/2024 (launch)

Pilot: Amplifying Voices

Pilot Start Date:	**9/1/2022**	**Pilot End Date:**	**8/31/2024**
Direct Costs		**Total Cost**	**Amount Requested***
Services (includes artist pay, staff salary, mental health professional fees and administrative costs)		$36,000.00	$17,000.00
Supplies (includes workshop session supplies for up to 48 participants - 24 in each location - for 11 workshops, art installation costs, other consumable and reusable		$35,000.00	$25,000.00
Access (includes translation and transportation services, facility fees and equity payments for partners)		$6,500.00	$6,500.00
Training (includes trauma-informed training for artists and program mentors)		$500.00	$500.00
Total Direct Costs	**Rate (%)**	**$78,000.00**	**$49,000.00**
Indirect Expenses	10.00%	$7,800.00	$0.00
Total Project Budget		**$85,800.00**	**$49,000.00**

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

Piloting a Health Navigation Station

Backbone Organization: St. Martin's Episcopal Church
Billing Address: 257 E. Milton St. Lebanon, OR
Site: Lebanon
County: Linn
Priority Areas:
· Providing digital technology and guidance to reduce health disparities
· Subpopulations of IHN-CCO members who experience health disparities especially lack of digital access to health care resources

Health Navigation Station (HNS) Outcomes

- **Access to Health1: Outcome 1:** Increase the percentage of Members who receive appropriate care at the appropriate time and place.
- **Access to Health2: Outcome 2:** Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers and that they are effectively engaged in their care.
- **Behavioral Health 4: Outcome 4:** Improve care for Members experiencing mental health crisis.
- **Social Determinants of Health2: Outcome 2:** Increase the percentage of Members who have access to affordable transportation.
- **Social Determinants of Health4: Outcome 4:** Increase health equity / reduce disparities of Members without digital access to health resources.

Pilot Contacts	Name	Email
Primary	Sara Jameson	stmartinslebanon@gmail.com
Proposal	Sara Jameson	stmartinslebanon@gmail.com
Contracting	Sara Jameson	stmartinslebanon@gmail.com
Financial	Sara Jameson	stmartinslebanon@gmail.com
Reporting	Sara Jameson	stmartinslebanon@gmail.com

A. Executive Summary

The Health Navigation Station kiosk at St. Martin's Church will provide underserved populations in rural East Linn County, especially Members and low-income and unhoused populations, with greater technological equity to improve their health by giving them the ability to navigate access to health services they need and are eligible for, through a dedicated phone, computer, guest Wi-Fi, printer, mail, and coaching so they can make and track appointments, check email from providers, research best practices for their personal health including side-effects of medications they have been prescribed, access transportation, etc.

ACCESS: We plan for the station to be available Monday-Wednesday-Friday 10 am to noon after our free breakfast, or 6 hours a week (could expand to 9 hours as demand grows). Although the kiosk will include a phone, we already provide phone charging in the breakfast area.

This pilot project is TRANSFORMATIONAL because it addresses NEED, EQUITY, BETTER ACCESS TO CARE and therefore BETTER HEALTH OUTCOMES / IMPROVEMENT, and, if successful, could be easily REPLICATED elsewhere.

Population to be served includes Members and potential Members in Lebanon and the surrounding community who have limited access to digital communications (either inadequate equipment and/or skills, such as those who tell us they have to wait for a friend or family member to help them go online). The number of Linn County residents living in poverty is higher than the national average, especially among women who tend to have lower access to / skills with / digital access to health care. Due to the pandemic, health care has tended away from personal interaction to online access, increasing disparity of access to care.

Although Lebanon has a few public computers at the Lebanon City Library and the Lebanon Senior Center, there is little technical assistance to guide folks for success to the sites they need. Our pilot includes COACHES / HEALTH NAVIGATORS to help people learn how to use the equipment and online resources, thereby empowering them for self-advocacy and self-care. We imagine that the main population will be lower-income, unhoused, and/or older adults, we are ready to serve all who need help.

Pilot Description Narrative

ACTIVITIES -- By helping people learn to effectively use online sites and services, by helping them learn to use a computer with compatible software (Google browser; Microsoft office) most likely available at other computers; by providing a printer to save information they have located; by allowing them to use our street address for personal mail delivery; by providing a safe, secure and confidential site to store important paperwork that might otherwise be lost if their possessions are lost, damaged, or stolen; by providing a telephone to call agencies/health care and other resources; etc., our Health Navigation Station (HNS) kiosk will help disadvantaged Members or potential members in our community increase access to improved health care and well-being.

OVERCOMING BARRIERS - Because a person's wellness (physical, mental, and behavioral health and awareness of / embracing of self-care) is affected by any or all of the following factors / barriers to better health, our HNS will address the following barriers:

1. environmental features including poverty / socioeconomic status /physical and/or mental disabilities including age-related issues, SUD, etc.
2. lack of stable, adequate housing,
3. lack of transportation (no reliable car, no driver's license or insurance, no money for gas),
4. previous trauma / low confidence / low self-esteem, lack of initiative or persistence
5. low literacy levels in English such as ability to read and reading comprehension / health vocabulary, plus effective eyeglasses,
6. low digital skills, such as typing – i.e., hunt + peck typing, lack of familiarity with computer terminology, such as *search bar, browser, open in a new tab,* etc. lack of medical terminology; unfamiliarity with email; inadequate method for storing and recalling passwords; (although it is usually assumed that all younger users have digital access and skills, that is not always the case)
7. lack of working digital devices – lost/ broken phone/tablet
8. lack of street address to receive mail

Therefore, our initial **goals will be realistic**, in terms of measuring success of the pilot HNS and recommendations for its continued use. One-to-one training and coaching will be available, and we hope that as people gain skills, they can continue to work on their own and with peers, so that we can keep up with the growing demand we hope for.

HEALTH EQUITY OUTCOMES

We will consider the pilot successful if we can serve 10 people per week by the end of the pilot, with each person having successfully made contact with services they need and been able to follow through for care.

ASSESSMENTS

To **assess achievements**, we can make both **quantitative** measurements – recording how many people use the station

- how many clients will try the HNS and use it more than once (sign in sheet)
- how many will be able to create an email account
- how many can use it to get a new phone or DMV ID which are steps to help them access health care

AND **qualitative** measurements – asking users to record their perception of what they accomplished, e.g., via a **check-out slip** – with questions and boxes to check off

- What did you do today?
- What did you learn today?
- How likely are you to use the station again?
- How likely are you to tell a friend?
- What do you need to know now?

Additional qualitative data includes anecdotal data from the coaches working with uses.

From this data, we can then extrapolate to

- Evaluate the pilot, and **assess impact**
- Reflect on best practices to make recommendations for **replication**
- Make recommendations for **sustainability**

The **COMMUNITY PARTNERS** and **Community Engagement** -- We already work with and with whom we will connect for this Pilot Project, include

- 211, Connect Oregon
- Oregon Department of Human Services, Lebanon office
- Linn County Health Department

- Community Services Consortium
- Live Longer Lebanon coalition
- C.H.A.N.C.E.
- Lebanon Soup Kitchen, and Crossroads Community in Lebanon
- Crisis Line services through IHN-CCO, Linn County
- FISH, Salvation Army, The River Center, St. Vincent de Paul, Lebanon Church of the Nazarene, Love Inc, Faith Community Health Network, Family Assistance and Resource Center East Linn County etc.

LOGISTICAL AND RELATIONAL

We envision our HNS pilot **primarily as logistical,** those] where a navigator targets task-oriented barriers such as making appointments, finding transportation to appointments, and acquiring health information." (https://www.thebodypro.com/article/health-navigation-a-review-of-the-evidence). To promote health equity and reduce disparities, our HNS can provide access tools that low income and/or older people may lack or not know how to use effectively. Many low-income and/or unhoused OHP members have insufficient access to online tools to locate health providers, transportation, information, resources, etc. By offering access to the technology and coaching for how to use it effectively, they can more readily access the services they are entitled to.

Our HNS Pilot will also have Relational Health Navigation benefits, those "where a navigator provides emotional support, builds a relationship with the client, gains their trust and strengthens the relationship between the client and provider". (TheBodyPro)

We already have a relationship with many members of our target population, including older, low-income, and unhoused people who come for free breakfast and assistance.

We do not envision our staff becoming permanent or personal navigators (though we will seek further health navigation training for volunteers / coaches / and our Faith Community Network Health Minister), as outlined on the OHA page https://www.oregon.gov/oha/OEI/Pages/THW-PHN.aspx , but rather our pilot is to help people become empowered to be their own **SELF-Navigators** – with coaching and practice and peer mentoring as well as with resource pages and handouts – and show how much can be done to achieve greater self-care, self-advocacy.

Peer support is already active among folks who visit St. Martin's – offering encouragement, advice, car repair, rides, etc. This peer support can expand as folks can work together at the computer to help each other with their experience and tips.

Our **Pilot Project Team** includes these **individuals**

1. Grant writer / report writer / project coordinator – Sara Jameson, St. Martin's volunteer outreach coordinator – Retired OSU Senior Writing Instructor, grant writer, technical report writing instructor
2. Technical Advisor – Shirley Bushnell, with expertise in electronics
3. Primary Health Navigator – Wendy Fierro, our Faith Community Network Health Minister, who currently provides intake, referrals and coaching

In addition, we recognize the potential need for **Translators** and plan to reach out to Linn County Health Department and other agencies to identify Spanish speaking (and other) translators. In 2021 we received Spanish language signs for our Little Free Library (where we stock bilingual children's books) from Marta Francisco at Samaritan Health (mafrancisco@samhealth.org), who may be able to help us again. And PUENTES, a current pilot project with IHN-CCO to improve language access and culturally appropriate messaging, may be a good resource as well even though they are in Benton County, and we are in Linn County. We could contact Ricardo Contreras, executive.director@casalatinosunidos.org

We will advertise our **Pilot Project** to prospective resources and volunteers, as well as to prospective clients using culturally appropriate messaging in language and access tools.

To reach resources, community partners, fellow providers, potential volunteers, we will advertise via meetings, email, flyers, Facebook postings, etc.

To reach prospective clients, we will make sure that our publicity uses culturally appropriate and welcoming messaging to reach all sections of the population, young and old, including speakers of other languages (primarily Spanish in East Linn County), and those who identify as BIPOC and /or LGBTQ+. The Episcopal Church is officially and extremely inclusive to these sometimes-marginalized populations.

We will use online and print media as well as word of mouth and handouts to reach as widely as possible. The Library and Senior Center would be good places to post information as well.

Potential risks include time, behavior, confidentiality, and privacy. To deal with time, we will create a sign-in / appointment feature / time slots/ for who gets access to the HNS and in what order. We will plan for how to limit time so that each person gets access. As our PILOT grows in popularity, we may need to recruit more volunteer coaching staff to work with people and train them to handle and assure appropriate behavior for folks using the computer so as not to disrupt others in the area. As for privacy and confidentiality, the hall alcove is a fairly quiet area. If needed, confidentiality could be increased by adding a privacy screen. We also pledge to follow standard ethical guidelines including (1) Respect for persons: respect for patient autonomy. (2) Beneficence: maximize benefits and minimize harm. and (3) Justice: Equitable distribution of burdens and benefits.

C. Sustainability

Once the HNS kiosk is set up and functioning, ongoing expenses are minimal in terms of supplies and overhead (electric, phone). Also important will be recruiting both paid and volunteer coaches to help users with their tasks. Some ideas include internships for area students (high school, college, COMP NW Medical Students) who want experience in public health; Faith Community Health Network nurses; RSVP Retired Senior Volunteer partners with compassion and digital skills.

St. Martin's outreach has been funded through the years by grants from the Episcopal Diocese of Oregon Commission on Poverty and Homelessness and by Siletz Tribal Foundation, as well as by individual donations by church and community members, and partnerships with area churches in funding outreach.

D. Replicability

Once our Pilot has completed, our report on most effective practices and suggestions for improvements will help other agencies / churches / non-profits see how they might set up their own HNS kiosk, with references to most effective equipment to use, keys for training and supporting the coaches, and lists of resources to tap into. We can create a DIY handbook for other interested groups on how they might carry out a similar project to improve access to care and decrease health disparities. We look forward to piloting this model to improve access to health care, strengthening behavioral health initiative taking and persistence, and improving health equity / reducing disparities by providing the kind of digital contact that current situation expects.

ACTIVITIES AND MONITORING GRID

Baseline Current – Fall 2022	Monitoring	Benchmark Future – Spring 2023	Met by dates

A1: Members do not receive appropriate care at the appropriate time and place.	Quantitative measurements of usage	More members effectively use digital tools to access care	**Feb 2023**
A2: Members do not receive care communicated in a way that ensures that they can understand & effectively engage in their care.	Qualitative measures; anecdotal data	Members have increased medical literacy where members comprehend and communicate more effectively with the terms / concepts used by providers	**Feb 2023**
BH 4: Members who are experiencing mental health crises don't / can't access care they need	Qualitative data; anecdotal observation	Members have increased ability to locate and utilize mental & behavioral health care – which we know is not as plentiful as needed nor seamlessly accessed	**Feb 2023**
SD 2: Members lack access to affordable transportation.	Quantitative and anecdotal data	More members successfully reach care via public transportation and Medical transport	**Feb 2023**
SD 4: Members experience care disparities due to lack of digital access to health resources.	Quantitative and anecdotal data	Members demonstrate increased confidence and online skills for accessing services	**Feb 2023**

Pilot: St. Martin's Episcopal Church - Health Navigation Station

Pilot Start Date:	**11/1/2022**	**Pilot End Date: 2/28/2023**	
Direct Costs : (some in-kind goods & services may be donated)		**Total Cost**	**Amount Requested***
Purchase of Computer/phone/printer equipment; software; supplies (paper, ink, etc.); tech assistance for installation; monthly access fees; maintenance, updates; etc.		$3000.00	$3000.00
Construction costs – accessible desk/chair/lighting, etc.		1000.00	1000.00
Staff / Training – for coaches, stipends may be important		5000.00	5000.00
Total Direct Costs	**Rate (10%)**	**$9000.00**	**$9000.00**
Indirect Expenses -overhead (not to exceed 15% of Direct Costs)	0.00%	900.00	900.00
Total Project Budget		**$9,900.00**	**$9,900.00**

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

The Health Collective

Backbone Organization: Samaritan Health Services

Billing Address: 525 N Santiam Hwy, Lebanon, OR 97355

Site(s): Lebanon Community Hospital Rehab Dept.

County(s): Benton, Lincoln, Linn County

Priority Areas: Developing a bilingual workforce, health literacy, translation of materials, reengaging the community in personal health and community resources, subpopulations of IHN CCO members including Latino/a/x

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

A2: Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.
BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.
HL1: Increase the percentage of Members who are living a healthful lifestyle.

Pilot Contacts	Name	Email
Primary	Micah Wong	micahw@samhealth.org
Proposal	Micah Wong	micahw@samhealth.org
Contracting	Micah Wong	micahw@samhealth.org
Financial	Micah Wong	micahw@samhealth.org
Reporting	Micah Wong	micahw@samhealth.org

A. Summary

There is a lack of evidence based resources on social media platforms to address lifestyle health for the local communities of Linn-Benton county. By leveraging the boom in short form content on platforms like Facebook, YouTube, Instagram, and Tik Tok as well as by translating current research to layman's terms to reach a multi-cultural and bilingual population, we could see more informed medical decision making and empowerment in members within their primary care homes.

This pilot would seek to create 6 30s-1min videos in English and Spanish with current research on the 6 pillars of life style medicine as described by the American Academy of Lifestyle Medicine:

(1) Nutrition
(2) Physical Activity
(3) Sleep and Health
(4) Stress Management
(5) Avoidance of Risky Substances: dealing with addictions
(6) Positive Social Connection

These would be further supplemented by single or multi panel educational digital posters that could be disseminated online or printed and handed out by clinicians.

B. Pilot Description

The goal of all education is to empower learning and self-directed action; the goal of this pilot is ultimately the same. This is served by seeking to reach as many members as possible through online interactions with content, providing links and graphics to local primary care clinics, the production of evidence-based share-able material, and the conversion of media into Spanish.

My name is Micah Wong and I am a physical therapist working at Lebanon Community Hospital. I am originally from the island of Oahu, Hawaii and came to Oregon for my doctorate in physical therapy; however, I am also a videographer and photographer who has led volunteer groups to Houston after Hurricane Harvey in 2018, assisted nurses, physicians, nurse practitioners, and pharmDs in Haiti with training of community health workers and creation of educational material, and currently heads continuing education within the LCH rehabilitation department.

As a new grad physical therapist, I have had the privilege to step into a new and growing health care field that is realizing that care cannot be silo'd to individual specialists or clinics. Lebanon's rehabilitation team is comprised of therapists looking to play a larger role in care management through comorbidity education, health coaching, and service coordination with local resources. Partnering with colleagues like Dr. Sharna Prasad, I was encouraged to see the effect that consistent health messaging could play in chronic disease conditions and pain. However, I have also seen that messaging through large organizations, like Samaritan Health or universities, often get little traffic, are not consistent, and do not often reflect best practice guidelines or current research. With my experience as a clinician and creative, I would like to step into this gap and see if a community focused and independent group could make a difference. While I am a Samaritan employee, this project will not be sponsored by or have any financial contribution by the Samaritan Health. However, there will be a high amount of collaboration with clinicians and other organizations that have ties with Samaritan.

As described by the 2018 Oregon's State Health Assessment, only 12% of US adults posses proficient health literacy according to the National Assessment of Health Literacy. It is well established that low health literacy leads to increased ED utilization, increased frustration when communicating with health care providers, and increased risk of provision of care outside of evidence based guidelines (Headly 2022). The provision of education and health information needs to be tailored to the community and population of consequence.

This pilot attempts to primarily target residents of Linn-Benton-Lincoln Counties (LBLC) from the ages of 14-30 without college education generally of Caucasian or Latino/a/x descent. This population would comprise nearly 30% of the total LBLC population as found in the 2019 census data and is also shown to gather most of their new and information from social media, 51% daily from social media compared to 13% daily from online news sites (Statistica). This means that it is not enough to have online content silo'd in specialized and trusted sites, it needs to be distributed on social networks to reach clicks and have impacts in this population.

This is an extremely large task and this pilot makes no play at being the end all be all of health education for the Linn-Benton-Lincoln Counties. However, it does seek to fill the gap of evidence based and current research translation on these social media platforms by partnering with clinicians, videographers, graphic designers, care coordinators, social media managers, and native Spanish speakers to create content for this community. Clinicians who would possibly be involved include Dr. Gina Miller MD (family medicine), Russel Whimmer PA (family medicine), Dr. Sharna Prasad DPT (physical therapy), Dr. Mythili Ransdell MD (pediatrics), and Dr. Joseph Mortimor DPT (physical therapy). Possible collaborators for Spanish content creation include Casa Latinos Unidos, the county public health department, traditional health workers, as well as students in the Western Oregon University School of Osteopathic Medicine and Physical Therapy.

As part of this pilot, I am looking to coordinate educational topics and script writing using the assistance of other clinicians and collaborators. Using DST funding, I am looking for $29,700 to hire a social media coordinator with experience in social media campaigns to increase targeted messaging and algorithm reach as well as videographers, editors, graphic design artists to design workshopped content created by clinicians. Finally, funds would also be used to hire native Spanish speakers to co-create the Spanish posters and graphics as well as subtitles for videos. Intense care and workshopping would go into plain language explanations of complex topics for both printed media and videos as well as gauging what future language needs content might need to adapt with to equitably reach the target demographics.

The goals for this pilot are as follows:

Goal 1. Produce and share 6 30s-1min within 1 year of account creation on Instagram, TikTok, and YouTube

Goal 2. Convert 4 recent article publications in the last 5 years into social media and hand-out ready posters that match the health literacy of the Linn-Benton-Lincoln communities within one year of account creation.

Goal 3. Accumulate a total of 1,000 interactions over 6 months over the collective social media accounts to guide the direction of further content.

Goal 4. Distribute posters as hand-outs to 15 clinics (Primary Care/Urgent Care/Physical Therapy/etc) in the Linn-Benton Community by the end of 1 year of content production.

Goal 5. Spanish graphics and posters as well as video translations produced within 1 month from time of publishing.

Distribution and community interactions would be through primary care and physical therapy clinics, using created hand outs and graphics, as well as with high traffic social media page interactions. Care coordinators and clinicians would be able to use hand outs as part of AVS and to refer patients to the page for updated information on current guidelines and research. While working as a PT in Samaritan LCH, I also have the unique placement of working in the Lebanon Family Medicine Resident clinic and have built relationships with the care coordinators and providers and can lean on these relationships for distribution. As a primary care physical therapist, I also will direct

patients to resources and educational content, of which this project could supplement and directly help with extended learning. However, the community will mostly need to be reached and hear about this program through organic social media interactions. This means that targeting local schools and health teachers could be valuable tool in increasing interactions and knowledge sharing to the community.

Potential challenges to this project are lack of social media interaction, delayed content creation, and difficulty in recruiting team members who are not only skilled in their craft, but also mindful towards health and equity topics. In a constantly changing and crowded social media sphere, a coherent and consistent message is necessary for breaking through to views and engagements. This makes recruitment of a social media manager/organizer of key importance with knowledge of current trends, posting time tables, and skills with organic subscriber building and the key to over coming this obstacle. However, social media interaction is also affected by the consistency of posts which means that videos and posters needs to be produced at a constant schedule. This challenge can be overcome by creating videos 6 months ahead of schedule and waiting to start launch of accounts until 10 pieces are produced (video or posters). Finally, many health accounts and content are produced by organizations but fail to gain traction. I believe the people involved in this project must not only be creatively talented but also have an interest in health and wellness. In this effort, as both a clinician and videographer/photographer, I will be hoping to bridge the gap with clinician round table meetings and huddles with video/design teams.

C. Sustainability Plan (½ page)

The joy and effectiveness of social media is its universal reach and relatively low operations cost. High quality content requires time, personnel, and investment but the structure and distribution can easily progress without heavy reliance on excessive funding. While there is no shortage of social media health pages and content, there is a surprising lack of current evidence based resources for the local valley area and even less targeted to a growing Spanish speaking population.

As a clinician in both a hospital based physical therapy clinic and family medicine clinic, there would be no shortage of expansive topics to cover in future content with specific application to noticed community trends or areas of interest. Content could also serve to support and highlight other groups including the Lebanon MAPS program, local gyms, mental health services and awareness, and other community resources.

Once this pilot has completed DST funding, work will continue in building organic interaction and content development. With the amount of designs produced, merchandise including clothing or stickers could be sold with all proceeds going back into upkeep and content creation.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Absence of health and wellness evidence based short form video content for the Linn-Benton-Lincoln communities	Creation of 6 30s-1 min short form content videos	Produce and share 6 30s-1min within 1 year of account creation on Instagram, TikTok, and YouTube	December-23
	Lack of updated information and guidline consistent handouts and fliers available to the Linn-Benton-Lincoln communities over social media about health and wellness	Design and distribution of 4 posters/handouts based on current evidence and treatment guidelines	Convert 4 recent article publications in the last 5 years into social media and hand-out ready posters that match the health literacy of the Linn-Benton-Lincoln communities within one year of account creation	December-23
	Average of 1-9 likes/interactions per post on the Samaritan Health Instagram page	Social media likes/shares/follows/saves/comments	Accumulate a total of 1,000 interactions over 6 months over the collective social media accounts to guide the direction of further content.	June-23
	After visit summaries are created with highschool/college level literacy. Lack of easily readable an visualized posters/handouts in clinics	Distribute posters as hand-outs to 15 clinics	Distribute posters as hand-outs to 15 clinics (Primary Care/Urgent Care/Physical Therapy/etc) in the Linn-Benton Community by the end of 1 year of content production	December-23
	Current small amount of social media posts and evidence based hand outs in English	Time to release of Spanish content and translations from publishing of original	Spanish graphics and posters as well as video translations produced within 1 month from time of publishing.	December-23

Pilot: The Health Collective

Pilot Start Date:	**9/1/2022**	**Pilot End Date:**	**12/31/2023**
Direct Costs		**Total Cost**	**Amount Requested***
Managing social media accounts, trend research, content updating, and website maintainence		$7,500.00	$7,500.00
Hiring video production, filming, editing, video graphics, voice overs, and equipment rentals		$7,500.00	$7,500.00
Design and creative expression of current research with poster and graphic creation		$5,000.00	$5,000.00
Creation of evidence based content in the form of video scripts and poster information		$3,000.00	$3,000.00
Ensuring high quality and culturally responsible Spanish language creation of content material (videos and posters)		$4,000.00	$4,000.00
		$0.00	$0.00
Total Direct Costs	**Rate (%)**	**$27,000.00**	**$27,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$2,700.00	$2,700.00
Total Project Budget		**$29,700.00**	**$29,700.00**

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

Transitioning into a Home

Backbone Organization: Furniture Share

Billing Address: PO Box 2224, Corvallis, Oregon 97339

Site(s): 4450 Marion ST. SE., Suite C, Albany, OR. 97332

County(s): Linn, Benton and Lincoln Counties

Priority Areas: Addressing trauma, including environmental-Toxic Stress, Innovative programs supporting housing, Reengaging the community in personal health and community resources, Rural community impact, Subpopulations of INH-CCO members that experience health disparities.

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

HL1-Increase the percentage of Members who are living a healthy lifestyle.

ii. Nutrition, v. Stress, vi. Sleep Quality, vii. Social Supports

SD1-Increase the percentage of Members who have safe accessible and affordable housing. Safe housing: sanitary and adequate space for residents.

i. Stable housing upon discharge from hospital or emergency room visit.

iii. Housing related, closed-loop referrals between clinical and community services

SD2-Increase the percentage of Members who have access to affordable transportation.

iv. Provider knowledge of. and referral to, available transportation services

SD3-Increase the percentage of Members who have access to healthy food.

i. Food Security, ii. Availability of fresh, affordable produce

SD4-Increase Health Equity

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

ii. Availability of health equity data

Pilot Contacts	Name	Email
Primary	Michelle Robinson	Michelle@furnitureshare.org
Proposal	Michelle Robinson	Michelle@furnitureshare.org
Contracting	Michelle Robinson	Michelle@furnitureshare.org
Financial	Michelle Robinson	Michelle@furnitureshare.org
Reporting	Drew Smythe	Drew@furnitureshare.org

Pilot Narrative Proposal- Transitioning into a Home

Executive Summary: Our overall pilot aims for healthy living and overcoming social determinants of health and equity. Our goals are to promote equity and reduce health disparities to Furniture Share's IHN-CCO clients. This pilot project will track and distribute 1,800 healthy fresh fruit and vegetable boxes, furniture and household items to 1,200 clients, waive the furniture and food delivery fee to 300 families and provide a pre, mid and post survey to track IHN-CCO members healthy living and overcoming social determinants of health and equity improvements. It has been proven that a child who sleeps in a bed often will experience better health, improved performance in school, and a better relationship with peers and family rather than practicing sleep-deprived habits. IHN-CCO members who wish to transition to improved conditions often experience better health, improved performance in jobs and school, better relationships from less worry, and greater self-confidence. Providing furniture and household items can ensure smooth transitioning to a better quality of life. Families that eat together experience better health from meals prepared within the home, and improved vocabulary and performance in school and at work. Currently, individuals receive food boxes at the time of service. We would like to expand on that program by partnering with local farmers to provide fresh produce to be available weekly thus providing them with healthy food options and food security. Having access to fresh, free produce will help families to cook healthier and to provide healthy food options for their children to establish healthy eating habits. Healthy living starts in the home with the basic needs. A place to relax, sleep, a place to nourish their bodies. Life is better when a house is a home. The timeline for this pilot project will be September 1, 2022- August 31, 2023. Furniture Share will dedicate a Case Manager to assist new clients by September 1, 2022. This Case Manager will overtake the day-to-day client interactions and track the progression of our IHN-CCO members.

Pilot Description:

Goal 1: Track and distribute 1,800 fresh fruits and vegetables food boxes to IHN-CCO Members

Goal 2: Distribution of Furniture and household items to 1,200 IHN-CCO Members

Goal 3: Waive transportation fee of furniture, household items and food boxes to IHN-CCO Members

Goal 4: Measure activities through surveys

G*oals and proposed outcomes* are to provide IHN-CCO members with a bed, pillow, sheets and a blanket, provide healthy food boxes filled with locally grown fruit and vegetables and locally, dinner tables to families and all other basic furniture and household items to individuals in need living within Linn, Benton, Lincoln and surrounding Counties to improve their health, performance, and self-esteem; to increase community awareness and build relations with referring agencies to provide as many children, families, and individuals as possible with furniture and basic household furniture; and increase individual and corporate donations for long-term fiscal sustainability of this and other programs.

To measure our goals and activities, each client will be asked to complete a short survey when scheduling their service. Questions will include such things as “how are you sleeping? How are your eating habits? Do you feel stressed or overwhelmed? Are you happy or well-rested?” After services are received our dedicated case manager will then follow up with each client two more times. Once at the 3-month mark and again at the 6-month mark. The questions on the survey will be adjusted to reflect how they are doing physically, mentally, and emotionally, and how their eating habits have improved since receiving services. Furniture Share will also collect the race and ethnicity of IHN-CCO Members and aggregate and report out.

Transitioning into a Home will support personnel to deliver services to clients, obtain donor furniture, market our services, and build and strengthen resources. Such as Staff and volunteers organize and carrying out the daily task to secure our programs by managing the Warehouse site; greeting donors and receiving their donations; unpacking donations; maintaining the organization of donations in the Warehouse space; packing items specific to client requests; interacting with clients and case managers of partnering agencies; tracking client requests. Using our 20’ box truck, we pick up and distribute these donated items five days per week. Other donations are brought to the Warehouse directly by the donors. IHN-CCC clients will then come to the Warehouse to pick up their items and food boxes or they can be delivered directly to their homes. Required resources and inputs to implement and maintain the direct client services include adequate staffing and operational hours,
organizing volunteers/recruiting, warehouse, delivery truck, community awareness, relations with referring agencies, food, furniture, and household item donors, and community support.

Furniture Share works with several referring state and local agencies. We collaborate with over 240 social service agencies and non-profit organizations that refer clients to our services, thereby helping people assemble the necessary resources from multiple non-profits that provide emergency and transitional services within our community. We partner with Albany General Hospital Foundation, Samaritan Albany General Hospital, Good Samaritan Medical Center, Community Outreach, Human Services, Domestic Violence and Homeless shelters, Linn Benton Housing Authority and other housing organizations to help clients transition into functional family situations. We anticipate serving a minimum of 1,200 IHN-CCO members (300 families) during this project timeline.

Our dedicated case manager will help create, develop and maintain our tracking system to track IHN-CCO members served, items received, surveys taken, survey data, furniture, and food delivery fees waived, and weekly fresh fruit and vegetable boxes distributed to IHN-CCO members. The case manager will also maintain high research quality, by requiring as many clients as possible to complete a survey to find out how different living conditions are with the furniture and food donations that they have received. Our plan is to research and understand how prevalent furniture and food poverty is. How many people are affected by it? And how can it be measured? We will assess how many people are living in furniture and food poverty, and which groups of people are affected by it the most, by analyzing several large national survey data sets. This will allow us to examine the extent of furniture poverty in our service area. We will look at age, sex, gender, ethnicity, income, benefit recipients, disability, educational attainment, social class, employment, and more. We will also be further exploring the impact furniture and food poverty can have on people's health, mental health, and financial and social wellbeing, an approach we used in our project "Transitioning to a Home". We will explore the lived experience of people who are living in furniture and food poverty, to help us understand the devastation it can cause.

Survey Questions

1st Survey: Before receiving donations:

1. On a scale of 1-10, how would you rate your average night's sleep?
2. How often do you have fresh fruits and vegetables in your diet? (Never, 1-2 times a week, 3-5 times a week, Daily)
3. Do you have physical access to nutritious foods? Y/N
4. Do you have financial access to nutritious foods? Y/N
5. What do you know about Furniture Share? (Never hear of FS, Have heard of FS, Familiar with FS)
6. How easy or difficult was the process of receiving your furniture and/or nutritious foods? (Very easy, somewhat easy, neutral, somewhat difficult, very difficult)

2nd Survey: 3 months after receiving donations:

1. How did we do, what can we improve on?
2. Have you taken advantage of our nutritious food boxes? Y/N
3. If so, did we supply everything you need to make a healthy meal? Y/N
4. On a scale of 1-10, how would you rate your average night's sleep?
5. How has work/school improved or worsened since you received your items? Y/N
6. Since having physical and financial access to nutritious food, how has that affected your diet and health? Rate the quality of food you have received? (Excellent, Good, Neutral, Unsatisfactory, Very Unsatisfactory)

3rd Survey: 6 Months after receiving donations:

1. On a scale of 1-10, how would you rate your average night's sleep?
2. Since having physical and financial access to nutritious food, how has that affected your diet and health?
3. Rate the quality of food you have received? (Excellent, Good, Neutral, Unsatisfactory, Very Unsatisfactory)
4. On a scale of 1-10, how would you rate your quality of life since you received furniture, Household items and healthy food boxes from Furniture Share.
5. On a scale of 1-10, how would you rate your overall experience with Furniture Share.
6. On a scale of 1-10, how would you rate your experience with Furniture Share's staff.

Our programs will be shared with the community through our referring partners, our networking groups/clubs, our website, and social media. We will also make efforts to have our program highlighted in the local newspapers, and publications.

Potential risks are possible. Clients may not be available to take the follow-up surveys. While we will make every attempt to have them complete the last two surveys there is a risk that the client will refuse or will not have updated us with their new contact information. While it is a possibility some surveys will not be completed, we are certain our clients will be happy to participate to ensure our programs continue.

We are confident that our pilot program will provide fair opportunities for our clients to have the tools to address any obstacles they may face to be as healthy and secure in their daily life and the opportunity to make a significant improvement in their health. Furniture Share can establish that there is a substantial need for this pilot and currently works with low-income families that are impacted the most. We will provide measured outcomes and provide data to show the improvement in the quality of life for our clients.

Furniture and food poverty is a chronic problem, not an acute one and this means that if someone is living in furniture and food poverty, providing them with the essential healthy food and furniture items that they need is a great start, but it will not solve all of their problems. Their problems are likely to be more complex and entrenched. A prime example are the families we helped in Lincoln and Linn county who not only lost their homes in the wildfire but to those whose homes were saved but lost their furniture to the toxic smoke damage left within their furnishings. This is why Furniture Share works with a wide range of partners with a shared goal to tackle poverty because furniture poverty, like food or fuel poverty, is about people not having enough money to live on. It is about an inadequate welfare system and rising housing costs, it is about insecure, low-paid jobs and rising unemployment.

The American Public Health Association published the following report. Amid the vast array of scientific literature on reducing teens' risk for substance use, a new report offers a method as pure and simple as pulling up chairs around the family dinner table. The report found that teens that infrequently break bread with their families are also more likely to have parents who fail to take the time to check in with their children on a regular basis.

Children and teens who are sleep deficient may have problems getting along with others. They may feel angry and impulsive, have mood swings, feel sad or depressed, or lack motivation. They also may have problems paying attention, and they may get lower grades and feel stressed. The average kid has a busy day. There's school, taking care of their pets, running around with friends, going to sports practice or other activities, and doing their homework. By the end of the day, their body needs a break. Sleep allows their body to rest for the next day. Their body and their brain need sleep. Most kids between 5 and 12 get about 9.5 hours a night, but experts agree that most need 10 or 11 hours each night. Sleep is an individual thing, and some kids need more than others. When your body doesn't have enough hours to rest, you may feel tired or cranky, or you may be unable to think clearly. You might have a hard time following directions, or you might have an argument with a friend over something petty.

A school assignment that's normally easy may feel impossible or feel clumsy playing your favorite sport or instrument. One more reason to get enough sleep: If you don't, you may not grow as well. That's right, researchers believe too little sleep can affect growth and your immune system— which keeps you from getting sick. Here are some facts about the importance of sleep as well as information about the effects of poverty on children and their education: 1 in every 7 children in Oregon is living in poverty, 45% of children in America are living in low-income families, and every 9 seconds during the school year, a public high school student drops out of school, Sleep deprivation can lead to obesity, hypertension, diabetes, and cardiovascular diseases. Children suffering from sleep deprivation tend to be more hyperactive and experience ADHD-like symptoms, Education has been shown to be the best way to break the cycle of poverty. Getting a good night’s sleep is necessary for a child to perform well at school and give them the tools to succeed!

Sustainability Plan: Transitioning into a Home is innovative, scalable, and transferable as it is the only program in our service area that provides IHN-CCO members with furniture and healthy food boxes. Furniture Share plans to continue to promote community awareness and gain new funding through private and individual donors, increase volunteer base and fundraising events, and enhance collaboration with other referring agencies to increase comfort and safety in our community's underserved populations. To prepare to implement this project Furniture Share will increase community awareness and volunteer support through social media and marketing/networking opportunities.

Furniture Share and its governing board actively recruiting new board members from diverse backgrounds. Building Furniture Share's capacity is the focus of our future planning. Assisting those who are socially and economically challenged to meet their basic needs and ultimately reach self-sufficiency is always at the forefront of the board discussion and planning.

We collaborate with over 240 social service agencies and non-profit organizations and partner with Albany General Hospital Foundation, Samaritan Albany General Hospital, Good Samaritan Medical Center, Community Outreach, Human Services, and Domestic Violence and Homeless shelters, Linn Benton Housing Authority and other housing organizations who have a vested interest in this pilot project as this program will help them help their client be successful.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Do not currently track IHN-CCO clients.	Create a Database.	Database created and tracking initiated.	09/2022
	Do not currently track IHN-CCO clients that receive our healthy food boxes.	Eating habits and quality of life will be measured by a series of three surveys to track improvement in health.	1,800 nutritious food boxes will be provided to all of our service users over the next year. Fresh fruits and vegetables will be distributed every Friday.	08/2023
	Do not currently track IHN-CCO clients that receive furniture and household items.	Quality of life will be measured after receiving furniture and household items by a series of three surveys to track improvement in menal health.	1,200 IHN-CCO members will receive furniture and household items when transitioning into their new home	08/2023
	Do not issue a pre-service survey to service users.	A survey will be created.	This initial survey will give us an excellent starting point to see where each individual stands before furniture and healthy food options were available.	09/2022
	Do not issue a survey during service.	A survey will be created.	This mid-level survey will be issued to all service users after three months.	03/2023
	Do not issue a final survey to service users after assistance is complete.	A survey will be created.	This final survey will be issued to all service users after six months.	06/2023
	Furniture Share does not waive delivery fees for IHN-OCC clients.	This pilot will allow Furniture Share to waive all delivery fees for all IHN-OCC service users. Being fully funded, Furniture Share will be able to reach all help more IHN-OCC clients.	With funding from this pilot project, we will waive all delivery fees for 1,200 IHN-CCO clients.	09/2022

Pilot: Transitioning into a Home

Pilot Start Date:	**9/1/2022**	**Pilot End Date:**	**8/31/2023**
Direct Costs		**Total Cost**	**Amount Requested***
On going case management to communitcate services and furniture needs to IHN-CCO members		$19,500.00	$19,500.00
Waive furniture and food delivery fee to 1,200 IHN-CCO member		$18,000.00	$18,000.00
Provide weekly case management to provide fresh fruit and vegitables to IHN-CCO members		$9,500.00	$9,500.00
Laptop, Office Supplies and printing materials		$3,000.00	$3,000.00
Total Direct Costs	**Rate (%)**	**$50,000.00**	**$50,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	4.00%	$2,000.00	$2,000.00
		$52,000.00	**$52,000.00**

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

WALK 'n ROLL

Backbone Organization: Friends of the Newport Senior Center
Billing Address: c/o Newport 60+ Activity Center, 20 SE 2nd Street, Newport, OR 97365
Site(s): Hybrid - simultaneous virtual and in-person from Newport 60+ Activity Center
County(s): In-person: Lincoln County. Virtual: Benton, Lincoln, Linn and other Oregon counties

Priority Areas:

- Addressing trauma, including environmental - combatting isolation and declining strength/balance/endurance
- Addressing technology disparities - access to technology
- Re-engaging the community in personal health and community resources - access to Newport Recreation Center walking track, Oregon Coast Aquarium, local resources in counties served; education regarding benefits of walking
- Rural community impact - closing access gap
- Subpopulations of IHN-CCO members that experience health disparities - supports older adults including seniors in assisted living facilities. The WWE programs offered through 60+ are free.

CHIP Outcomes, Indicator Concepts, and Areas of Opportunity:

Outcomes

- Increase the percentage of Members who receive appropriate care at the appropriate time and place (A1)
- Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care (A2)
- Increase the number of Members who are living a healthful lifestyle (HL1)
- Increase health equity (SD4)

Indicator Concepts

Percentage of Members who report that they receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care (A2a)

The number of IHN-CCO **members** who register for 60+ Activity Center hybrid Walk With Ease programs;
The number of IHN-CCO **members** who complete 12 or more WWE sessions; Assessments by IHN-CCO **participants** of the impact of the WWE program (HL1 *)
* Since "Outcome Indicator Concepts" was not on your template for Outcome HL1.These Indicator Concepts were added to our proposal

Areas of Opportunity

Disease prevention, management, and recovery; Physical activity; Stress; Sleep quality; Social supports, such as family, friends, and community (HL1 i, iii, v, vi, vii)

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 (SD4 i, ii)

Pilot Contacts	Name	Email
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Financial	Beverly Farrell	b.farrell2005@sbcglobal.net
Reporting	Sonia Graham	sonia.graham@newportoregon.gov

WALK 'n ROLL

A. Executive Summary:

Our pilot, **WALK 'n ROLL**, is a unique hybrid solution to allow equitable participation in the evidence-based program Walk With Ease (WWE). It will design and utilize a cross-platform delivery system to provide an egalitarian, interactive physical activity program and stimulating social environment simultaneously to virtual and on-site participants. We will leverage the support of our community partners to effectively reach individuals - whether homebound or mobile - with a program proven to increase strength and balance and decrease pain for seniors with arthritis and other chronic conditions. Our pilot's title reflects the program's adaptability.

The Newport 60+ Activity Center (60+) is one of only 108 senior centers to achieve national recognition and accreditation through the National Institute of Senior Centers. 60+ has a small staff supported by an extensive contingent of volunteers. Exercise programs are facilitated by volunteers after they have completed certification requirements. As a Regional Health Education Hub (RHEHub) member organization, 60+ has provided the evidence-based program Walk With Ease to senior Lincoln County residents at 60+ since 2017. A virtual adaptation was added in 2020, which broadened our reach to Samaritan's tri-county service area. These are examples of the personal stories gathered from participants:

- A woman introduced to WWE by her Samaritan physician in Corvallis; she completed the virtual program a second time -- this time as a co-facilitator.
- A participant who joined the on-site class using a rollator; she completed her last class with the assistance of a cane.
- A woman took the program virtually due to fear of falling; she went outside her home for the first time since Covid to enjoy *Beachcomber Days* events in Waldport this passed June.

Those completing the WWE program reported reduced pain, improved balance, gains in strength, and increased confidence. Other results include elevations in function, mood, quality of life and self-efficacy. This walking program is and designed for anyone capable of standing for 5 minutes. It is extremely adaptive and can benefit participants who engage from a chair or wheelchair, or using walking aids.

While conducting the program the greatest challenges have been:
--reaching homebound or isolated candidates, regardless of their tri-county location;
--reaching enough individuals to make the ongoing curriculum feasible;
--creating a virtual environment that fosters interaction and connection;
--lack of success in mitigating the limitations inherent in delivering an equitable experience to persons participating via virtual sessions.

It is our assertion we must provide all participants, whether at home, in assisted living facilities, or elsewhere, with a hybrid, virtual/on-site program that allows any isolated/homebound seniors in Samaritan's service area and beyond, a chance to participate simultaneously with participants situated at the Newport 60+ Activity Center. We have the opportunity to help people experience an environment where they can come together while improving physical, social and emotional health.

This newly formatted approach to WWE will be our pilot program, but the solutions will be replicable and scalable.

Our proposal uses technology in a new way -- it creates a setting which will re-frame the concept of demonstrating movement and holding conversation with a gathering that is physically separated but able to function as a single group.

By providing unique tools to our partners and promoting access to more prospective participants, we believe this cross-platform delivery system will benefit IHN-CCO and further serve a homebound subpopulation of its members. Ultimately, through focusing on common needs, our pilot will create a cohesive alliance among individuals with special needs, persons with disabilities, persons suffering from isolation, and individuals who are less restricted -- all with a common wish to live their best lives.

B. Pilot Description:

PILOT GOALS -- Using an equity lens, our proposal addresses the physical and emotional health of older adults. Focusing on common needs, our pilot featuring the evidence-based program Walk With Ease (WWE) will create a cohesive alliance between individuals with special needs, those with disabilities, persons suffering from isolation, and individuals who are less restricted. It will be accomplished in a manner that supersedes certain roadblocks negatively affecting potential participants. If our grant proposal is successful, the Newport 60+ Activity Center (60+) will provide free evidence-based exercise programs to composite groups of participants simultaneously gathered together at home and on-site. With the support of technological innovations, 60+ will be able to improve health equity while concomitantly reducing the social determinants of health barriers that negatively impact quality-of-life outcomes. Through intervention, this program will further reduce healthcare costs along with its participants' critical healthcare needs. OHA and IHN-CCO have identified Members by county and age, and have reported that 46% of the total IHN-CCO Members have chronic condition diagnoses. In conjunction with Samaritan's patient-centered primary care home which already supports healthcare delivery, 60+ will further advance health equity by offering live programming to a greater audience, regardless of each participant's geographical location or physical ability. We anticipate measurable and replicable improved physical and mental health outcomes for the homebound through a socially-interactive program attainable concurrently from home or at 60+.

We've all experienced well produced round-table discussions with in-house and/or remote participants, but still with certain limitations. Adding the element of physical instruction where the presenter's full range of motion is visible and is fully seen by all participants, whether on-site or homebound, and where all participants can also see each other, creates challenges not met by existing delivery systems. So far, the experience of virtual participants has not progressed toward achieving such equity, nor does it offer sufficient exposure to a sense of community for the homebound, underserved elderly population. This pilot project will enable no-fee evidence-based exercise programs to achieve participation and socialization equity with composite groups of participants gathered together simultaneously at home and on-site.

Goals will be measured by:

- The number of participants in each 12-18 session class referred via Regional Health Education Hub (RHEHub) and other organizations
- The method of participation; county of residence
- The number of class members who complete 70%-100% of the program
- Pre-and post-program participant surveys
- Feedback from clinics via Samaritan Health Education Department
- The number of participants who discuss the program and their goals with their patient care primary home
- Our success in providing information to other organizations in order for them to replicate the pilot.

Our partners include:

- Samaritan Health Services Health Education Department (SHSHED) -- 60+ has been working with SHSHED for several years under a CDC grant executed by National Recreation and Parks Association (NRPA) to explore implementation of an electronic referral system. Our first experience (pre-COVID) proved to be limited. SHSHED received a significant number of referrals; however, the program was on-site and the majority of referrals were for homebound or otherwise isolated individuals living in Linn or Benton Counties and other IHN-CCO members in the tri-county region who could not access the 60+ Center.
- In 2022, 60+ became a Regional Health Education Hub (RHEHub) member organization, and two of the pilot program team members are also members of the RHEHub Steering Committee. RHEHub provides centralized services in Benton, Lincoln and Linn counties that enable community members, health care professionals and partner organizations to easily access and refer people to evidence-based health education workshops and resources.
- National Recreation and Parks Association -- 60+ presently meets monthly with NRPA and SHSHED, and reports semi-annually to NRPA on the progress of our work.
- Corvallis Community Center (CCC), a new member of the NRPA project. CCC is not offering a virtual WWE program as they feel the exercise component cannot be experienced virtually. Our pilot will demonstrate that the homebound can participate fully and safely, with all of the same benefits as on-site participants.
- Comagine Health -- Comagine partners with the Community Integrated Health Network of Oregon (CINO) to build the statewide infrastructure to deliver and sustain evidence-based health education programs and interventions. One goal is to establish Medicaid reimbursement for fall prevention programs, including the WWE program.
- OSU Extension -- A sub-grantee to a Comagine Health grant. OSU Extension provides WWE student workbooks and facilitator training manuals and support through their sub-grant.
- Compass -- A data portal used by 60+, OSU Extension, and several more partners to register participants for evidence-based programming.
- Senior and Disability Services, Lane Council of Governments -- Dallas Abraham, the Disease Prevention and Health Promotion Coordinator, co-facilitated the May-July virtual WWE program with 60+ from her office. She agrees that not seeing the complete demonstrator's full body can severally impact program fidelity, and even increase a sense of isolation.

Improving Health Equity:
Specifically designed as a “cross-platform delivery system” promoting health equity and reducing health disparities, our project advances physical health in ways integral to re-framing the homebound way of living while challenging the corresponding chronic illness symptom cycle. It meets people where they are with a program designed to improve balance, increase strength and stamina, reduce pain of arthritis and other chronic conditions, and initiate a more healthy lifestyle.

Resiliency:
60+ pilot team members are familiar with the value of trauma-informed care. They work with a population which has suffered substantially from the isolation and fear brought on by Covid. Many seniors have lost partners and friends; more have yet to re-enter the community, and most have lost physical strength, flexibility and stamina. Team members are certified in one or more trauma intervention programs, including: Suicide Prevention Gatekeeper Program, Adult Mental Health First Aid, CPR, and OHA Naloxone Training Protocol. These and lived experience help them recognize

and support those who are at risk. 60+ is also a Unite Us/Connect Oregon licensee, and sees opportunities within this pilot to be a touch-point for connection to transportation, food security, the patient care primary home, and other vital services. Pre-program health questionnaires are also an important tool to connect our services with the health community

Promotion:
The program will be promoted locally in newspapers, radio interviews, and utility bill stuffers. It will be bolstered within Samaritan's service area via Compass; Samaritan Health Education Department will promote to clinics; 60+, SDS Lane County COG, and Corvallis Community Center will distribute announcements via activity brochures. In addition, 60+ will write and produce a promotional video about WWE for use by all of our partners, and tools for SHSHED promotional presentations to clinics. WWE program team members will be available to answer questions from prospective participants and to support RHEHub promotion efforts.

Cultural Responsiveness:
We recognize that ageism impacts "older adults" -- a broad and diverse group of individuals. WWE has improved the lives and health of participants ages 60 and up. We actively work to dismantle ableism, and believe this hybrid program will be a part of that process. We hope that in the future our success will allow the program to be taught in Spanish. In the interim, WWE workbooks are available in Spanish.

WWE program team:

- Lee Ritzman, President, Friends of the Newport Senior Center. In charge of oversight. “Equity and inclusion are essential to the realization of this mission and denying access to people with special mobility needs due to lack of transportation is antithetical to the mission of the Center and the principals that we support.”
- Bryn McCornack, 60+ Exercise programs Supervisor; instructor for WWE hybrid; administration and primary contact regarding the pilot grant. Secretary of Friends of the Newport Senior Center and member of 60+ Activity Center Advisory Committee. Facilitated WWE for 5 years, online and in person. Certificate in Dance from The New School in New York City, studying kinesiology and style; founder and choreographer for *Mobius Dance Company* in New York City, former performer with Oregon Shakespeare Festival, Developed the workshop *Folk Dance for Wheelchair-Enabled Folks*. Concrete-services interpreter at New York Society for the Deaf. Certified to lead Better Bones & Balance, WWE, and Silver Sneakers classes, and currently training as a Fit & Strong evidence-based program facilitator. September, 2019: co-presenter at the National Parks & Recreation Convention in Baltimore with Samaritan Health Education Department. The topic was *Furthering Your Agency's Mission Through Partnerships with Healthcare Organizations.* In November, 2022 she will co-present at the Oregon Parks and Recreation Association Annual Conference with Samaritan Health Education Department and Corvallis Community Center The topic, *Prescription to Parks & Recreation.* The presentation will discuss referral portals and strategies for collaboration with health care providers.
- Beverly Farrell, Accountant, treasurer and member of Friends of the Newport Senior Center.
- Sonia Graham, 60+ Activity Center Supervisor. Grant supervision. MBA, MHSA, MS Industrial/Organizational Psychology. Sonia is an experienced manager who has worked with the senior community for over 10 years.

Potential risks:

- Lack of trained instructors. Holding one program in-person, and one program on-line has stressed the small facilitator pool. (By combining in-person and virtual class members, registration for a single class can be doubled. Bryn has committed to four 6-week programs annually, which will be hybrid programs if grant is approved. She has coached and co-facilitated with new instructors in Corvallis and in Eugene. 60+ is actively recruiting new instructors.)
- Class member attrition, lack of referrals from provider. WWE requires a commitment by students to exercise 3x/week and to attend 1 hour combined education/exercise classes 2-3 times/week. Effective use of instructor time is compromised if class modules start with 6 but dwindle to 2 or 3 students in the last few classes. (By creating hybrid classes, it is estimated that classes can be conducted with 20-22 combined on-site/at home students. 60+ can also include students throughout Health Education Department's tri-county service area.)
- Some homebound prospective students may not have laptop computers or smart TVs to use to participate in the classes. (60+ will explore the best options for inclusion. iPads, hotspots, and some laptops are available for loan; volunteers are available to instruct students on their use.)
- CDC could withdraw its permission to present WWE as a virtual class. (Virtual WWE was approved in 2020, and the new delivery system presented thru this program will increase equity, inclusion, and program fidelity. We have no grounds to believe this withdrawal would take place.)

WALK 'n ROLL

PROPOSAL NARRATIVE

Pilot Timeline

Activity	Expected Date(s)
Pilot Start Date	November 1 2022
Collaborate with IHN-CCO DST members	November 2022
Engage IT consultant	November 2022
Identify, order, receive and learn video equipment	November 2022-March 2023
Join INN-CCO DST Sustainability Committee	November 2022 ongoing
Document baseline, Develop qualitative and quantitative measurement strategies for pilot	February 2023-ongoing
Form a Community of Practice with partners focused on furthering evidence-based programming with the aid of electronic referral and hybrid delivery	February 2023-ongoing
Engage IT videographer. Develop video for promotion within Samaritan Clinic system	March 2023
Develop marketing material including print and video. Share with partner organizations	March 2023-June 2023
Recruit and train additional instructors	March 2023-ongoing
Develop replicable PowerPoint presentation to support WWE syllabus; share presentation with other organizations	March 2023-June 2023
Fine-tune session presentations; record with mock class and review	April 2023 June 2023
First hybrid Class Zero	July, 2023
Mid-pilot assessment report	August 2023
Enrollment	Enrollment for first program ends after 3rd session in

	August, 2023. Enrollment for future programs ongoing
First WWE Hybrid program	August-September 2023
Second hybrid Class Zero	October 2023
Second WWE Hybrid program	November-December 2023
Third Class Zero	January 2024
Third WWE Hybrid program	February 2024
Fourth hybrid Class Zero	April 2024
Fourth WWE Hybrid program	starts May 2024
Tabulate participant surveys from third WWE Program. Program review, assessment, wrap-up	By May 31, 2024
Evaluate Outcomes, write Project Report	April 2024-May 2024
Share Project Report with cohorts	May 2024-ongoing
Pilot ends	May 31, 2024

C. Sustainability Plan:
A member of our organization will be participating in the DST Sustainability workgroup. We anticipate this cohort will give us the opportunity to share our experiences and to learn from our colleagues, improving our sustainability prospects.

Infrastructure Sustainability
In 2022, The Newport 60+ Activity Center became a RHEHub member organization. "Our goals parallel the four core elements that keep our collective work sustainable. Our members collaborate collectively, and the contributions of each member organization ensure the sustainability of our shared efforts." --Sonia Graham, 60+ Activity Center Supervisor. Partnerships with RHEHub members and additional community based organizations assure the dissemination of information regarding the program as well as registration options.

Partnership Sustainability:
This pilot will explore WWE resource navigation. We see our license with UniteUs/Connect Oregon as a doorway to linking participants to doctors, transportation, food security, housing, and more.

Financial Sustainability
Oregon Health Authority and Comagine Health have been working with Medicaid to establish reimbursement for fall prevention programs, including WWE. This work at the state level will impact the ability to financially sustain evidence-based programming. Through their Comagine grant, OSU Extension provides 60+ with WWE student workbooks and access to instructor training/certification. An NRPA grant supports the work to research and develop viable electronic referral options.

Program Sustainability
The WWE program has demonstrated its value to the older adult community, and 60+ is committed to continuing to recruit instructors and broaden the base of prospective participants. The mission of Friends of the Newport Senior Center is "To support the Newport 60+ Activity Center. To encourage residents and visitors to participate in a variety of activities including aerobics, chair exercise and to foster awareness of good health practices, to provide incentives to arouse and maintain senior participation in programs and activities." The processes for the pilot program will be documented and replicable for continued program offerings. Sessions will also be recorded and available for promotion. A promotional video will be created for, and assistance provided to, partner organizations who want to explore presenting cross-platform evidence-based programs.

New Horizons:
This pilot can open doors to many new opportunities for the integration of in-person and virtual audiences. For example, it is a perfect platform for Samaritan Health Services to discuss Preventing T2 (national diabetes prevention program) or Smoking Cessation. 60+ can also use the platform to explore best practices for other new and innovative events.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	EQUITY and SUSTAINABILITY: identify and implement most effective electronic referral system(s)	Determine with RHEHub, OSU Extension and Compass; monitor results from selected refeerral system(s), including UniteUs	Enrollment of 18-20 participants in each WWE -week 6program	11/2023-05/2024
	Funding not in place to implement the program	If pilot is approved, the issue will resolved; results documented for each phase of timeline. Appropriate adjustments made as pilot continues.	Administrative and detailed planning timeline completed; partners are notified; community of practice established	11/2022-05/2024
	SUSTAINABILITY: 60+ is not receiving fees for evidence-based programming provided to Medicare/Medicaid recipients	Support Oregon Health Authority and Comagine re. Medicaid billing	Evidence-based program providers will be able to bill Medicaid/IHN-CCO for services to Members	02/2024
	SUSTAINABILITY, REPLICABILITY and FIDELITY: No standardized facilitator script for intra-county co-facilitators	Design, create and train instructors to implement 12 session and 18 session PowerPoint supporting Arthritis Association WWE syllabus	Certified instructors, regardless of location, can co-facilitate or substitute for sessions; six facilitators engaged by 12/2023	12/2023
	SUSTAINABLE: 60+ is lacking appropriate audio and visual electronic equipment	Equipment recommendation reviewed by audiovisual consultant and equipment ordered. Demo class prepared. Initial feedback from mock class members is the beginning of assessment to assure EQUITY	REPLICABLE: Lessons learned from mock class and progress reports from pilot sessions will provide other organizations with the tools to seek funding and develop programs to be supported by cross-platform delivery systems	09/2023-05/2024
	EQUITABLE: Many homebound seniors lack the equipment and the training to access this program	A laptop lending library and experienced teachers will provide necessary tools	Homebound seniors will have access to the pilot, and knowledge to assist in other uses of the	10/2023-05/2024
	ACCESS and EQUITY: Inability for persons who are homebound and those in an in-person WWE class to have a comperable experience	Research, outreach, and implementation will be monitored; results reported	Data to assure that program continues effectively will be solicited. Participants will have equitable experience regardless of location	06/2023-05/2024
	FIRST equitable cross-platform WWE 6 week program delivery begins with a "Class Zero"	class recorded and reviewed by pilot team	Pilot team will fine-tune program delivery prior to WWE Class 1.	08/2023
	SUSTAINABILITY: Staffing limitations -- providing separate in-person and video programs not well enough attended to sustain	Begin pilot hybrid class; track recruitment sources, attrition, responses from participants. Recruit and train WWE	RHEHub and Compass will provide referrals to the pilot WWE program; first 18-22 registrations completed for August Session 0	11/2023-05/2024
	The pilot will transform the delivery of evidence-based programs. No study has been made to date.	Evaluate outcomes, write and deliver report to DST Committee, make information broadly available. Continue to monitor new 6-week WWE programs	Cross-platform delivery of evidence-based programs will be a keystone to improving health outcomes for people experiencing chronic pain, living with arthritis, or experiencing other health challenges requiring intervention	05/2024

Pilot: WALK 'n ROLL

Pilot Start Date: 11/01/2022		**Pilot End Date: 05/31/2024**	
Direct Costs		**Total Cost**	**Amount Requested***
Equipment to create and make accessible an equitable educational and physical environment for in-person and virtual program participants		$8,000.00	$8,000.00
Laptops and hotspots for lending library, and IT support for participants		$4,500.00	$4,500.00
Provide physical and emotional support to a hybrid community through adequate resources capable of supporting sustainability, replicability, and program fidelity		$24,000.00	$24,000.00
Establishing and maintaining a community of practice		$3,000.00	$3,000.00
Engaging consultants to support the hardware and vidography elements needed to insure sustainability		$4,000.00	$4,000.00
Promotion to cohorts and prospective participants		$3,000.00	$3,000.00
Identify service needs through community outreach		$1,000.00	$1,000.00
Total Direct Costs	**Rate (%)**	**$47,500.00**	**$47,500.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$4,750.00	$4,750.00
In-kind: Ongoing development of a CPR and program certified team of volunteer instructors. Each volunteer team will facilitate 4 six-week, 12-18 session WWE programs (144 class hours) annually.		$21,800.00	$0.00
Total Project Budget		**$74,050.00**	**$52,250.00**

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

Comagine Health

June 28, 2022

InterCommunity Health Network
Delivery System Transformation Committee
2300 NW Walnut Blvd.
Corvallis, OR 97330

Dear IHN Delivery System Transformation Committee,

Comagine Health is pleased to provide this letter of support for the Newport 60+ Activity Center's Patient-Centered Fitness Delivery funding request to the InterCommunity Health Network's (IHN) Delivery System Transformation (DST) Committee. The Newport 60+ Activity Center's proposal to offer evidence-based programs through a combination of virtual and on-site delivery will utilize technological innovations to bring together communities greatly impacted by the public health emergency and engage them in free evidence-based exercise programs. These physical activity programs have a strong foundation for improving health outcomes and reducing social isolation.

This pilot and the Newport 60+ Activity Center's mission to preserve the dignity and value of all older adults in the community by providing equitable and accessible opportunities for social interaction, healthy living options, recreation, support services, education, volunteerism, and community action aligns with the statewide infrastructure Comagine Health and partners in the Community Integrated Network of Oregon (CINO) are establishing. CINO is a network of diverse partners focused on building the statewide infrastructure to deliver and sustain evidence-based health education programs and interventions that is convened by Comagine Health. Comagine Health and CINO look to local partners such as Newport 60+ Activity Center to lead innovation at the local level to support and inform the statewide infrastructure development. The pilot proposed by Newport 60+ is an example of a best practice for investment and scaling.

Through our collaboration, we will work to engage and support older adults in evidence-based physical activity programs by sharing resources available through CINO. Comagine Health supports funding this valuable work to help reduce social isolation and increase self-efficacy among home-bound adults in Oregon.

Sincerely,

Tracy Carver

Tracy Carver, MPA
Senior Director, Community Health