2022 IHN-CCO DST Pilot Proposals Crosswalk: Large RFP

Pilot Champion		Olalla Center	Neighbors for Kids	OCWCOG	Old Mill Center	SHS Pop Health	Faith Community Health Network	SHS	OSU Moore Family Center	Unity Shelter	Capitol Dental Care	ReConnections Conseling	GNE	Family Assistance & Resource Center Group	The Arc of Benton County
	Budget	$150,000	$100,018	$148,120	$186,900	$148,825	$98,010	$63,883	$102,390	$108,261	$75,003	$132,720	$193,934	$237,360	$112,355
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														

Ahead of the Curve

Backbone Organization: Olalla Center

Billing Address: PO Box 893 Toledo OR 97391

Site(s): Main campus: 321 SE 3rd St. Toledo. Multiple service sites: public schools, charter schools, Head Starts, Yachats City Bldg., Oregon Coast Community Forest, and other partner locations.

County(s): Lincoln

Priority Areas: (see Guidelines)1. Addressing trauma, including environmental; Post-pandemic cultural trauma; Reduction of wait times for mental health services; Toxic stress. 2. Reengaging the community in personal health and community resources. 3. Rural community impact; Disparity in care for rural communities. 4. Subpopulations of IHN-CCO members that experience health disparities e.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, and more 5. Pay equity through building and sustaining the workforce.

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: (see Guidelines) A1, A2, BH2, BH3, BH4, BH5, BH6, CY1, CY2, HL1, SD4

Pilot Contacts	Name	Email
Primary	Diana Teem “Dee”	deet@olallacenter.org
Proposal	D. Teem, Dr. Jaimie Page	jaimiep@olallacenter.org
Contracting	Belinda Goody	belindag@olallacenter.org
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Reporting	Dr. Jaimie Page	jaimiep@olallacenter.org

2. Proposal Narrative

A. Executive Summary (½ page)

Provide a summary of the pilot including the overall pilot aims.

Olalla Center's Ahead of the Curve pilot proposal is an innovative behavioral health work-based learning and development project. This project is intended to address the workforce shortages in behavioral health, specifically trauma treatment in Lincoln County. Ahead of the Curve will increase behavioral health care for those impacted by trauma, while promoting increased equity and diversity in the workforce.

In light of rampant workforce shortages, Ahead of the Curve will implement a 'Grow Your Own' approach, by investing in existing residents of underserved communities who desire to give back by becoming behavioral health clinicians. Ahead of the Curve proposes to provide clinical supervision (learning and development support) and employment to those entering the field and/or upskilling for careers such as Qualified Mental Health Associates (QHMAs) - Behavior Specialists/Skills Trainers, and Qualified or Licensed Mental Health Professionals (QMHPs) specializing in innovative trauma treatments.

The Ahead of the Curve pilot project will help marginalized and vulnerable people heal from trauma, and increase the diversity and numbers of behavioral health workers in Lincoln County, and increase access to psychiatric evaluations and medication management for IHN members.

B. Pilot Description (5-7 pages)

Detailed description of the proposed pilot including:

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

The primary goals of the Ahead of the Curve pilot project are to help marginalized and vulnerable people heal from trauma, and to increase the diversity and numbers of behavioral health workers in Lincoln County, along with access to psychiatric evaluations and medication management.

Recruit and train diverse workers in behavioral health career paths, including those on 1) the LCSW and LPC tracks, as measured by initially hiring and retention of at least four Master's Level behavioral health interns, and 2) QMHA career track, as measured by hiring and retention of at least four undergraduate work experience students.

Decrease PTSD symptoms and effects of trauma in children, adolescents, and adults in Lincoln county by 1) providing training for two clinicians in Eye Movement Desensitization and Reprocessing (EMDR), and 2) providing training for one clinician in Somatic Experiencing (SE). Outcomes will be measured by PTSD Checklist-5, Subjective Units of Disturbance (SUD) scale and the Validity of Cognition (VOC) scale.

- **Target population**: ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members

Ahead of the Curve will provide mental health services to at least 125 individuals in Lincoln County, including children, adolescents, and adults from underserved communities including BIPoC, Latinx/a/o, LGBTQIA2S+ communities. 100% of these individuals will be IHN-CCO members.

- **Describe the intervention and detailed activities**, including an environmental scan of similar projects in the region

Career Pathways

Priority Areas: *Addressing Trauma, Subpopulations, Re-engaging the Community, Rural Impact, Pay Equity, Language Access, Bilingual/Bicultural Workforce*

1. Recruit and Develop Internship for four master's level behavioral health students; four undergraduate students on a behavioral health career path and hire psychiatrist and/or psychiatric nurse practitioner.

Olalla Center's variety of innovative programs and therapeutic approaches create a model learning environment to teach the next generation of clinicians how to work with people who have experienced trauma. The combination of diverse therapeutic services and community-based programs provides clinical supervisors unique perspective to guide students in how to help communities impacted by environmental, generational and developmental traumas. Students will work with qualified, experienced clinicians in a team-based approach to learn how to identify and help heal the wounds of trauma with the support of a diverse of clinical staff utilizing innovative trauma treatments. Due to the rural area, it is difficult to find clinicians, especially clinicians connected to the community.

Olalla's Ahead of the Curve project reflects the findings in Oregon's *Recruitment and Retention Recommendations for Oregon's Behavioral Health Workforce* (2019). For the State's goal of improving equitable geographic distribution of the behavioral health workforce across the state, we will follow the suggested strategies to: 1) increase the proportion of licensed and unlicensed behavioral health workforce that work in rural and underserved geographic areas; and 2) develop high-quality education and training programs for advanced practice provider behavioral health workers to serve in underserved, rural communities. Olalla will specifically seek interns who are bilingual/bicultural.

To further align with the State's goals, we will utilize our workforce partnerships and behavioral health education programs to: 1) include tuition and support services, and stipends for students in training; 2) develop additional curricula and training programs that can address gaps in behavioral health career ladders and opportunities; and 3) improve access to housing for behavioral health workers, in the form of relocation assistance.

Finally, for the State's goal of ensuring "that all counties have psychiatrists available to support advanced practice", we will seek an additional psychiatrist and/or psychiatric nurse practitioners to help provide critical pharmacological treatment for our clients and community who are otherwise unable to obtain psychiatric evaluations and medication management. In our community, primary health physicians typically prescribe psychotropic medications due to the lack of qualified psychiatrists/psychiatric nurses.

Eye Movement Desensitization and Reprocessing (EMDR)

Priority Areas: Addressing Trauma, Subpopulations, Re-engaging the Community, Rural Impact

2. Train two clinicians in EMDR (EMDRIA Approved Program). Eye Movement Desensitization and Reprocessing (EMDR) therapy is an extensively researched, effective psychotherapy method proven to help people recover from trauma, PTSD, anxiety, depression, and panic disorders with a 95% success rate (emdria.org). Once clinician will focus on adolescents and adults; the other will focus on children and adolescents.

EMDR therapy is an evidence-based, trauma-focused intervention in which clients focus on a traumatic event, while engaging in eye movement bilateral stimulation directed by the EMDR-trained therapist. EMDR is endorsed by the American Psychiatric Association as well as the World Health Organization (Moench & Billsten, 2021). In multiple studies, EMDR has been shown to be effective for treatment PTSD, anxiety, and depression in adults, adolescents, and children (Moench & Billsten, 2021; Scelles & Bulnes, 2021; Wilson, et al., 2018). In fact, EMDR is the most effective treatment for PTSD, with a 95% success rate (emdria.org). Scelles & Bulnes (2021) demonstrated that EMDR also helps with: addictions, somatoform disorders, sexual dysfunction, eating disorders, disorders of adult personality, mood disorders, reaction to severe stress, anxiety disorders, performance anxiety, Obsessive-Compulsive Disorder, pain, neurodegenerative disorders, mental disorders of childhood and adolescence, and sleep. Importantly, EMDR has recently been shown to significantly reduce negative psychological effects from the Covid-19 pandemic (Doherty, et al., 2021; McGowan, et al., 2021; Solomon & Hensley, 2020).

Somatic Experiencing

Priority Areas: Addressing Trauma, Subpopulations, Re-engaging the Community, Rural Impact

3. Train one clinician in Somatic Experiencing (Dr. Peter Levine's Somatic Experiencing Practitioner [SEP] Program), who can then train other clinicians and develop curriculum around Somatic Experiencing. Somatic Experiencing is a therapeutic model that combines mind-body orientations to address trauma and the effects of trauma. It can be used in multiple professions and settings including medicine, psychotherapy, physical therapy, etc. (traumahealing.org).

Somatic Experiencing(®) (SE) is a form of trauma therapy that has been demonstrated to effectively treat trauma symptoms and PTSD (Kuhfuß, et al., 2021 and Brom, et al., 2017). It is an effective body-oriented therapy approach that focuses on the physiological consequences of the traumatic event and on resolving the adverse symptoms of post-traumatic stress and chronic stress (Payne, et al., 2015). In addition, Kuhfuß, et al., (2021) found that SE also helps clients with panic disorders, depression, or chronic pain better regulate their nervous systems, reduce stress, and decrease disturbing symptoms.

In our anecdotal experience as Olalla clinicians since the pandemic, our clients have experienced increased complaints of depression and anxiety related to COVID and other current exigencies of modern life. Many clients have been unable to distinguish between physical and psychological symptoms, in part because most of our clients have experienced poverty and trauma in their lives at the same time it is difficult to gain access. As a result, many have sought medical care and were told

they are suffering from “stress”. By offering evidence based somatic experiencing therapy, clients will gain better body-mind awareness, learn to respond to triggers and emotional dysregulation, and incorporate self-regulation strategies.

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

Northwest Oregon Works (NOW), is a non-profit organization that provides strategic leadership for workforce development activities and coordinates the public workforce system within its five-county area. NOW’s Behavioral Health Work-Based Learning Career Pathway (BWLCP) project collaborates with Olalla Center to promote increased equity and diversity in the workforce. BWLCP provides tuition and essential supportive services for those engaged in entering the field and/or upskilling for careers such QMHA’s, QMHPs, and licensed Mental Health Professionals.

Community Services Consortium (CSC), Workforce & Education Department will refer students from underserved communities with an interest in behavioral health internships and work experience options with Olalla Center.

Lincoln County Health & Human Services partner in mental health and Inter Agency Planning Team to support children’s needs for Olalla Center’s Day Treatment / Outpatient Services.

Oregon Health Authority is a funding partner for Olalla Center’s social service wrap around support, resources and outreach to underserved communities for recruitment of those interested in behavioral health careers.

Lincoln County Schools, Lincoln City Cultural Center, Oregon Coast Community Forest, Integrity Health, City of Yachats are partners who provide space for clinical services that will be utilized by Ahead of the Curve interns and work experience students.

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

Olalla will promote health equity and reduce health disparities by recruiting, training, and supporting qualified master’s level clinicians. These clinicians (as well as clinicians who will supervise the interns) will provide for vulnerable and marginalized individuals and populations. We will address the lack of equity in mental health services by dedicating resources to hiring a psychiatrist/psychiatric nurse(s).

Olalla serves a wide range of clients, including LGBTQIA2S+, Latinx/a/o and Indigenous populations, people in poverty, food and housing insecure, those with mental health issues, disabled individuals, children in foster care and at the juvenile detention facility/youth shelter, individuals with substance use disorders/co-occurring disorders, and other marginalized and vulnerable populations. Health equity data will be tracked by in Olalla Center’s Health Records System, at intake and updated as needed.

- **Explain the social determinants of health** lens the pilot will be incorporating

Olalla Center and the Ahead of the Curve pilot's primary service population is marginalized community members living in poverty, who are food and housing insecure, unemployed or under employed, many are isolated and lack community supports. Ahead of the Curve will actively recruit underserved community members into our behavioral health education and workforce program connecting them with tuition and support services through Northwest Oregon Works. Our internships and work experiences lead to benefitted, living wage behavioral health jobs that help strengthen communities from within. These same behavioral health interns, workers and their care team will assist at least 125 underserved community members annually to reduce the impacts of trauma, and aid them in developing skills, community connection and cultural supports to improve health outcomes.

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

Danielle Walsh, LPC, will be trained in EMDR. They work with the LGBTQIA2S+ adolescent and adult clients, are a member of Olalla's Project Bravery Team, have managed programs and have 10 years of experience as a licensed therapist.

Jaimie Page, PhD, LCSW will oversee the student internship program and supervise some of the interns. She has 30+ years in social work, including 14 years as a social work professor. Dr. Page is an EMDRIA-trained EMDR trauma therapist. She will also receive the Somatic Experiencing training, and then train other clinicians at Olalla Center.

An additional Olalla Center child and family therapist/mental health therapist will be trained in EMDR (the individual has not been identified).

Maygen Blessman, LCSW will supervise Qualified Mental Health Associate (QMHAs) career pathways student workers and some interns. She has 10+ years of experience in social work and has led clinical staff teams. Maygen currently supervises clinical staff in Olalla Center's Outpatient Services Department.

All have lived experience as members of underserved communities, are highly qualified professional, compassionate and have a wealth of mental health service experience.

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

Ahead of the Curve's behavioral health workforce development project aligns with Olalla Center's strategic plans to reduce client waitlists and meet the rising need for behavioral health workers in Lincoln County, as well as increase accessible psychiatric evaluations and medication management. Our plans specifically indicate the need for trauma treatment providers in Behavioral Health: therapists/QMHPs, behavior specialist / skills trainers/ QMHAs, and psychiatric service providers. A fully implemented behavioral health master's level internship program and undergraduate workplace training program are an integral part of Olalla Center's strategic plan.

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

The Ahead of the Curve project will be marketed through social media pages/blog, sites and apps utilized by the service population and public. Additional marketing with be completed through community outreach, our network of community partners, relationships with higher education (e.g., Portland State University, Oregon Coast Community College), and traditional media outlets (radio stations, news publications, online news).

Olalla Center is grateful to have news media publisher, Jeremy Burke as Vice President of our Board of Directors. Their contribution to Olalla Center is free media announcements, news, and the development of a youth focused magazine.

- **Describe potential risks and how the pilot plans to address them**

Clinical Supervision of interns and behavioral health staff comes with a myriad of potential risks. We will mitigate risk with effective onboarding practices, background checks and screening, along with intensive team-based clinical supervisors who are credentialed, qualified, and experienced to provide Interns and QMHA career path students with a supportive learning and work environment. Interns and work experience students are supervised in all aspects of client services to enhance workplace learning and mitigate risks.

A potential risk is client concern's about EMDR and/or Somatic Experiencing. Clients will be given education and information about these strategies, which have built-in mechanisms for evaluating for appropriateness. Interns will be provided excellent onboarding, training, supervision, and support to lessen risk of direct care issues.

C. Pilot Timeline (1 page)
Provide a timeline of major activities and goals.

Ahead of the Curve Pilot will begin in January 2023 and continue beyond the funded period end date December 2023.

Prior to pilot start date: Behavioral health master's interns and QHMA career track work-based learners will be recruited in Fall 2022 and throughout calendar year 2023. Internship timelines will vary slightly based on university semesters. Work-based learning opportunities will begin in January/February 2023 and continue through hiring and onboarding process.

D. Sustainability Plan (½ page)
Explain how the pilot is innovative, scalable, and transferable. Describe how the pilot, if successful, will be sustained within your organization and how it could be spread to other organizations. Describe other organizations that have a vested interest in the pilot. Be sure to include other resources and organizations contributing to the success of the pilot. Explain how funding will continue after DST funding is completed.

Ahead of the Curve is innovative in its recruitment of Behavioral Health workers from the underserved served communities we serve. Recruiting community members experiencing

poverty, LGBTQIA2S+, BIPoC, Latinx/a/o, bilingual/bicultural to serve their own communities builds community connection, trust and natural supports. The trauma treatments and team-based clinical supports is innovative. Ahead of the Curve QHMP Interns and QHMA work based learners will have the opportunity to experience multiple innovative mental health and community programs including Walden Project outdoor activity therapy, Project Bravery LGBTQIA2S+ mental health groups and community supports, Arcoiris Cultural and Community Health Outreach, Pegasus Project equine assisted mental health therapy, Day Treatment (with Dance Movement Therapy), EMDR and Somatic Experiencing.

Tuition costs and support services are funded by NW Oregon Works up to $25,000/per student/worker annually. Work experience youth are supported in part workforce investment funding through Community Services Consortium work experience stipends. We will also explore options through the Oregon Employment Department – training unemployment insurance options.

Interns (QMHPs) and QHMAs track workers, once trained will participate in billable services to help support their wages and clinical supervision hours. The Psychiatrist/ Psychiatric Nurse Practitioner will also be sustained primarily through billable service hours.

Olalla Center will continue to raise funds through Behavioral Health grants and community fundraising support for the Ahead of the Curve project coordination, uncovered clinical time, supplies and training as needed.

This project would be replicable at other organizations who are open to diverse and innovative mental health and community services, collaborative care teams, supportive clinical supervision and the goal of breaking down barriers for underserved communities.

Oregon Health Authority funding for community outreach and resource navigation has been solid for more than 12 years and has grown to include social service wrap around support for clients and community members in need. These services would be available to students and clients ongoing to help meet their needs, overcome barriers and help them thrive.

3. Budget Worksheet

Provide a budget using the Budget Template (this template will be in Microsoft Excel).

Budget Attached.

4. SMART (Specific, Measurable, Attainable, Relevant, Timely) Goals and Measures Table

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

Goals and Measures Table / Activities Monitoring Grid Attached.

Bibliography

Brom, D., Stokar, Y., Lawi, C., Nuriel-Porat, V., Ziv, Y., Lerner, K. & Ross, G. (2017). Somatic experiencing for Posttraumatic Stress Disorder: A randomized controlled outcome study. *Journal of Traumatic Stress*, 304-312. doi: 10.1002/jts.22189. Epub 2017 Jun 6.

Doherty, A., Benedetto, V., Harris, C., Boland, P., Christian, D.L., Hill, J., Bhutani, G., Clegg, A.J. (2021). The effectiveness of psychological support interventions for those exposed to mass infectious disease outbreaks: a systematic review. *BMC Psychiatry.* 2021 Nov 24;21(1):592. doi: 10.1186/s12888-021-03602-7. PMID: 34814859; PMCID: PMC8610770.

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	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Clients and potential clients are not being effectively treated for trauma symptoms and PTSD	PCL-5 (PTSD symptom measurement); measurements at baseline, completion of EMDR target, and every six months thereafter.	50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms	December-23
	Clients and potential clients are not being effectively treated for trauma symptoms and PTSD	SUD Scales (Subjective Units of Disturbance); measurements at baseline.	50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms	December-23
	Clients and potential clients are not being effectively treated for trauma symptoms and PTSD	VOC scales (Validity of Cognition) (EMDR/SE); measurements at baseline.	50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms	December-23
	Clients and potential clients are not being effectively treated for trauma symptoms and PTSD	Beck Depression Inventory at baseline and every six months thereafter.	50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms	December-23
	Clients and potential clients are not being effectively treated for trauma symptoms and PTSD	Beck Anxiety Inventory at baseline and every six months thereafter.	50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms	December-23
	Lack of behavioral health / trauma treatment workforce in rural Lincoln County	Learning Contract signed and Internship starts	Recruit, train, support 4 Master's & 4 undergraduate behavioral health students	Recruit in Fall 2022 for Academic year 2023
	Lack of behavioral health / trauma treatment workforce in rural Lincoln County	Workramp* onboarding, learning, development, support & tracking	Hire 3/4 interns-QMHPs, 3/4 QMHAs retain with person centered supervision and support	December-23
	Lack of behavioral health / trauma treatment workforce in rural Lincoln County	Employment Offer is accepted and employment starts	Hire and retain psychiatrist and/or psychiatric nurse practitioner	January-23
	Lack of behavioral health / trauma treatment workforce in rural Lincoln County	DISC Assessments, Person Centered Supervision	Above staff to be onboarded in a culture of learning & development with team and individual support	December 23 and ongoing

*Note: Workramp LMS platform

Pilot: Ahead of the Curve

Pilot Start Date:	1/1/2023	Pilot End Date:	12/31/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Clinical Supervision of Interns*		$90,000.00	$45,000.00
Psychiatric evaluations and medication management*		$82,000.00	$40,000.00
Clinical Supervision of QMHA track students*		$67,000.00	$32,000.00
*Above are paid in part by behavioral health insurance		$0.00	$0.00
	Subtotal Resource Costs	**$239,000.00**	**$117,000.00**
Materials & Supplies			
Therapeutic supplies (client sessions)		$4,500.00	$4,500.00
Food/ nutrition for client service needs		$2,500.00	$2,500.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$7,000.00**	**$7,000.00**
Travel Expenses			
mileage for clients services		$2,500.00	$2,500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$2,500.00**	**$2,500.00**
Meeting Expenses			
Team Training Meetings, refreshments, space rental, technology		$1,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$1,000.00**	**$1,000.00**
Professional Training & Development			
WorkRamp		$5,000.00	$5,000.00
EMDR ($1500/person)		$3,000.00	$3,000.00
Somatic Experiencing (Train the Trainer)		$9,500.00	$9,500.00
	Subtotal Training & Development	**$17,500.00**	**$17,500.00**
Other Budget Items			
DISC Assessments and Person Center Supervision Team Development		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$5,000.00**	**$5,000.00**
Total Direct Costs	**Rate (%)**	**$272,000.00**	**$150,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
Total Project Budget		**$272,000.00**	**$150,000.00**

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

NORTHWEST OREGON WORKS

July 22, 2022

InterCommunity Health Network CCO
2300 NW Walnut Blvd.
Corvallis, OR 97330

To whom it may concern:

Northwest Oregon Works (NOW) is a non-profit organization that provides strategic leadership for workforce development activities in Benton, Clatsop, Columbia, Lincoln, and Tillamook counties. As the designated Local Workforce Development Board, NOW oversees and coordinates the public workforce system within its five-county area.

NOW was awarded funding to create, develop and implement a Behavioral Health Work-Based Learning Career Pathway (BWLCP) program. This project is intended to address the workforce shortages in behavioral health in the Northwest Oregon region, while concurrently promoting increased equity and diversity in the workforce. This program supports the behavioral health workforce in Lincoln County along a 3-level career pathway. BWLCP provides funding for tuition and essential supportive services for those engaged in entering the field and/or upskilling for careers such as behavior Specialists, QMHA's, QMHPs, and fully licensed Mental Health Professionals. NOW embraces a 'Grow Your Own' mentality by investing in existing residents of underserved Northwest Oregon communities who desire to give back by becoming practitioners in behavioral health and substance use professions.

NOW's program would pair nicely with Olalla Center's "Ahead of the Curve" workforce initiative. Through implementation of the BWLCP program, there has been an identified barrier of a lack of supervisors for students completing internships and practicums. NOW is in full support of the work that the Olalla Center provides for the community and welcomes all partnerships to address this dire workforce need in the Northwest region of Oregon.

Thank you in advance for your consideration of the Olalla Center's Ahead of the Curve proposal.

Sincerely,

Heather DeSart
Executive Director

Olalla Center

Ahead of the Curve

A Behavioral Health Workforce

Learning & Development Project

Pilot Summary and Goals

- **Ahead of the Curve** is an innovative behavioral health work-based learning and development project.

- Goal 1: Decrease effects of trauma in children, adolescents, and adults in Lincoln county
- Goal 2: Recruit and train diverse workers in behavioral health career paths
- Goal 3: Increase access to psychiatric evaluations and medication management

Member and Community Need

Ahead of the Curve

- Target Population: Underserved communities, BIPoC, Latinx/a/o, LGBTQIA2S+, and people in poverty with a history of trauma
- IHN-CCO Member Impact: 125 members served annually
- Community Needs:
  - Lack of Behavioral Health providers specializing in Trauma Treatment
  - Lack of Bilingual/bicultural, LGBTQIA2S+ BH providers

System Transformation

Ahead of the Curve is transformational

- Collaboration NW Oregon Works (NOW) & Olalla Center to increase equity and diversity in Behavioral Health
  - NOW - Tuition & Support services
  - Olalla Clinical Supervision, experiential learning
  - Proposal will reduce the impacts of trauma and improve IHN-CCO member's health

And Innovative

- Recruit underserved community members to work with underserved communities. Growing our own workforce
- Innovative trauma treatments, EMDR/SE, team of innovative programs to support learning with person-centered supervision

Partnerships/Collaboration

- **Northwest Oregon Works** (NOW),is a non-profit organization that provides strategic leadership for workforce development activities and coordinates the public workforce system within its five-county area. NOW's Behavioral Health Work-Based Learning Career Pathway (BWLCP) project collaborates with Olalla Center to promote increased equity and diversity in the workforce. BWLCP provides tuition and essential supportive services for those engaged in entering the field and/or upskilling for careers such QMHA's, QMHPs, and licensed Mental Health Professionals.
- **Community Services Consortium (CSC),** Workforce & Education Department will refer students from underserved communities with an interest in behavioral health internships and work experience options with Olalla Center.
- **Lincoln County Health & Human Services** partner in mental health and Inter Agency Planning Team to support children's needs for Olalla Center's Day Treatment / Outpatient Services.
- **Oregon Health Authority** is a funding partner for Olalla Center's social service wrap around support, resources and outreach to underserved communities for recruitment of those interested in behavioral health careers.
- **Lincoln County Schools, Lincoln City Cultural Center, Oregon Coast Community Forest, Integrity Health, City of Yachats** partners provide space for clinical services that will be utilized by Ahead of the Curve interns and work experience students.

Health Equity Plan

- Ahead of the Curve will promote health equity and reduce health disparities by recruiting, training, and supporting qualified master's level interns (QMHPs) and other seeking Behavioral Health careers.
- Therapists will provide treatment for underserved communities.
- We will address the lack of equity in mental health services by dedicating resources to hiring a psychiatrist/psychiatric nurse(s).
- Access to psychiatric evaluations and medication management.
- Increase behavioral health access for: LGBTQIA2S+, Latinx/a/o, Indigenous, in poverty, food / housing insecure, with mental health issues, disabled, children in foster care and at the juvenile detention center/youth shelter, with substance use disorders/co-occurring disorders, and other marginalized and vulnerable people. Health equity data will be tracked by in Olalla Center's Health Records System, at intake and updated as needed.

Definition of Success

- Measures & Outcomes – **Ahead of the Curve**
- Data to measure success: PCL-5, SUD and VOC scales, Beck Depression and Anxiety inventories
- At the end of your pilot, what will have changed?
  - 50 individuals will be engaged in trauma therapy and report significant reductions in trauma symptoms
  - 4 Qualified Mental Health Professions, 4 Behavior Specialists/ Skills Trainers will be hired from underserved communities.
  - Increased access to psychiatric evaluation and medication management.

Sustainability Plan

- Once established **Ahead of the Curve** will be primarily self funded through Behavioral Health services (insurance)
- Tuition and support services costs covered by NW Oregon Works $25K / student. Scholarships and Work Experience Stipends from workforce partners.
- Oregon Employment Department Training Unemployment Insurance funding
- Behavioral Health grants and fundraising will help with program coordination and any uncovered clinical costs in the future.

DST Member Questions?

Ahead of the Curve

Olalla Center

Dr. Jaimie Page, LCSW jaimiep@olallacenter.org

Diana “Dee” Teem, Community Health & Development
deet@olallacenter.org

Coastal Kids Mentoring Program

Backbone Organization: Neighbors For Kids (NFK)

Billing Address: P.O. Box 942 – Depoe Bay, OR. 97341

Site(s): NFK Facility: 634 SE Highway 101 – Depoe Bay, OR. 97341

County(s): Lincoln

Priority Areas: Addressing Trauma (post-pandemic and toxic stress), Reengaging the Community in Personal Health and Community Resources (connecting local volunteers with local youth), and Rural Community Impact (disparity in care for rural communities)

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: Behavioral Health - Outcome BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support. Child and Youth Health- Outcome CY1: Increase the percentage of children, youth, and families who are empowered in their health.

Pilot Contacts	Name	Email
Primary	Toby J. Winn	director@neighborsforkids.org
Proposal	Toby J. Winn	director@neighborsforkids.org
Contracting	Toby J. Winn	director@neighborsforkids.org
Financial	Nirvana Clifton	nirvana@neighborsforkids.org
Reporting	Toby J. Winn	director@neighborsforkids.org

Proposal Narrative

A. Executive Summary

Neighbors For Kids (NFK) cares deeply about the behavioral health of youth in the community. Research has shown how youth from underserved populations have many risk factors that can negatively affect their overall health and well-being. Most at-risk are those who come from low income families, have diverse ethnic backgrounds, LGBTQ+ youth, English Language Learners, youth in the foster care system, youth who are experiencing homelessness, youth who have special needs, and youth with mental health challenges. For youth and families living in rural Lincoln County there are additional challenges such as transportation barriers, lack of child care, less opportunities for safe, affordable recreation and limited access to healthy foods due to a family's financial resources or location of grocery stores. Our youth have endured two difficult years of the pandemic, and this strengthens the fact that we must address the behavioral and mental health of our region's underserved youth. This is critically important.

The main objectives of this pilot project, the Coastal Kids Mentoring Program, are to 1) build support systems and make interventions for youth experiencing significant behavioral and mental health challenges, 2) promote health equity and eliminate health disparities, and 3) improve the health of underserved populations of youth with specialized support (mentorship). Funding for this pilot program would be used for staffing costs, materials, supplies, food, incentives, training, and other indirect costs such as facility operations and scholarships for low income participants. NFK's facility would be used to coordinate this mentoring program, for training staff and volunteers, monthly support meetings, family night events and as a safe environment for mentor-mentee interactions. All youth in the mentoring program would receive scholarships due to their enrollment in Coastal Kids, giving them full access to child care, enrichment activities, healthy meals, supplies, equipment, transportation and field trips over the course of the year.

Underserved populations of youth have many obstacles to overcome. They need interventions to stay safe and healthy and would greatly benefit from a one-on-one matching mentorship experience. The supportive, healthy relationships formed between mentors and mentees are proven to have immediate and long-term benefits for both the youth and adult. The Coastal Kids Mentoring Program is a powerful and innovative model to support behavioral and mental health, and the volunteer-driven program is sustainable over time.

Provide a summary of the pilot including the overall pilot aims.

The specific aim of this pilot program is to develop and implement the Coastal Kids Mentoring Program, the first-time a program of this nature has ever been offered to youth in Lincoln County, Oregon. The program will utilize prevention, intervention and skill-building methods through mentorship, in order to improve the social, behavioral and emotional health of underserved youth in the region. Our organization believes that relationship-building, healthy, positive communications and shared life experiences can change a young person's life. The long-term goal is to develop and provide a quality mentoring program that will improve the well-being of youth in the community for many more generations.

B. Pilot Description (5-7 pages) - Pilot Program Goals:

The Coastal Kids Mentoring Program has a goal of using relationship-building, positive communication and consistent support as an innovative approach to improve the health of youth residing in Lincoln County. The Coastal Kids Mentoring Program addresses three of IHN-CCO's **Priority Areas**; Addressing Trauma (post-pandemic and toxic stress), Reengaging the Community in Personal Health and Community Resources (connecting local volunteers with local youth), and Rural Community Impact (disparity in care for rural communities). The pilot project will focus on the **Behavioral Health** using mentorship as the innovative strategy to improve health care and make a positive impact on the health of local youth and by implementing it NFK will help achieve outcomes from IHN-CCO's Community Advisory Council's 2019 Community Health Improvement Plan. One of the outcomes we aim to achieve will be **Outcome BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.** The nature of mentoring involves ongoing interventions, communication with family members and making referrals to specialists within the youth's support network when necessary. The next outcome the project aims to focus on is **Child and Youth Health.** By implementing the mentoring program there will be an ability to achieve **Outcome CY1: Increase the percentage of children, youth, and families who are empowered in their health.** While involved in the program youth will have a consistent advocate (the mentor) over an extended period and take part in goal setting and skill-building.

Mentoring will be a unique resource offered to youth in the region and it will make a positive impact and support their healthy development. Youth go through many challenging life transitions, including dealing with stressful changes at home or transitioning to adulthood. The goal of mentorship is to provide them close, healthy, supportive relationships that over a period of time will build external and internal assets. These assets will help underserved youth in the community grow up to become healthy, caring and responsible people. Importantly, mentors will have a chance to make interventions that support mentees behavioral health and mental health in a non-clinical way.

NFK plans to track and measure goals in the following ways: Attendance and activity tracking, youth surveys and interviews, parent surveys and interviews, adult mentor surveys and interviews, and communications with other health care providers and agencies. Data tracking will follow number of youth taking part in the program, number of hours spent per week/per month among mentor-mentee pairs, number of monthly support meetings, number of family night events, and number of quarterly full cohort activities attended. Upon entering the program, youth, parents and mentors will take a pre-survey and after 11 months there will be a post-survey. The surveys will utilize the Search Institute's 40 Developmental Assets and the list of external and internal assets. There will be questions specific to behavioral and mental health challenges at home, school and within relationships. Communication and debriefing with mentors, mentees, parents and health care providers will occur monthly to follow the mentoring relationship and build a close circle of support around each youth.

Target Population:

The pilot aims to serve school-age youth between the ages of 6-18 who reside within the rural communities of Lincoln County, Oregon. This target population will be youth who have been

identified by parents, school staff, therapists, counselors, juvenile justice system staff, and/or health professionals as needing significant behavioral, emotional and mental health support/interventions.

The program will recruit a diverse group of participants, emphasizing youth who come from disadvantaged circumstances and might not otherwise have access to a quality mentoring program. This includes youth who are among the region's underserved populations and come from low income families, have diverse ethnic backgrounds, LGBTQ+ youth, English Language Learners, youth in the foster care system, youth experiencing homelessness, youth who have special needs, and youth with behavioral and/or mental health challenges. Currently, NFK serves children ranging in ages 3-18. Among this group, 66% are Caucasian, and 34% come from Latinx, Native American, Asian, African American or bi-racial cultural and ethnic backgrounds. Approximately 95% of NFK's program participants qualify for the free or reduced price lunch program in the public school system, and 80% or more come from single-parent families.

NFK has 22 years of experience serving low income families in the county. Approximately 80% of people served are living at or below the federal poverty level and have Oregon Health Plan for medical insurance (some Medicare), with primary care providers at Samaritan Pacific Communities Hospital, Samaritan North Lincoln Hospital or Lincoln County Community Health Centers. Upon enrollment into the new mentoring program, NFK's registration form will ask specifically if youth are current IHN-CCO members, to help gauge the number of members served. NFK estimates that 75% of youth or more will be IHN-CCO members.

Intervention & Activities:

NFK's Coastal Kids Mentoring Program will use a one-on-one matching system to connect adult volunteers and youth. The program will provide a 12-month mentorship program with a goal of supporting 20 youth ages 6-18 who reside within the rural communities of Lincoln County, Oregon. The coordinator of this program will match each adult mentor with a youth mentee, matching based on shared life experiences, cultural backgrounds, common interests, compatibility and skill sets needed to best develop a safe, healthy relationship during the year long program. The goal is for the mentoring relationship to continue beyond the one-year program, and a new cohort will be served every year moving forward. The program will help each mentor-mentee pair develop a deeper bond of trust during the time spent together, and there will be opportunities for positive, healthy communication, interventions and referrals for additional support services if needed.

The mentoring program is an innovative approach to address the behavioral health of youth and it will have four main elements; 1) One-On-One Mentoring, 2) Monthly Family Support Meetings, 3) Quarterly Group Events, and 4) Community Awareness/Training. The structure of the mentoring program will engage youth in recreation, physical activities as well as social-emotional skill-building activities. This helps to support each youth's unique individualized needs and the interconnected health needs of each youth.

One of the most important pieces of this program is **Mentor Recruitment** and finding a cohort of safe, caring and qualified volunteers to spend time with these youth. Although Lincoln County is a rural area geographically there are several places for staff to do outreach and

recruit quality adult mentors. The region has a large retired population, many whom have time to give and could be excellent mentors. The Mentoring Program Coordinator will seek volunteers who are compassionate, communicate well, have shared past experiences, interests and/or cultural backgrounds with youth, and can commit to the time and energy it takes to participate in the program. We feel optimistic we can recruit mentors in Lincoln County from organizations such as the U.S. Coast Guard, Fire Departments, Law Enforcement Agencies, Hospitals, Public Schools, City Recreation & Community Centers, Senior Centers, Oregon Coast Community College, Civic Groups, in addition to other locals who take part in activities such as running, sailing, surfing, hiking, disc golfing, playing music or doing artwork.

NFK also has a built-in infrastructure and will offer the existing resources to the Coastal Kids Mentoring Program, including a 7,600 square foot facility with classroom space, an indoor gym, commercial kitchen, kayaks, surfboards, wetsuits, row boats, and two Ford 12-passenger vans for off-site field trips. In addition, all participants will have full access to the Kids Zone's year-round programs, child-care, summer day camp and enrichment activities such as visual arts, music lessons, science projects and cooking classes. The adult mentors could join their mentees on-site to take part in these types of activities if mutually agreed upon. The Lincoln County region has a healthy, diverse outdoor environment full of unique and fun opportunities to support this type of program.

One-On-One Mentoring is the main element of this program and when the adult-child pair will spend most of their time together. Over the course of the year, they can participate in new experiences together, such as outdoor recreation and physical activity, hiking, surfing, kayaking, art classes, bowling, enjoying meals or other opportunities as decided upon. NFK will use a portion of pilot program funds to support the costs of each mentor-mentee pair's experiences and the organization will seek other in-kind donations for this. The healthy, supportive relationship discovered while mentoring is where the power of a human connection can improve the health of our youth, and potentially change or save someone's life.

Monthly Family Support Meetings welcome mentor-mentee pairs and their family members to join at NFK's facility for healthy meals, activities, skill-building and to hear guest speakers. The group can engage in recreation activities, collaborative art or science projects, and guest speakers from the community will present about various topics relating to mentoring, modern day youth, culture/ethnicity, inclusiveness, special needs, and positive child to adult interactions.

Quarterly Group Events will occur every three months and the full cohort of 20 mentors and 20 mentees will gather to share a fun, structured experience. During this time, youth and adults can connect with other participants in the program, to socialize, develop friendships and have peer support. The four events tentatively planned include a Dockside Charters Whale Watching Trip, Bright Horizons Therapeutic Horseback Riding, Otter Rock Surf Camp and Salishan Resort's Aerial Park Challenge Course. The activities will incorporate skill-building such as teamwork, communication, trust and courage.

Community Awareness/Training will be held to reduce stigma around mental and behavioral health issues and to increase community awareness that these issues are normal and experienced by many people. NFK's program staff and all volunteer mentors will be trained in

topics such as Mental Health First Aid, Trauma Informed Care, Collaborative Problem Solving, Diversity, Equity & Inclusion, and Positive Youth Development. These trainings will help our team of staff and community members better understand, respect and serve the target populations. Mandatory training for adult mentors includes DHS's Recognizing and Reporting Child Abuse & Neglect. This high degree of training will help the cohort of adult mentors be well-equipped with the skills and knowledge needed to best serve the individual needs of their mentees.

*For safety purposes, all adults recruited into the program must successfully pass a strict, comprehensive screening process. This includes a criminal background check with Oregon Dept. of Education, national-level FBI fingerprinting, and multiple calls for character references. For safety and transportation of youth, volunteers must pass all DMV criteria, with proof of car insurance, a valid driver license, and safe driving record. Any potential concerns or red flags from any criteria above will automatically disqualify adults from being considered for the program. The safety of all youth participating is the number one priority.

Pilot Program Leadership:

The Coastal Kids Mentoring Program will use a collaborative team approach to implement the program activities. The program will be based out of the Neighbors For Kids (NFK) facility in Depoe Bay, Oregon.

Toby J. Winn, Executive Director of Development for NFK, wrote the proposal to IHN-CCO and helped to develop the new pilot program. He will oversee and support the project as the Administrator. Toby has 21 years of experience working with youth-serving non-profit organizations, with 4 years at the Boys & Girls Club of Emerald Valley and nearly 17 years at Neighbors For Kids. Toby helped to build a strong community partnership with Samaritan Health Services over the past 12 years, and together the organizations have addressed health equity issues such as childhood obesity prevention, nutrition education, hunger, food instability and child care. In addition, while at University of Oregon, Toby served as a mentor himself at Committed Partners For Youth, participating in 2 years of a structured mentorship program.

Nirvana Clifton, NFK's Director of Programs & Operations, will help manage the activities of the mentoring program, alongside a newly hired Mentoring Program Coordinator. Nirvana has worked for NFK for six years, coordinating programs, building relationships with children and families, managing parent registration and enrollment, while assisting with other administrative duties. Nirvana has a history attending a Big Brother, Big Sister type of mentoring program where she lived in Ireland. Nirvana is a skilled multi-tasker, excellent communicator and is highly organized.

A *Mentoring Program Coordinator* will be hired to oversee the program across the year. This staff person will be the lead person to recruit and match the cohort of mentors and mentees, provide screening and training, do case management and tracking for each pair, have ongoing communications with partner organizations, parents and providers, and plan and lead the program's monthly and quarterly events.

Community Partnerships:

NFK will work with community partners and use cross-sector collaboration to implement the mentoring program and meet the behavioral health needs of youth. Lead program staff, mentors and parents will inform primary care providers and behavior health practitioners that youth are enrolled and actively participating in the program. By creating awareness of the mentorship program and having ongoing communication with other providers, the circle of support for youth will be strengthened significantly.

Olalla Center For Children & Families - Olalla Center will partner with NFK as a referral source to serve youth with special needs and mental health challenges, and will collaborate for shared client case management as needed. Their Walden Project (a previously funded pilot) could potentially be a site for people interested in being mentors within outdoor therapy groups. Olalla Center also has a therapist with a mentoring program background who could provide staff and volunteers training.

Lincoln County School District – The regions school Principals and Counselors will work collaboratively with NFK to identify and recruit youth who could benefit from the mentoring program. They will provide other support to identify students who are enrolled in LCSD's Homeless Education Literacy Program.

Department of Human Services – Self Sufficiency Program & Child Welfare Program – DHS will help with making referrals to the program and provide government-level social service resources for families from underserved populations. DHS & NFK will partner to identify and recruit youth in foster care.

Samaritan House, Inc. – This organization serves homeless families within their transitional housing units and they will refer participants to benefit from mentorship. There are many single-parent mothers living there, with children who could benefit with a caring adult mentor.

Health Equity:

The pilot program will work to promote healthy equity and reduce disparities in the community. As a non-profit serving rural communities of Lincoln County, NFK strives to keep programs and services accessible and equitable to all people, especially the most underserved populations and economically disadvantaged. We are also aware that equity issues disproportionately impact communities of color, recent immigrants, families with children and particularly households led by single mothers, people with disabilities, the LGBTQ+ community and people living in the more isolated, rural areas of Oregon. As part of this pilot, our board, staff and volunteers will attend workshops and training around Diversity, Equity and Inclusion. Respect for cultural differences, human rights and systems change is critically important to address.

Within this mentoring program, staff will keep health equity in the forefront, focusing on matching mentors with mentees who share common racial, cultural, social and socioeconomic backgrounds. NFK understands the importance of "mirroring the population we serve", especially when developing trust, communication, and having sincere empathy for populations served. With this pilot program, NFK wants to help children and families who historically have not had access to quality programs, often due to barriers such as income, transportation, language or the challenges or safety issues that come along with serving specific children. NFK will determine which youth are IHN-CCO members upon enrollment into the program and Health Equity Data will be tracked using our parent registration intake forms and the member

tracking system. Other qualitative and quantitative data will be available from school records, pre and post surveys and from community partner organizations.

Youth who come from disadvantaged circumstances and underserved populations often struggle with behavioral health issues that can negatively affect their lives and will benefit from additional supports outside the normal clinical and medical setting. Several youth in the region live in poverty, have inconsistent school attendance, drop out of high school, engage in early substance abuse, have mental and emotional health challenges, have physical and verbal violent outbursts, and at times, suicide attempts.

Social Determinants of Health:

The Coastal Kids Mentoring Program will incorporate the social determinants of health lens during the pilot program, looking closely at resources youth have access to and resources they lack. We realize that the environmental conditions people are born into is beyond their control and it can affect their health and quality of life. Across rural Lincoln County, many youth lack the opportunities and resources others have, including adequate housing, healthy food, safe transportation, educational/recreational activities, or access to dental and medical care. The mentoring program will try to provide resources in addition to the program's activities, addressing issues like food instability, transportation, and the ability for youth to engage in healthy recreation and have social supports.

Over the course of each year, NFK is addressing health equity and staff respond to many identified community needs. This includes providing affordable (and free) child care, early childhood education for ages 3-5, transportation using the two 12-passenger vans improving access to the program, and preparing and serving nutritious meals during the USDA Food Program. During the pandemic NFK served nearly 30,000 meals to children experiencing food instability and hunger.

Organizational Alignment & Strategic Plans:

The Coastal Kids Mentoring Program fits closely with the mission and values of our non-profit organization. The **vision** of Neighbors For Kids is "to provide opportunities for positive youth development through the Kids Zone out-of-school-time programs. We believe that all children and youth have the potential to better their lives and become responsible, contributing adults in their communities. We endeavor to create an atmosphere where all children and youth are welcome to be themselves, learn and grow according to their skills and abilities, develop positive, nurturing relationships with adults in our community, and develop healthy lifestyles that demonstrate respect for themselves, their families, and their futures."

Our strategic planning looks at mission-centric, high value and sustainable programming as the best fit for where to invest our time and resources. Because a mentoring program is mainly volunteer-driven and supports the well-being of youth in the community, it is viewed as a sustainable and high impact effort.

Community Outreach & Marketing:

The new pilot program will be promoted in various ways and partner organizations will help NFK share information about the program and help recruit youth participants internally from

within their populations served. Strategies include outreach at local community events, community centers, and public spaces for mentor recruitment, radio PSA's, newspaper articles, social media and quarterly newsletter highlights. Because the program will target youth from underserved populations needing behavioral and/or mental health interventions, the following partners will help promote the program in the early stages of implementation; Olalla Center, LCSD schools, DHS and Samaritan House. To inform and recruit youth from the Latinx population, NFK will conduct outreach, marketing and translate materials into Spanish.

Pilot Program Outcomes:

Focusing on behavioral health, the pilot program's goals and objectives are to; 1) build support systems and make interventions for youth experiencing significant behavioral and mental health challenges, 2) promote health equity and eliminate health disparities, and 3) improve the health of underserved populations of youth with specialized support (mentorship).

Projected outcomes of the mentoring program include:

-Develop and implement the Coastal Kids Mentoring Program for youth in Lincoln County

-Provide mentoring program for 20 youth (mentees) from populations needing behavioral interventions

-Providing mentoring program utilizing 20 adult volunteers (mentors) from the community

On an individualized basis per youth, projected health outcomes include:

-Youth will show an increase in emotional and psychological well-being

-Youth will show decreased depressive symptoms

-Youth will show decreased disruptive and/or violent behaviors

-Youth will show increased communication skills and positive interactions with others

-Youth will have decreased behavioral referrals in school and increased academic success

*For youth pre and post surveys, NFK will use the Search Institute's Developmental Assets Profile (DAP) – a research-based social-emotional assessment. As stated in Search Institute's website, the DAP has been helping organizations and partnerships understand the social-emotional strengths of youth since 2005. To date, nearly a million young people between the ages of 8 and 18 have taken the DAP, making it one of the most widely used instruments in the world for measuring the strengths and supports that influence a youth's success in school and in life. Multiple studies have demonstrated that the DAP measures the important SEL skills (found in the internal assets) in valid and reliable ways. It has been listed in the CASEL compendium as a valid social-emotional assessment tool.

The DAP is built on the Developmental Assets Framework, which is a set of 40 positive supports, opportunities, and relationship qualities young people need across all aspects of their lives (called "external assets") and personal skills, social emotional strengths, self-perceptions, and values they need to make good choices, take responsibility for their actions, and be independent (called "internal assets").

Risk Factors: Describe potential risks and how the pilot plans to address them

During the middle of the pandemic when NFK first submitted a request in support of this pilot project, there were greater health and safety risks because there was not yet a vaccine available and there was a fear of contracting coronavirus. Now that people are vaccinated and the pilot activities would begin kick off in early 2023, NFK feels the program can proceed much more safely with its in-person activities. There are other potential risks, such as the failure of a good mentor-mentee match and people dropping out of the program. Therefore, NFK will have a second back-up pool of adult/youth applicants on a "waiting list" to fill slots if this happens.

C. Pilot Timeline

Oct. – Dec. 2022 (Prior to funding): Promotion and recruitment of adult mentors and youth
Nov. – Dec. 2022 (Prior to funding): Enrollment, Mentor Screening Process, Develop Surveys
Dec. 2022 – Jan. 2023: Mentor & Staff Mandatory Trainings, Hire Program Coordinator
Jan. 2023: Develop schedule of activities, events and arrange guest speakers/providers
Jan. 2023: Matching of mentors with mentees (20 pairs), Conduct pre-surveys
Feb. 2023: Launch Mentoring Program and one-on-one activities, 1st Family Support Night
Feb. 2023 – Dec.2023: Ongoing weekly/monthly mentoring activities, check-ins, interviews
March 2023: 1st Quarterly Group Event – horseback riding
June 2023: 2nd Quarterly Group Event – whale watching
Sept. 2023: 3rd Quarterly Group Event – surf camp and beach day
Dec. 2023: 4th Quarterly Group Event – aerial park and graduation celebration
Dec. 2023 – Jan. 2024: Post-surveys, interviews, evaluations/final reporting

D. Sustainability Plan

To sustain the project in future years, NFK will require ongoing community support, local resources and a strong degree of volunteerism. People are what drives this type of program and makes mentoring possible, so an influx of mentors and mentees is key. In Lincoln County, there are many talented, caring and dedicated people who will step up as mentors and without a doubt there are several youth whose lives will be enriched by mentorship.

NFK realizes the funding request to IHN-CCO is for a one-year pilot program. Therefore, NFK will seek other financial support from public grants, foundation grants, individual donations, corporate sponsors, fundraising event proceeds, and with community partnerships addressing health equity of children and families. If NFK's one-year pilot shows a positive impact on youth, past grantors such as The Ford Family Foundation, The Collins Foundation and Spirit Mountain Community Fund might consider the program worthy of support. NFK also envisions partnerships with the county government, local hospital system, and school district to work collaboratively and carry this work into the future. Please note: The funding request to IHN-CCO is for $100,017 and the proposed budget for the one-year pilot program is $125,015. In year one, NFK will dedicate contributions from local donors to fund the remaining $25,000.

With a diversified fundraising strategy and strong partnerships NFK is optimistic about securing future support for the **Coastal Kids Mentoring Program.**

E. Attachments: Budget Worksheet, SMART Goals & Measures Table

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	Behavioral Health: Integration: No mentoring program exists and no resources to fund program	Recruitment and screening of adult mentors. Identification and recruitment of youth mentees.	Mentoring Program begins and matches 20 mentor-mentee pairs.	February-22
	Child & Youth Health: Integration: Limited opportunities for youth and families to be empowered in their health	Tracking program attendance, activities, trainings and events.	Pairs and families are participating in program and planned activities. Mentors are making interventions monthly.	March-23
	Behavioral Health: Integration: Lack of mental health supports for underserved youth in region	Cross-sector collaboration with partner organizations and health care providers.	Increased support exists for under-served youth with mental and behavioral health challenges.	December-23
	Behavioral Health: Integration: Underserved youth show high rates of behavioral, mental, social and academic challenges	Youth Surveys and Parent Surveys. De-briefing with health care providers or other support networks.	Improved behavorial health of underserved youth. Increased emotional and psychological well-being.	January-24

Pilot: Coastal Kids Mentoring Program

Pilot Start Date:	1/1/2023	Pilot End Date:	12/31/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Goals: Alignment with Behavioral Health:Integration - offer support systems and interventions for underserved populations of youth. Increase access to new types of mental and behavioral health supports. Collaboration with partner organizations to identify, recruit and serve youth within mentoring program. Coordination of program activities, recruitment and screening of volunteer mentors. Providing training/education around health equity, reducing stigma around mental health, trauma informed care, mental health first aid, and diversity, equity and inclusion (DEI).		$75,000.00	$61,400.00
	Subtotal Resource Costs	**$75,000.00**	**$61,400.00**
Materials & Supplies			
Program Equipment & Supplies		$3,900.00	$2,100.00
	Subtotal Materials & Supplies	**$3,900.00**	**$2,100.00**
Travel Expenses			
Coastal Kids Mentoring Program - group field trips		$3,200.00	$2,500.00
Mileage Reimbursement - for mentors		$12,000.00	$10,000.00
	Subtotal Travel Expenses	**$15,200.00**	**$12,500.00**
Meeting Expenses			
Monthly Support Meetings (food, supplies, materials)		$2,000.00	$2,000.00
Quarterly Family Night Events (food, supplies, materials)		$1,600.00	$1,400.00
	Subtotal Meeting Expenses	**$3,600.00**	**$3,400.00**
Professional Training & Development			
Youth Mental Health First Aid & Trauma Informed Care		$500.00	$500.00
Consulting - Mentorship Model		$700.00	$475.00
Diversity, Equity & Inclusion training		$750.00	$550.00
	Subtotal Training & Develop	**$1,950.00**	**$1,525.00**
Other Budget Items			
Program Activities Support: 20 mentor-mentee pairs (gift certificates, tickets, meals, field trip fees) - 10 months		$14,000.00	$10,000.00
	Subtotal Other	**$14,000.00**	**$10,000.00**
Total Direct Costs	**Rate (%)**	**$113,650.00**	**$90,925.00**
Indirect Expenses	10.00%	$11,365.00	$9,092.50
Total Project Budget		**$125,015.00**	**$100,017.50**

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

Coastal Kids Mentoring Program

Neighbors For Kids – Depoe Bay, OR.

IHN-CCO Pilot PROPOSAL

Pilot Summary and Goals

- The Coastal Kids Mentoring Program will use a one-on-one matching system to connect adult volunteers and youth, as an innovative approach to address and support the behavioral health of youth.
- Goal 1: Build support systems and make interventions for youth experiencing significant behavioral and mental health challenges
- Goal 2: Promote health equity and eliminate health disparities
- Goal 3: Improve health of underserved populations of youth with specialized social support (mentorship)

Member and Community Need

Target Population:

- Youth ages 6-18, from underserved populations in rural Lincoln County
- Low income, diverse ethnic backgrounds, LGBTQ+, English Language Learners, foster care, homeless, special needs and disabilities
- IHN-CCO Member Impact: 75% or more will be members. Identified upon enrollment into program
- Community Needs: growing population of youth with behavioral health needs and lack of support services
- Youth identified by parents, school staff, therapists, counselors, juvenile justice system, or health professionals
- Examples at NFK – youth sent home from program consistently due to behavioral outbursts and safety concerns.

System Transformation

How is your proposal transformational?

- The power of the human connection
- Supportive, healthy relationships formed
- Youth non-profit partnering with mental health providers
- New approach for behavioral and mental health support
- Focus on communication, skill-building (assets) and new opportunities to experience
- Innovation: Trained adult mentors, structured program using one-on-one, family and group cohorts
- Addressing needs in aftermath of the pandemic

Partnerships/Collaboration

- Olalla Center For Children & Families – referral source, shared client case management, program integration
- Lincoln County School District - referral source and shared resources. Identification of mentees in need.
- Department of Human Services - Self Sufficiency Program & Child Welfare Program – referral source, social services and foster care system
- Samaritan House, Inc. - referral source and cross-sector services
- Health Care Providers – communication with primary care providers, counselors, therapists – SHS & county

Health Equity Plan

- Matching mentors with mentees - shared racial, cultural, social and socioeconomic backgrounds
- Looking at social determinants of health and access to resources in a rural area, such as:

  Adequate housing, healthy food, safe transportation, education, recreation, dental, medical and mental health care

NFK will provide all program participants full scholarships:

-year-round child-care, nutritious meals, transportation, recreation, educational enrichment, field trips

-access to NFK equipment – surfboards, wetsuits, kayaks, row boats, sports equipment, art supplies, books

Definition of Success

Measures & Outcomes include:

- Participation/Attendance (mentoring, family support, quarterly events, training)
- Pre and Post Surveys (Youth and Parents)
- Search Institute's Developmental Assets Profile (DAP) – a research-based social-emotional assessment

At the end of your pilot, what will have changed?

- New mentoring program will exist in Lincoln County, with an opportunity to expand numbers served
- Increased supports for youth with mental health and behavioral challenges
- Improved behavioral health, increased emotional and psychological well-being among youth

Sustainability Plan

- Community Support and Strong Volunteerism – pool of new youth and volunteer mentors
- Community Partnerships in place
- Diversified Funding Sources (public, foundation grants, individuals, corporate sponsors, fundraising events)
- Year one is critical to sustainability, must prove program is worthy of support – build the foundation
- Strategic Planning – vision and mission-focused

DST Member Questions?

Community Partnership Alliance

Backbone Organization: Oregon Cascades West Council of Governments

Billing Address: 1400 Queen Ave SE, Albany, OR 97322 Suite 206

Site(s): Albany

County(s): Linn

Priority Areas: Subpopulations of IHN-CCO members that experience health disparities,

Innovative programs supporting housing

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: SD1: SD1: Increase the percentage of Members who have safe, * accessible, affordable housing. SD4: Increase health equity.

Pilot Contacts	Name	Email
Primary	Randi Moore	rmoore@OCWCOG.org
Proposal	Danielle Hutchinson	Danielle.hutchinson@creatinghousing.org
Contracting	Randi Moore	rmoore@OCWCOG.org
Financial	Marit Nelson	mnelson@OCWCOG.org
Reporting	Randi Moore	rmoore@OCWCOG.org

2. Proposal Narrative

A. Executive Summary

This project would address the social determinants of health needs of Albany's most vulnerable by engaging community partners in service coordination. The aim is to make it possible for unhoused and housing insecure individuals to successfully access and obtain needed services by overcoming system barriers. This project aims to streamline interdepartmental processes regarding service delivery and coordination of care. Through coordination of providers and healthcare and community groups, gaps in communication can be identified between key organizations. Having a centralized resource to network through for all providers in Albany would have the effect of reducing duplication of work and services. The result of streamlined and coordinated responses to vulnerable community members would allow frequent and high utilizers of resources the level of support needed to reduce health disparities within Albany and Linn County.

The process would be to work closely with community partners, social service providers, school districts, health care coordinators and the faith community to facilitate access to services. A coordinator would develop and maintain communication and collaboration among all key social service agencies and community groups and health providers. The project coordinator would also develop further community resources; demonstrate and provide leadership among community partners; research and present viable information sharing and insure group meeting facilitation. Having a centralized leadership that is able to support the effective networking of agencies and support the success of shared goals will foster a more effective process that supports the urgent needs of individuals and families. This has been shown to reduce the impact on emergency services, policing responses and community resources. When the community can see the impact of better coordination for individuals, agencies and the community as a whole, sustainability of this project will prove invaluable.

B. Pilot Description

Pilot Goals of Community Partnership Alliance are (Also see Monitoring Grid):

- Determining gaps and creating a pathway for closure of those gaps by inventorying the gaps and developing a strategy for correction
- Streamlined collaboration between agencies
- Utilizing existing community resource software to be a focal point of requesting and disseminating resources and information interagency.
- Creation of MOU's that are consistent between organizations and facilitate rendering needed services
- Facilitate seamless referral loop
- Facilitate agency collaborative strategies with 5 high-utilizing clients to create stabilization

Target Population

Target population for this proposal includes those who are experiencing homelessness or are housing-unstable. This ensures that the IHN population is the primary target of this strategy. Because of the income demographic of this population, most, if not all, will qualify for Oregon Health Plan and will necessarily be IHN members.

Describe the intervention and detailed activities, including an environmental scan of similar projects in the region

The idea for this proposal came about as a result of the Creating Housing Coalition starting a street outreach program: Community Outreach Assistance Team (COAT). It quickly became apparent that many individuals who were in need of services had tried to access them at one time or another, but had "fallen through the cracks" when the service agency was unable to provide immediate assistance. Because of the trauma they were experiencing due to their living situation and/or mental or physical health issues, they were unable to navigate through the oftentimes complex systems in place by the agencies. To further complicate matters, there were numerous barriers to successfully utilizing services the agencies offered, such as lack of transportation, the inability of staff to check in with the client to make sure the client was successful in obtaining the services, and a general lack of knowledge between agencies of what assistance other agencies offered. Finally, there was no cohesive way for agencies to view services the client had accessed through other agencies, creating both a replication of services and unnecessary time spent researching whether the client had attempted to access services through other agencies.

When Carol Davies, representing COAT spoke to the city council requesting support for service coordination, Kris Schendel of Albany Police Department reached out to Stacey Bartholomew of the City Council to collaborate as he had been working with Emma Deane, Executive Director of Helping Hands Shelter (HH) to identify a means for addressing the needs of individuals that came into frequent contact with both these agencies. Realizing these groups shared a common need, we began meeting to understand other resources in other communities and what our needs were for our community. Amber Kramer, Polk County Service Integration Team coordinator, provided the history and process of that model and we were able to differentiate our goals from the goals of the SIT model. Their model focuses on preventative services at 85% and outreach at 10% and only 5% to immediate needs. Our model would like to address the complicated and interagency needs of higher utilization clients and others who have immediate needs related to housing and stabilization. The use of common data sharing was also identified as a barrier by looking at Eugene's service coordination through agencies all utilizing the same system allowing each agency to track an individual's interactions with service agencies.

Our model of intervention would involve a coordinator who would research the gaps and duplication in service pathways. This coordinator would then inform agencies of gaps and facilitate coordination to strategize a seamless referral loop. Coordination would require Memorandums of Understanding (MOU) between all agencies and willingness to coordinate with a centralized resource. Each agency that has agreed to collaborate has expressed willingness to participate in this project through engaging in supporting the assessment of systems integration and reduction of barriers and duplication.

A partner that will be working on this pilot will be Oregon Cascades West Council of Governments (OCWCOG), who will be the backbone agency to hire and support the coordinator as well as provide the periodic reports regarding the pilot. Creating Housing Coalition will provide the proposal documentation and initial training of the coordinator as well as a computer system to facilitate workload and communication. The City of Albany will provide office space for the coordinator. Helping Hands Shelter will coordinate shelter services and with Albany Police Department will assist in the coordination of agency collaboration. Anita Earl of Samaritan's Chronic Care Program will assist in health assessments of clients to facilitate housing placement. The City of Albany will provide office space to help facilitate a central location for coordinator accessibility. We plan to have the coordinator create MOU's between all of these collaborators in this pilot as well as future collaborators who have expressed interest in supporting this initiative.

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

The pilot will promote health equity and reduce health disparities by closing the referral loop and sustaining seamless support of vulnerable community members. The pilot will identify gaps in communication between key organizations and make quicker coordination possible, thus reducing the inequity of service to these members. We plan to track the data for IHN-CCO members using current data bases. We will be able to report our progress on our goals and the effectiveness of this pilot as a result.

Explain the social determinants of health lens the pilot will be incorporating

SD1: Increase the percentage of Members who have safe, * accessible, affordable housing. *Safe housing: a structurally sound, secure, sanitary, nontoxic residence with basic utilities, timely repairs, and adequate space for residents

SD4: Increase health equity.

Because of the focus on service coordination, our impact on Social Determinants of Health is broad. The majority of our target population is elderly and/or disabled, with an average age of around 60. Within this group are a large number of male veterans. The second largest demographic is single older women, most of whom have serious health issues, such as cancer and COPD. Almost all of our targeted population also suffers from PTSD and other stress-related ailments. This program will enable a large percentage of our clients to access and receive proper physical and mental health care through interventions with Samaritan's Chronic Care Program and Linn County Mental Health, and will enable a greater portion of the targeted population to receive stable, supported housing in assisted living facilities or adult foster homes. By partnering with Linn Benton Housing Authority and Community Services Consortium we'll also increase the number of people who are on the housing voucher wait list, with the ultimate goal of placement in permanent housing. For the segment of our population that are high utilizers of services, the most common issues that are seen are serious mental health conditions, such as schizophrenia and bipolar disorder. To address their needs, we'll first decrease the number of emergency department visits by referring them to the Department of Human Services so they can be enrolled in an IHN plan. The next referral will be made to Linn County Mental Health to get their mental health conditions managed. Permanent housing will also be emphasized to further reduce the need for visits to the emergency department.

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

Randi Moore, Senior and Disability Services Director, Oregon Cascades West Council of Governments. Overseeing the general operations of the pilot.

Marit Nelson, Finance Manager, Oregon Cascades West Council of Governments. Overseeing budget.

Carol Davies, Vice President, Creating Housing Coalition. Overseeing training

Danielle Hutchinson, Grant Chair, Creating Housing Coalition. Proposal writer.

Stacey Bartholomew, President, Creating Housing Coalition. Co-Proposal writer, city council representative.

Emma Deane, Executive Director, Helping Hands Homeless Shelter, Collaborator.

Kris Shendel, Code Compliance Officer, Albany Police Department, Collaborator, outreach and presentations to service providers

Peter Troedson, City Manager, City of Albany, Collaborator, provider of office space.

Dina Eldridge, Housing Services Manager, Community Services Consortium, Collaborator

Anita Earl, IHN chronic care coordinator, IHN, collaborator

Tony Decker, Executive Director, CHANCE, collaborator

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

Oregon Cascades West Council of Governments strives to enhance the independence, dignity, choice, and individual well-being of all people, to serve and protect individuals, and to expand our community members' opportunities for self-sufficiency, health, and wellness.

OCWCOG embraces these key values:

1. Service Equity: Providing fair and unbiased support to all people regardless of race, gender, sexual orientation, or culture.
2. Customer Service: To treat consumers with courtesy, respect, and dignity while providing exceptional customer service.
3. Innovation: To embrace an ever changing culture which creates and cultivates new programs, opportunities, and resources.

4. Community Collaboration: To build strong alliances with community partners in order to better leverage resources and increase impact.

These key values are operationalized in our region by providing stakeholders such as consumers, caregivers, community partners, and staff with quality and up to date information, listening to each person's unique perspective, and encouraging the advocacy and involvement of all. Because we hold to these values, OCWCOG is excited to support the Community Partnership Alliance Project through our oversight of the project and collaboration with community partners. The innovation and community collaboration we are supporting we hope will foster better service and equity in the community.

Describe how members of the community will hear about your project

From the beginning of the pilot we will require the cooperation and collaboration of many organizations including private, for-profit, government and IHN care coordinators. The coordinator will need to promote this work so that we can effectively utilize community resources in faith based organizations and other community collaborators. This dissemination of information and engagement will take place within the collaborative organizations. Outside of organizations, various media and forums will be utilized to share the pilot and its work.

Describe potential risks and how the pilot plans to address them

The potential risks of this proposal include the hesitation of change that a more defined coordination will require. Concerns of various agencies will be addressed and the use of MOU's developed in coordination with each agency will facilitate clear communication and good will. We also will work to recruit a qualified and quality coordinator who has the necessary skills to facilitate this process.

The risk that high utilizers of services will need longer than anticipated to stabilize. Projection of a two year timeline was proposed to address this risk.

C. Pilot Timeline

First Year Quarter 1

- Hiring Coordinator
- Training Coordinator
- Purchasing computer/phone
- Determining Gaps of communication and services.

First Year Quarter 2

- Create a regular coordination meeting of agencies and collaborators to address findings and propose system gap resolution
- Creation of MOU's
- Outreach to agencies and community groups

First Year Quarter 3

- Identify and begin collaboration for high utilizer gap coordination
- Address need for common data sharing by presenting findings from several other counties/cities in Oregon
- Seamless referral loop integration and assessment

First Year Quarter 4

- Continue Outreach
- Collaborator meetings continue
- Monitored engagement for service strategies for high utilizers
- Decide on and implement shared data system for Albany

Second Year Quarter 1

- Continue Outreach
- Collaborator meetings continue
- Reassess needs of Pilot processes
- Continue adding agencies to data base
- Assessing IHN member tracking

Second Year Quarter 2

- Begin Contract for sustainability for continuation of project
- Reassess referral loop
- Assess progress of high utilizers
- Collaborator meetings continue

Second Year Quarter 3

- Collaborator meetings continue
- Progress of high utilizer stabilization including gap coordinator meeting
- Finalize contract for project continuation

Second Year Quarter 4

- Finalization of all pilot metrics
- Finalization of documentation and reporting on pilot findings
- Collaborator meetings continue
- Begin identifying second round of high utilizers

D. Sustainability Plan

Albany lacks a central coordination of services. Bringing area agencies together to problem solve a viable solution through the facilitation of a coordinator allows for continuity of support. Because it is needed by the organizations within the city, there is a strong interest in the increased success that this project can bring to all the organizations involved. As shown previously, many organizations have stepped up to lead, train, provide office space and collaborate with this project with the belief that their organization will benefit from this kind of integrative support.

The success of this project is the key to sustaining ongoing coordination. Focusing on a small number of high utilizers and other unhoused individuals allows for project success. Project support increases as referrals become more seamless and higher utilizers are resourced rather than continuing to scramble for unmet needs.

As part of the project, the collaboration meetings will allow the agencies to assess and budget for this coordination as they see the benefit of decreased workload, increased employee support, decreased service duplication and reallocation of resources within each organization. As additional collaborators join the project, the funding pool will increase and budget demands will be reduced for each utilizer of this coordination. Finally, because of OCWCOG presence in multiple counties, the opportunity to replicate this process will be possible in other areas of high need.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Gaps in services for care continuation throughout the community	Determining gaps and create pathway for closure	Inventory of gaps and strategy for correction	March-23
	multiple information data bases that don't speak to each other	Information referral data bases	Streamlined access to data and referrals by all community partners	December-23
	some people know who to talk to and most people spend too much time trying to find out who to talk to for needs.	communication strategy through coordinator	Agencies have the ability to relay needs and disseminate to other agencies who can respond with resources.	May-23
	Need to have continuity of engagement between agencies regardless of employee contact	Memorandums of Understanding	Agencies are able to freely communicate needed information and collaborate on actions.	June-23
	disjointed referral process	Identify and warm transfer clients to partner agencies	have a seamless referral loop	September-23
	frequent utilizers of services are receiving intermittant service responses which lead to cyclical needs	bring together agencies to strategize plan with clients	5 high utilizers are housed and/or stabilized within the period of the grant	December-24

Pilot:

Pilot Start Date:	1/1/2023	Pilot End Date:	12/30/2024
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Coordinated care services for unhoused and housing unstable individuals in Albany, OR		$120,000.00	$120,000.00
	Subtotal Resource Costs	**$120,000.00**	**$120,000.00**
Materials & Supplies			
Computer and phone		$2,000.00	$600.00
Office Space		$8,400.00	$0.00
	Subtotal Materials & Supplies	**$10,400.00**	**$600.00**
Travel Expenses			
Mileage Reimbursement		$1,200.00	$1,200.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$1,200.00**	**$1,200.00**
Meeting Expenses			
Projector		$200.00	$0.00
Stipends		$3,000.00	$3,000.00
Food and drink		$3,000.00	$0.00
	Subtotal Meeting Expenses	**$6,200.00**	**$3,000.00**
Professional Training & Development			
Training fees		$4,000.00	$4,000.00
Background check		$40.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$4,040.00**	**$4,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$141,840.00**	**$128,800.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$21,276.00	$19,320.00
Total Project Budget		**$163,116.00**	**$148,120.00**

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

Community Partnership Alliance

Oregon Cascades West Council of Governments

Creating Housing Coalition

Pilot Summary and Goals

- This project would work to streamline interdepartmental processes regarding service delivery and coordination of care; identify gaps in communication between key organizations to effectively reduce duplication of work and services; and make quicker coordination possible for our frequent and high utilizers of resources to reduce health disparities within Albany and Linn County.

A few goals of ours are:

- Determining gaps and creating a pathway for closure of those gaps by inventorying the gaps and developing a strategy for correction.
- Streamlining collaboration between service agencies
- Facilitating agency collaborative strategies with 5 high utilizing clients to create stabilization.

Member and Community Need

- The target population for this proposal includes those who are experiencing homelessness or are housing-unstable. The majority of the targeted population will be elderly and/or disabled, with an average age of around 60. Veterans will be included in this group. This ensures that the IHN population is the primary target of this strategy. Therefore close to 100% of clients will be IHN members serviced through this pilot.
- Our model of intervention would involve a coordinator who would research the gaps and duplication in service pathways. This coordinator would then inform agencies of gaps and facilitate coordination to strategize a seamless referral loop. A software system that receives and disseminates communication of needed resources and facilitated by the coordinator would reward involvement of agencies in this collaboration.

System Transformation

How is your proposal transformational?

- The coordinator would work closely with community partners, social service providers, school districts, and the faith community on social service projects and issues; this role would provide facilitation and coordination of services, developing and maintaining communication and collaboration among all key social service agencies; developing community resources; demonstrating and providing leadership among community partners; and insuring group meeting facilitation. This will foster a reciprocal relationship with the shared goal of addressing a person's urgent needs before they become a crisis.
- Because of the focus on service coordination, our impact on Social Determinants of Health is broad. Our pilot in unique in the ability to reach many key players within the community to transform coordination of care.

Partnerships/Collaboration

- The partner that will be working on this pilot will be Oregon Cascades West Council of Governments, who will be the backbone agency to hire and support the coordinator, as well as provide the periodic reports regarding the pilot. Creating Housing Coalition will provide the proposal documentation and initial training of coordinator.
- The City of Albany will provide office space for the coordinator. Helping Hands Shelter and Albany Police Department will assist in the coordination of agency collaboration. We'll also be collaborating with Linn County Mental Health, Community Services Consortium, Linn-Benton Housing Authority, CHANCE, and Second Chance Shelter to create a seamless referral loop.
- We plan to have the coordinator create MOU's between all of these collaborators in this pilot as well as future collaborators who have expressed interest in supporting this initiative.

Health Equity Plan

- How will you address health equity and reduce health disparities?
- The pilot will promote health equity and reduce health disparities by closing the referral loop and sustaining seamless support of vulnerable community members.
- The pilot will identify gaps in communication between key organizations and help to close those gaps, making quicker coordination possible and reducing the inequity of service to these members.
- We plan to track the data for IHN-CCO members using current database. We will be able to report our progress on our goals and the effectiveness of this pilot as a result.

Definition of Success

- From the beginning of the pilot we will require the cooperation and collaboration of many city organizations and will need to promote this work so that we can effectively utilize community resources in faith based organizations and wider community. This dissemination of opportunity will take place within the collaborative organizations.

- At the end of our pilot we expect to see a seamless referral loop, collaborative coordination of services throughout the community; with seamless communication of needs and a clear and sustainable care plan for high utilizers; seeing a clear reduction in redundancy.

Sustainability Plan

- Funding will continue after DST funding is completed by contracting and collaborating with service providers and other organizations who have been added throughout the pilot's lifetime.
- These organizations, as stakeholders in the community, will each allocate a portion of their budget to support funding the coordinator and activities.
- Through their involvement in the pilot, each organization will experience the benefits of a reduction in work and service duplication. This benefit will continue as they continue to invest in this Community Partnership Alliance.

DST Member Questions?

End of Life Support

Backbone Organization: Samaritan Health Services/Population Health

Billing Address: 2300 NW Walnut Blvd. Corvallis, Oregon 97330

Site(s): Hospice House, Albany

County(s): Benton, Linn, Lincoln

Priority Areas: Health Equity, Innovative Housing concepts

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: A1, A2, BH4, BH6, SD1, SD2, SD3, SD4

Pilot Contacts	Name	Email
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Financial	Glen Cunningham	gcunningha@samhealth.org
Reporting	Anita Earl	aearl@samhealth.org

Executive Summary

Our proposal is to navigate the use of one room at the Evergreen Hospice House for one year to be utilized exclusively for room and board purposes while hospice supports the needs of an unhoused patient.

If picture paints a thousand words, then maybe a short story can best describe the heart of this proposal- a patient we'll call Greg.

Three years ago, our homeless outreach team encountered Greg panhandling underneath a sign at the Whiteside Theater in Corvallis. He had a large open wound on the top of his head which he seemed to struggle with getting adequate treatment for. He logged many ED visits but the level of medical intervention he required continued to allude him. He felt summarily dismissed by the healthcare system and struggled with the nagging feeling that his wound was cancerous, and he was slowly dying.

We offered him respite, which he accepted and then the slow process of trauma debriefing his medical history and 20 years of homelessness began. A home transitions nurse assisted him with developing a relationship with primary care and then requesting oncology consults. The engaging process of wound care began. He segued out of respite and into transitional housing as his treatment continued. Our community health worker collaborated with a dietician to provide him nutritionally dense food and we provided clothing, helped with transportation to his specialist appointments and he began to make friends, lots of friends.

Then the untreatable cancer diagnosis came and his subsequent decline. He made a trip home to see his family (after a 20-year absence) and when he returned, he requested use of the respite bed again because he was now too weak to climb stairs to his own room and could no longer use the communal toilet. Again, we placed him in respite, and he remained there for the next six months as he slowly declined. The support of a local hospice team and a specialized bed along with the privacy of the respite room provided him with necessary privacy. He was attended to by various out-patient teams from homeless outreach to hospice but at the end of the day it was a local community-based organization that provided volunteer staffing through the night. They worked with a local hospice to be trained on how to support his needs and administer his medication.

They tended to him with great grace and when he died our homeless outreach team assisted with mortuary efforts and removal of his body from respite placement. We also debriefed members of the transitional housing community he lived in, as the experience of his dying triggered many different reactions/emotional responses by staff and clients. Many take-aways from this experience. 'Just because good people will, doesn't mean they should ' was the primary one.

Most people receiving hospice services die with support in their own homes. What happens if you don't have a home? You die in the street, in a car or in the hospital. Beyond the hospital,

there is one medically orchestrated setting that is meant to feel like home and is particular to hospice needs, the Evergreen Hospice House. However, access to the Evergreen Hospice House is only for the acute phase of terminal illness and not typically for room and board of the terminally ill. The room and board piece of care is what we are seeking.

Pilot Description

Goal: The use of a designated bed at the Evergreen Hospice House for the unhoused to be utilized by the Care Hub's Homeless Outreach team to offer robust support/room and board for the unhoused.

Housed under the banner of Population Health is where the Care Hub lives. This is a team, whose mission has been to provide outreach support to the most medically fragile of the communities we serve. This is a tri-county program with provider partnerships with SHS clinicians, multi-region health systems, independent and county clinics and health centers, as well as other community-based resources.

The homeless outreach program is one program in the Care Hub. This particular path was created as an extension of our transitional care efforts. We recognized the extensive psychosocial needs of the unhoused and the interventions required to offer support to this community are extensive. Our social service team provides direct assessment and social determinant of health screening, as well as assistance obtaining food and shelter. Nurses on our team support physical health assessment and assistance. Outreach is performed in shelters, campgrounds, drop-in centers, on the street or in a tent. We advocate with local, community-based organizations to expedite substance abuse and mental health referrals and treatment. We also steward respite bed placement.

Medical respite or recuperative bed navigation is characterized by assessment, placement and management. The navigation of relationships with the community partners where these beds are contracted and the overall care and upkeep of these beds and the patients in them is the provision of this effort. Whilst managing referrals to respite a trend of increasingly debilitated people facing hospice diagnoses surfaced, it became clear that respite was not able to meet the needs of these people and attempting to manage those needs with our current team or with a community-based provider was clearly out of our scope of practice.

We reached out to the Evergreen Hospice House to see what support they could offer in terms of the provision of room and board for patients struggling at the end of life but not imminently dying. These conversations led us to the current proposal. Our hope is to secure funding to contract for one bed to be used in the service of the unhoused to be managed by the Care Hub's Homeless Outreach team, utilizing the services of the Evergreen Hospice House.

During the last year we have seen four respite clients reach the final crisis of their illness while in respite care. Two of them we were able to gain admission for the last days of their life to Evergreen Hospice House but prior to that, efforts were cobbled together between our outreach team and a local hospice agency. This means that the community-based agencies recruited volunteers to take 24/7 shifts to help support these patients. This process required tremendous education and systematic debriefing of their staff. These experiences vacillate between emotionally uplifting and demoralizing for all involved. The sacred intimacy that

comes with end-of-life care is present, as is the awareness by the patient and the staff that this care involved efforts above and beyond the scope or ability of the people involved.

The Evergreen Hospice house understood our need intimately. In their words: “Hospice is more art than science and nowhere is this more true than when a patient is imminently dying. As a specialized practitioner, a hospice nurse, knows that a “good death” means honoring choices, managing anxiety of families and caregivers, controlling symptoms, normalizing the experience and empowering family. Helping families and caregivers understand that their loved ones have the right to make choices that are difficult to accept-like refusing pain medication, choosing suffering over sedation, risk falling for independence, etc. Hospice staff are there to support and encourage, offer creative options and gently guide towards comfort. They are equally familiar with a “bad death”, which can look like extended (unwanted) medical intervention, exacerbated symptoms from IV fluid overload, undermanaged pain because of opioid concerns and isolation from community of choice by prolonged hospital stays. Even more heart wrenching are people that die alone in a car, a tent or outside in the elements. Providing a good death for marginalized populations, like the unhoused, is especially compelling for all involved.”

The marriage of our two efforts seemed the best fit for referral, tracking and provision of services.

Target population: The unhoused. The Evergreen Hospice House is well suited to our Homeless Outreach team’s patients who transition from respite shelter to the Evergreen Hospice house for symptom management during the dying process. While dying isn’t considered a medical emergency, it can be a complex and nuanced, especially in populations where trauma is present. Dying with trauma can present as agitation, delirium, fear, resistance to care and aggression, all of which are best managed in a skilled environment. Protecting our respite facilities from this experience is a responsibility we should assume in the order to keep respite staff healthy and receptive to continued partnership.

When looking for specificity in terms of IHN clients, it is fair to say that the unhoused, who are often very poorly funded, are reliant upon IHN for their healthcare. All of the four respite patients that died in the last year with hospice support, were IHN clients and all the respite placements over the last year reflect a clear trend dominated by IHN as their ins carrier (over 80 percent)

Intervention: Room and board at the Evergreen Hospice House. The staffing pattern of this facility is 24/7 and the care provided would focus on a meaningful and pain free treatment with assistance in all areas of care from grooming to medical symptom management. This proposal does not encompass billable services by hospice.

Primary partnerships: Referrals come to the Care Hub’s Homeless Outreach Team from all over the healthcare system and the greater community. Multiple CBO’s work with our team and request our assistance interfacing with the extremely ill and dying. They have often been

helpmates and always witnesses to the struggles the unhoused face and the need for safe, clean and kind medical care/housing at the end of life.

These organizations, as well as the Samaritan medical system as a whole would be the primary referral base but the partner to help us fulfill our goal is the Evergreen Hospice House.

Karen Daley, the Director of Evergreen Hospice House offered the following: "Samaritan's Evergreen Hospice is fortunate enough to have one of only three hospice houses in the state. This environment is highly regulated and has strict parameters for staffing and accepts very complex patients while operating on a Medicare per diem payment system. This model is not often financially viable, but our community and hospital system has decided the benefit is absolutely worth weathering the challenges. Due to the nature of our patients, they die quickly, and we have tremendous turnover, making it challenging to meet occupancy. We are often left with many empty beds and feel that in many ways we are an untapped resource. If we can lighten the load of the hospitals, while also serving a very marginalized population, we are fulfilling the mission of SHS to its' fullest capacity. At the heart of things, being able to partner with traumatized, dying patients is the most fulfilling work in hospice."

The promotion of health equity. The unhoused very rarely access any form of healthcare, with the exception of the emergency department. Environmental factors like lack of clean clothing, no transportation, poor personal hygiene, fear of discrimination and general shame prohibit the seeking of medical treatment. They are historically the most marginalized of all populations and typically the most fragile due to years of healthcare neglect, poor nutrition and other challenging environmental factors that can lead to health degradation.

The Homeless Outreach Program has reached hundreds of patients and impacted readmission rates significantly. We have built exceptionally strong relationships with 8 CBO's and our own staff provides weekly intervention and assistance to four of these organizations. We respond to all five hospitals in our system and work daily with care coordinators from the clinics to increase SDOH assessment and response to the houseless. We have created tracking metrics and have a presence on the HOPE Board for the last two plus years. Our promotion of health equity has spanned micro-outreach interventions to macro-level discussions with county officials. The most natural extension would be to offer respite in the form of hospice.

Because the request is for one bed to be occupied as needed by the unhoused for a one-year period, it will be quite easy to track who utilized this bed and if they were an IHN-CCO member. This tracking will be an extension of the respite tracking system that is currently utilized by the Homeless Outreach team to manage respite bed navigation and collect data accordingly.

The SDOH lens. If you are unhoused and terminally ill experiencing the final stages of the dying process you qualify for referral and assessment. I would suspect that typically the referrals will come from within our outreach efforts and respite beds, but I am certain that some referrals will be generated for patients new to our team. As our respite efforts are tri-county, (Linn, Benton and Lincoln) this program will be open to any patient from the tri-county region.

Organization roles is the pilot. The Care Hub's Homeless Outreach team will navigate all referrals. Karen Daley, Director of the Evergreen Hospice House and her staff will provide intake. Evergreen Hospice will provide clinical care and Evergreen Hospice House will provide room and board. This proposal is for the room and board.

The Care Hub's Homeless Outreach program has a primary goal of increasing access to healthcare for the unhoused and thereby supporting equity for our most marginalized. We navigate respite placement for the acutely ill or brutally injured. This proposal is an extension of that scope. Our robust relationships with community partners and experience referring patients to the Evergreen Hospice House puts us in a perfect position to spearhead this effort.

How to spread the word. If funding is in place, then our team will ensure that all community-based partners are aware of this opportunity. We will alert community health workers and care coordinators in the Samaritan system and discharge planners at all of our hospitals about this opportunity. The Hope Committees meetings and the Homeless Service Provider monthly meetings in Benton County and the HEART Board meeting in Linn County are also points of contact for discussing this new resource.

There are two foreseeable potential risks: An inability to maintain utilization of the bed and the need for psychoeducation for the Evergreen Hospice House staff regarding the psychosocial needs of the unhoused. I am hopeful that because our current network for homeless outreach is vast, we will have no issues finding patients that require the support this bed would offer. We have also worked out a plan to provide psychoeducation regarding the plight and psychosocial factors influencing the lives of the unhoused to the staff at Evergreen Hospice House, as well as, offering trauma debriefing as requested.

Pilot Timeline

3rd quarter 2022:

- Pilot proposal and funding
- Contracts with Evergreen Hospice House
- Metric builds for tracking patient costs, outcomes

4th quarter 2022:

- Program initiation
- Communication with CBOs regarding patient selection for referral
- Education for HH staff on care considerations for unhoused patients
- Initiation of discussions with IHN-CCO for APM

1st quarter 2023:

- APM model generation with IHN-CCO
- Assessment of program effectiveness, metrics
- Continued communication with CBOs on program needs
- Continued support for HH staff, debriefing

2nd quarter 2023:

- Assessment of program effectiveness, metrics
- Pilot of unhoused EOL care APM with IHN-CCO
- Continued support for HH staff, debriefing
- Continued communication with CBOs on program needs

3rd quarter 2023:

- End assessment of pilot effectiveness
- Initiation of EOL APM with IHN-CCO
- Referral process for CBOs developed

Sustainability Plan

Our proposal involves seeking $147,825.00 to effectively 'lease' a dedicated bed in the Evergreen Hospice House, similar to leasing a respite bed. This amounts to a reduced room and board charge of approximately $405 per day. This room will be dedicated only to unhoused patients referred from community providers to SHS CareHub. CareHub will continue to provide medical management, case management, and logistical services for the patients within the program, as well as support in optimizing treatment for these patients for the staff of the Hospice House.

Generally, insurance only pays for outpatient hospice services and a patient must be actively dying to qualify for a Hospice House stay. These typically are 1-2 weeks in length. There is a process for extending coverage beyond this through individual patient assessment and plan authorization, but there is not a method of providing room and board prior to the imminent death of the patient.

Our sustainability plan involves working with IHN-CCO to establish an alternative payment process for unhoused individuals at end-of-life. This will be a process of establishing eligibility, timelines for transfer to services, assessment processes and so forth. Our hope is that beyond this year-long proposal we will have a suitable process and funding to care effectively for this population and have a referral process that any community agency can access to utilize Hospice House resources.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Number of patients dying outside of HH vs. number of patients utilizing HH	Manual counts	Increase in number of patients utilizing HH from baseline	June-23
	Total cost of care for unhoused patients at EOL	CCO cost analysis	Decrease in total cost of care for unhoused patients at EOL	September-23
	Partner satisfaction with EOL services	Solicitation of satisfaction with program	Increase in stated satisfaction with EOL resources	September-23

Pilot: End of Life care for unhoused patients

Pilot Start Date:	10/1/2022	Pilot End Date:	10/1/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Room and Board for 1 bed at Evergreen Hospice House		$147,825.00	$147,825.00
Carehub services for patients		$31,200.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$179,025.00**	**$147,825.00**
Materials & Supplies			
Patient support supplies		$2,500.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$2,500.00**	**$0.00**
Travel Expenses			
Staff travel		$1,200.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$1,200.00**	**$0.00**
Meeting Expenses			
Community partner meetings		$200.00	$0.00
IHN CCO meetings		$500.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$700.00**	**$0.00**
Professional Training & Development			
HH staff training sessions/debriefing		$1,500.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$1,500.00**	**$0.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$184,925.00**	**$147,825.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	0.00%	$0.00	$0.00
Total Project Budget		**$184,925.00**	**$147,825.00**

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

End-of-Life (EOL) support for people experiencing homelessness

Pilot Summary and Goals

- Summary: Currently, patients experiencing homelessness with a terminal diagnosis are dying in environments not conducive to a dignified and comfortable death. We are requesting $147,825 to provide for a dedicated bed at Evergreen Hospice House to care for these patients in an environment where they are supported and comfortable.

- Goal #1: Provide a medically and socially supported EOL experience for our patients who are experiencing homelessness.
- Goal #2: Relieve the physical and psychosocial burden for our community partners (shelters and respite bed providers).
- Goal #3: Reduce unnecessary ED and hospital admissions to provide EOL care for the homeless, while improving access to palliative therapies and hospice services.

Member and Community Need

- Target Population: Patients experiencing homelessness with a terminal diagnosis (mostly IHN-CCO members)
- IHN-CCO Member Impact: Improve equity by providing a dignified and supported death for those with no home or social support
- Community Needs: Shelters and respite providers are carrying the physical and psychological burden of providing EOL care. They cannot sustain this and we need to help

System Transformation

How is your proposal transformational?

1. Collaboration: working with our community partners to reduce the burdens associated with caring for homeless patients experiencing end of life, including the trauma of substandard EOL care

2. Reducing burdens: elimination of patients dying in cars, on the streets, in shelters or in the hospital rather than in a loving, supportive environment. Easy transfer to Hospice House, without prior authorization or continued justification

3. Reducing costs: supported patients will not use emergency treatment, transportation, or hospital stays thus reducing costs for EOL care

4. Providing a dignified end: people with no home or social support network can feel comfortable, loved and supported throughout the dying process like other patients with a home and social support

Partnerships/Collaboration

We will partner with housing providers such as:

- Corvallis Housing First
- Chance
- Unity Shelter
- Albany Helping Hands
- Northwest Coastal Housing
- Area hospitals and Emergency Departments
- Outpatient hospice providers and palliative care providers

These collaborations will help us identify potential patients and work proactively to shift the care to Evergreen Hospice House before the burden of caring for these patients becomes too great.

We will continue to provide case management, disease support, medication assistance, social support, and necessities through CareHub to optimize patient experience

Health Equity Plan

This proposal is primarily about equity in treatment for patients at end of life who are homeless.

While most IHN-CCO patients have permanent housing and some sort of family or other social support, many of our homeless patients do not have these basic things to ensure a 'good death'.

We understand the reimbursement system is designed for those people requiring very little at EOL, we would like to expand our ability to care for homeless patients by providing a stable housing situation and social/personal support like most other patients have.

This does not appear to be feasible under the current reimbursement schema, so we would like to run this pilot until a satisfactory alternative reimbursement schema can be developed that hardwires equity into the treatment of homeless patients at EOL.

Definition of Success

- Measures & Outcomes:
  - Patient satisfaction with EOL care
  - Partner satisfaction with resources for EOL care
  - Reduced costs (hospital, ED, etc) at EOL
  - Increased use of Hospice House resources
- What data will you use to measure success?
  - # of patients dying in substandard environments vs. Hospice House
  - Total cost of care for patients in program
- At the end of your pilot, what will have changed?
  - Homeless patients at EOL will no longer die on the street or in shelters
  - Patients will be more comfortable and supported during the dying process
  - We will have engaged an alternative payment model for these patients
  - Community partners will feel a decreased burden and associated anxiety around EOL

Sustainability Plan

Our plan is to use this funding to secure 1 dedicated Hospice House bed to provide EOL care for patients who are homeless

We will use the pilot time to work with IHN-CCO to develop an alternative payment arrangement for these patients to access Hospice House services earlier, while avoiding authorization and justification obstacles

In the future, we would anticipate that referrals may come to Hospice House from any community provider without the issues surrounding the process currently

DST Member Questions?

Easy-A Coach Pilot Program

Backbone Organization: Old Mill Center

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

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

County(s): Benton

Priority Areas:
- Addressing trauma, including environmental
    - o Post-pandemic cultural trauma
    - o Reduction of wait times for mental health services
    - o Toxic stress
- Addressing technology disparities
    - o Phone and internet access
- Language access
    - o Health literacy
- Reengaging the community in personal health and community resources
- Rural community impact
    - o Disparity in care for rural communities
- Subpopulations of IHN-CCO members that experience health disparities
    - o E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, and more

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: A1c, BH1b, BH1i, BH1ii, BH3ii, BH5v, BH6ii, HL1ii, HL1iii, HL1v, HL1vi, HL1vii

Pilot Contacts	Name	Email
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Proposal Narrative

A. Executive Summary

The COVID-19 pandemic has exposed the persistent gaps in our educational systems, including the lack of investment in the well-being of our nation's educators. According to a 2022 nationwide survey conducted by the National Education Association, the pandemic has pushed more than half of teachers to plan to leave the profession sooner than they'd hoped–a drastic increase from the previous year's survey (37%).The devastating impact of the pandemic on educators–coupled with the lack of funding to address their well-being–has underscored the need for investment in our educators' well-being to prevent and address burnout.

Easy A is a comprehensive health and wellness curriculum that empowers educators to take care of their mental, physical, emotional, and behavioral health. The foundational motto of the curriculum is "self-care above service." Easy A was developed by a consortium of health care providers and educators, diverse across race, age, profession, and socioeconomic factors. This program has 11 modules focused on burnout, social determinants of health, impact of trauma on health, addiction, pain, diet, sleep, and physical activity. The goals of the Easy A Coach Pilot Program are to:

1. **Increase awareness of health care resources and services.** Educators continue to face high demands from school systems and parent communities, leaving little time for self-care and navigating health care systems. Easy A teaches educators how to locate services and utilize health resources. Coaches work one-on-one with educators to help increase awareness of resources and services that are unique to the individual educator's needs.
2. **Increase positive health outcomes by increasing feelings of community, safety, and well-being.** Often, educators don't feel comfortable discussing their mental and behavioral health experiences with peers. Easy A coaches will create a community for educators to have this support. Coaches will serve as community moderators to facilitate the kinds of peer-to-peer conversations educators may want to engage in, but don't have the safe space to do so.
3. **Promote healthy living.** Easy A coaches will teach educators about mindfulness, nutrition, hydration, physical activity, sleep, impact of loneliness, impact of gratitude, and the role of relationships. One-on-one interactions between coaches and educators will be customized for each educator's needs and individual health goals.

B. Pilot Description

1. Project Goals/Measurable Objectives

There are 3 goals of the Easy A Coach Pilot Program:

1) increase awareness of health care resources and services;

2) increase positive health outcomes by increasing feelings of community, safety, and well-being; and

3) promote healthy living.

To achieve these goals, there are several measurable objectives that need to be met:

a. Recruit 6 individuals to be trained as health coaches
b. Successfully matriculate all individuals through health coach training
c. Recruit 18 educators to engage with Easy A curriculum with the support of health coaches
d. Conduct process evaluation of health coach support with Easy A
    i. Evaluation from coach perspective
    ii. Evaluation from educator perspective
e. Evaluate health outcomes for educators
    i. Measure perceptions of general health
    ii. Measure perceptions of sleep
    iii. Measure perceptions of weight management
    iv. Measure perceptions of exercise
    v. Measure perceptions of mental health

2. Target Population

The target population for the pilot will be InterCommunity Health Network (IHN) members who are also educators in the Linn, Benton, and Lincoln counties. We define educators as any employee of a school in the aforementioned counties. When we think of educators, we generally think of teachers leading the classroom. To ensure we cast a wide net in engaging IHN members, we broadened the definition of educator to include other staff such as teacher's aides, janitorial staff, dietary staff, bus drivers etc., who all play pivotal roles in supporting the function of a school.

We currently have 19,651 IHN members that are 6-18 year olds that our educators are supporting in the Linn, Benton and Lincoln counties. Secondly 47% (about 38,714) of IHN-CCO membership have chronic conditions which our curriculum and the coaches will be addressing indirectly. Over 12% (10,159) have substance use disorder and 35% (28,694) have at least one mental health diagnosis. This curriculum and its coaches have the potential of starting to make an impact on.

3. Description of the Intervention and Detailed Activities

1. **Activity 1:** Recruit individuals to be trained as health coaches.The eligibility criteria to be a coach is as follows:
    a. Individuals must be 25 years of age or older
    b. Must hold a bachelor's degree in an area within or related to health and/or education
    c. Must have a basic understanding of technology
2. **Activity 2:** Train the individuals to become certified health coaches who are experts on the Easy A curriculum.Training will be done over the course of 6 months to 1 year (will be implemented in a modified self-paced fashion).
3. **Activity 3:** Recruit 18 educators to take part in EasyA with the support of a health coach. Each coach will support 3 educators. Communication will occur through discussions boards, phone calls, video calls, e-mail, and–if feasible–in-person meet-ups.
4. **Activity 4:** Process evaluation of both coaching and educator experiences with the Easy A curriculum. Coaches' process evaluation will include an assessment of the training and how they were able to support educators.Educators' process evaluation will include an evaluation of the Easy A program and coach support.
5. **Activity 5:** Evaluate educators' perceptions on various health indicators, including:
    a. Perceptions on general health
    b. Perceptions on sleep
    c. Perceptions on weight management
    d. Perceptions on exercise

4. Community Partners and Tasks

Our partners include educators of the school districts in the Linn, Benton, and Lincoln counties:

● Alsea School District

● Central Linn School District

● Corvallis School District

● Greater Albany Public Schools

● Harrisburg School District

● Lebanon Community

● Lincoln County School District

● Monroe School District

● Philomath School District

● Santiam Canyon School District

● Scio School District

● Sweet Home School District

The above school districts' primary role will be to recruit people interested in becoming coaches, as well as staff who want to participate in Easy A. The Old Mill Center for Children and Families will also provide support in recruiting potential coaches and program participants.

5. Promotion of Health Equity and Data Tracking

This project will promote health equity by recruiting a diverse group of people for consideration to be coaches and by defining educators (the group of people whose health we want to change) in a broad fashion. We will ensure that our coaches come from diverse racial and ethnic groups, sexual and gender identities, disability backgrounds, different education levels, and have diverse experiences so they can connect with a broad pool of educator participants. Our definition of educator is broad and includes staff and faculty that may not typically be included in health initiatives geared toward teachers. For example, a janitor or a bus driver may not be thought of as an educator because they are not teaching students in the classroom. However, they need the same amount of support because they also have to manage students and are pivotal in ensuring that students' education is accessible. It is because of gaps like those that health disparities exist, and our Easy A Coach Pilot Program has the potential to reduce health disparities by being more inclusive and open to various types of educators.

Health equity data will be tracked via an online questionnaire that will also capture various aspects of health and health behaviors that we hope to affect. The demographic data that we collect will help us track where specific health equity disparities exist among IHN-CCO members.

6. Social Determinants of Health Lens

The social determinants of health are embedded in the Easy A curriculum and helped guide the development of the program. There is also a specific module in the Easy A curriculum dedicated to the social determinants of health where we acknowledge the societal and systemic shortcomings and discuss how individuals can push for system changes and take care of themselves. The coaches training will also include a heavy emphasis on the social determinants of health so coaches are aligned with the Easy A curriculum.

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

Bettina Schempf, MBA (she, her, hers) is our fiscal agent. She has served as the Executive Director of Old Mill Center for Children and Families Inc., since July 2013. Bettina has worked in general management, project management and financial management roles in the for-profit and not-for-profit sector in Germany, New Zealand, and Oregon for more than 25 years. She has been involved in health management, equity work, and system transformation since 2013.

Dr. Sharna Prasad PT, DPT (she, her, hers) is a co-founder of Sol4ce, LLC. She will be coordinating the Easy A Coach Pilot Program. She works with Samaritan at Lebanon Community Hospital, working with complex chronic pain patients. Her role in this pilot will be leading recruitment of coaches, coordinating the health coach supervisor, Being the Easy A supervisor, coordinating training logistics, problem solving, and maintaining clear communication with the school district administration and all other parties involved. She has overseen two DST pilots that are fully sustained. She has practiced as a physical therapist in India and the U.S. for 36 years.

Dr. Joseph Mortimer, PT, DPT (he, him, his) is a co-founder of Sol4ce, LLC. He will support the Easy A Coach Pilot Program by coordinating the social media discussion boards, handling logistics and assisting the marketing team. He works at Samaritan at Lebanon Community Hospital in a primary care resident clinic. He is very interested in upstream health.

Velyn Scarborough, MBA (she, her, hers) is a co-founder of Sol4ce, LLC. She has extensive experience in entrepreneurial and strategic management. She teaches students at OSU in advertising, sales, creative marketing. In her role with the Easy A Coach Pilot Program, she will lead strategy for the marketing team.

Dr. Winston Kennedy, PT, DPT, MPH (he, him, his) is the lead research associate at Sol4ce, LLC. He will be leading the research team in collecting data for the Easy A Coach Pilot Program.

Dr. Shelley Dubkin-Lee, EdD (she, her, hers) will serve as the liaison in assisting educators with receipt of professional development credits, to encourage participation. She has extensive experience in education, health promotion, and life coaching.

Jasmine Berry, MPH, CHES (she, her, hers) will support the Easy A Coach Pilot Program as an assistant research associate. She has 10 years of experience in communication and health education. She has supported health communication projects across immunization, mental health, and health disparities in the federal and non-profit sectors.

8. Old Mill Center and Easy A Strategic and/or Long-Range Plans Alignment

The Old Mill Center for Children and Families provides programs and services that support the educational, social, emotional, mental health, and occupational health needs of children and families. This pilot program aligns with the center and pilot team's strategic and/or long-range plans of Sol4c4.LLC, through our shared goal of supporting the educational, social, emotional, mental health, and occupational health needs of community members. Specifically, the Easy A curriculum addresses health disparities and helps people gain the skills and knowledge to manage their health and well-being.

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

Community members will hear about the project through social media and email promotion, traditional media outreach, and our website, (https://sol4ce.com). The school districts that we partner with will also be helping to spread the word about our project to support recruitment of educators.

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

One risk of any new initiative in schools is fidelity. Fidelity is the commitment to policy and procedures when delivering an intervention. Educators often feel overwhelmed by the amount of instruction they need to do, which is why fidelity is often impacted. In 2019, we implemented a similar curriculum in the Corvallis School District, and lack of fidelity was a part of the outcome. To counteract this risk to fidelity, we are training coaches to support educators as they work with the Easy A Pilot Program. To support the training and implementation of health coaches, we are aiming to provide a stipend for their time and effort.

There is the potential for some psychological risk, including negative affective states such as anxiety, depression, guilt, loss of self-esteem, and altered behavior. To address this, educators will be given an overview of the Easy A intervention, then they will have to give informed consent to participate. Educators will be able to discontinue participation in the intervention at any point.

C. Pilot Timeline

Major Objective	Key Tasks	Timeline
1. Easy A train the coach curriculum Development	**1.1 Meet with the creators of Easy A and decide on the health coaching programs that are nationally approved.**	**January 2023-March 2023**

	1.2 Identify to be trained as a health coach	
2. Easy A train the coach curriculum implementation	**2.1 Assist coaches in signing up with the health coaching curriculum.**	**March 2023 (6 months-1 year)**
3. Easy A Train the coach evaluation	**Evaluate training of coaches**	**August 2023**
4. Recruitment of educators	**Recruit 18 educators to be supported by coaches**	**July to Sept-2023**
5. Implementation of Easy A coach		**May 2023**
	5.1 Coaches to lead online 12 week Easy-A intervention	**June to Dec 2023**
	5.2 Coaches to communicate weekly with the Easy- A participants	**June to Dec 2023**
	5.3 Coaches to be given feedback every week on their performance by supervisor	**June to Dec 2023**
6. Evaluate data	**Ongoing evaluation of data for Easy A participants**	**Jan 2023-Dec 2023**
7. Write up study findings (anticipated 3 manuscripts)	**6.1 Prepare manuscript 1: EASY-A Coach Implementation**	**Jan 2024**
	6.2 Prepare manuscript 2: Outcomes from EASY-A Coach pilot study	**February 2024-March 2024**
	6.3 Prepare manuscript 3: two-month follow-up of EASY-A Coach Intervention	**March 2024-May 2024**

9. Disseminate work at state and national conferences and submit manuscripts?	**7.1 Submit abstracts for conferences**	**August 2024-March 2024**
	7.2 Submit manuscripts to peer-reviewed journals. Potential candidate journals include disability and health journal and journal of physical therapy	**March 2024**

D. Sustainability Plan (1⁄2 page)

This program is innovative, comprehensive, and transformative as it creates a non-traditional pathway to physical, mental, and behavioral health. It is precise and practical. It is based on facilitating curiosity in our educators about health, so that their internal curiosity would lead them to discovering ways they can find their own answers. For the Easy A Coach Pilot Program, the majority of the funding will be used for initial set-up costs, including staff and training. Once appropriately trained staff members are in place, the program should be sustainable and scalable. Coaches will sign a contract that will outline their obligation to provide their services for 3 years. After the year is up a new contract can be negotiated. Recruitment and retention of coaches will vary by need, i.e., the number of educators who desire support with working through the Easy A program.

The Easy A Coach Pilot Program has the potential to be used in healthcare by insurance companies. This could be a source of income for Easy A that has the potential to fund the program for an extended period of time. Healthcare institutions, such as insurance companies can use Easy A as an adjunct to health care services, thus cutting health care costs significantly by helping patients become aware of their health behaviors. It also could be used as a first step for clinicians to recommend to their patients as they wait to have access to their providers. It could be an adjunct to healthcare and simultaneously be used as a preventive model. The Oregon Health Authority has expressed an interest in learning more about the Easy A program.

We currently have educators outside of Oregon, specifically, in Connecticut, Pennsylvania, Utah, Michigan and New York who are eagerly waiting for the course to be launched so that they can sign up. Because of the online access and self-paced nature of our program, it has the opportunity to be delivered outside of Oregon in the above mentioned states, as well as others.

SMART Goals and Measures Table

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Time-Bound	1. Development of Easy-A Coach Training curriculum	Develop with consultants	Face validity met by panel of experts	03/2023
	2. Recruitment of individuals to train as coaches	Advertise recruitment	6 individuals agree to participate to be trained as a health coach	03/2023
	3. Training of coaches	Assessments of potential coaches	Evaluation of training by coaches	09/2023
	4. Recruit educators to participate	Advertise recruitment	18 educators agree to participate	
	5. Begin Easy A Coach Pilot Program	Coaches and educators assigned	Educators successfully complete program	06/2023
	6. 12-week assessment of coaches and educators	Issue questionnaire	Students' complete outcomes assessment/questionnaire	10/2023
	6. Analysis of initial data	Data analysis and reporting	Data is cleaned then analyzed	10/2023
	7. 2 month follow up of educator participants	Issue questionnaire to students	Students complete 2 month follow up questionnaire	12/2023
	8. Completion of project with several conference and publications pending	Submit findings to grant agency and, various scholarly outlets	Findings write up	03/2024

Pilot: Easy-A-Coach

Pilot Start Date:	January 2023	Pilot End Date:	6/1/2024
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Coaching Project coordination		$55,000.00	$55,000.00
Research related expenses		$15,000.00	$15,000.00
Online platform development + app development		$65,000.00	$0.00
Health coach supervisor		$10,000.00	$10,000.00
	Subtotal Resource Costs	**$145,000.00**	**$80,000.00**
Materials & Supplies			
Books, Misc		$3,000.00	$3,000.00
Marketing plan (handouts, posters, online marketing, marketing intern, etc)		$20,000.00	$20,000.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$23,000.00**	**$23,000.00**
Travel Expenses			
Conference travels and accomodations		$10,000.00	$10,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$10,000.00**	**$10,000.00**
Meeting Expenses			
Food, meetings		$500.00	$500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$500.00**	**$500.00**
Professional Training & Development			
Health coaching training for 6 coaches		$60,000.00	$60,000.00
Other professional training (Trauma informed care, SDOH, behavioral health		$3,000.00	$3,000.00
		$0.00	$0.00
	Subtotal Training & Development	**$63,000.00**	**$63,000.00**
Other Budget Items			
Misc, postage, magnets, posters, stickers, printing, gifts for teachers.		$1,500.00	$1,500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$1,500.00**	**$1,500.00**
Total Direct Costs	**Rate (%)**	**$243,000.00**	**$178,000.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	5.00%	$12,150.00	$8,900.00
Total Project Budget		**$255,150.00**	**$186,900.00**

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

We would be applying to other grants for supporting the software development of the program.

Easy A Coach Pilot Program

Pilot Summary and Goals

1. **Increase awareness of health care resources and services.** Educators continue to face high demands from school systems and parent communities, leaving little time for self-care and navigating health care systems. Easy A teaches educators how to locate services and utilize health resources. Coaches work one-on-one with educators to help increase awareness of resources and services that are unique to the individual educator's needs.
2. **Increase positive health outcomes by increasing feelings of community, safety, and well-being.** Often, educators don't feel comfortable discussing their mental and behavioral health experiences with peers. Easy A coaches will create a community for educators to have this support. Coaches will serve as community moderators to facilitate the kinds of peer-to-peer conversations educators may want to engage in, but don't have the safe space to do so.
3. **Promote healthy living.** Easy A coaches will teach educators about mindfulness, nutrition, hydration, physical activity, sleep, impact of loneliness, impact of gratitude, and the role of relationships. One-on-one interactions between coaches and educators will be customized for each educator's needs and individual health goals.

Member and Community Need

- The COVID-19 pandemic has exposed the persistent gaps in our educational systems, including the lack of investment in the well-being of our nation's educators. According to a 2022 nationwide survey conducted by the National Education Association, the pandemic has pushed more than half of teachers to plan to leave the profession sooner than they'd hoped–a drastic increase from the previous year's survey (37%).

- Target Population:

    - The target population for the pilot will be InterCommunity Health Network (IHN) members who are also educators in the Linn, Benton, and Lincoln counties. We define educators as any employee of a school in the aforementioned counties. When we think of educators, we generally think of teachers leading the classroom. To ensure we cast a wide net in engaging IHN members, we broadened the definition of educator to include other staff such as teacher's aides, janitorial staff, etc., who all play pivotal roles in supporting the function of a school.

System Transformation

- Promotes self-management of health
- Promotes creating community to support health
- Addresses multiple areas of health

Partnerships/Collaboration

- Our partners include educators of the school districts in the Linn, Benton, and Lincoln counties

- The school districts' primary role will be to recruit people interested in becoming coaches, as well as staff who want to participate in Easy A.

- The Old Mill Center for Children and Families will also provide support in recruiting potential coaches and program participants.

Health Equity Plan

- This project will promote health equity by recruiting a diverse group of people for consideration to be coaches and by defining educators (the group of people whose health we want to change) in a broad fashion. We will ensure that our coaches come from diverse racial and ethnic groups, sexual and gender identities, disability backgrounds, different education levels, and have diverse experiences so they can connect with a broad pool of educator participants. Our definition of educator is broad and includes staff and faculty that may not typically be included in health initiatives geared toward teachers. For example, a janitor or a bus driver may not be thought of as an educator because they are not teaching students in the classroom. However, they need the same amount of support because they also have to manage students and are pivotal in ensuring that students' education is accessible. It is because of gaps like those that health disparities exist, and our Easy A Coach Pilot Program has the potential to reduce health disparities by being more inclusive and open to various types of educators.
-

Definition of Success

- Success includes:
  - Successful recruitment of potential health coaches
  - Successful recruitment of educators
  - Successful training of health coaches
  - All educators complete program with support of coaches

- What data will you use to measure success:
  - Measure perceptions of general health
  - Measure perceptions of sleep
  - Measure perceptions of weight management
  - Measure perceptions of exercise
  - Measure perceptions of mental health

Sustainability Plan

- This program is innovative, comprehensive, and transformative as it creates a non-traditional pathway to physical, mental, and behavioral health. It is precise and practical. It is based on facilitating curiosity in our educators about health, so that their internal curiosity would lead them to discovering ways they can find their own answers. For the Easy A Coach Pilot Program, the majority of the funding will be used for initial set-up costs, including staff and training. Once appropriately trained staff members are in place, the program should be sustainable and scalable. Coaches will sign a contract that will outline their obligation to provide their services for a year. After the year is up a new contract can be negotiated. Recruitment and retention of coaches will vary by need, i.e., the number of educators who desire support with working through the Easy A program.

DST Member Questions?

Faith Communities Engaging Health

Backbone Organization: Faith Community Health Network

Billing Address: PO Box 2466, Lebanon, OR 97355

Site(s): Various Linn, Benton and Lincoln County Faith Communities

County(s): Linn County

Priority Areas: (see Guidelines)

Addressing technology disparities **AND** language access, including health literacy.
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: (see Guidelines)

Access to Healthcare: Outcomes A1 and A2.
Behavioral Health: Outcomes BH3, BH4, BH6
Child and Youth Health: Outcomes CY1, CY2, CY3
Healthy Living: Outcome HL1
Maternal Health: Outcome M2
Social Determinants of Health and Equity: Outcome SD1, SD3, SD4

Pilot Contacts	Name	Email
Primary	Deb Fell-Carlson	faithcommunityhealthnetwork@gmail.com
Proposal	Deb Fell-Carlson	faithcommunityhealthnetwork@gmail.com
Contracting	Deb Fell-Carlson	faithcommunityhealthnetwork@gmail.com
Financial	Deb Fell-Carlson	faithcommunityhealthnetwork@gmail.com
Reporting	Deb Fell-Carlson	faithcommunityhealthnetwork@gmail.com

DST Proposal | July 25, 2022

Faith communities engaging health

Faith Community Health Network

A. Executive Summary:

The Faith Community Health Network (FCHN) supports a growing group of dedicated Faith Community Nurses (FCNs) (formerly called Parish Nurses) and health ministers from diverse faiths serving faith communities in the context of their faith tradition and/or community-at-large bringing healthcare access to vulnerable and diverse populations in a non-traditional setting. There are many doing work to support various groups of Intercommunity Health Network Coordinated Care Organization (IHN-CCO) members throughout Linn County, but IHN-CCO members are not currently served by these organizations in the faith context. As faith community members, their needs are different, and trusted FCNs and health ministers serving their faith community can assess the population and meet those needs from a culturally appropriate perspective, thus improving health equity. The FCHN welcomes all faith traditions and values and embraces the different needs among faith traditions - and among those who do not claim a faith tradition.

Our project involves:

1. Equipping the FCHN team with exhibit items (canopy, table, etc.) for local and regional outreach to educate Registered Nurses (RNs), community leaders, health system leaders, public health professionals, and faith community leaders of diverse faiths about faith community nursing and how FCNs and health ministers support culturally appropriate healthcare access inside faith communities, including culturally appropriate spiritual care.
2. Identifying and testing a faith community health assessment tool across three rural and three urban Linn County faith communities in the context of the respective faith tradition and culture to identify health disparities within these faith communities as well as commonalities and disparities across rural and urban faith community nursing practice. This assessment is intended to help identify culturally appropriate care needs for vulnerable faith community members, who are often IHN-CCO members.
3. Using the assessment findings to create a “health buzz;” coordinate/conduct focused events and outreach inclusive of all races, ages, faith traditions, and socioeconomic levels in these faith communities and spill into the community-at-large
4. Purchase of consulting services to build a simple website, populate a compatible email management application, and teach FCHN to maintain both for education, faith community and community outreach and health engagement in our tri-county area and beyond. The FCHN website will also be a conduit for Connect Oregon (Connect Oregon recommends this for us).
5. Improving FCHN team proficiency in online health information access, Connect Oregon, and use of MyChart to equip FCNs and Health Ministers to do just-in-time referrals and searches.
6. Renewing the FCHN-Westberg Educational Partnership to support Foundations of Faith Community Nursing Courses in 2023 and 2024 to train additional RNs in the faith community nursing practice specialty and health ministers.
7. Purchase of computers/peripherals/software/user training to facilitate documentation for ten health ministries (any faith) with trained FCNs developing a practice and to allow FCNs and health ministers to provide just-in-time resource connection and/or health information access for faith community members (and community members) on the spot.
8. Publication of the entire pilot project in a professional nursing journal.

B. Pilot description

About the Faith Community Health Network.

The FCHN supports a group of dedicated FCNs and health ministers from diverse faiths serving their faith communities and surrounding community-at-large who bring healthcare access to vulnerable and diverse populations in a non-traditional setting. There are many doing work to support various groups of IHN-CCO members throughout Linn County, but IHN-CCO members within faith communities are not currently served by these organizations in the context of their faith. As faith community members, their needs are different, and trusted FCNs and health ministers serving within the faith community can assess the population and meet those needs in a culturally appropriate context, thus improving health equity. FCNs and their health ministry teams are in various stages of developing their practice in their respective faith communities; the Network meets regularly for professional support, to discuss practice challenges, and for continuing education. The FCHN is a new 509(a)(2) public charity and can receive tax deductible donations under its 501(c)(3) tax exempt status.

The FCHN welcomes all faith traditions and values and embraces the different needs among faith traditions - and among those who do not claim a faith tradition. The FCHN currently has Lutheran, Baptist, Episcopal, Evangelical, Jewish, and non-denominational faith communities represented, along with FCNs and health ministers who choose not to affiliate with a specific faith tradition but prefer to serve in the community-at-large.

The increased focus on community-centered care has renewed regional interest in faith community nursing practice and, as a result, brought the Foundations of Faith Community Nursing Course back to our area[1] after a decade. RNs who desire to practice faith community nursing take this six-day Foundations course to prepare them for this specialized nursing practice. Nurses and health ministers who complete the Foundations of Faith Community Nursing Course are welcomed into the FCHN for support and learning. FCNs attend ongoing continuing education in community health, spiritual care, trauma-informed care, and other applicable topics, and develop their practice with their Health Ministry teams consistent with the Oregon Nurse Practice Act and the American Nurses Association Faith Community Nursing Scope and Standards of Practice.

Many RNs choosing this practice specialty are actively licensed with many years of experience. Some work in a traditional healthcare setting but are at a point in their career where they have the flexibility to "give back" and desire to use their nursing expertise in service to their faith community. Some have recently retired or are nearing retirement from paid nursing employment and want to keep their nursing license active by practicing in their faith community. Faith community nursing is typically unpaid, but it *is* nursing, and counts toward practice hours required to maintain RN licensure in Oregon. Others hold "Nurse Emeritus" licensure status, allowing them to practice to their full scope but *only* in an unpaid professional status. Retaining seasoned nurses in a faith community nursing capacity preserves vast nursing expertise and brings it into the community where improved healthcare access, advocacy, and equity is desperately needed.

FCNs within the FCHN serve as IHN-CCO member advocates and healthcare touch points within their respective faith communities and the community-at-large and refer as appropriate to simplify

[1] The course curriculum is provided by Westberg Institute for Faith Community Nursing and, in the past, was delivered with Linn-Benton Community College Extended Learning as an educational partner.

member access to care. The FCHN is a Connect Oregon partner committed to support the team as they use this platform to connect IHN-CCO members they serve with supportive services to help assure safe and stable housing, especially upon discharge from a hospital stay or emergency room visit. The FCHN also supports FCNs to coordinate with and augment existing transitional care systems to better meet IHN-CCO member needs by coordinating with providers, hospital case managers, discharge planners, clinic care coordinators and others on the care team

Not only do faith communities have differing needs, but individual and family needs inside each faith community are also different and reflect the diversity of that faith community's population. One faith community nursing practice may focus on home visits to new moms and young families, while another with an older population might be focused on diabetes prevention and heart health, and yet another may primarily address social determinants of health. In any case, FCNs serve as on-site health resources for faith community members, for example, those who have general health questions, do not understand how to implement their treatment plan, or who are unsure if they should seek medical care. Health ministry teams support FCNs where they can, based on their scope of practice, and can be especially helpful in addressing social determinants of health. Continuity of care would be much improved in our region if we had an FCN and health ministry team *in every house of worship*. This project most certainly meets the FCHN mission and vision:

Mission: The Faith Community Health Network meets regularly to provide training, mentoring and overall support to Faith Community Nurses and Health Ministers from diverse faiths who are committed to bringing advocacy, health equity, spiritual care, and improved healthcare access and literacy to their faith community's most vulnerable populations.

Vision: The Faith Community Health Network Vision is to equip Faith Community Nurses and Health Ministers for active Health Ministry in every faith community in Linn, Benton, and Lincoln Counties.

About Faith Community Nursing and Health Ministry and rationale for pilot

Faith Community Nursing is not well-understood or well-known in our region, although it is well-established in other parts of the United States. A Faith Community Nurse is not simply a registered nurse who happens to be a member of a faith community. Faith Community Nursing is a recognized nursing practice specialty. FCNs are uniquely positioned to improve health equity and health literacy for the diverse group of IHN-CCO members within faith communities. However, for FCNs and health ministers to be fully utilized and for the broad diversity of faith traditions in our region to be properly represented, the community must be made aware that FCNs exist.

Faith communities share a unilateral mission to serve the vulnerable. Maria Waters, Faith Liaison with the Oregon Health Authority, stated in a 2022 meeting that, prior to transitioning to the Coordinated Care Organization (CCO) model, FCNs were vital and active partners in Oregon's Medicaid system serving Oregon's most vulnerable population. The FCN role was perceived as less and less important as emphasis on the CCO model increased, resulting in waning interest and a resultant decline in Oregon's FCN population.

Faith community nursing touches all aspects of the human condition. As such, the FCHN team has the potential to impact every Delivery Systems Transformation (DST) priority area and Community Health Improvement Plan (CHIP) outcome, but access to healthcare, especially in rural areas, maternal health, behavioral health, healthy living, and social determinants of health are primary. An FCN from the faith community is a trusted healthcare access touch point, advocate, and can do just-in-time referrals in a non-traditional setting. FCNs assess needs in a culturally appropriate

context. This relevant information allows the FCN to plan culturally appropriate interventions, improving continuity of care and health equity. FCNs can identify individual (or group) health knowledge or health literacy deficits and intervene with their team to meet the need, including coaching on how to use technology. FCNs can assist faith community members with accessing credible online health information, *explaining* the information, and using their online portal. *FCNs and health ministers can identify and fill gaps in care that are invisible to others.*

Up to now, FCNs in the FCHN have conducted informal observational assessments and responded to health needs they have identified or that have been expressed by individuals or faith community leadership. This creates gaps in care and exacerbates existing health disparities. By identifying (or adapting/developing) and administering a standardized faith community health assessment that can be delivered in a culturally appropriate way, followed by careful analysis of assessment findings and using those findings to plan and execute interventional events and outreach, the FCHN is in a unique position to guide health ministry teams to stimulate individuals of all races, ages, faith traditions, and socioeconomic levels in faith communities and in the nearby community-at-large to refocus attention on health. A thoughtful evaluation of event participation and outcomes provides an opportunity for exploring the need for revision. Publishing the results of this pilot project in a professional nursing journal will add important contributions to the faith community nursing evidence-base.

Health ministry inspires those served to serve, key to sustainability. An example: Am HaSefer – People of the Book is a congregation of Biblical Jews - the first faith community to embrace faith community nursing in Lebanon. Their FCN learned in late 2020 that an elderly faith community member, R.S., had lost his wife and was homeless and medically fragile with serious unmanaged health conditions. Over the next year, the FCN and her new health ministry team worked with community partners to get emergency housing and coordinated appropriate care to stabilize his health during his transition to permanent housing, attending medical appointments with him for months until he understood and could follow his long-term plan of care. Permanent housing was secured for R.S. after collaborating with a different group of community partners. The health ministry team and members of his faith community moved him in and furnished his new home with donated items. His health has steadily improved, and he now easily climbs the three flights of stairs to his apartment! Today, his medical needs are few, but the FCN still serves as his health advocate when needed. Paying it forward, R.S. recently set aside Tuesdays to help B.C., an elderly Veteran who is currently being served by the same health ministry team, although he does not claim a faith community or faith tradition. An Am HaSefer Health Minister advocated for stable housing for B.C. and he is now in a different low-income apartment complex in Lebanon. R.S. drives to B.C.'s apartment each Tuesday, takes his garbage out, helps B.C. with his laundry, and takes B.C. on errands. This has been rewarding for R.S; it gives R.S. purpose, helps B.C., and provides important peer support to both gentlemen. It also frees up the FCNs and health ministers to deal with health-specific needs in the faith community.

Pilot description:

Goals and activities of this project:

1. Equip the FCHN team for local and regional community and faith community outreach and secure exhibit opportunities at two community venues by November 1, 2023. The durable items will be available for check out to Linn County FCHN Health Ministry teams. Needs include:

a. Items to support an exhibit booth at local and regional community venues (table, chairs, canopy, branded tablecloth, branded flag, display board, etc.)
b. Branded giveaways; branded shirts for those staffing the booth, name tags, etc.
c. Administrative staff time for coordination and to develop presentations for local and regional speaking venues
d. Travel and exhibit registration costs for two FCNs for conference exhibitor attendance within Oregon twice during grant period.
e. Services to create multimedia digital/printed marketing materials (including a video)
f. Door prizes and other incentives (often required of conference vendors)

2. Identify a faith community health assessment tool and pilot it with three rural and three urban faith communities in Linn County to evaluate its ability to identify faith community group and individual health needs, emergency management considerations, and insurance status/source by November 30, 2023. Needs include:
    a. Staff time for coordination
    b. Gift cards to incentivize survey participation
    c. Funds to pay for the data analysis
    d. Staff and consulting time to write up and edit findings for publication
3. Use the assessment findings to create a “health buzz;” coordinate/conduct focused events and outreach inclusive of all races, ages, faith traditions, and socioeconomic levels in these faith communities and spill into the community-at-large by December 31, 2024. Needs include:
    a. Staff time for event planning and administration
    b. Gift cards and giveaways for planners and participants
    c. Purchase of durable and culturally appropriate health-oriented learning activities/props that can be checked out by faith communities for engagement and to promote learning
    d. Culturally appropriate printed materials and handouts
    e. Evaluation of event outcomes
    f. Submitting entire project for publication in a professional nursing journal
    g. Consulting services to build a simple website, populate a compatible email management application for education/outreach/health engagement in our tri-county area and beyond. (website is recommended by Connect Oregon for ease of platform access).
    h. Consulting services to teach FCHN team to maintain website and email program
    i. Promotion materials/trackers for community-wide 5-2-1-0 initiative in faith communities
4. Improve FCHN access and proficiency in technology use by December 31, 2023. Needs include:
    a. Laptops/software/peripherals for FCHN team who do not yet have them and Linn County Foundations of Faith Community Nursing Course during grant period.
    b. Pittsburgh Mercy EDS training/retraining
    c. Connect Oregon training/retraining
    d. Training on signing up an individual for MyChart or who to refer someone to for signup
    e. Training on how to use MyChart and how to help others use it
    f. Staff time for coordination
5. Support the FCHN team to deliver the Westberg Foundations of Faith Community Nursing Course twice by December 31, 2024. Needs include:
    a. Funding support for course administration to keep tuition affordable
    b. Scholarships for two actively licensed RNs from within our tri-county area

c. Funds to apply to be a Westberg Foundations of Faith Community Nursing Educational Partner (required to teach the course) for the period from 7/2023-7/2028.
d. Zoom account for course delivery and monthly education and network meetings

Populations impacted:

COVID-19 has changed the face of worship. Even before COVID, insurance status is not something typically disclosed to a faith leader, so it is difficult to quantify the numbers of IHN-CCO members in faith communities to be served. If we plan on fifteen participating faith communities, averaging 60 active members, it assumes a conservative 900 individuals. Taking the 8-9% IHN-CCO membership in Linn County as a whole and applying 8.5% to that figure of 900, we project serving about 75 IHN-CCO members. It is likely more will be served in rural East Linn County and many of these will be served more than once. *The most important factor is not the number served, but who they are.* Some of these IHN-CCO members will be those who frequent emergency services when their most urgent need is someone to listen to a health concern, provide social engagement, or provide spiritual care. FCNs assess the needs of the IHN-CCO member and either develop a nursing care plan to address the need or make an appropriate referral. Over time, as the FCN role becomes known in the community, this will reduce unnecessary use of emergency services while helping to assure the member is referred to appropriate care at the earliest opportunity.

Partnerships and collaboration:

The FCHN has established partnerships with:

1. **Samaritan Care Hub.** This is a new partnership. This initiative dovetails nicely with the FCHN work, and Rosa Wolff and Anita Earl are eager to begin collaborating with the FCHN.
2. **Samaritan Lebanon Community Hospital.** Wendie Wunderwald, VP of Patient Care Services, is aware and supportive of this work. This support is demonstrated by:
    a. $2,500 to provide partial financial support for the 2021 and 2022 Foundations of Faith Community Nursing Courses and a spoken commitment to provide support for 2023.
    b. Invitation to speak about faith community nursing and transitional care to the Samaritan Lebanon Community Hospital Case Managers on 6/17/2021. The Samaritan partnership will expand with a presentation to Samaritan Albany General Hospital Case Management staff in the summer, 2022.
    c. Faith Community Nursing landing page on the Samaritan Community Health Initiatives landing page with the FCHN phone number as voice and text contact for Linn County (Albany). We will request this page be linked to our website when it goes live.
    d. Samaritan Heart to Heart publication announcements for the Foundations of Faith Community Nursing course and featured articles highlighting faith community nursing partnerships with patients and Samaritan Health Systems.
3. **Live Longer Lebanon.** The Live Longer Lebanon (LLL) coalition is composed of representatives from approximately 20 community groups that continuously scan the environment, assessing need and engaging in work to support the disenfranchised in the Lebanon area in various ways. The FCHN grew out of a LLL initiative.

4. **Family Assistance and Resource Center.** The informal partnership between the Family Assistance and Resource Center (FAC) and the FCHN is strong. Shirley Byrd, Executive Director of the FAC, is a Foundations of Faith Community Nursing Course alumnus. The two organizations collaborate to serve IHN-CCO members with overlapping service needs.
5. **St. Martin's Episcopal Church.** Wendy Fierro is a recent health minister graduate of our Foundations of Faith Community Nursing Course and staffs the St. Martin's homeless outreach ministry. One of our FCNs assists during homeless outreach hours twice a month to help with assessment and referral. This has been a valuable partnership for both.
6. **Oregon Health Authority.** The FCHN and Maria Waters, Faith Liaison with the Oregon Health Authority, have been collaborating to get the word out about the benefits of Faith Community Nursing. The OHA has approached the FCHN executive team with a request to present to Coordinated Care Organizations throughout Oregon about this work.
7. **Oregon State Board of Nursing.** Ruby Jason, OSBN Executive Director, invited the FCHN to submit an article to the OSBN publication, The Sentinel, and has invited FCNs to speak to the Board about faith community nursing. She sees FCNs as integral to our health care continuum.
8. **Westberg Institute (WI) for Faith Community Nursing.** This organization serves as the faith community nursing "north star" at the national level. They publish the Foundations of Faith Community Nursing curriculum and provide other faith community nursing educational and leadership opportunities. They manage a communication platform that connects FCNs across the country.
    a. FCHN partners and collaborates with WI on many levels; FCHN members share on the communication platform, serve as a Foundations of Faith Community Nursing Course host annually, serve on the annual symposium planning committee, and on the WI research committee.
    b. For this project, FCHN is partnering with WI Research Consultant for work on the assessment, project data analysis, and project write up. We will submit for publication jointly.
9. **Linn County Public Health**.
    a. Nova Sweet, Crisis & Admissions Supervisor, Linn County Mental Health served as a guest presenter on Behavioral Health and Mental Health for the 2021 Foundations of Faith Community Nursing Course, and has agreed to do the same again for 2022.
    b. FCNs learn about the Community Health Improvement Plan during the Foundations Course and are directed to it as they work on their faith community assessment.
10. **Linn-Benton Community College (LBCC) and other nursing programs**.
    a. The FCHN partners with the LBCC Nursing Program to deliver lectures to nursing students on community health nursing in general and the importance of social determinants of health on individual and population health outcomes.
    b. The FCHN team has precepted two nursing students to complete their CAPSTONE Community Health Project for their bachelor's degree in nursing requirements, prompting interest in replicating in Lincoln County. The team will precept another student

starting in October, 2022, and she will be doing a project specific to faith community nursing practice in Linn County.

11. **Faith communities, especially in rural East Linn County**.

    a. Faith communities, regardless of affiliation, unilaterally support services to their struggling members, and often, to some degree, to the community at large. They typically do this independent of any external funding source. FCNs are uniquely positioned inside these faith communities to assess, refer, and connect IHN-CCO members with appropriate care and resources.

    b. In addition, FCNs may serve as health advisors to faith community leadership. Faith community leaders struggled with what to do in this COVID-19 pandemic in the absence of consistent, accurate information, especially early on. The FCHN partnership with OHA and Linn County Public Health provides local FCNs with a conduit to get clear answers and direction for their faith communities. This is true in a pandemic but will also be true in any future natural disaster. These FCNs are key to informing our faith communities and getting appropriate and timely care to these populations.

Environmental scan/competitive landscape:

Many local faith leaders and nurses are unaware of faith community nursing and the potential benefits of such a practice within their own faith communities. Lack of awareness has hindered recruitment, but as they see how FCNs fit into their service mission, more diverse faith communities will likely sign on as they see the impact on individual lives. There has been interest in replicating in Lincoln County. Our outreach will keep this in context. Getting the word out is critical to the FCHN vision of equipping an FCN in every house of worship in our tri-county area.

Our local FCNs are in various stages of developing their practices within their faith communities. Some FCNs have been hesitant to seek permission from faith community leadership because they have been unsure of their scope in this autonomous practice environment. Ruby Jason, Executive Director of the Oregon State Board of Nursing, spoke to the team in May, 2022 and addressed concerns. She was encouraging and empowered FCNs to immerse themselves in this practice.

Faith community nursing is accepted nationally as a health improvement strategy and recognized as such by the Robert Wood Johnson Foundation. They list increased healthy behaviors and improved health outcomes as expected beneficial outcomes of FCNs as an intervention, and reduced hospital readmissions as a potentially beneficial outcome.

FCNs are well-positioned to serve as trusted healthcare touch points to properly assess and refer individuals within their faith communities and disenfranchised community members who may be served by faith community outreach programs, many of whom are IHN-CCO members or are elderly Medicaid recipients. Samaritan Health Services has clinic care coordinators and case managers throughout the system to help meet this need, but it is impossible for the health system to know and meet all needs in the community.

Sustainability:

This training, equipment, and supplies will support FCN nursing practice into the future. As FCN practice again becomes known, accepted, and valued in our region, additional faith communities will support FCN practice and Health Ministry.

The FCHN is sustained by in-kind donations, monetary donations, and team dedication. We rely on just-in-time donations to meet community needs and are usually able to meet the need because of the breadth of our Network. As this grows, our ability to meet needs in the community will grow organically within each faith community. Our team is comprised of FCNs, all unpaid professionals, and Health Ministers, who are dedicated volunteers supporting faith community nursing practice. Our Governing Board, including the Executive Director, draws no salary.

Offering the Foundations of Faith Community Nursing Course annually helps assure sustainability. Graduating each new cadre of FCNs feeds nurses into the FCHN and faith communities across the region. The FCHN is the only organization offering this course in Oregon.

The FCHN and LBCC Nursing Program partnership helps assure that nursing students are aware of community-based nursing practice options, including faith community nursing. This feeds students into the Foundations of Faith Community Nursing Course and then into faith community nursing practice. Publishing provides an evidence-based framework for replication.

The FCHN has collaborative leaders, with several nurses doing different things at different times to move the organization forward and maintain momentum for continued growth. Engaging the team in various leadership activities helps to ground the organization and embed it into the community for the long-term and gives FCNs confidence as they work within their own practice. Engagement has been shown to be a key factor in retention in any setting.

Together we will strive to achieve our vision of a faith community nurse and health ministry team in every house of worship in Linn, Benton, and Lincoln Counties!

	Baseline or Current State	Monitoring Activities	Benchmark or Future State
Specific Measurable Attainable Relevant Timely	1. Faith Community Nursing has faded from memory; we need to educate the community to engage RNs and Health Ministers representing greater diversity in faith tradition, ethnicity, etc. to provide culturally appropriate care in this non-traditional setting, including spiritual care, and in the context of the specific faith tradition.	A. Exhibit items purchased (canopy, table, tablecloth with logo, chairs, display board, etc.)	Equip the FCHN team for local and regional community and faith community outreach and secure exhibit opportunities at two community venues by November 1, 2023.
		B. FCHN exhibit at a minimum of two community events during grant period	
		C. Contract for multimedia digital and printed marketing materials	
		D. Contract for short marketing video	
		E. Purchase logo'd giveaways and incentives (also to be used in #3)	
	2. FCNs are hesitant to do a faith community health assessment without a valid, reliable, and equitable faith community health assessment tool that can also help track outcomes across faith communities. Furthermore, FCN practice appears to be distinctly different in rural (East Linn County) vs urban (Albany). We want to know if that is true.	A. Identify, adapt, or develop faith community health assessment tool	Identify a faith community health assessment tool and pilot it with three rural and three urban faith communities in Linn County to evaluate its ability to identify faith community group and individual health needs, emergency management considerations, and insurance status/source by November 30, 2023.
		B. Contract to evaluate assessment tool for validity, reliability, revise as needed	
		C. Administer assessment tool across six Linn County faith communities	
		D. Contract to analyze assessment findings in six faith communities	
	3. The overall community is lagging in healthy behaviors. This is also true in faith communities. Place matters; our environment and those we associate with impact our health behaviors. The faith community provides a great opportunity for health engagement and social support inside and outside faith community walls.	A. Use assessment findings to plan events in the six assessed faith communities to promote learning and engagement in healthy behaviors.	Use the assessment findings to create a "health buzz;" coordinate/conduct focused events and outreach inclusive of all races, ages, faith traditions, and socioeconomic levels in these faith communities and spill into the community-at-large by December 31, 2024.
		B. Purchase durable and culturally appropriate health-oriented learning activities/props that can be checked out by faith communities to assist with engagement and promote learning	
		C. Obtain and reproduce culturally appropriate teaching materials.	
		D. Contract for website design with event management and outreach features and FCHN team training to maintain (recommended by Connect Oregon)	
		E. Contract for website compatible (from "D" above) email management system, population of list from existing contact list, set up for newsletter template, and training on how to maintain	
		F. Engage FCHN-affiliated faith communities in February 2023 and 2024 5-2-1-0 campaign; distribute electronic and printed materials.	
	4. Our FCHN work in Oregon is unique and has captured national attention. It is important to contribute to the nursing literature to share examples of evidence-based faith community nursing practice.	A. Contract to analyze findings and evaluate entire pilot project	Submit for publication in a professional nursing journal by December 31, 2024
		B. Contract to write up for publication in a professional nursing journal.	
		C. Submit for publication	
	5. FCHN team needs more exposure to technology use to be able to access community resources and document. We have team members without access to a computer and will likely have local Foundations Course graduates who need electronics.	A. Purchase laptops, peripherals and software for Linn County Foundations Course graduates (estimate: 8-10 during 2 year grant period)	Improve FCHN team proficiency in technology use by December 31, 2023.
		B. Contract for Pittsburgh Mercy training/tetraining, assess for proficiency	
		C. Arrange Connect Oregon training/retraining, assess for proficiency	
		D. Arrange for Windows 11 and MS Office training/retraining, assess for proficiency	
		E. Arrange for MyChart training, assess for proficiency	
	6. The FCHN team is too small to meet the social determinants of health and health care access point needs; we serve those inside - and outside - our faith community walls.	A. Deliver course in fall, 2023, 2024.	Deliver the Westberg Foundations of Faith Community Nursing Course twice by December 31, 2024.
		B. Purchase Zoom account for course delivery.	
		C. Renew Westberg educational partner agreement	

Pilot: Faith Communities Engaging Health

Pilot Start Date:	**9/1/2022**	**Pilot End Date:**	**12/31/2024**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Marketing video (In-Kind: FCHN team editing and consultation, facility use		$4,000.00	$2,000.00
Website and email management system (In-kind: FCHN team get training on their own time)		$9,000.00	$7,000.00
Westberg Institute of Faith Community Nursing Educational Partnership Renewal		$2,000.00	$2,000.00
Assessment evaluation, data analysis, write up and submit for professional publication - Westberg Research Consultant (In-kind: possibility of OSU public health student, FCHN team editing)		$4,000.00	$2,000.00
	Subtotal Resource Costs	**$19,000.00**	**$13,000.00**
Materials & Supplies			
Items for event exhibits (Chairs, canopy, display board, printed materials, branded tablecloth, flag, shirts, nametags, swag, etc.) (In-kind: some items borrowed from faith communities at times)		$6,000.00	$4,000.00
Laptops/peripherals/software for documentation (some of the team already have or may choose to purchase own hardware for ministry)		$20,000.00	$14,000.00
Culturally appropriate educational activities for events		$1,000.00	$1,000.00
	Subtotal Materials & Supplies	**$27,000.00**	**$19,000.00**
Travel Expenses			
Two FCNs, two three-day conference trips within Oregon (FCN cost-share)		$6,000.00	$3,000.00
Local FCHN travel (donated by FCN)		$3,000.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$9,000.00**	**$3,000.00**
Meeting Expenses			
Zoom (2 years - for Foundations Course and meetings)		$300.00	$300.00
Room rental for meetings and events (some space is donated)		$6,000.00	$1,200.00
Food (six events - drop off catering - some food items donated)		$5,000.00	$2,500.00
	Subtotal Meeting Expenses	**$11,300.00**	**$4,000.00**
Professional Training & Development			
Documentation training (Windows 11, Office 365, Pittsburgh Mercy)(some just-in-time training in-house at no charge)		$5,000.00	$1,500.00
Annual Cultural Competency training x 2 (reduced rate for our team)		$1,000.00	$600.00
Foundations of Faith Community Nursing Funding Assistance x 2 during grant period (including nursing CEUs)(In-kind: scholarship donations x2, pro bono presenters)		$16,650.00	$5,000.00
	Subtotal Training & Development	**$22,650.00**	**$7,100.00**
Other Budget Items			
Exhibitor fees and required door prizes (some prizes donated)		$1,200.00	$1,000.00
Staff time for grant management, in-house training, and coordination for grant period (as assigned by FCHN executive team) In-Kind: unpaid professional hours for grant management		$90,000.00	$42,000.00
		$0.00	$0.00
	Subtotal Other	**$91,200.00**	**$43,000.00**
Total Direct Costs	**Rate (%)**	**$180,150.00**	**$89,100.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$18,015.00	$8,910.00
Total Project Budget		**$198,165.00**	**$98,010.00**

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

IHN-CCO Delivery Systems Transformation Pilot Grant Proposal

2023-2024

Faith Communities Engaging Health

Presented August 4, 2022 by Marcy Joy Shanks, MSN, MSEd, RN and Deb Fell-Carlson, BSN, RN, MSPH

Faith Community Health Network | PO Box 2466 Lebanon, OR 97355

The Faith Community Health Network is a 509(a)(2) public charity and can receive tax deductible donations.

About the Faith Community Health Network

- The Faith Community Health Network (FCHN) supports a growing group of dedicated Faith Community Nurses (FCNs) (formerly called Parish Nurses) and health ministers (all unpaid) from diverse faiths serving their faith communities (and surrounding community-at-large) *in the context of their faith tradition* providing healthcare access and advocacy in a non-traditional setting.
- Faith community nursing and health ministry were considered essential to the Oregon healthcare continuum in the past, but were not integrated into the Coordinated Care model.

Pilot Summary

- Educate the community to recruit increased numbers and diversity of FCHN team numbers, improving equity by delivering culturally appropriate care and resource support
- Identify and test a faith community health assessment that will reliably track outcomes across diverse urban and rural faith communities
- Use assessment findings to design culturally appropriate events to create a “health buzz,” leveraging the social supports a faith community provides to engage the community-at-large

Pilot Summary

- Improve FCHN team proficiency in healthcare technology, providing the capability for just-in-time referrals
- Provide partial funding support for Foundations of Faith Community Nursing Course to build sustainability
- Contribute to a body of evidence supporting faith community nursing practice through publication

Our vision: a trained faith community nurse and health ministry team in every house of worship!

Goals

- Equip the FCHN team for local and regional community outreach and secure two community exhibit venues by November 1, 2023.
- Identify a faith community health assessment tool and pilot it with three rural and three urban faith communities in Linn County; determine reliability and validity of the tool by November 30, 2023.
- Use the assessment findings to create a “health buzz;” coordinate/conduct focused events and outreach inclusive of all races, ages, faith traditions, and socioeconomic levels in these faith communities and spill into the community-at-large by April 30, 2024.
- Submit pilot project findings for publication in nursing journal by December 31, 2024.
- Improve FCHN team proficiency in technology use by December 31, 2023.
- Deliver the Westberg Foundations of Faith Community Nursing Course twice by December 31, 2024.

Member and Community Need

- Target populations: Any vulnerable community member *(i.e., IHN-CCO members, the unstably housed, Medicare/Medicaid recipients, Veterans, etc.)*
- IHN-CCO Member impact
  - We project serving ~ 75 IHN-CCO members JUST in faith communities with more in East Linn County, and many of these will be served more than once. *(Note: Insurance status is not something typically disclosed to a faith leader, so it is difficult to quantify the numbers of IHN-CCO members in faith communities to be served.)*
  - The most important factor is not the *number* served, but who they are.
- Community Needs
  - The FCHN is emerging as vitally important to improving social determinants of health and chronic disease management. **FCNs and health ministers can fill gaps in care that are invisible to others.**

System Transformation

- Faith community nursing is recognized nationally as a health improvement strategy. Bringing FCNs back into the CCO model as collaborative partners is transformational -- putting nursing expertise back out into the community where it is desperately needed.
- Faith community nurses serve as advocates, educators, coaches, and spiritual care advisors. They visit homebound faith community members, make hospital visits, assist with chronic disease management and referral, host health improvement events, and assist with housing, food insecurity, and other social determinants of health *in a non-traditional setting within the community.*

Our vision: a trained faith community nurse and health ministry team in every house of worship!

Faith Community Nursing and Health Ministry teams transform lives!

Meet Ron

The power of faith, friendship and exceptional care

When Lebanon resident and business owner Ron Steele unexpectedly lost his beloved wife of 35 years in 2019, his life was shattered. In addition to losing his great love, he lost his co-pilot. Steele is legally blind and his wife handled all of their affairs: finances, medical appointments, grocery shopping and cooking.

Now living alone in the motor home he once shared with his wife, Steele was having to learn to do it all on his own. He was staying on a friend's property with [illegible] running water or heat, and his [illegible]lth began to rapidly decline.

[illegible]ng with diabetes, he knew his persistent [illegible]n leg wounds were problematic. His feet [illegible]lled and he was unable to walk far without falling.

"[illegible]new things were getting bad, so I just started [illegible]ying," said Steele.

[illegible]eek later, while working on a church project, he showed [illegible]iend his wounds. The friend immediately called his wife, [illegible]h community nurse Deb Fell-Carlson, RN.

"[illegible]h community nurses are licensed nurses who have [illegible]en special training to minister to people at their [illegible]ces of worship.

"[illegible]soon as I saw Ron's legs and the overall condition he was [illegible]I knew action had to be taken," said Fell-Carlson.

[illegible] first step: help get Steele enrolled in a good Medicare [illegible]n to cover his medical needs. Then, help schedule a visit [illegible]h Bridget Shariat, DO, at Sweet Home Family Medicine. [illegible] Shariat instigated a series of referrals to several [illegible]naritan services for collaborative, comprehensive care.

"[illegible]banon Diabetes Education taught me how to really care [illegible]my diabetes," said Steele. "I learned what to eat, how to [illegible]itor my blood sugar levels, fun ways to exercise and how [illegible]heck my skin for infections."

[illegible]naritan Wound, Vein & Hyperbaric Medicine treated the [illegible]unds on his legs, which revealed problems with Steele's circulation. He underwent vein surgery that improved circulation, reduced pain and helped to prevent new leg ulcers.

Next came physical therapy.

"Physical therapy helps me manage my chronic pain and I have really come to enjoy it," said Steele.

For 15 years, Steele used opioids to control constant pain. His new treatments allowed him to manage the pain and transition to a safer medication.

"Dr. Matthews at Samaritan Recovery Clinic in Lebanon was another answer to my many prayers," said Steele. "He helped get me to where I didn't need the opioids anymore and I feel so much better without them in my system."

Besides medical services, Fell-Carlson helped get Steele an apartment, a pool membership, new dentures and glasses, and helped him access other needed community-based services.

"He's a whole new person and it has truly been a gift to be able to help him find health, comfort and safety," said Fell-Carlson.

Today, Steele is climbing stairs to his third-story apartment, enjoying water exercise and immersing himself in old hobbies.

"I don't know where I would be today without my faith, Deb, my congregation and the many care providers who supported my return to health," said Steele. "I am thankful for this community and the collaboration from everyone to give me a better life."

To learn more about faith community nursing or how to get involved, visit samhealth.org/FaithCommunityNursing.

Above: *Ron Steele at Linn-Benton Community College's machine tool technology laboratory enjoying his favorite pastime – machine tooling.*

[illegible] heart » *heart | Prevention*

Ron is a member of a local congregation. Homeless, hopeless and in poor health, he turned to his faith for help. There was ONLY ONE FCN in the local area at the time, in HIS congregation.

You may have read about him in the most recent Samaritan Heart-to-Heart publication.

Ron Steele has given us permission to share his story.

Meet Barlow

Barlow does not go to any church. He is a community member who described his immediate homelessness risk to an Am HaSefer Health Minister. The Am HaSefer Health Ministry Team sprung into action.

Barlow was evicted from his home on 5/31; the Health Minister worked with the VA to arrange temporary housing until he could move into an apartment; he moved in on June 13!

Barlow now looks at his eviction as a blessing. He says, "I'm happy with the place I've got. Me and my dogs. And I'm happy I have these people. ***If I didn't have these people, I don't know where I would be now."***

Barlow Carper has given us permission to share his story.

Partnerships/Collaboration

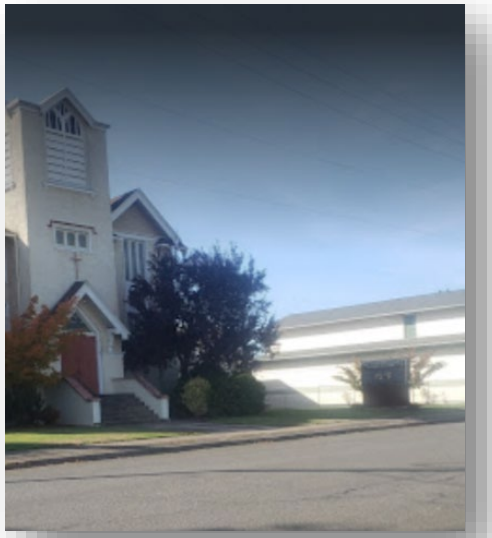
- Partners vary depending on the needs of who is being served. They currently include:
  - Samaritan Care Hub
  - Samaritan Lebanon Community Hospital
  - Live Longer Lebanon
  - Family Assistance and Resource Center
  - Oregon Health Authority
  - Westberg Institute for Faith Community Nursing
  - Oregon State Board of Nursing
  - Linn County Public Health
  - Linn Benton Community College Nursing Program
  - Connect Oregon
  - Linn-Benton Veteran's Service Office
  - Seven faith communities, including a synagogue of Biblical Jews

Faith communities in East Linn County with an established FCHN affiliation

Am HaSefer – People of the Book
Synagogue meets in Trinity Baptist Church
FCN nursing practice and Health Ministry focused on broader community
Lebanon, OR
Two trained FCNs
Three trained Health Ministers

New Hope Church
Lebanon, OR
One trained FCN

Southside Church of Christ
Lebanon, OR
One trained FCN – Also serves as FCN at Obria Medical Clinics



St. Martin's Episcopal Church
Lebanon, OR
One trained Health Minister

FCHN-affiliated, but not in faith community.
<u>Serving community at-large</u>
Lebanon and Sweet Home, OR
Three trained FCNs

Faith communities in Albany area with an established FCHN affiliation

Eastside Christian Church
Albany, OR
One trained FCN

North Albany Community Church
Albany, OR
One trained Health Minister

Immanuel Lutheran Church – Missouri Synod
Albany, OR
Two trained FCNs

Health Equity Plan

- The FCHN welcomes all faith traditions and values and embraces the different spiritual and health needs among faith traditions - and among those who do not claim a faith tradition. This promotes equity across faith traditions and the community-at-large.
- Members of a faith tradition have needs that differ from another faith tradition. Trusted FCNs and health ministers serving that faith tradition improve health equity by assessing that population and developing interventions to meet needs from a culturally appropriate perspective.
- Not only do faith traditions have differing needs from other faith traditions, but individual and family needs *inside* each faith community are also different and reflect the diversity of that faith community's population. Faith community nurses and health ministers in those faith communities are in a unique position to assess those individual and group needs.

Faith community nurses are in a unique and advantageous position to assess at various levels to assure needs are met. Testing the assessment tool will further promote health equity.

Definition of Success

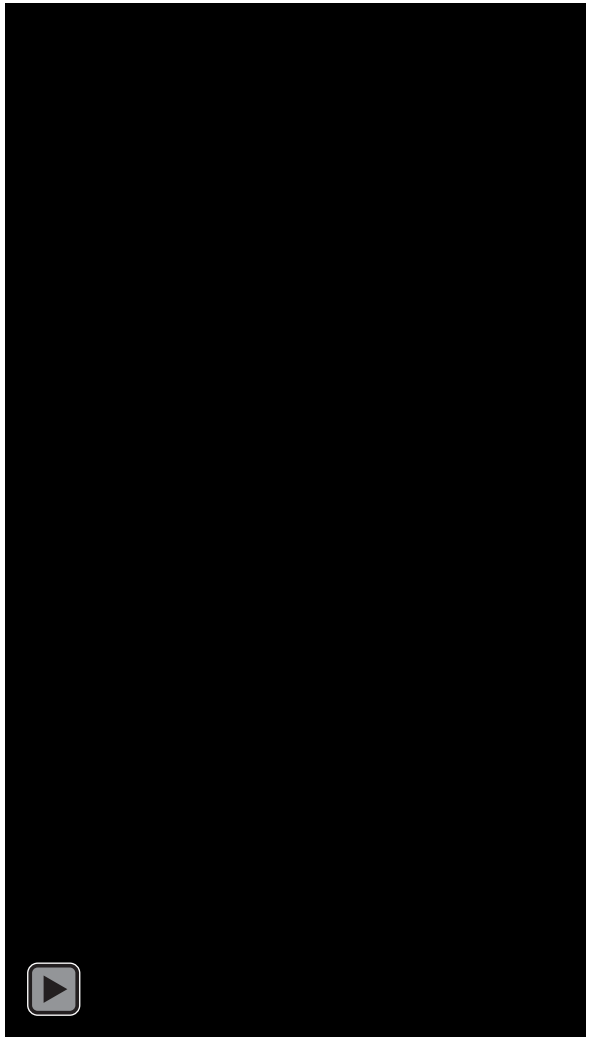
- The broad measures are defined in the goals.
- What data will you use to measure success? Each activity has opportunities for measurement. Here are examples:
  - Engagement in outreach at two community events
  - Number of assessment responses
  - Number of events that occur and number of folks who participate in events
  - Technology proficiency assessed by instructor with a pre- and post- asessment
  - Foundations Course: did the courses occur? How many students enrolled? Did numbers increase year by year as awareness increased?
- At the end of your pilot, what will have changed?
  - We will have trained FCNs and health ministry teams in more faith communities and more *diverse* faith traditions than now
  - We will have an assessment tool to confidently evaluate faith community individual and group health needs AND gather information about ethnicity, insurance status, and disaster preparedness special needs (such as medical equipment that would not function without power)
  - We will have culturally appropriate games/activities that can be reserved/checked out by FCHN faith communities so they can conduct culturally appropriate events independently

Sustainability Plan

- The goals and activities in this pilot set the FCHN up for sustainability.
  - With the community outreach and annual Foundations training, we expect to grow a larger regional team and increased awareness will happen naturally through word of mouth.
  - The display set-up and activities/props will be available to FCHN faith communities for events going forward.
  - In-kind donations and monetary donations will likely increase as awareness increases.
  - FCHN partnership to share community health expertise with LBCC nursing students and precepting partnership with Grand Canyon University will feed more nurses into the FCN practice specialty.
  - Publishing our outcomes will provide opportunities to replicate locally and beyond and help to establish evidence-base for further practice.
  - FCNs and Health Ministers are engaged in various aspects of FCHN activities. This serves to embed the practice in the community rather than having it be a passion of just a few.
  - Nursing literature suggests that, over time, faith communities will add this important community service as a budget item and fund it.

Together we strive to achieve our vision of a faith community nurse and health ministry team in every house of worship in Linn, Benton, and Lincoln Counties!

Transforming lives… one person at a time…



People who are served often want to serve others .. and serving helps them find purpose.

"Since I've gotten an apartment of my own, I've been able to help others, which I could not do a year ago. There is a gentleman called Barlow that got out of the same situation that I was in. He is now in an apartment where he needs some help to get his things together. And fortunately, because of the help that I had, now I can go help him. And I ENJOY helping him! He is so… so…. so LIVELY now. Before he was so depressed and so down. It was like he gave up."

Ron Steele has given us permission to share his story.

Thank you for this opportunity to share!
DST Member Questions?

Deb Fell-Carlson, BSN, RN, MSPH

Acting Executive Director/President & Board Chair,
Faith Community Health Network, Lebanon, OR
Faith Community Nurse, Am HaSefer Oregon – People of the Book, Lebanon, OR
faithcommunityhealthnetwork@gmail.com

Marcy Joy Shanks, MSN, MSEd, RN

Ethics Officer, Faith Community Health Network
Faith Community Nurse, New Hope Church, Lebanon, OR
Faculty and Clinical Coordinator, Linn-Benton Community College Nursing Program
marcyshanks@faithcommunityhealthnetwork.org

Homeless Data Harmonization

Backbone Organization: Samaritan Health Services

Billing Address: 2300 NW Walnut Blvd, Corvallis OR 97330

Site(s): Oregon State University

County(s): Benton, Linn, Lincoln

Priority Areas: Innovative programs supporting housing

Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: SD1 (increase the percentage of Members who have safe, accessible, affordable housing); SD4 (increase health equity)

Pilot Contacts	Name	Email
Primary	Paulina Kaiser	pkaiser@samhealth.org
Proposal	Paulina Kaiser	pkaiser@samhealth.org
Contracting	Paulina Kaiser	pkaiser@samhealth.org
Financial	Paulina Kaiser	pkaiser@samhealth.org
Reporting	Paulina Kaiser	pkaiser@samhealth.org

Proposal narrative

Executive summary (½ page)

The Homeless & Healthcare Systems Data Harmonization Pilot Project is an innovative, transformative, and collaborative data analysis project. We propose to bring together data on individuals with Housing Insecurity/Homelessness (HI/H) from three community organizations in Linn, Benton, and Lincoln (LBL) counties: Community Services Consortium (CSC), Samaritan Health Services (SHS), and the Community Health Centers (CHCs) of Benton & Linn Counties. This project directly addresses the need for better data and data systems related to homelessness at a local level, which was the top recommendation identified by the Benton County HOPE Advisory Board in 2021.

CSC is the HUD-designated Community Action Agency for the LBL region and maintains the Homeless Management Information System (HMIS) data system for Coordinated Entry (CE) and other programs across the LBL region. HMIS is the most robust available data source on people experiencing HI/H locally. SHS will provide data on healthcare utilization (ED visits and hospitalizations as well as primary care and behavioral health visits) from electronic health records as well as IHN-CCO claims data (note that no funding is requested for SHS participation in this project). Benton/Linn CHCs will provide data on primary care and behavioral health visits from their electronic health records. Data from HMIS and Epic have not been linked before; this project will create a rich combined dataset to allow us to describe patterns and quantify health disparities experienced by HI/H populations

Key to this pilot project is the partnership with the OSU Policy Analysis Laboratory (OPAL). OPAL will receive and analyze CSC, SHS, and CHC data as a neutral third party. This project will leverage OPAL's research infrastructure, scientific rigor, and policy acumen to promote data-informed decision-making related to HI/H interventions in the LBL region. Samaritan's research department will serve as fiscal sponsor for the project in order to minimize overhead costs and reduce administrative burden to community partners. Overall, this project will bring together disparate data sources to generate actionable information for local decisionmakers and inform future data systems improvement strategies.

Pilot description

Pilot goals

1. Identify strategies and challenges for data harmonization across key data sources (CSC, SHS, Linn/Benton CHCs) for people experiencing HI/H in the LBL region

2. Define target subpopulations among people experiencing HI/H using CSC's HMIS data. (Potential priority groups to explore: age; race/ethnicity; chronically homeless; veteran status; VI-SPDAT vulnerability index score; physical or mental disabilities)

3. Describe health status within target subpopulations. Health outcomes to compare: prevalence of physical and mental health comorbidities; acute care utilization; primary care & behavioral health visits.

4. Share actionable takeaways with regional community agencies to inform future data efforts and HI/H interventions.

Target population

This project will include all people served by CSC's housing and homelessness-related programs including Coordinated Entry in 2021-2022. Notably, CSC data includes individuals served by homeless service agencies including Unity Shelter, Corvallis Housing First, Corvallis Daytime Drop-In Center, C.H.A.N.C.E., and Community Outreach Inc. We will cross-reference available data from Samaritan Health Services (both hospital/clinic data from Epic and IHN-CCO claims data) as well as clinic data from Linn/Benton Community Health Centers to describe health needs and healthcare utilization patterns among key subpopulations within the H/HI community. Approx. 70% of homeless individuals flagged as homeless by Samaritan clinics and hospitals are IHN-CCO members, so we anticipate that most people included in CSC's HMIS data will be IHN-CCO members.

Describe the intervention and detailed activities, including an environmental scan of similar projects in the region

This project will focus on data analysis with existing data to generate new, actionable knowledge. No similar projects exist, though this project builds on momentum from the Benton County HOPE Board and other key partners. Despite the energy around addressing HI/I, there are key gaps in the data currently available that would help to inform priorities and track changes over time. This project proposes to explore the feasibility and challenges of combining existing data from different sectors.

Project activities include:

- Key partners (CSC, SHS, Linn/Benton CHCs) sign data use agreements with OSU Policy Analysis Laboratory (OPAL).
- Key partners pull data from their respective data systems and send to OPAL.
- OPAL team cross references health data (SHS and Linn/Benton CHC) with CSC data to correlate health needs & healthcare utilization for patients served by a CSC housing program.
- OPAL summarizes how health status/needs differ among subpopulations of people experiencing HI/H in the LBL region.
- Key results and key takeaways are shared with key stakeholders and local decisionmakers.

List all partners that will be working on the pilot and the tasks they will undertake; Describe the individuals tasked with portions of the pilot and their roles and experience

<u>OSU Policy Analysis Laboratory</u>

Individual(s): Mark Edwards, director
1 Master's student and 1 PhD student (TBN)

Responsibilities:

- Execute contracts & data use agreements for identifiable data sets with SHS, CSC, and Benton County Health Department
- Obtain IRB approval
- Provide technical assistance to project partners on data specifications
- Securely receive & store data extracts from SHS, CSC, and Benton County
- Identify best options for identifying individuals across datasets
- Conduct data analysis
- Prepare summary presentations for key project stakeholders & community audiences

Community Services Consortium

Individual(s): Melissa Egan, housing services coordinator
Cory Hackstedt, HMIS data analyst

Responsibilities:

- Pull HMIS data and send to OPAL
- Advise OPAL on analysis and interpretation

Benton County Health Department

Individual(s): Julie Arena, HOPE coordinator
Chris Campbell, health data & analytics manager

Responsibilities:

- Pull OCHIN-Epic data from the six Benton/Linn CHCs and send to OPAL
- Advise OPAL on analysis and interpretation
- Coordinate with HOPE Advisory Board to align with other ongoing work and share updates

Samaritan Health Services *[note: no funding requested for SHS activities]*

Individual(s): Paulina Kaiser, research director

Responsibilities:

- Serve as fiscal sponsor and provide administrative support for project
- Hire OPAL grad students as SHS consultants to reduce overhead costs
- Pull Epic data from SHS hospital/clinics and IHN-CCO claims data & send to OPAL

Describe how the pilot will promote health equity and reduce health disparities; include how health equity data for IHN-CCO members will be tracked; Explain the social determinants of health lens the pilot will be incorporating

People experiencing HI/H are some of the most vulnerable members of our community. Inadequate housing, one of the most fundamental social determinants of health, is associated with poor health outcomes due to physical exposure to the elements as well as the complex social and emotional traumas that are closely linked with houselessness. Racial/ethnic minorities, people with disabilities, veterans, and domestic violence survivors are all overrepresented in local HI/H populations (according to CSC's 2020 Point in Time Count). This project will allow deeper assessment of health equity related to homelessness in Benton County than has been possible before.

Rather than collecting new health equity data for IHN-CCO members, this project will explore how to combine existing data sources to quantify equity outcomes in new ways. For example, Samaritan has data on ED visits and hospitalizations for patients flagged as homeless in Epic. But the process of flagging patients as homeless is imperfect and Samaritan has very little information on the type or duration of homelessness. CSC has rich data on type and duration of homelessness (including vulnerability index scores from the VI-SPDAT assessment completed during Coordinated Entry screening) but no information on health utilization. By combining data from existing sources we will enable new insights into the health disparities and inequities experienced by people experiencing HI/H in the LBL region.

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

This project is directly aligned with the strategic plans of key partners. CSC's most recent Strategic Plan includes numerous goals related to Continuous Improvement, Creating a Data Driven Culture, and Transformation. The type of data analysis proposed in this project is crucial to advancing CSC's anti-poverty mission and designing programs that address community needs. In 2020-2021, Benton County's Housing, Opportunity, Planning & Equity (HOPE) Advisory Board generated 12 policy recommendations[1] to address HI/H in Benton County (these recommendations were formally adopted by the Corvallis City Council and the Benton County Commissioners in June 2021). The first recommendation is to "*facilitate and coordinate data improvement efforts with community partners.*" The vision of the HOPE Board is that everyone in Benton County should have the opportunity to live in decent, safe, and affordable housing. HOPE promotes racial and ethnic justice, prioritizes vulnerable populations, and values the use of data to drive assessments, prioritization, and accountability. In order to best use scarce resources, we must understand the scope of the problem, evaluate the outcomes of investments, assess progress, and demonstrate accountability.

This project also supports a new collaboration with OSU to leverage academic expertise in navigating complex analytic challenges with sensitive data. Cross-sector collaborations will be key to addressing the perpetual challenge of insufficient data to fully describe and identify patterns in the needs of the HI/H community. By supporting the integration of relevant, but distinct data sources

[1] HOPE Board recommendations available online at: https://www.co.benton.or.us/sites/default/files/fileattachments/health_department/page/8050/hope_policy_recommendations_4-28-21_approved.pdf

related to HI/H, this innovative, collaborative project will contribute novel information that will be directly actionable and transformative to guide future interventions.

Describe how members of the community will hear about your project

OPAL will coordinate with project stakeholders to disseminate results. Preliminary audiences include Linn, Benton and Lincoln County Board of Commissioners and local city councils in the LBL region; local HI/H service collaboratives that meet monthly (e.g. HEART Board, Linn County; HOPE Board, Benton County; and the Lincoln County Affordable Housing Providers group). Project partners will also share updates through their regular marketing channels. The HOPE Board has monthly meetings with resources available on the website.[2]

Describe potential risks and how the pilot plans to address them

The major risks of this project to analyze existing data are related to data security. OSU, as a major academic institution, has substantial experience and infrastructure to ensure the security of sensitive data. University data security experts have already been consulted by Mark Edwards for arranging secure transfer of the data to encrypted drives at the university, and data will only be accessed by Edwards and the one or two graduate assistants, using only university-approved computers. OPAL, as a neutral third party, will be only partner to have access to identifiable data from the data stakeholders (CSC, SHS, Linn/Benton CHCs). OPAL will have primary responsibility for interpretation of results and preparing dissemination materials. CSC, SHS, and Linn/Benton CHCs will receive aggregate summaries of identified patterns and key takeaways.

[2] https://www.co.benton.or.us/health/page/hope-community-engagement

Pilot Timeline

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
IRB approval	X	X										
Contracts / DUAs with OPAL		X	X									
Prepare data extracts		X	X	X								
Informational meetings with homeless service providers			X	X								
Cross-reference data sets for overlapping individuals				X	X	X						
Data analysis: define subpopulations & compare health outcomes						X	X	X	X			
Share findings w/ homeless service providers								X	X			
Generate white paper on lessons learned for harmonization projects with other sectors/partners										X	X	
Draft final report												X

Sustainability Plan

Successful completion of this pilot project will provide holistic HI/H service and health care provider utilization that currently does not exist. Once completed, the de-identified results of the project will be provided to the HOPE Advisory Board, the Corvallis City Council, the Benton County Commissioners, CSC, SHS, Benton County Health Department, and local HI/H service providers.

Importantly, successful completion of the project proposed here is only the beginning of the process to optimize data systems related to HI/H in the LBL region. This pilot project will generate important lessons learned about the challenges and feasibility of the process of harmonizing data across sectors, which will inform future projects to incorporate data from additional partners and plan for ongoing analysis of available data.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Fragmented, siloed data collected across sectors serving homeless/housing insecure individuals	Progress towards integrating cross-sector data	Ability to harmonize cross-sector data sources to generate a new analytic dataset	12/2023
	Limited analysis of siloed data across sectors serving homeless/housing insecure individuals	Share analytic progress with key stakeholders	Generation of actionable knowledge about differences in health needs/costs for different sectors of the homeless population in the LBL region	12/2023

Pilot: Homeless & Healthcare Services Data Harmonization

Pilot Start Date:	**1/1/2023**	**Pilot End Date:**	**12/31/2023**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
OPAL (director, 1 Master's student, 1 PhD student)		$48,550.00	$48,550.00
Community Services Consortium data analyst		$3,500.00	$3,500.00
Benton County Health Services data analyst		$1,000.00	$1,000.00
		$0.00	$0.00
	Subtotal Resource Costs	**$53,050.00**	**$53,050.00**
Materials & Supplies			
Computer(s) for OPAL per data security protocols		$2,500.00	$2,500.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$2,500.00**	**$2,500.00**
Travel Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$0.00**	**$0.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$55,550.00**	**$55,550.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$8,332.50	$8,332.50
Total Project Budget		**$63,882.50**	**$63,882.50**

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

Homeless & Healthcare Systems Data Harmonization

Presented by:
Mark Edwards, OSU Policy Analysis Laboratory
Melissa Egan, Community Services Consortium
Barbara Hanley, HOPE Advisory Board

Pilot Summary and Goals

Summary: Combine existing data from different sectors to address the need for better information about housing insecurity & homelessness (HI/H) in the LBL region.

Goals:

1. Identify strategies and challenges for data harmonization across key data sources for people experiencing HI/H *(CSC, SHS, Benton/Linn CHCs)*
2. Define target subpopulations using CSC's HMIS data
    - *Potential priority groups to explore: age; race/ethnicity; chronically homeless; veterans; VI-SPDAT vulnerability index score; physical or mental disabilities*
3. Describe health status within target subpopulations
    - *E.g. prevalence of physical and mental health comorbidities; acute care utilization; primary care & behavioral health visits*
4. Share actionable takeaways with regional community agencies to inform future data efforts and HI/H interventions

Member and Community Need

- Benton County's HOPE Advisory Board recommendation (2021): "facilitate and coordinate data improvement efforts with community partners"
- CSC data includes individuals served by homeless service agencies including Unity Shelter, Corvallis Housing First, Corvallis Daytime Drop-In Center, C.H.A.N.C.E., and Community Outreach Inc. We will cross-reference available data from Samaritan Health Services (both hospital/clinic data from Epic and IHN-CCO claims data) as well as clinic data from Linn/Benton Community Health Centers to describe health needs and healthcare utilization patterns among key subpopulations within the H/HI community. Approx. 70% of individuals identified as homeless by Samaritan clinics/hospitals are IHN-CCO members, so we anticipate that most people included in CSC's HMIS data will be IHN-CCO members.

System Transformation

- Novel collaboration between community organizations and OSU to leverage existing data to bring new knowledge to guide future HI/H interventions locally.

- This project will support CSC & Benton County in preparing data extracts to share with OPAL, a neutral third party with substantial experience in analysis and interpretation of sensitive data. The proposed cross-sector data analysis has not been done before and offers rich potential for informing local priorities and for improving local data systems.

- There is a lot of opportunity to improve the health of IHN-CCO members experiencing HI/H; this project will provide actionable information to ensure that future interventions can focus on the highest priority needs.

Partnerships/Collaboration

OSU Policy Analysis Laboratory (Mark Edwards, director)

- Execute contracts & data use agreements for identifiable data sets with SHS, CSC, and Benton County Health Department
- Obtain IRB approval
- Securely receive & store data extracts from SHS, CSC, and Benton County
- Conduct data analysis
- Prepare summary presentations for key project stakeholders & community audiences

Community Services Consortium (Melissa Egan, Cory Hackstedt)

- Pull HMIS data and send to OPAL
- Advise OPAL on analysis and interpretation

Benton County Health Department (Julie Arena, Chris Campbell)

- Pull OCHIN-Epic data from the six Benton/Linn CHCs and send to OPAL
- Advise OPAL on analysis and interpretation
- Coordinate with HOPE Advisory Board to align with other ongoing work and share updates

Samaritan Health Services (Paulina Kaiser) *[note: no funding requested for SHS activities]*

- Serve as fiscal sponsor and provide backbone support for project
- Hire OPAL grad students as SHS consultants to reduce overhead costs
- Pull Epic data from SHS hospital/clinics and IHN-CCO claims data & send to OPAL

Health Equity Plan

- Inadequate housing, one of the most fundamental social determinants of health, is associated with poor health outcomes due to physical exposure to the elements as well as the complex social and emotional traumas that are closely linked with houselessness.
- Racial/ethnic minorities, people with disabilities, veterans, and domestic violence survivors are all overrepresented in local HI/H populations (according to CSC's 2020 Point in Time Count).
- This project will allow deeper assessment of health equity related to homelessness in Benton County than has been possible before. For example, Samaritan has data on ED visits and hospitalizations for patients flagged as homeless in Epic. But the process of flagging patients as homeless is imperfect and Samaritan has very little information on the type or duration of homelessness. CSC has rich data on type and duration of homelessness (including vulnerability index scores from the VI-SPDAT assessment completed during Coordinated Entry screening) but no information on health utilization. By combining data from existing sources, we will enable new insights into the health disparities and inequities experienced by people experiencing HI/H in the LBL region.

Definition of Success

- Current status
  - Fragmented, siloed data collected across sectors serving homeless/housing insecure individuals
  - Limited analysis of siloed data across sectors serving homeless/housing insecure individuals
- Future state (definition of success)
  - Ability to harmonize cross-sector data sources to generate a new analytic dataset
  - Generation of actionable knowledge about differences in health needs/costs for different sectors of the homeless population in the LBL region

Sustainability Plan

- Successful completion of this pilot project will provide holistic HI/H service and health care provider utilization that currently does not exist. Once completed, the de-identified results of the project will be provided to the HOPE Advisory Board, the Corvallis City Council, the Benton County Commissioners, CSC, SHS, Benton County Health Department, and local HI/H service providers.

- Importantly, successful completion of the project proposed here is only the beginning of the process to optimize data systems related to HI/H in the LBL region. This pilot project will generate important lessons learned about the challenges and feasibility of the process of harmonizing data across sectors, which will inform future projects to incorporate data from additional partners and plan for ongoing analysis of available data.

DST Member Questions?

Hope Grows Here

Backbone Organization: Moore Family Center – Oregon State University

Billing Address: 101 Milam Hall, Corvallis, Oregon 97331

Site(s): Lebanon, Albany, Corvallis

County(s): Linn & Benton

Priority Areas:

Addressing trauma, including environmental

Reengaging the community in personal health and community resources

Subpopulations of IHN-CCO members that experience health disparities

Rural community impact

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

HL1: Increase the percentage of Members who are living a healthful lifestyle: Nutrition, Physical Activity, Social Supports, Stress/trauma.

SD3: Increase the percentage of Members who have access to healthy food: Availability of fresh, affordable produce.

Pilot Contacts	Name	Email
Primary	Candace Russo	candace.russo@oregonstate.edu
Proposal	Candace Russo	candace.russo@oregonstate.edu
Contracting	OSU Office of Sponsored Programs, Research & Award Administration	osraa@oregonstate.edu
Financial	Aedra McCarthy	OSRAA.Finance@oregonstate.edu
Reporting	Candace Russo	candace.russo@oregonstate.edu

Hope Grows Here

Executive Summary:

Hope Grows Here is a peer-support program focused on gardening, nutrition education, and social-emotional wellness for low-income cancer survivors. By cultivating partnerships between the local gardening community, the Linn-Benton Food Share, Master Gardeners, and Medicaid-eligible individuals who have experienced cancer, this program aims to strengthen the physical and mental health, well-being and resilience of low-income cancer survivors.

Up to 40 adult post-treatment, Medicaid-eligible cancer survivors in Linn and Benton counties participating in *Hope Grows Here* will learn to garden in a supportive environment that is sensitive to their lived experiences, yet builds on their individual strengths. All staff and volunteers in the project will be trained in trauma-informed nutrition, and hands-on garden activities will include the principles of therapeutic horticulture. Project milestones include: 1) a no-cost basic gardening class taught by trained Master Gardeners volunteers; 2) dissemination of gardening supplies and resources to participants; 3) pairing small-groups of survivors for weekly peer support and garden gatherings with Master Gardeners and the project coordinator; 4) engaging in-person sharing of nutrition education, food demonstrations, tastings, and additional fresh produce from the region through a Mobile Kitchen; and 5) harvest celebrations hosted by OSU nutrition and dietetic students, including curated recipes and food demonstrations and tastings.

Hope Grows Here also involves piloting a garden installation dedicated for project participants at a clinical location. Using the tenants of designing a therapeutic garden space, including a three-meeting process to involve stakeholders (clinical and facilities staff, project participants, and project staff), a small garden area will be established at a clinical site where participants can easily access a supportive garden space.

Looking to the future, data will be collected through an IRB-approved process to establish connections between participation in the project and metrics for physical activity, nutrition, social supports, and stress. Results from this project will have academic rigor and will aid in project scalability and transferability.

Hope Grows Here - Proposal Narrative

Outcomes:

1. Increase factors to facilitate cancer survivors reaching survivorship guidelines for a healthy lifestyle, including nutrition, physical activity, and social supports.
    a. **Goal 1)** Using the Mobile Kitchen, provide on-site food demonstrations, tastings, and recipes featuring garden-grown food, with supplemental produce distributions from the Linn-Benton Food Share Gleaners.
    b. **Goal 2)** Provide demonstration and guidance for ergonomically safe and supported gardening techniques, including the use and supply of adaptive garden tools.
    c. **Goal 3)** Facilitate weekly garden mentoring (with Master Gardener mentors, peer gardeners, and project coordinator) to share stories, ask questions, and connect socially with other cancer survivors learning to garden together.
2. Increase social and emotional supports and reduce perceived stress among low-income cancer survivors.
    a. **Goal 4)** Provide easy, everyday stress-reduction techniques related to nature/gardens using trauma-informed care practices.
3. Improve access to fresh fruits and vegetables for low-income cancer survivors.
    a. **Goal 5)** Provide basic vegetable garden skills class, community garden plots, start-up supplies, and mentored gardening support for the full growing season.
    b. **Goal 6)** Connect participants to local food assistance programs to improve food security and reduce stigma related to accessing such programs.

Target population:

With disparities in cancer incidence and detection for certain cancers attributed to socioeconomic status, the target population for *Hope Grows Here* are Medicaid-eligible, adult post-treatment cancer survivors (age 18 and older) in Linn and Benton counties. We define “post-treatment cancer survivor” as any living person who has completed their primary cancer treatment; adjuvant treatment may be ongoing.

Intervention Description - Detailed Activities

***Hope Grows Here* Project Preparation, Participant Recruitment, Staff Training:**

1) Using health literacy guidelines for effective and understandable information, outreach materials will be developed to recruit Medicaid-eligible adult cancer survivors in Linn & Benton counties (these will include fliers, a webpage on the Moore Family Center’s website, a simple eligibility survey, a descriptive video, and materials to use during community informational sessions).
2) Outreach materials will be disseminated in partnership with multiple community organizations, including, but not limited to: Samaritan Cancer Resource Centers, the Live Longer Lebanon coalition, the IHN-CCO’s Care Coordination Team, and the Linn Benton Food Share network.

We will specifically target cancer survivors living in housing developments with space to garden (Riverview, Clayton Meadows, and Millwood Manor in Albany), plus communities in Lebanon (Millwood Manor), and those close to Porter Park Community Garden.

3) Informational fliers will be developed to recruit OSU Extension Service Master Gardener volunteers in Linn and Benton counties during their winter training sessions. Fliers will include the project announcement and description, a commitment description, and how participation will earn required Master Gardener volunteer hours. We could provide an in-person or remote presentation (depending on venue for the trainings), if requested.
4) The Moore Family Center will provide trauma-informed nutrition training sessions for all staff and volunteers involved in the project.
5) Informational community meetings will be held in-person to further describe the project in detail, including going over the participant consent form, with time for Q&A.
6) An informational meeting will also be held for Master Gardener volunteers to describe the project in further detail and allow time for Q&A.
7) A training session will be held for Master Gardener volunteers to help familiarize them with our target population, including information around both limitations and strengths of cancer survivors as related to gardening, based on evidence-based horticultural therapy practices. Trauma-informed care training will be part of this session.
8) Meetings (approx. 2-3) will be conducted with Master Gardener volunteers to organize and coordinate the gardening course materials.
9) The Moore Family Center's project manager will develop "Grow Together" activities to share during summer garden gatherings (please see Active Project - Phase 2, #2, below for details).
10) Work with participants to secure additional community garden beds as needed.

***Hope Grows Here* Pilot Garden Bed Installation at Clinical Site:**

1) Meet with partners at potential clinical site options; select the best fit.
2) Conduct three meetings with the clinical site partner to design a *Hope Grows Here* garden installation. Invite clinical site staff, facilities, and *Hope Grows Here* project participants in the area to contribute to the design process.
3) Install pilot garden beds at clinical site, with community involvement (project participants, MGs, and other volunteers, e.g. OSU students).

***Hope Grows Here* Active Project - Phase 1:**

1) Provide orientation materials for all participants, including: calendar of events, handouts for gardening class, and safety considerations for gardening (e.g. sun safety, wearing gardening gloves, and safe bending/lifting).
2) Administer pre-project surveys (provide online link, with option to coordinate phone call or in-person survey completion with staff assistance).
3) In partnership with MG volunteers, deliver gardening courses for all project participants (in-person or remotely, depending on winter public health measures).
4) Order and deliver communal gardening supplies (e.g. shovels, rakes, hoses, buckets, soil amendments, shade canopies, etc.) to garden sites.
5) Coordinate community work parties (invite participants, MGs, and other volunteers, e.g. OSU students) to assist with garden preparation for any participants in need; this would include

basic preparations such as weeding, adding compost or other soil amendments - this part is often labor-intensive, so it will be helpful for many hands to make light work. This will also begin to cultivate social support for participants.

6) Pair MGs as mentors with small groups of gardeners (based on location).
7) Order and deliver personal gardening supplies to all participants, including personal protective equipment and adaptive gardening tools (e.g. garden gloves, sun hats, sunscreen, water bottle, kneelers, easy-touch pruners, etc.). These supplies are participants' own, to keep.
8) Order and deliver seeds and vegetable starts for all participants, in addition to providing donated starts from Peoria Gardens.

***Hope Grows Here* Active Project - Phase 2:**

1) Weekly gatherings with participants and Master Gardeners to answer questions, provide expertise and encouragement, and enable peer sharing. Additional support in fielding questions will be provided by OSU horticulture students as part of an experiential learning opportunity.
2) The Moore Family Center's project manager will visit gatherings to deliver hands-on "Grow Together" activities, which will include:
    a) Simple practical gardening tips (e.g. how to prune and trellis a tomato plant; simple, low-cost ways to start seeds for the fall; creating garden supplies from recycled materials; growing small 3-season salad bowls).
    b) Therapeutic horticulture activities and techniques.
3) Visits from the Mobile Kitchen team, including the Moore Family Center's nutrition educator and OSU nutrition and dietetics students as part of an experiential learning opportunity. Mobile Kitchen visits will provide recipes, on-site food demonstrations and tastings, and provide supplemental produce from the Linn Benton Food Share's Gleaners program.
4) Hold a harvest celebration at each site. Share stories, food, ideas, and plans for the future. Complete post-project surveys.
5) Data interpretation, summary and report. Share findings.

Environmental scan of similar projects and opportunities to align and strengthen:

The following opportunities can be shared with *Hope Grows Here* participants:

- In Lebanon, free organic gardening classes are offered by former organic garlic farmer and Master Gardener Sheryl Casteen. This generous service can be shared with participants in the Lebanon community who wish to take their gardening practice to the next level.
- *That's My Farmer* free classes for cancer survivors provide additional nutrition-related information related to fresh fruits and vegetables, with group visits to local farmers markets in Linn and Benton counties.
- Linn Benton Food Share's Youth Build garden program provides a mobile farmers market to residents at Riverview, Clayton Meadows, Garden View, and Millwood Manor low-income housing developments. Because we will target outreach to these developments, and with Linn Benton Food Share a partner on this project, we are able to coordinate our garden gatherings with this service.

Project Partners & Roles - Secured:

Samaritan Cancer Resource Centers: Recruitment support.

Linn Benton Food Share: Gleaners group to supply supplemental produce for Mobile Kitchen activities (food demos, tastings, recipe dissemination); help share fliers with target communities at food pantry locations in Linn & Benton counties, plus connection with housing authorities for our targeted developments in Albany and Lebanon.

Live Longer Lebanon: Help share fliers with target communities in Lebanon.

Porter Park Community Garden (Lebanon), Willamette Community Gardens (Albany): Additional community garden sites for participants to plant, tend, and harvest produce.

OSU Extension Master Gardener Program (Benton & Linn counties): Master Gardener mentors and garden class instructors.

OSU Nutrition and Dietetics students: Recipe curation and compilation.

Peoria Gardens: Plant start contributions.

(Ourselves) OSU Moore Family Center: Project coordination and Mobile Kitchen staffing.

Additional Potential Partners

The following are partners with which we wish to explore establishing a garden installation.

Samaritan Health Plans - Walnut Building (potential clinical garden site - will explore with the help of the DST team).

Community Health Centers of Benton & Linn Counties - Lincoln Health Center (potential clinical garden site - the Medical Director is excited about the idea; property is owned by the Corvallis School District, will need to include them in future discussions.)

Geary Street Clinic (potential clinical garden site - suggested by the Albany Cancer Resource Center)

Promoting health equity, reducing health disparities, and tracking data for IHN-CCO members:

Cancer is the leading cause of death in Oregon, with incidence rates of certain cancers above the Oregon average in Linn and Benton counties. However, improvements in care and treatment across the cancer continuum have increased survival rates for many leading cancers. The seminal report from the Institute of Medicine, “From Cancer Patient to Cancer Survivor: Lost in Transition,” highlights specific gaps in the continuum of cancer care. Specifically, cancer survivors report significant concern with a lack of support mechanisms and continuity of care, especially post-treatment. At the time when care support significantly diminishes, cancer survivors have an increasing need for support in health promotion strategies to prevent recurrence, prevent or decrease comorbidities, and improve overall quality of life. Confounding the often life-altering consequences of a cancer diagnosis (e.g. higher chance for second cancers, physical disabilities resulting from cancer treatment side effects, and effects on one’s livelihood), individuals of low income levels bear additional burdens of disease due to living conditions (such as those with greater exposure to environmental toxins), access to healthcare, healthful food, and safe places to be physically active, to name a few.

Hope Grows Here addresses and bridges these health disparities by providing resources, educational support, and facilitating a social community where participants can practice skill-building (in this case,

gardening) together. Tracking data for IHN-CCO members will begin with an eligibility survey which will establish whether or not a participant is a member, including their member #. We will then track participation in the gardening course and garden gatherings through attendance. Simple questions on the post-project survey will also track how much participants used their garden spaces, what recipes they tried, and what produce they harvested. IHN-CCO member demographics can be shared with the DST team, along with aggregated final project data.

Social determinants of health:

As a population, cancer survivors experience health disparities such as functional decline, an increased risk of chronic pain/fatigue, comorbidities, cancer recurrence or second cancers, emotional distress and decreased quality of life. Living within a low household income exacerbates these disparities with the addition of critical health barriers (social determinants of health), including sustainable access to and affordability of fresh, nutrient-dense foods.

Hope Grows Here implements a food access/food security lens to the participants it serves, in order to address this social determinant of health. The Social Ecological Model (SEM) describes that individual behavior is shaped by factors at multiple levels, including the community/social context, and that social relationships facilitate positive health behaviors. Following principles of SEM, *Hope Grows Here* not only teaches individuals *how* to grow their own vegetables and fruits and ways to enjoy them (gardening classes, recipes, food demos and tastings), but it also facilitates a social support network (peer gardeners and Master Gardener mentors), and connects participants to community resources (community garden sites, Linn Benton Food Share, the Mobile Kitchen, and pilot garden plots at health clinic), and connecting with other food assistance programs such as SNAP and local food pantries to address food security and access at multiple levels of SEM.

Project staff roles, responsibilities and experience:

Candace Russo, MS - Project manager/coordinator. Candace is the Program Manager with the Moore Family Center. She has more than 20 years of experience teaching youth through adults in subjects ranging from life sciences and environmental conservation, to gardening and nutrition. She secured funding for, managed and implemented last year's remote version of *Hope Grows Here* for 11 cancer survivors in Linn and Benton county who learned to garden at home, under the mentorship of Master Gardeners. Her previous work with the Healthy Youth Program at the Linus Pauling Institute at OSU included developing and implementing a Veggie Rx program for Latinx families in Corvallis where high school students grew food for and staffed a farm-stand-style CSA, in partnership with Benton County Health Department. Also through prior work she was a member of the Linn Benton Health Equity Alliance, where she participated in multiple health equity trainings and presentations. Candace is tandemly earning her Horticultural Therapy certification through Portland Community College and the American Therapeutic Horticulture Association, and is eager to share principles from this therapeutic discipline with this project.

Anna Soderlund, BS - Nutrition educator. Anna is the Education Program Assistant with the Moore Family Center and will work with OSU nutrition and dietetics students to curate recipes and lead the Mobile Kitchen team to provide food demonstrations and tastings for project participants. Anna has nearly 15 years of experience in community education with a focus on garden, culinary arts, and nutrition. With the help of additional experience working in the restaurant industry, she has taught

cooking and nutrition courses and created and led farm to table workshops. Her previous work at the Corvallis Environmental Center allowed her to develop a cooking and nutrition program for youth and train staff teachers and interns to lead the course. Anna has participated in more than 2 years of Equity, Diversity, and Inclusion training, including participating in a community needs assessment and education program evaluation.

Jenny Rudolph, MPA - Trainer: trauma-informed nutrition. As the endowed outreach coordinator at the Moore Family Center since 2018 and a Family and Community Health/SNAP-Ed faculty for OSU Extension Service in Columbia county since 2008, Jenny has coordinated and led nutrition education programs across the state. Through her work, Jenny has been trained as a trainer for trauma-informed nutrition, and is currently co-instructor of *Nourished and Thriving Children*, a trauma-informed online nutrition and feeding course for foster parents. She will be responsible for conducting trauma-informed nutrition training for all staff and volunteers involved in *Hope Grows Here*.

Stephanie Hagerty, Ambassador, Samaritan Cancer Resource Centers - The Samaritan Cancer Resource Centers (CRC) partner with anyone touched by cancer to provide the support they need to live with strength, determination and hope into the future. Stephanie Hagerty partnered with the Moore Family Center on the virtual version of *Hope Grows Here*, and is eager to continue this partnership. For this *Hope Grows Here* proposal, she will coordinate an advertisement of the project in the CRC newsletter, to help connect cancer survivors with the project, and provide additional resources (e.g. sunscreen donations, additional nutrition and physical activity classes for survivors). She also has a long-standing relationship with Peoria Gardens to donate vegetable starts for *Hope Grows Here*.

Ryan McCambridge, Director, Linn Benton Food Share - Linn Benton Food Share provides millions of pounds of food every year to our local community through a network of 68 non-profit partners. These include food pantries, meal sites, gleaning groups and supplemental agencies. This extensive network will be a valuable partner for *Hope Grows Here*. Specifically Ryan's team, including the Gleaners group, will help distribute project information to our target audience, and will provide supplemental produce to be disseminated by the Mobile Kitchen team.

Master Gardener volunteers - OSU Extension Master Gardeners are volunteer educators, neighbors, and on-the-ground researchers who serve their community with solid training in science-based, sustainable gardening and a love of lifelong learning. For *Hope Grows Her*e, Master Gardener volunteers will provide gardening classes and mentorship to all project participants.

OSU nutrition, dietetics, and horticulture students - As enthusiastic and bright students eager to put their newly learned skills to practice, OSU students in disciplines of nutrition, dietetics, and horticulture will provide support for both the Mobile Kitchen team (nutrition and dietetics students) as well as assisting participants in preparing garden beds in the spring and fielding gardening questions (horticulture students).

Siew Sun Wong, PhD - Project advisor. As a Professor, Extension Nutrition Specialist, and Interim Endowed Director of the Moore Family Center at Oregon State University, Siew Sun has chaired the Society for Nutrition Education and Behavior DigiTech Division and the Division of International Nutrition Education. Her expertise is nutrition education for behavior change, and dietary assessments with application of emerging technology and gamification. She has over 20 years of multistate and multidisciplinary experience with $8.7M funded projects that integrate research, education, and outreach. Nationally, she coaches multidisciplinary teams with Extension Foundation

Impact Collaborative. For *Hope Grows Here*, Siew Sun will provide technical expertise for both the Mobile Kitchen, and project evaluation.

Emily Ho, PhD - Project advisor. Dr. Ho is the endowed chair and director of the Linus Pauling Institute at Oregon State University (OSU). She is a full professor in the OSU Nutrition Program and has had an actively funded research program in the area of nutrition and chronic disease prevention at OSU since 2003. From 2012-2020, Dr. Ho was the Endowed Director of the Moore Family Center at the OSU College of Public Health and Human Sciences. Dr. Ho will provide technical expertise for data interpretation and presentation/publication of results.

How *Hope Grows Here* fits into the Moore Family Center's strategic/long-range plans:

The Moore Family Center at Oregon State University (MFC) is dedicated to helping individuals and communities live healthier through healthy foods and good nutrition, with an emphasis on preventive health. We foster collaborations among researchers, students, educators and community stakeholders by using awareness, research, education and services to help improve the health and well-being of the community. We take pride in catalyzing innovative projects, and believe that our impact is amplified when aligning ideas that span multiple disciplines. This *Hope Grows Here* pilot corresponds with our multi-disciplinary strategies by enabling the MFC to bolster our community networks, further develop and pilot test the Mobile Kitchen in conjunction with local community gardens, as well as explore mechanisms to incorporate mental well-being into our outreach efforts (a missing element in our current preventive health outreach).

How will the community hear about our project?

Fliers will be disseminated through a variety of networks, depending on the community.

In Albany:

- In coordination with Linn Benton Food Share, we will distribute fliers through food pantries and housing authorities managing Riverview, Clayton Meadows, and Millwood Manor developments in Albany.
- In coordination with Samaritan Cancer Resource Centers, we will provide an article for their newsletter, and distribute fliers at their Albany location.
- The IHN-CCO's Care Coordination Team is another important conduit to help the community hear about *Hope Grows Here*.

In Lebanon:

- The Live Longer Lebanon coalition will help disseminate fliers through their extensive network.
- In coordination with Linn Benton Food Share, we will distribute fliers through food pantries and housing authorities managing the Garden View development in Lebanon.
- The IHN-CCO's Care Coordination Team is another important conduit to help the community hear about *Hope Grows Here*.

In Corvallis:

- In coordination with Linn Benton Food Share, we will distribute fliers through food pantries in Corvallis.
- In coordination with Samaritan Cancer Resource Centers, we will provide an article for their newsletter, and distribute fliers at their Corvallis location.

- The IHN-CCO's Care Coordination Team is another important conduit to help the community hear about *Hope Grows Here*.

Potential Risks/Challenges and how to address them:

Challenges that we foresee for this project include the steps involved in signing up to participate in the project. Because we will be collecting data from participants and will therefore need to go through the Institutional Review Board (IRB), an IRB-approved consent form describing the project in detail, including all risks and benefits to participants is required. This additional step may be seen as a barrier to participation. Our plan to make this process as simple as possible will begin with initial project fliers that include a QR code to easily scan with a phone. This will take people to our website where we will have a brief and friendly video describing the project, including eligibility requirements. Interested individuals will then have the opportunity to provide their contact information on a simple survey. Eligible individuals will then be invited to attend one of several live, in-person informational meetings (remote option will only be used if recommended by local public health authorities). Together, we will go over the consent form, answer any questions, and provide technical assistance prior to participants signing their consent.

Survey fatigue is also an on-going challenge. We have had success administering pre- and post-project surveys as part of an event (garden gathering or harvest celebration), and using touch-screen tablets, with surveys that include simple, easy questions with photos when possible.

Another challenge could be transportation to garden sites for participants. The sites have been selected with this challenge in mind. The Corvallis area provides free bus transportation, and therefore both potential clinical sites that we wish to explore (Lincoln Health Center and Samaritan Health Plans' Walnut building) are located right by a bus stop. Additional community garden sites also exist in Corvallis very near to bus stops. In Lebanon, the Porter Park Community Garden site is situated in the heart of a low-income neighborhood. A potential site in Albany is at the Geary Street Clinic, also in close proximity to a low-income neighborhood.

An additional challenge will be scheduling weekly gatherings with project participants and Master Gardener mentors. To enable those with different schedules to participate, we plan to host gatherings up to two different times each week for each location, and will ask participants for feedback on the best meeting times prior to scheduling.

Pilot Timeline

January:

- Develop and disseminate outreach material
- Recruit Master Gardener volunteers
- Provide trauma-informed nutrition training to all project staff

February:

- Conduct informational community meetings; obtain participant consent
- Conduct Master Gardener informational meeting
- Provide Trauma-informed care training to all project volunteers
- Coordinate gardening classes with Master Gardeners
- Design pilot garden bed installation(s)
- Secure additional community garden beds as needed

March:

- Administer Pre-project surveys
- Deliver gardening classes
- Order gardening supplies
- Prepare garden beds
- Begin pilot garden bed installation(s)

April:

- Complete pilot garden bed installation(s)
- Match Master Gardeners with participant groups
- Deliver gardening supplies

May - September:

- Conduct weekly garden group gatherings

June - September:

- Drive the Mobile Kitchen to garden group gatherings - share recipes, conduct food demos, tastings, and provide supplemental produce

September:

- Conduct Harvest Celebrations
- Administer Post-project surveys

October - December:

- Analyze data, compile report, and share findings

Sustainability Plan

Innovation: This approach goes beyond just teaching people how to garden or giving them a recipe. The SEM – developing lasting change at the individual, relationship, and community levels – is the underpinning of *Hope Grows Here*. Unique to this project:

- Participants will be supported and encouraged as they build lifelong gardening skills that can positively impact the health of survivors, their families, and caregivers. An emphasis on organic practices provides a benign and supportive environment for engaging in gardening (one of the seven evidence-based characteristics of therapeutic gardens).
- The principles of trauma-informed care applied to nutrition will be incorporated into the program, with all staff and volunteers completing trauma-informed nutrition training. Community trauma will be addressed by igniting social bonds through small-group gatherings where cancer survivor gardeners learn a new skill together, while also sharing a significant diagnosis. Surviving cancer can be socially isolating; layer that with the isolation everyone has felt during the COVID pandemic, and strengthening social bonds arises as a critical community need.
- Our partnership with the Linn Benton Food Share will elevate resources provided by the Mobile Kitchen and help reduce stigma associated with accessing food-assistance resources.
- Therapeutic benefits of gardening will be highlighted, including stress and anxiety reduction, and metaphors between tending to the life cycles, changes, and imperfections of plants and the transformations experienced by cancer survivors.
- The pilot of a dedicated *Hope Grows Here* garden installation at a partnering clinical site not only provides a needed space for participants to practice gardening (often community garden plots are hard to come by), it may also encourage a connection to the clinic, potentially increasing the likelihood of attending regular health check-ups. Imagine these garden plots displaying rotating inspirational *Hope Grows Here* messages in the words of those touched by cancer.
- **IRB approval and data collection.** We will be submitting this project for IRB approval prior to participant recruitment because we will be collecting data that we hope to share with others in the future. Project evaluation will include the following metrics and validated instruments: 1) physical activity (Godin Leisuretime Activity Questionnaire); 2) social supports (PROMIS Global Health Scale v1.2 - social functioning); and 3) stress (Perceived Stress Scale). Additional data will be collected on number/types of provided recipes tried at home, produce harvested from gardens, and overall program satisfaction.

Scalability & Transferability: The Moore Family Center has a long-standing partnership with the OSU Extension & Engagement, with offices in all 36 counties across Oregon. *Hope Grows Here* bridges new partnerships in the Extension circle: Extension's Family and Community Health, and Extension's Master Gardeners, together working with IHN-CCO members. Once outreach materials are developed and project is evaluated, *Hope Grows Here* could be scaled to other counties through the help of Extension partners, especially if future versions include translation of outreach materials to additional languages. Further, the Moore Family Center Director, Dr. Siew Sun Wong, is active in the National Extension network, so scalability could go beyond statewide.

Sustainability within our organization: Outreach and activity development as a result of this project can be used with the Moore Family Center's Mobile Kitchen for many years, and will strengthen our

work. The establishment of a dedicated *Hope Grows Here* garden at a clinical site can open doors to a continuation of this work in the future, including enabling prior participants to become peer mentors for future participants. It is our vision that once this project is completed, we would be able to seek additional funding to translate all materials to Spanish and broaden our reach to the Latinx communities within IHN-CCO. Having a dedicated garden space. The Master Gardeners program is well established in Benton & Linn counties, as is the OSU nutrition and dietetic student volunteer program, enabling that piece of the project to seamlessly sustain in the future. The concept of the *Hope Grows Here* project is one that has garnered the attention of donors as well. We have some funding from a Foundation to deliver *Hope Grows Here*, which is the source of additional funding to cover the full project cost. With this proposal we wish to direct that effort specifically toward IHN-CCO members, hence the request for additional funding and the addition of a clinical garden installation and Mobile Kitchen materials. Future iterations of *Hope Grows Here* can include more donor involvement and additional community partners.

How to spread to other organizations (who has a vested interest?): Given the rigorous project evaluation component of this project, including IRB approvals, we will be able to share project results through presentations at local (e.g. Linn Benton Health Equity Alliance meetings, Linn Benton Lincoln Partners for Health conference), statewide (e.g. Oregon Public Health Association, Oregon Academy of Nutrition and Dietetics, Nutrition Council of Oregon), and national conferences (e.g. Society for Nutrition Education and Behavior). Organizations with a vested interest beyond those that might attend these meetings/conferences include additional housing authorities where participants are living and gardening, and community health centers; we also plan to share results from this project with these organizations, with acknowledgements of our project sponsors and donors, collaborators, community partners, participants, and volunteers .

	CHIP Focus Area	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	HL1: Increase the percentage of Members who are living a healthful lifestyle: **Nutrition.**	HGH participants will have access to food demonstrations, tastings, and recipes from the mobile kitchen.	At least 75% of HGH participants will try at least two recipes at home using fresh vegetables or fruits from their garden.	09/2023
	HL1: Increase the percentage of Members who are living a healthful lifestyle: **Physical activity.**	HGH participants will tend their gardens regularly through the summer.	At least 75% of HGH participants will report a significant increase in at least moderate physical activity using the Godin Leisuretime Activity Questionnaire, compared to before beginning their garden.	09/2023
	HL1: Increase the percentage of Members who are living a healthful lifestyle: **Social supports.**	HGH participants will be invited to garden gatherings to share stories, ask questions, and connect socially with other cancer survivors learning to garden.	At least 80% of HGH participants will report an increase in social supports using the PROMIS Global Health - Social Functioning scale, compared to before beginning their garden.	09/2023
	HL1: Increase the percentage of Members who are living a healthful lifestyle: **Stress/trauma.**	Garden gatherings will include mindfulness, breathing, and therapeutic horticulture techniques in their garden for stress reduction.	At least 70% of HGH participants will report a decrease in feelings of daily stress using the Perceived Stress Scale, compared to before beginning their garden.	09/2023
	SD3: Increase the percentage of Members who have access to healthy food: **Availability of fresh, affordable produce.**	HGH participants will learn basic skills in growing their own vegetables, fruits, herbs, microgreens, and sprouts.	At least 80% of HGH participants will successfully harvest fresh food from their garden at least three times during the growing season.	09/2023

Pilot: Hope Grows Here (Moore Family Center, Oregon State University)

Pilot Start Date:	**1/1/2023**	**Pilot End Date:**	**12/31/2023**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Outreach material development & dissemination		$62,585.00	$32,522.00
Garden support, mentorship, and education		$55,126.00	$27,563.00
Clinical garden design and installation		$12,000.00	$12,000.00
Mobile kitchen activities delivery		$7,000.00	$7,000.00
	Subtotal Resource Costs	**$136,711.00**	**$79,085.00**
Materials & Supplies			
Community garden supplies, seeds, and starts		$5,000.00	$0.00
Personal garden supplies and PPE		$5,000.00	$0.00
Community garden plot rental fees		$1,000.00	$1,000.00
Materials for garden gatherings		$1,000.00	$1,000.00
Mobile kitchen supplies (food & supplies for demos & tastings)		$3,000.00	$3,000.00
	Subtotal Materials & Supplies	**$15,000.00**	**$5,000.00**
Travel Expenses			
Mobile kitchen team travel		$400.00	$400.00
Project manager travel		$1,000.00	$1,000.00
Trauma-informed nutrition trainer travel		$300.00	$300.00
	Subtotal Travel Expenses	**$1,700.00**	**$1,700.00**
Meeting Expenses			
Informational meetings		$750.00	$350.00
Garden installation design/planning meetings		$300.00	$300.00
Partner meetings		$100.00	$100.00
	Subtotal Meeting Expenses	**$1,150.00**	**$750.00**
Professional Training & Development			
Trauma-informed nutrition training (staff and volunteers)		$2,500.00	$2,500.00
	Subtotal Training & Development	**$2,500.00**	**$2,500.00**
Other Budget Items			
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$157,061.00**	**$89,035.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$23,559.15	$13,355.25
Total Project Budget		**$180,620.15**	**$102,390.25**

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

HOPE GROWS HERE

IHN-CCO DST
PILOT PROPOSAL

Oregon State University
Moore Family Center

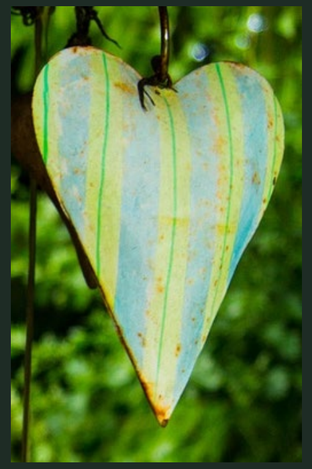
Pilot Summary and Goals

Hope Grows Here is a peer-support program focused on gardening, nutrition education, physical and social-emotional wellness for low-income cancer survivors.

GOAL 1: Improve nutrition, physical activity, and social supports for low-income cancer survivors to facilitate reaching survivorship guidelines for a healthy lifestyle.

GOAL 2: Reduce perceived stress among low-income cancer survivors.

GOAL 3: Improve access to fresh fruits and vegetables for low-income cancer survivors.



Project Elements

- Participants take gardening class from Master Gardeners (MG).
- Coordination & prep of garden space (housing developments, community gardens); student support.
- Gardening supplies provided.
- Participants grouped & paired with MG mentor.
- Weekly Garden Gatherings (share stories, Q&A, practice together, with MG mentors).
- Mobile Kitchen visits (recipes, food demos, tastings); student support.
- Harvest Celebrations.
- Pilot HGH Garden installation at a clinical partner site (dedicated space, future sustainability, build comfort/communication between members & clinic).

Member and Community Need

Target population:
Adult cancer survivors, post-treatment, Medicaid-eligible, living in Linn or Benton counties.

- Cancer = leading cause of death in Oregon.
- Improvements in treatment > survival rates for many cancers.
- “From Cancer Patient to Cancer Survivor: Lost in Transition” → lack of support post-treatment.
- Critical time for healthy lifestyle change to prevent recurrence, comorbidities, and increase QOL.
- Higher chance for second cancers + physical disabilities, low-income individuals bear added burdens of disease:
  - living conditions (e.g. exposure to environmental toxins);
  - access to healthcare, healthful food;
  - safe places to be physically active.

System Transformation

Primary transformations: alignment across disciplines and sectors.

1. Gardening community (local MGs, community gardens).
2. Nutrition/food security community (Linn Benton Food Share, Moore Family Center, Linus Pauling Institute).
3. Clinical sites (where we propose installing a garden space dedicated to Hope Grows Here).
4. Therapeutic emphasis.

System Transformation

Secondary transformations:

- Increased awareness and skills by training community volunteers and staff in trauma-informed care.
- Academic rigor in data collection; IRB process will allow data sharing of key metrics:
  - Physical activity;
  - Social supports;
  - Stress;
  - Nutrition.

Partnerships

Linn Benton Food Share

- Recruitment, supplemental food for Mobile Kitchen, food security resources (increase awareness, decrease stigma).

Master Gardeners program

- Garden expertise/mentorship, social supports.

Clinical site partner

- Garden site access; strengthen relationships with members.

Health Equity Plan

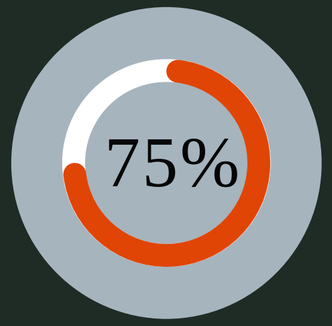
Cancer survivors experience:

- functional decline
- chronic pain/fatigue
- comorbidities
- cancer recurrence or second cancers
- emotional distress
- decreased quality of life

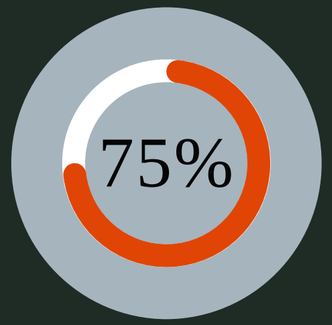
- Facilitate a social support system - individuals sharing a diagnosis learn together and from each other.
- Increase access to affordable, fresh, nutrient dense food and how to sustainably grow it.
- Provide resources for self-care through gardening.
- Experience enjoyable, easy ways to prepare home-grown food (recipe sharing, demonstrations, tastings).
- Connect members to food security resources.

What is Success?

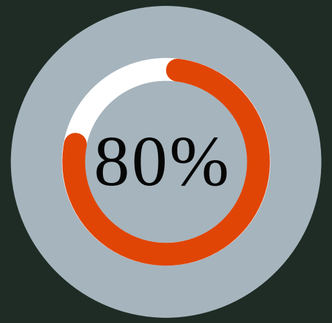
Participants will...



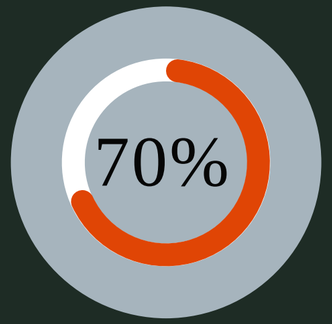
Try at least two recipes at home using fresh vegetables or fruits from the garden.



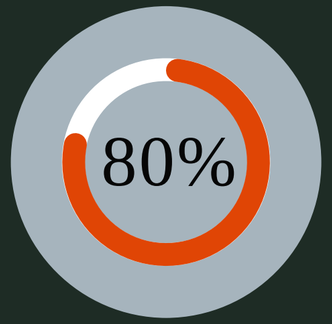
Report a significant increase in physical activity using the Godin Leisuretime Activity Questionnaire.



Report an increase in social supports using the PROMIS Global Health - Social Functioning scale.



Report a decrease in feelings of daily stress using the Perceived Stress Scale.



Successfully harvest fresh food from their garden at least three times during the growing season.

What is Success?

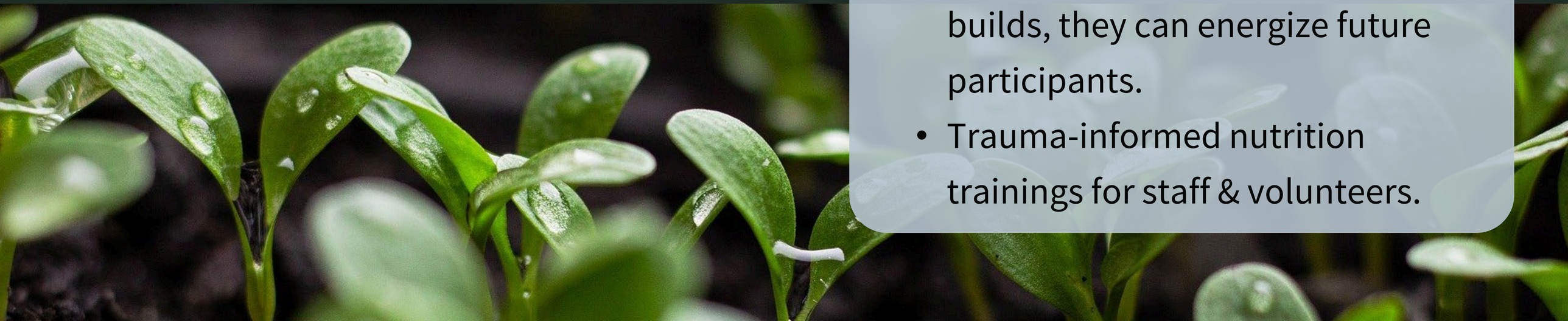
After participating in Hope Grows Here, members will…

- Know the basics of how to grow their own vegetables and fruits, and how to access resources.
- Have cultivated a social support group (including peers and local gardeners), that can continue beyond the project.
- Have a recipe book curated by OSU nutrition and dietetic students featuring simple, low-cost ways to prepare fresh garden-grown produce. (Many will have tried tastings from the Mobile Kitchen during Garden Gatherings.)
- Select and practice self-care activities using a Therapeutic Horticulture card deck.
- Be connected to garden, nutrition, and food security resources, including spaces to continuing their gardening practice.

Sustainability Plan

Scaffolding:

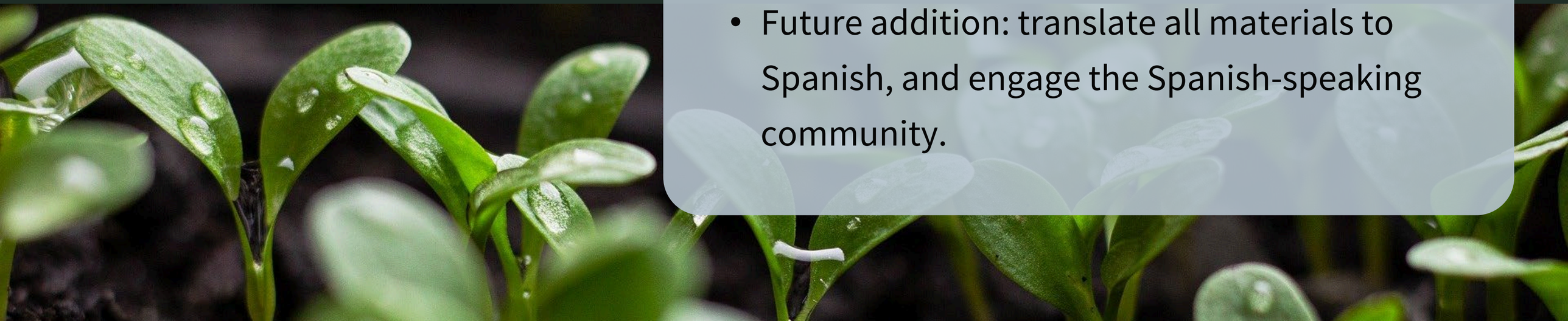
- Clinical garden installation = dedicated space for future gardeners.
- Outreach materials can be used for future years.
- Peer mentor development: as participants' garden confidence builds, they can energize future participants.
- Trauma-informed nutrition trainings for staff & volunteers.



Sustainability Plan

Future Funding:

- Extension partners across Oregon - amplify HGH in other communities.
- Academic evaluation/data sharing = bolster support from additional funders & partners.
- Project success = resonate with private donors (e.g. current private donor to supplement).
- Future addition: translate all materials to Spanish, and engage the Spanish-speaking community.



DST MEMBER QUESTIONS?

Improving Access with THW's

Backbone Organization: Unity Shelter
Billing Address: 4515 SW West Hills Rd, Corvallis, OR 97333
Site(s): Corvallis Men's Shelter, 211 SE Chapman Pl, Corvallis OR 97333
Room at the Inn, 1166 NW Jackson Ave, Corvallis OR 97330
Third St. Commons, 1480 SW 3rd St, Corvallis OR 97333
SafePlace: SafeCamp, 4515 SW West Hills Rd, Corvallis OR 97333
County(s): Benton

Priority Areas: (see Guidelines)

- Addressing trauma, including environmental
  - Reduction of wait times for mental health services
- Innovative programs supporting housing
- Language access
  - Health literacy
- Reengaging the community in personal health and community resources
- Subpopulations of IHN-CCO members that experience health disparities

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

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

Indicator Concepts:

a. Length of time from IHN-CCO enrollment to first appointment

b. Length of time from appointment request to appointment for behavioral, physical, and oral health services

A2: Increase the percentage of Members who receive care communicated in a way that ensures that they can understand and be understood by their care providers, and that they are effectively engaged in their care.

Indicator Concept:

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

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

Indicator Concepts

a. Screening, Brief Intervention, Referral to Treatment (SBIRT)rates

Areas of Opportunity:

ii. Peer delivered education and support

iii. Mental health service wait-times

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

Areas of Opportunity

i. Disease prevention, management, and recovery

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

Areas of Opportunity

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

ii. Evictions prevention and reduction

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

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

Areas of Opportunity

i. Food security

SD4: Increase health equity.

Areas of Opportunity

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

Pilot Contacts	Name	Email
Primary	Ailiah Schafer	ailiah@unityshelter.org
Proposal	Ailiah Schafer	ailiah@unityshelter.org
Contracting	Shawn Collins	director@unityshelter.org
Financial	DJ Weigand, Treasurer	treasurer@unityshelter.org
Reporting	Brad Smith	brad@bixbynw.com

Executive Summary:

Unity Shelter's mission is providing safe shelter through collaborative care, offering low-barrier emergency and transitional housing to those in our community who have none. When people lack safe shelter, they are often denied hygiene, access to clean water, nutritious food, and the ability to be located. In addition to recognizing the importance of these physical needs, Unity Shelter recognizes that people who lack safe shelter can also lack social connection and may suffer the complications of trauma, mental illness, and/or addiction. We strive to pay exquisite attention to the ethics of belonging, community, purpose, and dignity. Unity Shelter envisions a community where lack of housing or shelter is rare, brief, and nonrecurring, and where all people have a safe and stable place to live, connect, and thrive.

Unity Shelter operates two emergency shelters for men and women, a hygiene center, and two transitional housing programs. Unity Shelter's programs offer case management in partnership with

Corvallis Housing First, and resource navigation through one Unity Shelter staff member. It is clear that additional, culturally appropriate support is needed to serve individuals experiencing homelessness effectively. Unity Shelter hopes to add Traditional Health Workers (THW) to our team to increase access and utilization for current and future IHN-CCO members that utilize our programs. Through the addition of THW's to our staff, Unity Shelter can increase on-site supportive services, providing additional direct assistance and advocacy for individuals in the process of finding primary care, healthy and nutritious food options, and safe, permanent housing.

Pilot Description:

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

Achieving the goals of the pilot project will increase health and well-being among the chronically homeless population that utilize emergency shelter and transitional housing through Unity Shelter.

The pilot's first goal is to *identify the needs of Corvallis' homeless population that utilizes Unity Shelter programs*. THW's will spend a dedicated amount of time at each of Unity Shelter's four programs to build rapport with individuals. By further understanding the social determinants of health that are at play in an individual's social status, THW's can successfully identify needs, and assist in overcoming barriers to accessing healthcare, social services, healthy and nutritious food, and housing. This will be measured through Shelterware intake assessments that are completed upon entry to Unity Shelter programs, and further case notes that stem from engaging with individuals to understand their specific needs. THW's that have built rapport will provide improved data collection among the individuals that Unity Shelter serves This data can be complied to provide a broader understanding of the needs faced in this community.

The second goal of the pilot is to *increase access to mental, physical, and behavioral health for people experiencing homelessness*. THW's will assist guests in culturally sensitive resource navigation, application assistance, and advocacy to address a guest's specific needs. THW's will also assist in enrolling eligible individuals in IHN-CCO, then further assist them in accessing mental, physical, and behavioral health appointments. Immediate rapport building among guests of Unity Shelter and THW's will assist in decreasing untreated chronic illness and instead get people the care they need.

The third goal of the pilot is to *increase overall health and well-being through consistent on-site supportive services*. THW's will have the training necessary to fulfill their role, along with training in shelter staff responsibilities providing insight into the realities that both guests and staff face. THW's will have lived experience that can provide an extra level of understanding and compassion when understanding an individual's needs and hesitancies. THW's will be able to meet guests where they are at to increase comfort and trust within the relationship. Individuals who fill the THW roles will accompany guests to appointments when needed and help advocate for care that is in the guest's best interest. This approach can ultimately re-engage the guest in their personal health and increase the guest's self-confidence in advocating for their health, housing, and well-being in the future.

- **Target population: ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members**

The target population of the pilot program will be individuals experiencing homelessness, both situational and chronic, in the Corvallis area that utilize Unity Shelter services. In 2021, Unity Shelter served 958 unique individuals, and through July 11, 2022 we have served 288 in shelter and transitional housing, and 447 at the Hygiene Center, a nearly 40% increase in shelter users and 20% at the Hygiene Center. Individuals approached by and working with THW's will be encouraged and assisted in enrolling in IHN-CCO's plan if they are not already. Among the individuals that have been served where data has been collected, approximately 52% stated they are enrolled in OHP upon intake.

- **Describe the intervention and detailed activities, including an environmental scan of similar projects in the region**

Hire/Promote and onboard THW's- Unity Shelter staff represent a wide range of experiences, communities, and backgrounds. Many of our staff have shared lived experience with homelessness, and a desire to continue in the field helping others who have shared similar experiences. The intent is to fill two to three THW positions internally to further leverage the experience and enhance the abilities of Unity Shelter staff. Should there not be enough interest within existing personnel to fill all expected roles, the position with be extended to external applicants. THW's will participate in basic Unity Shelter core trainings and be introduced to community partners and resources that will be essential in the THW role.

Develop THW specific policies and procedures- The THW role within Unity Shelter is unique and specific policies and procedures will need to be in place for the program to be successful. This specific step will require the input and voices of the individuals fulfilling the THW role.

Train and Certify THW's- Individuals that will take on the THW roles will initially attend either Benton County Health Department or Oregon State University's community health worker training (depending on first available cohort dates). When available, two THW's will also be enrolled in the clinical navigation training program and will be able to integrate that training into their work moving forward.

Integrate THW's into Unity Shelter operations- Unity Shelter THW's will spend approximately 10-15 hours per week at their assigned Unity Shelter location. While THW's are on site, they will build rapport with guests to better understand their needs. THW's will complete US intake paperwork (if applicable), Coordinated Entry assessments, and necessary applications (IHN-CCO, SNAP, SSD/I) in collaboration with the guest according to their specific needs. If a guest is working with a Case Manager, the THW will consult and collaborate with the guest's case manager and the guest to identify immediate needs and goals. THW's will assist case managers or take the lead on specific tasks where having the unique rapport they build with the guest would be beneficial. These tasks can include advocating for specific needs within both clinical and housing settings

Analyze and evaluate data- Data collected in Shelterware for the duration of the program will be pulled periodically to ensure accuracy and prompt discussion on gaps in data collection as well as services. Near the conclusion of the program, all data collected will be pulled and analyzed to evaluate success and firmly establish guidelines for program permanency within Unity Shelter.

Other organizations such as Corvallis Housing First (CHF) and DevNW utilize community health workers within their permanent housing programs to ensure housing retention and to assist in meeting goals of individual guests. THW's within Unity Shelter however, will provide the extra support upon entry and through the process of accessing the shelter and housing continuum.

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

-*Benton County Health Department*- BCHD will be the primary point of contact for THW's outside of Unity Shelter leadership. If timing allows, Staff will complete the Community Health Worker training at Benton County Health Department (BCHD). If cohort is available with the timing of this pilot, THW's will participate in a clinical navigation component essential to appropriately assisting in medical and dental health navigation. The BCHD Community Health Worker team will also provide ongoing support for Unity Shelter CHW's in navigating difficult resources and building camaraderie with service providers from partnering agencies.

Corvallis Housing First- CHF provides case management at each of Unity Shelter's locations. THW's will work closely with case managers to ensure appropriate services are being provided based on each guest's individual needs.

Corvallis Daytime Drop-in Center- THW's will work closely with CDDC staff to ensure correct and appropriate services are being offered. The Drop-in Center will often see individuals on a more regular basis than Unity Shelter, so they can make appropriate referrals and contacts with THW's.

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

This pilot will promote heath equity by increasing the accessibility of becoming a member of the IHN-CCO and subsequently receiving the proper care to address a myriad of health issues both pre-existing and chronic, and emergent. With COVID-19 came a lack of health navigation and clinical support services within social services settings. Guests of Unity Shelter often arrive with untreated chronic illness, and a lack of awareness of how to address them, or an unwillingness to navigate the system on their own. With a THW, guests will have assistance in applying for or accessing their benefits within IHN-CCO and have advocacy to ensure they receive and understand the care they need. Individuals experiencing chronic homelessness experience a high rate of health disparities compared to a housed community because they can often not meet the expectations of filling out paperwork, making and attending multiple appointments, and understanding and consenting to needed care due to continued displacement and lack of stability. With safe and stable shelter, and on-site support through THW's, guests can address long-standing health conditions in a timely manner

and have support in understanding what medical professionals are describing in relation to their care. THW's can assist in ensuring guests are aware of, and make it to necessary appointments required to address health needs appropriately.

The data will be tracked in a system called Shelterware. All Unity Shelter guests are entered into this program at intake, and asked basic questions regarding resources, benefits, previous housing and homelessness, and basic needs. From this data, THW's will be able to assess where their services are needed and update the information regularly and added case specific notes to ease collaboration with staff and case managers. Through help from a data specialist and Shelterware administrators, Unity Shelter will be able to request health equity data so improvements can be addressed on the administrative and direct-service fronts.

- **Explain the social determinants of health lens the pilot will be incorporating**

Housing stability is central to Unity Shelter's values, with the belief that with safe and stable shelter, other determinants of health can be addressed to increase health and well-being. With consistency through emergency shelter and transitional housing, guests have the opportunity to address factors adversely impacting health such as medical and mental health needs, food insecurity, and community integration. Willingness and ability to successfully engage with support opportunities is directly related to a sense of security that basic needs will continue to be met, and that conditions which may have hindered access in the past (such as finances, sobriety, hygiene, and ability to get timely transportation to appointments) will not unfairly limit access in the future. Low-barrier emergency and transitional housing accepts the whole person for who they are and provides stability on their journey to increased health and well-being.

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

Shawn Collins, Executive Director, is an experienced people and project manager. Shawn began working in the area of housing and homelessness in 2016, serving as the program manager of the Housing Opportunity Action Council. In 2019, he was part of the group that formed Unity Shelter, with the intent to bring multiple shelter and transitional housing programs into one organization and was named Executive Director in July 2020. Shawn will provide primary supervision and support for THW's.

Ailiah Schafer, Operations Coordinator, holds a Master of Public Health degree, and has worked in youth mental health support, housing case management, development, and operations roles. She has extensive experience as a case manager, working with low-income individuals, and training in suicide awareness and prevention and trauma-informed care. She will assist in recruitment, onboarding, training, and supervision of THW's. Ailiah will attend the THW DST workgroup on a regular basis to further understand and incorporate best practices.

Lexi Greenley, Training Coordinator, has experience in direct service across multiple social service agencies in the Willamette Valley. She has worked with Unity Shelter guests and other individuals in Corvallis experiencing homelessness, along with youth in the justice system. She also has administrative experience, focused on the development of training programs and program policies and procedures. Lexi is trained in trauma-informed care, suicide prevention, and crisis de-escalation. She will act as the main point of contact for THW's in onboarding and training to ensure compliance with Unity Shelter training standards and procedures.

Tara Gray, Resource Navigator, has experience working in several social service agencies in Corvallis, and extensive knowledge of resources, programs, and requirements for eligibility. Trained in trauma-informed care, mental health support, suicide prevention and motivational interviewing, Tara has an ability to build and sustain trusted relationships with residents from a variety of backgrounds. Tara will assist in onboarding THW's and ensuring they are well connected to community resources and partners.

Data Entry Specialist TBD- The individual in this role will assist THW's in ensuring accurate data input into Shelterware and the Homeless Management Information System (HMIS). They will also be the point person for pulling data and reports to show success and improvements throughout the project.

- **Describe how the project fits into your organizations strategic of long-range plans**

In an ideal world, the services that Unity Shelter provides would not need to exist. Unfortunately, the need for our services continues to grow in our area, so the organizational plan is to continue to provide basic resources to the best of our capacity. Managed camping, emergency shelter, transitional housing, and permanent supported housing cannot be standalone resources without the supportive services that help increase housing retention and mental and physical well-being. Unity Shelter's long-term plans are to manage supportive services in-house and increase staff capacity to provide case management, resource navigation, life skills coaching. Traditional health workers such as community health workers and peer support specialists, and administrative positions are necessary to create an inclusive and well-rounded support system for all that utilize services.

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

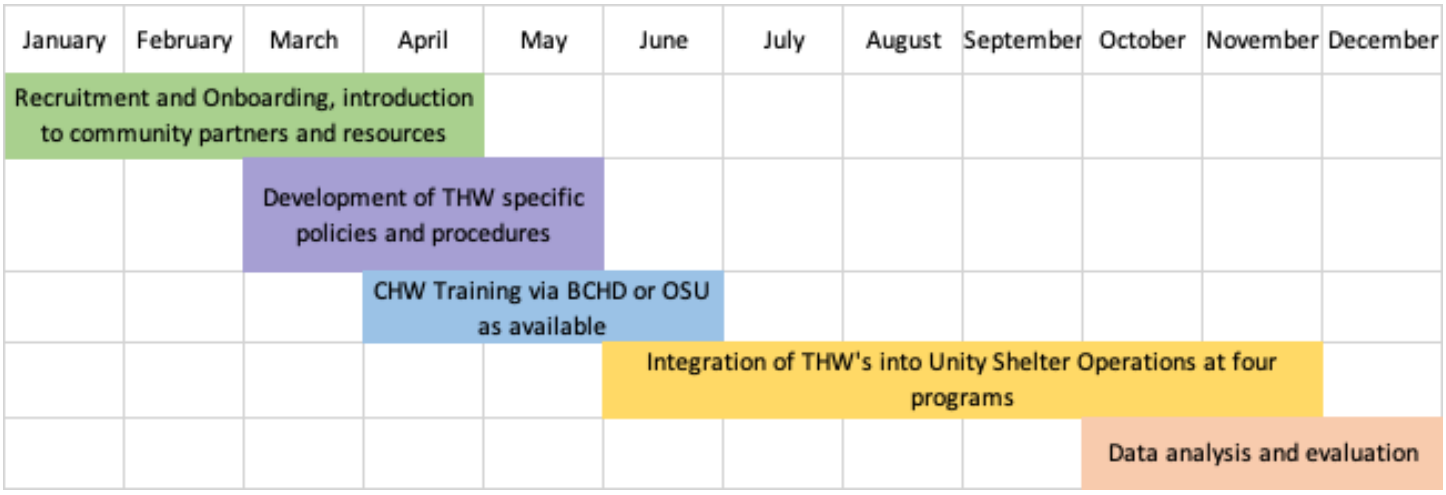
The individuals in the target population already utilize Unity Shelter's scope of services. Unity Shelter staff strive to build a sense of trust within the community, therefore outreach efforts for this project will begin immediately. Signage will be posted at each of the locations, and individuals will be able to ask questions of staff members that direct them to THW's to begin receiving the service. THW's will spend an allocated amount of time at each location and will approach each individual that has utilized shelter or transitional housing services for 7 days of a month to gauge interest and capacity.

- **Describe potential risks and how the pilot plans to address them**

COVID-19 continues to provide a significant risk for those that work in direct service roles. To continue to mitigate risk of infection among staff and guests, Unity Shelter will keep in place personal protective equipment requirements and increased sanitation throughout programs. The surge in homelessness throughout the pandemic also poses a risk to the success of the project. With the scope of needs that continue to arise from the effects of the pandemic it is possible that Unity Shelter and those involved in this project cannot meet the demand in a timely manner.

Distrust of social services agencies and reluctance to participate in services poses a risk to the success of the project. Barriers of access support in standard setting require flexibility of the participant to be able to make appointments and navigate a complex web of systems on their own. Due to this, many individuals have difficulty believing that any social service will be able to help them address their needs. Unity Shelter will address this by taking the time to build trust and strong relationships with individuals on a timeline that works for them. Meeting guests at a location where they are familiar and meeting them where they are in terms of readiness to participate in the process will be central to ensuring THW's are successful. Patience and consistency will be essential when working with individuals that have a history of poor experiences with social service agencies.

Pilot Timeline



Sustainability Plan

Traditional Health Workers within social services is not a new concept, however having THW with lived experience on staff to provide direct, consistent, and on-site support is an innovation with emergency shelter and transitional housing. Prior to the COVID-19 pandemic, health navigators were available to visit Unity Shelter guests at the emergency shelters upon request. Since March 2020, that service has not been available, and the inconsistency in supportive services often leads to distrust from individuals experiencing homelessness. Our vision is that an internal Traditional Health Worker program will provide Unity Shelter guests with the ability to rebuild trust and have true and consistent advocacy for them to continue forward in their health, wellness, and housing goals. If the implementation of the pilot is successful, Unity Shelter will integrate THW's into the core operations of the organization. Through close community partnerships with organizations serving this population, a strong team of THW's including community health workers, peer support specialists, peer wellness specialists, and personal health navigators can be established to focus specifically on increasing health and well-being across all social determinants of health among the unhoused community. If the integration of THW's into Unity Shelter staff through this pilot is successful, Unity Shelter's budget would be adjusted to include the roles as permanent and essential staffing costs. Unity Shelter will continue to seek and apply for funding opportunities that support staffing and operational costs.

***Budget**

Unity Shelter is requesting $108,261.45 for this pilot program. The requested amount solely supports the integration of three Traditional Health Workers into Unity Shelter, two of which will be trained in clinical navigation. The expected budget of $205,309.50 for the entire project includes staffing of case management and resource navigation which is already built into Unity Shelter's budget so will be covered for the duration of this project. The intent of this project is to hire THW's internally so the cost of Unity Shelter's core trainings will also be covered by existing funds.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	There is not enough consistent on-site supportive services to identify and address needs of the community.	Intake forms and case notes documented in Shelterware	Unity Shelter guests do intake with staff upon receiving services and data is recorded and pulled regarding the communities needs.	12/2023
	Guests of Unity Shelter have untreated chronic illness that has not been addressed in a timely manner.	Need is documented in Shelterware, and referral to direct support staff is made immediately	Unity Shelter guests are enrolled in IHN-CCO and have support and advocacy in addressing primary care for physical, mental, and behavioral health needs.	12/2023
	Guests of Unity Shelter who are interested in or are in need of supportive services cannot have needs met and goals achieved in a timely manner due to current support staff capacity.	Staff refer to support staff for quick follow-up. THW's and Case Managers document all appointments, goals, and progress	Unity Shelter guests are offered supportive services immediately upon and intake and staff (THW's CM's, frontline staff) have capacity to refer and assist.	12/2023
	Data is inconsistent regarding health equity and basic needs.	Consistent training of all Unity Shelter staff in data collection and input. Regular data reporting and analysis.	All data put into Shelterware is accurate, reliable, and consistent with the number of individuals served within Unity Shelter.	12/2023

Pilot: Improving Access with THW's

Pilot Start Date:	1/1/2023	Pilot End Date:	12/31/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Case Management/Resource Navigation staffing across Unity Shelter programs		$109,500.00	$0.00
Traditional Health Worker staffing (Three, .5 FTE)		$66,829.50	$66,829.50
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$176,329.50**	**$66,829.50**
Materials & Supplies			
IT Hardware to support 3 workers (Laptops, tablets, printers)		$7,950.00	$7,950.00
Communications, promotion: Printing, distribution costs		$1,500.00	$1,500.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$9,450.00**	**$9,450.00**
Travel Expenses			
Mileage reimbursement at $0.585/mile for daily and on-call visits to Unity Shelter sites or client transport.		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$5,000.00**	**$5,000.00**
Meeting Expenses			
Online / Teleconference licenses to support telehealth and program		$540.00	$540.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$540.00**	**$540.00**
Professional Training & Development			
CHW training x3		$3,600.00	$3,600.00
Clinical Navigation Training x2		$13,000.00	$13,000.00
Unity Shelter required core trainings (x3)		$1,002.00	$0.00
	Subtotal Training & Development	**$17,602.00**	**$16,600.00**
Other Budget Items			
			$0.00
			$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$208,921.50**	**$98,419.50**
Indirect Expenses (not to exceed 15% of Direct Costs)	10.00%	$20,892.15	$9,841.95
Total Project Budget		**$229,813.65**	**$108,261.45**

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

Improving access with THW's

Unity Shelter

IHN-CCO Pilot Proposal

Ailiah Schafer, MPH, Operations Coordinator

Shawn Collins, Executive Director

Pilot Summary and Goals

- Unity Shelter hopes to add Traditional Health Workers (THW) to our team to increase access and utilization for current and future IHN-CCO members that utilize our programs. Through the addition of THW's to our staff, Unity Shelter can increase on-site supportive services, providing additional direct assistance and advocacy for individuals in the process of finding primary care, healthy and nutritious food options, and safe, permanent housing.
- Goal #1: *identify the needs of Corvallis' homeless population that utilizes Unity Shelter programs*
- Goal #2: *increase access to mental, physical, and behavioral health for people experiencing homelessness*
- Goal #3: *increase overall health and well-being through consistent on-site supportive services*.

Member and Community Need

- THW's will have lived experience to bring to the work, and ideally be hired internally from existing staff that already has rapport with target population
- Target Population is individuals experiencing homelessness, both situational and chronic, in the Corvallis area that utilize Unity Shelter services
- Approximately 52% of guests are enrolled in OHP upon intake to Unity Shelter programs
- This community needs consistent, on-site, culturally appropriate support in accessing necessary physical, mental, and behavioral health needs.

System Transformation

How is your proposal transformational?

- Rebuild collaboration with Benton County Health department's CHW team to ensure Unity Shelter THW's have a CHW team to problem solve and consult with
- Access to THW's within emergency shelter and transitional housing provides support at the front door for the unhoused population
- Provides safe shelter for individuals with on-site access to support where they are are comfortable and without having to navigate system on own

Partnerships/Collaboration

- Benton County Health Department
- Corvallis Housing First
- Corvallis Daytime Drop-in Center

Health Equity Plan

- How will you address health equity and reduce health disparities?
  - Connect with guests immediately upon entry to program to assess need and refer to THW
  - Ensure eligible guests are enrolled in IHN-CCO and support in addressing untreated chronic illness as soon as possible
  - Safe and stable shelter provides a sense of security while navigating other health impacts

Definition of Success

- Measures & Outcomes
  - Intake completed in timely manner and needs of community determined
  - Consistent on-site support for anyone utilizing Unity Shelter Services
  - Increased IHN-CCO enrollment and established primary care
- What data will you use to measure success?
  - Service records and case notes recorded in Shelterware regarding services and resources accessed with the assistance of a THW
  - Number of individuals moving forward in housing continuum
- At the end of your pilot, what will have changed?
  - Guests have established needed physical, mental, and behavioral health care
  - Guests have increased self-confidence in advocating for their own heath needs and have vested interest in their personal health
  - Improved data collection

Sustainability Plan

- Community collaboration to increase THW services to meet the demand across community resources serving the unhoused population
- Integrate THW's into core operations of Unity Shelter and continue to seek funding that supports staffing and operational costs

DST Member Questions?

Overcoming Obstacles to Dental Care

Backbone Organization: Capitol Dental Care

Billing Address: 610 Hawthorne Ave, Suite 200

Site(s):

County(s): Linn/Benton/- (perhaps Lincoln -no community partner identified as of submission deadline)

Priority Areas: (see Guidelines)

Oral Health Integration,

Rural community impact (Disparity in care for rural communities),

Subpopulations of IHN-CCO members that experience health disparities.

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

Access to Healthcare

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

Indicator concepts:

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

SD4: Increase health equity.

Areas of Opportunity:

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

Pilot Contacts	Name	Email
Primary	Linda Mann	Mannl@interdent.com
Proposal	Linda Mann	mannl@interdent.com
Contracting	Victor Kintz	Kintzv@interdent.com
Financial	Linda Mann	mannl@Interdent.com
Reporting	Linda Mann	mannl@interdent.com

2. Proposal Narrative

A. Executive Summary

To improve oral health for children and adults with special needs by utilizing a Dental Community Health Worker (DCHW) to be the central hub of the care team, to improve daily preventive mouth care, improve access to and the quality of definitive dental treatment.

B. Pilot Description

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

Goal 1: Hire and train Dental Community Health Worker (DCHW)		
Activity 1:	Advertise and hire DCHW	
Activity 2:	DCHW complete CHW training and become certified CHW	
Activity 3:	DCHW complete additional oral health training	
Intervention	Activities	Measurement
After hiring the DCHW, she/he will take a certified CHW course and additional oral health training. The DCHW will apply for certification through the Oregon Health Authority	In addition to the state certified CHW course, the applicant will spend a minimum of 5 days shadowing current dental team members to gain a deeper understanding of oral health education and oral conditions for patients with special needs.	Measurement of success is hiring the applicant, having the applicant successfully complete all training, and become a certified CHW.

Goal 2: Create workflow and referral processes for DCHW and Expanded Practice Dental Hygienist (EPDH)		
Activity 1: DCHW will work with pilot manager to develop workflows and referral processes		
Activity 2: Field test workflows and referral processes, make adjustments as needed.		
Intervention	Activities	Measurement
Create and test workflows and referral processes for streamlined and replicable operations	Working with pilot manager and other dental team members, the DCHW will create and test workflows for the DCHW to use providing consistent and replicable guidelines for all steps in the engagement of caregiver/patient dyads, education of caregivers, and evaluation of pilot. The DCHW will design referral forms to refer dyads to the Expanded Practice Dental Hygienist (EPDH) that will ensure a closed loop referral.	Measurement of success will be fully tested workflows and referral forms that ensure efficient and thorough care for dyads in the pilot.
Goal 3: Improve patient experiences and health outcomes		
Activity 1: Engage 25 caregiver/patient dyads to complete pilot		
Activity 2: Create and execute surveys for dyads and dental team members		
Activity 3: Decrease in gingivitis of patients		
Intervention	Activities	Measurement
The DCHW will meet with partnering organization to identify a caseload of dyads recommended for the pilot.	DCHW will meet with partner organizations and collect lists of potential dyads. DCHW will connect with all potential dyads and enroll at least 25 dyads to	Enrolling and completing at least 25 caregiver/patient dyads through completion of the program would be a measure of success. We

	complete the program. Using motivational interviewing and videos designed to educate and engage caregivers, the DCHW will guide the dyads through the program and ensure patient engagement with EPDH and dental team.	anticipate there will be more dyads who initiate the program, but that there may be some attrition. Thus a completion rate of 25 dyads would be ideal.
Creation, distribution, and compilation of surveys to determine effectiveness of program	The DCHW will create surveys for caregiver dyads, EPDH, and dental team to evaluate effectiveness of program in improving health outcomes and streamlined workflows and referrals. Surveys will be distributed 6 months and 9 months after engagement for dyads, and 9 months for EPDH and dental team.	Measure of success will be a 50% return rate of surveys for caregiver/patient dyads, and 100% return rate for EPDH and dental team.
Improved oral health outcomes by decreasing gingivitis of participating patients	Using a gingivitis screening tool at first and subsequent appointments, the EPDH will evaluate the gingival health of patients. The EPDH will be designing a patient-specific oral health plan for the caregiver to understand and the DCHW to reinforce.	A 30% decrease in patient gingivitis as determined by the screening tool would show successful improvement in oral health. Ideally, there would be a greater improvement, but since gingivitis is multi-factoral and dependent on daily oral care, medications and diet, as well as compliance of both

		caregiver and patient, 30% improvement may be attainable.

• ***Target population: ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members***

Currently IHN-CCO estimates about 10%, or ~8,000 members have a disability according to the OHA definition which is based on program eligibility codes (PERC codes). These numbers are not obtained by self-identifying or diagnosis. We anticipate this project will serve 112 members over the course of one year- 100% of them will be IHN-CCO members. We came to this number by figuring we will have about 28 weeks to provide care once the DCHW and EPDH team are trained and ready, if they work on this project two days per week they could see four patients per day- these are best guess estimates.

• ***Describe the intervention and detailed activities, including an environmental scan of similar projects in the region***

"Overcoming Obstacles to Dental Care" aims to utilize a Community Health Worker as the primary hub of communication and education for care providers and clients. Long wait times to get dental care for adults and children with special needs has driven Capitol Dental Care to seek ways to stabilize the patients who are awaiting treatment as well as find ways to prevent the need for patients with special needs to need extensive dental treatment. Utilizing a Community Health Worker to provide the additional education, navigation and assistance to improve the oral health of these patients would be a big step toward that goal. We will create a case load for the Dental Community Health Worker based on the waitlists generated by our dental organization as well as the care homes where the clients reside. The DCHW will make initial contact with each care provider and engage both the care provider and the client in a program which includes Dr. Paul Glassman's "Obstacles to Oral health" videos and initial screening by the EPDH. The DCHW will use motivational interviewing to develop goals of oral care and follow up with care giver via in-person and telehealth visits for follow-up. He/She will also be responsible for scheduling the EPDH to return for a comprehensive assessment and preventive services as needed. In this next stage

of the program, the DCHW and EPDH will work together to stabilize the patient and to prevent further disease if they are awaiting definitive dental treatment. Utilizing preventive and therapeutic agents, patients can be placed in a “holding pattern” while they are on the wait list for further care. These services will help ease the pressure on the dental delivery system as well as on the caregivers. Providing stabilization and therapeutic care will decrease pain and the risk of worsening infection for these patients. Having less oral pain will undoubtedly make the patients more comfortable and improve their overall disposition as well as make eating more enjoyable and enabling better nutrition. For those patients who do not need restorative care, the EPDH can provide many dental services and tele-dentist exams from the patient’s home, reducing dental anxiety, transportation challenges, and other difficulties associated with taking patients with special needs to a dental office. Caregivers will feel empowered and supported in their role as it relates to obtaining dental care for their clients. Prevention and early intervention care delivered in the community location is most likely to result in daily mouth care and better oral health. Having support from the IHN-DST is vital to trying this model of care. While it is true that we will be focusing on Capitol Dental Care members, this model of care for this population is entirely new. We do not know how much time it will take for our EPDH to spend providing these services in home settings as opposed to clinical settings. Traditionally it takes more time, which is not reflected in reimbursement. Additionally, typical payment models do not support care coordination, education and caregiver activities that are needed to maintain an effective community based system of care. So to hire the DCHW and invest in this model, it is imperative to have grant funds to evaluate the overall feasibility.

Currently in the IHN region, Dr. Brian Summers and Dr. Patrick Hagerty’ s office -Calapooia Family Dental, performs the majority of hospital based treatment for patients with special needs and medical complexities, (primarily on adults). According to Dr. Summers, “there is a huge need for services outside of typical clinical setting.” He went on to say, “the adults in care facilities, are probably the most vulnerable. Their families are sometimes involved, care staff are often not fully trained, the care staff is often transient, these folks can more often be combative, and often times are left to manage their own oral hygiene.” Calapooia Family Dental is in support of this project.

“Access to care is even more pronounced for adults with special needs because they age out of pediatric care at 18, leaving them with limited options. OHSU is among the leading referral sources for the state and they are closed to external referrals,” according to the March 2022 edition of the Oregon Dental

Association Membership Matters, “Practitioners Discuss Challenges, Rewards of Special Needs Dentistry.” ENDS (Exceptional Needs Dental Service) does send some providers out to care facilities however; the demand is greater than their capacity. We are not aware of any other programs in the IHN region that are providing onsite preventive and therapeutic care to those patients with special needs.

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

Partnerships in Community Living, Inc. (PCL) is a non-profit organization founded in 1986 with the mission to “Expand the Horizons and Enhance the Quality of Life for the People we Support where they work, play and live.” Originally started in Polk County, Oregon, PCL has spread through several counties in the Willamette Valley including Linn and Benton. PCL has committed to facilitate the connections to clients needing dental care as they have expressed that dental care is a much needed service for the clients they serve.

The Disability Equity Center (DEC) serves as a community education and resource center for disabled people and their allies throughout the Willamette Valley. Dr. Allison Hobgood, Executive Director, Corvallis Daytime Drop-in center has agreed to serve as a thought partner and Equity consultant on this project. She is also willing to connect us to clients in need of these services.

The ARC of Benton County- through connections via the DST, I was made aware that this agency is also submitting a grant aimed at providing “workshops on wellness” for those living with intellectual and developmental disabilities. Our DCHW will be able to provide education at these workshops on oral health.

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

According to Health Affairs, Vol 30, No 10 Eliminating Health and Health Care Disparities among the Growing Population of People with Disabilities, “People with disabilities also experience health care disparities, such as lower rates of screening and more difficulty accessing services, compared to people without disabilities. Eliminating these multifaceted disadvantages among people with disabilities should be a critical national priority” This pilot will reduce health disparities by decreasing barriers to dental care for persons with special needs. Reducing or eliminating transportation barriers by providing care onsite, utilizing a Community Health Worker to assist families and care-givers with navigation to definitive dental care, and training and empowering care givers to provide daily mouth care are ways to improve and

reduce the health disparities. Health Equity data will be collected via a Social Determinants of Health screening form. These forms will be collected and reviewed prior to the end of the grant period.

We plan to obtain input and feedback from the Disability Equity Center to ensure our project is equitable. Since this organization focuses on serving those individuals with intellectual and developmental delays, they will have valuable input and advice.

Our staff will also be undergoing a hand on training put on by Dr. Paul Glassman who is an expert in providing dental care to the special needs population. He will cover tips and tricks of the trade as well as how to ensure equitable care.

- ***Explain the social determinants of health lens the pilot will be incorporating***

Health Equity and the social determinants of health are intertwined. The conditions in which we live, work and play affect overall health. By understanding the living conditions of the members with special needs, we will be able to adjust our approach and expectations in regards to the members and their caregiver's cooperation and ability to work with us to improve their oral health. Through the initial patient assessment, the DCHW will assess how the patient's social determinants of health impact their ability to obtain good oral health

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

Capitol Dental Care- Linda Mann, Director of Community Outreach, will provide oversight and direction to the project.

Dr. Leslee Huggins- Pediatric Dentist, and Capitol Dental Care Outreach Dental Director- will provide oversight and direction to the project.

Community Health Worker (CHW)- we will be recruiting and hiring an individual who due to life experiences is passionate about the special needs population. This CHW candidate will either already be certified or will be willing to undergo the training and education to become certified. The CHW will be key in the success of this project in that they will play a large role in connecting, scheduling, training care-givers, and tracking and following up on referrals.

Expanded Practice Dental Hygienist (EPDH)- we will also be recruiting an additional EPDH to our Capitol Dental Outreach team, or transferring an existing EPDH from another program to this program.

Similar to the CHW, we will strive to identify someone who is passionate about ensuring those members with special needs are able to obtain proper dental care.

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

This project fits perfectly in our company mission statement- "Capitol Dental Care is committed to preventing dental disease and improving the oral and systemic health of children and low income patients. We create access to quality care, use evidence-based methods and provide dental leadership within the communities we serve." Capitol Dental Care is committed to serving all of its members regardless of disability status and this pilot is an example of how we strive to increase access for vulnerable populations.

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

There are several ways the community we will be serving will learn about our project. Our Capitol Dental Case Managers will pull data identifying members who are waiting to get hospital dental care. Our partners have pledged to also provide lists of patients with special needs who have dental needs. The DCHW will reach out to each of the patients on these lists to engage the members and their care providers into the project.

- ***Describe potential risks and how the pilot plans to address them***

An identified potential risk is that many residential homes that support those with persons that experience intellectual/developmental disabilities are suffering from a severe shortage of residential leadership and support staff. Without this staff, we may experience difficulties with identifying members that we can work with. Our hope is that clients and families that we are able to serve will help spread the work to others and we will be able to grow the program through word of mouth rather than relying on care providers to refer clients to us.

Another potential risk is that working with care providers and the special needs member will likely take an excessive amount of time -time that is not billable or encounterable to the Coordinated Care Organization. While we anticipate this grant funding to cover the expenses to operate the program for the one year, our hope would be that we are able to sustain this work. We will be looking to identify "in lieu of service" funds for ongoing support.

There may be an attrition rate due to many factors- care provider burn out, patient non-compliance, and patients moving to list a few. Attrition from the program will limit the data showing effectiveness.

Lastly, one year may not be sufficient to show a decrease in wait times for hospital dental care needs. It is our hope that we will be able to positively influence the amount of time patients have to wait for hospital care, as well as decrease the number of patients needing hospital care. This data might not be available until several years of this project.

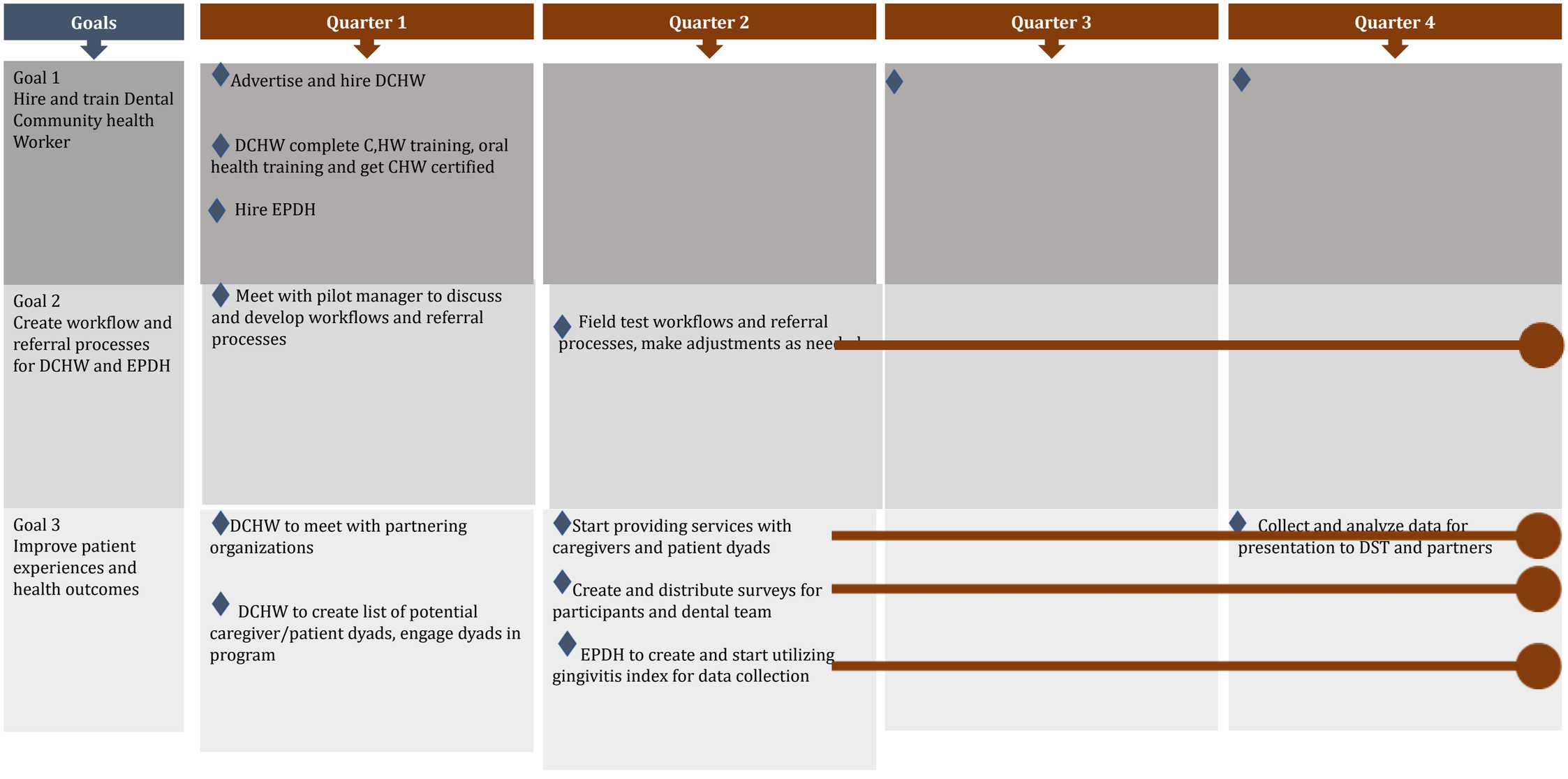
C. Project Timeline - attached

D. Sustainability Plan

Capitol will continue to use the Dental Community Health Worker as part of their patient outreach systems. As we learn and test a new version of community health worker, focused on those members with special needs, it is anticipated that other organizations will be interested in this type of program as well. Capitol supports the CHW role in ensuring our members are supported in their social determinants of health needs. As we figure out the billing systems, the funds obtained by reimbursement will help in support of this position. We also plan to explore how to obtain “in lieu of services” which are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan.

IHN-CCO DST PILOT PROPOSAL TIMELINE AND GOALS

Overcoming Obstacle for Oral Care



	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Hire and train Dental Community Health Worker (DCHW)	Place ad for DCHW, DCHW will take Community Health Worker training and additional oral health training with dental team	DCHW will be hired and successfully complete Community Health Worker training and gain certification, DCHW will complete all additional oral health training	December-22
	Create workflow and referral processes for DCHW and Expanded Practice Dental Hygienist (EPDH)	DCHW, project lead, and additional dental team members (as needed) will meet minimally three times to create initial workflows and referral processes.	Workflows and referral processes will be created and ready for use.	January 023
	DCHW will identify case load of clients and will have engaged with 25 care provider/patient dyads	DCHW will meet with partners in project and ensure a caseload of care provider/patient dyads.	DCHW will meet with partners in the pilot to determine dyads who would be good candidates for pilot. Partnering agencies will provide list of potential dyads for DCHW to meet and engage in services. DCHW will connect with and engage a minimum of 25 dyads for completing pilot	February, 2023
	DCHW will compile data on program acceptance for all participating dyads	DCHW, project lead and additional dental team members (as needed) will meet to create surveys for dyads, DCHW, EPDH, and partnering dentist.	Surveys will be completed and ready for distribution. DCHW will begin compiling data as surveys are distributed and collected.	August-23
	Participating patients will show a decrease in gingivits by 30%	EPDH and project lead will determine appropriate screning tool. Tool will be used as soon as EPDH starts seeing patients.	Data collected from screening tool will be collected at first EPDH visit and each visit.	August-23

Project Name: Overcoming Obstacles to Dental Care

Project Start Date:	**9/1/2022**	**Project End Date:**	**8/31/2023**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
1 FTE DCHW ($20/hr ~ $41,600)+ benefits		$49,400.00	$49,400.00
.10 FTE Outreach Manager ($25/hr~ 52,000)		$5,200.00	$5,200.00
1 FTE Expanded Practice Dental Hygienist		$99,840.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$154,440.00**	**$54,600.00**
Materials & Supplies			
Dental supplies (Toothbrushes, aids to adapt		$2,500.00	$2,120.00
Portable dental chair		$1,500.00	$1,500.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$4,000.00**	**$3,620.00**
Travel Expenses			
Travel for DCHW to sites/homes		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$5,000.00**	**$5,000.00**
Meeting Expenses (e.g. presenters, room rental, food, participation stipends, etc.)			
Present project at NOHC conference		$2,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$2,000.00**	**$1,000.00**
Professional Training & Development			
CHW education/training		$1,000.00	$1,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$1,000.00**	**$1,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$166,440.00**	**$65,220.00**
Indirect Expenses (not to exceed 15% of Direct	15.00%	$24,966.00	$9,783.00
Total Project Budget		**$191,406.00**	**$75,003.00**

Overcoming Obstacles to Dental Care

Linda Mann, Director of Community Outreach

Capitol Dental

Pilot Summary and Goals

- Our pilot aims to improve oral health for children and adults with special needs by utilizing a Community Health Worker to be the central hub of the dental care team, to improve daily preventive mouth care, improve access to and the quality of definitive dental treatment.
- Goal 1: Hire and train Dental Community Health Worker (DCHW)
- Goal 2: Create workflow and referral processes for DCHW and Expanded Practice Dental Hygienist (EPDH)
- Goal 3: Improve patient experiences and health outcomes

Capitol Dental

Member and Community Need

- **Target Population-** IHN CCO members with intellectual or developmental disabilities that are in need of dental care.

- **IHN-CCO Member Impact-**We anticipate this project will serve 112 members over the course of one year- 100% of them will be IHN-CCO members.

- **Community Need:**
  - Access to care very difficult for these members due to the following:
    - Limited number of providers willing to see these members
    - Transportation difficulties
    - Complexity of care
    - Time/involvement required to obtain care

System Transformation

- New partnerships with Partners for Community Living, the ARC of Benton County, Disability Equity Center
- Modeled after Dr. Paul Glassman's program in California- will be part of a multi state demonstration project
- Access to hospital dentistry for special needs adult nearing crisis point in Oregon as OHSU is closed to external referrals!
- Project expands use of a Community Health Worker to improve oral health outcomes for individuals with intellectual or developmental disabilities.

Partnerships/Collaboration

- Partnerships in Community Living Inc (PCL)
- Disability Equity Center
- The ARC of Benton County

Health Equity Plan

- According to Health Affairs, Vol 30, No 10 Eliminating Health and Health Care Disparities among the Growing Population of People with Disabilities, “People with disabilities also experience health care disparities, such as lower rates of screening and more difficulty accessing services, compared to people without disabilities. Eliminating these multifaceted disadvantages among people with disabilities should be a critical national priority”

- “Overcoming Obstacles to Dental Care” will:
  - Decrease barriers to care
  - Reduce or eliminate transportation barriers
  - Utilize a Dental Community Health Worker to assist families with navigation and training

Definition of Success

- Measures & Outcomes
  - DCHW hired, trained, certified
  - Workflows and referral systems tested and working
  - Enrolling and completing at least 25 caregiver/patient dyads through completion of the program
  - Satisfaction surveys indicated positive responses
  - Decrease in gingivitis will occur in members completing the program

Sustainability Plan

- Explore billing for DCHW services to supplement dental encounter rates

- Explore “in lieu of services” funding which are services determined by the state to be medically appropriate and cost-effective substitutes for covered services or settings under the State Medicaid Plan.

DST Member Questions?

THW Peer Wellness Doula Collaboration

Backbone Organization: ReConnections Counseling, LLC

Billing Address: 547 SW 7th St. Newport, OR 97365

Site(s): Newport & Corvallis, OR

County(s): Lincoln & Benton

Priority Areas: (see Guidelines)

- Addressing trauma, including environmental
    - Post-pandemic cultural trauma
    - Reduction of wait times for mental health services
- Addressing technology disparities
    - Phone and internet access
- Developing a bilingual and bicultural workforce
    - Traditional health workers reflective of the communities being served
- Oral health integration
- Pay equity through building and sustaining the workforce
- Reengaging the community in personal health and community resources
- Rural community impact
    - Disparity in care for rural communities
- Subpopulations of IHN-CCO members that experience health disparities
    - E.g. Latino/a/x, LGBTQ+, disabled folx, indigenous, foster care youth, and more

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

Access to Healthcare

- A1: Increase the percentage of Members who receive appropriate care at the appropriate time and place.
    - c. Trauma-informed care, such as Adverse Childhood Experiences (ACEs) and resiliency measures
    - d. Appropriate physical, behavioral, and oral preventive healthcare for all ages

- 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.

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

- A3: Improve integration of oral health services with behavioral and physical health services.
    - a. Percentage of Members who have a dental visit during pregnancy compared to total percentage of Members who have a dental visit

Behavioral Health

- BH1: Reduce stigma and increase community awareness that behavioral health issues are normal and widely experienced.
    - b. Peer-delivered behavioral health education and services
    - Areas of Opportunity
        i. Behavioral health stigma within the community
        ii. Community supports in the community to normalize behavioral health issues
- BH3: Increase mental health and substance use screenings, services, referrals, and peer and parent support.
    - Areas of Opportunity
        i. Mental health and substance use services, screenings, and referrals in venues other than traditional medical facilities, including schools
        ii. Peer delivered education and support

Child and Youth Health

- CY3: Increase breastfeeding initiation and duration rates.
    - Percentage of women who receive lactation consultation and support during pregnancy and following childbirth
    - Breastfeeding rates

Maternal Health

- M2: Increase the percentage of Members who receive early and adequate care and support before, during, and after pregnancy.
    - a. Behavioral health screenings and access to treatment with a behavioral health provider
    - Areas of Opportunity
        i. Healthy weight gain during pregnancy
        ii. Utilization of postpartum care and support
        iii. Partner education and involvement

Social Determinants of Health and Equity

- SD4: Increase health equity.
    - Areas of Opportunity

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

Pilot Contacts	Name	Email
Primary	LaLori Lager, Melissa Cheyney, Roslyn Burmood	lalori.lager@reconnectionscounseling.com; Melissa.Cheyney@oregonstate.edu; roslyn@communitydoulaprogram.org
Proposal	LaLori Lager, Melissa Cheyney, Roslyn Burmood	lalori.lager@reconnectionscounseling.com; Melissa.Cheyney@oregonstate.edu; roslyn@communitydoulaprogram.org
Contracting	LaLori Lager, Melissa Cheyney, Roslyn Burmood	lalori.lager@reconnectionscounseling.com; Melissa.Cheyney@oregonstate.edu; roslyn@communitydoulaprogram.org
Financial	LaLori Lager, Melissa Cheyney, Roslyn Burmood	lalori.lager@reconnectionscounseling.com; Melissa.Cheyney@oregonstate.edu; roslyn@communitydoulaprogram.org
Reporting	LaLori Lager, Melissa Cheyney, Roslyn Burmood	lalori.lager@reconnectionscounseling.com; Melissa.Cheyney@oregonstate.edu; roslyn@communitydoulaprogram.org

Executive Summary (1⁄2 page)

Provide a summary of the pilot including the overall pilot aims.

ReConnections Counseling (RC), in collaboration with the Community Doula Program (CDP), is proposing to establish site-based, wrap-around wellness care in Corvallis, OR for all IHN-CCO members who are pregnant and parenting with specialized services for members experiencing substance use disorder (SUD), and/or trauma and mental health conditions, including COVID-related stress. This project will implement an integrated care model for supporting pregnant IHN members, using lessons learned from the Nurture Oregon project currently piloted in five counties across the state, including Lincoln County, Oregon where RC and the CDP have had a successful collaboration since May 2021. RC has a demonstrated track record of supporting clients with substance use disorder, providing integrated care to pregnant individuals in Lincoln County; the RC model includes cross-training certified Peer Support Specialists (PSS) as Traditional Health Worker (THW) Birth Doulas. This project will draw from existing expertise and early successes to develop and expand services for individuals in Lincoln and Benton Counties with the hope of expanding to Linn County in the near future. This project will: 1) support the provision of services in a physical space aimed at offering site-based, wrap-around wellness care for all IHN-CCO members who are pregnant and parenting with specialized services for those experiencing substance use disorder (SUD), and/or trauma and mental health conditions, including COVID-related stress; and 2) support biannual cross-training for THW Doulas and Peer Support Specialists to become THW Doula Peer Wellness Specialists (n=20) in order to strengthen the workforce and provide expanded care to IHN-CCO members. This pilot will also strengthen relationships and foster non-overlapping collaborations among other DST pilots and regional CBOs by providing co-working space to all organizations serving the same communities of members.

Pilot Description (5-7 pages)

Describe the intervention and detailed activities, including an environmental scan of similar projects in the region

ReConnections Counseling (RC) and the Community Doula Program (CDP) are requesting funding to support site-based, wrap-around wellness care for IHN-CCO members who are pregnant and parenting young children (birth to three years) with specialized services for members experiencing substance use disorder (SUD) and/or trauma and mental health conditions, including COVID-related stress. This project will cultivate a physical space (paid for through a separate, non-DST funding stream) as a community resource hub in Corvallis to serve this subset of IHN-CCO members and will be open for community use to any DST pilot (or other aligned CBO) that can affect the wellbeing of the intended population of users. This project will be adapted from an existing model — Nurture Oregon's Lincoln County pilot program. The Nurture Oregon Program is a High Touch, Team Based Model that provides services through a collective impact approach. The Lincoln County site is led by RC, which provides behavioral health treatment, drug and alcohol counseling, and peer support services. This unique approach to community services and support is individualized to each pregnant person referred to the program. The Nurture Oregon team has regular, weekly "huddles" for case reviews, check-ins, participant appointments, and care coordination. This integrated-care model for pregnant individuals with SUD has shown that peer support increases prenatal visits, reduces child welfare involvement, and is cost saving. Data from March 2022 showed that 88% of participants received prenatal care, and 82% received postpartum care. In addition, 98% of infants born to participants had at least one well-child check, and 93% had at least two well-child checks in the first year of life. In addition, the Lincoln County site reports no relapses in either participants or PSS.

RC will purchase a property in Corvallis that this grant project can utilize as a community resource hub and furnish as a welcoming space for individuals and families. During the first two months of the project, we will coordinate with partners to identify needs to set up the space in order to most efficiently serve pregnant and early parenting IHN members. The property's size and layout will determine how many partners can be housed in this shared space.Ideally, the property will be on or near a bus route. The interior will need room for educational or support groups to meet, , a kitchen where food can be prepared, private counseling spaces for one-on-one conversations, and co-working space for partner organizations. The THW Doulas, PSSs, and PWSs trained by the CDP and RC will also use this space to meet with clients.

The strength of this project lies in our community partnerships and the ability for individuals to receive high-quality services and resources at no cost in one easily

accessed location. By providing integrated services in a physical space, we can better serve the needs of clients who have limited access to technology, are un- or underhoused, and who often cannot reliably participate in telehealth. Establishing a centrally located service hub, makes it easier for clients to drop in and have their needs met with THW Doulas and PWSs helping to navigate what can be a complex web of social, behavioral, and clinical health services. A physical space also helps avoid the need to share potentially private information (during intakes, prenatal visits and counseling sessions, for example) in public spaces. The ANNEX- Community Recovery Center space in Newport that this project will be modeled after is heavily utilized with daily meetings, groups, and events (managed via an on-line community calendar), with more than a dozen community partners sharing the space to offer non-judgmental, trauma-informed, wrap-around care. Additionally, a physical space for people to gather can help to ease the feelings of isolation heightened during the COVID-19 pandemic, both for members and for THWs doing critical work during challenging times. Research conducted with CDP doulas and RC PSSs indicates that a primary reason THWs stay in the work is the support provided by their professional community of peers.

Pregnancy and parenting are stressful in and of themselves, but the COVID-19 pandemic has additionally burdened families with concerns about illness transmission, availability of childcare for working parents, income instability, and isolation. Furthermore, stigma associated with the intersections of SUD, mental illness and parenthood can keep individuals from engaging with available resources. This project will work actively to combat stigma in program offerings and with partners. As we all work to find a “new normal”, this community resource hub can be a place for both formal support options such as counseling or art therapy, and informal support provided by making connections with others in the same stage of life.

The model we propose to replicate and grow uses a rotating responsibility approach where each month a different partner organization hosts a drop-in educational group on community-identified topics. For example, one month may be childbirth education with a different emphasis each week. Another partner organization could provide healthy food offerings for attending individuals. In this way, the task of providing education and support is shared among partners. Each partner organization will have unique expertise and offerings for pregnant and parenting individuals and/or those experiencing SUD, high-risk pregnancies, COVID-related stress, and more. Huddles will enable us to coordinate our services. Members, guided by their THW peer wellness doula, can drop-in to the weeks/events that work for them.

This community resource hub will have at least one day per week where our partner organizations are offering free services to IHN-CCO members. We will offer use of this space to other DST pilots at reduced or no cost. The space will be available for free,

when offerings are free. When partners wish to offer a service for a fee, a small, proportional payment will be collected for the ongoing support of the physical space. This mixed-income approach allows more community members to receive services, while building sustainability for this project. For example, a lactation consultant may see new parents at no cost on the free service day but could also use the space to see private clients another day of the week. We will partner with community providers to offer group classes on healthy cooking, parenting, safe sleep and more. We recognize that many health and social service entities already operate in our area, and we aim to de-duplicate offerings by inviting other organizations, to use the space while serving the same community members. For established organizations that offer tangible resources like food boxes, hygiene products, clothing and so on, this space will be a satellite location. The types of collaborative partners we are considering include, but are not limited to lactation support, pelvic floor therapy, massage, parenting education, yoga, housing support, oral health, cooking classes, mental health and addiction counseling and support groups, childbirth education, safe sleep, food pantry, baby wearing, art therapy, eye care, and more. Some of the DST pilot organizations we have identified to reach out to include Family Tree Relief Nursery, Capitol Dental Care, Corvallis Daytime Drop-In Center, Namaste Rx, and Corvallis Housing First.

In addition, this project will also fund two cross-trainings for THW Doulas, PSSs, and PWSs. This unique approach has the aim of providing high-quality care to clients with the goals of reducing negative birth outcomes and increasing family preservation. This will strengthen the THW workforce by expanding the scope of work for the cross-trained individual. This cross-training has already begun across our two organizations on a small scale, supported by funding from the Oregon Community Foundation, with more individuals expressing interest in future training opportunities. Leveraging existing THWs to expand their roles will increase sustainability by allowing for the provision and billing of additional services. Doula work in Oregon currently has limited reimbursement and is not a sustainable model for people with other family or work responsibilities. By providing education and a broader scope of practice, along with a nurturing space to facilitate community building, we expect less attrition and increased sustainability for the workforce. In addition, the recent announcement of intent by the state to increase doula reimbursement will hopefully contribute to increased recruitment and reduced attrition. The CDP actively recruits and trains doulas from a variety of cultural backgrounds in order to better serve the diversity of IHN-CCO clients; current CDP doulas speak more than ten different languages, and 40% are from Black, Indigenous and other communities of color. The increased scope of work combined with higher reimbursement will help in the recruitment of diverse community members—an essential component of our goal of centering those made most vulnerable by systems of oppression by offering culturally- and linguistically-matched care, to all IHN, CCO members regardless of language, literacy level, race, religion etc.

We hope to one day be able to offer this type of care in all three counties. We plan to focus on Benton County next because this is where the CDP has the strongest support and most extensive web of deeply invested community partners. Lessons learned from this expansion, combined with ongoing community partner development by RC and the CDP should enable eventual expansion of this model into Linn County as well.

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

The goal of this pilot is to partner with 10+ partners to serve over 100 IHN-CCO members on site and to cross-train a minimum of 20 Peer Support Specialist (PSS) and/or THW Doulas as Peer Wellness Specialists (PWS). This will create a robust and cross-trained workforce in multiple traditional health worker specialties.

In addition to both programs' current metrics, this project will track:

- Number of partners (including types of services offered) utilizing the Benton & Lincoln County spaces;
- Number of individuals (members and non-members) served on site;
- Number of training opportunities;
- Numbers of individuals cross-trained, credentialed and serving the field in Lincoln, Linn (if any) and Benton Counties.
- Number of diverse THW Doulas/PWSs trained in the development of a multilingual and multicultural workforce; and
- Using multimodal ethnography (art, poetry, and storytelling), describe the types of personal and systems-level transformation enabled by this project.

Target population: ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members

Currently the CDP's clients are 90% IHN-CCO members and the individuals served by ReConnections in Lincoln County are 90% IHN-CCO or uninsured (can be enrolled in OHP by the PWS). The CDP also serves 10% CAWEM and OHP clients.

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

- ReConnections Alcohol and Drug Treatment, Inc. – Project coordination, Counseling

- Community Doula Program – THW Doula training, Provide culturally- and linguistically- matched community doula services
- Namaste Rx – Yoga, self-care, and meditation for wellness classes
- BirthSwell – Strategic digital communications
- Shine Midwifery – Cranial sacral work for parent and infant
- Peg Kriz (LMT) – Pregnancy massage, Sleep bolstering for pregnancy
- Hanne Smith and Heidi Donahue – Childbirth education classes
- Heidi Donahue - Baby wearing classes
- Yesenia Sequera, Certified Breastfeeding Specialist (CBS) – Bicultural, bilingual lactation support, newborn weight checks
- Family Tree Relief Nursery – PWS training, early childhood supports
- Healing Motion – Postpartum pelvic floor therapy

All DST pilot or other aligned CBOs that can contribute to the wellbeing of pregnant and parenting IHN, CCO members are also welcome.

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

Healthy communities start with healthy births. As Michael Lu, former director of the Maternal and Child Health Bureau, said “We can’t all be created equal if we can’t get an equal start in life”. Through the provision of treatment for SUD, trauma, and mental health conditions, we will improve health outcomes for both parents and children by offering services and support from a robust group of Traditional Health Workers that are specialized and cross-trained as PWS, PSS, and Doulas. THWs are especially effective as reducing health disparities and providing transformational support as their approach and services are provided from a place of shared language, culture, community, and/or lived experience with addiction and/or mental health challenges (see references, pg. 11) Research shows that culturally and linguistically matched THW Doula care can further improve health outcomes, reducing inequalities that begin at birth. PSS and PWS services help keep families together and support healthy parenting. By connecting IHN-CCO members to a broader variety of essential resources and critical wellness services in a single, welcoming space, we are supporting the innate potential of members to

thrive and heal through community building and the promotion of resilience through peer support. This, we believe, is transformational.

Explain the social determinants of health lens the pilot will be incorporating

This collaborative approach works to address a variety of social determinants of health. While the primary focus of our organizations' current work is related to perinatal healthcare access, social support, mental health and SUD treatment, other partners will be able to work with individuals to address other areas such as nutrition, housing, early parenting and more. At the core is the goal of improving lifelong health outcomes and holistic wellbeing by ensuring that all people get the best possible start in life. We also believe that a generative and nurturing space with a focus on resilience and peer support will help add to the current dialog of deficit, suffering and inequality. While these are certainly realities for members, so are joy, resourcefulness, healing, transformation, and resilience.

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

ReConnections Team:

Lalori Lager, MA, CADC II is the Executive Director of ReConnections Counseling, Inc.; Karisa McGrane, BA, CADC II Program Manager Nurture Oregon; Melissa Gifford, PSS, CADC I Nurture Oregon Peer; Gina Myers, PSS/Doula, CADC I Nurture Oregon Peer; Chelsey Allen, PSS/Doula, CADC-R Nurture Oregon Peer

Community Doula Program Team:

Melissa Cheyney PhD, LDM, Professor of Clinical Medical Anthropology at Oregon State University (OSU), Community Midwife, Community Doula Program Champion, and PI; Roslyn Burmood, CPM, LDM, Program Coordinator for the Community Doula Program, Community Midwife. THW Doula; Alyssa Speece, MPH, Community Partner Liaison; Jeanette McCulloch and Denice Cox, *BirthSwell* Strategic Digital Communications; Marit Bovbjerg, PhD, Epidemiologist and CDP Co-Investigator; Holly Horan, PhD, Doula, Research Coordinator**;** Analuz Torres, THW Doula, Health Policy Analyst**;** Micknai Arefaine, Doula, Reflective Supervision Facilitator, Accountability Partner**;** Peg Kriz, THW Doula, Patient Advocate**;** Evangelina Steiling, Doula, Service User, Survivor Support Specialist**;** Carolina Amador, MD, MPH Community Pediatrician**;** Valentina Soares, Doula and Home Visitor, Early Learning and Education Specialist; Andy Radmacher, CPM, Community Midwife, Billing and Credentialing Specialist

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

Our organizations are guided by a single long-range goal: End inequity that begins at birth by ensuring that all birthing people are treated with dignity and respect and all babies are honored as sentient beings. We believe that health care that only meets clinical needs is the floor, and not the ceiling, of what we should be aiming to achieve. This project builds upon the expertise of RC and the CDP, expanding and strengthening the work being done in Lincoln County and across the tri-county area to provide critical, transformative support to pregnant and parenting individuals in collaboration with our clinical provider colleagues.

Describe how members of the community will hear about your project

Community members will hear about the project through social media posts, placement of flyers in locations frequented by those pregnant or parenting young children, and through referrals from other community organizations. BirthSwell is the strategic digital communications firm that has managed all the CDPs communications needs, including informational brochures, videos, website development, and service user infographics, since our initial pilot (see https://birthswell.com). They will continue to support this project.

Describe potential risks and how the pilot plans to address them

One of the challenges the CDP has faced is the attrition of trained doulas. This often stems from the current low reimbursement rate and the challenges of balancing on-call work with other responsibilities. By cross-training Birth Doulas and Peer Wellness Specialists, we are creating the potential to offer expanded services and employment opportunities. We were heartened to hear the recent announcement from OHA that will increase the fee-for-service reimbursement for doula services from $350 to $1,500 course of care. This significant increase may additionally help with the long-term sustainability of doula work as a career path in Oregon.

Pilot Timeline (1 page)

Provide a timeline of major activities and goals.

- Month 1 - Secure property
- Month 2 - Furnish and decorate the property
- Month 3 – Begin utilizing the space and bringing on partners
- Month 4 – Cross-training #1
- Month 6 - Mid-project evaluation, identify partners who will contribute to rent and utilities for years 2 and 3.
- Month 8 – Cross-training #2
- Month 12 - Pilot project evaluation

Grant writing, data collection, fundraising and the provision of direct services are ongoing across the entire timeline. No disruptions in current services and research activities are anticipated.

Sustainability Plan (1⁄2 page)

RC and the CDP have both been essential parts of developing sustainable THW services for IHN-CCO members. Sustainability for this project includes billing services, other foundation grants, and cultivating private donors.

Goal one – offering a site-based, wrap around wellness center for all IHN-CCO members who are pregnant and parenting with specialized services for those experiencing substance use disorder and/or trauma and mental health conditions, including COVID-related stress:

RC and the CDP will continue providing in-person, wrap-around services in Lincoln County and expand to Benton County by having a physical space open to IHN & private pay members. The space will have at least one day per week where our partner organizations are offering free services to IHN-CCO members. Partner organizations will have the ability to offer additional fee for service or donation-based offerings to the general public, while contributing a percentage towards the cost of maintaining the property - rent, utilities, cleaning, etc. This mixed-income approach allows more community members to receive services, while building sustainability for this project. This space will also be available to all DST pilots (or other aligned CBOs) that can affect the wellbeing of the intended population of users. Thanks to a non-DST funding source, the physical space will be owned by RC. This makes the project more sustainable because we do not need to worry about covering the costs of ongoing rent.

Goal two - supporting biannual cross-training for THW Doulas, PSSs, and PWSs in order to strengthen the workforce and provide expanded care to IHN, CCO members.

IHN-CCO members that receive services from RC and the CDP often have complex psycho-social concerns, are medically high-risk, and/or have complex needs and barriers. To sustainably support these members, it’s important to have a well-trained workforce where peers can provide billable support in multiple areas. For example, a THW doula can only provide reimbursable care for doula services that consist of two prenatal visits, labor and birth support, and two postpartum visits. However, CDP THW doula records shows that the doulas are providing many more services and supports that are not currently billable. This leads to burnout, frustration, and is not equitable. Cross training THW doulas as a Peer Wellness Specialists will enable to continue providing the supports IHN members need while increasing billable, reimbursable, services – a key to our continued sustainability. We are grateful for all the ways DST and other funders have supported the CDP and RC in the past, and we thank you in advance for considering this application.

References Cited

Ireland, S., Montgomery-Andersen, R., & Geraghty, S. (2019). Indigenous doulas: a literature review exploring their role and practice in western maternity care. Midwifery, 75, 52-58.

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Kathawa, C. A., Arora, K. S., Zielinski, R., & Low, L. K. (2022). Perspectives of doulas of color on their role in alleviating racial disparities in birth outcomes: a qualitative study. Journal of Midwifery & Women's Health, 67(1), 31-38.

Thurston, L. A. F., Abrams, D., Dreher, A., Ostrowski, S. R., & Wright, J. C. (2019). Improving birth and breastfeeding outcomes among low resource women in Alabama by including doulas in the interprofessional birth care team. Journal of Interprofessional Education & Practice, 17, 100278.

Wint, K., Elias, T. I., Mendez, G., Mendez, D. D., & Gary-Webb, T. L. (2019). Experiences of community doulas working with low-income, African American mothers. Health equity, 3(1), 109-116.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	Zero	Number of partnerships monitoried by agreements signed, community calendar schedule, & hudle notes (A1, A2, A3, BH1, BH3)	10 or more partner organizations providing services in the space	12/31/2023
	Zero	Number of individuals engaging in services at the site tracked through an upgrade to the current Vishnu & Qualtrics programs used by the CDP (A1, A2, BY3, CY3, M2)	100 or more individuals served on site	12/31/2023
	Zero	Number of individuals trained, credentialed, & supporting clients tracked through the current Vishnu program used by the CDP. (A1, A2, A3)	20 crosstrained THWs (PSS/PWS to Birth Doula, or vice versa)	12/31/2023
	40%	Increasing diversity of THWs so that they can provide culturally and linguistically matched care (SD4)	50%	12/31/2023

Pilot: THW Peer Wellness Doula Collaboration (see budget description for details)

Pilot Start Date:	**1/1/2023**	**Pilot End Date:**	**12/31/2023**
Goal 1: Wraparound Support Services			
Resource		**Total Cost**	**Amount Requested***
Educational Materials		$5,500.00	$5,500.00
Urgent Supplies		$4,500.00	$4,500.00
Office supplies		$12,000.00	$12,000.00
Systems navigation, integration, and resource coodination		$12,000.00	$12,000.00
CBO partnership & coordination for in-person wraparound servcies		$10,000.00	$10,000.00
Member outreach & education		$10,000.00	$10,000.00
CBO satellite office partnership		$5,000.00	$5,000.00
Enhance program diversity, equity, & inclusion through visual displays and support staff		$15,000.00	$15,000.00
	Subtotal Goal 1	**$74,000.00**	**$74,000.00**
Goal 2: THW cross-training			
Peer Support Wellness Training, 90 hours		$15,000.00	$15,000.00
THW Doula Training, 50 hours		$7,500.00	$7,500.00
State THW certification & IHN validation support		$10,000.00	$10,000.00
Removing training barriers		$12,000.00	$12,000.00
	Subtotal Goal 2	**$44,500.00**	**$44,500.00**
Total Direct Costs	**Rate (%)**	**$118,500.00**	**$118,500.00**
Indirect Expenses	12.00%	$14,220.00	$14,220.00
Total Project Budget		**$132,720.00**	**$132,720.00**

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

Traditional Health Worker (THW) Peer Wellness Doula Collaboration

A collaborative project of ReConnections Counseling, LCC and the Community Doula Program

Pilot Summary and Goals

This project will:

- 1) support the provision of services in a physical space aimed at offering site-based, wrap-around wellness care for all IHN-CCO members who are pregnant and parenting with specialized services for those experiencing substance use disorder (SUD), and/or trauma and mental health conditions, including COVID-related stress; and
- 2) support biannual cross-training for THW Doulas and Peer Support Specialists to become THW Doula Peer Wellness Specialists (n=20) in order to strengthen the workforce and provide expanded care to IHN, CCO members.

Member and Community Need

- Target Populations:
  - All IHN-CCO members who are pregnant and parenting with specialized services for members experiencing substance use disorder (SUD), and/or trauma and mental health conditions, including COVID-related stress.
  - THW Doulas and Peer Support Specialists in the tri-county area
- IHN-CCO Member Impact:
  - By providing integrated services in a beautiful and inviting physical space, we can better serve the needs of clients who have limited access to technology, are un- or underhoused, and who often cannot reliably participate in telehealth.
  - Establishing a centrally located service hub, easily reachable by public transportation makes it easier for clients to drop-in and have their needs met all in one location with THW Doulas and PWSs helping to navigate what can be a complex web of social, behavioral and clinical health services.
  - A physical space for people to gather can help to ease feelings of isolation heightened during the COVID-19 pandemic and lockdown, both for members and for THWs doing critical work during incredibly challenging times.

System Transformation

This pilot is transformative because it will:

- strengthen relationships and foster non-overlapping collaborations among other DST pilots and regional CBOs by providing co-working space to all organization serving the same communities of members;
- be adapted from an innovative model — Nurture Oregon's Lincoln County pilot program. The Nurture Oregon Program is a High Touch, Team Based Model that provides services through a collective impact approach;
- provide a place for both formal support options such as counseling and art therapy, and informal support provided by making connections with others in the same stage of life.

*We envision a community that thrives through the connections formed with providers and each other.

Partnerships/Collaboration

- ReConnections Alcohol and Drug Treatment, Inc. – Project coordination, Counseling
- Community Doula Program – THW Doula training, provide culturally- and linguistically- matched community doula services
- Namaste Rx – Yoga, self-care and meditation for wellness classes
- BirthSwell – Strategic digital communications
- Shine Midwifery – Cranial sacral work for parent and infant
- Peg Kriz (LMT) – Pregnancy massage, Sleep bolstering for pregnancy
- Hanne Smith and Heidi Donahue – Childbirth education classes
- Heidi Donahue - Baby wearing classes
- Yesenia Sequera, Certified Breastfeeding Specialist (CBS) – Bicultural, bilingual lactation support, newborn weight checks
- Family Tree Relief Nursery – PWS training, early childhood supports
- Healing Motion – Postpartum pelvic floor therapy

***All DST pilot or other aligned CBOs that can contribute to the wellbeing of pregnant and parenting IHN-CCO members are also welcome.**

Health Equity Plan: Healthy communities start with healthy births

“We can’t all be created equal if we can’t get an equal start in life”.

-Michael Lu

- Through the provision of treatment for SUD, trauma, and mental health conditions, we will improve health outcomes for both parents and children by offering services and support from a robust group of Traditional Health Workers that are specialized and cross-trained as PWS, PSS, and Doulas.
- THWs are especially effective as reducing health disparities and providing transformational support as their approach and services are provided from a place of shared language, culture, community, and/or lived experience with addiction and/or mental health challenges .
- Research shows that culturally- and linguistically-matched THW Doula care can further improve health outcomes, reducing inequalities that begin at birth. PSS and PWS services help keep families together and support healthy parenting.
- By connecting IHN-CCO members to a broader variety of essential resources and critical wellness services in a single, welcoming space, we are supporting the innate potential of members to thrive and heal through community building and the promotion of resilience through peer support.

Definition of Success

- Colloborate with 10+ partners to serve over 100 IHN-CCO members on site and cross-train a minimum of 20 Peer Support Specialist (PSS) and/or THW Doulas as Peer Wellness Specialists (PWS).
- In addition to both programs' current metrics, this project will track:
  - Number partners (including types of services offered) utilizing the Benton & Lincoln County space;
  - Number of individuals (members and non-members) served on site;
  - Number of training opportunities;
  - Numbers of individuals cross-trained, credentialed and serving the field in Lincoln, Linn (if any) and Benton Counties;
  - Number of diverse THW Doulas/PWSs trained in the development of a multilingual and multicultural workforce; and
  - Using multimodal ethnography (art, poetry and storytelling), describe the types of personal and systems-level transformation enabled by this project.
- Our organizations are guided by a single long-range goal: End inequity that begins at birth by ensuring that all birthing people are treated with dignity and respect and all babies are honored as sentient beings. We will be closer to this goal at the end of the project.

Sustainability Plan

- Economic sustainability for this project includes: 1) expanded billing for services, 2) other foundation grants, and 3) cultivating private donors. For example:
  - 1) THW Doulas and PSS cross-trained as PWS increases billable services;
  - 2) Funds awarded by Meyer Memorial Trust to support operations, and
  - 3) Stable space acquired through non-grant revenue, private donor (removes rent pressure).
- Sustainability of the workforce will be promoted by cross-training, the recent increase in state reimbursement rates for doulas, and the promotion of resilience and community building for THWs in a nurturing physical space.

DST Member Questions?

“Sweet Talk/Conversación Dulce” IHN CCO Proposal

Backbone Organization: Global Nutrition Empowerment

Billing Address: 3025 NW Hurleywood Drive, Albany, OR 97321

Site(s): Geary Street Clinic, Albany

County(s): Linn

Priority Areas addressed through Sweet Talk/Conversación Dulce:

- **Addressing technology disparities.**
    - The tablets to be used for the delivery of the diabetes education material, provide digital technology with simplified and concise information.
    - The health information is communicated in a manner that individuals can understand.
    - Guidance to the use of technology is provided initially, by demonstration and practice. Extra support provisioned as needed.

- **Developing a bilingual and bicultural workforce.**
    - The partnership for this pilot aims to create a bilingual taskforce to support the needs of the Spanish speaker population.
    - The SHS Population Health – Care Hub will be recruiting a bilingual Community Health Worker (CHW) from the community to be served.
    - The SHS Population Health – Care Hub will be responsible for the CHW and Diabetes Health Coaching training and education.

- **Language access:**
    - “Sweet Talk/Conversación Dulce” addresses issues of health literacy and equity. Principles of low literacy education and adult education are incorporated in all its components.
    - All digital, audio and printed materials are available in Spanish and English.
    - Sweet Talk/Conversación Dulce’s facilitators are bilingual, and some are native Spanish speakers.
    - The CHW will be bilingual, preferably a native Spanish speaker.

- **Subpopulations of IHN-CCO members that experience health disparities.**

    - The Spanish speaking or Hispanic/LatinX population has been historically underserved, marginalized, and disproportionately experience more chronic conditions than the non-Hispanic white population.
    - The CDC Diabetes Prevention Program foundations have been adapted and compressed in Sweet Talk/Conversación Dulce, into 6 sessions of 1 hour of education each, and thus increasing access to many who find travel and childcare an issue.
    - A monetary incentive reduces some burdens on participants from this financially strained subpopulation of IHN-CCO.

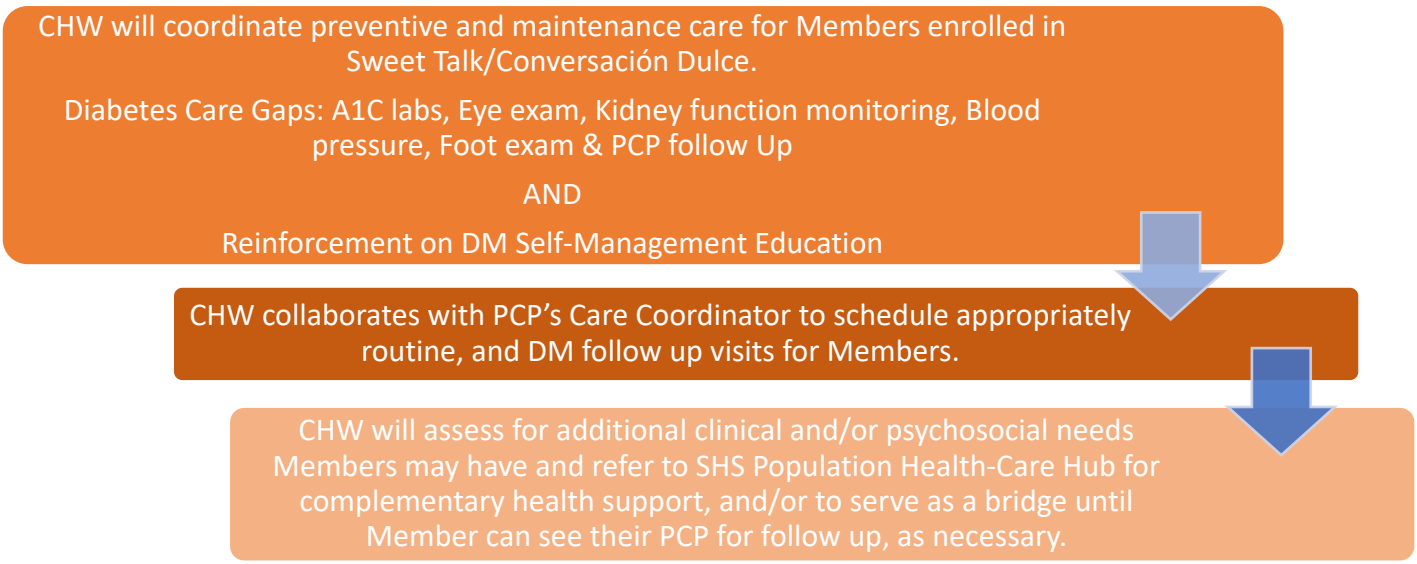
Community Health Improvement Plan (CHIP) Outcomes, Indicator Concepts, and Areas of Opportunity: (see Guidelines)

Outcomes, Indicator Concepts and Areas of Opportunities to be impacted by Sweet Talk/ Conversación Dulce are explained below.

ACCESS TO HEALTHCARE

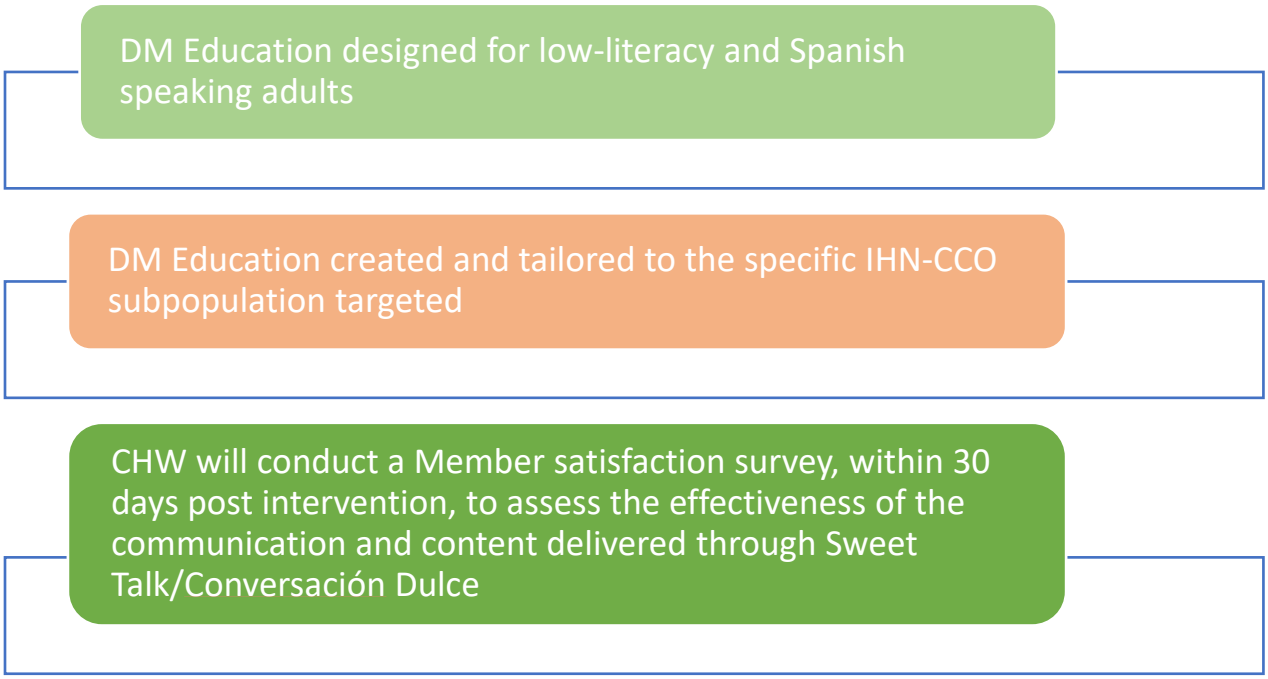
A1: Increase the percentage of Members who receive appropriate care at the appropriate time and place.

Sweet Talk/Conversación Dulce aims to collaborate and coordinate with Member's Primary Care Provider's (PCP) office and Care Coordinators, through the CHW, who will encourage Member's engagement in Diabetes and general care. CHW will assist with coordination of follow up care, refer to internal or external services and resources to help improve access to care.



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.

Conversación Dulce/Sweet Talk is specifically designed to meet the education needs of low literacy adults who speak Spanish as either their primary or secondary language. Its creators are diabetes educators, physicians, translators, and students who live and work in Linn County. It is appropriate across many cultures and eliminates literacy barriers.



HEALTHY LIVING

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

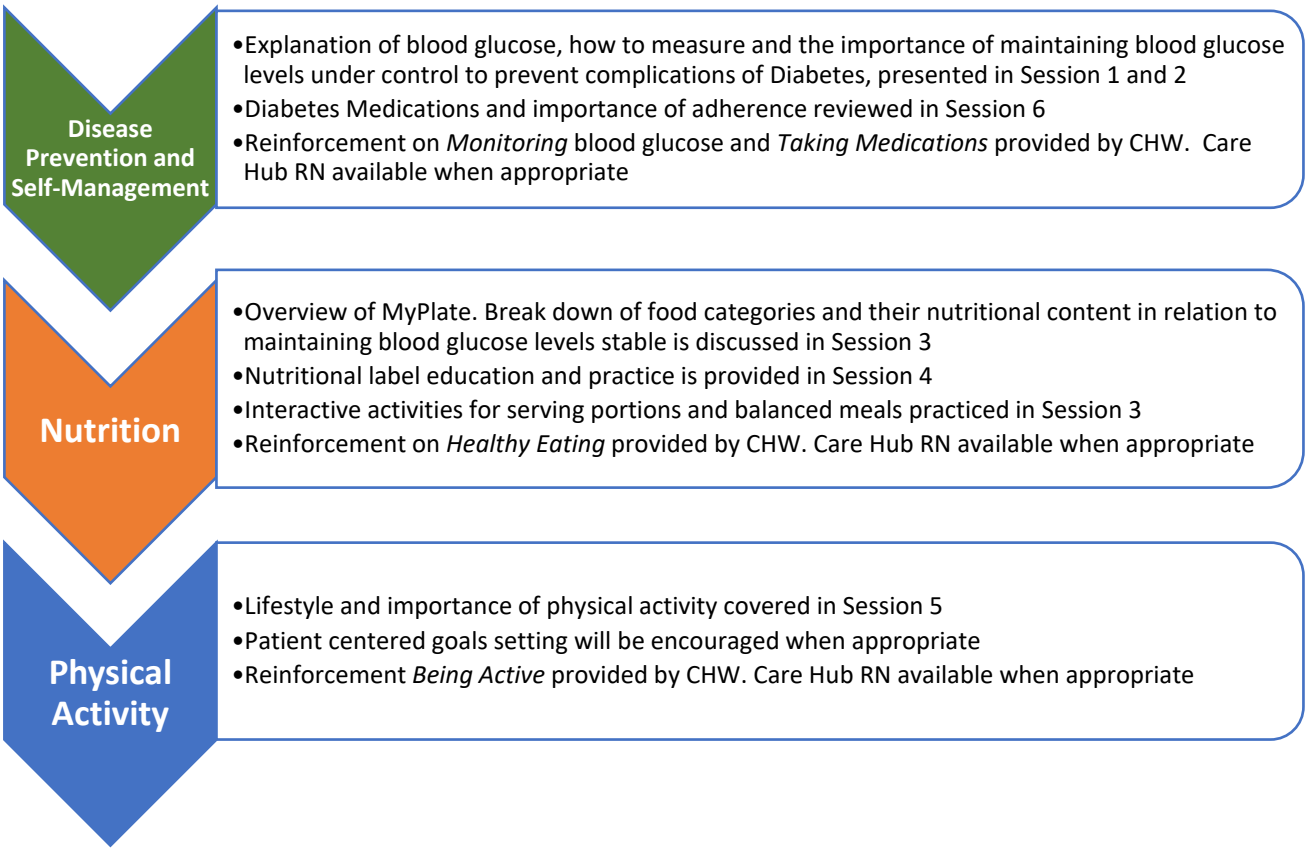
"Sweet Talk" explains concepts, uses hands on practical props, and employs teach back methods to improve nutrition, increase activity and reduce stress.

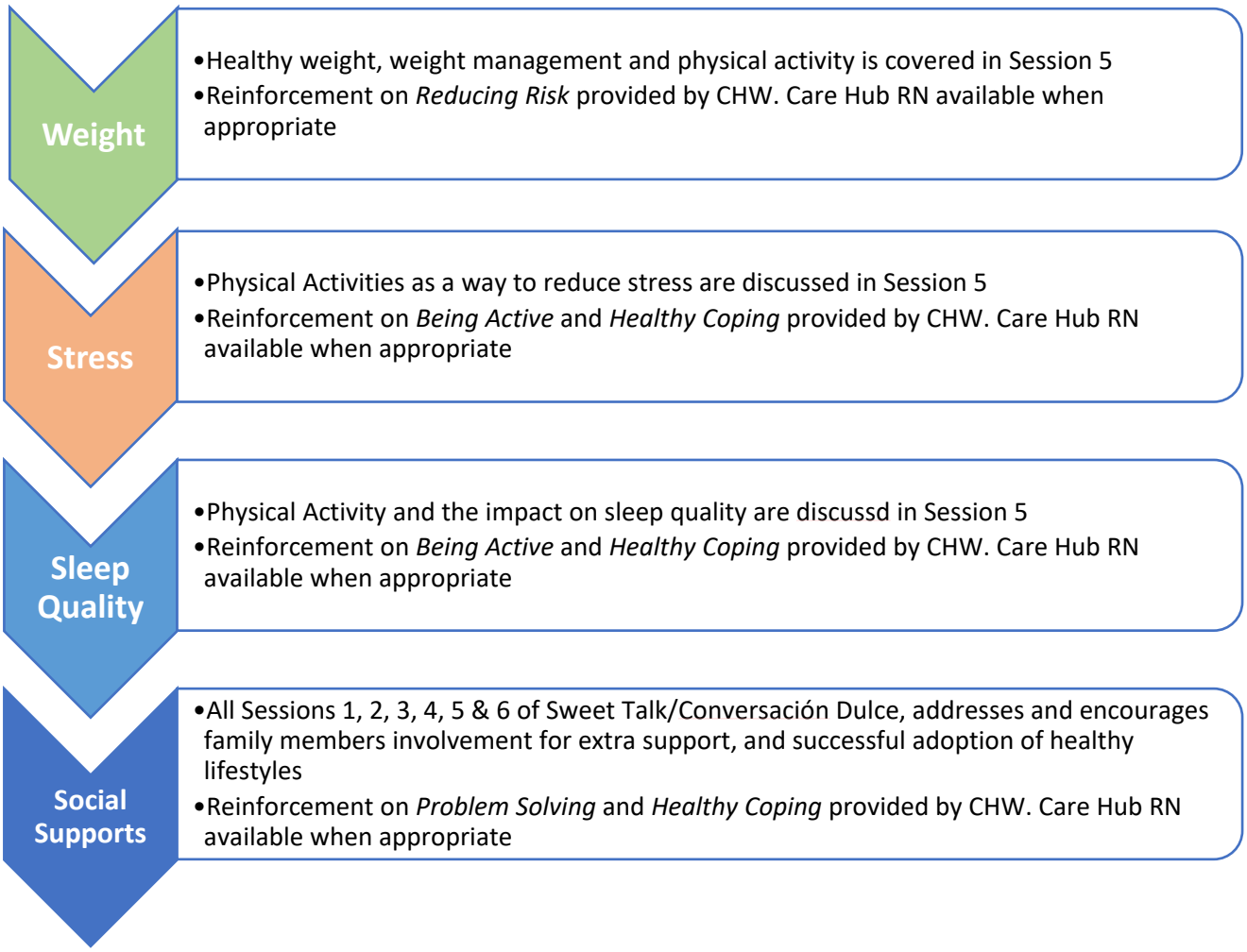
These classes are designed to provide prevention and self-management support to Members, while encouraging the adoption of healthy eating and healthy lifestyle while living with Diabetes.

Complementary to the Sweet Talk/Conversación Dulce, the CHW will complete specific training from the Association of Diabetes Care & Education Specialists (ADCES). This

course is the ADCES7 Self-Care Behaviors™, and it will help to support members more effectively during the outreach post-classes. In this manner they can reinforce all the areas that can be positively affected in the self-management of Diabetes and lifestyle changes.

ADCES7 Self-Care Behaviors™ covered during this training are: Healthy Eating, Being Active, Monitoring, Taking Medication, Problem Solving, Reducing Risk, & Healthy Coping.





SOCIAL DETERMINANTS OF HEALTH AND EQUITY

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

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

SD3 & SD4 will be completed by the CHW, who will be assessing Social Determinants of Health (SDOH) during the follow up outreach efforts.

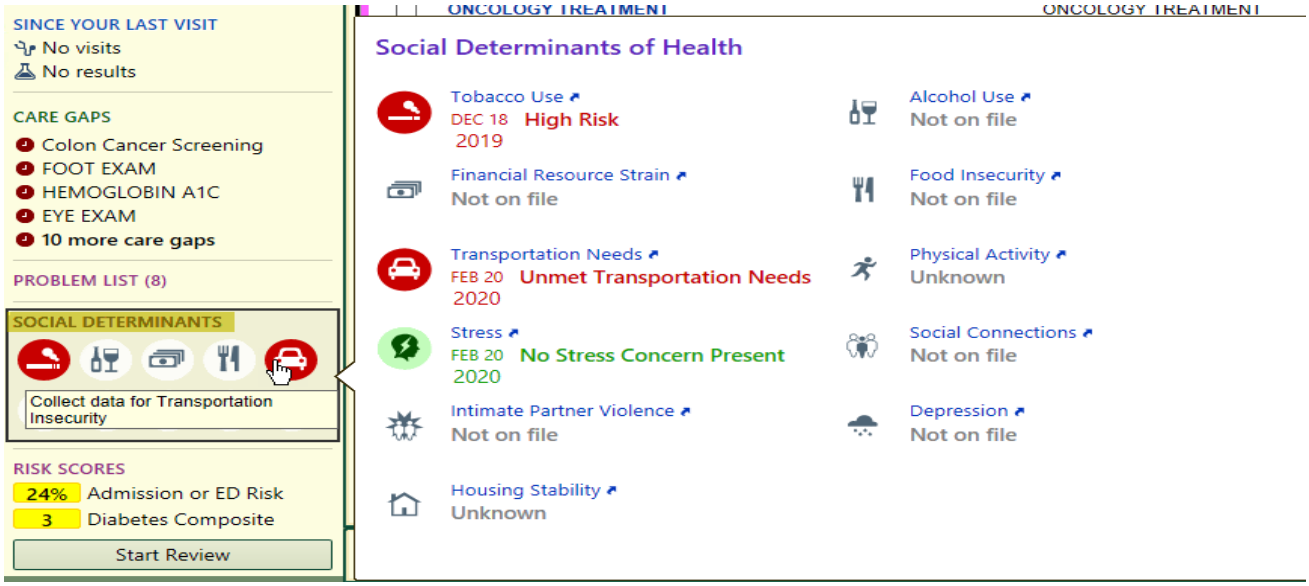
The SDOH assessment will be documented in the patient's EMR "EPIC" and the CHW will provision appropriate resources available in the community, will provide information about food pantries, food banks and other accessible food resources.

The CHW will make referrals to community services such as "meals on wheels" for those that qualify.

The CHW will connect members with available transportation and services.

The CHW will refer to SHS Population Health – Care Hub for specific interventions depending on the needs.

An example of the SDOH areas of assessment and documentation is shown below:



SD4: Increase health equity.

The cohort of members that will be contacted to participate in Sweet Talk/Conversación Dulce are already part of a disadvantage group. These individuals who are Spanish speaking and financially strained IHN-CCO members, experience disproportionately health disparities and the burden of disease and Diabetes is greater than the rest of the community. By providing Diabetes education, self-management support and education, in parallel to assessing for SDOH needs and provision of available resources, we will be providing more equity among that population. Moreover, the sessions have been created in a culturally appropriate manner, and have been designed with principles of adult low literacy, which is an innovative and inclusive model.

Pilot Contacts	Name	Email
Primary	Marie Long	Marie.l@globalnutritionempowerment.org
Proposal	Marie Long/Julia Saltzgiver/Rosa Wolf	Marie.l@globalnutritionempowerment.org Julia.S@globalnutritionempowerment.org rwolff@samhealth.org
Contracting	Doug McGirr	Doug.M@globalnutritionempowerment.org

Financial	Doug McGirr	Doug.M@globalnutritionempowerment.org
Reporting	Rosa Wolff/Marie Long	Marie.l@globalnutritionempowerment.org rwolff@samhealth.org

2. Proposal Narrative

A. Executive Summary
Background Information:

The Diabetes Prevention Program (DPP) designed by the CDC is an excellent platform for Diabetes Education. Their website states **"**Over the course of 1 year, CDC-recognized lifestyle change programs offer about 24 hours of instruction to lower your patients' risk of type 2 diabetes by more than half."[1]

According to the 2018-2022 Linn County Community Health Improvement Plan (CHIP), sixteen percent of Linn County community members experience food insecurity and 18% of 11th graders eat 5 servings of fruits/vegetables a day.

Official statistics for Linn County indicate that 89.9%[3] of those over 25 have a high school diploma, those of us who are health care providers encounter high rates of Health Literacy barriers.

GNE has conducted surveys of participants in the "Sweet Talk/Conversación Dulce" program in Linn and Marion Counties and the average number of years of formal education of attendees is eight years[4].

GNE surveys of over 100 participants has found that childcare and transportation issues are the primary reason for being unable to attend or complete classes.

Sweet Talk/Conversación Dulce developers noted the following barriers to participation in certified diabetes education programs:

- 1 year commitment to weekly classes. This is a long and costly commitment for people who must travel, have irregular schedules, or need childcare.
- Written material is in Spanish and English; however, literacy barriers remain.
- Classes may be restricted to a patient with a diagnosis of diabetes.
- Those with prediabetes may not be eligible.
- A physician referral and/or insurance may be necessary.
- These programs many times lack engagement and follow up after classes have ended. It has been noted the absence of support and reinforcement of the knowledge acquired through the sessions, which is needed to sustain lifestyle changes or to understand setbacks while making changes towards healthy habits.

Sweet Talk/Conversación Dulce closes these gaps in the following ways:

- Critical CDC and ADA diabetes education material is compressed into 6 hours (6 sessions of 1 hour each).
- The complexity of Diabetes Education and information is presented in a digitaly simple format on tablets.

- Classes are led by Bilingual/Bicultural Volunteer and CHW will reinforce, coach and follow up post education sessions.
- Family members and those with Prediabetes (including children over 3) are encouraged to participate in the class. A referral is not required.
- The classes are free, and a cash incentive covers travel and childcare expenses for participants who complete the class.
- The material emphasizes affordable food options and attainable lifestyle changes to prevent complications of diabetes.
- The CHW will assess SDOH needs and provide and connect members to available resources in the community.
- The CHW will encourage appropriate follow up for members with their PCP and/or Diabetes Educators or other specialists.

***Sweet Talk/Conversación Dulce* Goals:**

1. Improve the health and well-being of participants, by promoting and educating about healthy lifestyles, and by the provision of available resources in the community.
2. Improve access to appropriate Diabetes Care and education for participants from the Samaritan Geary Street Clinic.
3. Demonstrate improved participant understanding of diabetes, by education provided in a culturally appropriate manner and language.
4. Improve Diabetes Care Gaps and prevent complications from Diabetes for the participants from Samaritan Geary Street Clinic.

B. Description of *Sweet Talk/Conversación Dulce*

Project Rational and Description

Conversación Dulce/Sweet Talk is specifically designed to meet the diabetes education needs of low literacy adults who speak Spanish as either their primary or secondary language. Its creators are diabetes educators, physicians, translators, and students who live and work in Linn County. It has been tested, modified, and utilized as a diabetes education class for 18 months at the InReach Clinic in Albany and the Lancaster Family Health Center in Salem. Over 60 participants have completed the 6-hour class with improvement in their knowledge of key components of diabetes education of 32%, and excellent participant reviews. Participants have an average of 8 years of formal education.

"Patient Centered" was the constant and primary focus as the course was developed. Key components of the design include:

- Low literacy adult education principles are always used. (Practical, Engaging, Accessible and Relevant).
- There are no literacy requirements in either the course material or the surveys
- The CDC Diabetes Prevention Program (DPP) and ADA Diabetes Education material is compressed into 6 sessions.
- Each of the 6 sessions consist of three parts
    - A video (5 to 15 minutes) presents the most complex information.
    - A 20-minute hands on practical session emphasizes key information
    - Twenty minutes of Q and allows for teach back and discussion
- Classes are effectively coached by native Spanish speakers with 12 hours of training. They can be CHWs, THWs or Volunteers.
- A $25 cash incentive allows for attendance of some participants who would otherwise be restricted by lack of childcare or transportation.
- The videos and interactive surveys are presented on tablets which have been found to introduce technology to many of the participants.
- The CHW will collaborate with participant to coordinate follow up care and close Diabetes Care Gaps, which are preventive and maintenance of care to improve and either delay or avoid complications from the condition.
- The CHW will assess SDOH needs and provide intervention as appropriate. Referrals my occur internally to SHS Population Health - Care Hub or externally to other community partners or services that may serve the participants in meeting their SDOH needs.

***Sweet Talk/Conversación Dulce Talk* Goals:**

The goals of Sweet Talk/Conversación Dulce have been created with Patient-Centered principles, and these goals are aimed to meet the quadruple aim for Health Care transformation, as it attempts to improve the health of the participants, reduce costs associated with chronic conditions, improve access to care and preventive services, and enhance clinicians and their staff's satisfaction by supporting self-management and follow up care for their patients.

1. Improve the health and well-being of participants, by promoting and educating about healthy lifestyles, and by the provision of available resources in the community.
    - Post classes survey in relation to healthy behaviors and knowledge will be conducted by CHW
    - Provision of available resources will be documented and collected by CHW in EPIC.
    - Review of behavioral changes post classes and at 6 months will be collected by CHW and compared to baseline.
    - Obtain feedback by surveys and conversation with participants to improve the content and presentation of the program. This data will be collected and shared with providers.
    - Improve and alter the program to allow for greater distribution. The above data plus the outcome of satisfaction surveys will be analyzed and implemented
    - The use of technology to deliver the information content, frees Diabetes Educators to concentrate on individual care after the participant has a basic understanding of their condition.

2. Improve access to appropriate Diabetes Care and education for participants from the Samaritan Geary Street Clinic.
    - Provide a practical, engaging, accessible and relevant diabetes education program to members of IHN-CCO and other vulnerable populations. 200 participants are planned in the first year, with 500 participants the second year. This will be measured by documenting the numbers of referrals, attendance, and completion of the program.
    - Encourage and coordinate Diabetes care follow up visits with clinicians or Diabetes educators as appropriate.
    - Reduce the time Providers spend educating patients and families with the basic Diabetes care.
    - Document provider satisfaction with program.
    - Engage community leaders to train volunteers and provide diabetes education.

- The CHW will actively engage Community Based Organizations to increase referrals and implement programs in the community.

3. Demonstrate improved participant understanding of diabetes, by education provided in a culturally appropriate manner and language.
    - A pre and post course low literacy knowledge test will be conducted.
    - Provider assessment of participant knowledge pre and post, and in comparison, with other patients.
    - Follow up with Diabetes care education and reinforcement will be conducted by CHW, and teach back will be elicited to assure understanding of information.

4. Improve Diabetes Care Gaps and prevent complications from Diabetes for the participants from Samaritan Geary Street Clinic.
    - Improve the number of recommended ***Diabetes Care gaps*** to prevent complications for all participants:
        - ***HBa1c labs*** captured at baseline for all participants and follow up with clinician or Diabetes educator as appropriate:
            - >8% repeat HBa1c in 3 months and follow up visit
            - <8% repeat HBa1c in 6 months and follow up visit
            - HbA1c will be obtained as a baseline and followed as clinically relevant by providers.
        - ***Medication adherence***:
            - Diabetes medication education reviewed on session 6
            - Diabetes medication review and importance of adherence to regimen to be completed by CHW at follow up post classes
            - ***Statin medication*** use reviewed by CHW at follow up post classes
        - ***Eye exams completed***:
            - Every year is recommended for all people with Diabetes
            - Every year is required if there is *Retinopathy* present
            - Every other year is required in the absence of retinopathy
            - If participant does not have an eye exam, a referral will be placed with the collaboration between CHW and Care Hub RN's or CMA.
        - ***Kidney disease monitoring:***
            - Microalbumin urine test or nephropathy screening recommended yearly
            - Reinforcement of clinician or specialists' care recommendations
        - ***Foot Exam:***
            - Recommended yearly
            - Assess for daily self-foot care

    - Foot exam by clinician must be completed within 12 months prior to Diabetes Education referral
- ***Oral Health exam:***
    - Recommended yearly
    - Encourage to complete or provide resources
- ***Preventive Care:***
    - Flu vaccination recommended yearly
    - Smoking cessation when applicable
    - Blood pressure measurements and follow up as appropriate

Who is our Audience?

Most participants will be referred by Geary Street Clinic providers and will have either no insurance or IHN-CCO Insurance. The classes will be offered in either Spanish or English, but the focus will be on recruiting Hispanic participants from IHN-CCO.

Posters and invitations to community and family members will be prominently placed in the clinic, and in select locations in Albany, such as grocery stores, churches, and community centers.

CHW will obtain a list of IHN-CCO & Spanish speaking members, and actively outreach to offer the services.

A Web search for "Diabetes Education in Linn County" found:

- Samaritan Lebanon Community Hospital and the Corvallis Clinic Diabetes Care and Education. Both are ADA certified, are 1 year in length and require a referral from a physician. They may be virtual.
- Becoming a certified diabetes educator (3-month course) requires: Graduation in Public Health, Nutrition, Nursing, Pharmacology, Occupational and Physiotherapy etc.

Partners and Individual Roles/Experience

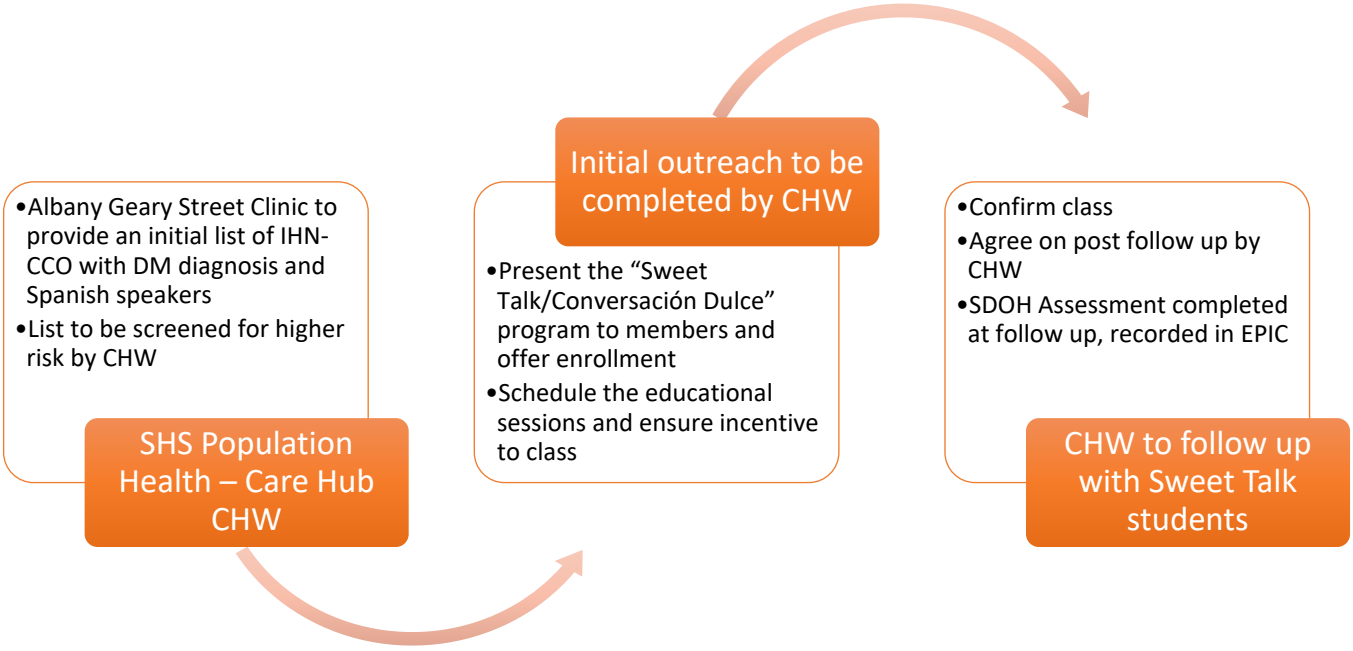
PILOT Partnership & Collaboration →	GNE	InReach Medical Clinic (Albany)	SHS Population Health – Care Hub	Samaritan Geary Street Clinic - Albany
↓ IHN – CCO Priorities Addressed				
Addressing technology disparities	✓			
Developing a bilingual and bicultural workforce	✓		✓	
Language access	✓	✓	✓	
Subpopulations of IHN-CCO Members that experience health disparities	✓	✓	✓	✓

Partners	Roles / Tasks	Experience
Global Nutrition Empowerment (GNE) Oregon non-profit, 501 (c)3 status	• Provides Tablets • Provides Tech expertise and support • Provides all Education materials • Trains volunteer Coaches • Administers funds for the coaches and participants • Administers funds for Tech Team	• Develops low literacy education material in 6 languages/dialects in the USA and internationally (13 yrs.) • Developed and implemented "Conversación Dulce/Sweet Talk" (2yrs.) • Recruits and educates volunteers to work in US and internationally (12 yrs.) • Uses tablets as a means of delivering education material (12 yrs.) • Dedicated Tech Team (10 yrs.)
InReach Medical Clinic (Albany)	• Trains Coaches as SHS volunteers including: o HIPPA o EPIC o Patient Communication	• Volunteer-based clinic providing free medical care to financially disadvantaged individuals and those with no health care insurance • Extensive experience with equity and marginalized population issues • Recruits and onboards volunteers for SHS
SHS Population Health – Care Hub	• Provides HR oversight of the CHW • Administers funds for CHW • Responsible for hiring and training of CHW in Program goals and EPIC documentation • Responsible for formal CHW training • Oversees documentation of members' interventions in the Electronic Medical Record (EMR) • Provides data related to Diabetes Care Gaps	• Provides outpatient health care programs for Samaritan Health Services, which serve the communities of Benton, Linn and Lincoln Counties • The services provided are clinical and psychosocial in nature, employing Registered Nurses (RN), Medical Social Workers (MSW), Care Coordinators (CC) and Community Health Workers (CHW). • The team partners with community services and resources to address medical and SDOH needs of the individuals served.

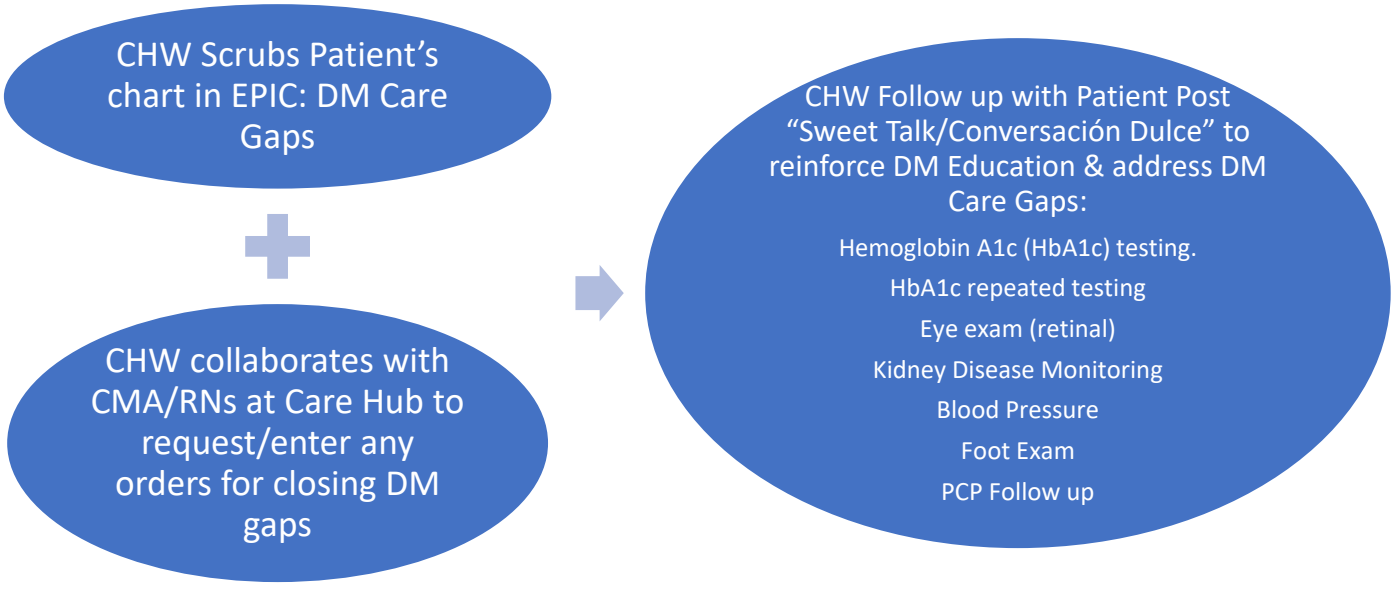
	• Liaison between GNE, In Reach and Geary Street Clinic and Patient	• Developed and Implemented Transitions of Care Programs for individuals with fragile health conditions, disadvantaged and marginalized populations. These programs are Home Transitions and Homeless Outreach. • Developed and implemented a longitudinal care program for patients with chronic conditions; Chronic Care Management (CCM). Currently CCM is being provided at the Albany Geary Street Clinic (since 2018) and Samaritan Toledo Clinic (since 2021).
Samaritan Geary Street Clinic - Albany	• Providers refer program participants. • Provides space and facilities for the program and the CHW.	• Primary Care Health Clinic and Patient-Centered Primary Care Home (PCPCH), providing medical services for more than 33,000 patients in Albany. • Extensive experience serving marginalized and low-income individuals. • Serving over 12,000 IHN-CCO members. >6,500 members are in the Diabetes registry From those 6500, >2,200 are in the Diabetes registry and identify as Hispanic or Latino ethnicity And >1,300 of the above group are IHN-CCO members

Sweet Talk / Conversación Dulce: SHS Population Health-Care Hub Collaboration

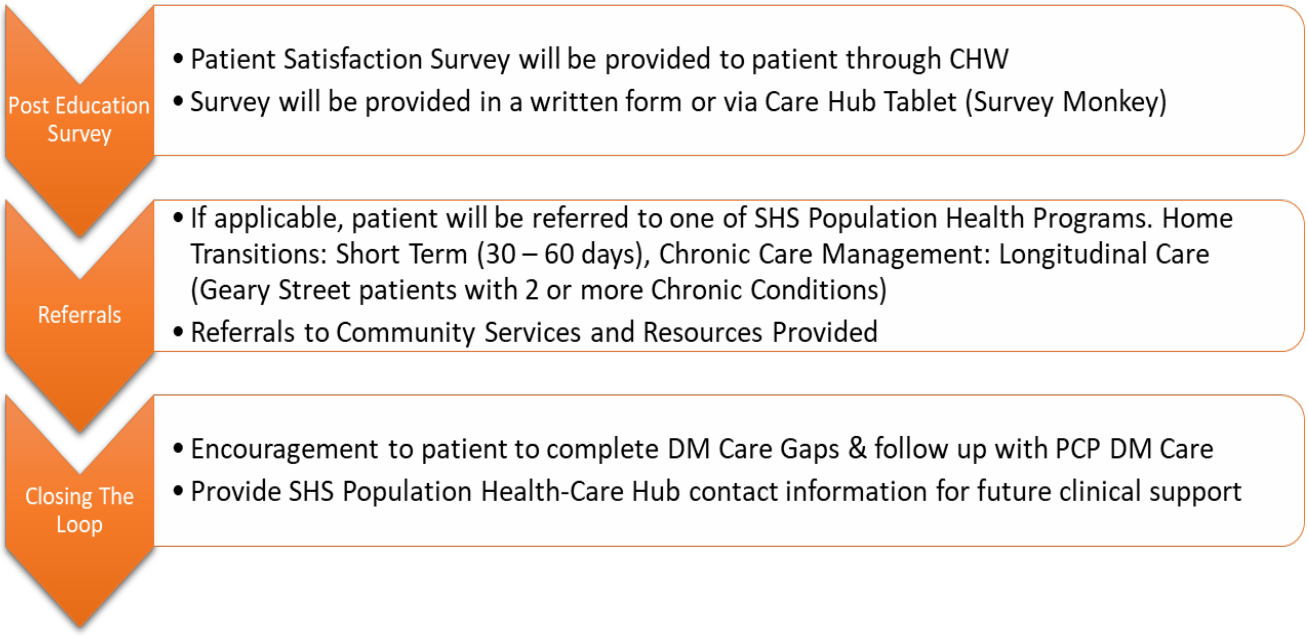
STEP 1: CHW Involvement



STEP 2: CHW Follow Up



STEP 3: Closing Case



How Conversación Dulce / Sweet Talk promotes health equity and reduces health disparities

This program addresses issues of health equity and reduces health disparities by:

- The consistent use of principles of adult and low literacy design (practical, engaging, accessible and relevant).
- A CHW plays a critical leadership role in the implementation of this program. They will find and engage community members, especially those who will benefit the most due to health and socioeconomic disparities.
- Engaging participants in their overall health and follow up with preventive services and Diabetes care, will enhance informed choices and promote equity for this disadvantage population.
- The reinforcement and support from CHW post completion of classes, will increase opportunity for adopting or improving healthy lifestyle choices.
- The SDOH assessment and follow up interventions, will provide access to otherwise underutilized available resources for marginalized individuals, and thus reducing health disparities accounted by those factors.
- The program will actively incorporate the CDC “Emerging Practices in Diabetes Prevention and Control: Engaging Community Health Workers in Diabetes Self-Management Education Programs.”
- Culturally appropriate promotional materials will be placed in locations to reach the target population. (For example, PSA on radio stations, posters in grocery stores, reaching out to undocumented workers in the agriculture industry).

How does the project fit into GNE's long-range/strategic plans?

GNEs mission the past 13 years has been to improve health using culturally 'education plus appropriate nutritional supplements supported by scientific evidence. The organization began its work in Nepal supplying women with education and prenatal vitamins to reduce the incidence of Birth Defects (specifically neural tube defects).
GNE plans to expand its expertise in education with innovative methods. The use of technology is central to this mission, and the GNE Tech team is energetic, committed for the long term, and constantly engaged in achieving this goal.

How will the community learn about Conversación Dulce/Sweet Talk?

Posters will be placed at the Geary Street Clinic. Invitations and referrals will be easy for the participants.

Culturally appropriate promotional materials will be placed in locations to reach the target population. (For example, PSA on radio stations, posters in grocery stores, reaching out to undocumented workers in the agriculture industry).
CHW will conduct an active outreach for Spanish speaking individuals from IHN-CCO.

Risks and possible pitfalls

GNE, InReach and Lancaster Family Health Center have encountered several potential obstacles during the development of this program. One major hurdle is a high "no show" rate. Interestingly, this rate is higher for English speakers (approaching 70%) than Spanish speakers (about 50%). The use of a cash incentive for completing the program has helped, but not eliminated the problem. Hopefully the leadership of a CHW with a specific responsibility and engagement with participants longitudinally will be helpful. Further attention and thought will be needed to address this issue.

CHWs are in high demand, and there is a potential for high turnover rate. Engagement with the community and volunteers will potentially make this an emotionally rewarding position. SHS Population Health-Care Hub intends to make this CHW position a permanent one and promote growth to this program, on year 2 of the pilot. The turnover rate in the SHS Population Health – Care Hub has been at 10% in the last two years. The CHW position will also have available opportunities for promotion within the department.

Tablets are an excellent tool but are expensive and require updating. The GNE Tech Team is working on creating an on-line version of the teaching material which will be easy to access and allow for greater sustainability and expansion of the program.

C. Pilot Timeline

Task	Responsible Partner	Initiation Date	Completion Date
Initial team meeting	GNE	Grant approval	Week 1
CHW hire	SHS Care Hub	Grant approval	Week 4
Prepare posters/invitations	GNE	Grant approval	Week 2
Purchase tablets/accessories	GNE	Grant approval	Week 2
Code/load tablets	GNE	Grant approval	Week 3
Second team meeting	GNE	Week 4	Week 4
CHW – SHS training	SHS Care Hub	Week 4	Week 7
CHW – Geary Orientation	Geary Street	Week 7	Week 7
CHW – GNE training	GNE	Week 7	Week 7
Purchase/prepare teaching aids	CHW/GNE	Week 7	Week 8
Volunteer Coach training	InReach/GNE	Week 4	Week 7
Referral process begins	CHW/Geary St	Week 4	Week 52
First Class	CHW/All Team	Week 6	Week 52
Data entry	CHW/Volunteers	Week 6	Week 52
Third Team Meeting	CHW/GNE	Week 8	Week 8
Adjustments/modifications	All Team	Week 8	Week 10
Monthly Team meetings	CHW	Week 12	Week 52
Last Class	CHW	Week 50	Week 50
Post-Class Survey	CHW	Week 51	Week 52
Data completion	CHW/volunteers	Week 50	Week 52
Written summary	All team	Week 50	Week 52

D. Sustainability Plan

This program was *designed* to be innovative, community based and sustainable. It is accessible to all learners independent of literacy. It is available to family members, children, and those with prediabetes as well as conventional patients with diabetes.

Bilingual/bicultural CHWs will increase access, participation, and attendance. Patient demand will drive its sustainability.

Follow up post classes will help reinforce education shared and may increase recommendation from participants to other individuals or family members that could benefit from Sweet Talk/Conversación Dulce.

Reducing provider (physicians, nurses, and diabetes educators) workload will lead to requests for its broader implementation.

Closing Diabetes Care Gaps and improving the health for this population, will drive interest in clinicians at Samaritan Geary Street Clinic, other Samaritan clinics and Samaritan Health Plans–IHN-CCO to support the efforts for expansion.

Tablets or online program access for all the teaching material plus data collection allows the program to be scaled.

CHWs or community volunteers who Coach the program encourages community-based organization involvement and opens access to non-traditional venues.

This program is easily translated into other languages or dialects and is completely portable.

Training coaches takes 12 hours. Materials are accessible and reproducible.

4. SMART Goals and Measures

Specific Goal	Measurable	Attainable	Relevant	Time
Improve the health and well-being of participants, by promoting and educating about healthy lifestyles, and by the provision of available resources in the community.	Post Class survey evaluation will yield:			By 12/2023
	90% satisfaction with the class	✓	✓	
	30% improvement in knowledge of Diabetes self-management & prevention, nutrition, physical activity, weight management, stress, sleep quality and social supports	✓	✓	
	100% of participants were provisioned with available community resources upon identification of SDOH needs	✓	✓	
Improve access to appropriate Diabetes Care and education for participants from the Samaritan Geary Street Clinic.	At least 200 participants referred to class and from those 60% will complete the class	✓	✓	By 12/2023
	60% of participants will complete recommended Diabetes follow up care with their PCP or Diabetes educator or specialist	✓	✓	
Demonstrate improved participant understanding of diabetes, by education provided in a culturally appropriate manner and language.	Post Knowledge Assessment Survey improved by 30% from baseline (Pre knowledge assessment)	✓	✓	By 12/2023
Improve Diabetes Care Gaps and prevent complications from Diabetes for the participants from Samaritan Geary Street Clinic.	90% of participants will have all Diabetes Care Gaps addressed at follow up	✓	✓	By 12/2023
	60% of participants will complete Diabetes Care recommended labs	✓	✓	
	60% of participants will complete preventive and maintenance care, including foot exam, Eye exam and Oral health exam	✓	✓	

3. Budget Worksheet

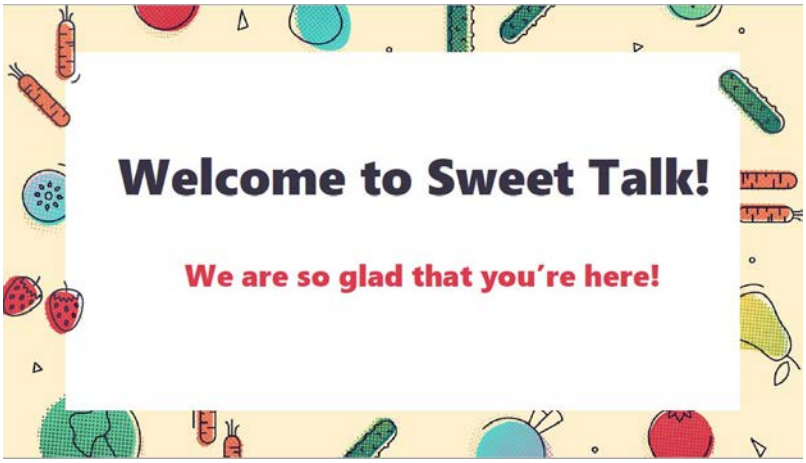
Pilot: *Conversación Dulce/Sweet Talk*

Pilot Start Date:	**12/1/2022**	**Pilot End Date:**	**12/1/2024**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Implementation Development		$2,000.00	$2,000.00
Evaluation development		$1,500.00	$1,500.00
Data Entry		$400.00	$400.00
Statistical Analysis/report generation		$5,000.00	$5,000.00
	Subtotal Resource Costs	**$8,900.00**	**$8,900.00**
Materials & Supplies			
Tablets (15 EN and 15 Spanish)		$9,000.00	$9,000.00
Teaching Materials		$2,500.00	$2,500.00
"Sweet Talk" Content and Coding (GNE contribution to project)		$0.00	$75,000.00
	Subtotal Materials & Supplies	**$11,500.00**	**$86,500.00**
Travel Expenses			
None		$0.00	$0.00
	Subtotal Travel Expenses	**$0.00**	**$0.00**
Meeting Expenses			
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Coaches Training (10 coaches)		$3,000.00	$3,000.00
Participant Incentives (500 participants)		$12,500.00	$12,500.00
CHW training (above salary)		$1,000.00	$0.00
CHW ADCES7 Self-Care Behaviors™ Training		$500.00	$0.00
	Subtotal Training & Development	**$17,000.00**	**$15,500.00**
Other Budget Items			
CHW Salary		$60,000.00	$60,000.00
Coaches Stipends (80 classes, 3 hours, $25/hr, 2 coaces/class)		$12,000.00	$12,000.00
	Subtotal Other	**$72,000.00**	**$72,000.00**
Total Direct Costs	**Rate (%)**	**$109,400.00**	**$182,900.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	6.00%	$6,534.00	$11,034.00
Total Project Budget		**$115,934.00**	**$193,934.00**

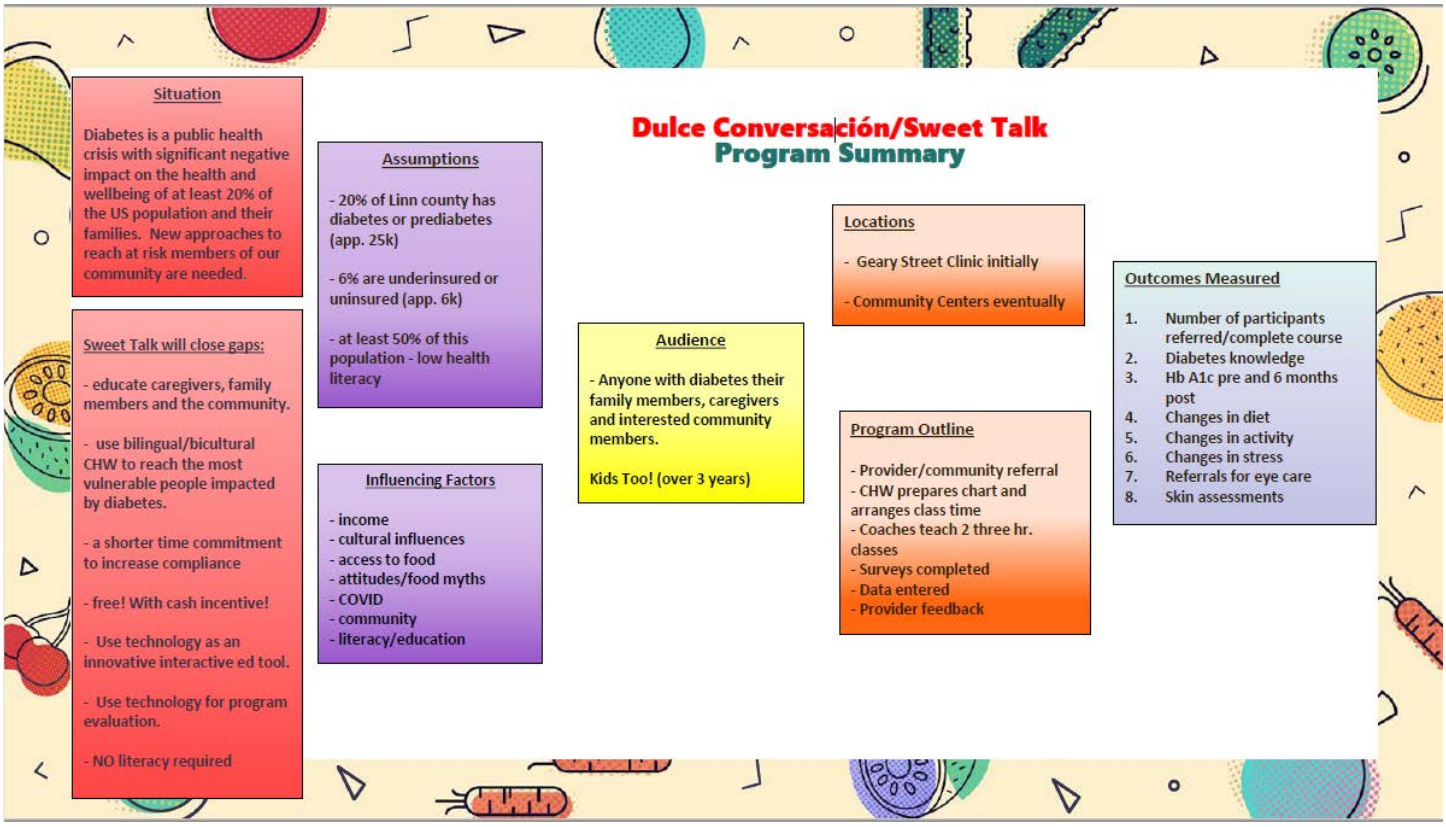
*if amount requested is different from total cost, please describe the source of the additional funds in the narrative.

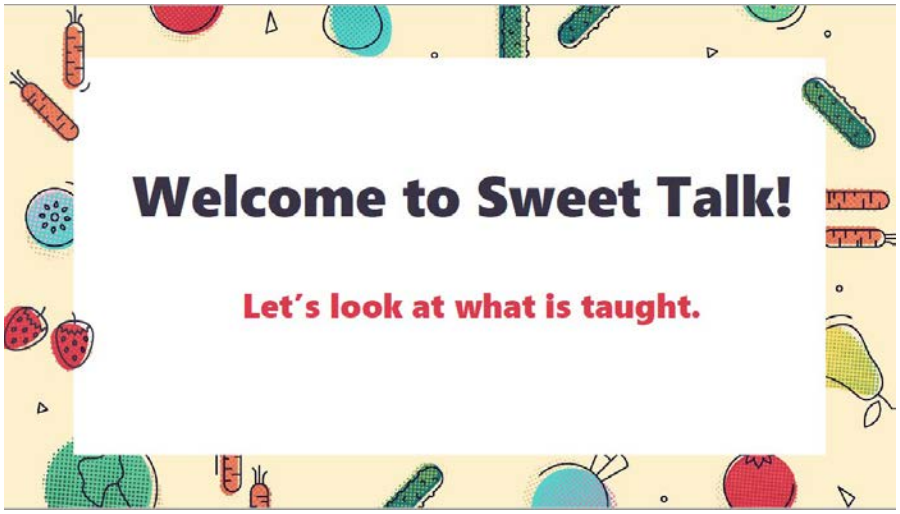
References

1. ADCES American Association of Diabetes Care and Education Specialists: The 7 Self-Care Behaviors
   ADCES7 Self-Care Behaviors Online Course (diabeteseducator.org)
2. ADCES American Association of Diabetes Care and Education Specialists: Diabetes Care and Education
   Diabetes Care and Education (diabeteseducator.org)
3. CDC Diabetes Prevention Program
   https://www.cdc.gov/diabetes/prevention/details-about-the-program.html
4. CDC Hispanic Health
   Hispanic Health | VitalSigns | CDC
5. Oregon Healthy Teens Survey 2017
6. Linn County Oregon website.
   https://www.census.gov/quickfacts/linncountyoregon
7. Global Nutrition Empowerment information. Unpublished.
8. Emerging Practices in Diabetes Prevention and Control: Engaging Commuity Health Workers in Diabetes Self-Management Education Programs.
   https://www.cdc.gov/diabetes/pdfs/programs/stateandlocal/emerging_practices-chw.pdf
9. Quality Improvement Targeting Diabetes Metrics Toolkit.
   https://www.oregon.gov/oha/HPA/dsi-tc/Documents/Diabetes-Metrics-Toolkit.pdf

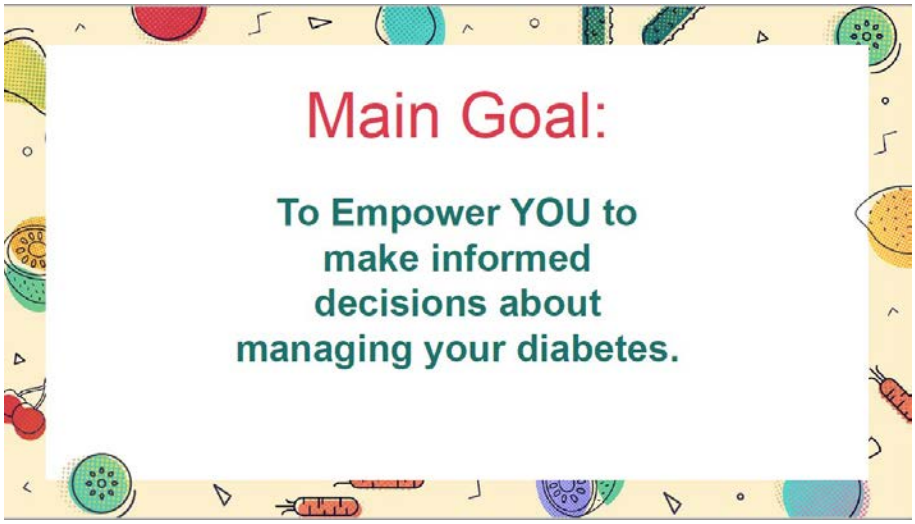

Welcome to Sweet Talk!
We are so glad that you're here!


Bienvenidos de nuevo a
Dulce Conversación

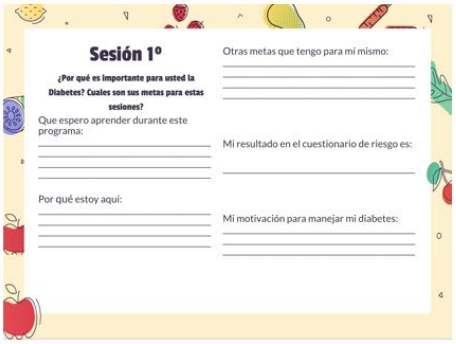

Dulce Conversación/Sweet Talk
Program Summary
Situation
Diabetes is a public health crisis with significant negative impact on the health and wellbeing of at least 20% of the US population and their families. New approaches to reach at risk members of our community are needed.
Assumptions
- 20% of Linn county has diabetes or prediabetes (app. 25k)
- 6% are underinsured or uninsured (app. 6k)
- at least 50% of this population - low health literacy
Locations
- Geary Street Clinic initially
- Community Centers eventually
Outcomes Measured
1. Number of participants referred/complete course
2. Diabetes knowledge
3. Hb A1c pre and 6 months post
4. Changes in diet
5. Changes in activity
6. Changes in stress
7. Referrals for eye care
8. Skin assessments
Sweet Talk will close gaps:
- educate caregivers, family members and the community.
- use bilingual/bicultural CHW to reach the most vulnerable people impacted by diabetes.
- a shorter time commitment to increase compliance
- free! With cash incentive!
- Use technology as an innovative interactive ed tool.
- Use technology for program evaluation.
- NO literacy required
Audience
- Anyone with diabetes their family members, caregivers and interested community members.
Kids Too! (over 3 years)
Influencing Factors
- income
- cultural influences
- access to food
- attitudes/food myths
- COVID
- community
- literacy/education
Program Outline
- Provider/community referral
- CHW prepares chart and arranges class time
- Coaches teach 2 three hr. classes
- Surveys completed
- Data entered
- Provider feedback

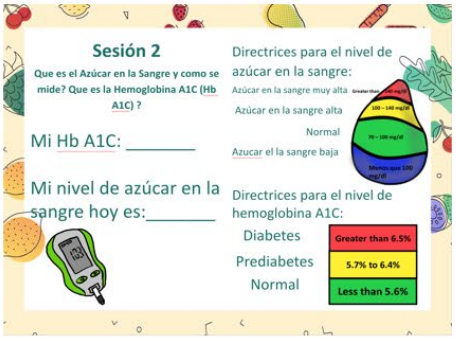

Welcome to Sweet Talk!
Let's look at what is taught.

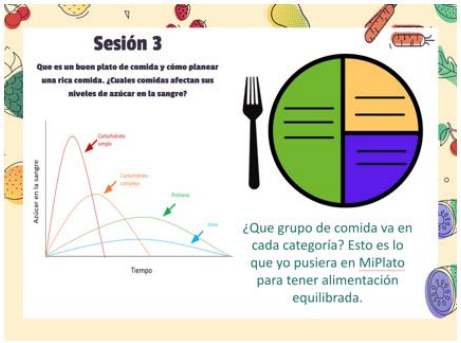

You are invited to:
"Sweet Talk"
a diabetes education class
The fun way to understand diabetes
Call: 541-812-4059
Email: diabetes@globalnutritionempowerment.org

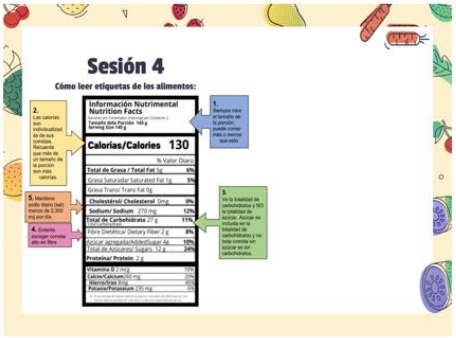

Main Goal:
To Empower YOU to
make informed
decisions about
managing your diabetes.

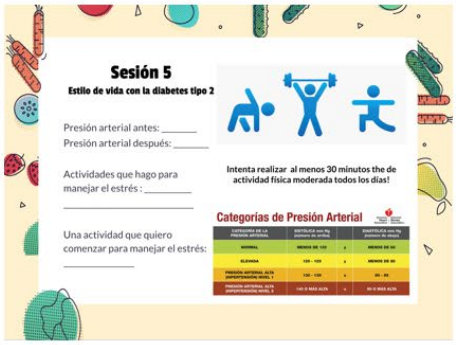
Six one-hour Session. Two 3-hour classes



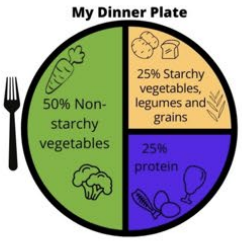


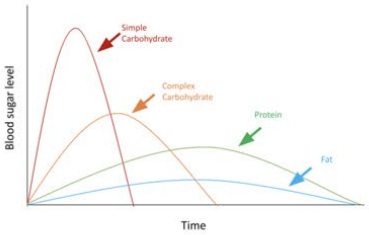


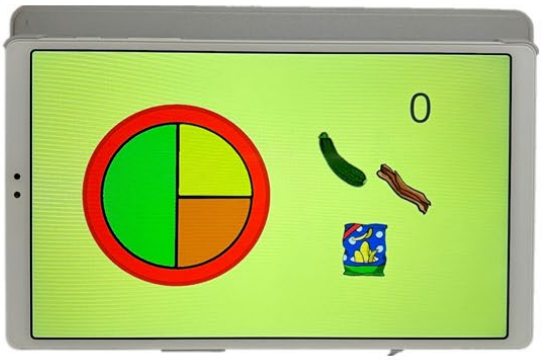




“Sweet Talk” Interactive Activities







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This program was *designed* to be innovative, community based and sustainable. It is accessible to all learners independent of literacy. It is available to family members, children, and those with prediabetes as well as conventional diabetic patients.

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Questions?


BH + A&D
Legal
FAC
Outreach
Partners
Services
Community
(L3C)

FAC Wellness Care Team

Backbone Organization: Family Assistance & Resource Center Group

Billing Address: P.O. Box 714

Site(s): Albany, East Linn County (Lebanon, Sweet Home)

County(s): Linn

Priority Areas:

- Addressing trauma, including environmental
- Post-pandemic cultural trauma
- Reduction of wait times for mental health services
- Toxic stress
- Addressing technology disparities
- Developing a bilingual and bicultural workforce
- Traditional health workers reflective of the communities being served
- Innovative programs supporting housing
- Language access
- Health literacy
- Interpreter services
- Translation of materials
- Oral health integration
- Pay equity through building and sustaining the workforce
- Reengaging the community in personal health and community resources
- Rural community impact
- Disparity in care for rural communities
- Subpopulations of IHN-CCO members that experience health disparities

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

Health Equity:

- Pursuing optimal health for all IHN-CCO Members:
- Addressing and preventing potential health disparities due to age, disability, education, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.
- Meeting people where they are
- Developing trust by transparency of purpose.
- Ensuring ease of access to healthcare for all IHN-CCO Members

Social Determinants of Health

- Recognizing that wellness starts in our homes, schools, workplaces, neighborhoods, and communities
- A commitment to addressing the social determinants of health such as housing, transportation, and access to healthy food

Empowerment

- Sharing ownership of individual, familial, and population health through:
- Holistic coordination between our healthcare providers
- Active individual participation
- Create accountability for clients own health
- Creating healthier communities through effective stewardship of resources by ensuring active community engagement in all aspects of our healthcare delivery system
- Communication, Collaboration, and Coordination is of primary importance for achieving the triple aim of better health and care at lower cost.

Pilot Contacts	Name	Email
Primary	Shirley Byrd	shirleybyrd@facforthehomeless.org
Proposal	Shirley Byrd / Brock Byers	shirleybyrd@facforthehomeless.org brock@facforthehomeless.org
Contracting	Brock Byers	brock@facforthehomeless.org
Financial	Sarah Morris-Carr	Finance@facforthehomeless.org
Reporting	Brock Byers	brock@facforthehomeless.org

Proposal Narrative Executive Summary

For unhoused people there are additional barriers. Recognition of the unmet special health care needs of unhoused people has encouraged the development of special services for them. We must be mindful of the heterogeneous nature of the unhoused population, as well as the Structural violence/racism of the communities. Unhoused people are more susceptible to certain diseases, have greater difficulty getting health care, and are harder to treat than other people, all because they lack a home. Similarly, attempts to provide health and mental health care services, regardless of variations in such areas as history, funding levels, and nature of support, also have certain common elements that simply does not meet their needs. Many arose in response to a crisis rather than developing as part of a well thought out plan. FAC will bring services to unhoused people rather than waiting for them to come in to less than accommodating inflexible and not mindful solutions.

Family Assistance & Resource Center Group (FAC) is putting in place a specialized wrap around care team of professionals and peers that will address health disparities in our rural unsheltered/homeless population. This team will provide individualized care to treat the whole person (mentally, physically and emotionally) through street outreach and in-reach at the FAC micro shelter and navigation site.

It is FAC's unique mission to establish trust and inspire hope by providing access to resources, services, and education to those who are experiencing homelessness and housing instability. For the last 4 years we provided Linn County's only mobile crisis intervention unit that responds to non-criminal situations that instills trust, provides partner connection, survival supplies, education, and transport to services as needed. Our Harm Reduction Program, unique to East Linn County, reaches clients who normally do not access street outreach services. Later this quarter FAC will be completing East Linn County's first 24-hour Managed Micro Shelter and Community Resource Facility, providing 30 low barrier micro shelters.

Homelessness is a growing problem in our area; the point-in-time counts nearly doubled in the last Few years in East Linn County's unsheltered population; to ~100-150 individuals which equates to approximately 2000-3000 interactions per year. Linn County has over 55% of the IHNCCO membership in the tri county region.

FAC is often a 1st point of contact in building trust and hope with our rural unhoused and unstably housed clients with our outreach program. FAC connects clients to our numerous partners who provide trauma informed medical, housing, treatment and other partner services. With this program we can go further to help this community in need.

There are no other programs like this in East Linn County.

Pilot summary including the overall pilot aims.

This pilot project is unique, a new approach and direction of Street Outreach that will be spread into rural Linn County. This is **Transformational,** there are no other street outreach/low barrier shelter care teams in Linn County. The care team will be made up of a individuals with specialized skills to go beyond traditional street outreach to provide behavior, A&D help, harm reduction and advocacy (Dr., nurse, behavioral health specialist, a social worker, a Harm Reduction specialist, peer counselor, and an outreach worker) This team will provide a holistic approach to outreach and in-reach unhoused health services.

The rural model of this extension will include Linn County's only mobile unit that can move through large rural areas to reach people who are less likely to seek out medical resources on their own. This will increase the number of people served in Linn County.

Pilot Description

Transformational: This pilot will be transformative and creates opportunities for innovation and new learning.

This pilot is transformational because it is the first mobile wellness care team to provide outreach in Linn County. More than 80% of existing clients suffer from TBI and require special engagement and advocacy care. Fentanyl poisoning is up over 400% in the last year and growing which makes the Harm reduction/behavioral health focus critical to saving lives. This project will also provide opportunities for traditional health care workers to train on the streets. This program will result in a reduction of costly emergency services.

Health Equity: This pilot has a defined approach for fair opportunities for members to be as healthy as possible.

Homelessness is toxic stress Toxic stress can alter how the brain and body respond to and process stress. It can damage executive function, memory, learning and social information processing. According to Healthcare for the Homeless 50-80% unhoused individuals have a traumatic brain injury (TBI) which is 10 times the rate of normal housed population. Emergency rooms are the only healthcare they are able to access. This is a pervasive and under recognized public health problem. Homelessness can exacerbate mental illness and prevent chronic physical health conditions from being addressed.

Unhoused individuals often do not seek help until late in the course of their illness, so the opportunity to intervene early in the course of the illness or injury is lost. The wellness care street outreach health checks we can reduce costly emergency services.

Medical care is often sought only at an advanced stage of disease when it requires more extensive and expensive treatment.

Clients also experience high levels of traumatic life experience and negative experiences with health services that do not comprehend or adapt to their specific needs. The standard medical model does not meet this need.

Rural America experiences many inequities compared to the nation as a whole. Often rural residents have fewer resources and, on average, are poorer and less educated. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities.

Health Improvement: This pilot holds promise for making a significant improvement in the health or health care of members.

This pilot will bring a team of medical professionals that provide trauma informed care through non-traditional healthcare workers for outreach/in-reach.

In East Linn County the majority (>75%) of our unhoused population are afflicted by substance use disorder (SUDS). The care teams and Harm Reduction program prevents overdose deaths and delivers services that enable people struggling with alcohol and drug usage to stay alive until they decide to choose recovery. The care team will work closely with partners to deliver warm handoffs for detox and treatment.

FAC is partnering with Linn County Health to provide the only street outreach harm reduction services.

The program provides combined medical and social interventions on the street/shelter and community. Rather than treat isolated health problems without considering the person's social or environmental situation, this program provides care that recognizes the interaction between the illness and the state of being homeless improving health and wellbeing.

Improved Access: The pilot activities will result in improved access of healthcare; availability of services, culturally considerate care, and quality and appropriate care.

The wellness care team will provide immediate individualized response and access to health care for people living on the streets. Racial and gender equity is no longer optional it is imperative.

FAC Wellness care team values diversity, equity, and inclusion in every aspect of our work, including internal and external activities to support our mission. We are committed to cultivating a culture of respect for the dignity and value of everyone. We welcome all, regardless of race, ethnicity, gender identity or expression, sexual orientation, age, veteran status, national origin, disability, household composition, housing status and/or belief system. These values are essential to provide fair treatment, access, opportunity, and advancement for all people, while at the same time eliminate barriers that have prevented the full participation of some groups who are unhoused or at risk of losing their homes.

FAC provides life solutions utilizing a trauma informed approach to individual needs. We serve with understanding, acceptance, kindness and respect for all. Through shared understanding, respect, and mutual empowerment, FAC support helps provide the best solution worked out together. FAC's understanding, acceptance, kindness and respect supports the client's personal recovery.

This program will breakdown structural violence implemented by high barrier programs and disjointed services.

Need: There is a substantial need for this pilot and has indicated the demographics of the Medicaid population impacted.

Sweet Home Emergency Police Services Quarter 1

	2021	2020		
Domestic Violence/Dispute Calls	125	105	19%	
Child Abuse(Physical/Sexual)	123	86	43%	
Suicidal Calls	31	13	138%	
Mental Health Calls	120	31	287%	1Q22 calls at 92!
Burglary (A&D increases this)	5	8	-37%	

Our proposed pilot will target considerations from this focus group and FAC mission.

Linn Local Advisory Committee recommendations

- Social Determinants of Health
- Health equity
- Opioids/pain management
- Access across all systems (technology, # of providers, etc.)
- Severe and persistent mental illness
- Rural communities
- Communicable disease
- Provider supports (burn out, respite training)
- Respite care (family and other care providers)
- Communication, connectivity, collaboration between clinical and social services and law enforcement and emergency preparedness, closed-loop referral.

FAC facts and focus a look into East Linn county:

- Lack of Linn County employment and employment programs
- Underserved marginalized LBGTQ/BIPOC community
- Covid made it difficult for rural unhoused clients access to care. The traditional medical model does reach the clients that need it the most.
- Linn county is facing a severe increase in substance usage and drug overdoses
- Traditional services do not reach the homeless or unhoused, community doesn't know how to find unless helped and clients mistrust traditional methods and solutions. (Structural violence from the legal and medical community)
- Future Reduction in behavioral health services, Linn County Mental health will only address the most severe cases of ongoing persistent chronic mental illness
- Emergency services experience substantial increases in mental health and health calls
- Increase in homelessness due to economics, FAC has seen a substantial increase in eviction and recently unhoused individuals over 50 years old.
- FAC addressed COVID trauma by providing a micro shelter solution rather than a congregate shelter to decrease compound trauma.
- Unhoused individuals with brain injuries including mental illness require step by step guidance. People with behavioral health issues in supportive housing use costly systems (emergency health services) less frequently and are less likely to be incarcerated. (Getting people with mental health issues off the streets is imperative)

Outcomes: Proposal outcomes and measures are aligned to pilot goals. This pilot yields measurable outcomes that are new or different. Our pilot outcomes are aligned with the Community Health Improvement Plan's Outcomes and Indicator Concepts.

The enormous economic costs of hospital care for people who are unhoused can be reduced when housing and other social determinants are considered. In Linn County in 2018 there were 125 hospitalizations from overdose in 2021 there were over 300 in the first 6 months. The average emergency room visit can be reduced by as much as a million dollars through the reduction of emergency transport and emergency room usage for drug overdoses alone. FAC has provided Narcan/Naloxone to save over 250 souls reversing overdoses.

Cost avoidance scenario below:

~Cost of transport and emergency room visit scenario (~$1.1M)	
250 clients utilize $1000 Emergency transport	$250K
188 clients utilize ~$1000 emergency visit and release	$125K
59 clients ~11,000 Emergency visit and short stay.	$649K
3 clients ~20,000 Emergency visit and ICU	$60K

This FAC pilot will provide combined medical and social interventions on the street to the shelter and to the clients will provide desired outcomes that results in durable social stabilization and engagement with long-term partners, which results in dramatic falls in hospital healthcare improved patient health and wellbeing. Other benefits below.

- Create a sense of community and belonging.
- Increase opportunities for dental care
- Creation FAC Wellness Care Team for in-reach and outreach
- Treat Physical health through non-traditional health care methods
- Reduce Mental health disparities by providing in the moment crisis intervention and follow up plans
- Save lives through Harm Reduction
- FAC will be able to provide close monitoring of individual care plans
- Relieve compound trauma through all-in-one treatment group and plan
- Increase the number of individuals with SUDS into recovery
- Increase entrance into long term housing
- Increase entrance into work programs

Total Cost of Care: This pilot will result in improvement in the total cost of care for members. The pilot targets areas of health care associated with rising costs or provides upstream healthcare that will reduce costs long-term.

Homelessness is associated with enormous health inequalities, including shorter life expectancy, higher morbidity and greater usage emergency services.

Funding support programs like this pilot should be considered as cost cutting measures rather than expenditure. The potential savings multiply more than fivefold when the financial impact of homelessness is examined across the many government services used heavily by homeless people. Taking more pragmatic and informed approaches and using evidence-based interventions such as street outreach and integrated medical and social care for homeless patients not only improve lives but also reduces ineffective, futile hospital and public service spending.

Resource Investment: The budget is reasonable and appropriate to the work proposed. It is well justified and directly tied to the pilot goals. The pilot has exhibited consideration for other funding sources.

Pilot: FAC Wellness Care Team			
Pilot Start Date:	**1/1/2023**	**Pilot End Date:**	**12/31/2023**
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Wellness care team (Doctor, Nurse, SUDS, Behavior Health, Peer Mental Health/A&D Specialists, Social Worker, Case Manager, CHW, Harm Reduction, Outreach Health Worker, Activites Coord, Dental)		$287,600.00	$150,000.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Resource Costs		**$287,600.00**	**$150,000.00**
Materials & Supplies			
Medical/hygiene, equipment,		$27,800.00	$20,000.00
Food		$44,800.00	$0.00
		$0.00	$0.00
Subtotal Materials & Supplies		**$72,600.00**	**$20,000.00**
Travel Expenses			
Client transportation to appointments		$6,400.00	$6,400.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Travel Expenses		**$6,400.00**	**$6,400.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Meeting Expenses		**$0.00**	**$0.00**
Professional Training & Development			
Training and development for staff, clients, community(Trauma informed care, Mental Health First Aid, Harm reduction, Outreach Training, Servicepoint, CHW)		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Training & Development		**$5,000.00**	**$5,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Other		**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$371,600.00**	**$181,400.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$55,740.00	$27,210.00
Total Project Budget		**$427,340.00**	**$208,610.00**
*if amount requested is different from total cost, please describe the source of the additional funds in the narrative.			

Donations: ~ $185K

- United Way: $15K
- Oregon Community Foundation: $30K
- City of Sweet Home: $40K
- Oregon Saves Lives: ~$50K
- Possible Private Donor: ~$50K

Priority Areas: This pilot has a new or innovative way to address one or more priority areas.

Access to Healthcare

- A1
  - a-A member of the wellness team can sign people up for OHP, while on the street or at the navigation center, and connect them to a provider in the moment.
  - b-The team will decrease time to see a provider by providing navigation assistance, appointment reminders, and being able to access service needs where the person is.
  - c-A behavioral health specialist on hand will help people through trauma with counseling, setting goals, and connection with long term treatment.
  - d-The wellness team will host dental events, at least once a quarter, partnered with Benton County Health Services Dental Outreach.
- A2
  - a-The wellness team will use trauma informed care and harm reduction techniques to communicate and advocate for clients. FAC is actively seeking a bilingual outreach team member and partners to help communicate with Spanish speaking clients. Language Line is used for interpretation services on the street. The outreach team believes in client autonomy and has a “Not about me, without me” lived experience perspective.
- A3
  - c-With a community approach to dental care events it will increase accessibility to care in patients with diabetes in East Linn County.

Behavioral Health

- BH1
  - a-Trauma informed care training is being offered regularly to the public through social media and word of mouth. With a behavioral health expert on the team classes will be offered at the navigation center to the community.
  - b-A peer counselor is one of the roles in a wellness team and lived experience is a valued skill.
- BH2
  - a-The behavioral health specialist will use OPAL-A for warm handoffs to care providers. Other team members will use OPAL-A to access behavioral health care advice and providers when the bh specialist is unavailable.
- BH3
  - a-The behavioral health specialist will do mental health screening, intervention, and warm handoffs to long term therapy providers.

    - b-Suicide prevention training will be taken by all staff. A behavioral health specialist will do crisis intervention and address individuals needs at the time. A peer counselor will provide support through trying times.
    - c-Overdose rates in Linn County have skyrocketed in the last year, as they have across the nation. The wellness team has a harm reduction worker to educate on safe usage, and treatment options. Harm reduction will also hand out supplies like Narcan to increase the number of lives saved.
- BH4
    - Linn County is experiencing a mental health care crisis. A huge gap in mental health services is evident in East Linn County. Clients are going without prescribed medication due to health status, ongoing mental health symptoms, transportation, and lack of available treatment and providers. The behavioral health specialist will provide access to crisis intervention and create a plan for long term treatment with individual options to ensure autonomy.
- BH5
    - Stigma is legal discrimination. The wellness team will treat everyone with trauma informed care and non-judgmental understanding. This will include peer support and advocacy. A case manager will help to make appropriate health appointments, with reminders and transportation. All services must be voluntary. With assertive support services that will continue to show up and check in the client/guest will have an option to engage in services at any time.
- BH6
    - The behavioral health specialist and case manager will ensure that clients/guests are treated holistically, with mental health issues addressed with the same importance as physical and oral health.

Healthy Living

- HL1
    - Working closely with people who suffer from mental health difficulties and substance use disorders can be very helpful in helping them manage their health. A case manager will help them set and monitor reachable goals. The sleep center will be invaluable for unsheltered guests to have a safe, 24-hour managed site to get appropriate rest. Sleeping on the streets is often criminalized by authorities so it is constantly interrupted. Clients are often victimized while sleeping unsheltered. The community navigation center will encourage access to health resources and education in East Linn County.
- HL2
    - b-A harm reduction partner with Linn County will be available to teach smoking cessation tools.

- c-A harm reduction partner with Linn County will be available to test for HIV, AIDS, and Hep C. They will give a warm handoff to partner providers who offer treatment services.

This pilot is innovative because it is one of a kind in the Linn County area. The combination of micro shelter in-reach and mobile street outreach brings critical care to the clients that need this type of care most. The program allows for more privacy and safety while serving an at-risk population. This program will also provide a spectrum of resources to all east Linn community members. FAC brings the homeless population, unstably housed population and the housed population together to provide a greater sense of community.

Financial Sustainability: This pilot has a sustainability plan including continued funding and new reimbursement models.
With great partners like the City of Sweet Home, Linn County Health and others, we plan on contracts and investments being part of the sustainability of this proposal. We also have community, private and corporate donors as well as giving partners. We will seek out new grant opportunities. Internal fundraising will also be used. New community awareness will help us develop and grow partnership opportunities.

Replicability: The pilot has a clearly defined plan to spread lessons learned to new organizations or regions such as rural or urban or a new county in the IHN-CCO community.

This pilot can be reproduced in other counties to better serve their marginalized populations, especially in rural areas where people are more spread out, are harder to reach and have higher levels of poverty. Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, poverty, higher rates of health risk behaviors, limited access to healthcare specialists and subspecialists, and limited job opportunities.

Among the impacts of poverty on health is the barrier it creates in paying for healthcare services and meeting basic living needs, such as food and shelter, that are necessary to be healthy. Poverty also exerts an influence over health in the stress it causes. Poverty is associated with greater perceived discrimination, which in turn is associated with worse health outcomes.

Other organizations that have an interest in this pilot are Linn County Public Health Harm Reduction program. They provide education to high-risk populations, HIV testing, advocate for entry into drug treatment and reduced drug use. A&D as well as behavioral health which reduces the need for crisis intervention and the use of emergency services. Samaritan Health Services whom we partner with in outreach services and the mobile medical unit. CSC that provides access to housing assistance. St. Martin's church outreach services who partner with us in providing outreach and hygiene services. Oxford House/hope center and enterprise services housing programs for housing options. Safe Haven helps to serve and treat unhoused pets.

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

- Improve acceptance and inclusion to reduce stigmas
- Create a sense of community and belonging.
- Create and setup FAC Wellness Care Team
- Treat Physical health through non-traditional health care methods
- Reduce Mental health disparities by providing in the moment crisis intervention and follow up plans
- Save lives through Harm Reduction
- Relieve compound trauma through all-in-one treatment group and plan
- Increase the number of individuals with SUDS into recovery
- Increase entrance into long term housing

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
# of individuals Contacted # Interactions	At first contact with target population	120 / 3500	12/31/2022
# of individuals Referred to partners	At time of intake/ enrollment or first receipt of program service	100%	12/31/2022
#/% of unhoused individuals that receive a care plan	At time of Intake, May include assessments of life skills, self-sufficiency, education/training needs, substance abuse problems, mental health status, housing needs, and physical health	45	12/31/2022
#/% of unhoused individuals that receive one or more partner services	Partner services include: Housing Assistance Health Assistance (Substance Abuse/Mental Health Treatment, Harm Reduction, Dental SVS) Other Assistance (advocacy, education, ID, Transportation, OHP)	120/75%	12/31/2022
#/% of unhoused individuals whose housing condition is upgraded	3, 6, and/or 12 months after point of enrollment At exit Upgrade categories: Street Emergency Shelter Transitional Housing Permanent Housing	45	12/31/2022
#/% of Homeless Individuals Employed	3, 6, and/or 12 months after point of enrollment At exit	15	12/31/2022
Number Harn Reduction delivered	3, 6, and/or 12 months after point of enrollment At exit	500	12/31/2022
# Reduce overdose deaths	Units of Narcan/Nalaxone used	200	12/31/2022
#/% Reduction of Emergency Service requests/calls	3, 6, and/or 12 months after point of enrollment At exit	25%	12/31/2022

Target population: ensure the IHN-CCO population is specifically addressed in terms of numbers of members expected to be served and the percentage of clients that are IHN-CCO members
Our target population is people experiencing homelessness in Linn County. There are currently 327 self-reported people experiencing homelessness in Linn County according to the 2020 PIT count.

As of 2017 approximately 71,000 IHN-CCO Members were served by IHN-CCO each year, 37,200 live in Linn County. Linn county had 55% of IHN-CCO members. 64% of those members are over 18 years old. - IHN-CCO Members by County Source: Oregon Health Authority

We have found through our std street outreach services majority of the clients are members of IHN-CCO (88%). We continue to facilitate enrollment and will plan with this effort to directly enroll clients (a past outreach service provided by Linn County Health)

Describe the intervention and detailed activities, including an environmental scan of similar projects in the region.

FAC will operate an interdisciplinary street outreach team comprised of mental health and substance use disorder professionals, medical clinicians, peer support specialists, and community health workers that will create a life plan for each client engaged in outreach services.
Respond to outreach requests from 211, other governmental and human service organizations (e.g. Police, EMS), neighborhood residents, businesses, clients, or other sources.

We plan to take on several partnership grant opportunities currently held by other agencies and require our services to fulfil street outreach/Harm Reduction grantee requirements, to engage clients who had been working with those providers and ensure continuity of care.

Activities include:

Engagement
• Assertively establishing a trust-based relationship with the community in need to engage them in services.

Demonstrating non-judgmental unconditional positive regard toward individuals to facilitate an authentic connection.
• Using motivational interviewing, harm reduction, and other evidence-based practices to improve individual and family health and well-being.

Assessments and Service Planning

• Assessing each client's needs in all life domains, with particular focus on health and safety, mental health, substance use, housing, and social needs.
• Creating and implementing an Individualized Service Plan with each enrolled client that is strengths-based and driven by client choice. Interventions
• Providing support with benefits, eligibility, applications, and troubleshooting.
• Helping to build or rebuild clients' family, social, and community connections.

Providing housing support including:
o An eligibility assessment for every type of housing (including market rate housing),
o A Coordinated Access assessment and navigation services for each client experiencing homelessness,
o In-person support as needed at every stage of the application process, o Assistance locating a unit in a community of choice with an emphasis on high-opportunity communities,

o Move-in support
o Facilitation of a safe transition to community-based health care.

Crisis Intervention/Mental Health First Aid
o Motivational Interviewing o Harm Reduction (Naloxone Distribution, Overdose Education, Water Distribution, STD/STI testing, etc.)
o Health Education (management of chronic conditions, TB, etc.)
o Recovery Planning
o Medical consultation and wound care
• Provide transportation to appointments, a warm hand-off to health and behavioral health providers, and remain engaged in each client's care plan until the client's needs are met by other care provider(s).
-perform critical tasks related to getting people to safety, engaging vulnerable people in safety planning, and helping ensure access to food, shelter, and partner services.

Community Relations
• Establishing relationships with business districts, neighborhood associations, hospitals, service providers, and other groups that can help identify persons in need of services.
• Communicating the purpose, process, and value of outreach to constituents and stakeholders. Policy and Systems Improvement
• Providing leadership, data, analysis, and recommendations to initiatives seeking to reduce street homelessness and related health and social conditions.
• Providing expertise related to street outreach on relevant committees.
• Participate in severe weather, natural disaster, and emergency-related planning, implementation, and response related to the unsheltered population.

Partners that will be working on the pilot and the tasks they will undertake:

Partner	Task	IMPACTED STRATEGY	SDOH
Samaritan Health Services Miranda Miller, Director of Primary Care (Corvallis) – mmiller@samhealth.org	• Case mgmt. • Coordinated care • Aftercare mgmt. • Client Contact • Advocacy	Transformational Health Equity Health Improvement Improve Access	SD4
Homeless Outreach Project Wendie Wunderwald, VP Patient Services wwundere@samhealth.org	• Advocacy • Education	Transformational Health Equity Improve Access	SD4
Linn County Health	• Telehealth • Behavioral Health	Transformational	SD4

Todd Noble, Linn County Health Administrator tnoble@co.linn.or.us	• Harm reduction • Education • HIV testing	Health Equity Health Improvement Improve Access	
Lebanon Alcohol and Drug Treatment center	• A&D Counseling • A&D Housing	Transformational Health Equity Health Improvement Improve Access	SD1 SD4
Community Service Consortium (Housing) Pegge Mcguire, Director – pmcguire@communityservices.us	• Housing • Rent Assistance	Transformational Health Equity Health Improvement Improve Access	SD1 SD3 SD4
Oxford House Housing (Housing) Mike Davis – Director - **voltagemd@comcast.net**	• A&D Housing	Transformational Health Equity Health Improvement Improve Access	SD1 SD4
Linn County Commissioner's Will Tucker – Commissioner **wtucker@co.linn.org.us**	• Liaison to State • Covid Testing Linkage • Advocacy & Support	Transformational Health Equity Health Improvement Improve Access	SD1 SD4
City Of Sweet Home (Community partner) Lagea Mull, Public Information Office – **lmull@sweethomeor.gov**	• Advocacy and Support • Case mgmt. • Outreach communications	Transformational Health Equity	SD2 SD4

	•	Health Improvement Improve Access	
City Of Lebanon (Community Partner) Paul Aziz	• Advocacy and Support	Transformational Health Equity Health Improvement Improve Access	SD4
City Of Albany (Community partner) Sharon Konopa, Mayor - Sharon.konopa@cityofalbany.net	• Advocacy and Support	Transformational Health Equity Health Improvement Improve Access	SD4
Live Longer Lebanon (Community partner) Deb Fel Carlson, Co-Lead debfelcarlson@gmail.com	• Linkages partner • Advocacy and Support •	Transformational Health Equity Health Improvement Improve Access	SD1 SD2 SD3 SD4
Welcome Center for Lebanon Community School District (Community partner, education) Julie Miller, Community liaison	• Advocacy and Support • Food Program • Sharing partnership • Clothing	Transformational	SD3 SD4
United Way (Community Partner) Chantell Schaumburg Director of Operations **chantell@uwlbl.org**	• Giving partner • Covid Relief Funding • Education • Marketing	Health Equity	SD4
Safe Haven (Partner) Katie Bateman Safehaven Outreach Coordinator humaneed@safehavenhumane.com	• Pet food • Pet service • Supplies • Education	Health Improvement	SD2 SD4

Advantage Dental (Partner) Rachael Gazeley Partner **rachelg@advantagedental.com**	• Giving Partner • Dental packages • Education	Improve Access	SD4
Faith Community Nursing Deb Fell Carlson 541-248-0595 **debfellcarlson@gmail.com**	• Spiritual Health Consult • Outreach Partner	Transformational	SD4
Lebanon Area Mental Health Alliance Corp David Butler 541-936-2580	• Referral • Education • Behavioral Health Support • Suicide Prevention	Health Equity	SD4
Adult Services Team Jeffery	• Continuity of care • Case Mgmt • Referrals	Health Improvement	SD1 SD2 SD3 SD4
CSC Veteran Services Scottie Mckee 971-701-1234	• Support and Advocacy • Outreach Partner • Referral	Improve Access	SD1 SD4
St. Martins Sara Jameson **SaraeJameson@gmail.com**	• Outreach Partner • Support and Advocacy • Emergency toilets	Transformational	SD2 SD3 SD4
Keitha's Kitty Rescue Keitha	• Giving Partner • Support	Health Equity	SD4
Hanes Brands Inc Winston NC	• Giving Partner • Marketing • Clothing • Covid Masks	Transformational	SD4
Bombas Inc New York New York	• Giving Partner • Marketing • Clothing	Health Equity	SD4
Big 5 Sporting Goods Albany Oregon	• Giving Partner • Marketing • Survival consultation • Community support	Health Improvement	SD4
Dutch Brothers Coffee Albany, Lebanon, Sweet Home	• Giving Partner • Promotional	Improve Access	SD4

The project "FAC Wellness Care Team", in a strong partnership with the City of Sweet Home, provides a needed low barrier medical focused outreach solution. It strengthens collaboration and access between related social service agencies, Lebanon Samaritan Health Services and Linn Co. Public Health in the Linn County area.

Depth of Support: FAC has a clear and strong depth of sponsoring organization support as well as community backing.

This program will include many **new** partners community, health, and resource solutions.

- City of Sweet Home
- Sweet Home police liaison officer
- Linn County Harm reduction
- Linn County alcohol and Drug
- Benton County Health services
- Exodus counseling
- Hope Center Women's Shelter
- FAC Sleep Center
- Mana Soup Kitchen
- Lebanon Community Pool
- Western University Medical School Outreach team
- OregonSavesLives
- Language Line
- National Healthcare for the Homeless

- City of Sweet Home – We have a MOU with the city in which the city provides a building for a navigation center to be moved on to the property and site preparations – clearing, laying power and water lines to the building, gravel, and fencing. The city will also provide nighttime security for the site to provide for 24-hour management.
- Linn County – Deeded 3 acres of land for the site to FAC. They will also provide a person, for support people with SUDS, to come out to the site weekly. Linn County will be offering an occupational opportunity to shelter guests at the future nearby County owned RV dump Station as a work program.
- Mana – The local soup kitchen at the Methodist church, Manna, will provide and deliver 2 meals per day to the guests staying on the site.
- Oregon Saves Lives – FAC was given access to the supply clearinghouse to obtain the supplies to perform harm reduction in Linn County up to $50,000 with the possibility of extensions.
- Josh Victor, NW Enterprise – FAC has a verbal agreement for low-cost transitional housing for guests of the shelter.

- Exodus – This local SUDS treatment program has agreed to provide a person to visit the site weekly and provide services at the site.
- Safehaven – This animal shelter will provide pet food and supplies as needed.
- Linn Shuttle -This transportation service has agreed to place a stop near the micro-shelter site.
- Grocery Outlet – Has agreed to provide snack food to have on site.
- Bombas/Hanes – FAC has giving partnerships with both companies to provide socks, t-shirts, masks, and underwear at a value of about $40,000.
- Sun Motel – The motel provides rooms for people in recovery after hospitalizations, the unsheltered elderly and sick, and people who are victims of fire or other disasters for FAC per verbal agreement.
- The National Healthcare for the Homeless group which provides guidance and best practices from around the nation.
- Community Faith Nursing who provides physical healthcare with care plan
- Western University School of Medicine provides on the street assessments and triage
- Linn County Health provides Harm reduction A&D counseling
- Mana is the local soup kitchen that provide meal for the community
- Sunshine industries, housing team that is committed to provide transitional housing
- Hope Center emergency shelter for women and children
- FAC microshelter and navigation

This program builds upon existing collaboration with partners such as Linn County Commissioners, Shem, CSC, Chance, Jackson Street Youth Services and United Way for program information for healthcare access for the homeless and unstably housed.

This pilot will promote health equity and reduce health disparities.
Family Assistance & Resource Center Group values diversity, equity, and inclusion in every aspect of our work, including internal and external activities to support our mission. We are committed to cultivating a culture of respect for the dignity and value of everyone. We welcome all, regardless of race, ethnicity, gender identity or expression, sexual orientation, age, veteran status, national origin, disability, household composition, housing status and/or belief system. These values are essential to provide fair treatment, access, opportunity, and advancement for all people, while at the same time eliminate barriers that have prevented the full participation of some groups who are unhoused or at risk of losing their homes.

FAC provides life solutions utilizing a trauma informed approach to individual needs. We serve with understanding, acceptance, kindness and respect for all. Through shared understanding, respect, and mutual empowerment, FAC support helps provide the best solution worked out together. FAC's understanding, acceptance, kindness and respect supports the client's personal recovery.

Explain the social determinants of health lens the pilot will be incorporating

SD4 Improve health equity in the homeless population

Being homeless is associated with shorter life expectancy [1], higher morbidity and greater usage of acute hospital services [2]. People experiencing homelessness are also less likely to access primary and preventive health services [3] resulting in increased risk for later-stage diagnosis of disease [4], poor control of manageable conditions and hospitalization for preventable conditions.

An accumulation of evidence from around the world shows a strong association between homelessness and health disadvantage and inequity.

Hospital attendance plummeted even in the short term when housing needs were addressed. Treating homelessness as a combined health and social issue is critical to improving the terrible health outcomes of people experiencing homelessness. In addition, the large costs of hospital care for people who are homeless can be reduced when housing and other social determinants are considered.

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

Almost 23.5 million people lived in food deserts in 2019. Nearly 50% of them were also low income. Poverty was associated with greater perceived discrimination, which in turn was associated with worse health measures. Our clients often face discrimination for participating in low-income food programs.

Hunger often proceeds homelessness because people who are forced to choose between paying for housing or groceries will most likely choose housing.

In rural areas access to food may be limited by financial means and other factors like transportation. Rural shoppers are more likely to choose less nutritious food, such as processed foods. Rural homeless are more likely to buy foods from a local convenience store or a fast-food restaurant than a grocery store resulting in lack of nutrition.

FAC will be partnering with Grocery Outlet stores and the Linn-Benton Food Share to ensure clients/guests will have access to healthy meals and snacks including fresh produce. Manna soup kitchen will be providing 2 meals per day per guest at the sleep center.

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

Mobile street outreach transports unstably housed and people experiencing homelessness to county wide resources, legal appointments, and social service agencies.

The population that are our clients do not have a home. The distance traveled varies to public transportation. Our program provides bus tickets locally to make it easier for clients to travel around town.

Clients often request transportation to appointments and resources they are unable to walk to and back from. Although public transportation is available people can only utilize it if they leave their belongings behind because you can only take on the bus what you can carry. This often leads to the loss of their property and a lack in accessing services. The situation causes a transportation gap that the mobile outreach team does fill because we have more room to transport people's belongings.

Another gap we experience is the lack of transportation options for people on medicare.

Family Assistance and Resource Center Group has made it a point to be knowledgeable about available transportation resources.

The team arranges transportation for clients needing to travel for resources, services, and appointments. They do so through bus tickets, gas cards, and a team member transport. FAC has arranged to have public transportation stop at the sleep center to make accessing transportation easy.

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

The 2020 Point in Time count showed Linn county's homeless population to be 327 people. The 2019 PIT count showed Oregon has 350 homeless people per 100,000. The national average is 168 per 100,000. Linn county has 229 people per 100,000.

This pilot would reduce the number of evictions by providing and working with housing and legal resources appropriate for the situation. We currently advocate directly for the unstably housed by assisting with paperwork and speaking with landlords.

Our **holistic team approach** will help prepare guests for transitional housing. FAC is partnering with a local housing developer to provide adequate low barrier transitional housing. The team and partners will provide support services through transition to ensure successful long-term housing. FAC has a verbal agreement with a local Sweet Home Motel to provide a room to rent for respite needs, people newly displaced from long term housing, and the elderly with medical needs. The wellness team would be the first point of contact on street outreach. They would be a second point of contact at the sleep center, and a third through transitional housing.

Human services providers will find that working with healthcare providers is an effective way to identify unaddressed needs. Connecting human services to healthcare can help make limited resources go further and leverage the close-knit nature of rural communities. Our case management system and the hub can provide follow through and follow up care assistance. By providing one place for unhoused community members to check in we can work closely with healthcare services and providers to communicate further client needs. Including outreach inside the medical system can help to close any gaps in planning aftercare services and improve the odds of people returning to stable housing.

This pilot programs case management system will allow us to work with partners that focus on SDOH and we can connect clients to social services, such as food, housing, and transportation assistance. Understanding rural cultural values can help to facilitate programs that focus on SDOH. Rural America experiences many inequities compared to the nation as a whole. Often rural residents have fewer individual resources and, on average, are poorer and less educated.

Individuals tasked with portions of the pilot and their roles and experience

We are fortunate to have an experienced Board supporting FAC's mission and vision.

Steve	Middendorff	Pharmacist, Navy Commander Retired
DR. Larry	Horton	Sweet Home Superintendent Retired
Cindy	Hansen	MS RN
Dennis	Stoneman	MS Psychology, Theology
Shirley	Byrd	CHW Homeless advocate Lived experience, RN Retired

FAC organization also runs a emergency micro shelter solution in East Linn County that has an additional sub-board membership consisting of;

DR. Larry	Horton	Sweet Home Superintendent Retired
Anita	Sanchez	Sweet Home City Council Member
Jason	Ogden	Sweet Home City Police Captain
Samuel	Milstein	Sweet Home Ridgeway Health Physician/Owner
Rob	Keene	Sweet Home Business Owner/Engineer
Addam	Reel	Lived Experience / Outreach worker
Scottie	McKee	Veteran Suport Services Dir.

Shirley Byrd – Executive Director retired RN, has formal Harm reduction training also serves on the Mental Health board for Linn County. There is no other Outreach and street outreach individual with more experience.

We have members from Linn County A&D/Mental Health working closely with our team and participate in bringing services to the clients. We also have close ties and partnerships with Community Health Nursing, Gentle Dental and a Non-Profit Dental team that provides services for the community.

Fac's plan is to for a wellness team composed of Doctor, Nurses, behavior health, peer specialists with emphasis on Mental Health/A&D, Social Worker, Case Manager, Community Health Workers, Harm Reduction, Outreach Health Worker, Activites Coord, Dental Group.

How this project fits into our organization's strategic or long-range plans

Behavioral Health - Harm Reduction

People can go without many things but going without a safe and comfortable space to live can be catastrophic for one's general well-being. Homelessness itself can trigger a mental illness or worsen an existing condition, without even considering other factors such as poverty, personal conflicts, death of a loved one, serious medical condition, social isolation and other personal issues.

Rates of drug overdose deaths are rising especially in rural areas, surpassing rates in urban areas. Most overdose deaths occurred in areas, where rescue efforts may fall to others who have limited knowledge of or access to naloxone and overdose follow-up care. Our program trains in understanding differences in illicit drug use, illicit drug use disorders, and drug overdose deaths in urban and rural areas and can respond.

In Linn County in 2018 there were 125 hospitalizations from overdose in 2021 there were over 300 in the first 6 months.

This program includes a Harm Reduction Specialist to help educate drug users on ways to be safer users. Part of outreach is prevention of overdoses through having Narcan available for clients and community. From providing street outreach for the last 4 years we have developed enough trust that clients and community users to feel free in reporting the use of Narcan for overdoses.

Individualized case management screening and client plans would guide clients through A&D education referral and treatment with partners.

Describe how members of the community will hear about your project

FAC is a contributing member of many groups, organizations and partner extensions that have many community touch points. There are community groups such as Live Longer Lebanon, and the East Linn County Cares Coalition, which have extensive community reach. We also have a presence in county and city meetings such as council meetings and community court. We are especial strong in social media, and we will utilize press releases to all local media outlets. Flyers, brochures, and co-branding materials for direct public marketing and information sharing is key. We will also extend marketing, promotional and educational reach through our service partners.

FAC potential risks and how the pilot plans to address them

Difficulty in hiring qualified wellness team resources	There are a lack of skilled resources in this county and some positions may be difficult to fill.

Funding scarcity or delays	We will continue to build corporate relationships and grants to fill needed gaps. We may have to scale down or delay solution tactics. We will prioritize increase internal fundraising to meet that need.
Greater need than pilot sizing to meet higher than planned demand	We will perform case management that will provide sizing details to partners, services and programs. We will explore other program resources and partners to fill gaps and need. Find suboptimal alternatives and innovative solutions to meet need.

Pilot Timeline of major activities and goals.

Sustainability Plan This pilot is innovative, scalable, and transferable.

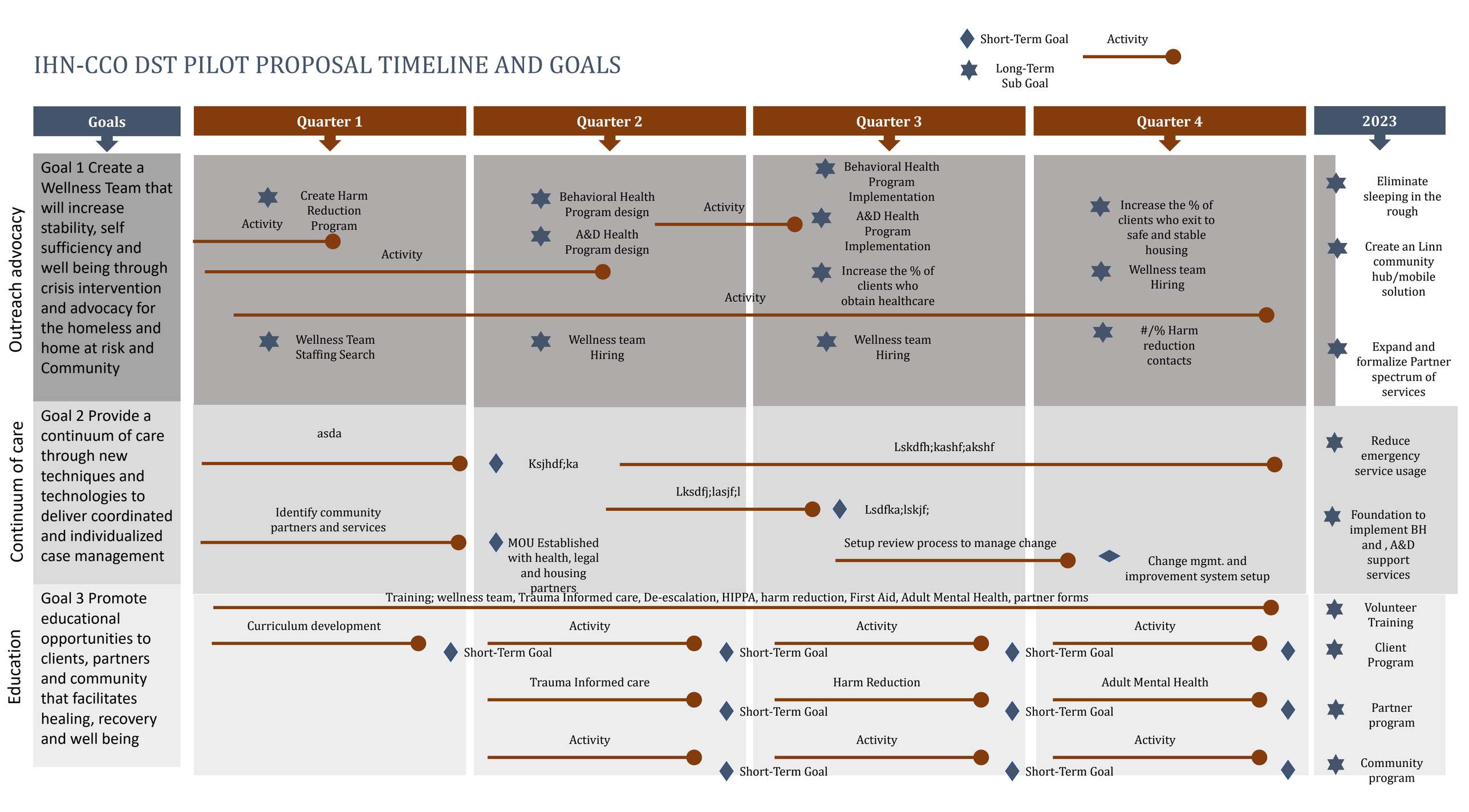
There is no program like this in the County. This program is critically needed in any community and recently at the National Homeless and Health conference was highlighted and successful proof of concepts from other areas of the country showed to massive benefits and payback.

With great partners like the City of Sweet Home, Linn County Health and others, we plan on contracts and investments being part of the sustainability of this proposal. We also have community, private and corporate donors as well as giving partners. Internal fundraising will also be used. New community awareness will help us develop/grow.

This program will include many new partners community, health, and resource solutions.

- City of Sweet Home
- Sweet Home police liaison officer
- Linn County Harm reduction
- Linn County alcohol and Drug
- Benton County Health services
- Exodus counseling
- Hope Center Women's Shelter
- FAC Sleep Center
- Mana Soup Kitchen
- Lebanon Community Pool
- Western University Medical School Outreach team
- OregonSavesLives (Harm Reduction)
- National Healthcare for the Homeless

IHN-CCO DST PILOT PROPOSAL TIMELINE AND GOALS



	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	# of individuals Contacted # Interactions	At first contact with target population	120 / 3500	12/31/2022
	# of individuals Referred to partners	At time of intake/ enrollment or first receipt of program service	100%	12/31/2022
	#/% of unhoused individuals that receive a care plan	At time of Intake, May include assessments of life skills, self-sufficiency, education/training needs, substance abuse problems, mental health status, housing needs, and physical health	45	12/31/2022
	#/% of unhoused individuals that receive one or more partner services	Partner services include: Housing Assistance Health Assistance (Substance Abuse/Mental Health Treatment, Harm Reduction, Dental SVS) Other Assistance (advocacy, education, ID, Transportation, OHP)	120/75%	12/31/2022
	#/% of unhoused individuals whose housing condition is upgraded	3, 6, and/or 12 months after point of enrollment At exit Upgrade categories: Street Emergency Shelter Transitional Housing Permanent Housing	45	12/31/2022
	#/% of Homeless Individuals Employed	3, 6, and/or 12 months after point of enrollment At exit	15	12/31/2022
	Number Harn Reduction delivered	3, 6, and/or 12 months after point of enrollment At exit	500	12/31/2022
	# Reduce overdose deaths	Units of Narcan/Nalaxone used	200	12/31/2022
	#/% Reduction of Emergency Service requests/calls	3, 6, and/or 12 months after point of enrollment At exit	25%	12/31/2022

Pilot: FAC Wellness Care Team

Pilot Start Date:	1/1/2023	Pilot End Date:	12/31/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Wellness care team (Doctor, Nurse, SUDS, Behavior Health, Peer Mental Health/A&D Specialists, Social Worker, Case Manager, CHW, Harm Reduction, Outreach Health Worker, Activites Coord, Dental)		$287,600.00	$175,000.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Resource Costs	**$287,600.00**	**$175,000.00**
Materials & Supplies			
Medical/hygiene, equipment,		$27,800.00	$20,000.00
Food		$44,800.00	$0.00
		$0.00	$0.00
	Subtotal Materials & Supplies	**$72,600.00**	**$20,000.00**
Travel Expenses			
Client transportation to appointments		$6,400.00	$6,400.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Travel Expenses	**$6,400.00**	**$6,400.00**
Meeting Expenses			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Meeting Expenses	**$0.00**	**$0.00**
Professional Training & Development			
Training and development for staff, clients, community(Trauma informed care, Mental Health First Aid, Harm reduction, Outreach Training, Servicepoint, CHW)		$5,000.00	$5,000.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Training & Development	**$5,000.00**	**$5,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
	Subtotal Other	**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$371,600.00**	**$206,400.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$55,740.00	$30,960.00
Total Project Budget		**$427,340.00**	**$237,360.00**

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

FAC WELLNESS TEAM

Family Assistance and Resource Center Group

Pilot Summary and Goals

- VERY brief description of pilot.

Family Assistance & Resource Center Group (FAC) is putting in place a specialized wrap around care team of professionals and peers that will address health disparities in our rural unsheltered/homeless population. This team will provide individualized care to treat the whole person (mentally , physically and emotionally) through street outreach and in-reach at the FAC micro shelter and navigation site.

- Goal #1 Treating Marginalized People Holistically Where They Are-Low Barrier.
- Goal #2 Saving Lives Through Harm Reduction
- Goal #3 Decrease The Number Of Unsheltered Homeless in Linn County.

Member and Community Need

- Talking points:
  - Highly Marginalized Unsheltered in Linn County. Over 55% of IHN members are in Linn County.
  - Reduce The Usage Of Emergency Services Due To Behavioral Health Issues.
  - Homelessness is a growing problem in our area; the point-in-time counts nearly doubled in the last 5 years in East Linn County's unsheltered population; to ~100-150 individuals which equates to approximately 2000-3000 interactions per year.
  - FAC is often a 1st point of contact in building trust and hope with our rural unhoused and unstably housed clients with our outreach program. FAC connects clients to our numerous partners who provide trauma informed medical, housing, treatment and other partner services.
  - There are no low barrier shelter services in East Linn County.
  - Harm Reduction is saving lives. Especially with the increase of alcohol and drug use in the past three years in the marginalized SUDS population.

System Transformation

How is your proposal transformational?

- Possible talking points:
  - Focus on collaboration between entities not previously connected.-
  - This is a brand new partnership with the City of Sweet Home. This collaboration between City Government and a grassroots organization, involving the local public school program. The Hope Center will work with the sleep center to shelter women and children, Manna Soup Kitchen will provide two meals a day delivered to the sleep center. Meeting with Lebanon community pool produced the availability of a shower program for the unsheltered on outreach. OregonSavesLives allows FAC to provide harm reduction supplies throughout the year.
  - Will your proposal reduce costs, positively affect CCO metrics, or improve IHN-CCO member's health?
  - Yes, decrease in BH emergency calls and usage.
  - What makes this pilot innovative?
  - Mobile street outreach team. New Studies through Healthcare for the Homeless show that 50%-80% of unhoused have traumatic brain injury.

    Harm reduction is saving lives, often without a 911 call in all populations.

Partnerships/Collaboration

- Describe any partnerships and collaborative relationships you have or are planning to create.
- the required cross-sector collaborator.

City of Sweet Home – We have a MOU with the city in which the city provides a building for a navigation center to be moved on to the property and site preparations – clearing, laying power and water lines to the building, gravel, and fencing. The city will also provide nighttime security for the site to provide for 24-hour management.

Linn County – Deeded 3 acres of land for the site to FAC. They will also provide a person, for support people with SUDS, to come out to the site weekly. Linn County will be offering an occupational opportunity to shelter guests at the future nearby County owned RV dump Station as a work program.

Mana – The local soup kitchen at the Methodist church, Manna, will provide and deliver 2 meals per day to the guests staying on the site.

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The National Healthcare for the Homeless group which provides guidance and best practices from around the nation.

Community Faith Nursing who provides physical healthcare with care plan

Western University School of Medicine provides on the street assessments and triage

Linn County Health provides Harm reduction A&D counseling

Mana is the local soup kitchen that provide meal for the community

Sunshine industries, housing team that is committed to provide transitional housing

Hope Center emergency shelter for women and children

FAC microshelter and navigation

This program builds upon existing collaboration with partners such as Linn County

Commissioners, Shem, CSC, Chance, Jackson Street Youth Services and United Way for

program information for healthcare access for the homeless and unstably housed.

Health Equity Plan

- How will you address health equity and reduce health disparities?
- Understanding trauma informed care for people with brain injuries will allow this marginalized and under-recognized population to have more access to a healthier lifestyle.
- Saving lives in the SUDS population through harm reduction supplies, education, and testing..
- Increase the number of sheltered unhoused people through individualized case management. Housing is healthcare.
- Increase personalized ongoing behavioral health care to reduce the need for emergency services.

Definition of Success

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

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
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#/% Reduction of Emergency Service requests/calls	3, 6, and/or 12 months after point of enrollment At exit	25%	12/31/2022

Sustainability Plan

- Specifically address how the pilot activities will be funded or continue on after DST funds are completed.
- There is no program like this in the County. This program is critically needed in any community and recently at the National Homeless and Health conference this need was highlighted and successful proof of concepts from Seattle, Yakima, Chicago etc showed to massive benefits from such an effort.
- With great partners like the City of Sweet Home, Linn County Health and others, we plan on contracts and investments being part of the sustainability of this proposal. We also have community, private and corporate donors as well as giving partners. We will seek out new grant opportunities. Internal fundraising will also be used. New community awareness will help us develop and grow partnership opportunities.

DST Member Questions?

Workshops on Wellness: A Community A Community Collaboration between The Arc and the Disability Equity Center

Backbone Organization: The Arc of Benton County

Billing Address: 928 NW Beca Ave., Corvallis, OR 97330

Site(s): Corvallis, Oregon and Toledo, Oregon

County(s): Lincoln, Benton, and Linn

Priority Areas: Traditional health workers reflective of the communities being served; Health literacy; Oral health integration; reengaging the community in personal health and community resources; disparity in care for rural communities; subpopulations of IHN-CCO members that experience health disparities

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

Healthy Living – HL1: Increase the percentage of members who are living a healthy lifestyle.

Indicator Concepts and Areas of Opportunity

i. Disease prevention, management, and recovery – preventing/improving conditions such as diabetes, tobacco related health conditions, oral health conditions, and mental health conditions through peer created, supported, and facilitated wellness programs.

ii. Nutrition – improving nutrition with curricula designed for accessibility and inclusion of people with intellectual and developmental disabilities.

iii. Physical activities – offering a variety of physical activity classes co-created and led by people with I/DD.

iv. Weight shaming and blaming – engaging through the wellness programs with healthier alternative narratives around weight and how to envision yourself as a healthy person.

v. Stress – alleviating stress by improving nutrition, increasing physical activity and social connections, and offering options and opportunities to directly improve resiliency to stressful life situations.

vi. Sleep quality – improving sleep quality by addressing common factors that lead to poor sleep – exercise, nutrition, substance use (caffeine, tobacco, sugar, etc.), sleep hygiene, and stress.

vii. Social supports (family, friends, and community) – Social and community isolation are huge challenges for people with I/DD. This pilot project takes a multifaceted approach to this issue by building a healthy and supportive community within the Workshops on Wellness themselves and through these workshops empowering people with the skills to create and sustain healthy relationships outside of the workshops.

Healthy Living – HL2: Reduce the percentage of members who use and/or are exposed to tobacco

a. Tobacco prevalence, including tracking prevalence of members who have intellectual and developmental disabilities (IDD).

Commercial tobacco use prevention and cessation are direct components of the curricula we will use. Tobacco use is an especially problematic behavior for many people with I/DD as there are many co-morbidities with an I/DD diagnosis that compound and can make the impacts of tobacco use particularly harmful.

Social Determinants of Health and Equity - SD4: Increase health equity

Areas of Opportunity

i. Health disparities experienced by members due to age, disability, gender identitiy, geographical location, income, race or ethnicity, sex, sexual orientation, etc. - Workshops on Wellness is a program designed specifically to address the health disparities faced by people with intellectual and developmental disabilities. These health disparities have increased during the COVID pandemic. Being a community with many already vulnerable health conditions, people with IDD have experienced prolonged impacts of social isolation and limited opportunities to access programs that encourage and support healthier lifestyles.

Pilot Contacts	Name	Email
Primary	Misha Marie	mmarie@arcbenton.org
Proposal	Misha Marie, Kate Williams, Joseline Raja	mmarie@arcbenton.org;kate@disabilitiyequitycenter.org; rajaj@oregonstate.edu
Contracting	Diane Scottaline	dscottaline@arcbenton.org
Financial	Diane Scottaline	dscottaline@arcbenton.org

Reporting	Misha Marie, Kate Williams, Joseline Raja	mmarie@arcbenton.org;kate@disabilitiyequitycenter.org; rajaj@oregonstate.edu

IHN-CCO DST Pilot Proposal Narrative: **Workshops on Wellness**

A Community Collaboration between The Arc and the Disability Equity Center

A. Executive Summary:

We are a cross-disability team with different skills, abilities, and understanding. We are writing this proposal to be clear and available to everyone in our community. Because of that, it is written in “plain language”. Plain language is text written to be easily understood by as many people as possible and easier to translate. The goal is to have ideas and information available to people with intellectual and developmental disabilities as well as people whose first language is not English.

Adults experiencing intellectual and developmental disabilities (IDD) are disproportionately impacted by dangerous combinations of negative health outcomes such as diabetes and depression. This is amplified by a lack of accessible and appropriately trained health care providers and health information. This means disabled folks often do not have the tools needed to make empowered health decisions.

The collaborative programming through The Arc, OSU, and DEC provides a three-tier level of support to address health and wellness inequities in the disability community. We are approaching health and wellness “holistically” which means we offer education, tools, and support for all the different parts of an individual’s life that promote feeling and being well: physical, social, emotional, health through activities, and creating a healthy community.

The second tier of these unique supports is the creation of our peer health facilitator cohort. Though there is a significant body of research to support its effectiveness, the disability community currently offers very little peer support models. Participants who demonstrate interest in learning more about holistic health and wellness and supporting peers in the community will be welcomed to an intensive peer facilitator training cohort. We see this as a way to uplift people with IDD into roles as traditional healthcare workers; people from within their community supporting each other to achieve better health outcomes.

The third tier of the program package is offering training around accessible peer health and wellness support. Trainings will be co-led by disabled health and wellness facilitators and will offer spaces to support other disability and health organizations to increase understanding of access needs and share tools to support health equity for the IDD community.

B. Pilot Description:

We have long recognized the need for improved, evidence-based, and co-created health and wellness programs for people with IDD. Both organizations have offer such programs in the community and have received funding from a range of sources to do so: IHN-CCO, Oregon Health Authority, Oregon Community Foundation, the Benton Community Foundation, and others. The funding for this pilot will support us in the critical piece of elevating people with disabilities to be trainers and leaders in this effort.

Transformational: Workshops on Wellness (WoW), will transform the way people with intellectual and developmental disabilities (IDD) participate in and create health programs that align with their needs and goals. It's an opportunity to implement a new pathway to healthy life strategies that puts people with IDD in a position to learn, create, and teach techniques and choices for better health.

Health Equity: Our program directly addresses the problems leading to health inequities for people with IDD. The programs we select will be those created with and for people with I/DD by organizations and individuals with a long and reliable history of productive work in this area. For us, the critical next step towards equity is providing the opportunity and conditions that support people with IDD to be the leaders and facilitators of these programs within their communities.

Health Improvement: The programs we select are programs with evidence-based results in improving health outcomes for people with IDD. They include exercise, nutrition, stress-reduction, social engagement, commercial tobacco use prevention, and other critical areas for achieving better health.

Improved Access: One of our top priorities is to ensure that the opportunities developed through this pilot program are accessible and inclusive. We are aware of the challenges that people with I/DD face in accessing programs that are meaningful and constructive in the areas of creating a healthier life. One of the primary goals of this project is to increase the accessibility, through peer-created, supported and led classes and improving the courses and classes themselves to be more applicable and accessible to the wide range of abilities in the IDD community.

Need:

- From Oregon Office on Disability and Health (OODH) only 65% of Oregonians with disabilities participate in some form of physical exercise outside of work as compared to 79% match-aged peers without disabilities
- people with disabilities are 19% more likely to be advised by health providers to engage in physical exercise
- from OODH, 19% of disabled Oregonians have diabetes as compared to only 7% of nondisabled Oregonians
- Diabetes is often treated as a causality of physical and cognitive disabilities; however, it is in fact the result of intersecting oppressions which disabled folks face - largely a lack of accessible education about supporting health and wellness through empowered dietary choices and barriers to accessing affordable whole foods to promote health
- From OODH, more than half of adults with disabilities in Oregon experience depression as compared to 18% of adults without disabilities
- Lack of accessible and understandable holistic wellness resources, high rates of isolation and extremely limited options for meeting friends and maintaining peer relationships as adults is the reality for people living with disabilities.

Outcomes: Workshops on Wellness programs are designed for improvements in nutrition, physical fitness, social engagement, communication, and self-advocacy. Pre- and post-surveys are already incorporated into some of the wellness curricula, additional and complementary surveys will be used to measure progress.

People with disabilities, especially those with IDD have a poorer quality of life (QOL) compared to those without disabilities. Although there is evidence-based research and programming to promote improved health outcomes for people with IDD, many of these are not sustainable, as they are not designed with the guidance and expertise of those who have lived experience in IDD. Our pilot program would be unique in partnering with community members identifying with IDD in every step of designing, implementing, and evaluating the pilot program over the span of a year.

Additionally, as mentioned above, people with IDD will be trained to serve in a leadership role within our pilot program. Seeing a person with IDD in a leadership position can motivate others to attend and continue in our programs. Besides enhancing health, self-esteem and QOL of budding health leaders with IDD in our pilot program, this program model will create a foundation for other community members to lead healthier lifestyles and aspire to become like their leaders with I/DD.

Total Cost of Care: Reduced health care costs are expected to result from health improvement targets that are directly related to conditions such as: diabetes, high blood-pressure, social isolation, physical mobility, mental health, and others. Seeing people with IDD lead sessions on healthy living will inspire more community members to participate in these programs, progressively improving the health of more people with IDD.

Organizational Commitment and Visioning:

The Arc has been enriching the lives of people with developmental disabilities in Benton County since 1958. As a local chapter of the nation's largest advocacy organization for people with developmental disabilities, the Arc of Benton County started as a grassroots group of concerned parents and community members who wanted more for their loved ones than institutionalization. We were instrumental in getting special education into Corvallis schools in the late 60’s and early 70’s. We were early on the scene of community housing for people coming out of Fairview Training Center. We started vocational programs to introduce people with IDD to community -based employment. Our vision is a fully inclusive community in which people with IDD can reach their highest potential.

The Arc has come a long way since 1958 and we know that progress toward respect and inclusion means having people with disabilities in the conversations, in the planning, and in the executing of programs and educational efforts. Training self-advocates is at the core of this approach.

Because the Arc of Benton County is one chapter of both the state and national Arc organizations there are many opportunities to share and disseminate what we learn from this pilot project. We see this component of the project as a critical outcome, our goal is to use the results of this work to launch greater opportunities for people with IDD to become the ones creating their own curricula and supporting each other from positions of leadership within their communities to build healthier lives.

The Disability Equity Center (DEC) is a grassroots disability justice organization in the mid-Willamette Valley amplifying the voices of people experiencing disabilities. DEC is made for disabled people by disabled people to connect, build, dream, and grow together in the community. One of our core values is leadership for disabled people by disabled people; our community programming is facilitated by disabled leaders. We pride ourselves on offering unique and person-centered support for people experiencing IDD to explore roles in the community which have not historically been available to

them. We also deeply value *organizational interdependence* to make sustainable and impactful community shifts towards disability access and equity.

DEC is committed to leadership by those most impacted, so self-advocates drive our programming and organizational decisions. Our Board likewise is composed of an 80% majority disabled people who understand lived disability from the inside. We are building an Advisory Board made up of disabled youth leaders, especially young people of color, who will shape the vision and direction of DEC. We likewise aim for diversity and inclusion across as many different disability experiences as possible. Acknowledging that impairment-specific supports are crucial, DEC embodies cross-disability solidarity that is key to collective liberation. Even as we do this, we know we have more work to do to center brown and black disabled people so collective access and justice can be truly realized.

Communicating our program to the community: Our plan is to leverage our deep connections to the I/DD community through our newsletters, contact lists, current participants, other provider organizations, and local agencies that support people with IDD.

Possible risks and plans to address them: We recognize that the Covid-19 pandemic is not over, and we have certainly learned that twists and turns can be expected as it continues. We have also learned how to shift gears and use alternative means to connect and deliver programming. Both the DEC and The Arc of Benton County have embraced virtual platforms, working outdoors, and other means to continue participating in our community when in-person options are limited and/or restricted.

We understand that it is important to collect reliable data but also recognize the challenge of doing so in ethical and noninvasive ways. We have connections to professionals working in this area who have collaborated with us previously to find and use best practices for this part of the work.

We know that being in diverse disability communities can be challenging and that it is hard to meet everyone’s mental and physical health and access needs. Our plan is to utilize an approach like the individual education plan, (IEP), used in schools, so that we approach each participant in ways that allow them to build on their strengths while giving opportunities for growth.

C. Pilot Timeline:

January and February: Identify stakeholders and partners for program planning, delivery best practices, training needs, and resources.

March and April: Schedule programming and recruit WoW participants; collaborate with agency and provider partners to share health and wellness advocacy resources; invite stakeholders to lay the foundation for the clubhouse model of peer-supported health and wellness.

May, June, and July: Deliver Workshops on Wellness, assessing as we go; offer opportunities for peers to train as co-facilitators and leaders of the workshops; offer opportunities for people to learn self-advocacy skills around health care; continue working with stakeholders to develop the clubhouse.

August, September, and October: Evaluate Workshops on Wellness in partnership those involved, make needed adjustments for improvement; deliver next round of Workshops on Wellness with peer leaders in an apprentice role; engage with self-advocates to practice advocacy; continue development of clubhouse.

November and December: Another round of evaluation and development in collaboration with participants, trainers, and other stakeholders; share outcomes with larger community; launch clubhouse model for on-going health and wellness peer support.

D. Sustainability Plan:

We plan to support the Workshops on Wellness program through a combination of Medicaid reimbursement, private pay options, use of a scholarship fund, and continued fund raising from the community.

Training and supporting people with IDD to become trainers and leaders of health and wellness programs is an innovative and foundational step to achieving better health outcomes. This model is fundamentally directed towards the goals of scaling and transfer as it continues to elevate those that experience IDD within the community to support peers and model a new view of the contributions from people with IDD.

We hear from other providers about the challenges of supporting and encouraging healthy lives for people with disabilities. Daily we all see how the impact of living with IDD, and often having intersectional identities, leads to dangerous health outcomes. Parents and home providers regularly transport people to the emergency room and are at the frontlines of the care required to treat the illness and disease that results from less healthy ways of living. We are excited to share this approach with the wider community and plan local, state, and national opportunities to do so.

	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
Specific Measurable Attainable Relevant Timely	There are extremely limited opportunities to participate in wellness courses and programs that are co-created with, and validated for, people with intellectual and developmental disabilities.	Stakeholders meeting; program planning, selection, and delivery;	Support 40+ adults experiencing an intellectual and/or developmental disability to complete at least one section of the holistic health and wellness program model	12/31/2023
	No wellness courses co-led or co-facilitated by people with I/DD.	Selection and training for people with IDD to become co-facilitators and leaders of health and wellness programs	4 - 6 trained peer health program facilitators	12/31/2023
	No clubhouse model of peer-supported healthy lifestyles for people with I/DD	Bring to together stakeholders to set the course for clubhouse program. Host community meeting to share new models of delivering health and wellmess programs in the I/DD community. Offer oral health and wellness outreach from Capitol Dental Care. Partner with	Cocreate a holistic health peer support group with self-advocate program participants to promote ongoing health and wellness support and community driven advocacy	12/31/2023

Workshops on Wellness - A Pilot Project Collaboration with The Arc of Benton County an

Pilot Start Date:	1/1/2023	Pilot End Date:	12/31/2023
General and Contracted Services Costs			
Resource		**Total Cost**	**Amount Requested***
Peer training, support, wages		$20,000.00	$12,700.00
Facilitation and delivery of programs - Benton County		$75,000.00	$50,000.00
Facilitation and delivery of programs - Lincoln County		$57,500.00	$25,000.00
		$0.00	$0.00
Subtotal Resource Costs		**$152,500.00**	**$87,700.00**
Materials & Supplies			
Promotional materials		$1,000.00	$1,000.00
Training manuals and program equipment		$2,000.00	$1,500.00
Incentives		$2,000.00	$2,000.00
Subtotal Materials & Supplies		**$5,000.00**	**$4,500.00**
Travel Expenses			
Mileage		$500.00	$500.00
Attending 1 state and 1 national meeting of professionals in the field of		$5,000.00	$2,500.00
		$0.00	$0.00
Subtotal Travel Expenses		**$5,500.00**	**$3,000.00**
Meeting Expenses			
Community engagement meetings		$500.00	$500.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Meeting Expenses		**$500.00**	**$500.00**
Professional Training & Development			
Health and Wellness Trainer courses		$2,000.00	$2,000.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Training & Development		**$2,000.00**	**$2,000.00**
Other Budget Items			
		$0.00	$0.00
		$0.00	$0.00
		$0.00	$0.00
Subtotal Other		**$0.00**	**$0.00**
Total Direct Costs	**Rate (%)**	**$165,500.00**	**$97,700.00**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$24,825.00	$14,655.00
Total Project Budget		**$190,325.00**	**$112,355.00**

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

Workshops on Wellness

A Community Collaboration of The Arc of Benton County and the Disability Equity Center

Pilot Summary and Goals

- Elevating people with intellectual and development disabilities into roles of leadership within health and wellness programs and health care advocacy.

- Goal #1: Offering evidenced based, co-created health and wellness programs with and for people with disabilities
- Goal #2: Training people with IDD to share, lead, and develop health and wellness programs and self-advocacy roles
- Goal #3: Create a clubhouse model peer program for ongoing health and wellness opportunities and support

Member and Community Need

- Talking points:
  - Target population: people with intellectual and developmental disabilities
  - IHN-CCO Member Impact:
    - reducing health disparities for people with IDD,
    - improving quality of life
    - basic health and wellness
    - shifting the power to the people experience the impact of disparate health outcomes
  - Community Needs
    - Healthier people
    - Inclusion and accessibility
    - Provider awareness and appropriate training

System Transformation

- Individual
  - Leaders- physical, mental, social well-being, leadership skills, self-esteem, financial benefits, QOL
  - Participants - physical, mental, social well-being, QOL
- Interpersonal - leaders and clients (role model?); Caregiver connections
- Organizational - Impact on the healthcare system - lower costs due to better health status - greater community engagement in PA, better mental health, reduced behavioral issues, overall enhanced QOL
- Community - New networks between PA leaders and local organizations; social connections between fitness centers and PA leaders to cater to a more diverse audience
- Policy - Employment based policy changes; equity in pay (Long-tem goals)

Partnerships/Collaboration

- The Arc of Benton County
- The Disability Equity Center
- Students from Oregon State University
- Capitol Dental
- The Arc of Oregon

People with intellectual and developmental disabilities

Health Equity Plan

- Other groups experiencing health disparities
- Service providers
- Family and Friends
- Local and regional agencies
- Healthcare providers

- People with Disabilities

Definition of Success

- More people engaging in health and wellness program
- Leaders and trainers from within the IDD community,
- Clubhouse to support community health and wellness

- A more accessible, inclusive pathway to a healthy, fulling life for people with disabilities

Sustainability Plan

- Medicaid waiver program funds
- Private pay
- Scholarships
- Community fundraising
- Employment for people with IDD as traditional health workers

DST Member Questions?