Agenda
Delivery System Transformation Committee

August 11, 2022 4:30 – 6:30 pm
Online Click Here: Click here to join the meeting
Phone: +1 971-254-1254
Conference ID: 869 236 043#

1. Welcome and Introductions	**Renee Smith,** Family Tree Relief Nursery	**4:30**
2. Large Request for Proposal Presentations		
• Community Partnership Alliance	Oregon Cascades West Council of Governments/Creating Housing Coalition	**4:45**
• Wellness Care Team	Family Assistance & Resource Center Group	**5:00**
• Coastal Kids Mentoring Program	Neighbors for Kids	**5:15**
• Homeless Data Harmonization	Samaritan Health Services	**5:30**
• Hope Grows Here	Oregon State University	**5:45**
• Improving Access with THWs	Unity Shelter	**6:00**
	*10 minutes built in for transition time	
3. Wrap Up	**Renee Smith,** Family Tree Relief Nursery	**6:25**
• Announcements		
• Next Meeting: August 18, 2022		

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

Delivery System Transformation (DST) Pilots and Workgroups

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

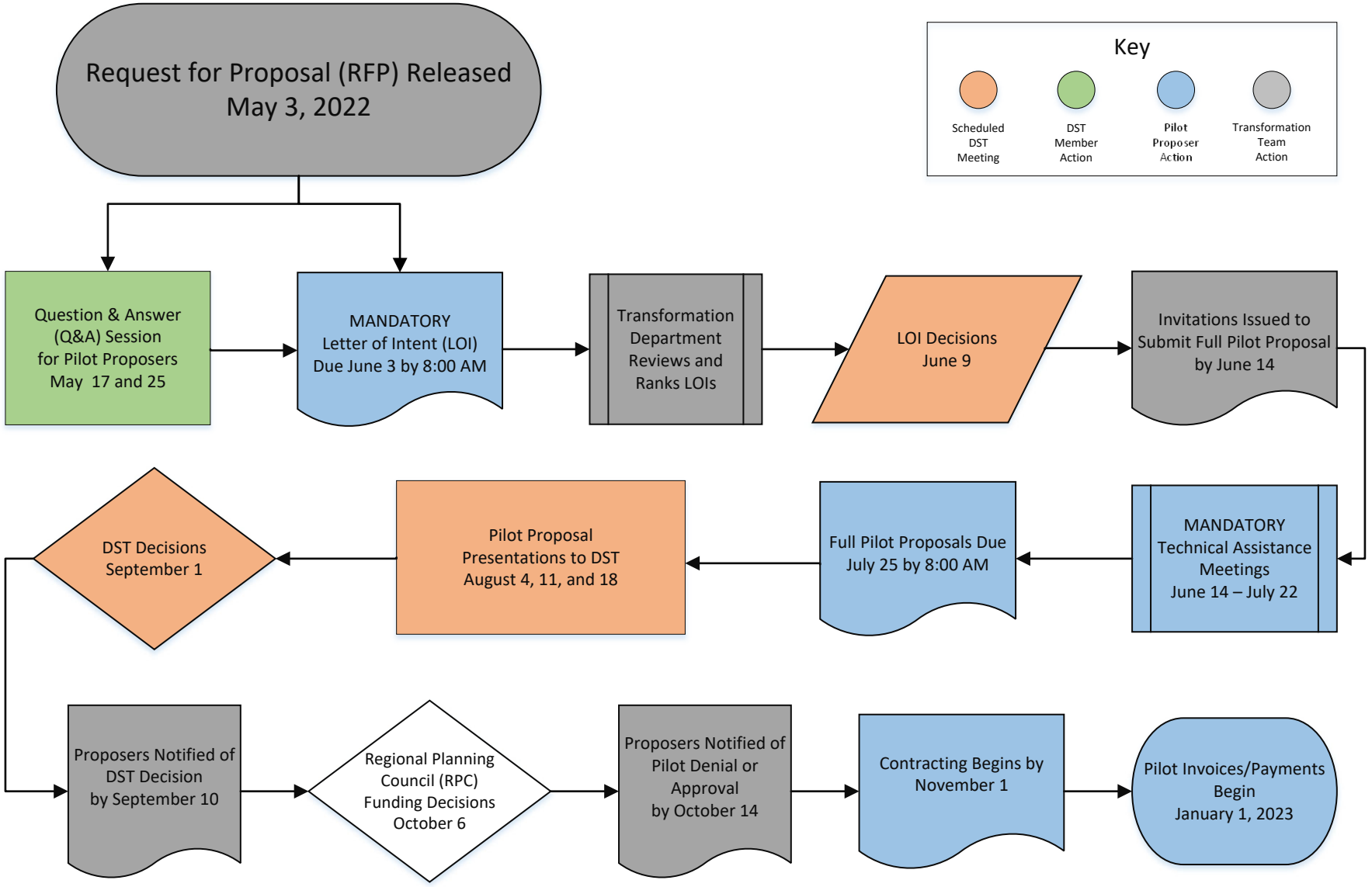
Delivery System Transformation Committee (DST) 2022 Calendar

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

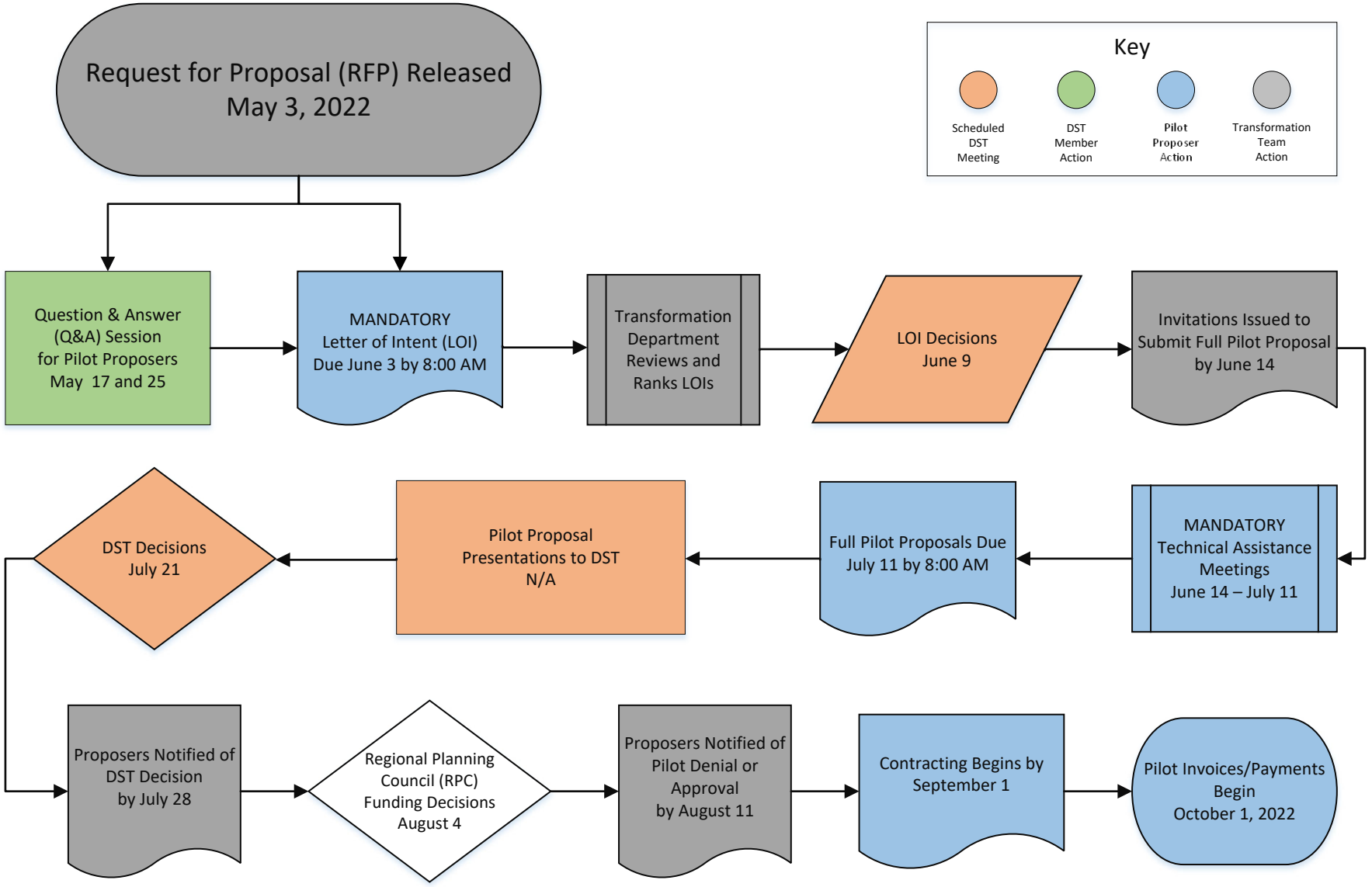
KEY

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

IHN-CCO DST Request for Proposal Timeline – Large RFP



IHN-CCO DST Request for Proposal Timeline – Small RFP



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

Present			
Chair: Melissa Isavoran	Abby Mulcahy	Andrea Myhre	Charissa Young-White
Anita Earl	Annie McDonald	Brandy Waite	Nicole Breuner
Alicia Bublitz	Britny Chandler	Danny Magana	Deb Fell-Carlson
Dick Knowles	Erin Gudge	Erin Sedlacek	Glen Cunningham
Jaimie Page	Kami Beard	Marcy Shanks	Stacey Bartholomew
Mica Contreras	Paige Jenkins	Paulina Kaiser	Laurel Schwinabart
Rebekah Fowler	Rolly Kinney	Roslyn Burmood	Sara
Shannon Rose	Linda Mann	Tristin Armstrong	Elizabeth Hazlewood
Brock Byers	Shirley Byrd		

Transformation Update: Charissa Young-White

- The Centers for Medicare & Medicaid Services (CMS) will respond to the submitted 1115 Waiver for Oregon CCOs in September 2022.
    - Not moving forward is the Community Investment Collaborative or changes to enrollment for those in the justice system.
- The Regional Planning Council (RPC) approved the five small pilot proposals.
- Faith Community Health Network was published in a nursing journal. Watch for it in the follow up email.
- Agenda update: The Community Partnership Alliance is unable to present tonight due to urgent health issues. We will forgo the Transformation Update next week to fit them in.

Pilot Proposal Presentation Questions and Answers

See Packet of Pilot Proposals for Full Proposals and Presentation Slides

Faith Communities Engaging Health: Deb Fell-Carlson & Marcy Shanks

- License/credentialling is required.
- The patient always has the ability to choose what they want to do in seeing a faith-based nurse. It is very doable for nurses to support patients, even if personal views and beliefs are not the same.
- Helps the congregation members feel and understand that they are all accepted.

Ahead of the Curve: Jaimie Page

- Would continue to move forward in smaller increments of the original plan (in the case of a disaster etc.).
- Lots of data has been compiled since COVID hit, and EMDR *can* be done over telehealth. There are extra protocols, but early data shows it is still effective.
- Trained in Somatic Experiencing (SE), important in helping people get in touch with their bodies to assess where they are having difficulties.
- Want to recruit folks as staff, through their paid internship.

End of Life Support: Glen Cunningham

- Referral will go through Care Hub. The hope for the future, once a payment model is in place; is that once a patient is identified they could then be referred. This would be changing the way that we pay for hospice.
- Care Hub is on Connect Oregon.
- Immediate plan is to stop the “bleeding” so to speak and use this year as a buffer. Then, work with IHN-CCO to continue work in this area.

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

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?

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

IHN-CCO DST
PILOT PROPOSAL

Oregon State University
Moore Family Center

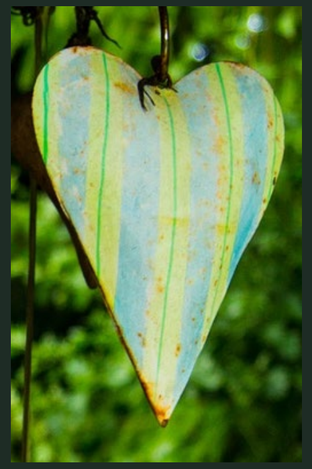
Pilot Summary and Goals

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

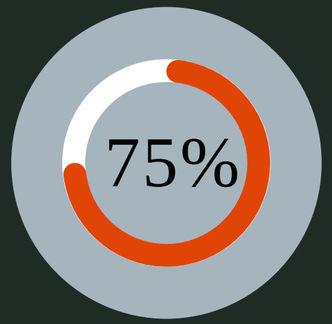
Cancer survivors experience:

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

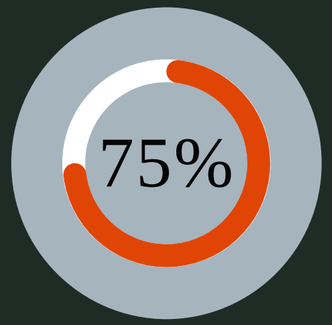
- Facilitate a social support system - individuals sharing a diagnosis learn together and from each other.
- Increase access to affordable, fresh, nutrient dense food and how to sustainably grow it.
- Provide resources for self-care through gardening.
- Experience enjoyable, easy ways to prepare home-grown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

What is Success?

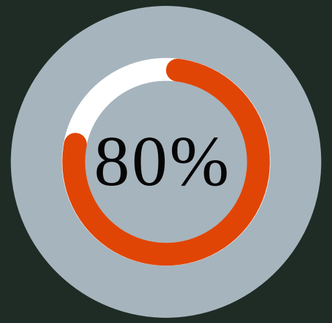
Participants will...



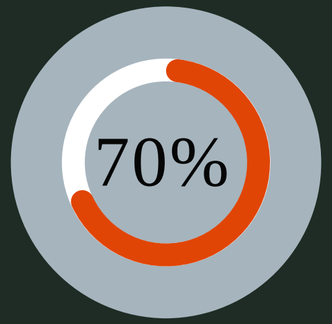
Try at least two recipes at home using fresh vegetables or fruits from the garden.



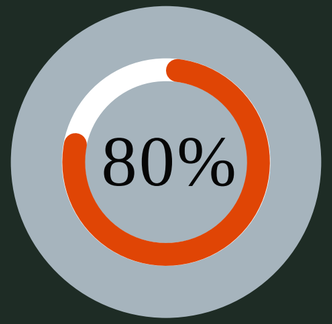
Report a significant increase in physical activity using the Godin Leisuretime Activity Questionnaire.



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?

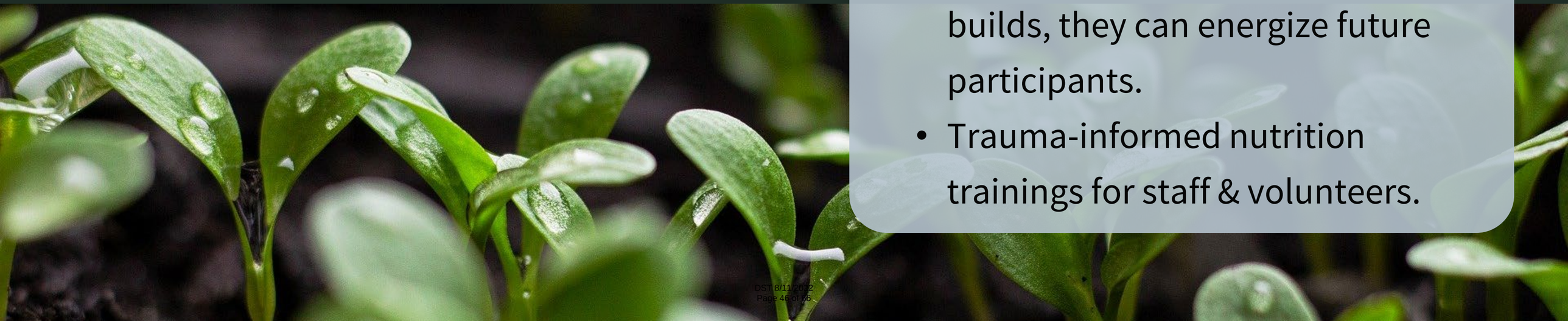
After participating in Hope Grows Here, members will…

- 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:

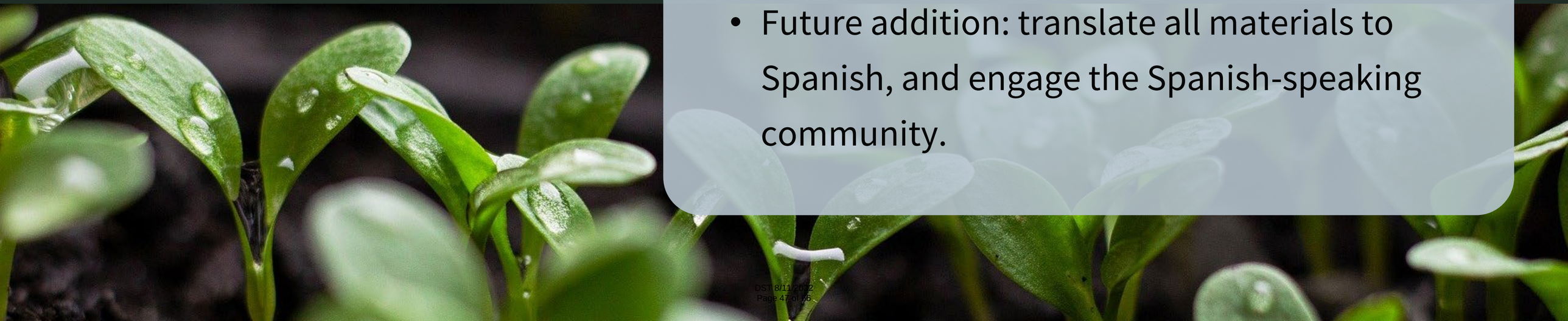
- Clinical garden installation = dedicated space for future gardeners.
- Outreach materials can be used for future years.
- Peer mentor development: as participants' garden confidence builds, they can energize future participants.
- Trauma-informed nutrition trainings for staff & volunteers.



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

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?

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.

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 guFocus primarily on ests 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.

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)
# 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

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?