2022 Letters of Intent Large RFP (over $50,000)

Name	Pilot Champion	Addressing trauma	Technology disparities	Bilingual/bilcultural workforce	Innovative housing	Language access	Oral health integration	Pay equity	Reengaging the community	Rural Impact	Subpopulations
"Sweet Talk" Program Evaluation	Global Nutrition and Empowerment		X			X			X		X
Ahead of the Curve	Olalla Center	X		X		X		X	X	X	X
Amplifying Voices	Samaritan Health Services ArtsCare Program	X							X	X	X
Community Partnership Alliance	Creating Housing Coailition	X			X				X		X
Easy-A: Train the coach	SOL4CE. LLC	X							X	X	X
End Of Life Support	SHS Population Health/CareHub	X			X						X
FAC Wellness Care Team	Family Assistance & Resource Center Group	X			X	X	X	X	X	X	X
Faith Communities Engaging Health	Faith Community Health Network	X	X			X			X	X	X
Homeless Data Harmonization	Samaritan Health Services				X						X
Hope Grows Here	Moore Family Center – Oregon State University	X							X	X	X
Improving access with CHW's	Unity Shelter	X			X	X	X		X		X
Overcoming Obstacles to Dental Care	Capitol Dental Care						X		X	X	X
Project Pill Minders	Coastal Support Services	X	X						X	X	X
School Based Health Center	Lebanon Community School District	X	X				X		X	X	X
THW Peer Doula Collaboration	ReConnections Alcohol and Drug Treatment, INC	X	X	X	X	X	X	X	X	X	X
Workshops on Wellness	The Arc of Benton County	X	X			X		X	X		X

"Sweet Talk" Program Evaluation

Primary Organization: Global Nutrition and Empowerment

Primary Contact: Marie Long

Primary Contact Email Address: marie.l@globalnutritionempowerment.org

Partnering Organization(s): Albany InReach Medical Clinic. Geary Street Clinic

Project Name (4 words or less): "Sweet Talk" Program Evaluation

Describe your project in a few paragraphs. The Global Nutrition Empowerment (GNE) team of Certified Diabetes Educators, Physicians, Community Organizations, Computer Scientists, Translators, Artists, Sound Engineers, Writers, and Voice Actors has created "Conversación Dulce"/ "Sweet Talk". This interactive evidence-based diabetes education program utilizes principles of adult and low literacy learning. The program has been extensively "field tested" and it is ready to introduce as a larger pilot project.

Introduction and Need
• Diabetes increases the burdens of ill health on individuals, families, communities, and the health care system.
• Many people with diabetes have low levels of literacy/numeracy and are disproportionately minorities or low income.
• Lifestyle changes early during diabetes prevents complications.
• Current diabetes education programs that meet CDC and CMS criteria require a 1-year commitment which may limit compliance.
• There is a need to evaluate new approaches to Diabetes Education outside of current ADA and CDC guidelines.
• Providers face barriers in delivering Diabetes Education including time, re-imbursement, access to language and culture-based information.
• Health Care Systems struggle to meet quality assessment standards set by Payers.

Organization Information
Global Nutrition Empowerment (GNE), a 501(c)3 Oregon Registered Non-Profit, has developed Education material for Low Literacy Adult Learners in Nepal, Indonesia, Philippines, and Guatemala. The 15 apps GNE has developed are in 6 languages and are culturally appropriate. A digital platform provides consistent, evidence-based messages in an engaging format. Many GNE volunteers have connections to Health Care in Linn, Benton, and Lincoln Counties

General Program Description
"Conversación Dulce"/ "Sweet Talk" consists of six one-hour sessions:
• Session 1 – Why is diabetes important to you? What are your goals?
• Session 2 – What is blood sugar and HbA1c and how is it measured?
• Session 3 – Diabetes Plate and how to build delicious meals
• Session 4 – How to read a food label

• Session 5 - Lifestyle and Diabetes (Stress, Activity, Diet, Blood Pressure, Smoking cessation)
• Session 6 – Common Diabetes Medications and Graduation
• Each one-hour session consists of three parts:
• A Video containing the critical information on a topic is presented on a digital tablet
• A Hands-on practical lesson emphasizes the messages from the lesson.
• A Q and A session clarifies individual concerns and address common misconceptions.

Geary Street Pilot Description
"Conversación Dulce"/ "Sweet Talk" will augment and leverages the skill of Diabetes Educators and other providers. The Geary Street Clinic will be the primary location for the program, with the addition of other SHS locations as experience and coaches training progresses.

A CHW will coordinate this program with oversight from a Geary Street Provider and GNE volunteers. This bilingual leader will identify and enroll participants.

Six or more "Conversación Dulce"/"Sweet Talk" coaches will be trained.

Participants and their family members will receive a monetary stipend upon completing the class.

Quality outcome measures will use National Standards for Diabetes Self-Management Education and Support and include lab tests and surveys.

Potential Benefits of the Program
Benefits to Patients/Family Members with Diabetes:
• Barriers of literacy, language, time, and access are reduced or eliminated.
• Coaches are Native Spanish speakers.
• Practical hands-on modules re-enforce the information in the apps.
• Q and A session with a Diabetes Educator on standby allows for community building.
• Group settings encourage discussion and address common misconceptions.
• Family members are encouraged to attend.
• Anonymous - no identifiable data collected or recorded.
Benefits to Providers:
• Simple, Time efficient referral and reporting. Providers can refer patients with either an invitation card or a direct referral.
• Every 6 months a report to demonstrates the metric values necessary for Quality Assurance will be provided.
• Diabetes Educators time is leveraged.
Benefits to a Health Care System:
• Unidentified data meeting several or all Comprehensive Diabetes Care (HEDIS) requirements will be collected.
  Hemoglobin A1c (HbA1c) testing.
  HbA1c
  Eye exam (retinal) performed.
  Medical attention for nephropathy.
  BP

Innovative Components

• Community Health Worker as Program Coordinator:
• Provides a bridge between participants, providers, and the community
• Increases the sense of community for participants and removes some barriers to improved self-care.
• Provides ongoing re-enforcement and follow-up.
• Community Based Coaches
• Community volunteers, Traditional Health Workers with connections to a Community Based Organization and Student volunteers are ideal Coaches. Coaching develops teaching and public speaking skills.
• Digital Technology
• Videos and interactive apps deliver evidence-based information on tablets. This allows coaches to focus on observing participants and leading discussion.
• Evidence based content is "PEAR" (Practical, Engaging, Accessible, Relevant)
• "Sweet Talk" draws on the skills GNE has developed working in low resource settings with marginalized groups. Content is culturally appropriate and accessible to all levels of literacy. Partnering with SHS Diabetes Educators and other CBOs has amplified GNE's experience.
• Length of Course
• Completing "Conversación Dulce"/ "Sweet Talk in 6 hours provides participants with the basic knowledge to improve their diabetes self-care.
• "Sweet Talk" It has been field tested in Spanish and English in the three clinics in the USA and in a Guatemala medical clinic.
• Portability
• The course can easily be conducted in remote locations without electricity.

New Connections for IHN-CCO
Utilizing a CHW as the Program Coordinator will increase collaboration with other Community Based Organizations and is a key component for the success of this program. The pilot will be conducted at Geary Street, but it is foreseen that if successful this program will be relevant to all areas of the INH-CCO region.
Global Nutrition Empowerment works locally and internationally and has many connections with other CBOs.

Priority Areas
This program touches on several priority areas of the INH -CCO Community Advisory Council's Community Health Improvement Plan Health Impact Areas:
• The primary target audience is recent Immigrant populations with a high incidence of diabetes and has many barriers to entry and ongoing participation in the health care system.
• Developing a bilingual bicultural workforce. Coaches will be primarily Native Spanish speakers. Many will be students beginning their careers in Health Care. Current coaches have found the experience valuable at developing relevant skills (teaching low literacy populations, public speaking, leading groups).
• All teaching materials and coaching will be in Spanish and English.
• There will be a goal, after establishing the program at Geary Street to conduct classes in rural areas in collaboration with agricultural businesses and health clinics.

Expected Health Outcome Improvements
• See appropriate section below
Connection with related activities in our region
• GNE collaborates with several local CBOs and will continue to grow those relationships. For example, GNE has trained 9 Health Workers at Mano a Mano in Salem, and educational

outreach is planned with food deliveries. Lancaster Family Clinic in Salem conducts Sweet Talk classes every month. Student volunteers have been trained at Community Outreach in Corvallis (6) and Albany InReach (7).

Anticipated Budget
Year 1 budget: $142,890) (all components of materials, staffing and training included).
Year 2 budget: $120,000.

Which of the following does your project focus on? Addressing technology disparities., Language access including health literacy, interpreter services, and translation of materials., Reengaging the community in personal health and community resources., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? The following Comprehensive Diabetes Care Metrics are expected to improve:
  Hemoglobin A1c
  Eye exam (retinal) performed.
  Medical attention for nephropathy.
  BP

Participant and provider satisfaction, BMI and estimates of physical activity, smoking and stress management will be collected and assessed for improvement.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? The pilot will be conducted at the Geary Street Clinic which has many non English speaking patients with diabetes. It is anticipated this program will be relevant to all areas of the INH-CCO region. Using Community Health Workers to connect with CBO's we hope to reach underserved rural communities and marginalized populations.
Utilizing a bilingual CHW as the Program Coordinator is a key component for the success of this program.

GNE is a 501(c)3 non-profit registered in Oregon. It has been working locally and internationally for over 12 years and has many connections with other organizations currently interested in Health Education in general, and Diabetes Ed in specific (e.g. Yakima Valley Farm Workers Clinic, Mano a Mano, Faith In Practice).
It is anticipated that all these factors will improve communication and collaboration with organizations interested in Health Literacy and Health Education.

What is your approximate budget? Over $50,000

Ahead of the Curve

Primary Organization: Olalla Center

Primary Contact: Diana Teem

Primary Contact Email Address: deet@olallacenter.org

Partnering Organization(s): OSU Stem Hub, OSU Ext. Services, NW Oregon Works, Lincoln County Health & Human Services, Oregon Health Authority, Safe Families, Lincoln City Cultural Center, City of Yachats, Oregon Coast Community Forest, Integrity Health.

Project Name (4 words or less): Ahead of the Curve

Describe your project in a few paragraphs. Ahead of the Curve is an Olalla Center innovative rural behavioral health workforce learning and development project, which addresses trauma and offers culturally appreciative community supports.

Priority Area: Addressing trauma, including environmental; Post-pandemic cultural trauma; Reduction of wait times for mental health services; Toxic stress

Olalla Center's project is to address the rural workforce shortage in behavioral health through an innovative "grow your own" approach to service gaps. Recognizing the lack of specialized mental health services and bilingual/bicultural providers in Lincoln County, we intend to establish clinically supervised paid work experiences, internships and learning opportunities in collaboration with workforce partners, universities, colleges and tuition assistance programs.

Olalla's clinical supervisors, outpatient therapy and psychiatric day treatment teams will work with undergraduates and graduate students on behavioral health career tracks, and provide clinical supervision towards licensure. Participants will have the opportunity for work experience in any of Olalla Center's innovative mental health programs.

Additionally, we will offer training and supervision for 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).

We will all 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).

Priority Area: Reengaging the community in personal health and community resources

Above the Curve will offer: 1) Post-pandemic mental health support groups

(Trauma/Depression/Anxiety). 2) Social activities, groups, and community integration for those who have been isolated, including LGBTQIA2S+ Project Bravery groups, Arcoiris Cultural workshops and activities, and prevention based healthy activities for youth and families. 3) Recruit and train a Peer Support Specialist/Mentor for higher-risk and/or disengaged clients and families.

Many of our clients are isolated due to COVID, language barriers, and the stigma around mental health issues, addiction, discrimination, poverty, and family issues. Clients regularly ask for ideas and opportunities to meet potential friends and/or support persons and have been open in sharing that they are currently finding this very difficult. The majority of our clients are IHN-CCO members.

Priority Area: Rural community impact; Disparity in care for rural communities
1) Paid graduate student internships and behavioral health work experiences with meaningful career pathways for advancement.
2) Relocation incentives recruitment.
3) Olalla locations: Co-located in Newport with Integrity Health (transgender medical services) and Arcoiris Cultural; Toledo (Bravery - LGBTQ+, Outpatient, Day Treatment, Relief Nursery), Community Forest (Walden Project outdoors), Siletz (Pegasus Equine-assisted Therapy) and space collaborations with Lincoln City Cultural Center and the City of Yachats. Adding a location in Waldport would increase access for rural clients and further reduce transportation barriers.
4) Host and collaborate with LC Public Health on community workshops, prevention and health/ mental health promotion in rural communities in Lincoln County.
The majority of Olalla Center clients are at or below the poverty level, and face multiple barriers including discrimination, language access, food and housing insecurity, wage discrimination, and access to behavioral health providers in rural coastal communities.

Which of the following does your project focus on? Addressing trauma, including environmental., Developing a bilingual and bicultural workforce., Language access including health literacy, interpreter services, and translation of materials., Pay equity through building and sustaining the workforce., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? Limited resources and behavioral health providers in rural Lincoln County creates a tremendous health disparities for IHN-CCO members, who are the majority of Olalla Centers clients.

Providing meaningful workforce development solutions through paid behavioral health work experiences and internships will reduce the number of IHN-CCO members on wait lists and increase their access to local providers and improve their mental health outcomes.

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.

(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).

The community supports and healthy prevention activities will create connection, reduce isolation, reduce risk behaviors, and decrease the associated stress response.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This project creates an opportunity for local emerging workforce to access a local, paid internship and/or work experience opportunities. Oregon State University Stem Hub, Hatfield Marine Science Center, Extension Service and Office of Innovation are current partners. Oregon Coast Community College is a potential education partner for undergraduates. OCCC has discontinued its internship program, we are hopeful to help bring it back as a location for interns and student work experience.

There are no similar existing programs in our region. NW Oregon Works is a current partner with Olalla Center on the How To Grants (for bilingual workforce) and Community Services Consortium Career Tech Charter School has partners with Olalla Center for Mental Health services, we intent to deepen that connection and provide a behavioral health track for Career Tech students.

What is your approximate budget? Over $50,000

Amplifying Voices

Primary Organization: Samaritan Health Services ArtsCare Program

Primary Contact: Erin Gudge

Primary Contact Email Address: egudge@samhealth.org

Partnering Organization(s): Potential Partners: Project Bravery, Casa Latinos Unidos, the Lincoln County School District, Disability Equity Center, Samaritan Foundation, Lincoln Co. School District

Project Name (4 words or less): Amplifying Voices

Describe your project in a few paragraphs. The Amplifying Voices pilot project focuses on the process of creating art as a method of improving mental health outcomes for teens in the BIPOC, LGBTQIA2S+, disabled and other marginalized/underserved subpopulations in the coastal community. Access to this program is key and will be increased by the availability of transportation and translation services for those in need. Participants will explore different artistic mediums while also exploring their emotions and the power of their voices. Delivering mental health services in combination with art is a transformative method. Neuroscience research findings show artistic activities are known to reduce stress and promote mental well-being (see resource links at end of this section). While the initial project will support tangible art creation, the goal of this pilot is to create a continuing program that will expand across the tri-county area that Samaritan serves. Lincoln County is ranked 27th among Oregon counties in health outcomes and 33rd for health factors according to the 2022 County Health Rankings (countyhealthrankings.org). 20% of Lincoln County children live in poverty and might not otherwise have access to art-as-healing opportunities.
Initial Project: The primary focus of Amplifying Voices is providing art-as-healing experiences to marginalized teens in the Lincoln County area. These art experiences will focus on developing healthy coping and processing mechanisms that address the social-emotional aspects of mental health challenges that these underserved and marginalized teens experience. Amplifying Voices seeks to help these teens find their voice, and then through the power of art and community, amplify those experiences to a larger audience. The project will give a platform and restorative dignity to these subpopulations through therapeutic self-expression and art. A final product of this pilot project is a public art installation. While a final art piece is the tangible outcome, the true product is the experience and empowerment the participants gain in the process. The public art piece will be determined by the project participants, with guidance from professional artists and program mentors.
The additional focus of this pilot project is to create a digital and social media campaign

telling the story of the participants and the process of making the art — using video, photos and testimonials. The campaign will educate a broader cross-section of Lincoln County about the difficult experiences of these teens, but also how inspiring and aspirational these stories can be. The social media campaign will seek to reduce stigma and increase the empathetic response to mental health issues.
Resources available if requested.

Which of the following does your project focus on? Addressing trauma, including environmental., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? The stigma surrounding mental health, especially among marginalized groups, is the antithesis of healing. By creating a self-empowered art and healing project for those in these groups, it is expected to see these teens not only find their voices and their inner strength, but to see them learn how to cope through hard times, address some of their challenges and realize they are not alone or isolated in their experiences. Adding access to art-as-healing opportunities and partnering with mental health practitioners working collaboratively with professional artists is a non-traditional approach to care but is supported by scientific findings. Additionally, the social media campaign will expand awareness about suicidality and mental health issues to a broader audience through carefully curated storytelling opportunities.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? ArtsCare will work with other community arts organizations in addition to the programs previously listed, including the Lincoln City Cultural Center, Oregon Coast Council for the Arts, and other agencies to be identified through a public call for involvement. Local coastal artists will be hired for this project, as is part of the ArtsCare mission. ArtsCare will seek to partner with the Confederated Tribes of Siletz Indians to honor local traditions and the ancestral lands upon which we do our work.

What is your approximate budget? Unsure

Community Partnership Alliance

Primary Organization: Creating Housing Coailition

Primary Contact: Stacey Bartholomew

Primary Contact Email Address: stacey.bartholomew@creatinghousing.org

Partnering Organization(s): Creating Housing Coalition, Oregon Cascades West Council of Governments, Albany Police Department, Linn County Mental Health, Community Services Consortium, HEART group members, AST group members

Project Name (4 words or less): Community Partnership Alliance

Describe your project in a few paragraphs. This project would work to streamline interdepartmental processes in regards to service delivery and coordination of care, being able to effectively identify gaps in communication between key organizations to effectively reduce duplication of work, services and make quicker coordination possible for our frequent and high utilizers of resources to reduce health disparities within Albany.

Working 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 persons urgent needs before they become a crisis.

Which of the following does your project focus on? Addressing trauma, including environmental., Innovative programs supporting housing., Reengaging the community in personal health and community resources., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? As a prevention focused project, addressing clients urgent needs before they become crises; we see this project reducing health disparities as well as promoting equity in the following ways:

*Community agencies will have reduction of duplicated services which in turn will reallocate modest funds towards other determined services and gaps this project brings forth.
*Establishing network and community channels allowing an ability to adapt to future needs.
* Allowing clients to utilize resources in a more efficient and timely manner.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This entire project is surrounding the connection of related activities happening in our region to collaborate with community organizations that are involved with similar work.

What is your approximate budget? Over $50,000

Easy-A: Train the coach

Primary Organization: SOL4CE. LLC

Primary Contact: Dr. Sharna Prasad

Primary Contact Email Address: Sharnapras@aol.com

Partnering Organization(s): Old Mill Center for Children and Families

Project Name (4 words or less): Easy-A: Train the coach

Describe your project in a few paragraphs. Our project is innovative because it seeks to take a primary preventative approach to address self-care, physical health, mental health, and behavioral health; while addressing pain and addictive behaviors in educators. We have already begun creating the educational material to support educators in Oregon as they are on the frontlines providing support to the youth in Oregon. Building off previous work, we want to create an online educational module that empowers educators to manage their health by teaching them about mental health, pain, substance misuse, and the culture around it. We have created and adapted a curriculum that can support the mental health and overall well-being of educators; however, the COVID-19 pandemic has brought to light the importance of accessibility. The ability to adapt the curriculum to be fully deliverable online, that educators can engage in at their own pace, will help create access that can support a diverse group of educators across Oregon. Educators lost access to resources to support their health because we could not convene in person; to prevent this from occurring again in the future, we want to create a training that can be implemented virtually. Educators persevered and were able to support students, so it is our duty to support them.

Currently, our curriculum has been evaluated and supported by various health professionals and educators themselves. It is through this evaluation from educators that we know that they also would like to be able to support their colleagues and overall school with this initiative. This is why the second initiative within creating a fully accessible online curriculum, will be to create a curriculum that supports educators in learning how to deliver and support other educators as they engage in the curriculum. The goal of the training will be to give educators the tools and skills to support their colleagues and school in adopting the skills that can be obtained in the original Easy-A curriculum.

Our program also addresses ACEs (adverse childhood experiences) and the protective and risk factors associated with them. We take into account the social determinants of health, bringing awareness of how that impacts health. We bring awareness to educator burnout and what can be done about it. The three main pillars of physical health-physical activity, diet, and sleep are also addressed in depth. We destigmatize addiction and increase awareness of the biopsychosocial nature of pain while using fun analogies and metaphors to make it easy for adults to grasp and remember.

We will use the latest research on how to adapt a curriculum to be accessible online as well as innovative pedagogical strategies that ensure that we are able to train educators. The train-the-

coach model is one that has been used extensively in the past and together with a fully accessible Easy-A curriculum that is online, we can shift the narrative of educators' health and wellbeing in Oregon. This ability to reach broader audiences in Oregon, via an online module, will help provide new connections or partnerships for IHN-CCO.

Which of the following does your project focus on? Addressing trauma, including environmental., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? The behavioral health outcomes that we expect to improve are:
Self-reported self-compassion
Self-reported self-efficacy
Self-reported Sleep quality
Self-reported physical activity engagement
Self-reported perceived stress
Self-reported nutritional awareness

Through our investigation, we have found that improvements in these behavioral health categories are associated with an increase in overall health and well-being

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This project is in direct connection with related activities in our region. In 2019, DST-IHN approved a grant to create a curriculum on opioids, pain science, and healthy self-care for teachers in the Corvallis School district which was successfully completed. In 2020 we created a plan to train teachers in Ralston Academy Lebanon, but that did not happen due to COVID; instead, we pivoted to revamping our curriculum and updating it to meet the needs of educators in Oregon. At the beginning of 2022, DST-IHN approved a grant for use to implement the curriculum with teachers in the Lebanon school district, which has already yielded major benefits in adapting the curriculum to meet the diverse group of educators in Oregon. Currently, we are seeing other initiatives related to overall health and wellness, specifically the Culture of Supports and Wellness in Neighborhood Stores. This shows alignment with a cultural shift in supporting health management and wellness in the region. We also plan to collaborate with most of the school districts in the Linn, Benton, and Lincoln counties; see the list below:
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

End Of Life Support

Primary Organization: SHS Population Health/CareHub
Primary Contact: Glen Cunningham
Primary Contact Email Address: gcunningha@samhealth.org
Partnering Organization (s): Evergreen Hospice House
Project Name (4 words or less): End Of Life Support

Describe your project in a few paragraphs including how it is innovative and will provide new connections or partnerships for IHN-CCO.
During the course of providing medical respite care to numerous unhoused and unsupported patients, it has come to the Care Hub's attention that the most marginalized of our patients coping with a hospice diagnosis have nowhere to live and no care providers to help them cope with their dying process. At present these patients are dying in hospitals, shelters, respite facilities and their cars. Their care is often cobbled together by well-intentioned community-based organizations who are working far outside their scope of practice and their workforce is paying a high emotive cost for their efforts. This lack of end-of-life care in unhygienic environment with poor supportive assistance often creates less than optimal outcomes for all involved and begs the question of how to respond more humanely.

The most brutally humbled by poor SDOH in our communities could have a markedly improved end-of-life experience in a hospice house setting where shelter and care would be provided by trained staff, thereby offering comfort and best practice health care.

Our goal is to partner with the Evergreen Hospice House to contract one hospice bed to be utilized in helping unhoused IHN-CCO patients with navigating the final stages of the dying process. Our hope is that the availability of this bed will provide a much needed support to not only our patients but the greater community as well.

Which of the following does your project focus on?

This project focuses on: Addressing environmental trauma, innovative programs supporting housing, and subpopulations of IHN-CCO experiencing health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members?

This project would look at providing a dignified and supported end-of-life experience for unhoused IHN-CCO patients. While we currently do not have an outcome metric, we would look to work with IHN-CCO to develop an appropriate measure. By its very definition, this project would help to provide equitable end-of-life care to patients who have no housing and no other social support.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations?

There are currently no CBO’s that provide this service. The Evergreen Hospice House would serve as the primary contact, and they typically provide short term stays (1-2 weeks) for medication management or imminent death care. We are hoping to utilize one of their beds in a longer-term capacity to help with compassionate end-of-life care for those who are alone is every sense of the word. We would plan to integrate this project with our respite providers (Corvallis Housing First, Albany Helping Hands, Chance, COI, Northwest Coastal Housing) and shelters in identifying appropriate patients and utilize the resources of Evergreen Hospice House to support these patients. To our knowledge, this program does not currently exist in this state, and there are only two hospice houses in Oregon.

What is your approximate budget? Consider expenses such as staff time, materials and supplies, meetings, education, travel, indirect costs, etc.

- ☐ Less than $50,000
- ☒ Over $50,000
- ☐ Unsure

FAC Wellness Care Team

Primary Organization: Family Assistance & Resource Center Group (FAC)

Primary Contact: Shirley Byrd - Executive Director

Primary Contact Email Address: shirleybyrd@facforthehomeless.org

Partnering Organization(s): Linn County, City of Sweet Home, OregonSavesLives, National Healthcare for Homeless council, Benton County Health services Exodus counseling Hope Center Women's Shelter FAC Sleep Center Mana Soup Kitchen, Western University Medical School

Project Name (4 words or less): FAC Wellness Care Team

Describe your project in a few paragraphs. 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 inreach at the FAC microshelter and navigation site.

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

Which of the following does your project focus on? Addressing trauma, including environmental., Innovative programs supporting housing., Language access including health literacy, interpreter services, and 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., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? Improve acceptance and inclusion to reduce stigmas
Create a sense of community, and belonging.

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

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? There is currently no comprehensive holistic inclusive Steet medicine group or team in our region. This project connects best practices to provide a wholeness model and guidance for success.

This project connects with :
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.

What is your approximate budget? Over $50,000

Faith Communities Engaging Health

Primary Organization: Faith Community Health Network

Primary Contact: Deborah Fell-Carlson, BSN, RN, MSPH

Primary Contact Email Address: faithcommunityhealthnetwork@gmail.com

Partnering Organization(s): Linn County Faith Communities, Samaritan Health Services

Project Name (4 words or less): Faith Communities Engaging Health

Describe your project in a few paragraphs. This project is intended to create a “health buzz” in faith communities that will spill into the community-at-large. We would like to assess three faith communities in Lebanon and in Albany and use our findings to organize health events at three Lebanon faith communities and at three Albany faith communities in 2023, along with an event at St. Martin’s Episcopal Church (designed specifically to serve the unsheltered.) We will do these as a team, helping Faith Community Health Network (FCHN) nurses gain skills in community assessment, program and event planning, and practical experience in autonomous nursing practice while providing valuable health screening, health coaching, and health equity supports to those served at these events.
We will leverage this “buzz” to educate how faith community nurses can provide much-needed spiritual care and reduce health disparities among our most vulnerable faith community members. To this end, we will intentionally engage faith leaders, health system and community-based-organization partners, faith community members, the public health community, and the community at large by speaking to local faith leader groups and congregations, having an engaging booth at faith community events and select community events, writing articles for publication, and seeking opportunities to present at conferences and other partner organization events in Oregon.
We will continue to host preparatory education for nurses entering the faith community nursing specialty each fall, and continuing education and networking at our regular meetings, all of which are critical to sustainment. We will continue to equip FCNs and Health Ministers with laptops and peripherals, expanding the project started under the SHARE grant, and will continue to build capacity and proficiency within our team to assist community members who do not have the skills or resources to access online health services and community resources.
There is some interest in replication in Lincoln County, and we will explore the depth of that interest as we pursue the above work.
This project will create new partnerships between participating Linn County faith communities and IHN-CCO.
This project will require:
1. funding for our 2022 and 2023 Foundations of Faith Community Nursing Courses,
2. funds for gift cards to encourage faith community member participation in faith community assessment activities
3. purchasing services to create multimedia digital and printed marketing materials (including video) educating faith communities and their leaders, the health system, and the general public about the existence and benefits of faith community nursing, and for promoting health events and health engagement-in-general

4. travel and lodging costs for out-of-area presentation venues
5. purchase of a display board, flag with logo, canopy, literature racks, and other durable items needed for in-person event displays,
6. purchase of polo shirts with logo for the FCHN team to wear at events
7. purchase of four off-the-shelf health-oriented learning activities/props to incentivize engagement and promote learning at health events
8. purchase of promotional materials (health-related "swag" – water bottles, flashlights, pens, etc.) for prizes to incentivize engagement at health events and to create brand familiarity
9. purchase of specific print materials to encourage faith community participation in the February 5-2-1-0 community challenge hosted by Live Longer Lebanon and Samaritan Health Services
10. purchase of laptops and peripherals for FCHN team who do not yet have them (for documentation and Connect Oregon access)
11. funds for staff time and other costs
12. gift cards for Faith Community Health Network team participation

Which of the following does your project focus on? Addressing trauma, including environmental., Addressing technology disparities., Language access including health literacy, interpreter services, and translation of materials., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? 1. Health events will bring health-related activities and/or screenings into the faith community and will serve those who likely would not have accessed the services or information otherwise. It is likely that spiritual care needs will be identified and addressed during this process, as well, potentially heading off mental health crises.

2. Holding events in both Albany and Lebanon will allow us to explore how faith community nursing differs in rural vs urban settings. We will use this qualitative data to improve events and processes as we discover it. Learning how faith community nursing functions best in a rural community is critical to reducing health disparities and promoting equity in faith communities and for the overall success of the faith community nursing roll-out in our area specifically, and also in Oregon.
3. Educating about faith community nursing benefits will help to improve acceptance of faith community nursing practice as part of overall service ministry programs and once it becomes part of the fabric of the faith community, will continue to bring health into faith community ministries in years to come.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This project furthers the work the FCHN started under the SHARE grant and begins to create an infrastructure for expansion and implementation into other faith communities, sustainability, and potential replication. This project connects with work at St. Martin's Homeless Outreach and Family Assistance and Resource Center Street Outreach, and better technology proficiency within FCHN will ultimately result in improved communication and partnerships with Samaritan case managers, discharge planners, clinic coordinators, other CBOs through Connect Oregon, and providers. It will create new partnerships between faith communities and IHN-CCO; one faith community is already planning to apply for funding as a result of our connected work.

Homeless Data Harmonization

Primary Organization: Samaritan Health Services

Primary Contact: Paulina Kaiser

Primary Contact Email Address: pkaiser@samhealth.org

Partnering Organization(s): Community Services Consortium, OSU Policy Analysis Laboratory

Project Name (4 words or less): Homeless Data Harmonization

Describe your project in a few paragraphs. We propose an analytic project to harmonize data related to homelessness across two key community organizations: Community Services Consortium (CSC) and Samaritan Health Services (SHS). CSC serves as the community action agency for Linn, Benton, and Lincoln (LBL) counties. As a member of the Rural Oregon Continuum of Care, CSC maintains the HMIS data system for Coordinated Entry assessments across the LBL region. This represents a robust source of data on people experiencing homelessness. SHS is the largest provider of health services in the LBL region, including operation of all emergency departments and hospitals. As such, SHS's electronic medical record system (Epic) contains robust data on the health needs and healthcare utilization of people with homelessness in Linn, Benton, and Lincoln counties.

Data from CSC's HMIS and Epic have not been linked before. Harmonization across these two key data sources will improve our ability to describe patterns and quantify health disparities experienced by the homeless population. We plan to use the OSU Policy Analysis Laboratory (OPAL) as a neutral third party to lead the data analysis for this project. OPAL leverages faculty and students from OSU's School of Public Policy to take on a wide range of real-world policy problems, and is able to provide the methodological rigor and research infrastructure to support this project.

Which of the following does your project focus on? Innovative programs supporting housing., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? This project will not directly improve health outcomes, but will provide key information to guide future investments and interventions. People experiencing homelessness have substantial health disparities in complex comorbidities and acute care utilization. Learning how to better harmonize and leverage existing data from agencies that serve the homeless population will provide actionable evidence to guide strategies to mitigate these disparities.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This project is aligned and integrated with related activities and community organizations. This project stems from conversations occurring at

the Benton County HOPE Board's Data Improvement workgroup, which includes key partners in Benton County as well regional partners such as SHS and CSC. OPAL has previously collaborated with CSC for the 2022 Point in Time count.

What is your approximate budget? Over $50,000

Hope Grows Here

Primary Organization: Moore Family Center – Oregon State University

Primary Contact: Moore Family Center – Oregon State University

Primary Contact Email Address: candace.russo@oregonstate.edu

Partnering Organization(s): Potential partners: Linn/Benton Master Gardeners; Samaritan Cancer Resource Centers; Linn-Benton Food Share/Gleaners; Community Gardens - Lebanon, Albany, S.Corvallis; OSU Nutrition/Dietetics students; Community Health Centers.

Project Name (4 words or less): Hope Grows Here

Describe your project in a few paragraphs. 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, community gardens, and Medicaid-eligible individuals who have experienced cancer, this program aims to strengthen the physical and mental health, well-being and resilience of cancer survivors.
Evidence has shown the positive effects of gardening on a variety of populations, both in physical health (e.g. providing motivation for physical activity, improving access to fresh fruits and vegetables), and mental health (e.g. stress and anxiety reduction through exposure to nature, increased self-worth through caring for living things). 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. Breakthroughs in cancer treatments have increased the number of individuals surviving cancer, yet a lack of support systems exists when treatment is over, for both survivors and their caregivers. Living within a low household income further confounds these factors with additional health disparities - sustainable access to and affordability of fresh, nutrient-dense foods, being just one.
Participants in Hope Grows Here will learn to garden in a supportive environment that is sensitive to the limitations of their lived experiences, yet builds on their individual strengths. Project milestones include: 1) a no-cost basic gardening class taught by trained Master Gardeners volunteers; 2) individual and small-group garden consultations with Master Gardeners and the project coordinator; 3) dissemination of gardening supplies and resources to participants; 4) pairing small-groups of survivors for weekly peer support and garden meet-ups; 5) engaging in-person sharing of nutrition education, food demonstrations, tastings, and additional fresh produce from the region through a mobile kitchen (including a mobile herb and microgreen garden); and 6) harvest celebrations hosted by OSU nutrition and dietetic students, including curated recipes and food demonstrations and tastings.
This innovative approach goes beyond just teaching people how to garden or giving them a recipe. The social ecological model – 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 and trauma-informed nutrition will be incorporated into the program, with all volunteers completing TIC 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.
The mobile kitchen will make weekly visits to small-group gatherings to share supplemental produce from the Linn-Benton Food Share's gleaners program, and host food demonstrations and tastings using common garden and gleaned produce. A container-based herb and microgreen garden will be a staple of the mobile kitchen.
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.
Harvest season will be celebrated and shared as a community.
A pilot of garden beds specifically for Hope Grows Here gardeners will be established at one community health center or local health clinic. Not only will this provide a dedicated space for participants to practice gardening, it may also encourage a connection to the health center, 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. Local health centers can be accessed using either free public transportation (Benton county), or through medical transportation (Benton & Linn counties).
The Moore Family Center, in partnership with OSU Extension Service Master Gardener Program and the Samaritan Regional Cancer Centers of Linn & Benton Counties have facilitated a remote version of Hope Grows Here in 2020, with a general population of adult cancer survivors (not necessarily low-income), and with success. Significant improvements were seen in both physical activity levels and mental health scores, along with 100% participant retention, engagement and enjoyment. We are eager to bring this project to a population that could potentially benefit even more, with the addition of a mobile kitchen (new to this proposal), and the pilot of dedicated growing spaces linked to a local health clinic. We see the latter as a potential means to build project sustainability.

Which of the following does your project focus on? Addressing trauma, including environmental., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? Positively impact physical and mental health for low-income cancer survivors.
Increase access to fresh fruits and vegetables.
Increase fruit and vegetable consumption.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? Samaritan Cancer Resource Centers provide additional nutrition-based workshops for cancer survivors (That's My Farmer) classes. Cross-promoting these no-cost opportunities will be part of this project.
The Garden Manager at Porter Park Community Garden in Lebanon, Sheryl Casteen, offers no-cost organic gardening classes that can supplement the initial basic gardening course offered in this project, as well as continuing education beyond the project scope.

Garden spaces exist in some housing developments, including DevNW properties, and some properties managed by Albany Partnership for Housing & Community Development, along with community gardens in lower-income neighborhoods (e.g. Porter Park Community Garden in Lebanon, Willamette Park Community Garden in South Corvallis, and Willamette Community Garden in Albany). Further exploration of partnerships with these community organizations will be an essential part of this project to identify garden spaces.
The strong network of community organizations through the IHN-CCO DST group, and other groups such as Live Longer Lebanon and Linn-Benton Partners for Health will be important partners to help disseminate outreach to the targeted population.

What is your approximate budget? Over $50,000

Improving access with CHW's

Primary Organization: Unity Shelter

Primary Contact: Ailiah Schafer

Primary Contact Email Address: ailiah@unityshelter.org

Partnering Organization(s): Benton County Health Services, Corvallis Daytime Drop in Center, Corvallis Housing First

Project Name (4 words or less): Improving access with CHW's

Describe your project in a few paragraphs. Unity Shelter's mission is to provide safe shelter through collaborative care. Unity Shelter programs include overnight emergency shelter through the Corvallis Men's Shelter, and Room at the Inn programs, transitional housing through the SafePlace microshelter program and Third Street Commons Project Turnkey hotel program, and day services with showers, laundry, charging, and lunch through the Hygiene Center. Unity Shelter aims to provide all program participants with the referrals and resources necessary to increase overall health and well-being of the community.

As a result of the COVID-19 pandemic, many in-person supports that our programs utilized had to cease, and many clients were left to navigate complicated systems on their own, as staff was limited and not trained in health or resource navigation. To fill this still existing gap within Unity Shelter's services, the IHN-CCO DST funding would provide Community Health Worker (CHW) and Clinical Health Navigation training to 2-3 existing Unity Shelter staff. Many of Unity Shelter staff have lived experience that will be beneficial to their training and their relationship to the clients they serve. Training existing staff to provide these services will decrease the time it takes to build rapport with individual clients, and increase the time it takes for clients to access mental and physical health services and basic needs.

Unity Shelter CHW's will work with individuals that are active participants in each of Unity Shelter's five programs, as well as with individuals that have transitioned into more permanent housing and need ongoing support. Additionally, Unity Shelter already partners closely with the Corvallis Daytime Drop-in Center's Street Outreach and Response Team (SORT) team, and the addition of CHW's on outreach will strengthen the partnership with SORT as well as the relationship with clients by meeting them where they are comfortable.

Many individuals distrust traditional healthcare and the people involved with health departments. By providing access to CHW's within a social service setting, individuals will have the ability gain access to healthcare and resources at their pace, with workers they have already built rapport with. This provides a new pathway for increased healthcare, housing, and basic needs access without the additional burden on an already strained county health department.

Which of the following does your project focus on? Addressing trauma, including environmental., Innovative programs supporting housing., Language access including health

literacy, interpreter services, and translation of materials., Oral health integration., Reengaging the community in personal health and community resources., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? Community Health Workers on site will have the ability to engage with clients immediately upon entrance to the program and assist with access to resources right away. Eligible individuals that are not already IHN-CCO members will be able to promptly collaborate with a CHW to enroll and begin receiving appropriate care. Clients that enter Unity Shelter services often have undiagnosed and/or untreated chronic conditions. The immediate access to a CHW and clinical navigator will increase chronic health condition diagnosis and treatment, regular primary care, and regular mental health care for IHN-CCO members. By partnering with Benton County Health Services, CHW's will have the ability to refer to the dental clinic with ease, increasing dental and oral hygiene.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? Unity Shelter would partner closely with Benton County Health services. Benton county has an existing health navigation team that would provide ongoing support and guidance to Unity Shelter's newly trained CHW's. By employing our own CHW's, there is not an undue burden on the county health navigation team to provide all required services to clients, but instead provide support to workers that work closely with the population and have existing relationships. Unity Shelter partners with Corvallis Housing first (CHF) for case management services. CHW's would collaborate with clients and their assigned case managers to ensure all health, housing, and basic need goals are being met, and barriers to access are being addressed in a timely manner.

The Community Health Worker training can be provided by multiple organizations and will be determined depending on cost and availability. Options for the training being considered are offered through Oregon State University and Benton County Health Services.

What is your approximate budget? Over $50,000

Overcoming Obstacles to Dental Care

Primary Organization: Capitol Dental Care

Primary Contact: Linda Mann

Primary Contact Email Address: mannl@interdent.com

Partnering Organization(s): To be determined

Project Name (4 words or less): Overcoming Obstacles to Dental Care

Describe your project in a few paragraphs. Accessing dental care for adults and children with developmental disabilities can be difficult for several reasons, including; limited number of providers willing to see these patients, difficulty with transportation, complexity of care needed, and the increased amount of time needed for procedures. Wait times to treat patients in the hospital to provide comprehensive restorative care can be months long, placing these patients at high risk of pain and anxiety which increases stress for them and their care providers. "Overcoming Obstacles to Dental Care" aims to address these issues in several ways.
First, we aim to shift the focus on acute care/surgical intervention to chronic disease management by training and supporting caregiver in improving daily mouth care. We will provide the "Overcoming Obstacles to Oral Health" training videos along with a continuous presence to provide support.
Next, we will utilize preventive measures such as fluoride varnish, Silver Diamine Fluoride (SDF), sealants, and Interim Therapeutic restorations (ITR's) to prevent and stabilize patients while they wait for surgical care.
Lastly, we will implement a community based, telehealth enabled delivery model to provide dental care at care facilities, day care program or other community setting utilizing and Expanded Practice Dental Hygienist (EPDH) and portable equipment.
This three-prong approach will allow those waiting for surgical care to be placed in a holding pattern while at the same time providing support to their caregivers, and focus on prevention of further dental disease.

Which of the following does your project focus on? Oral health integration., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? 1. Implement or improve daily mouth care of program participants. Proper daily mouth care is essential to dental disease management. We will educate and address barriers associated in implementing daily mouth care practices and empower caregivers to provide or assist in these services.
2. Stabilization of dental disease for those waiting for surgical care. Utilizing preventive and therapeutic agents, patients can be placed in a “holding pattern” while they are on the wait list for further care. This model will help ease the pressure on the dental delivery system as well as on the caregivers.

3. 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 should result in better mouth care and better oral health. Typical payment models do not support care coordination, education and caregiver support activities that are needed to maintain and effective community based system of care.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? While we have begun to reach out to community organizations to collaborate with those already serving persons with disabilities, we have yet to confirm a specific partner. In the next few weeks we will be talking with folks from the Disability Equity Center to receive their input and guidance. We have reached out to the Chamberlin House as a potential facility to work with. We have notified and asked for input from two local dentists; Dr. Summers, and Dr. Hagerty who treat a large number of children with disabilities. We are confident that we will be able to secure collaborations within the next few weeks. Capitol Dental has a proven track record with successful DST funding projects. We also plan to collaborate with other medical providers such as speech therapists, occupational and physical therapists, behavioral health providers and others who currently serve these groups onsite or through telehealth services.

What is your approximate budget? Over $50,000

Project Pill Minders

Primary Organization: Coastal Support Services

Primary Contact: Amanda Cherryholmes

Primary Contact Email Address: csslincolncounty@gmail.com

Partnering Organization(s): Lincoln County Mental Health / Lincoln County Public Health

Project Name (4 words or less): Project Pill Minders

Describe your project in a few paragraphs. In partnership with Lincoln County Mental Health and Lincoln County Public Health, we are creating a way for IHN-CCO members to become more involved and engaged with the medications that they are prescribed as well as improve communication between medical providers and IHN-CCO members for better medication regulation.

Coastal Support Services has certified community health workers that specialize in providing services to those experiencing homelessness and extreme hardship. Our community health workers would work with the partner agencies by coaching those who need help with pill minders to fill and keep track of their medications daily and fill prescriptions as needed as well as provide internet access and assistance navigating online portals to communicate symptoms to their therapists and medical providers regarding the medication they are prescribed.

This partnership and program allows for all medical outlets to be connected by means of making peer delivered services the bridge between the gap of IHN-CCO clients and medical providers.

Which of the following does your project focus on? Addressing trauma, including environmental., Addressing technology disparities., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? * IHN-CCO members will become more independent and learn how to manage the medications that they are prescribed.
* IHN-CCO members will become involved and engaged with regulating the medications that they are prescribed.
* IHN-CCO members access to community resources will increase significantly.
* Therapists will have the ability to better track an IHN-CCO member's symptoms for the medications that they are prescribed resulting in better medication regulation for IHN-CCO members.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? We are partnering with Lincoln County Mental

Health and Lincoln County Public Health in order to teach IHN-CCO members how to manage their prescribed medications for mental as well as physical, as well as improve the communication between therapists, medical providers and IHN-CCO members for better medication regulation for IHN-CCO members.

What is your approximate budget? Over $50,000

School Based Health Center

Primary Organization: Lebanon Community School District

Primary Contact: Rachel Cannon

Primary Contact Email Address: rachel.cannon@lebanon.k12.or.us

Partnering Organization(s): Samaritan Lebanon Community Hospital, LCMH, Obria

Project Name (4 words or less): School Based Health Center

Describe your project in a few paragraphs. In April 2021, the Lebanon Community School District (LCSD) formed an Advisory Committee with partnering agencies. Through looking at LCSD and partnering data agencies data the team concluded that LCSD students are not receiving basic medical care, behavioral health services and, often, dental services. Some of the data is listed below:

Below are the numbers for 12-18 year olds in the Lebanon practice that received a wellness child check (WCC).
In 2019, 54.6% of 12-18 year olds had a WCC
In 2020, 47.1% of 12-18 year olds had a WCC
In 2021, 10.4% of 12-18 year olds had a WCC
Prior to COVID LHS kept and logged on avg. 50 Student Health Room Visits a day.
As of December, LCSD has had 27 original referrals for help with Oregon Health Plan (OHP), and we have assisted connecting approximately 62 kids with OHP.
According to the Healthy teens survey our students struggle to access healthcare and have high ACE scores. According to Obria, 2019 Rates of STIs in Oregon Counties: (per 100,000 people)
Linn:
Chlamydia 542.5
Gonorrhea 157.3
Oregon:
Chlamydia 457.1
Gonorrhea 145.4

Based on data collected, in partnership with Samaritan Lebanon Community Hospital, Linn County Mental Health, Community Health Centers of Benton and Linn Counties Dental Program, and Obria Lebanon Community School District is creating a School Based Health Center at Lebanon High School.

According to Oregon.gov, school-based health center's "are a vital community tool with a youth-centered model that supports young people's health and well-being." They are "in schools or on school grounds and provide medical care, behavioral health services and, often, dental services. Because of these easily accessible services, school-aged youth have an equal opportunity to learn, grow and thrive." The University of Chicago Medical Center- results from multiple studies suggest that SBHCs are successfully serving adolescents from low-

income and minority families who do not traditionally access care from other safety net providers such as Federally Qualified Health Centers or free clinics.

The SBHC will be open at least 3 days a week with a minimum of 15 hours a week of a MD or DO doctor available for LCSD students to access care.
The goals for a SBHC is to:
Improve access to affordable quality primary care and mental health services for school-aged youth
Provide patient-centered care for all students, regardless of insurance status
Reduce costs related to unnecessary hospital stays and use of emergency rooms
Improve educational outcomes because healthy kids learn better
Save parents time by reducing missed work hours

The SBHC will offer a minimum of the following services for students regardless of their ability to pay:
Routine physicals, well-child exams, and sports exams;
Diagnosis and treatment of acute and chronic illnesses;
Treatment of minor injuries/illnesses;
Vision, dental and other health screenings;
Immunizations;
Alcohol and drug counseling and prevention;
Preventive health and wellness messaging delivery;
Mental health counseling;
Reproductive health services; on-site (health exam, STI prevention education and treatment, pregnancy prevention education, HIV counseling). Referral (prescriptions for contraceptives*, condom availability*, prenatal care, HIV treatment).
Health and wellness classroom education;
Medication prescription;
Help students find social support

Which of the following does your project focus on? Addressing trauma, including environmental., Addressing technology disparities., Oral health integration., Reengaging the community in personal health and community resources., Rural community impact., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? Improve access to affordable quality primary care and mental health services for school-aged youth.
Provide patient-centered care for all students, regardless of insurance status.
Reduce costs related to unnecessary hospital stays and use of emergency rooms.
Improve educational outcomes because healthy kids learn better.
Support families by saving parents time by reducing missed work hours.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to

to build healthier communities together.
Goal 1: Healthy Families
Goal 2: Greater Access
Goal 3: Better Networks
Goal 4 Healthy Kids
Goal 5 Healthy Teens
According to the Samaritan Lebanon Community Hospital Community Benefit Plan it says, "Mental health, behavioral health, dental health, and alcohol and drug treatment continue to be significant needs, with mental health being the county's number-one priority."
All 4 of these areas will be offered at the SBHC.
Activities regarding oral health through Linn Benton health communities, activities regarding pregnancy and sexual health from Obria, and mental health initiatives by LCMH are all aligned and supported.
Our sponsoring agency is Samaritan. However, we have collaborated with the following agencies and partners:
Samaritan Health Services
Obria
Linn County Alcohol and Drug Prevention Specialists
Linn County Juvenile Department
Linn County Mental Health
Greater Santiam Boys and Girls Club
Jackson Street Youth Services
Linn Benton Lincoln ESD
Western University of Health Sciences
A Community Faith-Based Organization
LCSD staff
LCSD Parent

What is your approximate budget? Over $50,000

THW Peer Doula Collaboration

Primary Organization: ReConnections Alcohol and Drug Treatment, INC

Primary Contact: Lalori Lager, MA, CADC II

Primary Contact Email Address: lalori.lager@reconnectionscounseling.com

Partnering Organization(s): Community Doula Program (CDP)

Project Name (4 words or less): Traditional Health Worker (THW) Peer Doula Collaboration

Describe your project in a few paragraphs. ReConnections and the Community Doula Program are requesting funding to support site-based, wrap-around wellness care for IHN members pregnant and parenting with Substance Use Disorders (SUDs), trauma and mental health conditions, including COVID-related stress. This project will implement an integrated care model for supporting pregnant IHN-CCO clients, using lessons learned from the Nurture Oregon project being piloted in six counties around the state. Findings from the program are promising for participants and their babies. ReConnections has 25 years of experience and a proven approach to supporting clients with substance use disorder and delivering integrated care to pregnant individuals in Lincoln County. This project will draw from this expertise and develop services for individuals in Linn and Benton Counties in collaboration with the Community Doula Program.

This project will cultivate a physical space for clients to participate in services; 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, easily reachable by public transportation makes it easier for clients to drop in and have their needs met. This also helps avoid the need to share potentially private information (during intakes, prenatal visits, counseling sessions, for example) in public spaces like libraries or parks. The community space in Newport that this space will be modeled after is heavily utilized with daily meetings, groups and events, with more than a dozen community partners sharing the space to offer non-judgmental, trauma-informed, wrap-around care to pregnant and parenting IHN,CCO members. It is also our hope that this space can be used by other DST pilots at reduced or no cost. Cost sharing for rent could be implemented in year two.

In addition, this project will cross-train Doulas and Peer Support Specialists to provide high-quality care to clients with the goal of reducing negative birth outcomes and increasing family preservation. This cross-training has already begun between the two organizations on a small scale, with additional individuals expressing interest in upcoming training opportunities. A cross-training approach will strengthen the THW workforce by offering quarterly training for current Doulas to become Peer Support Specialists and vice versa. Additionally, we will continue to recruit and train new community members to one or both of these roles. Leveraging existing THWs to expand their roles will increase sustainability by allowing for the provision and billing of additional services. Doula work in Oregon 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, we expect less attrition and increased sustainability for the workforce.

Which of the following does your project focus on? Addressing trauma, including environmental., Addressing technology disparities., Developing a bilingual and bicultural workforce., Innovative programs supporting housing., Language access including health literacy, interpreter services, and 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., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? The Nurture Oregon integrated-care model for pregnant individuals with substance use disorder shows peer support increases prenatal visits, reduces child welfare involvement, and demonstrates cost savings. Data from March 2022 showed that 88% of participants received prenatal care, and 82% received postpartum care. 98% of infants born to participants had at least 1 well-child check, and 93% had at least 2 well-child checks in the first year of life.

Doula-supported individuals have shorter labors with fewer complications, reach their infant feeding goals more easily, have fewer cesarean births, and describe more positive feelings about their birth. Research also suggests that support from a doula during pregnancy and childbirth could help improve health for women of color and potentially reduce racial and ethnic disparities in birth outcomes.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? This project builds upon the successes of existing programs in the tri-county area, strengthening partnerships between ReConnections, the Community Doula Program, public health in Linn, Benton, and Lincoln counties, and dozens of other social service agencies. This project will also explore collaborations with newer community-based organizations and DST pilots, including those that address housing insecurity, oral health, and parenting support.

What is your approximate budget? Over $50,000

Workshops on Wellness

Primary Organization: The Arc of Benton County

Primary Contact: Misha Marie

Primary Contact Email Address: mmarie@arcbenton.org

Partnering Organization(s): Lincoln County Schools, Benton County Schools, Oregon Health Authority

Project Name (4 words or less): Workshops on Wellness

Describe your project in a few paragraphs. The Workshops on Wellness project will develop and implement wellness programs in collaboration with people living with intellectual and developmental disabilities (I/DD) as well as with those that are knowledgeable in working people with I/DD.

The COVID-19 pandemic has greatly exacerbated the social, physical, and mental health disparities and challenges of people with intellectual and developmental disabilities (I/DD). Already facing many challenges and barriers to eating well, exercising sufficiently, connecting socially, and building healthy relationships, people with I/DD have been cut off from their peers, experienced greater isolation for fear of illness, and have had far fewer opportunities to learn and practice healthy eating and exercise.

In order to support recovery from COVID-19 and build on-going capacity to strengthen these skills, the Arc of Benton County, in partnership with Benton and Lincoln County schools, proposes using the Club Wellness Project for teens and adults with intellectual and developmental disabilities. Information on this program can be seen as requested.

This comprehensive instructional program provides fitness, nutrition, wellness training and education through a curriculum uniquely adapted for people with intellectual and developmental disabilities. Club Wellness aims to achieve sustainable behavior changes for the individual as well as increased societal emphasis on the improvement of the health and wellness of individuals with intellectual disabilities, addressing the social determinants of health.

In support of the curriculum provided by Club Wellness the Arc of Benton County hopes to offer on-going nutrition, exercise, relationship, and other wellness classes for people with I/DD, their families and friends.

The Arc of Benton County has recently acquired a facility to be used as a clubhouse. The clubhouse to be created and developed by those with I/DD to ensure that the approach is inclusive and informed by those with the lived experience of I/DD. We see this clubhouse model as an innovative approach to wholistic wellness programs guided by those experiencing the health inequities because of their I/DD experience.

People aged 21, graduating from the transition programs, needs continued, sustained support in order to achieve a healthy lifestyle.
The role of mentors and peers in this process is critical and will be provided with the clubhouse model.

Which of the following does your project focus on? Addressing trauma, including environmental., Addressing technology disparities., Language access including health literacy, interpreter services, and translation of materials., Pay equity through building and sustaining the workforce., Reengaging the community in personal health and community resources., Subpopulations of IHN-CCO members that experience health disparities.

What health outcomes do you expect to improve in order to promote equity and reduce health disparities for IHN-CCO members? We expect to see improved health outcomes in the areas of healthier eating, increased fitness, reduced risk of tobacco use, reduced social isolation and loneliness, and improved skills for communication and self-advocacy. Pre- and post-surveys are already incorporated into the Club Wellness curriculum and complementary surveys will be used with the other wellness workshops to measure progress.

How does this project connect with related activities happening in our region? Which other community organizations are involved with this idea or similar work? Do you plan to collaborate with any other organizations? We are inspired by the Pathfinders model of supporting people with mental health issues in the community. Their emphasis on building with and not for people to achieve their own, improved health outcomes. This project connects with the goals and activities of transition programs in the Linn, Benton, and Lincoln County schools, the Disability Equity Center, and with centers and research programs at Oregon State University. We plan to connect with these potential partners in the development and delivery of these wellness workshops.

What is your approximate budget? Over $50,000