Agenda
Delivery System Transformation Committee

March 16, 2023 4:30 – 6:00 pm

Online: Click here to join the meeting

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1.	**Welcome and Introductions**	**Renee Smith,** Family Tree Relief Nursery	**4:30**
2.	**Transformation Update**	**Beck Fox,** IHN-CCO	**4:45**
3.	**Peer Enhanced Emergency Response Pilot Closeout**	**Bryan Decker,** CHANCE Recovery	**5:00**
4.	**Overcoming Barriers, Foster Youth Pilot Closeout**	**Jennifer Solberg & Catherine Baker,** Casa-voices for Children	**5:20**
5.	**Request For Proposal & Priorities**	**Renee Smith,** Family Tree Relief Nursery	**5:40**
6.	**Adjourn**	**Renee Smith,** Family Tree Relief Nursery	**6:00**

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
AHEAD	Ahead of the Curve	Olalla Center	Lincoln	1/1/2023	12/31/2023
AMP	Amplifying Voices	SHS ArtsCare Program	Lincoln	9/1/2022	12/31/2023
ARCC	Arcoiris Cultural	Olalla Center	Lincoln	1/1/2022	12/31/2023
CRPS	Culturally Responsive Peer Services	Family Tree Relief Nursery	Benton; Linn	1/1/2022	12/31/2023
CSUP	Culture of Supports	North End Senior Solutions	Lincoln	1/1/2021	12/31/2023
DEC	Disability Equity Center	Disability Equity Center	Benton; Lincoln; Linn	1/1/2021	12/31/2023
EASYA	Easy A	Sol4ce LLC	Benton	1/1/2022	6/30/2023
EOL	End of Life Support	SHS Population Health/CareHub	Benton; Lincoln; Linn	1/1/2023	12/31/2023
FAITH	Faith Communities Engaging Health	Faith Community Health Network	Linn	1/1/2023	12/31/2023
HNS	Health Navigation Station	St. Martin's Episcopal Church	Linn	9/1/2022	12/31/2023
HHT	Healthy Homes Together	Family Tree Relief Nursery	Linn	1/1/2021	6/30/2023
IATHW	Improving Access with THWs	Unity Shelter	Benton	1/1/2023	12/31/2023
IFCW	Integrated Foster Child Wellbeing	Samaritan Health Services	Benton; Lincoln; Linn	1/1/2019	12/31/2023
NAMRX	Namaste Rx	Namaste Rx LLC	Benton; Lincoln; Linn	1/1/2022	12/31/2023
OODC	Overcoming Obstacles to Dental Care	Capitol Dental Care	Benton; Linn	1/1/2023	12/31/2023
PSLS	Pain Science Life Stories	Oregon Pain Science Alliance	Benton; Lincoln; Linn	1/1/2022	6/30/2023
PCPT	Primary Care Physical Therapy	Samaritan Lebanon Community Hospital	Linn	1/1/2022	6/30/2023
PSHR	PSH Respite and Housing Case Management	Corvallis Housing First	Benton	1/1/2022	6/30/2023
PUENTE	PUENTES	Casa Latinos Unidos	Benton; Linn	1/1/2022	12/31/2023
HEALTH	The Health Collective	Lebanon Community Hospital Physical Therapy	Benton; Lincoln; Linn	9/1/2022	12/31/2023
TIAH	Transitioning into a Home	Furniture Share	Benton; Lincoln; Linn	9/1/2022	12/31/2023
WnR	Walk 'n Roll	Newport 60+ Activity Center	Benton; Lincoln; Linn	9/1/2022	12/31/2023
WELLTM	Wellness Care Team	Family Assistance and Resource Center Group	Linn	1/1/2023	12/31/2023
WVC	Women Veterans Cohort	Red Feather Ranch	Benton; Lincoln; Linn	10/1/2021	12/31/2023
DBHS	Decolonizing Behavioral Health Supports	Corvallis Daytime Drop-in Center	Benton; Lincoln; Linn	1/1/2022	12/31/2023
MHHC	Mental Health Home Clinic	Samaritan Medical Group	Linn	1/1/2021	12/31/2023
NPSH	Navigation to Permanent Supportive Housing	Lincoln County Sheriff's Office	Lincoln	1/1/2020	12/31/2023
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

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 Committee (DST) 2023 Calendar

January	5	Racial Equity Training			
	19	Strategic Planning: Racial Equity Discussion, Charter, and Roles & Responsibilities			
February	2	CDP	TTH	Charter Review & Priorities	
	16	CCP	HUBV	Engagement	
March	2	DSDP	PBHT	Engagement	
	16	PEER	OBFY	RFP & Priorities	
	30	WINS	DDDW	Community Partnerships	
April	13	Strategic Planning			
	27	RFP			
May	11	Board Update	Strategic Planning		
	25	RFP			
June	8	CAC Update			
	22	RFP			
July	6	Board Update	Pilot Updates		
	20	RFP			
August		**Regional Planning Council August 3**			
	3	RFP			
	17	RFP PRESENTATIONS			
	24	RFP PRESENTATIONS			
	31	RFP PRESENTATIONS			
Sept	14	RFP DECISIONS			
	28			Workgroup Updates	
October		**Regional Planning Council October 5**			
	12				
	26		Pilot Updates		
Nov	9				
Dec	7				

KEY

- Closeout
- Request for Proposal
- Strategic Planning
- Miscellaneous
- Training
- Pilot Updates
- Workgroup Updates

Present			
Chair: Renee Smith	Annie McDonald	Alicia Bublitz	Allison Hobgood
Ashley Hoffman	Beck Fox	Bettina Schempf	Charissa Young-White
Danny Magana	Dick Knowles	Erin Gudge	Erin Sedlacek
Karen Weiner	Lalori Lager	Linda Mann	Laurel Schwinabart
Melissa Isavoran	Mica Contreras	Michael Couch	Shana Palmer-Whalen
Rebekah Fowler	Sara Jameson	Shannon Rose	Kristty Zamora-Polanco
Mary Ann Wren	Emma Chavez Sosa	Susan Trachsel	Elizabeth Hazelwood
Rolly Kinney			

Transformation Update – Beck Fox

- Polly Poll: Regularly scheduled meetings in a hybrid format or additional meetings in a hybrid format
    - Regularly scheduled meetings scored higher and are preferred.
    - More information to come

Pathfinder Behavioral Health Transformation Program Closeout – Elizabeth Hazelwood

- Success: Has the ability to meet every person interested in the program
- Program was expected to serve 100 by the end of 2022, served 167persons by the end of 2022
- 4 clubhouses currently
    - Portland, Roseburg, Medford, Corvallis
- Partnership opportunities/connections:
    - 1 page referral page: Transformation will help connect.
        - Patient must have MH diagnosis and be 18 years of age
- Staffing levels of clubhouse:
    - 8 staff members – fully staffed
    - 40 people per day would likely be considered full capacity
        - Clubhouse is looking for a bigger location

Depression Screenings in Dental Practices Closeout

- Data collection
    - Why it's important (OHA collection for example) but how does this affect the member/patient and how should the provider/health care professional have this conversation
        - How does having this conversation with the member/patient affect the provider/health care professional

Engagement Discussion

- This meeting needs to be more readily available to other types of users (barriers for users who aren't familiar with PowerPoint, MS teams, etc.)
    - Teams is not an accessible format
    - Having peoples voice matter and being heard
    - Having an ASL, Spanish interpreter
- This time of day that the meeting is conducted is very difficult
- Lack of score cards being filled out
    - Not feeling prepared, not taking the time to be prepared in order to fill out the scorecard
- Simplifying the voting process
- Having an orientation process
    - Creating a ‘buddy’ so you can build community but are also coming in and are familiar with what's going on
- Create a type of scoring committee?
    - Then possibly a full group synthesizes analysis and votes?
    - Maybe a few different groups do scoring for select pilots and then full vote?
- Simplify applications for RFP process - streamline

Delivery System Transformation Committee (DST)
Committee of the Regional Planning Council
2023 Charter [DRAFT]

Mission:

To positively impact the health and wellbeing of IHN-CCO members and our community.

Vision:

The Delivery System Transformation committee envisions a healthcare system rooted in community knowledge, values, and innovation. As such, the DST is committed to fostering an inclusive, engaged, collaborative space where innovative and transformational ideas are shared and supported with the intent of advancing health equity, centering community perspectives, and improving health outcomes for diverse communities across the Benton, Lincoln, and Linn County region.

Values:

Equity Inclusion Innovation Transformation

Respect Collaboration

2023 Goals and Strategies:

Goal 1: Advance health equity in all Committee projects including pilots & workgroups.

- **Strategy:** Center health equity and trauma-informed practices.
- **Strategy:** Create an environment of inclusion, shared learning, and accountability.

Goal 2: Improve community-driven and community-focused approaches to health and wellbeing by including and elevating the lived experiences and ideas of communities facing health disparities caused by systemic oppression.

- **Strategy:** Strengthen lines of communication between different organizations, the traditional healthcare system, and community-based heath.
- **Strategy:** Support meaningful, two-way relationships that foster trust, transparency, and a genuine commitment to partnership.

Goal 3: Support, sustain, and spread new and transformational initiatives.

- **Strategy:** Identify and support pilots that increase equitable access to affirming care, improve the health of communities, prevent provider and staff burnout, and demonstrate good stewardship of funds.

Goal 4: Welcome innovative ideas that are collaborative, aligned with IHN-CCO goals, and center the needs of IHN-CCO members.

Strategy: Align with the Community Advisory Council (CAC), its Community Health Improvement Plan (CHIP), and the State Health Improvement Plan (SHIP) priority areas.

Strategy: Identify and support champions that reflect the communities we serve, amplify the voices of marginalized communities, and prioritize new partnerships.

Goal 5: Use both quantitative (numbers) and qualitative (stories) data to analyze, understand, and share the impact of pilot projects.

Strategy: Use best practices for equitable data collection, analysis, and sharing that does not exploit or burden IHN-CCO members. This means engaging in data collection that is relevant, meaningful, and designed in collaboration with communities.

Strategy: Recommend system changes, report gaps and barriers, and provide information to the RPC.

As a member of the InterCommunity Health Network Coordinated Care Organization (IHN-CCO) **Delivery System Transformation Committee (DST)** I agree to the following principles:

Support the goals of the DST:

- Support, promote, and/or positively impact the health and wellbeing of IHN-CCO members.
- Advance health equity in all Committee projects including pilots & workgroups
- Improve community-driven and community-focused approaches to health and wellbeing by including and elevating the lived experiences and ideas of communities facing health disparities caused by systemic oppression.
- Support, sustain, and spread new and transformational initiatives.
- Welcome innovative ideas that are collaborative, aligned with IHN-CCO goals, and center the needs of IHN-CCO members.
- Use both quantitative (numbers) and qualitative (stories) data to analyze, understand, and share the impact of pilot projects.

Provide strategic guidance, vision, and oversight for the Committee:

- Commit to developing strategies that strengthen the community.
- Share data and information with the Committee.
- Encourage attendance and participation of the DST workgroups.

Play an active role:

- Participate in the meetings.
    - A member must attend at least fifty percent of meetings measuring from the end of the previous year's voting period to vote on funding recommendations or proposals.
- Review materials and be prepared for engaged discussion, active listening, and respectful dialogue.
- Foster and promote the spirit and message of the Committee.
- Identify members to join the Committee, workgroups, and pilots to successfully complete objectives.
- Serve as a vocal champion of the DST's work.

Avoid conflicts of interest:

- Abstain from voting on pilots that I am actively involved in.
- Communicate conflicts of interest that arise to the committee and abstain from voting.
- Always act in the best interests of IHN-CCO members.

Name **Date**

Sign_____

Print_____

Peer Enhanced Emergency Response

COMMUNITY HELPING ADDICTS NEGOTIATE CHANGE EFFECTIVELY

Pilot Summary

January 1, 2022/December 31st, 2022

$107,933

Setup a crisis phone with trained staff available to work with law enforcement and other community partners to help peers in crsis and ensure they get the resources they need to avoid jail or continued jeopardy

Train a team of four Peer Support Specialists to intervene with peers in crisis
Establish a crisis line and distribute the number to community partners
Respond to 90% of crisis calls

Key Outcomes

- A trained and experienced team of four Peer Support Specialists
- More than 90% of crisis intervention peers created a peer-led wellness plan
- More than 90% of crisis calls to the line and through other methods were responded to.
- Increased assistance to local community partners.
- Effective diversion from incarceration and emergency medical services.
- Provided a safe environment for peers in crisis.

Learning Experiences

Did you make any changes because you learned how to do something better?

- We learned to communicate better with community partners regarding our role and resources we offer.

Did you do something that didn't work? How/What did you adjust?

- One issue was partners who continued to use direct contact methods with staff instead of the crisis line. We will work with technology to try and direct all calls to the crisis line and ensure the right people take the call.

What were the key factors that helped the pilot through a difficult period?

- The members of the team built good relationships with partners and that helped to encourage patience and communication when problems occurred.

Successes

- An unhoused family with children had a parent who was having a mental health crisis and the team was able to de-escalate the situation, get them to a safe place in the shelter and begin to work on the families goals. They helped with food, shelter, stabilization, getting the children in school, finding permanent housing on the coast and today both parents are employed and the family is doing well.
- Linn Mental Health called about an individuals who refused to go back to the group home where they lived. The team met the peer in the community and got them into the shelter where they continue to work on their routine and trying to connect them with more mental health.

Partnerships & Collaboration

We worked with existing partners, but strengthened our ties through working on the scene of crisis and need. Further communication helped to strengthen the trust and partnership.

Remaining Challenges

- Funding will always be a challenge but one we are trying to address through our other sources of program revenue. We continue to refine the phone line experience to ensure that the right staff gets the call after hours.
- Language translation devices are in the works to assist with language needs in the field.
- Staffing is more of a challenge for team members due to the hours of on-call availability and need for more experienced individuals.

Post Pilot Sustainability

Will your pilot be sustained post pilot?

We continue to use the crisis team and phone line and intend for it to remain.

Replicability

This crisis team and line could be easily replicated and would avoid many of the pitfalls from the pilot.

Scalability

The system is easy to scale and depends most on staffing and availability. The team receives a higher wage than other staff for their flexibility, training, and on-call status.

Discussion

Peer Enhanced Emergency Response

January 1, 2022 to December 31, 2022

Summary:
Communities Helping All Negotiate Change Effectively (CHANCE) partners within the tri county region with a host of agencies to provide after hours and weekend peer support for people facing mental and/or physical health crisis. Through this work, CHANCE has identified service area gaps, and areas of opportunity to better service peers who are experiencing crisis. CHANCE is already doing this but believe these things can be done more appropriately and effectively with staff that is trained properly and are able to access the tools necessary to sustain these types of crisis intervention and care coordination among agencies. The program will focus on meeting the unique needs of someone experiencing a mental and/or physical health crisis, reducing emergency department utilization, and unnecessary jail visits. CHANCE will focus on five primary areas. Certified Peer Wellness Specialists trained in Mental Health first Aide, de-escalation and crisis intervention, a safe place to de-escalate and find support, Social Determinants of Health screening and referral for services, Peer Wellness Specialist (PWS) meeting the Linn County mental health crisis team in the field to support their efforts and connections to community-based support programs.

A. Budget:

- **Total amount of pilot funds used:** $107,933
- **Please list and describe any additional funds used to support the pilot.**
  An additional $45,000 for wages from other funds.

B. Provide a brief summary of the goals, measures, activities, and results and complete the grid below.

Click here to enter text.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Progress to Date
Single certified peer support specialist with minimal specialized training in handling crisis situations handling CHANCE's 24-hour crisis line; no team of Certified Peer Wellness Specialists (PWSs).	Develop Policy and procedure Manual for Crisis intervention Pilot Identify and schedule training for Pilot team members Number of people hired and trained.	Fully trained team (4 PWSs) skilled in crisis intervention, mental health first aide and de-escalation, as well as basic CPR and first aid.	One existing staff and three additional hires were put on the team for the project in early 2022. We had one staff leave and hired a replacement to maintain four individuals. The individuals were trained in de-escalation, mental health first aid, DEI,and CPR. Some continued to earn their CADC advancements as well.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Progress to Date
No comfort space for the warming center.	Number of people utilizing warming center's comfort space.	Provide a safe environment for peers experiencing a crisis; report out on utilization.	The 2nd Chance shelter underwent some dramatic improvements during the year to increase the safety and comfort of those in crisis. New flooring, paint, increased food nutrition all helped.
Create peer-led action plans.	Number of action plans created.	30% of the people referred to our PWS team creating an action plan.	We were able to create action plans for more than 80% of those referred.
PWS meet Linn County Crisis team in the field.	Number of Crisis calls that CHANCE's Team is called to.	90% of Crisis calls are responded to.	Almost 100% of crisis calls where CHANCE was needed were responded to.
PWS trained and using Unite Us Platform.	Number of PWS trained and using Unite Us.	75% of Referrals are made through Unite Us.	This goal was not fully attained. We did get many entered, but less than 75%. CHANCE was in the process of moving to a new internal HMIS software which became the priority.

C. Did your pilot utilize Traditional Health Workers? If so, please fill out the table below:

Type of THW (CHW, Doula, PSS, PWS, Navigator)	Full time or Part time	Race/Ethnicity	Disability (Yes, No, Unknown)	Preferred Language (English, Spanish, Sign Language)	Payment Type (FFS, Contract, Grant, Direct Employment, APM)	Location of THW (Clinic based or Community based)
PSS	Full-time	White	No	English	Grant	Community
PSS	Full-time	Bi-racial	No	English	Grant	Community
PSS	Full-time	Hispanic	No	English	Grant	Community
PSS	Full-time	White	No	English	Grant	Community
PSS	Full-time	White	No	English	Grant	Community

D. Did your pilot receive referrals for THW services? If so, please fill out the table below:

Number of referrals received from members for THW services	200+
Number of referrals received from care team for THW services	100+

E. What were the most important outcomes of the pilot?

An increase in interventions at the point of crisis and the ability to resolve the situations and get the individual resources they need. safety

F. How has the pilot contributed to Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care?

Through intervention, we are now able to prevent incarceration, ensure shelter, provide food and work to ensure they have healthcare options. Without this, many would endure incarceration, time in emergency healthcare services and a lack of supports moving forward.

G. What has been most successful?

We saw a great utilization of the service by law enforcement and community groups. We were able to meet peers and partners at locations to help de-escalate the situation and get them into the shelter as opposed to jail. Having a central number and assigned team made the work more consistent and a better community option. Partners were very excited to have the service and worked with us through some problems that arose.

H. Were there barriers to success? How were they addressed?

Law enforcement and community partners would often continue to contact staff through other methods they had used previously. This behavior change can be tough to overcome as we responded to whatever method they used. The need in the community is greater than the capacity of the team and we had to clearly define our role for the safety of our staff and the peers involved.

I. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)

The pilot is very scalable and could be replicated fairly easily. A caution is to properly communicate the role of a Peer Support Specialist in crisis scenarios so that they are not left to do things that are not qualified for.

J. Will the activities and their impact continue? If so, how? If not, why?

The crisis line continues and is funded through other operational revenues. It serves as an important outreach to our shelter and a great resource for the community.

Overcoming Barriers, Foster Youth

JENNIFER SOLBERG & CATHERINE BAKER

CASA-VOICES FOR CHILDREN

Pilot Summary

CASA-Voices for Children expanded our services with a number of new projects focusing on the overall well-being of a child in foster care. We have created these programs as we have identified barriers in our community that have put our foster children at a disadvantage when it comes to health equity and health disparities.

Monitoring 100% of foster children's health services, attending JCIP meetings, and engaging children/youth with our supportive programs (Trauma-Informed Tutoring, Specialized Advocate Partner, and ILP)

Key Outcomes

- 100% of foster children's medical, dental, vision, and mental health services are being monitored.
- Staff attending 100% of JCIP and JCIP's subcommittee meetings.
- Obtained a new Resource Center space which we are preparing to house our Independent Living Program.
  - Advocates are providing personalized mentoring on ILP topics on a one-on-one basis with eligible youth.
- 100% of foster children that have been identified as needing a tutor, have been assigned one.
  - Advocates also provide individualized support for their child's educational needs.
- Piloting Specialized Advocate Partner Program with partners who reflect demographics of foster children.
  - SAPP is an expansion of the Cultural Advocate Partner program, and now serves children from any historically marginalized groups including those with disabilities, developmental diversities, or special medical needs.
  - We have engaged several new SAPP volunteers who are supporting advocates and their case children.

Learning Experiences

To better serve our children with disabilities and those with special medical needs, we expanded our “Cultural Advocate Partner Program” to the “Specialized Advocate Partner Program” and redesigned it to be inclusive of all historically marginalized groups.

Experienced delays from taking on a new county that had been struggling and obtaining a great Resource Center space that needed renovations. Adjusted by being flexible and collaborating with partners in both counties to support the pilot.

Community and collaboration were key to this pilot’s success. Successfully advocating for the needs of children in care is a team effort and we are thankful to our partner agencies, community supporters, and volunteers.

Successes

- Expanded our service area to include Lincoln County in August 2022
  - Expanded pilot and are now providing advocacy, monitoring medical care, and making referrals to services for Lincoln County foster children as well
- Achieved All Children-All Families “Solid Foundation for Inclusion” designation for LGBTQ+ affirming practices
  - Now have access to specialized learning resources on advocating for LGBTQ+ youth, including health-related topics
- Developed new database to streamline tracking of records and services
- Will be hosting a conference this Spring and sharing what we’ve learned with other CASA programs

Partnerships & Collaboration

New partnerships or linkages because of the pilot?

- We were able to form new partnerships in Lincoln County after expanding our service area there in August:

- Lincoln County Juvenile Court & Juvenile Probation Department, Lincoln County Health & Human Services, Lincoln County School District, Samaritan Health Services/Samaritan House, Parenting Success Network, Family Promise of Lincoln County/Coastal Phoenix Rising, Youth TIDES Shelter, Nurture Oregon, and others

What is the status of your pre-pilot partners? Were any of your partners affected by the pilot? Did your relationship with any partners change?

- The pilot involved significant collaboration between organizations, and has strengthened our relationships with our pre-pilot partners.

Remaining Challenges

- The number of children coming into care continues to increase; need to be prepared to scale up our efforts to serve rising caseloads
- Recruiting advocates / general volunteers and continuing to rebuild community connections in our new service area of Lincoln County
- Recruiting advocates in Benton County to make up for decreases in volunteer base during COVID-19
- Continuing to develop the Resource Center and establish learning areas and tools for the Independent Living Program (kitchen area, etc.)

Post Pilot Sustainability

Pilot will be sustained in future

Can be replicated, especially by other CASA programs

Scalable as long as community partners and sufficient staff/volunteers are in place

Discussion

CASA
Court Appointed Special Advocates
VOICES FOR CHILDREN
BENTON & LINCOLN COUNTIES

Overcoming Barriers, Foster Youth

Overcoming Barriers, Foster Youth

January 1, 2021 to December 31, 2022

Summary:

CASA-Voices for Children plans to expand our services to include a number of new projects that focus on the overall well-being of a child in foster care. We have created these programs as we have identified barriers in our community that have put our foster children at a disadvantage when it comes to health equity and health disparities. Some of these barriers include lack of access to health care, lack of continuity with providers, and lack of self-advocacy skills when it comes to one's own health. One project that we will be focusing on during this pilot includes monitoring medical, dental, vision, mental health, and service referrals for our foster children. We will ensure that our foster children will attend medical appointments as recommended and any subsequential referrals are made. CASA-VFC will work with community partners like Old Mill, Encompass, and other service providers to request records from and communicate with.

A. Budget:

- **Total amount of pilot funds used:** $49,335
- **Please list and describe any additional funds used to support the pilot.**
  $32,309 in VOCA (Victims of Crime Act) funding was also utilized to support this pilot program, as well as our other direct advocacy work with children who have experienced abuse and neglect.

B. Provide a brief summary of the goals, measures, activities, and results and complete the grid below.

Baseline or Current State	Monitoring Activities	Benchmark or Future State	Progress to Date
Foster children's medical, dental, vision, mental health services have required timelines that are sometimes met.	Requesting records and communicating with service providers.	100% of foster children's medical, dental, vision, and mental health services will be monitored.	100% of foster children's medical, dental, vision, and mental health services are being monitored.
Community partners meet for the Juvenile Court Improvement Program monthly.	Attend monthly JCIP meetings and all subcommittee meetings. CASA-VFC will continue to chair the subcommittee.	CASA-VFC staff will attend 100% of JCIP and JCIP's subcommittee's meetings.	CASA-VFC staff have been attending 100% of JCIP and JCIP's subcommittee's meetings.
Foster children age out of the system with optional life skill services, most of which do not meet their specific needs.	Equip teens will self-advocacy skills, life skills, and readiness skills for adulthood. Train advocates on how to teach these skills to teens.	75% of teens will engage with the Independent Living Program that meet their unique needs.	CASA-VFC has obtained a new Resource Center space which we are preparing to house our Independent Living Program. The ongoing effects of COVID-19 and the time required to renovate the Resource Center space have continued to impact our program, creating delays in the ILP implementation timeline. In the meantime, advocates are providing personalized mentoring on ILP topics on a one-on-one basis with eligible youth.

Foster children enter the Child Welfare System academically below grade level.	Monitor the academic progress of each foster child. Request academic records. Attend school meetings.	100% of foster children that have been identified as needing a tutor, will be assigned one.	100% of foster children that have been identified as needing a tutor, have been assigned one. In addition to a tutor, advocates will often provide support for their child's academic needs.
Nationally, foster care includes a disproportional demographic of children who identify as a minority culture or identify with the LGBTQ+ community.	Recruit and train Cultural Advocate Partners. Create resources that represent our Cultural Advocate Partners. Diligently work to create and maintain diversity amongst the organization.	CASA-VFC will have implemented the Cultural Advocate Partner Program with partners who reflect the demographics of our foster children.	CASA-VFC has begun to implement the Specialized Advocate Partner Program with partners who reflect the demographics of our foster children. The Specialized Advocate Partner Program (SAPP) is an expansion of the Cultural Advocate Partner program, and now serves children from any historically marginalized groups including those with disabilities, developmental diversities, or special medical needs. We are continuing to develop and revise the program, and have engaged several new SAPP volunteers who are supporting advocates and their case children with knowledge gained through lived experience.

C. Did your pilot utilize Traditional Health Workers? If so, please fill out the table below: (N/A)

Type of THW (CHW, Doula, PSS, PWS, Navigator)	Full time or Part time	Race/Ethnicity	Disability (Yes, No, Unknown)	Preferred Language (English, Spanish, Sign Language)	Payment Type (FFS, Contract, Grant, Direct Employment, APM)	Location of THW (Clinic based or Community based)

D. Did your pilot receive referrals for THW services? If so, please fill out the table below: (N/A)

Number of referrals received from members for THW services	
Number of referrals received from care team for THW services	

E. What were the most important outcomes of the pilot?

One of the most important outcomes of the pilot was that 100% of foster children's medical, dental, vision, and mental health services are now being monitored consistently and effectively. CASA-VFC staff and advocates are requesting medical records, talking with biological parents/foster parents about medical, dental, vision, and mental

health needs and concerns, as well as speaking with medical professionals about individual children and youth. We ensure that each child is receiving consistent medical care and that their medical needs are being addressed with the appropriate services. One way we have been doing this is by partnering with Encompass to discuss how we can work together to ensure this consistency and break down any barriers a foster parent may have when making appointments for their youth. We request records quarterly to ensure that the child is in good health and that doctor's appointments and follow-ups have been attended as necessary, with referrals being made if needed. We meet with Encompass quarterly. We are utilizing our new secure database to track these efforts and provide a unified source of health information to refer to in each child's case. CASA staff and advocates have access to all appropriate services a child is engaged in during the duration of their case to ensure a child's needs are fully considered when making recommendations to the court and other parties.

Other key outcomes have included engaging with the Juvenile Court Improvement Program, achieving the Solid Foundation for Inclusion designation from the All Children - All Families program serving LGBTQ+ youth and families, and the implementation of our Independent Living Program, Trauma Informed Tutoring Program, and Cultural Advocate Partner Program (now expanded to Specialized Advocate Partner Program). With these projects, CASA-VFC has helped combat the disparities that our foster children face and has helped ensure that their physical, mental, and social-emotional health needs are being met successfully.

F. How has the pilot contributed to Triple Aim of improving health; increasing quality, reliability, and availability of care; and lowering or containing the cost of care?

The pilot has contributed to the Triple Aim of improving health, increasing quality, reliability, and availability of care, and lowering or containing the cost of care in several ways:

Improving Health: We ensure that each child is receiving consistent medical care and that their medical needs are being addressed with the appropriate services, which in turn improves their health.

Increasing Quality, Reliability and Availability of Care: We have monitored each child's doctor's appointments and follow-ups and ensured referrals are made as needed, which has increased the reliability and quality of care our children receive. We have also collaborated with Encompass to help overcome any barriers that parents may experience with scheduling or attending follow-up care.

Lowering or Containing the Cost of Care: The pilot program has made a significant difference in the consistency and quality of health care that our children are receiving. By monitoring care, requesting records, and tracking/encouraging needed referrals, the pilot program has prevented children's medical needs from "falling through the cracks". Children are now consistently receiving quality preventive care, and any medical issues that do come up are being addressed in a timely manner with referrals to the appropriate providers. This focus on prevention and communication improves children's health and empowers families to be involved in their children's healthcare, reducing the healthcare costs that they will incur across their lifespan.

G. What has been most successful?

The monitoring of 100% of foster children's medical, dental, vision, and mental health services has been a great success, and has enabled us to ensure that each child is receiving the care they need to thrive in a timely and reliable manner. It has also been incredibly beneficial for some of our children and families with more complicated medical conditions – our monitoring has helped us enhance the collaboration between providers on a child's care team and their families, and has allowed us to identify and resolve any gaps in services that may have been occurring.

Participating in the Juvenile Court improvement Program has also been a success – it's been beneficial to collaborate with other stakeholders and work to improve best practices throughout the Child Welfare and Juvenile Court systems. The Trauma-Informed-Tutoring program and Independent Living Program have also had successes; each

child who has been identified as needing a tutor has now been assigned one, and our advocates are providing individualized life-skills training to their teens in care. We have secured a new Resource Center space that will house our donation center, ILP, and trauma-informed tutoring program, and are currently restoring and adapting the space to meet those needs. Our participation in the Human Rights Campaign Foundation's "All Children-All Families" program was another significant achievement – we earned the "Solid Foundation for Inclusion" designation and will be participating in the program in future years, continuing to improve our LGBTQ+ inclusive and affirming practices and tapping into HRC's vast network of educational webinars and specialized trainings to support the health and well-being of our LGBTQ+ youth in care. The expansion of our Cultural Advocate Partners program to the Specialized Advocate Partners Program is another success; one of our advocates is currently serving a teen with significant health issues, and has said that the support that she and the teen have received from their Specialized Advocate Partner has been instrumental in ensuring that he receives the appropriate medical and mental health care to meet his needs. While we are continuing to develop the SAPP program, our initial SAPP volunteers have made a measurable difference in the cases they are assisting with, and we look forward to growing the program to help ensure representation and health equity for all our children in care.

H. Were there barriers to success? How were they addressed?

We did experience several barriers to success throughout the duration of the pilot project:
Some of the barriers faced by our youth and families included lack of access to health care, being waitlisted for services, lack of continuity with providers, lack of follow-through for necessary referrals for services, and lack of self-advocacy skills when it comes to one's well-being and health. By monitoring children's care and collaborating with other stakeholders, CASA-VFC helped to ensure that foster youth, foster parents, and biological parents understood the importance of health care, how to navigate the health care system, and advocate for themselves or their children.

The continued effects of COVID-19 have also been a barrier to the pilot project. In addition to its impacts on the medical system (overwhelmed hospitals and practitioners, extended wait times for care and delays in appointments, etc.) COVID-19 has also affected our recruitment and retention of advocates and other volunteers. Our community members are under a greater amount of stress (physically, emotionally, and economically) in the wake of the pandemic, which makes committing to a dedicated in-person volunteer service role difficult for many people. As restrictions have lifted, we have seen our number of applicants begin to increase again, but we are still working to build up and restore our volunteer base.

Youth and resource families also faced barriers to initial engagement with our new programs and services. (For our youth, the barriers were with engagement, while for our families, they were with time commitment & transportation.) We were able to secure a new Resource Center next to our Benton County office that will help remove these barriers and enhance the success of our programs. The Center will feature sensory-friendly meeting spaces that will provide a positive environment for youth to engage with our programming, and its convenient location near the downtown transit center will help families who were facing transportation difficulties. The efforts to obtain and restore/outfit this new space have created some delays in implementing our programs, but we anticipate it to be fully functional by Spring 2023, and are confident that the Center will be an incredibly helpful resource for the children and families we serve.

Another barrier that CASA-VFC faced was taking on a new county that had been struggling, and whose CASA program had been dissolved prior to the start of our service there. While we are excited to be serving the children and families of Lincoln County, it has been challenging to rebuild the program there. We inherited the program without staff in place and have had to focus on hiring and training new staff, rebuilding relationships and credibility in the local community, and establishing partnerships with Lincoln County organizations, while recruiting and training advocates to meet the needs of the high number of children in care. While CASA-VFC is continuing to adjust

to the additional demands of serving a new county, we feel confident that we are making significant progress and are honored to be advocating for Lincoln County's children in care.

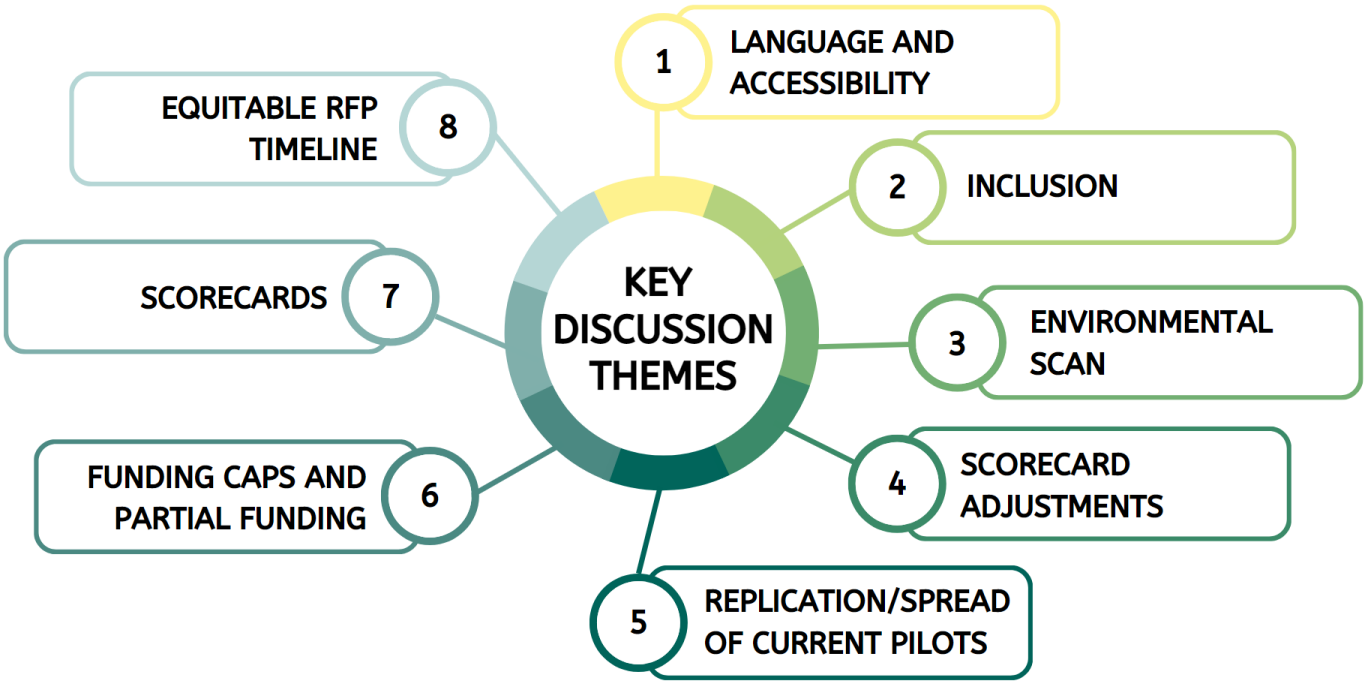
I. How readily would the pilot be scalable or replicable? Describe cautions and considerations when considering scaling, or replicating the Pilot. (i.e. Success dependent on personality/skills set, or activities appropriate under certain conditions like size, target population, etc.)

CASA-VFC believes that this pilot program would be scalable and replicable for other CASA organizations, as our unique mission and program structure allows us to be a "central source point" to encourage collaboration and innovation among stakeholders in the healthcare and child welfare communities.

The one caution we would point out is that a strong foundation of community relationships would be necessary to make such a pilot program successful. One of the most powerful things about the CASA program is our volunteers' ability to synthesize information from a wide variety of sources and providers to ensure that decisions are being made in the best interests of the child. We are fortunate to have strong community partnerships in place with many stakeholders across Benton County and are rebuilding a similar network in Lincoln County after expanding our service area there in August of 2022. As long as they work on strengthening their community partnerships and maintaining a positive, collaborative approach, we would strongly encourage CASA programs around Oregon to implement a similar pilot program.

J. Will the activities and their impact continue? If so, how? If not, why?

These activities and their impact will continue here at CASA-VFC, and we plan to share our findings with our CASA partners to extend the positive effects of the pilot beyond our direct service area as well. We were able to implement all of the practices involved in the pilot project in a sustainable manner, and they are now a permanent part of CASA-VFC's program going forward. We will also be hosting a conference for other CASA staff and volunteers across Oregon this Spring, where we will share the successes and challenges we faced in this pilot and encourage them to implement similar procedures within their own organizations.



1. **Language and Accessibility:** continually working to approve with the DST & Health Equity Workgroup
2. **Inclusion:** have had discussions, continually working to approve with the DST & Health Equity Workgroup
3. **Environmental Scan:** what organizations in or out of the area are already doing this? What works best? Can we partner with them?
4. **Scorecard Adjustments:** on agenda for future discussion
5. Prioritize current pilots by working with them on **replicability and spread**
6. Should a clear **funding cap** be included? What about considerations for **partial funding?**
7. Are **scorecards** a meaningful tool for setting the foundation for discussion and decision-making?
8. What is the decision-making **timeline** for a two RFP process? What is equitable?

Priority Area Recommendation: Social Determinants of Health & Equity based off the Community Advisory Council's Community Health Improvement Plan (CHIP).

Social determinants of health are the conditions in which we born, grow, live, work, play, worship, and age.

Reasons:

- Priority area must be aligned with the CHIP
- The DST has aligned itself even more with SDoH & E through this strategic planning process
- Allows a focus on inclusion and bringing communities of color to the table
- DST members have continually commented that the spectrum of pilot projects are often too broad, requesting a more focused RFP
- Behavioral health is nearly always a focus, but funding streams coming from the federal and state governments are driving a lot of the work in this region

Social Determinants of Health and Equity	
Outcomes	**Indicator Concepts and Areas of Opportunity**
SD1: Increase the percentage of Members who have **safe, * accessible, affordable housing.** *Safe housing: a structurally sound, secure, sanitary, nontoxic residence with basic utilities, timely repairs, and adequate space for residents	Indicator Concepts a. Number of homeless persons b. Number of homeless students
	Areas of Opportunity i. *Stable housing upon discharge from hospital or emergency room visit* ii. *Evictions prevention and reduction* iii. *Housing-related, closed-loop referral between clinical and community services* iv. *Social Determinants of Health claims data*
SD2: Increase the percentage of Members who have access to **affordable transportation.**	*Areas of Opportunity* i. *Non-medical transportation access* ii. *Distance between Members' homes and public transportation* iii. *Member utilization of available, covered transportation services* iv. *Provider knowledge of, and referral to, available transportation services*
SD3: Increase the percentage of Members who have **access to healthy food.**	Indicator Concept a. Percentage of Members living in a food desert
	Areas of Opportunity i. *Food security* ii. *Availability of fresh, affordable produce*
SD4: Increase health equity.	*Areas of Opportunity* i. *Health disparities experienced by Members due to age, disability, gender identity, geographical location, income, race or ethnicity, sex, sexual orientation, etc.* ii. *Availability of health equity data*

Recommendations/Options for RFP Process:

Mix and Match!

Small RFP (historically $50k and less)		Large RFP (historically over $50k)
Funding cap per proposal: $50k, $25k		Funding cap per proposal: $150k, $300k
Prioritize Small RFP (first to make decisions on)		Partially fund proposals
Cap Small RFP: $200- $300k		Prioritize Large RFP (first to make decisions on)
Provide an option for past pilots to apply for sustainability or spreading promising practices		Provide an option for past pilots to apply for sustainability or spreading promising practices
Make decisions at the same time		Make decisions at the same time
Prioritize new partners		Prioritize new partners
Prioritize historically marginalized community-led projects		Prioritize historically marginalized community-led projects