Agenda
Delivery System Transformation Committee

June 22, 2023 4:30 – 6:00 pm

Online: Click here to join the meeting
Phone: +1 971-254-1254,,455350178#

1.	**Welcome and Introductions**	**Renee Smith,** Family Tree Relief Nursery	**4:30**
2.	**Transformation Update**	**Beck Fox,** IHN-CCO	**4:45**
3.	**Letter of Interest Overview**	**Charissa Young-White,** IHN-CCO	**4:50**
4.	**Letter of Interest Discussion & Decisions**	**Renee Smith,** Family Tree Relief Nursery	**5:00**
5.	**Wrap Up**	**Renee Smith,** Family Tree Relief Nursery	**5:55**

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

Delivery System Transformation (DST) Pilots and Workgroups

Acronym	Project	Sites	Counties	Start	End
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

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	RFP & Priorities
April	13	RFP Discussion		
	27	RFP Finalization		
May	11	Scoring Exercise		
	25	Pilot Expansion Requests	Pilot Updates	
June	8	CAC UPDATE	IHN-CCO Health Equity Plan Review	
	22	LOI DECISIONS		
July	6	CAPACITY BUILDING DECISIONS		
	20		Pilot Updates	
August	3	SMALL RFP DECISIONS		
		Regional Planning Council August 10		
	17	RFP PRESENTATIONS		
	24	RFP PRESENTATIONS		
	31	RFP PRESENTATIONS		
Sept	14	RFP DECISIONS		
	28	PSLS	EASYA	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

DST Attendance and Voting Records

List includes all that attended in the past year based on the anchor date of previous voting decisions. Voters must attend at least 50% of the meetings since the previous voting period and have a signed and current Roles & Responsibilities form on file.

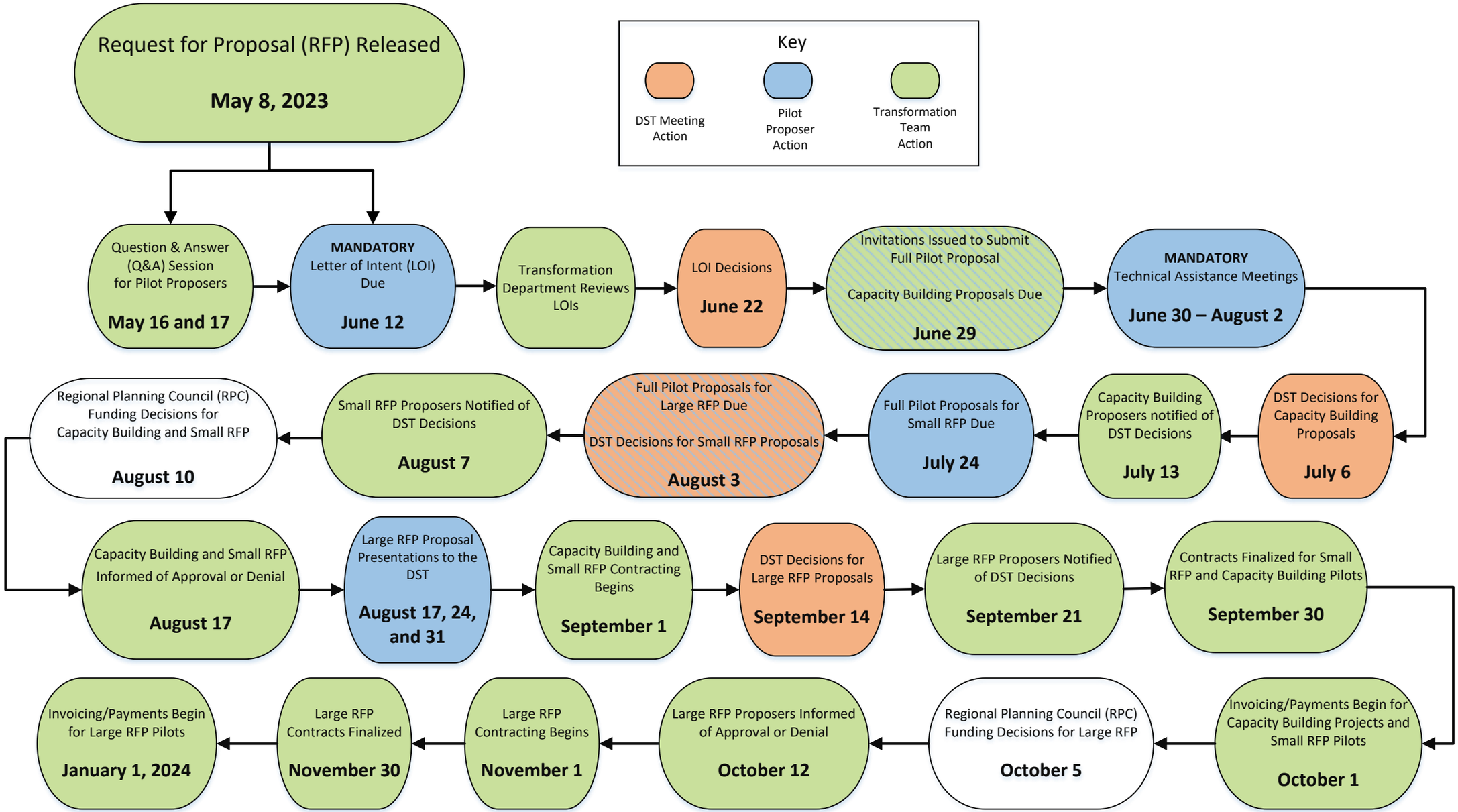
Name	R&R	Voting July 3 (13 to vote)	Voting August 6 (14 to vote)	Voting Sept 14 (13 to vote)
Abby Mulcahy	Yes	9	9	7
Adam Shanks	No	1	1	1
Ailiah Schafer	No	4	4	3
Alex Llumiquinga	No	3	3	3
Alicia Bublitz	Non-voter	17	17	13
Alison Hellums	No	2	2	2
Allison Hobgood	Yes	11	11	9
Allison Myers	No	2	2	1
Andrea Myhre	Yes	9	9	7
Angel Harris	No	3	3	3
Anita Earl	No	2	2	1
Annie McDonald	Yes	17	17	14
Ashley Hoffman	No	9	9	9
Beck Fox	Non-voter	21	21	18
Bettina Schempf	Yes	12	12	11
Brandy Waite	No	1	1	0
Britny Chandler	Yes	10	10	8
Brock Byers	No	5	5	3
Bryan Decker	No	12	12	10
Bryn McCornack	Yes	7	7	5
Caleb Larson	No	2	2	0
Candace Russo	No	1	1	0
Carissa Cousins	Yes	3	3	3
Carmen Moody	No	1	1	1
Carol Davies	No	2	2	1
Cassie McCrea-Bell	No	2	2	2

Catherine Baker	No	1	1	1
Charissa Young-White	Non-voter	19	19	15
Christian Moller-Andersen	No	1	1	0
Daniela Aguilar	No	2	2	2
Danny Magaña	No	20	20	17
Deb Fell-Carlson	Yes	12	12	9
Dee Teem	Yes	4	4	3
Diane Scottaline	No	1	1	1
Dick Knowles	Yes	20	20	16
Diego Nieto	No	1	1	1
Elijah Stucki	No	1	1	0
Elizabeth Hazlewood	Yes	12	12	8
Emma Chavez Sosa	Yes	18	18	16
Emma Deane	No	3	3	3
Eric Vinson	No	2	2	1
Erin Gudge	Yes	19	19	16
Erin Sedlacek	No	10	10	8
Erin Zolach	No	1	1	1
Gabriel Parra	No	1	1	1
Georgia Smith	Yes	2	2	1
Gillian Chandler	No	1	1	0
Glen Cunningham	No	1	1	0
Helen Higgins	No	1	1	1
Jaimie Page	No	1	1	0
Jan Molnar-Fitzgerald	No	1	1	1
Jay Yedziniak	Yes	3	3	2
Jennifer Solberg	No	1	1	1
Jill Byrd	No	1	1	0
Julia Saltzgiver	No	1	1	0
Kami Beard	No	13	13	9
Karen Hall	No	2	2	2
Karen Weiner	Yes	16	16	14
Kate Williams	No	1	1	0
Katelyn Hershberger	No	1	1	1

Kimberly Lane	No	3	3	1
Kristty Zamora-Polanco	No	9	9	8
Lalori Lager	No	5	5	4
Larry Eby	No	5	5	4
Laurel Schwinabart	Non-voter	19	19	16
Linda Mann	Yes	12	12	9
Liv Gifford	No	1	1	1
Lorenzo Froehle	No	2	2	2
Loretta Cordova	No	2	2	2
Marci Howard	No	4	4	1
Marcy Shanks	No	1	1	0
Marie Long	No	3	3	2
Maritza’s Leon	No	1	1	1
Mary Ann Wren	No	3	3	2
Melissa Cheyney	No	4	4	2
Melissa Isavoran	Yes	17	17	14
Miao Zhao	No	1	1	1
Mica Contreras	No	12	12	10
Michael Couch	Yes	13	13	13
Mike Jerpbak	No	1	1	1
Miranda Miller	No	11	11	11
Miranda Tasker	No	1	1	1
Miriam Cummins	No	3	3	3
Misty Sorte	No	1	1	0
Nicole Fields	No	7	7	5
Patti Kenyon	No	9	9	5
Peggy McGuire	No	11	11	10
Rachel Cannon	No	1	1	1
Rebecca Austen	No	1	1	1
Reenie Schwallie	No	20	20	16
Rhonda Green	No	17	17	15
Rich Blum	No	1	1	1
Ronda Lindley-Bennett	No	20	20	16
Roslyn Burmood	Yes	1	1	0

Ruby Moon	No	14	14	10
Sandi Phibbs	No	1	1	0
Sandy Bumpus	No	2	2	2
Sarah Goode	No	22	22	18
Seynabou Niang	No	1	1	1
Shannon Rose	Yes	1	1	1
Sharity Ludwig	No	21	21	17
Sharon Oldsfield	No	3	3	2
Shelagh Baird	No	1	1	0
Stacey Bartholomew	Yes	5	5	3
Stefani Sackinger	No	17	17	14
Tanya Grant	No	10	10	10
Therese Waterhouse	No	1	1	1
Tony Howell	No	1	1	1
Twila Karo	No	5	5	1

IHN-CCO DST Request for Proposal Timeline



Minutes
Delivery System Transformation Committee (DST)
June 8, 2023 4:30-6:00 pm
IHN-CCO Walnut Building (in-person)
Teams (online)

Present			
Beck Fox	Renee Smith	Andrea Myhre	Elizabeth Hazlewood
Miranda Tasker	Stacey Bartholomew	Rolly Kinney	Emma Chavez Sosa
Michael Couch	Susan Trachsel	Linda Mann	Roslyn Burmood
Karen Weiner	Sara Jameson	Rebekah Fowler	Bryn McCornack
Melissa Isavoran	Shannon Rose	Mike Jerpbak	Charissa Young-White
Paulina Kaiser	Rebekah Fowler	Dick Knowles	Mica Contreras
Erin Gudge	Larry Eby		

Transformation Update

- Hub City Village is breaking ground on June 10, 2023!
- All three pilot expansion requests were approved to the tune of $270k.
- It is not known yet how much funding will be received for pilots, awaiting the state for the final metrics. Funding for pilots is 10% of the CCO Incentive Metric Quality Pool.
- **Decision:** the Committee is supportive of moving to Zoom from Teams.
- Health-related social needs funding at the state level has been announced, $119 million in infrastructure building and over $900 million in building the benefit.

Community Advisory Council Update

- The updated slides will be sent out in the Committee follow up email.
- Key points:
    - the DST uses the Community Health Improvement Plan (CHIP) priority areas as the foundation for strategic planning and pilot decisions.
    - Changes to the CHIP process in 2023+ may impact how pilots are prioritized.
    - Youth are represented by partnering organizations and parents/guardians, but currently no youth sit on the Community Advisory Council (CAC). Youth 16 and older may apply and be a part of the CAC.

Health Equity Plan Update

- See packet for slides.
- Key points:
    - SOGI (sexual orientation gender identity) is a controversial and complex data structure.
    - Trainings are a high point of the health equity plan; the Community Learning Collaborative is working to build a repository and calendar to ensure the trainings are available to community partners.

Decolonizing Behavioral Health Supports for Unhoused and Low-Income Community Members

Pilot start date: January 1, 2022

Original end date: December 31, 2022
New end date: December 31, 2023 (we have received one timeline extension thus far)

Original pilot funding amount: $51,700 ($12,200 will remain from original grant as of 6/2023)
Additional funds requested: $49,450

Brief pilot summary: Our main aim is to decrease systemic barriers and promote increased health equity for CDDC guests through robust behavioral health direct support. At CDDC, we have been building an innovative, non-traditional model of "counseling" for guests that enables them to diversely engage in healing art practices, mindfulness writing activities, milieu counseling, storytelling, and 1-1 confidential counseling sessions, both single session and ongoing. We also offer guests acute mental health deescalation and direct connection with the Benton County ACT Team to receive check-ins and medication support. We are deeply invested in decolonizing approaches and unconventional opportunities for peoples' increased mental wellness. We employ compassionate listening, thoughtful hospitality, and low-pressure invitation for guests to engage in wholistic mental health supports so as to initiate healing.

A. Describe the requested change.

CDDC would like another timeline extension until December 31, 2024 to continue this pilot as well as expanded funding in the amount of $49,450.

B. **What is the reason for the requested change?**

This pilot is making a big impact, and we want to continue our good work! We are meeting various goals like: giving CDDC guests greater access to behavioral health services that address their distinct needs; seeing an increase in CDDC guests using in-house behavioral health services; and directly engaging individuals via street outreach to link them to CDDC behavioral health supports. This pilot is immediately addressing trauma. It is improving peoples' access to behavioral health services in *very* non-traditional ways. It is increasing and improving access to behavioral healthcare in light of continued COVID-19 fallout, and it directly impacts subpopulations of IHN-CCO members that experience severe health disparities due to poverty and, often, disability as well.

C. If this request is not granted, what, if any, activities or outcomes from the original proposal not be possible?

Goal 4 from our pilot (to engage CDDC guests who are BIPOC about the program's strengths/weaknesses as they impact racial minorities, and make changes) has been

most challenging to attain. This is because it takes time, trust-building, and focused intention to glean significant data around the experiences of BIPOC folks in our unhoused community when it comes to mental health and their desire/ability to access services at CDDC. We continue to work on gathering this insight and information, and an end to the pilot will make these ongoing conversations more challenging to have without dedicated staff and resources to do so.

D. If this request is granted, are there new activities or outcomes that will be possible?

Extension time and funds would enhance our behavioral health program's ongoing sustainability and also make more possible the following:

Increased wages for behavioral health frontline staff who have lived experience with homelessness and are BIPOC

Hiring a new/additional MSW to support clinic partnerships with MSW interns at PSU

Continuing to evolve our low-barrier systems for guest medication access and management at the Center

Engagement of CDDC guests who are BIPOC about the program's strengths/weaknesses as they impact racial minorities, and make changes

Overall Goal	Baseline or Current State	Monitoring Activities	Benchmark or Future State	Met By (MM/YYYY)
ACCESS and EQUITY: need for increased access to behavioral health services that address CDDC guests' distinct needs	Formal behavioral health activities happening at CDDC M-W; crisis de-escalation M-F; ACT and harm reduction connections M-F as possible; informal medication management; some supports tailored for BIPOC community members	research, communication, listening sessions, surveys, outreach, and implementation	Formal behavioral health activities happening at CDDC M-F; crisis de-escalation M-F; ACT and harm reduction connections M-F with consistency; formalized medication management; major supports tailored for BIPOC community members	12/31/2024

Resource		Amount Requested
Frontline Community Wellness Staff Wages		$28,000
Contracted Counselor Wages x 2 (MSW, LCSW, Addiction Specialist)		$15,000
Total Direct Costs	**Rate (%)**	**$43,000**
Indirect Expenses (not to exceed 15% of Direct Costs)	15.00%	$6,450
Total Expansion Budget		**$49,450**

Letter of Interest (LOI) Background & Context

Denied Proposals

- Caring Team Meal Site: Capitol expense, not covered by IHN-CCO.
- Patient Motivation Training: Training for the provider network, not covered through this funding stream.

Logic for Scoring

- Utilize the LOI process to only invite proposers to submit full applications that are best aligned with funding priorities.
- Unknown funding, though likely similar to past years
- 26 LOIs submitted
- Capacity building decisions to come as well
- Pilot Expansion Requests currently total ~$350k
- To support DST decision-making conversations, the Transformation Department consulted with the DST chairs and developed scoring system:
    - System Impact
        - 3-point scale, 3 being the highest
    - Population Focus
        - 3-point scale, 3 being the highest
    - Partnerships & Collaboration
        - 2-point scale (yes or no to cross-sector collaboration, led by historically marginalized community)

Small Request for Proposal Project Crosswalk

		Social Determinant of Health Domain				
Proposal Name	**Champion Organization**	**Healthcare Access & Quality**	**Neighborhood and Built Environment**	**Social and Community Context**	**Economic Stability**	**Education Access & Quality**
LBCC Public Health Hub	Linn-Benton Community College					
Housing Navigation for Sheltered	Northwest Coastal Housing					
ArroyoSalud: Decision-making Environmental Contaminants	Oregon State University					
Corvallis Street Medicine	Unity Shelter					
Nurturing Fathers Health and Wellbeing	Oregon Family Support Network					
Family Connections	Young Roots Oregon					
Partnerships in Health	Santiam Hospital and Clinics					
CariFree Community Outreach	Oral Biotech (CariFree)					

Small Request for Proposal Project Scoring

		Transformation Department Initial Scoring			
Proposal Name	**Champion Organization**	**System Impact**	**Focus Population**	**Partnerships & Collaboration**	**Total**
LBCC Public Health Hub	Linn-Benton Community College	3	3	2	**8**
Housing Navigation for Sheltered	Northwest Coastal Housing	3	2	2	**7**
ArroyoSalud: Decision-making Environmental Contaminants	Oregon State University	2	3	1	**6**
Corvallis Street Medicine	Unity Shelter	2	2	2	**6**
Nurturing Fathers Health and Wellbeing	Oregon Family Support Network	2	1	2	**5**
Family Connections	Young Roots Oregon	1	1	2	**4**
Partnerships in Health	Santiam Hospital and Clinics	1	1	2	**4**
CariFree Community Outreach	Oral Biotech (CariFree)	1	1	1	**3**

ArroyoSalud: Decision-making Environmental Contaminants

Primary Organization	Oregon State University
Primary Contact	Veronica Lea Irvin
Primary Contact Email	veronica.irvin@oregonstate.edu
Partnering Organization(s)	OSU Extension
Project Name	ArroyoSalud: Decision-making Environmental Contaminants

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Water contamination caused by nitrate is a pressing public health emergency in Oregon. Addressing the impact of water contaminants on social determinants of health and equity is crucial for ensuring fair and equitable health outcomes. Unsafe water sources contaminated with nitrates pose serious health risks to both children and adults, impairing the blood's oxygen-carrying capacity and leading to health conditions such as thyroid dysfunction, recurrent respiratory infections, and cancers. Pregnant persons are at risk for pre-term birth, miscarriage, and delivering a baby at low birth weight. Young children are at higher risk for health concerns such as Methemoglobinemia. Disadvantaged communities, particularly those with language barriers, face challenges in accessing understandable information and necessary resources, perpetuating existing health disparities. To address this, our project (Arroyo de Salud) aims to develop a mobile app for Spanish-speaking communities, leveraging mobile technology to provide practical resources and bridge the information gap.

Our project has two main objectives. First, we will develop an offline Spanish app that incorporates the decision-based tools from our existing English app. Second, we will conduct community-engaged formative evaluation in our region with Spanish-speaking users to ensure the app aligns with their needs, preferences, and cultural considerations.

Our collaborative team, composed of public health researchers, environmental experts, OSU Extension Staff, and app developers, adopts an inclusive design approach that prioritizes digital literacy, ensuring user-friendliness and easy navigation. With audio features explaining technical terms, the app ensures accessibility for all Spanish-speaking individuals, regardless of literacy levels. This empowers communities, promoting health equity and informed decision-making. The mobile app will provide comprehensive information on the health effects of contaminated well water, interpretation of test results, treatment options, and access to relevant resources. If participants have a test result with elevated levels, they could be referred to a current free program offered through OSU Extension to provide bilingual navigation services to provide expert guidance on action steps.

Our project represents an innovative and transformative solution, delivering evidence-based information and user-friendly resources through a mobile platform tailored for Spanish-

speaking communities. Building upon the success of our previously funded English app, we have received valuable feedback from stakeholders that highlights the need for a Spanish app to address the specific challenges faced by this community. Given the increasing accessibility of smartphones and tablets, even in low-income and rural areas, our app holds immense potential to effectively reach disadvantaged populations. Its user-friendly interface, intuitive navigation, and seamless access to local resources contribute to promoting health equity and fostering inclusive communities. By bridging the information gap, the app empowers individuals to address water contamination challenges and protect their health. Moreover, our project fosters transdisciplinary collaborations, bringing together experts from diverse fields to tackle this issue holistically. By leveraging the collective knowledge and expertise of professionals from various disciplines, we can create a comprehensive and impactful solution. This collaborative approach ensures that the Spanish app development incorporates the latest research and best practices, enhancing its effectiveness and relevance, while ensuring its alignment with DST's mission and goals.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Our project is dedicated to enhancing the health and well-being of IHN-CCO members by providing clear communication from trusted sources and actionable steps to address the issue of nitrate contamination in drinking water. Nitrate exposure poses significant health risks to both children and adults, with vulnerable populations, including low-income individuals, minorities, and rural communities, facing heightened concerns. This is particularly critical during pregnancy, as nitrate can increase the risk of birth defects, low birth weight, preterm birth, and miscarriage.

Recognizing the impact of nitrate in the news and its potential implications, our project aims to address member concerns by offering reliable information and local expert guidance. We understand that the abundance of information can be overwhelming, impacting mental well-being. To alleviate this burden, we will provide a consolidated and credible source of information, ensuring members have easy access to the knowledge they need.

Our resources will include guidance on testing options, accredited labs for water testing, and cost-saving measures to facilitate the process. Through our app, members can easily understand test results, water usage implications, and taking appropriate action steps to treat contaminated water.

Our project prioritizes both the physical health of adults and children and their mental well-being. By connecting members with trusted resources, we aim to ensure that they receive accurate information and avoid unnecessary purchases of products they may not need. Overall, our project equips IHN-CCO members with the necessary tools, knowledge, and resources to effectively address nitrate contamination in their drinking water. Through clear communication, actionable steps, and reliable information, we strive to enhance peace of mind, reduce anxiety, and promote the health and well-being of our community members.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Our project is specifically designed to promote equity and reduce health disparities for IHN-CCO members through various key initiatives. Firstly, we prioritize addressing the needs of Spanish-language speakers, including both homeowners and renters. Currently, there is a significant gap in available materials and resources in Spanish, with no existing audio or app options in the language. To bridge this gap, our project includes a doctoral student who is a native bilingual from our region and has a background in public health and healthcare. Her expertise will be instrumental in adapting the existing English-language nitrate app to cater to the specific needs of Spanish-language users.

To ensure the app aligns with the preferences and requirements of the Spanish-speaking community, we will conduct focus groups across the three counties. By actively involving the target audience, we can gather valuable feedback and insights to tailor the app to their cultural considerations, linguistic needs, and technological preferences.

Moreover, our project is designed to reach and benefit rural communities, which often encounter additional challenges in accessing resources and information. One key feature that addresses this issue is the offline functionality of the app. This ensures that individuals in rural areas with limited internet connectivity can still access and benefit from the app's content. By providing an easily shareable app resource, our stakeholders can efficiently distribute information to IHN-CCO members and community members, expanding the dissemination of knowledge and resources.

Through these efforts, we aim to promote equity by addressing language barriers, involving the target community in the development process, and reaching underserved populations. By providing equitable access to vital information and resources, our project seeks to reduce health disparities among IHN-CCO members and improve health outcomes.

4. **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? (250-500 words)**

Our project partners with OSU College of Public Health and OSU Extension. OSU is one of the U.S. land grant universities that offers the Extension Services. OSU Extension traditionally address issues in food, agriculture, and environmental management and partners with local communities to provide trusted expertise and science-based knowledge to address today’s health challenges. These alliances provide us with valuable access to their networks, enabling us to effectively promote the app and its benefits to a wider audience.

In 2019, Dr. Irvin at OSU received a small grant to demonstrate the feasibility of a navigation program delivered by OSU Extension Service. This program aimed to provide homeowners with private wells contaminated with arsenic with free well water tests, educational materials, and

meetings with an OSU Extension Agent. Building upon this foundation, co-PIs Irvin and Kile secured funding from the National Institutes of Health to expand the program for arsenic, nitrate, and lead. As part of this expansion, the team developed comprehensive print education materials for nitrate and arsenic, incorporating input from environmental experts and focus groups with English and Spanish speakers. This project also offered the extension-led navigator program to review action steps to treat contaminated water. Feedback from well owners has informed our understanding of their preferences, including the need for different delivery modalities. Based on input from Spanish-language focus groups, we recognized the demand for an audio component and plain language explanation. Therefore, in this application, we are seeking support to adapt the English-language version of the app for Spanish speakers and include an audio component.

To ensure the app's effectiveness, we received a pilot grant from the OSU Pacific Northwest Center for Translational Environmental Health Research to develop an English-language mobile application for our arsenic and nitrate treatment materials. We collaborated with the OSU Community Engagement Core to conduct community-engaged evaluations at the OSU Extension conference in December 2022, and further evaluations took place at the OSU Small Farms Conference in February 2023. The feedback from participants was highly encouraging, with over 85% expressing that the app was user-friendly. Beta testers commended the app's educational nature, intuitive interface, and user-friendly design. Importantly, multiple suggestions were made during the evaluation process to develop a Spanish version of the app, emphasizing the importance of inclusivity and accessibility.

In May 2023, we presented our work at the UConn mHealth Center annual conference, Health is Social. Our presentation, titled "Digital Technologies to Reach Rural Communities and Improve Drinking Water," highlighted our efforts in leveraging digital solutions to tackle water-related challenges in underserved areas.

Moving forward, we are fully committed to expanding our collaborations and engaging with additional organizations. We are presenting information about these projects and resources to the Hispanic Advisory Committee in June 2023. We aim to foster a synergistic blend of expertise, experience, and networks to enhance the reach and impact of our comprehensive and sustainable approach. Our goal is to empower individuals to lead healthy lives by providing a user-friendly app that effectively addresses water and home contaminants.

CariFree Community Outreach

Primary Organization	Oral Biotech (CariFree)
Primary Contact	Lacey Bergevin
Primary Contact Email	lbergevin@oralbiotech.com
Partnering Organization(s)	Albany Boys and Girls Club
Project Name	CariFree Community Outreach

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

We would host a community event with the Albany Boys and Girls Club (or event series) where Dr. Susan Maples would be brought in to educate parents and children about cavity-prevention, oral systemic health, nutrition, and healthy choices. She is a dentist and author of an amazing parenting book, "Brave Parent- Raising Healthy, Happy Kids Against All Odds in Today's World." Each family would receive a free copy of her book as well as CariFree dental products. We would provide a free healthy meal along with childcare. Dr. Maples also has some scientific learning labs she has created to get kids excited about dentistry that could be added. This event could coincide with Caries Disease Awareness Month in October depending on timing.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Dental caries (tooth decay) remains the most prevalent chronic disease in both children and adults, even though it is largely preventable. Providing cavity-prevention education and products can minimize the disease of dental caries in our community. By educating people to determine what their specific risk and protective factors are, we can help them make small daily adjustments that can change their future. We can also reach families that might not have access to oral-systemic health information. There are so many health issues related to the health of your mouth that people don't realize, and sharing as much information as we will make a huge difference in the lives of many community members. Dr. Maples can provide easy tips for parents to make healthier choices for their families.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Many of the children using the Boys and Girls Club Dental Clinic do not have dental insurance or access to quality dental products. Our project will help educate families on why certain products aren't good for them (acidic, unhealthy ingredients, etc) and provide them with healthy options at no cost. There might be community members that aren't even aware of

these services and/or products. Providing free childcare and a healthy meal will hopefully enable more community members to attend.

4. **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? (250-500 words)**

We are working on a collaboration with the Albany Boys and Girls Club Dental Clinic. The event would be hosted at the club and offered to the families who utilize their services and the public. During the informational webinar offered by IHN-CCO there were a few other organizations (Lincoln Co School District and Samaritan) that sounded interested in connecting, so it's possible we could do multiple events.

Corvallis Street Medicine

Primary Organization	Unity Shelter
Primary Contact	Ailiah Schafer
Primary Contact Email	ailiah@unityshelter.org
Partnering Organization(s)	SHS, BCHD, CDDC, JSYS, CSC
Project Name	Corvallis Street Medicine

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Humans live in the shelter of one another - in communities of belonging or in spaces of social abandonment.

Unity Shelter recognizes belonging as a primary human need and so our efforts to create collaborative, safe shelter necessarily involve cultivating communities of care between our neighbors, staff, volunteers and partners. Rather than building on the models of many transactional service providers, Unity Shelter is a community in-service to others.

We value relationships of equity where the inherent purpose, dignity, and wisdom of each individual results in mutual support and collaborative care.

Because the issues of poverty and systemic oppression belong to and affect the entire community; because the precarity of the most vulnerable members of our communities affects and reflects the stability of the entire community, we also work to impact the systems around which our communities are organized, through our commitment to education, advocacy, and nonviolence, enlisting all community members as co-advocates in-service to those who are vulnerable, traumatized, isolated, and disconnected.

Every day, we encounter individuals coming through the Hygiene Center who have various health needs (physical, mental, emotional and spiritual) that are not being addressed because of lack of access to provider networks. While there is also a lack of capacity in the provider community, many people living out are unable to walk into a medical facility and encounter a professional, clinical space because of a lifetime of poor encounters with the medical community, PTSD, or simply the anxiety of being indoors.

Benton County needs a Street Medicine team - the kind of mobile collaboration that can go directly to the places people live and seek shelter so that our most vulnerable citizens (often including the elderly, pregnant women, children, and the LGBTQ community) can connect with providers in ways that are accessible, trauma-informed, and rooted in the care of the whole person.

Health equity exists when our social and political determinants of health are equally distributed. If we can take resources and make access available where people are - we have a better chance of helping them feel connected to the larger community and their own humanity.

We know that the distribution of power in our systems means that folks living outside are often viewed as less-than-human and begin to adopt that mindset in their own psyche's. The extreme loneliness and isolation that our clients experience is an extreme example of what the U.S. Surgeon General refers to as an epidemic.

No such group exists in Benton County. Currently, people must be willing to travel to a medical facility or clinic to receive medical/psychological/or spiritual care. While there are outreach teams that connect with people where they are, we have never experimented with the street medicine model. By combining the trusted relationships of outreach workers who are engaged with folks living in camps with medical and other care professionals, we have the capacity to transform lives with holistic care of mind, body and spirit.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Many of the people living outdoors are not on the Oregon Health Plan because they lack the capacity and relationships to connect with resources. Barriers like leaving their vulnerable campsites, trauma from past experience with medical and care professionals, and the legitimate lack of availability (often 6+ weeks simply to be evaluated by a mental health professional) mean that people are not currently experiencing fair and equitable access to care.

Communities thrive when all of its citizens are experiencing health and wellness. Conversely, they erode when these basic rights are not available to all.

A Street Medicine team would be able to both sign individuals up for OHP, offer immediate treatment, and build relationships so that sustainable access to medical providers could be nurtured.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Creating relationships and a sense of dignity and belonging is the first step to humans trusting that they can receive the treatment they need.

Traveling to the places people are living (and often hiding in fear of being legally prosecuted for living outdoors) rather than requiring them to leave their personal belongings and homes is a step toward equity. Leaving a campsite is an incredibly vulnerable act and people will often not risk it, even in the most dire of circumstances. Proximity and access to care is not equitable between the housed and unhoused community. Even making clinic spaces available lacks an equity lens because it requires a mobility that is often not possible for many of these individuals.

By working to mitigate barriers of access and distrust, we will be able to better serve the most vulnerable members of our community in an equitable and humane way.

4. **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? (250-500 words)**

Piloting a Street Medicine program would be a first for Benton County. It is truly a need that has been overlooked in our tapestry of options for those living in extreme poverty and the resulting isolation.

However, this pilot would draw a group of collaborative practitioners from different fields and organizations.

The following individuals are committed to working together:

-Dr. Gabriel Ledger from the Good Samaritan Emergency Department

-Dr. Jim Phelps, retired psychiatrist

-Dr. Andrea McCann from the Good Samaritan OBGYN Department

-Dr. Mary Boucher, a private practice Naturopath and Midwife

-Pastor Garrett Beatty, spiritual care support from Corvallis Evangelical Church

-Rev. Jennifer Butler, interfaith spiritual care support from First Congregational United Church of Christ

-Hillary Bylund, chaplain from Good Samaritan Regional Medical Center

-Angela Koning, LPC, a therapist in private practice and volunteer with White Bird Clinic in Eugene

-Lisa Hawash, MSW program director, Portland State University

Unity Shelter's mission has collaboration and partnership at the core. We maintain partnerships with several providers in Corvallis, both formal and informal. We aim to be a trusted partner to key providers in the community, making effective referrals, and working alongside them to seek creative solutions to the challenges of extreme poverty.

We will continue to be involved with those organizations who connect directly with people living outside: the Corvallis Daytime Drop-In Center, Benton County Health Department, Community Services Consortium, Jackson Street Youth Services, and Samaritan Health Services.

Family Connections

Primary Organization	Young Roots Oregon
Primary Contact	Sarah Mosser
Primary Contact Email	sarahm@youngrootsoregon.org
Partnering Organization(s)	n/a
Project Name	Family Connections

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Young Roots Oregon serves adolescent parents (up to age 24) and their children to create equitable pathways for growth, health, and education. Our Parent Hub project focuses on the numerous social risk factors teen parents face and reduces barriers to accessing community resources. Adolescent parents are more likely than their peers to face poverty, homelessness, intimate partner violence, and young mothers are more than twice as likely to suffer from postpartum depression than older mothers. Yet in the midst of these risk factors, young parents face tremendous stigma as teen parents, from their communities, peers, and often even families, leaving few social supports and connections.

Young Roots Oregon combines community building and resource partnership to address the social risk factors young parents face. Our Family Connections uses the Protective Factors Framework from the Center for the Study of Social Policy to increase the family's well being, promote healthy outcomes, and prevent child maltreatment. Through mentorship, peer groups, and weekly family dinners, Young Roots Oregon builds a community in which each and every parent and child belongs and is celebrated for their tremendous worth and strengths. This program is based on engaging families and the community in building parental resilience, positive social connections, knowledge of parenting and child development, concrete support in times of need, and increasing the social and emotional competence of children.

Concurrently, Young Roots Oregon focuses on housing, food security, and economic growth and development through resource partnership with numerous community agencies. The Family Connections project hosts various community agencies throughout the year to provide essential life-skill courses to young families in areas such as childbirth classes, maternal and child health, financial literacy, housing stability, and parenting success. For each of these courses, Young Roots provides meals, monthly diaper supplies, on-site childcare, and strategic financial incentives to all participants to reduce economic burdens of attending. Through these courses, young families not only gain the life skills necessary to succeed, but they also build a network of relationships with community agencies and can access the various resources and opportunities those agencies provide.

Our multi-generational programming focuses not only on adolescent parents, but on the social

and emotional development of their children as well. Our on-site childcare and preschool program features trauma-informed care and a positive play environment. By focusing on the family as a whole, these approaches work to minimize and prevent Adverse Childhood Experiences (ACEs) and toxic stress that cause life-long health disparities, child welfare interventions, foster care placements, and generational poverty, which benefits the overall health and success of our community as a whole.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Mentoring is a proven support that increases educational attainment and prosocial behaviors, while decreasing poverty, substance abuse ,and violence. All staff (employees and volunteers) are trained in leading and nurturing with a trauma informed care lens, focusing on the strengths of the parent and child to help them build resilience and to provide positive experiences that promote security, healthy relationships, and belonging, supporting each mentee to grow into their fullest potential. The mentoring program has had a relationally fluid design with monthly activities and events that are organized intentionally to encourage positive parent-to-parent peer connection.

The Family Protective Framework works on a two-generational level. As parental resilience increases, adverse childhood effects decrease. Strong, well-connected, well-resourced parents lead to healthy families and healthy children.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Our project promotes equity by reducing barriers to accessing economic growth and opportunities and targeting the social risk factors young families face. Less than half of teen mothers graduate from high school, and nationally, only 2% of teen mothers go on to earn a secondary degree of any kind by the time they are 30. Teen parents therefore face increase risk of perpetual, generational poverty, and their children are more likely to experience abuse, foster care placement, and are more likely to drop out of high school and be incarcerated in their lifetime.

Barriers young families face include lack of child care, lack of transportation, and food and housing insecurity. Young Roots Oregon reduces these barriers by providing on-site childcare for all of our programming, providing transportation, and hosting meals for each event, as well as providing a strategic financial incentive for participation to offset financial burdens of attendance.

Our programing is designed to increase parental resilience by building positive social connections and reducing toxic stress. Young Roots Oregon focuses on building healthy relationships to encourage parents to manage stress effectively.

The results of the Protective Factors Framework is strong families, optimal child development,

and reduced likelihood of child abuse and neglect.

All of our programming is in both Spanish and English.

4. **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? (250-500 words)**

Young Roots Oregon collaborates with numerous community agencies. Our Family Connections program hosts community agencies that specialize in areas of healthcare, housing stability, financial literacy, and parenting success. Current partnerships include:

Prenatal and postnatal care courses are in partnership with Linn County Health Services to promote prenatal health, healthy birth outcomes, postpartum and infant care. Maternal Child Health Services nurses co-facilitate the course.

The financial and housing literacy course is co-facilitated with DevNW for financial literacy and Community Services Consortium (CSC) provides housing education through the Rent Well program with the goal of parents connecting with CSC services to enable housing security. The Oregon Cascades West Council of Governments (OCWCOG) introduces their Stand By Me financial coaching opportunity to clients in this class as well to support ongoing financial growth.

Parenting education courses are in partnership with Parenting Success Network, focusing on strengthening parent-child relationships, preventing and intervening in toxic stress, and teaching positive discipline strategies.

The Center Against Rape and Domestic Violence (CARDV) teaches about healthy relationships in prevention and intervention of domestic violence. The ABC House teaches about child abuse and neglect to prevent and interrupt childhood trauma, and to decrease Department of Human Service Child Welfare intervention and foster care placements.

Courses are continuing to be developed and partnerships are being cultivated with the primary focus on providing safety, mental health and abuse prevention.

YRO is engaged in community-based agency collaborative groups to continue deepening and broadening agency connections.

Housing Navigation for Sheltered

Primary Organization	Northwest Coastal Housing
Primary Contact	Sheila Stiley, Executive Director
Primary Contact Email	nwcoastalhousing@gmail.com
Partnering Organization(s)	ReConnections Counseling Inc.
Project Name	Housing Navigation for Sheltered

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

In 2021, Northwest Coastal Housing (NWCH) was awarded Project Turnkey 1.0 funds to purchase a 41-room hotel in Lincoln City that was converted into a low barrier shelter for the houseless in Lincoln County, now known as Coastal Phoenix Rising (CPR). The shelter is available to all Lincoln County houseless individuals referred to NWCH through collaborating agencies.

As of June 12, 2023, NWCH was also awarded additional Project Turnkey 2.0 funds for acquisition of a 46-room hotel (38 room hotel + 8-unit long term rental building) for Phase 2 transitional housing for individuals with Substance Use Disorder (SUD). NWCH will be the Owner/Sponsor while contracting with ReConnections Counseling, a Certified Addiction Treatment Center, as the Operator providing transitional housing with supportive SUD services and Peers onsite in Newport, Lincoln County.

The NWCH (CPR) low barrier shelter provides onsite navigation case management services through a NWCH Shelter Navigation Specialist to address Social Determinants of Health (SDoH) care and unmet needs by providing temporary shelter and food options. With a high percentage of clients suffering from SUD, ReConnections Counseling is partnering with NWCH adding an embedded Peer Recovery Mentor at the CPR shelter. The CPR shelter has weekly virtual “huddle meetings” with agency partners to allow for a whole health wrap around service model led by the NWCH Shelter Navigation Specialist. The Shelter Navigation Specialist works with agency partners to navigate shelter clients around barriers developing and strategizing a case management plan. The outcome for all clients is focused on the unmet need of housing the houseless. To obtain this outcome, the shelter staff and partners have goals and objectives supported through a series of activities to achieve this desired outcome.

However, after two years of operating the CPR shelter, there is a recognized gap and need to acquire a focused position of a Housing Navigator, understanding as a low barrier shelter, that individuals are received where they are and each one has the right to equitable opportunities addressing the need for housing regardless of their social position or other socially determined circumstances. This position will work with the Shelter Navigation Specialist and the Peer Recovery Mentor building a Navigation Team. This team will transform individual lives from the space of temporary sheltering to the SDoH need of stabilized housing through an innovative

and focused approach providing assistance and advocacy on behalf of the shelter clients to locate, secure and retain affordable permanent housing, employment, and other basic needs for the long term. The funds requested will be seed money until the OHA State Waiver is approved and process in the state, which we anticipate is over a year. The funds will ensure the position is funded for that introductory timeframe.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

As a nonprofit affordable housing developer now into sheltering, NWCH understands how homelessness leads to unhealthy lives including wound care, access to prescriptions, clean areas for sanitation and care, access to medical supports and ongoing health, even related to mental health and SUD. Stabilized housing provides improved health when not exposed to incremental weather conditions, but also provides community support through socialization and networks of care. The CPR Shelter is strategically located across the street from the Samaritan Health Clinic and one block from the Food Pantry. CPR also provides quality housing through independent units, housekeeping, roku tv, in room telephones, wifi, business center, linens, toiletries, laundry facilities, paid utilities, full time maintenance, all rooms equipped with ADA grab bars, refrigerator & microwaves. A playground & Cultural Art Center is a block away, the beach & two parks within 5 blocks for walking, hiking, camping. City Hall, Library, shopping is ½ mile away. CPR provides food assistance through SNAP, WIC, Food Pantry, Meals on Wheels, B'nai B'rith Camp meal delivery.

Though these needs are being met, the shelter is temporary and NWCH has identified the need for a Housing Navigator to focus on a targeted outcome of stabilization of long term housing to improve the health and wellbeing of the sheltered, IHN-CCO members, and support the Navigation Team for health and wellbeing of the project as a whole.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

The shelter is designed to break the predetermined notion of "shelter" by providing non congregate units with self-sufficient spaces in a clean and inviting environment complete with wrap services and supports with social service access regardless of socioeconomic status.

The shelter offers the following objectives to increase equitable access to housing, employment and supportive services in the community. To address economic stability, NWCH Shelter Navigation Services and partner agencies collectively work together to address poverty and employment. These services include signing the clients up for TANF, Social Security, Disability, SSI, Veteran Pensions & Employment assistance.

Instead of clients going to where the services exist, the services are coming to the clients to make it more equitable and inclusive access to the houseless sheltered at CPR. The agencies are meeting in the Shelter Service Center, in the Business Center and individually. The Business Center in the main building offers all ADA access and is used as a backup meeting space.

Though other partners include Samaritan Health Services, Family Promise of Lincoln County, CSC, DHS, Veteran Service Office of Lincoln County, Senior & Disability Services, CHANCE, ReConnections Counseling, Phoenix Wellness Center, LCHHSD, & Tribal Services among others, in order to meet the high needs of the shelter population, NWCH must hire the Housing Navigator to focus on the present and next phase reducing health disparity derived from houselessness.

4. **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? (250-500 words)**

With the passage of M110, there has been an unprecedented increase of SUD. The need for funding and services for SUD has a major impact in the state of Oregon. Lincoln County has seen a rise in deaths and use related to SUD.

Houselessness in the state is also nationally recognized. Though Lincoln County was not selected at the Governors State of Emergency for Homelessness, the HMIS system did not adequately reflect the accurate number of homeless, which is more than has ever been seen in Lincoln County. Nor was it effectively reflected in our region.

As a result of Project Turnkey, NWCH has effectively collaborated with several organizations to make the project successful in not only providing shelter, but also services needed to address the insurmountable need of care. NWCH has partnered with the Sheriff's Office and the Samaritan Health Services Hospitals identifying Frequent User Systems Engagement (FUSE) individuals where the CPR has committed 3 rooms to this cliental. To address this and other houseless population needs, NWCH has collaborated with Samaritan Health Services, Family Promise of Lincoln County, CSC, DHS, Veteran Service Office of Lincoln County, Senior & Disability Services, CHANCE, ReConnections Counseling, Phoenix Wellness Center, Lincoln County Sheriff's Office, LCHHSD, & Tribal Services among others. As an extension to this collaboration, NWCH was awarded M110 BHRN funding as a participant in two BHRN's in Lincoln County as the housing partner

To fully address the high need of services and housing, NWCH must go to the next level by increasing Navigation to Navigation Team with an additional position of a Housing Navigator. With the increase of SUD and mental health, NWCH is partnering with ReConnections Counseling who will be providing embedded Peer Recovery Mentors within CPR to meet the needs of those suffering from SUD. With the acquisition of Project Turnkey 2.0 (PTK 2.0) as an SUD Transitional Housing facility, the Housing Navigator will expose occupants to the Peer Recovery Mentor who will connect individuals to peer services as well as a referral process to the PTK 2.0 waitlist where housing and SUD specific services reside. With a vacancy rate of .01% in Lincoln County, the Housing Navigation is critical to the success of the collaboration of agencies producing the outcome of housing stabilization.

LBCC Public Health Hub

Primary Organization	Linn-Benton Community College
Primary Contact	Liv Gifford; Mike Jerpback
Primary Contact Email	gifforl@linnbenton.edu ; jerpbam@linnbenton.edu
Partnering Organization(s)	Community Doula Program, Casa Latinos Unidos, Benton County Health Department, Linn County Public Health, Old Mill Center for Children and Families
Project Name	LBCC Public Health Hub

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

This project equips Linn-Benton Community College (LBCC) to become a hub for training and developing public health workers in the Mid-Willamette Valley. In doing so, we aim to increase options for students, promote regional economic development, and build healthier rural and urban communities, especially among historically excluded populations.

COVID-19 revealed deeply entrenched health inequities and exacerbated a labor shortage in public health. Agencies struggle to find and retain qualified public health candidates who are representative of the communities they serve. This project addresses these issues by increasing recruitment for public health careers, creating new pathways to entry-level positions, and adding scaffolding for those who may someday wish to further their training. We will draw on the multi-dimensional framework of "servingness" to not only enroll Latinx students and other students of color, but to fully serve them. As such, this project moves LBCC closer to its goal of becoming an Hispanic-Serving Institution.

A homegrown approach to investing in a local workforce has many benefits, including the likelihood that workers will stay in the area and make a significant contribution to their communities. Skilled local workers will fill an immediate need for entry-level positions and serve as the backbone of the future Mid-Willamette Valley workforce.

With this grant, LBCC will build upon established programs to accomplish three linked goals: (1) Create a Certificate of Completion in Community Health that prepares students to work in fields of public health, health care, and community-based-organizations, (2) Focus on recruitment and retention for public health careers, while keeping equity, diversity, and inclusion at the center of all we do, and (3) Create a replicable and sustainable Public Health Hub that can be replicated at two-year colleges across the state or beyond. In pursuing these three goals, we will maintain a commitment to continuous improvement and strong community partnerships in order to best serve the region.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

We expect to improve the health and wellbeing of IHN-CCO members by equipping students to work in public health in our region. We will expose them to a variety of entry-level options, including Traditional Health Worker, Qualified Mental Health Associate, and Certified Drug and Alcohol Counselor pathways. We will connect students to local agencies and organizations through Cooperative Work Experience as well as guest speakers and instructors with diverse backgrounds and identities. The LBCC Public Health Hub has the potential to increase the number of public health workers in our region significantly, and to address some of the most critical health disparities in marginalized and excluded communities.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Our project will promote equity and reduce health disparities in a number of ways. First, we will place a high priority on creating a diverse, inclusive, and equitable program that prepares students to work in the field. We will incorporate anti-racist training for faculty, increase the capacity of our department so that we are more representative (guest speakers, part-time instructors), and offer Cooperative Work Experience, peer mentoring, and other best practices in higher education. We will provide scholarships for students to reduce financial barriers. Finally, we will prepare students to work in front-line positions that directly address health equity in our region.

4. **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? (250-500 words)**

The project's broad base of local support is one of its greatest assets. We are partnering with Benton County Health Department, OSU's Center for Health Innovation, and the Community Doula Project, all Oregon Health Authority-approved training sites for Traditional Health Workers. We are also partnering with Casa Latinos Unidos, an organization that specifically serves Latinx communities in Linn and Benton Counties. Our goal is not to duplicate or compete with existing projects but rather to enhance them in ways that increase the number of public health workers in our region. We will also collaborate with Central Oregon Community College, which is several steps ahead of us in creating a "stackable" one-year certificate in Community Health. We see great evidence that community colleges can play a powerful role in addressing health equity and are highly motivated to move forward with this project and make a difference in our region.

Nurturing Fathers Health and Wellbeing

Primary Organization	Oregon Family Support Network
Primary Contact	Tammi Paul
Primary Contact Email	tammip@osfn.net
Partnering Organization(s)	Linn, Benton, and Lincoln Mental Health Programs
Project Name	Nurturing Fathers Health and Wellbeing

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

In recent OFSN conducted listening session, mothers and fathers frequently identified issues around effectively engaging fathers in their child's lives required by state and local child serving systems. Fathers also seem to have inequitable access to resources that could help facilitate increased involvement in the child's lives. This is particularly true for families where mothers and fathers are living in separate households.

OFSN is proposing to deliver the evidence based Nurturing Fathers Program (NFP) in the IHN region. Nurturing Fathers is a 13-week training course designed to teach parenting and nurturing skills to men.

SAMHSA's Guide for Fathers in System of Care (2013) states "In the behavioral health field, sometimes we assume that fathers (and especially fathers of color) don't care when they are not present at their children's appointments. As a group, fathers are less likely to attend meetings than mothers. A father who is absent from an appointment, however, is often assumed to be an "absent father," while similar judgment is rarely expressed about a mother in the same circumstance. In fact, most fathers are not absent fathers. Both systemic and historical factors help us to understand why fathers may sometimes be—or appear to be—less involved in the lives of their children than mothers are."

Other barriers to father engagement mentioned in OFSN listening sessions showed that fathers perceive that "systems are more oriented to mothers."

"I've tried to gain access to information about how my child is doing, and often hear that meetings have already occurred and decisions have been made."

The net impact of this experience is that fathers feel increasingly disenfranchised by systems that are meant to help. Other fathers returning from being incarcerated find it harder to do everything to reintegrate into the community and with their children as well.

Finally, system attitudes and beliefs about fathers and their absence are not always accurate and many dads slip through the cracks - many who give up because they don't know what else to do.

Other research shows early and frequent involvement of fathers in their child's lives has shown positive impacts (R. Parke (1996-Fatherhood, Cambridge MA: Harvard University Press); including lowered levels of disruptive behavior, acting out, depression, as well as increasing positive attributes like being kind to others, and being willing to try new things. Multiple research findings on father engagement have concluded that the quantity and quality of father involvement positively influences child development over time.

OFSN believes this project is innovative and necessary because having both mothers and fathers involved in their child's life actually increases resilience, hope and wellbeing for the whole family. The Nurturing Fathers curricula is transformational because it offers a range of topics that helps moms and dads to work effectively together to bring about greater success, and this results in health promotion for the whole family. The presence of both mothers and fathers in their children's lives also has demonstrated effectiveness in addressing symptoms of anxiety and depression in children and youth.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Oregon Family Support Network, Inc. is a 501c3 non-profit organization serving the needs of families raising a child or youth experiencing significant behavioral health challenges. With funding support from IHN, OFSN will offer programming to increase support, education and advocacy for fathers by engaging a father friendly evidence-based parenting curriculum. The Nurturing Fathers curriculum will become the foundation of support to fathers who often feel disenfranchised by child serving systems in Oregon.

This project focuses on promoting and increasing family health and well-being using training and ongoing support for fathers through the use of a 'father-friendly' evidence based curricula known as Nurturing Fathers (NF). Information about Nurturing Fathers can be found at https://nurturingfathers.com/nfprogram. The program consists of a 13-week family psycho--education curricula aimed at supporting fathers in the care and development of their children along with regular monthly activities that support building nurturing skills for father figures.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

The proposed project aims to decrease health disparities for fathers in support and participation of their child/youth in treatment of mental and behavioral health challenges.

Health disparities are present most commonly when services and supports do not speak to specific needs of a population. In this case, fathers are the marginalized community for which this project is developed. Our capacity to improve supports to fathers will have a direct impact on their ability to promote and achieve better health outcomes for their child. Additionally, OFSN is prioritizing offering the Nurturing Fathers Program in both English and Spanish and the facilitators of the training all identify as both fathers and as members of historically marginalized communities.

4. **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? (250-500 words)**

OFSN will use existing and new community partnerships to collaborative and engage fathers in the Nurturing Fathers Program (NFP). OFSN has already engaged in work and community partnerships in the IHN region. Through this project, OFSN will have an expanded network of organizations to engage around information sharing, and promotion of the Nurturing Fathers program. This project allows for additional opportunities to leverage the partnerships that have been formed to continue partnering for this effort. The outreach strategies used will include: 1) 1:1 contact either virtual or when appropriate in person, 2) introduction to OFSN and the Nurturing Fathers Program, goals of the program, dates of training and 3) sharing flyers and brochures to promote registration/participation.

OFSN has also been in frequent conversation with OHA's Child & Family Services Division School Based Mental Health programming staff and has presented about OFSN and Reach out Oregon to school based mental health staff around the state. Conversations with these organizations will continue throughout the project, which will help to inform future efforts in this work with fathers. Building new partnerships is something that OFSN will continue to do through its Communications and Outreach programming.

Partnerships in Health

Primary Organization	Santiam Hospital and Clinics
Primary Contact	Kim Klotz
Primary Contact Email	kklotz@santiamhospital.org
Partnering Organization(s)	CHANCE, Capital Dental, Family Tree Nursery, Early Learning Hub, Linn CO Department of Health Services, Lions Club, Canyon Service Center, Scio School District, Santiam Canyon School District
Project Name	Partnerships in Health

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

The Partnerships in Health program stems from the premise that a system change is necessary to transform and improve the traditional healthcare model. It is based on the belief that health and wellbeing starts outside of the hospital and clinic system. Santiam Hospital and Clinics proposes improving access to health care and social resources through local assistance fairs; to include needed follow-up for longer-term support. This project will bring collaborative partners together for community oriented, single point of contact health fairs, enhanced by utilizing a traditional Health worker for follow up support. This project will help to strengthen existing and develop new relationships with Linn County partners to improve access to healthcare and social resources. Health fairs have been a commonplace and a great starting point to connect with community members. Unfortunately, single contact at health fairs lacks the necessary follow up and support that marginalized populations may need to address social determinant of health needs. This project is innovative as it will intentionally aim to identify general community members with social determinant of health needs in a traditional health fair style with the added piece of follow up. A traditional healthcare worker will aim to provide local resources and coordinate with community partners with the goal of closed loop referrals.

Santiam Hospital's Integrated Health and Outreach program will coordinate 2-3 outreach health fair events in Linn County. Through an already well-established Service Integration program, we are confident that we can collaborate to have Linn Co. host-site partners and resource partners included, aiming to decrease health disparities of Linn County. This project proposes to newly allocate a traditional health worker, .20 FTE to the outreach, coordination, and follow-up of the events. This would include learning about and referring to specific Linn County resources that are focused on SDoH needs to include transportation, food and housing. This traditional health worker would also participate and be a valuable contributor to the Delivery System Transformation meetings bringing a unique perspective from those in our service area, the rural Santiam region.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

The Partnerships in Health program is part of Santiam Hospital's Integrated Health and Outreach department. The goal of the integrated health workflow is to decrease overall costs of health care, increase health, improve access to care and resources and improve Provider satisfaction by assisting with social supports. This is successful by supporting members from their place in the community through the hospital system and in community based rural healthcare clinics. Santiam Hospital starts by supporting members from their place in the community by supporting a well-established Service Integration program that serves IHN-CCO members, this includes teams in Scio and the Santiam Canyon. The Scio team was recently added in 2022, as it becomes more well known, it has led to increased inquiries from the Linn County communities. This program will help to dedicate a staff member to be more knowledgeable about Linn County resources and more accessible to IHN-CCO community members. The purpose of Partnerships in Health is to provide a sense of community and provide resources for improved health and wellbeing of Linn County residents.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Our project recognizes that many factors may contribute to health disparities. Given the rural locality of Linn County IHN members in the Santiam service area, this project aims to bring health care to the members where they are at. Health fairs, within the community, limit transportation barriers and bring access to resources for community members locally. The project's overall intention is to address barriers that limit continued access to resources and healthcare. Follow-up by the THW may include supports that remove barriers, such as financial assistance for transportation, health club memberships for access to exercise equipment, or delivery of food as a few examples. The Partnerships in Health traditional health worker will work to promote equity and reduce health disparities by working with Linn County partners that serve the Santiam service area. An example includes working with Scio SD, Linn Benton Lincoln ESD and Santiam Canyon ESD to identify students that need better healthcare connection, such as coordinating for vaccines to avoid school exclusion day or leveraging with community partners or service integration for school supplies or clothing necessary to succeed in the classroom. This THW will be trained as an OHP assistant to help with enrolling into IHN-CCO or collaborating with ODHS (Oregon Department of Human Services) for appropriate additional resources. This can be followed by helping the members to establish a primary care provider. Further, if the Provider is in the Santiam Hospital system, then the member will stay within the care continuum of our integrated health care system, if needed they may continue services with a community health care worker.

4. **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? (250-500 words)**

Partnerships in Health plans to continue building relationships and connections with service area partners. We plan to invite community organizations that are already involved in general improvement of health and addressing SDOH needs, behavioral health supports, child and youth health, maternal health and those with a strong focus on improving access for Spanish speakers. Regional partners may include Family Tree Relief nursery, Capital Dental, Casa Latinos Unidos, Furniture Share, CHANCE, Lion Club, Linn County Department of Health and Services, Scio and Santiam Canyon School District, Santiam Service Integration Team members of Scio and Santiam Canyon teams, and others as we learn of more partners in the region.

Large Request for Proposal Project Crosswalk

Proposal Name	Champion Organization	Healthcare Access & Quality	Neighborhood and Built Environment	Social and Community Context	Economic Stability	Education Access & Quality
Bilingual McKinney-Vento Advocates	Lincoln County School District HELP Program					
Positive Outcomes: LGBTQ+ Youth	Jackson Street Youth Services					
Winter Houselessness Shelter	Lincoln County Health & Human Services					
Young Adult Cohort Housing	Community Outreach, Inc. (COI)					
Food for Many	Family Tree Relief Nursery					
Sleep Trailer Safe Shelter	Sleep Trailer LLC					
Asset Mapping Project	Pollywog					
AGL Client Service Extension	Applegate Landing LLC					
Healthy Eating Children's Cookbook	Furniture Share					
Improving access to quality education	Peaceful Gardens Montessori					
Community Based Postpartum Care	Corvallis Birth & Wellness Center					
Gardens as Therapeutic Spaces	Corvallis Environmental Center					
Dental Care Coordinated Service	Crossroads Communities					
Bridge to Better Health	The Corvallis Clinic PC					

Large Request for Proposal Project Scoring

		Transformation Department Initial Scoring			
Proposal Name	**Champion Organization**	**System Impact**	**Focus Population**	**Partnerships & Collaboration**	**Total**
Bilingual McKinney-Vento Advocates	Lincoln County School District HELP Program	3	3	2	**8**
Positive Outcomes: LGBTQ+ Youth	Jackson Street Youth Services	3	3	2	**8**
Winter Houselessness Shelter	Lincoln County Health & Human Services	3	3	2	**8**
Young Adult Cohort Housing	Community Outreach, Inc. (COI)	3	2	2	**7**
Food for Many	Family Tree Relief Nursery	2	2	2	**6**
Sleep Trailer Safe Shelter	Sleep Trailer LLC	2	2	2	**6**
Asset Mapping Project	Pollywog	2	2	2	**6**
AGL Client Service Extension	Applegate Landing LLC	2	1	2	**5**
Healthy Eating Children's Cookbook	Furniture Share	2	1	2	**5**
Improving access to quality education	Peaceful Gardens Montessori	1	2	2	**5**
Community Based Postpartum Care	Corvallis Birth & Wellness Center	1	1	2	**4**
Gardens as Therapeutic Spaces	Corvallis Environmental Center	1	1	2	**4**
Dental Care Coordinated Service	Crossroads Communities	1	1	2	**4**
Bridge to Better Health	The Corvallis Clinic PC	1	1	1	**3**

AGL Client Service Extension

Primary Organization	Applegate Landing LLC
Primary Contact	James Lutz
Primary Contact Email	james.cpcm@outlook.com
Partnering Organization(s)	Crossroads Communities, Cascade Management
Project Name	AGL Client Service Extension

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Applegate Landing (AGL) provides housing to low-to-moderate income households whose income is 60% or less than the area median income (AMI). For the past two years AGL has partnered with Crossroads Communities (CRC), a Lebanon-based non-profit organization that focuses on providing comprehensive service connection, service intake, and case management.

Applegate Landing in Lebanon Oregon is a 48-unit affordable housing facility with a large community building that has a meeting room, counseling rooms, exam room, exercise room and a gathering room for recreation and training. CRC's involvement at the AGL apartment complex has had noticeable success in helping to stabilize families living on site and keep them housed. AGL is proposing an increase in operating hours for CRC on site and is requesting funding to allow for the extra staffing required to accommodate a wider schedule.

Housing is a primary social determinate of health. Through stable housing, residents are able to have a solid foundation upon which to build their lives; they have a stable platform from which they can seek assistance with other socio-economic needs such as education, employment, and healthcare; having a consistent and predictable place to stay also comes with a dedicated address which guarantees mail delivery and an easy way to be located for follow-ups from service providers. CRC has already proven the effectiveness of having coordinated service and integrated services on site by helping AGL to retain 66% more residents than most affordable housing projects do on a year-over-year basis.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Applegate Landing is one of only a few affordable housing facilities in Oregon to have a dedicated social service provider partner available on site. Through CRC, residents are able to receive a s a variety of services, including:

Case management: Case managers help residents with a variety of tasks, such as advocacy, connection to services, applying for benefits, and accessing healthcare.

Financial assistance: Assists residents with obtaining financial assistance for rent shortfall, utilities, food, transportation and other expenses.

Job training: CRC is connected to programs that assist with job training and placement services to help residents find employment.

Although Applegate Landing provides housing, this is just one component of what is available on site and, together with Crossroads Communities, creates a positive impact on the social determinants of health and health equity. These combined efforts help to reduce poverty, improve access to healthcare, and increase employment. These factors all contribute to improved health outcomes.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

A study by the National Center for Children in Poverty found that children who live in poverty are more likely to experience chronic health conditions, such as asthma and obesity. The study also found that children who live in poverty are less likely to have access to healthcare. Co-locating a housing program and social service support provider helps to address these issues by providing affordable housing, connection to on-site services, and easier to access financial assistance programs.

At present, Crossroads Communities has office hours of 9am through 5pm; this extends service time for residents by one hour as the Property Manager office closes at 4. Although CRC does not address property management concerns, their presence provides support for residents who otherwise have no one with whom to communicate regarding concerns. AGL is proposing an increase in operating hours and adding Saturday as a service day. Many residents have expressed a preference for interacting with resident services but are unable to due to their work commitments during the work week. Having a greater level of availability will improve accessibility to services.

4. **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? (250-500 words)**

Applegate Landing works closely with Crossroads Communities because they know social services. They have over two dozen partnering agencies through which they can connect clients to support programs and resources. A few examples of programs they have brought to Applegate Landing include:

Financial Literacy: Partnering with Umpqua Bank, CRC provides financial literacy classes for free.

Access to healthcare: CRC has partners with local healthcare providers, teaching colleges, and OHA, allowing residents of AGL to sign up for physical therapy and occupational therapy on site (AGL has a full-service gym in the activity center run by CRC), free vaccination clinics, and free dental checks, sealants, and fluoride treatments. These on-site services improve residents' access to healthcare. This is important because healthcare is essential for preventing and treating illnesses.

Employment: CRC just completed a youth workforce education program located at Applegate Landing. Marketable skills training and workforce development helps to increase employment for low-income individuals and families. This is important because employment is essential for economic stability and improved quality of life.

Health Education: AGL, through CRC, hosts a variety of applicable healthy-living classes. These classes include making smart dietary decisions, understanding health needs, health awareness, and even applied healthy cooking classes. These are organized by CRC and operated by CRC's program partners, including Western University, LBCC, the Parenting Success Network, and several past IHN pilot fund recipients.

Applegate Landing is an affordable housing developer focused on bringing life-improving resident services to its housing sites. Its knowledge of and ability to implement social services is not sufficient to provide the quality and efficiency of programs available through Crossroads Communities. By working together, both organizations can bring to bear their expertise for the betterment of the partnership, the community, and the population served.

Asset Mapping Project

Primary Organization	Pollywog
Primary Contact	LeAnne Trask
Primary Contact Email	leanne.trask.@linnbenton.edu
Partnering Organization(s)	Early Learning Hub of Linn, Benton, and Lincoln Counties
Project Name	Asset Mapping Project

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Asset mapping is an innovative method of research originally developed in 1993 as a community development strategy that allows the community members to explore, describe, and map its assets, and then use these maps and family dialogue to develop solutions to gaps in resources that the mapping uncovers. Community members gather around large aerial maps of their community and place stickers on the map where various assets are located, such as a grocery store, a child care center, or a school. This method allows us to glean community knowledge about small cities in our region who are in need of supportive and equitable services, directly impacting the social determinants of health.

Our project is to create an asset map for Linn, Benton and Lincoln Counties with a goal of better understanding the needs, assets, resources, and gaps in services that families with young children in our region experience and hearing from families directly about their community needs. The results of the asset mapping will allow the Early Learning Hub to develop more strategic solutions that will have a higher likelihood of achieving outcomes. Sixteen cities throughout Linn, Benton and Lincoln counties have been identified as potential sites.

A complete family-driven asset mapping of our region has never been completed (to the best of our knowledge), and we believe that taking this community knowledge directly from our families and implementing it into our decision-making will transform the way that we serve families in our region.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

During each asset mapping session, participating families will be asked to place stickers on specific community assets they utilize:

- Health Care
- Mental/Behavioral Health
- Dental Care

- Food/Groceries
- Transportation
- Childcare
- Places to Hang Out
- Places of Learning
- Places for Exercise
- Places to Worship

Each of these stickers represent basic family needs and services, and if they aren't available in your community, this becomes a barrier to your family's health and well-being. As community service organizations, we can look at a map and see the assets in a town; however, if we don't actually live in the town and navigate those services personally, we may not recognize what is lacking for the families we serve. For example, there may be a beautiful park in a town, but we may not know there is drug activity going on in that park and families won't let their children play there.

We will also be asking families to tell us what they are most proud of about their city, what concerns they have about their city, and what is unique to their city. All of this information will allow us to better care for family health and well-being.

Our purpose is to:

- Show the available resources and services
- Show the gaps in services, barriers, concerns and unmet needs
- Align existing efforts and resources to develop effective plans to remove barriers and meet the needs of children and families
- To provide a foundation for strategic planning and implementation.

Secondly, by scaling the program, we can ensure that all patients within the clinic have access to both screenings and appropriate interventions. This proactive approach shifts the focus from treating acute medical conditions to addressing underlying social factors that contribute to poor health outcomes. We can help prevent the escalation of health issues and reduce the reliance on emergency services, leading to more effective and cost-efficient care for IHN patients.

Furthermore, the systematic collection and analysis of SDoH data will provide valuable insights into health disparities and inequities within the IHN population. These insights can guide policy changes, resource allocation, and community partnerships aimed at addressing the root causes of these disparities with payer partners. By actively working towards reducing health inequities, we can create a system that is responsive to the needs of patients, promoting health equity and improving overall health and wellbeing.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Pollywog (a program of the Early Learning Hub of Linn, Benton & Lincoln Counties) supports Oregon's young children and families to learn and thrive. All of our work is in service to children, families and communities. We know that historically underserved communities represent Oregon's best opportunity to improve outcomes. Strength-based approaches and asset-based mindsets will support our efforts to institutionalize equity.

Pollywog supports culturally responsive services that are respectful of, and relevant to, the beliefs, practices, culture and linguistic needs of diverse populations and communities. Cultural responsiveness describes the capacity to respond to the issues of diverse communities and requires knowledge and capacity at different levels of intervention and service delivery: systemic, organizational, professional and individual.

As Pollywog continues our work in creating systems change strategies to ensure that services and supports are aligned, coordinated and family-centered, we must engage with and center the voices of parents in this work. Parents know better than anyone how and why family-supportive programs and policies fall short and what changes can be made to improve program and policy outcomes. Partnerships develop when parents are given the opportunity to provide opinions and inform the strategic financial planning of our organizations. This asset mapping project will come to their town, listen to their opinions, and see through their eyes what resources and services are available and which are missing from rural communities in our region. This is an innovative tool for community-based participatory research, and will provide strength-based community knowledge for ongoing coordination.

4. **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? (250-500 words)**

Pollywog facilitates the Early Learning Hub's Health Care Integration Workgroup (HCI). Since 2022, the HCI has been assisting with the IHN-CCO's 4-year System-Level Social-Emotional Kindergarten Readiness Metric, which ensures that children ages 0-5 and their families have equitable access to services that support their social-emotional health and are the best match for their needs. Deliverables include a regional asset mapping of our three counties to capture services and resources that address children's Social-Emotional health, cross-sector engagement with community partners to assess barriers and opportunities to improve Social-Emotional Health service capacity and access, and an action plan to improve capacity and access for children and families. The IHN has expressed considerable interest in this more complete asset mapping and what it could bring to their current metric project. The IHN's Population Insights Program Manager is leading this project.

If Pollywog is granted these transformation funds, the HCI will also be working on the Regional Asset Mapping project. There are currently 75 partner agencies who regularly participate on

the HCI Workgroup, such as DHS, Old Mill Center, the three regional health departments, Samaritan Health Services, LBL-ESD, Young Roots, Family Tree Relief Nursery, the Community Doulas, Kidco Head Start, LBCC Parenting Education, the Parenting Success Network, Health Equity Alliance, OHSU, ABC House, and many others. These organizations have discussed this proposed project at several meetings, and made suggestions and recommendations as to how it can be strengthened. They have also expressed interest in the research outcomes for their organization's internal use. The IHN Population Insights Program Manager, Katie Walsh, has also been involved and requested to be kept apprised.

Additionally, the project will have assistance with data coordination and presentation from the EL Hub's Data and Evaluation Coordinator, Jinguang Lin, M.Stat. Jinguang facilitates the EL Hub's Data & Evaluation Workgroup, which will also be reviewing the data collected in this project.

The role of our organization in Linn, Benton and Lincoln Counties is to support underserved children and families to learn and thrive by making resources and supports more available, more accessible, and more effective. This project allows us to figure out how and where our children and families are being underserved, and where we need to make resources and support more available.

Bilingual McKinney-Vento Advocates

Primary Organization	Lincoln County School District HELP Program
Primary Contact	Woody Crobar
Primary Contact Email	woody.crobar@lincoln.k12.or.us
Partnering Organization(s)	HELP Program, LCSD
Project Name	Bilingual McKinney-Vento Advocates

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

The HELP Program, as part of the Lincoln County School District, identifies students experiencing homelessness. Staff within the program work alongside school building staff, community partners, and the families of children to identify barriers to student success. Social determinants of health are used to identify and track these needs, and HELP staff can offer a wide range of customized supports depending on the needs of a particular student or family. If something is identified as a barrier to student success- whether or not it's a basic resource need, mental health/medical support, or connection with a local housing agency, the HELP Program will work to eliminate that barrier.

The HELP Program has recently created two new positions, Bilingual Advocates, who work exclusively with families who do not speak English (most typically Spanish and Mam speakers). Through a shared cultural and linguistic background these staff are able to connect with these families in a way that can often be difficult for service providers. Bilingual Advocates can then act as a bridge to other services community even if those services lack support for non-English speakers. This can range from being as simple as a warm hand off to as complex as visiting a service provider in person to advocate and interpret on the student or parent's behalf.

Bilingual Advocates do not have any medical or community health training- but often find themselves in a place where they have to assist families in navigating the medical system. These are often the most complex and time-consuming cases that these staff are involved in. Examples of issues faced this year have included teaching students and parents about their diabetes diagnosis, teaching families about how to request a prescription refill and take it to the pharmacy, accompanying students to dental and medical appointments to act as in-person interpreters, and teaching parents about preventative care.

Funding through Delivery System Transformation is sought to provide medical training for Bilingual Advocates. Bilingual Advocates will receive training as Community Health Workers. This will provide Bilingual Advocates with the ability to more easily assist families in navigating the medical system.

Funding is also sought so that these positions can continue to provide services and expand the

scope of their work with families. This additional funding will be used, alongside other funds, to provide staffing time for Bilingual Advocates to assist with medical and social emotional needs of students and families.

Bilingual Advocates are able to establish themselves as a trusted source of information for families, and further training would allow them to more actively step into roles to assist the community at large. This would ensure the social services and medical system at large within Lincoln County is more robust as a whole: instead of funding a single organization or service, the funds would go to a staff person who could effectively work with a family in accessing any service that may prove useful.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

The Health and well-being of students and families within Lincoln County will be improved in several ways.

Continued funding for Bilingual Advocates within the HELP Program will allow the support provided by these staff to expand and serve a larger number of students and family medical needs. Incorporating Community Health Worker training into HELP Professional development will give these staff a more developed, recognized tool set to use when educating families on medical issues. It will also allow for easier communication with medical providers within the community. The role of these staff will be more easily understood, and the training provided to the staff will make navigating medical care easier for them and the families they serve.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

The targeted population served by Bilingual Advocates represent a cross section of high needs demographics.

The first among these are homeless students. In 2021-2022, 12.1% of students (630 students) within the Lincoln County School District were identified as Homeless. This gives Lincoln County one of the highest rates of student homelessness in Oregon.

Non-English speakers are the second marginalized group. Lincoln County is a rural community and, while services exist within the area, many of these services do not offer active on-site interpretation. Over the phone translation has been used in some organizations, but it rarely acts as an adequate substitute to in person support. By having our own staff who can provide this the HELP program eliminates a huge barrier.

Finally: the majority of the non-English speaking families Bilingual Advocates work with are Hispanic, Indigenous, or mixed-race. These families are often recent immigrants or asylum seekers, and require specialized support to determine which resources are accessible to them depending on their immigration status.

Training and funding for Bilingual Advocate positions will ensure that students and families in these demographics will be more easily able to navigate the medical system.

4. **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? (250-500 words)**

As a support system, school districts are often the entities families interact with the most and the earliest. Children come to school each day, which lets school staff see any changes in appearance, behavior, or health. This positions schools and school districts as a unique partner to social services and health providers as they are often the first step in identifying any health problems early and getting treatment started.

Beyond this a key partner of the HELP Program is Arcoiris Cultural. Arcoiris Cultural is a local organization that aims to serve the Hispanic population in Lincoln County. They host a wide variety of events and offer resource navigation in addition to funds assisting asylum seekers. For medically related issues they have staff who are trained OHP assister, able to help people enroll in OHP and navigate eligibility. They are a frequent collaborator with the HELP Program, and would be a key source for connecting with families in need.

The HELP Program is also supported by several other grants and donation streams. The McKinney-Vento subgrant, provided through ODE, gives flexible funding to assist students and families with a variety of resource needs that might help them access services. HELP is also the beneficiary of several charities and fundraisers within Lincoln County. Donors include the Board of Realtors, Food Share, the Booster Club, and several other organizations. Every donation is earmarked as funds related to student needs, which feeds into the resources HELP can provide to families and students.

Other organizations act as collaborators for generalized efforts. HELP partners with the affordable housing board to keep up to date knowledge on any and all affordable housing in the area. HELP is also a partner with county Health and Human Services, and regularly attends meetings to recommend students for more intensive mental health support. HELP is also partnered with several food banks and area churches to maintain food pantries in each area school. Students in need are sent home with meals over the weekend in backpack programs, and can access food through food pantries in each of the area's schools.

Bilingual Advocates have access to all of these resources to provide additional support to families in need.

Bridge to Better Health

Primary Organization	The Corvallis Clinic PC
Primary Contact	Samuel Robinson
Primary Contact Email	samuel.robinson@corvallis-clinic.com
Partnering Organization(s)	N/A
Project Name	Bridge to Better Health

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Our project is centered around the scaling of a pilot program for collecting and aggregating Social Determinants of Health (SDoH) data. Initially implemented with three providers in the Internal Medicine department, we are now expanding the program to encompass the entire Primary Care division at The Corvallis Clinic. This expansion includes the Asbury, Waverly, North Albany, and Philomath Family Medicine Clinics. The primary objective of this initiative is to gather data on social determinants of health specific to each clinic's patient population, ensuring a comprehensive understanding of patients' needs. By aggregating this data, we aim to promote equity by systematically identifying and addressing the non-medical factors that significantly impact patients' well-being. Additionally, we will establish connections with relevant community partners to better support patients in overcoming these challenges.

The use of the AAFP Social Needs Tool represents a transformative shift in our approach to SDoH data collection. While the previous program had a single SDoH question integrated into the Screening, Brief Intervention, and Referral to Treatment (SBIRT) process, the adoption of the AAFP Social Needs Tool allows for a more comprehensive and standardized assessment of patients' social needs. This innovative tool enables us to gather valuable data on a wider range of social determinants, including housing, food security, transportation, employment, and interpersonal safety. This project's impact on social determinants of health and equity is substantial. By integrating the AAFP Social Needs Tool into our routine primary care practices, we are embedding a proactive approach to addressing patients' social needs within our healthcare system. This shift from reactive to proactive care can help identify and address underlying social factors that often contribute to health disparities and inequities. By recognizing and addressing these determinants, we aim to promote better health outcomes, reduce healthcare disparities, and improve the overall well-being of our patients.

Our project entails not only scaling a pilot program for collecting and aggregating SDoH data, but also emphasizes the importance of staff and quality team professional training and development. we recognize that training and development of our staff and quality team members are critical components of this initiative. We will provide comprehensive training to ensure that all members involved in the SDoH data collection and integration process are equipped with the necessary skills and knowledge.

In summary, through the adoption of the AAFP Social Needs Tool, we aim to transform our approach to addressing social determinants of health. By systematically collecting and analyzing comprehensive SDoH data, we can develop targeted interventions, allocate resources more effectively, and promote health equity among our diverse patient population.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Firstly, the adoption of the AAFP Social Needs Tool allows for a more comprehensive assessment of IHN patients' social needs. By systematically identifying and documenting determinants such as housing instability, food insecurity, transportation barriers, and interpersonal safety concerns, we can gain a deeper understanding of the challenges faced by our patients. We will be able to tailor interventions and support services to better address needs.

Secondly, by scaling the program, we can ensure that all patients within the clinic have access to both screenings and appropriate interventions. This proactive approach shifts the focus from treating acute medical conditions to addressing underlying social factors that contribute to poor health outcomes. We can help prevent the escalation of health issues and reduce the reliance on emergency services, leading to more effective and cost-efficient care for IHN patients.

Furthermore, the systematic collection and analysis of SDoH data will provide valuable insights into health disparities and inequities within the IHN population. These insights can guide policy changes, resource allocation, and community partnerships aimed at addressing the root causes of these disparities with payer partners. By actively working towards reducing health inequities, we can create a system that is responsive to the needs of patients, promoting health equity and improving overall health and wellbeing.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

1. Systematic SDoH Assessment: Implementation of the AAFP Social Needs Tool will allow patients equal access to screening and subsequent resources, and standardize the assessment to ensure consistent identification of needs.
2. Tailored Interventions: The collection of comprehensive SDoH data allows healthcare providers to develop tailored interventions that specifically target the social factors affecting patients' health.
3. Resource Allocation: The aggregated SDoH data from Medicaid patients provides valuable insights into the social needs prevalent in this population. These insights enable healthcare organizations to identify and allocate resources more effectively to address the identified disparities.
4. Health Policy and Advocacy: The project's emphasis on collecting and analyzing SDoH data

from IHN patients contributes to the broader understanding of health disparities and inequities. This data can be used to advocate for policy changes that address the systemic factors contributing to these disparities. By actively engaging in health policy discussions and advocating for equitable healthcare practices, the project aims to reduce health disparities and promote equitable access to quality healthcare for IHN patients.

Overall, the project's systematic approach to SDoH assessment, tailored interventions, resource allocation, and advocacy work collectively to promote equity and reduce health disparities among IHN patients. By addressing the social factors that disproportionately affect this population, the project strives to create a more equitable healthcare system that provides fair and equal opportunities for all patients to achieve optimal health outcomes.

4. **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? (250-500 words)**

1. OHA Initiatives: This project aligns with the OHA's efforts by focusing on identifying and addressing social determinants of health among Medicaid patients. By collecting and analyzing SDoH data, the project contributes to the broader statewide efforts to understand and mitigate health disparities in Oregon.

2. Medicaid Transformation Project: This project aligns with the goals of the Medicaid Transformation Project by integrating the AAFP Social Needs Tool into primary care practices for Medicaid patients. The systematic collection of SDoH data and the provision of tailored interventions align with the project's focus on improving health equity and reducing disparities among Medicaid beneficiaries.

3. Collaborative Partnerships: Oregon emphasizes collaborative partnerships to address health disparities and promote health equity. This project provides an opportunity for The Corvallis Clinic to collaborate with local community organizations, public health agencies, and social service providers. By working together, these partners can leverage their expertise and resources to develop comprehensive solutions that address the social determinants of health impacting Medicaid patients. This collaboration connects with the broader statewide efforts to foster partnerships and collaboration for equitable healthcare delivery.

4. Health Equity Metrics: Oregon has been implementing health equity metrics to track progress in addressing disparities and improving health outcomes. This project's focus on collecting SDoH data and utilizing standardized assessment tools aligns with the state's commitment to measuring health equity metrics. The project's data collection and analysis contribute to the ongoing efforts to monitor and evaluate health equity initiatives statewide.

Potential community collaborators that you could consider include the Oregon Primary Care Association (OPCA), Oregon Health Equity Alliance (OHEA), Community Action Agencies (CAAs), IHN, Creach Consulting, Regional Health Equity Coalitions, and other supportive resource

entities that the data may highlight as valuable partners. Engaging with these community organizations can facilitate collaborative approaches, leveraging their existing resources and expertise. This collaboration will help ensure that our project aligns with broader initiatives in Oregon and creates a network of robust support systems for patients.

Community Based Postpartum Care

Primary Organization	Corvallis Birth & Wellness Center
Primary Contact	Susan Heinz, CNM
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Partnering Organization(s)	Community Doula program, Good Samaritan pediatrics, Old Mill Center
Project Name	Community Based Postpartum Care

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

This is a community based postpartum program including in-home postpartum care for the birthing parent and newborn, and postpartum group support. Currently Corvallis Birth & Wellness Center (CBWC) provides in-home postpartum care to all our clients, including those with IHN. These home visits are provided to all our clients, including those who transfer and birth at the hospital. This care is provided by a Certified Nurse Midwife (CNM)/Nurse Practitioner and provides postpartum care starting 1-2 days after discharge and initial newborn care till at least 2 weeks of age. As CNM's are Nurse Practitioners, they can provide newborn health care. This proposal program would extend that care to all IHN clients for in-home visits with CNM and a Lactation Consultant (IBCLC) providing additional lactation support and assessment. This program is unique in that the home visits are in the first critical days after birth and are provider-based care.

All IHN clients would receive one or two home visits after discharge from the hospital with comprehensive newborn well-child care by a CNM, and any follow up newborn care needed such as weight check, bilirubin follow up, feeding concerns/needs as deemed necessary by GSRMC pediatric team and/or as assessed by CNM. Home visits also provide assessment of the physical concerns of the birth parent such as concerns about postpartum bleeding or healing, lactation support, and postpartum mood assessment, as well as an opportunity to connect to additional resources as needed.

Postpartum home visits support the client by allowing them to remain in their home immediately after discharge after birth and thus prevent additional fatigue and stress of having to go to an office for follow up care that can be done in the home. Often transportation concerns or adjustment to parenting and fatigue prevent individuals from getting into a provider's office during this very intense time in the postpartum experience.

This proposal can include the opportunity for early discharge from hospital, 8-12 hours after birth, with reassurance that there will be comprehensive follow-up from a provider after discharge. Early discharge is currently only available to the clients of CBWC as the pediatric staff knows our Birth Center staff will be sure they will be seen at home between 24-36 hours

after birth to perform the newborn screening test, check weight and bilirubin, and offer assessment and support. Extending this opportunity to any IHN client will reduce their barriers to care and provide this option to all IHN clients saving health care dollars on extended hospital stay where needs could be managed, if client desired, at home. If an early discharge visit, at least one additional home visit would occur. After in home visits, clients can access and transition into a group setting of other postpartum people with their newborns. This provides an opportunity to connect with community, learn about and access other community resources, and learn about postpartum care, newborn care, parenting support, contraceptive education and easy access, and preventative health care following the postpartum period.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

This proposed program will improve the health and wellbeing of IHN-CCO members by providing comprehensive care to those who are at highest risk of postpartum complications. It will remove some significant barriers to care, and promote a sense of community involvement and support for parents.

In-home care for the initial postpartum period would reduce barriers to care like transportation to multiple appointments and provide an opportunity for the home environment to be part of the assessment and solution process for providers. This program would bring healthcare and care coordination into their home in the immediate postpartum period, when lactation, newborn care, postpartum physical care, and potential isolation from the community is in the most fragile state, and parental fatigue and overwhelm can be at its highest.

In a home setting, topics that can be difficult to approach in traditional healthcare settings can be addressed. This could include chest/breastfeeding support for non-birthing parents, culturally-sensitive support for nontraditional family units, home assessment and recommendations for adaptation for disabled persons, connecting non-english-speaking clients with translation resources.

This proposal also provides a postpartum community group offering an ongoing connection long after traditional postpartum care ends, which would help identify postpartum complications, mental and physical, and get those clients to care immediately. A facilitator would be tasked with facilitating group sessions, connecting with community programs and bringing in community group services to speak, and offering additional support and connection to clients who express a need for additional support in the group classes.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Typical postpartum care includes only a 6 week postpartum visit focused on the birthing person, with lactation support in clinic as needed, pediatric care 24-48 hours after discharge and again at 2 weeks after birth, and any additional care on an as-needed basis and exclusively in clinic with a variety of specialists. This program would be transformational in its ability to

provide additional (critical) preventative care, connect clients with resources from their homes, encompass existing resources, and start to incorporate them into a community of caregivers and other clients in the same stage of life who can provide additional support. It will remove some significant barriers to care and promote a sense of community involvement and support for new parents.

Up to half of the postpartum individuals in the U.S. do not receive routine healthcare after giving birth (1,2) with below 60% of Medicaid enrollees attending their routine postpartum visits (1,2). Barriers to care include transportation to in-person appointments, a variety of appointments with specialists (lactation support, obstetric provider, pediatricians, mental health support, etc.), and difficulty balancing the needs of a newborn with their own healthcare needs. 52% of pregnancy-related deaths happen in the postpartum period (1,2) defined as up to 1 year after birth, and it is during this time that coordination of care and routine follow-up is at its lowest. The disparities widen and the barriers exponentially increase for communities of color, disabled individuals, LGBTQIA2S+ and other communities impacted by health disparities overall (2).

References

Rodin D, Silow-Carroll S, Cross-Barnet C, et al. Strategies to Promote Postpartum Visit Attendance Among Medicaid Participants. J Womens Health (Larchmt). 2019 Sep;28(9):1246-53. doi: 10.1089/jwh.2018.7568. PMID: 31259648.

Thiel de Bocanegra H, Braughton M, Bradsberry M, et al. Racial and ethnic disparities in postpartum care and contraception in California's Medicaid program. Am J Obstet Gynecol. 2017 Jul;217(1):47.e1-.e7. doi: 10.1016/j.ajog.2017.02.040. PMID: 28263752.

Study on postpartum care: https://effectivehealthcare.ahrq.gov/products/postpartum-care-one-year/protocol#ref9

4. **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? (250-500 words)**

This program proposal is about home visit health care, access to resources and ongoing postpartum care and support. We will partner with any other home visiting programs such as Family Connects, Babies First, Healthy Families, and the Community Doula Program for additional home visit support. This proposed program will provide the additional service of newborn health care and IBCLC lactation support in the home in the early postpartum transition.

Corvallis Birth & Wellness Center will provide space and a facilitator for a weekly community parent support group. This group will be a setting for postpartum people with their newborns, with an opportunity to connect with each other and feel part of a “community”, connect with

other community resources, and learn about postpartum care, newborn care, parenting support and preventative health care following the postpartum period.

The facilitator would be tasked with attending weekly group sessions, being a connection with community programs, understanding resources available, and offering additional support and connection to clients who express a need for additional support in the group classes. It is anticipated that individual parents in this group will step into a leadership role during group sessions as well.

Representatives or guest speakers of various organizations such as Old Mill Center, WIC, LaLeche League, the Village (moms group), Family Connections, and WellMama Linn/Benton will be encouraged to participate. Additional mental health workers, pediatric providers, physical therapy, OMT resources, yoga and exercise focusing on postpartum, and others providing care to postpartum persons and babies/children will be encouraged to present or attend to provide information about services. The group facilitator will coordinate a monthly or bimonthly plan for guest speakers.

Dental Care Coordinated Service

Primary Organization	Crossroads Communities
Primary Contact	Michael Couch
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Partnering Organization(s)	Community Health Centers of Benton and Linn Counties
Project Name	Dental Care Coordinated Service

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Crossroads Communities (CRC) is a coordinator of services focused on connecting low-to-moderate (LMI) populations of Linn County to care organizations that help address their needs. CRC's focus has always been service coordination and collaborative care, but adding on the capacity to help cover the costs of service will improve service connections and empower clients with the ability to utilize identified partners who cannot offer service for free. The focus of this grant request is to increase staffing to address collaborative partnerships with service providers and to establish a benefit account to pay for LMI client dental care costs obtained through community partner referrals.

The Community Health Centers of Benton and Linn Counties specialize in dental care for low-to-moderate income households providing a sliding scale cost of service, thereby making care easier to afford. They receive HHS funding and have Federal Public Health Services (PHS) deemed status with respect to certain health or health-related claims, including medical malpractice claims, for itself and its covered individuals. Their expertise in the field and established status within the region makes them an obvious choice for a partner.

CRC and the Community Health Centers of Benton and Linn Counties are partnering to address the health needs of vulnerable populations of East Linn County by combining the case management, service coordination, and administrative capacity of Crossroads Communities with the dental services available through the Community Health Centers and their sliding scale billing system. A portion of the funding will be used for staffing while the remainder will be dedicated to establishing fee payments for dental services, and a small portion for administrative expenses.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

A study on dental care in the State of Oregon done by MGT Consulting found that 70% of tooth loss in the state is a result of decay or disease; the vast majority of this can be prevented with proper care and maintenance. Many rural LMI households do not frequent dental offices due to

a lack of insurance, funds, and/or knowledge of the importance of maintaining oral health.

By empowering social service case managers to assist with funding checks up and preventative care in the dental field, a reduction in tooth loss, dental pain, and vectors for more serious conditions (abscesses, sepsis, et al) will result in a marked improvement in health and wellbeing for the serviced market. Further, by proactively addressing both dental needs and educating on the importance of dental health, the likelihood that more severe medical intervention such as an ER trip or lifesaving intervention due to heart infections or sepsis (surprisingly common side effects of oral afflictions) will decrease.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Low income households in rural areas face three great challenges when it comes to dental service: Service Connection, Cost of Service, and Transportation/Coordination. This pilot program will address all of these barriers.

1) Many households do not take their dental health into consideration until it becomes a problem; this is often due to the fact that they do not have the time/energy/inclination to identify a provider and because they have not been properly educated as to the importance of dental health. CRC's program will combine dental health education with access to dental care, not only showing the target population why oral health is important, but also facilitating a connection to a service provider.

2) LMI households often lack insurance and/or funds to address dental needs. This program will allow CRC to engage Community Health Centers to provide service at a reduced price (sliding scale based on income) compared to traditional provider pricing.

3) LMI households in rural areas have difficulty with transportation and coordination of scheduling. CRC serves these households and coordinates care through case management. In addition to helping with coordination of care, CRC also has the ability to assist with transporting clients to appointments. The partnership between CRC and Community Health Centers allows for clear communication and scheduling as well as facilitating the movement of clients from home to office and office to home.

4. **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? (250-500 words)**

In addition to partnering with the Community Health Centers of Benton and Linn Counties, CRC also partners with a large number of service organizations in East Linn County. As a founding member of the LASAR (Lebanon Area Service, Advocacy, and Resource) Partnership, CRC is able to connect with a dozen social support teams in Lebanon, Sweet Home, and Albany. This

network creates a large broadcasting range to reach low-to-moderate income households in need of services. Examples include:

The Lebanon Soup Kitchen has provided meals three times a week since the early 1980s and has never missed a dinner session. They see most of the community's homeless, many of whom are in desperate need of dental care but do not have the ways or means to get help.

St Martin's Episcopal Church is another provider of meals to the homeless, serving breakfast three times a week. Like the Soup Kitchen, they encounter many individuals in need of dental care who do not have the capacity to obtain it without assistance.

The Lebanon School District Welcome Center addresses the needs of students who are in crisis, are from low-income families, and/or who meet the McKinney-Vento definition of homeless. They have been an amazing referral partner in the past and will certainly provide many referrals for services for youths and their families through this program when funded.

The Community Outreach Assistance Team (COAT) from Creating Housing Coalition (CHC) is an amazing street outreach partner for CRC and will be able to provide numerous referrals for the proposed program from among vulnerable populations in Albany. Further, CHC's Hub City Village, when open, will house individuals in need of services, which will create another avenue for referrals to assist with dental needs. Since COAT and CRC practice dual-employment of outreach staff, both organizations will be able to work in tandem to deliver on program referrals.

Food for Many

Primary Organization	Family Tree Relief Nursery
Primary Contact	Renee Smith
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Partnering Organization(s)	Potentially, Greater Albany Public Schools, CHANCE, Faith communities, Albany Boys and Girls Club and others
Project Name	Food for Many

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

This project will lay the ground work for a community based and collaborative Food Pantry , Meal Kitchen and Nutrition services supporting the south side of Albany. Family Tree proposes a capacity building project which focuses on; determining community and IHN member's food needs, identifying gap in needs, cultivation and creating of community wide, multi-partner steering and creation committee that will implement a multi-organizational collaborative culturally diverse food, meal and nutrition site for IHN-CCO members living south of Pacific Highway in Albany. Food insecurity has been identified as a focus are of needs that strong impacts an IHN-CCO members stability and health. The outcome for this grant is to Create an easily accessible, culturally diverse and collaborative delivery model that can be developed and implemented in the following year. Once the model is developed, it could serve as a replicable model in other communities through out the IHN-CCO regional service area. The model foundation will focus on UNITUS to offer referrals and data collection for impact and for it's ease of use. Developing the possible claims component will be explored to determine if it will support the sustainability of the food bank, meal site and nutrition services.

Recognizing that each unique cultural community within the Albany area has their own beliefs, preferences, values and traditions around food, voices from these communities will be critical in designing all aspects of the food resources and services. Connecting with those voices through multiple communication strategies will be critical in designing a model for success and equitable access.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

IHN-CCO member's health and well being will be improved by easier access to foods right in their neighborhoods. Designers of the project will listen to the member's needs and design the service/opportunities to fill the gaps they experience. The project will focus on nutrition as well as preferences for communities. Additional services and supports around nutrition could be offered, insuring that IHN-CCO members learned more about health foods and eating habits that can improve their health and their family's health.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

This project will bring food resources to the neighborhoods where many IHN-CCO members live reducing the transportation barriers many members experience. The pantry and meal services will focus on having a wide variety of culturally, ethnically and health foods and meal options ensuring that IHN members that access the pantry have enough food to eliminate food scarcity as a concern or stressor for each family.

4. **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? (250-500 words)**

We plan on collaborating with many organizations that support IHN-CCO members that live in the southern area of Albany. We recognize that FISH and Linn Benton Food share and the Salvation Army offer food resources across the community with their primary locations on the North side of Pacific Highway, which can be challenging for IHN members living in South Albany to access. We want to collaborate with multiple agencies that on their own, would not have the capacity to create, deliver and manage these food services but that together they could leverage each organizations' skills and resources to bring this idea to action. In this planning year, we will do an environmental screen and review to identify what is already happening, what is working, what are the gaps and how those gaps can be filled with an equitable approach. Once the model is designed and tested, we believe it could be replicated across the IHN region and perhaps across the State of Oregon.

Gardens as Therapeutic Spaces

Primary Organization	Corvallis Environmental Center
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Partnering Organization(s)	Old Mill Center for Children and Families
Project Name	Gardens as Therapeutic Spaces

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

The Corvallis Environmental Center (CEC) is a community-based, educational non-profit that has prioritized partnerships to implement programs to address community needs since 1994. CEC's mission is to create a healthy, sustainable community. We do this through pre-K through 8th environmental education, Farm to School programs, and food security. We are based in Corvallis and work in Benton and Linn counties. CEC's programs include after school programs, summer camps, a nature-based preschool in Avery Park, classroom education in partnership with school districts in Benton and Linn Counties, family events, and a 1-acre production and education garden in Starker Arts Park known as SAGE. The food grown at SAGE is donated to those in need through our social service partner agencies. Farm to School programs increase access to fresh produce among children while addressing food insecurity, community health issues, and learning outcomes. Activities support children's development of healthy eating habits such as preferences for and consumption of fruits and vegetables.

The project we are proposing focuses on using gardens and similar outdoor spaces to improve behavioral and mental health outcomes for children and families in Benton and Linn counties. We will begin with a needs assessment with potential partners and key stakeholders to refine the list of potential activities and select those that can be most impactful during the pilot phase supported by this grant. Staff training and workforce development will also occur in the early stages of the project in addition to development of an intern position focused on therapeutic horticulture. Partnership development will build or deepen connections with mental health professionals.

The target population is low income families with young children and their communities. Potential activities could include a Family Garden Group that meets once or twice a week, a class designed for Old Mill participants, an after school program, as well as augmented Classroom Food Adventure lessons as part of our overall Farm to School work with Title 1 schools. Activities within each program could include gardening, mindfulness practices, cooking classes, sharing cultural food experiences, scavenger hunts, games, and science lessons.

CEC's garden in Starker Arts Park is a unique educational resource for this region. The garden offers a wide variety of educational opportunities to teach people about food, science, and

sustainable agriculture. It hosts field trips, day camps, internships, and outreach programs. This project includes redesign of the Children's Garden at SAGE with intentionality: This will include creating a hard packed gravel path for increased wheelchair mobility, changing garden beds to accessible raised beds, adding a sensory garden to support children with disabilities, and a natural playspace that promotes exploration.

This project brings together the healing quality of outdoor garden spaces with behavioral and mental health programs and professionals to support healthy family goals. It utilizes Corvallis Environmental Center's expertise in Farm to School and food security work with new and expanded partnerships. The staff training and partnership work will support positive outcomes for thousands of children in this region for years to come.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

This project will improve the health and wellbeing of participants by encouraging physical activity and time spent in nature which builds connections to the natural world, family or social connections, and increases overall wellbeing.

The children's garden at SAGE will be redesigned to promote play for children. Outdoor play encourages problem-solving skills, creativity, and critical thinking abilities. Spending time in nature allows children to develop connections with the natural world and evokes feelings of wonder, awe, and tranquility. It promotes positive social connections and a sense of community. The intentional redesign of the garden will make the garden more accessible to individuals with disabilities. This improvement ensures that all participants can engage fully in the programs offered here. This space is available for the community at large to use.

As an example of one potential new program: The Family Garden Group will promote mental health through gardening, which has been shown to reduce stress, anxiety, and depression while promoting relaxation and mindfulness. The group's emphasis on child-caregiver relationships strengthens bonds within families. Through the activities offered, children and caregivers can engage in meaningful interactions that promote trust, understanding, and connection. The families will gain knowledge about growing their own food and healthy nutrition. These skills empower families to make informed choices about their food, promoting better dietary habits and overall physical health. The connections made within this group will build social connections and support networks for families.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

This project respects the varied cultural and socio-economic backgrounds of IHN-CCO members. It helps create a welcoming and inclusive environment. Activities and content are designed to

be culturally responsive, taking into consideration the unique needs, values, and traditions of different families. This recognizes and addresses the specific cultural factors that influence health and well being.

By offering free or reduced price programs, we lower financial barriers to access. This provides opportunities for all families, regardless of their background, to engage in gardening and spending more time in urban and rural greenspaces. By providing a program meeting at Title 1 schools, it will improve access by reducing transportation needs supporting a wider range of work schedules.

The project's focus on community building and engagement is crucial in reducing health disparities. For example, by meeting regularly, participants in Family Garden Groups will have the opportunity to connect with others who share similar experiences and challenges. This fosters social support networks, reduces isolation and provides a platform for exchanging knowledge and resources.

The redesign of the children's garden promotes inclusivity and addresses physical accessibility. A hard-packed gravel path increases wheelchair accessibility, ensuring that individuals with mobility challenges can fully participate in the program. Additionally, the inclusion of a sensory garden provides children with a supportive environment to explore and benefit from the garden experience. All of this ensures that individuals with a variety of abilities have opportunities to participate and enjoy the health benefits of the garden.

4. **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? (250-500 words)**

CEC is the primary source of Farm to School programming in this region. Therapeutic horticulture activities have been carried out by several other organizations in the state. They will be a great source of lessons learned as we further develop this idea and gain needed skills. In this work we interact with many partners and local businesses and impact hundreds of students each year. Potential core partners for this project are OSU's Therapeutic Horticulture program, Old Mill Center for Children and Families (Corvallis, Monroe, and Albany locations), school districts and health departments in Benton and Linn counties.

The Therapeutic Horticulture program at OSU is a valuable resource that aligns with the goals of this project. It focuses on the therapeutic benefits of engaging with plants and nature. Collaborating with this program can provide additional expertise and resources to enhance the therapeutic aspects of the children's garden redesign and as a key source of interns with specific training that can be utilized throughout the region.

The Old Mill Center for Children and Families, which has a location next to SAGE, supports families and children through a range of services. Their offerings include a preschool that is inclusive to children with special needs and an intensive psychiatric day treatment program for

young children with emotional and behavioral challenges. The Center is very interested in partnering on this project. There are several potential program ideas that could benefit the families they serve by blending the expertise of both organizations. This collaboration can enhance the program's ability to address the specific needs of children with special needs and behavioral challenges, as well as support the development of activities aimed to strengthen bonds within families.

CEC's existing relationships with school districts in Benton and Linn counties can be leveraged to expand and/or deepen existing programs both in class and after school. Schools with existing on-site or nearby community gardens would be prioritized for the early stages of the project in addition to the content offered to schools coming to SAGE garden for field trips in the fall and spring. Collaborating with parent groups and garden clubs presents an opportunity for community engagement and strengthening the school-community relationship. By involving these groups, the project can tap into existing resources and expertise related to gardening and community building.

And finally, the needs assessment portion of this pilot would include conversations with health navigators, pediatricians, LInn Benton Health Equity Alliance members, teachers and families with different cultural backgrounds, and others who can inform our understanding of community needs, health outcomes, and program priorities specific to using gardens and related educational content to support desired mental health outcomes..

By collaborating with these organizations and individuals, the project can leverage existing resources, expertise, and community connections to enhance the impact of the program. These collaborations contribute to a more comprehensive and integrated approach to promoting health and well being for the participating children and families, ensuring that the project aligns with and complements existing efforts in the region.

Healthy Eating Children's Cookbook

Primary Organization	Furniture Share
Primary Contact	Michelle Robinson
Primary Contact Email	michelle@furnitureshare.org
Partnering Organization(s)	Referring Agencies/Community Partners
Project Name	Healthy Eating Children's Cookbook

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Furniture Share's Healthy Eating Children's Cookbook Pilot Project is a new initiative that directly addresses social determinants of health and equity. By providing IHN-CCO families and their children in need with our Healthy Families-Thriving Communities Food Boxes comprised of 3 healthy meals for a family of 4 and have 12 servings of fresh meat, vegetables, and fruit along with educational and fun cookbooks that focus on simple ingredients and nutritious meals, we will make a significant impact on the overall well-being of these children and their families. Access to healthy food and the knowledge of how to prepare nutritious meals with minimal ingredients are crucial factors that can significantly influence a person's health. Unfortunately, many children facing economic challenges often lack access to proper nutrition and may rely on processed or unhealthy foods. This creates a cycle of poor health outcomes and further exacerbates existing health disparities.

Furniture Share's Healthy Eating Children's Cookbook Pilot Project disrupts this cycle by empowering children with the knowledge and skills needed to make healthier food choices. By distributing these cookbooks at schools, libraries, community partners, and alongside our Healthy Families-Thriving Communities food boxes, we ensure that IHN-CCO families and their children have access to resources that promote healthy eating habits. This initiative goes beyond simply providing food; it equips children and their families with the tools to make long-lasting positive changes in their diet and lifestyle.
The project's transformative nature lies in its innovative approach to addressing health and equity. By combining the distribution of food boxes with children's cookbooks, Furniture Share will help break the cycle of food insecurity and poor health. The Children's Cookbook focuses on simple ingredients, making it easier for families to create affordable, healthy meals. This not only addresses immediate nutritional needs but also builds resilience and self-sufficiency within our communities.

By providing children with simple cookbooks that teach them how to cook simple healthy meals, Furniture Share hopes to not only improve their physical health but also their mental well-being. Cooking can be a fun and rewarding activity that can help children develop a sense

of independence and confidence. It can also be a way for families to spend quality time together and bond over a shared activity.

By targeting schools, libraries, and community partners as distribution points, Furniture Share ensures that even children who may not directly benefit from our food box program have access to these valuable resources. This inclusive approach helps bridge the gap in health equity by reaching out to children from diverse backgrounds and providing them with the necessary tools for a healthier future.

Furniture Share's Healthy Eating Children's Cookbook Pilot Project is a transformative and innovative initiative that tackles social determinants of health and promotes equity. By empowering children with the knowledge of healthy cooking and providing them with the means to access nutritious meals, we can make a lasting impact on the well-being of children and their families.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

By providing IHN-CCO members with our Healthy Families-Thriving Communities Food Boxes and children's cookbooks that focus on simple ingredients and nutritious recipes, Furniture Share is empowering children and families to make healthier food choices and positively impact their overall health.

We understand that IHN-CCO members often face various health and economic challenges, including limited access to nutritious food options. This can contribute to higher rates of chronic conditions and overall poor health. By introducing the Children's Cookbook Pilot Project, Furniture Share is addressing a crucial social determinant of health for these individuals and families.

The cookbooks will provide IHN-CCO members with practical guidance on how to prepare affordable and nutritious meals using readily available ingredients. This initiative not only helps improve their dietary choices but also promotes skills development and self-sufficiency in the kitchen. By learning how to cook healthy meals, IHN-CCO members can reduce their reliance on processed and unhealthy foods, leading to improvements in their children’s overall well-being and self-confidence.

Furniture Share's Healthy Eating Children's Cookbook Pilot Project has the potential to significantly improve the health and well-being of IHN-CCO members. By promoting access to nutritious meals, developing cooking skills, and fostering supportive and quality time, this

initiative empowers individuals and families to make sustainable changes that positively impact their overall health.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

This project plays a crucial role in promoting equity and reducing health disparities among IHN-CCO members. This initiative recognizes the systemic barriers that often hinder access to healthy food options and aims to bridge the gap by providing practical resources to promote nutritious cooking and eating habits.

One of the main factors contributing to health disparities is the unequal distribution of resources and opportunities. The Healthy Eating Children's Cookbook Pilot addresses this disparity by offering our Healthy Families-Thriving Communities Food Boxes and children's cookbook with simple recipes that utilize affordable and easily accessible ingredients. By making nutritious cooking more attainable, Furniture Share will help level the playing field and provides an opportunity for IHN-CCO members to improve their health and well-being.

This project actively reduces health disparities by promoting knowledge and skills development. The cookbooks not only provide recipes but also offer practical tips and guidance on meal planning, budgeting, and making healthier choices. By equipping them with the skills to make informed decisions and prepare nutritious meals, Furniture Share will help foster a sense of self-sufficiency that contributes to reducing health disparities.

By offering accessible recipes, and fostering knowledge and skills development, this project helps break down barriers and empowers individuals to make healthier choices. Through these efforts, Furniture Share is actively working towards reducing health disparities and ensuring that all IHN-CCO members have an equal opportunity to improve their health and well-being.

4. **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? (250-500 words)**

Furniture Share's Healthy Eating Children's Cookbook Pilot Project aligns with many related activities happening in our region and has the potential for collaboration with various community organizations that share a similar vision of promoting healthy eating habits and addressing food insecurity in the Willamette Valley.

Furniture Share will collaborate with local public schools, community health centers, community partners, and public libraries. Having partners that prioritize health promotion and inspiring healthy habits makes them natural partners for our Healthy Eating Children's Cookbook aimed at improving nutrition and overall well-being. By working together, we can pool our expertise and networks to reach a broader audience and create a more impactful approach to addressing health disparities.

Furniture Share will be collaborating with all of our referring agencies and community partners for the success of this project, mainly those who focus on providing food assistance to individuals and families in need and overcoming poverty. By joining forces, all organizations can enhance their impact by combining the distribution of nutritious food with the provision of children's cookbooks. This collaboration would offer a comprehensive approach to addressing food insecurity, ensuring that individuals not only have access to food but also the knowledge and resources to prepare inexpensive and healthy meals.

With this pilot project in full motion, Furniture Share will extend our reach to other community-based organizations focused on child and family welfare. After-school programs, youth centers, or organizations providing support to low-income families, would be valuable collaborators to join our initiative to put Children’s Cookbooks in as many hands as possible. These organizations have established relationships with our target population and can play a vital role in distributing the Children's Cookbooks and implementing related educational activities.

Furniture Share's Healthy Eating Children's Cookbook Pilot Project has the potential to connect with many related activities happening in the region and collaborate with various community organizations. By partnering with organizations such as our community partners, public schools, libraries, and community-based organizations, Furniture Share can maximize our impact, reach a wider audience, and create a comprehensive approach to promoting healthy eating habits, addressing food insecurity, and improving the overall well-being of children and families in the community.

Improving Access to Quality Education

Primary Organization	Peaceful Gardens Montessori
Primary Contact	Claire Douglas
Primary Contact Email	clairethedouglas@gmail.com
Partnering Organization(s)	TBD
Project Name	Improving Access to Quality Education

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

PGM's mission is to provide quality education and childcare for families of all income levels and cultural backgrounds. Students from low income families can access the same private school education as children from more privileged backgrounds.

We are bilingual (Spanish and English)- Several of our staff are fluent in Spanish and English. Fluency in Spanish and English will be a major consideration as we find new staff to join our growing school.

We accept children ages 6 months - 6 years and we are working on expanding to include students up to third grade. Other Montessori schools in the area often only take students from age 3-5.

We serve families who come from a variety of economic backgrounds. We are open to committing to enrolling a specific number of families using IHN-CCO.

A person's experiences in their first several years of their life have a lasting impact on their health and wellbeing for the rest of their life. Quality childcare and early childhood education are essential for healthy growth and development. Unfortunately access to this kind of care and education is a privilege largely reserved for families who can pay for private school.

Poverty takes a major toll on a person's health, not only in access to medical care or nutritious food but also stress and access to quality child care. It has been shown that access to high quality child care and an environment that fosters a secure attachment style for the child, can counteract the damage to a person's health that is caused by the intermeshed forces of poverty, racism, segregation and inequity.

The constant mental and emotional stress parents experience makes it more difficult for them to treat their children with patience and attention.
Parents of our students have told us that the way we intentionally communicate with the children has had a major impact on their communication at home.

Our teaching philosophy is based around caring for the whole child. The institution we hope to build nurtures the whole community.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

PGM can provide the enriched learning environment, supported by thoughtful, compassionate staff that are essential for young minds to develop the foundation the will grow from for the rest of their lives.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Providing bilingual education to families from a variety of economic backgrounds allows IHN-CCO members to access the kind of quality care that is essential for building healthy, happy humans.

4. **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? (250-500 words)**

We plan to reach out to organizations that serve marginalized communities such as:

Jackson St.

DHS

Linn County Child Outpatient

Head Start

Casa Latinos Unidos

Dual immersion program

Positive Outcomes: LGBTQ+ Youth

Primary Organization	Jackson Street Youth Services
Primary Contact	Lauren Winchester
Primary Contact Email	Grants@jacksonstreet.org
Partnering Organization(s)	Linn-Benton Community College, Parenting Strengths Network, PSU
Project Name	Positive Outcomes: LGBTQ+ Youth

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

Jackson Street Youth Services offers a continuum of services that prevent and intervene in youth homelessness. Through this project, by increasing Outreach staffing and designing innovative curriculum for youth and guardians, Jackson Street will more effectively reach youth, especially youth who identify as LGBTQ+, and offer specific, engaging services to prevent homelessness, repair or build relationships with caregivers, and encourage social and emotional well-being.

Youth who identify as LGBTQ+ are at a significantly higher risk of being homeless than their cis, heterosexual peers, and much of that is due to family and social rejection. Jackson Street will utilize paid youth listening sessions to design curriculum for two purposes: 1) to equip parents/guardians to have healthy relationships with their LGBTQ+ youth; 2) to create new Queer Peers curriculum for youth to have a safe place to talk about gender and sexuality, understand themselves, and support each other. Outreach staff will connect with youth in schools, expand Queer Peers to Benton County and maintain Linn County's Queer Peers chapter, and assist with transportation.

Self-acceptance and peer acceptance—including of one's gender and sexuality—are crucial to social and emotional well-being. Families who are equipped to safely parent youth who are LGBTQ+ will be less likely to fracture or fight based on those issues. Safe spaces for youth to talk through problems and build relationships with each other are an incredible protective factor. Together, those factors will help prevent conflicts that force youth out of their homes and will keep youth safely housed. Referrals through the school system will help us locate youth and families that will particularly benefit from this programming.

We will reduce barriers to accessing these services wherever possible, including using our activities van to pick up and drop off rurally-located youth so they can attend Queer Peers (because rural areas often do not have adequate public transportation options to Corvallis and Albany in the evenings). When necessary, we may use taxi services and rideshare as well. Additionally, guardians attending the parenting class will receive hot meals and childcare vouchers each week for free as part of attending the class, which is also free.

This project will be transformational as it coaches parents through safe, caring strategies to interact with LGBTQ+ youth. Youth who are parented in an accepting way and have tools to accept and celebrate themselves will grow into emotionally-stable adults. Parents and guardians who are equipped with these tools have the ability to be a safe presence for all youth—including those that are not part of their immediate families—and thus be protective factors in their wider communities. Youth homelessness is a pathway to chronic adult homelessness, so early prevention measures like this have long-term positive effects on the whole community by keeping people stably housed from an early age.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

Youth and families will experience greater health and well-being through acceptance and celebration of youths' (and possibly caregivers') LGBTQ+ identities. Safe parenting and conflict-resolution skills will help keep youth housed. Youth with access to safe, stable housing have higher likelihoods of completing school, finding employment, and experiencing a lifetime of well-being.

Additionally, for youth who are homeless, Jackson Street will offer safe shelter and access to Queer Peers and parenting classes for their guardians (if applicable). The continuum of services that Jackson Street offers for youth experiencing homelessness shows them a path to long-term success through building positive relationships and teaching skills for self-sufficiency.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

LGBTQ+ youth are at more than double the risk of homelessness compared to non-LGBTQ peers, and LGBTQ youth had over twice the rate of early death among youth experiencing homelessness (Voices of Youth Count, Chapin Hall). This project promotes equity by specifically focusing on youth who identify as LGBTQ+ and are at-risk of homelessness or are homeless. At all possible opportunities, Jackson Street works to reduce barriers to accessing these services. Our Education Outreach Coordinator will connect with youth in schools—meeting them where they are—to refer youth to Queer Peers and other Jackson Street services. All Jackson Street programming is free for youth and families, including the parenting classes. Youth and families receive hot meals at Queer Peers and parenting courses (respectively), and families attending courses will receive weekly childcare vouchers so they can pay for childcare while they attend the course.

Youth may not have transportation options to get to Queer Peers in Corvallis or Albany (or listening sessions guiding the curriculum design), so Jackson Street will provide transportation when needed—either through our activities van or using rideshares and taxi services. Rural youth often have the most difficult time accessing resources like this, so our transportation services will especially focus on ensuring rural youth have access to these preventative and protective services.

4. **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? (250-500 words)**

Jackson Street has been asked to expand Queer Peers, which currently meets in Albany, to Corvallis as well after another queer support group for youth stopped operating in Benton County. We will draw on our existing partnerships and structure from Albany's Queer Peers. Jackson Street is the fiscal sponsor for Albany's Pride events in 2023 and participates in Pride events across both counties, including Philomath (Benton County). We will leverage these partnerships as possible to create a robust curriculum and resources for LGBTQ+ youth in both counties.

We have worked with Portland State University to design staff training and certification in the past, and we will work with them to conduct youth listening sessions again and design the Queer Peers curriculum. Youth report boredom with the current curriculum—now several years old—and nothing that meets the needs of our youth exists in the current resources in Oregon or nationally. PSU is a strong partner with a skillset that will create a refined, youth-driven, engaging curriculum.

For parenting classes, we will work with Parenting Strengths Network and Linn-Benton Community College. We have worked with both partners to create and host other parenting classes and look forward to continuing that work together.

Sleep Trailer Safe Shelter

Primary Organization	Sleep Trailer LLC
Primary Contact	Jason Christensen
Primary Contact Email	Jason@sleeptrailer.com
Partnering Organization(s)	Crossroads Communities
Project Name	Sleep Trailer Safe Shelter

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

The first year we will be working with Crossroads Communities and their partners including myself to build a coalition of project partners and organizations to finalize locations to run the pilot projects for the following year. The second year we would implement and complete a pilot project in 4 different locations (each lasting 3-4months) giving us data and examples from different populations and hopefully paving the way for permanent or more long term safe shelter projects and helping people connect to the next resources they need for their health and safety. The project would consist of at least 1 trailer that would be leased giving 8-16 people a safe place to sleep each night. This space is lockable, and enclosed giving people privacy, space to secure belongings and there is an emergency exit in each space as well as a CO2/Smoke detector. In the first year of coalition creation there is opportunity for us to fundraise or find sponsors that may help us build more so that we could potentially offer 24-32 beds and places for people to sleep. Crossroads Communities has agreed to partner with us providing oversight management and staffing & security/surveillance.

One of the key components of health is having stability and a safe place to sleep that is clean. Sleep Trailers Pilot Project can provide this with also giving opportunities to focus on their health needs physically/mentally. This can also be used as an emergent option while other options are created or resources located giving a central location for other partner providers to reach and find people and connect them to resources they may have to offer. Nobody is doing anything like this making it extremely innovative. After we prove it can be successful, this could lead the way for organizations across the state and country to try similar projects giving thousands of people a safe option to sleep at night and get connected to next resources for their health and well-being. This could Transform services giving people who often feel left out or forgotten a clear path from living on the streets or in cars to safe shelter and then more affordable housing while at the same time increasing health and wellbeing.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

We prioritize providing a safe and secure environment which promotes physical well-being of the people staying there. Our spaces will have access to basic hygiene facilities on site and

through community partners. Having stability in housing has shown to be a big boost to health and well-being it can help reduce stress & anxiety that is caused when people are caught in a more “survival mode” type of thinking where the only concern is about the next 12 hrs. A stable and safe environment allows people to start thinking more long term about needs and health and provides hope for a better future.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

We recognize that individuals experiencing homelessness often come from marginalized backgrounds and face additional barriers to accessing healthcare. As a Siletz Tribal member I am hopeful in including my tribe as a project partner with this project. We will prioritize fairness in our services and ensure that our shelter is accessible to all individuals regardless of gender, age, ethnicity or any other characteristic. This project will allow for many people to have a low barrier entry option, a place to stabilize and connect with health and other resources.

4. **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? (250-500 words)**

We have experience in coalition building with Crossroads Communities putting together a coalition that included CRC, First Christian Church, City of Lebanon, St Martin’s Church and the LASAR Partnership when we ran our first pilot project. We have connections and good relationships already with cities and leaders in Albany, Lebanon and hope to take that first year to strengthen our relationship with Lincoln City, and the Siletz Tribe of which I am an enrolled member. From there we hope to reach out to many other cities that may be interested and organizations that would like to get involved making it a community effort. We have already had several organizations throughout the county and state that have shown a lot of interest in this project and expressed a great deal of interest in reviewing the data from a longer pilot project. We have also received a lot of interest through social media with people wanting to see this project realized. We plan to collaborate and work with any other interested organizations in be a solution to a problem that has become a huge issue in the last several years.

Winter Houselessness Shelter

Primary Organization	Lincoln County Health & Human Services
Primary Contact	Jayne Romero
Primary Contact Email	jromero@co.lincoln.or.us
Partnering Organization(s)	Housing Authority of Lincoln County
Project Name	Winter Houselessness Shelter

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

There is a critical need to develop emergency overnight shelter for people experiencing homelessness in Lincoln County. While the County, cities, and local tribe are working on a strategy for long-term solutions, a plan is needed to provide a reliable emergency option during the winter months. The County Health and Human Services Department (LC HHS) is developing a plan to operate an overnight shelter. The low-barrier shelter will operate from 10/1/23 to 3/1/24 in one or two locations in the county, comprising accommodations for 50-75 people. The program will serve adults in the shelter and offer hotel vouchers for families with children. The shelter will not discriminate based on race, gender identity, sexual orientation and/or religion.

The facility will provide bathrooms, showers, community space, kitchen facilities, and storage space. Ideally, and in time, the facility will be available for use as a year-round day shelter as well. The shelter will be managed by a Program Coordinator (PC) who will manage staff and volunteers. During the summer months, the PC work on building shelter capacity and connections – developing partnerships and resources to maintain and increase shelter operations, with a goal of ultimately providing year-round overnight/daytime shelter support. The shelter will be staffed by paid staff and volunteers who will manage shelter tasks and make referrals for needed services/supports.

There is currently no consistent winter emergency/walk-in shelter in the County (previous temperature-triggered warming shelters have operated inconsistently, with one of the two providers announcing they are shutting down completely in June 2023. Reports of the number of unhoused individuals in the official PTC is considered highly unreliable. The 2022 count suggested 133 total people were experiencing homelessness with 60% unsheltered. The 2021-22 Lincoln Co SD records count 630 students (K-12) experiencing housing instability with 24% completely unsheltered. A review by county staff determined that countywide there were a minimum of 50 to 60 people per evening at temperature-triggered warming shelters in 2022/23.

Providing emergency shelter to our unhoused individuals ties to the SDH of Housing and Health Care. Not only does shelter address peoples' immediate need for safe, reliable shelter (and essential needs like access to phones and a mailing address), but it also provides a "door" to

connect to the OHP, primary care and behavioral health, and other services and supports that will improve their housing stability and overall health. The LC HHS operates many of the other key services needed by folks experiencing homelessness such as the Lincoln Community Health Center (the FQHC for the County) and behavioral health.

Creating a shelter is a key (and missing) link in our housing continuum and will transform our systems by building our capacity to offer shelter and connect those at the shelter to supportive services. Developing this shelter will include establishing new connections and referral pathways among nonprofits, government, health care, and other providers in our community and encourage increased coordination among the many entities that serve our homeless population.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

People experiencing homelessness are at an increased risk of mental health conditions, infectious diseases, violence, and substance use, among other things. Providing shelter creates an intervention point where we can connect people experiencing homelessness to the resources and supports that already exist. We expect to improve physical and mental health and housing stability of IHN-CCO members by providing temporary respite and stability through shelter and then increasing access to services and support that will address their housing and health needs.

Providing emergency shelter addresses both immediate and long-term health outcomes for IHN-CCO members. In the short term, shelter provides a safe, warm space where people can rest and stabilize, tending to immediate survival needs like food and shelter. With these basic needs met, people are then better positioned to address more complex, long-term needs like health and stable housing.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

Homelessness disproportionately affects historically excluded and underserved communities. Based on the 2022 PIT count and current U.S. Census data, Hispanic, Black, and Native American populations are overrepresented in people experiencing homelessness in Lincoln County. It is also notable that 24.1% of people documented in the PIT self-reported as having a serious mental illness and/or disability and 10% reported having a substance use disorder. (Again, these numbers are likely low based on the limits of the PIT count and research that shows the correlation and co-occurrence of homelessness, mental illness, disability, and/or SUD are high.)

A low-barrier shelter will provide a starting point for vulnerable populations to access services. It is common for people experiencing homelessness to be hesitant to engage with institutions and other “official” systems; creating a safe, trusted shelter space can encourage connection with and service to people ready to seek support.

4. **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? (250-500 words)**

There are coordinated efforts currently in our region (Lincoln, Linn, and Benton Counties) to address homelessness at a whole new scale. For example, Lincoln County is one of eight pilot communities for created by Oregon HB 4123. As part of this legislation, Lincoln County received $1 million in state funding to create and run a coordinated office to strengthen our community's homeless response. This pilot is intended to leverage and coordinate existing work in the community and identify gaps in partnership with existing service providers.

In addition to this systemic work, there are several affordable housing projects in development in our community. The County and partners like Housing Authority of Lincoln County (HALC) are currently developing more than 75 units of affordable housing throughout the County, a rehabilitation shelter for people with mental health illness, a referral-only shelter, and additional units funded by OHCS's Project Turnkey. Creating low-barrier emergency shelter leverages this increase in our housing capacity as a first step in accessing housing and other stabilizing services.

Specifically for the emergency shelter, the County will partner with churches and non-profit organizations to recruit and train volunteers to provide additional support and oversee services available to participants at the shelter (e.g., showers, food/snack preparation and distribution, recreational activities). Support from community organizations will also be solicited to secure needed supplies (e.g., shampoo, laundry detergent, snacks, towels, paper products, food from the food banks, etc.). Partnerships with other government agencies will be developed such as with the County Jail (for food preparation support); County Probation and Parole (shelter cleaning and laundry by community service workers), Lincoln County Transit, local law enforcement (for referrals of unhoused individuals to the shelters, immediate response to disruptive/threat of violence situations, and ongoing safety sweeps of the perimeter), and the Health and Human Services Mental Health Crisis Response Team (for mental health crisis situations). Translation and interpretation support will be provided as needed.

We have also identified other potential funding sources for this project including ARPA funding, Oregon HB 5019, Oregon Community Foundation Community Grant, and the LC Homeless Advisory Board (funding anticipated in Fall 2023).

Young Adult Cohort Housing

Primary Organization	Community Outreach, Inc. (COI)
Primary Contact	Greg Moore
Primary Contact Email	gmoore@communityoutreachinc.org
Partnering Organization(s)	Oregon Youth Authority, Youth Development Oregon, Jackson Street Youth Services
Project Name	Young Adult Cohort Housing

1. **Describe your project and how it impacts social determinants of health & equity in a few paragraphs. Include how it is transformational and innovative. (250-500 words)**

In 2015, COI participated in a study used to determine the best practices for serving LGBTQIA2S+ folks experiencing housing instability in Oregon, the findings of which encouraged COI to create a dedicated space and programming to serving this population. Since opening the doors of our young adult (YA) dorm in September 2021, we have made tremendous progress and celebrated great success. Our vacancy rate is consistently low and our success rate with this demographic has increased dramatically. Prior to opening the YA dorm, the average stay for an 18-25 year old in our shelter was about three days; now we have young adults staying with us for months at a time, choosing to stay after they make their parole, and completing our programs. Making a space specifically designed to serve this demographic—including emphasis on access to educational opportunities and implementing gender-neutral language in our policies—is hugely important in improving client outcomes and cultivating peer-support networks.

Following the success of our YA dorm, COI is expanding our services for young adults aged 18-25. This project will be a natural extension of our current young adult-specific programming and will create another step on our YA clients' journey to long-term stability.

We aim to procure an offsite location to house a small cohort (6-8 individuals) of young adults. This additional location will increase our capacity to serve this demographic, help young adults transition from the structure and support of life in our dorms to stable independent living, and help our young adult clients maintain long-term stability. At this location, clients will have a space where they can continue to learn and practice skills (such as maintaining healthy habits) with a greater degree of independence without being overwhelmed or isolated.

Our experience with the YA dorm has shown us that support and camaraderie with peers is especially important in working with this demographic, and this peer-led cohort housing model will serve as a gentler intermediary step between life in our supportive dorm environment and life outside of our programs.

The appointed Peer Support will be an alum from our YA dorm and, in exchange for their

leadership, they will receive free housing and a part-time salary for coordinating with our case managers. Case managers will regularly check in with the cohort's peer leader and the residents as needed. Case managers will provide residents with ongoing advocacy and service navigation supports to facilitate continued access to COI's programs and allow them to keep progressing toward stability.

2. **How do you expect to improve the health & wellbeing of IHN-CCO members? (100-250 words)**

IHN-CCO member's health and well being will be improved by easier access to foods right in their neighborhoods. Designers of the project will listen to the member's needs and design the service/opportunities to fill the gaps they experience. The project will focus on nutrition as well as preferences for communities. Additional services and supports around nutrition could be offered, insuring that IHN-CCO members learned more about health foods and eating habits that can improve their health and their family's health. Helping our clients access services that are often out of their reach—such as affordable preventative healthcare, behavioral health counseling, and stable transitional housing—allows our clients to make progress toward stability and self-sufficiency in all areas of their lives.

This project is one of the ways in which COI aims to expand our aftercare services for clients who have exited our housing dorms. We aim to help our clients break the cycle of chronic homelessness, and providing an intermediary step on their journey outside of our dorms will allow them to continue accessing supportive services, participating in and benefitting from peer support.

Expanding the spectrum of services available to our young adult clients will help them remain stable as they transition to living independently and ultimately reduce the chance of relapse into drug abuse and/or homelessness.

3. **How will your project promote equity and reduce health disparities for IHN-CCO members? (100-250 words)**

The overall goal of the young adult program is to reduce disparities by providing wraparound services to stabilize youth, provide access to the resources and teach the skills necessary to obtain stable employment and housing, and to ensure that they are able to remain employed and housed. The YA program aims to reduce disparities by creating access to educational and employment opportunities, mental health and substance abuse counseling, medical and dental care, healthy food, positive outlets for emotional stress, and linking individuals to peer support networks.

Our YA program also aims to reduce disparities by working with underserved and/or historically excluded populations such as youth who have been adjudicated, youth aging out of the foster system, and LGBTQIA2S+ youth, all of whom are at greater risk for experiencing poverty and homelessness.

4. **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? (250-500 words)**

COI has been providing for the basic needs of the most vulnerable members of our community since 1971. Clients in our YA cohort housing will continue to have access to the entire suite of services COI provides, including programs and resources provided by our partners (such as our medical and dental clinics) as well as referral services to our diverse network of community partners. We have established relationships with local agencies to meet the scope of needs required to serve this population including the Community Services Consortium youth programs, Linn-Benton Community College (LBCC), Oregon Department of Human Services, Linn-Benton Food share, Benton County Mental Health, the Center Against Rape and Domestic Violence, and more.

COI's medical services rely on approximately 200 volunteer and intern providers and nurses from LBCC, Samaritan Health Services, Corvallis Clinic, and Oregon State University to streamline operating costs. Medical students and residents do rotations at our clinic and the LBCC dental assistant students get their clinical hours by participating at our dental clinics. These collaborations allow us to provide more in-depth care than we would otherwise be available to youth experiencing homelessness.

Our partnership with Oregon Youth Authority (OYA) has been a key component in the success of our YA program since its genesis. We have a contract with OYA to provide housing and supportive services to youth who have been adjudicated and our program has been producing some of the best outcomes in the state. As the time to renew our contract approaches, OYA has expressed interest in expanding their relationship with us and increasing the number of beds we have reserved in our YA dorm for their clients. In recent months, a few of our OYA clients have shared that they chose our program specifically because of the gender inclusive and secure environment we have created in our YA dorm. In some cases, OYA staff have taken to referring clients with any gender identity concerns to us for this specific reason. We are proud that this has become an important and well known feature of our YA dorm. Creating a gender safe space for young adults was part of the vision for this portion of our housing program and we are thrilled to that goal realized in these ways.

Youth Development Oregon (YDO) has also supported our YA program. As a Youth Solutions grantee, we have collaborated with YDO in developing and improving our YA program to meet our shared goals of improving outcomes for young adults experiencing poverty, homelessness, and other barriers to resources and success.

COI maintains a close relationship with Jackson Street Youth Services (JSYS). During the early stages of developing our YA program, we worked with JSYS to create a program that would complement the work they were already doing with young adults aged 18-21. Now, after implementing and growing our YA program and celebrating many successes, JSYS still frequently refer clients to us when their needs are outside the scope of what JSYS can provide.